



Mental Health Information Development

National Outcomes and Casemix Collection

OVERVIEW OF CLINICAL MEASURES AND DATA ITEMS

Version 1.02

*Compiled by Quality and Effectiveness Section
Mental Health & Special Programs Branch
Commonwealth Department of Health and Ageing
July 2002*



Document information

Title: National Outcomes and Casemix Collection: Overview of clinical measures and data items
Version: 1.02
File: NOCC Clinical Measures Overview V1_02 Final.doc

Document history

Version	Date	Details
1.0	18/02/2002	Distributed to all States and Territories via membership of National Mental Health Working Group Information Strategy Committee
1.01	03/06/2002	Distributed to participants in the National Mental Health Outcomes Training Forum.
1.02	8 July 2001	Final version for printing.

Acknowledgments

Acknowledgment of the developers of each of the standard clinical measurement scales outlined in this document is presented in the sections relating to each instrument.

Note that each the standard clinical measurement scales is subject to its own copyright and licensing arrangements. Details are summarised on page 15.

Suggested citation for this document:

National Outcomes and Casemix Collection: Overview of clinical measures and data items. Commonwealth Department of Health and Ageing, Canberra, 2002

Other related publications:

National Outcomes and Casemix Collection: Technical specification of State and Territory reporting requirements for the outcomes and casemix components of 'Agreed Data' under National Mental Health Information Development Funding Agreements. Commonwealth Department of Health and Ageing, Canberra, 2002.

Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998 – 2003 (First Edition). Commonwealth Department of Health and Aged Care, Canberra, June 1999.

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About this document

The Second National Mental Health Plan, agreed by all Australian Health Ministers in 1998, saw Australia enter a second five-year period of the National Mental Health Strategy. Information development, particularly focused on the areas of outcomes and casemix, was identified as high priority for the Second National Mental Health Plan.

Under the Australian Health Care Agreements, the Commonwealth government provided an additional \$300 million to further mental health reform. Of this, in excess of \$38 million was provided to all States and Territories to support the workforce training and information system development needed to enable the routine collection of outcome and casemix data in public mental health services.

In June 1999, the Australian Health Ministers Advisory Council Mental Health Working Group agreed to a plan that committed all States and Territories to, amongst other things:

- the introduction of routine consumer outcomes assessments using a standard clinical assessment scales and a consumer self-report instrument;
- the further development of a casemix classification for mental health as a clinical and management information tool; and
- national analysis of data for development of ‘service quality’ benchmarks.¹

This package has been prepared to provide details of the specific clinical measures to be introduced. It provides summary details about each measure as well as including copies of the various rating scales.

Readers should consult the following documents for further background information.

National Outcomes and Casemix Collection: Technical specification of State and Territory reporting requirements for the outcomes and casemix components of ‘Agreed Data’ under National Mental Health Information Development Funding Agreements, Version 1.0. Commonwealth Department of Health and Ageing, Canberra, 2002.

Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998 – 2003 (First Edition). Commonwealth Department of Health and Aged Care, Canberra, June 1999.

¹ For further detail, see *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003*. Commonwealth Department of Health & Aged Care, Canberra, June 1999

Overview of the Measures

1. Measures specific to adults and older people

Four measures will be collected for adult and aged consumers that are completed by clinicians:

- HoNOS/HoNOS65+ (Health of the Nation Outcome Scales);
- LSP-16 (an abbreviated version of the Life Skills Profile);
- RUG-ADL (Resource Utilisation Groups – Activities of Daily Scale) – for over 65s only; and
- Focus of Care.

In addition, an agreed consumer self-rated measure will be introduced. The specific measure to be used is to be decided by each State and Territory but generally will be drawn from one of the following:

- The MHI (Mental Health Inventory);
- The BASIS (Behaviour and Symptom Identification Scale); or
- K-10 (Kessler-10).

1.1 Health of the Nation Outcomes Scales (HoNOS and HoNOS 65+)

The HoNOS was developed by the Royal College of Psychiatrists in the United Kingdom as a tool to be used by clinicians in their routine work to measure consumer outcomes. It was designed specifically for use with people with a mental illness and is best considered as a general measure of severity of mental health disorder.

The focus of the HoNOS is on health status and severity of symptoms. It consists of 12 items that cover the sorts of problems that may be experienced by people with a significant mental illness with each item rated on a five-point scale (0 = no problem, 1-4 = minor problem to very severe problem). In assigning ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated. The clinician rates the consumer on each of the scales in terms of their assessment of the person's situation over the recent period, usually defined as the previous two weeks. The clinician is expected to draw on all relevant and useful information to make their ratings, for example case notes, interviews with the consumer and carers, team meetings and so forth. Because it is designed to easily fit into day-to-day work, it does not need any special interviews or procedures. The HoNOS takes about 5 minutes to complete once the clinician becomes familiar with the scales.

Since the release of the 'general adult' HoNOS, additional versions have been developed for different mental health consumer groups:

- HoNOS65+: for services for older adults;

- HoNOSCA: for services for children and adolescents;
- HoNOS-LD: for services for people with learning disabilities;
- HoNOS-MDO: for services for mentally disordered offenders; and
- HoNOS-ABI: for services for people with acquired brain injury.

The HoNOS65+ is a variant of the general adult version of the HoNOS and was developed by the Royal College of Psychiatrists in the United Kingdom specifically for use with older people with a mental illness. A study evaluating the general adult version of HoNOS in an older population found that although the scales performed well, a number of modifications would make them better suited to older people with mental illness. The designers describe the issues as follows:

“A meeting was held at the Royal College of Psychiatrists in May 1996 to gather views from psychiatrists, nurses, psychologists and other professionals concerning the suitability of HoNOS in older people. The need for the scale to be understood by and completed by nurses and other members of the multi-disciplinary team was noted as was the fact that the scale is a measure independent of diagnosis or aetiology. A number of further amendments were suggested: the scale needed to reflect the main reasons why an old age psychiatrist might be asked to see a patient, for example, for sleep disturbance, agitation and restlessness; a rating of conscious level was needed; specific identification of aspects of depression in older people, such as guilt and passive aspects of suicidal ideation, needed to be identified; the place for rating symptoms in patients with dementia whose paranoid ideas are based on cognitive deficits; cognitive impairment to be rated as acute or chronic; inappropriate urination (eg., in a waste paper bin) to be coded as behavioural disturbance, whereas incontinence due to a urinary tract infection coded under physical disability; a rating of judgement included under cognitive impairment and issues of competence in activities of daily living should be coded separately. It was felt that the points raised could be dealt with successfully with an amended glossary, while retaining the basic HoNOS structure.” (Burns et al, 1999a)

The 65+ variant of the HoNOS consists of the same item set and is scored in the same way, however the accompanying glossary has been modified to better reflect the problems and symptoms likely to be encountered when assessing older persons.

Table 1 summarises the 12 HoNOS scales for the ‘general’ HoNOS and the HoNOS65+. A full copy of each instrument is included in the Appendices.

Table 1: The 12 HoNOS and HoNOS65+ scales

Scale 1:	Overactive, aggressive, disruptive or agitated behaviour
Scale 2:	Suicidal thoughts or behaviour
Scale 3:	Problem-drinking or drug-taking
Scale 4:	Cognitive problems involving memory, orientation, understanding
Scale 5:	Physical illness or disability
Scale 6:	Hallucinations and delusions
Scale 7:	Depressed mood
Scale 8:	Other mental and behavioural problems
Scale 9:	Supportive social relationships
Scale 10:	Activities of Daily Living (ADL): overall disability
Scale 11:	Accommodation
Scale 12:	Occupational and recreational activities

Key references for the general adult HoNOS

Wing JK, Curtis RH, Beevor AS (1994) 'Health of the Nation': Measuring mental health outcomes *Psychiatric Bulletin*, 18, 690-691.

Wing JK, Beevor AS, Curtis RH, Park SBG, Hadden S, Burns A (1998) Health of the Nation Outcome Scales (HoNOS). Research and development. *British Journal of Psychiatry*, 172, 11-18.

Wing JK, Curtis RH, Beevor AS (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432-434.

Also see <http://www.rcpsych.ac.uk/cru/honoscales/index.htm>

Key references for the HoNOS65+

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

Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999b) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+): Glossary for HoNOS 65+ score sheet. *British Journal of Psychiatry*, 174, 435-438.

Also see <http://www.rcpsych.ac.uk/cru/honoscales/honos65/index.htm>

1.2 The Abbreviated Life Skills Profile (LSP-16)

The Life Skills Profile, also known as the LSP, was developed by an Australian clinical research group to assess a consumer's abilities with respect to basic life skills. Its focus is on the consumer's general functioning and disability rather than their clinical symptoms – that is, how the person functions in terms of social relationships, ability to do day-to-day tasks and so forth. When combined with the HoNOS, which requires ratings of the most serious problem encountered, the LSP contributes towards gaining a more comprehensive understanding of the consumer.

The original form of the LSP consists of 39 items. Work undertaken as part of the Australian Mental Health Classification and Service Costs (MH-CASC) study saw the 39 items reduced to 16 by the original designers in consultation with the MH-CASC research team. This reduction in item number was undertaken to reduce the rating burden on clinicians when the measure is used in conjunction with the HoNOS. The final 16 items selected cover four broad domains:

- withdrawal;
- antisocial behaviour;
- self-care; and
- compliance.

Like the HoNOS, the LSP-16 also takes about five minutes to complete once the clinician gets used to its format and content. The clinician is required to rate the consumer's overall situation over the past three months. This differs from the HoNOS because it is necessary to take a longer-range view to make a proper assessment in these areas, rather than be swayed by the temporary ups and downs that may occur in a person's day-to-day functioning.

As with the HoNOS, the LSP-16 is used both as an outcomes assessment and a casemix measure. The LSP will generally only be used with consumers seen in the community and for those undergoing extended-stay residential care. This is because the LSP is largely designed to measure longer-term functioning and is not suited to brief episodes of hospital care. Individual jurisdictions may however choose to implement the LSP-16 across all treatment settings.

Key references for the LSP (original 39 item version)

Rosen A, Hadzi-Pavlovic D, Parker G (1989) The Life Skills Profile: A measure assessing function and disability in schizophrenia. *Schizophrenia Bulletin*, 1989, 325-337.

Parker G, Rosen A, Emdur N, Hadzi-Pavlov D (1991) The Life Skills Profile: Psychometric properties of a measure assessing function and disability in schizophrenia *Acta Psychiatrica Scandinavica* 83 145-152.

