DOCTORAL THESIS

Personalised outcome measurement

using goals to evidence outcomes that are important to young people in therapeutic mental health settings

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Personalised Outcome Measurement: Using Goals to Evidence Outcomes That are Important to Young People in Therapeutic Mental Health Settings

by

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Preface

This supporting document is submitted for the degree of Doctor of Philosophy by Published Works at the University of Roehampton. The published works comprise two chapters published in books focused on outcome measurement and five journal articles. Copies of the presented works may be found in the attached portfolio. Consideration of the requirements for the award of Doctor of Philosophy by Published Works is organised into the following chapters. The research being presented is integrated within the existing literature, to provide a balanced reflection. This includes critical appraisals of the methodologies, consideration of the contribution which the research has made to the field of study and suggestions for further work.

The author's previous surname was Bradley. The citations and references for the published works presented in this supporting document are highlighted in bold and with asterisks, for example, ***Jacob et al., 2018.**

"Young people" and "youth" are used to refer to children, young people and their families, where applicable. "Client" is used to refer to patients, young people or adults attending mental health services. "Mental health" is used to refer to mental health and wellbeing.

Abstract

To assess progress in therapeutic settings, routine outcome measures are regularly administered to clients (Carlier et al., 2012). The presented research explores mental health outcomes through personal goal measurement in youth therapeutic settings. The aims of this research are to demonstrate the unique contribution of client-defined outcome measurement, to consider what goals are set in therapeutic settings and to explore the association between goal-based measures and other outcome measures. The research was conducted between 2013 and 2018 and is based on the secondary analyses of routinely collected clinical datasets in the UK. Mixed methods research was used to give careful consideration to the use of the goal content and goal change score data. The key findings include the creation of parent-led, child-led and jointly agreed goal taxonomies, the presentation of a method of analysing aggregate goals in a comparable way to metrics used for standardised measures and evidence to support the hypothesis that goal-based measures capture areas of change which are as yet unexplored. Investigations into the relationships between goal progress and symptomology and impact on daily life, found greater change in goal progress. The first exploration of the psychometric properties of the Goals and Goal-based Outcomes tool (GBO; Law, 2011) provides insight into the reliability of the measure. Challenges of implementation and data analysis are addressed through the research. The findings suggest that goal-based measures may be more sensitive to the type of change that is meaningful to young people, highlighting the importance of ensuring outcomes are client-led. Future work is suggested, which will contribute to the understanding of client-defined measures for evidencing outcomes that are important to young people.

Declaration and Acknowledgements

I, Jenna Jacob, declare that except where otherwise indicated, this is my own work and is not substantially the same as any other work submitted before for any degree or other qualification.

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The biggest thank you goes to Richard and Albie who are the centre of my everything; words are not enough. To AFB, I hope you are proud.

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Chapter 1

Introduction

It is crucial to explore the mental health of young people, since this is a critical time when the majority of difficulties first emerge (Patel, Flisher, Hetrick & McGorry, 2007). Mental health difficulties have long term implications on the individual and wider society specific to later mental health, life satisfaction and economic burden (Campion, Bhugra, Bailey, & Marmot, 2013; Clark, Fleche, Layard, Powdthavee & Ward, 2016), which are more damaging than poor physical health implications (Delaney & Smith, 2012). Longitudinal research indicates that there has been an increase in both the prevalence and severity of youth mental health difficulties across the UK (Edbrooke-Childs, Deighton, & Wolpert, 2017; NHS Digital, 2018; Pitchforth et al., 2019). This, coupled with recent national reductions to resources in statutory services, has placed an enormous strain on existing youth services. Several reports and academics have highlighted the worsening situation and growing concern for the state of young people's mental health, including inadequate service provision and waiting times (Care Quality Commission, 2017; Children's Commissioner's Office, 2017; Department of Health, 2015; Edbrooke-Childs, et al., 2017; Fink et al., 2015; House of Commons, 2017; Kowalenko, 2018; NHS Digital, 2018; NHS Benchmarking Network, 2018; Rimmer, 2018).

With this pressure, comes an increased requirement to demonstrate service effectiveness to key stakeholders. To assess this, routine outcome measures are regularly administered to clients, from which healthcare professionals are able to gauge to what extent therapy is progressing (Carlier et al., 2012). Such measures are widely used in youth mental health services across the UK and beyond (Child Outcomes Research Consortium; CORC, 2019; Fleming, Jones, Bradley, & Wolpert, 2014). The use of outcome measurement has become more widespread in recent years due to knowledge-sharing and government implementation schemes with a central focus on outcome measurement, such as Children and Young People's Improving Access to Psychological Therapies (Law & Wolpert, 2014). In the absence of externally verifiable factors, outcomes tracked in mental health settings

include subjective symptom change, functioning, wellbeing and perception of recovery (Wolpert et al., 2014). There are a number of standardised outcome questionnaires available, comprising fixed items which span difficulties identified by clinicians and are specific to certain population groups. The information from these measures is used to evidence the impact of therapies, for service evaluation and as clinical tools that may help facilitate better collaborative practice; to extrapolate discussions about how a young person or family sees progress and their experiences of the work with the clinician (Law & Wolpert, 2014).

There is an important distinction between the use of outcome measures for monitoring and for feedback purposes. Monitoring is where, based on ratings on the measure, progress is tracked over time but not necessarily shared with the clinician or client. Where the measure of progress is not shared with the clinician, it is collected by a third party within the service, such as an Assistant Psychologist or a researcher. Where measures are used for feedback purposes, progress on the measure is shared with the client and/or the clinician. To track change and benchmark at an aggregate level, incorporating feedback from standardised measures into ongoing therapy sessions has been evidenced as useful (Gondek, Edbrooke-Childs, Fink, Deighton & Wolpert, 2016; Green & Latchford, 2012), although recent Cochrane reviews have suggested that there is still a paucity of evidence in both adult and youth settings (Bergman et al., 2018; Kendrick et al., 2016). Nevertheless, on an individual level, evidence suggests that these types of measures may be less clinically meaningful and person-centred (Chapter 2). An alternative, client-defined approach, is to elicit the client's therapeutic goals, for example, *"Becoming more confident in myself…"* **(*Bradley, Murphy, Fugard, Nolas, & Law, 2013, p.14)**. It is an intrinsic part of human nature to have goals (Deci & Ryan, 2000). Motivation to strive towards goals is often understood in terms of a fundamental need to return to a state of equilibrium when internal states are imbalanced (Reeve, 2018). This means where there is a perceived gap, which may be implicit or explicit, between the current and desired end state (Austin & Vancouver, 1996). Goal theory is grounded in purposive behaviourism (Innis, 1999) and motivation (Bandura, 1988) conceptual frameworks, where behavioural acts have a goal or purpose, and underlying cognitive processes drive motivation to achieve goals. Intrinsic and extrinsic

goals are considered to be separate, whereby extrinsic goals speak to a biological and fundamental need. In order to meet extrinsic goals necessary for the maintenance of life, strivings manifest themselves in the consciousness as psychological drives. Only psychological drives and not the underlying psychological needs, have motivational properties (Reeve, 2018). Through conditional positive regard, intrinsic motivations develop, which may be contingent on external approval and rewards (Cooper, 2013; Kasser & Ryan, 1996). Individuals then move onto higher level goals once more immediate goals have been achieved, promoting a continuous cycle of personal development and self-discovery (Maslow, 1989). Conscious human conduct is understood in terms of purposeful efforts to strive towards goals which act as a regulative or heuristic principle of human knowledge (Deci & Ryan, 2000; Latham & Locke, 1991). Clients attending mental health settings are there for a purpose, which may be translated into goals; they want their lives to be different to how they presently are. These experiences of difficulties have motivated help-seeking behaviour in the client/s, which may have been led by the young person, or by the parent.

Goals may be referred to as targets, aims, desires, objectives or purposes and while the sentiment may be the same, there are differences in the conceptualisation of these terms. For example, a goal is likely to be less of a desire and more of a conscious and almost tangible entity; albeit still a cognitive phenomenon (Cooper & Law, 2018). Goal setting is also based on social and cultural norms, with each individual's goals being unique and personal in content (Carver & Scheier, 1990; Oyserman & Fryberg, 2006). Goal-based measures are distinct from standardised measures due to the factors identified here, but also, because goal striving and attainment are thought to be influenced by motivation, locus of control and the desire for attainment (Karoly, 1993). Within the context of young people's mental health and specifically outcomes, goals are the ultimate desired state (Austin & Vancouver, 1996), described as '*intended changes in behaviour and experience to be attained by therapy'* (Michalak & Holtforth, 2006, p. 354) and are collaboratively agreed upon at the beginning of treatment. Goal setting is an intrinsic feature of some types of therapies, where there is a focus on self-reflection, incorporating and identifying goals, such as psychoanalysis (Gollwitzer & Moskowitz, 1996), Cognitive Behavioural Therapy (Beck, 1997; Nurmi, Poole, & Kalakowski, 1994), family therapy, (Diamond, Liddle, Hogue, & Dakof,

1999) and parent training programmes (Reid, Webster-Stratton, & Beauchaine, 2001). These therapies which are commonly provided by UK statutory services, often follow goal-focused approaches due to their limited time focus (Cooper & Law, 2018).

Further, goals are at the centre of the therapeutic relationship (Bordin, 1979) which is widely considered to be the key element of effective therapy (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Duncan, Miller, Wampold & Hubble, 2010; Messer & Wampold, 2002). Therefore, it is essential that clinicians work with clients on the goals they want to achieve throughout their time in therapy. Whilst goal-based measurement may lead to a shift in clinicians' work to be goal-focused (Di Malta, Oddli & Cooper, 2019) goals may also sit alongside usual clinical work (Law & Jacob, 2015). Goals may change over the course of therapy and it is important to balance this with the complexity of tracking progress over time. Clinicians may instead work flexibly with clients and deviate from goals as required, perhaps treating them as guidance topics to remain on track (Alves, Sales, Ashworth & Faisca, 2018; Feltham, Martin, Walker & Harris, 2018). Goals set in therapy tend to be focused and specific, for example, to deal with something in the immediacy, like a phobia (Grosse Holtforth & Grawe 2002). This type of goal fits with a SMART (Specific, Measurable, Achievable, Realistic and Timely; Doran, 1981) method of goal setting, which lends itself to tracking goal progress for outcome purposes (Law & Jacob, 2015). However, it is important that these very immediate and specific goals or 'vehicles' are attaining to more global 'destination' goals (Law, 2018) or a 'means to an end'. Systematically tracking goal progress through outcome measurement in youth mental health settings is relatively new, thus there is sparse evidence for its use (Lloyd, Duncan & Cooper, 2019). Much of the literature is situated in related fields, such as physical health, education and adult mental health (Ames, 1992; Clare et al., 2010; Farrand & Woodford, 2013; Schwartz & Drotar, 2006). Therefore, little is known about the use of goal-based outcomes in youth mental health settings (***Jacob et al., 2018;** Chapters 2 and 5).

To address this lacuna, the presented research explores the data derived from the Goals and Goal-Based Outcome tool (GBO; Law, 2011, see appendix A), which is primarily used in youth mental health settings. GBO data are analysed and interpreted mainly to inform therapeutic practice and individual outcomes. Therefore, the research considers

young people's mental health outcomes through the measurement of personal goal progress in therapeutic settings. This is important because as outlined, it is crucial to track young people's mental health to reduce distress and mitigate wider consequences. Further, tracking outcomes can inform service provision more widely (Chapters 2, 3 and 4). The goal data analysed take the form of up to three goals which are agreed upon at the start of therapy. Goals may be the result of one or more conversations about what the young person, family and clinician feel it is important to work on and try to achieve through the therapeutic process. A rating from zero (no progress towards goal) to ten (goal achieved) is then assigned to each goal. Goal striving is collaborative, through the clinical work. Goal progress is then revisited and scored in each therapeutic meeting, thus providing a longitudinal assessment of individual progress.

The presented research is based on the secondary analyses of large routinely collected clinical datasets, conducted between 2013 and 2018 in the UK. The datasets consist of demographic information pertaining to the young people seen by a range of statutory and non-statutory services. Alongside the demographic information is information from standardised symptom focused and client-defined routinely completed outcome measures. The research involved secondary analysis of anonymised administrative data and therefore, ethical review was not required (NHS Health Research Authority, 2018). Services who added data to the dataset were advised to gain consent from young people and their families that their anonymised data could be used for reporting and research, in line with local Research and Development ethical guidelines at each site. At the time of writing, the datasets are the largest young people's outcome datasets in the UK, consisting of data derived from a wide range of services providing mental health support to children, young people and their families. The overall dataset the analyses were based on consisted of data pertaining to approximately 263,928 young people, which has continued to augment.

The presented research adds to the field of outcome measurement in young people's mental health by addressing three novel and overarching research questions: *How can client-defined measures contribute to outcome measurement in therapeutic settings?* This explores the need for client-defined measurement alongside standardised measures to compliment the approach (Chapter 2); W*hat goals are set in therapeutic settings?* This

important question is related to what goals young people set in therapy (Chapter 3); *How do goal-based measures relate to other outcome measures?* This explores the relationship between clinical change and personal change, of which little is known (Chapter 4).

The presented research provides practical solutions to mitigate the complexities of all outcome measurement implementation, including advice on the clinical and meaningful use of measures, data and signposting to key resources (***Jacob et al., 2017[a]**; Chapter 2). Furthermore, a fundamental challenge for a goal-based outcome approach is whether it can achieve the standard of rigour that is associated with standardised measures; this issue is directly addressed, with an analytical solution provided (***Edbrooke-Childs, Jacob, Law, Deighton, & Wolpert, 2015**; Chapter 2). Support for the use of goal-based measures is imparted through the presentation of the considered benefits to clients and services derived from existing literature (***Jacob et al., 2018**; Chapter 2), the analysis of who sets goals (***Jacob et al., 2017[b]**; Chapter 4), the demonstration of improvements on goal-based measures despite standardised measures not showing such change and evidence of associations with parental satisfaction (***Edbrooke-Childs et al., 2015; *Jacob et al., 2017[b]**; Chapters 2 and 4). The important gap in the literature regarding what goals young people and their families set for themselves in therapeutic settings is addressed through the development of goal taxonomies for clinical use (***Bradley et al., 2013; *Jacob, Edbrooke-Childs, Holley, Law, & Wolpert, 2015**; Chapter 3).

Further explorations include an analysis of goal content compared to widely used standardised measures, with unique areas measured by goals identified and implications discussed. The research challenges the mainstream practice of selecting standardised outcome measurement based on service requirements or targets (***Jacob, et al., 2017[c]**; Chapter 4). Finally, a discussion includes the main contributions this work brings to the field, implications and suggestions of how to progress the work to further understand how these measures function (Chapter 5).

Chapter 2

How Can Client-defined Measures Contribute to Outcome Measurement in Therapeutic Settings?

As discussed in the previous chapter, outcome measurement is a method for gathering information to systematically track the progress of clients receiving therapeutic care (Carlier et al., 2012; Worthen & Lambert, 2007). While clinical judgement is paramount in assessing such changes, a randomised controlled trial demonstrated that clinicians may be less able to predict deterioration amongst young people compared to self-reported measures (Hannan et al., 2005). This highlights the need for measurement, but in what form? The aim of this chapter is to demonstrate how client-defined outcome measurement, specifically goal-based, fits into a landscape dominated by standardised measures in youth mental health settings. The research question is, *"How can client-defined measures contribute to outcome measurement in therapeutic settings?"*

Implementing routine outcome measurement requires adjustment in practical and sometimes philosophical terms (Boswell et al., 2015). Clinicians and others may feel overwhelmed with elements of implementation including data entry, understanding and administering the measures and decisions about which measures to use (Wolpert, Fugard & Deighton, 2013). To address these challenges, ***Jacob and colleagues (2017[a])** conducted a conceptual analysis and synthesis of the key limitations. These include the reliance upon proxy measurement, especially with young children and work with clients at different developmental stages. Consequently, the work has since been used as a main reference for practical solutions to mitigate the complexities of all outcome measurement implementation, including advice on the clinical and meaningful use of measures, the considered presentation of data and signposting to key resources (Hudson, 2018; Sharples, Albers, & Fraser, 2018).

