What kind of goals do children and young people set for themselves in therapy? Developing a goals framework using CORC data

Jenna Bradley, Samantha Murphy, Andrew J.B. Fugard, Sevasti-Melissa Nolas & Duncan Law

Agreement on goals is thought to be central in successfully building a good therapeutic alliance which in turn improves outcomes. The qualitative idiosyncratic nature of goals set by children and young people in therapy has been relatively unexplored. We investigated service users' account of the goals they set for themselves in UK child and adolescent mental health services (CAMHS) using data collated by CAMHS Outcomes Research Consortium (CORC) members. Six services supplied their goals data for analysis: NHS targeted, specialist, and highly specialist services; a modality specific professional body; and a therapeutic community. Service users were 80 children and young people who had visited the services between 2007 and 2011. Emerging themes arising from key aspects of 241 goals from the participants (as agreed with and recorded by the clinician) were analysed using thematic analysis. The resulting taxonomy of goals consisted of three overarching themes and 25 lower level categories. Inter-rater reliability between two researchers was substantial for major themes (Cohen's kappas from 0.78 to 0.88 and statistically significantly above 0.6) and 14 of the 25 subthemes had substantial agreement. The top five goals mainly concerned personal growth, functioning, and coping with specific symptoms and problems. We discuss these results and differences with a large analysis done in the USA on the inverse 'top problems'.

AGREEMENT on goals is thought to be central to successfully building a good therapeutic alliance, which in turn improves outcomes (Shirk et al., 2011). Goal-based outcome (GBO) measures, used to record goals and progress towards attainment, have been used in various guises in child and adolescent mental health services (CAMHS) for some decades. For instance one variant, Goal Attainment Scaling (Kiresuk & Sherman, 1968), involving recording goals and combining weighted scores of degree of attainment, has been used by some services with adolescents with conduct problems since the early 1980s (Maher & Barbrack, 1984). Systematically collecting GBOs across services is a relatively more recent endeavour. GBOs have been included in the CAMHS Outcomes Research Consortium (CORC) since 2007 (see Law, 2006, 2011) and have recently been introduced in the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme in the UK (CYP IAPT Outcomes and Evaluation Task and Finish Group, 2011; Wolpert, Fugard et al., 2012). The CORC/IAPT measure simply asks young people and carers to record up to three goals they would like to work on, and then each session they rate progress on a scale from 0 (absolutely no progress) to 10 (goal completely achieved), with 5 being exactly half way to achieving the goal.

Moran et al. (2012) investigated carers' attitudes towards outcome measures. Out of all the measures, they had the most concern about the validity of GBOs. For instance, they worried that goals would be hard to

© The British Psychological Society 2013

operationalise, especially getting the balance right between the generality and specificity of goals, and that it would be difficult to quantify goal progress. However, the sample in the study included parents of children with learning disabilities and autism spectrum condition, who tend to have long-term needs and ongoing difficulties and so the nature of their goals might be quite different to other areas of CAMHS. A recent analysis of the national CORC dataset found that symptom improvement, rated both by carer and clinician, correlated with making progress on goals (Wolpert et al., 2012), suggesting that GBOs have some construct validity.

Although GBOs are a way of quantifying progress towards a goal, the qualitative idiosyncratic nature of goals set by children and young people in therapy has been relatively unexplored. Basic questions of interest include: What kinds of goals do CAMHS users tend to have? Are particular goals associated with particular psychosocial problems? Do the goals chosen have an impact on outcomes, for instance are some goals more achievable in a CAMHS context than others? To what extent do goals chosen by children and young people agree with those chosen by carers? The present paper reports first progress towards developing a framework or taxonomy of goals in the CORC dataset. First we give an overview of how goals are typically used in UK CAMHS.

Using goals in clinical practice

This section is based on work by Law (2011) and sets out the kind of clinical processes that typically lead to the generation of goals.

Setting goals

To work effectively, goals should be those that the young person (and/or their family/carers) themselves want to reach from attending a particular service, not the goals a clinician or practitioner might wish to see them achieve, although there is often need for some negotiation to reach agreed goals that fit with the service user and what the service is able to offer. GBOs give 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. In this respect, GBOs are considered to be child-centred and come much closer to capturing a child's desired lived experience from the child's perspective.

