Goals and Goal Based Outcomes (GBOs)

Some Useful Information

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Duncan Law

Consultant Clinical Psychologist

Hertfordshire Partnership NHS Foundation Trust

CONTENTS

Acknowledgements 4

Introduction 5
- Goal Based Outcomes (GBOs)
- Why Measure Outcomes
- Using this information

Goal Based Outcomes 7
- What are goal based outcomes (GBOs)?
- They are a measure of what the service user wants to achieve
- They allow measurement across a broad spectrum of interventions
- Do GBOs dictate a way of working?
- Do GBOs fit with the CAPA model?

Goal Setting & Negotiating 9
- Helping to set goals
- Goals can be problem focused
- Goal setting should be collaborative
- The goal must be agreed on, and owned by the person asking for help
- How many goals and ranking of goals
- Scoring goals
- Dangerous and 'Unacceptable' Goals
- 'Stuck' goals
- What if goals change?

Cautions When Using GBOs 12
- Subjectivity – "A Double Edged Sword"
- Beware 'Perverse' Goal Setting
- Guarding Against GBOs Problems

Using Goals in Clinical Practice: Goals Focused Interventions 13
- What are goal focused interventions?
- It is a therapeutic stance rather than a therapeutic model
- Promoting shared decision making
- It works on the principle that there are many potential vehicles that can get you to the same destination

Using Goals in Clinical Practice: Tracking Progress 14
- Regular and session-by-session monitoring of goals
- GBO Progress Charts

References 16

Appendix 1 17

CORC Protocols for GBOs
Submitting data to CORC central
Collecting GBOs from multiple perspectives
Some Examples of Scoring Goals
Summary and Record Sheets

Appendix 2 20

Summary and Record Sheet

Acknowledgements

I can't really begin to pass this off as my own work – it is a combination of hard work over many years from pioneers of clinical outcome measurement, those who have striven to make it useful, simple and effective. The ideas here are particularly shaped by the members of the CORC collaboration, alongside the team of excellent clinicians, and the children, young people, their families and carers I have worked with over the years in Hertfordshire CAMHS.

Introduction

Goal Based Outcomes (GBOs)

Sometimes it is important to know what you don't want, and where you don't want to be, before you can be clear about what you do want, and where you want to get to. In my clinical experience this is often where Children and Young People (CYP) and their families who come to services are, at the first appointment. With this in mind, let me start by saying what Goal Based Outcomes (GBOs) are not, and then move on to say what they are – a bit like you might do in a session helping a young person move from knowing what they don't want, and towards some idea of where they want to get to in the future:

1. First of all GBOs are not purporting to be anything new, the ideas and techniques on the following pages have been used by therapists, clinicians and practitioners over many years, and in many different ways. What I hope to do here is to bring together some useful ideas about goals and goal based outcomes into one place, and offer a chance to share some of the learning of using GBOs. It is intended as a guide for you to pick out ideas that you might want to use – the only bit that is a manual, is the section that relates to using GBOs as part of the CORC protocols, to ensure that there is some consistency in the way GBOs are recorded, and the data that is passed on to CORC (see appendix). It is written with CORC in mind but I hope the ideas will be of use to people who are not part of the CORC collaboration. It won't tell you everything you might want to know about the subject, but I hope it gives a useful summary for clinicians wishing to use GBOs either as part of CORC, or more broadly as a clinician interested in using goals as a tool to work more collaboratively with children and young people.

2. GBOs are not a model of therapy, nor do they try to promote any one particular therapeutic modality above another. GBOs can be used with any intervention, and any therapeutic modality. GBOs are simply a way of deciding at the beginning of an intervention where you want to head for, and a way of allowing you to track progress along the way, or at the end to see how far along your agreed track you have managed to get. Having said that, it is true that some therapeutic modalities have goals, and the monitoring of goals, already built into the intervention themselves, e.g. Cognitive Behavioural Therapy (CBT), Cognitive Analytic Therapy (CAT), and Solution Focused therapies, but hopefully any therapeutic process starts with a joint understanding of what the goals of the intervention are (the destination) before the therapy (the vehicle to get you there) begins.

