AMHOCN

Australian Mental Health Outcomes and Classification Network

Sharing Information to Improve Outcomes

National Outcomes and Casemix Collection (NOCC) basic training manual:

CHILD AND ADOLESCENT SERVICES

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For further information: Email: contact@amhocn.org Website: www.amhocn.org

Contents

1. Introduction to the manual

This training manual has been developed as part of a training package designed to provide a basic introduction to:

- the context of the National Outcomes and Casemix Collection (NOCC);
- the data collection protocol; and
- the measures used specific to each age group and service setting.

This training manual identifies the core information that should form the basis of any local training for the age group and service setting of the title. 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
- that participants have the opportunity to engage with the material.

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

- Child and Adolescent Training Manual (this document);
- Child and Adolescent Self Report Measure – Strengths and Difficulties Questionnaire;
- 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 point.

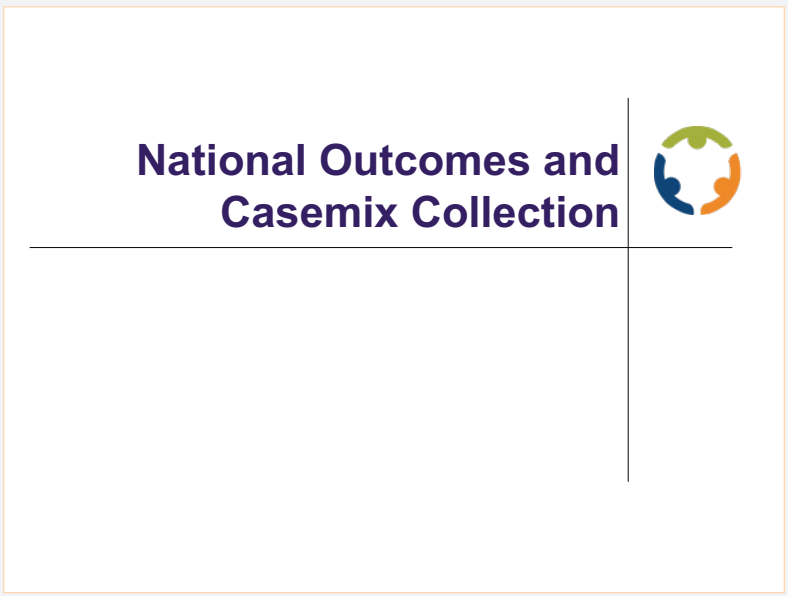
This symbol indicates that trainers should distribute specific handout materials.

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

This symbol indicates the notional time each section should take.

This symbol indicates that trainers should encourage group discussion.

2. Training introduction and learning objectives



This slide simply provides an introduction to 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.

This context section should take approximately 10 minutes to complete.

2. Training introduction and learning objectives

Learning Objectives

- Understanding of the context of the collection of Outcome Measures in Mental Health
- Understanding of the National Outcomes and Casemix Collection Data Collection Protocol and local adaptation
- Development of skills in the completion of the standard measures of Outcome and Casemix

Participants should be given a brief orientation to the content of the workshop and the expected outcomes of participation. This includes:

- the background and rationale for the introduction of outcomes and casemix measures;
- the agreed national data collection protocol and the local adaptations to this protocol; and
- the development of skills in the completion of the measures introduced into routine clinical practice.

Ask the group what they know about the activities and outcomes of mental health services?

- How do we measure outcome?
- How do we monitor outcome?
- How do we know if someone has improved or deteriorated and how do we share this information?

Write the responses on a whiteboard and discuss them with the group.

3. Use of NOCC information

The collection and use of information from the National Outcomes and Casemix Collection should benefit multiple stakeholders, including consumers and carers, clinicians, managers, policy makers, funding bodies and the broader community.

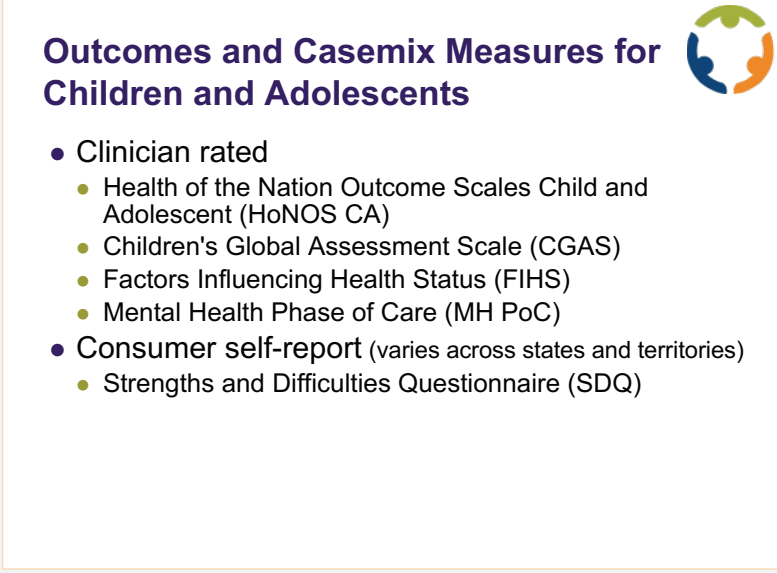
These are summarised in the table below.

