Australian Mental Health Outcomes and Classification Network

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

Rater and Clinical Utility Training Manual

Child and Adolescent

A joint Australian, State and Territory Government Initiative

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Suggested Citation: Coombs, T. (2006) *Rater and Clinical Utility Training Manual: Older Persons.* Australian Mental Health Outcomes and Classification Network. Sydney, New South Wales.

Published by the NSW Institute of Psychiatry.

First edition June 2006.

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1. ACKNOWLEDGEMENTS

The following people were responsible for the development of these training materials.

Tim Coombs, Luke Hatzipetrou, Kerrie Jones, Erika Heslin, Alexis Stockwell, Pamela McIntosh, Tania Lewis, Jennifer Black, Creswell Surrao, Chris Howard and Peter Brann, Rosemary Dickson and Rebecca Seib.

INTRODUCTION TO MANUAL

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

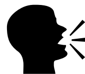
This manual has been structured to provide the contents of a one day training workshop which not only provides refresher training but also resources to assist mental health staff explore the clinical utility of the measures introduced under the National Outcomes and Casemix Collection (NOCC).

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
- participants having the opportunity to engage with the material.

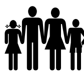
Before commencing training, trainers should have a good understanding of the measures introduced under NOCC and their clinical application. Additionally, trainers should possess knowledge and/or experience in the use of aggregate reports in service development and/or improvement activities.

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.

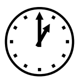
This symbol indicates that trainers should show a particular video clip or written vignette.



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.



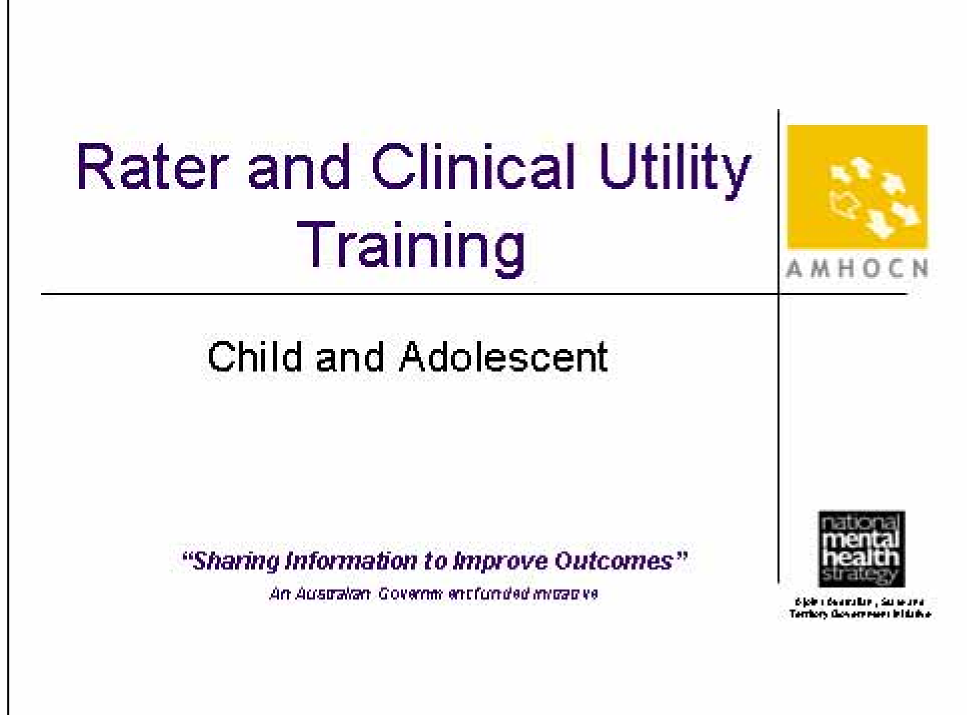
This symbol indicates the notional time each section should take.

2. WORKSHOP TIMETABLE

This is a notional timetable, 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 • Objectives of Workshop
45 minutes	Refresher HoNOSCA Rating Play Vignette Read Vignette Material
45 Minutes	HoNOSCA Feedback/discussion of ratings Review of HoNOSCA and clarification of rating rules
	Morning Tea
10 Minutes	CGAS
15 Minutes	Review other Measures • Factors Influencing Health Status • Diagnosis • Legal Status
90 minutes	Consumer Self Assessment and Carer Assessment • Consumer Self Assessment and Carer Assessment Fidelity Checklist • DVD "Whose Outcome is it Anyway? Consumer, carer and clinician perspectives. • Discussion
	Lunch
20 minutes	Making Sense of the Numbers • Exploring reference material
45 minutes	Care and treatment planning • Preparation, action and expectations
	Afternoon tea
30 minutes	Understanding Variation across Teams • What additional information is required?

3. TRAINING INTRODUCTION AND LEARNING OBJECTIVES



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.

