Duncan Law and Jenna Jacob

GOALS AND GOAL BASED OUTCOMES (GBOs)
Some Useful Information

Third Edition

Press
CAMHS

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Contents

Acknowledgements

Introduction

This is the third revised edition of this booklet: the first edition was published in 2006 as an internal CORC publication, revised in 2011 and published through CAMHS Press. This version has been revised and edited (May 2015) to bring it up to date. We are very pleased to be able to include in this revision, a section on setting goals when working with children and young people with learning disabilities, by Ro Rossiter and Heather Armstrong (see p.25).

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. From clinical experience, this is often where Children and Young People (CYP) and their families are at the first appointment with services. With this in mind, let us 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 by helping a young person move from knowing what they don't want 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 we hope to do here is to bring together some useful ideas about goals and goal based outcomes into one place, and offer the 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 manual is the section that relates to using GBOs as part of the Child Outcomes Research Consortium (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 1). It won't tell you everything you might want to know about the subject, but we hope it gives a useful summary for clinicians wishing to use GBOs either as part of CORC, or CYP-IAPT, or more broadly as a tool to work 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. They are also a powerful tool to facilitate shared decision making and more personalised care in children and young people's mental health and wellbeing services.   It is true that some therapeutic modalities have goals and the monitoring of goals is already built into the intervention themselves: e.g., Cognitive Behavioural Therapy (CBT), Cognitive Analytic Therapy (CAT), and solution focused therapies. 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. 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. They 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 young person, 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 children and young people (CYP) and their families and carers, the ideas can equally be used in adult mental health and other 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 make proper reference to this document: **Law. D. & Jacob. J.** (2015). *Goals and goal based outcomes (GBOs): Some useful information (third edition)* CAMHS Press: London.

Why measure outcomes

Over the past decade, clinical outcome monitoring in child and adolescent mental health services 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 us, 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 database, 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 children, young people and families.

The interest in developing a goal-based measure was due to the belief that the

most important measure of change is that which children, young people and their families have chosen to make themselves.

We hope you find the ideas helpful and we 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 earlier versions of this booklet, it should seem quite familiar in terms of its format and structure. Most of what was added to in the second version was in response to requests from people using GBOs – these included requests for suggestions of what you might actually say to a CYP or family when setting goals – so we added some suggestions of wording, but these are just suggestions, not scripts. Also by request, a section on using GBOs on a session-by-session basis, and a section on using the GBOs as a focus of therapy were added. Again, these were just a sharing of ideas and not a suggestion that GBOs should always be used in this way.

New to this edition, apart from some minor edits, is a section specifically looking at the use of goals and GBOs with families and children and young people with learning disabilities. 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 goals in clinical work with children and young people and their families and carers (but the ideas can equally be adapted to work in other 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: GBOs record sheets from 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).

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 measurement 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

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 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 or young person) 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 it is important to measure the amount of movement towards a goal and not the goal itself.

Goal setting facilitates shared decision making

Although we are largely focus on tracking progress towards goals in this booklet, the process of collaborating to set goals with CYP and families is a process that facilitates better shared decision making about the kind of therapy or intervention a family or CYP might want. Done well, the act of writing down goals in order to track them leads to an explicit expression of the shared work to be done between the therapist, young person and family, which can lead to better agreement and working alliance in therapy. Collaborative working has also been shown to improve outcomes and satisfaction from service users.

"Setting goals makes you see where you need to go, makes you see what you are working on and what still needs to be worked on."

Young Person
(from Bromley & Westwood, 2013, p. 43)

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: Cognitive Behavioural Therapy, Solution Focused Therapy, Cognitive Analytic Therapy, Personal Construct

Psychology and many more…equally the goals set as part of GBOs outcome tracking can be used in the work if this is helpful.

Do GBOs fit with the Choice and Partnership Approach (CAPA) model and Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT)

GBOs fit very well with the 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 initial (time 1) scoring with the young person and/or family over the next two sessions, where necessary. Remember, for benchmarking purposes, we recommend that the time 1 goals be set and scored by the end of the third session.

Similarly with CYP-IAPT, one of the main principles is to promote better collaborative practice and demonstrate outcomes of therapy that are transparent to young people and commissioners alike: using goals and GBOs well provides this and scores from GBOs are able to be recorded as part of the CYP-IAPT dataset.

