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IMR Deconstruction and Reconstruction: Mental Health Group Recovery

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Abstract

In recent years the recovery process of people with mental illness has been extensively researched. Program models such as Illness Management and Recovery (IMR) have been proven to be successful with a high degree of fidelity. The overall goal of this project is to design client and clinician manuals based on IMR that allow the modules to be implemented in groups within a residential setting. The nine IMR modules have been reconstructed into four 12-week group sessions for Transition Services (TS) at St. Peter Regional Treatment Center (SPRTC), St. Peter, MN. It is expected the curriculum constructed will be implemented to provide TS with an evidence based curriculum. The student researchers reconstructed nine IMR modules into a client and clinician manual that are written specifically for TS at SPRTC. The impact of TS utilizing the manuals will be the provision of an evidence based curriculum. It is expected the curriculum in the manuals will be implemented and evaluated. Currently, the programming at SPRTC is not evidence based and the recovery rate of the clients is undetermined. By using and evaluating the reconstructed IMR modules the staff at SPRTC will be able to initially establish a baseline for client recovery which will be used for a comparison studies of client recovery rates in the future.

Introduction

Until the 1980s, “clinicians defined best practices from the guild’s platform, and then the public tacitly accepted them...as the best practices” (Rosenthal, 2004, p. 20). However, in 1980 the term evidence-based practice was coined. Evidence based practice is the “conscientious explicit and judicious use of the current best evidence in making decisions about the care of individuals” (Rosenthal, 2004, p. 20). Implemented correctly, evidence-based practices have the proven potential to prevent death and injury and provide a better quality of life. It should come as no surprise to learn many other professions, including social work and mental health specialists, have started to focus on evidence based practices. Yet, due to the concept’s recent introduction and the extensive amount of time needed to determine a practice as evidence based, the filtration of the term into facilities such as St. Peter Regional Treatment Center (SPRTC) has been limited.

For many facilities using evidence based practices can be difficult because it does not fit the unique aspects of each facility. This is the case for SPRTC and its attempts to implement Illness Management and Recovery (IMR), an evidence based practice. The IMR curriculum was created to work with individuals suffering from mental illness. However, the Transitions Services (TS) section of SPRTC does not focus on individual work, but rather, it focuses on group work. This study was designed to create group programming for TS at SPRTC based on the IMR curriculum.

Literature Review

The Illness Management and Recovery (IMR) program was designed to provide individual clients with knowledge and skills to help them develop personal strategies for coping with mental illness, to develop, and pursue goals, and gain more control over their lives. IMR is

an evidence based model that has been implemented with people who have experienced symptoms of schizophrenia, bipolar disorder, or major depression and is appropriate for people at various stages of the recovery process. The program incorporates psycho-education and cognitive-behavioral methods for using medication effectively, relapse prevention, and coping skills training (Bullock 2004). Research has shown people with mental illness who partake in IMR show improvements in knowledge about mental illness, using medications more effectively, reducing relapses and re-hospitalizations, coping more effectively, and reducing distress from symptoms (Bullock, 2004).

Although IMR is an evidence-based practice the curriculum was designed for individual use. Yet, numerous research studies have shown participation in groups has several benefits for people recovering from mental illness. These benefits include: decreasing denial, increasing awareness, providing more real life situations, seeing other's point of view, feedback, ideas, treating others with more respect, and encouragement (Drake, Goldman, & American Psychiatric Association, 2003; Revheim & Marcopulos, 2006). Although there are numerous benefits, Young (1999) states groups also have a variety of issues including: "disruptive behavior from other members interfere with learning, group size is too large, and too much information is presented in too short a time period" (p. 115-116).

The group therapist, according to Roan (2001) plays a central role in aiding the success of the group. Effective strategies therapists can use to help avoid issues include: having shorter sessions, being active in the groups, providing effective structure, being prepared, including clear visual examples and handouts, following up with members to ensure understanding, allow members to have some control, praising members for participation, being aware of each member's individual needs, maintaining hope, and believing in the potential of each member to

achieve his or her goals (Bellus, Kost, & Vergo, 2000; Drake, Goldman, & American Psychiatric Association, 2003; Revheim & Marcopulos, 2006; Roan, 2001; Roe et al, 2007).

