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“Closing the efficacy-effectiveness gap”

Editor’s note: This article continues our series on a recovery model of care. Helping veterans to identify their goals for treatment and to break down those goals into manageable steps is the foundation of recovery oriented services. However, clinicians may be just as puzzled about how to solicit veterans’ goals as the veterans themselves are when asked to identify their treatment goals. This article suggests guidelines for soliciting treatment goals.

Goal-Setting in a Recovery System of Care

Delores Hendrix-Giles, LCSW
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There are many paths to recovery from mental illness, but common to all of them is the consumers’ identification of self-determined goals. Historically, the medical model of health care has taken a parental approach to goal-setting and treatment planning. The goals identified in the medical model often have more to do with the program’s available services and the provider’s care priorities, rather than the consumer’s desires. Although this model is well-intentioned, it loses a key element of recovery: the consumer’s voice.

By contrast, in the recovery model, consumers’ involvement in goal-setting is not just important but is essential, as described and endorsed in the Mental Health Systems Act- Consumer Rights:

Right to Participate in Treatment Decisions - Consumers can and should be encouraged to be full participants in all treatment and treatment planning decisions. Consumer participation should be demonstrated by more than a signature-through active mutual goal planning, assessment, and decision making, no matter how long or involved the process may be (Adapted from Title V., Section 501 of the Mental Health Systems Act, 42 U.S.C. 9501) (Curtis & Hodge, 1994).

Goal-setting in recovery necessitates that consumers prioritize goals and objectives according to their personal experience and values. Ideally, in determining their goals, consumers should integrate knowledge about the opportunities and constraints of their social environment with their providers’ assessments and with their own preferences about the best paths for achieving their goals (Pratt et al., 2002).

However, soliciting consumers’ goals can be difficult. Consumers may never have been asked before to think about their goals, and they may need help in formulating them. Providers can assist consumers in identifying goals by using behaviorally specific and consumer-friendly language and techniques, such as the following ones taken from the *Psychiatric Rehabilitation Skills Manual* (2002):

Give the veteran advanced notice – Consumers should know that you plan to discuss recovery goals in the next session. This allows them time to think about their goals.

Give clear directions/instructions – It is important to help consumers understand exactly what’s needed. For clear communication, define the meaning of “goals,” give examples (e.g., learn how to

use a computer), and distinguish between short-term (e.g., six months) and long-term (e.g., two years) goals.

Give appropriate examples and prompts – Consumers often say “I don’t know” to questions about goals. While some persons may be satisfied with the status quo, most people can identify some goals when given a few prompts. To prompt thinking, ask questions about how things are going in various areas of life (e.g., socially, interpersonally, recreationally, spiritually, occupationally).

Give ample time for responses; don’t rush – When goals are set too quickly or without careful thought, it is difficult for consumers to be committed to reaching them.

Give meaningful categories or topics for goals – Treatment outcomes identified as important to consumers include recovery, empowerment, quality of life, autonomy and choice, personhood, improved functioning, and symptom reduction. Think about what these terms mean to the consumer you’re working with. For instance, autonomy might mean that “I make decisions for myself.” An example of a goal question might be, “John, do you have any trouble making decisions or living with the decisions you make?”

Phrase goals as statements developed through discussion – Consumers may have trouble translating what they would like to achieve or change into sensible goal statements. Offer examples and ask questions to help them clarify what they want. For example, a consumer might say, “I want to live some place different.” You might follow up with, “Tell me more about what you mean when you say ‘some place different.’ Do you mean a different group home, a different city, or a different type of home?”

Goals should be behaviorally specific (what will the consumer *do?*), challenging but realistic, and stated in a positive form; they should include a target date for review and or completion. You can also help consumers with goal setting by helping them acquire improved skills in decision making, motivation, cost-benefit analysis, and problem-solving.

Most people want to make decisions and plans for their own lives. Self-determined goals empower consumers to take ownership and responsibility for their lives—a crucial step in recovery. Goal-setting through the recovery model offers consumers and providers an opportunity to partner with one another in this important task.

Curtis, L.C., and Hodge, M. (1994). Old Standards, New Dilemmas: Ethic and Boundaries in Community Support Services. *Introduction to Psychosocial Rehabilitation*, 344.

Pratt, C.W., Gill, K.J, Barrett, N.M. & Roberts, M.M. (2002). *Psychiatric Rehabilitation*. San Diego, CA: Academic Press.