Suppose a goal of parents of a young child with autism spectrum disorder and challenging behaviour is to 'cope with tantrums', an intervention might help the parents feel more confident about dealing with the tantrums, for example, 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. Once a goal has been set it is possible to use any suitable intervention to collaborate to reach it. GBOs are compatible with any 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 (CBT), solution focused therapy, cognitive analytic therapy (CAT), personal construct psychology and many more. Equally, the goals set as part of GBO tools can be used in the work if this is helpful.

Some service users are very clear about the goals they want to achieve; others have very little idea of what they want to achieve other than a notion that 'something must change'. There are many ways of facilitating the goal-setting 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 and then the idea of goals can be introduced 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 subsequent discussion can begin to be shaped into goals, for instance summarised by:

'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: '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 child/young person (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.

There is a certain art to helping people develop their goals. 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', as often 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 that is different?'

Another approach is to ask 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 recorded. Clinicians vary in their recording of goals. Some summarise the goal in a shorter sentence:

'OK, so we have agreed that one of your goals is to: 'get back into school full time'.'

Others choose to make the goals Specific, Measurable, Attainable, Realistic and Timely (SMART; Doran 1981), to really tie down the focus, but this is not always necessary or indeed desirable in some aspects of clinical work.

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 walk 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 0 (the problem has not even started to shift) to 10 (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.

Scoring goals

Each session's progress towards the goal is rated on the scale from 0 to 10. 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 0 to 10, where 10 means that you have fully reached your goal, and 0 means you haven't even begun to make progress towards it, and a score of 5 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.

Where there is disagreement between clinician and service users

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 (for example, 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 in CAMHS (for example, 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 (for example, 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, either to 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 CYP 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.

Developing a framework of goals

There has been previous work on developing goal taxonomies in adult mental health. Based on an analysis of around 1,000 goals from adult outpatients, Grosse Holtforth and Grawe (2002) developed a three-level taxonomy. At the highest level the categories include 'Coping with Specific Problems and Symptoms', 'Well-being and Functioning' and 'Existential Issues'. The second level goes into more detail, for example, the 'Well-being' super category includes 'Exercise and Activity'. Finally the lowest level categories include 'Increase exercise', 'Improve leisure activities' and 'Learning to delegate responsibility'.

Also relevant is John Weisz and colleagues' work on the top problems that families want to work on in CAMHS interventions which led to, in some ways, the inverse of the GBO measures (Weisz et al., 2011), that is, the goal of treatment is score reduction rather than increase. Hawley and Weisz (2003) coded problems by choosing the closest item of the Child Behavior Checklist (CBCL) and then developing additional codes for problems not present.

There has been little work examining the goals children and young people set in therapy. The present paper aims to contribute to this area.

Methodology

A qualitative methodology was employed to analyse the data. Qualitative research enables the exploration of meanings and experiences (McLeod, 2011). The methodology is most often associated with in-depth methods of data collection and analysis that in turn produce 'thick descriptions' (Geertz, 1973). Interviews, focus groups and participant observation are traditional qualitative research methods used to elicit accounts of lived experience, biographical narratives, and social interactions.

Qualitative data in clinical settings is often collected in more distributed and fragmented ways such as, for instance through the collection of short responses indicative of desired, and achievable, lived experiences (e.g. 'get back into school full time'). As such, as well as enabling the therapeutic alliance through creating shared meanings and negotiated order (Strauss, 1978) in the therapeutic setting, these qualitative data fragments have the potential to provide us with initial glimpses into what children and young people themselves would like to accomplish through therapy.

Yet, experience of collecting such routine outcome monitoring data suggests that on the ground there is little time or resources for such secondary qualitative analyses at a local level and the data remains unused in this way.

To address this gap a thematically-driven analysis (Braun & Clarke, 2006; Attride-Stirling, 2001) of the responses to the CORC goal-based outcome measure was carried out. The analysis focused on the issues (minimal units of meaning) and themes (clusters of issues) that were apparent in children and young peoples' responses to the question of setting goals. *In vivo* coding was carried out, thus keeping the issues and themes in the children's language, and honouring their perspectives in the goal setting process.

In doing so, the attempt was made to preserve the thinking embodied in the methodologies that qualitative methods are derived from, while at the same time acknowledging the limitations of both our method and data from a qualitative perspective. To this effect, the qualitative method employed here is described as a 'thin form' of qualitative research that responds to pragmatic concerns (for example, how can we improve therapeutic alliance and outcomes for children through better goal setting), as well as the constraints on research on clinical practice (for example, the luxury of resources to carry out a full scale qualitative research projects on children's desired outcomes of clinical therapy in a particular context).

