

# NSW Mental Health Outcomes & Assessment Training for Children and Adolescents (MH-OATCA)

Facilitator's Manual

NSW HEALTH DEPARTMENT

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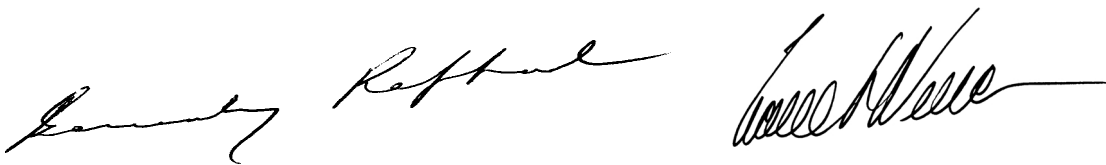
The Mental Health Outcome Assessment Training Child and Adolescent (MH-OATCA) is a statewide initiative to improve the quality of mental health care in NSW. It involves strengthening mental health assessment skills, training in standard protocols for assessment documentation, and training in using the standard measures being implemented nationally under the Second National Mental Health Plan. It is a process which aims to support clinicians in Child and Adolescent services in their provision of clinical care and to improve mental health outcomes.

The values guiding the development and implementation of the initiative are consistent with those stated in the Charter for Mental Health Care in NSW "to improve the mental health of consumers".

The NSW Institute of Psychiatry and the Centre for Mental Health have collaborated in the development of the training manual.

One of the longer term aims of MH-OAT is to strengthen the culture of ongoing learning and clinical competence to ensure mental health services are consumer focussed, accountable and developed to achieve the best possible outcomes. The implementation of MH-OATCA will enable outcomes to be measured throughout all Child and Adolescent mental health services within NSW.

The NSW Institute of Psychiatry and the Centre for Mental Health are committed to the production and distribution of high quality, effective educational material in the field of mental health. We hope this manual becomes a valuable resource to assist all clinical staff in the ongoing implementation of Mental Health Outcome Assessment Training Child and Adolescent.



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OVID Technologies

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## **Introduction**

With the recognition that Child and Adolescent Services have specific specialised needs the second phase of the MH-OAT initiative is to focus on those needs and develop standard modules and protocols accordingly. The MH-OATCA initiative aims to provide assessment documentation and outcome evaluation guidelines suitable for use in CAMHS and when assessing young people.

The MH-OATCA modules have been sent out to all local area health services for review and feedback. This feedback has been duly noted and many of the suggested amendments have been incorporated into the MH-OATCA modules. All modules will be reviewed in an ongoing way.

The Assessment modules include a combined **T1** (Triage) and **T2** (Telephone Contact and Action) module Assessment and Review Management modules.

The protocols for the collection of information remain the same as with the adult modules. Facilitators should familiarise themselves with **Data** and **Clinical Collection Protocol** in the resource section.

The MH-OATCA modules are presented as a unit covering the 0-17 yr period. It was decided that it would be more appropriate to go with one suite covering all age within that the modules allow for documentation of age specific and developmental information.

This manual outlines the modules and data collection protocols and training activities for trainers. Trainers may adapt training material for local area needs.

For this reason it is suggested that facilitators familiarise themselves with the relevant additional resources at the end of the resource. This will be necessary specifically with regard to the data and clinical collection protocols pertaining to the MH-OATCA modules.

Trainers who have already facilitated or attended the two-day MH-OAT training will be familiar with the standard forms and collection protocols. However, for more detailed descriptions of the domains of each module it is recommended that the facilitator refers to the information contained within the 'option 2' sections in the MH-OAT Facilitator's Manual. **Please note however, that the adult modules include a T2 and an A3 as mentioned earlier.**

## Points of Clarification

- › The training modules are **NOT** scripted assessment guidelines.
- › Clinicians are not being asked to base their assessments around these modules however the information they collect in their normal practice needs to be recorded onto the appropriate module
- › Un-completed domains should be signed by the person completing the form
- › The standard measures however, do need to be completed.
- › Clinical practice drives documentation, documentation does not drive clinical practice

Throughout this resource the terms ‘Child’ or ‘Children’ and “Young Person” are used to refer to people under the age of 18. Similarly the term ‘Family’ is used to denote descriptions such as parent, carer, guardian etc.

## Learning Outcomes

This training pack is designed to provide the facilitator with materials to run a **one-day** workshop with the aim of. . .

- › . . . developing and building on existing assessment skills
- › . . . providing instruction in the use of MH-OATCA standard modules
- › . . . developing an understanding of the role that standard documentation
- › . . . introduce the participants to the uses of outcomes and casemix measures
- › . . . providing information concerning clinical protocols
- › . . . providing familiarity with data collection protocols

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## Layout of Training Pack

The training resource comprises three sections (**Topic Section**, **Modules Section** and **Resource Section**). It is also accompanied by a short video of practice vignettes plus a HoNOSCA training pack.

### Topic Section

Each of the topic sections comprises;

- › **Learning Outcomes**  
Giving the overall learning outcome required from the section

› **Facilitator Information**

Providing the facilitator with information concerning the topic subject. This aims to provide information both generic and, child and adolescent specific to the topic being discussed

› **Core Reading(s)**

In most instances the articles referred to under the Core Reading heading can be found in the resource section pertaining to this topic – if they are not contained within the resource section it is suggested that participants seek out the articles. The readings may be used for further exercises or as additional reading for participants.

› **Supplementary Readings**

A list of references that will provide the reader further information with regard to the particular topic

› **Suggested Activities**

An activity that the facilitator may wish to use to enhance the learning outcome. Facilitators can choose to use one of the suggested exercises or develop an exercise themselves. Materials needed for the suggested exercises are located in the resource section.

**NOTE - Over-Heads**

No over-heads are included with this manual. Facilitators are encouraged to produce their own overheads or use/adapt those in the adult training manual

**Modules & Protocols Section**

This section has been kept separate to make the modules\* available to hand for reproduction. This section also includes the Clinical, and Data collection protocols.  
\*(clinical, data and SDQ)

**Resource Section**

The resource section contains the following;

- › **Core Reading(s) - Extra readings relevant to the section topic**
- › **Written Vignettes**
- › **HoNOSCA Rating Grid**
- › **Additional Readings**
- › **Adult Education Principles**

**HoNOSCA Video Workshop**

This training pack is accompanied by a HoNOSCA Video Workshop that is a self-contained teaching resource designed to deliver HoNOSCA training. It can be used independently or in conjunction with the HoNOSCA section of this resource.

## **Learning Outcomes**

At the completion of this session participants will be able to -

- ▶ **Understand how the MH-OATCA initiative complements national and state priorities and strategic policy contexts**
- ▶ **Identify the opportunities for improvements in mental health care**
- ▶ **Identify opportunities and challenges for clinicians in the introduction of the MH-OATCA initiative**

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## **Facilitator Information**

MH-OATCA Mental health Outcomes and Assessment Training (Child and Adolescents) is a component of the significant mental health service development initiative MH-OAT which aims to strengthen the mental health assessment and documentation skills of all clinical staff and to introduce standardised measures as part of the routine care of children and young people. MH-OATCA is designed to meet the training needs of those mental health staff who work with child and adolescent consumers.

The main focus of MH-OATCA is to improve the quality of mental health assessments undertaken within mental health services. This will ensure that the needs of children and young people involved with mental health services are accurately assessed and children and families are involved in decisions relating to their care and subsequently provided with appropriate interventions to achieve the best possible outcomes.

Currently in NSW, each service, sometimes each team within a service, has its own protocol for conducting and recording clinical assessments. In some cases, clinical documentation in the medical record may be incomplete. MH-OATCA aims to

- ▶ Improve the quality of mental health assessments by strengthening the mental health assessment skills of all direct care clinical staff
- ▶ Introduce standard clinical documentation format for mental health assessments
- ▶ Implement standardised measures of outcomes and casemix into child and adolescent services.

MH-OATCA will provide all direct-care clinical staff with training to strengthen their mental health assessment skills of children and adolescents while assisting them with the

integration of standard documentation and the collection of standardised measures into their usual clinical practice.

## **Why should we standardise documentation within and across child and adolescent mental health services?**

- ▶ Accurate, comprehensive documentation is essential. It is important for a person in need of mental health care to receive a comprehensive clinical mental health assessment from a suitably qualified mental health professional and that this assessment is accurately documented.
- ▶ To communicate to others what they know about a child in order to facilitate care planning and delivery.
- ▶ To identify individual patterns or norms so that deviation from these is noted as soon as possible.
- ▶ To communicate to other service providers what still needs to be done.
- ▶ To illustrate how the general plan of care (interventions) has been tailored to the individual, so that care outcomes can be more closely evaluated.
- ▶ To protect themselves and their employers from threats of malpractice.
- ▶ To provide evidence that assists in determining patient acuity which can be used to determine staffing requirements.
- ▶ To help build and provide a retrievable database that can serve to study linkages between interventions and other variables and be used to help improve care.
- ▶ To adhere to the mandates of the National Standards for Mental Health Services and to meet the requirements of the New South Wales Strategic Plan, caring for mental health and to meet the requirements of regulatory bodies.

The process of clinical assessment is a critical component of good mental health care. Policy and standards formulated at both State and National levels pay particular attention to clinical assessment.

NSW Health's policy framework for mental health

In the NSW Health Department's policy framework for mental health *Caring for Mental Health: A Framework for Mental Health Care in NSW* states the following under *Strategy 4.1.1 – Mental health assessment*:

Comprehensive biopsychosocial and cultural assessment at the earliest stage of illness provides the basis for treatment and monitoring progress and ensures more accurate diagnosis. Systematic triage, assessment and measurement are essential for the development of an appropriate management plan. This should be done in collaboration with the individual child, family or carers and significant others where appropriate.

Assessment should determine the nature of problems, the diagnosis, contributing factors and strengths of the person/family and should be conducted by skilled clinical staff at the earliest and at all stages of illness.

This statement of the central role of comprehensive clinical assessment is supported by two key aims:

To ensure systematic and consistent triage and assessment are available to all those who present to mental health services.

To ensure that triage and assessment findings are documented and form the basis of the individual care plan.

Under *Strategy 4.1.3 – Discharge and follow up* the importance of communication between service providers is also emphasised. This is supported by two aims:

To ensure seamless and informed communication between all relevant parties when a child is discharged, with responsive and flexible follow up arrangements.

To improve the follow up of children experiencing their first episode of mental illness.

These aims form the clear basis for the Mental health Outcomes and Assessment Training initiative under which the data collection requirements detailed in this document have been developed.

The National Standards for Mental Health Services

The *National Standards for Mental Health Services* address the assessment process in some detail under *Standard 11 – Delivery of Care*, placing particular emphasis on communication and continuity of care between service settings. The most relevant criteria are reproduced below.

Standard 11.3 – Assessment and Review states that:

**Consumers and their carers should receive a comprehensive, timely and accurate assessment and regular reviews of progress.**

In relation to assessment at admission a number of specific criteria are given, however in respect of the requirements for data collection, the key is:

**11.3.5 The assessment process is comprehensive and, with the consumer's informed consent, includes the consumer's carers, other service providers, and other people nominated by the consumer.**

In the notes and examples following that criteria the standards indicate that this means that a:

Multidisciplinary assessment which includes physical social and psychological strengths, risks, family and functional components, relevant history (including previous treatments

such as medication, diagnosis and short term individual care plan) is conducted and recorded in a standardised format for the mental health service.

In relation to review during care two criteria are of particular relevance:

**11.3.17 All active consumers, whether voluntary or involuntary, are reviewed at least every three months.**

**11.3.18 A review of the consumer is additionally conducted when: the consumers declines treatment and support, the consumer requests a review, the consumer injures themselves or another person, the consumer receives involuntary treatment, there has been no contact between the consumer and the mental health service for three months, or the consumer is going to exit the mental health service.**

The issue of assessment is also addressed under Standard 11.4.E – Inpatient Care. Two criteria emphasise the importance of communication and continuity of care between service settings:

**11.4.E.4 The mental health service ensures that the admission assessment includes the views of other current service providers and the consumer’s carers.**

**11.4.E.5 The mental health service ensures that there is continuity of care between inpatient and community settings.**

**Standard 11.6 – Exit and Re–entry also indicates the need for assessment, communication and continuity of care. In particular:**

**11.6.1 Staff review the outcomes of treatment and support as well as ongoing follow–up arrangements for each consumer prior to their exit from the mental health service.**

These standards and policy decisions support clear communication between all those involved in a person’s care. They reinforce, that no matter how well an assessment may have been conducted, if it is poorly documented it will have less influence than it should on the quality of the care provided by others involved in the person’s care. The aim of good documentation is so that a clinician may go to the clinical record for any child or young person using a mental health service within NSW and know where to look for the information they need, with confidence and that it will have been obtained and recorded in an appropriate manner.

## Why should we use standard measures of outcomes and casemix?

Mental Health Services aim to provide **appropriate** and **effective** services to all those in need of such services. The New South Wales quality framework identifies the need for services to be delivered under six broad domains

As a consequence, we should constantly attempt to adopt best-practice models for all aspects of the provision of mental health services. We want the decisions about the kind of services we provide and the way in which they are provided to be based on these explicit criteria of quality. Whether that happens will depend on the extent to which we clearly understand –

- ▶ the needs of persons with mental illness
- ▶ the value for money gained delivered by the services provided
- ▶ the health and other outcomes attributable to those services.

In 1989 these questions were succinctly summarised by Leginski and his colleagues in the US Department of Health and Human Services as:

“Who receives what services from whom, at what cost and with what effect?”

Answers to these questions, in one form or another, are needed by Policy Makers, Service Administrators, Clinical Managers (team leaders and the like), and Clinicians.

The lack of reliable and timely information of this kind is one of the greatest obstacles to the effective planning, delivery and improvement of the services we provide.

In order to answer these questions at the service level we need to collect information in a standardised format. Collecting data in accordance with common standards has many advantages and some disadvantages.

The major advantage is that it enables us to speak a common language when we describe who receives care and what happens as a result. The ICD-10 - AM is a well developed example of a standardised language for describing health related problems.

By having a common language to describe symptoms, disability, types of care, and interventions we are more easily able to compare outcomes across different types of services, across different types of care or interventions, and across different groups of children. This ability to make meaningful comparisons is essential if we are to understand what interventions and service delivery mechanisms work best.



The disadvantage is that because we must use a predetermined set of categories to describe each person, some of the complexity and uniqueness of each individual's situation is lost. We could collect more detailed information about each person and the care they receive. However, we must balance this against the costs of doing so. The problem is that busy clinicians simply don't have the time to collect very much information. So therefore, what we do collect must be very useful.

MH-OATCA can be seen as the introduction of standard documents, or modules, based on local protocols which are used to document clinical activity at triage, admission, review and discharge. These clinical activities are also used to gather information to complete the standard measures of outcome and casemix as per the data collection protocol. This relationship can be conceptualised as per figure 1

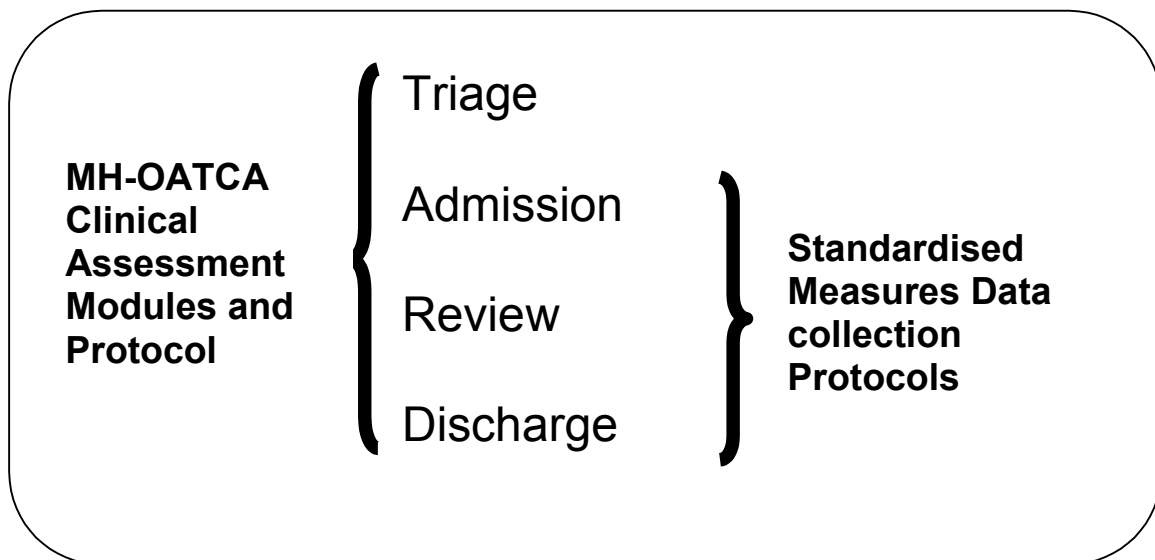


Figure 1 – MH-OAT

## **Core Readings**

NSW Health Department. (1998) *Caring for Mental Health: A Framework for Mental Health Care in NSW*. Sydney: NSW Health Department. [NOT INCLUDED IN RESOURCE SECTION]

Commonwealth Department of Health and Family Services. (1996) *National Standards for Mental Health Services*. Canberra: Commonwealth of Australia. [NOT INCLUDED IN RESOURCE SECTION]

## **Supplementary Readings**

Buckingham W, Burgess P, Solomon S, Pirkis J, and Eagar K. (1998) Developing a Casemix Classification for Mental Health Services. Volume 1: Main Report. Canberra: Commonwealth Department of Health and Family Services.

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New South Wales Health Department (2001) Data Collection and System Requirements for the Mental Health Outcomes & Assessment Training initiative (MH-OAT). Sydney: NSW Health Department.

