



AMHOCN

Australian Mental Health Outcomes and Classification Network

'Sharing Information to Improve Outcomes'
An Australian Government funded initiative

Rater and Clinical Utility Training Manual

OLDER PERSONS



A joint Australian, State and
Territory Government Initiative

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1. ACKNOWLEDGEMENTS

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INTRODUCTION TO MANUAL

This training manual has been developed as part of a training package designed to provide rater and clinical utility training.

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

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

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

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

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 or additional material to support training.



This symbol indicates the notional time each section should take.

2. WORKSHOP TIMETABLE


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

Approximate Timing	Content
15 minutes	Introduction <ul style="list-style-type: none"> • Formation of teams and team naming • Nomination of spokesperson and scribe • Objectives of workshop
45 minutes	Refresher HoNOS 65+ rating Play vignette Read vignette material
45 Minutes	HoNOS feedback/discussion of ratings Review of HoNOS 65+ and clarification of rating rules
	Morning tea
10 Minutes	LSP-16 (as appropriate)
15 Minutes	Review other measures <ul style="list-style-type: none"> • Focus of Care • Diagnosis • Legal Status
60 minutes	Consumer self assessment <ul style="list-style-type: none"> • Consumer Self Assessment Fidelity Checklist • Discussion
	Lunch
20 minutes	Making sense of the numbers <ul style="list-style-type: none"> • Exploring reference material
45 minutes	Care and treatment planning <ul style="list-style-type: none"> • Preparation, action and expectations
	Afternoon tea
30 minutes	Understanding variation across teams <ul style="list-style-type: none"> • What additional information is required?

3. TRAINING INTRODUCTION AND LEARNING OBJECTIVES

The slide is a white rectangle with a black border. It is divided into four quadrants by a horizontal and a vertical line. The top-left quadrant contains the title "Rater and Clinical Utility Training" in a large, purple, sans-serif font. The top-right quadrant contains the AMHOCN logo, which is a yellow square with white arrows pointing outwards, and the text "AMHOCN" below it. The bottom-left quadrant contains the text "Older Persons" in a black, sans-serif font. The bottom-right quadrant contains the "national mental health strategy" logo, which is a black square with white text, and the text "A joint Australian, State and Territory Government Initiative" below it. In the bottom-left quadrant, there is also a quote: "*Sharing Information to Improve Outcomes*" followed by "An Australian Government funded initiative" in a smaller font.

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

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

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

The trainer should facilitate the formation of small groups. These groups should be referred to as teams and each team should nominate a spokesperson and a scribe. Participants should choose a name for their team and this team name should be used to describe the outputs of individual teams.

Objectives of the workshop



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

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Trainers should outline the objectives of the workshop:


- Provide an opportunity for clarification of the rating rules of the measures which make up the National Outcomes and Casemix Collection (NOCC).
- Provide an opportunity to explore the clinical utility of the measures which make up NOCC.
 - Using the consumer self assessment to support engagement and the delivery of services.
 - Using the clinician rated measures to support clinical practice.
- Provide an opportunity to use NOCC to better understand variation between mental health services.



This section should take approximately 15 minutes to complete.

4. MEASURES REFRESHER TRAINING

Rate the HoNOS 65+



- Read the vignette
- Watch video
- Rate HoNOS 65+ and refer to the glossary!

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Distribute copies of the written vignette material, Health of the Nation Outcomes Scales (HoNOS) Glossary and blank rating sheet.



Show the appropriate video vignette which accompanies the written material.



Participants should rate the HoNOS 65+.



It is suggested that trainers use the first collection occasion of either the Bill or Helen vignettes that can be found on the AMHOCN Rater and Clinical Utility Training CD or available for download at www.mhnooc.org. The vignette being used will be referred to later in the workshop. This vignette provides core information upon which discussion regarding the clinical utility of the measures is based.

Trainers should have a good knowledge of the vignette being used and the HoNOS 65+ and its rating rules.

Feedback on rating



- Have the group share their HoNOS 65+ ratings.
- Why are there differences in ratings?

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Let's share our ratings.



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



Training in the HoNOS 65+ is a three-stage process:

1. Trainees read a written vignette or watch a video vignette.
2. Trainees practice rating the HoNOS 65+ referring to their glossaries.
3. Trainees share ratings and compare and contrast their ratings to the provided consensus ratings.

This is refresher training. Do not spend excessive time in discussing variation, it is to be expected, however the concern is of extreme differences with the consensus rating.

It is important to note:


- Perfect inter-rater reliability has never been demonstrated.
- Poor Inter-rater reliability can be the result of misapplication of the rating rules on any measure.

- Inter-rater reliability can be affected by the quality of assessment or lack of information between raters.
- Note that the instrument usually demonstrates satisfactory inter-rater reliability during training.

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


HoNOS65+ revision


- 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.
- Training required.

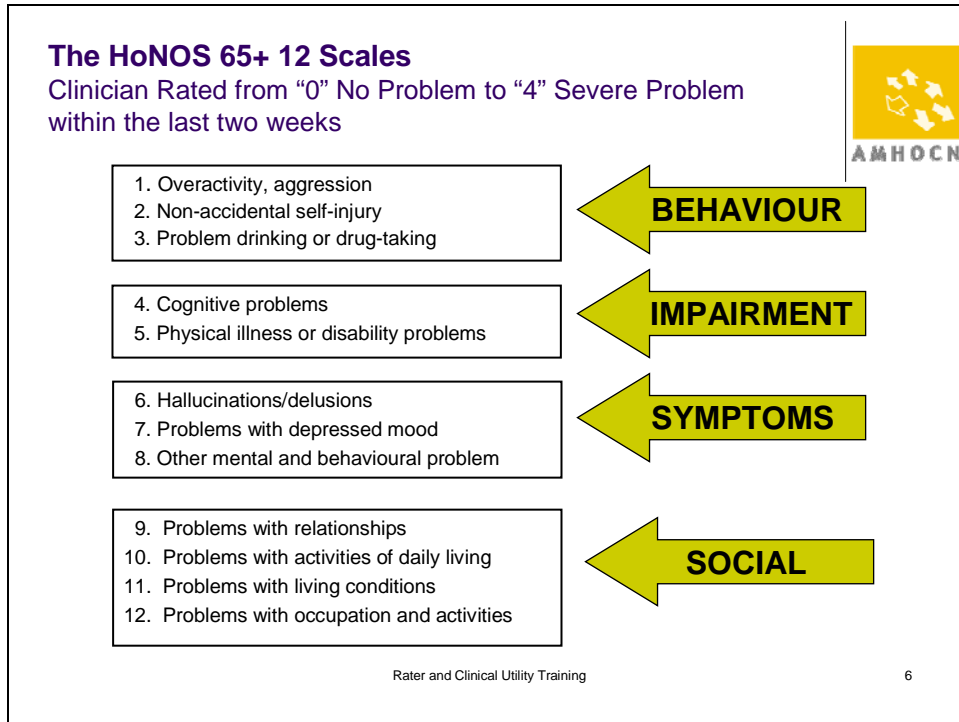



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 The HoNOS 65+ is not a diagnostic or screening tool but was specifically designed to be a broad spectrum measure of the severity of consumers' problems over the past two weeks. It does display adequate psychometric properties.