Further, outcome measures have been placed into two groups: nomothetic or standardised and idiographic or client-defined. Standardised measures consist of a set of fixed items allowing for comparisons across groups (Barkham et al., 2001; Barkham, Hardy, & Mellor-Clark, 2010; Lutz et al., 2005). They can thus be completed by most clients

attending therapeutic services as long as the items are broad enough to capture a gamut of difficulties and experiences. This type of measure is often brief and well evidenced in terms of psychometric properties (Green, 2016). To date, standardised measures in mental health settings have focused on subjective and often proxy ratings of symptomology, functioning and wellbeing (Wolpert et al., 2014). In contrast, client-defined measures are bespoke to the individual and seek to capture the client's aims in their own words (Beresford & Branfield, 2006). At least part of client-defined measures is idiographic, yet some parts such as the scaling, may be standardised (Haynes, Mumma & Pinson, 2009). Standardised measures in mental health settings have taken precedence, due to the perceived need to systematically and scientifically measure symptomology (Duncan, Miller, & Sparks, 2011). A debate exists about the merits of standardised versus client-defined measures, particularly regarding how each type of measure may be used to support clinical practice and for service evaluation (Elliott, 1998; Sales, 2017; Sales, Goncalves, Fragoeiro, Noronha, & Elliott, 2007; Wolpert, Cheng, & Deighton, 2015). Providing feedback from standardised measures, to both clinicians and clients, or to only clinicians, has been evidenced as useful in mental health settings (Gondek et al., 2016; Green & Latchford, 2012), particularly when the client is going off track from a trajectory of improvement determined by an algorithm (Boswell et al., 2015). There are several specifically developed software solutions which allow for the measured progress to be fed back to the clinician and/or the client, which include expected trajectories of change to compare progress to: the Outcome Questionnaire System (OQ; Lambert, 2012), the Treatment Outcome Package (TOP; Kraus, Seligman, & Jordan, 2005), the Partners for Change Outcome Management System: International Center for Clinical Excellence (PCOMS ICCE; Miller, Duncan, Sorrell & Brown, 2005) and Clinical Outcomes in Routine Evaluation (CORE; Barkham, Mellor-Clark, Connell & Cahill, 2006). Many systematic reviews and meta-analyses of studies comparing treatment as usual (including outcome monitoring) with feedback conditions in both adult and youth mental health settings have found favourable results for the feedback of progress with clinicians and/or clients (Gondek et al., 2016; Knaup, Koesters, Schoefer, Becker & Puschner, 2009; Lambert et al., 2003; Lambert, Whipple & Kleinstäuber, 2018; Østergård, Randa & Hougaard, 2020; Lambert, Shimokawa & Smart, 2010). However, there is an argument that more evidence is

required (Bergman et al., 2018; Kendrick et al., 2016). Standardised measures are routinely used for aggregate data analysis and benchmarking across services, which in turn can be used to inform provision (CORC, 2019; Fleming et al., 2016; ***Jacob et al., 2017[a]**). This should be conducted via careful discussion about what service improvements may be required, in collaboration with additional information about the service (Wolpert et al., 2014). The use of standardised and client-defined measures together is encouraged (Alves et al., 2018; ***Edbrooke-Childs et al., 2015**; Green, 2016; Wolpert et al., 2014; see Chapter 4).

However, concerns have been raised about generic measures not possessing the specificity and sensitivity required to capture the unique experiences of individuals. This includes the non-linear trajectory of the therapeutic journey (Evans, 2012). Further, the validity of standardised measures for individuals in an aggregate sample is overestimated because not all items are likely to be relevant to everyone within the sample (Haynes, et al., 2009). In response, client-defined measures provide a more nuanced method with which to track the course of therapy. They promote informed reflective conversations between clients and clinicians on whether a change of direction is needed. Clinicians have reported neutral or positive attitudes to all types of outcome measurement but demonstrated a strong predilection to the use of client-defined measures (Jensen-Doss et al., 2018).

Widely used client-defined measures include Target Complaints (Battle et al., 1966) Psychological Outcome Profiles (PSYCHLOPS, Ashworth et al., 2004) and the Personal Questionnaire (PQ; Elliott et al., 2016) in adult mental health and PSYCHLOPS Kids (Godfrey et al., 2019) and Youth Top Problems (Hawley & Weisz, 2013) in young people's mental health settings. All of these measures follow a clinical interview method of eliciting the main difficulties to be worked on and have been found to be useful clinical tools (Cuijpers, 2019). Within this client-defined measurement field, all of the aforementioned measures (PSYCHLOPS, PQ, PSYCHLOPS Kids and Youth Top Problems) focus on moving away from difficulties, or complaints or problems. However, goal setting is more flexible because goals may be approach or avoidant in focus, as outlined in Chapter 3. Nine client-defined goal-based outcome measures which have been used in psychotherapy settings were recently identified by Lloyd and colleagues in a systematic review (2019). Of

those, the most widely used goal-based outcome measure in young people's mental health settings in the UK is the GBO.

To address the paucity of research on goal-based measurement in youth mental health settings, ***Jacob and colleagues (2018)** provide a commentary review of existing literature. This includes the introduction of goal setting in adult and youth mental health settings, consideration of the psychometric properties of a range of goal-based measures and a discussion about the key benefits and challenges specific to client-defined measures which had not been addressed in the earlier work **(*Jacob et al., 2017[a]).** Goal-based measures have many benefits. First, goal setting ensures that the voice of the young person is central to their care and outcomes because the measurement items are in their own words (Department of Health, 2012; Sales & Alves, 2016). Second, goals help to establish greater transparency for clinicians by enabling hidden or unconscious 'wants' from the treatment to be collaboratively discussed (Cooper & Law, 2018). Third, clinicians use goals to capture *clients*' preferences, priorities and phenomenological experiences, unlike standardised measures, which have traditionally focused on *clinicians'* perceived areas of importance (Robinson, Ashworth, Shepherd, & Evans, 2006). Fourth, goals have been shown to have good face validity amongst adults (Cooper & Norcross, 2016; Levack et al., 2015; Toto, Skidmore, Terhorst, Rosen, & Weiner, 2015) and young people and their representatives (Badham, 2011; Feltham et al., 2018; Law & Jacob, 2015; Moran, Kelesidi, Guglani, Davidson, & Ford, 2012) and have been linked to increased therapeutic retention (Cairns, Kavanagh, Dark & McPhail, 2019).

Despite these positive attributes, client-defined measurement is not an easy endeavour. Both practical (for example, they take longer to complete than standardised measures) as well as theoretical challenges (for example, the clinician and client may hold diametrically opposing views about what goals should be formulated) have been discussed (Green, 2016; ***Jacob, Edbrooke-Childs, Law & Wolpert, 2017**). By formulating easily attainable goals, client-defined measures are arguably more susceptible to gaming than standardised measures (Bevan & Hood, 2006; Law & Jacob, 2015; Wolpert et al., 2015[a]). Further, there is a risk to wellbeing if goals are not in line with each other, are not well formulated or do not fit the client or therapeutic approach well (Michalak & Holtforth, 2006).

These challenges could potentially be mitigated by training clinicians in the use of outcome measures. Clinicians have demonstrated higher levels of self-efficacy in the use of patient-reported outcome measures after attending focused training (Edbrooke-Childs, Wolpert & Deighton, 2016).

Client-defined measures have primarily been used as clinical tools and to inform outcomes on an individual level, whereby the client is in effect their own control 'group' (Molenaar, 2004). Consequently, advice is to plot individual scores on a line graph and assess change by sight on a case-by-case basis and to explore trends in run charts, to gauge significance (Cohen, Feinstein, Masuda, & Vowles, 2013; Perla, Provost & Murray, 2010). On an aggregate level, goal-based data are commonly analysed by testing statistical significance between mean scores over time using t-tests (CORC, 2018; Kim, 2015), however there are challenges with this, including biases (Borckardt, Murphy, Nash, & Shaw, 2004). Whilst t-tests are easy to understand and there is little noise within the measurement, the complexities of the data, including clinical or meaningful change, are lost. To address the challenge of analysing goal data with the same level of rigour as standardised measures at a group level, ***Edbrooke-Childs and colleagues (2105)** calculated a proxy of the Reliable Change Index (Jacobson & Truax, 1991), which indicates change that is beyond that which may be attributed to measurement error. Parent-reported goal data (Goals and Goal-based Outcomes; GBO; Law, 2011; see Chapter 1) were used, which was due to the quality of the child-reported data (see note on missing data, Appendix D; see also Chapter 4).

The presented research **(*Edbrooke-Childs et al, 2015)** contributes to the wider agenda of the considered use of aggregate goal-based outcome data to inform service provision. This research was the pinnacle of thought in this area. NHS England and NHS Improvement have adopted a version of this calculation which incorporates goal-based measures, called 'measurable change', exploring individual, as opposed to averaged, goal progress. It has been disseminated nationally as a metric to compliment the analysis of standardised measures. It also furthers the field of thought by promoting the use of client-defined measurement (Newlove-Delgado, 2016; Twigg et al., 2016). Some national mental health initiatives focus on measuring movement from a clinical to a non-clinical range (Gray & Mellor-Clark, 2007; Improving Access to Psychological Therapies; National Collaborating

Centre for Mental Health, 2018). However, ways of measuring client progress are evolving; clinical thresholds are not considered as meaningful as they once were unless used on an individual level, particularly in youth mental health (CORC, 2018; Wolpert et al., 2015[b]).

Divergent goals have previously been found in the GBO data **(*Jacob et al., 2015)** which may be a concern when aggregating data. However, acceptable internal consistencies were also found by ***Edbrooke-Childs and colleagues (2015)**, which may suggest that despite the 'surface features' the GBO behaves in a more cohesive way than expected, similar to standardised measures (see jangle fallacy; Marsh, 1994). None of the statistical methods discussed consider whether change is clinically or personally meaningful but they are the best indications of assessing change at an aggregate level that are currently available. Whilst reliable change analysis may be more robust than simple change, it does not demonstrate the amount of change and suggests that change smaller than what is considered reliable is irrelevant (CORC, 2018). However, even small changes may be meaningful to an individual. The proxy of reliable change calculation should be used cautiously because it is a novel approach. Further, the original calculation was based on goal data ratings from the parent perspective, so particular caution should be exercised when applying the calculation to goal data based on young people's ratings. Future research should seek to replicate the inception study on young person rated goal data. Leading on from this, many client-defined measures are conceived of as clinical tools first and foremost. Therefore, critiques of aggregate client-defined data analysis argue that the very personalised nature of these measures makes analysis at this level challenging because the main advantages may be considered lost when comparing across clients (Elliott et al., 2016; Maggin & Chafouleas, 2013). Because of these concerns, it may be useful to group goals by themes to further understand the types of goals being measured and to ensure homogeneity of analysis, as discussed in the following chapter.

Outcome measurement has transformed therapeutic work from being solely qualitative to something more quantitative with predictive validity (Loades et al., 2018) which would not have occurred without standardised measurement. The presented research highlights the need for client-defined measurement alongside standardised measures to compliment the approach, which is important to the consideration of a range of outcomes. A

key reference has been developed for mitigating strategies to counter the complexities of all outcome measurement implementation **(*Jacob et al., 2017[a])**. The presented research furthers support for the use of client-defined measures by highlighting the key benefits to clients and services **(*Jacob et al., 2018)**. Finally, an innovative way for goal-based measures to be analysed at an aggregate level with the same level of rigour as standardised measures is suggested and a version is being trialled nationally **(*Edbrooke-Childs et al., 2015).** With the importance of personalised care becoming more established in mental health settings (Sales & Alves, 2016), clinicians are referring to client-defined measures as a way to ensure that the voice of the client is central to outcomes, as well as tracking their perception of personal change, as discussed in Chapter 4.

Chapter 3

What Goals are Set in Therapeutic Settings?

The research presented in the previous chapter addressed the measurement gap filled by goal-based measures and provided a suggestion for aggregate goal-based data analysis. The main strength of client-defined outcome measurement is its personalised nature. This is also the main critique of considering aggregate goal analysis, because it may introduce difficulties in comparing results across client groups. Therefore, when working on an aggregate level to assess change, it may be important to consider what kinds of goals are being measured. This may provide invaluable insights for clinicians and service managers to consider service provision in light of these goal themes. The focus of this chapter is goal-based taxonomies used in mental health settings. The research presented used routinely collected data from the Goals and Goal-Based Outcomes tool (GBO, Law, 2011; see Chapter 1). The research question is, *"What goals are set in therapeutic settings?"*

A number of taxonomies based on adult therapy goals exist, which are often concerned with general personal goals (Little, 1983; Pöhlmann, 2001; Winell, 1982). When considering young people, research on personal goal setting is inclined towards the educational (Ames, 1992; Morisano, Hirsh, Peterson, Pihl, & Shore, 2010), physical health (Schwartz & Drotar, 2009; Schwartz & Brumley, 2017) and occupational health literature (Austin & Bobko, 1985; Rodger, Ireland, & Vun, 2008) from which much may be learnt. However, instead of goal taxonomies, most of the literature is focused on goal dimensions within which goal themes may vary. Cooper (2018) identified several goal dimensions, including *'approach-avoidance'* goals (Elliot, 1999) which may be pertinent to clinical work. Clients work towards approach-goals and away from avoidance-goals. Educational research has demonstrated that goal dimensions are linked to motivation: young people demonstrate poorer outcomes and levels of wellbeing when focusing on avoidance-goals (Kaplan, Middleton, Urdan, & Midgley, 2002; Emmons, 1992) whilst approach-goals are more likely to promote wellbeing (Elliot & Sheldon, 1997).

Further, clinical goals set through work with young people have been categorised into dual goals, whereby the achievement of a *'behavioural'* goal contributes to the achievement of an *'internal'* goal (Troupp, 2013). This is similar to work with older adults in physical health, where two goal dimensions are suggested in addition to symptom goals: *'fundamental'* goals related to values, core relationships and life priorities and *'functional'* goals related to behaviour, day-to-day functioning and emotional health (Vermunt, 2018). The concept of setting 'layers' of goals further supports the model of vehicle and destinations goals, as discussed in Chapter 1. Continuing in youth mental health settings, Hawley and Weisz (2013) present 'Top Problems', which could be conceived of as transposed goals. They compared young people's 'Top Problems' to a symptom-based standardised assessment tool (Child Behaviour Checklist; CBCL; Achenbach, 1999) to create themes, they then created further themes for any remaining problems. The most common themes from the child, parent and clinician's perspective were related to anger and behavioural symptoms, in line with the focus of the CBCL.

Further, youth mental health settings are unique due to multiple stakeholder involvement. Therefore, it is important to consider parent-led goals. '*Functional success', 'physical movement', 'leading happy fulfilling lives', 'being accepted', 'improving child's quality of life', 'household management', 'striking a balance and shifting roles'* and '*responsibilities'* form the basis of parent-led goal taxonomies from occupational health settings and from parents of young people attending mental health settings (Donovan, VanLeit, Crowe, & Keefe, 2005; Wiart, Ray, Darrah, & Magill-Evans, 2010). Parents accessing an online counselling service's goals were also categorised into three dimensions: *'therapy goal'* (for example, '*to explore difficult feelings towards baby'*), *'life goals'* (for example, '*to communicate needs better to partner'*) and *'life and therapy goal'* (for example, '*to develop confidence to reach out to other mums locally'*; Grey et al. 2018, p. 196). This research is insightful, however, there is very little literature which addresses therapy goals of young people, which is considered an important area of interest (Weinberger & Eig, 1999).

In order to address this dearth of research, GBO data were analysed through a process of thematic analysis (Braun & Clarke, 2006) to create child-led, parent-led and jointly agreed goal taxonomies **(*Bradley et al., 2013; *Jacob et al., 2015).** The majority of

the analysis was data driven, however, an adult clinical mental health goals taxonomy was also consulted (Grosse Holtforth & Grawe, 2002). The goal categories used from this taxonomy were '*obsessive thoughts and compulsive behaviours'* and '*responsibility and self-control'*. The derived taxonomy of child-led goals consisted of three overarching themes and 25 subthemes (see attached portfolio of published works). The most common subthemes were '*managing negative mood', 'confidence'* and '*personal growth'*. The taxonomy of parent-led goals consisted of four overarching themes and 19 subthemes. The most common subthemes were '*better sleep routine', '"inappropriate" behaviour'* and '*strategies to manage behaviour'.* The jointly agreed taxonomy consisted of five overarching themes and 19 subthemes. The most common subthemes were '*parent goals', 'understanding managing and expressing emotions'* and '*school and learning'*. This was the first set of GBO taxonomies and the first comparisons of child, parent-led and jointly agreed goals generally, which progressed the research in this area. Clinicians and others are able to consider outcomes from the GBO by using the taxonomies created. These child- and parent-led goal taxonomies have since been used to inform further thematic analyses (Odhammar & Carlberg, 2015; Duncan, Cooper, & Baxon, 2019) and the jointly agreed taxonomy remains the only one of its kind.

In further research, Odhammar and Carlberg (2015) created goal taxonomies for parents, young people's therapists and parents' therapists. There are similarities between the themes identified from the parents' goals and the parent-led goals identified by ***Jacob and colleagues (2015).** The similar and overlapping themes spoke to the parents' individual personal goals, understanding the young person's difficulties, the relationship and providing support and strategies to the parents. Odhammar and Carlberg (2015) also found that parents focused mainly on young people's symptom reduction which is similar to the previous work whereby the most commonly occurring parent-led goal themes were related to better sleep routines and managing the young person's behaviour **(*Jacob et al., 2015).** Hanley and colleagues (2017) also used thematic analysis to categorise young people's counselling goals into '*intrapersonal goals*, *interpersonal goals'* and '*intrapersonal goals related to others'*. These goal themes align to an existing school counselling goals taxonomy (Rupani et al., 2014), whereby four overarching themes related to '*emotional',*

'interpersonal', 'specific issues' and '*personal growth'*, were found. This converges with the work conducted on the child-led goals by ***Bradley and colleagues (2013)** by having full coverage of the previously developed themes. Hanley and colleagues (2017) also found that young people's counselling goals set online were mainly related to personal growth, whilst face-to-face goals were mainly related to relationships. These findings raise important clinical implications about the types of support required, which may lead onto further research into the coverage of different modes of therapy.

Further, between one half of parent-child-clinician dyads and one third of parents and therapists have shown agreement about young people's therapy goals (Hawley & Weisz, 2003; Odhammar & Carlberg, 2015). ***Jacob and colleagues (2015)** found that when comparing goal themes across child-led, parent-led and jointly agreed goals, all of the child-led goal themes mapped onto the parent-led and jointly agreed themes. However, themes from the other perspectives not found in the child-led data were '*parent co-operation'*, '*being calmer'* and '*"inappropriate" behaviour'* (parent-led) and '*family support and guidance'* (jointly agreed). This research highlights the disparate views often found between the multiple stakeholders involved and serves to highlight the subsequent importance of having open conversations about the expectations of therapy. These findings also highlight the importance of the young person's voice being central to outcomes, whereby their views must be heard and incorporated and goal setting is a useful tool to facilitate this process.

