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The next issue of the *South Central MIRECC Communiqué* will be published June 3, 2009. Deadline for submission of items to the June newsletter is May 25, 2009. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Mary Sue Farmer, at Mary.Farmer2@va.gov

South Central MIRECC Internet site: www.va.gov/scmirecc

National MIRECC Internet site: www.mirecc.va.gov

RECOVERY CORNER

USING GAS TO FUEL RECOVERY: A LOOK AT GOAL ATTAINMENT SCALING

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The VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (2008), states, "Mental health services must be recovery-oriented." One approach to achieving this is offering evidence-based practices (EBP) to those with chronic mental health concerns, which subsequently addresses implementation at the systems level. The Schizophrenia Patient Outcomes Research Team (PORT) study describes some of these EBPs including Assertive Community Treatment, family interventions, Supported Employment, skills training, Cognitive-Behavioral Therapy, and Token Economy Interventions (Lehman et al, 2004). The implementation of these services and others is supported in the Uniform Mental Health Services handbook, and monitoring has been established to determine if VA medical centers and associated community clinics are, in fact, adequately employing these practices across the country.

Another approach examines recovery-oriented implementation at

the individual level, namely between the provider and the Veteran. The task is to identify practices applicable to various mental health settings and providers, which captures the diverse needs of Veterans. One potential recovery-oriented practice that meets these needs is goal setting. Goals are the foundation of the therapeutic interaction, though they may not always be explicit. Setting goals has been determined to be an effective way of achieving behavioral changes (Locke & Latham, 2002), and according to Turner-Stokes (2009), "there is emerging evidence that goals are more likely to be achieved if patients are involved in setting them". Goal Attainment Scaling (GAS) developed by Kiresuk and Sherman (1968) to evaluate treatment-induced change provides a method by which to set and measure individualized goals. This is critical in the recovery transformation occurring within VA mental health services as GAS is both an intervention and outcome measure that can be used across levels of care, is person-centered, and encourages collaboration and communication

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Using GAS to Fuel Recovery continued...

Goal Attainment Scaling (GAS) provides a method for the provider and Veteran to set and monitor goals that are important to the individual. There are six steps described by Kiresuk et al. (1982; 1994) involved in setting the goals, which upon completion is documented on the Goal Attainment Follow-Up Guide. The process for setting the goals draws from the well-known SMART principles. SMART goals are **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**imed. In the first step of GAS, the Veteran would describe broad goals he/she would like to achieve. This could be anything from obtaining a job or making a friend to improving self-esteem.

In the second step of Goal Attainment Scaling, the broad goal is broken down into the behavior, skill, process, or affect on which the Veteran could focus. From among these indicators, one element is selected as a relevant and accurate measure of progress on the goal. Examples could include obtaining a paycheck, socializing with a person in the community, or attributing more positive attributes to one's self than negative ones.

A realistic time frame is chosen to achieve the goal in the third step. Time frames can be based on the length of the intervention (e.g., span of hospitalization or stay in a residential facility or number of sessions in a manualized treatment) or some collaboratively established time frame (e.g., six months).

In the fourth step, the expected outcome is defined. Frequencies, percentages, intensities, or judgments are recommended to describe what the Veteran and provider believe can be achieved. Talking with a friend twice a week and feeling more positively about one's self 50% of the time in the last two weeks are just a few examples of outcomes.

Other possible outcomes include "more" and "much more than expected" along with "less" and "much less than expected", and are described in the fifth step. Describing these outcomes is easily accomplished by varying the frequency, percentage, intensity or judgment, being mindful to leave no gaps between outcome levels, and limiting the outcomes to only one variable per level. Using the socialization example, "less than expected,"

could be defined as talking once per week with a friend, while not talking at all with a friend could be "much less than expected". To incorporate the idea of ranges of behaviors, "more than expected," for this goal could be talking with a friend 3-5 times per week, and "much more than expected," could be talking to a friend six or more times in a week.