 For more information on the psychometric properties of the measures introduced under the NOCC refer to: Pirkis J, Burgess P, Kirk P, Dodson S, and Coombs T. (2005) *Review of standardised measures used in the National Outcomes and Casemix Collection (NOCC)* available for download at www.mhnooc.org .



 Note that the 12 scales of the HoNOS 65+ 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. Check your local systems for the current reports.

HoNOS65+ Scoring



- Each item is scored:
 - 0 = no problem
 - 1 = sub-clinical problem
 - 2 = mild problem
 - 3 = moderate problem
 - 4 = severe problem
 - 9 = not known
- Users are provided with a set of criteria for each rating level

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Note that the HoNOS 65+ is scored on a 5-point scale from 0 to 4 as below:

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



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

1. the HoNOS 65+ is completed following an assessment, allowing the clinician to make a judgement about the severity of the consumer’s problems; and
2. the provision of a rating provides a point of reference for subsequent ratings which allows for reflection on the consumer’s presentation.

Sources of Information



- The measures are not clinical interviews. 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.

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The measures are not clinical interviews. 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.

All information available to the clinician when making a clinical judgement on the severity of the consumer's problems is used to guide the rating of the HoNOS 65+.

HoNOS 65+ 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.
- When in doubt read the glossary.

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This slide outlines the basic rating rules of the HoNOS 65+.

It is important to avoid overlapping ratings when completing the HoNOS 65+. The HoNOS 65+ is a 12 item scale that identifies problem areas for the consumer. 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 “overactivity, aggression...” 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. (The exception is rating the discharge from inpatient and residential services where the rating is the previous 3 days.) 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



SCALE	'CORE RULES'	
	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 applies 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. This is particularly relevant for inpatient settings.


Rating the HoNOS 65+			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. <i>Note – patient can get worse.</i>	✓	✓
	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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 The HoNOS 65+ is completed after a comprehensive assessment at admission, review or discharge. Following assessment, the clinician is able to make a judgement on the clinical significance of the problems experienced by the consumer. In this context clinical significance is seen as a problem that is monitored by the clinician and there are documented interventions. If clinically significant, a rating of 2, 3 or 4 is appropriate and the clinician should refer to the glossary to determine specific ratings. If not clinically significant then a rating of 0 or 1 is more appropriate.

 It is important to reinforce that the completion of the HoNOS 65+ is an overt judgement by the clinician of the severity of the consumer's problems in a particular domain. Later activities in this workshop rely on clinician's reflections on the significance of ratings and possible interventions.


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

 This section should take approximately 90 minutes to complete.


5. LSP-16

LSP-16

- Key measure of function and disability in people with mental illness.
- Complements the problem-based HoNOS 65+.
- Developed by a New South Wales team in the 1980's.
- Original scale = 39 items; reduced to 16.
- Brief; 5 minutes to rate.
- Good inter-rater reliability.
- Sensitive to change.
- A non-technical instrument - originally designed to require little or no training.
- Focus is on the person's general functioning - how the person functions in terms of their social relationships, ability to do day-to-day tasks etc.


AMHDCN


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 Inform participants about two important aspects of the Life Skills Profile 16 (LSP-16) that are commonly misunderstood:

1. It is based on the general or average level of functioning over the last 3 months.
2. The clinician attempts to rate each item according to what the client would do without assistance or prompting.

When combined with the HoNOS 65+, which requires ratings of the most serious problem encountered, the LSP-16 contributes towards gaining a more comprehensive understanding of the consumer.

For each item, higher scores reflect higher levels of disability, as is the case for the HoNOS 65+.

 Distribute copies of the LSP-16 to workshop participants.

LSP-16 Rating Rules



- Use all available information, from any source.
- The LSP-16 is not a clinical interview.
- Rate **the general level of functioning** over the last 3 months.
- Four Subscales:
 - Withdrawal;
 - Antisocial behaviour;
 - Self-care; and
 - Compliance.

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The 16 items cover four broad domains:

- Withdrawal;
- Antisocial behaviour;
- Self-care; and
- Compliance.

Reinforce to clinicians that they are not scoring the quality of care and assistance a consumer receives. They should score what the consumer would do without assistance or prompting.



This section should take approximately 10 minutes to complete.

6. OTHER MEASURES

Rating the Focus of Care



- Assesses the primary goal of care.
- Based on concept of 'phase of illness' in people with psychiatric disorders.
- Rate main focus of care over whole episode - is therefore a **retrospective measure**.
- Single rating item to identify the main 'focus of care'.
- Measures categories not rankings.

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The Focus of Care is rated by the clinician, and requires judgement about the consumer's primary need for care and objectives of treatment. Clinicians are asked to identify which one of four types of focus of care best describes the care provided to the consumer over the preceding period of care (Acute, Functional Gain, Intensive Extended and Maintenance).

Note that over time, the Focus of Care may change so the clinician is asked to only identify the primary focus of care during the preceding period.



Distribute copies of the Focus of Care to participants.



FOCUS OF CARE	PRIMARY GOAL
Acute	Short-term reduction in severity of symptoms and/or personal distress associated with recent onset or exacerbation of psychiatric disorder.
Functional Gain	Improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder.
Intensive extended	Prevent or minimise further deterioration and reduce risk of harm in a patient who has a stable pattern of severe symptoms/frequent relapses/severe inability to function independently, and is judged to require care over an indefinite period.
Maintenance	Maintain level of functioning , minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently.

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Clinicians are asked to identify one of four alternatives:

- Acute;
- Functional Gain;
- Intensive Extended; and
- Maintenance.

Judgements regarding the primary focus of care are based on a combination of the consumer's characteristics and service requirements. So a consumer with an Acute Focus of Care would have high levels of symptom severity and poor functioning. There is an expectation that improvement will occur within a short time frame (days to weeks) however frequent contact with services has been required.

This contrasts with a Maintenance Focus of Care for consumers whose level of symptom severity is low and their functioning is poor. There is an expectation that the improvement will take place in the longer term, and service contact has been required infrequently in the preceding period.

Diagnosis



- **Principal Diagnosis**

The Principal Diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the consumer's care during the preceding *Period of Care*.

- **Additional Diagnoses**

Identify main secondary diagnoses that affected the consumer'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.


Implementation to date indicates two approaches to this issue. All mental health staff should have access to 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 available ICD-10 codes.