Stakeholder	Benefits
Consumers	• Provides the opportunity to have input into the process of care through active engagement by sharing their perspective • Gives consumers a voice and input into the system to describe issues important to them • Provides information back to the consumer regarding their completion of the measure and change over time • Provides an opportunity for dialogue between clinicians, consumers, carers and families, enabling different perspectives to be represented and discussed
Carers/Parents	• Provides the opportunity to have input into the process of care through sharing their perspective and being actively engaged in the process of care • Gives carers and families a voice and input into the system to describe issues important to them • Provides information back to carers and families regarding measures and progress • Provides an opportunity for dialogue between clinicians, consumers, carers and families, enabling different perspectives to be represented and discussed
Clinicians	• Provides tools to support care planning, goal setting and monitoring change over time • Provides tools that support reflective practice and the evaluation of care
Service Managers	• Provides tools that support service development through the use of information to inform decision-making • Provides information that describes clinician workload • Provides information that can describe variation in groups of consumers presenting to mental health services • Provides information that describes the outcomes of care
Policy Makers	• Provides information that describes the needs of consumers and carers • Provides information that informs policy development
Funders	• Provides information that informs decisions regarding value for money
Communities	• Provides information to support transparency and accountability, highlighting how mental health services operate and where opportunities for quality improvement can occur
Researchers and Evaluators	• Provides information to support both research into, and evaluation of services, with the aim of supporting clinical practice and quality improvement activities

Use of NOCC information

4. Brief overview of measures

Provide a brief overview of the measures that comprise the National Outcomes and Casemix Collection (NOCC).



Hand out copies of the measures. Use your local service material.

Provide a brief overview of the measures being used in public sector mental health services, highlighting that there are clinician rated measures as well as a consumer rated measure (parent rated for younger children).

The Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) is a collection of 15 scales designed to capture information regarding the severity of problems for a consumer in 15 common areas.

The Children's Global Assessment Scale (CGAS) is used as the measure of functioning for children or adolescents seen by specialist child and adolescent mental health services.

The Factors Influencing Health Status (FIHS) measure is a checklist of 'psychosocial complications' and is based on the problems and issues identified in the International Classification of Disease Version 10 (ICD-10). It was developed specifically as part of the Mental Health Classification and Service Costs (MH-CASC) project.

The Mental Health Phase of Care (PoC) aims to operationalise the concept of a phase of illness with people moving between stable and acute phases within an episode of illness.

The Strengths and Difficulties Questionnaire (SDQ) is the consumer rated measure. For those in the 4-10 years age band, the parent/family member completes the measure. For those in the 11-17 years age band, the child /adolescent completes the measure.

4. Brief overview of measures

These instruments were selected on the following criteria:

- Acceptable
  - Brief - minimum rater workload
  - Practical - fit clinical processes
  - Minimal cost
  - Simple scoring & interpretation
  - Minimal training required
- Valid
- Reliable
- Sensitive to change

This brief overview should take approximately 5 minutes to complete.

5. The data collection protocol

The Basic Data Collection Protocol

Standardised measures of consumers' clinical status are collected at three critical occasions during episodes of mental health care:

- **Admission** (to episode of health care)
- **Discharge** (from episode of care)
- And where an episode lasts for more than 91 days, at **Review**

Provide a brief overview of the 3 critical occasions during episodes of mental health care when data should be collected. The National Outcomes and Casemix Collection protocol is outlined in the table below.

NOCC - Collection Protocol

Collection Occasion: Child and Adolescent	A	R	D
HoNOSCA	✓	✓	✓
CGAS	✓	✓	×
Consumer completed measure (SDQ) [1]	✓	✓	✓
Factors Influencing Health Status	×	✓	✓
Principal and Additional Diagnosis	×	✓	✓
Phase of Care	✓	✓	×
Mental Health Legal Status	×	✓	✓

Abbreviations and Symbols	
A Admission to mental health care	✓ Collection of data on this occasion is mandatory
R Review of mental health care	× No collection requirements apply
D Discharge from mental health care	

Notes

[1] The classification of consumer self-report measure as mandatory is intended only to indicate the expectation that consumer's will be invited to complete self-report measure.

