

Instructions for Scoring the Illness Management and Recovery (IMR) Fidelity Scale (12/11//02)

This document is intended to help guide you in administering the Illness Management and Recovery (IMR) Fidelity Scale. In this document you will find the following:

1) Introduction: This gives an overview of IMR and a who/what/how of the scale, plus a checklist of suggestions for before, during, and after the fidelity assessment that should lead to the collection of high quality data, positive interactions with respondents, and an efficient data collection process.

2) Protocol: The protocol explains how to rate each item. In particular, it provides:

a) A *definition* and *rationale* for each fidelity item. These items have been derived from controlled research on illness management.

b) A list of *data sources* most appropriate for each fidelity item (e.g., chart review, program leader, clinician/practitioner and consumer interviews). When it is appropriate, a set of *probe questions* is provided to help you elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is relatively free from bias such as social desirability.

c) *Decision rules* will facilitate the correct scoring of each item. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

3) Cover sheet: This form obtains background information on the study site. The data are not used in determining fidelity, but to provide important information for classifying programs, such as size and duration of program, type of parent organization, and community characteristics.

4) Score sheet: The score sheet provides instructions for scoring, including how to handle missing data and which cut-off scores to use for full, moderate, and inadequate implementation.

5) Progress note: This is a sample of a progress note form recommended by the IMR Implementation Resource Kit developers (Susan Gingerich and Kim Mueser) for use or adaptation in the implementation of IMR. The progress note is an important data source in IMR fidelity assessment. Each site implementing the IMR practices should be encouraged to adopt a similar style of progress note as a part of its daily practice in order to facilitate fidelity assessments.

IMR Fidelity Scale: Introduction

What Is Illness Management and Recovery?

Illness Management and Recovery (IMR) is an evidence-based psychiatric rehabilitation practice. The primary aim of IMR is to empower consumers with severe mental illness (SMI) to manage their illness, find their own goals for recovery, and make informed decisions about their treatment by teaching them the necessary knowledge and skills. IMR involves a variety of interventions designed to help consumers improve their ability to overcome the debilitating effects of their illness on social and role functioning. Evidence supporting the effectiveness of illness management is available in studies focusing on the specific interventions as well as those evaluating comprehensive intervention packages.

The core evidence-based components of illness management are psychoeducation, behavioral tailoring for medication, relapse prevention training, and coping skills training. Psychoeducation provides the basic information about the nature of specific psychiatric disorders and the principles of treatment. Behavioral tailoring helps consumers manage daily medication regimes by teaching them strategies that make taking medication a part of their daily routine. Relapse prevention training teaches consumers to identify triggers of past relapses and early warning signs of an impending relapse, and helps them develop plans for preventing relapse. Coping skills training involves identifying people's current coping strategies for dealing with persistent psychiatric symptoms and either increasing their use of these strategies or teaching new strategies. To effectively teach these components and to ensure that knowledge is put into practice, practitioners use a variety of techniques including motivational, educational and cognitive-behavioral strategies. Throughout the IMR program, practitioners help people to set and achieve their personal goals.

Overview of the Scale

The IMR Fidelity Scale contains 13 items that have been developed to measure the adequacy of implementation of IMR programs. Each item on the scale is rated on a 5-point behaviorally-anchored rating scale ranging from 1 ("Not implemented") to 5 ("Fully implemented"). The standards used for establishing the anchors for the "Fully implemented" ratings were determined through a variety of expert sources as well as empirical research.

What is Rated

The scale is rated on current behavior and activities, not planned or intended behavior. For example, in order to get full credit for Item 3 ("Comprehensiveness of Curriculum"), it is not enough that the program is currently developing a curriculum.

How the Rating Is Done

The fidelity assessment is conducted through a site visit. It requires a minimum of 4 hours to complete, although a longer period of assessment will offer more opportunity to collect information and hence should result in a more valid assessment. The data collection procedures

include chart review, review of educational handouts, and semi-structured interviews with the IMR program leader, IMR practitioners, and IMR consumers. When feasible, fidelity assessors should observe one or more IMR sessions (either live or a videotaped session).

