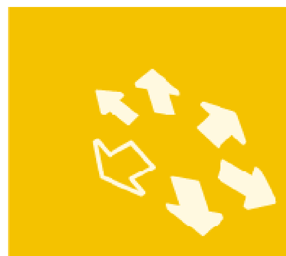
Australian Mental Health Outcomes and Classification Network

Training Manual

Older Persons Inpatient



A joint Australian, State and Territory Government Initiative

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Compiled by Tim Coombs.

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Additional copies of the report can be obtained from:
Network Coordinator, AMHOCN, NSW Institute of Psychiatry, Locked Bag 7118, Parramatta BC NSW 2150. Tel: (02) 9840 3833. Fax: (02) 9840 3838.
Email: amhocn@mhnocc.org Website: www.mhnocc.org

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1. ACKNOWLEDGEMENT

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2. INTRODUCTION TO 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.

A separate manual describing the consumer self report measure has also been produced as part of this training package.

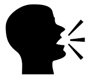
Some of the underlying principles, which shape this training manual, include:

- 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:

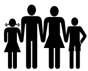
- Older Persons Inpatient Training Manual (this document);
- Adult Self Report Measure appropriate to jurisdiction;
- Whiteboard or PowerPoint projector and laptop;
- White board markers;
- Vignette material (Video, written material); and
- Example reports.

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.

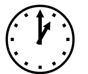
This symbol indicates that trainers should show a particular video clip or written vignette.



This symbol indicates that trainers should encourage group discussion.

This symbol indicates that trainers should distribute specific handout materials.

This symbol indicates that trainers should be prepared with background knowledge. Trainers will be provided with additional reference material in this section.



This symbol indicates the notional time each section should take.

3. TRAINING INTRODUCTION AND LEARNING OBJECTIVES

National Outcomes and Casemix Collection Training Workshop

Older Persons Inpatient

national mental health strategy
A joint Australian, State and Territory Government Initiative

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AMHOCN

This slide simply provides an introduction to the title of the workshop

Take this opportunity to undertake house keeping activities – bathrooms, messages, mobile phone etiquette.

Introduction of presenter and, depending on group size, participants.

This context section should take approximately 10 minutes to complete

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

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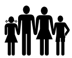
Participants should be given a brief orientation to the content of the workshop and the expected outcomes of participation. This includes:

- 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 we 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 White board and discuss them with the group.

4. CONTEXT

The Guiding Question ...

- Who receives .....
- What services .....
- From whom .....
- At what cost ......
- With what effect ...

from Leginski et al 1989

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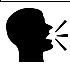
This is the central question that the collection of information in mental health services is designed to answer.

Reflecting on participant responses indicates that mental health services have been good at collecting information on inputs and processes but less successful in demonstrating outcomes.
You should note that the collection of outcomes measures aims to demonstrate the *EFFECT* of the delivery of mental health care.

Note that Andrews et al (1996) defined a consumer outcome as "the effect on a patient's health status that is attributable to an intervention". The measurement of consumer outcome is therefore integral to reflecting on practice.



Under this plan there is a continued commitment to the development of outcome measurement in mental health and the further development of a casemix classification system.

States, Territories and the Australian Government all identified the need for improvements in the collection of information in Mental Health Services.

There are many misconceptions regarding casemix classification – indeed, it is often just seen as a way of funding services. However, the word casemix can simply be defined as the “mix of cases”. Casemix classification aims to group episodes of care into different classes based on two criteria. First, each class is clinically similar (people with broken legs are in one class while people who are having appendectomies are in another). Second, each class has similar resource consumption or costs, the implicit assumption being that people who consume similar amounts of resources have similar needs. Casemix classification is essential to understanding variation in the

types of consumers being seen by services. Understanding the variation in consumers is the key to understanding variation in the providers of services. Controlling for variations in consumers through casemix classification can support a range of service development activities including:

a. *Quality assurance and service utilisation reviews* – by understanding variations in casemix, the focus is on variation in the way services are delivered.

b. *Interpretation of consumer outcomes* – variation in outcomes between different services, may be a function of differences in consumers receiving services or variation in the casemix.

c. *Benchmarking* – adjustments for casemix is essential to enable services to compare different performance indicators such as length of stay, with different lengths of stay for different types of cases.

d. *Development of Clinical Protocols* – casemix classification can provide a framework to determine what package of services different groups of consumers should receive.

Casemix classification is not simply about funding as funding may be changed without casemix. However, a variety of service development activities require casemix classification.

5. BRIEF OVERVIEW OF MEASURES

Outcomes and Casemix Measures for Older People

- Clinician rated
  - Health of the Nation Outcome Scales (HoNOS)
  - Life Skills Profile (LSP-16)
  - Focus of Care (FoC)
- Consumer self-report (varies across states and territories)
  - Mental Health Inventory (MHI)
  - Kessler 10 (K-10)
  - Behaviour and Symptom Identification Scale (BASIS 32)

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

Provide a brief overview of the measures being used in Mental Health Services.

The Health of the Nation Outcome Scales (HoNOS) is a collection of 12 scales designed to capture information regarding the severity of problems for consumer in 12 common areas.

The HoNOS65+ is a variant of the general adult version of the HoNOS and was developed specifically for use with older people with a mental illness. The HoNOS65+ variant of the HoNOS consists of the same item set and is scored in the same way, however the accompanying glossary has been modified to better reflect the problems and symptoms likely to be encountered when assessing older persons.

The Life Skills Profile 16 (LSP-16) is an abbreviated version of the Life Skills Profile – a measure of function and disability. The LSP is NOT used for Older Persons in an Inpatient setting.

The Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) is only applicable to consumers aged 65 years and over and measures ability with respect to what are called 'late loss' activities – those activities that are likely to be lost last in life (eg eating, mobility)

The Focus of Care (FoC) aims to operationalise the concept of a phase of illness with people moving between stable and acute phases within an episode of illness. The FoC is NOT used for Older Persons in an Inpatient setting.

Consumer self-report measures differ across jurisdictions and trainers should refer to the appropriate measure for their jurisdiction (see consumer self report measure training manual).

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

Different jurisdictions are using different consumer self report measures. This highlights the developmental nature of outcome measurement within mental health.

This brief overview should take approximately 5 minutes to complete.

6. 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**

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Provide a brief overview of the 3 critical occasions during episodes of mental health care when data should be collected.

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.

This Data Collection Protocol section should take approximately 20 minutes with questions.

Episode of Mental Health Care

- Defined as "a more or less continuous period of contact between a consumer and a *Mental Health Service Organisation* that occurs within the one *Mental Health Service Setting*"
- Mental Health separated into 3 types of service settings:
  - Inpatient episodes (Overnight admitted)
  - Community Residential episodes (24 hour staffed)
  - Ambulatory episodes
- Two business rules:
  - 'One episode at a time'
  - 'Change of setting = new episode'
- Start and end of each episode triggers a collection occasion
- Different measures are collected for different age groups

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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.