Navuluri RB. (2001) Documentation: what, why, when, where, who, and how? *Research for Nursing Practice*, 3(1):9

## **† Suggested Activities**

List advantages for:

1. Children and Families
2. CAMHS

in improving documentation

## Triage & Telephone Contact

### Learning Outcomes

At the completion of this session participants will be able to-

- ▶ **Identify when triage information is to be collected**
- ▶ **Describe the essential components of triage**
- ▶ **Understand the role of triage within child and adolescent mental health services**

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### Facilitator Information

The objective of any triage system is to quickly sort the child or young person by priority of care at the time they present to the mental health service. Triage refers to the decision-making process that occurs when the alternatives for acute care are being considered. What factors contribute to the decision that acute inpatient care is the most appropriate choice? A biopsychosocial approach is called for to ensure all relevant aspects of the person's symptoms and current situation are considered.

The National Triage Scale of Australia and the Canadian Triage and Acuity Scale are 5-level rating systems, with levels ranging from 1 (resuscitation) to 5 (non urgent).

**The principle of any triage system is for the right person to be directed to the right place at the right time for the right reasons.**

Decision-making is based on the assessment of **Risk**, taking into account:

- ▶ historical factors,
- ▶ dispositional factors such as (specific symptoms of mental illness or child's capacity to control their cognition or behaviour)
- ▶ situational factors such as (adherence to treatment or opportunity for follow up in the community).
- ▶ for children risk assessment must involve assessment of risk and maltreatment, capacity of caretaker to protect and nurture the child and developmental implications.

This assessment should be completed at a face to face presentation to emergency departments, psychiatric inpatient units, community mental health services, hospital or community based ambulatory care services (acute), and overnight inpatient services (acute, non-acute).

## **Crisis and emergency responses**

When families experience crises these may impact on the mental health of children and adolescents. Appropriate and efficient responses are needed at such times to improve mental health outcomes for children, adolescents and their families. Specialist mental health support should be available for families affected by traumatic events or acute mental health problems.

- Several initiatives are being set up to provide assistance to children, adolescents and their families when they most need it. Examples of initiatives include:
- Southern and Wentworth Health Areas have piloted a 24-hour 1800 number staffed by skilled mental health professionals.
- Links between Child and Adolescent Mental Health Services and Physical Abuse and Neglect of Children (PANOC) teams have been established in several Areas.
- Central Coast have trialed the **Green Card** to provide emergency contact numbers to young people who have attempted suicide or display suicidal behaviour. Over 500 cards have been given out over 2 years with studies showing the cards have been successful in reducing suicide reattempts. The pilot is now being expanded in the New England Area.

The NSW Child and Adolescent Mental Health Training Program will provide Emergency Department workers with protocols for best practice in responding to the mental health needs of children and adolescents in times of crises.

Links are being strengthened between mental health services and telephone hot lines such as Kids Help Line, Lifeline and Child Protection and Family Crisis Service to ensure support and effective responses are available for children, adolescents and their families. [www.health.nsw.gov.au/health-public-affairs/publications/mentalstrategy/mentstrategyp3.html](http://www.health.nsw.gov.au/health-public-affairs/publications/mentalstrategy/mentstrategyp3.html)

Of course many of those dealing with child and adolescents will not themselves have received or triaged the presenting child. However, for those that do have consumers presenting at their services the following information taken and adapted from a Hunter AHS circular may be useful.

## **Some practical steps for the management of paediatric behavioural emergencies**

Children will often be brought to paediatric emergency departments as a result of disturbed behaviour with risk of harm to the child or others.

Behaviours will have most typically occurred in the home, and will consist of assaults on family members, threats with kitchen knives or other weapons readily at hand, and damage to property (eg kicking a hole in the wall). Most presentations will have arisen out of some interpersonal crisis such as discipline, or the frustration of wishes. Children may also self-harm. Any possible suicidal behaviour needs urgent evaluation. Common underlying mechanisms for this disturbed behaviour are as follows:

1. Exacerbation of a long standing disruptive behaviour disorder (such as *Conduct Disorder* or *Oppositional Defiant Disorder*)
2. Intoxication with alcohol or drugs
3. Disinhibited behaviour associated with mental retardation
4. Disinhibited behaviour associated with brain injury or other medical illness
5. Major mental illness such as psychosis or bipolar disorder
6. Behavioural disturbance related to trauma and abuse.

Aggressive behaviour may be a reaction to aggression directed to the child or adolescent, witnessing domestic violence and family disturbance.

## **Paediatric Emergency Department**

### **Nursing Staff Should:**

1. Room – Arrange for the child and accompanying persons to wait in a room where there is minimum equipment or other items that could be damaged or used to damage.
2. Assess whether accompanying persons are having a calming influence or aggravating influence on the child. If the latter is true tactfully suggest accompanying persons wait some distance from the child.
3. Make a judgment whether security staff should be present either with the child or close by.
4. Ensure that assessment by medical staff is given priority. There may be a temptation to put people on 'Hold'. Such a strategy may lead to an exacerbation of behaviour and increase risk to the child.
5. Ensure that whoever delivered the child to the hospital remains at the hospital until the child has been medically assessed and a management plan has been instituted.

### **Medical Staff Should:**

1. Perform screening examination particularly looking for signs of abuse, maltreatment, intoxication, neurological disorder.
2. Attend to the medical state of the child considering evidence for intoxication such as dysarthria, ataxia, apraxia, nystagmus, papillary changes, tachycardia, and elevated blood pressure. Look for evidence of injury to the child.

3. Obtain a history of the violent episodes paying attention to the degree of violence, aggravating factors and the context of the behaviour.
4. Obtain a history of past and recent treatment. If regular medication is prescribed, determine whether this has to be adhered to.
5. Ask whether the regular treating clinician has outlined a plan for such emergencies.
6. Discuss disposition with a paediatric consultant who may in some circumstances consult with the paediatric mental health worker (**Local contact protocols should be noted**)

## **Disposition**

In many circumstances the acute behavioural disturbances will have settled by the time that the young person has reached the hospital or has waited there for some time. A typical caregiver response will be “I am not leaving here until somebody does something”. If inpatient care is not required, (and it commonly won’t be) it is unwise to institute a new management plan. Families are better advised to contact their regular treating clinician on the next business day. A courtesy phone call from the paediatric emergency staff outlining the presentation to hospital can be helpful. If there is no regular treating clinician (uncommon) then the caregivers may be advised to call the age appropriate Child and Adolescent Mental Health Facility on the next business day. (**Again, be aware of local services**)

The child who continues to manifest aggressive and disruptive behaviour in the Paediatric Emergency Department may require:-

1. Admission to a children’s hospital or paediatric ward with an appropriate level of supervision and staff support.
2. Transfer to an adult mental health facility, after consultation with the paediatric mental health worker or on call psychiatrist.
3. On occasion police involvement may be necessary.

Physical restraint may be applied by security staff to prevent the child from harming himself or others. Pharmacological treatment might be initiated in a Paediatric Emergency Department *only under exceptional circumstances*. Be aware that if this treatment is initiated the hospital has by definition been committed to providing inpatient and monitoring the child.

## **Inpatient Management**

Children at risk of aggressive behaviour should be nursed close to the nursing station. The paediatric mental health worker should be informed about the child as soon as practicable. A paediatric mental health worker will if necessary obtain consultant psychiatric opinion regarding pharmacological treatment and management post discharge.

In the event of an unexpected aggressive episode medical staff should assess the child promptly, with specific reference to detecting evidence of delirium, (fluctuating consciousness, disorientation, perceptual disturbance, plus tachycardia, fever and other stigmata of intercurrent medical illness). If delirium is present the cause should be actively sought and treated.

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## **Y Suggested Activities**

### 1. Discussion Topics

- Is it possible to accurately assess a child or young person 's condition over the telephone?
- Can one determine which children should be seen in the emergency department or the office, and which children and their families can follow your advice for home treatment?
- Can telephone triage save time and money-if it's done effectively?

**Explain that the T1 module is for both telephone and face contact and that only relevant sections of the module need to be completed**

2. Work through the MH-OATCA (or locally adapted) module briefly describing the purpose of each domain. Refer to the Clinical Assessment Protocols in the resource section for further details. If required, refer to the MH-OAT (adult) Train the Trainer – Facilitator’s Manual for more specific detail.

Promote discussion around domains discussing the way in which they should be used.

Allow reasonable time to give participants the opportunity to express their concerns and support for the modules – record salient points for feedback through local MH-OAT coordinators.

## **Learning Outcomes**

On completion of this section it is anticipated that participants will be able to. . .

- **Identify the principles of a biopsychosocial assessment**
  - **Identify when assessment information is to be collected**
  - **Identify the components of a Mental Status Examination**
  - **Identify the essential components of a risk assessment with regard to child and adolescents**
  - **Describe the importance of social, family and developmental history as an essential component of a comprehensive assessment**
- 

## **Facilitator Information**

**Assessment can be defined as –**

- Gathering
- Classifying
- Categorising
- Analysing
- Documenting the child or young person’s information about health status.

Whilst assessment is an ongoing process, it is important to ensure the complexities of the child have been identified and documented in an initial assessment. This information is essential for clinicians to plan care and treatment and develop realistic goals with their patients.

The purpose of the psychiatric history is to gain knowledge about the presenting individual. This knowledge will assist with decisions about diagnosis, will increase the understanding of the factors that may influence symptoms or problems, and will help determine the most appropriate treatment and management plan.

Mental Health Assessment is a process of utilising skills to obtain information about an individual’s mental health through interview and acquiring information from other sources to create a picture. The skills and qualities crucial to conducting a comprehensive assessment include engagement, communication and respect.

When assessing a child for the first time, information needs to be gathered in order to answer the following questions –

- ▶ Does the individual have a mental health problem? If so what is the problem?
- ▶ What is the most suitable treatment for this individual?
- ▶ Are there any concurrent social or health problems that need urgent attention before psychiatric treatment commences?

## **Biopsychosocial model of assessment**

It includes a detailed history of the –

- ▶ presenting problem
- ▶ a history of any physical and mental problems, interventions, treatments, medications and response to interventions.
- ▶ Current and past family environment
- ▶ comprehensive, developmental, educational, and relationship histories are required, including significant stressors and an understanding of current social and cultural context.
- ▶ Temperamental and personality characteristics and usual coping mechanisms should be identified, and a detailed assessment of the child or young person's suicidal ideation, impulse control, aggression or violent behaviour.

In addition, a thorough mental health assessment would include a comprehensive biological assessment. A complete physical examination, with particular reference to the possibility of organic syndromes, is required.

The assessment aims to provide an understanding of the presenting problem, provisional and differential diagnoses. Further investigations and information gathering - gathering help to refine the diagnostic formulation.

A complete psychiatric assessment generally requires a psychiatrist, psychiatric registrar or suitably qualified mental health practitioner.

## **Biopsychosocial Assessment of Children and Adolescents**

Comprehensive mental health Assessment of Children and Adolescents should be based on an understanding of the child's developmental stage and developmental tasks.

Attainment of developmental milestones and socioemotional should be listed.

Information regarding the child's development may be obtained from several sources including the family, teacher, school counselor, or child care centre, general practitioner or paediatrician. Observation of the children during assessment and in other settings can provide valuable developmental information.

Assessment of Children and Adolescents should include a description of the child's family/social caretaking environment and its functioning. Mental health and well-being of

children is influenced by family and community context and assessment is aimed at identification of risk factors for the development of mental health problems. Risk factors include parental depression, anxiety and personality vulnerability, family conflict and domestic violence, family breakdown or loss of attachment relationships, coercive parenting practices and child maltreatment.

## **Mental Status Examination**

The mental status examination (MSE) is an integral tool for assessing objective data in the psychosocial assessment. It includes data about appearance and level of consciousness, motor status and behaviour, attitude, intellectual functioning, speech, cognitive status, mood and judgement. The mental state examination is one of the most important components of the clinical assessment in mental health services.

It is crucial that all clinicians, no matter what their discipline, are able to elicit the symptoms and signs of mental disorder on examination of the mental state and document them clearly and precisely using examples from what the child or adolescent actually said (in quotation marks).

By the time clinicians have completed the history and mental status examination, they have gathered probably more than 99% of the information necessary for a comprehensive assessment. Therefore, it is crucial that all mental health clinicians become proficient in performing and recording a mental state examination.

Even when the child or adolescent is mute, incoherent, or refusing to answer questions a wealth of information can be obtained through careful observation. The mental state examination is performed along recommended lines, just as the general medical examination is, employing a more- or- less structured interview. It should be completed on presentation/admission even if the child or adolescent is uncooperative.

## **Attitudes to Family**

Indications during conversation or play

## **Attitudes to School**

Does the child like school? Attitudes towards schoolwork, teachers and other staff, other pupils play and games

## **Fantasy Life**

The child's three magic wishes. The three most desired companions on an uninhabited island. What dreams are reported or made up? What is the worst thing – and the best thing that could happen to the child?

## **Placement Away From Home**

Has the child been placed or lived away from home at any time? If so, where, when, and for how long and what is the child's understanding of the reason for this? Reaction to the experience?

## **Other Problems**

Worries, pains, headaches, other somatic symptoms, relationship difficulties?

## **Play**

A general description should be provided of the child's play. What is played with and how? To what extent is play symbolic? Content of play? Concentration, distractibility, and constructiveness?

## **Self Image**

This has usually to be inferred from the sum total of what the child does and says, the ambitions and fantasy ideas expressed, and the child's estimate of what others think of him or her.

## **Appearance**

This section refers to the child or adolescent's appearance and overall physical status. Document posture, poise, clothing, and grooming. Observe for signs of poor nutrition, maltreatment and intoxication. Unusual dress may give clues to the diagnosis (eg. self-neglect may indicate underlying depression or dementia). Children or adolescents with schizophrenia may dress in a bizarre way, carrying numerous accessories or bags full of personal possessions. Loss of weight may indicate underlying anorexia or be secondary to depression. Note any extrapyramidal side effects.

## **Behaviour**

This section refers to the quantitative and qualitative aspects of the child or adolescent motor behaviour. Document abnormalities such as restlessness, wringing of hands, gestures and pacing. Note psychomotor retardation or agitation. Document abnormal movements as well as any aimless, purposeless activity.

## **Attitude Toward Assessor:**

Document the child or adolescent attitude toward the assessor. It could be described using adjectives such as cooperative, friendly, attentive, interested, frank, seductive, defensive, hostile or guarded. The level of rapport established should be documented.

## **Speech**

Although much of the assessment process focuses on the content of what child or adolescent says and experiences, the form of verbal expression and thinking are also important. This section refers to the child or adolescent's physical characteristics of speech including stuttering or accents. Document if the child or adolescent is talkative,

garrulous, responsive or lacking in spontaneity. Speech may be described as rapid, slow, pressured, hesitant, emotional, loud, whispered or mumbled. Is the speech slurred?

### **Mood**

Mood is defined as a pervasive and sustained emotion that colours the child or adolescent's perception of the world. Document the child or adolescent's mood as depressed, despairing, irritable, anxious, angry, euphoric, empty, guilty, frightened or perplexed. Mood may be labile, fluctuating or alternating rapidly between extremes.

### **Affect**

This section refers to the child or adolescent's present emotional expressiveness. Document if the child's affect is within normal range, labile, constricted, blunted or flat. It may be inappropriate or appropriate, depending on circumstances.

### **Thought (form and content)**

Document abnormalities of thought form such as circumstantiality, overinclusiveness, tangentiality, flight of ideas and loosening of associations. Describe pre-occupations or predominant themes. What does the child or adolescent talk about? Is he/she abnormally concerned about any topics such as bodily health, guilt, how people have treated them? Document main themes of conversation, evidence of delusions and obsessions, behaviour or thoughts.

### **Perception**

Major perceptual disturbances such as illusions and hallucinations are often associated with major functional illness or organic disturbances of brain function. Document any evidence of illusions or hallucinations eg. auditory, visual, olfactory. Visual or olfactory disturbances are more suggestive of organic disturbances.

### **Cognition**

Cognition refers to the mental process of appraisal, judgement, memory and reasoning. Cognitive function may be impaired in organic or functional mental disorders with deficits in one or more of the following areas: orientation, memory for recent events, learning of new information, attention and concentration, comprehension, calculation, the ability for abstract thinking and judgement. Each of these areas of function should be documented.

The child or adolescent who can give a clear and accurate history is unlikely to be cognitively impaired. Discrepancy between a child's previous level of functioning assessed from their educational and work record and their present performance at work or home should raise the suspicion of impairment.

The Mini Mental State Examination MMSE (Folstein et al. 1975) is the most widely used measure for assessing cognitive impairment.

## **Insight and Judgement**

Is the child or adolescent aware of their problems and, if so, to what do they attribute them? Are they aware of a need for assistance and are they motivated to accept this? Are their plans reasonable given their current presentation? To say insight is good or bad is meaningless on its own.

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## **Supplementary Readings**

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## Y Suggested Activities

To allow the participants to practise recording information in the A1 module, choose one of the case vignettes in the resource section (with accompanying video segments) and allow sufficient time for the participants to read it and watch the video. The vignette “Martin” describes a 14-year-old adolescent with mania, and the vignette “David” describes a 3½-year-old boy with autism. Select the vignette which, in your opinion, would be more familiar to your group of participants.

