

# Australian Mental Health Outcomes and Classification Network

## Training Manual

### Child & Adolescent All Service Settings



A joint Australian, State and  
Territory Government Initiative

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## 1. ACKNOWLEDGEMENTS

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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 in 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:

- Child and Adolescent Ambulatory Training Manual (this document)
- Copies of the Clinical and Consumer and Carer self report measures
- Whiteboard
- White board markers
- PowerPoint projector and laptop
- Vignette material (Video, written material)
- 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.

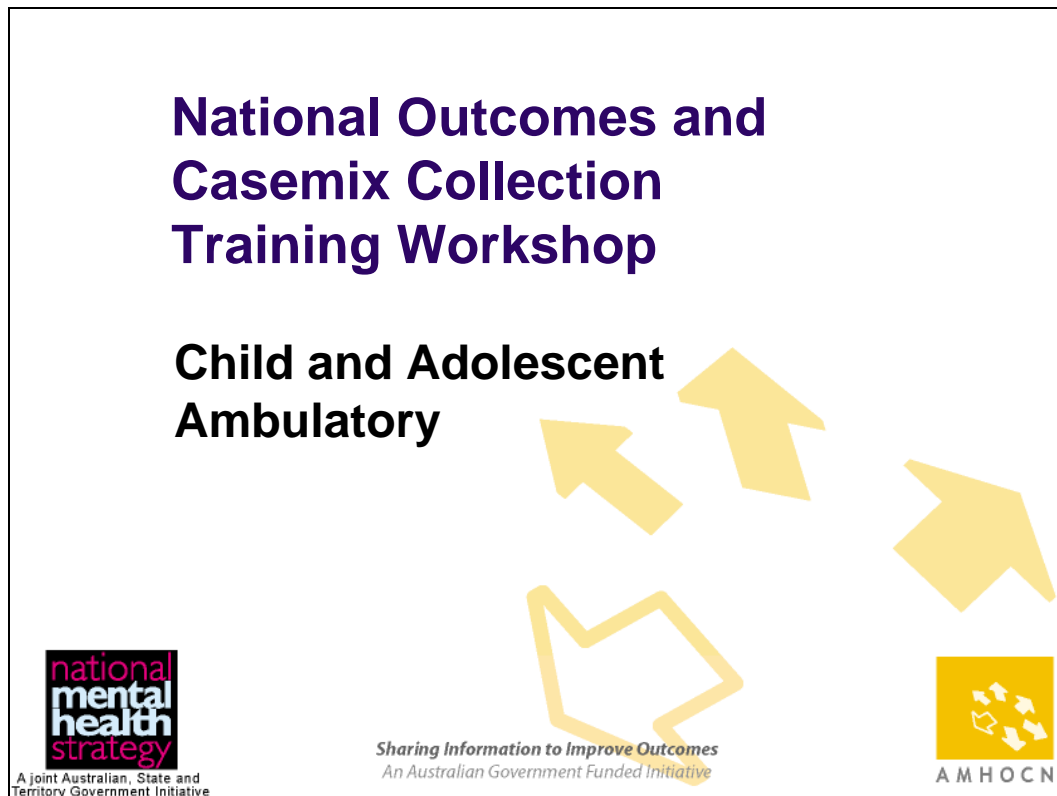


This symbol indicates that trainers should be prepared with background knowledge. Trainers will be provided with additional reference material in this section.



This symbol indicates the notional time each section should take.

### 3. TRAINING INTRODUCTION AND LEARNING OBJECTIVES



**National Outcomes and  
Casemix Collection  
Training Workshop**

**Child and Adolescent  
Ambulatory**

**national  
mental  
health  
strategy**  
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**A M H O C N**

The slide features a central graphic of three yellow arrows pointing upwards and to the right, with a yellow outline of a house or building below them. The text is arranged in a clear, hierarchical manner, with the main title at the top and the specific workshop focus below it. Logos for the national mental health strategy and AMHOCN are positioned at the bottom corners.

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 patients health status that is attributable to an intervention”. The measurement of consumer outcome is therefore integral to reflecting on practice.



**Outcome 28: Comprehensive implementation and further development of routine consumer outcome measures in mental health**

**Key direction 28.1:** Continue to support and develop outcome measurement systems, including full implementation of routine outcome measurement systems, in the mental health sector and for use by other mental health providers and related service sectors

**Key direction 28.2:** Establish a national strategy in collaboration between the Commonwealth, States and Territories for database development, data analysis (which may include normative comparisons and benchmarking exercises), dissemination and training.

**Key direction 28.3:** Support the implementation of routine outcome measurement

**Outcome 30: Reform of public sector funding models to better reflect need**

**Key direction 30.1:** Continue the development of mental health casemix classifications through the Australian Mental Health Outcomes and Classification Network

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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;

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

- Clinician rated
  - Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)
  - Children's Global Assessment Scale (CGAS)
  - Factors Influencing Health Status (FIHS)
- Consumer self-report
  - Strengths and Difficulties Questionnaire (SDQ)

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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 for Children and Adolescents (HoNOSCA) is a collection of 15 scales designed to capture information regarding the severity of problems for consumers in 15 common areas.

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

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

Trainers should refer to the Strengths and Difficulties Questionnaire Training Manual for more detailed information on the Child and Adolescent Self report measure.



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

7.