The research by ***Jacob and colleagues (*Bradley et al., 2013; *Jacob et al., 2015)** used thematic analysis to analyse a thin form of qualitative data (Braun & Clarke, 2006). It was important to retain the voice of the child as central to the analyses, therefore in vivo coding was used. However, data saturation (Faulkner & Trotter, 2017) was not reached due to the relatively small amount of data available. Consequently, further exploration of the taxonomies is warranted. It is important to find a compromise between procuring existing taxonomies to avoid replicating existing work and being purely led by the data. Braun and Clarke (2006) argue that themes do not 'emerge', because they do not exist independently of the researcher's interpretation of the data. By using an existing taxonomy, the prior interpretation of another dataset is imposed on the new data. Further, using themes derived

from existing data still limits the applicability of the themes to other users for similar reasons. Relying solely on the available data for analysis ensures a data driven approach which may provide different results reflective of a wider range of goals and enables the data to be completely open to novel themes. This may be considered in future work, rather than the approach taken by ***Jacob and colleagues (2013; 2015)**. However, for preliminary taxonomies, this was a helpful strategy.

Further, goals reflect broader social and cultural concepts about what is important to the individual (MacIntyre,1981) which will have been captured to a certain extent, but the sample was from England only and mainly consisted of White British young people. Therefore, further cross-cultural work would be beneficial. Moreover, because research has shown that some goal types are linked to wellbeing, goal attainment and other outcomes (Berking, Grosse Holtforth, Jacobi, & Kröner-Herwig, 2005, Kaplan et al., 2002; Emmons, 1992; Elliot & Sheldon, 1997), future work should include inferential analysis to explore whether this is also true of goal themes. To date, no differences in attainment of goal themes has been found in the young people's literature (Rupani et al., 2014).

In conclusion, ***Jacob and colleagues (2015)** created the first taxonomies based on GBO data in therapeutic settings, which have since been built upon (Odhammar & Carlberg, 2015; Duncan et al., 2019). These taxonomies provide a useful tool for clinicians, service managers and researchers to analyse GBO data in a meaningful way. The formalisation of goal themes from a larger dataset comprising data from several services helps to create a homogenous source to analyse and consider the goals data. Analysing the types of goals young people and others set at the outset of therapy is considered helpful for service planning: to focus work, identify gaps in the service and provide training. There seems to be a tendency to set two or three goals which speak to different goal setting dimensions (Grey et al., 2018; Troupp, 2013; Vermunt, 2018) and this may be a useful consideration for clinicians to adopt in their work. Further, the differences in types of goals across perspectives (Hawley & Weisz 2003; ***Jacob et al., 2015**; Odhammar & Carlberg, 2015) serves to highlight the importance of having open conversations about expectations of therapy and differing experiences of difficulties. The considered use of goal themes is encouraged alongside other elements of goal analysis to ensure a breadth of information is

used. The presented research led to further work which emphasised how goal-based measures might practically relate to other measures, including how goal themes might be used as a basis of standardised measure selection in therapeutic settings (see Chapter 4). Further exploration and testing of the taxonomies is recommended.

Chapter 4

How do Goal-based Measures Relate to Other Outcome Measures?

The previous chapters focused on ways to analyse goal-based outcome measures in youth mental health settings to ensure a range of information is considered. This chapter explores how goal-based measures link to symptomology, impact on daily life and satisfaction measures and how that may further understanding in the field. The research question is, *"How do goal-based measures relate to other outcome measures?"*

The mental health recovery paradigm seeks to eliminate or reduce symptoms (Yanos, Roe, Markus & Lysaker, 2008). However, this focus has been recently challenged and many researchers advocate for a client goal-orientated, rather than a symptom-based focus to therapy (Mulley, Trimble, & Elwyn, 2012; Reuben & Tinetti, 2012; Tinetti, Naik, & Dodson, 2016). This consists of a shift away from the present primary attention on treating symptoms, towards a focus on achieveing goals which may or may not be medicalised (Clarke, Lumbard, Sambrook, & Kerr, 2016; Kidd, Kenny, & McKinstry, 2015; Macpherson et al., 2016; Maybery, Reupert, & Goodyear, 2015). The basis of this is the view that personal change is more complex than originally thought, due to its idiosyncratic nature. To track therapy progress, the recommendation is that client-defined measures, for example goal-tracking, are used alongside standardised, symptom-based measures (Alves et al., 2018; ***Edbrooke-Childs et al., 2015**; Green, 2016; Sales et al., 2007; Wolpert et al., 2014; see also Chapter 2). However, whilst personal and clinical outcomes are considered to be separate (Bentley, Bucci & Hartley, 2019; Lavik, Veseth, Frøysa, Binder & Moltu, 2018), there is little evidence to support the view that the two types of measurement are complementary.

In secondary analysis of routinely collected data from parents of young people attending mental health support settings in the UK, ***Edbrooke-Childs and colleagues (2105)** analysed goal progress based on the Goals and Goal-based Outcomes tool (GBO; Law, 2011; see Chapter 1), psychosocial difficulties and impact on life (Strengths and Difficulties Questionnaire; SDQ; Goodman, 1997) and functioning (Children's Global

Assessment Scale; CGAS; Shaffer et al., 1983). The primary aim was to test the convergent validity of the GBO by exploring the relationship between goal-based and standardised outcome measures as reported by parents and clinicians. Of the parent and young person-reported measures, the parent sample was the largest, hence the focus on this perspective. See Appendix D for a note about the impact of the high proportion of missing data. All outcomes improved over time (paired samples t-tests), with the largest effect size demonstrated for goal progress. Parents who reported high levels of deterioration in psychosocial difficulties and impact reported less change in goal progress and satisfaction at the follow up time point. Parents reporting higher levels of goal progress also reported higher levels of impact over time and higher satisfaction (bivariate correlations). The relationships between goal progress and change in functioning or satisfaction were consistently stronger than the relationships between change in psychosocial difficulties or impact and change in functioning or satisfaction (comparisons between the correlations). Further, the main effects of goal progress accounted for 35% of variance in change in functioning (hierarchical regressions). No other significant interactions were found. Finally, goal-based measures demonstrated the highest proportion of reliable improvement when compared across measures.

Whilst other research has also demonstrated more change on focused compared to general measures (Alves et al., 2018; Lee, Jones, Goodman, & Heyman, 2005), none has compared data from the GBO to standardised measures since the publication of ***Edbrooke-Childs et al. (2015).** Correspondingly, comparisons of client-defined and standardised measures have previously been qualitative in nature (Ashworth et al., 2007) or focused on adult populations (Alves et al., 2018) making drawing comparisons challenging. Since publication, ***Edbrooke-Childs et al. (2015)** remains the sole paper to evidence the psychometric properties of the GBO and has been referenced as such (Pearce et al., 2017). ***Edbrooke-Childs and colleagues' (2015)** findings suggest that the areas captured by goal-based measures may be more aligned to functioning than to symptomology. The client's understanding of their difficulties or experience may not be congruent with the therapist's and the knowledge underpinning standardised measure development (Green, 2016), which is often based on symptomology and diagnostic criteria.

The differences demonstrated between goal-based and symptom-based measures align with other research demonstrating that mental health and wellbeing are separate, but related constructs (Black, Panayiotou & Humphrey, 2019; Patalay & Fitzsimons, 2018). Moreover, broad measures are more likely to be prone to false negatives, where they erroneously demonstrate no change, because the questions do not match the client's concerns (Green, 2016). Such underestimations may be indicated in the national reporting of young people's mental health outcome data, whereby up to 48% of clients seen by statutory mental health services in the UK do not show reliable improvement on standardised measures of symptomology, functioning and wellbeing (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004; NHS Digital, 2016; Wolpert et al., 2017).

Research into young people's perceptions of personal change is sparse (Kelly & Coughlan, 2019) but there is some suggestion that it may be associated with a stronger sense of autonomy, a safer identity (Lavik et al., 2018) relationships, insight and acceptance as well as symptom change (Binder, Holgersen & Nielsen, 2010). Adult recovery literature suggests that clients align personal change with factors not widely captured by standardised measures. These include coping, hope, acceptance, sense of self, motivation and religion or spiritual belief (Barber, Parsons, Wilson, & Cook, 2017; Clarke et al, 2016; Griggs, 2017). Personal change is considered a process of growth, which means having a satisfying and meaningful life with or without the presence of symptoms (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; Slade, Amering, & Oades, 2008; Jacobson & Greenley, 2001; Onken, Craig, Ridgway, Ralph, & Cook, 2007). Therefore, because symptomology may not shift over the course of therapy, it may not feature in clients' perceptions of personal change or 'recovery' (Clarke et al, 2016; Kidd et al., 2015; Lutchman et al., 2007; Macpherson et al., 2016; Maybery et al., 2015; Pulford, Adams & Sheridan, 2009; Thurgood, Crosby, Raistrick & Tober, 2014). Clients may assign more importance to tracking and exploring feedback on progress in areas that are significant to them, such as quality of life (Las Hayas et al., 2016; Malla & Payne, 2005) which are not currently widely incorporated in youth aggregate outcome analyses (Krause, Bear, Edbrooke-Childs & Wolpert, 2018). Clients have also expressed concerns about the ability of standardised measures to capture personal change effectively (Crawford et al., 2011).

Such gaps were explored by ***Jacob and colleagues (2017[c])** who, through a constant comparative approach, matched goal themes to items from standardised symptom-based measures widely used in youth mental health settings. Almost a quarter of goal themes did not correspond to standardised items. Those themes were existential factors which included understanding oneself, confidence and help-seeking behaviour **(*Jacob et al., 2017[c]).** This links to adult mental health research, whereby up to 45% of personalised data items are not present in standardised measures (Alves et al., 2018; Ashworth et al., 2004; Hunter et al., 2004). In a fundamental reformulation of how outcome measures are presently chosen and used with young people, ***Jacob and colleagues (2017[c])** suggest that clincians may consider using goal themes to choose the corresponding standardised measure. This mapping exercise could form the basis of outcome assessment protocols in clinical practice, whereby further work could be done to practically suggest which measures may be used with which population groups of young people, based on their goal themes. This would mititgate against the chance of clients responding to items that are irrelevant to them and it would also assist clincians to choose measures to use, which is currently challenging because there are numerous options (Jacob, 2019). Relatedly, Holtforth and Castonguay (2005) suggest tailoring the therapeutic interventions to the personal goals to foster the therapeutic relationship and outcome. Moltu and colleagues (2018) have also created an online measure, which based on item response theory, adapts to the client's needs over time and informs on the content of the therapeutic sessions (Norse Feedback, 2019). This approach sees the adoption of standardised measures in a personalised way, but aligns with the overall concept suggested by ***Jacob and colleagues (2017[c])** to incorporate client-defined measurement. The taxonomies derived from the GBO data could be built into a system like Norse (Norse Feedback, 2019) to enable goal setting to inform standardised measure selection. Ideally, this would be at an item level, where the goal themes would lead to the selection of a bespoke list of items, which would mitigate the existing problem of clients being asked to respond to irrelevant questionnaire items. However, the implementation of this development would be constrained by the existing publicly funded youth mental health services that have existing IT challenges and targets based on outcomes from specific measures (***Jacob et al., 2017[a]**).

Young people have indicated that they want to be involved in decisions about their care (Kelsey, Abelson-Mitchell & Skirton, 2007). Shared Decision-Making (SDM) is a process of discussion about preferences and options to ensure a shared agreement is reached about clinical treatment (Santana & Feeny, 2014). Research into what aspects of SDM may enhance the client's satisfaction and outcomes is developing (Abrines-Jaume et al., 2016). Goal setting and SDM are interlinked whereby sharing information between the clinician and client leads to mutual agreement about all aspects of care (Coulter, Edwards, Elwyn, & Thomson, 2011) and goal-based measures may also be used as decision tools. A more tailored approach to therapy and outcomes may lead to higher satisfaction ratings. However, existing research into young people's satisfaction with health services is limited (McCann & Lubman, 2012). Parental involvement in therapy is key due the central role parents play in the management of young people's difficulties (Rey, Plapp & Simpson, 1999). ***Jacob and colleagues (2017[b])** were the first to compare goal setting with ratings of parental satisfaction. Parents of children with goals set were more likely to be completely satisfied than those who did not (zero poisson regression; ***Jacob et al., 2017[b]**). Further research has demonstrated that clients who do not demonstrate 'recovery' at the end of treatment may perceive their care as unsatisfactory (Biering, 2010). This highlights the importance of clear conversations and expectation management, which may be achieved through the process of goal setting (Pender, Tinwell, Marsh & Cowell, 2013). Discussion about goals may highlight sources of disagreement faster and provide an opportunity to negotiate, resulting in improved satisfaction (Bradley et al., 1999).

Disagreement about goals is more likely to happen in cases with chronic illnesses where there are multiple stakeholders and the goals are not obvious because 'recovery' is not likely (Vermunt, et al., 2019). This is relevant in youth mental health settings, where co-morbidity is extremely common (Ford, Goodman & Meltzer, 2003), as well as difficulties where symptoms are unlikely to change, such as learning disabilities and developmental disorders. Indeed, pre-schoolers, those with learning disabilities and with comorbid hyperactivity and behavioural difficulties were found to be more likely to set goals (logistic regression; ***Jacob et al, 2017[b])**, which may provide further evidence that goal-based measures fill an important measurement gap.

The presented research contributes to the understanding of the relationship between clinical change and personal change, of which little is known (Macpherson et al., 2016) and how goals are at the centre of personalised outcomes. This is demonstrated in a number of ways. First, it has shown that improvements on goal-based measures might be demonstrated despite standardised measures not showing such change (***Edbrooke-Childs et al., 2015**). Second, there are unique areas of functioning which are not measured by existing standardised items that may be tracked through goal setting (***Jacob et al., 2017[c]**). Third, the formulation of goals, which is part of the SDM process, has been shown to be associated with higher rates of parental satisfaction **(*Jacob et al, 2017[b]).** Finally, a radical way of using outcome measures has been presented whereby goal themes may inform the choice of standardised measure **(*Jacob et al., 2017[c])**. All findings need to be interpreted cautiously in light of the data quality, which includes the high proportion of missing child-reported outcome data. A replication of the analyses on more complete datasets, including young person-rated satisfaction is recommended. Together, these findings suggest that goal-based measures may track important areas of personal change, which align to impact and functioning, in turn leading to more improvement and satisfaction.

Chapter 5

Discussion and Conclusion

The presented research explores both the content and change scores of personal goal-tracking as a client-defined outcome measure. Crucially, it provides insights into how goal-based measures may be used and considered by clinicians working in youth mental health settings and beyond. To develop the field, it was necessary to give careful consideration to the use of goal data through the novel application of statistical techniques, in a landscape which has been historically dominated by standardised, symptom-based measures.

The aims of this research were to consider how client-defined measures can contribute to outcome measurement, what goals are set in therapeutic settings and to explore the association between goal-based measures and other outcome measures. These aims were addressed through the key findings, which include the presentation of a method of analysing aggregate goals in a comparable way to metrics used for standardised measures **(*Edbrooke-Childs et al., 2015),** the creation of parent-led, child-led and jointly agreed goal taxonomies **(*Bradley et al., 2013; *Jacob et al., 2015)** and evidence to support the hypothesis that goal-based measures capture areas of change which are as yet unexplored **(*Jacob et al., 2017[c])**. Investigations into the relationships between goal progress, symptomology and impact change scores found greater change in goal progress. Positive associations between goal setting and parental satisfaction were found, along with the suggestion that goal-based measures may be more useful in clinical work with certain client groups **(*Jacob et al., 2017[b]).** The research demonstrates the need for client-defined measures alongside other forms of measurement and that these measures may be more sensitive to the type of change that is important to clients.

Impact

Much of the research was the first of its kind, which filled a large knowledge-gap related to the Goal and Goal-based Outcomes tool (GBO; Law, 2011) and the general exploration of goals set in youth mental health settings. The research comparing goal

change with other outcome measures has implications for how personal change is conceived, such that meaningful change might not be the same as clinical change as demonstrated on widely used measures (Chapter 2). The exploration of the background of goal-based measures, including practical examples to mitigate barriers to the use of outcome measurement, is of interest to those working clinically (Chapter 2). The development of goal taxonomies provided a stepping stone for subsequent research (Duncan et al., 2019; Odhammar & Carlberg, 2015; Rupani et al., 2014; Chapter 3). Innovative analysis techniques allowed the consideration of goals at an aggregate level, which had not been evidenced before. Thus, the 'measurable change' metric has been adopted for trial nationally by the government (Jacob, 2019). The first and only exploration of the psychometric properties of the GBO provides insight into its reliability (Chapter 2). There have been no further comparisons between goal setting and satisfaction of care in adult or youth mental health settings. A novel suggestion concerning how goals may inform standardised measure selection is the first to provide a practical solution to the knowledge-gap related to how to use different types of measurement collectively. This suggestion offers a reformulation of the current practice of selecting outcome measures for young people, to ensure that the client's requirements are central (Chapter 4). See appendix C for a breakdown of citations of the published works.

Analysis techniques

The use of mixed research methods that produced a wealth of information is a significant strength. The methodologies are brought together through a balancing of analysis techniques and the human experience, which is vital when findings are used to suggest areas of service improvement. The statistical approaches were selected to answer the specific research questions of the studies and were also based on a pragmatic response to the challenging nature of real-life secondary datasets and the subsequent data quality, which includes a high proportion of missing data. The analysis techniques enabled goal-based measures to be considered on an individual, team and service level, so the data may be used to identify areas of need, catchment and to inform personalised care.