However, if they do not feel comfortable doing this (especially in the community), 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



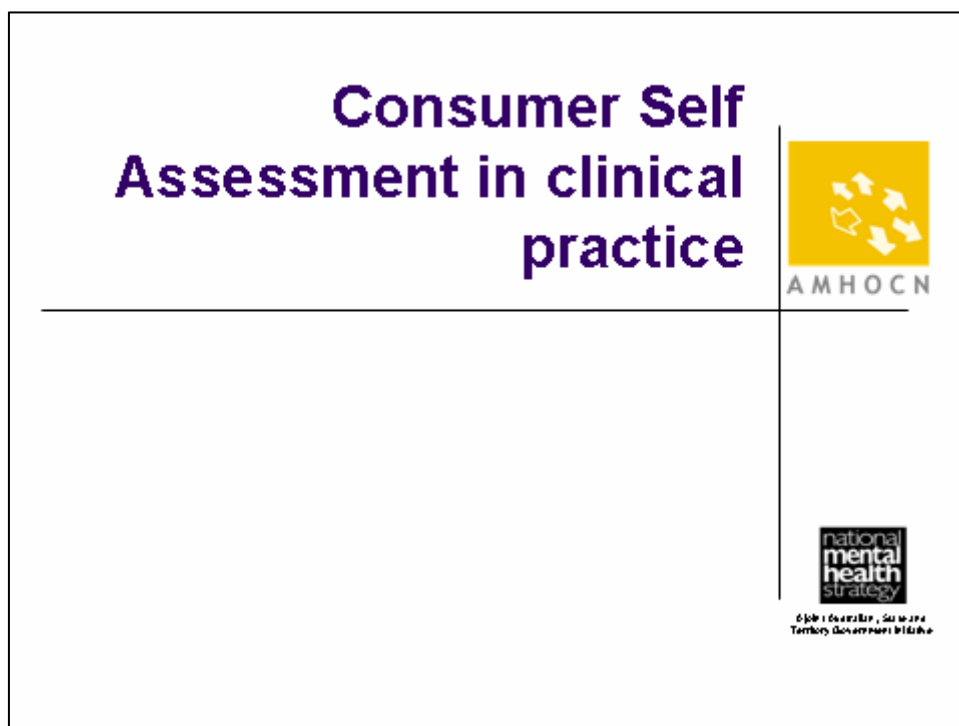
- Was the person treated on an involuntary basis (under the relevant mental health legislation) at some point during the preceding *Period of Care*?


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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.


 This section should take approximately 15 minutes to complete.

7. CONSUMER SELF ASSESSMENT IN CLINICAL PRACTICE



 The consumer self assessment measure provides an opportunity for the clinician and the consumer to engage in a dialogue during the assessment, review and discharge process. This section of the workshop provides an opportunity for participants to practice offering the consumer self assessment measure and to practice providing feedback on the completed measure to the consumer. It also provides the opportunity for workshop participants to hear the views of consumers, carers and clinicians around using the consumer self assessment measure as part of routine clinical practice.

Note that services may approach offering the consumer self assessment in a variety of ways. Some services post the measures to consumers or included the measure in admission paperwork. This activity is an example of how the clinician may be involved in offering the consumer self assessment that involves a discussion of the measure.

 Play introduction "Whose Outcome is it Anyway?" Consumer, Carer and Clinicians Perspectives – Consumer Self Assessment.

Activity



- Part One
 - Offering the consumer self assessment
- Part Two
 - Providing feedback on the consumer self assessment

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The aim of this two part activity is to provide participants with an opportunity to better understand the consumer self assessment measure and practice offering the measure.

- This exercise involves role-play.
- Participants form groups of three.



Trainers should be prepared for this activity by being familiar with the Consumer Self Assessment and its interpretation. This activity will show:

- how the Consumer Self Assessment can be used to facilitate consumer and clinician engagement; and
- how the act of offering the Consumer Self Assessment can be used to support the process of care and treatment planning.

The activity outlined in this training manual is offering the Consumer Self Assessment. Trainers are given the option of having participants practice offering the Consumer Self Assessment. Trainers should generate copies of these measures from their local clinical information systems to assist training.

Part 2 of this activity involves providing feedback to the consumer on the results from completing the Consumer Self Assessment. To support training, example reports are available in Section 11 of this manual, however trainers should generate sample reports from their local clinical information systems.



Distribute Part One of the Consumer Self Assessment Fidelity Checklist (Section 11 sub section; (a) Consumer Self Assessment Fidelity Checklist Part One) and a copy of the Consumer Self Assessment used by the organisation in which training is occurring.



Part One

- Participant one plays the consumer and has a copy of the Consumer Participant Character Information sheet (Section 11 sub section (b) Consumer Participant Character Information).
- Participant two plays the clinician and has a copy of the Consumer Self Assessment to offer.
- Participant three is the observer and holds a copy of the Consumer Self Assessment Fidelity Checklist to guide observation of consumer clinician interaction (Section 11 sub section; (a) Consumer Self Assessment Fidelity Checklist Part One).



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

Encourage those playing the consumer to not “over play” the role exaggerating the consumer characteristics that prevent the consumer completing the measure. Part One of the activity does not end until the Consumer Self Assessment has been completed.

Indicate to those playing the clinician that they are offering the measure on admission to ambulatory services

The activity involves;

1. The clinician offering the Consumer Self Assessment to the consumer.
2. The consumer completing the measure based on the character information.
3. During the offering and completion of the measure, the observer looks for fidelity with **Part One** of the check list.
4. Once the measure has been offered and completed the observer gives feedback in relation to the fidelity checklist.



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



Play part 2 from the DVD “Whose Outcome is it Anyway?” Consumer, Carer and Clinicians Perspectives – Dialogue and Engagement.



Regardless of how the consumer self assessment measure is offered, it is important that there is some discussion with the consumer about the results on the completion of the measure. Part Two of this exercise involves workshop participants exploring the process of providing feedback to the consumer on what information can be uncovered from a completed consumer self assessment.



Part Two

Participants swap roles:

- The consumer now becomes the clinician.
- The clinician now becomes the observer.
- The observer now becomes the consumer.



Distribute the appropriate example report on the consumer self assessment measure to the participant now playing the clinician. Trainers should generate an example report from local clinical information systems. This report should include at least two collection occasions so that clinicians are able to discuss change between two collection occasions.

1. The clinician provides feedback to the consumer on how the measure has been completed, what it indicates and possible implications.
2. During the feedback, the observer looks for fidelity with **Part Two** of the check list.
3. Once the feedback has been provided the observer gives feedback in relation to the fidelity checklist.

The trainer facilitates a general discussion of the activity and its implications in routine clinical practice.



Play part 3 from the DVD “Whose Outcome is it Anyway?”
Consumer, Carer and Clinicians Perspectives – Change Over Time.