3. Third, GBOs are certainly not making any claims to be the 'silver bullet' of outcome measures, they are one way of getting useful information about progress in an intervention, and are best used as part of a battery of outcome measures, in conjunction with sound clinical feedback and judgement, to get the best picture of how well an intervention has gone – to share with the client, to use in supervision, for your own reflective practice, or as evidence of good work for service managers and commissioners.

Although most of the ideas in this document are focused on work with CYP and their families and carers, the ideas can equally be used in adult mental health and learning disability settings. All of the material is free to use, and none of the materials are copyrighted. Feel free to copy and adapt pages as you wish, all we ask is that you give us (me, my NHS trust, and the CORC collaboration) a bit of credit if you do!

Why Measure Outcomes

Over the past decade clinical outcome monitoring in CAMHS has become part of the therapy landscape; its importance has grown due to political drivers to monitor and evaluate services and new initiatives, commissioners have increasingly been interested in receiving evidence that the services they commission provide good value and effectiveness, and supervisors and managers have encouraged clinicians to produce more objective information to evidence their practice. But, for me, the most important use of outcome monitoring is to use the information it provides to change clinical practice; you can have all the outcome monitoring in the world, the most sophisticated measures, and the most powerful data base, an army of data analysts, and a sea of data – but the only valuable use

of clinical outcomes is when the information is used by clinicians to improve what they do when they are in a room with a client.

My interest in developing a goals based measure was my belief that the most important measure of change is that which children, young people and their families have chosen to make themselves.

I hope you find the ideas helpful and I hope the ideas here help you move a little further forward in your clinical practice.

Using this information

For those of you familiar with the first version of this paper it should seem quite familiar in terms of its format and structure. Most of what has been added has been in response to requests from people using GBOs – these have included requests for suggestions of what you might actually say to a CYP or family when setting goals – so we have added some suggestions of wording along the way - but these are just suggestions, not scripts. Also, by request, is a section on using GBOs session-by-session, and a section on using the GBOs as a focus of therapy – but again these are just sharing of ideas and not a suggestion that GBOs should always be used in this way. Some sections you will find more interesting and useful than others – feel free to dip in and out as you please.

Goal Based Outcomes

What are goal based outcomes (GBOs)?

Goal based outcomes (GBOs) are a way to evaluate progress towards a goal in clinical work with children and young people, and their families and carers (but the ideas can equally be adapted to work in adult mental health or learning disability settings). They simply compare how far a young person feels they have moved towards reaching a goal they set at the beginning of an intervention, compared to where they are at the end of an intervention (or after some specified period of input). GBOs use a simple scale from 0-10 to capture the change (see Appendix 1. - GBO record sheets which can be downloaded from the CORC website, www.corc.uk.net). The outcome is simply the amount of movement along the scale from the start to the end of the intervention. (see Examples section below).

They are a measure of *what the service user wants* to achieve

Goals should be those that the young person (and/or their family/carers) themselves want to reach from coming to a particular service – not the goals a clinician or practitioner might wish to see them achieve (although there is often need for some negotiation – see the next section on goal setting & negotiating). As such it gives a different perspective to clinical outcome measures and can measure different sorts of change that might not always be captured using only behavioural or symptom based outcome measures. For example, let's say a goal of parents of a young child with Autism and challenging behaviour is to "cope with tantrums", an intervention might help the parents feel more confident about dealing with the tantrums, e.g. by working on ways of helping them to keep calm at the time. Such an intervention may not necessarily have much of an impact on the child's behaviour (in the short term at least), but despite this, it is clearly an important and successful intervention for the family, if they feel more confident in dealing with their Child's tantrums.

They allow measurement across a *broad spectrum* of interventions

Goal based outcomes (GBOs) enable us to measure the effectiveness of an intervention across the whole spectrum of work we do, across a variety of settings, and with a variety of service users. The goals could be those of a young person in individual therapy, or a family in a systemic intervention. Similarly they can be used to track progress towards the goals through a staff team in a care home receiving consultation from a service, or a teacher implementing a new class based approach to managing behaviour. In this sense the 'service user' is the person involved in the intervention (not always the child) and the goals that are set are should be the goals of the person doing the work. Goals are, by their nature, varied and subjective – in GBOs what is important to measure is the amount of movement towards a goal – and not the goal itself.

