



EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Building Your Program

Illness Management and Recovery



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Building Your Program

Building Your Program is intended to help mental health authorities, agency administrators, and Illness Management and Recovery (IMR) leaders think through and develop the structure of IMR programs. The first part of this booklet gives you background information about the evidence-based model. This section is followed by specific information about your role in implementing and sustaining your IMR program. Although you will work closely together to build IMR programs, for ease, we separated tips into two sections:

- *Tips for Mental Health Authorities; and*
- *Tips for Agency Administrators and Program Leaders.*

In preparing this information, we could think of no one better to advise you than people who have worked successfully with IMR programs. Therefore, we based the information in this booklet on the experience of veteran IMR leaders and administrators.

Illness Management and Recovery

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Illness Management and Recovery KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP



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What's in *Building Your Program*

What Is Illness Management and Recovery?	1
Tips for Mental Health Authorities	5
Tips for Agency Administrators and Illness Management and Recovery Leaders	13

Illness Management and Recovery

Building Your Program

What Is Illness Management and Recovery?

Serious mental illnesses such as schizophrenia, bipolar disorder, and major depression are widely accepted in the medical field as illnesses that have well-established symptoms and treatment. As with other disorders such as diabetes or hypertension, it is both honest and useful to give people practical information about their mental illnesses. Many people with mental illnesses report that this information is helpful because it lets them know that they are not alone and it empowers them to take control over their symptoms and their lives.

As one person with schizophrenia said:

If we do acknowledge and seriously study our illnesses, if we build on our assets, if we work to minimize our vulnerabilities by developing coping skills, if we confront our illnesses with courage and struggle with our symptoms persistently, we will successfully

manage our lives and bestow our talents on society (Leete, 1989).

Illness Management and Recovery (IMR) is an evidence-based psychiatric rehabilitation practice whose primary aim is to empower consumers to manage their illnesses, find their own goals for recovery, and make informed decisions about their treatment by teaching them the necessary knowledge and skills.

IMR is appropriate for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression. It is appropriate for consumers at various stages of the recovery process. William Anthony defined recovery as:

... the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

In the IMR program, practitioners meet weekly with consumers either individually or as a group for 3 to 10 months.

The content and teaching methods used in IMR are derived from multiple studies of professionally based illness management training programs.

Critical components of IMR are summarized in IMR Handouts (see *Practitioner Guides and Handouts* in this KIT) that practitioners review and distribute to consumers in IMR sessions.

IMR includes a variety of interventions designed to help consumers improve their ability to overcome the debilitating effects of their illnesses on social and role functioning. The core components of IMR are as follows:

- Psychoeducation;
- Behavior tailoring;
- Relapse prevention; and
- Coping skills training.

Illness Management and Recovery Handouts

- Recovery strategies
- Practical facts about mental illnesses
- The Stress-Vulnerability Model and treatment strategies
- Building social supports
- Using medication effectively
- Drug and alcohol use
- Reducing relapses
- Coping with stress
- Coping with problems and persistent symptoms
- Getting your needs met by the mental health system

Core Components of Illness Management and Recovery

- **Psychoeducation** provides the basic information about mental illnesses and treatment options.
- **Behavioral tailoring** helps consumers manage daily medication regimes by teaching them strategies that make taking medication part of their daily routine.
- **Relapse prevention** teaches consumers to identify triggers of past relapses and early warning signs of an impending relapse. It also helps them develop plans for preventing relapse.
- **Coping skills training** involves identifying consumers' current coping strategies for dealing with psychiatric symptoms and either increasing their use of these strategies or teaching new strategies.

To effectively teach these core components to consumers, IMR practitioners use a variety of techniques including motivational, educational, and cognitive-behavioral strategies. Throughout the IMR program, practitioners help consumers set and achieve their personal goals.

How we know that IMR is effective

The IMR model is based on research that shows that by learning more about managing mental illnesses, people who have experienced psychiatric symptoms can take important steps toward recovery. Specifically, evidence (Mueser et al., 2002) shows that consumers can do the following:

- Learn more about mental illnesses;
- Reduce relapses and rehospitalizations;
- Reduce distress from symptoms; and
- Use medications more consistently.

Most of the research focuses on people with schizophrenia spectrum disorders, with less research addressing major affective disorders. The studies include services provided in both urban and rural settings, as well as inpatient and outpatient mental health settings. No evidence suggests that race, diagnosis, gender, geographic setting, age, inpatient status, or outpatient status are related to a person's ability to benefit from the components of IMR (Mueser et al., 2002).

In summary, many mental health systems and agencies are confronted with the challenge of meeting the needs of consumers in an environment of limited resources. The IMR model, an evidence-based practice, has demonstrated consistent, positive outcomes for consumers.

Building Your Program

Tips for Mental Health Authorities

Successfully implementing evidence-based practices requires the leadership and involvement of mental health authorities. This section discusses why you should be involved in implementing Illness Management Recovery (IMR) and the types of activities that mental health authorities typically

Why should you be interested in Illness Management and Recovery?

The Illness Management Recovery KIT gives public mental health authorities a unique opportunity to improve clinical services for adults with serious mental illnesses. Research has demonstrated that IMR has a consistent, positive impact on the lives of consumers. The KIT gives you information and guidance for implementing this evidence-based practice in a comprehensive and easy-to-use format.

Can Illness Management and Recovery make a difference?

Whenever new programs come along, administrators have to ask whether it is worth it to reorganize: Is the new program really going to make a difference?

When it comes to IMR, extensive research shows that the answer is, “Yes.” Most impressive is the extent to which it has been subjected to rigorous research and the consistency of favorable findings.

Briefly stated, extensive research shows that consumers who received the components of IMR improved in the following areas:

- Knew more about mental illnesses;
- Reduced relapses and rehospitalizations;
- Reduced distress from symptoms; and
- Used medications more consistently.

In short, IMR services promote consumers' recovery process. For more information, see *The Evidence* in this KIT.

Aren't we already doing this?

Your mental health system may already provide an illness management program or wellness activities. While these services share some characteristics of IMR, important distinctions exist. First, IMR incorporates the main components of effective illness management programs and includes materials that are user friendly both for practitioners and consumers. Second, the content of the sessions focuses on the following 10 topic areas:

- Recovery strategies;
- Practical facts about mental illnesses;
- The Stress-Vulnerability Model and treatment strategies;
- Building social supports;
- Using medication effectively;
- Drug and alcohol use;
- Reducing relapses;
- Coping with stress;
- Coping with problems and symptoms; and
- Getting your needs met by the mental health system.