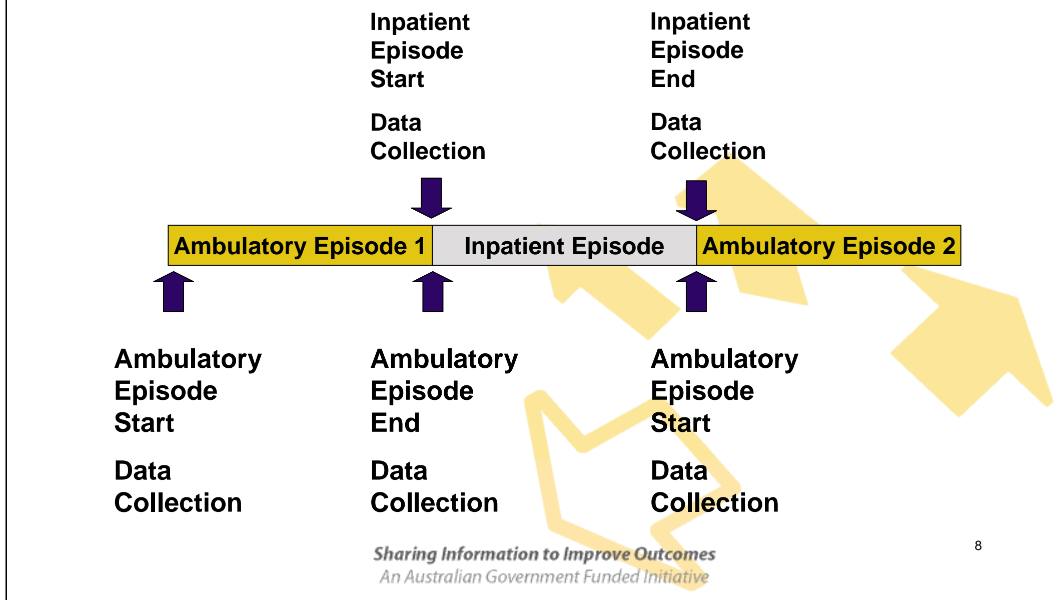
Note that this nationally agreed collection protocol might use different terminology than your local service hence the need for local adaptation.

The data collection protocol was designed to meet a number of 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.

Note: Ambulatory mental health includes any hospital-based services for consumers who are not in overnight inpatient care.



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.

The National Outcomes and Casemix Collection protocol is outlined in the table below

Collection Occasion: Inpatient, Older Persons	A	R	D
HoNOS 65+	●	●	●
LSP-16	×	×	×
RUG-ADL	●	●	×
Consumer self-report (MHI, BASIS32, K10+ Check Jurisdiction) (1)	×	×	×
Principal and Additional Diagnoses	×	●	●
Focus of Care	×	×	×
Mental Health Legal Status	×	●	●

Abbreviations and Symbols

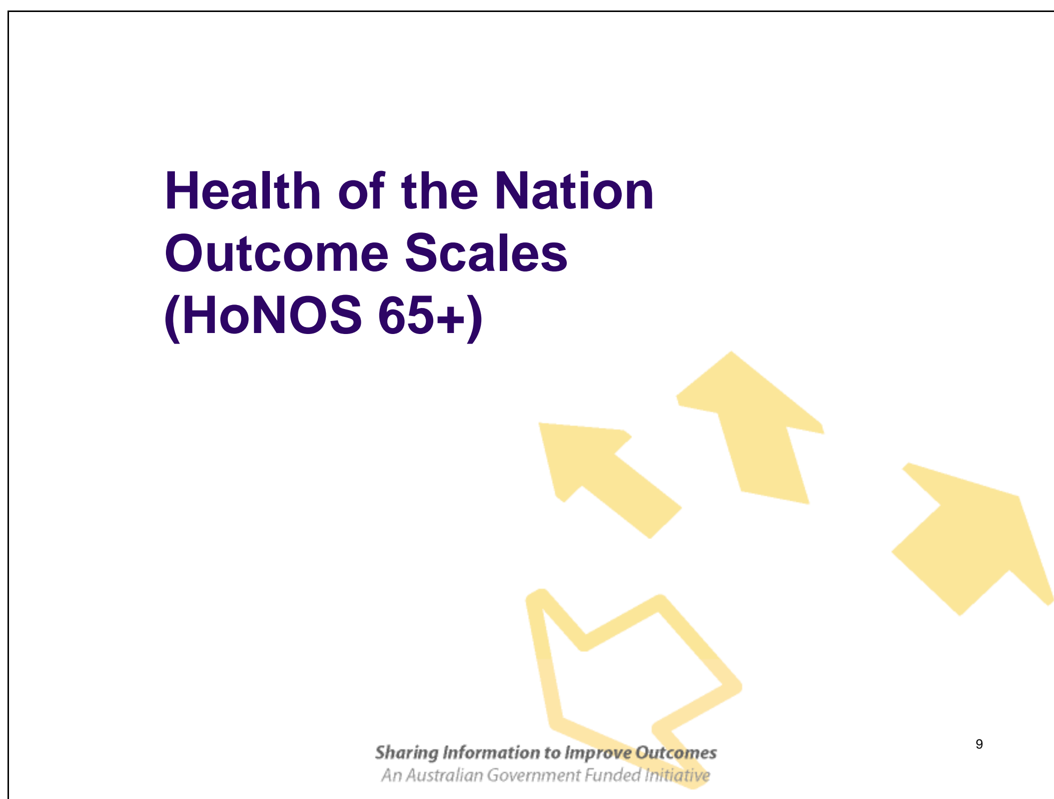
A	Admission to Mental Health Care	●	Collection of data on this occasion is mandatory
R	Review of Mental Health Care		
D	Discharge from Mental Health Care	×	No collection requirements apply

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. Some jurisdictions and services have decided to trial the consumer self report measure in inpatient settings.

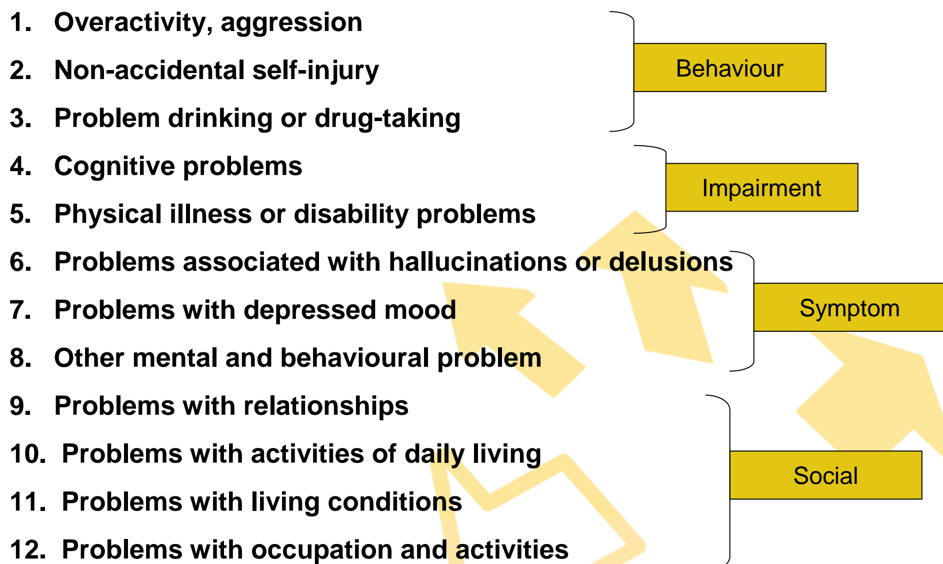
Trainers should hand out copies of the local adaptation to the data collection protocol that are pertinent to the unit or group they are training.