Do GBOs dictate a way of working?

Once a goal has been set it is possible to use any suitable intervention to collaborate to reach it. GBOs should not dictate any particular way of working or therapeutic approach – they are merely another piece of information to help assess the success of an intervention. They work on the principle that there are many potential routes to the same destination. Having said that, there are many approaches that use goals as part of the work: CBT, Solutions Focused Therapy, CAT, Personal Construct Psychology and many more……equally the goals set as part of GBO measures can be used in the work if this is helpful.

Do GBOs fit with the CAPA model?

GBOs fit very well with the Choice and Partnership Approach (CAPA) model of service delivery, which is being increasingly adopted across CAMHS, both nationally and internationally. One of the cornerstones of CAPA is the idea of negotiating an agreed contract for the therapeutic intervention: what the service user and therapist agree together is the focus of the work. In the language of CAPA the

'choice point' is reached when the service user and therapist agree a set of shared goals to work on in 'Partnership'. It is a logical next step to use these goals as a way of monitoring progress in Partnership. A helpful approach is to set some provisional goals at the Choice appointment (first session), then hand these on to the Partnership therapist to firm up the goals and do the time one scoring with the young person and/ or family, over the next two sessions, where necessary. Remember, for benchmarking purposes, we recommend that the time one goals be set and scored by the end of the third session.

Goal Setting & Negotiating

Helping to set goals

Some service users are very clear about the goals they want to achieve and others are more vague, and some have very little idea of what they want to achieve other than a notion that 'something must change'. For many people the first step is identifying some potential goals. There are many ways of facilitating this process and these depend on the particular context of the work. It is important to hear from the service user what has brought them to the service – to hear their story. At the point where you feel the family have told you enough initial information it can be helpful to start to introduce goals along the lines of:

> *"That has been really useful in helping me understand a little about what has brought you here today, next it might be helpful for us all to think together about what your hopes for the future might be?"*

What comes out of the following discussion can begin to be shaped into goals,

> *"So, from what you have told me so far, what would you say your main goals are from coming to this service? If we were to work together in a very helpful way, what things would you hope to be different in the future, when we agree to stop meeting, from how things are now?"*

Sometimes it is easier for families to start with what they know they don't want (as we did in the introduction to this document): "I don't want to be depressed", "I don't want to get into fights," "I don't want to feel so scared all the time". In some cases these statements can be good enough to start work (the "anywhere but here" goal), however, if a family or CYP can be helped to think more specifically about where they want to get to – rather than where they don't want to be - it helps bring a focus to the goal, making it clearer to therapist and client where they are both heading, and it can help the process become more collaborative.

One way of turning a problem into a goal can be simply to turn the problem on its head by asking,

> *"When you are no longer depressed, what would you want life to look like then?", or "When you are no longer getting into fights, what do you want to be doing instead?".*

With more entrenched problems some of the more solution focused techniques can help with goal setting. Good examples are the 'miracle question' used in solution focused therapy,

> *"Imagine when you go to bed tonight a miracle happens that makes all the difficulties you have go away. When you wake up in the morning, what will you notice is different ....?"*

or by asking what a person might change if they were given three wishes:

> *"If you had three wishes, what are the things you would wish to change that would make life better for you than it is now?"*

Once a goal has been agreed it is useful to find a sentence that summarises the goal:

> *"Ok, so we have agreed that one of your goals is to: 'get back into school full time'"*

This helps make reference to goals easier – the summary sentence can then be recorded on the GBO record sheet (see appendix 2.) At this point some choose to make the goals SMART – Specific, Measurable, Attainable, Realistic and Timely, to really tie down the focus, but this is not always necessary or indeed desirable in some aspects of clinical work.

Goals can be problem focused

Having said all that, some families and clinicians prefer to keep the goal identified as what the family does not want – to be more problem focused rather than solution focused. For some people to work away from a problem makes more intuitive sense. This is fine, as the key to using goals is to help work with people in a way that is most helpful to them. When scoring these problem focused goals the scale needs to run from zero = the problem has not even started to shift, to ten = the problem has gone. Whether a goal is problem focused or solution focused depends on what works best for that particular CYP or family working in collaboration with the clinician.