Will it work in your mental health system?

The IMR model has been adapted in diverse settings and a wide range of geographic locations. Studies of the core components of IMR were conducted in settings that included people from different races and ethnicities, including:

- Caucasians;
- African Americans;
- Latinos;
- Native Americans; and
- French Canadians.

IMR programs have been implemented throughout the United States as well as in Canada, England, and Germany. The studies included services provided in both urban and rural settings as well as inpatient and outpatient mental health settings. No evidence suggests that race, diagnosis, gender, geographic setting, age, inpatient status, or outpatient status are related to a person's ability to benefit from the components of IMR (Mueser et al., 2002).

How can mental health authorities support Illness Management and Recovery?

As you read about IMR, you may think that it sounds great but unaffordable. We want to challenge that notion because other mental health systems with limited resources throughout the U.S. have successfully applied their resources to implement IMR programs systemwide. These systems have visionaries who recognized the benefits of providing this evidence-based practice and persisted in overcoming challenges.

Implementing this evidence-based model takes a consolidated effort by agency staff, mental health authorities, consumers, and families. However, for this initiative to be successful, mental health authorities must lead and be involved in developing IMR programs in local communities.

Be Involved in Implementing Illness Management Recovery

- Step 1** **Create a vision** by clearly articulating evidence-based practice principles and goals. Designate a staff person to oversee your IMR initiative.
- Step 2** **Form advisory groups** to build support, plan, and provide feedback for your IMR initiative.
- Step 3** **Establish program standards** that support implementation. Make adherence to those standards part of licensing criteria.
- Step 4** **Address financial issues** and align incentives to support implementation.
- Step 5** **Develop a training structure** tailored to the needs of different stakeholders.
- Step 6** **Monitor fidelity and outcomes** to maintain and sustain program effectiveness.

Create a vision

Agencies commonly set out to implement one program, but end up with something entirely different. Sometimes these variations are intentional, but often they occur for the following reasons:

- One administration starts an initiative and another with a different vision and priorities subsequently assumes leadership;
- The model wasn't clearly understood to begin with; or
- The staff drifted back to doing things in a way that was more familiar and comfortable.

Articulating the vision that providing IMR helps consumers recover from mental illnesses is essential for successfully implementing an IMR program. Place the IMR initiative in the context of the larger recovery paradigm. Talk about how IMR programs help agencies fulfill their mission—assisting consumers in their recovery process.

To ensure that your vision is clearly communicated, designate a staff person who has experience with the evidence-based model to oversee your IMR initiative. Some mental health authorities designate an office or staff with whom agencies may consult throughout the process of building and sustaining their IMR programs. Designated staff may also have oversight responsibility for IMR programs across the state.

Form advisory groups

You can help ensure that the IMR model is implemented appropriately if you contractually mandate that stakeholder advisory groups guide the implementation initiative. Your IMR initiative can benefit in many ways from an advisory group. Among other things, an advisory group can help you do the following:

- Build internal and external support;
- Increase program visibility; and
- Advise you about ongoing planning efforts.

Consider forming both local and state-level advisory groups. State-level advisory groups may include the following members:

- Representatives of state agencies (housing, employment, substance abuse, and criminal justice departments) that would be invested in the initiative;
- Leadership from implementing agencies; and
- Representatives from consumer and family state advocacy organizations.

Local advisory groups can serve as liaisons between the community and agencies that are implementing IMR programs. Community stakeholders who have an interest in the success of IMR programs include the following:

- Local consumer organizations;
- Local family organizations;
- Agency administrators; and
- IMR practitioners.

Facilitating your advisory group

From the beginning, lead your advisory groups in understanding and articulating what IMR is and how it is going to be developed in your mental health system. For training materials that you can use to help stakeholders develop a basic

understanding of IMR, see *Using Multimedia to Introduce Your EBP* in this KIT.

Advisory groups should continue to meet well after your IMR program has been established. We suggest that they meet about once a month for the first year, once every 2 months for the second year, and quarterly for the third year. By the second and third years, advisory groups may help IMR programs sustain high fidelity by assisting with fidelity evaluations and outcomes monitoring or translating evaluation data into steps for continuous quality improvement. For more information about the role of advisory groups, see *Getting Started with EBPs* in this KIT.

Planning your IMR initiative

With a vision firmly in place, the process of unfolding IMR programs across the service system can begin. Carefully planning this process will help ensure a successful outcome.

Implementing IMR programs first in pilot or demonstration sites may be useful. Working with pilot sites can help you manage problems as they arise and also give constituents the opportunity to see that the evidence-based model works. Multiple pilot sites are preferable to just one. When only one site is used, idiosyncratic things can happen that misrepresent the model. In contrast, when programs do a system-wide rollout, it is difficult to adequately train all IMR program staff. In that case, system problems that may have been resolved easily on a smaller scale with a few IMR programs can cause havoc.

Establish program standards

Studies of agencies that have tried to replicate evidence-based practices have found that if agencies did not achieve positive outcomes, it was often because they failed to implement all of the

model's components (Becker et al., 2001; Bond & Salyers, 2004; Jerrell & Ridgely, 1995). As a mental health authority, you have the capacity to ensure that the system has incentives to implement the evidence-based model. Attention to aligning these incentives in a positive way (such as attaching financial incentives to achieving improved outcomes) is vital to successfully implementing IMR programs.

States have the authority to adopt regulations that govern services to consumers. These regulations set standards for the quality and adequacy of programs, including criteria that govern these areas:

- Admission and discharge;
- Staffing;
- Service components;
- Program organization and communication;
- Assessment and treatment planning;
- Consumer medical records;
- Consumer rights; and
- Supervision and program evaluation.

Support the implementation of IMR by explicitly referencing the evidence-based model in licensing standards and other program review documents (for example, grant applications, contracts, requests for proposals, and so forth). It is also important to review current administrative rules and regulations to identify any barriers to implementing IMR. Work closely with agency administrators to ensure that mental health authority policies support high-fidelity IMR practice.

Address financial issues

Each state is different. In many cases, while your IMR initiative can be mounted with little or no additional appropriations, it is important to review funding streams to ensure that they support

implementing the evidence-based model. Financing should correspond with services, and policymakers must ensure that IMR programs are reimbursed at a realistic level by some combination of state mental health dollars, Medicaid, and other payers.