Epistemology

All researchers' knowledge, understanding and beliefs influence their research decisions and interpretation of data (Singh & Walwyn, 2017). The author takes a critical stance towards the concept of a singular knowledge. Further, the presented research relocates mental health difficulties away from the pathologised essentialist scope of traditional psychology (Adriaens & De Block, 2013; Haslam, 2000). This is by the rejection of the dominance of the recovery paradigm, through the exploration of personal change which is of importance to young people, as opposed to an overreliance on clinical change. There is a fundamental tension between standardised and client-defined outcome measurement, which has been explored in the presented research (see Chapters 2 and 4 in particular). This tension is multifaceted and related to the epistemological beliefs that the measures are grounded in, the perceived hierarchy of evidence derived from the measures and the differing statistical analyses suited to the data (Slade, 2012). Within the presented research, there is also a tension between the exploration of outcomes which are representative of personal change, which may align to functioning and quality of life, and those which are representative of traditionally defined symptoms and diagnoses. Standardised measures are considered to be reflective of underlying mental health constructs, whereas client-defined measures are not considered to be reflective of any one underlying mental health construct, but are rather considered to be related to young people's personal growth, which is likely to differ from person to person. These tensions are balanced within the presented research. This is through the promotion of the complementary use of the measures and the mixed-method approaches to analyses across the research. A fundamental element of the presented research is the emphasis on the importance of the weighting towards personal change, as opposed to the predominant clinical model of recovery. As well as taking a critical stance towards the concept of a singular knowledge, or an absolute truth, when exploring outcome data, a pragmatism which allows the application of research techniques to real-world therapeutic settings has been important to the author. Pragmatism (Allen & Clough, 2015) places emphasis on the consequences of research and the best way to explore the research questions, rather than on the methods employed. Consequently, mixed-methods research is often grounded in pragmatism (Kaushik & Walsh, 2019).

Pragmatism also allows an amalgamation of the epistemological positions behind standardised and client-defined measurement and the methodologies that are used to explore the associated data. This tension results from differing beliefs in the nature of reality, specifically, whether there is an absolute reality independent from the individual and society, or whether there may be multiple realities.

The recovery paradigm, with its reliance upon symptoms and diagnoses and the subsequent popularisation of standardised outcome measurement, is grounded in objectivism (Peikoff, 1993; Rand, 1990). This is also evidenced by the common belief in the importance of replicable findings which are generalisable to the wider population and predictors of treatment response (Slade, 2012). Within this paradigm, as discussed, the results from standardised measures derived from fixed items are typically numerical and thus lend themselves to quantitative statistical analyses which are also traditionally grounded in objectivism (Peikoff, 1993; Rand, 1990). This is due to the nature of the research questions that quantitative analyses address; that is the 'how' and the exploration of relationships or associations, rather than the 'why'. However, the subjective nature of mental health means that there is a mismatch with this standpoint which is based on the assumption of a scientific approach to the development of knowledge, or an absolute truth. The personalised recovery paradigm is gaining further traction, accompanied by client-defined outcome measurement. Subjectivism (Orange, 2013) may be considered as an appropriate epistemological position for mental health recovery, however from this perspective, all experiences are considered to be perceptions, which do not occur independently of the experience. This would not account for externalising factors such as behavioural difficulties, commonly seen in youth mental health settings. For many years, the importance of bringing the two standpoints of objectivism and constructivism into equilibrium in the study of the person has been discussed (Allport, 1961). Within the context of outcome measurement, this fusion of epistemological positions sees the complementary use of client-defined and standardised measurement (Alves et al. 2013).

A pragmatism-realism epistemology has been suggested as appropriate for outcome measurement, which acknowledges the need for pragmatism, but also still grounds all types of measurement in realism (Guyon, Kop, Juhel & Falissard, 2018) albeit with an

implicit emphasis on standardised measurement. The author proposes a pragmatism-constructionism standpoint in order to balance the approaches and epistemologies and to give consideration to the practicalities required of outcome measurement. This is along with the belief that all outcome measurement is based on the exploration of an inference of difficulties and experiences, and not the objective measurement of them. The pragmatism and/or constructionism perspectives are evidenced throughout this supporting document and portfolio of works through the balancing of analyses of standardised and client-defined measurement and the priority given to the direct application of the research findings to everyday clinical work. Further, the research provides practical solutions to mitigate the complexities of outcome measurement (pragmatism; Chapter 2) with analytical solutions provided for the consideration of client-defined measurement alongside standardised measures (pragmatism-constructionism; Chapter 2, 3 and 4). Chapter 2 in this supporting document addresses the tension between standardised and client-defined outcome measurement and the associated epistemologies they stem from. Pragmatism-constructionism is demonstrated through the complementary analyses of both types of measures and the application of the reliable change index to the GBO data, as well as the promotion of client-defined outcome measurement in Chapter 2. In Chapter 3, pragmatism-constructionism is demonstrated through the use of grounded theory to develop taxonomies of goals which may be used as tools in direct clinical work. The suggestion that the derived themes may be integrated into a system like Norse (Norse Feedback, 2019) demonstrates the pragmatism-constructionism standpoint through the proposal of a flexible way forward to consider the balancing of outcome information. Similarly, Chapter 4 again addresses the tension between the aggregate level analysis of client-defined measurement with other outcome measures and how this may be clinically useful, with particular consideration given to the importance of the balancing of personal and clinical change. The three layers of goal-based outcome analyses proposed in this supporting document demonstrates the pragmatism-constructionism perspective through the balancing of approaches to analysis and the exploration of the data derived in a range of ways. Finally, the emphasis on the client's perspective and balancing this with clinical expertise further demonstrates a

constructionism standpoint where multiple perspectives must be considered. The emphasis on how this may be achieved in a practical way is grounded in pragmatism.

Limitations

First, data may be compromised in many ways (Wolpert and Rutter, 2018). A common challenge for all the presented research is the high proportion of missing data, which brings into question the generalisability of the work (see Appendix D). This is an artefact of real-world research and the use of secondary datasets. The findings should not be discounted, rather, the best use of available data and data quality should be considered when interpreting results. Second, for much of the quantitative analysis, the goal content was not available. Correspondingly, the goal content used for the thematic analyses was linked to little further information about the young people, which leads to similar issues of analysis and understanding. Future work will explore the statistical inferences between goal scores and additional information. For example, research suggests that wellbeing goals are more likely to be achieved compared to others, including interpersonal, existential and symptom goals (Berking et al., 2005). Third, whilst a mixed-methods approach was taken, the approaches have not been brought together substantially in individual works. Future work would benefit from further alignment and integration of methodologies. Fourth, the 'measurable change' calculation was based on parent-reported goals due to data quality, yet it should have been from the young people's perspective, particularly as the main argument in the presented research is the personalised nature of outcomes, which is also an ethical imperative. Further, goal weighting was not considered, nor was the anticipated goal difficulty, because they are not recorded on the GBO. This means that whether aggregate goal scores represent movement towards the same latent factor or not is an uncertainty, which is the main limitation of the 'measurable change' calculation. This is despite the good internal consistency finding, which has been previously calculated for idiographic measures (Elliott et al, 2016) but has challenges of its own (Meier, 2008). This is given further consideration in the following section.

Formative and reflective indicators

It has been argued that classical test theory and psychometric testing, which has been traditionally derived for standardised measures, should not be applied to idiographic or client-defined outcome measurement (Meier, 2008; Podsakoff et al., 2003). In addition to the classification of measures as standardised or client-defined, the terms 'reflective' and 'formative' indicator are also used to distinguish different types of measurement (Diamantopoulos, 2008). Reflective indicators relate to an underlying construct, for example, intelligence testing, where the measure itself is not impacted by the latent factor. In opposition, formative indicators are considered to have an effect on the latent variable, for example, social economic status is an indicator which is affected by a number of contributing factors (Diamantopoulos & Winklhofer, 2001). Further, within formative indicators, causal-formative indicators measure a single concept, whilst composite-formative indicators measure a summary of the effects of several variables (Bollen & Diamantopoulos., 2017).

There is an argument that goal-based measures may be formative indicators, because theory suggests that working towards goals has a reciprocal impact on self-efficacy (Bandura, 1988; Manderlink & Harackiewicz, 1984) as also demonstrated by Maslow's (1989) theory of goals contributing to a continuous cycle of personal development and self-discovery. In aggregate analysis of reflective indicators, the measurement items are expected to remain static, which lends itself to certain assumptions of psychometric testing and statistical analyses (Bollen & Diamantopoulos, 2017). The use of such analyses with formative indicators has been critiqued (Edwards, 2011). Such critiques suggest that using the incorrect statistical models undermines the construct validity of the measure, misrepresents the structural relationships between the measure and any comparison measures and, limits the usefulness of the findings to contribute to overarching theory (Coltman, Devinney, Midgley & Venaik, 2008). Further, there is an argument that more unexplained variance is resultant in the analysis of formative indicators using these techniques (Wilcox, Howell & Breivik, 2008) and formative measurement is more predisposed to interpretational confounding than reflective indicators (Howell, Breivik & Wilcox, 2007). However, such arguments have been refuted by Bollen and Diamantopoulos (2017) who, amongst other arguments, state that both types of measurement are

multidimensional and that criticisms made of formative indicators in fact also apply to reflective indicators. This is also evident in recent literature which has brought into question the factor structure of a widely used self-report standardised and reflective outcome measure, the SDQ (Black, Mansfield & Panayiotou, 2020). More advanced statistical techniques than those that had been previously used were applied to SDQ data, which demonstrates that new knowledge stimulates more questions about the validity of all outcome measures (Rodgers, 2017), which further highlights the need for measures to be considered in a 'mindful' way (Wolpert et al., 2014). This is indicative that there is more to learn about these statistical techniques applied to all types of measurement. Most approaches in the social and behavioural sciences assume that measures rely on the latent variable and therefore do not take into consideration formative indicators (Bollen & Diamantopoulos, 2017). This is a challenge for formative indicators, but because a type of measurement runs against convention does not mean it should be dismissed (Bollen & Diamantopoulos., 2017). This stems from the position that standardised measures are considered to be more accurate and scientific than client-defined measures because they are grounded in objectivism and lend themselves to quantitative analysis techniques. However, a lack of published literature on such psychometric tests and analyses of formative indicators at an aggregate level does not mean that this approach is fatally flawed. Further, Bollen and Diamantopoulos (2017) argue that using measures which affect the latent variable is neither inferior to reflective measurement, nor inherently problematic. More consideration needs to be given to these debates.

Although demonstrably refuted (Bollen & Diamantopoulos, 2017), critiques of traditional statistical techniques to formative measurement may be applied as a further criticism of the aggregate analysis of the GBO. However, within the presented research, the GBO is considered as both a reflective indicator and a composite-formative indicator. For example, throughout the presented research, caution is also advised for the interpretation of all findings, given the assumption that goal-based measures may work in a different way to standardised outcome measures. This suggests that goal-based measures are formative indicators, along with the treatment of the GBO data as an overall indicator of change for the application of the proxy of the reliable change calculation (Chapter 2), which assumes that

they are composite-formative. Further, whilst the surface features of goal-based measures suggest that they may be formative indicators, taking all of the literature discussed in this supporting document into consideration, the presented research argues that the underlying construct is personal change. This mismatch between the assumption that goal-based measures are formative indicators and the subsequent research linking them to personal change is linked to Jangle fallacy (Marsh, 1994) whereby the 'surface features' of goal-based measures may indicate that there is no underlying construct but this may be a false assumption. The thematic analysis of the goal content (Chapter 3) assumes that the goals are a representation of personal change as an underlying construct, therefore suggesting that they are also reflective indicators. The challenge of goal-based measures in this debate is that personal change is so unique to the individual. The goals set within therapeutic settings have been demonstrated as diverse in the presented research, however, they may or they may not measure an underlying construct when presented in groups, where client goals fall into the same theme, for example. The presented research demonstrated that most young person-led goals were related to the reduction or elimination of symptoms (***Bradley et al., 2013**) so this could also be an indication that the measure is reflective, but dependent on the nature of the goal that has been set. Because there are elements of goal-based measures that suggest they are reflective, whilst other elements suggest that they are formative, they may in fact be somewhere in between formative and reflective indicators, where goal progress affects outcome, but they are also an indicator of an underlying construct. This is also supported by the good internal consistency finding in the presented research (***Edbrooke-Childs et al., 2015).**

The distinctions between formative and reflective indicators do not seem to be clear, or at least do overlap in some ways. For example, when considering outcome measurement, research has demonstrated that knowing a score on a reflective indicator may also change the outcome of that measure. This is evidenced through research that suggests that feeding back ongoing progress scores to clinicians and young people is effective (Boswell et al., 2015; Gondek et al., 2016; Green & Latchford, 2012). Whilst these findings are based on reflective indicators, this feedback loop model would be suggestive of a formative indicator. Therefore, the question of whether in fact all outcome measures are formative is raised. This

is linked to a more general challenge of how to measure the inner subjective world. It is not possible to access subjective experience and it is only possible to investigate the observable world, which means that the relationship between what is observed and the subjective experience is informative (Slade, 2012). All mental health outcome measurement is only ever able to measure inferential validity (Cronbach & Meehl, 1955; Loevinger, 1957) that is, no measures are objectively and concretely measuring mental health. All measures represent an individual's unique experience of difficulties which may map onto medicalised versions of the symptoms, which in turn is considered a reflective indicator.

The argument of the presented research is that inferential validity is diluted through the aggregate analysis of broad outcome measures and due to the individualised nature of client-defined measurement, this type of measurement may indicate a more accurate inference. It may be too restrictive to say that a set of indicators is a fixed conceptual and empirical representation of a construct, as argued in support of reflective indicators. This is consistent with the idea that mental health is a continuum and not a neat set of symptoms that individuals may be easily slotted into (Kinderman, Kamens, Robbins & Farley, 2020; Krueger, Hopwood, Wright, & Markon, 2014; Krueger et al., 2018; Widiger & Samuel, 2008), and that symptoms differ from person to person, which calls into question this precise argument (Cuijpers, 2019). Psychometric testing specifically for formative indicators may need to be developed, but in the meantime, researchers must continue to make the best use of tools and available tests to enable the further exploration of both the measures themselves (Bollen & Diamantopoulos., 2017) and the outcomes of young people, on the individual and the aggregate level. There is a lack of research in this area specific to goal-based measures and therefore further research should continue to explore these multi-faceted measures.

Conclusions and future outlook

Overall, in mental health settings, the best measures to use for tracking outcomes for monitoring and feedback purposes continues to be debated. With appropriate knowledge and training, much can be learnt about both personal and clinical change from the considered use of outcome measurement in all its forms. There are several examples of measurement-focused care which have been recently implemented, including Improving Access to Psychological Therapies (Clark, 2011) in the UK; the primary mental health collaborative care model in the Netherlands (Van Orden, Hoffman, Haffmans, Spinhoven & Hoencamp, 2009) and the TrueBlue model in Australia (Morgan et al., 2013). However, little attention has been given to client-defined measures as part of these initiatives. The presented research challenges this.

Clinicians may find the use of goal taxonomies helpful to consider areas of service improvement. Future work should include comparisons of the goal taxonomies, testing the taxonomies on new data, exploring factor structures and trialling their use; this is all required to take the taxonomies forward into everyday clinical work. Emerging research on goal setting dimensions (Grey et al., 2018; Troupp, 2013; Vermunt, 2018) also requires further exploration and cross-validation. There are practical examples of how client-defined and standardised measures may be used alongside each other (***Jacob, et al., 2017[c])** and standardised measures used in an individualised way (Norse Feedback; 2019). However, the practicalities of this and experiences of clients and clinicians following these approaches warrants exploration.

It may be useful to consider the use of goal-based measures in three layers. At the most personal layer is the use of the measure in the clinical setting, with the young person. For this purpose, the goal content is considered and progress on the scale is monitored over time. This is where the tracking of outcome scores on run charts, or simple line graphs is effective (Cohen et al., 2013; Perla et al., 2010). At the second layer is the consideration of goals grouped by theme, where clinical teams and services may determine what kinds of goals are being set by the young people attending their service. Anecdotally, this approach to grouping goals has been found to be useful to consider service provision and for training purposes, as discussed in Chapter 3. At the third layer is the consideration of goal-based

outcomes as an overall indicator of change. Removing the goal content and focusing solely on the progress on the numerical scale transforms the GBO into an overall indicator of change, rather than a focus on the client-defined element. The standardised part of GBO is the scaling, and arguably this is the part that is appropriate for reporting on in a standardised way. One consideration might be to combine two layers of analysis: to explore aggregate goal change via the 'measurable change' calculation at the theme level. Combining analyses in this way would mitigate concerns that the individualised nature of the measures become lost in aggregate analysis (Elliott et al., 2016; Maggin & Chafouleas, 2013). This may be important because there is uncertainty about whether goals are formative or reflective, as discussed in the previous section. However, if the goals set are indicative of an individual's personal perception of recovery or important change and research suggests that this takes many forms, perhaps only the scores need consideration at this level. This may be the true strength of goal-based outcome measures; that they may be used at the individual level for discussion and to inform treatment, whilst also being used at different levels to consider various elements of outcome information.

