Australian Mental Health Outcomes and Classification Network

Sharing Information to Improve Outcomes

Rater and Clinical Utility Training Manual

CHILD AND ADOLESCENT

Acknowledgements

Acknowledgement of Country
We acknowledge the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of Australia. We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of AMHOCN resources.

Acknowledgment of Lived Experience
We would like to recognise those with lived experience of mental health conditions in Australia. We acknowledge that we can only provide quality care through valuing, respecting and drawing upon the lived experience and expert knowledge of consumers, their families, carers and friends, staff and the local communities. We acknowledge their contribution to the development of AMHOCN resources.

Suggested citation for this document
Australian Mental Health Outcomes and Classification Network. (2021). Rater and clinical utility training manual: Child and adolescent. Rev. ed. Sydney: Australian Mental Health Outcomes and Classification Network.

Contents

1. Introduction to the manual

This training manual has been developed as part of a training package designed to provide rater and clinical utility training. It has been structured so that it provides the contents of a one day training workshop which not only covers refresher training but also includes resources to assist mental health staff explore the clinical utility of the measures introduced under the National Outcomes and Casemix Collection (NOCC).

Some of the underlying principles, which shape this training manual, include:

- the need to utilise the principles of adult learning;
- ensuring that participants can relate the material to their work environment; and
- giving participants the opportunity to engage with the material.

Before commencing training, trainers should have a good understanding of the measures introduced under NOCC and their clinical application. Additionally, trainers should possess knowledge and/or experience in the use of aggregate reports in service development and/or improvement activities.

Before commencing training, trainers should ensure that they have access to the following training materials:

- Child and Adolescent Rater and Clinical Utility Training Manual (this document);
- Child and Adolescent self report measure;
- PowerPoint projector and laptop;
- Materials to support discussion e.g., white board, flip chart, markers;
- Vignette material (Video, written material); and
- Example service reports of outcome measures.

In this training manual symbols are used to indicate activities that the trainer should undertake:

This symbol indicates that trainers should make explicit certain important training points.

This symbol indicates that trainers should show a particular video clip or written vignette.

This symbol indicates that trainers should encourage group discussion.

This symbol indicates that trainers should distribute specific handout materials.

This symbol indicates the notional time each section should take.

2. Workshop timetable

This is a notional timetable as groups will vary in size and knowledge of the measures. Given this potential variation and its impact on the amount of discussion that takes place during activities, the timing of each activity may vary. The optimum group size is 15. This enables the creation of 3 teams of 5 people and 5 groups of 3 for individual activities. These notional timings are based on 15 participants.

Approximate Timing	**Content**
10 minutes	Introduction • Objectives of workshop
90 minutes	Refresher HoNOSCA rating • Overview of rating the HoNOSCA • Practice rating - vignette • HoNOSCA feedback/discussion of ratings • Clarification of rating rules
	Morning tea
10 Minutes	CGAS and FIHS
15 Minutes	Review other measures • Phase of Care • Diagnosis • Legal Status
90 minutes	Consumer self assessment – The SDQ • Measure overview and offering • Activity - Consumer Self Assessment Fidelity Checklist • Discussion
	Lunch
15 minutes	Making sense of the numbers • Exploring reference material
45 minutes	Care and treatment planning • Preparation, action and expectations
30 minutes	Understanding variation across teams • What additional information is required?
	Afternoon tea / Close

AMHOCN

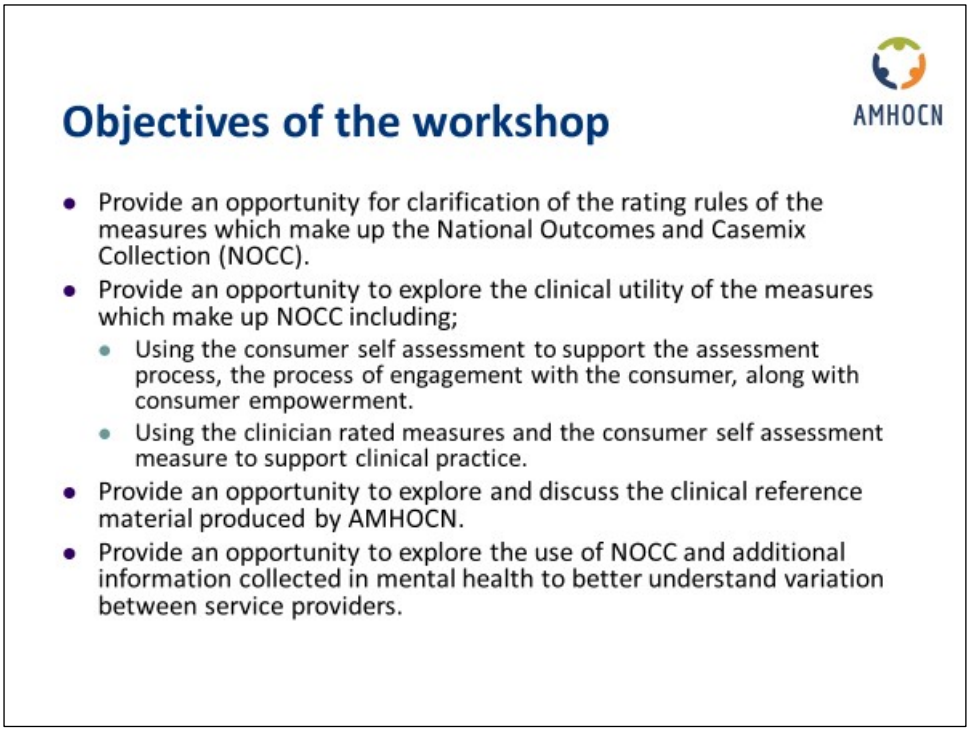
NOCC Rater and Clinical Utility Training

Child and Adolescent Services

This slide simply introduces the title of the workshop.

Take this opportunity to have acknowledgement of country, recognition of lived experience, undertake housekeeping activities such as fire and evacuation procedures, bathrooms, messages, mobile phone etiquette. Introduce presenter and, depending on group size, participants.

3. Training introduction and learning objectives



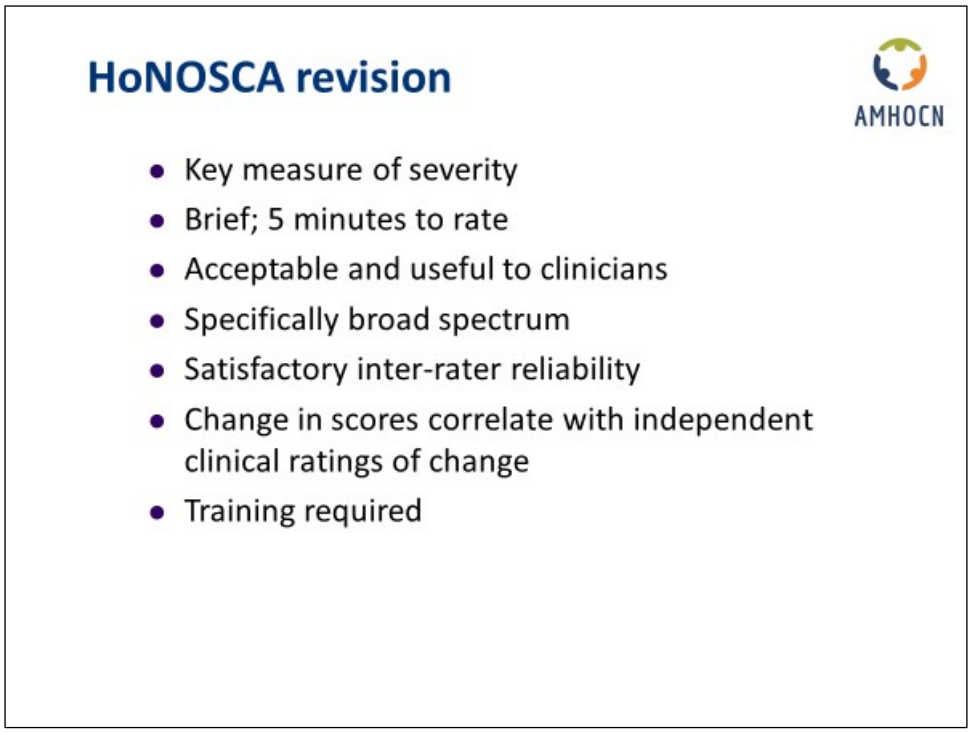
Trainers should identify the objectives of the workshop:

- Provide an opportunity for clarification of the rating rules of the measures which make up the National Outcomes and Casemix Collection (NOCC).
- Provide an opportunity to explore the clinical utility of the measures which make up NOCC including:
  - Using the consumer self assessment to support, the assessment process, the process of engagement with the consumer along with consumer empowerment; and
  - Using the clinician rated measures and the consumer self assessment measure to support clinical practice.
- Provide an opportunity to explore and discuss the clinical reference material being produced by AMHOCN.
- Provide an opportunity to explore the use of NOCC and additional information collected in mental health to better understand variation between service providers.

This section should take approximately 10 minutes to complete.

4. HoNOSCA refresher training

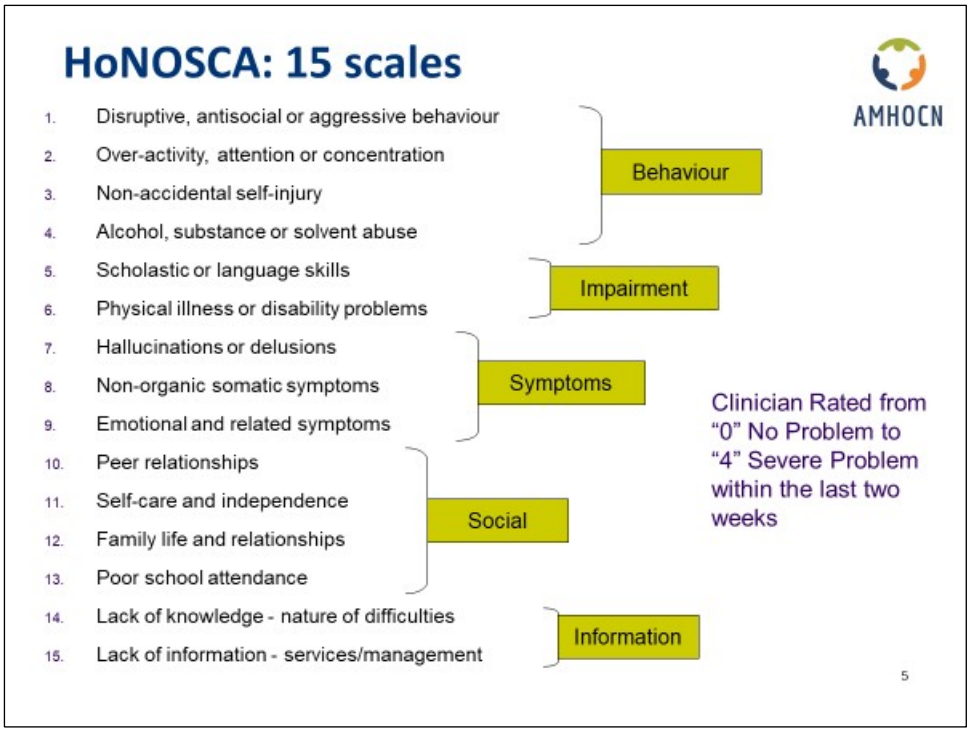
The slides that follow are simply an opportunity to provide refresher training in relation to the measures introduced under the NOCC.



The HoNOSCA is not a diagnostic or screening tool but was specifically designed to be a broad-spectrum measure of the severity of the consumer's problems over the past two weeks. It does display adequate psychometric properties.

Refer participants to the HoNOSCA Glossary and note that the HoNOSCA:

- is a key measure of severity;
- is brief – approximately 5 minutes to rate;
- is acceptable and useful to clinicians - specifically broad spectrum;
- has satisfactory inter-rater reliability;
- change in scores correlate with independent clinical ratings of change; and
- training required.