Goal setting and negotiating

Helping to *set goals*

Some service users are very clear about the goals they want to achieve, 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 to help 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, when we agree to stop meeting, what things would you hope to be different in the future 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 child/young person where they are both heading. It can also 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, 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 GBOs 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.

"Knowing when and how to use the outcome measures is important. They must become an integrated part of the session – not something that is kept as an abstract form-filling exercise."

Young Person

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 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. It is also be 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 or young person 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 upon and owned* by the person asking for help

The key rule is that the person setting the goal is the person doing the work. In a care home, for example, an okay goal would be for the staff team to set goals on managing the behaviour of a child or young person if the work is with a team on what they can do differently, but it is not okay for the team to set a behaviour change goal if the focus of the work is individual therapy with the child or young person 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 protocol allows 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. 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 child/young person the GBOs 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 to set goals *they* chose to work on. However, there are occasions when a young person may choose a goal that is unacceptable; either because it is dangerous (e.g. a 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 or young person 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). Even though these 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 10kg?

This gives the young person the opportunity to talk about their hopes: *"I 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 young person 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 you 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. Depending on the type of intervention you are working on with a young person, you may want to formally reset the goals. (For CORC members: when it comes to scoring the GBOs to submit for analysis, *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 setting goals

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.

"It was difficult filling out the questionnaire because I filled it out according to how I felt at that moment, which could be different an hour later..."

Young Person

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 children/young people in perverse ways to set easy goals that are more achievable – not to help provide children/young people 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 young person'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 discussions from the practitioner's perspective help towards this, as does 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 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 therapist takes a particular stance to work in collaboration with a young person to reach the goals they have set for themselves (usually in consultation with the therapist). 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 the young person wishes to change and not those that other parts of the system, or the therapist themselves, feel the need to change.

Promoting *shared decision making*

Interventions are focused on the overlap between what the child/young person wants to change (their goals) and what the service is best able to offer. This stance promotes 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 goals.

Such shared decision-making helps strengthen the overlap between what the young person wants and what the therapist is able to provide – this is when 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.

"Make sure you listen to the young person! Some of the data may highlight things that don't feel right for the young person or things that they would like to change, make sure you listen and make sure that the young person knows that you have heard them."

Young Person

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 meets the goals of the young person – this will include a way of working that is understandable and comfortable for the young person 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-A, 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 young person wants.

Using goals in clinical practice

Children and young people with learning disabilities, their parents/carers and networks

Ro Rossiter and Heather Armstrong

This section summarises some ways goals and goal based outcomes can be used with children and young people with learning disabilities and their parents/carers and networks. First, it identifies common themes from other sections and then some areas of difference in emphasis/practice which can help maximise the utility of goals and goal based outcomes for children and young people with learning disabilities. This section will likely be relevant for a broader group of children and young people with a range of physical and sensory impairments, disabilities and/ or neurodevelopmental conditions and for very young children.

Common themes in using goals and goal based outcomes with children and young people with learning disabilities, their parents/carers include their use with both children and young people with learning disabilities directly and/or their parents/carers (p. 12), the value of discussion and negotiation, goal focus versus problem focus (p. 15–17) and the importance of ownership, prioritising and ranking (p. 17). Clarification of what would it look like if it were better/ worse?, what would be happening when..? enables fuzzy concepts such as agitated, anxious and aggressive to be expressed in individualised, concrete and measurable and performance terms. Setting and tracking goals can assist with engagement, assessments and formulation as well as monitoring and evaluation.

Some differences in emphasis and practice include individualised approaches, which may be necessary given the diverse range of children and young peoples' abilities and needs. These include more creativity in communication with children and young people to match their cognitive and communicative needs (simplified language/concepts, symbols, use of pictures, ladders, thermometers, card-sort activities or "Talking Mat" type supports, concrete props such as rulers, lengths of string, floor mats, road maps, bulls eye diagrams, shaded circles); more concrete, smaller steps; more goal setting and review with parents/carers and networks (such as schools, short breaks, leisure and other community settings) as well as, and sometimes instead of, with children and young people. Scales may need personalising and, for some, a 0–10 scale may be too great and need simplifying. Some examples in "The Incredible 5-Point Scale" and "A 5 could make me lose control" (Dunn Buron, 2003) show how scales can be developed for a range of emotions and behaviours.