Due to the prevalence of research on standardised tools, 'good' outcomes are considered those that can be tracked with these measures (Krause et al., 2018; McLeod, 2001). However, if a broad-brush approach continues to be implemented, clients are unlikely to be tracking outcomes that are meaningful to them; thus, demonstrating less true change than for client-defined measures (***Edbrooke-Childs et al., 2015;** Haynes et al., 2009). Further, there is more work to be done to explore how goal-based measures may be cognitively separate from standardised measures, particularly where goal tracking, including feedback, may be used as a method of self-regulation (Eccles & Wigfield, 2002; Harkin et al., 2016). Whilst it is worth exploring whether goal-based measures can be used to help inform change on a larger scale, goals should be pursued in therapy regardless of such considerations, because the client finds them to be important and working towards them a rewarding endeavour. Outcomes should not be tracked solely due to external constraints or pressure (Michalak & Holtforth, 2006) such as to meet targets, because there is a risk of an iatrogenic impact (Wolpert, 2014). The primary use of goal-based measures is clinical utility (Law, 2011) and any use of goals to inform service delivery needs to be conducted with

caution. Further, the intrinsic nature of goals and goal setting, which is underpinned by purposive behaviourism (Innis, 1999) and motivation (Bandura, 1988) theories, means that setting goals will not be suited to all clients and may be impacted by a number of mediating and moderating factors. For example, goal theory emphasises rational decision-making processes, however people generally prefer simpler, optimistic decision-making processes (Eccles & Wigfield, 2002). Further, motivation and locus of control theories have informed goal theory, where research suggests that working towards goals and achieving them has a positive impact on self-efficacy (Bandura, 1988; Manderlink & Harackiewicz, 1984) whilst not attaining goals has a negative impact (Di Malta et al., 2019). This means that goal tracking with feedback assumes agency, where therapy and personal change are contingent on the participation of the client as such, a goal-focused way of working may align more to clients with particular moderating personality traits. For example, if a young person has an external locus of control, they are less likely to engage in challenging tasks (Mellat & Levasani, 2011). Additionally, there may be particular scenarios when outcome monitoring through self-reported questionnaires, or goal setting, may be inappropriate; for example, if the client is in a crisis situation. Furthermore, goal setting may be mediated by clients not explicitly knowing what their goals are and they may need more than a few sessions to determine what it is they find it important to work on. The key to the use of goal-based outcome measures is that they are used flexibly (Di Malta et al., 2019), which in itself speaks to personalised outcomes for personalised care. Additionally, goals themselves are subject to a number of moderating factors, as discussed by Latham (2016). It is argued that the young person must show commitment to the goal, for without this they do not have a goal at all, they must receive feedback on their progress towards the goal and the goal must be achievable. In turn, goal achievement is moderated by the young person's resources, both internal and situational, and the resources provided by the therapeutic setting and the clinician.

There is limited research on whether existing measures to track outcomes are meaningful to clients. Work by Moran and colleagues (2012) and Feltham and colleagues (2018) are good examples, but this area needs development. Therefore, the face validity of goals and what change really means to people warrants further research. From young

people's own perspectives, outcome measures should be recovery-focused based on personal goals (Lavik et al., 2018). Mental health is not a quantitative attribute and thus there are issues with measuring it in the current way (Cuijpers, 2019; Rodgers, 2017). There may be a need to consider whether measures in their existing form are the most effective way of tracking and exploring outcomes, for example, gathering more accurate information from narratives, or therapy themes, although these approaches also come with specific challenges.

Arguably less attention should be placed on fixed treatments that are delivered according to a manual and more emphasis given to a fluid approach to supporting young people who have individual needs and aims of seeking support. One model which gives consideration to individual needs is pluralistic therapy (Cooper & McLeod, 2011), which is an integrated approach whereby the clinician draws on a range of established therapeutic methods in response to the individual to create personalised care. Further, the UK government is moving towards co-producing commissioning plans and personalised health budgets (NHS England, 2019). In order to implement these initiatives effectively, personalised outcomes and individualised plans based on what the client wants to work on will be key. In this context, when more attention is also being given to client-defined outcome measurement, there are opportunities to learn more about these measures and to give real consideration to personal change that is of importance to young people. Separate viewpoints, based on unique experiences of the world place limitations on the capacity to understand others' difficulties. A clinician's or researcher's theoretical affiliation will lead them to place emphasis on different key outcomes (Binder et al., 2010; Cuijpers, 2019). Therefore, it is imperative to ask clients, as experts in their own experience (Ashworth et al., 2004; Bohart & Tallman, 2010), what areas of change they want to monitor over the course of their therapeutic journey (Cuijpers, 2019).

Considering this, there may be some work to do to align the clinical goals and the young person's perspective. This is particularly true when the goals are very diverse or either fall outside what is considered achievable throughout the therapeutic process, or are considered to be 'dangerous' goals, for example, a young person with an eating disorder who wants to set a goal to lose weight (see, Law & Jacob, 2015). Therefore, presenting

difficulties may be a moderating factor of goal setting and clinical judgement should be used. A trained clinician should be able to work with young people to set appropriate and achievable goals for monitoring and feedback purposes. There is a critical tension to be held at the clinical and methodological level, between the young person being an expert in their own experience and the clinician's theoretical view of change. The suggestion here is for the clinician to work flexibly with the young person; to come to an agreement on what falls within the realms of the therapeutic process, what the clinician, whilst utilising clinical judgment, feels are the most appropriate goals to monitor and feedback. Where agreement cannot be reached, the clinician may hold their own goals for the young person in mind, or record them separately but openly expressed – as appropriate. When goals are held by the clinician, it may allow for hidden or unconscious goals to emerge throughout the therapeutic process (see, Sales, Ferreira & Matos, 2019). This is where consideration must be given to the 'vehicle' and 'destination' goals whereby the achievement of proximal goals leads to the achievement of an overarching goal (Law, 2020). Research has shown that clinicians are not accurate at predicting progress (Hannan et al., 2005) and tend to over-report symptoms compared to data from self-reported measures (Cuijpers et al., 2010) but this does not mean that the clinician's expertise is diminished. There may be a need to work on multiple goals and best practice is to triangulate outcome information in order to gain a full picture of the young person's difficulties (Fleming et al., 2014; ***Jacob et al., 2017a**; Wolpert et al., 2014). When reporting outcomes, the different perspectives should be reported on separately (Wolpert et al., 2014) with the emphasis on what is important to the client.

Further, the presented research offers some early indicators of characteristics that may be mediators of goal setting in youth mental health settings: pre-schoolers, young people with learning disabilities and certain combinations of difficulties were found to be more likely to set goals (***Jacob et al, 2017[b]**). Additionally, goals set by young people may be mediated by parental influence: the presented research demonstrates overlap between young person- and parent-led goals (***Jacob et al., 2015**). Further the culture and value systems in which young people live may mediate the goals they set. For example, research suggests that clients from minority ethnic groups view and report symptoms and progress differently to white British clients (Zane et al., 2017).

Research demonstrates that children do have the capacity to set goals (Allen, Kelly & National Research Council, 2015). Age may be a particular moderating factor and working with very young children may mean setting collaboratively agreed goals. Not collecting and reflecting on personalised outcomes is an important ethical and political issue. In mental health settings to date, the young person's view has scantly been taken into consideration. Young people are often infantilised in the realm of healthcare and parents are often consulted with by default (Redsell & Hastings, 2010). However, the UN Rights of the Child (Alderson & Montgomery, 1996) stipulates that young people's views need to be considered in all elements of care as soon as the young person is able to express their views; this is not contingent on age or ability. Ultimately, there is a need to move towards working with young people from a position of understanding which incorporates a focus on the areas of change that are important to them.

Presented here is research that for the first time explores data from the GBO, providing solutions to challenges of implementation and data analysis. It gives insight into how the measure may be used to inform service delivery and track outcomes of importance to the client. The future direction for idiographic outcome measurement, in particular goal-based measures, is contingent on the further exploration and understanding of the measures. The replication of the presented research is suggested: more complete datasets and data from the young person's perspective. Presently, there is a turning point in the serious consideration of client-defined outcome measurement for the national exploration of aggregate level outcome information. The analysis of GBO data as part of NHS England and NHS Improvement's children and young people's mental health service's outcome metric shadow year will be observed with interest and the learning taken forward into everyday outcome measurement. Further, work has begun to explore the inferential statistical analysis of young person-rated goal themes and goal outcomes. Testing the use of the derived goal taxonomies, both to explore aggregate outcome information and to select other outcome measures as suggested, and additional exploration of the psychometric properties, will advance the knowledge of the utility of the measures both for clinical practice and in aggregate outcome evaluation. All the presented research promotes the use of client-defined measurement, which contributes to the promotion of 'idiographic science': the

scientific study of the individual (Haynes et al., 2009). This is a starting point for research in the area and a future recommendation is a client-defined focus for evidencing outcomes that are important to young people and, the further understanding of how these measures function.

References

Abrines-Jaume, N., Midgley, N., Hopkins, K., Hoffman, J., Martin, K., Law, D., & Wolpert, M. (2016). A qualitative analysis of implementing shared decision making in child and adolescent mental health services in the United Kingdom: Stages and facilitators. *Clinical Child Psychology and Psychiatry, 21*(1), 19-31.

Achenbach, T. M. (1999). *The Child Behavior Checklist and related instruments*. In M. E. Maruish, (Ed.), *The use of psychological testing for treatment planning and outcomes assessment* (pp. 429-466). Mahwah, USA: Lawrence Erlbaum Associates Publishers.

Adriaens, P. R., & De Block, A. (2013). Why we essentialize mental disorders. *Journal of Medicine and Philosophy, 38*(2), 107-127.

Alderson, P., & Montgomery, J. (1996). *Health care choices: making decisions with children (Vol. 2).* London, UK: Institute for Public Policy Research.

Allen, L., Kelly, B. B., & National Research Council. (2015). *Child development and early learning.* In L. Allen & B. B. Kelly. (Eds.) *Transforming the workforce for children birth through age 8: A unifying foundation.* Washington, USA: The National Academies Press. https://doi.org/10.17226/19401.

Allen, P. M., & Clough, S. (2015). Philosophical commitments, empirical evidence, and theoretical psychology. *Theory & Psychology, 25*(1), 3-24.

Allport, G. W. (1961). *Pattern and growth in personality.* New York, USA: Holt, Rinehart & Winston. Cited in Ashworth, M., Guerra, D., & Kordowicz, M. (2019). Individualised or standardised outcome measures: A co-habitation?. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(4), 425-428.

Alves, P. C., Sales, C. M., & Ashworth, M. (2013). Enhancing the patient involvement in outcomes: a study protocol of personalised outcome measurement in the treatment of substance misuse. *BMC Psychiatry, 13*(1), 337-343.

Alves, P. C. G., Sales, C. M. D., Ashworth, M., & Faísca, L. (2018). “There are things I want to say but you do not ask”: A comparison between standardised and individualised evaluations in substance use treatment. *International Journal of Mental Health and Addiction.* Retrieved from https://link.springer.com/article/10.1007%2Fs11469-018-9985-6.

Ames, C. (1992). Classrooms: goals, structures, and student motivation. *Journal of Educational Psychology, 84*(3), 261-271.

Ashworth, M., Robinson, S., Evans, C., Shepherd, M., Conolly, A., & Rowlands, G. (2007). What does an idiographic measure (PSYCHLOPS) tell us about the spectrum of psychological issues and scores on a nomothetic measure (CORE-OM)? *Primary Care & Community Psychiatry, 12*(1), 7-16.

Ashworth, M., Shepherd, M., Christey, J., Matthews, V., Wright, K., Parmentier, H.,Robinson, S., & Godfrey, E. (2004). A client-generated psychometric instrument: The development of 'PSYCHLOPS'. *Counselling and Psychotherapy Research, 4*(2), 27-31.

Austin, J. T., & Bobko, P. (1985). Goal-setting theory: Unexplored areas and future research needs. *Journal of Occupational Psychology, 58*(4), 289-308.

Austin, J. T., & Vancouver, J. B. (1996). Goal constructs in psychology: Structure, process, and content. *Psychological Bulletin, 120*(3), 338-375.

Badham, B. (2011). *Talking about talking therapies: thinking and planning about how to make good and accessible talking therapies available to children and young people*. London, UK: YoungMinds.

Bandura, A. (1988). *Self-regulation of motivation and action through goal systems.* In V. Hamilton, G. H. Bower, & N. H. Frijda. (Eds.) Cognitive perspectives on emotion and motivation (pp. 37-61). Dordrecht, Netherlands: Springer.

Barber, J. M., Parsons, H., Wilson, C. A., & Cook, C. C. (2017). Measuring mental health in the clinical setting: What is important to service users? The Mini-Service user Recovery Evaluation scale (Mini-SeRvE). *Journal of Mental Health, 26*(6), 530-537.

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (Eds.). (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. London, UK: John Wiley & Sons.

Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K., & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology, 69*(2), 184-196.

Barkham, M., Mellor-Clark, J., Connell, J., & Cahill, J. (2006). A core approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE System. *Counselling & Psychotherapy Research, 6*(1), 3-15.

Battle, C. C., Imber, S. D., Hoehn-Saric, R., Stone, A. R., Nash, E. R., & Frank, J. D. (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy, 20*(1), 184-192.

Beck, A. T. (1997). The past and future of cognitive therapy. *The Journal of Psychotherapy Practice and Research, 6*(4), 276-284.

Bentley, N., Bucci, S., & Hartley, S. (2019). Measuring outcomes within inpatient child and adolescent mental health services: an evaluation of the Recovery Questionnaire for Young People. *Child and Adolescent Mental Health, 24*(1), 329-337.

Beresford, P., & Branfield, F. (2006). Developing inclusive partnerships: user-defined outcomes, networking and knowledge− a case study. *Health & Social Care in the Community, 14*(5), 436-444.

Bergman, H., Kornør, H., Nikolakopoulou, A., Hanssen-Bauer, K., Soares-Weiser, K., Tollefsen, T. K., & Bjørndal, A. (2018). Client feedback in psychological therapy for children and adolescents with mental health problems. *Cochrane Database of Systematic Reviews*, (8). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6513116/.

Berking, M., Grosse Holtforth, M., Jacobi, C., & Kröner-Herwig, B. (2005). Empirically based guidelines for goal-finding procedures in psychotherapy: Are some goals easier to attain than others? *Psychotherapy Research, 15*(3), 316-324.

Bevan, G., & Hood, C. (2006). What's measured is what matters: Targets and gaming in the English public health care system. *Public Administration, 84*(3), 517-538.

Biering, P. (2010). Child and adolescent experience of and satisfaction with psychiatric care: A critical review of the literature. *Journal of Psychiatric and Mental Health Nursing, 17*(1) 65-72.

Binder, P. E., Holgersen, H., & Nielsen, G. H. S. (2010). What is a "good outcome" in psychotherapy? A qualitative exploration of former patients' point of view. *Psychotherapy Research, 20*(3), 285-294.

Black, L., Mansfield, R., & Panayiotou, M. (2020). Age Appropriateness of the Self-Report Strengths and Difficulties Questionnaire. *Assessment,* https://journals.sagepub.com/doi/abs/10.1177/1073191120903382.

Black, L., Panayiotou, M., & Humphrey, N. (2019). The dimensionality and latent structure of mental health difficulties and wellbeing in early adolescence. *PloS one, 14*(2), e0213018.

Bohart, A. C., & Tallman, K. (2010). *Clients: The neglected common factor in psychotherapy.* In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble. (Eds.), *The heart and soul of change second edition: Delivering what works in therapy* (pp. 83-111). Washington, USA: American Psychological Association.

Bollen, K. A., & Diamantopoulos, A. (2017). In defense of causal-formative indicators: A minority report. *Psychological Methods*, *22*(3), 581-596.

Borckardt, J. J., Murphy, M. D., Nash, M. R., & Shaw, D. (2004). An empirical examination of visual analysis procedures for clinical practice evaluation. *Journal of Social Service Research, 30*(3), 55-73.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-260.

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research, 25*(1), 6-19.

Bradley, E. H., Bogardus Jr, S. T., Tinetti, M. E., & Inouye, S. K. (1999). Goal-setting in clinical medicine. *Social Science & Medicine, 49*(2), 267-278.

***Bradley, J., Murphy, S., Fugard, A. J. B., Nolas, S. M., & Law, D. (2013). What kind of goals do children and young people set for themselves in therapy? Developing a goals framework using CORC data. *Child & Family Clinical Psychology Review, 1*(1), 8-18.**

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Cairns, A. J., Kavanagh, D. J., Dark, F., & McPhail, S. M. (2019). Goal setting improves retention in youth mental health: A cross-sectional analysis. *Child and Adolescent Psychiatry and Mental Health, 13*(1), 31-39.

Campion, J., Bhugra, D., Bailey, S., & Marmot, M. (2013). Inequality and mental disorders: opportunities for action. *The Lancet, 382*(9888), 183-184.

Care Quality Commission. (2017). *Review of children and young people's mental health services. Phase one report.* The Stationery Office. Retrieved from https://www.cqc.org.uk/sites/default/files/20171103_cypmhphase1_report.pdf.

Carlier, I. V. E., Meuldijk, D., Van Vliet, I. M., Van Fenema, E., Van der Wee, N. J. A., & Zitman, F. G. (2012). Routine outcome monitoring and feedback on physical or mental health status: Evidence and theory. *Journal of Evaluation in Clinical Practice, 18*(1), 104-110.

Carver, C. S., & Scheier, M. F. (1990). Origins and functions of positive and negative affect: A control-process view. *Psychological Review, 97*(1), 19-35.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64*(3), 497-504.

Child Outcomes Research Consortium (CORC) (2018). *Recommendations for using outcome measures.* London: Child Outcomes Research Consortium. Retrieved from https://www.corc.uk.net/information-hub/recommendations-for-using-outcome-measures/.

Child Outcomes Research Consortium (CORC) (2019) *Homepage*. Retrieved from www.corc.uk.net.