Participants

The participants were 80 children and young people who had visited one of six CORC member services for treatment during 2007 to 2011. As discussed below, these participants were taken from a subset of a larger dataset of goal information completed by other perspectives, including parent and clinician.

Procedure

The goals were submitted to the CORC Central Team by CORC members and constituted the goal in its final form, post any negotiation and discussion of what the service is able to provide; the goal for the young person and their family for coming to the service as agreed with and recorded by the clinician. All CORC member services were invited to submit the descriptive content of their recorded goals as well as goal scores and this descriptive goal information was received from eight services with a total of 933 goals between them. Those services self-selecting and submitting descriptive detail of goals were based across the UK and included NHS CAMH services including teams from targeted, specialist, and highly specialist services (Tier 2 – 4); a modality specific professional body and a therapeutic community (see Table 1 for a breakdown of the number of goals from each service).

The goals submitted to the Central Team were agreed and set by different combinations of the CYP, family members and clini-

Table 1: Number of goals from each service

Member Service	*Number of goals*	*Percentage*
A modality specific professional body	6	3
Specialist CAMHS in a hospital (Tier 3)	22	9
Third sector network of therapeutic communities	38	16
Specialist CAMHS (Tier 3)	93	39
Targeted and specialist CAMHS (Tier 2 & 3)	69	29
Universal, targeted and specialist CAMHS (Tier 1, 2 & 3)	9	4
Total	**237**	**100**

cians. The researchers made the decision to attend only to goals ascribed to the CYP; while the goals-based approach may indicate collaboration in authorship, it may often be the case that those involved in treatment have different priorities for care and different conceptions of what would indicate things being better. Therefore, the final dataset constituted 237 goals from six services.

Each dataset was considered in turn and all 237 goals were considered by both researchers independently; emerging themes arising from key aspects of the goals were noted in a process of thematic analysis following that indicated by Braun and Clarke (2006). As each subsequent dataset was analysed and further themes emerged, the prior datasets were revisited and the themes reconsidered and tested against the goals in an iterative process.

In addition to this, the Bern Inventory of Goals (Grosse Holtforth & Grawe, 2002) framework was used as a reference point and some of the themes standing out as similarly relevant were identified in that framework and added to the CORC framework, that is, 'obsessive thoughts and compulsive behaviours' and 'responsibility and self-control'.

Two of the authors (JB and SM) led the development of the framework. The version reported here is the second iteration of a combined framework, whereby the two authors met twice; firstly to combine the individual frameworks and then to refine the combined framework upon using the framework to code the goals independently.

Findings

The framework consisted of three major themes and 25 subthemes (see Table 2, with example goals). The agreement of the goal placement into themes between the two researchers was tested with Cohen's kappa (Cohen 1960) and was high at 0.76.

Cohen's kappa broken down by subtheme ranged from 0.4 ('stop feeling anxious, stressed or worried') to 1.0 for three subthemes ('stop harming myself', 'sleep on my own' and 'letting people know the help I need'), with 14 out of 25 of the subthemes having a kappa statistically significantly ($p < .05$) over 0.6, indicating substantial agreement (Landis & Koch, 1977). Cohen's kappas were also high for the major themes, ranging from 0.78 to 0.88. See Table 3 and Table 4 for frequencies and kappas for each of the themes.

The major themes uncovered in the analyses were:

Relationship/Interpersonal: Listening and understanding. This theme brought together goals around family and social relationships, improving living situation, communication with others, including peers and family and being able to talk about feelings and thoughts. It tended to focus on wanting to improve on how the CYP interacted with others.

