Future research on the process of case management, which documents necessary to widely implement high-fidelity teams.

Implementation in every state, most state mental health authorities have not committed the resources peer-reviewed studies (Bjorkland, Monroe-De Vita, Reed, Toulon, & Morse, 2009). Of the 41 states that ACT has been implemented in 41 states and has been endorsed by Federal reports and a multitude of and may be the most significant factor in prevention of relapse and subsequent rehospitalization (Kuno, recovery. The provision of direct support services may help clients manage difficulties in community living and may be needed rather than in staff offices or clinics. Providing services in this way, consumers receive Most services are provided in 50 states, is the community settings where problems may occur and where support is needed, rather than in staff offices or clinics. Providing services in this way, consumers receive the treatment and support they need to address the complex, real-world problems that can hinder their recovery. The provision of direct support services may help clients manage difficulties in community living and may be the most significant factor in prevention of relapse and subsequent rehospitalization (Kuno, Rothbard, & Sands, 1999).

ACT has been implemented in 41 states and has been endorsed by Federal reports and a multitude of peer-reviewed studies (Bjorkland, Monroe-De Vita, Reed, Toulon, & Morse, 2009). Of the 41 states that have implemented the program, only 20 report that they monitor fidelity and only 15 report statewide ACT implementation (Garu, 2003). Despite ACT's strong evidence base and broad consensus for ACT implementation in every state, most state mental health authorities have not committed the resources necessary to widely implement high-fidelity teams.

Illness Management and Recovery (IMR)

IMR is a model designed to help people pursue recovery goals and learn to successfully manage their illness. Practitioners use a combination of motivational, educational and cognitive-behavioral strategies to help people develop life skills and all participants identify personally meaningful recovery goals. Illness management strategies are based on specific evidence-based practices including education, relapse prevention training, behavioral tailoring for medication (for people who choose to take medications), and coping skills training.

The individual components of the IMR model are supported by research that has shown persons with psychiatric symptoms can show improvements in: (1) Knowledge about mental illness, (2) Using medications more effectively, (3) Reducing relapses and re-hospitalizations, and (4) Coping more effectively and reducing distress from symptoms (SAMHSA, 2003; Bullough, 2004).

Preliminary studies of IMR suggest that general and specific domains of mental health recovery can be assessed via self-report measures and that participation in IMR is associated with significant self-reported increases across an array of measures (Bullough, 2004; Bullough et al., 2005; Salyers et al., 2009).

Wellness Recovery Action Planning (WRAP)

WRAP is a program in which participants identify internal and external resources for facilitating recovery, and then use these tools to create their own, individualized plan for successful living (Copeland, 2002). The creation of a WRAP plan begins with the development of a personal Wellness Toolbox, containing a variety of self-management strategies (Copeland, 2004). The plan includes identification of “early warning signs” of symptom exacerbation or crisis, and how the Toolbox can help people to manage life events. WRAP also encourages development of a crisis plan as well as a post-crisis plan for recovery. WRAP educators are trained to avoid talking directly about psychiatric diagnoses or using medical or illness-oriented language to frame personal needs (Copeland, 2002). WRAP encourages people to move beyond simply managing symptoms to building a meaningful life in the community.

Minnesota’s evaluation of its WRAP program examined the results of 42 WRAP cycles held throughout the state in 2002 and 2003. A total of 305 mental health consumers participated, and 234 of these completed pre-tests and post-tests (Buffington, 2003). Of the 234 respondents, 140 responded to a follow-up survey conducted 90 days after the end of WRAP training. All of these respondent reported feeling more hopeful about their recovery and 130 said they had encouraged other consumers to participate in WRAP training (Buffington, 2003).