Trauer T, Duckmanton RA, Chiu E (1995) The Life Skills Profile: A study of its psychometric properties. *Australian and New Zealand Journal of Psychiatry*, 29, 492-499.

Key references for the LSP-16 (abbreviated 16 item version)

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*. Canberra: Commonwealth Department of Health and Family Services.

1.3 Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)

This measure is only applicable to consumers aged 65 years and over. Developed by Fries et al for the measurement of nursing dependency in nursing home facilities in the USA, the RUG-ADL measures ability with respect to what are called 'late loss' activities – those activities that are likely to be lost last in life (eg., eating, mobility). 'Early loss' activities (such as dressing and grooming) are included in the LSP.

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

Key references for RUG-ADL

Fries BE, Schneider DP, et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). *Medical Care*, 32, 668-685.

Williams BC (1994) Activities of daily living and costs in nursing homes. *Health Care Financing Review*, 15, 117-135.

1.4 Focus of Care

Focus of Care is a measure developed in the Australian MH-CASC study that requires the clinician to make a judgement about each consumer's primary goal of care. It is a single item requiring selection of one of four options: acute; functional gain, intensive extended care, and maintenance.

The item is based on the concept of 'phase' and recognises that, while individual consumers may experience the same illness over prolonged periods:

- their needs often change over time as they move between stages of the illness; and
- the focus of treatment changes as the person moves between these various phases.

The MH-CASC project represented the first attempt to trial the Focus of Care concept and was motivated by clinician views that some concept like Focus of Care was integral to the definition of clinically meaningful mental health episodes. For example, rather than regarding a prolonged period of community care for an individual consumer as a single episode, it can be broken into multiple episodes, with a new episode beginning each time there is a change in Focus of Care.

An understanding of Focus of Care is also necessary to interpret differences in consumer outcomes because different outcomes can be expected under different goals. For example, the outcome that might be expected for a consumer with a long standing but stable mental illness will differ from that which could be expected in a young person who is acutely ill but has a recent onset of an acute illness. In the first example, the desired outcome might be for the consumer to remain out of hospital, build up their social networks and develop a satisfying life. In the other example, the outcome might be rapid relief from the acute symptoms of mental illness and helping the consumer restore the level of functioning that they had prior to the onset of their illness.

Key references for Focus of Care

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 1: Main Report*. Canberra: Commonwealth Department of Health and Family Services.

1.5 Consumer self-rated measures

While the *National Mental Health Information Priorities* document proposed the national use of a specific self-rated measure (the Mental Health Inventory – MHI), this has been changed to allow States and Territories to introduce an 'agreed' alternative measure. This recognises that limited Australian research has been undertaken on consumer rated measures, and additional exploratory work in this area is important.

Table 2 provides a summary of the consumer self rated measure to be utilised within Australian States and Territories. These are one of the following:

- the Mental Health Inventory (MHI);
- the Behaviour and Symptom Identification Scale (BASIS); and
- the Kessler–10 (K10).

Table 2: State and Territory selected Consumer Self Rated Measures

Jurisdiction	Consumer self-rated outcome measure
Victoria	BASIS 32
NSW	K10
Tasmania	To be determined
ACT	BASIS 32
NT	K10
SA	To be determined
WA	MHI
Queensland	MHI

1.5.1 The Mental Health Inventory (MHI)

The MHI was designed to measure general psychological distress and well-being in the RAND Health Insurance Experiment (Veil & Ware, 1983), a study designed to estimate the effects of different health care financing arrangements on the demand for services as well as on the health status of the patients in the study. The RAND research group developed the MHI alongside another measure (SF-36) used widely in population general health surveys. A number of questions were taken directly from the MHI to make up the mental health subscale of the SF-36. Reflecting its roots in measurement in the general population, the measure includes positive aspects of well-being (such as cheerfulness, interest in and enjoyment of life) as well as negative aspects of mental health (eg., anxiety and depression).

The full form contains 38 items. Each item includes a description of a particular symptom or state of mind, and the respondent indicates on a scale the degree to which they have experienced this in the past month, measured in terms of frequency or intensity. All of the scales, except two, are scored on a six-point scale.

A number of summary scores are derived from the MHI. These include:

- a global Mental Health Index score;
- psychological distress and well-being scores; and
- six sub-scale scores representing anxiety (eg., feeling tense or highly-strung, feeling nervous or jumpy), depression (eg., low spirits, moody), loss of behavioural or emotional control (eg., feeling like crying, concern about losing control of mind), general positive affect (eg., daily life interesting, feeling calm and peaceful), emotional ties (eg., feeling loved and wanted) and life satisfaction..

The MHI can be completed either as a self-report measure or as part of an interview.

Key references for MHI

Veit CT and Ware JE (1983) The structure of psychological distress and well-being in general populations. *Journal of Consulting and Clinical Psychology* , 51 730-742

Davies AR, Sherbourne CD, Peterson JR and Ware JE (1998) *Scoring manual: Adult health status and patient satisfaction measures used in RAND's Health Insurance Experiment*. Santa Monica: RAND Corporation.

1.5.2 Behaviour and Symptom Identification Scale (BASIS)

The BASIS was developed in the early 1990's by a team in the United States for use in outcome assessment. It is described by its authors as being derived from consumer perspectives and covers the major symptoms and functioning difficulties often experienced by people as a result of a mental illness.

The BASIS asks the consumer to respond to 32 questions that assess the extent to which the person has been experiencing difficulties on a range of dimensions. The items differ slightly in their format but each one offers a choice of five responses. The consumer can respond by simply ticking the box to indicate whether they are having no difficulty; a little difficulty; moderate difficulty; quite a bit of difficulty; and extreme difficulty.

The 32 items are grouped into five domains, representing:

- Relation to self and others;
- Daily living and role functioning;
- Depression and anxiety;
- Impulsive and addictive behaviour; and
- Psychosis.

Scores can be derived for each of these groups, and for the whole scale.

Key references for BASIS

Eisen, SV, Dill DL and Grob MC (1994) Reliability and validity of a brief patient-report instrument for psychiatric patient outcome evaluation. *Hospital and Community Psychiatry*, 45, 242-247.

Eisen SV, Dickey B and Sederer LI (2000) A self-report symptom and problem rating scale to increase inpatients' involvement in treatment. *Psychiatric Services*, 51, 349-353.

1.5.3 The Kessler-10 (K10)

The scale was developed by R Kessler at the School of Public Health, Harvard University, Boston (unpublished manuscript) and has been used in Australia's National Survey of Mental Health and Wellbeing and the NSW Health Survey.

The K10 is a ten-item self-report questionnaire intended to yield a global measure of "psychosocial distress" based on questions about the level of anxiety and depressive symptoms in the most recent four-week period. It is designed to span the range from few or minimal symptoms through to extreme levels of distress, which is an essential feature of an instrument for use in population studies. Thus the K10 contains both low-threshold items which many people may endorse, through to high-threshold items which very few will endorse. Within each, there is a five-level response scale based on the amount of time (from none through to all) during a four-week period when the person experienced the particular problem.

The instrument also includes four additional items that are follow-up questions aimed at quantifying the level of disruption and disability resulting from the problems reported, in terms of the degree of limitation of normal activity, and/or seeking help for the problems. This augmented measure is referred as either the K10+ or K10-L3D (where the rating period is the last three days rather than last month).

Overall, the K10 results provide a 'normative' basis for a measure which can readily be employed by health services as a simple 'thermometer' for their populations. With further development it may also suit other purposes, because it is a brief standard measure of psychological distress which has a known relationship to other measures of physical and mental health.

The NSW Health Department has translated the K10 into 15 different languages (Arabic, Bosnian, Chinese, Croatia, Farsi, Greek, Hindi, Italian, Korean, Macedonian, Serbian, Spanish, Tagalog, Turkish, and Vietnamese). It is expected that the translated versions will be available in July 2002.

Key references for Kessler-10

Andrews G and Slade T (2001) Interpreting scores on the K10. *Australian and New Zealand Journal of Public Health*, 25, 494-497.

Note:

Additional resource material is being prepared by the Centre for Mental Health, New South Wales Health Department and will be made available to all jurisdictions. See also <http://www.health.nsw.gov.au/policy/cmh/mhoat>

2. Measures specific to child and adolescent consumers

Three clinical scales will be collected for child and adolescent consumers that are completed by clinicians:

- HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents);
- Children's Global Assessment Scale (CGAS); and
- Factors Influencing Health Status (FIHS).

A standard self-report measure for child and adolescent services has not been included in version 1 of the national specifications. The Strengths and Difficulties Questionnaire (SDQ) has been recommended for routine use by the National Child and Adolescent Outcomes Expert Group. It is however not included in version 1 of the NOCC specification because most jurisdictions do not have the information system capacity to collect and report the data. It will be included in Version 2. Introduction of the SDQ at an earlier stage is at the discretion of individual States and Territories. The SDQ is described below.

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

In response to similar needs that drove the development of the HoNOS, the United Kingdom Department of Health funded the Department of Child and Adolescent Psychiatry at the University of Manchester to develop a brief rating instrument for application by child and adolescent mental health services. The resulting instrument is a 15-item clinician-rated measure modelled on the HoNOS and designed specifically for use in the assessment of child and adolescent consumer outcomes in mental health services (see Table 3). Items 1–13 require assessment of a specific aspect of the 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 very severe problem). In assigning ratings, the clinician makes use of the special glossary prepared for the instrument (see Appendices).

Key references for HoNOSCA

Gowers SG, Harrington RC, Whitton A, Lelliott P, Beevor A, Wing JK, Jezzard R (1999a) 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, 413-416.

Gowers SG, Harrington RC, Whitton A, Beevor A, Lelliott P, Jezzard R, Wing JK (1999b) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433.

See also <http://www.liv.ac.uk/honosca/>

Table 3: The 15 HoNOSCA scales

1	Disruptive, antisocial or aggressive behaviour
2	Problems with over-activity, attention or concentration
3	Non-accidental self injury
4	Alcohol, substance or solvent misuse
5	Problems with scholastic or language skills
6	Physical illness or disability problems
7	Problems associated with hallucinations, delusions, or abnormal perceptions
8	Problems with non-organic somatic symptoms
9	Problems with emotional and related symptoms
10	Problems with peer relationships
11	Problems with self care and independence
12	Problems with family life and relationships
13	Poor school attendance
14	Problems with lack of knowledge or understanding about the nature of the child or adolescent's difficulties
15	Problems with lack of information about services or management of the child or adolescent's difficulties

2.2 Children's Global Assessment Scale (CGAS)

The CGAS is used as the measure of level of functioning for patients seen by specialist child and adolescent mental health services. The instrument was developed by Schaffer and colleagues at the Department of Psychiatry, Columbia University to provide a global measure of severity of disturbance in children and adolescents. Similar to the HoNOSCA, it is designed to reflect the lowest level of functioning for a child or adolescent during a specified period.