In the final step, the Goal Attainment Follow-Up Guide is reviewed for potential problems that an independent rater could experience in determining the level of goal achievement. The provider can do this by taking a perspective of not-knowing and by reviewing the outcomes for consistency with SMART principles. If you knew nothing about the Veteran, would you be able to rate the outcome based on the information on the Follow-Up Guide? Are the outcomes described specific, measurable, attainable, realistic, and timed? An example of a more formal method to evaluate follow-up guides is provided in Kiresuk, Smith, and Cardillo (1994).

A brief look at the Goal Attainment Scaling (GAS) research is meant to further support the inherent assertion that this is a recovery-oriented evidence based practice. GAS has been found to be widely and enthusiastically utilized in a variety of fields including nursing, social work, rehabilitation, and in various settings within mental health like drug and alcohol treatment, day treatment, and inpatient units (Kiresuk, Smith, & Cardillo, 1994; Lewis et al., 1987). A more recent review by Hurn et al. (2006) established that GAS has "reliability, validity and sensitivity" with adults and older adults. In terms of recovery orientation, Grenville and Lyne (1995) deemed GAS to be a "truly patient-centered approach", which could assist in multidisciplinary collaboration. The individualized approach, empowerment and self-direction aspects of recovery are evident across the specified process of setting goals as described earlier. While there are research and quality assurance applications of GAS, usefulness as a clinical intervention is a relevant focus for Communiqué readers. Austin et al. (1979) asserted, "GAS is a treatment intervention by itself since it stimulates therapist and patient alike to set concrete, realistic goals and to monitor their progress toward them".

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RECENT MIRECC PUBLICATIONS

RACIAL AND ETHNIC DIFFERENCES IN THE TREATMENT OF SERIOUSLY ILL PATIENTS: A COMPARISON OF AFRICAN-AMERICAN, CAUCASIAN AND HISPANIC VETERANS

Braun UK, McCullough LB, Beyth RJ, Wray NP, Kunik ME, Morgan RO

Journal of the National Medical Association, 2008, 100(9): 1041-1051

No national data exist regarding racial/ethnic differences in the use of interventions for patients at the end of life. Our objective was to test whether, among three cohorts of hospitalized seriously ill Veterans with cancer, noncancer or dementia, the use of common life-sustaining treatments differed significantly by race/ethnicity. We conducted a retrospective cohort study during fiscal years 1991-2002. The sample included hospitalized Veterans >55 years, defined clinically as at high-risk for six-month mortality, not by decedent data. Utilization patterns were identified by race/ethnicity for five life-sustaining therapies.

Logistic regression models evaluated differences among Caucasians, African Americans and Hispanics, controlling for age, disease severity and clustering of patients within Veterans Affairs (VA) medical centers. Among 166,059 Veterans, both differences and commonalities across diagnostic cohorts were found. African Americans received more or the same amount of end-of-

life treatments across disease cohorts, except for less resuscitation [OR = 0.84 (0.77-0.92), $p = 0.002$] and mechanical ventilation [OR = 0.89 (0.85-0.94), $p < 0.0001$] in noncancer patients. Hispanics were 36% (cancer) to 55% (noncancer) to 88% (dementia) more likely to receive transfusions than Caucasians ($p < 0.0001$). They received similar rates as Caucasians for all other interventions in all other groups, except for 161% higher likelihood for mechanical ventilation in patients with dementia.

Increased end-of-life treatments for both minority groups were most pronounced in the dementia cohort. Differences demonstrated a strong interaction with the disease cohort. Differences in level of end-of-life treatments were disease-specific and bidirectional for African Americans. In the absence of generally accepted, evidence-based standards for end-of-life care, these differences may or may not constitute disparities.

THE FAMILY FORUM: DIRECTIONS FOR THE IMPLEMENTATION OF FAMILY PSYCHOEDUCATION FOR SEVERE MENTAL ILLNESS

Cohen AN, Glynn SM, Murray-Swank AB, Barrio C, Fischer EP, McCutcheon SJ, Perlick DA, Rotondi AJ, Sayers SL, Sherman MD, Dixon LB

Psychiatric Services 2008; 59(1): 40-48

It is well documented that family psychoeducation decreases relapse

rates of individuals with schizophrenia. Despite the evidence, surveys indicate that families have minimal contact with their relative's treatment team, let alone participate in the evidence-based practice of family psychoeducation. The Department of Veterans Affairs (VA) sponsored a conference, the Family Forum, to assess the state of the art regarding family psychoeducation and to form a consensus regarding the next steps to increase family involvement.