It is important to note that the National Outcomes and Casemix Collection specifies the minimum requirement and that States and Territories as well as regions or units have made modifications to this protocol. Review the NOCC Technical Specifications, available on the AMHOCN website at www.amhocn.org, for more detail.

This data collection protocol section should take approximately 10 minutes with questions.

5. The data collection protocol

This slide outlines the core concepts of the data collection protocol:

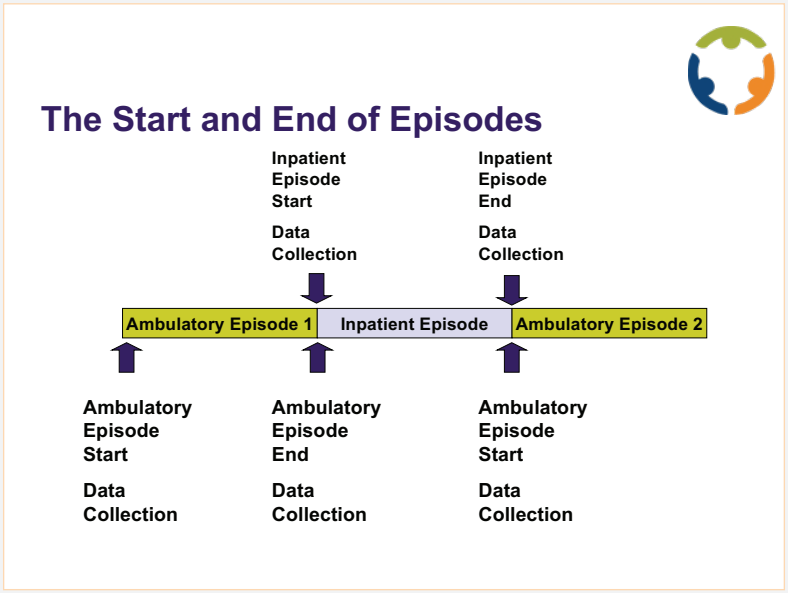
- the definition of an episode of care;
- the three service settings where mental health care can be delivered; and
- the basic business rules.

Note that this nationally agreed collection protocol might use different terminology than your local service hence the need for local adaptation.

The data collection protocol was designed to meet several criteria:

- the data collection protocol should be clinically meaningful - it should be consistent with and encourage good clinical practice;
- the data collection protocol should not be overly complicated;
- the protocol must give rise to data that can be statistically analysed; and
- the protocol should assist individual services to collect data at the most appropriate occasions that are consistent with generally agreed criteria.

5. The data collection protocol



This slide provides the opportunity to discuss the complex nature of mental health care and the potential for consumers to move between various service settings during their treatment. These moves between service settings, as we have seen, are a trigger for data collection

Trainers should hand out copies of the local adaptation to the data collection protocol that are pertinent to the unit or group they are training.

6. Consumer self report measure

– Strengths and Difficulties Questionnaire (SDQ)

The introduction of the consumer self report measure, the Strengths and Difficulties Questionnaire (SDQ), provides several potential benefits. These include:

- supporting the process of assessment;
- demonstrating a genuine interest in the carers and consumers point of view;
- encouraging dialogue between clinicians, carers and consumers;
- highlighting differences between the perceptions of the consumer, carers and clinicians; and
- involving carers and the consumer in the process of care planning.

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

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

First, if the consumer is distressed and offering the SDQ 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 SDQ 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 or carers, then it should not be offered.

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

6. Consumer self report measure

– Strengths and Difficulties Questionnaire (SDQ)

When administering the SDQ, 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 they are telling the truth).

6. Consumer self report measure

– Strengths and Difficulties Questionnaire (SDQ)

Offering the Measure

- Why is it important to complete a consumer self rated measure?
- What happens if the consumer refuses to complete the measure, will it effect their treatment?
- Who is going to use the information?
- What is the information going to be used for?
- Assure the consumer of privacy and confidentiality.

This slide identifies the types of concerns that consumers often have when offered a consumer self report measure.