Table 2: Jointly agreed framework with example goals from the dataset

Theme	Example goal
Relationship/interpersonal: Listening and understanding	
To make family (or living) situation feel better	To feel better within the family
Getting on better with mum/dad (or both)	To get on better with (name) and mum better
To be able to communicate with people more (includes parents)	To be able to talk to others
Make more friends/ get along with others better	I want to work on not being nasty to other children
Talk about feelings and thoughts	To be able to talk easier about thoughts and feelings
Letting people know what help I need	Be more organised and be able to ask for help
Coping with specific problems and symptoms	
Manage negative mood and negative thoughts and feelings or patterns	Managing more negative feelings
Stop harming myself	Find other strategies other than self-harm
Better sleep	Better sleep pattern (not waking up)
Sleep on my own	To be able to sleep in my own room
Controlling and managing my anger	Controlling my anger – when people aggravate me I get angry, I shout, hit and kick
Understanding my anger	To understand why I get angry
Be good/ help with behaviour	Help with behaviour, anger – help not getting into trouble
Control and manage anxiety, worries	To manage feelings more effectively to reduce anxiety, anger and stress
Stop feeling anxious, stressed, worried	To feel as if I'm normal. Don't want to feel this anxiety and depression, I feel like I'm the odd one out
Feel happier	To feel happier and less worried and more satisfied
Personal growth & functioning: Understanding and improving self	
Feeling more confident or feeling better within myself	Becoming more confident in myself and my abilities
I would like to…(goals with personal meaning or related to a hobby)	To go to a football match and catch the ball
Thinking about me and understanding my past	To sort through some of the past order
Doing better at school (includes behaviour)	I would like to do better at school
Feeling comfortable at school and being able to go to school	Feel comfortable about going to school regularly
Relationships at school including bullying	Deal with bullying at school
Enjoying life	To be able to do the things you enjoy
To be more responsible for myself (including care of myself) or to be more independent	To be more in charge when I'm not feeling well, e.g. when I'm out
Meaning unclear	To be more comfortable being transparent. Stop vicious cycle

Table 3: Percentage of overall number of goal units placed into each theme, reverse sorted by the mean percentage

Sub theme	Major theme	per cent of goal units		Cohen's kappa	95 per cent confidence	
		Rater 1	Rater 2		Lower	Upper
Manage mood and negative thoughts and feelings or patterns	Coping	8.6	9.8	0.84	0.71	0.96
Feel more confident or feeling better within myself	Growth	8.6	8.1	0.94	0.86	1.00
I would like to … (goals with personal meaning or related to a hobby)	Growth	9.5	6.8	0.79	0.65	0.94
To be more responsible for myself (including care of myself) or to be more independent	Growth	5.9	8.9	0.86	0.72	0.99
Controlling and managing my anger	Coping	7.7	6.8	0.84	0.69	0.98
Stop feeling anxious, stressed, worried	Coping	4.5	9.4	0.40	0.18	0.62
Control and manage anxiety, worries	Coping	8.6	4.7	0.55	0.32	0.77
Make more friends/get along with others better	Relations	3.6	5.5	0.58	0.32	0.84
To make family (or living) situation feel better	Relations	4.1	3.8	0.82	0.61	1.00
Be able to communicate with people more (includes parents)	Relations	4.1	3.8	0.82	0.61	1.00
Be good / help with behaviour	Coping	5.0	2.6	0.45	0.15	0.75
Better sleep	Coping	4.1	3.4	0.94	0.82	1.00
Feel happier	Coping	4.1	3.4	0.82	0.61	1.00
Doing better at school (includes behaviour)	Growth	3.6	3.0	0.79	0.57	1.00
Feeling comfortable at school and being able to go to school	Growth	2.7	3.0	0.92	0.77	1.00
Talk about feelings and thoughts	Relations	2.3	3.4	0.66	0.30	1.00
Thinking about and understanding me and my past	Growth	2.7	2.6	0.66	0.34	0.97
Getting on better with mum or dad (or both)	Relations	2.3	2.6	0.91	0.72	1.00
Relationships at school including bullying	Growth	2.7	1.7	0.80	0.52	1.00
Stop harming myself	Coping	1.4	1.3	1.00	1.00	1.00
Sleep on my own	Coping	1.4	1.3	1.00	1.00	1.00
Meaning unclear	N/A	1.8	0.9	0.66	0.22	1.00
Understanding anger	Coping	0.5	1.3	0.50	-0.10	1.00
Enjoying life	Growth	0.5	1.3	0.67	0.05	1.00
Letting people know what help I need	Relations	0.5	0.9	1.00	1.00	1.00

Coping with specific problems or symptoms. The wish to control or cease perceived problematic behaviours and thoughts. Feelings expressed within this theme included difficulties with anger, negative thoughts, self-harm, anxiety, stress, panic and low mood. In addition, specific problems with sleep were included here as well as goals focusing rather on feeling happier and what achieving that may involve.

Personal growth and functioning: Understanding and improving self. Goals in this theme related to confidence and self-esteem; understanding of past experience; school experience (including behaviour and bullying); and independent living. Goals here tended to focus on working on the self, self-perception and understanding, and on functioning in everyday life.