Objectives of the workshop

- Provide an opportunity for clarification of the rating rules of the measures which make up the National Outcomes and Casemix Collection (NOCC).
- Provide an opportunity to explore the clinical utility of the measures which make up NOCC including;
  - Using the consumer self assessment and carer assessment measure to support the assessment process, the process of engagement and consumer and carer empowerment.
  - Using the clinician rated measures and the consumer self assessment and carer assessment 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.

Rater and Clinical Utility Training 2

- Provide an opportunity for clarification of the rating rules of the measures, which make up the National Outcomes and Casemix Collection (NOCC).
- Provide an opportunity to explore the clinical utility of the measures which make up NOCC including;
  - Using the consumer self assessment and carer assessment measure to support: the assessment process; the process of engagement; and consumer and carer empowerment
  - Using the clinician rated measures and the consumer self assessment and carer assessment 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.

This section should take approximately 15 minutes to complete.

4. MEASURES REFREHSER TRAINING

Rate the HoNOSCA and CGAS

- Read the vignette
- Watch video
- Rate HoNOSCA and CGAS refer to the glossary!

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Distribute copies of the written vignette material, copies of the the Heath of the Nations Outcomes Scales Child and Adolescent (HoNOSCA) and Children's Global Assessment Scale (CGAS) glossaries and blank rating sheets.

Show the appropriate video vignette, which accompanies the written material.

Participants should rate the HoNOSCA and CGAS

It is suggested that trainers use the first collection occasion of either, the Carmen and Danny vignettes that can be found on the AMHOCN Rater and Clinical Utility Training Resources CD, OR available for download at www.mhnocc.org.

The vignette 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, the HoNOSCA and its rating rules.

Feedback on rating

- Have the group share their HoNOSCA ratings
- Why are there differences in ratings?

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Lets 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 HoNOSCA is a three-stage process:

1. Trainees read a written vignette or watch a video vignette.
2. Trainees practice rating the HoNOSCA 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.

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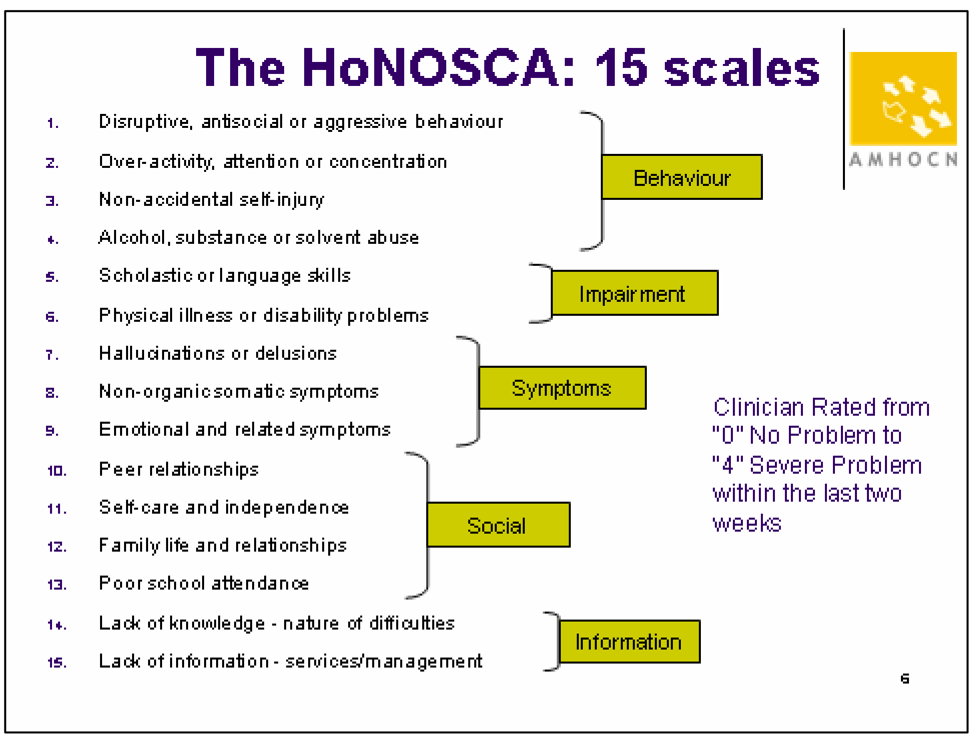
The HoNOSCA is not a diagnostic or screening tool but was specifically designed to be a broad spectrum measure of the severity of consumers' problems over the past two weeks. It does display adequate psychometric properties.

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.mhnocc.org .



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

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

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

Note: There is continued debate regarding the validity of the 5 sub scales and as a result reports at this level may not be generated in every jurisdiction. Check your local systems for the current reports.

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

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

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

1. the HoNOSCA 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 <u>not clinical interviews</u>. 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
  - information provided by other agencies including general practitioner, housing, police and ambulance staff

Rater and Clinical Utility Training 8

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.