Children's Commissioner's Office. (2017). *Briefing: children's mental healthcare in England.* Children's Commissioner's Office. Retrieved from https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Childrens-Commissioner-for-England-Mental-Health-Briefing-1.1.pdf.

Clare, L., Linden, D.E.J., Woods, R.T., Whitaker, R., Evans, S.J., Parkinson, C.H., van Paasschen, J., Nelis, S.M., Hoare, Z., Yuen, K.S.L., & Rugg, M.D. (2010). Goal oriented cognitive rehabilitation for people with early-stage Alzheimer disease: A single-blind randomized controlled trial of clinical efficacy. *American Journal of Geriatric Psychiatry, 18*(10), 928-939.

Clark, A., Fleche, S., Layard, R., Powdthavee, N., & Ward, G. (2016). Origins of happiness: Evidence and policy implications*. VOX CEPR Policy Portal.* Retrieved from https://voxeu.org/article/origins-happiness.

Clarke, C., Lumbard, D., Sambrook, S., & Kerr, K. (2016). What does recovery mean to a forensic mental health patient? A systematic review and narrative synthesis of the qualitative literature. *The Journal of Forensic Psychiatry & Psychology, 27*(1), 38-54.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry, 23*(4), 318-327.

Cohen, L. L., Feinstein, A., Masuda, A., & Vowles, K. E. (2013). Single-case research design in pediatric psychology: Considerations regarding data analysis. *Journal of Pediatric Psychology, 39*(2), 124-137.

Coltman, T., Devinney, T. M., Midgley, D. F., & Venaik, S. (2008). Formative versus reflective measurement models: Two applications of formative measurement. *Journal of Business Research, 61*(12), 1250-1262.

Cooper, M. (2013). The intrinsic foundations of extrinsic motivations and goals: Toward a unified humanistic theory of well-being and change. *Journal of Humanistic Psychology, 53*(2), 153-171.

Cooper, M. (2018). *The psychology of goals: A practice-friendly review.* In M. Cooper, & D. Law. (Eds.), *Working with goals in psychotherapy and counselling* (pp. 35-71). Oxford, UK: Oxford University Press.

Cooper, M., & Law, D. (2018). *Introduction*. In M. Cooper & D. Law (Eds.), *with goals in psychotherapy and counselling* (pp. 1-13). Oxford, UK: Oxford University Press.

Cooper, M., & McLeod, J. (2011). *Pluralistic counselling and psychotherapy.* London, UK: Sage.

Cooper, M., & Norcross, J. C. (2016). A brief, multidimensional measure of clients' therapy preferences: The Cooper-Norcross Inventory of Preferences (C-NIP). *International Journal of Clinical and Health Psychology, 16*(1), 87-98.

Corrigan, P. W., Giffort, D., Rashid, F., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. *Community Mental Health Journal, 35*(3), 231-239.

Coulter, A., Edwards, A., Elwyn, G., & Thomson, R. (2011). Implementing shared decision making in the UK. *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen, 105*(4), 300-304.

Crawford, M. J., Robotham, D., Thana, L., Patterson, S., Weaver, T., Barber, R., Wykes, T., & Rose, D. (2011). Selecting outcome measures in mental health: the views of service users. *Journal of Mental Health, 20*(4), 336-346.

Cronbach, L. J., & Meehl, P. E. (1955). Construct validity in psychological tests. *Psychological Bulletin, 52*(1), 281-302.

Cuijpers, P. (2019). Targets and outcomes of psychotherapies for mental disorders: An overview. *World Psychiatry, 18*(3), 276-285.

Cuijpers, P., Li, J., Hofmann, S. G., & Andersson, G. (2010). Self-reported versus clinician-rated symptoms of depression as outcome measures in psychotherapy research on depression: a meta-analysis. *Clinical Psychology Review, 30*(6), 768-778.

Deci, E. L., & Ryan, R. M. (2000). The" what" and" why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry, 11*(4), 227-268.

Delaney, L., & Smith, J. P. (2012). Childhood health: Trends and consequences over the life-course. *The Future of Children, 22*(1), 43-63.

Department of Health. (2012). Liberating the NHS: No decision about me, without me. London, UK: NHS. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf.

Department of Health. (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.* London, UK: The Stationery Office. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf.

Di Malta, G., Oddli, H. W., & Cooper, M. (2019). From intention to action: A mixed methods study of clients' experiences of goal-oriented practices. *Journal of Clinical Psychology, 75*(10), 1770-1789.

Diamantopoulos, A. (2008). Formative indicators: Introduction to the special issue. *Journal of Business Research, 61*(1) 1201-1202.

Diamantopoulos, A., & Winklhofer, H. M. (2001). Index construction with formative indicators: An alternative to scale development. *Journal of Marketing Research*, *38*(2), 269-277.

Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance-building interventions with adolescents in family therapy: A process study. *Psychotherapy, 36*(4), 355-368.

Donovan, J. M., VanLeit, B. J., Crowe, T. K., & Keefe, E. B. (2005). Occupational goals of mothers of children with disabilities: Influence of temporal, social, and emotional contexts. *The American Journal of Occupational Therapy, 59*(3), 249-261.

Doran, G. T. (1981). There's a SMART way to write management's goals and objectives. *Management Review, 70*(11), 35-36.

Duncan, B. L., Miller, S. D., & Sparks, J. A. (2011). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. San Francisco, USA: John Wiley & Sons.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). (Eds.), *The heart and soul of change second edition: Delivering what works in therapy.* Washington, USA: American Psychological Association.

Duncan, C., Cooper, M., & Baxon, D. (2019). *Analysing Goals and Expectations in Counselling with Young People (AGENCY): A PhD study protocol and preliminary findings.* Paper presented at the 2nd International Conference of Pluralistic Psychotherapy and Counselling, University of Roehampton, London, UK.

Eccles, J. S., & Wigfield, A. (2002). Motivational beliefs, values, and goals. *Annual Review of Psychology, 53*(1), 109-132.

Edbrooke-Childs, J., Wolpert, M., & Deighton, J. (2016). Using patient reported outcome measures to improve service effectiveness (UPROMISE): Training clinicians to use outcome measures in child mental health. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(3), 302-308.

Edbrooke-Childs, J., Deighton, J., & Wolpert, M. (2017). Changes in severity of psychosocial difficulties in adolescents accessing specialist mental healthcare in England (2009–2014). *Journal of Adolescence, 60*(1), 47-52.

***Edbrooke-Childs, J., Jacob, J., Law, D., Deighton, J., & Wolpert, M. (2015). Interpreting standardized and idiographic outcome measures in CAMHS: what does change mean**

and how does it relate to functioning and experience? *Child and Adolescent Mental Health, 20*(3), 142-148.

Edwards, J. R. (2011). The fallacy of formative measurement. *Organizational Research Methods, 14*(2), 370-388.

Elliot, A. J. (1999). Approach and avoidance motivation and achievement goals. *Educational Psychologist, 34*(3), 169-189.

Elliot, A. J., & Sheldon, K. M. (1997). Avoidance achievement motivation: A personal goals analysis. *Journal of Personality and Social Psychology, 73*(1), 171-185.

Elliott, R. (1998). Editor's introduction: A guide to the empirically supported treatments controversy. *Psychotherapy Research, 8*(2), 115-125.

Elliott, R., Wagner, J., Sales, C., Rodgers, B., Alves, P., & Café, M. J. (2016). Psychometrics of the Personal Questionnaire: A client-generated outcome measure. *Psychological Assessment, 28*(3), 263-278.

Emmons, R. A. (1992). Abstract versus concrete goals: personal striving level, physical illness, and psychological well-being. *Journal of Personality and Social Psychology, 62*(2), 292-300.

Evans, C. (2012). Cautionary notes on power steering for psychotherapy. *Canadian Psychology, 53*(2), 131-139.

Farrand, P., & Woodford, J. (2013). Impact of support on the effectiveness of written cognitive behavioural self-help: A systematic review and meta-analysis of randomised controlled trials. *Clinical Psychology Review, 33*(1), 182-195.

Faulkner, S. L., & Trotter, S. P. (2017). Data saturation. *The International Encyclopedia of Communication Research Methods, 1*(1), 1-2.

Feltham, A., Martin, K., Walker, L. & Harris, L. (2018). *Using goals in therapy: The perspective of people with lived experience.* In M. Cooper, & D. Law. (Eds.), *Working with goals in psychotherapy and counselling* (pp. 73-85). Oxford, UK: Oxford University Press.

Fink, E., Patalay, P., Sharpe, H., Holley, S., Deighton, J., & Wolpert, M. (2015). Mental health difficulties in early adolescence: A comparison of two cross-sectional studies in England from 2009 to 2014. *Journal of Adolescent Health, 56*(5), 502-507.

Fleming, I., Jones, M., Bradley, J., & Wolpert, M. (2014). Learning from a learning collaboration: The CORC approach to combining research, evaluation and practice in child mental health.

Administration and Policy in Mental Health and Mental Health Services Research, 43(3), 297-301.

Ford, T., Goodman, R., & Meltzer, H. (2003). The British child and adolescent mental health survey 1999: The prevalence of DSM-IV disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(10), 1203-1211.

Godfrey, E., Aubrey, M., Crockford, S., Haythorne, D., Kordowicz, M., & Ashworth, M. (2019). The development and testing of PSYCHLOPS Kids: a new child-centred outcome measure. *Child and Adolescent Mental Health, 24*(1), 54-65.

Gollwitzer, P. M., & Moskowitz, G. B. (1996). *Goal effects on action and cognition.* In E. T. Higgins, & A. W. Kruglanski. (Eds.), *Social psychology: Handbook of basic principles* (pp.361-399). New York, USA: The Guilford Press.

Gondek, D., Edbrooke-Childs, J., Fink, E., Deighton, J., & Wolpert, M. (2016). Feedback from outcome measures and treatment effectiveness, treatment efficiency, and collaborative practice: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(3), 325-343.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38*(5), 581-586.

Gray, P., & Mellor-Clark, J. (2007). CORE: A decade of development. Rugby, UK: CORE Information Management Systems.

Green, D. (2016). Making the case for using personalised outcome measures to track progress in psychotherapy. *European Journal of Psychotherapy & Counselling, 18*(1), 39-57.

Green, D., & Latchford, G. (2012). *Maximising the benefits of psychotherapy: A practice-based evidence approach*. London, UK: John Wiley & Sons Inc.

Grey, N., Byrne, S., Taylor, T., Shmueli, A., Troupp, C., Stratton, P., Sefi, A., Law, R. & Cooper, M. (2018). *Goal-oriented practice across therapies.* In M. Cooper, & D. Law, (Eds.), *Working with goals in psychotherapy and counselling* (pp. 181-203). Oxford: Oxford University Press.

Griggs, S. (2017). Hope and mental health in young adult college students: An integrative review. *Journal of Psychosocial Nursing and Mental Health Services, 55*(2), 28-35.

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*(1), 79-99.

Guyon, H., Kop, J. L., Juhel, J., & Falissard, B. (2018). Measurement, ontology, and epistemology: psychology needs pragmatism-realism. *Theory & Psychology, 28*(2), 149-171.

Hanley, T., Ersahin, Z., Sefi, A., & Hebron, J. (2017). Comparing online and face-to-face student counselling: What therapeutic goals are identified and what are the implications for educational providers? *Journal of Psychologists and Counsellors in Schools, 27*(1), 37-54.

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*(2), 155-163.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343.

Harkin, B., Webb, T. L., Chang, B. P., Prestwich, A., Conner, M., Kellar, I., Benn, Y. & Sheeran, P. (2016). Does monitoring goal progress promote goal attainment? A meta-analysis of the experimental evidence. *Psychological Bulletin, 142*(2), 198-229.

Haslam, N. (2000). Psychiatric categories as natural kinds: Essentialist thinking about mental disorders. *Social Research, 67*(4), 1031–1058.

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*(1), 62-70.

Haynes, S. N., Mumma, G. H., & Pinson, C. (2009). Idiographic assessment: Conceptual and psychometric foundations of individualized behavioral assessment. *Clinical Psychology Review, 29(2),* 179-191.

Holtforth, M. G., & Castonguay, L. G. (2005). Relationship and techniques in cognitive-behavioral therapy--A motivational approach. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 443-455.

House of Commons. (2017). *Children's and adolescents' mental health and CAMHS*. London, UK: The Stationery Office. Retrieved from https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf.

Howell, R. D., Breivik, E., & Wilcox, J. B. (2007). Reconsidering formative measurement. *Psychological Methods, 12*(2), 205-218.

Hudson, K. G. (2018). *Optimising the potential of mindfulness programs in schools: Learning from implementation science (PhD thesis).* University of Leeds, UK.

Hunter, R., McLean, J., Peck, D., Pullen, I., Greenfield, A., McArthur, W., Quinn, C., Eaglesham, J., Hagen, S., & Norrie, J. (2004). The Scottish 700 outcomes study: A comparative evaluation of the Health of the Nation Outcome Scale (HoNOS), the Avon mental health measure (AVON), and an idiographic scale (OPUS) in adult mental health. *Journal of Mental Health, 13*(1), 93-105.

Hurn, J., Kneebone, I., & Cropley, M. (2006). Goal setting as an outcome measure: a systematic review. *Clinical Rehabilitation, 20*(9), 756-772.

Innis, N. K. (1999). *Edward C. Tolman's purposive behaviorism.* In: W. O'Donohue & R. Kitchener (Eds.), *Handbook of behaviorism* (pp. 97-117). Academic Press, https://doi.org/10.1016/B978-0-12-524190-8.X5000-1.

Jacob, J. Moving toward a better understanding of idiographic outcome measurement: A commentary on Lloyd, Duncan, and Cooper (2019). *Clinical Psychology: Science and Practice,* 26(3) e12287. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1111/cpsp.12287.

***Jacob, J., De Francesco, D., Deighton, J., Law, D., Wolpert, M., & Edbrooke-Childs, J. (2017[b]). Goal formulation and tracking in child mental health settings: when is it more likely and is it associated with satisfaction with care? *European Child & Adolescent Psychiatry, 26*(7), 759-770.**

***Jacob, J., Edbrooke-Childs, J., Holley, S., Law, D., & Wolpert, M. (2015). Horses for courses? A qualitative exploration of goals formulated in mental health settings by young people, parents, and clinicians. *Clinical Child Psychology and Psychiatry, 21*(2), 208-223.**

***Jacob, J., Edbrooke-Childs, J., Law, D., & Wolpert, M. (2017[c]). Measuring what matters to patients: Using goal content to inform measure choice and development. *Clinical Child Psychology and Psychiatry, 22*(2), 170-186.**

***Jacob, J., Edbrooke-Childs, J., Lloyd, C., Hayes, D., Whelan, I., Wolpert, M., & Law, D. (2018). *Measuring outcomes using goals.* In M. Cooper, & D. Law. (Eds.), *Working with goals in psychotherapy and counselling* (pp. 111-137). Oxford, UK: Oxford University Press.**

***Jacob, J., Napoleone, E., Zamperoni, V., Levy, L., Barnard, M., & Wolpert, M. (2017[a]). *How can outcome data inform change? experiences from the child mental health context in great Britain, including barriers and facilitators to the collection and use of data.* In T. Tilden, & B. E. Wampold. (Eds.), *Routine outcome monitoring in couple and family therapy* (pp. 261-279). Cham, Switzerland: Springer International Publishing AG.**

Jacobson, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52*(4), 482-485.

Jensen-Doss, A., Smith, A. M., Becker-Haimes, E. M., Ringle, V. M., Walsh, L. M., Nanda, M., Walsh, S. L., Maxwell, C. A., & Lyon, A. R. (2018). Individualized progress measures are more acceptable to clinicians than standardized measures: Results of a national survey. *Administration and Policy in Mental Health and Mental Health Services Research, 45(3),* 392-403.

Kaplan, A., Middleton, M. J., Urdan, T., & Midgley, C. (2002). *Achievement goals and goal structures.* In C. Midgley. (Ed.), *Goals, goal structures, and patterns of adaptive learning* (pp. 21-53). London, uk: Laurence Erlbaum Associates.

Karoly, P. (1993). Goal systems: an organizing framework for clinical assessment and treatment planning. *Psychological Assessment, 5*(3) 273-280.

Kasser, T., & Ryan, R. M. (1996). Further examining the American dream: Differential correlates of intrinsic and extrinsic goals. *Personality and Social Psychology Bulletin, 22*(3), 280-287.

Kaushik, V., & Walsh, C. A. (2019). Pragmatism as a research paradigm and its implications for social work research. *Social Sciences, 8*(9), 255-271.

Kelly, M., & Coughlan, B. (2019). A theory of youth mental health recovery from a parental perspective. *Child and Adolescent Mental Health, 24*(2), 161-169.

Kelsey, J., Abelson-Mitchell, N., & Skirton, H. (2007). Perceptions of young people about decision making in the acute healthcare environment. *Nursing Children and Young People, 19(6)* 14-18.

Kendrick, T., El-Gohary, M., Stuart, B., Gilbody, S., Churchill, R., Aiken, L., Bhattacharya, A., Gimson, A., Bruett, A. L., de Jong, K., & Moore, M. (2016). Routine use of patient reported outcome measures (PROMs) for improving treatment of common mental health disorders in adults. Cochrane Database of Systematic Reviews, (7). Retrieved from https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011119.pub2/abstract.

Kidd, S., Kenny, A., & McKinstry, C. (2015). The meaning of recovery in a regional mental health service: an action research study. *Journal of Advanced Nursing, 71*(1), 181-192.

Kim, T. K. (2015). T test as a parametric statistic. *Korean Journal of Anesthesiology, 68*(6), 540-546.