Center for Psychiatric Rehabilitation. (2002). In *2002 Psychiatric Rehabilitation Certificate Program Instructors Manual: Psychiatric Rehabilitation Skills Lecture 3: Interactive Skills for Setting and Achieving Goals* (pp. 3.2-3.3). Chicago, IL: University of Chicago.

MIRECC Retreat & Grants Workshop in Houston

South Central MIRECC investigators and administrators as well as VISN 16 Mental Health clinical leaders will meet in Houston March 7-8 for a Retreat. The purpose of the meeting is to discuss current issues in the MIRECC and ongoing research and clinical education initiatives and to plan for the next year. Trainees will also attend and will have the opportunity to present their research.

The Retreat will be immediately followed by a 1.5 day workshop on grant writing.

Meet the MIRECC Researchers: Dr. Ellen Fischer

Ellen P. Fischer, PhD

Research Health Scientist, Center for Mental Healthcare & Outcomes Research (CeMHOR),
Central Arkansas Veterans Healthcare System
Associate Professor, Departments of Psychiatry and of Epidemiology,
University of Arkansas for Medical Sciences, Little Rock, Arkansas

Editor: *What is your area of research?*

Dr. Fischer: I am an epidemiologist by training. Since coming to Arkansas in 1991, I've been doing mental health services research, mostly related in some way to healthcare for people with schizophrenia. My colleagues and I have developed interview instruments for measuring outcomes of care for people with schizophrenia. We have also looked at the influence of dual diagnosis and of rural residence on outcomes; consumer, family, and provider priorities among various outcomes and services, as well as factors influencing sustained involvement in care for schizophrenia.

Editor: *What active studies do you have going?*

Dr. Fischer: At the moment, I'm completing analysis of data from an HSR&D-funded study of consumer and family member perspectives on what helps and hinders long-term involvement in care among people with schizophrenia. It is a mixed qualitative and quantitative methods study that combines information from interviews with consumers (half of whom use VA care) and their family members with analysis of a utilization dataset from earlier studies to try to get a different perspective on retention in care and attrition from care. I have also been working with colleagues from Ann Arbor on their related study of retention that takes advantage of the very large VA National Psychosis Registry dataset. In October 2006, I ended a 5-year "tour of duty" as chair of the UAMS College of Public Health Department of Epidemiology. I'm looking forward to having time to be able to develop a research agenda in a new (for me), but related, area – recovery. I think this is a very exciting moment in VA with the transformation of VA mental healthcare services to a recovery-orientation. It's exciting in terms of what it can mean for veterans with mental disorders and in terms of research. I think expanding my focus to do research around recovery and the

recovery transformation will let me pull together a lot of my ongoing interests around SMI, family involvement in care, retention in care, preferences and decision-making.

Editor: *What are the implications or potential benefits of your research?*

Dr. Fischer: I think everything we do in mental health services research is done with the intention of improving the health and healthcare of veterans. I hope that the work I'm doing on retention will help the VA make it easier for veterans to sustain an appropriate level of involvement in care and, because most people with schizophrenia who are receiving services have better clinical and functional outcomes when they have regular patterns of service use, that that will lead to better outcomes for more veterans.

Editor: *How did you get started in this area of research?*

Dr. Fischer: Serendipity. I had recently completed my doctorate and was looking for new opportunities. The VA and UAMS centers in mental health services research were looking for an epidemiologist. I had done my dissertation on suicide and become interested in mental health. A friend of mine who was also friends with folks at Little Rock got us together and I've been happily learning more and more about mental health and mental health services research ever since.

Editor: *What person or experience had the most influence on your research career?*

Dr. Fischer: I really couldn't identify one person who single-handedly had the greatest influence on my career. That's not how it happened for me. I have been privileged to work with an amazing team of talented and generative investigators who have guided my career and who have connected me with

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an even broader group of investigators outside of Little Rock with similar research interests.

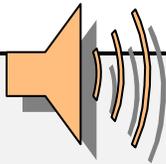
Editor: *What advice would you give to junior investigators and to people who are new to research?*

Dr. Fischer: I would advise anyone new to research to actively seek out and take advantage of opportunities for mentoring – no matter how old you are. I was a “late PhD” who did not take advantage of the protected time and mentoring

opportunities connected to post-doctoral fellowships; that was a big mistake on my part. I would also advise new investigators to look for what I did and do enjoy – a team of talented and nurturing colleagues with whom to work. Collaboration is so much fun and so much more effective than trying to do things in isolation.

Editor: *How can people get in touch with you if they have questions about your work?*

Dr. Fischer: E-mail is the surest and most efficient way to reach me: FischerEllenP@uams.edu.