The 15 scales of the HoNOSCA can be broken down into 5 sub-scales:

- Behaviour;
- Impairment;
- Symptoms
- Social; and
- Information

Reports on the measure can be generated at the scale, sub-scale and total score. Check your local systems for the current reports. You can also go to the AMHOCN web Decision Support Tool (wDST) or AMHOCN Reports Portal to view national or jurisdictional aggregated reports of the NOCC measures collected across states and territories.

Rating the HoNOSCA

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				Monitor ?	Active treatment or management plan ?
Clinically Significant	4	Severe to very severe problem	Most severe category for patient's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. *Note – patient can get worse.*	✓	✓
	3	Moderate problem	Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	2	Mild problem	Warrants recording in clinical notes. May or not be incorporated in care plan.	✓	✓
Not Clinically Significant	1	Minor problem	Requires no formal action. May or may not be recorded in clinical file.	Maybe	×
	0	No problem	Problem not present.	×	×

Note that the HoNOSCA is scored on a 5-point scale from 0 to 4 as below:

0 = no problem
1 = sub-clinical problem
2 = mild problem
3 = moderate problem
4 = severe problem
9 = not known

Trainees should be encouraged to avoid rating a "9" as much as possible, because:

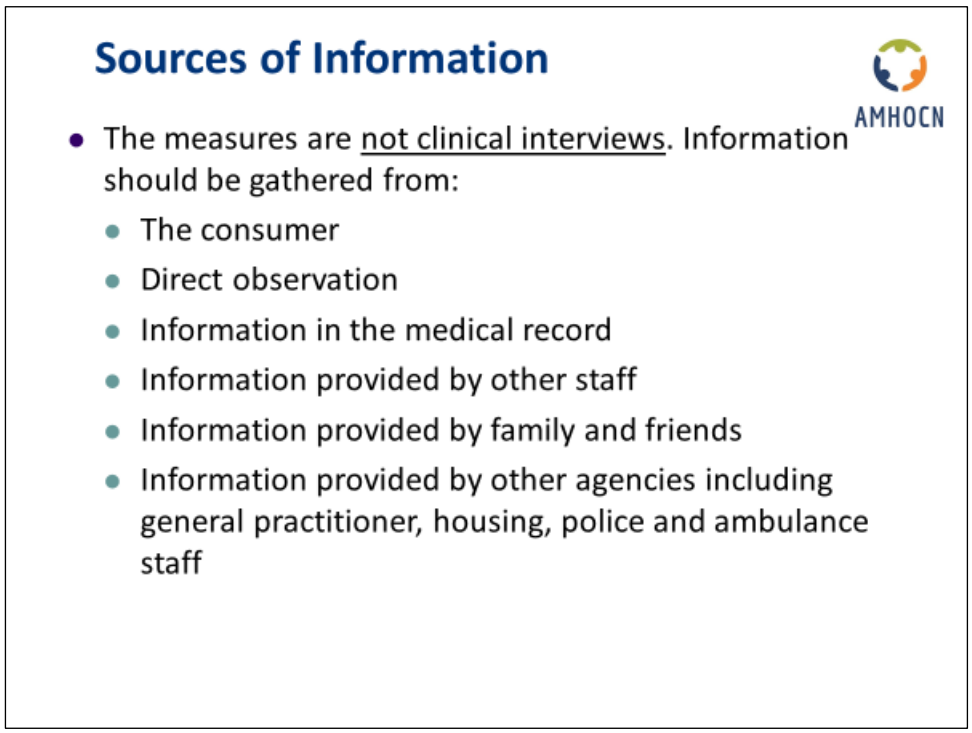
- the HoNOSCA is completed following an assessment, allowing the clinician to make some judgement about the severity of the consumer's problems; and
- the provision of a rating provides a point of reference for subsequent ratings. Without this reference point, valuable opportunities for reflection are lost.

The HoNOSCA is completed after a comprehensive assessment at admission, review or discharge. Following assessment, the clinician can make a judgement on the clinical significance of the problems experienced by the consumer. In this context clinical significance is seen as a problem that is monitored by the clinician and there are documented interventions.

If clinically significant, a rating of 2, 3 or 4 is appropriate and the clinician should refer to the glossary to determine specific ratings. If not clinically significant then a rating of 0 or 1 is more appropriate.

It is important to reinforce that the completion of the HoNOSCA is an overt judgement by the clinician of the severity of the consumer's problems in a particular domain. Later activities in this

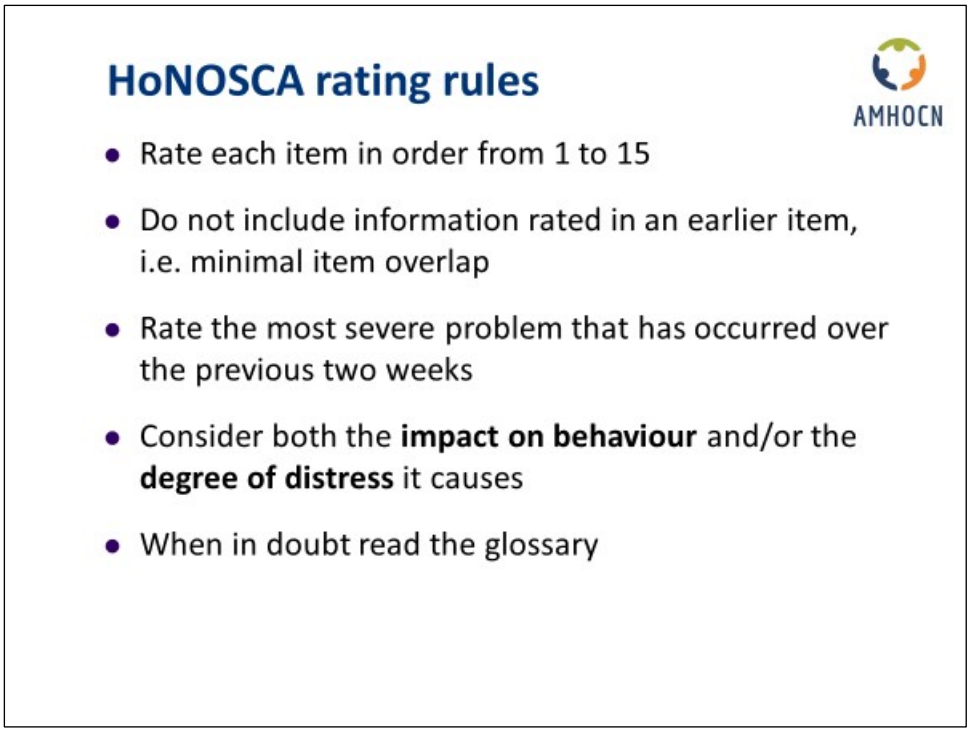
workshop rely on clinicians' reflections on the significance of ratings and possible interventions.



The HoNOSCA is not a clinical interview. Information should be gathered from:

- the consumer;
- direct observation;
- information in the medical record;
- information provided by other staff;
- information provided by family and friends; and
- information provided by other agencies including general practitioner, housing, police or ambulance staff.

Whatever information the clinician has available to make a clinical judgement on the severity of the consumer's problems is the information used to guide the rating of the HoNOSCA.

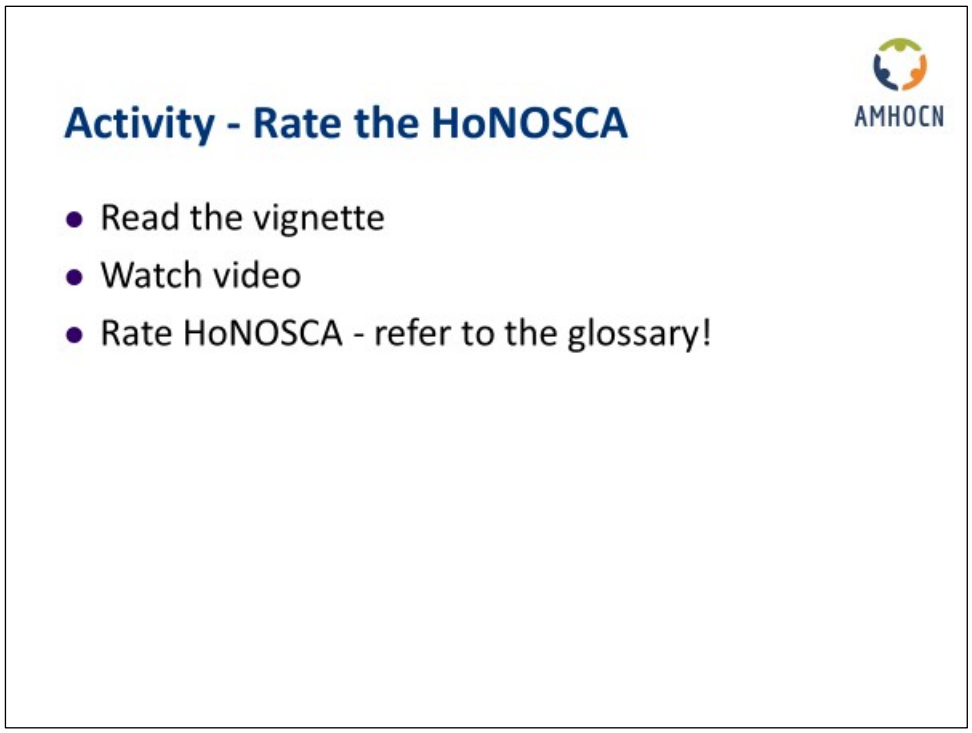


This slide outlines the basic rating rules of the HoNOSCA.

It is important to avoid overlapping ratings when completing the HoNOSCA. The HoNOSCA is a collection of 15 scales and, as such, to get as clear an impression of the unique presentation of the consumer, it is important to ensure that only problem areas for that consumer are identified. Therefore, once a problem has been rated, the severity of that rating should not influence subsequent ratings.

For example, consider the following example:
Last week, Tommy had an argument with a friend and, as a result, hits him. This behaviour would score higher on a Scale 1 (”disruptive, antisocial or aggressive behaviour…”) as a result of the hitting, but may not score high on Scale 10, (”peer relationships”) given that the argument was a one off.

Ratings are made on the worst manifestation of the problem over the preceding two weeks. Ratings are based on the degree of distress the consumer is experiencing and/or the frequency or intensity of behaviour associated with the problem.



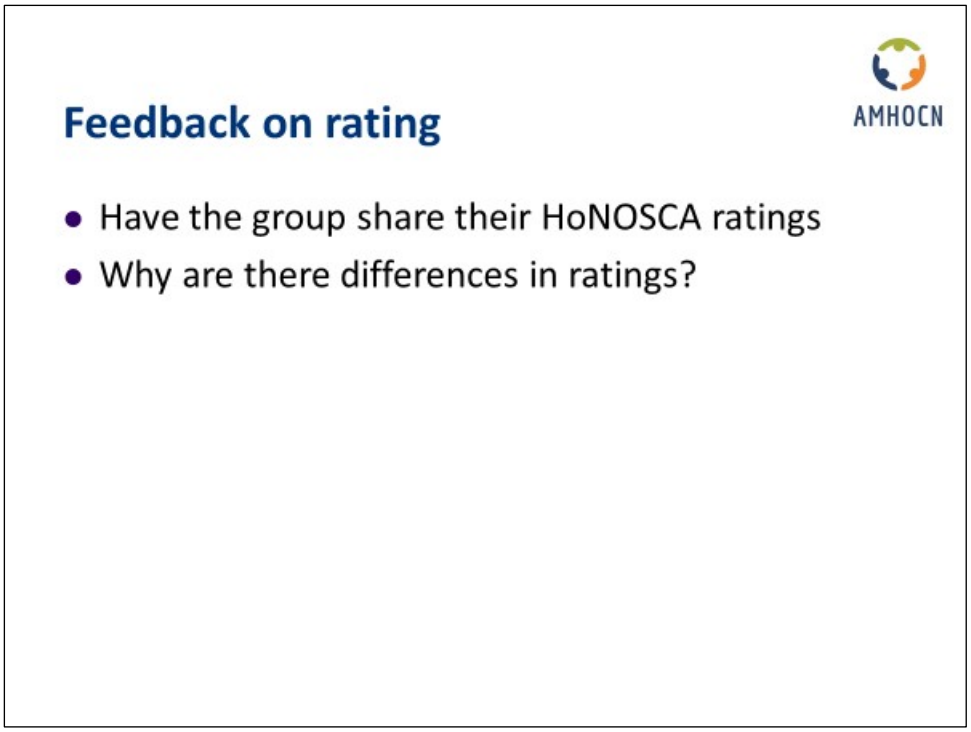
The practice rating of the HoNOSCA is a useful training activity where:

- Participants read a written vignette or watch a video vignette.
- Participants practice rating the HoNOSCA, referring to the glossary.
- Participants share their ratings and compare and contrast their ratings to the provided consensus ratings.