The forum reached consensus on these issues: family psychoeducation treatment models should be optimized by efforts to identify the factors mediating their success in order to maximize dissemination; leadership support, training in family psychoeducation models for managers and clinicians, and adequate resources are necessary to successfully implement family psychoeducation; because family psychoeducation may not be appropriate, indicated, or acceptable for all families, additional complementary strategies are needed that involve families in the mental health care of the patient; and work is required to develop and validate instruments that appropriately assess the intervention process and consumer and family outcomes. A treatment heuristic for working with families of persons with severe mental illness is also offered and provides a match of interventions at varying levels of intensity, tailored to family and consumer needs and circumstances. The article describes opportunities for the research and clinical communities to expand the proportion of families served.

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INFLUENCE OF FAMILY INVOLVEMENT AND SUBSTANCE USE ON SUSTAINED UTILIZATION OF SERVICES FOR SCHIZOPHRENIA.

Fischer EP, McSweeney JC, Pyne JM, Williams DK, Naylor AJ, Blow FC, Owen RR

Psychiatric Services, 59(8):902-908

This observational study assessed the influence of family support and substance abuse on patterns of service use by individuals with schizophrenia. Polychotomous logistic regression was used to

analyze an existing database for 258 individuals with schizophrenia who were between the ages of 18 and 67 and were recruited from public mental health care settings. Analyses determined the extent to which two consumer-identified factors, family support and substance abuse status, influenced patterns of outpatient service use (regular, irregular, and infrequent) for schizophrenia. After the analysis adjusted for insight into illness, cognitive functioning, rural or urban residence, and gender, comorbid substance abuse and the interaction between substance abuse status and family support were significantly associated with patterns of service use. Comorbid substance abuse predicted irregular or infrequent patterns of service use over time. Stratified analyses indicated that weekly family support

substantially reduced the adverse impact of substance abuse status on consumers' patterns of service use, especially for those living in rural areas.

This study provides evidence that ongoing family support is associated with substantial reductions in the adverse impact of substance abuse on consumers' patterns of service use, especially for consumers living in rural areas. If confirmed in other populations, study findings suggest that reinforcing services and support for family members who provide informal care helps to sustain involvement in care by the especially vulnerable population of individuals with a dual diagnosis of schizophrenia and substance abuse.

MAY CONFERENCE CALLS

CALL-IN NUMBER: 1-800-767-1750

		ACCESS CODE
12	MIRECC Leadership Council, 3:30 PM CT	19356#
19	VISN 16 Mental Disaster Team, 11AM CT	76670#
20	MIRECC Program Assistants, 2PM Central	43593#
25	MIRECC Education Core, 3:00 PM CT--CANCELLED	16821#
26	MIRECC Leadership Council, 3:30 PM CT	19356#
28	National MIRECC & COE Education Implementation Science Group, 1:00 PM CT	28791#

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For Local Recovery Coordinators, helping mental health providers and Veterans utilize recovery-oriented practices is critical. The reality is that the transformation to recovery-oriented practice is laden with many barriers. This article is meant to assist you in enhancing the recovery journey of Veterans by offering one practical approach. My use of Goal Attainment Scaling on an individual and group level excites me about what this method has to offer for furthering recovery-oriented practice. For more information, contact me at Cristina.Gamez-Galka@va.gov.