You may wish to spend several minutes to allow the participants to discuss the salient features of the chosen vignette, using the following questions as prompts:

### For the “Martin” vignette

- What are the important features of Martin’s current problem that you would need to record?
- From the brief video segment, can you describe the main features to be noted in his “Mental State Examination”? (You may wish to refer to the categories in Item 16 of the A1 modules.)
- Using the scale from 1 (low) to 4 (extreme), how would you rate his risks of suicide, self-harm, and harm to others? How vulnerable is he to exploitation or abuse using this numerical scale?
- What is your provisional diagnosis, based on the history and mental state examination? What else could the diagnosis be (i.e. differential diagnosis)?  
[Suggested responses: Provisional diagnosis – “Bipolar I Disorder, Single Manic Episode” (DSM-IV) or “Manic Episode” (ICD-10); Differential diagnosis – the list of possibilities may include “Substance-induced Mood Disorder”, “Mood disorder due to general medical condition (e.g. thyroid disease, degenerative brain disorder)”, and “Psychotic disorder”.]

### For the “David” vignette

- What are the important features of David, as described by Susan, that you would like to record in the “History of Current Problem”?
- What would you consider to be the relevant maternal history to record? What about paternal history?

- Using the scale from 1 (low) to 4 (extreme), how would you rate his risks of suicide, self-harm, and harm to others? How vulnerable is he to exploitation or abuse using this numerical scale?
- What is your provisional diagnosis, based on the history and mental state examination? What else could the diagnosis be (i.e. differential diagnosis)?  
*[Suggested responses: Provisional diagnosis – “Autistic Disorder” (DSM-IV) or “Childhood Autism” (ICD-10); Differential diagnosis – possibilities may include “Mental Retardation” and “Expressive Language Disorder”.]*

After a brief discussion of the above, ask the participants to attempt to complete the blank A1 module provided. The purpose of this exercise is to give them an opportunity to practise their documentation and to become more familiar with the format of the module. Remind them that, in real life situations, they would have more information available to them, and more time to observe the child or young person’s mental state. The vignettes clearly do not provide sufficient information for them to fill in the whole module, so they may leave certain items blank or incomplete.

## **Learning Outcomes**

At the completion of this session participants will be able to:

- › **Recognise the importance of collecting and documenting information based on the physical examination of the child or young person**

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## **Facilitator Information**

The Physical Examination module is a two-page module for recording physical state findings. Undertaking a biopsychosocial assessment includes collecting information on the biological presentation of the individual. It is therefore important to understand why obtaining this information is essential.

As a basic aspect of the diagnostic process, the appraisal of the physical states of the child includes an evaluation of data both from the medical history and from the general physical examination and special studies. Although often the physical studies have already been done when the child is referred for mental health diagnosis, the child mental health worker must be concerned with the adequacy, interpretation and integration of these previous studies. He/she must decide whether further studies would be helpful or in some instances even of crucial importance. This is especially true when physicians who over emphasise emotional factors refer children without having carefully assessed the child's somatic status. When children are referred from non-medical sources, it is the responsibility of the child psychiatrist to plan for reliable physical examination.

## **Signs of Maltreatment**

The following (adapted) extract (Wisslow) highlights signs and symptoms that should arouse concern about child abuse or neglect (see full article in Resource section)

### **Subnormal Growth**

Weight, height or both less than the 5<sup>th</sup> percentile for age

### **Head Injuries**

Torn lip or unexplained dental injury

Bilateral black eyes with history of single blow or fall

Traumatic hair loss

Retinal haemorrhage

### **Skin Injuries**

Bruise or burn in shape of an object

Bite marks

Burn resembling a glove or stocking or with some other distribution suggestive of an immersion injury

Bruises of various colours (in various stages of healing)

Injuries to soft-tissues areas that are normally protected (thighs, stomach or upper arms)

**Injuries of the gastrointestinal or genitourinary tract** – needs full assessment

**Bone injuries** – unexplained or unusual fractures

### **Significance of maltreatment**

The following taken from the (Council on Scientific Affairs American Medical Association) highlights some of the consequences of maltreatment

Although the incidence of death and serious physical injury as an immediate and direct result of maltreatment is lower for adolescents than for younger children, long-term consequences of maltreatment pose serious threats to their health and psychological development. Research addressing the long-term consequences of maltreatment has been correlational, and firm conclusions about the precise relationship between abuse and risk behaviours are impossible. Few studies have separated the effects of maltreatment on later risk behaviours from the influence of living in a dysfunctional family that is not abusive. Despite these research limitations, however, the magnitude of health problems experienced by adolescent victims of maltreatment is daunting.

Health consequences associated with a history of sexual abuse for adolescents include premature or increased sexual activity, increased risk of unintended pregnancy, depression, increased attempts at suicide, chronic anxiety and feelings of vulnerability or powerlessness, confused sexual identity, alcohol and other drug abuse, and delinquency. Similarly, adolescent victims of physical abuse have been reported to show generalized anxiety, depression, extreme adjustment and acting-out problems, academic difficulties, sleeping problems, increased drug use, self-destructive or reckless behaviors, suicidal ideation, and suicidal actions. Physical abuse of youth is also associated with violence by adolescents against both siblings and parents. Studies of abused youths also report an increased incidence of eating disorders and emotional problems, such as difficulty controlling anger or increased aggression.

Adolescents who are incarcerated, homeless or runaway, involved in drug abuse, or who have had a pregnancy during early adolescence are more likely to have a history of either physical or sexual abuse than are other youths. In one study of runaway youths from eight states, 28% of the youths coming to the shelter reported that they had been abused prior to running away, and more than two thirds of these reported being abused more than five times. Another study reported that 38% of males and 73% of females ran away from home to avoid further sexual abuse.

Some adolescent responses to abuse, such as running away, increase the at risk of additional abuse or assault or lead to problems that are only indirectly related to abuse (eg, prostitution). A particular concern is the risk of acquiring human immunodeficiency virus infection. Clinical populations of abused males have been found to have higher rates of human immunodeficiency virus infection than comparable groups of nonabused males (Council on Scientific Affairs American Medical Association)

Child maltreatment and abuse occurring within the first three months of life during periods of rapid brain growth and organisation has significant adverse effects on development. Early development is affected by neglect (the absence of crucial organizing experiences) and if severe will damage cognitive and psychological potential. Trauma and abuse in early childhood will produce ongoing difficulties with stress management and affect regulation difficulties in interpersonal relatedness and vulnerability to a range of mental health problems. Children experiencing maltreatment are frequently exposed to family conflict and domestic violence which are also damaging to development.

Children experiencing trauma and maltreatment may present with hierarchical disruption, over activity, sleep disturbance, withdrawal or depression. Comprehensive assessment should always consider the possibility of child maltreatment and examine family risk factors.

## **Core Reading(s)**

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## **Y Suggested Activities**

1. Work through the MH-OATCA (or locally adapted) module briefly describing the purpose of each domain. Refer to the Clinical Assessment Protocols in the resource section for further details. If required, refer to the MH-OAT (adult) Train the Trainer – Facilitator’s Manual for more specific detail.

Promote discussion around domains discussing the way in which they should be used.

Allowing reasonable time give participants the opportunity to express their concerns and support for the modules – record salient points for feedback through local MH-OAT coordinators.

## **Learning Outcomes**

At the completion of this session participants will be able to:

- **Identify when a care plan is to be completed**
- **Describe the essential components of a care plan including:**
  - **The assessment of need**
  - **Establishing collaborative working relationships**
  - **Negotiation**
  - **Review issues**

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## **Facilitator Information**

A care plan is an integrated plan covering medium term goals and developed with input from the child or young person, family, appropriately qualified mental health practitioners, paediatricians GPs and other agencies (domain 7 of the C1-CA module). The aim of the plan is to move beyond the problem identification to a model that builds on strengths and develops capacities to enhance problem solving (Rapp, 1998, Mental Health Strategies). If the child is unable to participate in the collaboration process, the plan is developed with the key care partners and care coordinators.

Care planning is a collaborative process involving the child, their family and the mental health worker/s.

### **Care plans should –**

- Be comprehensive and realistic
- Ascertain the persons long term goals
- Allow time to contemplate decisions
- Should clearly define the goals and outcomes and the methods to achieve them
- Delineate the responsibilities of interdisciplinary team members
- Incorporate the child or young person's education
- Ensure appropriate referrals to ensure continuity of care
- Build on existing strengths

Assessment data is used to inform planning and goal setting. To begin the planning process treatment goals are established by the family based on problem areas identified in assessment.

The interdisciplinary care plan model is the most appropriate means of ensuring that child receives consistent information and integrated care. The terms multidisciplinary and interdisciplinary are used interchangeably at times. However, there is a very important distinction that is critical to the outcome of treatment and to the understanding of the philosophical basis of interdisciplinary care planning. The interdisciplinary model necessitates collaboration and negotiation by team members and is the most appropriate means of ensuring that child receives consistent information and integrated care.



## **Core Reading(s)**

David Goldberg, Percy Aggett (1998), On the Engagement of Adolescents and their Families, *Clinical Child Psychology and Psychiatry Vol3(2)* pp 183-197

## **Supplementary Readings**

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Hersen, Michel (Ed). (1989). **Innovations in child behavior therapy.** [Edited Book] New York, NY, US: Springer Publishing Co, Inc. xiii, 434pp.

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**Summary of the Practice Parameters for the Assessment and Treatment of Children and Adolescents Who are Sexually Abusive of Others (2000).** *Journal of the American Academy of Child & Adolescent Psychiatry.* Vol 39(1), 127-130. Williams & Wilkins Co., US

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## **Y Suggested Activities**

1. Work through the MH-OATCA (or locally adapted) module briefly describing the purpose of each domain. Refer to the Clinical Assessment Protocols in the resource section for further details. If required, refer to the MH-OAT (adult) Train the Trainer – Facilitator’s Manual for more specific detail.

Promote discussion around domains discussing the way in which they should be used.

Allowing reasonable time give participants the opportunity to express their concerns and support for the modules – record salient points for feedback through local MH-OAT

2. Discuss the strengths and difficulties in the involvement of family in care planning

## **Learning Outcomes**

At the completion of this session participants will be able to:

- ▶ **Identify principles of review**
  - ▶ **Identify when reviews are to be undertaken**
  - ▶ **Describe the essential components of review**
  - ▶ **Describe relationship between review and outcome measurement**
- 

## **Facilitator Information**

Why undertake a review?

- ▶ To ensure current plan success
- ▶ To determine directions
- ▶ To evaluate other interventions and plans and assess why they did or didn't achieve the desired outcomes

**Review is a continuous process**

## **The MH-OATCA Review Modules**

### **R1-CA - Supplementary Assessment And Plan**

#### **Purpose**

This module is a two page document designed to encompass management issues relating to current admissions to acute psychiatric units and is to be completed *during ward rounds, case conference or following individual consultations with medical/ nursing/ allied health as supplementary assessments*. It can also be used as a supplementary assessment in the community.

### **R2-CA - Management And Outcome Review**

#### **Purpose**

The R2-CA module is primarily used for major management and outcome reviews where a sufficient interval has occurred within the same period of care, namely the three monthly or 35 day reviews or any other major review of the child. The module consists of three main sections including brief assessment, treatment review, and outcome review.

People are always changing, as are the circumstances in which they find themselves. The problems that were originally identified may be resolved or they may have escalated, creating new problems. As these problems change, the interventions that were initially felt appropriate need to be reviewed. This review is an evaluation of activities that requires a new assessment of the child's presenting problems. This should be done in an interdisciplinary team setting.

The process of review should reflect the relationship between the problems and **strengths** of the child and the interventions that have been instituted. The emphasis should be on the assessment of the **current situation**, not on the proposed plan. This requires the periodical reconsideration of the presentation of the child or young person

This process of review or evaluation should show

- ▶ If the child or young person's needs have been met
- ▶ If progress has been made in altering the presenting problems of the child
- ▶ If the child or young person's condition has deteriorated
- ▶ If the child or young person has developed strengths in coping/managing current difficulties.

The above should also be applicable to the family

It has been stated that the mental health worker should always assume that a treatment is ineffective unless there is evidence to the contrary.

**Reviews should be conducted by an interdisciplinary team where possible. They should focus on the strengths identified by the child or young person and team members to assist in care planning, review and discharge from service.**

In community services and overnight inpatient services the management review should be completed as part of a supplementary assessment or as a review of current management plan.

In an acute inpatient unit, the supplementary assessments and review should ideally occur within the first three days of admission.

### **Why a Management review?**

- ▶ Change in the nature of the care provided (eg, significant increase in the frequency of contact in response to a crisis)
- ▶ Admission into the current service unit following transfer from another service unit providing ambulatory mental health care within the same mental health service

- ▶ Occurrence of a critical incident in which the child injures them self or another person
- ▶ On the child or young person's request
- ▶ Admission into a particular ward following transfer from another ward within the same psychiatric facility
- ▶ Statistical change in the type of care (Acute, Non-acute) at any time other than the 35<sup>th</sup> day following admission
- ▶ Change in the nature of the care provided (eg, placement of the child under close observation for an extended period)

## **Core Reading(s)**

Commonwealth Department of Health and Family Services. (1996) *National Standards for Mental Health Services*. Canberra: Commonwealth of Australia. [NOT INCLUDED IN RESOURCE SECTION]

## **Supplementary Readings**

Eels, TD. Kendjelic Em. Lucas. CP. (1998) What's in a case formulation? Development and use of a content coding manual. *Journal of Psychotherapy Practice and Research*. 7 (2):144-53,

Maden, A. (1996) Risk assessment in psychiatry. *British Journal of Hospital Medicine*. 56(2-3):78-82,.

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Simon GE. VonKorff M. (1995) Recall of Psychiatric History in Cross-Sectional Surveys: Implications for Epidemiologic Research. *Epidemiologic Reviews*. 17(1):221-7,.

Verhulst J. Tucker G. (1995) Medical and narrative approaches in psychiatry. *Psychiatric Services*. 46(5):513-4,.

## **Y Suggested Activities**

1. Discuss the differences between the R1-CA and R2\_CA modules
2. Work through the MH-OATCA (or locally adapted) module briefly describing the purpose of each domain. Refer to the Clinical Assessment Protocols in the resource section for further details. If required, refer to the MH-OAT (adult) Train the Trainer – Facilitator's Manual for more specific detail.

Promote discussion around domains discussing the way in which they should be used.

Allow reasonable time to give participants the opportunity to express their concerns and support for the modules – record salient points for feedback through local MH-OAT coordinators.

## **Learning Outcomes**

At the completion of this session participants will be able to:

- ▶ **Describe the principles of discharge planning**
  - ▶ **Identify the essential information to be documented on discharge**
  - ▶ **Identify risks during the discharge process**
- 

## **Facilitator Information**

NSW Health is committed to ensuring effective discharge through shared management by Hospitals, GP's and community service providers in the transfer of care of patients between hospitals and the community. Effective discharge involves the use of approaches including clinical pathways and care co-ordination, chronic disease management programs and the provision of post-acute services, together with access to required community support service to meet the health and personal needs of the child or young person.

Effective discharge places the child at the centre of the discharge process. It promotes continuity of care through adequate information and communication flow between the child or young person, family and service providers to ensure optimum health outcomes for the child.

Discharge prepares the child or young person for –

- ▶ Re-socialisation and reintegration into the community
- ▶ minimises the occurrence of relapse or re-hospitalisation by ensuring the availability and accessibility of community resources for the child and their family.

The development of a discharge plan is an essential step in ensuring effective discharge planning. A discharge plan is essential in :

- ▶ Identifying post-discharge needs of the child or young person particularly children who are likely to have intensive needs;
- ▶ Communicating with the person, family and carers about the discharge date, expected outcomes and availability of relevant community services;
- ▶ Ensuring that the potential needs of the person upon discharge can be met through consultation and communication with the general practitioner, other community service providers and staff from community residential mental health care.

- ▶ Discharge or closure from community care requires identification of needs and planning to ensure continued recovery and should also begin on admission and include an interdisciplinary approach.

The information to be collected on discharge falls into three main categories

- ▶ Information about the course of the admission
- ▶ Risks to successful integration into the community
- ▶ Ongoing community support

This should, by necessity, include involvement of the school in relation to a child's re-integration by looking at things such as a reduction in hours or support

**Discharge planning should be identified in terms of need for:**

- A) the child or young person**
- B) the family's perception of needs and their capacity to respond to the child's needs and their own**



## **Core Reading(s)**

Lyons, John S; Uziel-Miller, Nina D; Reyes, Frank; Sokol, Patricia T. (2000) Strengths of children and adolescents in residential settings: Prevalence and associations with psychopathology and discharge placement. *Journal of the American Academy of Child & Adolescent Psychiatry*. Vol 39(2), 176-181. Williams & Wilkins Co., US

## **Supplementary Readings**

Frank, Susan J; Paul, Jennifer S; Marks, Melissa; Van Egeren, Laurie A. (2000) Initial validation of the Functional Impairment Scale for Children and Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. Vol 39(10), 1300-1308. Williams & Wilkins Co, US

Hasle, N. J. (1997) Children and adolescents under 18 years of age admitted to a psychiatric department for adults. *Ugeskrift for Laeger*. Vol 159(30), 4649-4653. Unknown Publisher, US

Stout, Chris E. Child and adolescent issues in transition. (1993). [Chapter] Ruben, Douglas H. (Ed); Stout, Chris E. (Ed). *Transitions: Handbook of managed care for inpatient to outpatient treatment*. (pp. 59-71). Westport, CT, US: Praeger Publishers/Greenwood Publishing Group, Inc. ix, 172pp.

Ruben, Douglas H. (Ed); Stout, Chris E. (Ed). (1993). *Transitions: Handbook of managed care for inpatient to outpatient treatment*. [Edited Book] Westport, CT, US: Praeger Publishers/Greenwood Publishing Group, Inc. ix, 172pp.

