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ABSTRACT

The process of implementing Goal Attainment Scaling at the Reno Veterans' Administration Center Mental Health Service, where it had never been employed and where most of the staff had never heard of the technique, is described. The difficulties of introducing a unique measurement instrument such as Goal Attainment Scaling into an existing system are presented, together with the theoretical issues surrounding the use of Goal Attainment Scaling and the many practical problems that arise with any attempt to implement innovations in existing systems. This report describes in detail the method of implementation, the specific problems encountered, and the actions taken in response to those problems. The concluding section provides an account, based on follow-up interviews, of the overwhelming positive response of the patients to the implementation of Goal Attainment Scaling. (Author)

GOAL ATTAINMENT SCALING: AN EXPERIENCE IN IMPLEMENTATION*

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GOAL ATTAINMENT SCALING: AN EXPERIENCE IN IMPLEMENTATION

In the fall of 1976 efforts were initiated to implement Goal Attainment Scaling (GAS) in the Mental Health Service of the Reno Veterans Administration Hospital. This report describes the method of implementation, specific problems encountered, and actions taken to overcome those problems. Initially, a little background information is helpful.

Background

After years of no psychiatric beds at the Reno VA Hospital, a 24-bed Inpatient Unit of the Mental Health Service opened in February 1976. Outpatient Services and the Medical-Surgical Liaison Unit of the Mental Health Service were activated somewhat earlier, in October 1975.

Both the inpatient and outpatient units employ a multidisciplinary team approach to treatment. Treatment goals represent the negotiated product of patient concerns and staff suggestions. For each patient a primary therapist is designated who has the responsibility for assuring that the treatment plan is followed. While there are two major classifications of treatment, inpatient and outpatient, the components of that treatment, such as medication or individual psychotherapy, will vary and will be determined by the needs of the individual patient and the resources of the Mental Health Service.

Given the expected heterogeniety of the patient population and the variety of treatment approaches that were to be employed, it was proposed

that Goal Attainment Scaling might prove to be of value for both clinical and research purposes. A one-year Feasibility Study, funded by the Veterans Administration Health Services Research and Development Service, began in the fall of 1976. The study provided an opportunity to try out GAS in a situation in which it had never been employed, the Reno VA Mental Health Service, and with a staff who for the most part had never heard of the technique.

Initial Implementation

Introducing a totally unique measurement instrument, such as GAS, and attempting to incorporate it into an existing system is not a simple task. We were fortunate in having the active support of the Chief of the Mental Health Service and his personal interest in making the study a successful undertaking.

A two-day training workshop on GAS was provided for all staff. a post-training test demonstrated a high level of understanding of the method, and unsigned evaluations of the workshop indicated a very positive reception on the part of the Mental Health Service staff. Thomas Kiresuk, Ph.D., Director of the Program Evaluation Resource Center, followed up the workshop three weeks later with a two-day consultation session with the Research staff.

After that time, the Research staff provided all necessary consultation to the Mental Health Service on the construction of Goal Attainment Follow-up Guides and the development and refinement of necessary skills. As new personnel joined the Mental Health Service the two research interviewers provided all necessary training in GAS.

Procedural guidelines were formulated, in concert with the administrators of the Mental Health Service, to provide step-by-step guidance for staff in handling as many issues as could be foreseen in implementing the Feasibility Study. All patients to whom treatment was provided, beginning November 1, 1976, were considered as potential participants.

Among the responsibilities of the primary therapist was the development, in conjunction with the patient, of a tentative treatment plan and a personalized set of goals or expectations based upon that patient's specific problems and abilities. Without GAS the establishment of treatment goals would still be one of the first steps in the treatment process. These personalized goals were used to define, in behavioral terms, possible treatment outcomes using the GAS format. The Goal Attainment Scales were required within 72 hours for inpatients or prior to the third outpatient session.