References

- Austin, N. K., Liberman, R. P., King, L. W., & DeRisi, W. J. (1979). A comparative evaluation of two day hospitals. *Journal of Nervous and Mental Disease*, 163(4), 253-262.
- Grenville, J., & Lyne, P. (1995). Patient-centered evaluation and rehabilitative care. *Journal of Advanced Nursing*, 22, 965-972.
- Hurn, J., Kneebone, I., & Cropley, M. (2006). Goal setting as an outcome measure: A systematic review. *Clinical Rehabilitation*, 20, 756-772.
- Kiresuk, T. J., & Sherman, R. E. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community Mental Health Journal*, 4(6), 443-453.
- Kiresuk, T. J., Smith, A., & Cardillo, J.E. (Eds.). (1994). Goal attainment scaling: Applications, theory, and measurement. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Kiresuk, T. J., Stelmachers, Z. T., & Schultz, S. K. (1982). Quality assurance and goal attainment scaling. *Professional Psychology*, 13(1), 145-152.
- Lehman, A.F., Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., Dixon, L. B., Goldberg, R., et al. (2004). The schizophrenia patient outcomes research team (PORT): Updated treatment recommendations 2003. *Schizophrenia Bulletin*, 30(2), 193-217.
- Lewis, A. B., Spencer, J. H., Haas, G. L., & DiVittis, A. (1987). Goal attainment scaling: Relevance and replicability in follow-up of inpatients. *Journal of Nervous and Mental Disease*, 175(7), 408-418.
- Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist*, 57, 705-717.
- Turner-Stokes, L. (2009). Goal attainment scaling (GAS) in rehabilitation: A practical guide. *Clinical Rehabilitation*, 23, 362-370.
- VHA Handbook 1160.01 (2008). Uniform Mental Health Services in VA Medical Centers and Clinics, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762

CLINICAL EDUCATOR GRANTS REQUESTS COMING SOON!

The South Central MIRECC will soon release a request for applications for **2010 Clinical Educator grants**. These grants are designed to encourage frontline clinicians and educators to develop innovative educational tools or programs that target under-served or hard-to-reach veterans and/or their families and address their mental health needs, especially in rural settings.

Clinicians and educators have previously used these grants in a number of ways: to develop new educational tools, develop new educational programs and modify existing materials or put them in a new format.

Watch your email for this announcement!

THE SOUTH CENTRAL MIRECC CONSUMER ADVISORY BOARD (CAB) VETERAN PROFILE: RAY WODYNSKI

Interviewed By Carrie Edlund, MS

To ensure that the SC MIRECC is responsive to consumers of VA mental health services, and in keeping with the direction of the President's New Freedom Commission recommendations, the SC MIRECC and the VISN 16 Mental Health Product Line established the network Consumer Advisory Board. This month we profile CAB Recorder and Vet to Vet Program Facilitator Ray Wodynski.

What does the CAB Recorder do, and how long have you been serving in that position?

The Recorder for the CAB coordinates and records monthly meetings, distributes meeting information to members, and keeps an archive of CAB activities. I've served on the Michael E. DeBakey VAMC CAB in Houston for 11 years. I have also served on the MIRECC CAB, which includes 10 hospitals within the VISN 16 network, for 10 years. Being a member of this CAB allows me to share information and bring back valuable information to our local council.

You must enjoy the work.

All the CAB work is interesting and I enjoy all of it as it is representing all the Veterans. Bringing the Vets' concerns to the Board is very important. It validates their concerns and lets them know we respect their opinions. This year I assisted with the rewrite and updating of the Mental Health Consumer/Advocate Council Guide, a valuable tool for the consumer councils.

You are a Veteran yourself, aren't you?

Yes, I did ten years in the Marine Corps and three Vietnam tours. I was in the infantry. I remember the early morning hours of July 16, 1966 when we were overrun by a combo Viet Cong/North Vietnamese unit and ended up in hand-to-hand combat. We finally called artillery air strikes in on ourselves to keep from being annihilated. I volunteered to stay an extra 6 months on that first tour and returned for two more.

Are you involved in other activities to support Veterans?