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 at each anchor point that depict behaviours and life situations applicable to children and adolescents.

Key references for CGAS

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

2.3 Factors Influencing Health Status (FIHS)

The Factors Influencing Health Status measure is a checklist of 'psychosocial complications' based on the problems and issues identified in the chapter of ICD-10 regarding Factors Influencing Health Status. It was developed specifically as part of the MH-CASC project.

The ICD-10 code descriptors constituting the factors are shown in Table 4.

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 the 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 is present. The seven categories of ICD codes included in the scale were selected on the basis of advice from clinicians about the most frequently occurring factors.

Table 4: Factors influencing health status in child and adolescent mental health consumers

1	Maltreatment syndromes
2	Problems related to negative life events in childhood
3	Problems related to upbringing
4	Problems related to primary support group, including family circumstances
5	Problems related to social environment
6	Problems related to certain psychosocial circumstances
7	Problems related to other psychosocial circumstances

Key references for FIHS

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 1: Main Report*. Canberra: Commonwealth Department of Health and Family Services.

2.4 Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief behavioural screening questionnaire about 4-17 year olds developed by Goodman et al in the United Kingdom. While not included under the National Information Development Agreements, the instrument will be included in Version 2 of the national outcomes and casemix collection specifications.

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 components:

- 25 items on psychological attributes - all versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales:
- emotional symptoms (5 items)

- conduct problems (5 items)
- hyperactivity/inattention (5 items)
- peer relationship problems (5 items)
- prosocial behaviour (5 items).
- Scales 1 – 4 are summed to generate a total difficulties score.
- An impact supplement - several two-sided versions of the SDQ are available with the 25 items on strengths and difficulties on the front of the page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, enquires further about chronicity, distress, social impairment, and burden to others.
- Follow-up questions - the follow-up versions of the SDQ include not only the 25 basic items and the impact question, but also two additional follow-up questions for use after an intervention: Has the intervention reduced problems? Has the intervention helped in other ways, eg. making the problems more bearable?

The basic 25-item version can be completed in 5 minutes by the parents or teachers of children aged 4 - 10 and 11 to 17; there is also a self-report version for 11-17 year olds.

The NSW Health Department has entered into a contractual arrangement with the author Dr Robert Goodman, who holds copyright for the SDQ, to permit NSW Health to use the adapted SDQs and supporting resources in public mental health services. The Agreement will be made available to all jurisdictions to model the copyright arrangements.

Key references for SDQ

Goodman, R. (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38, 581-586.

Goodman, R. & Scott, S. (1999) Comparing the Strengths and Difficulties Questionnaire and the Child Behaviour Checklist: Is small beautiful? *Journal of Abnormal Child Psychology*, 27, 17-24.

Goodman, R. (1999) The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry*, 40, 791-801

Goodman, R, Ford, T, Simmons H, Gatward R and Meltzer H. (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *British Journal of Psychiatry*, 177, 534-539.

See also <http://www.sdqinfo.com>

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Appendices

APPENDIX 1: Health of the Nation Outcome Scales (HoNOS)

HoNOS rating guidelines

- Rate items in order from 1 to 12.
- Use all available information in making your rating.
- Do not include information already rated in an earlier item.
- Consider both the degree of distress the problem causes and the effect it has on behaviour
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks, except at discharge from inpatient care, when it is the previous three days.
- Each item is rated on a five-point item of severity (0 to 4) as follows:

0	No problem.
1	Minor problem requiring no formal action.
2	Mild problem.
3	Problem of moderate severity.
4	Severe to very severe problem.
9	Not known or not applicable.
- As far as possible, the use of rating point 9 should be avoided, because missing data make scores less comparable over time or between settings.
- Specific information on how to rate each point on each item is provided in the Glossary.

HoNOS glossary

1 Overactive, aggressive, disruptive or agitated behaviour

Include such behaviour due to any cause, e.g., drugs, alcohol, dementia, psychosis, depression, etc.

Do not include bizarre behaviour, rated at Scale 6.

- | | |
|---|---|
| 0 | No problems of this kind during the period rated. |
| 1 | Irritability, quarrels, restlessness etc. not requiring action. |
| 2 | Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g., broken cup or window); marked over-activity or agitation. |
| 3 | Physically aggressive to others or animals (short of rating 4); threatening manner; more serious over-activity or destruction of property. |
| 4 | At least one serious physical attack on others or on animals; destruction of property (e.g., fire-setting); serious intimidation or obscene behaviour. |

2 Non-accidental self-injury

Do not include accidental self-injury (due e.g., to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.

Do not include illness or injury as a direct consequence of drug or alcohol use rated at Scale 3, (e.g., cirrhosis of the liver or injury resulting from drunk driving are rated at Scale 5).

- | | |
|---|--|
| 0 | No problem of this kind during the period rated. |
|---|--|

- 1 Fleeting thoughts about ending it all, but little risk during the period rated; no self-harm.
- 2 Mild risk during period; includes non-hazardous self-harm e.g., wrist-scratching.
- 3 Moderate to serious risk of deliberate self-harm during the period rated; includes preparatory acts e.g., collecting tablets.
- 4 Serious suicidal attempt or serious deliberate self-injury during the period rated.

3 Problem drinking or drug-taking

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

Do not include physical illness or disability due to alcohol or drug use, rated at Scale 5.

- 0 No problem of this kind during the period rated.
- 1 Some over-indulgence, but within social norm.
- 2 Loss of control of drinking or drug-taking; but not seriously addicted.
- 3 Marked craving or dependence on alcohol or drugs with frequent loss of control, risk taking under the influence, etc.
- 4 Incapacitated by alcohol or drug problems.

4 Cognitive problems

Include problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia, etc.

Do not include temporary problems (e.g., hangovers) resulting from drug or alcohol use, rated at Scale 3.

- 0 No problem of this kind during the period rated.
- 1 Minor problems with memory or understanding e.g., forgets names occasionally.
- 2 Mild but definite problems, e.g., has lost way in a familiar place or failed to recognise a familiar person; sometimes mixed up about simple decisions.
- 3 Marked disorientation in time, place or person, bewildered by everyday events; speech is sometimes incoherent, mental slowing.
- 4 Severe disorientation, e.g., unable to recognise relatives, at risk of accidents, speech incomprehensible, clouding or stupor.

5 Physical illness or disability problems

Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning.

Include side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drunk driving etc.

Do not include mental or behavioural problems rated at Scale 4.

- 0 No physical health problem during the period rated.
- 1 Minor health problem during the period (e.g., cold, non-serious fall, etc).
- 2 Physical health problem imposes mild restriction on mobility and activity.
- 3 Moderate degree of restriction on activity due to physical health problem.
- 4 Severe or complete incapacity due to physical health problem.

6 Problems associated with hallucinations and delusions

Include hallucinations and delusions irrespective of diagnosis.

Include odd and bizarre behaviour associated with hallucinations or delusions.

Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at Scale 1.

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

7 Problems with depressed mood

Do not include over-activity or agitation, rated at Scale 1.

Do not include suicidal ideation or attempts, rated at Scale 2.

Do not include delusions or hallucinations, rated at Scale 6.

- 0 No problems associated with depressed mood during the period rated.
- 1 Gloomy; or minor changes in mood.
- 2 Mild but definite depression and distress: e.g., feelings of guilt; loss of self-esteem.
- 3 Depression with inappropriate self-blame, preoccupied with feelings of guilt.
- 4 Severe or very severe depression, with guilt or self-accusation.

8 Other mental and behavioural problems

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

- 0 No evidence of any of these problems during period rated.
- 1 Minor non-clinical problems.
- 2 A problem is clinically present at a mild level, e.g., patient/client has a degree of control.
- 3 Occasional severe attack or distress, with loss of control e.g., has to avoid anxiety provoking situations altogether, call in a neighbour to help, etc., that is, a moderately severe level of problem.
- 4 Severe problem dominates most activities.

9 Problems with relationships

Rate the patient's most severe problem associated with active or passive withdrawal from social relationships, and/or non-supportive, destructive or self-damaging relationships.

- 0 No significant problems during the period.
- 1 Minor non-clinical problems.
- 2 Definite problems in making or sustaining supportive relationships: patient complains and/or problems are evident to others.
- 3 Persisting major problems due to active or passive withdrawal from social relationships, and/or to relationships that provide little or no comfort or support.
- 4 Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social relationships.

10 Problems with activities of daily living

Rate the overall level of functioning in activities of daily living (ADL): e.g., problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, organising where to live, occupation and recreation, mobility and use of transport, shopping, self-development, etc.

Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.

Do not include lack of opportunities for exercising intact abilities and skills, rated at Scale 11 and Scale 12.

- 0 No problems during period rated; good ability to function in all areas.
- 1 Minor problems only e.g., untidy, disorganised.
- 2 Self-care adequate, but major lack of performance of one or more complex skills (see above).
- 3 Major problems in one or more areas of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills.
- 4 Severe disability or incapacity in all or nearly all areas of self-care and complex skills.

11 Problems with living conditions

Rate the overall severity of problems with the quality of living conditions and daily domestic routine.

Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones?

Do not rate the level of functional disability itself, rated at Scale 10.

NB: *Rate patient's usual accommodation. If in acute ward, rate the home accommodation. If information not obtainable, rate 9.*

- 0 Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.
- 1 Accommodation is reasonably acceptable although there are minor or transient problems (e.g., not ideal location, not preferred option, doesn't like food, etc).
- 2 Significant problems with one or more aspects of the accommodation and/or regime (e.g., restricted choice; staff or household have little understanding of how to limit disability, or how to help develop new or intact skills).

- 3 Distressing multiple problems with accommodation (e.g., some basic necessities absent); housing environment has minimal or no facilities to improve patient's independence.
- 4 Accommodation is unacceptable (e.g., lack of basic necessities, patient is at risk of eviction, or 'roofless', or living conditions are otherwise intolerable making patient's problems worse).

12 Problems with occupation and activities

Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities, e.g., staffing and equipment of day centres, workshops, social clubs, etc.

Do not rate the level of functional disability itself, rated at Scale 10.