Goals for children and young people or parents/carers can relate to objective behavioural goals (head banging, throwing toys, time staying in bed, playing with sibling/parent, parent trying new activity, doing mindfulness etc.) and more subjective feelings-related goals (ratings of calmness, anxiety, understanding, coping). Individualised behaviour/emotions measures of frequency, duration, intensity, latency and/or settings (i.e. home, school, shops etc.) can be the focus for tracking relevant aspects of assessment and intervention.

The behaviour grids framework developed by Sussex Partnership NHS Trust (Wedge & Singh, 2014) is designed to enable parents to specify and prioritise up to 3 behaviours of concern across dimensions of severity and/or frequency of the behaviour, the distress caused by the behaviour and confidence in managing the behaviour and coping. Evaluation of the use of these behavioural grids as part of a suite of goal based tools and measures in their family intensive support service found reductions in problematic behaviours and increased sense of coping and ability to manage the behaviour for parents (Mulligan et al 2014).

Involving children and young people with learning disabilities in the setting and tracking of goals increases their power, agency and voice. This is especially important for children and young people who are often marginalised and relatively, powerless. It can also assist in communication, partnerships and changing patterns of relating within families which can get skewed or stuck around disability and development issues. Goals can be for children, young people, parents/carers and networks to try out new/different activities and op-portunities and strategies to evaluate responses rather than focus on change. Some aspects may not change: a parent may remain worried about their child whilst developing more understanding of their child's behaviours and moods, e.g. *"I feel more confident in parenting my child", "I now know what to do when my child does...",* and seeing their child developing communication, social, emotional and self-help skills. Goals might relate to different kinds of activities across and within networks such as schools, neighbours and short term breaks. It may take longer for engagement and assessment before goals can be set.

Change can happen slowly over many months, so goals and their tracking must be appropriate and realistic. It could be unhelpful and depressing for parents to be ticking the same boxes week after week. Goals may need breaking down into smaller steps, and monitoring/tracking scheduled for 1 week in 4, for example, rather than session by session. Planning how and when to collect and collate goal-based information to fit in with key meetings such as care and education reviews can increase motivation and meaningfulness. Using photos/videoing can be really helpful. For some children and young people with complex health or life-shortening conditions, profound and multiple disabilities or severe challenging

behaviour, goals may be focused on stabilising and maintaining skills and activities, or building in support and fun for families including siblings.

Some outcomes tools in the CYP-IAPT suite can help identify goals and measure change but they are not all appropriate for all children and young people with LD. Other tools include, for example, "P levels" from the National Curriculum for Personal, Health, Social and Relationship Education (QCA, 2007) for emotions/feelings, and other more detailed measures of behaviours and parental coping etc. are found in Rossiter et al (2014).

"I can pin them up where I go past them every day and think 'I can do that goal, I can try my best' and then try and achieve it. (p10, female, age 14)"

Cairns et al., 2015, p.256

Using goals in clinical practice

Tracking progress

Regular and session-by-session monitoring of goals

Although GBOs were originally 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 collects GBOs data from multiple time points; the progress chart on the page 30 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 young person and/or with a supervisor, as well as being useful for clinicians to use themselves to reflect on progress.

Tracking progress regularly allows the therapist and young person to monitor progress together. Sharing the information in sessions can lead to helpful discussions about what helps to reach a goal 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 young person about why progress may be heading in a particular direction. Discussion can allow any necessary issues to be addressed such as how well the therapist and young person 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 young person's motivation. It may be helpful to score the GBOs early in a session to allow 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 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 young person'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 the phrasing of the questions would be adapted to fit the child/young person and based on the clinical judgement of the therapist, but is always helpful to keep these four broad areas in mind.

"Clinicians must ensure that the feedback they give is understandable to the young person…if it feels like random form filling just for the service, tagged on at the end of each session, then this has no meaning for young people."

Yong Person

Goal progress chart

Goal N°

This is one of up to three goals to track.
You can turn this chart on its side for a quick look at progress over the sessions.

GOAL: ....