A 2006 study of 80 individuals in Ohio was done to examine changes in psychosocial outcomes among participants in an eight-week, peer-led WRAP group. Paired t tests of pre- and post-intervention at baseline and one month after the intervention showed scores that revealed significant improvement in self-reported symptoms, recovery, hopefulness, self-advocacy, and physical health (Cook, 2009). Confirmation of the efficacy and effectiveness of peer-led self-management has led to the design of a national dissemination and promote recovery for people with psychiatric disabilities (Cook et al., 2009). WRAP is now being offered in all 50 states and U.S. territories (Cook, 2009).

Re-engineered Discharge Planning (RED)

At Boston Medical Center the Quality Management Department analyzed patient data from 2003-2004 and identified that almost 20% of discharged patients readmitted within 30 days (Greenwald, 2007; Jack et al., 2009). Communication between the multiple providers, before, during, and after the hospitalization was often inconsistent and problematic (Jack et al., 2008).

Principles and components of the Re-Engineered Discharge (RED) include a set of 11 distinct components that prepare patients for discharge. Three tools were created: 1) training manual used to train discharge nurses to provide the RED, 2) an individualized, patient-friendly “After Hospital Care Plan” (AHCP), and 3) a booklet used to prepare patients for discharge. It was proposed that the program hire a Discharge Advocate (DA) to facilitate coordination with treatment team members, educate patients about their disease, arrange aftercare with the patient & family, and provide medication education; assist with making transportation arrangements for appointments in the community and reinforce the After Hospital Care Plan. The DA assumed that written discharge materials were provided at the appropriate literacy level and that discharge materials contained visual aids to assist in medication management.

The RED concept has been applied and studied at several medical centers. Programs have reported that patients who received follow up calls were less likely to require ER visits (Howell, 2006; Greenwald, 2007; Jack et al., 2009). Specifically, at Boston Medical Center Jack reported a 30% decrease in hospital utilization within 30 days of discharge (Jack et al., 2009).

Components of Relapse Prevention Models

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>EBP</th>
<th>Fidelity Scale</th>
<th>Family Education</th>
<th>Psychosocial Education</th>
<th>Medication Education</th>
<th>Education Case Management</th>
<th>Cognitive Behavioral Component</th>
<th>Fidelity in Rural Communities</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
<td>No</td>
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<td>WRAP</td>
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<td>No</td>
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<td>RED</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, short term</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Findings

- Studies of relapse prevention programs which teach the early warning signs of relapse are associated with better outcomes, including fewer relapses and rehospitalizations and lower treatment costs (Novacek & Raskin, 1998; Bond et al., 2001; Torrey et al., 2001).
- Illness management skills, ranging from greater knowledge of psychiatric illness and its treatment to coping skills and relapse prevention strategies, play a critical role in people’s recovery from mental illness (Cook et al., 2009).
- Research on illness management has thus far focused on programs developed and run by professionals. Similar research on peer-based illness self management programs may inform professional-based services and lead to collaborative efforts (Cook et al., 2009).
- While early research studies centered on program implementation more recent studies have focused on measuring consumer outcomes Preliminary results have identified improved consumer outcomes relevant to recovery, such as illness management, hope and satisfaction with services (Salyers et al., 2009).
- Future research on the process of care management, which documents staff qualities, organizational and service characteristics, combined with client outcome evaluation, would have a great importance in the development of mental health system which is responsive to the needs of people with serious mental illness (Kuro et al., 1999).
- No single treatment is appropriate for all individuals (SAMHSA, 2003). Evidence-based practices (EBP) must be adapted and personalized for individuals based on their culture, interests, and circumstances (NAMI, 2007).

Recommendations

The South Central Crisis Center recognizes the need for treatment to remain focused on client goals and functioning, and to match intervention strategies to each individual client’s clinical assessment. The autonomy of the setting would make it impossible to fully implement, with fidelity, any of the models this writer researched. For this reason SWRC utilizes individual relapse prevention components of the IMR, ACT, WRAP and RED models. The program’s eclectic approach has resulted in garnering high marks on the client discharge satisfaction survey however, information regarding client outcomes is difficult to interpret. The development of an information system to collect and measure client outcomes would provide the program with data that could be used to evaluate the effectiveness of clinical services provided.