Trainers should have a good knowledge of the vignette, the HoNOSCA and its rating rules.

Distribute copies of the written vignette material, the Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA) Glossary and a blank rating sheet. The HoNOSCA Glossary and blank rating sheet are available in Section 12.4 of this manual. Written and video vignettes are available from the AMHOCN website.

Participants should then rate the HoNOSCA.



Participants share their ratings.

An essential component of training is promoting discussion around reasons for particular ratings. This discussion cannot be overlooked as it provides a valuable opportunity to clarify the rating rules of the measures.

As this is refresher training, trainers should not spend excessive time in discussing variation - it is to be expected. However, when there is wide variation in the ratings for scales, take the time to discuss.

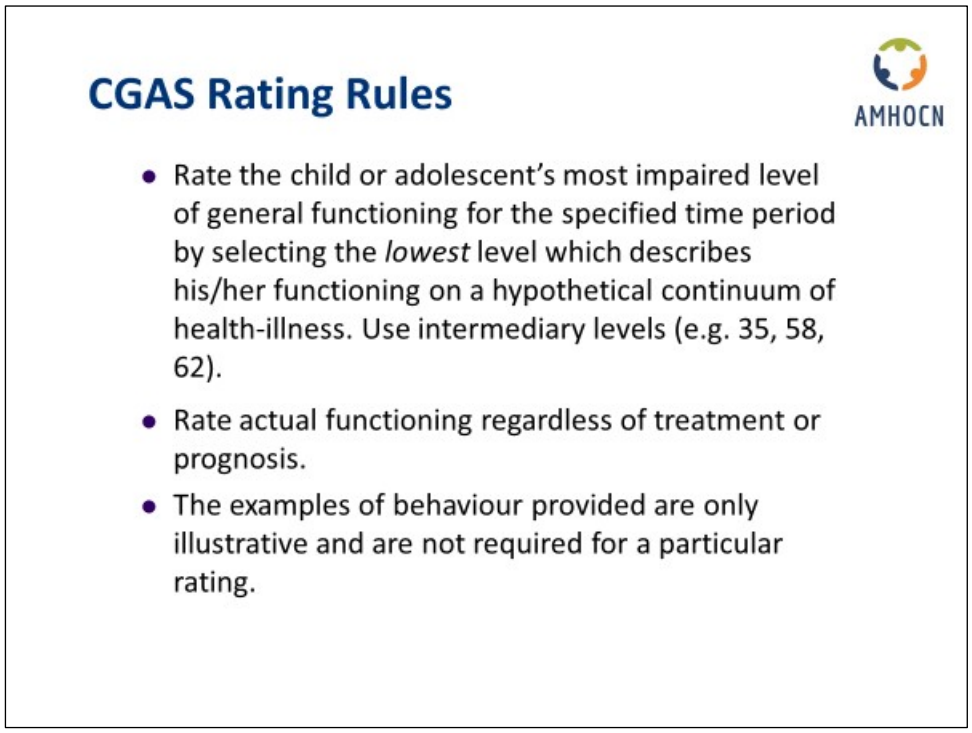
It is important to note:

- Perfect inter-rater reliability has never been demonstrated.
- Poor inter-rater reliability can be the result of misapplication of the rating rules on any measure.
- Inter-rater reliability can be affected by the quality of assessment or lack of information between raters.
- Note that the instrument usually demonstrates satisfactory inter-rater reliability during training.

This section should take approximately 90 minutes to complete.

Trainers should now take the opportunity to provide a brief recap of the other measures introduced under the NOCC.

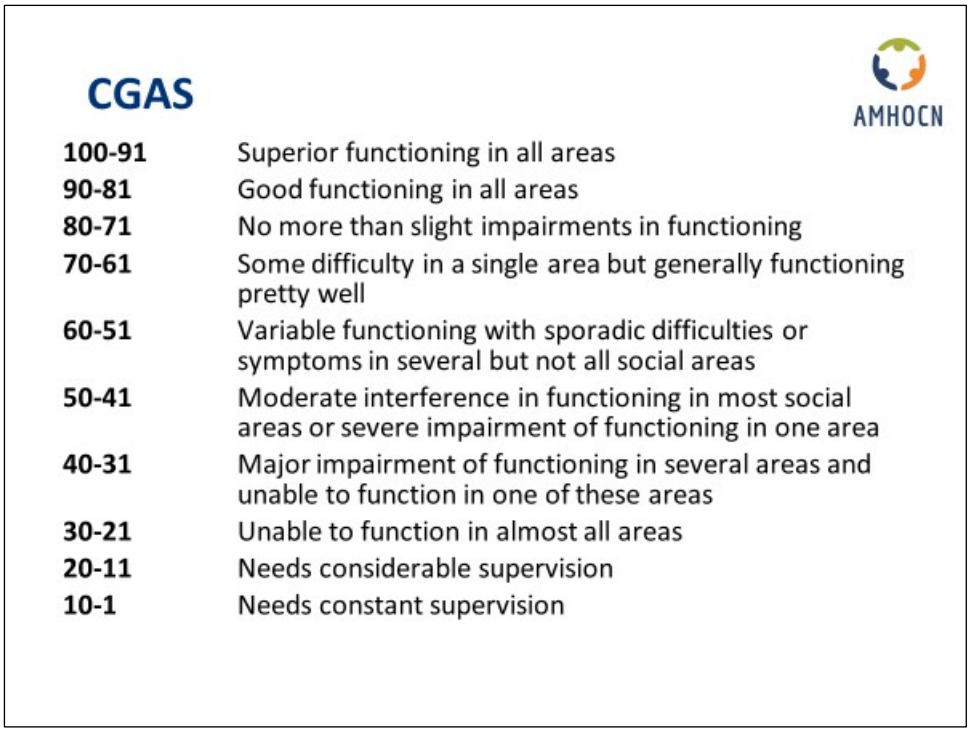
5. CGAS refresher training



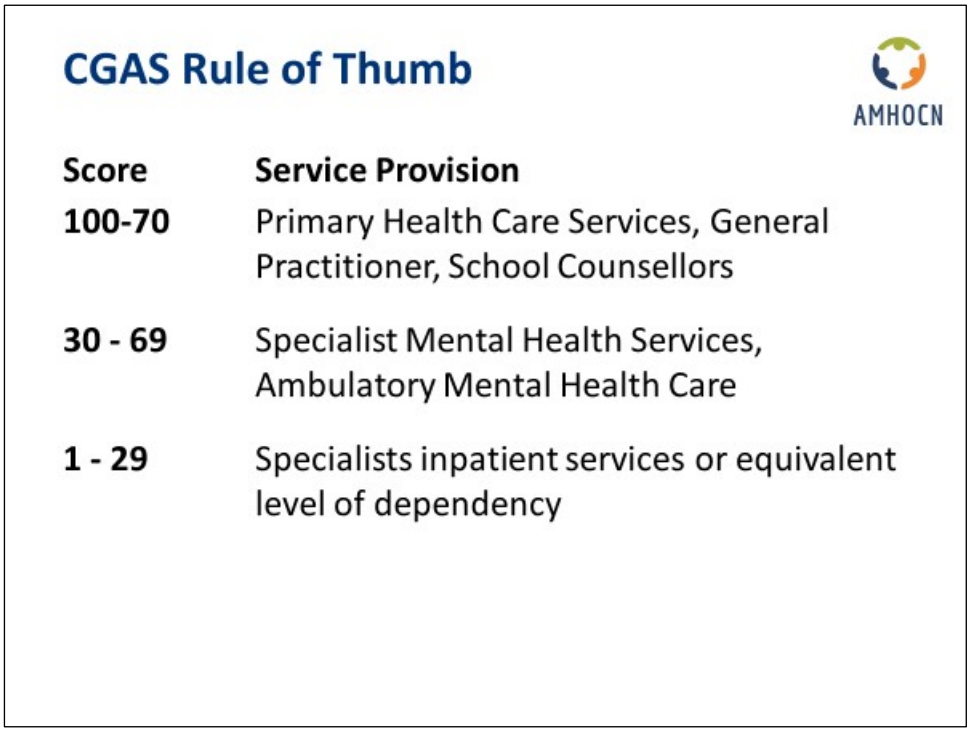
Distribute copies of the CGAS to workshop participants.

Give participants an overview of the Children's Global Assessment Scale (CGAS).

The CGAS was developed by Schaffer and colleagues at the Department of Psychiatry, Columbia University to provide a measure of severity of disturbance in children and adolescents. It is designed to reflect the lowest level of functioning for a child or an adolescent during a specified period.

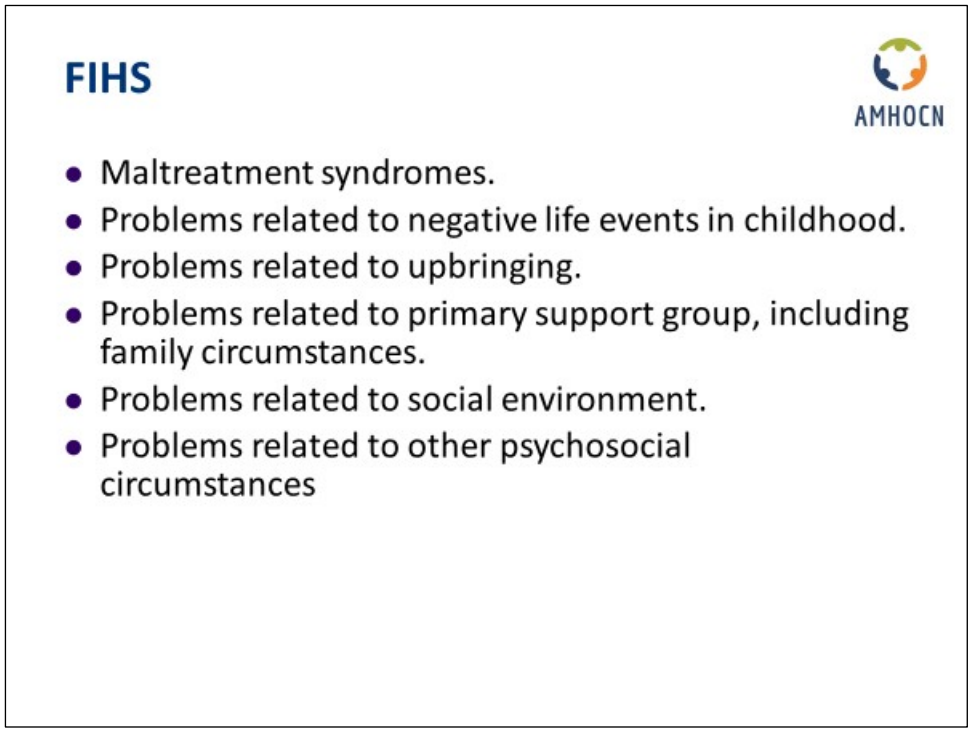


This slide provides an overview of the scales for the CGAS. The measure provides a single global rating only, on a scale of 1- 100. Clinicians assign a score, with 1 representing the most functionally impaired child, and 100 the healthiest. The CGAS contains detailed behaviourally oriented descriptions of each anchor point that depict behaviours and life situations applicable to children and adolescents.