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 15-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 "disruptive antisocial or aggressive behaviour…" as a result of the assault but may not score high on Scale 4, "alcohol substance or solvent abuse" 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 community 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

	'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 applies for scales 1 through to 9.

However, the social and information scales are more problematic. For example, simply having an argument with a peer on one occasion does not indicate the child has problems in terms of the quality and quantity of peer relationships (Scale 10). Trainees are therefore asked to consider the usual or typical situation for the consumer over the preceding 2 weeks for Scales 10 – 15.

Rating the HoNOSCA

				Monitor?	Active treatment or management plan?
Clinically Significant	4	Severe to very severe problem	Most severe category for patient's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. *Note – patient can get worse.*	✓	✓
	3	Moderate problem	Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	2	Mild problem	Warrants recording in clinical notes. May or not be incorporated in care plan.	✓	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

AMHOCN

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The HoNOSCA 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 HoNOSCA is an overt judgement by the clinician of the severity of the consumer's problems in a particular domain. Later activities in this workshop rely on clinicians reflections on the significance of ratings and possible interventions.

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. 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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Have participants share their CGAS ratings. Discuss variation in CGAS ratings.

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

Schaffer and colleagues at the Department of Psychiatry, Columbia University developed the CGAS 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

AMHOCN

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 on a scale of 1-100. Clinicians assign a score, with 1 representing the most functionally impaired child, and 100 the most highly functioning.

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

This section should take approximately 10 minutes to complete.

6. OTHER MEASURES

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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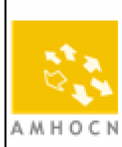
The purpose of FIHS is to identify the degree to which the child or adolescent has 'complicating psychosocial factors' that require additional clinical input during an episode of care. They are important in understanding variations in outcomes, and are based on advice by clinicians that children or adolescents 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.

Distribute copies of the Factors Influencing Health Status to participants.

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 has indicated 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 AND CARER ASSESSMENT IN CLINICAL PRACTICE

Consumer Self Assessment and Carer Assessment in clinical practice

AMHOCN

national mental health strategy

The consumer self assessment and carer assessment measure the Strengths and Difficulties Questionnaire (SDQ) provides an opportunity for the clinician, consumer and carer 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 SDQ and to feedback, the results of the completed measure to the consumer and/or carer.

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

Activity

- **Part One**
  - Offering the carer assessment
- **Part Two**
  - Providing feedback on the carer assessment

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

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

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

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

The activity outlined in this training manual is offering the Carer Assessment or Parent SDQ. Trainers are given the option of having participants practice offering either the Parent SDQ or the Youth SDQ. 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 or carer on the results from completing the SDQ. 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 Carer Assessment Fidelity Checklist (Section 11 sub section; (b) Carer Assessment Fidelity Checklist Part One) and a copy of the Parent SDQ.

Part One

- Participant one plays the carer and has a copy of the Carer Character Information sheet (Section 11 sub section; (d) Carer Character Information).

- Participant two plays the clinician and has a copy of the Parent SDQ to offer.

- Participant three is the observer and holds a copy of the Carer Assessment Fidelity Checklist to guide observation of carer clinician interaction (Section 11 sub section; (a) Consumer Self Assessment Fidelity Checklist Part One).

Encourage participants playing the carer or holding the Carer Assessment Fidelity Checklist not to share this information with the person playing the clinician.

Encourage those playing the carer to not "over play" the role exaggerating the carer characteristics that prevent the carer from completing the measure. Part One of the activity does not end until the Carer 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 SDQ to the carer.
2. The carer 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 SDQ 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 carers in completing the Carer Assessment. Reinforce the clinical skills necessary to integrate the carer SDQ into clinical practice.

Play part 2 from the DVD "'Whose Outcome is it Anyway?' Consumer, Carer and Clinician Perspectives - Dialogue and Engagement".

Regardless of how the Consumer Self Assessment or carer SDQ is offered, it is important that there is some discussion regarding the results. Part Two of this activity involves workshop participants exploring the process of providing feedback to the carer on what information can be uncovered from a completed SDQ.

Part Two

Participants swap roles:

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

Distribute the appropriate example report on the results of the SDQ based on the Character Information sheet (See section 11 sub-section (f) Example Report Carer Assessment) and Part Two of the Carer Assessment Fidelity Checklist (Section 11 sub section; (b)).

1. The person now playing the clinician has access to both the completed measures (having completed the measure in part one of the activity) along with an example report. The clinician now provides feedback to the carer on how the measure has been completed, and what has or has not changed from the carers perspective.

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 and Carer Assessment

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

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

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

It can also be used to support consumer and carer 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 and Carer Assessment

General Rule: Always offer the Consumer Self Assessment and Carer Assessment.