Dalton, Richard; Forman, Marc A; Daul, George C; Bolding, Dorothy. (1988) Psychiatric hospitalization of preschool children: Admission factors and discharge implications. *Annual Progress in Child Psychiatry & Child Development*, 430-440. Brunner/Mazel Inc,

## **Y Suggested Activities**

3. Work through the MH-OATCA (or locally adapted) module briefly describing the purpose of each domain. Refer to the Clinical Assessment Protocols in the resource section for further details. If required, refer to the MH-OAT (adult) Train the Trainer – Facilitator’s Manual for more specific detail.

Promote discussion around domains discussing the way in which they should be used.

Allowing reasonable time give participants the opportunity to express their concerns and support for the modules – record salient points for feedback through local MH-OAT coordinators.

# Overview and background to the collection of Standardised Measures

## Learning Outcomes

At the completion of this session, participants should be able to

- Describe what data is collected and what will be done with it
- The rationale for the collection of standardised measures

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## Facilitator Information

Note: This section is a discussion of the data to be collected as part of the Mental Health Outcomes and Assessment Data Collection (MH-OAT) – see Circular 2001/35.

### **What data to collect**

#### **Data is collected at three occasions during care:**

- Admission to and Discharge from the three principal mental health service settings  
Review during extended episodes of care in any of those settings

Variations in the data to be collected are mostly based on the Age group of the person

**HoNOSCA:** The HoNOSCA is a 15-item clinical rating scale covering the person's symptoms, disability and their environment. It was developed by the Royal College of Psychiatrists specifically to measure outcomes in mental health services. It is comprehensive and clinically relevant, yet brief.

**CGAS:** The Children's Global Assessment Scale is a single 100 point clinical rating scale. It is used to provide a global measure of severity of disturbance in children and adolescents.

**FIHS:** The Factors Influencing Health Status scale is a 7-item checklist of psychosocial complications based on the Chapter of the ICD-10 which identifies a large range of factors influencing health status and contact with health services. The items cover maltreatment, negative life events in childhood, upbringing, family circumstances, the social environment, and various other psychosocial circumstances.

**SDQ:** The extended version of the Strengths and Difficulties Questionnaire (SDQ) has been recommended as a consumer rated measure in Children and Adolescents. The extended version of the SDQ is a questionnaire used to assess the psychological adjustment of children and youths plus a brief impact supplement to enquire about

overall distress, social impairment, burden and chronicity. Identical or near identical versions can also be completed by Parents for 4-10 year olds and 11-18 year olds.

## **Recording the data**

The Data is collected using set designed modules for Standardised measures and Individual data items and six versions for the SDQ. Note that the Standardised measures can be categorised into two groups, clinician-rated measures and consumer self-report measures.

## **What is done with the data you collect?**

The submission of data to the NSW Health and then to the Commonwealth Health Department will inform the local use of the data (by enabling comparison of similar services and the provision of benchmarks) as well as being used in policy development and program evaluation.

## **Background**

### **Why is the data being collected**

**The data collected will enable reasonably comprehensive answers to the key questions regarding “Who receives services” and “With what effect”, and that some of the information collected will also enable a reasonable description of “What services” have been provided.**

**“Who receives”:** Combining basic demographic information (Age group) and clinical classification (principal and additional diagnoses) with more detailed clinical information (HoNOS profile at Admission or Review) will enable a quite comprehensive description of the likely needs for care of the persons who are in contact with the service.

**“What services”:** Three individual data items – Mental health service setting, Focus of care, and Mental health legal status – provide a broad description of the kind of care being provided. By combining that information with data about length of stay in Inpatient settings and frequency of contact in Ambulatory settings a relatively complete description of the general type and intensity of care provided can be derived.

**“With what effect”:** Comparison of rating on the Standardised measures from one Collection occasion to the next will enable us to describe the outcomes of care.

Emphasise that the interpretation of data about outcomes will be made in the context of information about “Who receives what services”. We all understand that different outcomes are expected for different persons, depending on the nature, severity and chronicity of their problems. This is the reason why we say that the data will be used for both outcomes evaluation and casemix classification. The casemix classification enables us to compare like with like.

## Why do we need to measure outcomes?

### Policy context

The introduction of outcome measures for consumers of public mental health services is an essential component of current mental health policy at both National and State levels. The requirement for the routine collection of data on consumer outcome is clearly identified in the *National Standards for Mental Health Services*, the NSW mental health policy, *Caring for Mental Health*, and in the Commonwealth's *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003 (First Edition June 1999)*, which is agreed by all States and Territories.

Fundamentally the goal of outcomes measurement is to support decision making to produce the best result for consumers. Traditionally, this decision making has relied on 'proxy measures' with the inputs (staffing levels) and the processes (length of stay and occasions of service) equated to the outcome of service provision for the consumer. For example, the severity of the consumers' condition has been equated to the level of service use. Greater users of services are assumed to have much more complex conditions. Use of services is assumed to result in cure of conditions and mortality or frequent relapse is seen as a result of service failure. Although relatively easy to collect, these proxy indicators do not reflect the complex activity of mental health care and the array of outcomes achieved through service delivery.

Health professionals, as the 'experts', have traditionally undertaken the assessment of change or outcome in health status as part of routine clinical practice. Collecting information and making clinical decisions about who is better and who is not. However, this approach to measuring outcome has some inherent limitations.

Firstly, it is well recognised that clinical judgements can vary depending on the level of training and experience of the clinician. Therefore using clinical judgements to measure outcome can be quite unstable.

Second, unless there are shared and agreed criteria for assessing outcomes it makes it impossible to make comparisons. How do you compare an apple with an orange? With agreement on a standard way of measuring outcomes meaningful comparisons between consumers at different points in time, comparison between different groups of consumers and the effects of various interventions can be undertaken.

Third, it is only relatively recently that the consumers view has been considered in service provision and development. Although competent clinicians will rely on the views of consumers in regards to how they feel, or the outcome of intervention from the consumers perspective, there has been no standard or routine way that that information on this perspective can be shared and compared.

Finally, information is required to monitor and manage a mental health service. As we have seen, the information collected by mental health services must answer five questions. “Who receives what services from whom, at what cost, and with what effect?” Leginski et al (1989). Outcome measurement addresses the fifth of these questions.

## **Selection of Measures**

Consumers of mental health services are unique and their problems are often complex. A major research program was begun under the First National Mental Health Strategy that aimed to identify direct consumer outcome measures that were both: useful in routine clinical practice in monitoring the progress of individual children; and suitable for monitoring outcomes at a broader service level

The results of that research are reported in two documents you can access on the web:

- The Measurement of Consumer outcome in Mental Health: A report to the National Mental Health Information Strategy Committee.
- Measuring Consumer outcomes in Mental Health: Field testing of selected measures of consumer outcomes in mental health and Consumer measurement systems for Child and Adolescent Mental Health

The selected measures were chosen because:

- They cover the three critical dimensions of the concept of outcomes: clinical severity, disability and consumer self-rating.
- Of the measures trialed in Australia, they represent the most acceptable to clinicians and consumers across a broad range of treatment settings.
- A number of major studies have taken place in Australia that provide substantial normative data.
- The HoNOS and the Life Skills Profile serve a purpose beyond outcome measurement and have been shown to be useful in the development of mental health casemix classifications
- To achieve the collection of consistent data across the state and the nation a limited number of core instruments need to be identified

## **Use of casemix classification**

Each child or young person treated in the mental health sector is unique and it is fundamental to high quality care that this uniqueness is recognised. However, given this variation it is helpful to classify patients into groups. There are three important reasons why the concept of classification is important to the mental health sector. The first is that the mental health sector is so complex. We deal with so much information that we

need to organise it in a coherent and logical way. The second is because what the mental health sector does is important, it is critical to be able to measure need, monitor changes over time. And finally, because the mental health sector is so diverse, measurement tools are required which help to understand this diversity.

There are two principle sources of this diversity:

- Variation due to differences in the way that Mental Health Services are provided. Different interventions or services are provided with differing quality, and produce different outcomes.
- Variation due to differences in the kinds of consumers receiving services. Different consumers use different amounts of resources and achieve different outcomes from the same intervention.

Traditionally, efforts to measure the quality or the outcomes of the mental health sector have run into trouble because they have failed to come to terms with this variation in the types of consumers receiving services. The word "casemix" means exactly what it says – it is the mix of cases that are receiving support from a service. Casemix classification provides a standardised method for describing the activities of health services in terms of the types of persons treated, the type of care provided and the associated resource use. A casemix classification provides a method of controlling for variations in consumers so that variations in outcomes associated with different types of care and methods of service provision can be revealed. This can then help to identify best practice.

## **Core Reading**

Commonwealth Department of Health and Aged Care. (1999) Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003 (First Edition June 1999). Canberra: Commonwealth of Australia. **[NOT INCLUDED IN RESOURCE SECTION]**

New South Wales Health Department (2001) Data Collection and System Requirements for the Mental Health Outcomes & Assessment Training initiative (MH-OAT). Sydney: NSW Health Department. **[NOT INCLUDED IN RESOURCE SECTION]**

# Data Collection Protocol

## Learning Outcomes

At the completion of this session, participants should be able to

- › Describe the principles underlying the data collection protocol
- › Identify the measures to be completed within specific service settings
- › Identify the triggers for data collection

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## Facilitator Information

Note: This section is a discussion of the data collection protocol and not the clinical assessment module and protocols.

A comprehensive data collection protocol must specify

**what** data is to be collected,  
**when** it is to be collected, and  
**who** is to take responsibility for its collection.

### **What data to collect**

In order to answer the question “who receives what services from whom with what effect and at what cost”, we must first accurately describe the demographic and clinical characteristics of the consumers of mental health services. The demographic information to be collected includes the data items of the National Minimum Data Set – Mental Health. This includes sociodemographic information such as the age, country of birth and marital status of the consumer. The National Minimum Data Set- Mental Health also includes service and administrative data such as the pension status of the consumer, the source of referral and the number of service contacts in the community. The National Minimum Data set also includes clinical information such as the principle diagnosis of the consumer. However in mental health, diagnosis alone does not always describe the clinical variation in the health status of the consumer. Other information that indicates the clinical severity of the problems confronting the consumer along with information on the degree of disability (the level of functioning) the consumer experiences adds value to the description of the consumer of mental health services. This clinical information can not only be used to describe the health status of the consumer at a particular point in time, but can be collected on different occasions to demonstrate change over time as a result of an intervention.

The data collection protocol therefore outlines not only demographic information but also complex clinical information about the presentation of the consumer which is more than simply their diagnosis.

## **When to collect data**

The data collection protocol must take the requirements of clinical assessment and care into consideration because the data required for both outcomes evaluation and casemix classification is best derived from information ascertained by clinical staff in the normal course of a comprehensive clinical assessment. Clinical assessment takes place throughout the process of care, however those conducted when a person is first admitted, at critical intervals during their care, and during the process of planning for their discharge from an episode are conducted in depth and formally documented in the clinical record.

Casemix classification requires the identification of the principal reasons for the child or young person's utilisation of services during the episode or period of care. The resulting classifications generally group child or young person on the basis of the nature and severity of their clinical status *during* the episode or period in question.

The evaluation of the outcomes of care requires a comparison of child or young person's clinical status before and after the provision of that care. Also, because care may sometimes be required over many months or even years, the assessment of outcomes may also require the consideration of the child or young person's clinical status at regular intervals during care. The protocols for routine evaluation of outcomes should therefore be based around the recurrent assessment of the person's clinical status at clearly defined clinically relevant transition points - admission, review, and discharge.

These key occasions – Admission, Review and Discharge – when data is to be collected are referred to in the data collection protocol as a **Collection Occasion**.

In specifying the standard data collection we must take into consideration a number of practical factors.

First the protocol must allow the data to be collected in a recurring pattern that is both clinically meaningful and statistically coherent. There is no point in collecting the data if we can't relate the information to the process of service provision. Similarly, all individual service providers and services need to collect the data using the same standard procedure in order for the data to be aggregated together for statistical purposes.

Second, there is wide variation in the way in which mental health services are organised. For example: some services have separate extended hours or acute care teams, others do not; some services have highly centralised intake procedures, others do not; and some services are based around general hospital psychiatric inpatient units, others are not.



These variations in service structure influence the clinical pathways the child is likely to follow through the service. Thus the data collection protocol must be defined in such a way as to accommodate such variations in service structure and also fit in with clinical practice.

Finally, the protocol should be defined in a way that helps avoid duplication of effort or excessive demands on clinicians or consumers.

## **The basic data collection protocol**

There are three factors determining the data collection protocol. First is the age of the child (in this case an adolescent between less than 18 years of age); Second, the Mental health service setting in which care is provided to the child (Inpatient, Community Residential and Ambulatory Care; Third is the Collection Occasion – that is whether the child is being admitted, reviewed or discharged.

### **1. Age group**

Three different age groups are identified and there are some variations in the protocol across the three age groups. The three age groups are:

**Child and Adolescents** (0-17 years)

**Adults** (18-64 years)

**Older Adults** (65+ years)

Some differences in the Standardised measures to be collected at any Collection occasion depend on the person's **Age group**. For Older adults, the HoNOS 65+ rather than the HoNOS is collected together with an additional measure, the RUG-ADL. For Children and Adolescents, a different set of measures – the HoNOSCA, CGAS, FIHS and SDQ – are collected.

### **2. Service Setting**

Three different Mental health service settings are identified and there are some variations in the protocol across the three settings. The settings are:

**Inpatient psychiatric care:** Includes care provided to persons admitted overnight or longer at a public psychiatric facility or a designated psychiatric unit in a public hospital. Note that care provided on a day-patient or outpatient basis is defined as Ambulatory care.

**Community-residential mental health care:** Includes care in a staffed residential unit (24-hour or less) established in a community setting which provides specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Psychogeriatric hostels and psychogeriatric nursing homes are included in this

category. This category does not include group homes where specialist mental health staff only visit as required.

**Ambulatory mental health care:** Includes non-admitted, non-residential care such as mental health day programs and psychiatric outpatients provided by either hospital or community-based services. Care provided by community workers to children or young people in staffed community residential settings is included under this setting. For the purposes of mental health outcomes and casemix data collection, same-day admitted non-procedural (eg, not ECT) care and care provided by hospital-based consultation-liaison services to admitted children or young people in non-psychiatric and hospital emergency settings is also included under this setting.

For the purposes of the data collection protocol, **a person may only be the subject of care in one Mental health service setting at any given point in time.** Where a person is being treated in two settings simultaneously the following order of precedence applies: Inpatient, Community residential, Ambulatory.

The principal reason for these restrictive rules is to enable all Mental Health Services to collect data under a common data collection protocol. If the protocol was to be based on the care provided by individual service units or teams then the variations in the resulting information would make it very difficult to compare the care provided by different Services. The main problem is that the organisation of Mental Health Services into distinct Service Units is inherently local in character, being based on local clinical needs, availability of staff, and many other current and past factors which have contributed to the Mental Health Service's existing structure. Therefore, the standard local data collection protocol must be based on Mental health service settings.

### 3. Reason for collection

The **Reason for collection** identifies whether the data is being collected at Admission, Review or Discharge and, within each of those occasions, which special circumstances apply that might change whether or not either the clinician-rated measures or the self-report measure should be collected. These variations will be discussed in greater detail in the MH-OAT facilitators manual for adults.

**Admission** takes place when a child or young person is admitted into the care of an identified Service Unit within one of the above *Mental health service settings*, either as a result of new referral from outside the Mental health service or as a result of having been transferred from another setting within the Service.

**Discharge** takes place either when the person is fully discharged from the Mental health service or when they are transferred into the care of a Service Unit in a different *Mental health service setting*.

Except under certain specified circumstances, the transfer of the person between Service Units within the same *Mental health service setting* and Mental Health Service does not require Discharge from one and admission to the other Service unit.

**Reviews** are scheduled to take place every 13 weeks. An exception occurs during acute Inpatient care, when the first Review should be completed at 35 days following Admission.

## **Modules For Data Collection**

There is a standard module (SM2 – Standardised Measures Module 2 – Children & Adolescents) for the collection of the clinician-rated measures and the additional information to be collected at the collection occasion (see section on the SM2 Module). This module automatically assigns the child to the Child & Adolescent age group (< 18 years of age).

There are six versions of the standard module to collect self-report measures in children and adolescents. This includes four versions for parents – one for parents of children aged 4-10 years and one for parents of children aged 11-17 years – to complete on initial contact and follow up and two self report versions for youths aged 11-17 years – see section on SDQ.

## **Who Takes Responsibility For Data Collection?**

This is not a simple question to answer. As with the clinical assessment protocol and modules, there is a need for local determination of the responsible clinician. In relation to the data collection protocol and completion of the SM2 Module and offering the SDQ, the most obvious choice is that clinician with the greatest contact with the individual consumer. In the community it is often easy to identify the case manager of the consumer and this clinician would most likely be responsible for collection of information as per the standard data collection protocol. However at times given the complexity and variation in service provision arrangements, responsibility for completion of the SM2 module may fall onto another clinician. For example, in inpatient units, depending on local determination the admitting doctor or nurse may be responsible for completing the standard measures module. The general rule however is that completion of the SM2 module must be undertaken (where possible) following a comprehensive assessment of the individual consumer

## **Core Reading(s)**

Commonwealth Department of Health and Aged Care. (1999) Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003 (First Edition June 1999). Canberra: Commonwealth of Australia. **[NOT INCLUDED IN RESOURCE SECTION]**

New South Wales Health Department (2001) Data Collection and System Requirements for the Mental Health Outcomes & Assessment Training initiative (MH-OAT). Sydney: NSW Health Department. **[NOT INCLUDED IN RESOURCE SECTION]**

## **Y Suggested Activities**

There are no suggested activities for this section. It is a foundation session that provides the background and framework for Discussion Regarding the Standard Measures 2 Module.