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
		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

Who agreed this goal (tick below):

Child/young person

Family members

Practitioner

Other (please specify) :

....

NHS ID: ....

Service allocated

case ID ....

Goal Progress Chart— *C h i l d / Y o u n g   P e r s o n*

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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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Using goal charts

Goal progress chart

Goal Nº ⭕

...ook at progress over the sessions.

> **Circle the score each time you use the scale**

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
		Remember a score of **zero ...ns no progress has been made towards a goal,** a score of ten means a goal has been reac... 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						
3		0	1	2	3	4						
4		(0)	1	2	3	4						
5		0	1	2	3	4						
6		0	1	2								
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

> **You do not have to score every session. Do what makes most sense**

Who agreed this goal (tick below):

Child/young person ⭕

Family members ⭕

Practitioner ⭕

Other (please specify) :

....

NHS ID: ....

Service allocated

case ID ....

Goal progress chart

This is one of up to three goals to track.
You can turn this chart on its side for a quick look at progress.

Goal Nº

Session **Date**

Today I w... (please c... below)

Goal:

Remember a score of **zero means no**... a score of ten means a goal has been reached f... and a score of five is exactly half way between the two

Session	Date	0	1	2	3	4	5	6	7	8	9	10
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
		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

You can turn the form on its side, join up the circles , and use it to see how things are changing
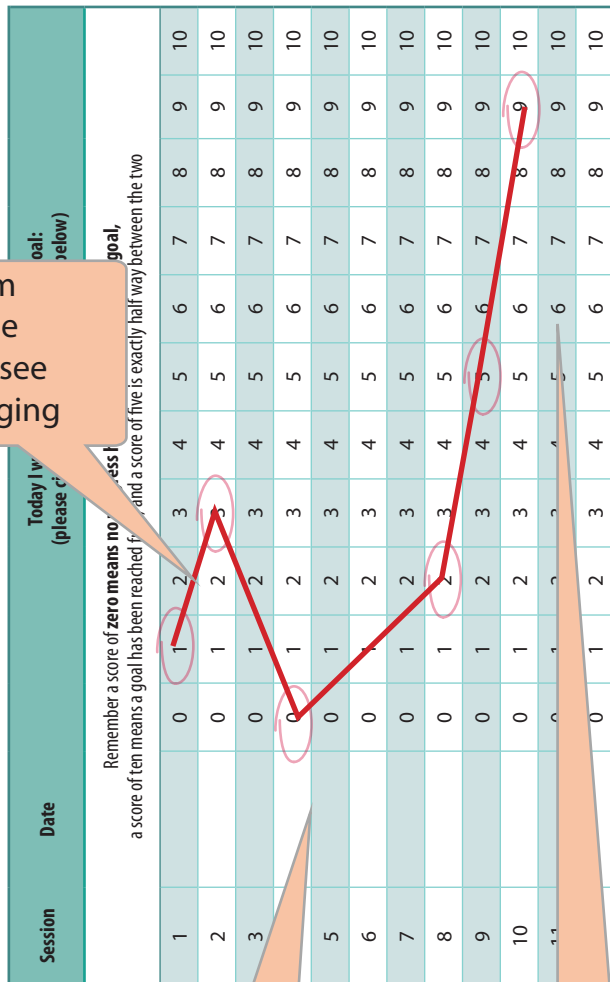
You can use the chart to see what is going well or less well and use this to facilitate further discussion

Using goals in clinical practice

Clinical supervision

Goals can be used to facilitate better dialogue in supervision. Information from goal progress charts, alongside information from other feedback and outcomes tools, can help to share information about a young person and how therapy is progressing in a succinct and concrete way, to guide case discussions in supervision. Supervisors may want to particularly look out for cases where there has been little or no progress towards goals over a number of sessions – this may give clues to cases that are slipping off-track and heading to potential drop-out.

Supervisors can help look for these off-track clues and help supervisees make best clinical sense of them. It is important to get a full picture of these cases: does the wider clinical picture fit with the apparent lack of goal progress? Does the young person's description of their life fit with the information on the chart? Are they describing positive changes that are not reflected in the chart? Does the lack of progress fit with the context the young person is in? Are the goals specific enough to give focus to capture change? Is the lack of progress towards goals backed up by lack of progress in other tools and measures much as symptom trackers or impact scales? Does the apparent lack of progress fit with the therapist or counsellor's experience of the young person? Once these questions have been explored, supervisors can help supervisees come up with narratives that fit with the goal information and the wider clinical picture and use these narratives to shape the direction of the intervention.