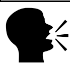
7. HoNOS65+



This slide introduces the section on training in the clinical measures. The aim of this section is provide participants with the skills to complete the primary measure of problem severity, the Health of the Nation Outcome Scales 65+.

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





Refer trainees to the HoNOS65+ Glossary and note that the HoNOS65+ is:

- Key measure of severity;
- Brief – 5 minutes to rate;
- Acceptable and useful to clinicians – specifically broad spectrum;
- Satisfactory inter-rater reliability;
- Change in scores correlate with independent clinical ratings of change; and
- Training required.

Note that the 12 scales of the HoNOS65+ can be broken down into 4 sub-scales: behaviour; impairment; symptom; and social.

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

The Health of the Nation Outcome Scales 65+ (HoNOS65+) is the key measure of problem severity in the suite of outcome measures for older persons. Usually, some trainees will have had experience completing the HoNOS or HoNOS65+. Ask them how long it usually takes to complete, remembering to make the distinction between first completing the measure and completing following some practice.

The HoNOS was designed as a broad spectrum measure, capturing information about the consumer in a number of domains, not just symptoms. Sukhwinder et al (1999) however found that, although the general adult HoNOS performed reasonably well with older persons, a number of modifications could be made to improve its applicability for this group. In 1996 a meeting of the Royal College of Psychiatrists was called and a number of amendments were suggested to improve the ability of the HoNOS to demonstrate outcomes for older people.

These amendments included the need to better reflect the physical and cognitive problems of older people along with the issues that often prompted referral to mental health services such as sleeplessness, restlessness and agitation. At this meeting, it was believed that changes to the glossary would meet the need for amendments to the measure, while retaining the basic HoNOS structure. A field trial of the modified HoNOS glossary was undertaken and the new measure demonstrated good inter-rater reliability, validity in relation to other established scales used to measure the mental health of older persons and was generally acceptable to clinical staff (Burns et al (1999)).

Stedman et al (1997) found that clinicians identified the HoNOS as acceptable and useful during field trials in Australia. The HoNOS has identified satisfactory inter-rater reliability during development (Wing et al (1995)) and in subsequent trials (Trauer et al (1999)). Given this work in relation to the HoNOS and the demonstrated reliability and validity of the HoNOS 65+ in the Burns et al (1999) work, the HoNOS 65+ was felt the most appropriate measure for introduction into Australian public sector mental health services for older persons.

However, questions have been raised about the inter-rater reliability of the HoNOS (Brooks (2000)).

These concerns hold true for the HoNOS 65+ and these limitations should be acknowledged. However it is important to note:

- Perfect inter-rater reliability has never been demonstrated for any measure;
- 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 poor information sharing between raters; and
- During training, reasonable inter-rater reliability will be demonstrated, with the majority of participants, the majority of the time, rating in a similar fashion.

References

Brooks, R. *The reliability and validity of the Health of the Nation Outcome Scales: Validation in the relation to patient derived measures*. Australian and New Zealand Journal of Psychiatry. 2000, 34: 504-511.

Burns, A., Beevor, A., Elliott, P., Wing, J., Blakey, A., Orrell, M., Mulinga, J. & Hadden, S. *Health of the Nation Outcome Scales for Elderly People (HoNOS 65+)*. British Journal of Psychiatry. 1999, 174(5):424-427.

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Trauer, T., Callay, T., Little, J., Shields, R. and Smith, J. *Health of the Nation Outcome Scales (HoNOS) : results of the Victorian field trial*, British Journal of Psychiatry. 1999, 174:380 - 388.

Wing, J., Curtis, R. H. and Beevor, A.S. *HoNOS: Health of the Nation Outcome Scales: Report on the Research and Development July 1993 -*

December 1995. 1996, Royal College of Psychiatric Research Unit: London.

Rating the HoNOS65+

				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.	✓	Maybe
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.	×	×

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Note that the HoNOS65+ 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

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 and 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 HoNOS65+.

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

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

HoNOS65+ Rating Rules

- Rate each item in order from 1 to 12
- Do not include information rated in an earlier item, i.e. minimal item overlap
- Rate the most severe problem that has occurred over the previous two weeks
- Consider both the **impact on behaviour** and/or the **degree of distress** it causes

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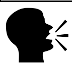

This slide outlines the basic rating rules of the HoNOS65+.

It is important to avoid overlapping ratings when completing the HoNOS65+. The HoNOS65+ is a collection of 12 scales and in order 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 consumer who has been intoxicated once in the past two weeks but while intoxicated hits someone. This behaviour would score high on Scale 1, as a result of the assault, but may not score high on Scale 3, “drug and alcohol use” given that alcohol has only been consumed once in the past two weeks.

Ratings are made on the worst manifestation of the problem over the preceding 2 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.

Important Variations in Rating Guides

	'CORE RULES'	
SCALE	**RATE THE WORST MANIFESTATION**	**RATE OVER THE PAST 2 WEEKS**
Scales 1-8	Always	Always
Scales 9-10	Based on usual or typical	Always
Scales 11-12	Based on usual or typical	May need to go back beyond two weeks to establish the usual situation

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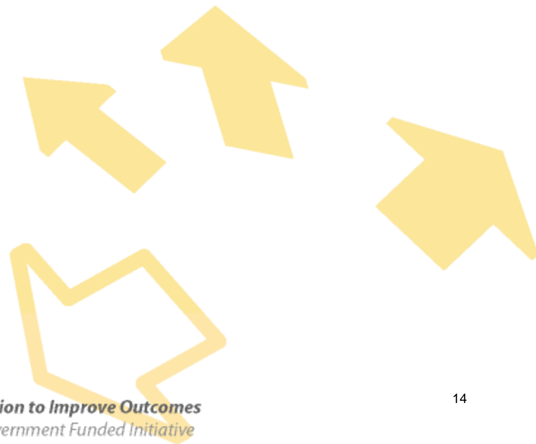
The general rating rule is to rate the worst manifestation of a problem over the preceding two weeks. This holds true for scales 1 through to 8.

However, the social scales are more problematic. For example, simply having an argument with your spouse does not mean you have problems in terms of the quality and quantity of your relationships (Scale 9).

Trainees are therefore asked to consider the usual or typical situation for the consumer over the preceding 2 weeks for Scales 9 – 12.

It is also important to point out that scales 11 and 12 may need to be rated outside the two week rating period.

Practice Rating HoNOS 65+ Time 1



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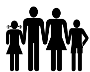
During training practice, rating the HoNOS65+ is a multi-stage process:

1. Have trainees read a written vignette or watch a video vignette;
2. Have trainees review the consumer self report measure if available;
3. Have trainees practice rating the HoNOS65+ referring to their glossaries; and
4. Have trainees share ratings and compare and contrast 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, it provides a valuable opportunity to clarify the rating rules of the measures.