### 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.



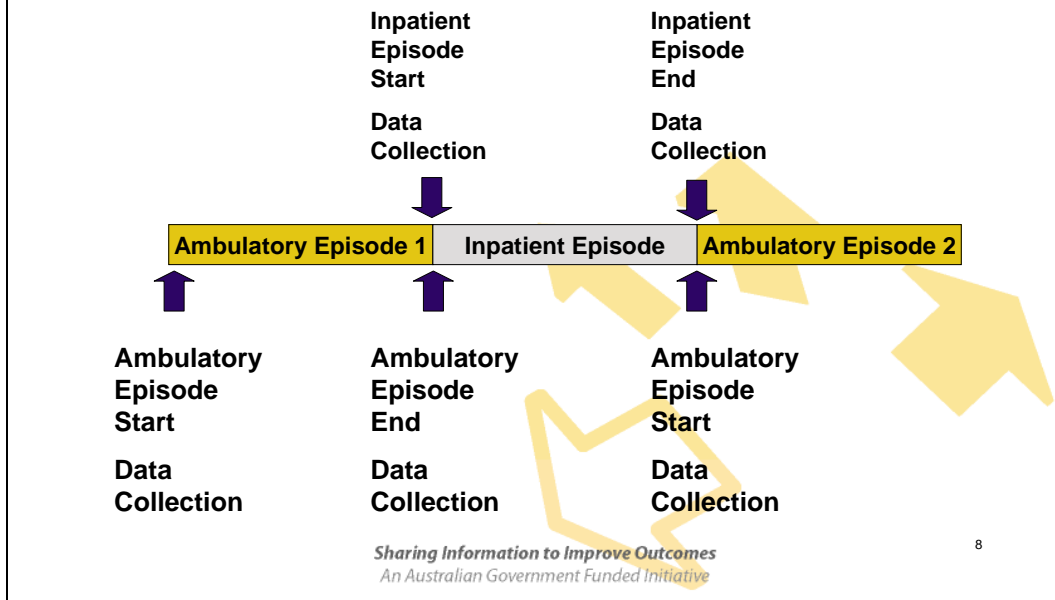
The data collection protocol was designed to meet a number of criteria.

- 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.

- 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.

# The Start and End of Episodes



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. The move between service settings, as we have seen, is a trigger for data collection. The National Outcomes and Casemix Collection protocol is outlined in the table below.

Collection Occasion: All Service Settings, Child and Adolescent	A	R	D
HoNOSCA <sup>(1)</sup>	●	●	●
CGAS	●	●	✘
FIHS	✘	●	●
Parent / Consumer self report (SDQ) <sup>(1)</sup>	●	●	●
Principal and Additional Diagnoses	✘	●	●
Mental Health Legal Status	✘	●	●

### Abbreviations and Symbols

<b>A</b>	Admission to Mental Health Care	●	Collection of data on this occasion is mandatory
<b>R</b>	Review of Mental Health Care		
<b>D</b>	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.



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. CONSUMER AND CARER SELF REPORT MEASURE

### Consumer Self Report Measure: When not to offer

- The consumer is too unwell or distressed to complete the measure
  - Psychotic or mood disturbance prevents the consumer from understanding the measure or alternatively, completing the measure would increase their level of distress
- The consumer is unable to understand the measure
  - As a result of an organic mental disorder or a developmental disability to consumer
- Cultural or language issues make the self-report measure inappropriate

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

- Supporting the process of assessment;
- Demonstrating a genuine interest in the carers and consumers point of view;
- Encouraging dialogue between clinicians, carers and consumers;
- Highlighting discrepancies between the consumers, carers and clinicians perceptions; and
- Involving carers and consumer in the process of care planning

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

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

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

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



When administering the SDQ, there are some general activities or approaches to be avoided. These constitute the Don'ts of SDQ Administration.

- Do not force or command consumers or carers to fill out the SDQ;
- Do not tell the consumer or carer that treatment is dependent on their filling out the SDQ;
- Do not minimise the importance of filling out the SDQ;
- Do not accept an incomplete SDQ without first encouraging the consumer or carer to fill out unanswered questions;
- Do not paraphrase, rephrase, interpret or explain a question;
- Do not answer the question for the consumer or carer;
- Do not tell the consumer or carer how you feel they should answer;
- Do not allow other people to help the consumer or carer fill out the SDQ; and

- Do not assume the consumer or carer can do it and just doesn't want to (i.e. if a person tells you they cannot do it – accept that they are telling the truth).

## Offering the Measure

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

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This slide identifies the types of concerns that consumers and carers often have when offered a consumer self report measure such as the SDQ.

When offering the SDQ it is important to:

- Identify for consumers and carers that the completion of the SDQ will provide useful information for the clinician that will inform their work;
- Assure carers and consumers that refusal to complete the SDQ will not see them treated differently;
- Explain to consumers and carers that the information will be available to those involved in the direct care of the consumer but also that de-identified information will be available to service managers and those involved in policy development;

- Explain that, in the first instance, the information will be used for individual treatment planning and, in a de-identified form, for service development and research activities; and
- Assure the carers and consumer that the SDQ is subject to the same rules of confidentiality and privacy as all other information held within the medical record.



When administering the SDQ, there are some general activities or approaches to be adopted. These are the Do's of SDQ Administration.