# **Standard Measures 2 Module for Children and Adolescents (SM2)**

## **Learning Outcomes**

At the completion of this session, participants will be able to:

- › **Describe the need for the other data items collected on the SM2 Module**
- › **Describe the rules for completion the other data items**
- › **Identify an approach to training in relation to the other data items**

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## **Facilitator Information**

As we have seen, the data collection protocol specifies the collection of a variety of demographic and clinical information. This information is documented on the Standard Measures 2 Module (SM2).

The SM 2 Module allows the documentation of the a variety of information

### **Background information**

- Mental health service setting
- Reason for collection
- Collection date (defined as the Date of admission)
- Responsible service unit and facility
- Responsible staff member

### **Information about the previous period of care**

- Principal and Additional diagnoses
- Focus of care
- Mental health legal status

### **Other data items**

- Previous specialised treatment
- Early psychosis intervention eligibility

### **Standardised measures**

- Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA)
- Children's Global Assessment scale (CGAS)
- Factors Influencing Health Status (FIHS)

## **Background information**

### **Responsible Facility Unit Name and Code.**

The Service Facility is the location where the Mental Health Team or service providing group or person provided this instance of care. Names and codes for the facility units are available from your MHIDP Manager and are the same as those used for the Mental Health National Minimum Data sets. Clinicians should be aware of the difference between Mental Health Service Units and facilities. Service Units provide care. Service Facilities are the location at which these services are provided.

### **Mental Health Service Setting.**

The Service Setting is either one of the following three settings as defined in the previous section:

- Inpatient Service
- Community Residential
- Ambulatory Service

### **Reason for collection**

The Reason for collection data item serves several purposes:

It identifies the Collection occasion and, within each occasion, also identifies the specific conditions that may give rise to important variations in the data collection protocol.

It identifies the reason why the Periods of care marked by the Collection occasion has either begun or ended, and what if any, is the reason for continuation of care. This information provides part of the context within which the standardised measures will be used for outcomes evaluation.

It also identifies a number of important reasons why a Review may be completed. These include the standard scheduled Review at 13 weeks, together with a number of other reasons for Review based on the requirements specified in the National Standards for Mental Health Services.

### **Collection date**

The *Collection date* is the reference date for all reports and statistical analyses of the data collected at any given *Collection occasion*.

For data collected at admission the *Collection date* is the *Admission date*. For data collected at Review, it is the date on which the Review was scheduled in accordance with the standard data collection protocol. For data collected at discharge, the *Collection date* is the *Discharge date*, that is, the *Date of separation* in Inpatient or Community residential mental

health service settings, or the *Date of last contact* in Ambulatory mental health service settings.

Note that the *Collection date* should be distinguished from the *Date of completion* of any of the individual standardised measures. In practice, the various measures may be completed by the staff member and the child or young person over several days. For example, at Review during ambulatory care, the child's case manager might complete the HoNOSCA during the clinical case review on the scheduled date. In order to include their client's and the Family's responses to the self-report measures they would most likely have asked the client to complete these measures at their last contact with them. For reporting and statistical purposes, a single date is required which ties all the standardised measures and other data items together in a single *Collection occasion*.

### **Responsible Service Unit Name and Code.**

The Service Unit is the Mental Health Team or service providing group or person which provided this instance of care. Names and codes for the service units are available from your MHIDP Manager and are the same as those used for the Mental Health National Minimum Data sets. Clinicians should be aware of the difference between Mental Health Service Units and facilities. Service Units provide care. Service Facilities are the location at which these services are provided.

### **Responsible staff member**

Identification of the Responsible staff member is recorded for purely local purposes. It enables reports, such as case lists and so forth, to be generated by the database application into the data is entered. Note that the identity of the Responsible staff member is NOT included in the data extract to be submitted to NSW Health.

### **Information about the previous period of care**

#### **Principal Diagnosis**

The Principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the child or young person's care during the Period of care preceding the Collection occasion. The 1st and 2nd Additional Diagnoses identify secondary diagnoses that affected the person's care during the period in terms of requiring therapeutic intervention, clinical evaluation, extended management, or increased care or monitoring. For example, a child may be cared for in an inpatient unit for Attention Deficit Disorder (F90) but on admission is found to have acute upper respiratory infection (J06.9) which required investigation. The Principal diagnosis is F90 while the secondary diagnosis is J06.9.

Note that the Principal diagnosis is different to the Primary clinical diagnosis. In the context of the collection of the standardised measures the Primary clinical diagnosis is information about the person's current clinical status. In contrast, the Principle diagnosis is a summary description of the person's problems or diagnosis over the preceding Period of care – it is a retrospective judgement which may be made on the basis of clinical information obtained throughout that period.

The diagnoses may be coded using either any valid diagnosis in ICD-10-AM or from the subset of ICD-10-AM diagnoses listed in your reference ("Your Guide to MH-OAT").

## **Focus of care**

The focus of care identifies the principal clinical intent of the care provided during the Period of care preceding the Collection occasion. It is the key indicator of the intensity and nature of the care provided during the period. As such, it will be an important variable influencing the interpretation of outcomes.

The domain of Focus of care covers four alternatives – Acute, Functional gain, Intensive extended and Maintenance – defined as follows:

**Acute:** The focus of care is on the immediate reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of psychiatric disorder. Interventions are focused on symptom reduction with a reasonable expectation of substantial improvement in the short-term.

**Functional Gain:** The focus of care is the improvement of personal, social or occupational functioning or the promotion of psychosocial adaptation in a child with impairment arising from psychiatric disorder. Interventions are focused on disability and the promotion of personal recovery, with an expectation of substantial improvement over the short to medium term. At this stage the person will generally have a relatively stable pattern of clinical symptoms, with treatment being focused on the prevention of any relapse of the illness.

**Intensive Extended:** The focus of care is on the prevention or minimisation of further deterioration and the reduction of risk of harm (to self or others) in a child who has a stable pattern of severe symptoms, frequent relapses, and/or a severe inability to function independently, and is judged to require care over an indefinite period.

**Maintenance:** Care provided over an indefinite period for children and young people who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.



## **Mental health legal status**

An indication that the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the Period of care preceding the Collection occasion.

## **Other data items**

### **Previous specialised treatment**

An indicator of whether the person has previously had any specialist mental health treatment, regardless of whether the previous treatment was provided within the Mental Health Service in which the person is now being treated, or another equivalent service, including private psychiatric care, but excluding GP care.

### **Early psychosis intervention eligibility**

An indicator of the eligibility of the person for treatment within a specialist early intervention program for psychosis. A person is eligible if they are experiencing a possible or definite psychotic illness, at first contact or within first two years of registration with any specialist mental health service for this problem.

## **Standardised Measures**

### **Collection status (of each standardised measure)**

The status of the data recorded and, if missing data is recorded, the reason for the non-completion of the measure. In particular, in those instances where a self-report measure was not collected, this data item enables the reason why that occurred to be identified.

Collection of this information will facilitate the monitoring of adherence to the data collection protocol and will also be important in evaluating the problems encountered with the collection of self-report measures in various service settings and patient groups.

### **Date of completion (of each standardised measure)**

The date on which the standardised measure was actually collected (that is, the date on which the clinician completed the rating scales or the child completed the self-report measure). This date may often not be the same as the Collection date of the Collection occasion within the context of which the measure was collected.

## **Mode of administration (of each standardised measure)**

An indicator of the procedure or method used in the ascertainment and recording of the standardised measure. For clinician-rated measures it enables ratings completed in the context of a comprehensive clinical assessment to be distinguished from those which were not. For self-report measures it identifies if the person completed the measure themselves, or had it read to them. Collection of this information will also facilitate the monitoring of adherence to the data collection protocol.

## **Questionnaires**

These three standardised questionnaires are included on the SM2 and are discussed in the next section.

- Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA)
- Children's Global Assessment scale (CGAS)
- Factors Influencing Health Status (FIHS)

## **Y Suggested Activities**

Have participants reflect on a recent consumer of their service and complete the first two pages of the Standard Measures 2 Module

## **Clinician - rated measures: HoNOSCA**

### **Learning Outcomes**

At the completion of this session, participants will be able to:

- › **Describe the Rating Rules for Completion of the HoNOSCA**
- › **Identify the various uses of the HoNOSCA**
- › **Identify an approach to training the HoNOSCA**

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### **Facilitator Information**

One of the target aims of the United Kingdom's Health of the Nation Strategy (1992) was to "to improve significantly the health and social functioning of mentally ill people", including child and adolescents. As a result, the United Kingdom Department of Health funded the Department of Child and Adolescent Psychiatry at the University of Manchester to develop a brief rating instrument modelled on the HoNOS, for application by child and adolescent mental health services.

In a large field trial in the UK, it has demonstrated satisfactory reliability and validity and was reasonably acceptable to clinicians from a range of disciplines (Gowers et al 1999). Gowers et al (1999) found the HoNOSCA to be psychometrically sound, sensitive to change, its ability to measure change accorded with clinicians independent ratings and found that the group scores moved in direction expected (Eg. Inpatient scored higher than Outpatients; increased scores with increasing severity; decreased scores with increasing age; increase in depression scores with increasing age). Yates et al (1999) found that the HoNOSCA was sensitive to intake differences between clinics. In Australia, a modified version of the HoNOSCA was used during the Mental Health Casemix and Service Costing (MH-CASC) Project. All studies report that the reliability of the HoNOS family of measures is reliant on training.

The HoNOSCA is made up of 15 subscales, which can be separated into two sections. Section A made up of 13 subscales covers four broad domains that include Behaviour, Impairment, Symptoms and Social problems. These subscales cover such problems as disruptive or aggressive behaviour or overactivity and attention deficits, scholastic or language skills, peer relationships and school attendance. Section B (2 subscales) identifies information deficits experienced by the family of the child or adolescent into the nature of the difficulties currently being experienced or the services available to offer support

## **The items in the HoNOSCA:**

1. Problems with disruptive, antisocial or aggressive behaviour
2. Problems with overactivity, attention or concentration
3. Non-accidental self-injury
4. Problems with alcohol, substance/solvent misuse
5. Problems with scholastic or language skills
6. Physical illness or disability problems
7. Problems associated with hallucinations, delusions or abnormal perceptions
8. Problems with non-organic somatic symptoms
9. Problems with emotional and related symptoms
10. Problems with peer relationships
11. Problems with self-care and independence
12. Problems with family life and relationships
13. Poor school attendance
14. Problems with knowledge or understanding about the nature of the child's/adolescent's difficulties (in the previous two weeks)
15. Problems with lack of information about services or management of the child's/adolescent's difficulties

## **General procedure for training staff in the HoNOSCA**

Begin the training in making HoNOSCA ratings by briefly identifying each item and explaining its purpose.

The use of the vignettes is an essential part of training participants to make ratings on the HoNOSCA. Allow time for all members of the group to read through the vignette and to arrive at a rating (or, when using the narrative vignettes, to make all their ratings). Then, for each scale in turn, ask a person to volunteer their rating. Check that everyone agrees. If not, ask someone who disagrees to offer a rationale for their rating. Discuss the issues raised with the group. Continue discussion until group consensus is reached.

When eliciting ratings from participants it is important to do so in such a way that they feel able to raise objections and discuss points of disagreement freely. Occasionally this may mean that the trainer has to set the example by making a deliberate point of carefully discussing a trainee's incorrect rationale for their rating, even though the other trainees may clearly understand the point. This process of discussion to reach consensus is a critical component of effective training in the use of the measures. Sufficient time should be devoted to allow all participants a chance to voice concerns and opinions.

Participants in HoNOSCA training should have hands on experience in completion of the measures.

Both written and video vignettes are available to support skills development in completion of the HoNOSCA. Facilitators are encouraged to use the appropriate medium in relation to the resources available.

The standard approach to training in skills development for completion of the HoNOSCA involves

- Didactic presentation of the background and development of the HoNOSCA,
- Presentation of the rating rules for completion of the HoNOSCA.
- Providing a clinical vignette (either written or video) which participants use to practice rating
- Have participants rate the vignette on a provided SM2 module
- Create overhead using blank rating grid supplied
- Have participants share their ratings (document on overhead)
- Promotion of discussion of the ratings provided by participants and compare these to consensus or expert ratings provided
- Sources of information used to complete rating (including idiosyncratic approaches)
- Reinforcement of rating rules
- Identification of inter-rater reliability

## **General rating guidelines**

Rate each scale in order from 1 to 12 (or 15).

Use all available information in making your rating.

Do not include information already rated in an earlier item.

Consider both the degree of distress the problem causes and the effect it has on behaviour

Rate the most severe problem that occurred in the period rated.

The rating period is generally the preceding two weeks, except at discharge from inpatient care, when it is the previous 3 days.

The glossary explains the meaning of the points on the underlying scale of 0 to 4.

Always refer to the glossary when making the ratings.

The Standard Measures Module SM2 is used by clinicians to document the HoNOSCA

## First Practice Vignette: Jemma

Jemma is a 15 year old girl who lives at home with her mother. She has suffered bulimia nervosa for six months, starving herself in the early part of each day and bingeing in the evenings followed by vomiting. Her weight is within the normal range.

Jemma started a fight at the weekend with another girl after a dispute about a boyfriend. This occurred after she had been to a nightclub where she had been drinking. Neither of the girls were hurt during the fight. Jemma has not been involved in fighting before or since.

Jemma's school work has deteriorated recently. Her teachers complain about her attitude in class. She appears bored, her behaviour sometimes causes others to be disruptive.

On two occasions, in the last fortnight, Jemma has superficially scratched her legs with a pin drawing blood. There has been no evidence to suggest that she is at risk from more serious self-harm

At weekends Jemma has been going to a night club where she drinks approximately 12 standard drinks. Her friends often take speed when they go to a night club. Jemma has tried it a few times but hasn't taken any in the last two weeks. She had been drinking on the night when she was involved in the fight.

Jemma attends a private girls school and was expected to pass with good marks. She used to go to school reliably. Over the past six months she had started playing truant. Her work has deteriorated recently and teachers complain about her attitude. She occasionally misses school and goes to town with her friends. She has however been to school everyday in the past month.

Jemma has never suffered from any problems associated with hallucinations or delusions.

Jemma complains of headaches which occur mainly in the afternoons. She struggles getting to sleep at night. She often lays awake worrying about how she can lose weight. Jemma has felt low in mood for about the last six months. She feels fat and ugly. She is becoming increasingly more anxious about eating and dieting and is preoccupied with fears about losing control of her weight.

Jemma socialises little with her old school friends preferring the company of acquaintances five years older. At weekend she regularly goes out with her older friends. Jemma has felt low recently but she does take care of herself and is very concerned about her appearance. She is organised and can take responsibility for herself.

Jemma's father drinks heavily. He has had an affair recently and her parents are undergoing a trial separation. Jemma live with her mother and is very angry with both her parents and says she can't wait to leave home as soon as possible. Jemma's mother is very distressed by Jemma's behaviour and doesn't know "what to do with the girl".

Jemma's father is says that "no one tells me anything".

### 1 **PROBLEMS WITH DISRUPTIVE, ANTISOCIAL OR AGGRESSIVE BEHAVIOUR**

Include behaviour associated with any disorder, such as hyperkinetic disorder, depression, autism, drugs or alcohol. Include physical or verbal aggression (e.g. pushing, hitting, vandalism, teasing), or physical or sexual abuse of other children.

*Include antisocial behaviour (e.g. thieving, lying, cheating) or oppositional behaviour (e.g. defiance, opposition to authority or tantrums).*

Do not include overactivity rated at Scale 2. Truancy, rated at Scale 13, self-harm rated at Scale 3.

- 0 No problems of this kind during the period rated.
- 1 Minor quarrelling, demanding behaviour, undue irritability, lying etc.
- 2 Mild but definitely disruptive or antisocial behaviour, lesser damage to property or aggression, or defiant behaviour.
- 3 Moderately severe aggressive or antisocial behaviour such as fighting or persistently threatening or very oppositional or more serious destruction to property or moderate delinquent acts.
- 4 Disruptive in almost all activities, or at least one serious physical attack on others or animals, or serious destruction to property.

\* Consensus for Jemma is 2

One incident of physical aggression which did not result in either participant being hurt occurred within the last two weeks as a result, this indicates a mild problem and a rating of 2

### 2 **PROBLEMS WITH OVERACTIVITY, ATTENTION OR CONCENTRATION**

Include overactive behaviour associated with any cause such as hyperkinetic disorder, mania or arising from drugs. Include problems with restlessness, fidgeting, inattention or concentration due to any cause, including depression.

- 0 No problems of this kind during the period rated.
- 1 Slight overactivity or minor restlessness etc.
- 2 Mild but definite overactivity and/or attention problems, but these can usually be controlled.
- 3 Moderately severe overactivity and/or attention problems that are sometimes uncontrollable.
- 4 Severe overactivity and/or attention problems that are present in most activities and almost never controllable.

\* Consensus for Jemma is 1

Jemma appears to be bored in class and her behaviour appears to be disruptive. This inattention warrants a rating of 1 as a subclinical problem.

### 3 **NON-ACCIDENTAL SELF-INJURY**

Include self-harm such as hitting self and self-cutting, suicide attempts, overdoses, hanging, drowning etc.

Do not include scratching, picking as a direct result of a physical illness rated at Scale 6.

Do not include accidental self-injury due e.g. to severe learning or physical disability, rated at Scale 6. Illness or injury as a direct consequence of drug/alcohol use, rated at Scale 6.

- 0 No problem of this kind during the period rated.
- 1 Occasional thoughts about death, or of self-harm not leading to injury. No self-harm or suicidal thoughts.
- 2 Non-hazardous self-harm, such as wrist-scratching, whether or not associated with suicidal thoughts.
- 3 Moderately severe suicidal intent (including preparatory acts e.g. collecting tablets) or moderate non-hazardous self-harm (e.g. small overdose).
- 4 Serious suicidal attempt (e.g. serious overdose) or serious deliberate self-injury.