The promotion of discussion should take the following form:

Using a white board, draw a grid capable of indicating individual scores for each of the 12 HoNOS65+ items as shown below.

	HoNOS65+ Items											
Rating	1	2	3	4	5	6	7	8	9	10	11	12
4												
3												
2	5											
1	6											
0												
9												

Working one at a time through each item, have trainees identify their ratings. Indicate in the appropriate grid square the number of trainees who rated in a particular way. For example, in the above grid, 5 trainees rated "2" on scale 1, while 6 trainees rated 1.

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.

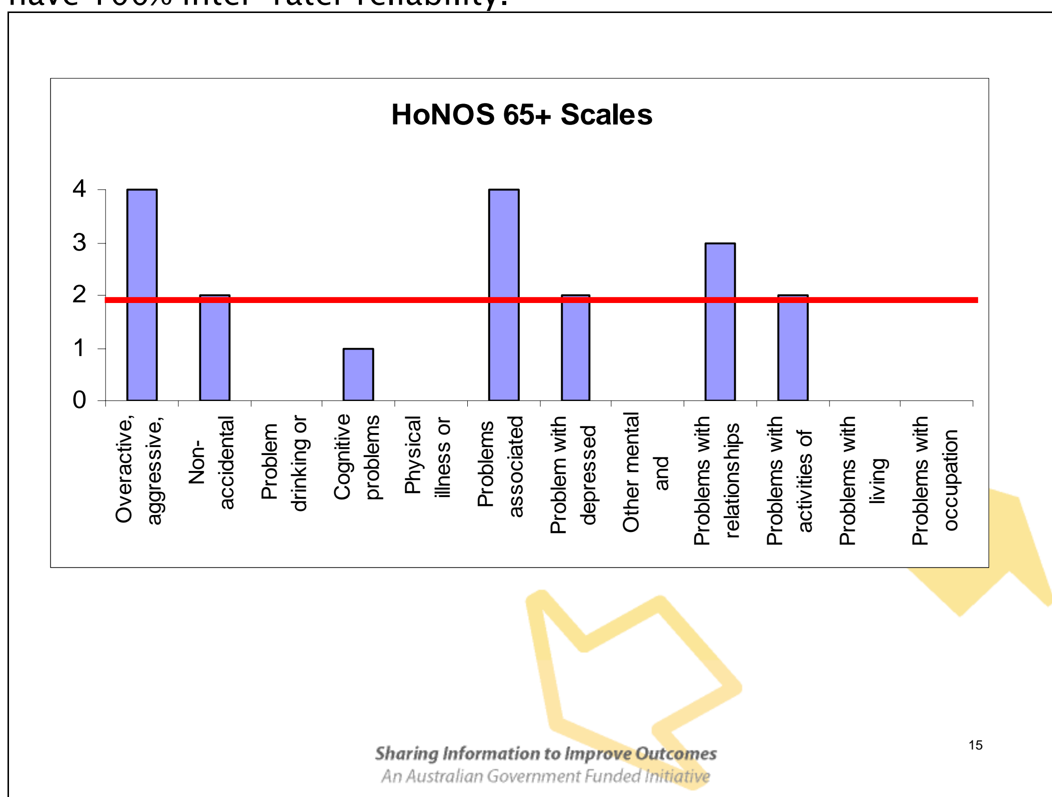
Take opportunities to clarify and reinforce the rating rules.

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.

Remind trainees that a better understanding of the measure will develop as a result of use within clinical practice and discussion of appropriate ratings during team meetings/ clinical reviews.

Remember that some variation in ratings may be the result of the training materials and not a lack of ability on the part of trainees. Also note that variation is to be expected, the HoNOS65+ does not have 100% inter-rater reliability.



It is useful to present the consensus HoNOS65+ ratings as a simple histogram. Trainers may wish to develop these using local system reports.

DO NOT DO THIS BEFORE HAVING THE DISCUSSION REGARDING THE CONSENSUS RATING AS DESCRIBED ABOVE.

Given the problems identified for the consumer, promote discussion around interventions that may be appropriate for a consumer with these problems.

- Which problems would be the focus of clinical attention at this time?
- Which problem areas require additional assessment?
- Which problem areas require the input of different members of the multidisciplinary team?
- What other agencies need to be involved in providing services for this consumer?

How could the HoNOS65+ be used in Mental Health? A variety of potential uses for the HoNOS65+ have been identified, these include:

- Standard record of progress across 12 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 patients' needs to practitioners' 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, 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. RUG-ADL

The RUG-ADL

- Used to measure physical dependency in the aged - only used for over 65's
- Brief; 2 minutes to rate
- Good inter-rater reliability
- High level of prediction in previous studies
- 4 items only:
  - bed mobility
  - toileting
  - transfer
  - eating

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Give a brief overview of the Resource Utilisation Groups – Activities of Daily Living (RUG-ADL).

To complete the RUG-ADL, clinicians are asked to rate the consumer's needs for assistance in four activities of daily living: bed mobility; toileting; transfer; and eating. The instrument is simple to use, taking only a few minutes to complete.

The RUG-ADL measure is only applicable to consumers aged 65 years and over.

It was developed for the measurement of nursing dependency in nursing home facilities. The RUG-ADL measures ability with respect too what are called 'late loss' activities – those activities that are likely to be lost last in life (e.g. eating, mobility). 'Early loss' activities (such as dressing and grooming) are included in the LSP.

RUG - General Scoring Rules

- Record what the person actually does, not what they are capable of doing. i.e. record the poorest performance of the assessment period.
- Do not leave any spaces blank except if the person is deceased.
- It is essential that the rater knows what behaviours and/or tasks are contained within each scale and has a ‘working knowledge’ of the scale.

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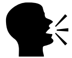

This slide provides the basic rating rules for the RUG-ADL

Diagnosis

- Principal Diagnosis
  - The Principal Diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the patient or client's care during the preceding *Period of Care.*
- Additional Diagnoses
  - Identify main secondary diagnoses that affected the person's care during the period in terms of requiring therapeutic intervention, clinical evaluation, extended management, or increased care or monitoring. Up to two *Additional Diagnoses* may be recorded.

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Note: 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.

Two approaches to this issue have been taken during implementation. All mental health staff have been supplied with ICD-10 codes. If they feel comfortable, given their training and experience, to identify the principal diagnosis, then they are able to do so using the supplied codes.

However, if they do not feel comfortable doing this (especially in ambulatory settings), they are to review the consumer's file for a diagnosis made by a medical practitioner and transcribe this diagnosis as the principal diagnosis.

In short, resolution of this issue will depend on local circumstances including the training and experience of staff and the availability of medical practitioners.