The research interviewer conducted a follow-up interview with the patient at the termination of treatment. Based on this interview the research worker scored each scale on the Goal Attainment Follow-up Guide for that patient and computed a total Goal Attainment Score. At the end of the interview the patient was asked to fill out a 34-item Patient Satisfaction Scale, to respond to several open ended questions on the patient's perception of his or her own progress, and to make whatever recommendations the patient wished about the treatment program of the Mental Health Service.

A Word About Accountability

A host of recently established accreditation, legal, and funding requirements mandated the implementation of some management information and accountability system for all treatment services. GAS can be viewed as the start of such an accountability system. For example, the primary therapists became openly accountable, through the formal documentation of GAS, for the setting of specific, initial treatment goals and for the relative success in achieving those goals. Nevertheless, even without GAS, some methods and procedures for adequate documentation and accountability would have been required.

The introduction of accountability into any system can produce, at the very least, some feelings of discomfort, distrust, or apprehension among treatment staff. The problem can be especially acute in mental health treatment settings wherein a relatively high degree of uncertainty prevails in many determinations of etiology, diagnosis, or course of treatment for individual patients. Several of the functional problems arising with the implementation of GAS clearly were related to or confounded with the more general issue of accountability.

Problems with GAS

The initial response of the clinical staff to GAS was mixed. Some staff members were found to be cooperative and willing to make the necessary effort to learn the method and to develop treatment goals for their patients. Other staff members were resistive despite repeated efforts to explain the

rationale, resolve questions, and facilitate the development of skill and ease in scaling goals. As a result of both the early imprecision of our procedures and the relative lack of enthusiasm of the clinical staff, the number of patients given follow-up interviews in the early months of the study was much smaller than the number of patients treated during that pe[redacted].

Finally, in a potentially risky effort to directly confront the resistance, an Evaluation Participation Form was devised and distributed to each primary therapist. This form offered an opportunity to withdraw from the study for those staff members who were not interested in participating or alternatively asked for a signed commitment to cooperate with the study by providing specified forms and materials at indicated times. The decision to fully participate in the study was unanimous. The Research staff saw this as symbolic recognition of the permanence of the research program and a foretaste of an increasingly visible and viable research effort.

Despite the fact that one of the original purposes of the Feasibility Study was to gain insight into the clinical implications of GAS, the clinical staff initially regarded this technique as more paper work, as a task to aid the Research Office with no value for the patient or therapist. Through persistent yet supportive monitoring by the Research staff the inherent clinical merits of GAS eventually "hooked" the mental health staff on its direct relevance to patient treatment.

From a position of resistance by many staff members, the Mental Health Service staff gradually moved into and then through a position of compliance and finally, about five months into the study, to acceptance with varying degrees of enthusiasm. Symbolic of the attitudinal change was the formal decision of the Mental Health Service staff to adopt GAS as a clinical treatment planning tool in addition to its use as a criterion measure for research purposes. Subsequently a gradual and progressive improvement in the quality of the Goal Attainment Scales took place, and submission of the Goal Attainment Follow-up Guides to the Research Office became more prompt.

Unfortunately, the optimism felt by the Research staff after the fifth month of the study proved to be somewhat premature. Despite the stated acceptance of GAS as a clinical tool by the Mental Health Service, when problems developed, staff still found it convenient to adopt the attitude that GAS was just more paper work that took valuable time away from clinical duties. Such an attitude usually led to complaints that the Research staff was too rigid and uncompromising. The following list describes 15 of the most troublesome problems that had to be dealt with.

1. The intake person was not always the assigned therapist; hence who would be responsible for the goals?
2. When would Goal Attainment Follow-up Guides be done? The lengthy intake procedure for outpatients might take two or three sessions. Some therapists maintained that treatment issues were not immediately

discernable and requested longer periods before goal setting.