NB: *Rate the patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.*

- 0 Patient's day-time environment is acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.
- 1 Minor or temporary problems, e.g., late pension cheques, reasonable facilities available but not always at desired times etc.
- 2 Limited choice of activities, e.g., there is a lack of reasonable tolerance (e.g., unfairly refused entry to public library or baths etc.); or handicapped by lack of a permanent address; or insufficient carer or professional support; or helpful day setting available but for very limited hours.
- 3 Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access.
- 4 Lack of any opportunity for daytime activities makes patient's problem worse.

HoNOS sample rating sheet

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

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

Key for Item 8

- A Phobias – including fear of leaving home, crowds, public places, travelling, social phobias and specific phobias.
- B Anxiety and panics.
- C Obsessional and compulsive problems.
- D Reactions to severely stressful events and traumas.
- E Dissociative ('conversion') problems.
- F Somatisation – persisting physical complaints in spite of full investigation and reassurance that no disease is present.
- G Problems with appetite, over- or under-eating.
- H Sleep problems.
- I Sexual problems.
- J Problems not specified elsewhere including expansive or elated mood.

HoNOS scoring and subscales

All HoNOS items are answered on an item-specific anchored four-point scale with higher scores indicating more problems.

The 12 HoNOS items can be aggregated into four subscales as shown in below.

The four HoNOS subscales and their component items

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

The total score, E, range 0–48, represents overall severity. Items scored 9 or with missing data are generally excluded from the calculation.

For some purposes, items 11 and 12 may be excluded from this total because they measure features of the consumer's environment rather than of the consumer.

APPENDIX 2: Health of the Nation Outcome Scales for Elderly People (HoNOS65+)

HoNOS65+ rating guidelines

- Rate items in order from 1 to 12.
- Use all available information in making your rating.
- Do not include information already rated in an earlier item.
- Consider both the degree of distress the problem causes and the effect it has on behaviour.
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks, except at discharge from inpatient care, when it is the previous three days (see Chapter 5).
- Each item is rated on a five-point item of severity (0 to 4) as follows:

0	No problem.
1	Minor problem requiring no formal action.
2	Mild problem.
3	Problem of moderate severity.
4	Severe to very severe problem.
9	Not known or not applicable.
- As far as possible, the use of rating point 9 should be avoided, because missing data make scores less comparable over time or between settings.
- Specific information on how to rate each point on each item is provided in the Glossary.

HoNOS65+ glossary

1 **Behavioural disturbance (e.g., overactive, aggressive, disruptive or agitated behaviour, uncooperative or resistive behaviour)**

Include such behaviour due to any cause, e.g., dementia, drugs, alcohol, psychosis, depression, etc.

Do not include bizarre behaviour, rated at Scale 6.

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

virtually constant restlessness or wandering; severe problems related to non-compliant or resistive behaviour.

2 Non-accidental self-injury

Do not include accidental self-injury (due e.g., to dementia or severe learning disability); any cognitive problem is rated at Scale 4 and the injury at Scale 5.

Do not include illness or injury as a direct consequence of drug or alcohol use rated at Scale 3, (e.g., cirrhosis of the liver or injury resulting from drunk-driving are rated at Scale 5).

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

3 Problem drinking or drug-taking

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

Do not include physical illness or disability due to alcohol or drug use, rated at Scale 5.

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

4 Cognitive problems

Include problems of orientation, memory, and language associated with any disorder: dementia, learning disability, schizophrenia, etc.

Do not include temporary problems (e.g., hangovers) which are clearly associated with alcohol, drug or medication use, rated at Scale 3.

- 0 No problem of this kind during the period rated.
- 1 Minor problems with orientation (e.g., some difficulty with orientation to time) or memory (e.g., a degree of forgetfulness but still able to learn new information), no apparent difficulties with the use of language.
- 2 Mild problems with orientation (e.g., frequently disorientated to time) or memory (e.g., definite problems learning new information such as names, recollection of recent events; deficit interferes with everyday activities); difficulty finding way in new or unfamiliar surroundings; able to deal with simple verbal information but some difficulties with understanding or expression of more complex language.

- 3 Moderate problems with orientation (e.g., usually disorientated to time, often place) or memory (e.g., new material rapidly lost, only highly learned material retained, occasional failure to recognise familiar individuals); has lost the way in a familiar place; major difficulties with language (expressive or receptive).
- 4 Severe disorientation (e.g., consistently disorientated to time and place, and sometimes to person) or memory impairment (e.g., only fragments remain, loss of distant as well as recent information, unable to effectively learn any new information, consistently unable to recognise or to name close friends or relatives); no effective communication possible through language or inaccessible to speech.

5 Physical illness or disability problems

Include illness or disability from any cause that limits mobility, impairs sight or hearing, or otherwise interferes with personal functioning (e.g., pain).

Include side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drunk driving etc.

Do not include mental or behavioural problems rated at Scale 4.

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

6 Problems associated with hallucinations and delusions

Include hallucinations and delusions (or false beliefs) irrespective of diagnosis.

Include odd and bizarre behaviour associated with hallucinations or delusions (or false beliefs).

Do not include aggressive, destructive or overactive behaviours attributed to hallucinations, delusions or false beliefs, rated at Scale 1.

- 0 No evidence of delusions or hallucinations during the period rated.
- 1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.
- 2 Delusions or hallucinations (e.g., voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, that is, a present, but mild clinical problem.

- 3 Marked preoccupation with delusions or hallucinations, causing significant distress or manifested in obviously bizarre behaviour, that is, moderately severe clinical problem.
- 4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with a major impact on patient or others.

7 Problems with depressive symptoms

Do not include over-activity or agitation, rated at Scale 1.

Do not include suicidal ideation or attempts, rated at Scale 2.

Do not include delusions or hallucinations, rated at Scale 6.

Rate associated problems (e.g., changes in sleep, appetite or weight; anxiety symptoms) at Scale 8.

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

8 Other mental and behavioural problems

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

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

9 Problems with relationships

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

- 0 No significant problems during the period.
- 1 Minor non-clinical problems.
- 2 Definite problems in making, sustaining or adapting to supportive relationships (e.g., because of controlling manner, or arising out of difficult, exploitative or abusive relationships), definite but mild difficulties reported by patient or evident to carers or others.

- 3 Persisting significant problems with relationships; moderately severe conflicts or problems identified within the relationship by the patient or evident to carers or others.
- 4 Severe difficulties associated with social relationships (e.g., isolation, withdrawal, conflict, abuse); major tensions and stresses (e.g., threatening breaking down of relationship).

10 Problems with activities of daily living

Rate the overall level of functioning in activities of daily living (ADL): e.g., problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, recreation and use of transport, etc.

Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.

Do not include lack of opportunities for exercising intact abilities and skills, rated at Scales 11 and Scale 12.

- 0 No problems during period rated; good ability to function effectively in all basic activities (e.g., continent – or able to manage incontinence appropriately, able to feed self and dress) and complex skills (e.g., driving or able to make use of transport facilities, able to handle financial affairs appropriately).
- 1 Minor problems only without significantly adverse consequences, for example, untidy, mildly disorganised, some evidence to suggest minor difficulty with complex skills but still able to cope effectively.
- 2 Self-care and basic activities adequate (though some prompting may be required), but difficulty with more complex skills (e.g., problem organising and making a drink or meal, deterioration in personal interest especially outside the home situation, problems with driving, transport or financial judgements).
- 3 Problems evident in one or more areas of self-care activities (e.g., needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted) as well as inability to perform several complex skills.
- 4 Severe disability or incapacity in all or nearly all areas of basic and complex skills (e.g., full supervision required with dressing and eating, frequent urinary or faecal incontinence).

11 Problems with living conditions

Rate the overall severity of problems with the quality of living conditions, accommodation and daily domestic routine, taking into account the patient's preferences and degree of satisfaction with circumstances.

Are the basic necessities met (heat, light, hygiene)? If so, does the physical environment contribute to maximising independence and minimising risk, and provide a choice of opportunities to facilitate the use of existing skills and develop new ones?

Do not rate the level of functional disability itself, rated at Scale 10.

***NB:** Rate patient's usual accommodation. If in acute ward, rate the home accommodation. If information not obtainable, rate 9.*

- 0 Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible and minimising any risk, and supportive of self-help; the patient is satisfied with their accommodation.
- 1 Accommodation is reasonably acceptable with only minor or transient problems related primarily to the patient's preferences rather than any significant problems or risks associated with their environment (e.g., not ideal location, not preferred option, doesn't like food).

- 2 Basics are met but significant problems with one or more aspects of the accommodation or regime (e.g., lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems of access); may be associated with risk to patient (e.g., injury) which would otherwise be reduced.
- 3 Distressing multiple problems with accommodation; e.g., some basic necessities are absent (unsatisfactory or unreliable heating, lack of proper cooking facilities, inadequate sanitation); clear elements of risk to the patient resulting from aspects of the physical environment.
- 4 Accommodation is unacceptable: e.g., lack of basic necessities, insecure, or living conditions are otherwise intolerable, contributing adversely to the patient's condition or placing them at high risk of injury or other adverse consequences.

12 Problems with occupation and activities

Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, lack of access to supportive facilities, e.g., staffing and equipment of day centres, social clubs, etc.

Do not rate the level of functional disability itself, rated at Scale 10.

NB: Rate the patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.

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

HoNOS65+ scoring and subscales

See HoNOS for details, Appendix 1.

APPENDIX 3: Abbreviated Life Skills Profile (LSP-16)

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

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

LSP-16 item elaboration and clarification

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

- 1 **Does the person generally have difficulty with initiating and responding to conversation?** Measures the ability to begin and maintain social interaction, ensuring the flow of conversation; taking turns in conversation, silence as appropriate.
- 2 **Does the person generally withdraw from social contact?** Does the person isolate themselves when part of a group? Does the person participate in leisure activities with others? Spend long hours alone watching TV or videos?
- 3 **Does the person generally show warmth to others?** Does the individual demonstrate affection, concern or understanding of situation of others?
- 4 **Is this person generally well groomed (e.g. neatly dressed, hair combed)?** Does the person use soap when washing, shave as appropriate/ use make-up appropriately, use shampoo?
- 5 **Does this person wear clean clothes generally, or ensure that they are cleaned if dirty?** Does the person recognise the need to change clothes on a regular basis? Are clothes grimy, are collars and cuffs marked, are there food stains?
- 6 **Does this person generally neglect her or his physical health?** Does the person have a medical condition for which they are not receiving appropriate treatment? Does the person lead a generally healthy lifestyle? Does the person neglect their dental health?
- 7 **Is this person violent to others?** Does the person display verbal and physical aggression to others?
- 8 **Does this person generally make or keep friendships?** Does the person identify individuals as friends? Do others identify the person as a friend? Does the person express a desire to continue to interact with others?
- 9 **Does this person generally maintain an adequate diet?** Does the person eat a variety of nutritious foods regularly? Do they watch their fat and fibre intake?
- 10 **Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?** Does the person adhere to their medication regimen as prescribed? The right amount at the right time on a regular basis? Does the person need prompting or reinforcement to adhere to their medication regimen?
- 11 **Is this person willing to take prescribed medication when prescribed by a doctor?** Does the person express an unwillingness to take medication as prescribed, bargain or inappropriately question the need for continuing medication?
- 12 **Does this person cooperate with health services (e.g. doctors and/or other health workers)?** Is the person deliberately obstructive in relation to treatment plans? Do they attend appointments, undertake therapeutic homework activities?
- 13 **Does this person generally have problems (eg friction, avoidance) living with others in the household?** Is the person identified as 'difficult to live with'? Do they have difficulty establishing or keeping to "house rules" or are they always having arguments about domestic duties?
- 14 **Does this person behave offensively (includes sexual behaviour)?** Does the person behave in a socially inept or unacceptable way demonstrating inappropriate social or sexual behaviours or communication?
- 15 **Does this person behave irresponsibly?** Does the person act deliberately in ways that are likely to inconvenience, irritate or hurt others? Does the person neglect basic social obligations?
- 16 **What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?** What level of assistance/guidance does the individual require to undertake occupational activities?