\* Consensus for Jemma is 2

Jemma has scratched her self with a pin on several occasions over the last two weeks. There is no evidence of suicidal intent. As a result this warrants a rating of 2, non-hazardous self harm.

**4 PROBLEMS WITH ALCOHOL, SUBSTANCE/SOLVENT MISUSE**

Include problems with alcohol substance/solvent misuse taking into account current age and societal norms. Do not include aggressive/disruptive behaviour due to alcohol or drug use, rated at Scale 1. Physical illness or disability due to alcohol or drug use, rated at Scale 6.

- 0 No problems of this kind during the period rated.
- 1 Minor alcohol or drug use, within age norms.
- 2 Mildly excessive alcohol or drug use.
- 3 Moderately severe drug or alcohol problems significantly out of keeping with age norms.
- 4 Severe drug or alcohol problems leading to dependency or incapacity.

\* Consensus for Jemma is 2

In the last two weeks Jemma has been drinking on several occasions up to 12 standard drinks. It is not constant drinking. This warrants a rating of a mild problem.

**5 PROBLEMS WITH SCHOLASTIC OR LANGUAGE SKILLS**

Include problems in reading, spelling, arithmetic, speech or language associated with any disorder or problem, such as a specific developmental learning problem, or physical disability such as hearing problem. Children with generalised learning disability should not be included unless their functioning is below the expected level.

Include reduced scholastic performance associated with emotional or behavioural problems. Do not include temporary problems resulting purely from inadequate education.

- 0 No problems of this kind during the period rated.
- 1 Minor impairment within the normal range of variation.
- 2 Mild but definite impairment of clinical significance.
- 3 Moderately severe problems, below the level expected on the basis of mental age, past performance or physical disability.
- 4 Severe impairment much below the level expected on the basis of mental age, past performance or physical disability.

\* Consensus for Jemma is 2

Recent deterioration in school work is below what is expected of her and warrants a mild rating of 2.

**6 PHYSICAL ILLNESS OR DISABILITY PROBLEMS**

Include physical illness or disability problems that limit or prevent movement, impair sight or hearing, or otherwise interfere with personal functioning.

Include movement disorder, side-effects from medication, physical effects from drug/alcohol use, or physical complications of psychological disorders such as severe weight loss.

Include self-injury due to severe learning or physical disability or as a consequence of self-injury such as head-banging.

Do not include somatic complaints with no organic basis, rated at Scale 8.

- 0 No incapacity as a result of a physical health problem during the period rated.
- 1 Slight incapacity as a result of a health problem during the period (e.g. cold, non-serious fall etc.).
- 2 Physical health problem that imposes mild but definite functional restriction.
- 3 Moderate degree of restriction on activity due to a physical health problem.
- 4 Complete or severe incapacity due to physical health problems.

\* Consensus for Jemma is 0

No indication of physical illness or disability.



**7 PROBLEMS ASSOCIATED WITH HALLUCINATIONS, DELUSIONS OR ABNORMAL PERCEPTIONS**

Include hallucinations, delusions or abnormal perceptions irrespective of diagnosis.

Include odd and bizarre behaviour associated with hallucinations and delusions.

Include problems with other abnormal perceptions such as illusions or pseudohallucinations, or overvalued ideas such as distorted body image, suspicious or paranoid thoughts.

Do not include disruptive or aggressive behaviour associated with hallucinations or delusions, rated at Scale 1.

Overactive behaviour associated with hallucinations or delusions, rated at Scale 2.

0 No evidence of abnormal thoughts or perceptions during the period rated.

1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.

2 Abnormal thoughts or perceptions are present (e.g. paranoid ideas, illusions or body image disturbance), but there is little distress or manifestation in bizarre behaviour, i.e. clinically present but mild.

3 Moderate preoccupation with abnormal thoughts or perceptions or delusions; hallucinations, causing much distress and/or manifested in obviously bizarre behaviour.

4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations or abnormal perceptions, with severe impact on child/adolescent or others.

\* Consensus for Jemma is 0

No indication of problems associated with hallucinations, delusions or abnormal perceptions.

**8 PROBLEMS WITH NON-ORGANIC SOMATIC SYMPTOMS**

Include problems with gastrointestinal symptoms such as non-organic vomiting or cardiovascular symptoms or neurological symptoms such as non-organic vomiting or cardiovascular symptoms or neurological symptoms or non-organic enuresis or encopresis or sleep problems or chronic fatigue.

Do not include movement disorders such as tics, rated at Scale 6; physical illnesses that complicate non-organic somatic symptoms, rated at Scale 6.

0 No problems of this kind during the period rated.

1 Slight problems only; such as occasional enuresis, minor sleep problems, headaches or stomach aches without organic basis.

2 Mild but definite problem with non-organic somatic symptoms.

3 Moderately severe, symptoms produce a moderate degree of restriction in some activities.

4 Very severe or symptoms persist into most activities. The child is seriously or adversely affected.

\* Consensus for Jemma is 3

Jemma has been suffering headaches and difficulty getting to sleep. The combination of these problems indicates a moderate rating.

**9 PROBLEMS WITH EMOTIONAL AND RELATED SYMPTOMS**

Rate only the most severe clinical problem not considered previously.

Include depression, anxiety, worries, fears, phobias, obsessions or compulsions, arising from any clinical condition including eating disorders.

Do not include aggressive, destructive or overactive behaviours attributed to fears, phobias, rated at item 1.

Do not include physical complications of psychological disorders, such as severe weight loss, rated at Scale 6.

0 No evidence of depression, anxieties, fears or phobias during the period rated.

1 Mildly anxious; gloomy; or transient mood changes.

2 A mild but definite emotional symptom is clinically present, but is not preoccupying.

3 Moderately severe emotional symptoms, which are preoccupying, intrude into some activities and are uncontrollable at least sometimes.

4 Severe emotional symptoms which intrude into all activities and are nearly always uncontrollable.

\* Consensus for Jemma is 3

Jemma has been increasingly anxious about eating and dieting and is preoccupied with fears about losing weight.

## 10 PROBLEMS WITH PEER RELATIONSHIPS

Include problems with school mates and social network. Problems associated with active or passive withdrawal from social relationships or problems with over-intrusiveness or problems with the ability to form satisfying peer relationships.

Include social rejection as a result of aggressive behaviour or bullying.

Do not include aggressive behaviour, bullying rated at Scale 1; problems with family or siblings rated at Scale 12.

0 No significant problems during the period rated.

1 Either transient or slight problems, occasional social withdrawal.

2 Mild but definite problems in making or sustaining peer relationships. Problems causing distress due to social withdrawal, over-intrusiveness, rejection or being bullied.

3 Moderate problems due to active or passive withdrawal from social relationships, over-intrusiveness and/or to relationships that provide little or no comfort or support: e.g. as a result of being severely bullied.

Severe social isolation with no friends due to inability to communicate socially and/or withdrawal from social relationships.

\* Consensus for Jemma is 1

Although she socialises with acquaintances five years older than her, these relationships are generally supportive but recent conflict indicates tension that warrants monitoring.

## 11 PROBLEMS WITH SELF-CARE AND INDEPENDENCE

Rate the overall level of functioning: e.g. problems with basic activities of self-care such as feeding, washing, dressing, toileting, also complex skills such as managing money, travelling independently, shopping etc., taking into account the norm for the child's chronological age.

Include poor levels of functioning arising from lack of motivation, mood or any other disorder.

Do not include lack of opportunities for exercising intact abilities and skills, as might occur in an over-restrictive family, rated at Scale 12; enuresis and encopresis rated at Scale 8.

0 No problems during the period rated; good ability to function in all areas.

1 Minor problems only; e.g. untidy, disorganised.

2 Self-care adequate, but definite inability to perform one or more complex skills (see above).

3 Major problems in one or more areas of self-care (eating, washing, dressing) or inability to perform several complex skills.

4 Severe disability in all or nearly all areas of self-care and/or complex skills.

\* Consensus for Jemma is 0

No indication of problems with self care and independence.

## 12 PROBLEMS WITH FAMILY LIFE AND RELATIONSHIPS

Include parent-child and sibling relationship problems.

Include relationships with foster parents, social workers/teachers in residential placements. Relationships in the home and with separated parents/siblings should both be included. Parental personality problems, mental illness, marital difficulties should only be rated here if they have an effect on the child.

Include problems with emotional abuse such as poor communication, arguments, verbal or physical hostility, criticism and denigration, parental neglect/rejection, overrestriction, sexual and/or physical abuse.

Include sibling jealousy, physical or coercive sexual abuse by a sibling.

Include problems with enmeshment and overprotection.

Include problems associated with family bereavement leading to reorganisation.

Do not include aggressive behaviour by child, rated at Scale 1.

0 No problems during the period rated.

1 Slight or transient problems.

2 Mild but definite problem e.g. some episodes of neglect or hostility or enmeshment or overprotection.

3 Moderate problems e.g. neglect, abuse, hostility. Problems associated with family/carer breakdown or reorganisation.

4 Serious problems with child feeling or being victimised, abused or seriously neglected by family or carer.

\* Consensus for Jemma is 3

Recent family break down and difficulties between mother and daughter indicate a moderate problem with family life and relationships.

**13 POOR SCHOOL ATTENDANCE**

Include truancy, school refusal, school withdrawal or suspension for any cause.

Include attendance at type of school at the time of rating e.g. hospital school, home tuition etc.

If school holiday, rate the last two weeks of the previous term.

- 0 No problems of this kind during the period rated.
- 1 Slight problems, e.g. late for two or more lessons.
- 2 Definite but mild problems, e.g. missed several lessons because of truancy or refusal to go to school.
- 3 Marked problems, absent several days during the period rated.
- 4 Severe problems, absent most or all days. Any school suspension, exclusion or expulsion for any cause during the period rated.

\* Consensus for Jemma is 0

No indication of truancy in the last two weeks.

**Scales 14 and 15 are concerned with problems for the child, parent or carer relating to lack of information or access to services. These are not direct measures of the child's mental health but changes here may result in long-term benefits for the child.**

**14 PROBLEMS WITH KNOWLEDGE OR UNDERSTANDING ABOUT THE NATURE OF THE CHILD'S/ADOLESCENT'S DIFFICULTIES (IN THE PREVIOUS TWO WEEKS)**

Include lack of useful information or understanding available to the child/adolescent, parents or carers.

Include lack of explanation about the diagnosis or the cause of the problem or the prognosis.

- 0 No problems during the period rated. Parents/carers have been adequately informed about the child's problems.
- 1 Slight problems only.
- 2 Mild but definite problem.
- 3 Moderately severe problems. Parents/carers have very little or incorrect knowledge about the problem which is causing difficulties such as confusion or self-blame.
- 4 Very severe problem. Parents have no understanding about the nature of their child's problems.

\* Consensus for Jemma is 0

No indication of problems with knowledge or understanding about the nature of Jemma's difficulties.

**15 PROBLEMS WITH LACK OF INFORMATION ABOUT SERVICES OR MANAGEMENT OF THE CHILD'S/ADOLESCENT'S DIFFICULTIES**

Include lack of useful information available to the child/adolescent, parents or carers or referrers.

Include lack of information about the most appropriate way of providing services to the child such as care arrangements or educational placements or respite care or statementing.

- 0 No problems during the period rated. The need for all necessary services has been recognised.
- 1 Slight problems only.
- 2 Mild but definite problem.
- 3 Moderately severe problems. Parents/carers have been given little information about appropriate services or professionals are not sure where a child should be managed.
- 4 Very severe problem. Parents have no information about appropriate services or professionals do not know where a child should be managed.

\* Consensus for Jemma is 2

Jemma's mothers confusion indicate a knowledge deficit in regards to management of Jemma's behaviour and warrants a mild rating.

## Second Practice Vignette: Todd

Todd is a 10 year old boy. He is an only child who lives with his mother. Todd has suffered from asthma since he was six. His asthma has often restricted him from outdoor activities and he has never been allowed to take part in games at school. In the past he has always been teased by other children because of this but this has not happened recently. He has always been timid but has two friends he plays with at school although he has no social life out of school hours.

Todd has started to miss school regularly due to apparent stomach pains and nausea. His mother is anxious and inclined to be protective of him. She has never let him travel to school alone. She allows him to stay at home if he complains of feeling ill. When Todd attends school he seems pre-occupied and is unable to concentrate but can usually complete the requests of teachers. His school work has deteriorated recently and he has slipped from being one of the most able children to slightly below average. Poor school attendance has threatened his fragile social relationships.

He is anxious and worried which seems to be related to going out of the house unaccompanied and in particular at the thought of meeting other children. Todd doesn't like playing out and prefers to stay at home with his mother. Recently he has started picking and scratching his skin occasionally drawing blood.

Todd's mother was ill about six months ago with newly diagnosed diabetes and needed hospitalisation. Todd has since been very worried about his mother's health. His parents separated about a year ago. He used to see his father fortnightly. However recently there has been a dispute about maintenance payments and Todd's father has stopped visiting and taking him out. Todd has felt low in mood since his father stopped visiting.

Todd's mother is aware of the reason for his behaviour and the services available to support

**HONOSCA ITEM 1 \*** Consensus for Todd is 0  
No evidence of problems with disruptive, antisocial or aggressive behaviour.

**HONOSCA ITEM 2 \*** Consensus for Todd is 2.  
Todd is unable to concentrate at school at school but these can be controlled indicating a mild problem

**HONOSCA ITEM 3 \*** Consensus for Todd is 2  
Todd has started picking and scratching at his skin drawing blood. This is indicative of non-accidental self harm and warrants a rating of 2.

**HONOSCA ITEM 4 \*** Consensus for Todd is 0  
No evidence of problems with alcohol, substance/solvent misuse

**HONOSCA ITEM 5 \*** Consensus for Todd is 3  
Todd's school work has recently deteriorated and he is currently functioning below his expected level from past performance. This indicates a moderate problem.

**HONOSCA ITEM 6 \*** Consensus for Todd is 3  
Todd has suffered from Asthma for the last four years. This has restricted his behaviour and is seen as a moderate problem.

**HONOSCA ITEM 7 \*** Consensus for Todd is 0  
No evidence of problems associated with hallucinations, delusions or abnormal perceptions.

**HONOSCA ITEM 8 \*** Consensus for Todd is 3  
Todd had been experiencing stomach pains and nausea which restricts his behaviour and indicates a moderate problem.

**HONOSCA ITEM 9 \*** Consensus for Todd is 3  
Todd is anxious and worried and these restrict his activities indicating a moderate problem.

**HONOSCA ITEM 10 \*** Consensus for Todd is 3  
Todd has limited peer relationships. Having two friends with whom he plays negates the higher rating and scale 10 is viewed as a moderate problem.

**HONOSCA ITEM 11 \*** Consensus for Todd is 2  
Todd relies on his mother to travel and therefore has a moderate problem in the area of independence.

**HONOSCA ITEM 12 \*** Consensus for Todd is 3  
Todd has both an over-protective mother and a failing family structure. This indicates a moderate problem in the area of family life and relationships.

**HONOSCA ITEM 13 \*** Consensus for Todd is 3  
Todd misses school regularly which is a marked problem.

**HONOSCA ITEM 14 \*** Consensus for Todd is 0  
No evidence of problems with knowledge or understanding about the nature of Todd's difficulties.

**HONOSCA ITEM 15 \*** Consensus for Todd is 0  
No evidence of problems with lack of information about services or management of Todd's difficulties.

## Core Reading(s)

Garralda E. Yates P. & Higginson I. (2000) Child and adolescent mental health service use. HoNOSCA as an outcome measure. *British Journal of Psychiatry*. 177:52-8

## Supplementary Readings

Brann P. Coleman G. Luk E. Routine outcome measurement in a child and adolescent mental health service: an evaluation of HoNOSCA. The Health of the Nation Outcome Scales for Children and Adolescents. *Australian & New Zealand Journal of Psychiatry*. 35(3):370-6, 2001 Jun

Garralda, E & Yates P. (2000) HoNOSCA: Uses and limitations. *Child Psychology & Psychiatry Review*. Vol 5(3) 131-132.

Jaffa, T (2000) HoNOSCA: Is the enthusiasm justified? *Child Psychology & Psychiatry Review*. Vol 5(3) 130.

Gowers, S. Bailey-Rogers, S. Shore, A & Levine, W. (2000). The Health of the Nation Outcome Scales for Child & Adolescent Mental Health (HoNOSCA). *Child Psychology & Psychiatry Review*. Vol 5(2) 50-56.

Gowers SG. Harrington RC. Whitton A. Beevor A. Lelliott P. Jezzard R. & Wing JK. (1999) Brief Scale for Measuring emotional and behavioural disorders in children: Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry*. 174:428-31..

Yates P. Garralda ME. & Higginson I. (1999) Paddington Complexity Scale and Health of the Nation Outcome Scales for Children and Adolescents. *British Journal of Psychiatry*. 174:417-23.

Gowers SG. Harrington RC. Whitton A. Lelliott P. Beevor A. Wing J. & Jezzard R.(1999) Brief scale for measuring the outcomes of emotional and behavioural disorders in children. Health of the Nation Outcome Scales for children and Adolescents (HoNOSCA). *British Journal of Psychiatry*. 174:413-6,

## Y Suggested Activities

Both the 'Jemma' and "Todd' vignettes may be used to practice rating the HoNOSCA. The vignettes and the HoNOSCA rating grid can be found in the resource section for copies.

Ask the group(s) to read the vignettes and to rate accordingly. Discuss variations in ratings but do not dwell on them.