Goal setting should be *collaborative*

Although the goals set should reflect the wishes of the service users there clearly needs to be some collaboration between the clinician and the service user to ensure that the service is the right place to help with an intervention. It is also helpful to guide users to make more focused and achievable goals whilst still keeping to the spirit of what they want - if say an adolescent wanted to "be happier" it might be helpful to think about what the markers might be for them in being 'happier'. Similarly, carers of a looked after child wanting to "cope better", might need some input to unpick what 'coping better' might look like, and to break this broad statement down into some smaller focused goals. We would expect this process to be achieved within the first three meetings.

The *goal must be agreed on, and owned* by the person asking for help

The key rule is that the person setting the goal is the person doing the work – so, in the care home example an OK goal would be for the staff team to set goals on managing the behaviour of a child if the work is with a team on what they can do differently, but it is not OK for the team to set a behaviour change goal if the focus of the work is individual therapy with the child in question. The reason for this is that the person working towards the goal needs to agree and own it themselves – otherwise you are measuring someone else's outcome!

How many goals and ranking of goals

The CORC protocols allow for up to three goals to be scored and rated. Sometimes families come with long lists of things they want to be different. This is fine and suggests motivation to really make big changes to their lives, however, too many goals can be distracting; trying to do everything at once can result in very little focus to the work. For this reason, asking a service user for their top three goals brings a focus to the intervention. Taking it a step further and asking service users to rank their top three goals can help bring further focus. You may agree together that, for practical reasons, you don't always choose to start with tackling the top ranked goal.

For families with certain presenting difficulties, picking only one goal to work on might be the most helpful strategy – this is particularly useful in work around conduct and behaviour difficulties. For other families, acknowledging a long list of goals can be helpful and validating, but by agreeing up to three goals to focus on gives a clear focus as to what the shared agreement for the intervention is from the start.

Scoring goals

Once a goal has been set the next step is to get the initial (time 1) score for the goal. You may want to say something like:

> *"Ok, now we have agreed the goals you want to work on, it would be helpful to get an idea of where you are now with each of the goals. This will help us get an idea of where we are starting from, and what you have already managed to achieve, and it can help us keep track of how far you have moved on at a later date" (you may want to specify at this point how often you would expect to review progress towards the goal - every session, at the end of the intervention etc.) "Taking your first goal: 'To get back into school full time'. On a scale from nought to ten, where ten means that you have fully reached your goal, and nought means you haven't even begun to make progress towards it, and a score of five is exactly half way between the two, today what score would you give your progress towards 'getting back into school full time'?"*

It can help to make the scale visual by showing the service user the GBO score sheet with the numbers on, or by drawing a line on a white board. Younger children might prefer a visual metaphor such as a ladder with the numbers 0 – 10 on the rungs, or (if you have the space) you can have squares set out on the floor and children can walk or jump to the relevant square.

Dangerous and 'Unacceptable' Goals

In most cases the clinician should take on the role of facilitator to help shape and guide a young person in settings goals they chose to work on. However, there are occasions where a client may choose a goal that is unacceptable – either because it is dangerous (e.g. an teenager with anorexia wanting to set a goal to lose 10kgs, or someone with depression wanting to be helped to end their life), or because a goal is so unrealistic that it may be unethical to try to work towards it (e.g. a child with a physical disability wanting to be a professional footballer), or where a goal simply does not fit with what a service is able to provide (e.g. a parent who wants an assessment for dyslexia in a service that is not able to provide such an assessment). In each of these cases, even though the goals may be judged unacceptable, they should not be simply dismissed but there needs to be more careful negotiation, to either steer a goal to a place of overlap between what the young person wants and what the service feels able to provide – safely and ethically – or to signpost a family to another service that may be better placed to help.

Even the most seemingly unacceptable goals can yield acceptable goals if the time is taken to ask a young person more about they want; by understanding what is hidden behind an initially stated goal, it is usually possible to find some point of overlap to agree goals and begin a collaborative intervention. It is often helpful to ask,

"What would you hope to be different if you lost the 10kgs?"

This gives the young person the opportunity to talk about their hopes, "I would hope I'd feel more confident if I was thinner" or "I would feel I had achieved something." This then opens the door to negotiating goals that both therapist and service user can agree to work together on: building confidence, being successful. But, beware 'perverse' Goal Setting – (See the next section on Cautions).