No MIRECC Research Rounds in March

No Bringing Science to Practice Presentation in March

Due to the timing of the South Central MIRECC Retreat later this month, the Research Rounds and the Bringing Science to Practice web-based presentation have been cancelled for March. These programs will resume at their regularly scheduled times in April. Watch this newsletter for details.

Online Resources for Psychiatric Rehabilitation

Compiled by Kathleen Dohoney, PsyD, VA North Texas Health Care System, Dallas, and Lisa Martone, APN, Central Arkansas Veterans Health Care System, Little Rock

www.gacps.org/Home.html Georgia Certified Peer Specialist Project

The mission of the Georgia Certified Peer Specialist Project is to identify, train, certify and provide ongoing support and education to consumers of mental health services, to provide peer support as part of the Georgia mental health service system, and to promote self-determination, personal responsibility and empowerment inherent in self-directed recovery. This site provides a description of their training program, scheduled trainings, a consumer’s manual that can be downloaded, a code of ethics for Peer Specialists, an on-line “bulletin board” for Peer Specialists, and other links and resources.

www.healthyplace.com HealthyPlace.com

This is the largest consumer mental health website, providing comprehensive information on psychological disorders and psychiatric medications from both a consumer and expert point of view. The site has active chat rooms, hosted support groups, breaking mental health news, mental
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health videos, online documentary films, and a mental health radio show. HealthyPlace.com is divided into various “communities” representing major psychological interests and psychiatric diagnoses. In each “community,” there are independently run sites that provide information and support. You will also find transcripts from relevant chat conferences, links to people who keep online diaries/journals of what it’s like living with a specific disorder, and buddy lists to find a support pal.

www.iccd.org/default.aspx **International Center for Clubhouse Development**

The International Center for Clubhouse Development (ICCD) was created in 1994 to serve and represent the rapidly growing and dynamic clubhouse community. The ICCD is a global network, creating opportunities for people living with mental illness to be respected members of society. ICCD clubhouses are founded on the realization that recovery from serious mental illness must involve the whole person in a vital and culturally sensitive community. A clubhouse community offers respect, hope, mutuality and unlimited opportunity to access the same worlds of friendship, housing, education and employment as the rest of society. The ICCD promotes the development and strengthening of clubhouses; oversees the creation and evolution of standards; facilitates and assures the quality of training, consultation, certification, research and advocacy; and provides effective communication and dissemination of information.



Coding Books Available in Stat!Ref

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Stat!Ref has the complete ICD-9-CM - Volumes 1, 2 and 3 (2007) and Ingenix® CPT with RVUs Data File (2007). Now you can quickly and easily locate ICD-9 and CPT codes from your desktop! [Click here to learn how now!](#)

New Grants & Publications by MIRECC Personnel

Below are selected new grants and publications by South Central MIRECC personnel since May 2006. MIRECC personnel are indicated in bold face. Please contact the lead author for further information about the study or paper. A partial list of recent presentations will appear in the April issue.

Grants:

Fortney J (PI), Pyne J, Sullivan G, Edlund M, Steffick D, Williams K, Bynum A, Mattox R, Rost K. Telemedicine-based collaborative care to reduce rural health disparities. NIMH, 1 R01 MH076908-01. 9/21/2006 to 6/30/2011. \$2,192,824.

Mulvihill J (PI), **Teasdale T** (Co-PI). Neurofibromatosis 1 in Old Age: International Interdisciplinary Analyses of the Issues. Department of Defense. 1/01/2006 to 2009.

Teasdale T (PI). Contract to produce a series of 10 Self-Instructional / Distance Learning Modules in Geriatric Medicine. Mt. Sinai School of Medicine. 1/01/2007 to 12/31/2007.

Publications

Clancy J, & Sheafor B (2006). Social work with U.S. casualties of the Middle Eastern Wars. In A. Morales, B. Sheafor, & M. Scott (Eds.), *Social work: A profession of many faces, 11th edition*, (pp. 273-287). Boston: Allyn & Bacon.

Cully JA, Graham DP, Stanley MA, Ferguson CJ, Sharafkhaneh A, Soucek J, Kunik ME (2006). Quality of life in patients with chronic obstructive pulmonary disease and comorbid anxiety or depression. *Psychosomatics*, 47, 312-319.

Fischer P (2006). The link between posttraumatic growth and forgiveness: An intuitive truth. In L. Calhoun and R. Tedeschi (Eds.), *Handbook of posttraumatic growth*, (pp. 311-333). Mahwah, NJ: Lawrence Erlbaum.