Give a brief overview of the CGAS rule of thumb indicator of the consumer's level of functioning and potential service requirements.

6. FIHS refresher training



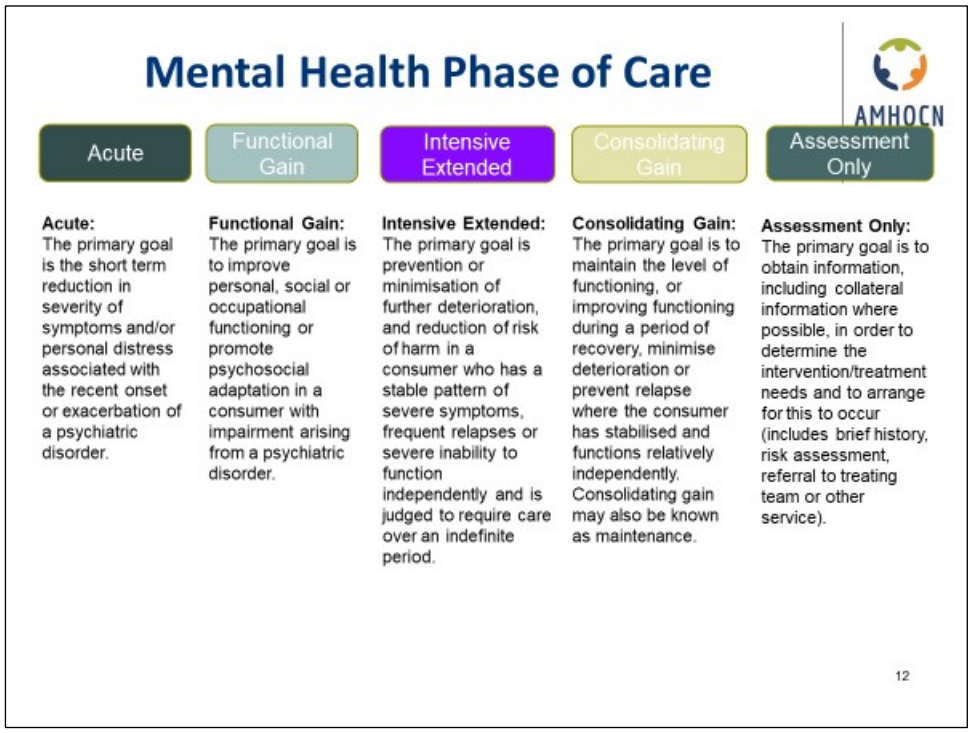
The purpose of these items is to identify the degree to which the child or adolescent has 'complicating psychosocial factors' that require additional clinical input during an episode of care. They are important in understanding variations in outcomes and are based on advice by clinicians that children or adolescents, seen by specialist mental health services, may present in the context of a range of circumstances which influence the person's health status, but are not in 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 FIHS comprises a simple checklist, requiring the clinician to indicate whether one or more factors are present. The seven categories come from the International Classification of Disease (ICD) - 10 and were selected on advice from clinicians about the most frequently occurring factors that influence health status.

The CGAS and FIHS sections should take approximately 10 minutes to complete.

7. Other measures

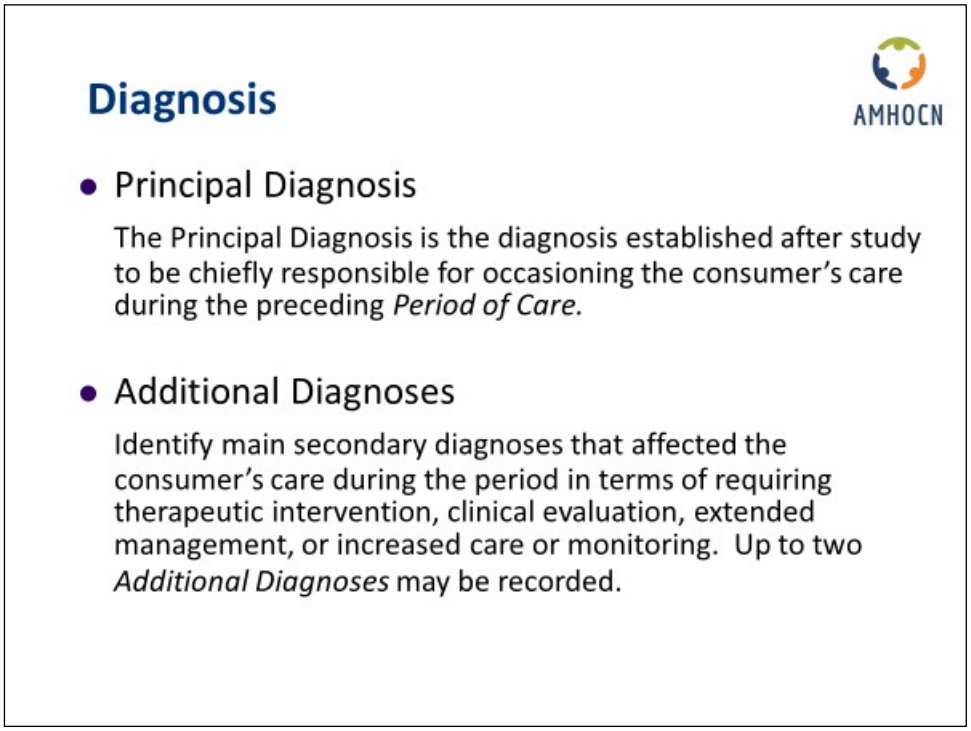
7.1 Mental Health Phase of Care



The Phase of Care is rated by the clinician and requires judgement about the consumer's primary goal of care and the duration and intensity of expected care.

The clinician selects one of 5 phases on admission and the consumer stays within that phase until there is a substantial and sustained change in the consumer's presentation prompting a change in care. The appropriate phase that reflects the new duration and intensity of care is then selected.

7.2 Diagnosis

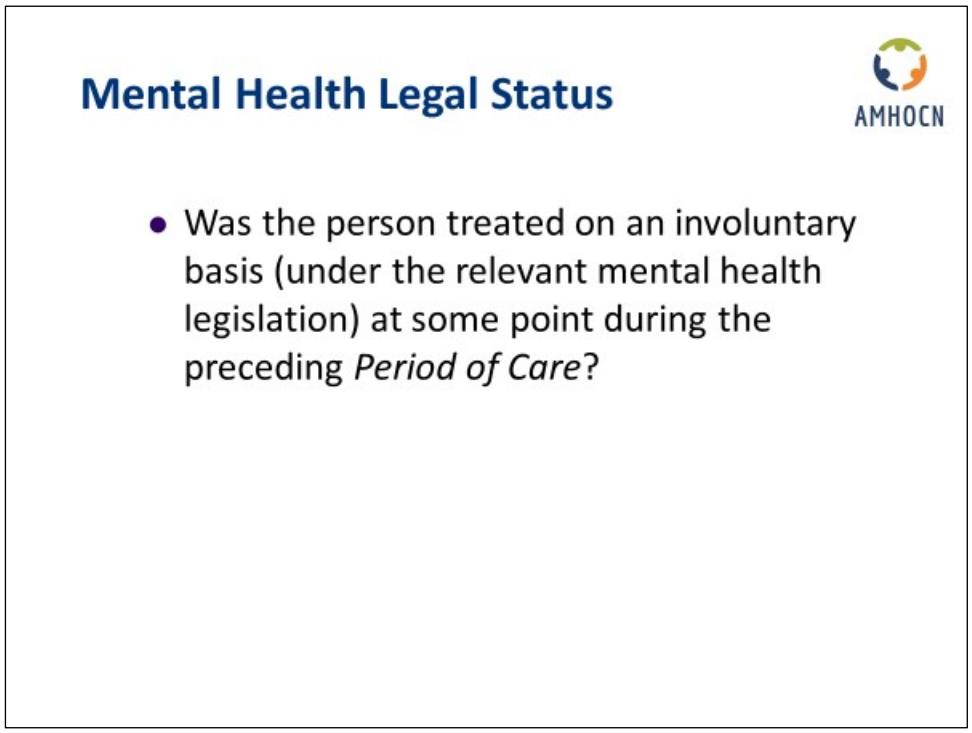


Principal diagnosis is only collected on review and discharge and may be different to the diagnosis identified on admission.

For example, a consumer who has a diagnosis of schizophrenia is admitted to an inpatient unit. Over the course of admission, it is clear that the consumer is suffering a severe depression. Although the admission diagnosis is "schizophrenia" (F20) the principal diagnosis is (F32.2) "severe depressive episode without psychotic symptoms".

The collection of Principal Diagnosis can be a contentious issue during training. Some clinicians feel uncomfortable attaching a diagnostic label to consumers. Others feel that legally only a medical practitioner can make a diagnosis; while others feel that, as a result of their educational preparation, they are more than capable of making a diagnosis and collecting this information.

7.3 Mental Health Legal Status

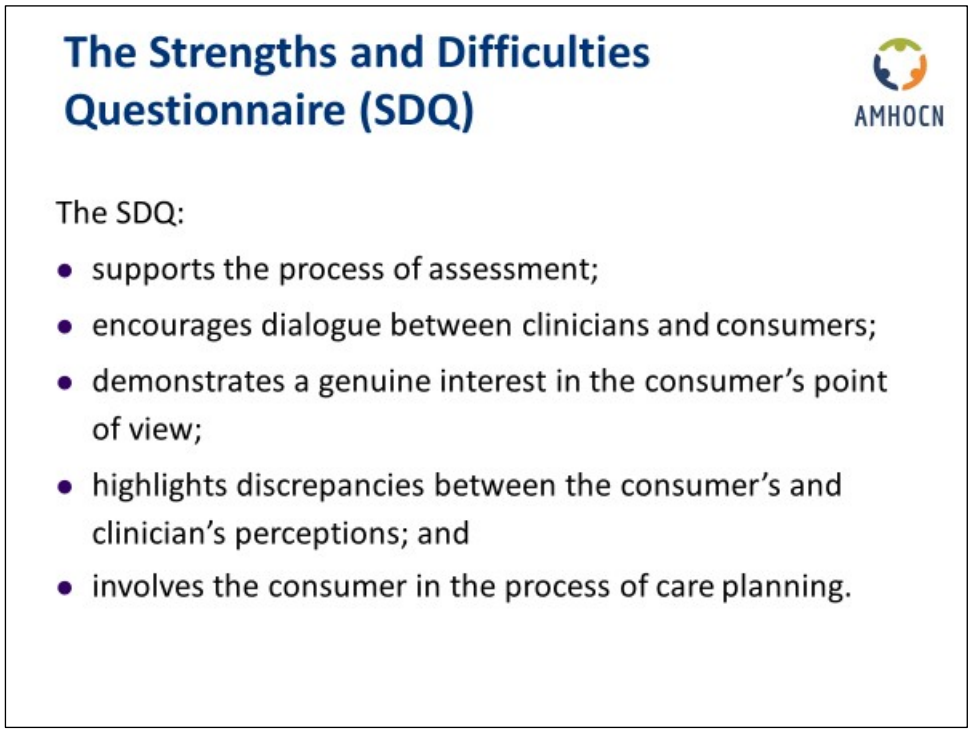


The Mental Health Legal Status is a retrospective indicator and is only collected on review and discharge. The consumer only has to have one episode of involuntary care during their episode of care for this indicator to be positive.

This section should take approximately 15 minutes to complete.