When offering the SDQ it is important to:

- identify for consumers that the completion of the SDQ will provide useful information for the clinician that will inform their work;
- assure consumers and carers that refusal to complete the SDQ will not see them treated differently;
- explain to consumers and carers 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 and carers that the SDQ is subject to the same rules of confidentiality and privacy as all other information held within the medical record.

When administering the SDQ, there are some general activities or approaches to be adopted. These are the Do's of consumer self report measure administration.

- do be warm, friendly and helpful;
- do request and encourage carers and consumers to fill out the SDQ 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;

6. Consumer self report measure

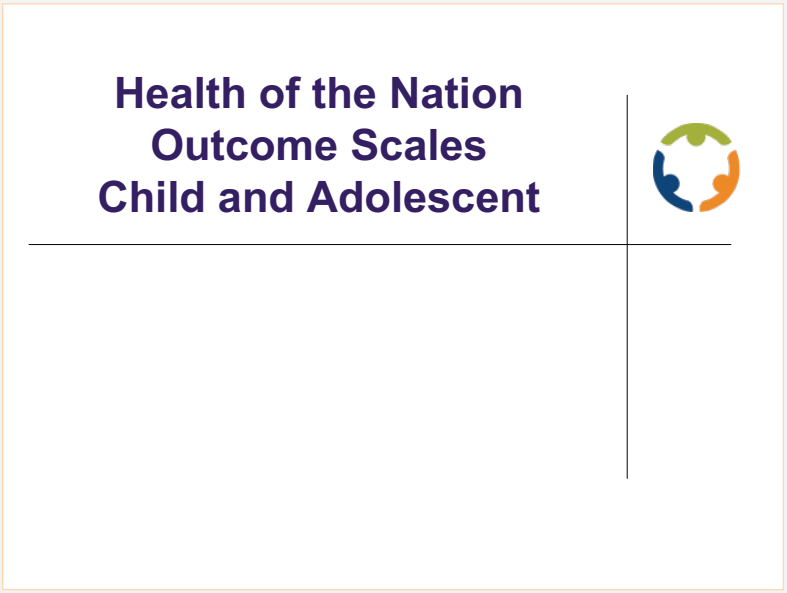
– Strengths and Difficulties Questionnaire (SDQ)

- 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 the consumer that they will be asked to fill out the SDQ again at a later date; and
- do thank carers and the consumer for filling out the SDQ.

Trainers should hand out a copy of the Strengths and Difficulties Questionnaire (SDQ). See appendix for the versions of the SDQ.

Session length should take no longer than 30 minutes.

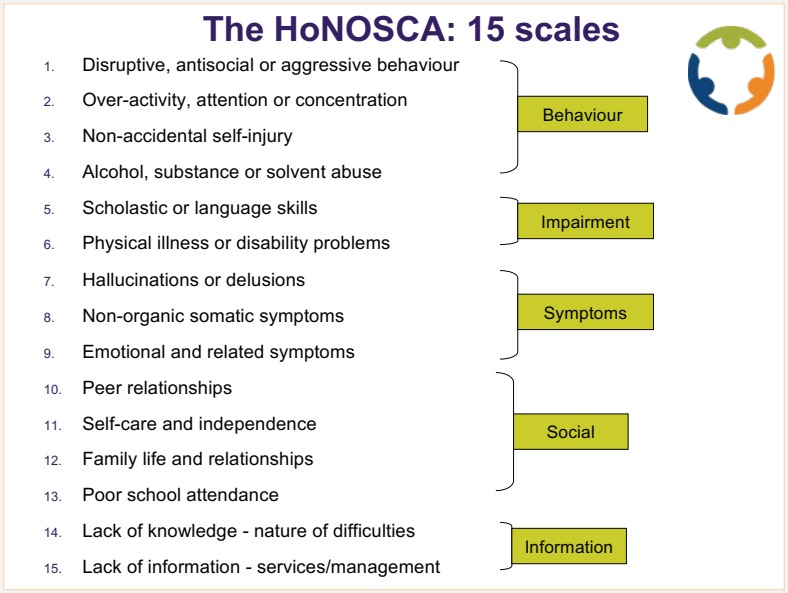
7. Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA)



This slide introduces the section on training in the clinical measures. The aim of this section is to provide participants with the skills to complete the primary measure of problem severity the Health of the Nation Outcome Scales Child and Adolescent.

This section should take the majority of any session, approximately 1.5 hours.

7. Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA)



Refer trainees 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.

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

- Behaviour;
- Impairment;
- Symptom;
- Social; and
- Information.

Reports on the measure can be generated at the scale, sub-scale and total score.

The Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) is the key measure of problem severity in the suite of outcome measures. Usually, some trainees will have experienced completing the HoNOSCA. Ask them how long it usually takes to complete. Remember to make the distinction between first completing the measure and completing following some practice.

7. Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA)

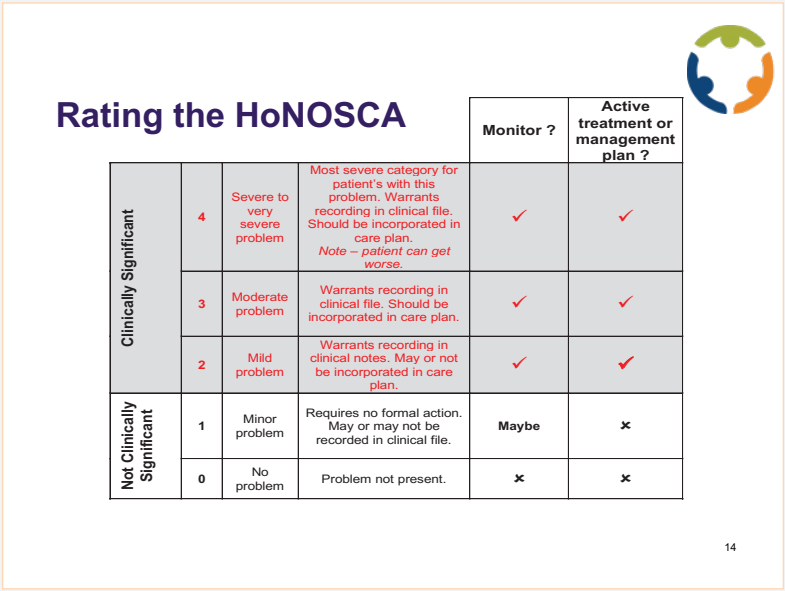
The HoNOSCA was designed to be broad spectrum, capturing information about the consumer in a number of domains, not just symptoms. Field trials have identified the HoNOSCA:

- as acceptable and useful to clinicians; and
- shown satisfactory inter-rater reliability during development and in subsequent Australian trials.

See Mental Health National Outcomes and Casemix Collection: Overview of clinician-rated and consumer self-report measures V.2.1, available on the AMHOCN website (www.amhocn.org), for further information.

Limitations of the HoNOSCA should be acknowledged, however it is important to note that:

- perfect inter-rater reliability has never been demonstrated;
- poor inter-rater reliability can be the result of misapplication of the rating rules;
- inter-rater reliability can be affected by the quality of assessment or lack of information between raters; and
- satisfactory inter-rater reliability will be demonstrated during practice in this training.



Rating the HoNOSCA

				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.	×	×

14

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

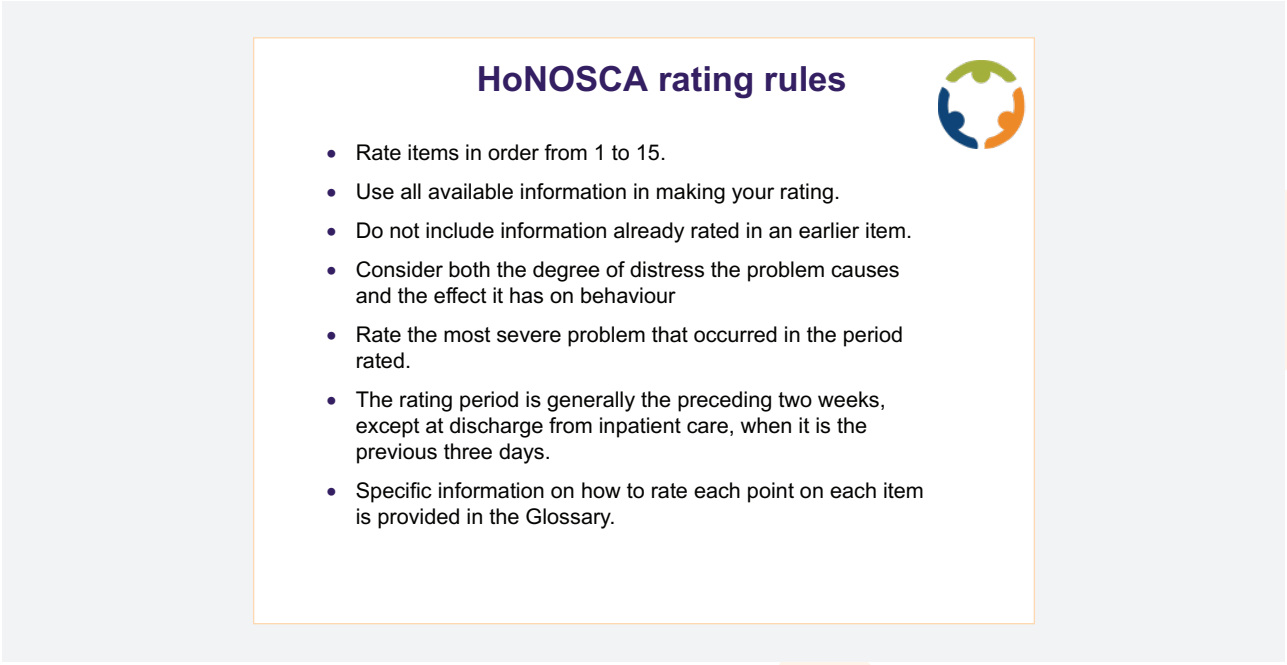
7. Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA)