The IMR fidelity assessment is primarily based on documentation in progress notes. Consequently, if these notes do not exist or are not easily available, the fidelity assessment will take a very different course. The goal is to examine the charts and 5 most recent progress notes of IMR sessions for each of 5 IMR consumers (preferably ones who have received IMR training for several months) for each of 3 IMR practitioners. If a practitioner has fewer than 5 IMR consumers, then use the charts and progress notes for all IMR consumers for that practitioner. If the site has more than 3 IMR practitioners, then the program leader should select 3 IMR practitioners for review. The fidelity assessors should aim to interview at least 3 consumers (one each per practitioner) for whom progress notes are available.

The ideal is that the consumers chosen for review are randomly selected. It is also possible that the progress notes will not be integrated into the consumer charts (although this is optimal). In any situation, both the charts and the progress notes should be reviewed.

Who Does the Ratings

Fidelity assessments should be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews). In addition, interviewers need to have an understanding of the nature and critical ingredients of IMR. We strongly recommend that all fidelity assessments be conducted by at least two assessors.

IMR Fidelity Assessor Checklist

Before the Fidelity Site Visit:

- *Establish a contact person at the program.* The fidelity visit is coordinated by the site IMR program leader (or equivalent), with whom you arrange your visit. The program leader should communicate beforehand the purpose and scope of your assessment to the IMR practitioners. Schedule your visit when key staff are available and ideally when you can observe an IMR session. Exercise common courtesy in scheduling well in advance, respecting the competing time demands on practitioners, etc.
- *Create a timeline for the fidelity assessment.* Fidelity assessments require careful coordination and good communication, particularly if there are multiple assessors. For instance, the timeline might include a note to make reminder calls to the program site to confirm interview dates and times.
- *Establish a shared understanding with the site being assessed.* It is essential that the fidelity assessment team communicates to the each site the goals of the fidelity assessment. Assessors should also inform sites about who will see the report, whether the program site will receive this information, and exactly what information will be provided. The most successful fidelity assessments are those in which there is a shared goal among the assessors and the program site to understand how the program is progressing according to evidence-based principles. If administrators or line staff fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. It is particularly important that fidelity assessors explain during a baseline interview that the goal is to obtain an initial picture of the program, and that high fidelity is not expected when a program is just starting.
- *Indicate what you will need from respondents during your fidelity visit.* In addition to the purpose of the assessment, briefly describe what information you will need, who you will need to speak with, and how long each interview or visit will take to complete. *The first step is to determine which practitioners are providing IMR training and which consumers are receiving IMR.* The site visit will go more smoothly if the contact person can assemble the following information beforehand:
 - List of names of IMR practitioners
 - Roster of IMR consumers assigned to each practitioner
 - A copy of agency brochure
 - A copy of IMR program mission statement
 - Copies of curriculum and educational handouts
 - Total number of consumers served by the IMR program in the previous year
 - Number of consumers who dropped out of the IMR program in the previous year
 - Charts and progress notes

The goal is to examine the charts along with the 5 most recent progress notes for IMR sessions for each of 5 IMR consumers (preferably ones who have received IMR training for several months) for each of 3 IMR practitioners. (See Appendix for sample progress note.)

During Your Fidelity Site Visit:

- *Overview:* The general strategy in conducting program fidelity assessments is to obtain data from as many sources as possible. When all these data sources converge, then one can be more confident in the validity of the ratings. However, experience suggests that the sources often disagree. A review of progress notes should precede practitioner and consumer interviews. If the IMR interventions are well documented in progress notes, and the fidelity assessor is convinced that practitioners both understand the forms and have completed them conscientiously (by querying the practitioners and the program leader), then these progress notes can be used as the primary source for making ratings on the fidelity scale. If the information from different sources is not in agreement, (for example, if the program leader indicates a higher rate of use of a particular technique than is documented in the records), then ask the program leader to help you understand the discrepancy. The results from a chart or progress note review can be overruled if other data (e.g., team leader interview, internal statistics) refute it.