- Do be warm, friendly and helpful;
- Do request and encourage carers and consumers to fill out the SDQ;
- Do let consumers and carers know that you will be there to assist them if needed;
- Do tell carers and consumers to answer a question based on what THEY think the question means;
- Do encourage consumers and carers to answer ALL the questions;
- Do read and repeat a question verbatim for the consumer or carer if necessary;
- Do provide definition of a single word with which a person is unfamiliar;
- Do stress there is no right or wrong answer;
- Do inform carers and consumers that they will be asked to fill out the SDQ again at a later date; and
- Do thank carers and consumers for filling out the SDQ.



Trainers should hand out copies of the SDQ. This is a brief behavioural screening measure about 4–17 year olds. The SDQ exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes between one and three of the following measures:

25 items on psychosocial attributes – all versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales:

- a. emotional symptoms (5 items);
- b. conduct problems (5 items);
- c. hyperactivity / inattention (5 items);
- d. peer relationship problems (5 items); and
- e. prosocial behaviour (5 items).

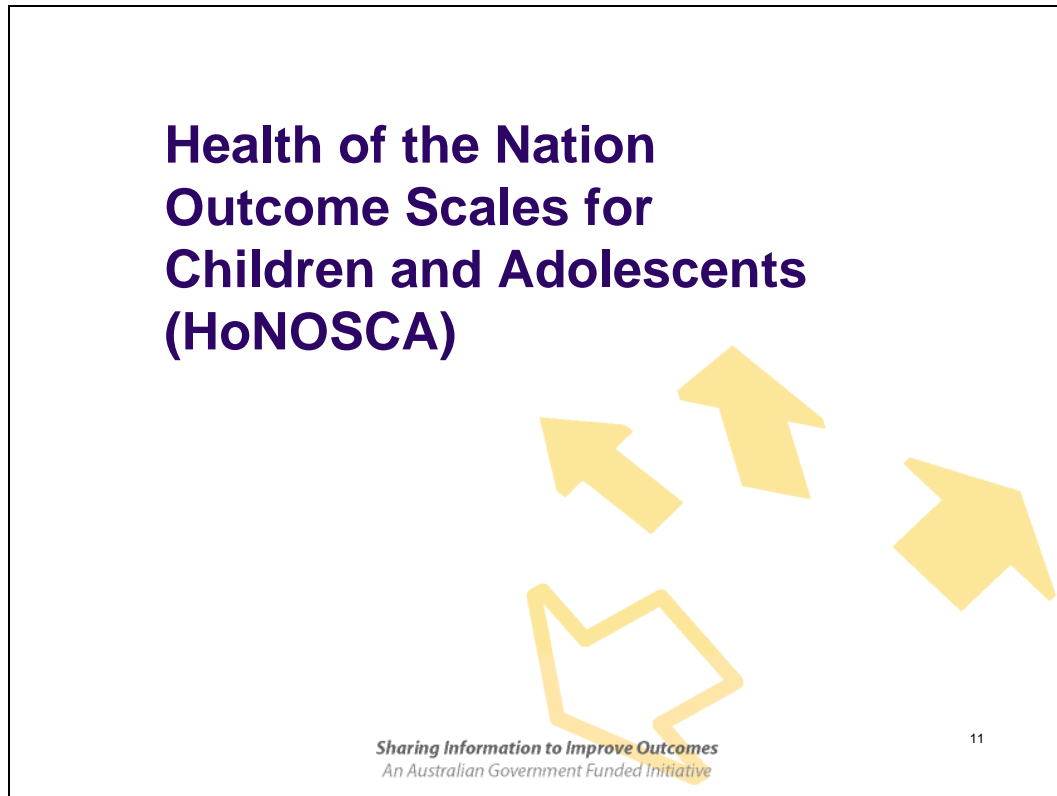
Scales 1 – IV are summed to generate a total difficulties score.

**Refer to the AMHOCN Strengths and Difficulties Training Manual for more detail**



Session length may vary depending on the consumer self report measure, but should take no longer than 30 minutes

## 8. HoNOSCA

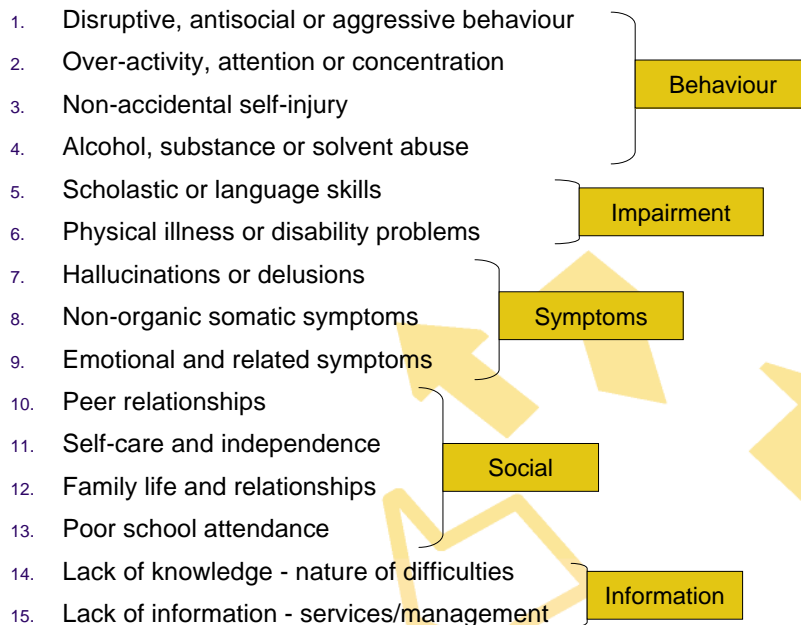


This slide introduces the section on training in the clinical measures. The aim of this section is to provide participants with the skills to complete the primary measure of problem severity, the Health of the Nation Outcome Scales for Children and Young People (HoNOSCA).