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*

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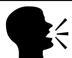
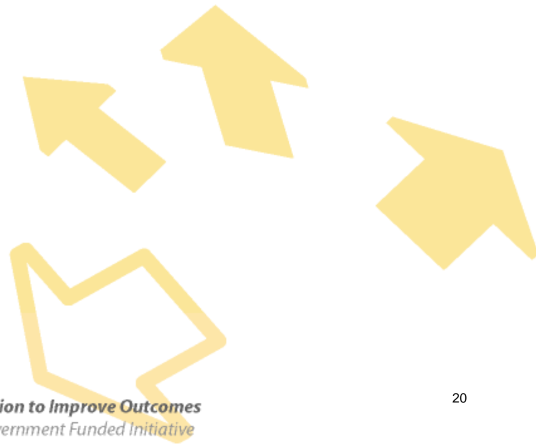


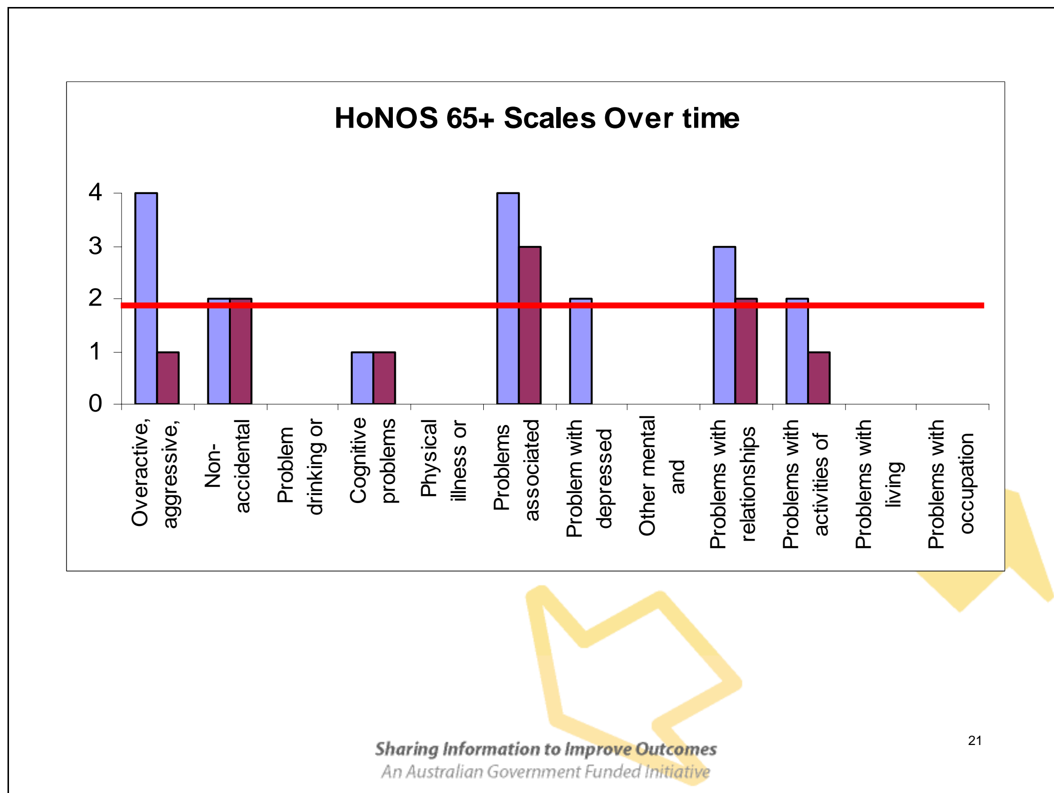
Note: The mental health legal status is a retrospective indicator and is only collected on **review** and **discharge**. The consumer only has to have one episode of involuntary care during their episode of care for this indicator to be positive.

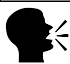
RATE THE HoNOS

Practice Rating HoNOS 65+ Time 2



Each vignette in this training package has information on two collection occasions. For this seconding collection occasion, follow the feedback and discussion procedure as outlined above.





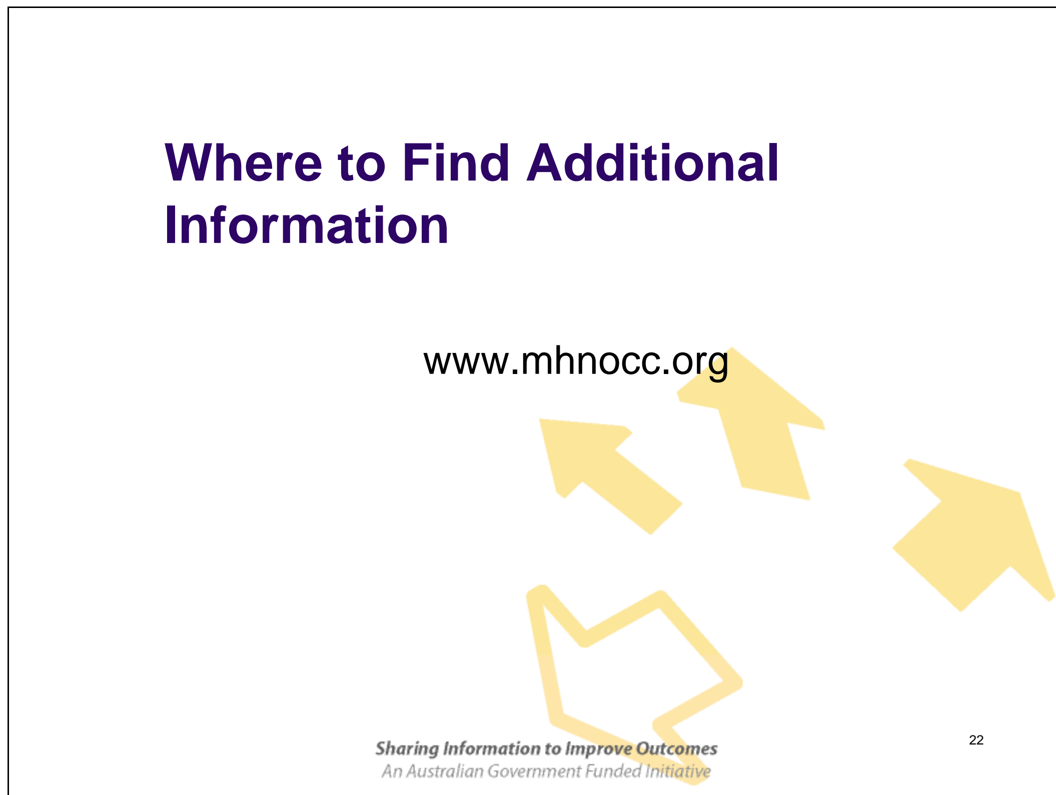
On this second collection occasion provide trainees with a comparison graphical representation of change over time.

DO NOT DO THIS BEFORE HAVING THE DISCUSSION REGARDING THE CONSENSUS RATING AS DESCRIBED ABOVE.

- Promote discussion around those interventions that may have produced this change. How has the focus of clinical intervention altered?
- Which problem areas are now the focus of intervention?
- Which problem areas require additional assessment?
- Which problem areas require the input of different members of the multidisciplinary team?
- What other agencies need to be involved in providing services for this consumer?

Provide feedback on the rating of the Mental Health Legal Status and the Principal and Additional Diagnosis for this vignette.

10. ADDITIONAL INFORMATION



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

11. REFERENCES

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Wing, J., Curtis, R. H. and Beevor, A.S. *HoNOS: Health of the Nation Outcome Scales: Report on the Research and Development July 1993 – December 1995*. 1996, Royal College of Psychiatric Research Unit: London.