The first step in the fidelity assessment is an interview with the IMR program leader. The fidelity assessors should begin by reviewing the purpose for the visit and the schedule for the day. Explain that after the interview with the program leader, you will begin by reviewing charts and that the goal is to examine 5 progress notes for each of 5 IMR consumers (preferably ones who have received IMR training for several months) for each of 3 IMR practitioners. The schedule will then include interview with the 3 practitioners and with 1 IMR consumer for each practitioner.

- The recommended schedule is as follows:
 - Interview with program leader
 - Review of progress notes and charts
 - Observation of IMR session(s)
 - Interviews with 3 IMR practitioners
 - Interviews with 3 IMR consumers
 - Final interview with program leader (to clarify information from the day; fill in gaps, etc.)

Tips:

- *Tailor terminology used in interviews to the site.* For example, if the site uses the term “client” for consumer, use that term. Similarly, if practitioners are referred to as clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the assessor will improve communication.
- During the interview, *record all the important names and numbers* (e.g., numbers of practitioners, active IMR consumers, etc.) on the cover sheet.
- *If discrepancies between sources occur, query the IMR program director/coordinator, practitioners, or program leaders to get a better sense of the program’s performance in a*

particular area. The most common discrepancy is likely to occur when the interview with the program staff gives a more idealistic picture of the program's functioning than do chart reviews or consumer interviews. For example, on Item 5 ("Involvement of Significant Others"), the practitioners may report that involvement of significant others in the IMR program was a common practice, while the majority of the charts reviewed may not document involvement of significant others. To understand and resolve this discrepancy, the assessor may need to go back to the practitioners and say something like, "*Involvement of family members or friends was rarely documented in the charts we reviewed. Since you had reported that you always try to involve significant others, we wanted your help to understand the difference.*"

- *Before you leave, check for missing data.* The scale is designed to be filled out completely. If information cannot be obtained at time of the site visit, it will be important for you to be able to collect at a later date

After Your Fidelity Site Visit:

- If necessary, *follow up on any missing data* (e.g., phone calls to the program site).
- Assuming there are two assessors, *both should independently rate the fidelity scale.* The assessors should then compare their ratings and resolve any disagreements. Come up with a consensus rating.
- *Tally the item scores and determine which level of implementation was achieved* (See Score Sheet).
- *Send a follow-up letter to the site.* In most cases, this letter will include a *fidelity report*, explaining (to the program) their scores on the fidelity scale and providing some interpretation of the assessment, highlighting both strengths and weaknesses. The report should be informative, factual, and constructive. The recipients of this report will vary according to the purposes, but would typically include the key administrators involved in the assessment.
- As fidelity is assessed over time, it is useful to create an Excel spreadsheet from which a graph of the total fidelity scores over time can be created and incorporated into the fidelity report.

IMR Fidelity Scale Protocol: Item Definitions and Scoring

Initial Questions:

Which practitioners are providing IMR training? Which consumers have you identified as receiving IMR? The fidelity assessment refers only to these practitioners and consumers.

Note: The program leader identifies who is defined as the IMR sample. The fidelity ratings will be influenced by the definition of the target population of consumers receiving the IMR interventions. If the definition is inclusive, the site will have a high penetration rate but possibly a low fidelity rating. Conversely, if the group is restricted to a small number, the site will have a low penetration rate but possibly a high fidelity rating.

In the questions below, the wording of the program leader interview should be modified, prefaced with the phrase, *“Do the practitioners you supervise in providing IMR...”*

1. # People in a Session or Group

Definition: IMR is taught individually or in groups of 8 or less consumers.

Rationale: IMR can be taught using either an individual or group format, each of which has its advantages. The main advantages of the individual format include individualized pacing of the teaching and increased attention. Group format, on the other hand, provides consumers with more sources of feedback, support, role models, and may be more economical; however, if the group size exceeds 8 consumers, individualized attention and participation by all consumers are likely to be compromised.