Kauth MR (2006). The evolution of human sexuality: An introduction. *Journal of Psychology & Human Sexuality*, 18(2/3).

Kauth MR (2006). A brief history of evolutionary theory: Context, concepts, assumptions, and human sexuality. *Journal of Psychology & Human Sexuality*, 18(2/3).

Kauth MR (2006). Epilogue: Implications for conceptualizing human sexuality. *Journal of Psychology & Human Sexuality*, 18(4).

Kauth MR (Ed., 2006). *The Handbook of the Evolution of Human Sexuality*. Binghamton, NY: Haworth.

Kauth MR (2006). Sexual orientation and identity. In RD McAnulty and MM Burnette (Eds.), *Sex and Sexuality: Volume I*, (pp. 208-257). Westport, CT: Praeger.

Pyne JM, McSweeney J, Kane HS, Harvey S, Bragg L, Fischer E (2006). Agreement between patients with schizophrenia and providers on factors of antipsychotic medication adherence. *Psychiatric Services*: 57(8); 1170-1178.

Rachal F, **Kunik ME** (2006, March). Treating aggression in patients with dementia. *Psychiatric Times*, XXV(3), 90.

Sautter FJ, Lyons J, Manguno-Mire G, Perry D, Han X, Sherman M, Myers L, Landis R, & Sullivan G (2006). Predictors of partner engagement in PTSD treatment. *Journal of Psychopathology and Behavioral Assessment*, 28, 123-130.

Sherman MD (2006). Updates and five-year evaluation of the S.A.F.E. Program, A family psychoeducational program for serious mental illness. *Community Mental Health Journal*, 42(2), 213-219.

Sherman MD, Sautter F, Jackson H, Lyons J, & Han X (2006). Domestic violence in veterans with posttraumatic stress disorder who seek couples therapy. *Journal of Marital and Family Therapy*, 32(4), 479-490.

Stanley MA, Veazey C, Hopko D, Diefenbach G, **Kunik ME** (2005). Anxiety and depression in chronic obstructive pulmonary disease: a new intervention and case report. *Cognitive Behavioral Practice*, 12(4), 424-436.

Sullivan G, Han X, Moore S, Kotrla K (2006). Disparities in hospitalization for diabetes among persons with and without co-occurring mental disorders. *Psychiatric Services*: 57(8); 1126-1131.

Tan G, Alvarez JA, Jensen JP (2006). Complementary and alternative medicine (CAM) approaches to pain management. *Journal of Clinical Psychology: In session*, 62(11), 1419-1431.

Tan G, Jensen M, Thornby J, Anderson KO (2006). Are patient ratings of chronic pain services related to treatment outcome? *Journal of Rehabilitation Research & Development*, 43(4), 451-460.

Tan G, Rintala D, Yang J, Wade W, Vasilev C (2006). Treating spinal cord injury pain with cranial electrotherapy stimulation. *Journal of Rehabilitation Research & Development*, 43(4), 461-474.

Teasdale TA, & Taffet GE (2006). Constructing a research budget. In Gerontological Society of America, *Multidisciplinary Guidebook for Clinical Geriatric Research*.

Teng E, Friedman LC, Green CE (2006). Determinants of colorectal cancer screening behavior among Chinese Americans. *Psychooncology*, 15(5), 374-381.

Wardell DW, Rintala DH, Duan Z, **Tan G** (2006). A pilot study of healing touch and progressive relaxation for chronic neuropathic pain in persons with spinal cord injury. *Journal of Holistic Nursing*, 24(4), 231-240.



March Conference Calls 1-800-767-1750

- 5—Education Core, 2:00 PM CT, *cancelled due to retreat*
- 12—Research Rounds, 2:00 PM CT, *cancelled due to retreat*
- 13—Directors Call, 3:30 PM CT, access code 19356#
- 15—PSR Group Call, noon PM CT, access code 85388#
- 21—Program Assistants, 2:00 PM CT, access code 43593#
- 22—National MIRECC Recovery Interest Group, access code 22233#
- 27—Directors Call, 3:30 PM CT, access code 19356#

The next issue of the *South Central MIRECC Communiqué* will be published April 2, 2007. Deadline for submission of items to the April newsletter is March 27. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Michael R. Kauth, Ph.D., at Michael.Kauth@med.va.gov.

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

SC MIRECC intranet site: yaww.visn16.med.va.gov/mirecc/mirecc.htm

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