Develop a training structure

Agencies who implement evidence-based practices are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of IMR.

We encourage you to support agency administrators in their efforts to develop a training structure for implementing IMR. The training plan should include basic training for key community stakeholders including the following people:

- Consumers;
- Families;
- Mental health authorities; and
- Staff from key community organizations.

The training plan should also include basic training for staff at all levels across the agency and intensive training for IMR practitioners (staff designated to provide IMR services).

Choose your trainer

An intensive training plan for IMR practitioners may be designed in several different ways, but you must first decide who will conduct the training. The IMR leader may facilitate the initial training for IMR practitioners by using the training tools in *Training Frontline Staff* in this KIT. Some mental health authorities choose to hire external trainers.

One successful strategy for training IMR practitioners entails having new IMR practitioners visit an existing, well-functioning, high-fidelity IMR program to observe how the program works. New IMR practitioners will benefit most from this visit if they have a basic understanding of the IMR model.

Once trained IMR leaders and practitioners will be able to use the tools in *Using Multimedia to Introduce your EBP* in this KIT to provide basic training to key stakeholders.

Offer ongoing training and consultation

Throughout the first year of your IMR program, we encourage you to offer intermittent booster training sessions to IMR practitioners. After the first year, consider establishing an annual statewide conference on the evidence-based model.

Routine onsite and telephone consultation is also important, particularly for IMR leaders. Leading an IMR team requires a complex set of administrative and clinical skills. For example, IMR leaders provide direct services and supervision, which may require a shift in thinking from how services were traditionally provided. IMR leaders also have administrative responsibilities such as hiring, preparing administrative reports, and developing policies and procedures. Perhaps more important, IMR leaders are responsible for ensuring that the IMR program operates with fidelity to the evidence-based model, including ensuring the quality and content of practitioner-consumer interactions.

It is very difficult for any IMR leader to grasp everything that has to be learned in a brief time. Also, understanding what must be done and translating that understanding into action are different and equally difficult. Strong daily leadership is essential to ensure that the IMR model is faithfully carried out.

For at least the first year a new program is in operation, IMR leaders need someone who is experienced in the evidence-based model to give ongoing consultation on organizational and clinical issues. Consultation ranges from integrating evidence-based practice principles into the agency's policies and procedures to case consultation.

Some states develop a few IMR programs at a time so that staff from the first program can help train those in newly developed programs. Generally, it takes about a year for staff to feel confident providing the evidence-based model, but this can vary depending on how much structural change is needed. IMR practitioners who are reluctant to accept new models can take longer to change.

It may take 2 to 3 years for an agency to become sufficiently proficient in the evidence-based model before it can assume the added responsibility of training other agencies' IMR practitioners. Agencies that have become training sites indicate that involving their staff in training staff from new IMR programs reinforces the practice principles and knowledge of the evidence-based model.

Other states have established training centers or enhanced existing education and training centers that offer education, training, and ongoing consultation or supervision. A state- or county-wide coordinator who is experienced with the evidence-based model can also help new IMR programs through ongoing contact, assessment, and troubleshooting.

Monitor fidelity and outcomes

Providing IMR involves incorporating a new program into the service delivery system. The best way to protect your investment is to make certain that agencies actually provide services that positively affect the lives of consumers.

Programs that adhere more closely to the evidencebased model are more effective than those that do not follow the model. Adhering to the model is called *fidelity*.

The IMR Fidelity Scale measures how well programs follow key elements of the evidence-based model. Research tells us that the higher an agency scores on a fidelity scale, the greater the likelihood that the agency will achieve the favorable outcomes (Becker et al., 2001; Bond & Salyers, 2004; Jerrel & Ridgely, 1995). For this reason, it is important to monitor both fidelity and outcomes.

As a central part of the initial planning process, you must address how you will monitor the fidelity and outcomes of IMR programs. Too many excellent initiatives had positive beginnings and enthusiastic support but floundered at the end of a year because they did not plan how they would maintain the program. Monitoring fidelity and outcomes on an ongoing basis is a good way to ensure that your IMR programs will continue to grow and develop. For more information about monitoring fidelity and outcomes, see *Evaluating Your Program* in this KIT.

Consider developing routine supervision and evaluations of your IMR programs. If it is not possible, use strategies (for example, rules, contracts, financial incentives, and so forth) to support fidelity and outcomes monitoring on the local level or within individual agencies.

The characteristics of an IMR program that would have a perfect score on the IMR Fidelity Scale are shown on the next page. For the entire IMR Fidelity Scale, see *Evaluating Your Program* in this KIT.



Characteristics of an IMR Program that Would Have a Perfect Score on the IMR Fidelity Scale

Number of people in a session or group	IMR is taught individually or in groups of eight or fewer consumers.
Program length	Consumers receive at least 3 months of weekly IMR sessions or equivalent (for example, biweekly sessions for at least 6 months).
Comprehensiveness of the curriculum	Curriculum materials include at least nine of the 10 following topic areas: <ul style="list-style-type: none"> ■ Recovery strategies ■ Facts about mental illnesses ■ Stress-Vulnerability Model ■ Building social supports ■ Using medication effectively ■ Drug and alcohol use ■ Reducing relapses ■ Coping with stress ■ Coping with problems and persistent symptoms ■ Getting your needs met by the mental health system
Educational handouts	All consumers who participate in IMR receive IMR Handouts.
Involving significant others	<ul style="list-style-type: none"> ■ At least one IMR-related contact in the last month, or ■ Involvement with the consumer in pursuit of goals (for example, helping with homework assignments).
IMR goal setting	Consumers have at least one personal goal in their chart that is realistic, measurable, individualized, pertinent to their recovery process, and linked to their IMR plan.
IMR goal followup	Practitioners and consumers collaboratively follow up on goals.
Motivation-based strategies	IMR sessions use at least one motivation-based strategy.
Educational techniques	IMR sessions use at least one educational technique such as: <ul style="list-style-type: none"> ■ Interactive teaching ■ Checking for understanding ■ Breaking down information
Cognitive-behavioral techniques	IMR sessions use at least one cognitive-behavioral technique such as: <ul style="list-style-type: none"> ■ Reinforcement ■ Shaping ■ Modeling ■ Role-playing ■ Cognitive restructuring ■ Relaxation training
Coping skills training	All practitioners are familiar with the principles of coping skills training and use it regularly.
Relapse prevention training	All practitioners are familiar with the principles of relapse prevention training and use it regularly, as documented by relapse prevention plans in clients' charts.
Behavioral tailoring for medication	All practitioners are familiar with the principles of behavioral tailoring for medication and either teach or reinforce it regularly.