Sources of Information:

a) Program leader and practitioner interviews.

- *“Do you teach IMR both individually and in a group format?”* [If yes] *“On what condition do you provide individual sessions?”*
- *“How many consumers were in the largest group you have taught in the last 6 months?”*

b) Consumer interview.

- *“Do you attend individual or group IMR sessions? Did you have a choice between the two formats?”*
- *“How many consumers were in the largest group you have ever attended?”*

Item Response Coding: If all IMR sessions are taught individually or in groups of 8 or less consumers, the item would be coded as a “5”. In some programs more than one practitioner may co-instruct a large group session. In such a case, the rating depends on the amount of individual attention given during the session. For example, if 3 practitioners break up a class of 15 consumers into smaller groups of 5 for discussion and/or exercises, then the item would be coded as a “5”.

2. Program Length

Definition: Consumers receive at least 3 months of weekly IMR sessions or an equivalent number of IMR sessions (e.g., biweekly for at least 6 months).

Rationale: In general, between 3 and 6 months of weekly sessions are required to learn the information and skills in the modules of IMR, depending on the frequency/duration of sessions, the consumer's prior knowledge and level of skills, and the presence of cognitive impairment or symptoms that may slow the learning process. Following completion of all modules, consumers may also benefit from booster sessions or support groups aimed at using and expanding skills.

Note: Fidelity assessors should rate the scheduled duration of the training as planned by the practitioner. Consumers who drop out prematurely should be excluded from consideration of program length.

Sources of Information:

a) Chart review for consumers who completed the program.

Look for frequency of sessions and program length per consumer.

b) Program leader and practitioner interviews.

- “How long and how often are your IMR sessions?”
- “On average, how long does it take for a consumer to complete your IMR program?”
- “Do you find that some consumers only require a couple of sessions of IMR?”

c) Consumer interview.

- “How often do you attend the IMR sessions here? How long is a session?”
- “How long have you been with this program?” [If less than 3 months] “How long do you plan to continue with this program?”

Item Response Coding: If $\geq 90\%$ of IMR consumers receive weekly or an equivalent number of sessions for at least 3 months, the item would be coded as a “5”.

3. Comprehensiveness of the Curriculum

Definition: Curriculum materials for each of the following nine topic areas are available for IMR practitioners to use in their sessions:

- Recovery strategies
- Practical facts about mental illness and treatment
- The stress-vulnerability model (i.e., an illness results from an enduring predisposition that interacts with environmental stress to cause illness)
- Building social support
- Effective use of medication
- Reducing relapses
- Coping with stress
- Coping symptoms
- Getting needs met in the mental health system

Rationale: Studies of professionally based IMR training programs have identified these 9 areas as key topics. The more comprehensive the curriculum, the more beneficial the program is to the participating consumers.

Sources of Information:

a) Program leader and practitioner interviews.

- “What kinds of topics are covered in the IMR sessions?”
- “Is there an established curriculum for the IMR sessions?” [If yes] Request a copy for review. “Who developed the curriculum?”
- [To Program leader] “Do you provide practitioners with training on the curriculum? How do you make sure that the practitioners follow it?”
- [To practitioners] “Have you received training on the curriculum?”

b) Educational curriculum and handouts review.

Look to see if the curriculum and handouts adequately cover the 9 areas.
Do handouts reflect program philosophy and critical ingredients of IMR?

Item Response Coding: If the IMR curriculum materials cover 8 or more topic areas, the item would be coded as a “5”.

4. Provision of Educational Handouts

Definition: All consumers participating in IMR receive IMR handouts.

Rationale: An educational handout summarizes the main teaching points in plain language and includes useful forms and exercises. These handouts can be reviewed in the session as well as outside the session (e.g., for homework assignments). In addition, consumers can share the handouts with significant others to inform them about IMR.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of provision of educational handouts.

b) Educational curriculum and handouts review.