Yes, I am a Facilitator, twice a week, for the Vet to Vet Program (a peer support program for Vets) at the Houston Michael E. DeBakey VAMC. I am also an active member of the Trauma Recover Program (TRP) Alumni group. That group was originally started in 1997 or 1998 by six Veterans, including myself, who had just

completed the twelve-week hospital trauma recovery program. After completing our program, where for 12 weeks we went through together as a structured group 9-3 Monday through Friday, we felt somewhat abandoned when we moved to after care. We started this alumni group, met for coffee, made it a self-help group, talked, bonded, and started a picnic with wives. Now ten years later we have 40-45 members, with two staff members from TRP as the liaisons. We meet every Friday at the VAMC. Once a month we prepare breakfast for the current TRP patients. On the other Fridays of the month we support the TRP patients by attending the breakfast they prepare and share with us. The alumni are available to talk with the current TRP patients at these breakfasts. The alumni group also has an off-site picnic once a month and the current TRP patients are invited to attend with spouse and family members. We have each other to fall back on, we have each other's phone numbers, and our wives can call each other for support too.

It sounds like the group does a lot of good.

Yes, and I'm happy we're starting to get some OEF/OIF Veterans involved. We post notices at the hospital and in the hospital newsletter, and I speak to Veterans groups and reserve units to let them know about our work. Our Christmas party sponsors homeless Veterans as well. Homeless walk-in Vets not ready to seek more extended care can get a good meal. In addition, the TRP staff members offer an open door policy, so members can get right in to an appointment with participating staff members who will see you right away.

What do you wish the public knew about mental health?

Mental Illness is nothing to be ashamed about or looked at as something terrible. Those individuals with a mental illness are not special or different than anyone else.

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It is also important for the public to have a better understanding of how mental illness happens, for example the circumstances surrounding its onset.

Do you want to tell us something about your hobbies and interests outside work?

My hobbies are golf, boating, and belonging to the Galveston Bay Parrot Head Club. The club does community involvement—cleans a section of highway, does a beach clean up, and holds a car wash to raise money for Alzheimer's, among other activities. Our yearly fundraiser collects money for the local shelter for battered women and children, and more. It's one of 3000 clubs like it around the country.

MEET YOUR CBOC: WICHITA FALLS, TX

PARENT FACILITY: FAYETTEVILLE, VAMC

By Mary Farmer & Kristin Ward

In October 2008, the SC MIRECC team had the opportunity to visit the Wichita Falls CBOC. The City of Wichita Falls is located in the North East corner of the Panhandle/Plains area of North Texas. Wichita Falls can be summed up with two words, pleasant and comfortable. It is conveniently located within two hours of two metropolitan areas with populations exceeding one million citizens; Dallas-Fort Worth and Oklahoma City. Wichita Falls has a population of approximately 107,000, is the county seat of Wichita County, and is considered the population center of North Texas. The city has a wonderful thirteen-mile-long trail system that winds through neighborhoods and along attractive streams for use by walkers, joggers, bicyclers and rollerbladers and an additional parks system featuring 39 parks within the city limits.



The greater Wichita Falls area has 185 manufacturing companies producing products for major automotive manufacturers, oil and gas production, construction, aircraft manufacturers, food service providers, water recreation and more. Within a 60-mile radius of Wichita Falls, there are more than 393,000 people, of whom approximately 152,000 are in the workforce.

Wichita Falls also offers state-of-the-art medical facilities and services that have made it the health care choice of residents throughout North Texas and Southern Oklahoma. Included in these facilities is the **Veterans Clinic of North Texas CBOC**. This CBOC has very high scores on patient satisfaction, which was evident as we met the staff at the clinic. The CBOC has one VA psychologist, Russell Smith, Ph.D., and also one social worker, Jack Ramsey, LCSW. Russell is new to the VA, and provides VA video telemedicine (VTEL) services to Blackwell, Konawa and Ardmore, OK. The primary care team is an integral part that provides screening and referrals to Russell. The mental health portion of the clinic provides individual therapy, relaxation training, biofeedback, and cognitive processing therapy (CPT) as part of their services. Russell is also working with Michelle Sherman, Ph.D. on the SAFE program at the OKC VA Medical Center. In

April, Russell attended the SC MIRECC retreat in Houston and served as a member of a CBOC panel that provided insights into how the SC MIRECC can partner with the VISN 16 CBOCs to provide the best mental health care for our Veterans.

Russell and his wife, Tracy, had dinner with us at a wonderful Mexican restaurant. If you are in Wichita Falls, drop by and see Russell!