3. Some therapists said that the goals were constantly changing so that immediate issues became irrelevant later in treatment.
4. The tracking system set up by treatment staff to monitor patient assignments, both to therapists and treatment modalities, was never current. Hence tracking for Follow-up Guides that were due was difficult.
5. Goals were sometimes not submitted when due, and reminders that goals were overdue produced staff promises that were on occasion not kept.
6. Non-negotiated goals. Sometimes goals were submitted that had not been developed with the participation of the patient.
7. Assignment of a new admission to a therapist scheduled to be off duty for two or more days, thereby making it impossible to have goals submitted within 72 hours of admission.
8. Follow-up Guides hastily constructed with continued use of scaling methods previously designated as not feasible for effective follow-up.
9. Setting goals that were not clinically relevant; that is, they were not related to the patient's mental health problems.
10. Technically deficient goals. For example, goals that were much too vague, overlapping scales, etc.

11. Failure to notify the patient of an appointment with the research interviewer for follow-up. In some cases lack of communication between shifts, or between clerical and treatment staff, was a factor.

12. Notifying the Research Office of a patient's discharge too late to arrange for a follow-up interview.

13. Occasional "misunderstanding" of the requirements and procedures of the Feasibility Study.

14. Some patients remained in treatment indefinitely, thus making follow-up impossible.

15. Some patients dropped out of treatment prematurely with no advance warning, thus making follow-up difficult to arrange.

In addition, a subtle, persistent, and perhaps even insidious phenomenon arose that was based upon the acronym for Goal Attainment Scaling - GAS. There developed a tendency among all clinical staff, not just those resistant to GAS, to refer to the technique as "gassing". Although such terminology may seem innocuous, patients overhearing staff references to "gassing" or comments such as, "Has that patient been gassed yet?" frequently do not understand such terminology.

From the very beginning of the Feasibility Study, the Research staff took steps to prevent many problems and to deal with others as soon as they appeared. Listed below are some of the ongoing efforts by the Research staff.

1. The two research interviewers reviewed every Goal Attainment Follow-up Guide produced by the treatment staff and provided feedback and individual supervision in the construction of the goals.
2. Research staff attended all mental health staff meetings, both clinical and administrative, to provide ongoing training and supervision in GAS, to establish effective liaison between the Mental Health Service and Research Office, and to facilitate communication of mutual problems for discussion and resolution.
3. The Research Coordinator attended the regular meetings of the Program Coordinators of the Mental Health Service to resolve administrative issues (including staff resistance to the Feasibility Study).

The fact that these efforts were not successful in resolving all problems and eliminating all resistance early in the year of the Feasibility Study does not imply that such actions are ineffective. Retrospectively, the consensus of the Research staff is that such procedures were absolutely essential to any success in implementing GAS.

Operational Difficulties

A large factor contributing to the reoccurrence of problems throughout the year was the relative instability of the Mental Health Service itself. The "growing pains" of the Mental Health Service produced severe problems in the implementation of GAS. Some of the specific difficulties that may be

classified as "operational" or "system-based" are listed below:

1. Relatively high, unanticipated turnover of professional mental health staff that resulted in a need for continual training in GAS for new staff members.
2. High turnover of ward clerks who are key people in providing continuity and timely compliance with established procedures.
3. Recurring changes in organizational structure or administration.
4. Instability of unit policies and procedures that at times seemed to change almost daily.

Signs of increasing stability did not emerge until the Feasibility Study was nearly complete. With so many changes in staffing, structure, procedures, and administration, a certain degree of periodic confusion and inefficiency was inevitable. In addition, every organization can expect to have at least occasional problems with individual staff members related to inexperience, personal difficulties, or conflicts. Any and all such problems can, and in our experience usually did, lead to or exacerbate one or more forms of resistance to GAS.

All of the many new clinical staff that began employment during the year were unfamiliar with GAS. Moreover, the later staff additions did not have the benefit of an initial and very intensive workshop. Therefore, the Research staff conducted a second workshop in October 1977 to provide both refresher training for existing staff and more intensive training for newer staff.

The second workshop addressed several issues. For training purposes a live goal-setting interview was presented followed by extensive group discussion. In response to some growing concern among clinical staff regarding all the data being collected by the Research Office, the workshop included a presentation, with group discussion, of a preliminary analysis of the data from the Feasibility Study. A final, but perhaps most important, objective of the workshop was to provide treatment staff with an opportunity to ventilate any unresolved problems with GAS, the activities or accessibility of the Research staff, or issues concerning the research project.