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

## The HoNOSCA: 15 scales



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Refer trainees to the HoNOSCA Glossary and note that the HoNOSCA 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.

The HoNOSCA is a 15-item clinician-rated measure modeled on the HoNOS and designed specifically for use in the assessment of child and adolescent consumer outcomes in mental health services. Items 1–13 require assessment of a specific aspect of a young person's mental health, while the remaining two items concern environmental aspects related to lack of information or access to services.

The HoNOSCA scales are rated in an equivalent manner to the adult HoNOS, with each item scored on a five-point scale (0 = no problem; 1–4 = minor problem to severe problem).

A total score is calculated as the sum of the scores for items 1–13 only, with a range 0–52. Items scored '9', or with missing data, are generally excluded from the calculation.

Unlike the HoNOS, subscale scores have not yet been defined for the HoNOSCA, although the authors note that the items can be logically grouped into similar categories (as marked on slide above - "1–4 = 'Behaviour'; 5–6 = 'Impairment'; 7–9 = 'Symptoms'; 10–13 = 'Social'; 14–15 = 'Information').



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

The Health of the Nation Outcome Scale (HoNOS) was developed to be used a part of routine clinical practice in mental health services to measure health and social functioning. However, it was evident that this measure was not appropriate for child and adolescent mental health services (Gowers et al 1997). A multi-disciplinary steering group was formed to develop a measure which could be used for children and adolescents, which resembled the HoNOS, was brief and sensitive to change, and was useful to both managers and clinicians. Extensive field trials of the measure developed by this steering committee were undertaken in the UK and the measure demonstrated satisfactory, reliability, validity and sensitivity to change (Gowers et al 1999).

In Australia, Brann et al (2001) found that, although the measure is only moderately reliable, with the use of the HoNOSCA, routine

outcome measurement in child and adolescent mental health services is possible.

In training, the limits of the reliability of the measures and some individual items should be acknowledged, however it is important to note:

- Perfect inter-rater reliability has never been demonstrated by any measure;
- Poor inter-rater reliability can be the result of misapplication of the rating rules and may demonstrate the need for more training;
- Inter-rater reliability can be affected by the quality of assessment or lack of information sharing between raters; and
- Satisfactory inter-rater reliability will be demonstrated during practice training.

## References

Brann, P., Coleman, G., Luk, E., (2001) Routine outcome measurement in a child and adolescent mental health service: an evaluation of HoNOSCA. *Australian & New Zealand Journal of Psychiatry*. 35(3):370-376

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Gowers, S. G., Harrington, R. C., Whitton, A., Elliott, P., Beevor, A., Wing, J. Jezzard, R., (1999) A Brief scale for measuring the outcomes of emotional and behavioural disorders in children: Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry*. 174(5):413-416.

## Rating the HoNOSCA

			Monitor ?	Active treatment or management plan ?	
Clinically Significant	4	Severe to very severe problem	Most severe category for patient's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <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	x
	0	No problem	Problem not present.	x	x

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

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

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 HoNOSCA.



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

1. the HoNOSCA 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.

## HoNOSCA Rating Rules

- Rate each item in order from 1 to 15
- 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 HoNOSCA.

It is important to avoid overlapping ratings when completing the HoNOSCA. The HoNOSCA is a collection of 15 scales and, to get the clearest possible impression of the unique presentation of the consumer, it is important to ensure that only problem areas for each 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 two weeks.

Ratings are based on the degree of distress the consumer is experiencing and/or the frequency or intensity of behaviour associated with the problem.

## Important Variations in Rating Guides

‘CORE RULES’		
SCALE	RATE THE WORST MANIFESTATION	RATE OVER THE PAST 2 WEEKS
Scales 1-9	Always	Always
Scales 10-15	Based on usual or typical	Always

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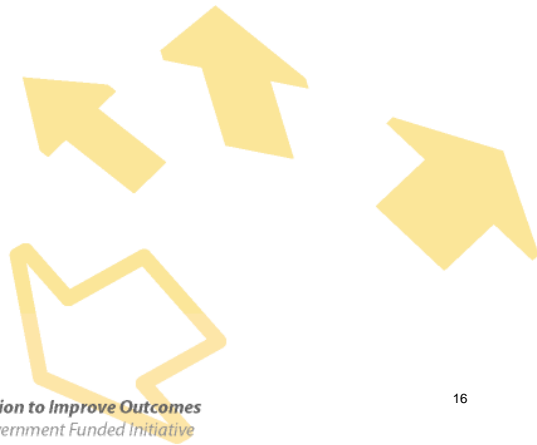


The general rating rule is to rate the worst manifestation of a problem over the preceding two weeks. This holds true for scales 1 through to 9.

However, the social scales are more problematic. For example, simply having an argument with your friend does not mean you have problems in terms of the quality and quantity of your relationships (Scale 10).

Trainees are therefore asked to consider the usual or typical situation for the consumer over the preceding two weeks for Scales 10 – 15.

# Practice Rating HoNOSCA Time 1



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During training practice, rating the HoNOSCA 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 HoNOSCA 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 as 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 15 HoNOSCA items as shown below.

	HoNOSCA Items														
Rating	1	2	3	4	5	6	7	8	9	10	11	11	13	14	15
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.