Kinderman, P., Kamens, S., Robbins, B. D., & Farley, F. (2020). Regarding the reform and revision of diagnostic systems: an open letter from Div. 32 (Society for Humanistic Psychology). Retrieved from https://www.apadivisions.org/division-32/leadership/task-forces/diagnostic-alternatives.

Knaup, C., Koesters, M., Schoefer, D., Becker, T., & Puschner, B. (2009). Effect of feedback of treatment outcome in specialist mental healthcare: meta-analysis. *The British Journal of Psychiatry*, *195*(1), 15-22.

Kowalenko, N. M., & Culjak, G. (2018). Workforce planning for children and young people's mental health care. *The Lancet Public Health, 3*(6), e266-e277.

Kraus, D. R., Seligman, D., & Jordan, J. R. (2005). Validation of a behavioral health treatment outcome and assessment tool designed for naturalistic settings: The Treatment Outcome Package. *Journal of Clinical Psychology, 61*(1), 285-314.

Krause, K. R., Bear, H. A., Edbrooke-Childs, J., & Wolpert, M. (2019). What outcomes count? Outcomes measured for adolescent depression between 2007 and 2017. *Journal of the American Academy of Child & Adolescent Psychiatry, 58*(1), 61-71.

Krueger, R. F., Hopwood, C. J., Wright, A. G., & Markon, K. E. (2014). Challenges and strategies in helping the DSM become more dimensional and empirically based. *Current Psychiatry Reports, 16*(12), 515-520.

Krueger, R. F., Kotov, R., Watson, D., Forbes, M. K., Eaton, N. R., Ruggero, C. J., Simms, L.J., Widiger, T.A., Achenbach, T.M., Bach, B., & Bagby, R. M. (2018). Progress in achieving quantitative classification of psychopathology*. World Psychiatry, 17*(3), 282-293.

Lambert, M. J. (2012). Helping clinicians to use and learn from research-based systems: The OQ-Analyst. *Psychotherapy, 49*(1), 109-114.

Lambert, M. J., & Ogles, B. M. (2004). *The efficacy and effectiveness of psychotherapy.* In M. J. Lambert, (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change: 5th edition* (pp. 139-193). New York, USA: John Wiley & Sons Inc.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology: Science and Practice*, *10*(3), 288-301.

Lambert, M. J., Whipple, J. L., & Kleinstäuber, M. (2018). Collecting and delivering progress feedback: A meta-analysis of routine outcome monitoring. *Psychotherapy, 55*(4), 520-537.

Las Hayas, C., Padilla, P., del Barrio, A. G., Beato-Fernandez, L., Muñoz, P., & Gámez-Guadix, M. (2016). Individualised versus standardised assessment of quality of life in eating disorders. *European Eating Disorders Review, 24*(2), 147-156.

Latham, G. P. (2016). Goal-Setting Theory: Causal relationships, mediators, and moderators. In *Oxford Research Encyclopedia of Psychology*. DOI: 10.1093/acrefore/9780190236557.013.12.

Latham, G. P. & Locke, E. A. (1991). Self-regulation through goal setting. *Organizational Behavior and Human Decision Processes, 50*(2), 212-247.

Lavik, K. O., Veseth, M., Frøysa, H., Binder, P. E., & Moltu, C. (2018). What are "good outcomes" for adolescents in public mental health settings? *International Journal of Mental Health Systems, 12*(1), 3-13.

Law, D. (2011). *Goals and goal based outcomes (GBOs): some useful information. Version 2.0.* London: CAMHS Press.

Law, D. (2018). *Goal-orientated practice.* In M. Cooper, & D. Law. (Eds.), *Working with goals in psychotherapy and counselling* (pp. 161-180). Oxford, UK: Oxford University Press.

Law, D. (2020). *Understanding the difference between 'vehicles' and 'destinations' in goal-setting and goal-oriented practice.* Retrieved from https://goals-in-therapy.com/2019/01/03/understanding-the-difference-between-vehicles-and-destinations-in-goal-setting-and-goal-oriented-practice/.

Law, D., & Jacob, J. (2015). *Goals and Goal Based Outcomes: Some Useful Information. 3rd Edition*. London, UK: CAMHS Press.

Law, D., & Wolpert, M. (Eds.). (2014). *Guide to using outcomes and feedback tools with children, young people and families: 2nd edition*. London, UK: CAMHS Press.

Lee, W., Jones, L., Goodman, R., & Heyman, I. (2005). Broad outcome measures may underestimate effectiveness: an instrument comparison study. *Child and Adolescent Mental Health, 10*(3), 143-144.

Levack, W. M., Weatherall, M., Hay-Smith, E. J. C., Dean, S. G., McPherson, K., & Siegert, R. J. (2015). Goal setting and strategies to enhance goal pursuit for adults with acquired disability participating in rehabilitation. *Cochrane Database of Systematic Reviews, 7*. Retrieved from https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009727.pub2/full.

Little, B. R. (1983). Personal projects: A rationale and method for investigation. *Environment and Behavior, 15*(3), 273-309.

Lloyd, C. E. M., Duncan, C., & Cooper, M. (2019). Goal measures for psychotherapy: A systematic review of self-report, idiographic instruments. *Clinical Psychology: Science and Practice 26*(3) e12281. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1111/cpsp.12281.

Loades, M. E., Taylor, C., Stark., D., McFarlane, F., Heyman, I., & Hadji-Michael, M. (2018). To score or not to score. *The Psychologist. Retrieved from https://thepsychologist.bps.org.uk/score-or-not-score.*

Loevinger, J. (1957). Objective tests as instruments of psychological theory [Monograph No. 9]. *Psychological Reports, 3*(1)*,* 635-694.

Lutchman, R., Thompson, A., Tait, H., Savage, A. L., Aitchison, R., Ruru, R., & Mellsop, G. (2007). In search of a standardised, comprehensive assessment of functioning. *New Zealand Journal of Occupational Therapy, 54*(1), 33-38.

Lutz, W., Leach, C., Barkham, M., Lucock, M., Stiles, W. B., Evans, C., Noble, R., & Iveson, S. (2005). Predicting change for individual psychotherapy clients on the basis of their nearest neighbors. *Journal of Consulting and Clinical Psychology, 73*(5), 904-913.

MacIntyre, A. (1981). The nature of the virtues. *Hastings Center Report, 11*(2), 27-34.

Macpherson, R., Pesola, F., Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2016). The relationship between clinical and recovery dimensions of outcome in mental health. *Schizophrenia Research, 175(1-3),* 142-147.

Maggin, D. M., & Chafouleas, S. M. (2013). Introduction to the special series: Issues and advances of synthesizing single-case research. *Remedial and Special Education, 34*(1), 3-8.

Malla, A. & Payne, J. (2005) First-episode psychosis: psychopathology, quality of life and functional outcome. *Schizophrenia Bulletin, 31*(3) 650-671.

Manderlink, G., & Harackiewicz, J. M. (1984). Proximal versus distal goal setting and intrinsic motivation. *Journal of Personality and Social Psychology, 47*(4), 918-928.

Marsh, H. W. (1994). Sport motivation orientations: Beware of jingle-jangle fallacies. *Journal of Sport and Exercise Psychology, 16(4),* 365-380.

Mellat, N., & Lavasani, M. G. (2011). The role of epistemological beliefs, motivational constructs and Information processing strategies in regulation of learning. *Procedia-Social and Behavioral Sciences, 30*(1) 1761-1769.

Morse, J. M., Stern, P. N., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. E. (2016). *Developing grounded theory: The second generation.* New York, USA: Routledge.

Maslow, A. H. (1989). *A theory of human motivation*. In H. J. Leavitt, L. R. Pondy, & D. M. Boje. (Eds.), *Readings in managerial psychology* (pp. 20-35). Chicago, USA: The University of Chicago Press.

Maybery, D., Reupert, A., & Goodyear, M. (2015). Goal setting in recovery: Families where a parent has a mental illness or a dual diagnosis. *Child & Family Social Work, 20*(3), 354-363.

McCann, T. V. & Lubman, D. I. (2012). Young people with depression and their satisfaction with the quality of care they receive ftom a primary care youth mental health service: a qualitative study. *Journal of Clinical Nursing, 21*(1)*,* 2179-2187.

McLeod, J. (2001). An administratively created reality: Some problems with the use of self-report questionnaire measures of adjustment in counselling/psychotherapy outcome research. *Counselling and Psychotherapy Research, 1*(3), 215-226.

Meier, S. T. (2008). *Measuring Change in Counseling and Psychotherapy: 1st Edition.* New York: The Guildford Press.

Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice, 9*(1), 21-25.

Michalak, J., & Holtforth, M. G. (2006). Where do we go from here? The goal perspective in psychotherapy. *Clinical Psychology: Science and Practice, 13*(4), 346-365.

Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology*, *61*(2), 199-208.

Molenaar, P. C. (2004). A manifesto on psychology as idiographic science: Bringing the person back into scientific psychology, this time forever. *Measurement, 2*(4), 201-218.

Moltu, C., Veseth, M., Stefansen, J., Nøtnes, J. C., Skjølberg, Å., Binder, P. E., Castonguay, L. G., & Nordberg, S. S. (2018). This is what I need a clinical feedback system to do for me: A qualitative inquiry into therapists' and patients' perspectives. *Psychotherapy Research, 28*(2), 250-263.

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*(1), 65-79.

Morgan, M. A., Coates, M. J., Dunbar, J. A., Reddy, P., Schlicht, K., & Fuller, J. (2013). The TrueBlue model of collaborative care using practice nurses as case managers for depression alongside diabetes or heart disease: a randomised trial. *BMJ Open, 3*(1), e002171. Retrieved from https://bmjopen.bmj.com/content/bmjopen/3/1/e002171.full.pdf.

Morisano, D., Hirsh, J. B., Peterson, J. B., Pihl, R. O., & Shore, B. M. (2010). Setting, elaborating, and reflecting on personal goals improves academic performance. *Journal of Applied Psychology, 95*(2), 255-264.

Mulley, A., Trimble, C. & Elwyn, G. (2012). Stop the silent misdiagnosis: Patients' preferences matter. *BMJ, 345*(7883), 23-26.

National Collaborating Centre for Mental Health. (2018). *The Improving Access to Psychological Therapies Manual.* London: NHS. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2019/02/improving-access-to-psychological-therapies-manual.pdf.

Newlove-Delgado, T. V. (2016). *Service use and unmet mental health need in children and young adults: Analysis of three years of follow up from the 2004 British child and adolescent mental health survey & description of primary care psychotropic prescribing & transition in young adults with Attention Deficit Hyperactivity Disorder (PhD thesis).* University of Exeter, UK.

NHS Benchmarking Network. (2018). *2018 CAMHS Project - Results Published.* Retrieved from https://www.nhsbenchmarking.nhs.uk/news/2018-camhs-project-results-published.

NHS Digital. (2016). *Psychological therapies: Annual report on the use of IAPT services 2015-16.* Health and Social Care Information Centre. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services.

NHS Digital. (2018). *Mental health of children and young people in England, 2017.* Official Statistics. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017.

NHS England. (2019). *Integrated personal commissioning: Co-production for personal health budgets and integrated personal commissioning. Summary guide.* NHS England Publications Gateway. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Co-production-for-personal-health-budgets-and-Integrated-Personal-Commissioning_S7.pdf.

NHS Health Research Authority. (2018). *Governance Arrangements for Research Ethics Committees (GAfREC).* Retrieved from http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/.

Norse Feedback (2019) *About us.* Retrieved from https://www.norsefeedback.no/en/about-us/.

Nurmi, J. E., Poole, M. E., & Kalakowski, V. (1994). Age differences in adolescent future-orientated goals, concerns and related temporal extension in different sociocultural contexts. *Journal of Youth and Adolescence, 23*(4), 471-487.

Odhammar, F., & Carlberg, G. (2015). Parents' and psychotherapists' goals prior to psychodynamic child psychotherapy. *European Journal of Psychotherapy & Counselling, 17*(3), 277-295.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22.

Orange, D. M. (2013). *Subjectivism, relativism, and realism in psychoanalysis.* In A. I. Goldberg. (Ed.), *Progress in self psychology, Volume. 8* (pp. 189-197). New Jersey, USA: The Analytic Press.

Østergård, O. K., Randa, H., & Hougaard, E. (2020). The effect of using the Partners for Change Outcome Management System as feedback tool in psychotherapy—A systematic review and meta-analysis. *Psychotherapy Research*, *30*(2), 195-212.

Oyserman, D., & Fryberg, S. (2006). The possible selves of diverse adolescents: Content and function across gender, race and national origin. *Possible Selves: Theory, Research, and Applications, 2*(4), 17-39.

Patalay, P., & Fitzsimons, E. (2016). Correlates of mental illness and wellbeing in children: are they the same? Results from the UK Millennium Cohort Study. *Journal of the American Academy of Child & Adolescent Psychiatry, 55*(9), 771-783.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet, 369*(9569), 1302-1313.

Pearce, P., Sewell, R., Cooper, M., Osman, S., Fugard, A. J., & Pybis, J. (2017). Effectiveness of school-based humanistic counselling for psychological distress in young people: Pilot randomized controlled trial with follow-up in an ethnically diverse sample. *Psychology and Psychotherapy: Theory, Research and Practice, 90*(2), 138-155.

Peikoff, L. (1993). *Objectivism: the philosophy of Ayn Rand.* New York, USA: Penguin.

Perla, R. J., Provost, L. P., & Murray, S. K. (2011). The run chart: a simple analytical tool for learning from variation in healthcare processes. *BMJ Quality & Safety, 20*(1), 46-51.

Pender, F., Tinwell, C., Marsh, E. & Cowell, V. (2013). Evaluating the use of goal-based outcomes as a single patient rated outcome measure across CWP CAMHS: A pilot study, *Child and Family Clinical Psychology Review, 1*(1), 29-40.

Pitchforth, J., Fahy, K., Ford, T., Wolpert, M., Viner, R. M., & Hargreaves, D. S. (2019). Mental health and well-being trends among children and young people in the UK, 1995–2014: Analysis of repeated cross-sectional national health surveys. *Psychological Medicine, 49*(8), 1275-1285.

Podsakoff, P. M., MacKenzie, S. B., Podsakoff, N. P., & Lee, J. Y. (2003). The mismeasure of man(agement) and its implications for leadership research. *The Leadership Quarterly*, *14*(6), 615-656.

Pöhlmann, K. (2001). *Agency- and communication-orientation in life goals: impact on goal pursuit strategies and psychological wellbeing.* In P. Schmuck, & K. M. Sheldon. (Eds.), *Life goals and well-being: Towards a positive psychology of human striving* (pp. 68-84). Gottingen, Germany: Hogrefe & Huber.

Pulford, J., Adams, P., & Sheridan, J. (2009). Client/clinician discrepancies in perceived problem improvement and the potential influence on dropout response. *International Journal of Mental Health and Addiction, 7*(4), 497-505.

Rand, A. (1990). *Introduction to objectivist epistemology: Expanded second edition.* New York, USA: Penguin.

Redsell, S. Hastings, A. (2010). *Listening to children and young people in healthcare consultations.* Oxford, UK: Radcliffe Publishing.

Reeve, J. (2018). *Understanding motivation and emotion. 6th edition.* New Jersey, USA: Wiley.

Reid, M. J., Webster-Stratton, C., & Beauchaine, T. P. (2001). Parent training in Head Start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science, 2*(4), 209-227.

Reuben, D. B., & Tinetti, M. E. (2012). Goal-oriented patient care—an alternative health outcomes paradigm. *New England Journal of Medicine, 366*(9), 777-779.

Rey, J. M., Plapp, J. M., & Simpson, P. L. (1999). Parental satisfaction and outcome: a 4-year study in a child and adolescent mental health service. *Australian & New Zealand Journal Of Psychiatry, 33*(1), 22-28.

Rimmer, A. (2018). GPs think that lack of mental health services is putting young people at risk. *BMJ, 363*, k5436. Retrieved from https://www.bmj.com/content/363/bmj.k5436.full.

Robinson, S. I., Ashworth, M., Shepherd, M., & Evans, C. (2006). In their own words: a narrative-based classification of clients' problems on an idiographic outcome measure for talking therapy in primary care. *Primary Care Mental Health, 4*(3), 165-173.

Rodger, S., Ireland, S., & Vun, M. (2008). Can Cognitive Orientation to daily Occupational Performance (CO-OP) help children with Asperger's syndrome to master social and organisational goals? *British Journal of Occupational Therapy, 71*(1), 23-32.

Rodgers, B. (2017). The trouble with numbers: Some fundamental flaws with using standardised outcome measures. *Psychotherapy and Politics International, 15*(3), e1423. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1002/ppi.1423.

Rupani, P., Cooper, M., McArthur, K., Pybis, J., Cromarty, K., Hill, A., Levesley, R., Murdoch, J. & Turner, N. (2014). The goals of young people in school-based counselling and their achievement of these goals. *Counselling and Psychotherapy Research, 14*(4), 306-314.

Sales, C. (2017). Seeing the person in the patient: Making the case for individualized PROMs in mental health care. *Current Psychiatry Reviews, 13*(3), 184-187.

Sales, C., & Alves, P. C. (2016). Patient-centered assessment in psychotherapy: A review of individualized tools. *Clinical Psychology: Science and Practice, 23*(3), 265-283.

Sales, C. M., Ferreira, S., & Matos, P. M. (2019). How routine patient-centered monitoring relates to therapeutic gains in family therapy: A single-case study. *Journal of Marital and Family Therapy, 45*(4), 606-620.