8. SDQ - Consumer self assessment in clinical practice

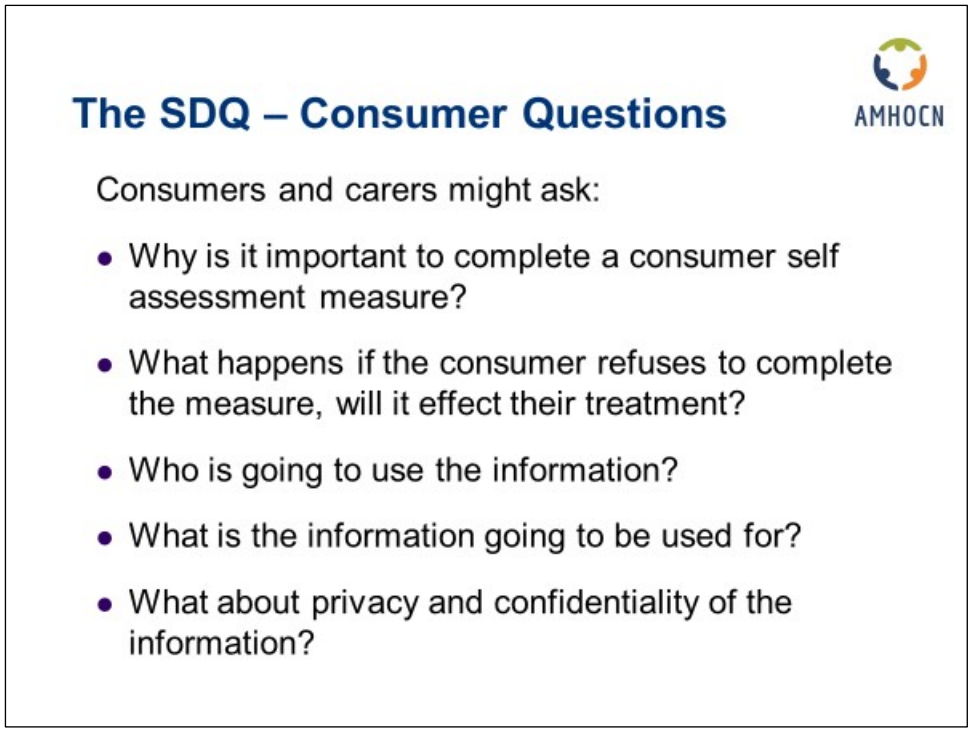
8.1 About the SDQ



The introduction of a consumer self report measure (i.e., the Strengths and Difficulties Questionnaire) provides a number of potential benefits. These include:

- supporting the process of assessment;
- demonstrating a genuine interest in the consumers point of view;
- encouraging dialogue between clinicians and consumers;
- highlighting discrepancies between the consumer's and clinician's perceptions; and
- involving consumer in the process of care planning.

These benefits provide an opportunity to support the development of the therapeutic relationship between the clinician and consumer. Offering the SDQ demonstrates a genuine attempt on the part of the clinician to better understand the consumer's and carer's perceptions and needs and involve them in the process of care.



This slide identifies the types of concerns that consumers and carers often have when offered the SDQ. Therefore, when offering the measure it is important to:

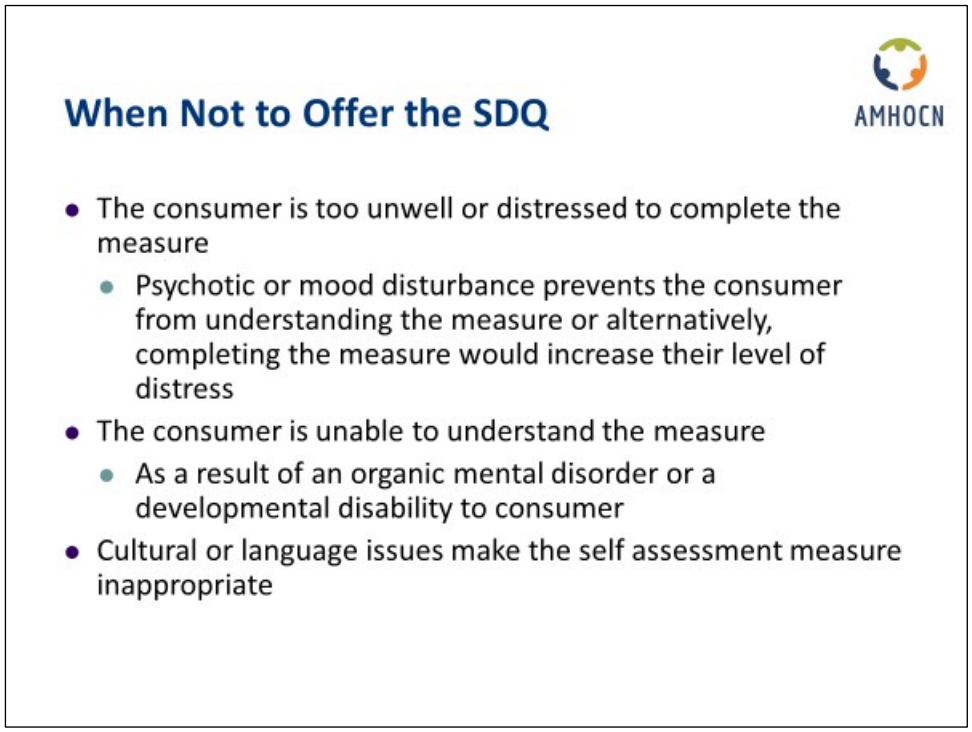
- identify for consumers that the completion of the consumer self assessment measure will provide useful information for the clinician that will inform their work;
- assure consumers that refusal to complete the consumer self assessment measure will not see them treated differently;
- explain to consumers that the information will be available to those involved in the direct care of the consumer but also that de-identified information will be available to service managers and those involved in policy development;
- explain that, in the first instance, the information will be used for individual treatment planning and in a de-identified form for service development and research activities; and
- assure consumers that the consumer self assessment measure is subject to the same rules of confidentiality and privacy as all other information held within the medical record.

When offering the SDQ, there are some general approaches to be adopted i.e., the “Do’s”:

- do be warm, friendly and helpful;
- do request and encourage carers and consumers to fill out the consumer self assessment measure;
- do let consumers and carers know that you will be there to assist them if needed;
- do tell carers and consumers to answer a question based on what THEY think the

question means;

- do encourage consumers and carers to answer ALL the questions;
- do read and repeat a question verbatim for the consumer or carer if necessary;
- do provide definition of a single word with which a person is unfamiliar;
- do stress there is no right or wrong answer;
- do inform carers and consumers that they will be asked to fill out the SDQ again at a later date; and
- do thank carers and consumers for filling out the consumer self assessment measure.



However, there are circumstances when the clinician should exercise clinical judgement when offering the SDQ.

First, if the consumer is distressed and offering the consumer self report measure makes them more distressed, then offering the measure is counter-productive because it interferes with establishing rapport and promoting dialogue. Second, if the consumer is unable to understand the content and requirements for completing the consumer self report measure given their disordered or compromised metal state, then it is counter-productive to offer the measure. Third, if there are cultural or language impediments to offering the measure to consumers, then it should not be offered.

The general rule is that clinicians should exercise clinical judgement when offering the consumer self report measure and be mindful of the purpose of offering the measure i.e., to engage the consumer in their care.

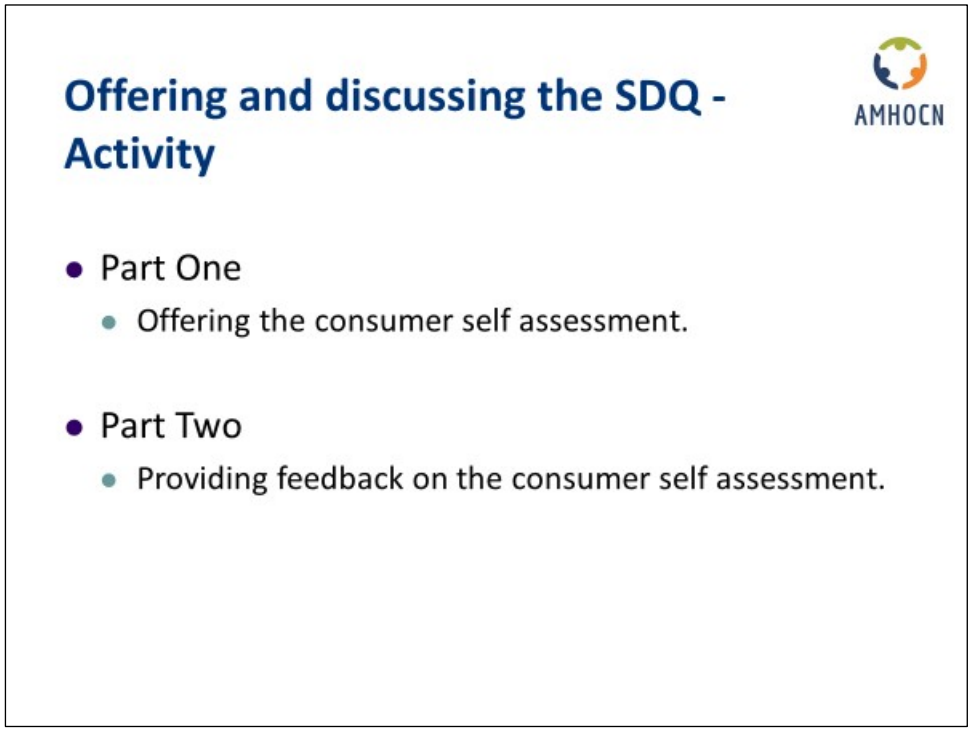
When administering the consumer self assessment measure, there are some general activities or

approaches to be avoided. These constitute the Don’ts of consumer self report measure administration:

- do not force or command consumers or carers to fill out the consumer self report measure;
- do not tell the consumer or carer that treatment is dependent on their filling out the consumer self report measure;
- do not minimise the importance of filling out the consumer self report measure;
- do not accept an incomplete consumer self report measure without first encouraging the consumer or carer to fill out unanswered questions;
- do not paraphrase, rephrase, interpret or explain a question;
- do not answer the question for the consumer or carer;
- do not tell the consumer or carer how you feel they should answer;
- do not allow other people to help the consumer or carer fill out the consumer self report measure; and
- do not assume the consumer or carer can do it and just doesn’t want to (i.e., if a person tells you they cannot do it - accept that).

Trainers should hand out copies of the SDQ.

8.2 Consumer Self Assessment Measure - Activity



The aim of this two part activity, which includes role play, is to provide participants with an opportunity to better understand the clinical utility of the SDQ and practice offering the measure. This activity will show:

- how the SDQ can be used to facilitate consumer, carer and clinician engagement; and
- how the act of offering the SDQ can be used to support the process of care and treatment planning.

Part 1 of the activity focuses on offering the SDQ and Part 2 of the activity involves providing feedback to the consumer or parent/carer on the results of the completion of the SDQ. Trainers should be prepared for this activity by:

- being familiar with the versions of the SDQ;
- having copies of the SDQ available to assist in the training activity; and
- having sample reports for completed consumer self assessments (showing Time 1 and Time 2 completions) that can be generated from local clinical information systems.

Activity - Part 1

In Part 1 of the activity, participants could practice offering the Youth SDQ (i.e., SDQ-YR) to a consumer or offering the Parent SDQ (i.e., SDQ-PC or SDQ-PY) to a parent/carer. Trainers should generate copies of these measures from their local clinical information systems so that participants are familiar with local formats.