Discussion

We introduced how goal-based outcomes (GBO) may be used in clinical practice and reported a first thematic analysis – a 'thin form' of qualitative research – of the goals children and young people agree to work on. Three overarching themes emerged with 25 lower level goal categories – and good inter-rater reliability. Inter-rater reliability across the major themes was consistently high. When broken down into subthemes, it is clear that the inter-rater reliability was lower for themes relating to distinctions between understanding or stopping specific symptoms. The top five most frequent goals mostly concerned personal growth, functioning and coping with specific symptoms and problems – a mix of positively worded and negatively worded goals.

How do the themes relate to those uncovered in other CAMHS-relevant work? Hawley and Weisz (2003) found that the top five problems young people wanted to work on were (1) poor schoolwork, (2) disobedience at home or school, (3) trouble getting along with family members, (4) not getting on with other kids, and (5) temper tantrums or hot temper. (These categories are based on items from the Child Behaviour Checklist rather than couched in language used by the young people themselves.) There is a large degree of overlap with the top goals we found, for example, concerning improving relationships and behaviour. One noticeable difference is that schoolwork features at position 14 on our list rather than first. Present in goals in the top three but not in the top five problems are goals with personal meaning such as pursuing a hobby. It could be that phrasing the question in the positive – what you would like to achieve rather than what problem you would like to work on – subtly changes the focus of attention. We also found more references to emotions, for example, anxiety, in the top five than in the top problems work.

We noted earlier that there is some variability in how clinicians use and record goals, for example, how achievable they are. Previ-

Table 4: Percentage of overall number of goal units placed into each major theme, reverse sorted by the mean percentage

Major theme	per cent of goal units		Cohen's kappa	95 per cent confidence interval for kappa	
	Rater 1	Rater 2		Lower	Upper
Coping	42.6	43.5	0.85	0.78	0.92
Growth	33.8	35.0	0.88	0.82	0.95
Relations	15.6	19.8	0.78	0.67	0.89
Overall			0.76	0.70	0.82

ous work has shown that carers worry about the generality and specificity of the goals chosen (Moran et al., 2012). Many of the goals in the CORC dataset seem relevant for and achievable through CAMHS work, for instance, 'Find … strategies other than self-harm'. Others not so, for instance some children had the goal of visiting a foreign country or joining a sporting team. Another distinction observed in the goals is between stopping and controlling a symptom, for example, 'I do not want to feel anxious, stressed or down' versus 'control anxiety … better'. It's not obvious what to do with less CAMHS-achievable goals. It is probably desirable to be clear what goals the clinician can help the young person achieve and collaborate in choosing them; however, for engagement purposes it might make sense to show that all goals which are important to the young person have been acknowledged.

There was some variability in the extent to which goals chosen by the young person were written in their own language, for example, 'Closure on the anxiety of humiliation' seems influenced by clinical nomenclature; 'Controlling my anger – when people aggravate me I get angry, I shout, hit and kick' seems more likely to be expressed in the young person's own language. In terms of shared decision making and engagement, perhaps there is a case to be made for staying as close as possible to the child or young person's language.

Limitations

Limitations of this research include the small size and unknown representativeness of the self-selected sample. Due to the nature of the datasets at the current time, we have been unable to link the goals to demographics information, thus, we do not yet know whether the sample is representative of the wider CAMHS population. A further limitation is that we cannot be sure what information or instructions are given to the CYP and family upon setting goals. Linked to this, we also cannot be certain that the goal information recorded and submitted for analysis is a true reflection of the meaning of the goal set in treatment. Some goals were written in a shorthand version which it seems likely is quite different from the original wording used by the young person in the therapeutic discussion.

Further work

The present paper introduced a child and young person's view. We plan to extend the work to examine the parent perspective. One important line of research is to examine agreement and disagreement between different perspectives. Hawley and Weisz (2003) showed that only around half of child-clinician pairs agreed on at least one problem to work on. This fell to under a quarter when examining child-carer-clinician triads.

There is a tension between, on the one hand, giving children and young people, parents and clinicians complete freedom when recording goals, and on the other using qualitative analyses such as those reported here to develop a questionnaire of goals which can be selected with a tick box. The latter has advantages in terms of national analyses of the sorts of goals children and families more widely have, but there may be serious clinical disadvantage in terms of how personalised the goal-setting is felt to be.

Further work will also explore relationships between goals and presenting problems and the moderating effect of goals on outcomes. Clearly there is still much to do – we hope the resulting research will help clinicians make better use of goals in treatment and ultimately improve the quality of care children, young people, and their families receive.

Acknowledgements

Many thanks to Tamsin Ford and Catriona McCallum for helpful comments on an earlier draft.