Look to see if the curriculum and handouts adequately cover the 9 areas.
Do handouts reflect program philosophy and critical ingredients of IMR? Are they written in simple language, tailored to both consumers and their significant others (i.e. information specifically for consumers as well as information specifically for significant others), and visually effective (e.g. information is presented in an attractive and organized way)?

c) Program leader and practitioner interviews.

- “Do you provide consumers with educational materials? [If yes] Request a copy for review. “Who developed them?”

- “Do all IMR consumers receive them? When do you provide them (e.g. upon admission, in class)? How do you use them in the session?”
- “What do you provide for consumers who cannot read?”

d) Consumer interview.

- “Do you use an educational handout/text in the IMR sessions?”
- “When did you get the handout/text?”
- “How do you use the handout/text inside and outside the session?”

Item Response Coding: If $\geq 90\%$ of IMR consumers receive written (or alternative) educational materials, the item would be coded as a “5”.

5. Involvement of Significant Others

Definition: Significant others refer to family members, friends, or any other individual in the consumer’s support network excluding professionals. “Involvement” is defined here as at least one IMR-related contact in the last month between the practitioner and the significant other OR the significant other’s involvement with the consumer in pursuit of goals identified in the IMR plan, such as assisting the consumer with homework assignments.

Rationale: Research has shown that social support has been found to help people generalize information and skills learned in sessions to their natural environment, leading to better social functioning. Social support also plays a critical role in reducing relapse and hospitalization in persons with SMI. Because developing and enhancing natural support is one of the goals of IMR, consumers are encouraged to identify significant others with whom they can share the handout materials and who will support them in applying newly acquired skills. However, the decision to involve significant others is the consumer's choice.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of involvement of significant others.

b) Practitioner interviews.

Go through the entire roster of IMR consumers. For each consumer, ask if a significant other(s) has had a least one contact with IMR staff in the last month or worked with consumer to attain IMR goals.

- “In what way do you involve consumers’ significant others? Then probe for specifics, e.g., frequency of contact, frequency of homework assignments that require participation of significant others.
- “What do you do if a consumer refuses to involve his/her significant others?”

c) Consumer interview.

- “Are your family members or friends involved in your treatment?” [If yes] “In what way?”
- “Do they help you with your homework?”
- “Have they attended the sessions with you?”
- “Do they have regular contact with your practitioners?”

- “What has the program done to get them involved?”
- “Do you want them to be more involved?”

Item Response Coding: If $\geq 90\%$ of IMR consumers involve significant others (i.e., at least monthly contact reported by the practitioner, or involvement reported by the consumer), the item would be coded as a “5”.

6. **IMR Goal Setting**

Definition: Practitioners help consumers identify realistic and measurable goals. The goals should be pertinent to the recovery process and can be very individualized, but there should be linkage between the goal and the IMR plan.

Rationale: One of the objectives of the IMR program is to help consumers establish personally meaningful goals to strive towards. In addition to being teachers, practitioners are collaborators in helping the consumers learn how to cope with their illness and make progress towards their goals.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of IMR goal(s) and collaborative goal setting process. (Examples are given in the IMR practitioner workbook).

b) Program leader and practitioner interviews.

- “Please describe the process of IMR goal setting.”

c) Consumer interview.

- “What are your goals for IMR? Did your practitioner ask what your goals were?”

Item Response Coding: If $\geq 90\%$ of IMR consumers have at least 1 measurable personal goal(s), the item would be coded as a “5”.

7. **IMR Goal Follow-up**

Definition: Practitioners and consumers collaboratively follow up on goal(s) identified in Item 6.

Rationale: A core value of IMR is to facilitate consumers’ pursuit of their goals and progress in their recovery at their own pace. Therefore, the goals and the steps to be taken toward the goals need ongoing evaluation and modification.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of follow-up on IMR goal(s) (Examples are given in the IMR practitioner workbook).

b) Program leader and practitioner interviews.

- “Do you review the consumers’ progress towards achieving their IMR goal(s) on a regular basis?” [If yes] “How often? Please describe the review process.”
- “What do you do if a consumer would like to change his/her IMR goal(s)?”

c) Consumer interview.