Participants form into groups of three where they will practice offering the SDQ:

- Participant one plays EITHER the parent/carer OR the consumer and has a copy of the Parent/Carer Character Information sheet or the Consumer Character Information sheet as appropriate (See copies in Section 12.1).
- Participant two plays the clinician and has a copy of the SDQ to offer.
- Participant three is the observer and holds a copy of Part A of the Consumer Self Assessment Fidelity Checklist to guide observation of the interaction between the clinicians and the parent/carer or consumer as appropriate (See a copy in Section 12.2)

The activity involves:

- The clinician offering the SDQ to the parent/carer or consumer.
- The parent/carer or consumer completing the measure based on the character information.
- During the offering and completion of the measure, the observer looks for fidelity with Part A of the Consumer Self Assessment Fidelity Checklist.
- Once the measure has been offered and completed, the observer gives feedback in relation to the fidelity checklist.

Encourage participants playing the parent/carer or consumer or holding the Consumer Self Assessment Fidelity Checklist not to share this information with the person playing the clinician.

Encourage those playing the parent/carer or consumer to not "over play" the role exaggerating the consumer characteristics that prevent the consumer completing the measure. Part One of the activity does not end until the consumer self assessment has been completed. Indicate to those playing the clinician that they are offering the measure on admission to ambulatory services.

Once all observers have given feedback, facilitate a general group discussion on the opportunities and challenges that face clinicians and consumers in completing the consumer self assessment. Reinforce the clinical skills necessary to integrate the consumer self assessment into clinical practice.

Activity - Part 2

Part 2 of this activity involves providing feedback to the consumer on the results from completing the SDQ.

During this activity, participants swap roles:

- The parent/carer or consumer now becomes the clinician.
- The clinician now becomes the observer.
- The observer now becomes the parent/carer or consumer.

Regardless of how the SDQ is offered, it is important that there is some discussion with the consumer about the results of completion of the measure. Part Two of this activity involves workshop participants exploring the process of providing feedback to the parent/carer or consumer on the issues and information identified in the SDQ.

Distribute a sample report on the SDQ from your service to the participant now playing the clinician. This report should include at least two collection occasions so that clinicians are able to discuss change between two collection occasions.

- The person now playing the clinician has access to both the completed measure (having completed the measure in part one of the activity) along with a sample report.
- The clinician provides feedback to the consumer on how the measure has been completed, and what has or has not changed from the consumer's perspective.
- During the feedback, the observer looks for fidelity with "Part B: Reviewing and Providing Feedback" of the Consumer Self Assessment Fidelity Checklist (See a copy in Section 12.2).

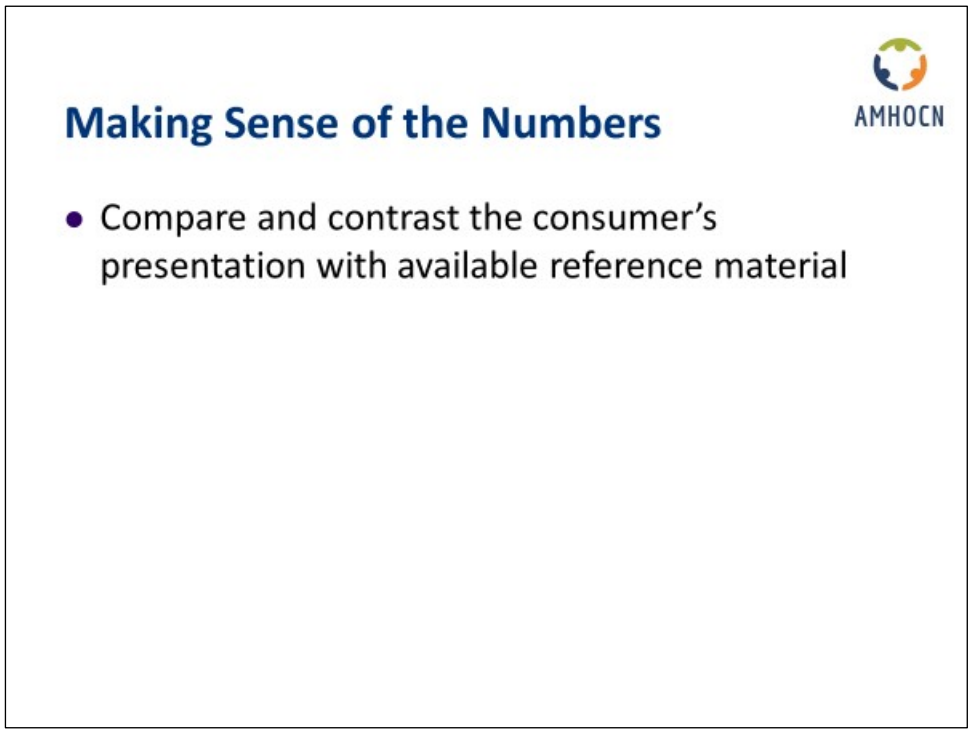
The trainer facilitates a general discussion around the clinical skills required to integrate this type of feedback into clinical practice noting that the consumer self assessment process:

- is an opportunity to support and demonstrate a genuine commitment on the part of mental health service providers to engage the consumer in the care/treatment planning process;

- can be used as a basis for discussion and exploration of differences in opinion;
- can also be used to support consumer empowerment, which includes:
    - the right to make decisions;
    - access to information and resources;
    - having choice and options;
    - listening and being listened to;
    - real people with 'real' lives – respect and recognition;
    - opportunity to effect change; and
    - reclaiming hope.

This section should take approximately 90 minutes to complete.

9. The measures and care / treatment planning



Given the reporting of national aggregate material by the Australian Mental Health Outcomes and Classification Network (AMHOCN), clinical reference material is increasingly available for the measures that make up the NOCC.

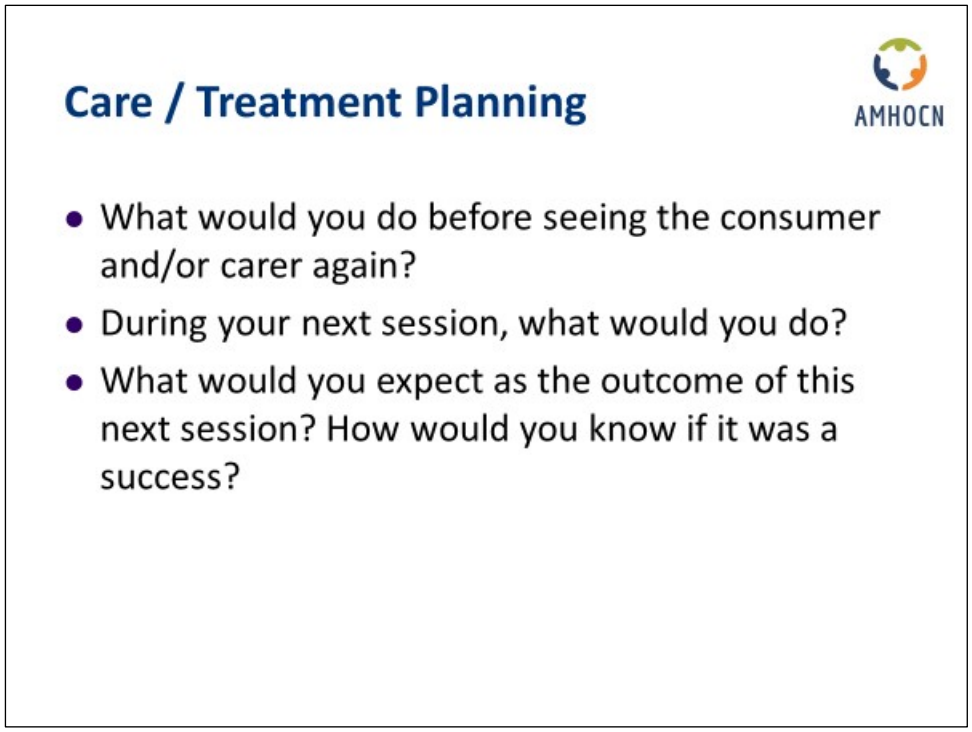
Trainers should generate reports on the outcomes of care from their local information systems or from the AMHOCN web Decision Support Tool which shows national aggregated data or

jurisdictional aggregated data.

The purpose of this activity is to have participants begin to reflect on the use of clinical reference material to support or inform decision making in clinical practice. Trainers should facilitate a discussion around comparison of the consumer's presentation with the available clinical reference material:

- How does the case study HoNOSCA score compare to the clinical reference material?
- If there is a difference, what does that tell you about the consumer's presentation?
- How would this information impact upon treatment/care planning for this case?

This section should take approximately 15 minutes to complete.



This activity aims to have participants understand how the measures can be used to inform the process of care or treatment planning.

Distribute butcher's paper and pens. Participants to remain in their teams.

You are a part of a multi- disciplinary team where the assessment of a consumer is presented. Using the HoNOSCA ratings and a completed SDQ (as available), discuss the following:

- What would you do before seeing the consumer and/or carer again?

- During your next session what would you do?
- What would you expect as the outcome of this next session?
- How would you know if it was a success?

Trainer facilitates discussion around team feedback and then uses above questions to promote further discussion about good clinical practice. Teams are asked to address the three questions outlined in the slide. The teams' responses on the butcher's paper should be posted on walls in room.

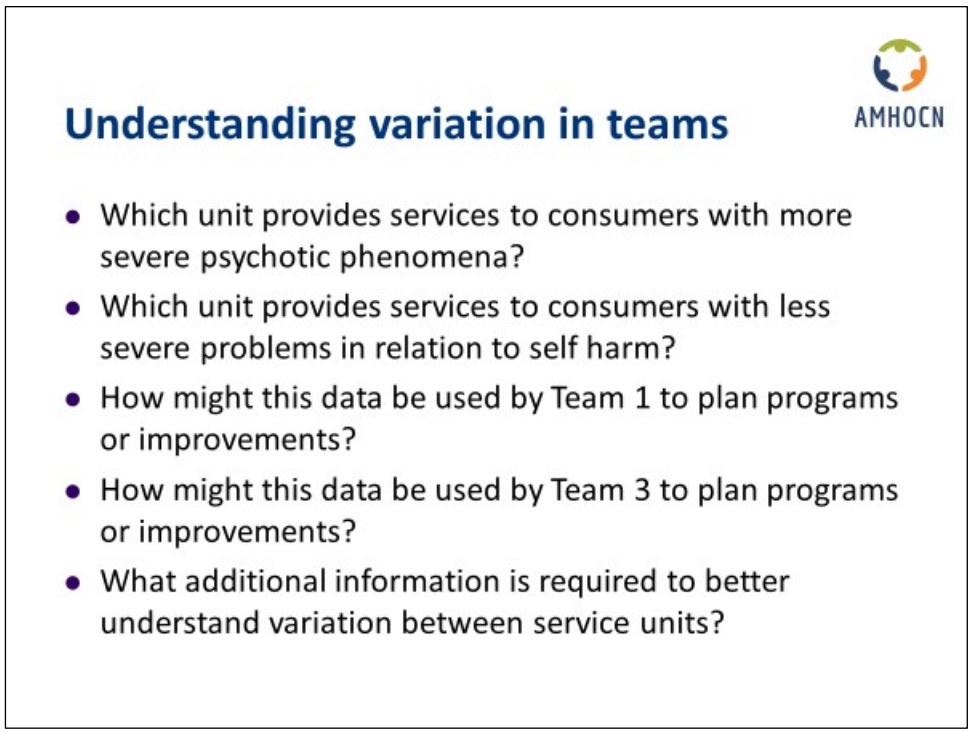
The trainer should expect teams to provide information about a treatment plan, processes to engage the consumer, processes to feedback information and reflection of good clinical practice.

During the course of the feedback, participants should be asked to reflect upon the activity and address the following questions:

- Does involving the consumer in the care planning process enhance the therapeutic alliance?
- Have you considered using the HoNOSCA and the SDQ in this way in clinical practice?
- What other information would you require to enhance this process?
- How would this process impact upon clinician behaviour?

This section should take approximately 45 minutes to complete.