Consumer Self Assessment



- Tool to support clinician assessment and consumer understanding of change over time.
- A process to engage the consumer and clinician in a meaningful dialogue to strengthen the working partnership.
- An opportunity for the consumer to contribute to their journey of recovery.

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



The consumer self assessment process could be used as a basis for discussion and exploration of differences in opinion.

It can also be used to support consumer empowerment, which includes:

- The right to make decisions.
- Access to information and resources.
- Having choice and options.
- Listening and being listened to.
- Real people with 'real' lives – respect and recognition.
- Opportunity to effect change.
- Reclaiming hope.

Offering the Consumer Self Assessment Measure



General Rule: Always offer the Consumer Self Assessment.

- Complements the clinician rated measures
- Completion by the consumer is always voluntary
- Consumer self assessment information is subject to the same rules of confidentiality and privacy as all the other information held in their file
- Explain why it is important that the consumer completes the consumers self assessment measure
- Non completion will not have any detrimental effect on treatment
- Encourage them to answer all the questions but accept partial completions
- Explain who is going to use the information
- Explain what the information is going to be used for

Q10 March 2006

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

When offering the consumer self assessment measure it is important to:

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

When not to offer the Consumer Self Assessment



- Temporary Contraindication
 - Cognitive
 - Distressed
 - Behaviourally disturbed
- General Exclusion
 - As a result of an organic mental disorder or a developmental disability
- Cultural or language issues make the self-report measure inappropriate.

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



This section should take approximately 60 minutes to complete.

8. THE MEASURES AND CARE/TREATMENT PLANNING

Making Sense of the Numbers



- Compare and contrast the consumer's presentation with available reference material.

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



Distribute copies of example reports for the vignette used for initial HoNOS 65+ training in this workshop along with components of the first edition NOCC Standard Reports found in the workshop training resources section of this document (Section 11, sub-section (e); National Aggregate Clinical Reference Material). These reports provide clinical reference material.



Trainers should consider:

- generating sample reports from local clinical information systems to support training. See example in Section 11, sub-section (c); Example Report – Consumer Self Assessment.
- incorporating the NOCC Decision Support Tool into training. This tool can provide additional contextual information to make

sense of the numbers. This tool can be downloaded from www.mhnocc.org/amhocn/dst.



Have participants form small teams, distribute butcher's paper and pens.

Have these teams review the example reports for the vignette used to rate the HoNOS 65+ earlier in this workshop. Have teams compare and contrast these example reports with the national aggregate clinical reference material. Note that participants will have to calculate the HoNOS 65+ total score for the vignette being used; the total score for the consumer self assessment is provided. What does this comparison reveal? Are scores on the example reports higher or lower than the clinical reference material? What are the implications for practice? What additional information would be required?

The purpose of this activity is to have participants begin to reflect on the use of clinical reference material to support or inform decision making in clinical practice. Trainers may need to explain the structure of these reports to participants and should facilitate feedback with structured questions:

1. What does the current HoNOS 65+ profile reflect for this case study?
2. Did the additional reference material provide assistance?
3. How would this information impact upon treatment/care planning for this case?



This section should take approximately 20 minutes to complete.

Care/ Treatment Planning



- What would you do before seeing the consumer and/or carer again?
- During your next session what would you do?
- What would you expect as the outcome of this next session? How would you know if it was a success?

Rater and Clinical Utility Training

24



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



Distribute butcher's paper and pens.



Participants to remain in their teams. You are a part of a multi-disciplinary team where the assessment of a consumer is presented. Using the HoNOS 65+ ratings and completed consumer/carer self assessment (as available), discuss the following:

- What would you do before seeing the consumer and/or carer again?
- During your next session what would you do?
- What would you expect as the outcome of this next session?
- How would you know if it was a success?



Trainer facilitates discussion around team feedback and then uses the above questions to promote further discussion about good clinical practice.

Teams are asked to address the three questions outlined in the slide. The teams' responses on the butcher's paper should be posted on walls in room.

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

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

1. Does this process enhance the therapeutic alliance between the consumer and clinician?
2. Have you considered the similar use of the HoNOS 65+ in clinical practice?
3. What other information would you require to enhance this process?
4. How would this process impact upon clinician behaviour?



This section should take approximately 45 minutes to complete.

9. UNDERSTANDING VARIATION BETWEEN TEAMS

Understanding variation in teams



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

Rater and Clinical Utility Training

25



Distribute copies of the 'Aggregate Report: Team Variation' found in section 11, sub-section (f) of this manual and additional butcher's paper.



Review the service profile reports for each of the three services.



Teams answer the questions on the handout material and feedback using butcher's paper. The trainer facilitates discussion of the team's deliberations.

The slide should remain on the screen for the duration of the activity.



The table displays the percentage of clinically significant HoNOS 65+ scores (2 or higher) for three different services. For example, 85% of consumers of Tambar Springs have clinically significant problems associated with hallucinations and delusions. Trainers should be aware that additional information might be required to provide an understanding of the reasons for variation between service units. For


example, Werris Creek may be an older persons service given the predominance of clinically significant cognitive problems seen by this service. The trainer should highlight the potential utilisation of HoNOS 65+ aggregate data to inform and support service level activities such as service review and evaluation, quality improvement and service initiatives.