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. 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.



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.

7. Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA)

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.

Practice Rating the HoNOSCA

During training, practicing a rating the HoNOSCA is a multi-stage process which involves having training participants:

- reading a written vignette or watch a video vignette;
- reviewing the SDQ, if available, as part of the vignette;
- practice rating the HoNOSCA referring to the glossary; and
- sharing their ratings and comparing and contrasting their ratings to the provided consensus ratings.

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

Ask trainees who rated the consensus score to explain their rationale for rating in the way that they did. Promote discussion around differences between consensus ratings and trainees' ratings.

Work through all the scales in the same fashion, one at a time. Take opportunities to clarify and reinforce the rating rules.

7. Health of the Nation Outcomes Scales Child and Adolescent (HoNOSCA)

Take opportunities to reinforce that there is generally agreement between raters.

It is important to provide an environment within which trainees feel comfortable sharing their ratings, discussing their reasons for particular ratings and correcting misunderstandings as they arise. It is important that this session does not become a battle between the trainees and trainer. A trainee rating one point either side of the consensus rating for the purposes of training is quite acceptable.

How could the HoNOSCA be used in Mental Health? A variety of potential uses for the HoNOSCA have been identified, these include:

- a standard record of progress across 15 common types of problems;
- a simple check list for notes;
- a measure of outcome against expectation based on intervention or natural course;
- an audit tool;
- a method of matching consumer's needs to practitioner skills;
- a standard tool for clinical research;
- a means of assessing the outcomes and efficiency of services; and
- a means of facilitating discussion between clinicians, the consumer and carers.

Indeed, all the measures introduced as part of NOCC have the potential to be used in this way, not only individually but in combination.

8. Children's Global Assessment Scale (CGAS)

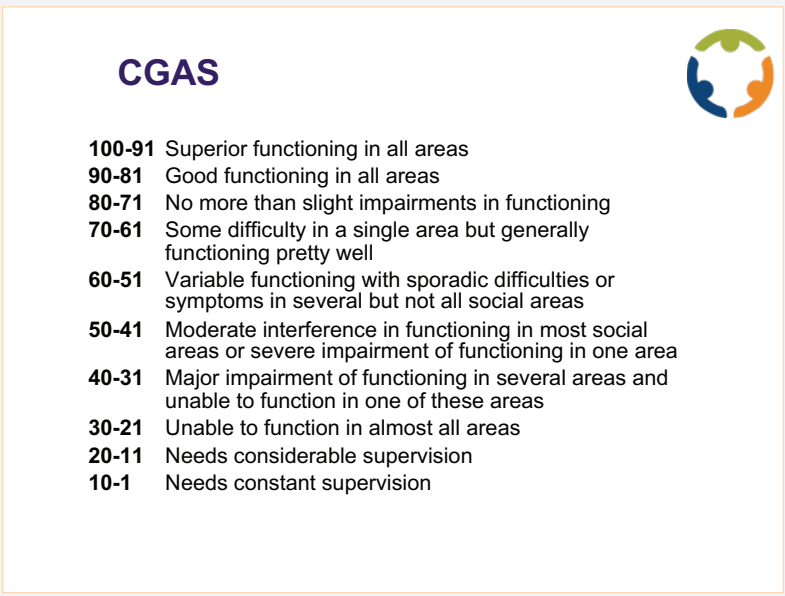
Rating the CGAS

- Rate the child or adolescent's most impaired level of general functioning for the specified time period by selecting the *lowest* level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g. 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.

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.

8. Children's Global Assessment Scale (CGAS)



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.