LSP-16 scoring and subscales

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

A total LSP scale score is calculated by adding individual scores for the whole scale together. Therefore, for the LSP-16, the total score can range from 0 to 48. Items with missing data are excluded from the calculation.

Four subscale scores can also be calculated by adding together the scores for the items that form each subscale as shown in below.

The Four LSP-16 subscales and their component items

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

APPENDIX 4: The Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL)

Rating guidelines

- *Record what the person actually does, not what they are capable of doing. That is, record their poorest performance during the period rated.*
- *Do not omit any ratings.*
- *It is essential that the rater knows what behaviours and tasks are contained within each scale and has a “working knowledge” of the scale.*

Glossary

1 Bed mobility

Ability to move in bed after the transfer into bed has been completed.

- 1 Independent/supervision: Is able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. No hands-on assistance is required. May be independent with the use of a device.
- 3 Limited assistance: Is able to readjust position in bed, and perform own pressure area relief, with the assistance of one person.
- 4 Other than two-person: Requires use of a hoist or other assisting device to readjust position in bed and physical assist pressure relief. Still requires the assistance of only one person for task.
- 5 Two-person physical assist: Requires to assistants to readjust position, and perform own pressure area relief.

(note: a rating of 2 is not included in the domain of valid ratings)

2 Toileting

Includes mobilising to the toilet, adjustment of clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes.

If the person cares for the catheter or other device independently and is independent on all other tasks, rate 1.

- 1 Independent/supervision: Is able to mobilise to the toilet, adjust clothing, cleans self, has no incontinence or soiling of clothing. All tasks performed independently or with prompting from carer. No hands-on assistance required. May be independent with the use of device.
- 3 Limited assistance: Requires hands-on assistance of one person for one or more of the tasks.
- 4 Other than two-person: Requires the use of a catheter, uridome or urinal, or a colostomy, bedpan or commode chair, or insertion of enema or suppository. Requires the assistance of one person for the management of the device.
- 5 Two-person physical assist: Requires two assistants to perform any step of the task.

(note: a rating of 2 is not included in the domain of valid ratings)

3 Transfer

Includes the transfer in and out of bed, bed to chair, in and out of shower or tub.

- 1 Independent/supervision: Is able to perform all transfers independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
- 3 Limited assistance: Requires hands-on assistance of one person to perform any transfer of the day or night.
- 4 Other than two-person: Requires the use of a device for any of the transfers performed in the day or night.
- 5 Two-person physical assist: Requires two person to perform any transfer of the day or night.

(note: a rating of 2 is not included in the domain of valid ratings)

4 Eating

Includes the tasks of cutting food, bringing food to the mouth and the chewing and swallowing of food. Does not include preparation of the meal.

- 1 Independent/supervision: Is able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. No hands-on assistance required. If individual relies on parenteral or gastrostomy feeding which he or she administers him or her self then rate 1.
- 2 Limited assistance: Requires hands on assistance of one person to set-up or assist in bringing food to mouth, or requires food to be modified (soft or staged diet).
- 3 Extensive assistance/total dependence/tube fed: Person needs to be fed meal by assistant, or if the individual does not eat or drink full meals by mouth but relies on parenteral or gastrostomy feeding and does not administer feeds by him or her self.

RUG-ADL scoring

The total score is calculated as the sum of the 4 item scores, as per the table below. If any item is not completed, it should be treated as a zero score in the total.

Item	Item description	Item score	Summary score
RUGADL item 1	Bed mobility	1–5	
RUGADL item 2	Toileting	1–5	
RUGADL item 3	Transfer	1–5	
RUGADL item 4	Eating	1–3	
RUGADL total score			4–18

APPENDIX 5: Focus of Care

Definitions

Focus of Care is rated retrospectively. Clinicians are asked to identify which of one of four types of care focus best describes the goals of care provided to a consumer over the episode of care. There are four options.

- **Acute**, where the primary emphasis is the short term reduction in severity of symptoms and/or personal distress associated with recent onset or exacerbation of a psychiatric disorder; or
- **Functional gain**, where the main goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder; or
- **Intensive extended**, where the main goal is prevention or minimisation of further deterioration, and reduction of risk of harm for people who have a stable pattern of severe symptoms, frequent relapses; or severe inability to function independently; or
- **Maintenance**, where the goal is to maintain the current status of a consumer who has become stable and is functioning relatively independently.

It is recognised that all of these aspects may be found in the mental health care of any particular consumer. But the concept here is to identify the goal that underpinned the care provided during the episode.

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

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

Focus of Care item clarifications and elaborations

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

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

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

APPENDIX 6: The Mental Health Inventory (MHI)

INSTRUCTIONS: Please read each question and tick the box by the ONE statement that best describes how things have been FOR YOU during the past month. There are no right or wrong answers.

1. How happy, satisfied, or pleased have you been with your personal life during the past month? **(Tick one)**

- 1 Extremely happy, could not have been more satisfied or pleased
 2 Very happy most of the time
 3 Generally, satisfied, pleased
 4 Sometimes fairly satisfied, sometimes fairly unhappy
 5 Generally dissatisfied, unhappy
 6 Very dissatisfied, unhappy most of the time

2. How much of the time have you felt lonely during the past month? **(Tick one)**

- 1 All of the time
 2 Most of the time
 3 A good bit of the time
 4 Some of the time
 5 A little of the time
 6 None of the time

3. How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month? **(Tick one)**

- 1 Always
 2 Very often
 3 Fairly often
 4 Sometimes
 5 Almost never
 6 Never

4. During the past month, how much of the time have you felt that the future looks hopeful and promising? **(Tick one)**

- 1 All of the time
 2 Most of the time
 3 A good bit of the time
 4 Some of the time
 5 A little of the time
 6 None of the time

5. How much of the time, during the past month, has your daily life been full of things that were interesting to you? **(Tick one)**

- 1 All of the time
 2 Most of the time
 3 A good bit of the time
 4 Some of the time
 5 A little of the time
 6 None of the time

6. How much of the time, during the past month, did you feel relaxed and free from tension? **(Tick one)**
- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |
7. During the past month, how much of the time have you generally enjoyed the things you do? **(Tick one)**
- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |
8. During the past month, have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? **(Tick one)**
- 1 No, not at all
- 2 Maybe a little
- 3 Yes, but not enough to be concerned or worried about
- 4 Yes, and I have been a little concerned
- 5 Yes, and I am quite concerned
- 6 Yes, I am very much concerned about it
9. Did you feel depressed during the past month? **(Tick one)**
- 1 Yes, to the point that I did not care about anything for days at a time
- 2 Yes, very depressed almost every day
- 3 Yes, quite depressed several times
- 4 Yes, a little depressed now and then
- 5 No, never felt depressed at all
10. During the past month, how much of the time have you felt loved and wanted? **(Tick one)**
- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

11. How much of the time, during the past month, have you been a very nervous person?
(*Tick one*)

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

12. When you have got up in the morning, this past month, about how often did you expect to have an interesting day? (*Tick one*)

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

13. During the past month, how much of the time have you felt tense or “high-strung”? (*Tick one*)

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

14. During the past month, have you been in firm control of your behaviour, thoughts, emotions or feelings? (*Tick one*)

- | | | | |
|----------------------------|------------------------|----------------------------|---------------------------------|
| 1 <input type="checkbox"/> | Yes, very definitely | 4 <input type="checkbox"/> | No, not too well |
| 2 <input type="checkbox"/> | Yes, for the most part | 5 <input type="checkbox"/> | No, and I am somewhat disturbed |
| 3 <input type="checkbox"/> | Yes, I guess so | 6 <input type="checkbox"/> | No, and I am very disturbed |

15. During the past month, how often did your hands shake when you tried to do something?
(*Tick one*)

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

16. During the past month, how often did you feel that you had nothing to look forward to?
(*Tick one*)

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

17. How much of the time, during the past month, have you felt calm and peaceful? *(Tick one)*

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

18. How much of the time, during the past month, have you felt emotionally stable? *(Tick one)*

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

19. How much of the time, during the past month, have you felt downhearted and blue? *(Tick one)*

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

20. How often have you felt like crying, during the past month? *(Tick one)*

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

21. During the past month, how often have you felt that others would be better off if you were dead? *(Tick one)*

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

22. How much of the time, during the past month, were you able to relax without difficulty? *(Tick one)*

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

23. How much of the time, during the past month, did you feel that your love relationships, loving and being loved, were full and complete? **(Tick one)**

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

24. How often, during the past month, did you feel that nothing turned out for you the way you wanted it to? **(Tick one)**

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

25. How much have you been bothered by nervousness, or your “nerves”, during the past month? **(Tick one)**

- | | | | |
|----------------------------|--|----------------------------|----------------------------------|
| 1 <input type="checkbox"/> | Extremely so, to the point where I could not take care of things | 4 <input type="checkbox"/> | Bothered some, enough to notice |
| 2 <input type="checkbox"/> | Very much bothered | 5 <input type="checkbox"/> | Bothered just a little by nerves |
| 3 <input type="checkbox"/> | Bothered quite a bit by nerves | 6 <input type="checkbox"/> | Not bothered at all by this |

