



USING RATING SCALES FOR GOAL WRITING



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MAKING GOALS SPECIFIC & MEASUREABLE

- SMART Goals
- Using standardized rating scales
- Use of self-rating scales

SMART GOALS

Specific-Who, what, when, where & how. What exactly do you want to accomplish?

Measurable-How will you know if you have reached your goal?
Intensity, frequency, duration of symptoms.

Attainable-A reasonable expectation within a certain treatment period.
Decide if the change is reasonable. Is the goal set too high or too low?

Relevant-How is this goal relevant to the member's treatment? Does it address an aspect of the member's diagnosis?

Timely-In what time frame will the goal be achieved?

SMART GOALS

Using the **SMART** format:

- Helps a therapist write specific measurable goals
- Helps you and your client know if they are making progress
- Demonstrates to the utilization staff that you are working on goals related to the diagnosis
- Provides utilization staff with concrete information to show that the client is making progress

Self-rating scales

Depression

1	2	3	4	5	6	7
None	Very Mild	Mild	Moderate	Moderately Severe	Extremely Severe	Severe

Anxiety

1	2	3	4	5	6	7
None	Very Mild	Mild	Moderate	Moderately Severe	Extremely Severe	Severe

Anger

1	2	3	4	5	6	7
None	Very Mild	Mild	Moderate	Moderately Severe	Extremely Severe	Severe

SMART GOAL EXAMPLES

Diagnosis: Major Depression-(Behaviors/Symptoms=sad mood, suicidal thoughts, sleep disturbance, diminished interest)

Goal/Objective examples:

- Decrease the number of suicidal thoughts per day/week from ___ to ___.
(client self report)
- Decrease the score on the Suicide Behaviors Questionnaire from ___ to _____.
(standardized rating scale)
- Decrease the score on the PHQ-9 Scale from ___ to _____.
(standardized rating scale)
- Improve overall mood as evidenced by an increase in their self-rating score from ___ to _____.
(10=+mood) (self-rating scale)
- Improve sleep from ___ hours per night to ___ hours per night
(self-rating scale)

Step 1: Need one or both of the first two questions endorsed as a "2" or "3"

PHQ-9

Over the past 2 weeks, how often have you been bothered by any of the following symptoms?	Not at all	Several Days	More than half the days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

1

Need a total of five or more boxes endorsed within the shaded area

Column Totals _____ + _____ + _____

Add Totals Together _____



PHQ-9

Question 10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all Somewhat difficult Very difficult Extremely Difficult
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PHQ-9 Score	Provisional Diagnosis
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5-9	Minimal Symptoms
10-14	Minor Depression, Dysthymia, Mild MDD
15-19	Major Depression, mod. severe
>20	Major Depression, severe



HHW / HIP OUTPATIENT TREATMENT REQUEST (OTR)
Please print clearly – incomplete or illegible forms will delay processing

MEMBER INFORMATION
 Patient Name _____
 Health Plan _____
 DOB _____
 Medicaid RID # _____
 Last Authorization # _____

PROVIDER INFORMATION
 Provider Name _____
 Provider Credential MD _____ PHD _____ OTHER _____
 Group / Agency Name _____
 Physical Address _____
 Telephone Number _____ Facsimile Number _____
 Medicaid / TPI / NPI # _____ Tax ID # _____
 Please indicate to whom the authorization should be made Individual Provider (Y/N) _____ Group / Facility (Y/N) _____

PREVIOUS BH/SA TREATMENT None or OP MH SA and/or _____
 List names / dates including hospitalizations if applicable: _____

Substance Abuse: None By History and/or Current/Active **Tobacco A** _____
 Substance(s) used, amount, frequency & last used: _____

DSM IV Axis: (Please include relevant medical conditions on Axis III)
 AXIS I _____
 AXIS II _____
 AXIS III _____
 AXIS IV _____
 AXIS V _____ CURRENT _____ PAST YEAR _____

If the Member has a substance use and / or HIV diagnosis, has a consent to release information for these related conditions been obtained?
 Yes No N/A

Primary Medical Physician (PMP) Communication
 Has information been shared with the PMP regarding:
 • The initial evaluation & treatment plan? Yes No
 • This updated evaluation & treatment plan Yes No
 PMP Name/Date last notified: _____
 If No, explain: _____

Current R

Suicidal	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW*	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*
Homicidal	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW*	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*
Assault/ Violent Behavior	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW*	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*

Current Risk/Lethality *2-5, Progress/Compliance *1-2 checked, give intervention: _____

Please answer YES or NO to the following questions:
 Is Member currently participating in any community based support groups / interventions? _____
 Are the Member's family/supports involved in treatment? _____
 Coordination of care with other behavioral health providers? _____
 Coordination of care with medical providers? _____
 Has Member been evaluated by a Psychiatrist? _____
 Is this Member currently receiving Medicaid Rehabilitation Option Services? (If yes, please describe) _____

Treatment Goals
 List primary complaint / problem to be addressed: _____
 List measureable treatment goals: _____

Discharge Goals
 List measureable discharge goals: _____

***Overall Progress toward goal:**

<input type="checkbox"/> 1 NONE*	<input type="checkbox"/> 2 MIN*	<input type="checkbox"/> 3 MOD	<input type="checkbox"/> 4 MAX	<input type="checkbox"/> 5 MET
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***Compliance with treatment:**

<input type="checkbox"/> 1 NONE*	<input type="checkbox"/> 2 MIN*	<input type="checkbox"/> 3 MOD	<input type="checkbox"/> 4 MAX	<input type="checkbox"/> 5 MET
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Individual Group
 Frequency of visits: _____ CPT Codes: _____
 Episode: _____ Requested Start Date: _____

This goal is specific, measurable, attainable, relevant to the member's treatment, and timely

Treatment Goal: Julie will decrease her score on the PHQ-9 from 14 to 9 within 4 months of beginning therapy.

Progress: PHQ-9 score decrease from 14 to 11.

Prior to the next treatment request, have the member complete another PHQ-9 and enter the progress on the treatment request form.