- Complements the clinician rated measures
- Completion by the consumer and carer assessment is always voluntary
- Consumer self assessment and Carer 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 I complete the Consumer self assessment and Carer assessment measures
- 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

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

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

- Identify for consumers and carers that the completion of the consumer self assessment and carer assessment measures will provide useful information for the clinician that will inform their work.
- Assure consumers and carers that refusal to complete the consumer self assessment or carer assessment measure 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.
- Assure consumers and carers that the consumer self assessment and the carer assessment measures are 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 and Carer 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 assessment or carer assessment measure and be mindful of the purpose of offering the measure, **to engage the consumer and carer in care**.

This section should take approximately 90 minutes to complete.

8. THE MEASURES AND CARE/TREATMENT PLANNING

Making Sense of the Numbers

- Compare and contrast the consumers presentation with available reference material

Rater and Clinical Utility Training 23

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

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

Trainers should consider generating sample reports from local clinical information systems to make this activity more locally meaningful.

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 HoNOSCA earlier in this workshop. Have teams compare and contrast these example reports (total scores) with the national aggregate clinical reference material. Note that participants will have to calculate the HoNOSCA total score for the vignette being used; the total score for the SDQ 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 HoNOSCA 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?

If trainers have access to the NOCC Decision Support Tool (DST), they should consider including an exploration of this feedback tool into their training. This tool provides even more detailed access to the national aggregate reports. It gives additional contextual information to make sense of the numbers that are increasingly being made available to clinicians. The DST can be downloaded from www.mhnocc.org/amhocn/dst.

A useful activity is to have participants answer questions (example questions are found in Section 11 sub- section (i) of this manual).

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

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

Distribute additional butcher's paper.

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

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

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

Teams are asked to address the three questions outlined in the slide. The teams' responses on the butcher's paper should be posted on walls in the 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 involving the consumer and carer in the treatment planning process enhance therapeutic alliance?
2. Have you considered using the HoNOSCA and SDQ in your 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 eleven sub-section (j) of this manual and additional butchers paper.

Review the service profile reports for each of three services.

Teams answer the questions on the handout material and feedback on butchers 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 HoNOSCA 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. The trainer should highlight the potential

utilisation of HoNOSCA aggregate data to inform and support service level activities such as service review and evaluation, quality improvement and service initiatives.

This section should take approximately 30 minutes to complete.

ADDITIONAL INFORMATION

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

AMHOCN

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. WORKSHOP TRAINING RESOURCES

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 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 consume in assessment and care planning
  - Tool for clinician to monitor progress
  - Tool for consumer to monitor progress
  - Information can be used for service development and quality improvement processes
- ☐ Clinician reinforces consumer ownership and personal responsibility for completion of self assessment, promoting personal responsibility for illness self-management
- ☐ Clinician explains the self assessment is part of the medical record and subject to the same protections of privacy and confidentiality
- ☐ Clinician supports and encourages the consumers completion of the self assessment in an appropriate manner
- ☐ Provides appropriate assistance and prompting during completion of the measure
- ☐ Clinician provides positive reinforcement for completion of the measure
- ☐ Clinician offers appropriate assistance if consumer becomes distressed or cannot complete the measure

Comments/Feedback:

PART TWO: Reviewing and Providing Feedback of 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) Carer Assessment Fidelity Checklist

PART ONE: Offering the Carer 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 responses.

- ☐ Clinician presents the carer assessment as positive experience and a genuine attempt to engage the carer in treatment planning
- ☐ Clinician assesses for potential difficulties the carer may have in completing the assessment
- ☐ Clinician presents rationale for completion of the carer assessment measure including
  - Genuine attempt to understand carer perspective
  - Genuine attempt to involve carer in assessment and care planning
  - Tool for clinician to monitor progress
  - Tool for carer to monitor progress
  - Information can be used for service development and quality improvement processes
- ☐ Clinician explains the assessment is part of the medical record and subject to the same protections of privacy and confidentiality
- ☐ Clinician supports and encourages the carer 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 carer becomes distressed or cannot complete the measure

Comments/Feedback:

PART TWO: Reviewing and Providing Feedback on the Completed Carer 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 carer to discuss items in more detail
- ☐ Clinician provides summary of carer assessment
- ☐ Clinician explains graphical report to carer
- ☐ Clinician provides clarification of graphical report to carer as required
- ☐ Clinician discusses any change in the presentation of the consumer and its relationship to interventions or carer activities promoting recovery
- ☐ Clinician discusses carer assessment in the context of goal setting
- ☐ Clinician links summary to collaborative goal setting
- ☐ Clinician discusses future review of carer assessment
- ☐ Clinician offers the carer a copy of the self assessment

Comments/Feedback:

c) Consumer Self Assessment Fidelity Checklist Exercise: Consumer Character Information