26. During the past month, how much of the life has living been a wonderful adventure for you? **(Tick one)**

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

27. How often, during the past month, have you felt so down in the dumps that nothing could cheer you up? **(Tick one)**

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

28. During the past month, did you think about taking your own life? **(Tick one)**

- 1 Yes, very often
 2 Yes, fairly often
 3 Yes, a couple of times
 4 Yes, at one time
 5 No, never

29. During the past month, how much of the time have you felt restless, fidgety, or impatient? **(Tick one)**

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

30. During the past month, how much of the time have you been moody or brooded about things? **(Tick one)**

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

31. How much of the time, during the past month, have you felt cheerful, lighthearted? **(Tick one)**

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

32. During the past month, how often did you get rattled, upset or flustered? **(Tick one)**

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

33. During the past month, have you been anxious or worried? **(Tick one)**

- 1 Yes, extremely to the point of being sick or almost sick
- 2 Yes, very much so
- 3 Yes, quite a bit
- 4 Yes, some, enough to bother me
- 4 Yes, a little bit
- 5 No, not at all

34. During the past month, how much of the time were you a happy person? **(Tick one)**

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

35. How often during the past month did you find yourself trying to calm down? (*Tick one*)

- | | | | |
|----------------------------|--------------|----------------------------|--------------|
| 1 <input type="checkbox"/> | Always | 4 <input type="checkbox"/> | Sometimes |
| 2 <input type="checkbox"/> | Very often | 5 <input type="checkbox"/> | Almost never |
| 3 <input type="checkbox"/> | Fairly often | 6 <input type="checkbox"/> | Never |

36. During the past month, how much of the time have you been in low or very low spirits? (*Tick one*)

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

37. How often, during the past month, have you been waking up feeling fresh and rested? (*Tick one*)

- | | | | |
|----------------------------|-------------------|----------------------------|------------------------------|
| 1 <input type="checkbox"/> | Always, every day | 4 <input type="checkbox"/> | Some days, but usually not |
| 2 <input type="checkbox"/> | Almost every day | 5 <input type="checkbox"/> | Hardly ever |
| 3 <input type="checkbox"/> | Most days | 6 <input type="checkbox"/> | Never wake up feeling rested |

38. During the past month, have you been under or felt you were under any strain, stress or pressure? (*Tick one*)

- | | |
|----------------------------|---|
| 1 <input type="checkbox"/> | Yes, almost more than I could stand or bear |
| 2 <input type="checkbox"/> | Yes, quite a bit of pressure |
| 3 <input type="checkbox"/> | Yes, some more than usual |
| 4 <input type="checkbox"/> | Yes, some, but about normal |
| 5 <input type="checkbox"/> | Yes, a little bit |
| 6 <input type="checkbox"/> | No, not at all |

MHI scoring and subscales

All of the 38 MHI items, except two, are scored on a six-point scale (range 1-6). Items 9 and 28 are the exception, each scored on a five-point scale (range 1-5). The pre-coded values of each item are shown on the copy of the instrument on the preceding pages.

The MHI may be aggregated into:

- Six subscales – Anxiety, Depression, Loss of Behavioural / Emotional Control, General Positive Affect, Emotional Ties and Life Satisfaction
- Two global scales - Psychological Distress and Psychological Well-being; and
- A global Mental Health Index score

Scoring is made relatively complicated by the fact that items making up the various subscales and global scales may be recoded (or reversed scored) differently depending on the underlying construct being measured.

Details of subscale and global scale scoring are provided below and are based on the following source:

Davies AR, Sherbourne CD, Peterson JR and Ware JE (1998) *Scoring manual: Adult health status and patient satisfaction measures used in RAND's Health Insurance Experiment*. Santa Monica: RAND Corporation.

Scoring the subscales

The subscales are scored in two steps: (1) item scoring; and (2) the subscales themselves. Of the 38 items, 35 are used to score the six mental health subscales (items 2, 22 and 38 are omitted from the subscales). Each item appears in only one subscale. Table 5 shows the mapping of items to the various subscales.

Table 5: Item composition of the six MHI subscales

Subscale	Component items	Subscale directionality	Subscale raw score range
Anxiety	Items 3, 11, 13, 15, 25, 29, 32, 33 and 35	Higher scores = greater Anxiety	9-54
Depression	Items 9, 19, 30 and 36	Higher scores = greater Depression	4-23
Loss of Behavioural / Emotional Control	Items 8, 14, 16, 18, 20, 21, 24, 27 and 28	Higher scores = greater Loss of Behavioural / Emotional Control	9-53
General Positive Affect	Items 4, 5, 6, 7, 12, 17, 26, 31, 34 and 37	Higher scores = greater Positive Affect	10-60
Emotional Ties	Items 10 and 23	Higher scores = stronger Emotional Ties	2-12
Life Satisfaction	Item 1	Higher scores = greater Life Satisfaction	1-6

Note: Three items (2, 22, 38) are not used to score the subscales

When deriving subscale scores, individual item scoring depends on two things:

1. whether higher scores on the coded values of the item responses indicate more frequent or intense occurrence of *favourable* or *unfavourable* mental health symptoms; and
2. whether the item belongs to a *positively* or *negatively* scored mental health subscale.

All subscales are scored so higher scores indicate more of the construct named by the subscale label. Thus, higher scores on three subscales indicate positive states of mental health (General Positive Affect, Emotional Ties, Life Satisfaction); higher scores on the other three subscales indicate negative states of mental health (Anxiety, Depression, Loss of Behavioural/Emotional Control). The aim of item scoring is to ensure that higher scores on each item reflect more of the construct named by the scale to which it belongs

To illustrate this aspect of the MHI, consider a consumer who responds to Item 4 with the value '6':

4. During the past month, how much of the time have you felt that the future looks hopeful and promising? (**Tick one**)

- | | | | |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | All of the time | 4 <input type="checkbox"/> | Some of the time |
| 2 <input type="checkbox"/> | Most of the time | 5 <input type="checkbox"/> | A little of the time |
| 3 <input type="checkbox"/> | A good bit of the time | 6 <input type="checkbox"/> | None of the time |

The consumer's response indicates that this favourable experience occurred very infrequently during the past month. Item 4 forms a component of the subscale General Positive Affect, a *positively scored subscale* (ie. higher scores indicate better mental health). Therefore, for the purpose of deriving the General Positive Affect subscale score, the original response must be reversed so higher scores will indicate more frequent occurrence of a favourable aspect of mental health.

Details of item coding rules for calculating raw subscale scores are shown in Table 6 below. After scoring items as indicated, items belonging to each subscale are summed to give subscale scores.

Table 6: Coding rules for MHI items used to score subscales

Item Number	Code Value	Recoded value
1, 3, 4, 5, 6, 7, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 23, 24, 25, 26, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37	1	6
	2	5
	3	4
	4	3
	5	2
	6	1
8, 14, 18	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
9, 28	1	5
	2	4
	3	3
	4	2
	5	1

Scoring the global scales - Psychological Distress and Psychological Well-being

The Psychological Distress and Psychological Well-being global scales represent complementary summary scales with Psychological Distress indicating negative states of mental health and Psychological Well-being indicating positive states. Together, they use all 38 items to derive the scores (24 items for Distress, 14 items for Well-being) with no item overlap. Table 7 shows the mapping of items to the two global scales.

Table 7: Item composition of the MHI global scales

Global mental health scale	Component items	Subscale directionality	Scale raw score range
Psychological Distress	Items 2, 3, 8, 9, 11, 13, 14, 15, 16, 18, 19, 20, 21, 24, 25, 27, 28, 29, 30, 32, 33, 35, 36 and 38.	Higher scores = greater Psychological Distress	24-142
Psychological Well-being	Items 1, 4, 5, 6, 7, 10, 12, 17, 22, 23, 26, 31, 34 and 37	Higher scores = greater Psychological Well-being	14-84

Like the scoring of the subscales, calculation of the Psychological Distress and Psychological Well-being global scales occurs in two steps: (1) item scoring; and (2) the global subscales themselves. Item scoring depends on two things:

3. whether higher scores on the coded values of the item responses indicate more intense or frequent occurrence of *favourable* or *unfavourable* symptoms of one's mental health; and
4. whether the item belongs to a *positively* or *negatively* scored global scale.

Both global scales are scored so higher scores indicate more of the construct named by the scale's label. Thus, higher scores on Psychological Distress indicate negative states of mental health, while higher scores on Psychological Well-being indicate positive states. Rules for scoring the items used to construct the two global scales are shown in Table 8. After scoring items as indicated, items belonging to each global scale are summed to give scale scores.

Table 8: Coding rules for MHI items used to score the global scales

Item Number	Code Value	Recoded value
<i>Rules used to score Psychological Distress</i>		
2, 3, 4, 11, 13, 15, 16, 19, 20, 21, 24, 25, 27, 29, 30, 32, 33, 35, 36, 38	1	6
	2	5
	3	4
	4	3
	5	2
	6	1
8, 14, 18	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
9, 28	1	5
	2	4
	3	3
	4	2
	5	1

Item Number	Code Value	Recoded value
<i>Rules used to score Psychological Well-being</i>		
1, 4, 5, 6, 7, 10, 12, 17, 22, 23, 26, 31, 34 and 37	1	6
	2	5
	3	4
	4	3
	5	2
	6	1

Scoring the Mental Health Index

The Mental Health Index is a single score based on all 38 items designed as high level summary index of the person's mental health status. High scores on the Mental Health Index indicate greater psychological well being and relatively less psychological distress. The raw score range is 38-226.

The Mental Health Index is calculated in two steps: (1) item scoring; and (2) the Index itself. The objective of item scoring for the Index is to ensure that higher scores on each item reflect more frequent occurrence of favourable mental health symptoms or less frequent occurrence of negative mental health symptoms. Item recoding rules are shown in Table 9. After scoring the 38 items as indicated, item scores are simply summed to calculate the Index score.

Table 9: Coding rules for MHI items used to score the Mental Health Index

Item Number	Code Value	Recoded value
1, 4, 5, 6, 7, 8, 10, 12, 14, 17, 18, 22, 23, 26, 31, 34, 37	1	6
	2	5
	3	4
	4	3
	5	2
	6	1
2, 3, 11, 13, 15, 16, 19, 20, 21, 24, 25, 27, 29, 30, 32, 33, 35, 36, 38	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
9, 28	1	1
	2	2
	3	3
	4	4
	5	5

Summary of item subscale and global scale membership and recoding

Table 10 summarises the mapping of each MHI item to the 6 subscales, two global scales and the overall Mental Health Index as well as indicating whether the item is reverse scored for the purposes of constructing the specific summary measure. Note that if an item is reverse scored for calculating its 'parent' subscale score, it is similarly handled for the calculation of the Psychological Distress and Psychological Well-being global scores. However, the majority of items are handled differently in the construction of the Mental Health Index.