More Reference Material is available on the Mental Health National Outcomes and Casemix Collection website www.mhnocc.org

12. TRAINING VIDEO

The following video timings enable trainers to readily find the appropriate vignette during training. Note that video vignettes are also available in Mpeg format on the CD-ROM which forms part of this training package.

Age Group	Vignette	Video Timing
Older	Bill Admission	0.00.36
Older	Bill Discharge	0.01.56
C&A	Carmen Admission	0.03.28
C&A	Carmen Review	0.06.13
Adult	Maria Admission	0.07.32
Adult	Maria Review	0.08.58
C&A	Danny Admission	0.10.00
C&A	Danny Review	0.11.28
Older	Helen Admission	0.12.20
Older	Helen Discharge	0.13.20
Adult	Paul Review 1	0.14.05
Adult	Paul Review 2	0.16.35
C&A	Tim Admission	0.18.04
C&A	Tim Review	0.20.38

13. APPENDICES

Health of the Nation Outcome Scales for Older People (HoNOS65+)

HoNOS65+ rating guidelines

- Rate items in order from 1 to 12.
- Use all available information in making your rating.
- Do not include information already rated in an earlier item.
- Consider both the degree of distress the problem causes and the effect it has on behaviour.
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks, except at discharge from inpatient care, when it is the previous 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.

HoNOS65+ glossary

1 Behavioural disturbance (eg, overactive, aggressive, disruptive or agitated behaviour, uncooperative or resistive behaviour)

<u>Include</u> such behaviour due to any cause, eg, dementia, drugs, alcohol, psychosis, depression, etc.
<u>Do not</u> include bizarre behaviour, rated at Scale 6.

0 No problems of this kind during the period rated.
1 Occasional irritability, quarrels, restlessness etc., but generally calm and co-operative and not requiring any specific action.
2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (eg, broken cup, window); significant over-activity or agitation; intermittent restlessness or wandering (day or night); uncooperative at times, requiring encouragement and persuasion.
3 Physically aggressive to others or animals (short of rating 4); more serious damage to, or destruction of, property; frequently threatening manner, more serious or persistent over-activity or agitation; frequent restlessness or wandering; significant problems with co-operation, largely resistant to help or assistance.
4 At least one serious physical attack on others (over and above rating of 3); major or persistent destructive activity (eg, fire–setting); persistent and

threatening behaviour; severe over-activity or agitation; sexually disinhibited or other inappropriate behaviour (eg, deliberate inappropriate urination or defecation); virtually constant restlessness or wandering; severe problems related to non-compliant or resistive behaviour.

2 Non-accidental self-injury

Do not include accidental self-injury (due eg, to dementia or severe learning disability); any cognitive problem is rated at Scale 4 and the injury at Scale 5.
Do not include illness or injury as a direct consequence of drug or alcohol use rated at Scale 3, (eg, cirrhosis of the liver or injury resulting from drunk–driving are rated at Scale 5).

0 No problem of this kind during the period rated.
1 Fleeting thoughts of self-harm or suicide; but little or no risk during the period rated.
2 Mild risk during period; includes more frequent thoughts or talking about self-harm or suicide (including 'passive' ideas of self-harm such as not taking avoiding action in a potentially life-threatening situation, eg, while crossing a road).
3 Moderate to serious risk of deliberate self-harm during the period rated; includes frequent or persistent thoughts or talking about self-harm; includes preparatory behaviours, eg, collecting tablets.
4 Suicidal attempt or deliberate self-injury during period.

3 Problem drinking or drug-taking

Do not include aggressive or destructive 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 5.

0 No problem of this kind during the period rated.
1 Some over-indulgence but within social norm.
2 Occasional loss of control of drinking or drug-taking; but not a serious problem.
3 Marked craving or dependence on alcohol or drug use with frequent loss of control, drunkenness, etc.
4 Major adverse consequences or incapacitated due to alcohol or drug problems.

4 Cognitive problems

<u>Include</u> problems of orientation, memory, and language associated with any disorder: dementia, learning disability, schizophrenia, etc.
<u>Do not</u> include temporary problems (eg, hangovers) which are clearly associated with alcohol, drug or medication use, rated at Scale 3.

0 No problem of this kind during the period rated.
1 Minor problems with orientation (eg, some difficulty with orientation to time) or memory (eg, a degree of forgetfulness but still able to learn new information), no apparent difficulties with the use of language.
2 Mild problems with orientation (eg, frequently disorientated to time) or memory (eg, definite problems learning new information such as names, recollection of recent events; deficit interferes with everyday activities); difficulty finding way in new or unfamiliar surroundings; able to deal with simple verbal information but some difficulties with understanding or expression of more complex language.
3 Moderate problems with orientation (eg, usually disorientated to time, often place) or memory (eg, new material rapidly lost, only highly learned material retained, occasional failure to recognise familiar individuals); has lost the way in a familiar place; major difficulties with language (expressive or receptive).
4 Severe disorientation (eg, consistently disorientated to time and place, and sometimes to person) or memory impairment (eg, only fragments remain, loss of distant as well as recent information, unable to effectively learn any new information, consistently unable to recognise or to name close friends or relatives); no effective communication possible through language or inaccessible to speech.

5 Physical illness or disability problems

<u>Include</u> illness or disability from any cause that limits mobility, impairs sight or hearing, or otherwise interferes with personal functioning (eg, pain).
<u>Include</u> side–effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drunk driving etc.
<u>Do not</u> include mental or behavioural problems rated at Scale 4.

0 No physical health, disability or mobility problems during the period rated.
1 Minor health problem during the period (eg, cold); some impairment of sight or hearing (but still able to function effectively with the aid of glasses or hearing aid).
2 Physical health problem associated with mild restriction of activities or mobility (eg, restricted walking distance, some degree of loss of independence); moderate impairment of sight or hearing (with functional impairment despite the appropriate use of glasses or hearing aid); some degree of risk of falling, but low and no episodes to date; problems associated with mild degree of pain.
3 Physical health problem associated with moderate restriction of activities or mobility (eg, mobile only with an aid – stick or zimmer frame – or with help); more severe impairment of sight or hearing (short of rating 4); significant risk of falling (one or more falls); problems associated with a moderate degree of pain.
4 Major physical health problem associated with severe restriction of activities or mobility (eg, chair or bed bound); severe impairment of sight or hearing (eg, registered blind or deaf); high risk of falling (one or more falls) because of physical illness or disability; problems associated with severe pain; presence of impaired level of consciousness.

6 Problems associated with hallucinations and delusions

<u>Include</u> hallucinations and delusions (or false beliefs) irrespective of diagnosis.

<u>Include</u> odd and bizarre behaviour associated with hallucinations or delusions (or false beliefs).
<u>Do not</u> include aggressive, destructive or overactive behaviours attributed to hallucinations, delusions or false beliefs, rated at Scale 1.

0 No evidence of delusions or hallucinations during the period rated.
1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2 Delusions or hallucinations (eg, voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, that is, a present, but mild clinical problem.
3 Marked preoccupation with delusions or hallucinations, causing significant distress or manifested in obviously bizarre behaviour, that is, moderately severe clinical problem.
4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with a major impact on patient or others.