The authors

Jenna Bradley, Senior Research Officer, CAMHS Outcomes Research Consortium & CAMHS Evidence Based Practice Unit, University College London and the Anna Freud Centre.

Samantha Murphy, Research Officer, CAMHS Outcomes Research Consortium & CAMHS Evidence Based Practice Unit, University College London and the Anna Freud Centre.

Andrew Fugard, Research Lead, CAMHS Outcomes Research Consortium & Research Fellow, CAMHS Evidence Based Practice Unit, University College London and the Anna Freud Centre.

Sevasti-Melissa Nolas, Lecturer in Social Work, University of Sussex.

Duncan Law, Consultant Clinical Psychologist, Specialist CAMHS, Hertfordshire Partnership NHS Foundation Trust.

Contact details

Jenna Bradley, Senior Research Officer, CAMHS Outcomes Research Consortium, 21 Maresfield Gardens, London, NW3 5SD. corc@annafreud.org .

References

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research, 1*(3) 385–405.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Assessment, 20*, 37–46.

CAMHS Outcomes Research Consortium (2011a). *CORC measures.* Available at www.corc.uk.net.

CAMHS Outcomes Research Consortium (2011b). *CORC protocol.* Available at www.corc.uk.net

CYP IAPT Outcomes and Evaluation Task and Finish Group (2011). *Children & Young People's IAPT routine outcome monitoring briefing note.* Retrieved 4 May 2012 from www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf.

Doran, G.T. (1981). There's a S.M.A.R.T. way to write management goals and objectives. *Management Review 70*(11).

Geertz, C. (1973). *The interpretation of cultures.* New York: Basic Books.

Grosse Holtforth, M. & Grawe, K. (2002). Bern inventory of treatment goals: part 1. development and first application of a taxonomy of treatment goal themes. *Psychotherapy Research, 12*, 79–99.

Hawley, K.M. & Weisz, J.R. (2003). Child, parent, and therapist (dis)agreement on target problems in outpatient therapy: The therapist's dilemma and its implications. *Journal of Consulting and Clinical Psychology, 71*, 62–70.

Kiresuk, T.J. & Sherman, R.E. (1968). Goal attainment scaling: A general method for evaluating community mental health programs. *Community Mental Health Journal, 4*, 443–453.

Landis, J.R. & Koch, G.G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*, 159–174.

Law, D. (2006) *Goal based outcomes (GBOs): Some useful information.* Internal CORC publication. Retrieved from www.corc.uk.net.

Law, D. (2011). Goals and goal based outcomes (GBOs): Some useful information. Version 2.0. Retrieved 5 August 2012 from www.corc.uk.net/wp-content/uploads/2012/03/Goals-and-Goal-Based-Outcomes_Sep2011.pdf.

Maher, C. A. & Barbrack, C.R. (1984). Evaluating the individual counseling of conduct problem adolescents: the goal attainment scaling method. *Journal of School Psychology, 22*, 285–297.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy.* Sage Publications Ltd.

Moran, P., Kelesidi, K., Guglani, S., Davidson, S. & Ford, T. (2012). What do parents and carers think about routine outcome measures and their use? A focus group study of CAMHS attenders. *Clinical Child Psychology and Psychiatry, 17*, 65–79.

Shirk, S.R., Karver, M.S., Brown, R. (2011). The alliance in child and adolescent psychotherapy. *Psychotherapy, 48*, 17–24.

Strauss, A. (1978). *Negotiations: Varieties, contexts, processes, and social order.* San Francisco: Jossey-Bass Inc Pub.

Weisz, J.R., Chorpita, B.F., Frye, A., Ng, M.Y., Lau, N., Bearman, S.K., Ugueto, A.M., Langer, D.A. & Hoagwood, K.E. (2011). Youth top problems: Using idiographic, consumer-guided assessment to identify treatment needs and to track change during psychotherapy. *Journal of Consulting and Clinical Psychology, 79*(3), 369–380.

Wolpert, M., Ford, T., Law, D., Trustam, E., Deighton, J., Flannery, H. & Fugard, A.J.B. (2012). Patient reported outcomes in child and adolescent mental health services (CAMHS): Use of idiographic and standardized measures. *Journal of Mental Health, 21*, 165–173.

Wolpert, M., Fugard, A.J.B., Deighton, J. & Görzig, A. (2012). Editorial commentary: Routine outcomes monitoring as part of Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) – improving care or unhelpful burden? *Child and Adolescent Mental Health, 17*, 129–130.