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

d) Carer Assessment Fidelity Checklist Exercise: Carer Character Information

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

e) Example Report Consumer Self Assessment

Self Assessment	Scores Consumer Self Assessment 2/3/2005	Scores Consumer Self Assessment 15/6/2005	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Total Difficulties Score	26		0-15	16-19	20-40
Emotional Symptoms Score	6	4	0-5	6	7-10
Conduct Problem Score	2	2	0-3	4	5-10
Hyperactivity Score	8	7	0-5	6	7-10
Peer Problem Score	5	3	0-3	4-5	6-10
			'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly low, which may reflect clinically significant problems'	'This score is low - there is a substantial risk of clinically significant problems in this area'
Prosocial Behaviour Score	5	7	6-10	5	0-4

f) Example Report Carer Assessment

Carer Assessment	Scores Carer Assessment 2/3/2005	Scores Carer Assessment 15/6/2005	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Total Difficulties Score	26		0-13	14-16	17-40
Emotional Symptoms Score	6	4	0-3	4	5-10
Conduct Problem Score	2	2	0-2	3	4-10
Hyperactivity Score	8	7	0-5	6	7-10
Peer Problem Score	5	3	0-2	3	4-10
			'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly low, which may reflect clinically significant problems'	'This score is low - there is a substantial risk of clinically significant problems in this area'
Prosocial Behaviour Score	5	7	6-10	5	0-4

g) Vignette Sample Reports

i. Carmen Admission

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

CGAS 55

Carmen Admission SDQ

Carmen SDQ

Self Assessment	Scores Consumer Self Assessment	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Total Difficulties Score	6	0-15	16-19	20-40
Emotional Symptoms Score	5	0-5	6	7-10
Conduct Problem Score	0	0-3	4	5-10
Hyperactivity Score	1	0-5	6	7-10
Peer Problem Score	0	0-3	4-5	6-10
		'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly low, which may reflect clinically significant problems'	'This score is low - there is a substantial risk of clinically significant problems in this area'
Prosocial Behaviour Score	9	6-10	5	0-4

Carmens Mothers SDQ

Carer Assessment	Scores Carer Assessment	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Total Difficulties Score	8	0-13	14-16	17-40
Emotional Symptoms Score	2	0-3	4	5-10
Conduct Problem Score	3	0-2	3	4-10
Hyperactivity Score	3	0-5	6	7-10
Peer Problem Score	0	0-2	3	4-10
		'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly low, which may reflect clinically significant problems'	'This score is low - there is a substantial risk of clinically significant problems in this area'
Prosocial Behaviour Score	8	6-10	5	0-4

ii. Danny Admission

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

CGAS 45

Dannys' Mothers SDQ

Carer Assessment	Scores Carer Assessment	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Total Difficulties Score	6	0-13	14-16	17-40
Emotional Symptoms Score	3	0-3	4	5-10
Conduct Problem Score	1	0-2	3	4-10
Hyperactivity Score	0	0-5	6	7-10
Peer Problem Score	2	0-2	3	4-10
		'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly low, which may reflect clinically significant problems'	'This score is low - there is a substantial risk of clinically significant problems in this area'
Prosocial Behaviour Score	10	6-10	5	0-4

h) National Aggregate Clinical Reference Material

Table 1.1.2: Core Clinical Summary Score Profiles by Mental Health Service Setting for each Reason for Collection for all data reported to April 2005 for Children and Adolescents with all Mental Health Summary Diagnostic Groups for all Demographic Groups within Age Group for all Jurisdictions