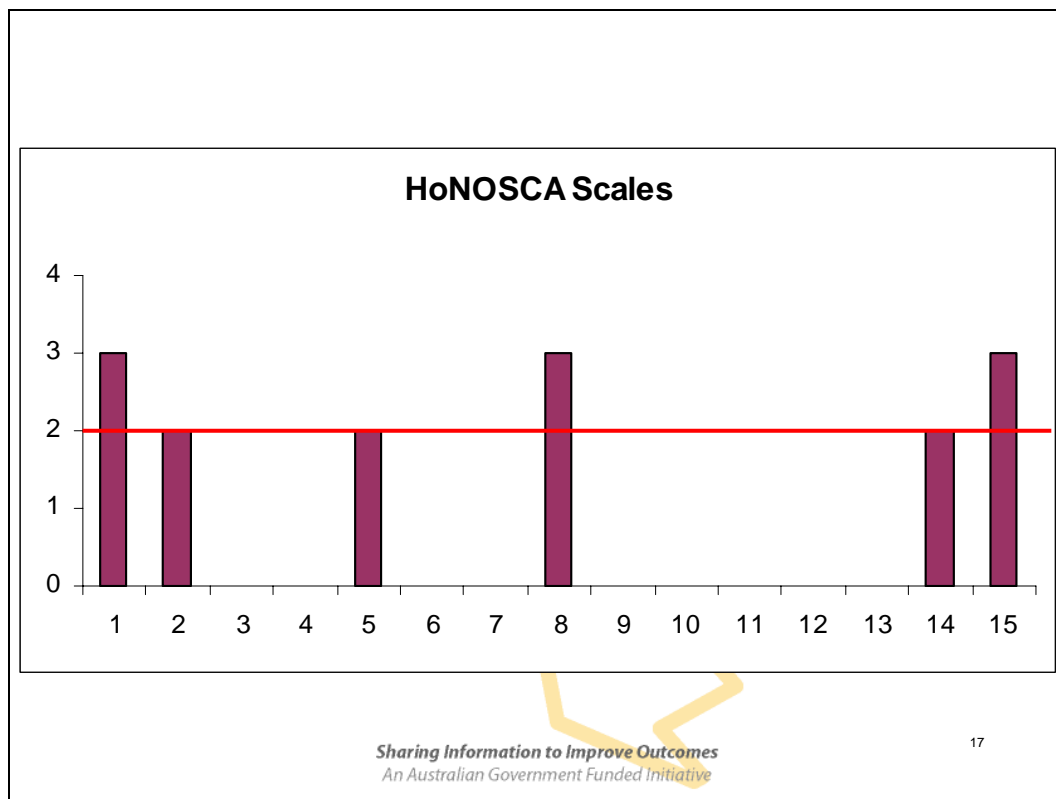
Take opportunities to reinforce that there is generally agreement between raters and that this demonstrates the reasonable inter-rater reliability of the measure.

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 HoNOSCA does not have 100% inter-rater reliability.



It is useful to present the consensus HoNOSCA 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 HoNOSCA be used in Mental Health? A variety of potential uses for the HoNOSCA have been identified, these include;

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

## 9. CHILDREN'S GLOBAL ASSESSMENT SCALE (CGAS)

### RATING THE CGAS

- Rate the patient's most impaired level of general functioning for the specified time period by selecting the *lowest* level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g. 35, 58, 62).
- Rate actual functioning regardless of treatment or prognosis.
- The examples of behaviour provided are only illustrative and are not required for a particular rating.

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

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

## CGAS

- 100-91** Superior functioning in all areas
- 90-81** Good functioning in all areas
- 80-71** No more than slight impairments in functioning
- 70-61** Some difficulty in a single area but generally functioning pretty well
- 60-51** Variable functioning with sporadic difficulties or symptoms in several but not all social areas
- 50-41** Moderate interference in functioning in most social areas or severe impairment of functioning in one area
- 40-31** Major impairment of functioning in several areas and unable to function in one of these areas
- 30-21** Unable to function in almost all areas
- 20-11** Needs considerable supervision
- 10-1** Needs constant supervision

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This slide provides an overview of the scales for the CGAS.

The measure provides a single global rating only, on a scale of 1–100. Clinicians assign a score, with 1 representing the most functionally impaired child, and 100 the healthiest.

The CGAS contains detailed behaviourally oriented descriptions of each anchor point that depict behaviours and life situations applicable to children and adolescents.

## CGAS - Rule of Thumb

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

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

## 10. FACTORS INFLUENCING HEALTH STATUS (FIHS)

### Factors Influencing Health Status (FIHS)

- Maltreatment syndromes
- Problems related to negative life events in childhood
- Problems related to upbringing
- Problems related to primary support group, including family circumstances
- Problems related to social environment
- Problems related to other psychosocial circumstances

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The purpose of these items is to identify the degree to which the child or adolescent has ‘complicating psychosocial factors’ that require additional clinical input during an episode of care. They are important in understanding variations in outcomes, and are based on advice by clinicians that children or adolescents seen by specialist mental health services may present in the context of a range of circumstances which influence the person’s health status, but are not in themselves a current illness or injury. For example, the child may be severely affected by a history of sexual abuse but does not have a formal psychiatric diagnosis.

The FIHS comprises a simple checklist, requiring the clinician to indicate whether one or more factors are present. The seven categories come from the International Classification of Disease (ICD) –10 and were selected on advice from clinicians about the most frequently occurring factors that influence health status.