8. Children's Global Assessment Scale (CGAS)

CGAS - Rule of Thumb

Score	Service Provision
100-70	Primary Health Care Services, General Practitioner, School Counsellors
30 - 69	Specialist Mental Health Services, Ambulatory Mental Health Care
1 - 29	Specialists inpatient services or equivalent level of dependency

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

9. Factors Influencing Health Status (FIHS)

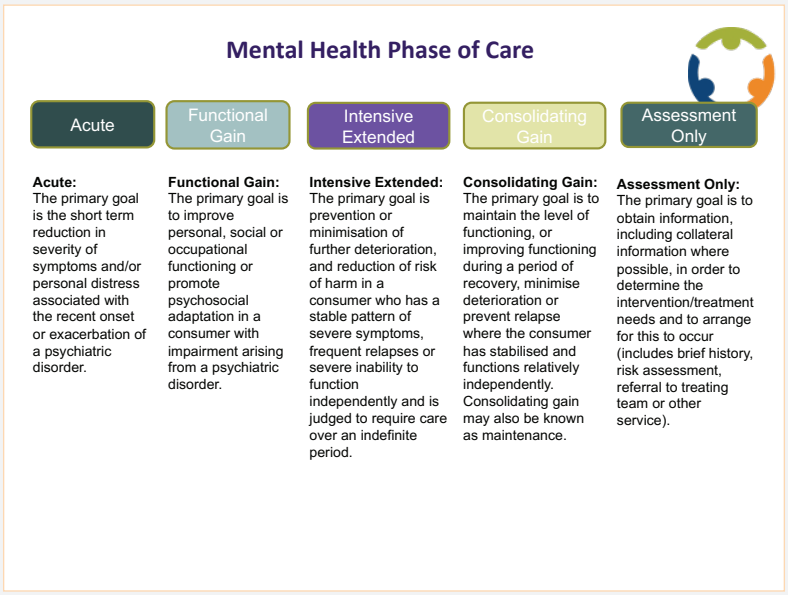
The purpose of these items is to identify the degree to which the child or adolescent has 'complicating psychosocial factors' that require additional clinical input during an episode of care.

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.

10. Other measures

10.1. Mental Health Phase of Care

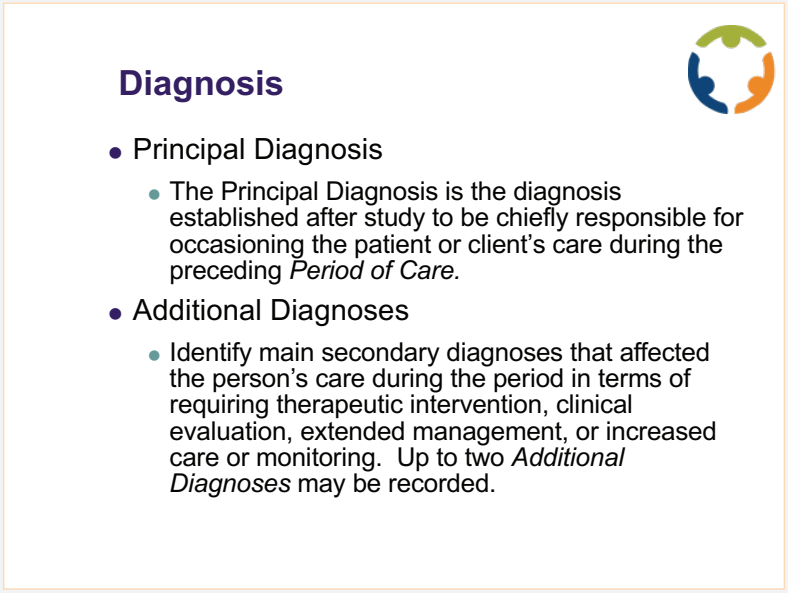


The Phase of Care is rated by the clinician and requires judgement about the consumer's primary goal of care and the duration and intensity of expected care.

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.

10. Other measures

10.2. 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 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.

10. Other measures

10.3. Mental Health Legal Status

Mental Health Legal Status

- Was the person treated on an involuntary basis (under the relevant mental health legislation) at some point during the preceding *Period of Care*

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.

11. Additional information

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

The AMHOCN website (www.ahmocn.org) contains information about the NOCC. Additional self-paced training is available at the AMHOCN online learning site: https://learning.amhocn.org/.

12. Appendices

12.1. 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).