Building Your Program

Tips for Agency Administrators and Illness Management and Recovery Leaders

Whether your agency is interested in enhancing an existing program or developing a new program, you will need a broad range of activities to successfully implement Illness Management and Recovery (IMR). This section outlines the range of implementation activities in which agency administrators and IMR leaders are often involved.

Recruit your staff

Illness Management and Recovery (IMR) programs typically consist of three to eight practitioners and an IMR leader. Depending on the size of the agency, the IMR program may also include an IMR coordinator or director.

Broadly speaking, you can consider agency staff who are involved in providing IMR as a team, including practitioners, the IMR leader, the IMR coordinator or director, and the agency director. But when more than eight practitioners

are involved in providing IMR services, you may form multiple teams. Typically, agencies with multiple IMR teams include multiple practitioners and IMR leaders but only one coordinator or director who oversees the IMR program as a whole.

IMR teams can be composed of practitioners from within an existing team (such as an Assertive Community Treatment team or a large outpatient multidisciplinary team). However, some agency administrators choose IMR practitioners from different teams or service areas, for example, from case

management teams, more than one Assertive Community Treatment team, continuing day treatment providers, and residential services.

Choose an IMR leader

It is important to hire or designate a leader for your IMR program. We suggest that IMR leaders be full-time employees whose time is completely dedicated to the IMR program. IMR leaders are often mid-level managers who have the authority to make or suggest administrative changes with the agency. Successful IMR leaders have both administrative and clinical skills and authority. As part of their administrative responsibilities, they undertake the following tasks:

- Hire and train IMR practitioners;
- Develop IMR policies and procedures;
- Act as a liaison with other agency coordinators;
- Manage referrals to the program;
- Monitor the program's fidelity to the IMR model; and
- Oversee other quality control and financial responsibilities.

As part of their clinical responsibilities, IMR leaders provide the following services:

- IMR services to one or two consumers;
- Weekly group supervision;
- Individual supervision as needed; and
- Program feedback to IMR practitioners.

Since IMR leaders must have an active role in setting up the structures and processes needed to support the IMR team, we encourage you to make the KIT available to candidates during the hiring process so they will understand what they must do.

Choose an IMR coordinator or director

If your IMR program includes more than eight practitioners, you will have to hire or designate an IMR coordinator or director to assume the following responsibilities:

- Develop IMR policies and procedures;
- Monitor the program's fidelity to the IMR model; and
- Oversee other quality control and financial responsibilities.

We suggest that your IMR coordinator or director meet weekly with your IMR leader and report monthly to your agency director.

Select the best IMR practitioners

IMR practitioners can come from a wide range of clinical backgrounds, including the following:

- Social work;
- Occupational therapy;
- Counseling;
- Case management;
- Nursing; and
- Psychology.

We recommend recruiting IMR practitioners who understand serious mental illnesses and believe that consumers can live full and productive lives in the community.

Effective IMR practitioners are warm, kind, and empathic. Good listening skills are important, including the ability to reflect back what consumers say and seek clarification when necessary. Good eye contact, a ready smile, and a good sense of humor are other helpful attributes that put people at ease.

Specific teaching skills are also important. IMR practitioners must be able to structure sessions that follow a predictable pattern. They must also be able to establish clear objectives and expectations and to set goals and follow through on them.

Another important practitioner attribute is the ability to take a shaping approach to increasing consumers' knowledge and skills. Shaping means that practitioners recognize that people often need a significant period of time to learn new information and skills. They give consumers positive feedback for their efforts and acknowledge small successes along the way. Having a shaping attitude means that practitioners acknowledge and value even very small steps and encourage consumers to achieve their personal goals.

In addition, IMR practitioners must be able to work both independently and as team members—providing cross-coverage for consumers and participating in group supervision.

Requirements for Illness Management and Recovery Practitioners

- Have specific knowledge of mental illnesses
- Be willing and able to actively involve consumers in making decisions about their own treatment and services
- Have strong clinical and rehabilitative skills
- Be warm, kind, positive, empathic people with good listening and teaching skills
- Be willing to work both independently and collaboratively as a team

Reflect your community's cultural diversity

IMR teams should reflect the cultural diversity of the communities in which they operate. More important, IMR practitioners must be aware of and sensitive to cultural differences and consumer preferences. IMR teams should include bilingual practitioners as needed. If bilingual staff are not available, you should provide translators as needed.

Having a balance of male and female IMR practitioners may also be helpful. Your IMR program must also have resources available to allow practitioners to work with consumers who have hearing and visual impairments.

Consider these hiring tips

Thoroughly check references for job candidates. The best predictor of work performance is likely to be candidates' performance in previous jobs, particularly jobs that required some of the same skills and personal qualities that are desirable for IMR practitioners. The IMR leader should talk to previous supervisors, ask in detail about candidates' previous work responsibilities and performance, and seek opinions about their capabilities.

Invite all candidates who are being seriously considered for employment to spend half a day or more in your IMR program so that they can see practitioners at work firsthand. Candidates can then better evaluate how well they might fit in and will be able to make a more informed decision about taking the job.

This visit will also give IMR practitioners a chance to talk with and observe candidates. Ask them to offer their feedback during the hiring process. This type of screening may help you weed out people who may not be appropriate for your IMR program.

Build support for your program

Developing a successful IMR program depends on the support and collaboration of a number of stakeholders. Internally, it is important that the director and staff across the agency understand and support implementing IMR. Your program is more likely to achieve high fidelity if the agency director is informed and involved in the implementation process from the start.

It is important that the agency director take the lead in promoting the IMR program and addressing any misconceptions. Articulate internal and public support for the IMR program by telling key stakeholders that consumers can recover from mental illnesses. Inform key stakeholders that the core components of IMR are linked to positive consumer outcomes and emphasize the importance of your IMR program by demonstrating how practitioners help consumers get on with life beyond illness to achieve their personal recovery goals.