		CO	HoNOSCA-13			CGAS			FIHS Total		
		N	V%	M	SD	V%	M	SD	V%	M	SD
Psychiatric Inpatient		***4942***	***77***	***16.2***	***7.6***	***87***	***48.4***	***14.0***	***60***	***3.7***	***1.9***
Admission		2740	80	17.9	7.1	88	48.8	13.6	NR	-	-
	New referral	1914	81	17.9	7.1	86	49.2	13.8	NR	-	-
	From other setting	733	83	18.3	7.0	94	47.6	13.2	NR	-	-
	Other	93	58	15.4	7.4	67	52.7	14.2	NR	-	-
Review		265	89	17.5	7.7	86	44.6	16.2	70	4.0	2.0
	91-day review	134	96	17.8	7.6	96	40.6	16.5	90	4.2	1.9
	Other	131	81	17.2	7.9	76	50.4	14.0	50	3.8	2.1
Discharge		1937	71	13.3	7.4	NR	-	-	59	3.6	1.9
	No further care	462	74	11.9	6.8	NR	-	-	77	3.4	1.9
	Change of setting	1378	73	13.9	7.5	NR	-	-	56	3.7	1.9
	Death	0	-	-	-	NR	-	-	-	-	-
	Other	97	14	8.9	4.4	NR	-	-	14	4.0	2.4
Community Residential		***188***	***76***	***12.6***	***6.7***	***94***	***58.8***	***14.1***	***53***	***2.9***	***2.0***
Admission		97	87	14.0	6.4	95	58.5	15.0	NR	-	-
	New referral	82	89	13.6	6.2	98	56.7	12.1	NR	-	-
	From other setting	11	64	18.3	7.3	82	58.2	18.4	NR	-	-
	Other	4	100	14.8	7.5	75	98.3	1.2	NR	-	-
Review		39	92	11.8	5.8	92	59.5	12.1	79	3.0	1.9
	91-day review	30	100	11.5	5.7	100	60.8	12.3	93	3.0	2.0
	Other	9	67	13.3	6.6	67	51.8	8.0	33	2.7	1.5
Discharge		52	42	8.4	7.1	NR	-	-	33	2.7	2.1
	No further care	33	45	6.9	7.0	NR	-	-	42	2.5	2.2
	Change of setting	8	88	11.6	6.6	NR	-	-	38	3.7	1.5
	Death	0	-	-	-	NR	-	-	-	-	-
	Other	11	-	-	-	NR	-	-	-	-	-
Ambulatory		***49496***	***77***	***11.9***	***6.7***	***92***	***58.2***	***12.5***	***61***	***2.6***	***1.9***
Admission		22752	90	13.2	6.3	90	57.3	12.3	NR	-	-
	New referral	20110	92	13.0	6.2	91	57.7	12.1	NR	-	-
	From other setting	1975	74	15.1	6.9	78	54.2	13.2	NR	-	-
	Other	667	74	12.9	6.8	91	55.6	14.7	NR	-	-
Review		10568	86	12.0	6.5	95	60.0	12.9	80	2.7	1.9
	91-day review	7925	87	11.6	6.4	97	60.7	12.6	86	2.6	1.9
	Other	2643	81	13.0	6.9	87	57.4	13.5	61	3.0	1.8
Discharge		16176	54	8.7	6.7	NR	-	-	49	2.5	1.9
	No further care	10168	59	7.8	6.1	NR	-	-	64	2.4	2.0
	Change of setting	2229	71	12.8	7.7	NR	-	-	33	3.0	1.8
	Death	9	44	12.0	7.6	NR	-	-	56	3.2	2.2
	Other	3770	30	7.8	6.5	NR	-	-	19	2.3	1.8

Explanatory Notes:

NR	Not Required	V%	Percentage of Valid Observations	HoNOSCA-13	HoNOSCA 13 item total
-	No Valid Observations	M	Mean		
CO	Overall Collection Occasions	SD	Standard Deviation		

Table 1.1.3: Core Consumer Summary Score Profiles by Mental Health Service Setting for each Reason for Collection for all data reported to April 2005 for Children and Adolescents with all Mental Health Summary Diagnostic Groups for all Demographic Groups within Age Group for all Jurisdictions

	CO	CO-C	CO-Y	SDQ-P-C			SDQ-P-Y			SDQ-Y		
	N	N	N	V%	M	SD	V%	M	SD	V%	M	SD
Psychiatric Inpatient	***4942***	***217***	***2658***	***47.5***	***23.2***	***6.5***	***3.9***	***19.1***	***7.5***	***39.0***	***18.1***	***6.6***
Admission	2740	112	1542	72.3	23.7	6.7	5.3	19.5	7.6	54.6	18.5	6.5
New referral	1914	71	1245	70.4	23.7	7.4	4.0	18.8	7.5	54.7	18.4	6.4
From other setting	733	41	297	75.6	23.7	5.8	10.4	22.1	7.6	54.2	19.0	6.6
Other	93	0	0	-	-	-	-	-	-	-	-	-
Review	265	2	132	50.0	17.0	.	0.8	19.5	6.1	40.2	17.2	7.9
91-day review	134	2	100	50.0	17.0	.	1.0	19.3	6.4	41.0	18.4	7.9
Other	131	0	32	.	.	.	.	20.6	4.9	37.5	13.4	6.9
Discharge	1937	103	984	20.4	21.1	5.3	2.1	16.7	6.9	14.4	15.8	6.5
No further care	462	26	297	3.8	19.0	.	0.3	13.3	6.9	11.1	13.7	6.0
Change of setting	1378	77	687	26.0	21.2	5.5	2.9	18.2	6.5	15.9	16.6	6.6
Death	0	-	-	-	-	-	-	-	-	-	-	-
Other	97	0	0	-	-	-	-	-	-	-	-	-
Community Residential	***188***	***0***	***4***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***
Admission	97	0	2	-	-	-	-	-	-	-	-	-
New referral	82	0	2	-	-	-	-	-	-	-	-	-
From other setting	11	0	0	-	-	-	-	-	-	-	-	-
Other	4	0	0	-	-	-	-	-	-	-	-	-
Review	39	0	1	-	-	-	-	-	-	-	-	-
91-day review	30	0	0	-	-	-	-	-	-	-	-	-
Other	9	0	1	-	-	-	-	-	-	-	-	-
Discharge	52	0	1	-	-	-	-	-	-	-	-	-
No further care	33	0	0	-	-	-	-	-	-	-	-	-
Change of setting	8	0	1	-	-	-	-	-	-	-	-	-
Death	0	-	-	-	-	-	-	-	-	-	-	-
Other	11	0	0	-	-	-	-	-	-	-	-	-
Ambulatory	***49496***	***6387***	***16289***	***59.0***	***20.1***	***6.7***	***23.2***	***19.1***	***7.0***	***39.7***	***17.3***	***6.4***
Admission	22752	2926	7150	82.5	20.8	6.5	33.8	19.6	6.7	57.1	18.0	6.1
New referral	20110	2559	6047	86.4	20.9	6.6	36.5	19.6	6.8	60.6	17.8	6.1
From other setting	1975	367	1103	55.6	20.0	4.7	18.5	19.3	6.2	38.0	19.5	5.2
Other	667	0	0	-	-	-	-	-	-	-	-	-
Review	10568	1579	3899	59.7	20.1	6.6	24.2	19.3	7.1	43.5	16.9	6.6
91-day review	7925	1281	3104	58.5	20.2	6.6	24.1	19.2	7.2	44.7	16.8	6.6
Other	2643	298	795	65.1	19.6	6.7	24.4	19.7	6.9	38.9	17.7	6.5
Discharge	16176	1882	5240	22.0	16.1	6.8	7.9	16.2	7.1	13.3	14.2	6.7
No further care	10168	1687	4403	17.5	15.5	6.7	6.7	14.8	6.7	10.8	13.0	6.5
Change of setting	2229	194	834	61.3	18.2	6.5	14.3	19.9	6.8	26.6	17.7	6.0
Death	9	1	3	-	-	-	-	-	-	-	-	-
Other	3770	0	0	-	-	-	-	-	-	-	-	-