## 11. ADDITIONAL MEASURES

### 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.

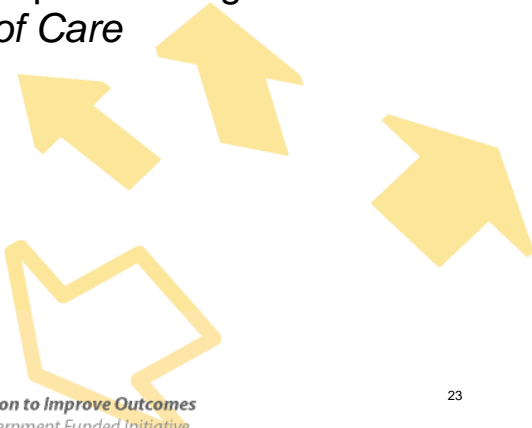
Two approaches to this issue have been taken during implementation. All mental health staff have been supplied with ICD–10 codes. If they feel comfortable given their training and experience to identify the principal diagnosis, then they are able to do so using the supplied codes.

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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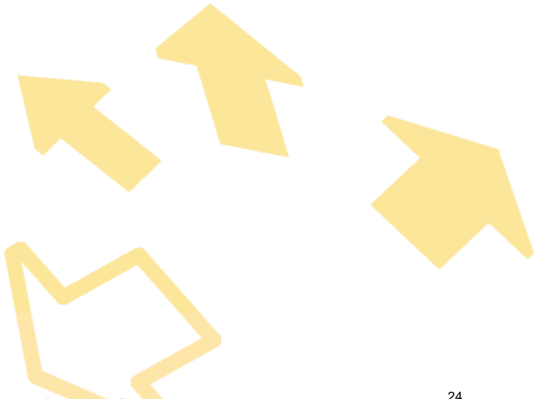
23



**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 HoNOSCA

# Practice Rating HoNOSCA Time 2

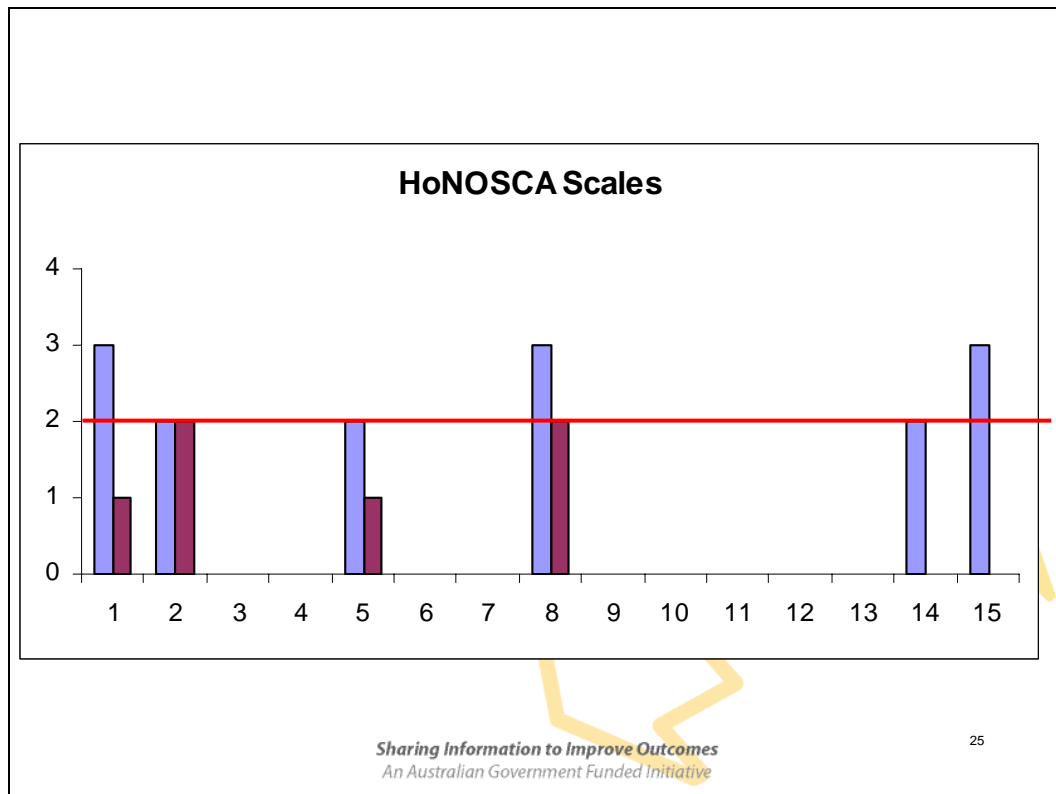


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Each vignette in this training package has information on two collection occasions. For this second collection occasion, follow the feedback and discussion procedure as outlined above. This is also a good opportunity for participants to practice rating the CGAS and FIHS.



On this second collection occasion provide trainees with a comparison graphical representation of change over time. Trainers may wish to develop these from their local reporting systems.

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.

## 12. ADDITIONAL INFORMATION

**Where to Find Additional Information**

[www.mhnooc.org](http://www.mhnooc.org)



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

### 13. REFERENCES

Australian Health Ministers. *National Mental Health Plan (2003–2008)*. 2003, Australian Government: Canberra.

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

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

*Mental Health National Outcomes and Casemix Collection: Overview of clinician-rated and consumer self-report measures, Version 1.50*. 2003, Department of Health and Ageing: Canberra.