Once the agency director has articulated a clear vision for implementing the evidence-based model, continue to bolster internal support for your program by giving all agency staff basic information. For more information, see *Develop a training plan* later in this booklet.

Form advisory groups

Forming a local advisory group for your IMR program is an effective way to gain key stakeholders' support for your program. Identify community stakeholders who have an interest in the success of your IMR program to serve on your committee. Committees often include the following people:

- Representatives from local consumer organizations;
- Members of local family organizations;

- Representatives from local mental health agencies;
- Key agency staff; and
- IMR practitioners.

Provide basic training to help advisory group members understand the evidence-based model. Once established, advisory groups may help implement your program in a variety of ways. For more information, see *Getting Started with EBPs* in this KIT.

Sustain support for your program

Building support for your IMR program should be an ongoing effort. To start, your mental health authority representatives or agency director should voice support for the IMR initiative. Once your program is operational, find ways to recognize and reward the achievements of IMR practitioners and consumers. For example, organize meetings with key stakeholders during which consumers share their success stories and administrators highlight staff achievements.

Another option is to sponsor a banquet to celebrate your program's accomplishments with consumers, family members, policymakers, and agency staff members. Banquets are particularly helpful if a wide array of stakeholders (such as physicians, administrators, and key public officials) attend.

Your agency director and IMR leader should meet regularly to review program evaluation data, discuss roadblocks, and plan ways to improve your IMR program. Building support from internal staff and key community stakeholders is essential to implementing an effective IMR program.

Agency Directors Can Lead This Effort

- Articulate clear support for the IMR program to internal staff and key community stakeholders.
- Attend some IMR trainings, supervision, and advisory group meetings.
- Meet monthly with the IMR leader to address roadblocks to providing IMR.
- Facilitate ongoing planning and program improvement efforts.
- Engage local and state mental health authority representatives.

Develop effective policies and procedures

Starting a new IMR program means developing policies and procedures that support the activities of the IMR model.

What Policies and Procedures Should Cover

- Admission and discharge criteria
- Staffing criteria
- Program organization and communication
- Service components
- Assessment and treatment planning criteria
- Consumer records requirements
- Consumers' rights
- Program and team member performance evaluation

Develop admission and discharge criteria

Set up a process to identify consumers who are appropriate for your IMR program and acquaint referral sources with your procedures. Since the research on IMR components focuses on consumers with schizophrenia spectrum disorders and major affective disorders, IMR Handouts cover schizophrenia, bipolar disorder, and major depression. However, because much of the information presented in the IMR program is not specific to any one mental illness, consumers with other psychiatric diagnoses may also benefit.

No evidence suggests that race, diagnosis, gender, or age are related to consumers' ability to benefit from the components of IMR. Almost everyone who experiences psychiatric symptoms will find they can learn something new from the program. In addition, consumers may benefit from IMR regardless of how long they have experienced symptoms of their mental illnesses.

For anyone who recently had a relapse or is under extreme stress due to personal circumstances, it may be preferable to wait until the symptoms have stabilized and undue stressors have been resolved before beginning the program. However, consumers who are often in crisis—due to problems such as homelessness, substance abuse, medical illness, or poverty—may benefit from IMR services. When consumers learn about their symptoms and develop problem-solving and coping skills, they can more effectively resolve stressors. Since IMR programs may work with a variety of consumers, you must decide which types of consumers to target. Some agencies choose to target consumers who have the following characteristics:

- Are new to the agency;
- Had multiple hospitalizations in the past year;
- Are returning from extended hospital stays; or
- Were recently released from correctional facilities.

Set up referral procedures

Agency administrators and IMR leaders must also develop referral procedures. Some agencies encourage referrals through the following sources:

- Treatment team meetings;
- Internal or external service providers;
- Community presentations; or
- Consumer self-referrals.

Put the admission criteria into operation by identifying and educating referral sources about the IMR program. Procedures for advertising your IMR program will depend on your referral approach. For example, if your IMR program will primarily depend on referrals from treatment team members and other internal service providers, you should routinely conduct agency-wide presentations to develop a basic understanding of your IMR program.

Consumers do not have to accept that they have a mental illness to be referred to the IMR program. IMR practitioners can effectively work with consumers even if they do not believe that their mental health issues are causing problems in their lives. Develop a process for explaining your IMR program to consumers in a way that helps them make an informed decision about accepting services.

Establish staffing criteria

Your policies and procedures should also specify the staffing criteria for your program. Generally, IMR teams should plan on having a practitioner-to-consumer ratio of no more than four consumers per practitioner (for individual sessions) in the first year.

This staff-to-consumer ratio is small enough to ensure that all practitioners learn how to practice high-fidelity IMR during the first year of implementation. No matter how well a team

is organized or how competent practitioners may be, the team will be unable to achieve high-fidelity practice if its caseload is too large during the first year.

If you exceed the maximum number of consumers, work effectiveness breaks down and practitioners will react to crises (or the imminent threat of crises) rather than help consumers take proactive steps toward recovery.

Create useful job descriptions

For job applicants, a good position description clarifies whether a particular position matches their skills and expectations. Include clear and useful job descriptions within the staffing criteria of your policies and procedures, as follows:

- Develop task-specific position descriptions;
- Outline the main task categories; and
- Detail specific duties.

Clear job descriptions allow IMR leaders to effectively supervise new employees and also allow employees to focus on the basic elements of their jobs.

Discuss program organization and communication

Policies and procedures for your IMR program should include criteria for how the IMR program is organized and how practitioners communicate. To be effective, IMR practitioners must be able to work both independently and as team members. As team members, IMR practitioners should communicate regularly and provide cross-coverage for consumers. IMR practitioners should also attend weekly group supervisory meetings that the IMR leader facilitates. These meetings give IMR practitioners the opportunity to discuss and problem-solve consumers' cases.

Your policies should outline clear procedures for how IMR practitioners will communicate with multidisciplinary treatment team members. It is essential that IMR practitioners be part of a multidisciplinary treatment team that communicates frequently and meets weekly.

When working with treatment team members, IMR practitioners should model evidence-based practice treatment skills. They should also coordinate services with other team members to ensure that treatment supports recovery goals.

IMR practitioners can work on several multidisciplinary treatment teams. However, if they work on more than two teams, they generally have to spend too much time in meetings or don't have the chance to adequately communicate with other team members.

Decide how to structure IMR sessions: Individual or group format

Policies for your IMR program should specify whether IMR will be provided individually or in a group format. Each format has its advantages.