10. Understanding variation between teams



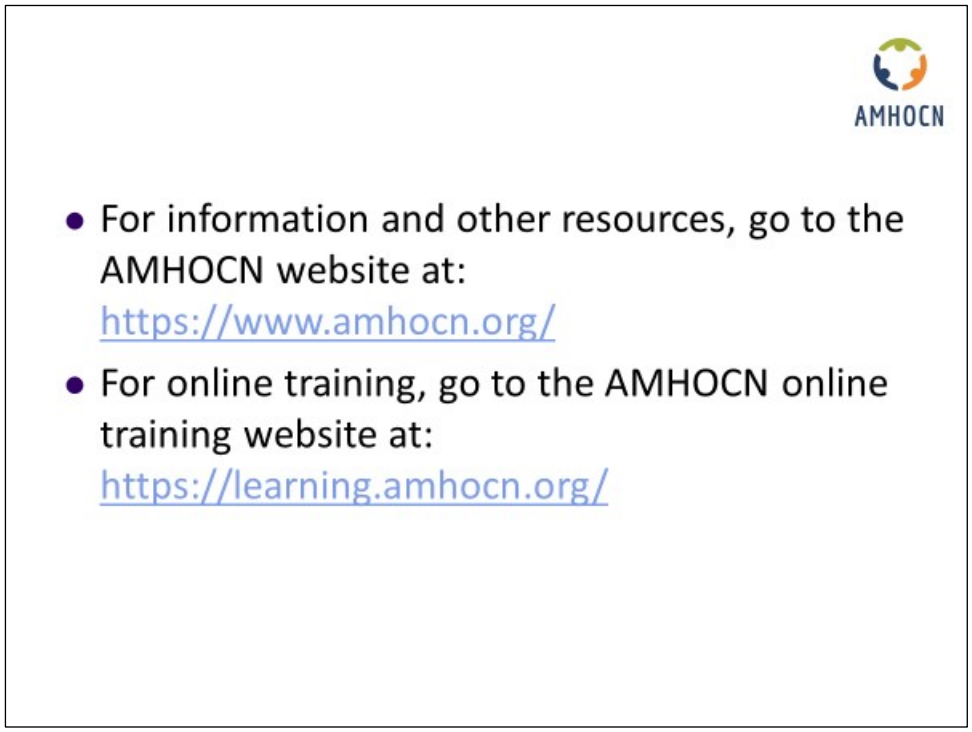
Distribute copies of the "Aggregate Report: Team Variation" found in Section 12.3 of this manual and additional butcher's paper.

Review the service profile reports for each of the three services, answer the questions on the handout material and feedback using butcher's paper. The trainer facilitates discussion of each the teams' deliberations. The slide should remain on the screen for the duration of the activity.

The table displays the percentage of clinically significant HoNOSCA scores (2 or higher) for three different services. For example, 70% of consumers of Team 1 have clinically significant problems associated with hallucinations and delusions. Trainers should be aware that additional information might be required to provide an understanding of the reasons for variation between service units. The trainer should highlight the potential utilisation of HoNOSCA aggregate data to inform and support service level activities such as service review and evaluation, quality improvement and service initiatives.

This section should take approximately 30 minutes to complete.

11. Other information



Discuss with trainees the availability of additional resources, local contact people or those responsible for ongoing support.

12. Materials used during training

12.1 Consumer Self Assessment Fidelity Checklist Activity: Consumer and Carer Character Information

Consumer Character Information

The consumer is willing to complete the measure however they are initially unsure about the reasons for completing a consumer self assessment such as the SDQ. The consumer is hesitant during the completion of the measure and requires clarification of the meaning of some items. The consumer is reluctant to complete one item. The consumer is anxious and stressed and sometimes has difficulty concentrating. The consumer has a good supportive family network but poor relationship with peers. The consumer has had no thoughts of self harm and does not use drugs or alcohol.

Carer Character Information

The carer is willing to complete the measure however they are initially unsure about the reasons for completing a consumer self assessment such as the SDQ. The carer requires clarification of the meaning of some items and is reluctant to complete one item. The carer describes a consumer who is anxious and fidgety. They have poor relationships with siblings and have difficulty concentrating. The carer indicates that they believe the consumer has had no thoughts of self harm and does not use drugs or alcohol.

12.2 Consumer Self Assessment Fidelity Checklist

PART A: Offering the Consumer Self Assessment

Observer instructions: Tick each item as you observe the clinician display that behaviour. Make notes on those clinician activities that supported completion of the self assessment and those that may have hindered completion or biased the responses.

- ☐ Clinician presents consumer self assessment as positive experience and genuine attempt to engage the consumer in treatment planning.
- ☐ Clinician assesses for potential difficulties the consumer may have in completing the self assessment.
- ☐ Clinician presents rationale for completion of the consumer self assessment including:
    - Genuine attempt to understand consumer perspective.
    - Genuine attempt to involve consume in assessment and care planning.
    - Tool for clinician to monitor progress.
    - Tool for consumer to monitor progress.
    - Information can be used for service development and quality improvement processes.
- ☐ Clinician reinforces consumer ownership and personal responsibility for completion of self assessment, promoting personal responsibility for illness self-management.
- ☐ Clinician explains the self assessment is part of the medical record and subject to the same protections of privacy and confidentiality.
- ☐ Clinician supports and encourages the consumers completion of the self assessment in an appropriate manner.
- ☐ Provides appropriate assistance and prompting during completion of the measure.
- ☐ Clinician provides positive reinforcement for completion of the measure.
- ☐ Clinician offers appropriate assistance if consumer becomes distressed or cannot complete the measure.

Comments/Feedback:

PART B: Reviewing and Providing Feedback on the Completed Self Assessment

Observer instructions: Tick each item as you observe the clinician display that behaviour. Make notes on those clinician activities that supported the review process of the self assessment and those that may have hindered review or obstructed collaboration.

- ☐ Clinician explores reasons why items are not completed.
- ☐ Clinician seeks clarification of responses to individual items as required.
- ☐ Clinician provides opportunities for consumer to discuss items in more detail.
- ☐ Clinician provides summary of consumer self assessment.
- ☐ Clinician explains graphical report to consumer.
- ☐ Clinician provides clarification of graphical report to consumer as required.
- ☐ Clinician discusses any change in the presentation of the consumer and its relationship to interventions or personal activities promoting recovery.
- ☐ Clinician discusses consumer self assessment in the context of goal setting.
- ☐ Clinician links summary to collaborative goal setting.
- ☐ Clinician discusses future review of consumer self assessment.
- ☐ Clinician offers the consumer a copy of the self assessment.

Comments/Feedback:

12.3 Aggregate Report: Team Variation

Comparison Consumer Variation Between Services: Percentage of all HoNOSCA item scores 2 or greater

HoNOSCA Scale	Team 1 (% scores 2>)	Team 2 (% scores 2>)	Team 3 (% scores 2>)
Disruptive, antisocial or aggressive behaviour	30	67	12
Overactivity, attention or concentration	75	55	13
Non-accidental self injury	20	78	24
Alcohol, substance/solvent misuse	10	24	67
Scholastic or language skills	5	33	65
Physical illness or disability problems	14	85	21
Hallucinations, delusions	70	30	22
Non-organic somatic symptoms	80	34	14
Emotional and related symptoms	65	44	42
Peer relationships	40	23	82
Self-care and independence	20	66	13
Family life and relationships	23	71	14
Poor school attendance	14	8	7
Lack of knowledge about child's difficulties	8	35	45
Lack of information about services or management	65	35	80

- Which unit provides services to consumers with more severe psychotic phenomena?
- Which unit provides services to consumers with less severe problems in relation to self harm?
- How might this data be used by Team 1 to plan programs or improvements?
- How might this data be used by Team 3 to plan programs or improvements?
- What additional information is required to better understand variation between service units?

12.4 Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) Glossary and Sample Rating Sheet

Health of the Nation Outcome Scales Child and Adolescent Glossary

HoNOSCA rating guidelines

- Rate items in order from 1 to 15.
- Use all available information in making your rating.
- Do not include information already rated in an earlier item.
- 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 three days.
- Each item is rated on a five-point item of severity (0 to 4) as follows:

  0 No problem.
  1 Minor problem requiring no formal action.
  2 Mild problem.
  3 Problem of moderate severity.
  4 Severe to very severe problem.
  9 Not known or not applicable

- As far as possible, the use of rating point 9 should be avoided, because missing data make scores less comparable over time or between settings.
- Specific information on how to rate each point on each item is provided in the Glossary.

HoNOSCA Glossary

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 (eg, pushing, hitting, vandalism, teasing), or physical or sexual abuse of other children.

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

Do not include: Over-activity 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 behaviour such as fighting, persistently threatening, very oppositional, more serious destruction of property, or moderately delinquent acts.

4 Disruptive in almost all activities, or at least one serious physical attack on others or animals, or serious destruction of property.

2 Problems with over-activity, attention or concentration

Include overactive behaviour associated with any disorder 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 over-activity or minor restlessness, etc.

2 Mild but definite over-activity or attention problems, but can usually be controlled.

3 Moderately severe over-activity or attention problems that are sometimes uncontrollable.

4 Severe over-activity or attention problems that are present in most activities and almost never controllable.

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 physical illness rated at Scale 6.

Do not include accidental self-injury due, eg, to severe learning or physical disability, rated at scale 6.

Do not include illness or injury as a direct consequence of drug or alcohol use, rated at scale 6.

0 No problems 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, eg, collecting tablets) or moderate non-hazardous self-harm (eg, small overdose).

4 Serious suicidal attempt (eg, serious overdose), or serious deliberate self-injury.

4 Problems with alcohol, substance or solvent misuse

Include problems with alcohol, substance or solvent misuse taking into account current age and societal norms.

Do not include aggressive or disruptive behaviour due to alcohol or drug use, rated at Scale 1.

Do not include 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.

5 Problems with scholastic or language skills

Include problems in reading, spelling, arithmetic, speech or language associated with any disorder or problem, such as specific developmental learning problems, or physical disability such as hearing problems.

Include reduced scholastic performance associated with emotional or behavioural problems.

Children with generalised learning disability should not be included unless their functioning is below the expected level.

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 Minor 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.

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 or alcohol use, or physical complications of psychological disorders such as severe weight loss.

Include self-injury due to severe learning disability or as of 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 physical health problems during the period rated.

1 Slight incapacity as a result of a health problem during the period (eg, 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 physical health problems.

4 Complete or severe incapacity due to physical health problems.

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 pseudo-hallucinations, 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.

Do not include 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 (eg, paranoid ideas, illusions or body image disturbance), but there is little distress or manifestation in bizarre behaviour, ie, clinically present but mild.

3 Moderate preoccupation with abnormal thoughts or perceptions or delusions; hallucinations, causing much distress, 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 the person or others.

8 Problems with non-organic somatic symptoms

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

Do not include movement disorders such as tics, rated at Scale 6.

Do not include 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 problems or symptoms persist into most activities. The child or adolescent is seriously or adversely affected.

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 over-activity behaviours attributed to fears or phobias, rated at Scale 1.

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

0 No evidence of depression, anxiety, 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.

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.

Do not include 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, or to relationships that provide little or no comfort or support, eg, as a result of being severely bullied.

4 Severe social isolation with hardly any friends due to inability to communicate socially or withdrawal from social relationships.

11 Problems with self-care and independence

Rate the overall level of functioning, eg, problems with basic activities of self-care such as feeding, washing, dressing, toilet, and 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.

Do not include enuresis and encopresis, rated at Scale 8.

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

1 Minor problems, eg, untidy, disorganised.

2 Self-care adequate, but major 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 major inability to perform several complex skills.

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

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 with separated parents and 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 or adolescent.

<u>Include</u> problems such as poor communication, arguments, verbal or physical hostility, criticism and denigration, parental neglect or rejection, over-restriction, sexual or physical abuse.

<u>Include</u> sibling jealousy, physical or coercive sexual abuse by sibling.