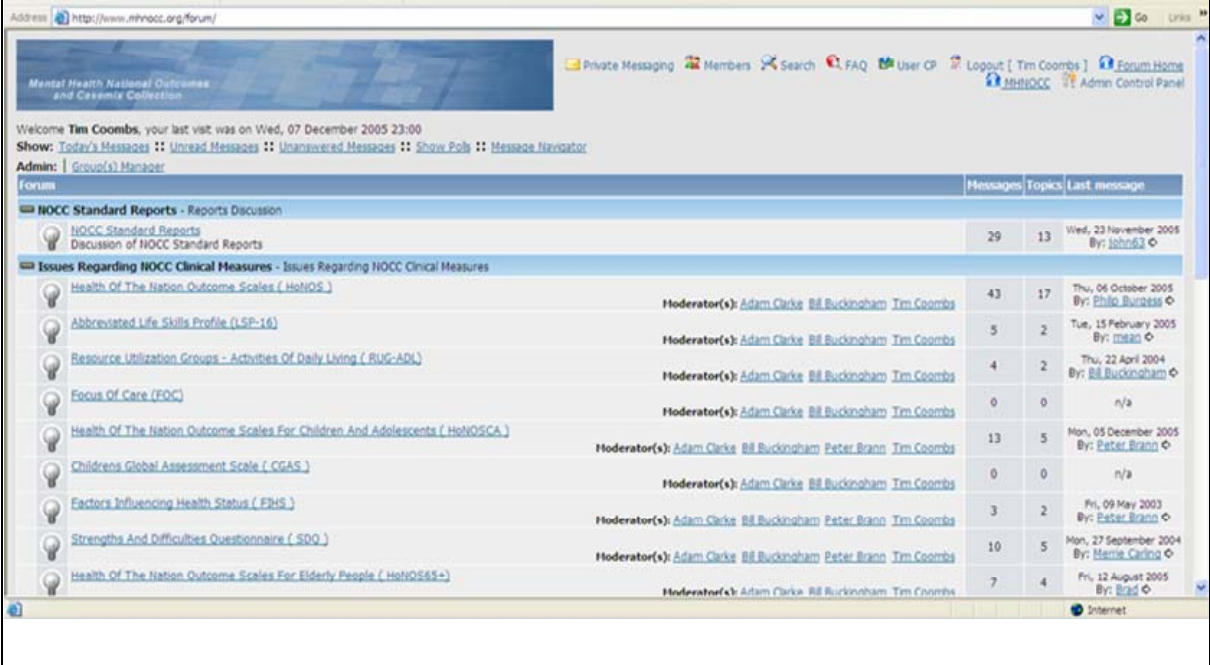


This section should take approximately 30 minutes to complete.

ADDITIONAL INFORMATION

For information, news and an online forum see www.mhnocc.org





The screenshot shows the forum interface for Mental Health National Outcomes and Coombs Collection. It includes a navigation bar with links for Private Messaging, Members, Search, FAQ, User CP, Logout, Forum Home, MHNOCN, and Admin Control Panel. A welcome message is displayed for user Tim Coombs. Below is a table of forum topics:

Forum	Messages	Topics	Last message
NOCC Standard Reports - Reports Discussion			
NOCC Standard Reports Discussion of NOCC Standard Reports	29	13	Wed, 23 November 2005 By: John63
Issues Regarding NOCC Clinical Measures - Issues Regarding NOCC Clinical Measures			
Health Of The Nation Outcome Scales (HoNOS)	43	17	Thu, 06 October 2005 By: Ethel Burgess
Abbreviated Life Skills Profile (LSP-16)	5	2	Tue, 15 February 2005 By: mean
Resource Utilization Groups - Activities Of Daily Living (RUG-ADL)	4	2	Thu, 22 April 2004 By: Bill Buckingham
Focus Of Care (FOC)	0	0	n/a
Health Of The Nation Outcome Scales For Children And Adolescents (HoNOSCA)	13	5	Mon, 05 December 2005 By: Peter Brann
Childrens Global Assessment Scale (CGAS)	0	0	n/a
Factors Influencing Health Status (FIHS)	3	2	Fri, 09 May 2003 By: Peter Brann
Strengths And Difficulties Questionnaire (SDQ)	10	5	Mon, 27 September 2004 By: Marie Carino
Health Of The Nation Outcome Scales For Elderly People (HoNOS65+)	7	4	Fri, 12 August 2005 By: Brad



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

10. REFERENCES

Pirkis J, Burgess P, Kirk P, Dodson S, and Coombs T. (2005) *Review of standardised measures used in the National Outcomes and Casemix Collection (NOCC)*.

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

11. MATERIALS USED DURING TRAINING

a) Consumer Self Assessment Fidelity Checklist

PART ONE: Offering the Consumer Self Assessment

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

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

Comments/Feedback:

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

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

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

Comments/Feedback:

b) Consumer Participant Character Information

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

c) Example Report – Consumer Self Assessment

K-10

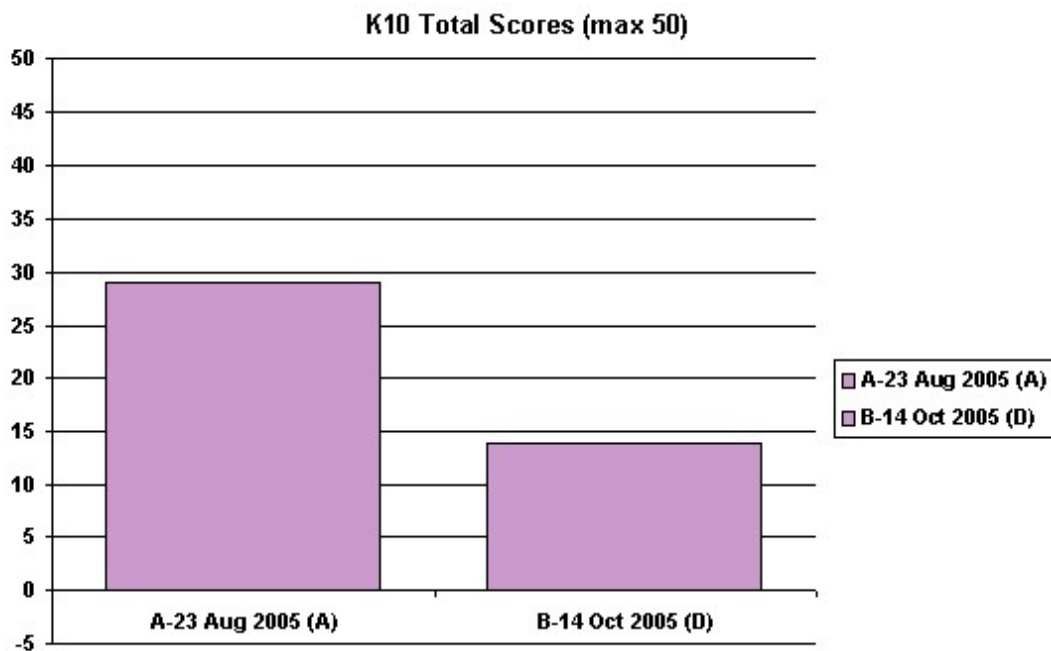
The consumer's K-10 Score is 27.

10-19: The score indicate that the client or patient may currently not be experiencing significant feelings of distress

20-24: The client or patient experience mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder.

25-29: The client or patient experience moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder.