Individual format

The primary advantages of the individual format are that you can more easily pace teaching the material to meet the consumer's needs and you can devote more time to addressing any specific concerns.

Group format

IMR groups typically consist of six to eight consumers. The main advantages of the group format are that it gives consumers more sources of feedback, motivation, ideas, support, and it provides more role models. Teaching in a group may also be more economical.

Offering IMR in a group is especially advantageous because it provides the opportunity for peer support to develop; consumers will help other consumers. Peer support can help motivate and prolong the attention of consumers. In addition, role-playing and problem-solving in a group setting enrich the learning experience because several good ideas and solutions are likely to be generated.

Although the advantages of providing IMR in a group are significant, certain challenges are associated with this format. First is the difficulty in setting a pace for teaching the material for each IMR topic. If you go too fast, you may lose those consumers who struggle to maintain attention, have memory impairments, or need extra time to understand. If you go too slowly, you risk boring those consumers who need to be challenged and stimulated at a quicker pace. Being able to balance the pace so that it is reasonable for all consumers takes significant skill from IMR practitioners.

Another challenge is the difficulty of maintaining an ongoing focus on each consumer's goals. IMR practitioners must make a concentrated effort to help keep consumers motivated to reach their goals in a manner that does not become routine.

In addition, actively involving family members and other supporters in the IMR practice is more challenging when you use a group. (See *Involve other supporters* for suggestions.)

Combining individual and group formats

To offer the best of both worlds, some IMR programs use a combination of group and individual sessions. Some IMR practitioners teach the core educational material in an individual format, and then offer an optional support group to provide social support, share coping strategies, and encourage consumers to pursue their personal recovery goals.

Other IMR practitioners use individual sessions to supplement the IMR group. These practitioners meet individually with consumers every 1 to 4 weeks to support the learning and skill-building done in the IMR group. Individual sessions allow IMR practitioners and consumers to focus on personal goals.

Information available in *Training Frontline Staff* in this KIT gives IMR practitioners guidance for providing IMR in both individual and group formats.

Determine the length of your sessions and program

Policy and procedures for your IMR program should outline the length of IMR sessions and the program. Typically individual or group sessions are offered weekly and last between 45 and 90 minutes.

The most critical determinant of session length is consumers' ability to stay engaged and learn the relevant material. Some consumers may have limited attention spans, comprehension problems, or severe symptoms that make it difficult to focus for more than 30 minutes. Consider taking breaks during teaching sessions or simply having brief sessions. You could also conduct more frequent, brief sessions, such as meeting for 20 to 30 minutes two or three times a week. In general, consumers participate in weekly group or individual IMR sessions for 3 to 10 months.

The length of the IMR program also depends on a variety of factors, including the following:

- Prior knowledge and level of skills;
- Problem areas on which consumers would like to work; and
- Cognitive difficulties or severe symptoms that may slow the learning process.

After completing the 10 topic areas, consumers may also benefit from participating in either booster sessions or support groups aimed at using and expanding skills.

Structure your IMR sessions

Policies and procedures for your IMR program should also outline the structure of IMR sessions. We recommend that you follow a prescribed structure for your IMR sessions using the materials included in this KIT. Following a prescribed structure helps consumers and practitioners work through the curriculum more efficiently.

Suggested Structure for IMR Individual and Group Sessions		
	Individual sessions	Group sessions
Informally socialize and identify any major problems	1–3 minutes	1–3 minutes
Review previous sessions	1–3 minutes	1–3 minutes
Review homework	3–5 minutes	5–10 minutes
Follow up on goals	1–3 minutes	5–10 minutes
Set agenda for current session	1–2 minutes	1–2 minutes
Teach new material or review previously taught material	30–40 minutes	20–25 minutes
Agree on new homework assignment	3–5 minutes	5–10 minutes
Summarize progress made in current session	3–5 minutes	3–5 minutes

Involve other supporters

Policies and procedures for your IMR program should encourage and facilitate involving family members and other supporters to help consumers increase their natural supports. With consumers' permission, family members and other supporters may participate by doing the following:

- Reading the IMR Handouts used in sessions;
- Participating in selected sessions;
- Helping develop relapse prevention plans;
- Participating in homework assignments; and
- Helping consumers pursue their recovery goals.

Outline core service components

IMR is a comprehensive, structured program that includes 10 topics. To make sure that you maintain a high-fidelity IMR program, policies should specify that the IMR curriculum cover the following 10 topics:

- Recovery strategies;
- Practical facts about mental illnesses;
- The Stress-Vulnerability Model and treatment strategies;
- Building social supports;
- Using medication effectively;
- Drug and alcohol use;
- Reducing relapses;
- Coping with stress;
- Coping with problems and persistent symptoms; and
- Getting your needs met by the mental health system.

The IMR Handouts summarize critical ingredients of the curriculum topics for consumers. The Handouts are not meant to stand alone. Rather, practitioners are expected to help consumers select and apply the knowledge and strategies that are most helpful to them.

For copies of the Handouts, see *Training Your Frontline Staff—Practitioner Guides and Handouts* in this KIT.

Develop assessment and treatment planning criteria

IMR practitioners use two tools to assess and track consumers' goals and progress:

- Strengths and Knowledge Inventory; and
- IMR Progress Note.

The Strengths and Knowledge Inventory is completed for each consumer in the second or third IMR session to help practitioners assess consumers' talents, abilities, skills, and knowledge. On the next few pages is an example of a Strengths and Knowledge Inventory assessment form.

Talents, Abilities, and Skills

Daily routine

Where are you living?

Do you live with roommates, family members, a spouse, or a significant other?

- Yes
- No

Describe a typical day.

Educational and work activities

Are you taking classes?

- Yes
- No

Do you study any subjects on your own?

- Yes
- No

Are you working (part-time, full-time, volunteer)?

- Yes
- No

Are you in a training program?

- Yes
- No

What kind of hobbies, work, chores, and relaxing activities do you regularly spend time on?

Are there times when you are not doing anything?

- Yes
- No

Leisure activities and creative outlets

What do you like to do when you have time off?

What are your hobbies? Do you like to...

Read?

- Yes. What kind of books? _____
- No

Write or keep a journal?

- Yes
- No

Play an instrument?

- Yes
- No

Listen to music?

- Yes. What kind of music? _____
- No

Go to the movies or watch television?