'Stuck' goals

Sometimes families and young people come to child services "stuck" in their attempts to reach a goal - in such cases it may be helpful to move away from goal focused talk to "un-stick" the problem before moving on. The goal might always be in the mind of the therapist but not always the direct focus in the room. Taking a sailing analogy – it might be thought of as similar to 'tacking'– depending on the direction of the wind, it is quicker and easier to divert away from the direct route you are heading in but still know where you want to get to in the end.

What if goals change?

Goals often do change during the course of an intervention and the work should change focus accordingly if this is helpful - although you may want to question how helpful it is if goals change regularly throughout an intervention. And, depending on the type of intervention you are working on with a young person, you may want to formally reset the goals. (But, if you are using GBOs as part of the CORC collaboration, when it comes to scoring the GBOs to submit to CORC **you must only record the scores of the original goals set at the start of the intervention** - in the first three sessions). For your own records you might find it helpful to keep a note of those cases where the goals changed mid-intervention, and those that did not. This may help in interpreting the data in a more meaningful way if you choose to dig deeper into the GBOs data.

Cautions When Using GBOs

Subjectivity – "A Double Edged Sword"

Goals, by their nature, are subjective – this gives them strengths as well as weaknesses. The difficulty with such subjective measures is that their scientific validity is difficult to establish – as a young person moves towards a goal it is difficult to be sure that what they rate on the 11 point scale reflects a "true" shift. The strength is that in much work with young people it is their ***subjective view*** of change that is arguably a vitally important measure of success.

Beware 'Perverse' Goal Setting

Remember the aim of using any outcome measure is to gain useful feedback on our work to improve services we and our teams provide. However, it is easy to be seduced into 'collaborating' with clients in perverse ways, to set 'easy' goals that are more achievable – not to help provide users with a sense of achievement, but to make our outcomes look good! Watch out, and question yourself, ***"is this refinement in goal for my benefit or the client's?"***

This process can equally be at play from the young person's side; if they feel that setting complex goals may lead to their receiving a 'better' service, or if they fear that showing progress towards a goal may lead to a useful service being stopped.

Guarding Against GBOs Problems

Transparency and dialogue are very helpful tools to help guard against the potential pitfalls in collaborating to set goals. Discussions with the goal setter about their choice, and scoring, of the goals, and from the practitioner's perspective help towards this; also, using supervision structures to explore any possible unspoken motivation that might be at work. However, as with most other outcome measures, we can never be entirely confident that the goals and their scoring are representations of the 'truth'. For this reason, as with all outcome measures, the gold standard is to not rely on just one measure of change, but to gather information from more than one source to help provide a more detailed picture.

Using Goals in Clinical Practice:

Goal Focused Interventions

What are goal focused interventions?

Goal Focused Interventions are simply interventions which have a clear focus and end point agreed with the service user - young person, family/carer, teacher - from the start of the intervention.

It is a therapeutic stance rather than a therapeutic model

Goal focused interventions are not a therapeutic model in their own right but rather they are interventions where the clinician or practitioner takes a particular stance to work in collaboration with a child or young person by focusing on working with the service user to reach the goals that they have set for themselves (usually in consultation with the practitioner). Such a stance does not dictate a particular therapeutic model for the intervention; many therapeutic approaches could be used and integrated as long as the goal remains the focus of the work. The therapist's skills are used initially to facilitate goal setting based on the areas of their life that the client wishes to change - and not those that other parts of the system, or the therapist themselves, feel need to change.

Promoting Shared Decision Making

The intervention is focused on the overlap between what the client wants to change (their goals) and what the service is best able to offer. Such a stance leads to promote a decision about an intervention that is shared between the service user and the therapist – using goals as the basis for further discussions about the best ways to reach those goals. This might include sharing knowledge of the evidence base for the effectiveness of certain interventions and how these might fit with the young person's particular context and wishes, discussions about how often to meet, based on the therapist's expertise about the intervention and the service user's expertise on their own life, and discussions about how to track progress towards a goal.