*Mental Health National Outcomes and Casemix Collection: Technical specification of State and Territory reporting requirements for the outcomes and casemix components of 'Agreed' Data, Version 1.50*. 2003, Department of Health and Ageing: Canberra.

*Mental Health Outcomes and Assessment Tools (MH-OAT) Facilitators Manual*. 2000, New South Wales Department of Health.

*Proceedings 1<sup>st</sup> Australian Mental Health National Outcomes Training Forum*. Melbourne June 23 –26 2002.

*Proceedings 2<sup>nd</sup> Australian Mental Health National Outcomes Training Forum*. Adelaide April 7 – 8 2003.

## 14. 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.

<b>Age Group</b>	<b>Vignette</b>	<b>Video Timing</b>
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

## 15. APPENDICES

### Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

#### HoNOSCA rating guidelines

- Rate items in order from 1 to 15.
- Use all available information in making your rating.
- Do not include information already rated in an earlier item.
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks, except at discharge from inpatient care, when it is the previous three days.
- Each item is rated on a five-point item of severity (0 to 4) as follows:
  - 0 No problem.
  - 1 Minor problem requiring no formal action.
  - 2 Mild problem.
  - 3 Problem of moderate severity.
  - 4 Severe to very severe problem.
  - 9 Not known or not applicable
- As far as possible, the use of rating point 9 should be avoided, because missing data make scores less comparable over time or between settings.
- Specific information on how to rate each point on each item is provided in the Glossary.

#### HoNOSCA glossary

##### 1 Problems with disruptive, antisocial or aggressive behaviour

*Include behaviour associated with any disorder, such as hyperkinetic disorder, depression, autism, drugs or alcohol.*

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

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

*Do not include: Over-activity rated at scale 2; Truancy, rated at scale 13; Self-harm rated at Scale 3.*

- 0 No problems of this kind during the period rated.
- 1 Minor quarrelling, demanding behaviour, undue irritability, lying, etc.
- 2 Mild but definitely disruptive or antisocial behaviour, lesser damage to property, or aggression, or defiant behaviour.

- 3 Moderately severe aggressive behaviour such as fighting, persistently threatening, very oppositional, more serious destruction of property, or moderately delinquent acts.
- 4 Disruptive in almost all activities, or at least one serious physical attack on others or animals, or serious destruction of property.

**2 Problems with over-activity, attention or concentration**

*Include overactive behaviour associated with any disorder such as hyperkinetic disorder, mania, or arising from drugs.*

*Include problems with restlessness, fidgeting, inattention or concentration due to any cause, including depression.*

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

**3 Non-accidental self-injury**

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

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

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

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

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

**4 Problems with alcohol, substance or solvent misuse**

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

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

*Do not include physical illness or disability due to alcohol or drug use, rated at Scale 6.*

- 0 No problems of this kind during the period rated.

- 1 Minor alcohol or drug use, within age norms.
- 2 Mildly excessive alcohol or drug use.
- 3 Moderately severe drug or alcohol problems significantly out of keeping with age norms.
- 4 Severe drug or alcohol problems leading to dependency or incapacity.

**5 Problems with scholastic or language skills**

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

*Include reduced scholastic performance associated with emotional or behavioural problems.*

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

*Do not include temporary problems resulting purely from inadequate education.*

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

**6 Physical illness or disability problems**

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

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

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

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

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

**7 Problems associated with hallucinations, delusions or abnormal perceptions**

*Include hallucinations, delusions or abnormal perceptions irrespective of diagnosis.*

*Include odd and bizarre behaviour associated with hallucinations and delusions.*

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

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

*Do not include overactive behaviour associated with hallucinations or delusions, rated at Scale 2.*

- 0 No evidence of abnormal thoughts or perceptions during the period rated.
- 1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.
- 2 Abnormal thoughts or perceptions are present (eg, paranoid ideas, illusions or body image disturbance), but there is little distress or manifestation in bizarre behaviour, ie, clinically present but mild.
- 3 Moderate preoccupation with abnormal thoughts or perceptions or delusions; hallucinations, causing much distress, or manifested in obviously bizarre behaviour.
- 4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations or abnormal perceptions, with severe impact on the person or others.

## **8 Problems with non-organic somatic symptoms**

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

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

*Do not include physical illnesses that complicate non-organic somatic symptoms, rated at Scale 6.*

- 0 No problems of this kind during the period rated.
- 1 Slight problems only, such as occasional enuresis, minor sleep problems, headaches or stomach aches without organic basis.
- 2 Mild but definite problem with non-organic somatic symptoms.
- 3 Moderately severe, symptoms produce a moderate degree of restriction in some activities.
- 4 Very severe problems or symptoms persist into most activities. The child or adolescent is seriously or adversely affected.

## **9 Problems with emotional and related symptoms**

*Rate only the most severe clinical problem not considered previously.*

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

*Do not include aggressive, destructive or over-activity behaviours attributed to fears or phobias, rated at Scale 1.*

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

- 0 No evidence of depression, anxiety, fears or phobias during the period rated.
- 1 Mildly anxious, gloomy, or transient mood changes.

- 2 A mild but definite emotional symptom is clinically present, but is not preoccupying.
- 3 Moderately severe emotional symptoms, which are preoccupying, intrude into some activities, and are uncontrollable at least sometimes.
- 4 Severe emotional symptoms which intrude into all activities and are nearly always uncontrollable.