**NOTE: This training pack is accompanied by the HoNOSCA Video Workshop pack which can be used as per the training guidance suggested within.**

## **Clinician rated measures: FIHS / CGAS**

### **Learning Outcomes**

At the completion of this unit, participants will be able to:

- › Describe the Rating Rules for Completion of the CGAS and FIHS
  - › Identify an approach to training the CGAS and FIHS
- 

### **Facilitator Information**

#### **Childrens Global Assessment Scale (CGAS)**

The Children's Global Assessment Scale (CGAS), an adaptation of the Global Assessment Scale for adults. It has been found to be a useful measure of overall severity of disturbance. Which is has good reliability between raters and across time (Rey et al 1995). Moreover, it demonstrated both discriminant and concurrent validity. Given these favourable psychometric properties and its relative simplicity, the CGAS is recommended to both clinicians and researchers as a complement to syndrome-specific scales and has been found of heuristic value to complement other methods of diagnostic categorisation. (Bird et al 1987)

It should be noted, that in a study of 95 children admitted to an inpatient unit, CGAS ratings were unrelated to measures of symptomatology but were significantly related to indices of children's competence. Therefore, the CGAS ratings obtained in clinical contexts may reflect evaluations of functional competence rather than severity of symptomatology (Green et al 1994)

A cutoff score of 70 has been proposed to differentiate normal functioning from problems in need of treatment. While the scale has been shown to demonstrate change due to therapeutic interventions. (Steinhausen 1987)

#### **Rating guidelines for the CGAS**

Always refer to the glossary when making the rating.

Rate the individual's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his or her functioning on a hypothetical continuum of health-illness. Rating is made on a continuous scale from 1-100. Use intermediary levels (e.g. 35, 58, 62).

## Glossary for CGAS rating

- 100-91** *Superior functioning* in all areas (at home, at school and with peers); involved in a wide range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc); likeable, confident; ‘everyday’ worries never get out of hand; doing well in school; no symptoms.
- 90-81** *Good functioning in all areas*; secure in family, school, and with peers; there may be transient difficulties and ‘everyday’ worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasional ‘blowups’ with siblings, parents or peers).
- 80-71** *No more than slight impairments in functioning* at home, at school, or with peers; some disturbance of behaviour or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.
- 70-61** *Some difficulty in a single area but generally functioning pretty well* (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behaviour; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
- 60-51** *Variable functioning with sporadic difficulties or symptoms in several but not all social areas*; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.
- 50-41** *Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area*, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.
- 40-31** *Major impairment of functioning in several areas and unable to function in one of these areas* (i.e., disturbed at home, at school, with peers, or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
- 30- 21** *Unable to function in almost all areas* e.g., stays at home, in ward, or in bed all day without taking part in social activities *or* severe impairment in reality testing *or* serious impairment in communication (e.g., sometimes incoherent or inappropriate).
- 20- 11** *Needs considerable supervision* to prevent hurting others or self (e.g., frequently violent, repeated suicide attempts) *or* to maintain personal hygiene *or* gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
- 10-1** *Needs constant supervision* (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.

## Factors Influencing Health Status

The purpose of this item is to identify the degree to which the child or adolescent had “complicating psychosocial factors” that required additional clinical input. Children and adolescents may present to specialist mental health services in the context of a range of circumstances which influence the persons health status but are not by themselves a current illness or injury. For example, the child may be severely affected by a history of sexual abuse but does not have a formal psychiatric diagnosis. The International classification of Disease (ICD) includes a coding system for ‘select factors influencing health



*status and contact with health services'* which covers the range of issues. The FIHS was developed as a checklist of psychosocial complications prepared from the ICD-10.

## **Rating guidelines for the FIHS**

A positive rating is given if any of the identified problems had an impact on the provision of care during the specified period.

## **Glossary for FIHS**

### **1. Maltreatment syndromes**

Includes: Neglect or abandonment; Physical abuse; Sexual abuse; Psychological abuse.

### **2. Problems related to negative life events in childhood**

Includes: Loss of love relationship in childhood; Removal from home in childhood; Altered pattern of family relationships in childhood; Problems related to alleged sexual abuse of child by person within primary support group; Problems related to alleged sexual abuse of child by person outside primary support group; Problems related to alleged physical abuse of child; Personal frightening experience in childhood; Other negative life events in childhood.

### **3. Problems related to upbringing**

Includes: Inadequate parental supervision and control; Parental overprotection; Institutional upbringing; Hostility towards and scapegoating of child; Emotional neglect of child; Other problems related to neglect in upbringing; Inappropriate parental pressure and other abnormal qualities of upbringing; Other specified problems related to upbringing.

### **4. Problems related to primary support group, including family circumstances**

Includes: Problems in relationship with spouse or partner; Problems in relationship with parents and in-laws; Inadequate family support; Absence of family member; Disappearance or death of family member; Disruption of family by separation and divorce; Dependant relative needing care at home; Other stressful life events affecting family and household; Other problems related to primary support group.

### **5. Problems related to social environment**

Includes: Problems of adjustment to lifecycle transitions; Atypical parenting situation; Living alone; Acculturation difficulty; Social exclusion and rejection; Target of perceived adverse discrimination and rejection.

### **6. Problems related to certain psychosocial circumstances**

Includes: Problems related to unwanted pregnancy; Problems related to multiparity; Seeking or accepting physical, nutritional or chemical interventions known to be hazardous or harmful; Seeking or accepting behavioural or psychological interventions known to be hazardous or harmful; Discord with counsellors.

### **7. Problems related to other psychosocial circumstances**

Includes: Conviction in civil and criminal proceedings without imprisonment; Imprisonment or other incarceration; Problems related to release from prison; Problems related to other legal circumstances; Victim of crime or terrorism; Exposure to disaster, war or other hostilities.

## **Core Reading(s)**

Green B. Shirk S. Hanze D. Wanstrath J. The Children's Global Assessment Scale in clinical practice: an empirical evaluation. *Journal of the American Academy of Child & Adolescent Psychiatry*. 33(8):1158-64, 1994 Oct. [NOT INCLUDED IN RESOURCE SECTION]

## **Supplementary Readings**

Buckingham W, Burgess P, Solomon S, Pirkis J, and Eagar K. (1998) Developing a Casemix Classification for Mental Health Services. Volume 1: Main Report. Canberra: Commonwealth Department of Health and Family Services.

Buckingham W, Burgess P, Solomon S, Pirkis J, and Eagar K. (1998) Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials. Canberra: Commonwealth Department of Health and Family Services.

Dyrborg J. Larsen FW. Nielsen S. Byman J. Nielsen BB. Gautre-Delay F. The Children's Global Assessment Scale (CGAS) and Global Assessment of Psychosocial Disability (GAPD) in clinical practice--substance and reliability as judged by intraclass correlations. *European Child & Adolescent Psychiatry*. 9(3):195-201, 2000 Sep.

Bird HR. Canino G. Rubio-Stipec M. Ribera JC. Further measures of the psychometric properties of the Children's Global Assessment Scale. *Archives of General Psychiatry*. 44(9):821-4, 1987 Sep.

Shaffer D. Gould MS. Brasic J. Ambrosini P. Fisher P. Bird H. Aluwahlia S. A children's global assessment scale (CGAS). *Archives of General Psychiatry*. 40(11):1228-31, 1983 Nov.

## **Y Suggested Activities**

- ▶ Give a brief didactic overview of the Children's Global Assessment Scale (CGAS) and the Factors Influencing Health Status (FIHS)
- ▶ Have participants rate the CGAS after reading the short Vignette.
- ▶ Undertake a similar activity in relation to completing the FIHS

## Consumer Self report measures: SDQ

### Learning Outcomes

At the completion of this unit the participant will be

- › Familiar with the Strengths and Difficulties questionnaire
- › Correctly use the versions of the Strengths and Difficulties Questionnaire according to the NSW data collection protocol

### Facilitator Information

#### Background

The Strengths and Difficulties questionnaire (SDQ) is a brief behavioural screening questionnaire about 4-17 year olds developed by Dr Robert Goodman from the UK. It exists in several versions to meet the needs of researchers, clinicians and educationalists. The extended version of the SDQ is a questionnaire used to assess the psychological adjustment of children and youths plus a brief impact supplement to enquire about overall distress, social impairment, burden and chronicity. Near identical versions are completed by the parents of 4-10 year olds by the parents of 11-17 year olds and by 11-17 year olds themselves. Copyright of these instruments are held by Dr Robert Goodman, 114 Court Lande, London SE21 7EA.

Each version includes of the following components:

#### **A) 25 items on psychological attributes (Symptom Items)**

All versions of the SDQ ask about 25 attributes, some positive and others negative. For each item, the box is marked for Not True, Somewhat True or Certainly True.

| Item | Problem                       | Item | Problem                      |
|------|-------------------------------|------|------------------------------|
| 1    | Considerate....               | 14   | Generally liked ...          |
| 2    | Restless, overactive....      | 15   | Easily distracted ....       |
| 3    | Often complains of headaches. | 16   | Nervous .....                |
| 4    | Shares readily....            | 17   | Kind to younger children     |
| 5    | Often loses temper            | 18   | Often lies or cheats         |
| 6    | Rather solitary...            | 19   | Picked on or bullied....     |
| 7    | Usually obedient..            | 20   | Often offer help ....        |
| 8    | Many worries ....             | 21   | Thinks things out....        |
| 9    | Helpful...                    | 22   | Steals from home ....        |
| 10   | Constantly fidget..           | 23   | Gets along with adults ..... |
| 11   | Has at least one good friend  | 24   | Many fears....               |
| 12   | Often fights ...              | 25   | Good attention span.....     |
| 13   | Often unhappy ....            |      |                              |

These 25 items are divided between 5 scales:

- emotional symptoms (5 items)
  - conduct problems (5 items)
  - hyperactivity/inattention (5 items)
  - peer relationship problems (5 items)
- } added together to generate a total difficulties score (based on 20 items)
- prosocial behaviour (5 items)

The same 25 items are included in questionnaires for completion by the parents of 4-17 year olds (Goodman, 1997). Questionnaires for self-completion by adolescents ask about the same 25 traits, though the wording is slightly different (Goodman et al, 1998). This self-report version is suitable for young people aged around 11-17, depending on their level of understanding and literacy.

### B) An impact supplement

The SDQ is a two-sided version with the 25 items on strengths and difficulties on the front of the page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, enquire further about chronicity, distress, social impairment, and burden to others. This provides useful additional information for clinicians and researchers with an interest in psychiatric caseness and the determinants of service use (Goodman, 1999).

| ITEM | PROBLEM                           | RATING  |
|------|-----------------------------------|---|
| 26   | Difficulties in areas.....        | No , Yes (Minor, Definite or Severe)              |
| 27   | How long present.....             | <1 month; 1-5 months;<br>6-12 months; Over a year |
| 28   | Upset or distress child.....      | Not at all; A little; Medium; A great deal        |
| 29   | Interfere with HOMELIFE           | Not at all; A little; Medium; A great deal        |
| 30   | Interfere with FRIENDSHIPS        | Not at all; A little; Medium; A great deal        |
| 31   | Interfere with CLASSROOM LEARNING | Not at all; A little; Medium; A great deal        |
| 32   | Interfere with LEISURE ACTIVITIES | Not at all; A little; Medium; A great deal        |
| 33   | Burden .....                      | Not at all; A little; Medium; A great deal        |

### C) Follow-up questions

The follow-up versions of the SDQ include not only the 25 basic items and the impact question, but also two additional follow-up questions for use after an intervention. Has the intervention reduced problems? Has the intervention helped in other ways, eg. making the problems more bearable? To increase the chance of detecting change, the follow-up versions of the SDQ ask about 'the last month', as opposed to 'the last six

months or this school year', which is the reference period for the standard versions. Follow-up versions also omit the question about the chronicity of problems.

| ITEM | PROBLEM  | SCORE  |
|------|--|--|
| 34   | Since coming to the service – are the problems | Much worse; A bit worse; About the same; A bit better; Much better |
| 35   | Coming to service has been helpful             | Not at all; A little; A medium; Great deal                         |

## Uses of the SDQ

### Clinical assessment.

Many child and adolescent mental health clinics now use the SDQ as part of the initial assessment, getting parents, teachers and young people over the age of 11 to complete questionnaires prior to the first clinical assessment. The findings can then influence how the assessment is carried out and which professionals are involved in that assessment. For example, if a child has been referred with marked conduct problems, an assessment that focused too narrowly on these behaviours and related family issues might overlook associated hyperactivity. Advance knowledge that the child has been given high SDQ hyperactivity ratings by parents and teachers can help ensure that the assessment enquires in detail about hyperactivity. It may also be important to obtain a psychiatric or paediatric opinion early on in the assessment process with a view to establishing suitability for medication. (Goodman R. Renfrew D. Mullick M. (2000))

### Evaluating outcome.

"Before" and "after" SDQs can be used to audit everyday practice (eg. in clinics or special schools) and to evaluate specific interventions (eg. parenting groups). Studies using the SDQ along with research interviews and clinical ratings have shown that the SDQ is sensitive to treatment effects.

### Epidemiology.

The SDQ's emphasis on strengths as well as weaknesses makes it particularly acceptable to community samples. It is being used in many large epidemiological study, eg. the British national survey of child mental health, and the Avon longitudinal study.

### Research.

The SDQ is being used as a research tool throughout the world - in developmental, genetic, social, clinical and educational studies.

### Screening.

In community samples, multi-informant SDQs can predict the presence of a psychiatric disorder with good specificity and moderate sensitivity (Goodman R. Ford T. Simmons H. Gatward R. Meltzer H. (2000))

Information on Normative scores can be found from the website:  
<http://www.sdqinfo.com/bb1.html>

### Use in NSW

In New South Wales we have adapted the extended US versions (including impact information) for Parents and Self Rating for initial contact and follow up, resulting in six modules to collect the SDQ in a variety of different situations. This will enable information on children of different ages at admission, review and discharge to be collected. These modules will also enable the capture of information in relation to the various domains of the SDQ. These are:

- PC1 –Parent Report Measure for Children aged 04-10 on initial contact with service
- PC2 - Parent Report Measure for Children and Adolescents aged 04-10 on follow up contact with service
- PY1 - Parent Report Measure for Youth aged 11-17 on initial contact with service
- PY2 - Parent Report Measure for Youth aged 11-17 on follow up contact with service
- YR1 – Youth self report measure (11-17) on initial contact with service
- YR2– Youth self report measure (11-17) on follow up contact with service

**Table : SDQ Versions and Data Collection Occasion**

| Age Range       | Collection Occasion | Completed by | Rating Period | Domains |
|-----------------|---------------------|--------------|---------------|---------|
| 4 - 10          | Admission           | Parent       | Last 6 Months | PC1     |
|                 | Review/Discharge    | Parent       | Last Month    | PC2     |
| 11-17 year olds | Admission           | Youth        | Last 6 Months | YR1     |
|                 |                     | Parent       | Last 6 Months | PY1     |
|                 | Review/Discharge    | Youth        | Last Month    | YR2     |
|                 |                     | Parent       | Last Month    | PY2     |

## **Issues in offering the SDQ**

### **When not to offer**

In general, all adolescent patients (youths) and their families should be asked to complete the SDQ measures at the same scheduled Collection occasions as the clinical rating scales are completed (that is, admission, review and discharge). However, due to the nature and severity of their mental health or other problems some youths should never be asked to complete self-report measures, others may not be able to complete the self-report measures at the scheduled occasion, whilst still others may sometimes find completion of the self-report measures to be difficult or very stressful. In these circumstances only the parent version will be collected.

The criteria defining the reasons why the collection of self-report measures would be contraindicated are outlined below. In all cases, the judgement of the Responsible staff member as to the appropriateness of seeking the child or young person's response to such measures should be the determining factor at any given Collection occasion. Where collection of self-report measures is contraindicated, the reasons should be recorded and also coded using the Collection status data item.

### **General SDQ Youth Self Report exclusions**

Some youths may not be able to complete self-report measures at any time and should not be asked to do so. Included in this group are children with a principal or additional diagnosis of an organic mental disorder (F00–F09 in ICD–10–AM) or mental retardation (F70–F79 in ICD–10–AM) of sufficient severity to make it unlikely that their responses to a self-report questionnaire could be obtained, or that if their responses were obtained it would be considered unlikely that they were a reasonable indication of the child or young person's feelings and thoughts about their current emotional and behavioural problems or wellbeing.

Still try to collect the information from the families.

### **Temporary contraindication**

Under certain conditions, a youth and/or their parent may not be able to complete the questionnaire at the scheduled occasion. Youths or families in this group need not be asked to complete self-report measures at the time when they meet the specified criteria. At all other times, an attempt should be made to obtain their responses. This group includes youths whose current clinical state is of sufficient severity to make it unlikely that their responses to a self-report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that they were a reasonable indication of their feelings and thoughts about their current emotional and behavioural problems or wellbeing. If depressed, such youths are likely to report that their current emotional or

mental state is such that they find the completion of the self-report questionnaire(s) to be too distressing, or to require a level of concentration or effort they feel unable to give.

Usually the severity of the youth's clinical state will be brought under control quite quickly. It is recommended that if within a period of no more than 72 hours following the scheduled assessment occasion in an inpatient setting and no more than 7 days in an ambulatory care setting the child or young person appears likely to be able to complete the self-report questionnaire then their responses should be sought at that time. Otherwise, no further attempt to administer the self-report questionnaire at that Collection occasion should be made.

### **Offering the measure**

The SDQ should be offered in as positive a manner as possible. It should not be presented as another piece of paper work that is "required" but a genuine attempt on the part of the clinician to collect information on the child or youth's current condition and establish a productive dialogue.

In general, children and parents will require an explanation of the self report measure that covers the following areas:

- ▶ Why is it important to complete these self rated measures?
- ▶ What happens if they refuse to complete the measure, will it have any detrimental effect on the treatment their child receive?
- ▶ Who is going to use the information?
- ▶ What is the information going to be used for?