Studies have indicated effective adult learning occurs with active participation in the learning process; therefore, curriculum for groups usually involves numerous activities (Drake, Goldman, & American Psychiatric Association, 2003). Daniels and Roll (1998) state “behavioral and cognitive approaches to social skills training, interactive-behavioral training which utilizes role-play, group feedback, interpersonal problem solving, and other social skills building techniques” (p. 274) have been effective in involving the members. Overall, whether the session topic is social skills, education, medication use, coping skills, or relapse prevention, a combination of activities that involve group members is most effective in helping to keep members attention, helping members to learn better, and providing opportunities to practice new skills (Ahmed & Goldman, 1994).

In the past six years, researchers have developed group curriculum based on IMR. However, each facility has different consumers, procedures, staffing, facilities, and formats which makes the creation of a generic group IMR curriculum difficult. For that reason an IMR group-based curriculum is going to be developed to meet the needs of St. Peter Regional Treatment Center (SPRTC). Using the information gathered on the components of IMR, effective methods for group implementation, and the role of the therapist/group leaders, a client and clinician manual will be created for groups at SPRTC.

Methodology

The overall goal of this project was to design client and clinician manuals based on IMR that allow the modules to be implemented in groups. In order to provide client and clinician

manuals, each of the nine IMR modules were deconstructed and reconstructed to fit with the programming at SPRTC.

Before the manuals could be created, extensive research was conducted on current TS programming, IMR curriculum, and group programming models. The authors gained knowledge about the current programming and curriculum by meeting with TS staff and through an internship by one of the researchers. To gain knowledge on the IMR curriculum the authors reviewed the current clinician and client manuals, as well as several research studies. The results of the authors research was used in the reconstruction of the IMR modules.

After the research phase was completed the deconstruction of the nine IMR modules process began. It was determined through meetings with the TS staff the nine IMR modules would be split into four groups, which coincides with SPRTCs current four quarters group structure. Then each of the four groups was split into twelve weekly sessions to coincide with SPRTCs structure of twelve sessions per quarter.

While reconstructing the sessions, it became clear research on icebreakers needed to be conducted because IMR curriculum and articles on group programming suggested the benefit of such exercises. A compilation of icebreakers from the research was created in a separate manual for clinicians to use.

Once the first IMR group was completed it was reviewed by TS staff to provide feedback. The feedback was then applied to the first reconstructed IMR group. These steps were then applied to the remaining three IMR groups. The four groups were then placed into four client manuals which will be used for the group sessions, and four clinician manuals which will be used to provide information to the clinician about effective ways to conduct each session.

Results

Completion of four client, four clinician, and one ice breaker manual. The manuals were given to the social service supervisor in TS and will later be implemented by a member of staff or a future graduate student intern.

Discussion

After showing our first draft copy to the TS supervisor, she had only a few comments on how to make the final copy better. We believe that once we turn in all our final manuals, the TS supervisor will be excited to have a program model that can be easily implemented into the SPRTC curriculum. If implemented, the staff at SPRTC will have a better idea of how the patients are doing in their recovery processes.

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Author Biography:

Lauren Harding grew up in Eagan, Minnesota, and graduated from Eastview High School in June 2006. She is a graduating senior, majoring in Social Work at Minnesota State University, Mankato. During her time at Mankato she has been a member of the Student Ambassadors, Habitat for Humanity, Social Work Club, and Phi Alpha Honor Society. She also spent the summer of 2009 in Bristol, England with fellow social work students; her focus was on the health care system in England. Lauren is looking forward to start graduate school at St. Catherine University in the fall to study to become a Licensed Independent Clinical Social Worker concentrating on the field of mental health.

Author Biography:

Renee Lips is a senior double-majoring in Social Work and Alcohol and Drug Studies at Minnesota State University, Mankato. She grew up in Owatonna, MN and graduated from Owatonna High School in June 2006. Since her enrollment at MSU, in August 2006, she has been involved with the Social Work Club, Student Conduct Board, and Phi Alpha Honor Society. She has also been employed at MSU through the Office of Student Affairs and as an Orientation Peer Assistant since 2007. After graduation in December 2010, she plans to find employment in the human services field and begin working on a master's degree in Social Work, possibly a dual degree in Social Work and Law. Renee aspires to one day work in the political arena to improve the current human services system.

Faculty Mentor:

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