Such shared decision making helps strengthen the overlap between what the service user wants and what the therapist is able to provide; this is where the therapeutic alliance is likely to be strongest. The approach very much fits with the Recovery Model – popular in adult mental health services, and research has indicated that strengthening the therapeutic alliance can have a big impact on clinical outcomes.

It works on the principle that there are many potential vehicles that can get you to the same destination

Once the goals are clearly established and overlap agreed, the intervention can continue. There is not one therapeutic model best suited to this type of intervention; the best model is that which best meets the goals of the young person – this will include a way of working that is understandable and comfortable with the client and the therapist - ideally, grounded on an evidence based intervention. The idea allows for many different therapeutic approaches (vehicles) to be used: CBT, Solutions Focused Therapy, Systemic Family Therapy, Focused Psychodynamic Psychotherapy, CAT, Personal Construct Psychology, IPT and many more. There are many vehicles that can take you to your destination, it is a case of finding the vehicle that best fits what the service user wants.

Using Goals in Clinical Practice:

Tracking Progress

Regular and session-by-session monitoring of goals

Although originally Goals Based Outcomes (GBOs) were adopted to use as an outcome tool: to measure the amount of change towards a goal at the end of an intervention compared with where things were at the start of an intervention, it is possible to use the GBOs rating more frequently throughout an intervention, to track progress as an intervention proceeds.

CORC will now collect data on frequent GBO scores – the chart on the following page can be used to track GBOs regularly or every session if required, it is written in a way that allows progress to be monitored and shared with the service user and/or with a supervisor, as well as being useful for clinicians and practitioners to use themselves to reflect on progress.

Tracking progress regularly allows the therapist and service user to monitor progress together. Sharing the information in sessions can lead to helpful discussions about what is helping a goal to be reached and how this progress can be maintained, or conversely can flag if progress appears to be moving away from a goal. This can be the basis of a useful shared discussion between therapist and service user about why the progress may be heading in a particular direction and can allow any necessary issues to be addressed such as how well the therapist and service user are working together, if the model is still the most appropriate for the intervention, if there are any external factors that need addressing, or to review the client's motivation. It may be helpful to score the GBOs early in a session to allow for discussion and for issues to be addressed quickly where necessary.

The idea of regular monitoring should be introduced at the first therapy session. Each subsequent session might helpfully be introduced by saying:

> *"OK, let's have a look at where you feel you are at with the goals we agreed on at the start of the work together. Let's look at goal one first which was to… (insert goal summary sentence)" - on a scale from nought to ten…. etc....., today how would you rate your progress on that goal?"*

Once the rating has been obtained it may be helpful to compare it to last week's score and discuss as appropriate:

> *"OK, it looks like you have moved 3 points towards that goal – what do you think has helped?"*
> *Or "Ok, it looks like you have moved back three points – what do you think might be the reasons"*

It might be necessary to guide a young person to think what the reasons may be: With the external context:

> *"Has anything particular happened this week that might have affected progress.... at home, school etc..."*

Or with the therapeutic alliance:

> *"Is there anything that we could do differently in this session which might help things move forward? Is there anything I could do that would make things more helpful?"*

Or with the model:

> *"Does the way we have been working still seem to be helpful – or do you have some thoughts on what might be a more useful way of doing things?"*

Or with the service user's motivation:

> *"Do the goals we set at the beginning of the intervention still feel the right ones that you want to work towards? …. how much do you feel you want to work towards the goals we agreed?"*

Clearly these questions, and the phasing of the questions would be adapted to fit the client and based on the clinical judgement of the therapist - but is always helpful to keep these four broad areas in mind.

GBO progress charts

For use with frequent, or session-by-session, monitoring

My Name ....

Goal Number .... **My Goal is to** ....