Sales, C., Goncalves, S., Fragoeiro, A., Noronha, S., & Elliott, R. (2007). Psychotherapists openness to routine naturalistic idiographic research? *Mental Health and Learning Disabilities Research and Practice, 4*(2), 145-161.

Santana, M. J., & Feeny, D. (2014). Framework to assess the effects of using patient-reported outcome measures in chronic care management. *Quality of Life Research, 23*(5), 1505-1513.

Schwartz, L. A., & Brumley, L. D. (2017). What a pain: the impact of physical symptoms and health management on pursuit of personal goals among adolescents with cancer. *Journal of Adolescent and Young Adult Oncology, 6*(1), 142-149.

Schwartz, L. A., & Drotar, D. (2009). Health-related hindrance of personal goal pursuit and well-being of young adults with cystic fibrosis, pediatric cancer survivors, and peers without a history of chronic illness. *Journal of Pediatric Psychology, 34*(9), 954-965.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry*, *40*(11), 1228-1231.

Sharples, J., Albers, B., & Fraser, S. (2018). *Putting evidence to work: a school's guide to implementation (guidance report).* London, UK: Education Endowment Foundation. Retrieved from http://discovery.ucl.ac.uk/10068468/.

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology*, *78*(3), 298-311.

Singh, V., & Walwyn, D. R. (2017). Influence of personal epistemology on research design: Implications for research education. *Journal of Research Practice, 13*(2), 2-20.

Slade, M. (2012). *The epistemological basis of personal recovery.* In A. Rudnik. *Recovery of people with mental illness. Philosophical and related perspectives* (pp. 78-94). Oxford, UK: Oxford University Press.

Slade, M., Amering, M., & Oades, L. (2008). Recovery: an international perspective. *Epidemiology and Psychiatric Sciences, 17*(2), 128-137.

Thurgood, S., Crosby, H., Raistrick, D., & Tober, G. (2014). Service user, family and friends' views on the meaning of a 'good outcome' of treatment for an addiction problem. *Drugs: Education, Prevention and Policy, 21*(4), 324-332.

Tinetti, M. E., Naik, A. D., & Dodson, J. A. (2016). Moving from disease-centered to patient goals–directed care for patients with multiple chronic conditions: Patient value-based care. *JAMA Cardiology, 1*(1), 9-10.

Toto, P. E., Skidmore, E. R., Terhorst, L., Rosen, J., & Weiner, D. K. (2015). Goal Attainment Scaling (GAS) in geriatric primary care: a feasibility study. *Archives of Gerontology and Geriatrics, 60*(1), 16-21.

Troupp, C. (2013). "What do you want to get out of coming here?" Distinguishing a patient-generated outcome measure in CAMHS from a bespoke sandwich. *Child and Family Clinical Psychology Review, 1*(1), 19-28.

Twigg, E., Cooper, M., Evans, C., Freire, E., Mellor-Clark, J., McInnes, B., & Barkham, M. (2016). Acceptability, reliability, referential distributions and sensitivity to change in the Young

Person's Clinical Outcomes in Routine Evaluation (YP-CORE) outcome measure: Replication and refinement. *Child and Adolescent Mental Health, 21*(2), 115-123.

Van Orden, M., Hoffman, T., Haffmans, J., Spinhoven, P., & Hoencamp, E. (2009). Collaborative mental health care versus care as usual in a primary care setting: A randomized controlled trial. *Psychiatric Services*, *60*(1), 74-79.

Vermunt, N. (2018) *Collaborative goal setting: Towards a goal-oriented approach of shared decision-making in complex elderly care* (PhD Thesis) Radbound University Nijmegen, Someren, The Netherlands.

Vermunt, N., Elwyn, G., Westert, G., Harmsen, M., Rikkert, M. O., & Meinders, M. (2019). Goal setting is insufficiently recognised as an essential part of shared decision-making in the complex care of older patients: A framework analysis. *BMC Family Practice, 20*(1), 76-87.

Weinberger, J., & Eig, A. (1999). *Expectancies: the ignored common factor in psychotherapy.* In I. Kirsch. (Ed.), *How expectancies shape experience* (pp. 357-382). Washington, USA: American Psychological Association.

Wiart, L., Ray, L., Darrah, J., & Magill-Evans, J. (2010). Parents' perspectives on occupational therapy and physical therapy goals for children with cerebral palsy. *Disability and Rehabilitation, 32*(3), 248-258.

Widiger, T. A., & Samuel, D. B. (2005). Diagnostic categories or dimensions? A question for the Diagnostic and statistical manual of mental disorders. *Journal of Abnormal Psychology, 114*(4), 494-504.

Wilcox, J. B., Howell, R. D., & Breivik, E. (2008). Questions about formative measurement. *Journal of Business Research, 61*(12), 1219-1228.

Winell, M. (1982). *Personal goals: The key to self-direction in adulthood*. In M. E. Ford, & D. H. Ford. (Eds.), *Humans as self-constructing living systems: Putting the framework to work* (pp. 261-287). Hillsdale, USA: Erlbaum.

Wolpert, M. (2014). Uses and abuses of patient reported outcome measures (PROMs): Potential iatrogenic impact of PROMs implementation and how it can be mitigated. *Administration and Policy in Mental Health and Mental Health Services Research, 41*(2), 141-145.

Wolpert, M., & Rutter, H. (2018). Using Flawed, Uncertain, Proximate and Sparse (FUPS) data in the context of complexity: Learning from the case of child mental health. *BMC Medicine, 16*(1), 82-93.

Wolpert, M., Cheng, H., & Deighton, J. (2015[a]). Measurement issues: Review of four patient reported outcome measures: SDQ, RCADS, C/ORS and GBO–their strengths and limitations for clinical use and service evaluation. *Child and Adolescent Mental Health, 20*(1), 63-70.

Wolpert, M., Deighton, J., De Francesco, D., Martin, P., Fonagy, P., & Ford, T. (2014). From 'reckless' to 'mindful' in the use of outcome data to inform service-level performance management: Perspectives from child mental health. *BMJ Qual Saf, 23*(4), 272-276.

Wolpert, M., Fugard, A., & Deighton, J. (2013). *Issues in evaluation of psychotherapies.* In P. Graham, & S. Reynolds. (Eds.), *Cognitive Behaviour Therapy for children and families* (pp. 34-47). Cambridge, UK: Cambridge University Press.

Wolpert, M., Görzig, A., Deighton, J., Fugard, A. J., Newman, R., & Ford, T. (2015[b]). Comparison of indices of clinically meaningful change in child and adolescent mental health services: difference scores, reliable change, crossing clinical thresholds and 'added value'–an exploration using parent rated scores on the SDQ. *Child and Adolescent Mental Health, 20*(2), 94-101.

Wolpert, M., Jacob, J., Napoleone, E., Whale, A., Calderon, A. & Edbrooke-Childs, J. (2017) *Child- and parent-reported outcomes and experience from child and young people's mental health services 2011–2015.* London, UK: CAMHS Press.

Worthen, V. E., & Lambert, M. J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling and Psychotherapy Research, 7*(1), 48-53.

Yanos, P. T., Roe, D., Markus, K., & Lysaker, P. H. (2008). Pathways between internalized stigma and outcomes related to recovery in schizophrenia spectrum disorders. *Psychiatric Services, 59*(12), 1437-1442.

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., Srinivasan, S., Chun, K., Kurasaki, K., & Lee, E. (2005). Beyond ethnic match: Effects of client–therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology, 33*(5), 569-585.

Goals and goal-based outcomes (GBOs)

Goals 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

Completed by *(tick below)*:

- ☐ Child/young person
- ☐ Parent/carer
- ☐ Other *(please specify)*: _____

Service ID/NHS number: _____

Name: *(optional)* _____

Date _____

Appendix A

Goals and goal-based outcomes (GBOs)

Goal rating sheet

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 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

YOUR FIRST GOAL

Enter brief description of goal and goal number as recorded on the Goals 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

Enter brief description of goal and goal number as recorded on the Goals 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

Enter brief description of goal and goal number as recorded on the Goals 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

Completed by *(tick below)*:

- ☐ Child/young person
- ☐ Parent/carer
- ☐ Other *(please specify)*: _____

Service ID/NHS number: _____

Name: *(optional)* _____

Date _____

Goals and goal-based outcomes (GBOs)

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 over the sessions.

Goal No:

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

Whose goal is this *(tick below)*:

- ☐ Child/young person
- ☐ Parent/Carer
- ☐ Practitioner
- ☐ Other *(please specify)*:

Service ID/NHS number:

Name: *(optional)*

Appendix B Author Contributions

Table B.1 below details the contributions of the author to the published works.

Table B.1: Author contributions to the published works

Reference	Author contribution
Jacob, J., Edbrooke-Childs, J., Lloyd, C., Hayes, D., Whelan, I., Wolpert, M., & Law, D. (2018). *Measuring outcomes using goals.* In M. Cooper, & D. Law. (Eds.), *Working with goals in psychotherapy and counselling* (pp. 111-137). Oxford, UK: Oxford University Press.	The author led on the research concept, manuscript writing and revisions.
Jacob, J., De Francesco, D., Deighton, J., Law, D., Wolpert, M., & Edbrooke-Childs, J. (2017). Goal formulation and tracking in child mental health settings: when is it more likely and is it associated with satisfaction with care? *European Child & Adolescent Psychiatry, 26*(7), 759-770.	The author led on the research concept, manuscript writing and revisions, including management and oversight of analyses. This paper was based on an original concept and analyses conducted as part of the author's dissertation for the MSc in Developmental and Educational Psychology (completion date 2013). The analyses for the paper were based on a slightly different dataset due to different decisions made in the filtering process. Analyses were redeveloped specifically for this paper, in collaboration with the second author, including the zero poisson regression, which was not used as an

	analysis technique for the MSc dissertation. The MSc was much wider in focus and the analyses consisted only of ANOVA and Chi Squares. The introduction and discussion sections were also substantially developed for this paper, given the wider scope of the dissertation. The paper was not published as part of the MSc.
Jacob, J., Napoleone, E., Zamperoni, V., Levy, L., Barnard, M., & Wolpert, M. (2017). *How can outcome data inform change? experiences from the child mental health context in great Britain, including barriers and facilitators to the collection and use of data.* In T. Tilden, & B. E. Wampold. (Eds.), *Routine outcome monitoring in couple and family therapy* (pp. 261-279). Cham, Switzerland: Springer International Publishing AG.	The author led on the research concept, manuscript writing and revisions.
Jacob, J., Edbrooke-Childs, J., Law, D., & Wolpert, M. (2017). Measuring what matters to patients: Using goal content to inform measure choice and development. *Clinical Child Psychology and Psychiatry, 22*(2), 170-186.	The author led the analysis, manuscript writing and revisions. The author co-conceived of the research concept with the last author.
Edbrooke-Childs, J., **Jacob, J.,** Law, D., Deighton, J., & Wolpert, M. (2015). Interpreting standardized and idiographic outcome measures in CAMHS: what does change mean and how does it	The author had input into the analysis decisions and made a significant contribution to the manuscript writing and revisions.

relate to functioning and experience? *Child and Adolescent Mental Health, 20*(3), 142-148.	
Jacob, J., Edbrooke-Childs, J., Holley, S., Law, D., & Wolpert, M. (2015). Horses for courses? A qualitative exploration of goals formulated in mental health settings by young people, parents, and clinicians. *Clinical Child Psychology and Psychiatry, 21*(2), 208-223.	The author led on the research concept, analysis and manuscript writing and revisions. This paper was based on an original concept and analyses conducted as part a module for the author's MSc in Developmental and Educational Psychology (completion date 2013). Additional analysis was conducted by the third author to develop the research for this publication. Specifically, the third author conducted thematic analysis on the parent-led and jointly agreed goal data as a second coder, then the author compared the taxonomies across the perspectives, referring back to the previously published child-led taxonomy (***Bradley et al., 2013**). The introduction and discussion sections were substantially developed for the paper, particularly to reflect the additional focus on the comparisons between the taxonomies. The paper was not published as part of the MSc.

Bradley, J., Murphy, S., Fugard, A. J. B., Nolas, S. M., & Law, D. (2013). What kind of goals do children and young people set for themselves in therapy? Developing a goals framework using CORC data. *Child & Family Clinical Psychology Review, 1*(1), 8-18.	The author led on the analysis, manuscript writing and revisions. The author co-conceived of the research concept with the third author. Analysis decisions were primarily made in collaboration with the fourth author.

Appendix C

Table of Citations

Table C.1 below details the number of citations each of the published works has received to date, according to Scopus (www.scopus.com) which is a citation database of peer-reviewed literature. Additionally, some citation counts were obtained by Google Scholar (https://scholar.google.com/schhp?hl=en) which is a search engine for scholarly research. Citation counts from Google Scholar are indicated in the table below with asterisks.

Table C.1: Number of citations per article

Reference	Number of citations
Jacob, J., Edbrooke-Childs, J., Lloyd, C., Hayes, D., Whelan, I., Wolpert, M., & Law, D. (2018). *Measuring outcomes using goals.* In M. Cooper, & D. Law. (Eds.), *Working with goals in psychotherapy and counselling* (pp. 111-137). Oxford, UK: Oxford University Press.	2*
Jacob, J., De Francesco, D., Deighton, J., Law, D., Wolpert, M., & Edbrooke-Childs, J. (2017). Goal formulation and tracking in child mental health settings: when is it more likely and is it associated with satisfaction with care? *European Child & Adolescent Psychiatry, 26*(7), 759-770.	2

Jacob, J., Napoleone, E., Zamperoni, V., Levy, L., Barnard, M., & Wolpert, M. (2017). *How can outcome data inform change? experiences from the child mental health context in great Britain, including barriers and facilitators to the collection and use of data.* In T. Tilden, & B. E. Wampold. (Eds.), *Routine outcome monitoring in couple and family therapy* (pp. 261-279). Cham, Switzerland: Springer International Publishing AG.	4*
Jacob, J., Edbrooke-Childs, J., Law, D., & Wolpert, M. (2017). Measuring what matters to patients: Using goal content to inform measure choice and development. *Clinical Child Psychology and Psychiatry, 22*(2), 170-186.	7
Edbrooke-Childs, J., **Jacob, J.,** Law, D., Deighton, J., & Wolpert, M. (2015). Interpreting standardized and idiographic outcome measures in CAMHS: what does change mean and how does it relate to functioning and experience? *Child and Adolescent Mental Health, 20*(3), 142-148.	8
Jacob, J., Edbrooke-Childs, J., Holley, S., Law, D., & Wolpert, M. (2015). Horses for courses? A qualitative exploration of goals formulated in mental health settings by young people, parents, and clinicians. *Clinical Child Psychology and Psychiatry, 21*(2), 208-223.	7
Bradley, J., Murphy, S., Fugard, A. J. B., Nolas, S. M., & Law, D. (2013). What kind of goals do children and young people set for themselves in therapy? Developing a goals framework using CORC data. *Child & Family Clinical Psychology Review, 1*(1), 8-18.	15*
Total	45

Appendix D

A Note on Missing Data

Generally, there is a lot of missing data in routinely collected datasets, due to a number of factors including high attrition rates, particularly in youth mental health settings (O'Brien, R., & Singh, 2009). A further prominent factor is the essence of naturalistic data collection, with participants not being required to provide data in the same structured way as for Randomised Controlled Trials (RCTs). This may be because the data are collected for "Business as Usual" activities, therefore the primary use and purpose is for record keeping rather than for research, which is in contrast to RCTs which often record high quality data because that is the main purpose of the data collection. Therefore, people do not feel as committed to accurately record data they collect primarily for record keeping. Consequently, decisions about how to analyse datasets with large proportions of missing data and specifically on how to deal with missingness need to be made.

There are several ways to deal with missing data and in the presented research, listwise deletion was used, whereby missing data were excluded from statistical testing so that only valid cases are considered. The decision to use listwise deletion was made because research suggests that those with missing outcome data may be different to those who complete outcome measurement (Stiles et al., 2003). When analysing change over time, bringing the last score forward is common practice in RCTs. This means that no change is assumed for cases with missing follow up data (Clark, Fairburn & Wessely, 2008). Further strategies employ the group or individual means. These strategies enable a larger dataset to be retained. Adopting listwise deletion means that the sample size is smaller and that any findings may be an overestimation of the magnitude of change. Future work seeks to explore existing datasets to investigate alternative strategies to deal with missing data, including multiple imputation and an investigation of case characteristics for subjects with missing data compared to those with complete data. The use of Flawed, Uncertain, Proximal and Sparse (FUPS) data is encouraged, recognising that routinely collected outcomes datasets often have data quality issues. Therefore, data quality should be taken into consideration, whereby the findings should be an important starting point for discussions

between key stakeholders about aggregate level performance when looking at outcomes at a service level (Wolpert & Rutter, 2018). However, the presented research should also be replicated on larger, more complete datasets.

References

Clark, D. M., Fairburn, C. G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS services: A commentary on Stiles et al. (2007). *Psychological Medicine, 38*(5), 629-634.

O'Brien, A., R., F., & Singh, S. P. (2009). Disengagement in mental health services. *Social Psychiatry and Psychiatric Epidemiology, 44*(1), 558-568.

Stiles, W. B., Leach, C., Barkham, M., Lucock, M., Iveson, S., Shapiro, D. A., Iveson, M., & Hardy, G. E. (2003). Early sudden gains in psychotherapy under routine clinic conditions: Practice-based evidence. *Journal of Consulting and Clinical Psychology, 71*(1), 14-21.

Wolpert, M., & Rutter, H. (2018). Using Flawed, Uncertain, Proximate and Sparse (FUPS) data in the context of complexity: Learning from the case of child mental health. *BMC Medicine, 16*(1), 82-93.