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	✓	✗	✓	✗	✓	✓
28-33	Impact	✓	✓	✓	✓	✓	✓
34-35	Follow up progress	✗	✓	✗	✓	✗	✓
36-38	Cross-Informant information	✓	✗	✓	✗	✗	✗
39-42	Cross-Informant information	✗	✗	✗	✗	✓	✗

12. Appendices

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 (Ad-mission);
- TC2 - Teacher Report Measure for Children and Adolescents aged 04-10 on follow up con-tact with service (Review & Discharge);
- TY1 - Teacher Report Measure for Youth aged 11-17 on initial contact with service (Admis-sion); and
- TY2 - Teacher Report Measure for Youth aged 11-17 on follow up contact with service (Re-view & 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 ar-rangements 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 web-site. This resource is for use in AMHOCN training activities.

Interpreting SDQ scores

PARENT VERSIONS	'This score is close to av-erage - clinically signifi-cant 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 av-erage – clinically signifi-cant problems in this area are unlikely'	'This score is slightly low, which may reflect clinical-ly significant problems'	'This score is low - there is a substantial risk of clini-cally significant problems in this area'
Prosocial Behaviour Score	6-10	5	0-4

12. Appendices

SELF COMPLETED VERSIONS	'This score is close to av-erage - clinically signifi-cant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant prob-lems'	'This score is high - there is a substantial risk of clinically significant prob-lems 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 av-erage - clinically signifi-cant problems in this area are unlikely'	'This score is slightly low, which may reflect clinical-ly significant problems'	'This score is low - there is a substantial risk of clini-cally 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.

12. Appendices

12.2. Health of the Nation Outcome Scales Child and Adolescent Glossary (HoNOSCA)

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 sui-cidal 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 disabil-ity such as hearing problems.

Include reduced scholastic performance associated with emotional or behavioural prob-lems.

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 alco-hol 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 delu-sions, 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; hallu-cinations, causing much distress, or manifested in obviously bizarre behaviour.

4 Mental state and behaviour is seriously and adversely affected by delusions or hallu-cinations 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 cardio-vascular 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 ac-tivities.

4 Very severe problems or symptoms persist into most activities. The child or adoles-cent 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 prob-lems 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 caus-ing 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 social-ly 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, travel-ling independently, shopping etc.; taking into account the norm for the child's chronologi-cal age.

Include poor levels of functioning arising from lack of motivation, mood or any other disor-der.

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. Pa-rental personality problems, mental illness, marital difficulties should only be rated here if they have an effect on the child or adolescent.

Include problems such as poor communication, arguments, verbal or physical hostility, crit-icism and denigration, parental neglect or rejection, over-restriction, sexual or physical abuse.

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

Include problems with enmeshment and overprotection.

Include problems with family bereavement leading to reorganisation.

Do not 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

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

Include 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 in-formation 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)

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

Include lack of explanation about the diagnosis or the cause of the problem or the progno-sis.

0 No problems during the period rated. Parents and carers have been adequately in-formed 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 adoles-cent'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 infor-mation 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.

12. Appendices

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. Appendices

HoNOSCA scoring and subscales

All HoNOSCA items are answered on an item-specific anchored four-point scale with higher scores indicating more problems. A total score is calculated as the sum of the scores for items 1–13 only, with a range 0–52. Items scored 9 or with missing data are generally excluded from the calculation.

Structure of the 15 HoNOSCA scales

Scale	Scale item	Section
1	Disruptive, antisocial or aggressive behaviour	Behaviour
2	Over-activity, attention or concentration	
3	Non-accidental self injury	
4	Alcohol, substance or solvent misuse	
5	Scholastic or language skills	Impairment
6	Physical illness or disability problems	
7	Hallucinations, delusions or abnormal perceptions	Symptoms
8	Non-organic somatic symptoms	
9	Emotional and related symptoms	
10	Peer relationships	Social
11	Self-care and independence	
12	Family life and relationships	
13	Poor school attendance	
14	Lack of knowledge – nature of difficulties	Information
15	Lack of information – services/management	

12. Appendices

12.3. Children's Global Assessment Scale Glossary (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; 'every-day' 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 tran-sient 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 iso-lated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor dif-ficulties 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 re-lationships; most people who do not know the child well would not consider him/her de-viant 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 conver-sion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent epi-sodes of aggressive or other antisocial behaviour with some preservation of meaningful so-cial 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 ag-gression without clear instigation; markedly withdrawn and isolated behaviour due to ei-ther 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).

12. Appendices

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.

Source: Schaffer D, Gould MS, Brasic J, et al (1983) A children's global assessment scale (CGAS). Archives of General Psychiatry, 40, 1228-1231

12. Appendices

12.4. 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.

12. Appendices

	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.