- “Do you and your practitioner together review your progress toward achieving your personal goal(s)? [If yes] How often? Please describe the review process.”

Item Response Coding: If $\geq 90\%$ of IMR consumers have documentation of continued follow-up on their goal(s), the item would be coded as a “5”.

8. Motivation-Based Strategies

Definition: Practitioners regularly use motivation-based strategies, which include:

- Helping the consumer see how learning specific information and skills could help him/her achieve short and long-term goals
- Helping the consumer explore the pros and cons of change
- Helping the consumer put past experiences in more positive perspectives
- Instilling hope and increasing self-efficacy (i.e., belief that the consumer can achieve the goal).

Rationale: Motivation-based strategies reflect the understanding that a therapeutic relationship must be established before attempting to address IMR. Furthermore, unless consumers view learning specific information or skills as being relevant to their own needs or desires, they will not be motivated to invest the necessary effort in learning.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of motivation-based strategies used in a session.

b) Practitioner interview.

For each of the motivation-based strategies checked in the recent progress/session notes, probe for details by asking open-ended questions, e.g., “I notice you checked ‘explore pros & cons of change’ in 6 of 10 sessions. Could you describe the process you used with the consumer to ‘explore pros & cons of change’ in your most recent session.”

c) Consumer interview.

For each of the motivation-based strategies checked in the recent progress/session notes, probe for details using a layperson’s language. For example, if the majority of the progress/session notes reviewed indicate ‘instilling hope & self-efficacy’ as a common practice, ask, “Do the practitioners make you feel hopeful [confident]? Please describe how they made you feel that way in your most recent session.”

Item Response Coding: If $\geq 50\%$ of IMR sessions use at least 1 motivation-based strategies, the item would be coded as a “5”.

9. Educational Techniques

Definition: Practitioners embrace the concept of and regularly apply educational techniques, which include:

- **Interactive teaching:** Frequently pausing when presenting information to get the consumer's reaction and perspective, talking about what the information means, and clarifying any questions that may arise.
- **Checking for understanding:** Asking consumers to summarize information in their own language rather than asking yes or no questions, such as, "Did you understand?"
- **Breaking down information:** Providing information in small chunks
- **Reviewing information:** Summarizing previously discussed information (both by the practitioner and the consumer)

Rationale: Educational techniques are the pillars in teaching basic information and ensuring that consumers understand. For example, interactive teaching not only makes learning an interesting and lively activity, but also conveys to consumers that they have important contributions to make to the learning process and that the practitioner is interested in what they have to say.

Sources of Information:

a) **Chart review (especially IMR progress/session notes).**

Look for documentation of educational techniques used in a session.

b) **Practitioner interview.**

For each of the educational techniques checked in the recent progress/session notes, probe for details by asking open-ended questions, e.g., "*I notice you checked 'interactive teaching' in 6 of 10 sessions. Could you please describe the 'interactive teaching' in your most recent session.*"

c) **Consumer interview.**

For each of the educational techniques checked in the recent progress/session notes, probe for details using a layperson's language. For example, if the majority of the progress/session notes reviewed indicate 'checking for understanding' as a common practice, ask, "*Do the practitioners check your understanding of the material covered during the session? Can you think about your most recent session and describe how they made sure you understood what was covered in the session.*"

Item Response Coding: If $\geq 50\%$ of IMR sessions use at least 1 educational technique, the item would be coded as a "5".

10. Cognitive-Behavioral Techniques

Definition: Practitioners regularly use cognitive-behavioral techniques to teach IMR information and skills, which include:

- **Positive reinforcement:** Positive feedback following a skill or behavior designed to increase it or to encourage a consumer's efforts to use a skill.