- Yes. Which movies or shows? _____
- No

Draw or do other kinds of art?

- Yes
- No

Look at artwork?

- Yes
- No

Relationships

Which people do you spend time with regularly? Co-workers? Classmates? Spouse or significant other? Family? Friends?

Is there anyone with whom you would like to spend more time?

- Yes. Who? _____
- No

Who would you say are the supportive people in your life, the ones you can talk to about problems?

Which supporters would you like to involve in the Illness Management and Recovery Program?



Spiritual supports

Is spirituality important to you?

Yes

No

What do you find comforting spiritually?

How do you take care of your spiritual needs?

Are you involved in a formal religion?

Yes

No

Do you meditate?

Yes

No

Do you look to nature for spirituality?

Yes

No

Do you look to the arts for spirituality?

Yes

No

Health

What do you do to take care of your health?

How would you describe your diet?

Do you exercise?

Yes

No

Do you have any health problems for which you see a doctor?

Yes

No

What is your sleep routine?

Knowledge

Previous experience with peer-based education or recovery programs

Have you been involved in a program that was described as a *recovery program*? (Check all that apply)

- Recovery Education program
- Self-help program
- Peer support program
- Wellness Recovery Action Plan (WRAP) program
- Groups that talked about recovery

Previous experience with a practitioner-based educational or recovery program

Have you taken a class about mental health?

- Yes
- No

Have you attended a family education program?

- Yes
- No

Knowledge about mental health

In your opinion, what does *recovery* from mental illnesses mean?

What is an example of a psychiatric symptom you have experienced?

What do you think about psychiatric symptoms?

What are some of the pros and cons (benefits and risks) of taking medication for psychiatric symptoms?

What do you do to help yourself prevent relapses?

How does stress affect you?

What helps you cope with stress or symptoms?

What mental health services have helped you?

About the Illness Management Recovery program

Do you have any specific questions that you would like to have answered in the Illness Management and Recovery program?

What would you like to gain from the Illness Management and Recovery Program?

The second tool is the IMR Progress Note. This form is completed after every IMR session. It tracks consumers' goals and IMR practitioners' motivational, educational, and cognitive-behavioral interventions.

The form also facilitates followup between IMR sessions and the accurate completion of IMR fidelity assessments. On the next few pages is an example of an IMR Progress Note.

IMR Progress Note

About the person

Name _____ I.D. number _____ Date ____/____/____

Name of family member or other supporter involved in session _____

Problem or goal specified by the treatment plan that is the focus of treatment

Personal goal that was set in this session or followed up on in this session

Treatment or interventions provided

Motivational interventions (Check all that apply):

- Connect information and skills with personal goals
- Promote hope and positive expectations
- Explore pros and cons of change
- Re-frame experiences in positive light

Educational interventions (Check the topics that were covered):

- Recovery strategies
- Practical facts about mental illnesses
- The Stress-Vulnerability Model and treatment strategies
- Building social supports
- Using medication effectively
- Drug and Alcohol Use
- Reducing relapses
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met by the mental health system



IMR Progress Note

Continued

Cognitive-behavioral interventions (Check all that apply):

- Reinforcement
- Shaping
- Modeling
- Role playing
- Cognitive restructuring
- Relaxation training

Specific evidence-based skill taught (Identify which ones):

Coping skill for dealing with symptoms _____

Relapse prevention skill _____

Behavioral tailoring for medication _____

Homework that was agreed upon: _____

Outcome (Consumer's response to information, strategies, and skills provided in the session)

Consumer's perspective _____

Practitioner's perspective _____

Plan for next session

Consumer's signature

Practitioner's signature

We strongly encourage you to adapt these two forms and incorporate them into your routine paperwork. For printable copies, see the CD-ROM for this KIT. For a more detailed discussion of the assessment and treatment planning process, see *Training Frontline Staff* in this KIT.

Describe how to maintain consumer records

In your IMR policies and procedures, describe how you will maintain consumers' records. You must keep records for each consumer and safeguard them against loss, tampering, and unauthorized use. The records should be consistent with The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) or other applicable accrediting and regulatory bodies including the Centers for Medicaid and Medicare Services.

If you are setting up a new recordkeeping system, you will need materials to create records (for example, binders and forms) and to store them appropriately. You also need written policies and procedures for documenting and maintaining records.

Make sure that IMR practitioners are familiar with your policies and procedures for documenting and maintaining records. Supervise them in completing the required documentation and monitor that records are properly stored and protected.

Discuss how to ensure consumers' rights

In your IMR policies and procedures, discuss how you will ensure that consumers' rights are upheld. IMR practitioners should do the following:

- Be aware of the state and federal consumer rights requirements;
- Inform consumers of their rights in a meaningful way; and
- Help consumers exercise their rights.

Also, your policies and procedures should reflect the model's recovery orientation. Traditional services were developed with a biomedical approach to mental health; they focus on reducing symptoms and preventing relapse.

In contrast, the evidence-based model is based on the concept of *recovery*. In the recovery framework, the expectation is that consumers can have lives in which mental illnesses are not the driving factors. Recovery means more than maintaining people with mental illnesses in the community. Recovery-oriented services encourage consumers to define and fulfill their personal goals.

IMR practitioners must believe in and be true to the recovery principles within the evidence-based model. Be careful not to replicate those elements of traditional services that simply emphasize containing symptoms and complying with medication.

The value of consumer choice in service delivery and the importance of consumer perceptions must be infused in how you provide IMR. Most practitioners have never examined their own attitudes and behaviors about consumer recovery and uncritically accept many clinical traditions without paying attention to how disempowering these practices are for consumers.

In recovery-based services, establishing a trusting relationship is critical. Interactions with consumers should be based on mutuality and respect. Challenge IMR practitioners to listen to, believe in, and understand consumers' perspectives and take into account consumers' reasons for noncompliance.

IMR practitioners should also focus on consumer-defined needs and preferences and accept consumer choice in service delivery. Providing services with a recovery orientation means that you support and empower consumers to achieve their individual goals.

How Administrators and IMR Leaders Can Help Provide Recovery-Oriented Services

- Clearly explain consumer rights in IMR policies and procedures.
- Offer training on recovery principles and consumer rights.
- Hold community forums using the multimedia tools in this KIT.
- Involve consumers in local advisory groups.