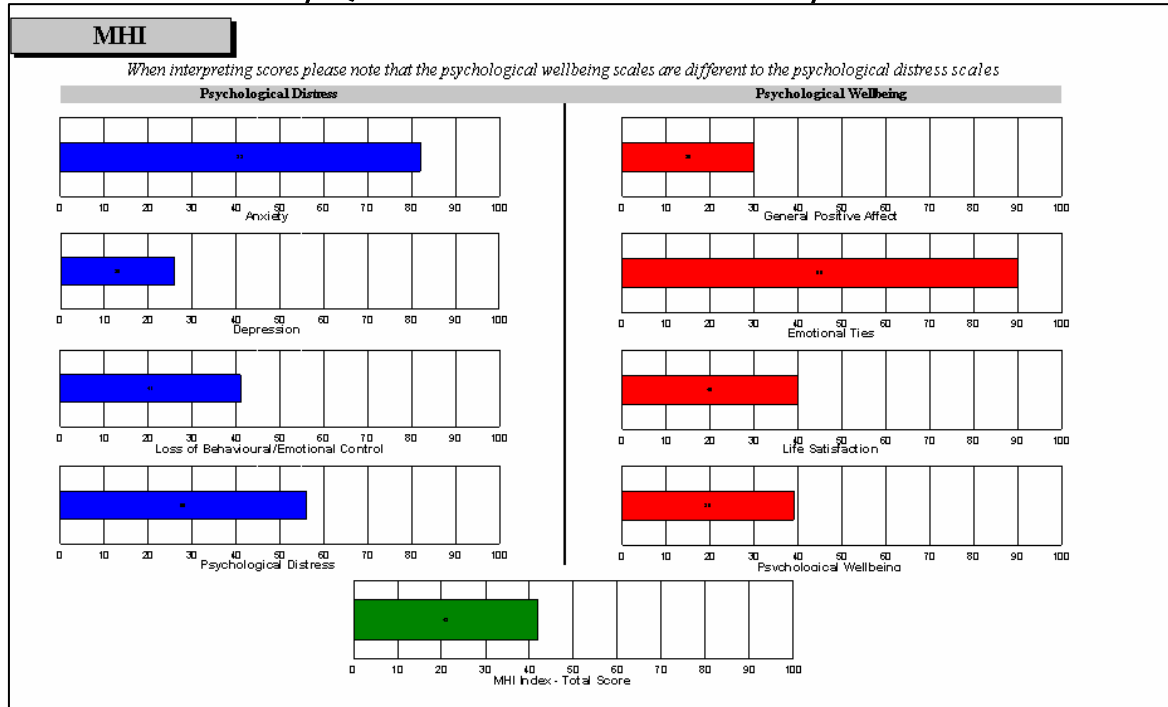
30-50: The client or patient experience severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder.



K10 Scores

<i>Collection Date</i>	<i>Collection Occasion</i>	<i>Service Setting</i>	<i>K10 Items</i>										<i>TS</i>	<i>11</i>	<i>12</i>	<i>13</i>	<i>14</i>		
			<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>							
23 Aug 2005	19	Admission - Other	3	Ambulatory	1	2	1	4	2	2	5	4	5	3	29				
14 Oct 2005	31	Discharge - No fur	1	Inpatient psy	4	1	1	1	2	1	1	1	1	1	14	99	99	99	

Mental Health Inventory: Queensland Outcomes Information System



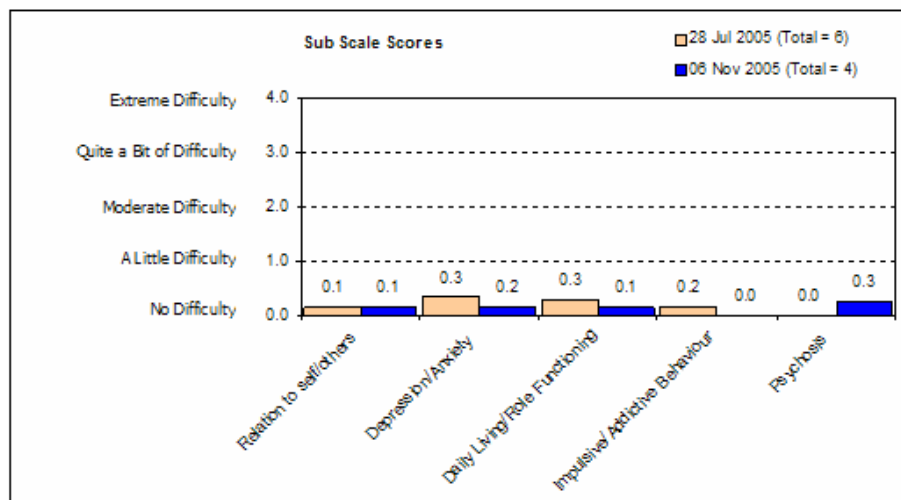
BASIS - 32: Victorian Wellbeing Reporting Tool

Wellbeing Report

C3 : Individual Consumer Profile - Comparison of 2 Time Points

Client : <input type="text"/>	Local UR No : <input type="text"/>	Statewide UR No : <input type="text"/>
Current Case Manager : <input type="text"/>	Report Generated : 16 February 2006 09:59am	
Date of Assessment 1 : 28 July 2005	Date of Assessment 2 : 06 November 2005	
Reason For Assessment : Review Other	Reason For Assessment : ISP Review	
Subcentre : <input type="text"/>	Subcentre : <input type="text"/>	

BASIS-32



d) Vignette Sample Reports

i. Bill Admission

Bill's HoNOS 65+ scores at Admission

1	Overactive, aggressive, disruptive or agitated	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	H
	(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.

ii. Helen Admission

Helen's HoNOS 65+ score at Admission

1	Overactive, aggressive, disruptive or agitated	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 (specify disorder A, B, C, D, E, F, G, H, I, or J)	0	1	2	3	4	H
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.

Helen's K-10 Scores at Admission

Helen's K-10 score is **15**.

10-19: The score indicate that the client or patient may currently not be experiencing significant feelings of distress

20-24: The client or patient experience mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder.

25-29: The client or patient experience moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder.

30-50: The client or patient experience severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder.

e) National Aggregate Clinical Reference Material

Table 3.1.2: Core Clinical Summary Score Profiles by Mental Health Service Setting for each Reason for Collection for all data reported to April 2005 for Older Persons with all Mental Health Summary Diagnostic Groups for all Demographic Groups within Age Group for all Jurisdictions