Table 10: Summary of MHI items: Membership and scoring rules for subscales, Global scales and the Mental Health Index

ITEM	SCORE RANGE	SUBSCALES		PSYCHOLOGICAL DISTRESS		PSYCHOLOGICAL WELL-BEING		MENTAL HEALTH INDEX	
		Subscale membership	Reverse scored	Included?	Reverse scored	Included?	Reverse scored	Reverse scored	Flag
1	1-6	Life Satisfaction	Yes			✓	Yes	Yes	
2	1-6			✓	Yes			No	*
3	1-6	Anxiety	Yes	✓	Yes			No	*
4	1-6	General Positive Affect	Yes			✓	Yes	Yes	
5	1-6	General Positive Affect	Yes			✓	Yes	Yes	
6	1-6	General Positive Affect	Yes			✓	Yes	Yes	
7	1-6	General Positive Affect	Yes			✓	Yes	Yes	
8	1-6	Loss of Behav/Emot Control	No	✓	No			Yes	*
9	1-5	Depression	Yes	✓	Yes			No	*
10	1-6	Emotional Ties	Yes			✓	Yes	Yes	
11	1-6	Anxiety	Yes	✓	Yes			No	*
12	1-6	General Positive Affect	Yes			✓	Yes	Yes	
13	1-6	Anxiety	Yes	✓	Yes			No	*
14	1-6	Loss of Behav/Emot Control	No	✓	No			Yes	*
15	1-6	Anxiety	Yes	✓	Yes			No	*
16	1-6	Loss of Behav/Emot Control	Yes	✓	Yes			No	*
17	1-6	General Positive Affect	Yes			✓	Yes	Yes	
18	1-6	Loss of Behav/Emot Control	No	✓	No			Yes	*
19	1-6	Depression	Yes	✓	Yes			No	*
20	1-6	Loss of Behav/Emot Control	Yes	✓	Yes			No	*
21	1-6	Loss of Behav/Emot Control	Yes	✓	Yes			No	*
22	1-6					✓	Yes	Yes	
23	1-6	Emotional Ties	Yes			✓	Yes	Yes	
24	1-6	Loss of Behav/Emot Control	Yes	✓	Yes			No	*
25	1-6	Anxiety	Yes	Y	Yes			No	*
26	1-6	General Positive Affect	Yes			✓	Yes	Yes	
27	1-6	Loss of Behav/Emot Control	Yes	✓	Yes			No	*
28	1-5	Loss of Behav/Emot Control	Yes	✓	Yes			No	*
29	1-6	Anxiety	Yes	✓	Yes			No	*
30	1-6	Depression	Yes	✓	Yes			No	*
31	1-6	General Positive Affect	Yes			✓	Yes	Yes	
32	1-6	Anxiety	Yes	✓	Yes			No	*
33	1-6	Anxiety	Yes	✓	Yes			No	*
34	1-6	General Positive Affect	Yes			✓	Yes	Yes	
35	1-6	Anxiety	Yes	✓	Yes			No	*
36	1-6	Depression	Yes	✓	Yes			No	*
37	1-6	General Positive Affect	Yes			✓	Yes	Yes	
38	1-6			✓	Yes			No	*

* Flag indicates the direction of scoring for calculating the Mental health Index differs from that used to construct the subscale and global scale scores.

APPENDIX 7: The Kessler-10 (K-10)

Data element	K10 item number and description	Item score	Summary score
Core items			
OVER THE PAST 4 WEEKS			
K10 item 01	1. ... how often did you feel tired out for no good reason.	1 – 5	
K10 item 02	2. ... how often did you feel nervous.	1 – 5	
K10 item 03	3. ... how often did you feel so nervous that nothing could calm you down.	1 – 5	
K10 item 04	4. ... how often did you feel hopeless.	1 – 5	
K10 item 05	5. ... how often did you feel restless or fidgety.	1 – 5	
K10 item 06	6. ... how often did you feel so restless you could not sit still.	1 – 5	
K10 item 07	7. ... how often did you feel depressed.	1 – 5	
K10 item 08	8. ... how often did you feel that everything was an effort.	1 – 5	
K10 item 09	9. ... how often did you feel so sad that nothing could cheer you up.	1 – 5	
K10 item 10	10. ... how often did you feel worthless.	1 – 5	
K10 Total score			10 – 50
Additional items			
K10 item 11	11. ... how many days were you totally unable to work, study or manage your day to day activities because of these feelings.	0 – 28	
K10 item 12	12. ... how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of these feelings.	0 – 28	
K10 item 13	13. ... how many times have you seen a doctor or any other health professional about these feelings	0 – 89	
K10 item 14	14. ... how often have physical health problems been the main cause of these feelings.	1 – 5	

Scoring:

- 1 None of the time
- 2 A little of the time
- 3 Some of the time
- 4 Most of the time
- 5 All of the time

K10 scoring

The K10 Total score is based on the sum of K10 item 01 through 10 (range: 10-50). Items 11 through 14 are excluded because they refer to the degree of disability associated with the problems referred to in the preceding ten items.

The Total score is computed using the equation shown below, with the result being rounded to the nearest whole number. If any item has not been completed (that is, has not been coded 1, 2, 3, 4, 5), it is excluded from the calculation and not counted as a valid item. If more than one item is missing, the Total Score is set as missing.

$$Total\ score = \left(\frac{Sum\ of\ (Item\ scores)}{N\ of\ valid\ (completed)\ Items} \right) \times Number\ of\ Items$$

Standard values must be used for coding missing item and Total scores. For individual items, the missing values are 7, 8 and 9 (ie, is coded 7 (unable to rate), 8 (Protocol exclusion) or 9 (missing data)). For the Total score, the missing value used should be 99.

APPENDIX 8: 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 (see Chapter 5).
- 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 (e.g., pushing, hitting, vandalism, teasing), or physical or sexual abuse of other children.

Include antisocial behaviour (e.g., thieving, lying, cheating) or oppositional behaviour (e.g., 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, e.g., 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, e.g., collecting tablets) or moderate non-hazardous self-harm (e.g., small overdose).
- 4 Serious suicidal attempt (e.g., 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 (e.g., 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 (e.g., paranoid ideas, illusions or body image disturbance), but there is little distress or manifestation in bizarre behaviour, i.e., 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, e.g., 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, e.g., 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, e.g., 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, e.g., some episodes of neglect or hostility or enmeshment or overprotection.
- 3 Moderate problems, e.g., 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, e.g., 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, e.g., late for two or more lessons.
- 2 Definite but mild problems, e.g., 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	<input type="text"/>
Section B: Problems for the child, parent or carer relating to lack of information or access to services.							
14	Lack of knowledge – nature of difficulties	0	1	2	3	4	<input type="text"/>
15	Lack of information – services/management	0	1	2	3	4	<input type="text"/>

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

Scale	Scale item	Section
1	Disruptive, antisocial or aggressive behaviour	Behaviour
2	Over-activity, attention or concentration	
3	Non-accidental self-injury	
4	Alcohol, substance/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.

APPENDIX 9: Children's Global Assessment Scale (CGAS)

Rating guidelines

Rate the patient's most impaired level of general functioning for the specified time period by selecting the *lowest* level which describes his/her current 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.

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 (e.g., 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 (e.g., 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 (e.g., 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** (e.g., 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** (i.e., disturbed at home, at school, with peers, or in society at large, e.g., 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** e.g., 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 (e.g., sometimes incoherent or inappropriate).
- 20-11 **Needs considerable supervision** to prevent hurting others or self (e.g., frequently violent, repeated suicide attempts) *or* to maintain personal hygiene *or* gross impairment in all forms of communication, e.g., 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.

APPENDIX 10: Factors Influencing Health Status (FIHS)

Rating guidelines

The clinician is required to rate the items retrospectively, at the end of the episode or at 90-day review.

Completing the scale simply requires, for each item, an indication of whether any of the listed factors required special clinical evaluation, therapeutic treatment, diagnostic procedures or increased clinical care and/or monitoring during the course of the episode.

FIHS item elaboration

- | | YES | NO | |
|---|--------------------------|--------------------------|--|
| 1 | <input type="checkbox"/> | <input type="checkbox"/> | <p>Maltreatment syndromes
 <i>Includes:</i></p> <ul style="list-style-type: none"> • neglect or abandonment; • physical abuse; • sexual abuse; and • psychological abuse. |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> | <p>Problems related to negative life events in childhood
 <i>Includes:</i></p> <ul style="list-style-type: none"> • loss of love relationship in childhood; • removal from home in childhood; • altered pattern of family relationships in childhood; • problems related to <u>alleged</u> sexual abuse of child by person within primary support group; • problems related to <u>alleged</u> sexual abuse of child by person outside primary support group; • problems related to <u>alleged</u> physical abuse of child; • personal frightening experience in childhood; and • other negative life events in childhood. |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> | <p>Problems related to upbringing
 <i>Includes:</i></p> <ul style="list-style-type: none"> • inadequate parental supervision and control; • parental overprotection; • institutional upbringing; • hostility towards and scapegoating of child; • emotional neglect of child; • other problems related to neglect in upbringing; • inappropriate parental pressure and other abnormal qualities of upbringing; and • other specified problems related to upbringing. |

- | | YES | NO | |
|---|--------------------------|--------------------------|---|
| 4 | <input type="checkbox"/> | <input type="checkbox"/> | <p>Problems related to primary support group, including family circumstances</p> <p><i>Includes:</i></p> <ul style="list-style-type: none"> • problems in relationship with spouse or partner; • problems in relationship with parents and in-laws; • inadequate family support; • absence of family member; • disappearance and death of family member; • disruption of family by separation and divorce; • dependent relative needing care at home; • other stressful life events affecting family and household; • other specified problems related to primary support group; • problem related to primary support group; and • unspecified. |
| 5 | <input type="checkbox"/> | <input type="checkbox"/> | <p>Problems related to social environment</p> <p><i>Includes:</i></p> <ul style="list-style-type: none"> • problems of adjustment to life cycle transitions; • atypical parenting situation; • living alone; • acculturation difficulty; • social exclusion and rejection; and • target of perceived adverse discrimination and persecution. |
| 6 | <input type="checkbox"/> | <input type="checkbox"/> | <p>Problems related to certain psychosocial circumstances</p> <p><i>Includes:</i></p> <ul style="list-style-type: none"> • problems related to unwanted pregnancy; • problems related to multiparity; • seeking and accepting physical, nutritional and chemical interventions known to be hazardous and harmful; • seeking and accepting behavioural and psychological interventions known to be hazardous or harmful; and • discord with counsellors. |
| 7 | <input type="checkbox"/> | <input type="checkbox"/> | <p>Problems related to other psychosocial circumstances</p> <p><i>Includes:</i></p> <ul style="list-style-type: none"> • conviction in civil and criminal proceedings without imprisonment; • imprisonment and other incarceration; • problems related to release from prison; • problems related to other legal circumstances; • victim of crime and terrorism; • exposure to disaster; and • war and other hostilities. |

FIHS scoring

The summary score derived from the items is simply the count of positive (Yes) responses.