Develop procedures to evaluate program and staff performance

When it is properly implemented, IMR is associated with a variety of positive outcomes. Evaluating the performance of your IMR program will help you provide high-quality services to consumers and assure stakeholders of your program's effective performance. Develop procedures to evaluate your program early using the guidelines in *Evaluating Your Program* in this KIT.

Also, develop procedures for how you will supervise and evaluate the performance of your IMR team. To a large extent, clinical supervision is the process that will determine whether IMR staff understand and are consistently applying the evidence-based practices for IMR or whether further leadership, training, and accountability are required to meet this goal.

We recommend that IMR teams do not exceed eight practitioners so that the IMR leader can properly supervise them. If your IMR programs has more than eight practitioners, split them into multiple teams with multiple IMR leaders but with one IMR coordinator or director.

IMR leaders should provide weekly group supervision to IMR practitioners. Group supervision should review all consumers involved in the IMR program and problem-solve ways to help them better meet their individual goals.

Because IMR leaders also dedicate some time to direct services, they will be familiar with all of the parts of providing IMR services. IMR leaders will not just review cases that IMR practitioners present, but will also be able to actively problem-solve using evidence-based principles and techniques. IMR leaders also provide individual, side-by-side supervision to achieve the following goals:

- Assess performance;
- Give feedback; and
- Model interventions.

IMR leaders may schedule regular meetings with IMR practitioners to review specific cases. They should be regularly available to consult with IMR practitioners, as needed.

Some aspects of the IMR practitioner's job are hard to understand without seeing them done by an experienced IMR practitioner. Once IMR leaders thoroughly understand the evidence-based model, they should model aspects of the job—such as engagement or motivational interventions—and directly coach them in their work. For training tools and recommendations, see *Training Frontline Staff* in this KIT.

If the IMR program is working with a consultant, the IMR leader should involve the consultant in group supervision, treatment team meetings, and IMR group sessions. Many new IMR programs have found that feedback from an external consultant is a crucial component for improving staff performance and the quality of their program as a whole.

Develop a training plan

Developing an IMR team is a complex undertaking. Recruiting and retaining practitioners who know the IMR model or who know how to treat consumers can be difficult. Agencies that have successfully implemented IMR indicate that offering one-time training for IMR practitioners is not enough. Instead, you should assess the knowledge level of key stakeholders (See *Evaluating Your Program* in this KIT) and develop a training plan.

What Should Your Training Plan Include?

- Basic training for staff at all levels across the agency
- Basic training for key stakeholders, including consumers, families, mental health authorities, and members of key community organizations
- Intensive training for IMR practitioners

Practitioners who implement evidence-based practices are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of IMR. This training will build support for your IMR program. Your staff will find that they are better able to generate referrals for their program, engage consumers, and provide effective treatment.

In addition to these internal basic training activities, consider organizing routine educational meetings for consumers, families, or other key stakeholders in the community where consumers who have received services through IMR programs share their experiences. These key stakeholders may hold misconceptions about the goals of the IMR program. It is important to correct false beliefs before they impede implementing the evidence-based model.

Next, consider how you will offer the staff of your IMR program intensive training to allow them to learn and master the evidence-based model. We suggest organizing a group training series that includes at least four half-day sessions. The IMR KIT includes *Training Frontline Staff*, which gives IMR practitioners in-depth information about the evidence-based model and skills for providing effective services to consumers. IMR leaders may facilitate a structured group training using these materials.

Once IMR practitioners have a basic understanding of the model, we recommend that they visit an existing, well-functioning, high-fidelity IMR program to observe how IMR practitioners work with consumers, interact with one another, and collaborate in multidisciplinary treatment teams. Once trained, IMR leaders and practitioners will also be able to use the basic training materials in the KIT to conduct routine community workshops and inservice seminars. For materials to support basic training, see *Using Multimedia to Introduce Your EBP* in this KIT.

Hire an external consultant and trainer

Establishing the initial processes that must be in place to provide quality services requires great attention to detail. Consequently, during the first 1 to 2 years after forming a new IMR program, many agencies have found it helpful to work with an experienced external consultant and trainer. Consultants and IMR leaders often work together over the 2 years to ensure that the IMR program is structured appropriately. They integrate evidence-based practice principles into the agency's policies and tailor procedures to meet local needs.

Once the IMR program has been launched, it is important that you do not allow IMR practitioners to revert to older and more familiar ways of doing things. External consultants and trainers who are experienced in running IMR programs can provide ongoing technical assistance, side-by-side supervision, and periodic booster training sessions. This type of assistance, along with ongoing evaluation of fidelity and outcomes, has been found to be critical in maintaining adherence to the evidence-based practice.

Select a location for your IMR program

You can conduct IMR sessions in almost any location that is convenient for the IMR practitioner and consumer. For example, you could conduct your IMR sessions in the following locations:

- Your mental health agency;
- Consumers' homes;
- Consumers' family members' home; or
- Public settings (such as a coffee shop or restaurant).

The setting should have ample lighting to allow you to easily read the IMR Handouts, comfortable seating, and some privacy. Regardless of the location, IMR practitioners should strive to create an environment that is quiet, free of unnecessary distractions, and conducive to learning and practicing the material.

Because of the extensive number of IMR Handouts required to conduct sessions, practitioners also need office space with access to file cabinets, copy machines, and shelf space.

Review your IMR program budget and revenue sources

It is important that you understand the budget for your IMR program and revenue sources so that you can actively participate in the budgeting process, make informed management decisions, and understand where collateral revenue sources are most needed.

In some mental health systems, programs receive a fixed rate for each consumer who receives services. In other systems, programs are only reimbursed based on the specific services provided. In that case, you should be familiar with how services must be tracked to capture billing from various funding streams. You will also need to know the billing process and billing codes.

Financing mechanisms for IMR programs vary from agency to agency. Administrators use federal, state, and private funding opportunities to fund IMR programs (Mueser et al., 2002).

Financial barriers can slow implementation. Be aware that over time the mission and activities of programs can become defined by the funding that supports them. Know the principles of the evidence-based model and be vigilant that funding opportunities support the model rather than shape and corrode it. Consult with agencies and system administrators who have been successful in this area for useful ideas and strategies.

In summary, building an effective, well-functioning IMR program is a developmental process. We encourage you to periodically revisit the information in this KIT throughout the first year after you start your new program. We believe that these materials will take on a new meaning as the process of implementing an IMR program evolves.