- **Shaping:** Reinforcement of successive approximations to a goal. The practitioner recognizes the multiple steps and individualized pacing necessary for consumers to learn complex skills, and provides frequent reinforcement as they progress toward the goal.
- **Modeling:** Demonstration of skills.
- **Role playing:** A simulated interaction in which a person practices a behavior/skill.
- **Cognitive restructuring:** Practitioners help the consumer describe the situation leading to the negative feeling, make a link between the negative emotions and the thoughts associated with those feelings, evaluate the accuracy of those thoughts, and, if they are found to be inaccurate, identify an alternative way of looking at the situation that is more accurate.
- **Relaxation training:** Teaching strategies to help consumers relax.

Rationale: There is strong evidence for the efficacy of cognitive-behavioral techniques in helping consumers to develop and maintain social skills, use medication effectively, develop coping strategies for symptoms, and reduce relapses.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of cognitive-behavioral techniques used in a session.

b) Practitioner interview.

For each of the cognitive-behavioral techniques checked in the recent progress/ session notes, probe for details by asking open-ended questions, e.g., “*I notice you checked ‘cognitive restructuring’ in 6 of 10 sessions. Could you describe the ‘cognitive restructuring’ in your most recent session.*”

c) Consumer interview.

For each of the motivation-based strategies checked in the recent progress/session notes probe for details using a layperson’s language. For example, if the majority of the progress/session notes reviewed indicate ‘role playing’ as a common practice, ask, “*Do you get to practice new skills with others in the session [or as a homework]? How often? Could you give us examples from your most recent session?*”

Item Response Coding: If $\geq 50\%$ of IMR sessions use at least 1 cognitive-behavioral technique, the item would be coded as a “5”.

11. Coping Skills Training

Definition: Practitioners embrace the concept of, and systematically provide, coping skills training that includes:

- Exploring the coping skills currently used by the participant;
- Amplifying the current coping skills and/or teaching new coping strategies;
- Behavioral rehearsal of the coping skill;
- Evaluating the effectiveness of the coping skill; and
- Modifying the coping skill as necessary.

Rationale: Coping skills training is used to improve the ability of consumers to cope with persistent symptoms.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of coping skills training in a session.

b) Practitioner interview.

For each practitioner who checked coping skills training in the recent progress/ session notes, probe for details by asking open-ended questions, e.g., *“I notice you checked ‘coping skills training’ in 6 of 10 sessions. Could you describe the ‘coping skills training’ methods you used in your most recent session?”*

c) Consumer interview.

If coping skills training is indicated in the recent progress/session notes as a common practice, probe for specific components using a layperson’s language, e.g., *“Have you talked about or learned new coping skills in your recent sessions? Could you give me some examples?”*

“Do you feel more confident today in your ability to cope with symptoms?”

Item Response Coding: If all practitioners are familiar with and regularly practice coping skills training, the item would be coded as a “5”.

12. Relapse Prevention Training

Definition: Practitioners embrace the concept of and systematically apply relapse prevention training that include:

- Identification of environmental triggers;
- Identification of prodromal signs;
- Stress management;
- Ongoing monitoring;
- Rapid intervention when indicated

Rationale: Studies have shown that training in relapse prevention strategies is effective in reducing symptom severity, relapses, and rehospitalization.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of relapse prevention training in a session.

b) Practitioner interview.

For each practitioner who checked relapse prevention training in the recent progress/ session notes, probe for details by asking open-ended questions, e.g., *“I notice you checked ‘relapse prevention training’ in 6 of 10 sessions. Could you describe the ‘relapse prevention training’ methods you used in your most recent session?”*

c) Consumer interview.

If relapse prevention training is indicated in the recent progress/session notes as a common practice, probe for specific components using a layperson's language, e.g.,
"Have you discussed ways that you can avoid going back to the hospital your recent sessions? What kind of things did you learn about relapse prevention?"
"Do you feel more confident today in your skills in preventing relapse?"

Item Response Coding: If all practitioners are familiar with and regularly practice relapse prevention training, the item would be coded as a "5".

13. **Behavioral Tailoring for Medication**

Definition: Practitioners embrace the concept of and use behavioral tailoring for medication. Behavioral tailoring includes developing strategies tailored to each individual's needs, motives and resources (e.g., choosing medication that requires less frequent dosing, placing medication next to one's toothbrush so it is taken always before brushing teeth).