APPENDIX 11: Strengths and Difficulties Questionnaire (SDQ)

Extensive support materials are available on the SDQ developers' website, including copies of the various versions of the instrument, back ground information and scoring instructions. See <http://www.sdqinfo.com>.

In the pages that follow, the SDQ self-report and parent-rated versions used for 11-17 year olds are from the Annexure to the contract between Dr Goodman and the NSW Health Department and are included here for sample purposes only. Other versions can be found on the website listed above.

YR1
Youth Report Measures for
Children and Adolescents
SDQ(S)11-17

Facility Name: _____

Code: |_|_|_|_|_|

Please used gummed label if available

Patient or Client Identifier: _ _ _ _ _ _ _ _ _ _ _ _ _ _	
Surname:	Other names:
Date of Birth: ____/____/____	Sex: Male <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:	

Instructions: For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you **over the last six months.**

Strengths and Difficulties Questionnaire	Not True	Somewhat True	Certainly True
1. I try to be nice to other people. I care about their feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I am restless, I cannot stay still for long	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I get a lot of headaches, stomach-aches, or sickness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I usually share with others, for example CDs, games, food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I get very angry and often lose my temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I would rather be alone than with people of my age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I usually do as I am told	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I worry a lot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I am helpful if someone is hurt, upset or feeling ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I am constantly fidgeting or squirming	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I have one good friend or more	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I fight a lot. I can make other people do what I want	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I am often unhappy, depressed or tearful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Other people my age generally like me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I am easily distracted, I find it difficult to concentrate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I am nervous in new situations. I easily lose confidence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I am kind to younger children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I am often accused of lying or cheating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Other children or young people pick on me or bully me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I often offer to help others (parents, teachers, children)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I think before I do things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I take things that are not mine from home, school or elsewhere	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I get along better with adults than with people my own age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I have many fears, I am easily scared	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I finish the work I'm doing. My attention is good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please turn over – there are a few more questions on the other side

Do you have any other comments or concerns?

	No	Yes – minor difficulties	Yes – definite difficulties	Yes – severe difficulties
26. Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you have answered “Yes”, please answer the following questions about these difficulties:

	Less than a month	1-5 months	6-12 months	Over a year
27. How long have these difficulties been present?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not at all	A little	A medium amount	A great deal
28. Do the difficulties upset or distress you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do the difficulties interfere with your everyday life in the following areas?				
29. HOME LIFE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. FRIENDSHIPS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. CLASSROOM LEARNING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. LEISURE ACTIVITIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Your Signature _____

Today's Date _____

Thank you very much for your help.

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PY1
Parent Report Measures for
Children and Adolescents
SDQ(P)11-17

Facility Name: _____

Code: _____

Please used gummed label if available

Patient or Client Identifier: _____	
Surname: _____	Other names: _____
Date of Birth: _____ / _____ / _____	Sex: Male <input type="checkbox"/> _1 Female <input type="checkbox"/> _2
Address: _____	

Instructions: For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behaviour **over the last six months.**

Strengths and Difficulties Questionnaire	Not True	Somewhat True	Certainly True
1. Considerate of other people's feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Restless, overactive, cannot stay still for long	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Often complains of headaches, stomach-aches, or sickness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Shares readily with other youth, for example CDs, games, food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Often loses temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Would rather be alone than with other youth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Generally well behaved, usually does what adults request	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Many worries or often seems worried	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Helpful if someone is hurt, upset or feeling ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Constantly fidgeting or squirming	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Has at least one good friend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Often fights with other youth or bullies them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Often unhappy, depressed or tearful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Generally liked by other youth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Easily distracted, concentration wanders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Nervous or clingy in new situations, easily loses confidence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Kind to younger children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Often lies or cheats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Picked on or bullied by other youth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Often offers to help others (parents, teachers, children)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Thinks things out before acting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Steals from home, school or elsewhere	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Gets along better with adults than with other youth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Many fears, easily scared	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Good attention span, sees chores or homework through to the end	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please turn over – there are a few more questions on the other side

Do you have any other comments or concerns?

		No	Yes – minor difficulties	Yes – definite difficulties	Yes – severe difficulties
26.	Overall, do you think that your child has difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you have answered “Yes”, please answer the following questions about these difficulties:

	Less than a month	1-5 months	6-12 months	Over a year	
27.	How long have these difficulties been present?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not at all	A little	A medium amount	A great deal	
28.	Do the difficulties upset or distress your child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Do the difficulties interfere with your child’s everyday life in the following areas?				
29.	HOME LIFE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30.	FRIENDSHIPS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31.	CLASSROOM LEARNING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32.	LEISURE ACTIVITIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33.	Do the difficulties put a burden on you or the family as a whole?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SDQ (P) 11-17 SELF-REPORT MEASURE (2 of 2)

Signature _____ Date _____

Mother/Father/Other (please specify): _____

Thank you very much for your help.

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Scoring the Strengths and Difficulties Questionnaire

The first 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. Somewhat True is always scored as 1, but the scoring of Not True and Certainly True varies with item, as shown by below scale by scale. For each of the 5 scales the score can range from 0 to 10 if all 5 items were completed. Scale score can be pro-rated if at least 3 items were completed.

Note: Item numbers are shown in brackets following each

Emotional Symptoms Scale	Not True	Somewhat True	Certainly True
Often complains of headaches, stomach-aches ... (3)	0	1	2
Many worries, often seems worried (8)	0	1	2
Often unhappy, downhearted or tearful (13)	0	1	2
Nervous or clingy in new situations ... (16)	0	1	2
Many fears, easily scared (24)	0	1	2

Conduct Problems Scale	Not True	Somewhat True	Certainly True
Often has temper tantrums or hot tempers (5)	0	1	2
Generally obedient, usually does what... (7)	2	1	0
Often fights with other children or bullies them (12)	0	1	2
Often lies or cheats (18)	0	1	2
Steals from home, school or elsewhere (22)	0	1	2

Hyperactivity Scale	Not True	Somewhat True	Certainly True
Restless overactive, cannot stay still for long (2)	0	1	2
Constantly fidgeting or squirming (10)	0	1	2
Easily distracted, concentration wanders (15)	0	1	2
Thinks things out before acting (21)	2	1	0
Sees tasks through to the end, good attention span (25)	2	1	0

Peer Problems Scale	Not True	Somewhat True	Certainly True
Rather solitary, tends to play alone (6)	0	1	2
Has at least one good friend (11)	2	1	0
Generally liked by other children (14)	2	1	0
Picked on or bullied by other children (19)	0	1	2
Gets on better with adults than with other children (23)	0	1	2

Prosocial Scale	Not True	Somewhat True	Certainly True
Considerate of other people's feelings (1)	0	1	2
Shares readily with other children (4)	0	1	2
Helpful if someone is hurt, upset or feeling ill (9)	0	1	2
Kind to younger children (17)	0	1	2
Often volunteers to help others (20)	0	1	2

The Total Difficulties Score:

is generated by summing the scores from all the scales except the prosocial scale. The resultant score can range from 0 to 40 (and is counted as missing if one of the component scores is missing).

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Interpreting Symptom Scores and Defining 'Caseness' from Symptom Scores

Although SDQ scores can often be used as continuous variables, it is sometimes convenient to classify scores as normal, borderline and abnormal. Using the bandings shown below, an abnormal score on one or both of the total difficulties scores can be used to identify likely 'cases' with mental health disorders. This is clearly only a rough and ready method for detecting disorders – combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect. Approximately 10 % of a community sample scores in the abnormal band on any given score, with a further 10% scoring in the borderline band. The exact proportions vary according to country, age and gender – normative SDQ data are available from the website. You may want to adjust banding and caseness criteria for these characteristics, setting the threshold higher when avoiding false positives is of paramount importance, and setting the threshold lower when avoiding false negatives is more important.

Self Completed	Normal	Borderline	Abnormal
Total Difficulties Score	0-15	16-19	20-40
Emotional Symptoms Score	0-5	6	7-10
Conduct Problems Score	0-3	4	5-10
Hyperactivity Score	0-5	6	7-10
Peer Problems Score	0-3	4-5	6-10
Prosocial Behaviour Score	6-10	5	0-4

Parent Completed	Normal	Borderline	Abnormal
Total Difficulties Score	0-13	14-16	17-40
Emotional Symptoms Score	0-3	4	5-10
Conduct Problems Score	0-2	4	5-10
Hyperactivity Score	0-2	3	4-10
Peer Problems Score	0-2	3	4-10
Prosocial Behaviour Score	6-10	5	0-4

Teacher Completed	Normal	Borderline	Abnormal
Total Difficulties Score	0-11	12-15	16-40
Emotional Symptoms Score	0-4	5	6-10
Conduct Problems Score	0-2	3	4-10
Hyperactivity Score	0-5	6	7-10
Peer Problems Score	0-3	4	5-10
Prosocial Behaviour Score	6-10	5	0-4

Generating and Interpreting Impact Scores

When using a version of the SDQ that includes an 'Impact Supplement', the items on overall distress and social impairment can be summed to generate an impact score that ranges from 0 to 10 for the self report and parent-completed versions and from 0-6 for the teacher-completed version.

Self report	Not at all	A little	A medium amount	A great deal
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2

Parent Report	Not at all	A little	A medium amount	A great deal
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2

Teacher Report	Not at all	A little	A medium amount	A great deal
Difficulties upset or distress child	0	0	1	2
Interfere with PEER RELATIONSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered 'no' to the first question on the impact supplement (i.e. when they do not perceive the child as having any emotional or behavioural difficulties), they are not asked to complete the questions on resultant distress or impairment; the impact score is automatically scored zero in these circumstances.

Although the impact scores can be used as continuous variables, it is sometimes convenient to classify them as normal, borderline or abnormal: a total impact score of 2 or more is abnormal; a score of 1 is borderline; and a score of 0 is normal.