Explanatory Notes:

NR	Not Required	CO-Y	Collection Occasions, Consumers Aged 11-17	SDQ-P-C	SDQ Parent Version, Consumers Aged 4-10
-	No Valid Observations	V%	Percentage of Valid Observations	SDQ-P-Y	SDQ Parent Version, Consumers Aged 11-17
CO	Overall Collection Occasions	M	Mean	SDQ-Y	SDQ Youth Version, Consumers Aged 11-17
CO-C	Collection Occasions, Consumers Aged 4-10	SD	Standard Deviation		

Table 1.1.4.1: Distribution of HoNOSCA Total Scores by Mental Health Service Setting for each Reason for Collection for all data reported to April 2005 for Children and Adolescents with all Mental Health Summary Diagnostic Groups for all Demographic Groups within Age Group for all Jurisdictions

			HoNOSCA-13						
		N	P5	P10	P25	P50	P75	P90	P95
Psychiatric Inpatient		***3805***	***5***	***7***	***11***	***16***	***21***	***27***	***29***
Admission		2204	7	9	13	18	23	27	30
	New referral	1543	7	9	13	17	23	27	31
	From other setting	607	7	9	13	18	24	28	30
	Other	54	4	5	10	15	21	25	27
Review		235	5	8	11	17	23	28	31
	91-day review	129	6	8	12	18	23	28	31
	Other	106	4	7	11	17	23	29	31
Discharge		1366	3	5	8	12	18	24	27
	No further care	340	3	4	7	11	16	21	25
	Change of setting	1012	3	5	8	13	18	24	28
	Death	0	-	-	-	-	-	-	-
	Other	14	-	1	7	9	12	16	-
Community Residential		***142***	***1***	***4***	***8***	***12***	***17***	***23***	***24***
Admission		84	4	6	9	13	19	24	26
	New referral	73	5	6	9	12	17	23	26
	From other setting	7	4	4	14	21	24	-	-
	Other	4	5	5	7	16	21	-	-
Review		36	4	5	7	12	15	20	24
	91-day review	30	3	4	7	12	15	20	23
	Other	6	6	6	8	13	19	-	-
Discharge		22	-	-	1	9	15	19	20
	No further care	15	-	-	1	3	13	18	-
	Change of setting	7	-	-	7	12	16	-	-
	Death	0	-	-	-	-	-	-	-
	Other	0	-	-	-	-	-	-	-
Ambulatory		***38202***	***2***	***4***	***7***	***11***	***16***	***21***	***24***
Admission		20420	4	6	9	13	17	22	25
	New referral	18472	4	5	8	12	17	21	24
	From other setting	1455	5	7	10	14	19	25	28
	Other	493	3	4	8	12	17	22	25
Review		9073	3	4	7	11	16	21	24
	91-day review	6923	3	4	7	11	16	20	23
	Other	2150	3	5	8	12	18	22	25
Discharge		8709	-	2	4	7	12	18	22
	No further care	5981	-	1	3	6	11	16	20
	Change of setting	1585	2	3	7	12	18	23	27
	Death	4	4	4	5	11	20	-	-
	Other	1139	-	1	3	6	11	17	20