You can turn this chart on its side for a quick look at progress over the sessions

Session number/ week	Today I would rate my progress to this goal as? (please circle the appropriate number below)										
(date of session)	Remember a score of **zero means no progress has been made towards a goal,** a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two										
1	0	1	2	3	4	5	6	7	8	9	10
2	0	1	2	3	4	5	6	7	8	9	10
3	0	1	2	3	4	5	6	7	8	9	10
4	0	1	2	3	4	5	6	7	8	9	10
5	0	1	2	3	4	5	6	7	8	9	10
6	0	1	2	3	4	5	6	7	8	9	10
7	0	1	2	3	4	5	6	7	8	9	10
8	0	1	2	3	4	5	6	7	8	9	10
9	0	1	2	3	4	5	6	7	8	9	10
10	0	1	2	3	4	5	6	7	8	9	10
11	0	1	2	3	4	5	6	7	8	9	10
12	0	1	2	3	4	5	6	7	8	9	10
13	0	1	2	3	4	5	6	7	8	9	10
14	0	1	2	3	4	5	6	7	8	9	10
15	0	1	2	3	4	5	6	7	8	9	10
16	0	1	2	3	4	5	6	7	8	9	10

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Further Reading

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Appendix 1
CORC Protocols for GBOs

Duncan Law, Jenna Bradley & Halina Flannery:
CORC Central Team

In order to be able to provide a reasonable benchmark with which to compare services, it is important that all member services collecting GBOs do so in a similar way. We have agreed that CORC will only record three goals centrally (but locally, depending on practice, you may collect as many goals as you choose). Send goals of those most directly involved in the intervention (i.e. the parent, if the intervention is parent training, the child, if it is individual child work). However, we recommend, where possible, to agree the main three goals with all those involved in the intervention (see the section on 'multiple perspectives' below, for advice where this is not possible). Below is set out the current CORC protocols around collecting GBO – to be used alongside the other core measures (SDQ, CGAS, HoNOSCA and CHI-ESQ):

- **Set the goals over the first three sessions of the intervention/assessment** - Some clients come with very clear ideas of the goals they want to achieve – others take a little longer to decide. It may not take three sessions to agree goals with clients but all goals, to be measured, should be fixed by the end of the third session at the latest.
- **Record up to three goals -** More goals may be set with the client but the top three of the hierarchy of goals should be recorded for the CORC outcomes data. Give each goal an identity number – from one to three – which should correspond to the rank the service user has given each of their goals. ('one' being the top ranked)
- **Once a goal is agreed, record how close the client feels they are to reaching the goal (this is the time one (T1) rating**) - Record the rating on a scale from zero to ten where 'zero' means the goal is not met in any way, 'ten' means the goal is met completely and a rating of 'five' means they are half way to reaching the goal – see the section on 'scoring goals' above, for more advice.
- **At the end of the intervention – or after six months – (whichever is the soonest), record again how close to reaching the goal the client now feels they are (this is the time two (T2) rating)** - Again, record the rating on a scale from zero to ten where 'zero' means the goal is not met in any way, 'ten' means the goal is met completely and a rating of 'five' means they are half way to reaching the goal. Although goals may sometimes change during the course of an intervention, when it comes to scoring the GBOs to submit to CORC you must only record the scores of the original goals set at the start of the intervention (see 'What if goals change?' section above).
- **Multiple time points** - CORC will also now collect multiple data scores (data points) for GBOs, to allow for services to score goals at more regular intervals throughout an intervention – even session-by-session if required. If doing this it is important to keep a clear record on the database of the date of the start of the intervention and the date each score was recorded.

See the section giving 'Examples of Scoring Goals; below.

Submitting data to CORC central database

You can submit goals data from as many time points as you are collecting (including every session if you are doing so) or just data from time 1 and time 2 if you prefer.

This information should be sent along with any other outcome data for the client (SDQ, CGAS, HoNOSCA, CHI-ESQ). CORC would now like to start accepting the narrative of the goals which have been set, in addition to the numerical ratings. For reasons of confidentiality – as the goals will be very personal to the client and may make it possible to clearly identify a client from the goals they set – please make sure that any identifiable information, such as names, places etc. are removed from the goals before submitting this information to CORC.

Collecting GBOs from multiple perspectives

We are aware that on some occasions it is sometimes not possible to reach agreed goals between all those involved in an intervention. In these cases we suggest the following rule is used to determine whose GBO scores are sent to CORC:

If a range of people are equally involved in the work and it has not been possible to reach their mutually agreed goals, then select the goals to send to us in the following order:

1. Goals agreed from referred child's perspective,
2. if this not available, then send the mothers goals scores
3. if this not available, then send the fathers goal scores
4. if this not available, then send the goal scores of another family member/carer.