<u>Include</u> problems with enmeshment and overprotection.

<u>Include</u> problems with family bereavement leading to reorganisation.

<u>Do not</u> include aggressive behaviour by the child or adolescent, rated at Scale 1.

0 No problems during the period rated.

1 Slight or transient problems.

2 Mild but definite problem, eg, some episodes of neglect or hostility or enmeshment or overprotection.

3 Moderate problems, eg, neglect, abuse, hostility. problems associated with family or carer breakdown or reorganisation.

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

13 Poor school attendance

<u>Include</u> truancy, school refusal, school withdrawal or suspension for any cause.

<u>Include</u> attendance at type of school at time of rating, eg, 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, eg, late for two or more lessons.

2 Definite but mild problems, eg, 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. Include school suspension, exclusion or expulsion for any cause during the period rated.

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 or adolescent's difficulties (in the previous two weeks)

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

<u>Include</u> lack of explanation about the diagnosis or the cause of the problem or the prognosis.

0 No problems during the period rated. Parents and carers have been adequately informed about the child or adolescent's problems.

1 Slight problems only.

2 Mild but definite problems.

3 Moderately severe problems. Parents and carers have very little or incorrect knowledge about the problem which is causing difficulties such as confusion or self-blame.

4 Very severe problems. Parents have no understanding about the nature of their child or adolescent's problems.

15 Problems with lack of information about services or management of the child or adolescent's difficulties

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

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

0 No problems during the period rated. The need for all necessary services has been recognised.

1 Slight problems only.

2 Mild but definite problems.

3 Moderately severe problems. Parents and carers have been given very little information about appropriate services, or professionals are not sure where a child should be managed.

4 Very severe problems. Parents have no information about appropriate services or professionals do not know where a child should be managed.

HoNOSCA sample rating sheet

Enter the severity rating for each item in the corresponding item box to the right of the item. Rate 9 if Not Known or Not Applicable.

Section A							
1	Disruptive, antisocial or aggressive behaviour	0	1	2	3	4	
2	Over-activity, attention or concentration	0	1	2	3	4	
3	Non-accidental self injury	0	1	2	3	4	
4	Alcohol, substance or solvent misuse	0	1	2	3	4	
5	Scholastic or language skills	0	1	2	3	4	
6	Physical illness or disability problems	0	1	2	3	4	
7	Hallucinations, delusions or abnormal perceptions	0	1	2	3	4	
8	Non-organic somatic symptoms	0	1	2	3	4	
9	Emotional and related symptoms	0	1	2	3	4	
10	Peer relationships	0	1	2	3	4	
11	Self-care and independence	0	1	2	3	4	
12	Family life and relationships	0	1	2	3	4	
13	Poor school attendance	0	1	2	3	4	
Section B: Problems for the child, parent or carer relating to lack of information or access to services							
14	Lack of knowledge – nature of difficulties	0	1	2	3	4	
15	Lack of information – services/management	0	1	2	3	4	

12.5 Children's Global Assessment Scale (CGAS)

Rating guidelines

Rate the patient's most impaired level of general functioning for the previous two week period by selecting the *lowest* level which describes his/her current functioning on a hypothetical continuum of health-illness. Use intermediary levels (eg, 35, 58, 62).

Rate actual functioning regardless of treatment or prognosis. The examples of behaviour provided are only illustrative and are not required for a particular 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 (eg, 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 (eg, 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 (eg, 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*** (eg, 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*** (ie, disturbed at home, at school, with peers, or in society at large, eg, 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*** eg, 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 (eg, sometimes incoherent or inappropriate).

20-11 ***Needs considerable supervision*** to prevent hurting others or self (eg, frequently violent, repeated suicide attempts) *or* to maintain personal hygiene *or* gross impairment in all forms of communication, eg, 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.

12.6 Factors Influencing Health Status (FIHS)

Rating guidelines

The clinician is required to rate the items retrospectively, at the end of the episode or at 91-day review.

Completing the scale simply requires, for each item, an indication of whether any of the listed factors required special clinical evaluation, therapeutic treatment, diagnostic procedures or increased clinical care and/or monitoring during the course of the episode.

Only record a problem as being present where the problem has required specific intervention or additional treatment resources over the preceding Period of Care.

Where a problem can be coded under more than one FIHS category, it should be recorded once, using the category of 'best fit'.

FIHS item elaboration

	YES	NO	
1	☐	☐	**Maltreatment syndromes** *Includes:* • neglect or abandonment; • physical abuse; • sexual abuse; and • 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; and • 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; and • other specified problems related to upbringing.

	YES	NO	
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 and death of family member; • disruption of family by separation and divorce; • dependent relative needing care at home; • other stressful life events affecting family and household; • other specified problems related to primary support group; • problem related to primary support group; and • unspecified.
5	☐	☐	**Problems related to social environment** *Includes:* • problems of adjustment to life cycle transitions; • atypical parenting situation; • living alone; • acculturation difficulty; • social exclusion and rejection; and • target of perceived adverse discrimination and persecution.
6	☐	☐	**Problems related to certain psychosocial circumstances** *Includes:* • problems related to unwanted pregnancy; • problems related to multiparity; • seeking and accepting physical, nutritional and chemical interventions known to be hazardous and harmful; • seeking and accepting behavioural and psychological interventions known to be hazardous or harmful; and • discord with counsellors.
7	☐	☐	**Problems related to other psychosocial circumstances** *Includes:* • conviction in civil and criminal proceedings without imprisonment; • imprisonment and other incarceration; • problems related to release from prison; • problems related to other legal circumstances; • victim of crime and terrorism; • exposure to disaster; and • war and other hostilities.

12.7 Mental Health Phase of Care (MH-PoC)

Phase of Care

Definition: The mental health phase of care is defined as the prospective primary goal of treatment within the episode of care in terms of the recognised phases of mental health care. Whilst it is recognised that there may be aspects of each mental health phase of care represented in the consumer's mental health plan, the mental health phase of care is intended to identify the main goal or aim that will underpin the next period of care. The mental health phase of care is independent of both the treatment setting and the designation of the treating service, and does not reflect service unit type.

Domain:
1 – Acute
2 – Functional Gain
3 – Intensive Extended
4 – Consolidating Gain
5 – Assessment Only
9 – Not stated/inadequately described

Acute
The primary goal of care is the short term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder.

Functional Gain
The primary goal of care is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder.

Intensive Extended
The primary goal of care is prevention or minimisation of further deterioration, and reduction of risk of harm in a patient who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period.

Consolidating gain
The primary goal of care is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance.

Assessment only
The primary goal of care is to obtain information, including collateral information where possible, in order to determine the intervention/treatment needs and to arrange for this to occur (includes brief history, risk assessment, referral to treating team or other service).

12.8 Strengths and Difficulties Questionnaire (SDQ)

Extensive support materials are available on the SDQ developers' website, including copies of the various versions of the instrument, background information and scoring instructions. See http://www.sdqinfo.org. There are six versions (parent-report and youth-self report) currently specified for NOCC reporting with an additional four versions (teacher-report) that may be of use at the clinical level (see appendices). Versions of the SDQ used in Australian specialised public sector mental health services are available on the AMHOCN website.

The "1" versions are administered on admission and are rated on the basis of the preceding 6 months. The "2" follow up versions are administered on review and discharge and are rated on the basis of the previous 1 month period. The versions specified for NOCC reporting are:

- PC1 – Parent Report Measure for Children aged 04-10, Baseline version;
- PC2 – Parent Report Measure for Children and Adolescents aged 4-10, Follow up version;
- PY1 – Parent Report Measure for Youth aged 11-17, Baseline version;
- PY2 – Parent Report Measure for Youth aged 11-17; Follow up version;
- YR1 – Youth self report measure (11-17), Baseline version; and
- YR2 – Youth self report measure (11-17), Follow up version.

Please note that the item numbering in the SDQ versions is deliberately non sequential because it covers all items in all versions, both to indicate item equivalence across versions and to assist data entry, especially of translated versions. The table below indicates the items that are included in each version, the rating periods used and the broad content covered by each item.

	Informant	**Parent**				**Young Person**	
	Age range	**4-10**		**11-17**		**11-17**	
	Application	*Baseline*	*Followup*	*Baseline*	*Follow-up*	*Baseline*	*Followup*
	Rating period	*6 months*	*1 month*	*6 months*	*1 month*	*6 months*	*1 month*
Items	**Item Content**	**Version**					
		PC1	**PC2**	**PY1**	**PY2**	**YR1**	**YR2**
1-25	Symptoms	✓	✓	✓	✓	✓	✓
26	Overall	✓	✓	✓	✓	✓	✓
27	Duration	✓	**x**	✓	**x**	✓	
28-33	Impact	✓	✓	✓	✓	✓	✓
34-35	Follow up progress	**x**	✓	**x**	✓	**x**	✓
36-38	Cross-Informant information	✓	**x**	✓	**x**	**x**	**x**
39-42	Cross-Informant information	**x**	**x**	**x**	**x**	✓	**x**

In addition to the measures listed above, the SDQ has four 'teacher' versions, not specified for NOCC reporting, but which have considerable clinical utility in the assessment and treatment of children and adolescents. These are similar to the Parent-report versions, but do not contain "cross-informant" items. These measures are included here for information only:

- TC1 –Teacher Report Measure for Children aged 04-10 on initial contact with service (Admission);
- TC2 - Teacher Report Measure for Children and Adolescents aged 04-10 on follow up contact with service (Review & Discharge);
- TY1 - Teacher Report Measure for Youth aged 11-17 on initial contact with service (Admission); and
- TY2 - Teacher Report Measure for Youth aged 11-17 on follow up contact with service (Review & Discharge).

Please note:

- The various versions of the SDQ, whether in English or in translation, are copyright documents not in the public domain. Australian jurisdictions have entered into contractual arrangements with the author, Dr Robert Goodman, who holds copyright for the SDQs, to permit each jurisdiction to use the adapted SDQs and supporting resources in public mental health services. For further information about use of the SDQ, go to the Youth in Mind website. This resource is for use in AMHOCN training activities.

Interpreting SDQ scores

PARENT VERSIONS	**'This score is close to average - clinically significant problems in this area are unlikely'**	**'This score is slightly raised, which may reflect clinically significant problems'**	**'This score is high - there is a substantial risk of clinically significant problems in this area'**
Total Difficulties Score	0-13	14-16	17-40
Emotional Symptoms Score	0-3	4	5-10
Conduct Problem Score	0-2	3	4-10
Hyperactivity Score	0-5	6	7-10
Peer Problem Score	0-2	3	4-10
	'This score is close to average – clinically significant problems in this area are unlikely'	**'This score is slightly low, which may reflect clinically significant problems'**	**'This score is low - there is a substantial risk of clinically significant problems in this area'**
Prosocial Behaviour Score	6-10	5	0-4
SELF COMPLETED VERSIONS	**'This score is close to average - clinically significant problems in this area are unlikely'**	**'This score is slightly raised, which may reflect clinically significant problems'**	**'This score is high - there is a substantial risk of clinically significant problems in this area'**
Total Difficulties Score	0-15	16-19	20-40
Emotional Symptoms Score	0-5	6	7-10

Conduct Problem Score	0-3	4	5-10
Hyperactivity Score	0-5	6	7-10
Peer Problem Score	0-3	4-5	6-10
	'This score is close to average - clinically significant problems in this area are unlikely'	**'This score is slightly low, which may reflect clinically significant problems'**	**'This score is low - there is a substantial risk of clinically significant problems in this area'**
Prosocial Behaviour Score	6-10	5	0-4

Note: This broad classification is based on information from the http://www.sdqinfo.org/ web site © R Goodman and is derived from British norms. It is used with permission and is intended to provide a general reference range only, while more detailed clinical interpretations are being developed with Dr. Goodman. It is anticipated that Australian norms will become available.

See http://www.sdqinfo.org/ for more information.