**10 Problems with peer relationships**

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

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

*Do not include aggressive behaviour, bullying, rated at Scale 1.*

*Do not include problems with family or siblings rated at Scale 12.*

- 0 No significant problems during the period rated.
- 1 Either transient or slight problems, occasional social withdrawal.
- 2 Mild but definite problems in making or sustaining peer relationships. Problems causing distress due to social withdrawal, over-intrusiveness, rejection or being bullied.
- 3 Moderate problems due to active or passive withdrawal from social relationships, over-intrusiveness, or to relationships that provide little or no comfort or support, eg, as a result of being severely bullied.
- 4 Severe social isolation with hardly any friends due to inability to communicate socially or withdrawal from social relationships.

**11 Problems with self-care and independence**

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

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

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

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

- 0 No problems of this kind during the period rated; good ability to function in all areas.
- 1 Minor problems, eg, untidy, disorganised.
- 2 Self-care adequate, but major inability to perform one or more complex skills (see above).
- 3 Major problems in one or more areas of self-care (eating, washing, dressing) or major inability to perform several complex skills.
- 4 Severe disability in all or nearly all areas of self-care or complex skills.

**12 Problems with family life and relationships**

*Include parent-child and sibling relationship problems.*

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

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

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

*Include problems with enmeshment and overprotection.*

*Include problems with family bereavement leading to reorganisation.*

*Do not include aggressive behaviour by the child or adolescent, rated at Scale 1.*

- 0 No problems during the period rated.
- 1 Slight or transient problems.
- 2 Mild but definite problem, eg, some episodes of neglect or hostility or enmeshment or overprotection.
- 3 Moderate problems, eg, neglect, abuse, hostility. problems associated with family or carer breakdown or reorganisation.
- 4 Serious problems with the child or adolescent feeling or being victimised, abused or seriously neglected by family or carer.

### **13 Poor school attendance**

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

*Include attendance at type of school at time of rating, eg, hospital school, home tuition, etc. If school holiday, rate the last two weeks of the previous term.*

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

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

### **14 Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the previous two weeks)**

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

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

- 0 No problems during the period rated. Parents and carers have been adequately informed about the child or adolescent's problems.
- 1 Slight problems only.
- 2 Mild but definite problems.

- 3 Moderately severe problems. Parents and carers have very little or incorrect knowledge about the problem which is causing difficulties such as confusion or self-blame.
- 4 Very severe problems. Parents have no understanding about the nature of their child or adolescent's problems.

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

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

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

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

**HoNOSCA sample rating sheet**

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

Section A							
1	Disruptive, antisocial or aggressive behaviour	0	1	2	3	4	<input type="text"/>
2	Over-activity, attention or concentration	0	1	2	3	4	<input type="text"/>
3	Non-accidental self-injury	0	1	2	3	4	<input type="text"/>
4	Alcohol, substance/solvent misuse	0	1	2	3	4	<input type="text"/>
5	Scholastic or language skills	0	1	2	3	4	<input type="text"/>
6	Physical illness or disability problems	0	1	2	3	4	<input type="text"/>
7	Hallucinations, delusions	0	1	2	3	4	<input type="text"/>
8	Non-organic somatic symptoms	0	1	2	3	4	<input type="text"/>
9	Emotional and related symptoms	0	1	2	3	4	<input type="text"/>
10	Peer relationships	0	1	2	3	4	<input type="text"/>
11	Self-care and independence	0	1	2	3	4	<input type="text"/>
12	Family life and relationships	0	1	2	3	4	<input type="text"/>

13	Poor school attendance	0	1	2	3	4
<b>Section B:</b> Problems for the child, parent or carer relating to lack of information or access to services.						
14	Lack of knowledge – nature of difficulties	0	1	2	3	4
15	Lack of information – services/management	0	1	2	3	4

## HoNOSCA scoring

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

Unlike the HoNOS, subscale scores have not yet been defined for the HoNOSCA although the authors note that the items can be logically grouped into similar categories as shown below.

**Structure of the 15 HoNOSCA scales**

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

From Gowers et al 1999a.

## Children's Global Assessment Scale (CGAS)

### Rating guidelines

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

Rate actual functioning regardless of treatment or prognosis. The examples of behaviour provided are only illustrative and are not required for a particular rating.

### CGAS glossary

- 100-91 **Superior functioning** in all areas (at home, at school and with peers); involved in a wide range of activities and has many interests (eg, has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc); likeable, confident; 'everyday' worries never get out of hand; doing well in school; no symptoms.
- 90-81 **Good functioning in all areas**; secure in family, school, and with peers; there may be transient difficulties and 'everyday' worries that occasionally get out of hand (eg, mild anxiety associated with an important exam, occasional 'blowups' with siblings, parents or peers).
- 80-71 **No more than slight impairments in functioning** at home, at school, or with peers; some disturbance of behaviour or emotional distress may be present in response to life stresses (eg, parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.
- 70-61 **Some difficulty in a single area but generally functioning pretty well** (eg, sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behaviour; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
- 60-51 **Variable functioning with sporadic difficulties or symptoms in several but not all social areas**; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.
- 50-41 **Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area**, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.

- 40-31 **Major impairment of functioning in several areas and unable to function in one of these areas** (ie, disturbed at home, at school, with peers, or in society at large, eg, persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
- 30-21 **Unable to function in almost all areas** eg, stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (eg, sometimes incoherent or inappropriate).
- 20-11 **Needs considerable supervision** to prevent hurting others or self (eg, frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, eg, severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
- 10-1 **Needs constant supervision** (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.