	CO	HoNOS			LSP-16			RUG-ADL		
	N	V%	M	SD	V%	M	SD	V%	M	SD
Psychiatric Inpatient	12816	68	13.1	7.4	NR	-	-	78	6.2	3.9
Admission	6114	69	15.4	7.0	NR	-	-	77	6.0	3.7
New referral	3585	74	15.5	7.1	NR	-	-	78	5.9	3.5
From other setting	2078	65	15.5	6.8	NR	-	-	78	6.1	3.8
Other	451	53	13.7	6.4	NR	-	-	59	6.1	3.8
Review	1942	66	14.0	6.7	NR	-	-	83	7.0	4.4
91-day review	983	65	14.4	6.3	NR	-	-	85	7.7	4.7
Other	959	66	13.7	7.1	NR	-	-	81	6.2	4.0
Discharge	4760	69	9.8	6.9	NR	-	-	NR	-	-
No further care	637	70	9.0	5.8	NR	-	-	NR	-	-
Change of setting	3831	70	9.9	7.0	NR	-	-	NR	-	-
Death	47	32	10.6	8.9	NR	-	-	NR	-	-
Other	245	54	10.2	6.2	NR	-	-	NR	-	-
Community Residential	756	58	15.4	8.0	70.5	16.1	13.2	79	6.6	4.1
Admission	244	59	14.0	6.9	42.6	14.3	12.5	73	5.8	3.4
New referral	203	61	14.1	6.4	42.9	14.3	12.9	74	5.9	3.5
From other setting	28	68	13.5	10.0	46.4	16.8	9.8	79	5.3	2.8
Other	13	15	13.5	7.8	30.8	6.8	7.4	31	4.3	0.5
Review	378	65	16.9	8.3	87.8	18.7	13.2	83	7.0	4.4
91-day review	293	68	17.1	8.4	91.5	18.7	13.1	89	7.3	4.6
Other	85	52	15.8	7.8	75.3	18.6	13.8	62	5.4	2.9
Discharge	134	37	12.4	8.1	72.4	8.9	11.0	NR	-	-
No further care	72	31	11.1	7.5	87.5	6.7	9.3	NR	-	-
Change of setting	39	56	12.9	8.8	51.3	15.3	11.3	NR	-	-
Death	8	63	16.6	7.4	62.5	24.4	13.4	NR	-	-
Other	15	-	-	-	60.0	2.4	7.3	NR	-	-
Ambulatory	33880	74	10.9	6.5	70.8	10.8	8.9	NR	-	-
Admission	12391	75	12.7	6.4	NR	-	-	NR	-	-
New referral	8888	73	13.0	6.3	NR	-	-	NR	-	-
From other setting	2848	82	11.9	6.3	NR	-	-	NR	-	-
Other	655	78	13.0	6.5	NR	-	-	NR	-	-
Review	11501	79	9.9	5.9	78.7	10.7	8.3	NR	-	-
91-day review	9023	81	9.8	5.8	85.5	10.5	8.1	NR	-	-
Other	2478	74	10.4	6.4	54.2	11.6	8.8	NR	-	-
Discharge	9988	67	9.7	6.7	61.7	11.0	9.8	NR	-	-
No further care	5394	72	8.2	5.9	71.0	10.6	9.7	NR	-	-
Change of setting	2856	75	12.0	7.4	56.2	13.0	10.2	NR	-	-
Death	311	35	13.6	7.0	41.8	9.6	10.3	NR	-	-
Other	1427	39	9.8	6.2	41.8	8.1	8.5	NR	-	-

Explanatory Notes:

NR	Not Required	V%	Percentage of Valid Observations	-	No Valid Observations
CO	Overall Collection Occasions	M	Mean	SD	Standard Deviation

Table 3.1.3: Core Consumer Summary Score Profiles by Mental Health Service Setting for each Reason for Collection for all data reported to April 2005 for Older Persons with all Mental Health Summary Diagnostic Groups for all Demographic Groups within Age Group for all Jurisdictions

	CO		BASIS-32			K10+				MHI-38			
	N	N	V%	M	SD	N	V%	M	SD	N	V%	M	SD
Psychiatric Inpatient	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Admission	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
New referral	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
From other setting	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Other	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Review	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
91-day review	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Other	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Discharge	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
No further care	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Change of setting	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Death	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Other	NR	NR	-	-	-	NR	-	-	-	NR	-	-	-
Community Residential	756	69	16	1.8	1.1	26	15	21.5	4.9	240	4	169.5	38.1
Admission	244	26	15	2.1	0.3	21	19	21.5	4.9	36	3	200.0	-
New referral	203	19	5	1.7	-	20	20	21.5	4.9	28	4	200.0	-
From other setting	28	7	43	2.2	-	0	-	-	-	8	-	-	-
Other	13	0	-	-	-	1	-	-	-	0	-	-	-
Review	378	27	26	1.7	1.4	5	-	-	-	189	5	166.1	38.8
91-day review	293	0	-	-	-	4	-	-	-	178	5	166.1	38.8
Other	85	27	26	1.7	1.4	1	-	-	-	11	-	-	-
Discharge	134	16	-	-	-	0	-	-	-	15	-	-	-
No further care	72	1	-	-	-	0	-	-	-	5	-	-	-
Change of setting	39	15	-	-	-	0	-	-	-	5	-	-	-
Death	8	0	-	-	-	0	-	-	-	5	-	-	-
Other	15	0	-	-	-	0	-	-	-	0	-	-	-
Ambulatory	33880	11356	4	0.8	0.7	1552	6	23.9	10.5	9171	4	159.1	36.7
Admission	12391	4958	4	0.9	0.7	729	6	26.4	10.3	2328	3	139.6	36.1
New referral	8888	3082	4	0.9	0.8	635	6	25.8	10.0	1404	4	136.5	36.8
From other setting	2848	1763	4	0.8	0.6	63	6	32.8	12.6	579	2	144.3	30.9
Other	655	113	-	-	-	31	-	-	-	345	2	160.8	35.5
Review	11501	2359	7	0.7	0.6	551	9	23.2	10.3	4649	6	163.0	34.9
91-day review	9023	1038	10	0.6	0.5	518	8	22.5	9.8	4252	6	164.0	34.5
Other	2478	1321	6	0.8	0.7	33	21	27.3	12.8	397	11	157.1	36.8
Discharge	9988	4039	3	0.7	0.6	272	2	11.2	1.2	2194	1	173.4	39.5
No further care	5394	2202	1	0.4	0.4	63	3	12.0	1.4	1303	2	173.2	40.3
Change of setting	2856	1828	5	0.7	0.7	48	-	-	-	362	-	-	-
Death	311	9	-	-	-	9	-	-	-	143	-	-	-
Other	1427	0	-	-	-	152	3	10.8	1.0	386	0	179.0	-
Explanatory Notes:													
NR	Not Required		V%	Percentage of Valid Observations			-	No Valid Observations					
CO	Overall Collection Occasions		M	Mean			SD	Standard Deviation					

Table 3.1.4.1: Distribution of HoNOS65+ Total Scores by Mental Health Service Setting for each Reason for Collection for all data reported to April 2005 for Older Persons with all Mental Health Summary Diagnostic Groups for all Demographic Groups within Age Group for all Jurisdictions