7 Problems with depressive symptoms

<u>Do not</u> include over-activity or agitation, rated at Scale 1.
<u>Do not</u> include suicidal ideation or attempts, rated at Scale 2.
<u>Do not</u> include delusions or hallucinations, rated at Scale 6.
Rate associated problems (eg, changes in sleep, appetite or weight; anxiety symptoms) at Scale 8.

0 No problems associated with depression during the period rated.
1 Gloomy; or minor changes in mood only.
2 Mild but definite depression on subjective or objective measures (eg, loss of interest or pleasure, lack of energy, loss of self-esteem, feelings of guilt).
3 Moderate depression on subjective or objective measures (depressive symptoms more marked).
4 Severe depression on subjective or objective grounds (eg, profound loss of interest or pleasure, preoccupation with ideas of guilt or worthlessness).

8 Other mental and behavioural problems

*<u>Rate</u> only the most severe clinical problem <u>not</u> considered at Scales 6 and 7 as follows: specify the type of problem by entering the appropriate letter: **A** phobic: **B** anxiety; **C** obsessive–compulsive; **D** stress; **E** dissociative; **F** somatoform; **G** eating; **H** sleep; **I** sexual; **J** other, specify.*

0 No evidence of any of these problems during period rated.
1 Minor non-clinical problems.
2 A problem is clinically present, but at a mild level, for example the problem is intermittent, the patient maintains a degree of control or is not unduly distressed.
3 Moderately severe clinical problem, for example, more frequent, more distressing or more marked symptoms.
4 Severe persistent problems which dominates or seriously affects most activities.

9 Problems with relationships

Problems associated with social relationships, identified by the patient or apparent to carers or others. <u>Rate</u> the patient's most severe problem associated with active or passive withdrawal from, or tendency to dominate, social relationships or non-supportive, destructive or self-damaging relationships.

0 No significant problems during the period.
1 Minor non-clinical problems.
2 Definite problems in making, sustaining or adapting to supportive relationships (eg, because of controlling manner, or arising out of difficult, exploitative or abusive relationships), definite but mild difficulties reported by patient or evident to carers or others.
3 Persisting significant problems with relationships; moderately severe conflicts or problems identified within the relationship by the patient or evident to carers or others.

4 Severe difficulties associated with social relationships (eg, isolation, withdrawal, conflict, abuse); major tensions and stresses (eg, threatening breaking down of relationship).

10 Problems with activities of daily living

Rate the overall level of functioning in activities of daily living (ADL): eg, problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, recreation and use of transport, etc.
Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.
Do not include lack of opportunities for exercising intact abilities and skills, rated at Scales 11 and Scale 12.

0 No problems during period rated; good ability to function effectively in all basic activities (eg, continent – or able to manage incontinence appropriately, able to feed self and dress) and complex skills (eg, driving or able to make use of transport facilities, able to handle financial affairs appropriately).

1 Minor problems only without significantly adverse consequences, for example, untidy, mildly disorganised, some evidence to suggest minor difficulty with complex skills but still able to cope effectively.

2 Self-care and basic activities adequate (though some prompting may be required), but difficulty with more complex skills (eg, problem organising and making a drink or meal, deterioration in personal interest especially outside the home situation, problems with driving, transport or financial judgements).

3 Problems evident in one or more areas of self-care activities (eg, needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted) as well as inability to perform several complex skills.

4 Severe disability or incapacity in all or nearly all areas of basic and complex skills (eg, full supervision required with dressing and eating, frequent urinary or faecal incontinence).

11 Problems with living conditions

Rate the overall severity of problems with the quality of living conditions, accommodation and daily domestic routine, taking into account the patient's preferences and degree of satisfaction with circumstances.
Are the basic necessities met (heat, light, hygiene)? If so, does the physical environment contribute to maximising independence and minimising risk, and provide a choice of opportunities to facilitate the use of existing skills and develop new ones?
Do not rate the level of functional disability itself, rated at Scale 10.
***NB:** Rate patient's usual accommodation. If in acute ward, rate the home accommodation. If information not obtainable, rate 9.*

0 Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible and minimising any risk, and supportive of self-help; the patient is satisfied with their accommodation.

1 Accommodation is reasonably acceptable with only minor or transient problems related primarily to the patient's preferences rather than any significant problems or risks associated with their environment (eg, not ideal location, not preferred option, doesn't like food).

2 Basics are met but significant problems with one or more aspects of the accommodation or regime (eg, lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems of access); may be associated with risk to patient (eg, injury) which would otherwise be reduced.

3 Distressing multiple problems with accommodation; eg, some basic necessities are absent (unsatisfactory or unreliable heating, lack of proper

cooking facilities, inadequate sanitation); clear elements of risk to the patient resulting from aspects of the physical environment.

4 Accommodation is unacceptable: eg, lack of basic necessities, insecure, or living conditions are otherwise intolerable, contributing adversely to the patient’s condition or placing them at high risk of injury or other adverse consequences.

12 Problems with occupation and activities

Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, lack of access to supportive facilities, eg, staffing and equipment of day centres, social clubs, etc.
Do not rate the level of functional disability itself, rated at Scale 10.
***NB:** Rate the patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.*

0 Patient's day–time environment is acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and maximising autonomy.
1 Minor or temporary problems, eg, good facilities available but not always at appropriate times for the patient.
2 Limited choice of activities; eg, insufficient carer or professional support, useful day setting available but for very limited hours.
3 Marked deficiency in skilled services and support available to help optimise activity level and autonomy, little opportunity to use skills or to develop new ones; unskilled care difficult to access.
4 Lack of any effective opportunity for daytime activities makes the patient's problems worse or patient refuses services offered which might improve their situation.

HoNOS65+ 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.

1	Behavioural disturbance	0	1	2	3	4	☐
2	Non-accidental self-injury	0	1	2	3	4	☐
3	Problem drinking or drug-taking	0	1	2	3	4	☐
4	Cognitive problems	0	1	2	3	4	☐
5	Physical illness or disability problems	0	1	2	3	4	☐
6	Problems with hallucinations and delusions	0	1	2	3	4	☐
7	Problems with depressed mood	0	1	2	3	4	☐
8	Other mental and behavioural problems	0	1	2	3	4	☐
	(specify disorder A, B, C, D, E, F, G, H, I, or J)						☐
9	Problems with relationships	0	1	2	3	4	☐
10	Problems with activities of daily living	0	1	2	3	4	☐
11	Problems with living conditions	0	1	2	3	4	☐
12	Problems with occupation and activities	0	1	2	3	4	☐

Key for Item 8

A Phobias – including fear of leaving home, crowds, public places, travelling, social phobias and specific phobias.

B Anxiety and panics.

C Obsessional and compulsive problems.

D Reactions to severely stressful events and traumas.

E Dissociative (‘conversion’) problems.

F Somatisation – persisting physical complaints in spite of full investigation and reassurance that no disease is present.

G Problems with appetite, over- or under-eating.

H Sleep problems.

I Sexual problems.

J Problems not specified elsewhere including expansive or elated mood.