Even the best approach may result in the youth or the family declining to complete the measures. This should be seen as an opportunity to demonstrate to the family and the child that their opinion is important by re offering the measure. In inpatient units this should be within three days of admission or review. In the community, it would be appropriate to offer the self-rating measure within the next week. If the youth again refuses to complete the measure then further attempts should not be attempted until the next collection occasion.

## **Detailed Guidelines On How To Offer Self-Report Measures And How To Respond To Questions From The Youth And The Family.**

### **On Admission**

The following words (or a variation appropriately reworded to match your own style) is suggested for introducing the SDQ measures.

*Parents:*



*We would like you to fill out this questionnaire on your child's behaviour over the last six months . For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's (or youth's) behaviour over the last six months*

*It is important to us because it provide us with information as this gives us extra information that we may not get from our interviews and the more information we get the more we will be able to help you.*

#### **Youth**

*We would like you to fill out this questionnaire on your behaviour over the last six months . For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give us the information on the basis how things have been for you over the last six months.*

*It is important to us because it provide us with information about the way you feel and how well you are able to cope with your usual activities. This gives us extra information that we may not get from our interviews and the more information we get the more we will be able to help you.*

#### **Both**

*The information will be kept confidential and only those people involved in your care will have access to it. [Remember to emphasise that] **However, if you choose not to complete this questionnaire, it will in no way effect the treatment you receive.***

*This questionnaire should take about 10 minutes to complete. Please read the instructions before you start. Remember there are no right and wrong answers, just choose the response that best shows how you feel. My self or another member of staff will be here to answer any questions you may have.*

### **At Review**

As the youth and/or the family will have completed the questionnaire on admission into the unit or service, a brief introduction is suitable. The following words are recommended.

*I would like you to fill out this questionnaire again. It was the same one you filled in when you first arrived (started seeing me). By filling this in now, we can compare it to the last one and see what has changed. There are no right or wrong answers **Remember, if you choose not to complete this questionnaire, it will in no way effect the treatment you receive.***

### **Prior to Discharge**

An introduction similar to that used at review should be offered. The following words are recommended.

*Before you leave we would like you to fill out the questionnaire again. By filling this out now, we can compare how things have changed for you. Remember there are no right and wrong answers and **if you choose not to complete the questionnaire, it will in no way effect the treatment you receive.***

### **Administration and Completion of the SDQ**

In all clinical settings and at all occasions, the consumer should be provided with privacy and be free from distractions. Whether in the Hospital, community or home setting, provide a firm writing surface such as a table or clipboard.

## **Closing**

Closing should be the same regardless of setting and occasion. When the youth and or family return the questionnaire, check that they have been completed. If not complete, ask them whether he or she had any difficulty or whether they accidentally missed a question(s). Encourage them to complete the questionnaire. Offer them assistance but do not force them or indirectly indicate that they must complete the questionnaire. Finally, thank them.

When the questionnaire is returned to you, quickly browse through it to make sure that all the questions have been answered. If you notice there are missing items point this out to the consumer and try to elicit the reason in a casual, non-threatening fashion.

*Thanks for filling in the questionnaire – that’s great, I’m really pleased you made the effort. I just wanted to check something with you because you’ve left this out. Did you leave it out because you don’t want to fill it in or did you accidentally skip over it.*

Encourage the youth and/or family to complete the questionnaire. Your exact response should be determined by their reason for non-completion. If they have missed questions accidentally say:

*That’s okay. Would you mind filling them in now? That would be really great.*

## **If you run out of time**

If there are time constraints you may need to leave the questionnaire with them and collect it later. In an outpatient setting you may need to arrange another time or alternatively let them take the questionnaire home with them. In the latter case give them an envelope and ask them to return the completed questionnaire at their next visit. Ask that they finish the questionnaire within the next day or two. Stress the importance of having information about how they are feeling now. Also remind them to complete the questionnaire on their own - you are interested in how they feel. Tell them that when they have finished they should put them in the envelope and then bring them back at their next visit.

## **On completion**

After the questionnaire has been completed you may notice the youth and/or parent has circled more than one answer. If this has only occurred for one question – take the most extreme response. If several or all responses are answered in this fashion try to find out why, then help the consumer to correct their responses.

*This is interesting. I’ve noticed you’ve circled more than one response for these questions. How come you’ve answered in that way – would you like to tell me about it?*

## **Addressing Problems and Questions: Refusal to Complete the Questionnaire**

Youths and their families must not be forced or ordered to fill out the questionnaire. If they refuse, try to find out their reasons for refusal. Acknowledge that their reasons are valid and point out that refusal will in no way affect their treatment. Encourage them to

fill in the questionnaire using the suggested words as outlined below. If they still maintain refusal, take back the questionnaire.

### **Addressing Problems and Questions: Don't want to**

A youth or family member may simply state that he or she does not want to fill in the questionnaire. If they refuse to complete the self report measure, on the Standard Measures Module 2, under codes for collection status **rate 4 Not completed due to refusal by the child or young person.**

### **If the child/young person is hostile**

In an **inpatient** setting it is best to come back later (around three days). Before leaving the youth say:

*I can see you're a bit unsettled at the moment. Why don't we leave these for now?*

Still try to collect the information from the parents.

When you return, say:

*I'm sorry you were upset the other day, it was a bad time to offer you the questionnaire. I know you've only just got here. I hope your feeling a bit more settled. How about I leave this questionnaire with you now. It would be really great if you could fill it in for me.*

In an **ambulatory** care setting it is best to re-present at the next session using similar words as for the inpatient unit.

*I'm sorry you were upset last session, it was a bad time to offer you the questionnaire. I hope your feeling a bit more settled. How about you complete this questionnaire now. It would be really great if you could fill it in for me.*

If when re presented, the youth and or family member remains hostile and you are unable to offer the self report measure, then on the SM2 Module under Collection status rate: 2 (Not completed due to temporary contraindication).

### **If the youth and/or parent is not hostile**

Encourage him or her to complete the questionnaire. If they still say no, discontinue (using the same response as that if the youth and/or parent is hostile) and try again in a day or two, or at the next session (outpatients) or visit (community care). The following words are suggested.

*We are really doing this so we can get a good idea of how you are feeling. This questionnaire is a really useful tool for doing this.*

If the youth and/or parent continues to refuse to complete the self report measure, then on the SM2 Module, under Collection status rate: 4 (Not completed due to refusal by child or young person).

### **Addressing Problems and Questions: Trust**

The youth and/or parent may not trust what you are trying to find out. If this happens, re-emphasise the purpose of the questionnaire and **how the information will help you to help them**. However, care must be taken because the more you re-present the more suspicious they may become. If the youth and/or parent is suspicious to the point of paranoia, there is very little you can do – the more you push the more they will become anxious and concerned about your motives. In this case it is best to discontinue and maybe try again at a later date when the youth and/or parent feels more settled and safe.

### **Addressing Problems and Questions: Time**

If the youth and/or parent states he or she does not have the time, be understanding and encourage them.

*Yes, I understand it can be seen as time consuming, but this information will give us a better understanding of how you feel, and this will help in planning your treatment.*

If the youth and/or parent continues to refuse to complete the self report measure, then on the SM2 Module under Collection status rate: 4 (Not completed due to refusal by child or young person).

### **Addressing Problems and Questions: Confidentiality**

If the youth and/or parent is concerned about people seeing the information, re-emphasise that the information is confidential.

*Like all your medical records, We assure you that the information you provide will be kept in strict confidence. We follow very strict policies and procedures to make sure that only the people involved in your treatment have access to the information.*

*If another clinician requires information about you we would only give them that information if you give us your consent. Also, if you are referred to another clinician, you will be asked to sign a consent form that allows us to talk to that clinician about your treatment.*

If, because of concerns about confidentiality, the youth and/or parent refuses to complete the self report measure, then on the SM2 Module under Collection status rate: 4 (Not completed due to refusal by child or young person).

### **Addressing Problems and Questions: Content**

If the youth and/or parent feels the questionnaire is irrelevant re-emphasise the purpose of the questionnaire. For example, you might say:

*You may not feel this questionnaire is relevant to you but it **does** provide us with very useful information about how you feel and how well you are able to cope with your daily activities. Remember the more information we have the more we will be able to help you.*

If the youth and/or parent feels particular items are irrelevant the following words may be used

*Although this question doesn't seem to apply to you at present, it has been found to be a useful question to ask people with problems like those you currently have. So that we get a clear and reliable picture of how you feel about your problems we need to ask you the same questions we ask everyone else. So its important that you try and answer every question, even though some of them may not seem relevant.*

or

*This questionnaire may not be exactly appropriate for you but just answer it as best you can. Don't worry if some of the questions don't seem to apply to you but, your responses to them can still give us useful information.*

If the youth and/or parent only completed some of the items due to feeling that some were irrelevant, rate on the SM2 under Collection status rate: 1 (Complete or partially complete).

### **Addressing Problems and Questions: Comprehension**

If a youth and/or parent has trouble understanding particular items, ask them which part of the items they are having trouble with. Re-read the question slowly and exactly as it is written. Do not rephrase the question. If the youth and/or parent is unfamiliar with, or does not know the meaning of, a word it is appropriate to provide a definition of that word.

*Try your best, just put down what you feel. There is no right or wrong answer.*

If they are still having trouble and leave some questions unanswered on the measures because of concerns about content, then on the SM1 Module rate: 1 (Complete or partially complete).

If a youth and/or parent asks for clarification of an item so that they can better understand and respond to the question, assist them by slowly re-reading the question exactly as it is written. If they what the question means, do not try to explain it, but suggest he or she:

*Use your own interpretation. We need you to answer the question based on what you think it means. As stated previously, it is appropriate to provide the definition of an unfamiliar or unknown word.*

If the youth and/or parent leaves some questions unanswered on the self report measure because of poor comprehension, then on the SM1 Module under Collection status rate: 1 (Complete or partially complete).

If the youth and/or parent is unable to complete any of the self report measure because of poor comprehension, then on the SM1 Module under Collection status rate: 2 (Not completed due to temporary contraindication).

### **Addressing Problems and Questions: Confusion**

Some youths and/or parents may find some questions confusing, repetitive or similar. They may feel they've already answered a question and then don't know how to answer one that is similar. If this occurs, explain that

*Yes, some of the questions are (seem) a bit the same, but asking things in different ways can sometimes give us more reliable information about the way you feel. Just answer it as best you can. Remember there is no right or wrong answer – this is purely to monitor how you are feeling about your problems. If some of the questions are similar that's okay. Don't think about it too hard – you'll probably have an immediate reaction – so if that's how you feel when you read it, that's what you should answer.*

If the youth and/or parent is unable to complete the self report measure because of confusion, then on the SM1 Module under Collection status rate: 2 (Not completed due to temporary contraindication).

### **Addressing Problems and Questions: Poor memory**

Some youth and/or parents may have difficulty with their memory. By the time they have read through all the response alternatives to a question they can't remember what the first one was or, what the question was. A youth and/or parent may inform you of this difficulty or you may notice it yourself. In either case it may be best to sit with him or her and work through the questionnaire with them. Read the questions and responses aloud to them. In this way you can act as a memory prompt. Ask them:

*Would you like me to sit with you. We can work through the questions together.*

If the youth and/or parent is unable to complete the self report measure because of poor memory, then on the SM1 Module under Collection status rate: 2 (Not completed due to temporary contraindication).

### **Addressing Problems and Questions: Poor eyesight**

If a youth and/or parent has forgotten his or her glasses, offer to sit with them and read the questions aloud for them.

If the youth and/or parent is unable to complete the self report measure because of poor eyesight and **there is not** sufficient time to read the questionnaire to them, either initially or at a later occasion, then identify that on the SM1 Module under Collection status rate: 2 (Not completed due to temporary contraindication).

### **Addressing Problems and Questions: Uncertainty**

Youth and/or parents may feel uncertainty as to how to answer. Try to ease their uncertainty and encourage them. Often their uncertainty is focussed around the limited responses available to them in a particular question. In those cases you need to help them to stop worrying too much about accuracy and encourage them to make their best guess.

If the youth and/or parent says something like “I'm sort of half this - half that, what should I put down?” you may say:

*Do the best you can - just answer how you **most** feel – whichever one suits you best.*

If the youth and/or parent leaves some questions unanswered on the self report measure because of uncertainty, then on the SM1 Module under Collection status rate: 1 (Complete or partially complete).

If the youth and/or parent is unable to complete any of the self report measure because of uncertainty on the SM1 Module under Collection status rate: 2 (Not completed due to temporary contraindication).

**Addressing Problems and Questions: Don't think the questions were relevant – It's a waste of time**

If the youth and/or parent feels the questionnaire or some questions in a questionnaire are irrelevant choose one of the following responses:

*Although this question doesn't seem to apply to you at present, it has been found to be a useful question to ask people with problems like those you currently have. So its important that you try and answer every question, even though some of them may not seem relevant.*

or

*This questionnaire may not be exactly appropriate for you but just answer it as best you can. Don't worry if some of the questions don't seem to apply to you – your responses to them will give us useful information.*

If the youth and/or parent leaves some questions unanswered on the self report measure because they feel it is a waste of time, then on the SM1 Module under Collection status rate: 1 (Complete or partially complete).

If the youth and/or parent is unable to complete any of the self report measure because they feel it is a waste of time, then on the SM1 Module under Collection status rate: 4 (Not completed due to refusal by child or young person).

**Addressing Problems and Questions: Too Long**

If a youth and/or parent indicates he/she did not complete the questionnaire because it is too long say:

*Sorry about that, but it does provide us with important information which we can use to help you and others like you.*

If the youth and/or parent leaves some questions unanswered on the self report measure because they feel it is too long, then on the SM1 Module under Collection status rate: 1 (Complete or partially complete).

If the youth and/or parent is unable to complete any of the self report measure because they feel it is too long, then on the SM1 Module under Collection status rate: 4 (Not completed due to refusal by the child or young person).

## **The Don'ts of questionnaire administration**

### **Things to be avoided when offering self-report questionnaires:**

- Do not force or command the child or young person to fill out the questionnaire.
- Do not tell the child or young person that treatment is dependent on their filling out the questionnaire.
- Do not minimise the importance of filling out the questionnaire.
- Do not accept an incomplete questionnaire without first encouraging the child or young person to fill out unanswered questions.
- Do not paraphrase, rephrase, interpret or explain a question.
- Do not answer the question for the child or young person.
- Do not tell the child or young person how you feel they should answer.
- Do not allow other people to help the child or young person fill out the questionnaire .
- Do not assume the child or young person can do it and just doesn't want to (i.e.. if a person tells you they cannot do it - accept that he is telling the truth.
- Do not tell the child or young person to go home and get their family to help them.

## **The Do's of questionnaire administration**

### **Things to do when offering self-report measures:**

- Do be warm, friendly and helpful.
- Do request and encourage the child or young person to fill out the questionnaire.
- Do have the child or young person fill out the questionnaire before any others that are in the battery.
- Do let the child or young person know that you will be there to assist them if needed.
- Do tell the child or young person to answer a question based on what THEY think the question means.
- Do encourage the child or young person to answer ALL the questions.
- Do read and repeat a question verbatim for the child or young person.
- Do stress there is no right or wrong answer.
- Do inform the child or young person that they will be required to fill out the questionnaire again at a later date.
- Do thank the child or young person for filling out the questionnaire.
- Do provide definition of a single word a person is unfamiliar with.



## **Core Reading(s)**

Goodman, Robert; Ford, Tamsin; Simmons, Helen; Gatward, Rebecca; Meltzer, Howart (2000), *Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample*, *The British Journal of Psychiatry*, Volume 177 pp 534-539

## **Supplementary Readings**

Adams JW. Snowling MJ. Hennessy SM. Kind P. (1999) Problems of behaviour, reading and arithmetic: assessments of comorbidity using the Strengths and Difficulties Questionnaire. *British Journal of Educational Psychology*. 69 ( Pt 4):571-85.

Goodman R. Ford T. Simmons H. Gatward R. Meltzer H. (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *British Journal of Psychiatry*. 177:534-9.

Goodman R. (1999) The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology & Psychiatry & Allied Disciplines*. 40(5):791-9.

Goodman R. Scott S. (1999) Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: is small beautiful?. *Journal of Abnormal Child Psychology*. 27(1):17-24.

Goodman R. Meltzer H. Bailey V. (1998)The Strengths and Difficulties Questionnaire: a pilot study on the validity of the self-report version. *European Child & Adolescent Psychiatry*. 7(3):125-30.

Goodman R. (1997)The Strengths and Difficulties Questionnaire: a research note. *Journal of Child Psychology & Psychiatry & Allied Disciplines*. 38(5):581-6.

Goodman R. Renfrew D. Mullick M. (2000) Predicting type of psychiatric disorder from Strengths and Difficulties Questionnaire (SDQ) scores in child mental health clinics in London and Dhaka. *European Child & Adolescent Psychiatry*. 9(2):129-34.

Koskelainen M. Sourander A. Kaljonen A. (2000)The Strengths and Difficulties Questionnaire among Finnish school-aged children and adolescents. *European Child & Adolescent Psychiatry*. 9(4):277-84.

Goodman, R (2001) Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40:11, November 2001.

Useful links:

<http://www.sdqinfo.com>

## **Y Activity**

Try the SDQ quick quiz, which versions of the SDQ are to be used in the following situations

| Situation   | SDQ Form |
|---|----------|
| Bernie is 3 years old and presents with his mother for review                                       |          |
| You are seeing Jenny for the first time, she is 17 years old and she comes to her appointment alone |          |
| Bill is 12 years old and attends his first appointment with his mother                              |          |
| Tim is 18 years old and attends his first appointment with his mother                               |          |

What is the rating period of the SDQ on admission, review and discharge?