	N	HoNOS-12						
		P5	P10	P25	P50	P75	P90	P95
Psychiatric Inpatient	8768	2	4	7	13	18	23	26
Admission	4227	5	7	10	15	20	25	28
New referral	2641	5	7	10	15	20	25	28
From other setting	1347	5	7	11	15	20	25	27
Other	239	3	6	10	13	18	22	26
Review	1277	4	6	9	14	19	23	26
91-day review	640	4	6	10	14	19	23	25
Other	637	3	5	8	13	19	23	26
Discharge	3264	1	2	4	9	14	19	23
No further care	448	1	2	5	8	13	17	20
Change of setting	2669	1	2	4	9	14	20	24
Death	15	-	-	-	11	18	23	-
Other	132	2	2	5	10	15	18	20
Community Residential	438	4	5	9	15	21	27	30
Admission	145	4	6	9	13	18	23	28
New referral	124	4	6	9	14	18	23	25
From other setting	19	-	2	8	11	17	30	-
Other	2	8	8	8	14	-	-	-
Review	244	4	6	10	17	23	28	31
91-day review	200	4	6	10	17	24	28	31
Other	44	4	6	10	16	21	28	31
Discharge	49	1	2	6	11	19	24	28
No further care	22	-	1	4	11	17	23	24
Change of setting	22	1	2	6	10	19	29	32
Death	5	5	5	11	17	23	-	-
Other	0	-	-	-	-	-	-	-
Ambulatory	25207	2	3	6	10	15	20	22
Admission	9342	3	5	8	12	17	21	24
New referral	6489	3	5	8	13	17	21	24
From other setting	2344	3	4	7	11	16	20	23
Other	509	3	5	8	13	17	21	25
Review	9133	1	3	5	9	14	18	21
91-day review	7301	1	3	5	9	14	18	20
Other	1832	2	3	6	9	15	19	22
Discharge	6732	1	2	4	9	14	19	22
No further care	3908	-	1	4	7	12	16	19
Change of setting	2155	1	2	6	11	17	22	25
Death	109	1	4	10	13	18	25	27
Other	560	1	3	5	9	14	18	21

Explanatory Notes:

N Number of Valid Observations - No Valid Observations Pnn nnth percentiles

f) Aggregate Report: Team Variation

Comparison Consumer variation between services: Percentage of all HoNOS item scores 2 or greater

Mental Health Service Organisation	Overactive, aggressive, disruptive or	Non-accidental self injury	Problem drinking or drug taking	Cognitive problems	Physical illness or disability problems	Problems associated with hallucinations and delusions	Problem with depressed mood	Other mental and behavioural problems	Problems with relationships	Problems with activities of daily living	Problems with living conditions	Problems with occupation and activities
Bingara	30	75	20	10	5	14	70	80	65	40	20	23
Tambar Springs	67	55	78	24	33	85	30	34	44	23	66	71
Werris Creek	12	13	24	67	65	21	22	14	42	82	13	14

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

g) Blank Rating Forms and Measures Information

1	Overactive, aggressive, disruptive or agitated	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.

Abbreviated Life Skills Profile (LSP-16)

		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

Focus of Care

Definitions

Focus of Care is rated retrospectively. Clinicians are asked to identify which of one of four types of care focus best describes the primary goal of care provided to a consumer over the period preceding the Collection Occasion.

- **Acute**, where the primary goal is the short term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder.
- **Functional gain**, where the primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder.
- **Intensive extended**, where the primary goal is prevention or minimisation of further deterioration, and reduction of risk of harm in a patient who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period.
- **Maintenance**, where the primary goal is to maintain the level of functioning, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently.

It is recognised that all of these aspects may be found in the mental health care of any particular consumer. But the concept here is to identify the goal that underpinned the period of care preceding the Collection Occasion.

Because the Focus of Care can change, it is necessary to define 'main' when there has been more than one Focus of Care within the period (eg, flare up of symptoms in a consumer receiving maintenance care such that the focus is now treating the acute symptoms). In such circumstances, clinicians should choose the main Focus of Care on the basis of the goal that consumed the most treatment effort during the period being rated. For example, if the Focus of Care was 'Maintenance' for most of the episode and 'Acute' for just a few days, the clinician would rate the main Focus of Care as 'maintenance'.

There is no provision for missing data in the Focus of Care scale as there is only one item to rate.

Focus of Care item clarifications and elaborations

The following table is copied from training materials developed for the Victorian Mental Health Outcomes Strategy. It provides additional guidelines to assist clinicians in making Focus of Care ratings by separately considering the 'typical' clinical characteristics and service requirements associated with each Focus of Care category.

	Consumer Characteristics				Service Requirements	
	Symptoms	Functioning	Primary Goal	Indicative time to achieve Primary Goal	Indicative treatment intensity	Examples of typical documentation in care plan to support the rating
Acute	High & of recent onset	Low-High	Reduce symptoms	Days to weeks	Daily contact over a short period	Interventions designed to reduce the intensity of positive symptoms, (eg, reduce hallucinations and delusions, ameliorate thought disorder; reduce severity of depressive symptoms or the level of anxiety manage hostile or aggressive behaviour related to mental illness).
Functional Gain	Low	Low-Medium	Improve functioning	Weeks to months	Weekly contact, or more multiple attendances per week in a structured rehabilitation program	Interventions designed to result in a significant improvement in the consumers personal, social and/or occupational functioning in the short term (weeks to months). This may include the development of basic 'community survival' skills (eg, shopping, cooking), social skills (eg, conversation) or vocational skills (eg, job seeking or job maintenance).
Intensive Extended	High & unremitting	Low	Reduce risk that arises from symptoms and/or low functioning	Months to years	Minimum of multiple weekly contacts, more frequent as required; delivered over an indefinite period.	Inpatient- or outreach-based interventions, (the latter typically in the consumer's own environment) aimed to (1) minimise the risks and handicaps associated with the ongoing symptoms and psychosocial dysfunctions arising from a psychiatric disorder (2) strengthen the consumer's capacity to use supportive professional and non-professional networks.
Maintenance	Low	Low-High	Improve functioning	Months to years	Scheduled weekly to monthly contact	Interventions designed to consolidate the consumer's current functioning (at least in the short-term) while working toward improvement in the long-term or planning for the consumers exit from the service.

Table source: Eagar K, Buckingham W, Coombs T, Trauer T, Graham C, Eagar L and Callaly T (2000) *Outcome Measurement in Adult Area Mental Health Services: Implementation Resource Manual*. Department of Human Services Victoria.

h) Health of the Nation Outcomes Scales 65+ Glossary

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.

Glossary

- 1 Behavioural disturbance (eg, overactive, aggressive, disruptive or agitated behaviour, uncooperative or resistive behaviour)
Include such behaviour due to any cause, eg, dementia, drugs, alcohol, psychosis, depression, etc.
Do not 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
Include problems of orientation, memory, and language associated with any disorder: dementia, learning disability, schizophrenia, etc.
Do not 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
Include illness or disability from any cause that limits mobility, impairs sight or hearing, or otherwise interferes with personal functioning (eg, pain).
Include side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drunk driving etc.
Do not 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
Include hallucinations and delusions (or false beliefs) irrespective of diagnosis. Include odd and bizarre behaviour associated with hallucinations or delusions (or false beliefs). Do not 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
Do not include over-activity or agitation, rated at Scale 1. Do not include suicidal ideation or attempts, rated at Scale 2. Do not 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
*Rate only the most severe clinical problem not 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. Rate 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.