Rationale: Behavioral tailoring is especially effective in helping consumers manage their medication regime as prescribed.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of behavioral tailoring in a session.

b) Practitioner interview.

For each practitioner who checked behavioral tailoring for medication in the recent progress/session notes, probe for details by asking open-ended questions, e.g., *"I notice you checked 'behavioral tailoring for medication' in 6 of 10 sessions. Could you describe the 'behavioral tailoring for medication' methods you used in your most recent session?"*

c) Consumer interview.

If behavioral tailoring for medication is indicated in the recent progress/session notes as a common practice, probe for specific components using a layperson's language, e.g.,
"Sometimes we miss taking medication and regret it later. Have you and your practitioner discussed what you can do at home to prevent that? Could you give us some examples of the strategies?"
"Do you feel more confident today in taking medication as prescribed?"

Item Response Coding: If all practitioners are familiar with and regularly practice behavioral tailoring, the item would be coded as a "5".

IMR Fidelity Scale Cover Sheet

Date: _____ Rater(s): _____

Program Name: _____

Address: _____

Contact Person: _____ (Title _____)

☎: _____ Fax: _____

E-mail: _____

Names of the IMR Practitioners:

Number of consumers identified as receiving IMR services: _____
(The IMR questions refer to these consumers.)

Sources Used:

____ Progress notes ____ Chart review

____ IMR curriculum review

____ Interview with IMR Program Director/Coordinator

____ Interview with IMR Program leader

____ Interview with IMR practitioners

____ Interview with consumers

Number of IMR practitioners: _____

Number of IMR consumers served in preceding year: _____

Date program was started: _____

IMR Fidelity Scale Score Sheet

Program: _____ Date of Visit: _____

Informants – Name(s) and Positions: _____

Number of Records Reviewed: _____ Rater: _____

RATINGS

1. # People in a Session or Group	1	2	3	4	5
2. Program Length	1	2	3	4	5
3. Comprehensiveness of the Curriculum	1	2	3	4	5
4. Provision of Educational Handouts	1	2	3	4	5
5. Involvement of Significant Others	1	2	3	4	5
6. IMR Goal Setting	1	2	3	4	5
7. IMR Goal Follow-up	1	2	3	4	5
8. Motivation-Based Strategies	1	2	3	4	5
9. Educational Techniques	1	2	3	4	5
10. Cognitive-Behavioral Techniques	1	2	3	4	5
11. Coping Skills Training	1	2	3	4	5
12. Relapse Prevention Training	1	2	3	4	5
13. Behavioral Tailoring for Medication	1	2	3	4	5

TOTAL SCORE _____

APPENDIX

Illness Management and Recovery Progress Note 8/3/02B

Name: _____ ID# _____ Date: _____

Name of significant other(s) involved in session: _____

Problem or goal specified by the treatment plan that is the focus of the person's treatment:

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

TREATMENT/INTERVENTIONS PROVIDED:

Motivational interventions (check all that apply):

- connect info and skills with personal goals
- promote hope & positive expectations
- explore pros and cons of change
- re-frame experiences in pos. light

Educational interventions ((check the topic(s) that were covered)):

- Recovery strategies
- Practical Facts about Mental Illness
- Stress-Vulnerability
- Social Support
- Using Medication
- Reducing relapses
- Coping with Stress
- Coping w/ Symptoms & Problems
- Mental Health system

Cognitive-behavioral interventions (check all that apply):

- reinforcement
- shaping
- modeling
- role playing
- cognitive restructuring
- relaxation training

Specific evidence-based skill taught (identify which one(s))

coping skill for dealing with symptoms: _____

relapse prevention skill: _____

behavioral tailoring for medication: _____

Homework that was agreed upon: _____

OUTCOME (person's response to info, strategies & skills provided in the session)

Person's perspective: _____

Practitioner's perspective: _____

PLAN for next session: _____

Person's signature: _____ Practitioner's signature _____