At the conclusion of the workshop all attendees were asked to complete a questionnaire, anonymously, that was designed to assess the extent to which the clinical staff believed the objectives of the workshop had been achieved. The questionnaire responses were consistently positive and encouraging.

By the end of 1977 stability on the inpatient unit had improved considerably with much less turnover of personnel. GAS seemed to be accepted as a way of life. Though problems with individual therapists did emerge from time to time, the Research staff had increasing success in resolving those problems.

By that time the staff and administration of the Mental Health Service recognized that many of the problems preventing the successful implementation of GAS also seriously impeded the efficient provision of mental health services. Specific procedures, listed below, were initiated following

joint development by service providers and Research staff.

1. All new outpatients would be contracted for a given length of treatment, usually not to exceed six months. Goal Attainment follow-up would occur at the end of the contracted period or at six months, whichever came first.
2. A grid sheet was developed to accurately track the status and flow through the system of each patient.
3. At a weekly outpatient staff meeting a multidisciplinary screening committee would review and recommend all transfers, intake assignments, status changes, therapist assignments, and contracted length of treatment.

Research and Mental Health Service staff are continuing to meet in efforts to develop mutually acceptable methods and procedures for successfully achieving their respective objectives. As part of the current research project that followed the Feasibility Study, a three-member Goal Monitoring Committee was established to review the goals and scales developed by the primary therapists. This committee consists of the Chief of the Mental Health Service, Chief of the Nursing Service, and a faculty member of the Department of Psychiatry and Behavioral Science of the Medical School at the University of Nevada at Reno.

None of these three people are directly involved in setting treatment goals for individual patients or providing direct services to patients, yet all three are mental health experts who have been key persons in the

development of the treatment philosophy and the treatment programs of the Mental Health Service. This committee, using a random selection process, reviews one out of every four Goal Attainment Follow-up Guides and makes a set of judgments on each scale: is the scale appropriate and relevant to the concerns and identified problems of the patient; is the scale clinically realistic, that is, are the outcome statements reasonable in light of the clinical condition of the patient, the treatment resources available, and the time span planned for treatment? Feedback from this committee to the primary therapist is producing a high level of goal setting proficiency.

Reaction of Patients

The patients have overwhelmingly supported the efforts of the Research staff in the evaluation of the Mental Health Service, as evidenced by their interest, enthusiasm, and participation in the follow-up interview.

At the start of the project, patients often were confused or uncertain about the purpose of the interview, despite the fact that a complete and personal orientation to the research program was to be given by the primary therapists. Since the Research staff believed it was essential to provide each patient with an early and consistent explanation about the follow-up interview, the information giving procedure was changed. The research interviewers personally met new patients and once monthly presented information on the research program at the patient government meeting. The presentation

covered the purpose and goals of the mental health research project, the GAS method, the reasons it was employed, the nature of the follow-up interview, and the importance of patient participation.

Much interest has been displayed in the kinds of information being collected and in what form and to whom it would be presented. Unsolicited comments by the patients supported the importance of having treatment goals that they participated in establishing. The Patient Satisfaction Scale and the related questions put to them by the research interviewers seemed to appeal to the altruism of the patients. Although their evaluation of services at termination could not improve the quality of their treatment experiences, it might benefit the next veteran hospitalized in the Mental Health Service. The research project clearly had the support and active participation of most patients as soon as they were acquainted with its purpose and the relevance of their cooperation to its success.

Concluding Statement

At the Reno VA Hospital Goal Attainment Scaling has been successfully implemented under very difficult circumstances. Hopefully this discussion of some of the specific problems encountered during one implementation effort will help others who may be planning or initiating implementations elsewhere. Meanwhile our research project has begun to generate extensive data on Goal Attainment Scaling that should enhance our understanding of this fairly recent innovation.