Some Examples of Scoring Goals

EXAMPLE 1.

Sally is a 17 year old who was referred by her GP with concerns about possible depression and self-harm. At the first appointment she was clear that one of her goals was "to feel less down". **She rated herself on this first goal (goal one) as currently 2/10** – as she had been feeling down much of the time recently. In the next session there was more time to talk about the self-harm. Sally said she had been frightened to give it up but as there had now been some chance to discuss alternative coping styles and wanted to stop cutting herself. This became **her second goal (goal two) which she rated at 3/10** – she said she had already tried stopping cutting and was having some success, even if it was only delaying the harm rather than stopping it completely.

When Sally had been seen in the service for six months, she was asked to rate her progress on the goals (even though the intervention had not finished): **goal one (feeling low) she now rated at 7/10** – she felt less low much of the time. Goal two (self-harm) she now rated at 5/10 – despite a lot of effort she still found it difficult at this stage to stop.

So her outcomes were:

Goal one (low mood)	T1 = 2/10, T2 = 7/10, therefore GBO score = 7 – 2 = 5
Goal two (self harm)	T1 = 3/10, T2 = 5/10, therefore GBO score = 5 – 3 = 2

EXAMPLE 2.

David is a ten year old referred due to, "difficult behaviour at home". He attended with his parents. All agree to work to try and find better ways for David to manage. Part of this work will be individual work with David, to develop some strategies to control his aggression when he gets upset – **This is the first goal (goal one) and David scores himself 1/10.** As David's parents are also going to do some work around this, they set the same goal for themselves – they score this (goal two) as 3/10.

After four months all agree that things are going well and it is agreed to end the intervention at this stage. All agree there have been great improvements. **David now rates himself 7/10 (goal one) and his parents' rate things 9/10 (goal two).**

So the outcomes here are:

Goal one (David)	T1 = 1/10, T2 = 7/10, therefore GBO score = 7 – 1 = 6
Goal two (Parents)	T1 = 3/10, T2 = 9/10, therefore GBO score = 9 – 3 = 6

Appendix 2

Goals Based Outcomes

Summary and Record Sheet

GOAL - BASED OUTCOMES RECORD SHEET

In coming to this service, what are some of the problems you want help with or goals you want to get to? (List up to three goals)

Goal Number	Goal Description
1	
2	
3	

If you have any other goals, please list them here

Clinic ID .... Date ....

Completed by child/young person / parent/carer / other (please specify) ....

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HOW CLOSE ARE YOU TO THE GOALS YOU WANT TO GET TO?

On a scale from zero to ten, please circle the number below that best describes how close you are to reaching your goal today. Remember: zero is as far away from your goal as you have ever been, and ten is having reached your goal completely.

YOUR FIRST GOAL IS:
Enter brief description of goal and goal number as recorded on the GOAL BASED OUTCOMES RECORD SHEET

....

....

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

YOUR SECOND GOAL IS:
Enter brief description of goal and goal number as recorded on the GOAL SETTING RECORD SHEET

....

....

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

YOUR THIRD GOAL IS:
Enter brief description of goal and goal number as recorded on the GOAL SETTING RECORD SHEET

....

....

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

Clinic ID .... Date ....

Completed by child/young person / parent/carer / other (please specify) ....

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HOW CLOSE ARE YOU TO THE GOALS YOU WANT TO GET TO?

On a scale from zero to ten, please circle the number below that best describes how close you are to reaching your goal today. Remember: zero is as far away from your goal as you have ever been, and ten is having reached your goal completely.

YOUR FIRST GOAL WHEN WE STARTED MEETING WAS:
Enter brief description of goal and goal number as recorded on the GOAL BASED OUTCOMES RECORD SHEET

....

....

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

YOUR SECOND GOAL WHEN WE STARTED MEETING WAS:
Enter brief description of goal and goal number as recorded on the GOAL SETTING RECORD SHEET

....

....

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

YOUR THIRD GOAL WHEN WE STARTED MEETING WAS:
Enter brief description of goal and goal number as recorded on the GOAL SETTING RECORD SHEET

....

....

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

Clinic ID .... Date ....

Completed by child/young person / parent/carer / other (please specify) ....

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