Explanatory Notes:

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

i) NOCC Decision Support Tool Exercise

	Question	Result
1	What is the average HoNOS score for all adult consumers regardless of sex, age or diagnosis on discharge from inpatient units?	
2	How many HoNOS records are reported for adult consumers regardless of sex, age or diagnosis on review in community residential settings?	
3	What is the median HoNOSCA total score for all child and adolescent consumers regardless of sex, age or diagnosis on review in ambulatory settings?	
4	What is the average HoNOS 65+ total score for males aged between 65 – 74 with a mood disorder on admission to ambulatory settings?	
5	Tina is a 27 year old woman who has been diagnosed with a personality disorder and admitted to an inpatient unit. Tina's HoNOS total score is 9 on admission to the unit. What percentage of consumers with a similar profile score higher than 9?	
6	Andrew is 40 years old with a long history of schizophrenia. He was admitted to ambulatory care with a HoNOS total score of 23. On his first review at 91days, his HoNOS total score is 19. What percentage of consumers show a difference of 4 or less between their admission and review HoNOS total scores in ambulatory services?	

j) Aggregate Report: Team Variation

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

Mental Health Service Organisation	Disruptive, antisocial or aggressive behaviour	Over-activity, attention or concentration	Non-accidental self-injury	Alcohol, substance/solvent misuse	Scholastic or language skills	Physical illness or disability problems	Hallucinations, delusions	Non-organic somatic symptoms	Emotional and related symptoms	Peer relationships	Self-care and independence	Family life and relationships	Poor school attendance	Lack of knowledge	Lack of information
Bingara	30	75	20	10	5	14	70	80	65	40	20	23	14	8	7
Tambar Springs	67	55	78	24	33	85	30	34	44	23	66	71	8	35	45
Werris Creek	12	13	24	67	65	21	22	14	42	82	13	14	65	35	80

- 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?

k) Blank Rating Forms and measures information

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

I) Children's Global Assessment Scale Glossary

Rating guidelines

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

100-91	***Superior functioning*** in all areas (at home, at school and with peers); involved in a wide range of activities and has many interests (eg, has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc); likeable, confident; 'everyday' worries never get out of hand; doing well in school; no symptoms.
90-81	***Good functioning in all areas***; secure in family, school, and with peers; there may be transient difficulties and 'everyday' worries that occasionally get out of hand (eg, mild anxiety associated with an important exam, occasional 'blowups' with siblings, parents or peers).
80-71	***No more than slight impairments in functioning*** at home, at school, or with peers; some disturbance of behaviour or emotional distress may be present in response to life stresses (eg, parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.
70-61	***Some difficulty in a single area but generally functioning pretty well*** (eg, sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behaviour; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
60-51	***Variable functioning with sporadic difficulties or symptoms in several but not all social areas;*** disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.
50-41	***Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area,*** such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.
40-31	***Major impairment of functioning in several areas and unable to function in one of these areas*** (ie, disturbed at home, at school, with peers, or in society at large, eg, persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
30-21	***Unable to function in almost all areas*** eg, stays at home, in ward, or in bed all day without taking part in social activities *or* severe impairment in reality testing *or* serious impairment in communication (eg, sometimes incoherent or inappropriate).
20-11	***Needs considerable supervision*** to prevent hurting others or self (eg, frequently violent, repeated suicide attempts) *or* to maintain personal hygiene *or* gross impairment in all forms of communication, eg, severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
10-1	***Needs constant supervision*** (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.

m) Health of the Nation Outcomes Scales Glossary

HoNOSCA rating guidelines

- Rate items in order from 1 to 15.
- Use all available information in making your rating.
- Do not include information already rated in an earlier item.
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks, except at discharge from inpatient care, when it is the previous three days.
- Each item is rated on a five-point item of severity (0 to 4) as follows:

  0 No problem.

  1 Minor problem requiring no formal action.

  2 Mild problem.

  3 Problem of moderate severity.

  4 Severe to very severe problem.

  9 Not known or not applicable
- As far as possible, the use of rating point 9 should be avoided, because missing data make scores less comparable over time or between settings.
- Specific information on how to rate each point on each item is provided in the Glossary.

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.

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

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

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

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

0 No problems during the period rated.

1 Slight or transient problems.

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

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

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

13 Poor school attendance

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

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

0 No problems of this kind during the period rated.

1 Slight problems, eg, late for two or more lessons.

2 Definite but mild problems, eg, missed several lessons because of truancy or refusal to go to school.

3 Marked problems, absent several days during the period rated.

4 Severe problems, absent most or all days. Include school suspension, exclusion or expulsion for any cause during the period rated.

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

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

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

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

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

1 Slight problems only.

2 Mild but definite problems.

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

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

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

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

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

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

1 Slight problems only.

2 Mild but definite problems.

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

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