Lack of progress towards goals

If there is a genuine lack of progress it is helpful to revisit the goals themselves: are the goals set at the start of therapy still relevant to the young person? Have the goals changed? Has the context around the young person changed and affected their goals? Are the goals realistic? Are they focused enough? Does the young person understand how the therapy might help them reach their goals? These questions can help supervisees explore their view of working alliance with the young person, and consider how best to discuss this with the young person in future sessions.

Lack of progress towards goals might indicate difficulties in the therapeutic alliance: supervisors can help supervisees think how best to explore this with the young person they are working with – other tools such as the Session Rating Scale (SRS; Miller, Duncan & Johnson, 2002)] might be considered to help facilitate

these discussions. It can be helpful for supervisors to help supervisees consider if the therapy has gone as far as it can: is further therapy likely to produce more progress towards goals? Might a different model of therapy be more helpful? Might a different therapist be more helpful at this stage? Ultimately, supervisors should create a safe space in supervision where these questions can be considered and thought about as helpful interventions for the young person to help them achieve their goals, rather than a failure of the therapy or the therapist.

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Appendix 1

CORC protocol for GBOs

Duncan Law & Jenna Jacob

With thanks to Halina Flannery for contribution to an earlier version

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). Ensure you send the 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). 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 GBOs, to be used alongside other measures.

- **Set the goals over the first three sessions of the intervention/ assessment** – Some young people 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 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 young person but the top three of the hierarchy of goals should be recorded for the CORC data submission. Give each goal an identity number – from one to three – which should correspond to the rank the young person has given each of their goals, where applicable (one being the top ranked).

- **Once a goal is agreed, record how close the child/young person 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) – Ideally you would track progress towards goals on a regular basis, perhaps every time you meet, but at the least, you should follow up with goal progress either at case closure or six months into therapy if that is sooner. 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 collects 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 the CORC central team

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 young person. Please double check on the CORC website for information on the type of approach you are following (Snapshot or CORC+) to ensure you are recording your data in the correct format. Alternatively, get in touch with one of the team corc@annafreud.org.

If you are submitting the content of the goals as part of your data submission to the central team (as opposed to just the scores), for reasons of confidentiality – as the goals will be very personal to the young person and may make it possible to clearly identify them 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 us.

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 GBOs scores are sent to the CORC central team:

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 young person's perspective.
2. If this not available, then send the jointly agreed goal information.
3. If this not available, then send the parental goal information.
4. If this not available, then send the goal information of another family member/ carer.

Appendix 2

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

Goal progress chart

Goal Nº **1**

This is one of up to three goals to track.
You can turn this chart on its side for a quick look at progress over the sessions.

GOAL: .... *To feel less down* ....

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
		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

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 is $7 - 2 = 5$

Goal two (self-harm)

$T1 = 3/10$

$T2 = 5/10$,

therefore GBO score is $5 - 3 = 2$

Goal progress chart

Goal Nº **2**

This is one of up to three goals to track.
You can turn this chart on its side for a quick look at progress over the sessions.

GOAL: .... *Stop cutting* ....

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
		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

Example 2

David is a 10 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.**

Goal progress chart

Goal Nº **1**

This is one of up to three goals to track.
You can turn this chart on its side for a quick look at progress over the sessions.

GOAL: ...... *Not get so angry when i get upset* ......

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
		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

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 is **7 – 1 = 6**

Goal two (Parents)

   T1 = **3**/10

   T2 = **9**/10

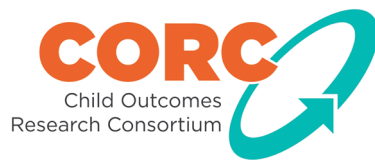therefore GBO score is **9 – 3 = 6**

Goal progress chart

Goal Nº **2**

This is one of up to three goals to track.
You can turn this chart on its side for a quick look at progress over the sessions.

GOAL: .... *Help David control his anger* ....

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
		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

CORC
Child Outcomes
Research Consortium