HoNOS65+ scoring and subscales

Subscale and brief item name			Item scores	Subscale scores
A	Behavioural problems			0–12
	1	Behavioural disturbance	0–4	
	2	Self-harm	0–4	
	3	Substance use	0–4	
B	Impairment			0–8
	4	Cognitive dysfunction	0–4	
	5	Physical disability	0–4	
C	Symptomatic problems			0–12
	6	Hallucinations and delusions	0–4	
	7	Depression	0–4	
	8	Other symptoms	0–4	
D	Social problems			0–16
	9	Personal relationships	0–4	
	10	Overall functioning	0–4	
	11	Residential problems	0–4	
	12	Occupational problems	0–4	
E	Total score (1–12)		0–48	

Abbreviated Life Skills Profile (LSP-16)

Assess the patient's general functioning over the past three months, taking into account their age, social and cultural context. Do not assess functioning during crises when the patient was ill or becoming ill. Answer all 16 items by circling the appropriate response.

		0	1	2	3
1	Does this person generally have any difficulty with initiating and responding to conversation?	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty
2	Does this person generally withdraw from social contact?	Does not withdraw at all	Withdraws slightly	Withdraws moderately	Withdraws totally or near totally
3	Does this person generally show warmth to others?	Considerable warmth	Moderate warmth	Slight warmth	No warmth at all
4	Is this person generally well groomed (eg, neatly dressed, hair combed)?	Well groomed	Moderately well groomed	Poorly groomed	Extremely poorly groomed
5	Does this person wear clean clothes generally, or ensure that they are cleaned if dirty?	Maintains cleanliness of clothes	Moderate cleanliness of clothes	Poor cleanliness of clothes	Very poor cleanliness of clothes
6	Does this person generally neglect her or his physical health?	No neglect	Slight neglect of physical problems	Moderate neglect of physical problems	Extreme neglect of physical problems
7	Is this person violent to others?	Not at all	Rarely	Occasionally	Often
8	Does this person generally make and/or keep up friendships?	Friendships made or kept up well	Friendships made or kept up with slight difficulty	Friendships made or kept up with considerable difficulty	No friendships made or none kept
9	Does this person generally maintain an adequate diet?	No problem	Slight problem	Moderate problem	Extreme problem
10	Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?	Reliable with medication	Slightly unreliable	Moderately unreliable	Extremely unreliable
11	Is this person willing to take psychiatric medication when prescribed by a doctor?	Always	Usually	Rarely	Never
12	Does this person co-operate with health services (eg, doctors and/or other health workers)?	Always	Usually	Rarely	Never
13	Does this person generally have problems (eg, friction, avoidance) living with others in the household?	No obvious problem	Slight problems	Moderate problems	Extreme problems
14	Does this person behave offensively (includes sexual behaviour)?	Not at all	Rarely	Occasionally	Often
15	Does this person behave irresponsibly?	Not at all	Rarely	Occasionally	Often
16	What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?	Capable of full time work	Capable of part time work	Capable only of sheltered work	Totally incapable of work

LSP-16 item elaboration and clarification

The following item clarifications were developed as part of the training materials for the *Victorian Mental Health Outcomes Strategy* and are offered as a useful adjunct to the basic LSP-16.

1 **Does the person generally have difficulty with initiating and responding to conversation**? Measures the ability to begin and maintain social interaction, ensuring the flow of conversation; taking turns in conversation, silence as appropriate.

2 **Does the person generally withdraw from social contact**? Does the person isolate themselves when part of a group? Does the person participate in leisure activities with others? Spend long hours alone watching TV or videos?

3 **Does the person generally show warmth to others?** Does the individual demonstrate affection, concern or understanding of situation of others?

4 **Is this person generally well groomed (eg, neatly dressed, hair combed)?** Does the person use soap when washing, shave as appropriate/ use make-up appropriately, use shampoo?

5 **Does this person wear clean clothes generally, or ensure that they are cleaned if dirty?** Does the person recognise the need to change clothes on a regular basis? Are clothes grimy, are collars and cuffs marked, are there food stains?

6 **Does this person generally neglect her or his physical health?** Does the person have a medical condition for which they are not receiving appropriate treatment? Does the person lead a generally healthy lifestyle? Does the person neglect their dental health?

7 **Is this person violent to others?** Does the person display verbal and physical aggression to others?

8 **Does this person generally make or keep friendships?** Does the person identify individuals as friends? Do others identify the person as a friend? Does the person express a desire to continue to interact with others?

9 **Does this person generally maintain an adequate diet?** Does the person eat a variety of nutritious foods regularly? Do they watch their fat and fibre intake?

10 **Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?** Does the person adhere to their medication regimen as prescribed? The right amount at the right time on a regular basis? Does the person need prompting or reinforcement to adhere to their medication regimen?

11 **Is this person willing to take prescribed medication when prescribed by a doctor?** Does the person express an unwillingness to take medication as prescribed, bargain or inappropriately question the need for continuing medication?

12 **Does this person cooperate with health services (eg, doctors and/or other health workers)?** Is the person deliberately obstructive in relation to treatment plans? Do they attend appointments, undertake therapeutic homework activities?

13 **Does this person generally have problems (eg friction, avoidance) living with others in the household?** Is the person identified as 'difficult to live with'? Do they have difficulty establishing or keeping to "house rules" or are they always having arguments about domestic duties?

14 **Does this person behave offensively (includes sexual behaviour)?** Does the person behave in a socially inept or unacceptable way demonstrating inappropriate social or sexual behaviours or communication?

15 **Does this person behave irresponsibly?** Does the person act deliberately in ways that are likely to inconvenience, irritate or hurt others? Does the person neglect basic social obligations?

16 **What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?** What level of assistance/guidance does the individual require to undertake occupational activities?

LSP-16 scoring and subscales

All items are answered on an anchored four-point scale, with higher scores indicating a greater degree of disability. In the 16-item version, a score of 3 represents greater dysfunction and a score of 0 represents good functioning . Specific anchor points are provided for each item. For example, in relation to the medication compliance item, the specific anchor points are (0) "reliable with medication", (1) "slightly unreliable", (2) "moderately unreliable" and (3) "extremely unreliable".

A total LSP scale score is calculated by adding individual scores for the whole scale together. Therefore, for the LSP-16, the total score can range from 0 to 48. Items with missing data are excluded from the calculation.
Four subscale scores can be also be calculated by adding together the scores for the items that form each subscale as shown in below.

The Four LSP-16 subscales and their component items

Subscale and brief item name			Item scores	Subscale scores
A	Withdrawal			0–12
	1	Difficulty in conversation	0–3	
	2	Withdraw from social contact	0–3	
	3	Shows warmth	0–3	
	8	Maintain friendships	0–3	
B	Self-care			0–15
	4	Well groomed	0–3	
	5	Clean clothes	0–3	
	6	Neglect health	0–3	
	9	Adequate diet	0–3	
	16	Work capability	0–3	
C	Compliance			0–9
	10	Look after own prescribed medication	0–3	
	11	Willing to take prescribed medication	0–3	
	12	Co-operate with health services	0–3	
D	Anti-social			0–12
	7	Violent	0–3	
	13	Problems with others	0–3	
	14	Offensive behaviour	0–3	
	15	Irresponsible behaviour	0–3	
E	Total score (1–16)		0–48	