

National Outcomes and Casemix Collection

National Outcomes and Casemix Collection
Clinicians' reference guide - Version 2, 2009

Clinicians' reference guide
Version 2
2009

For more information

MH-CIAO Team
SA Health
PO Box 287 Rundle Mall
Telephone: (08) 8226 7351
Fax: (08) 8226 6235
www.health.sa.gov.au

TTY calls: for people who are deaf or have hearing/speech impairments, contact (08) 8233 2574.
Non-English speaking: for information in languages other than English, call the interpreting and Translating Centre and ask them to call The Department of Health. This service is available at no cost to you, contact (08) 8226 1990.

© Department of Health, Government of South Australia.
All rights reserved. ISBN: 978-1-74243-993-8
FIS: 9080. Printed August 2009.



© SA Health, South Australia

SA Health acknowledges the NSW Health Department and materials prepared for the MH-OAT Initiative.

In particular, the work of Allen Morris-Yates, Jennifer Chipps, Tim Coombs, Carolyn Muir and Gavin Stewart.

For further copies, please contact:

MH-CIAO Team

SA Health

PO Box 287 Rundle Mall

ADELAIDE SA 5000

Ph: (08) 8226 7351

Fax: (08) 8226 6235

Document version control

Version 1.1 February 2004

Version 2 May 2009

Contents

1 The Outcome Measures	5
2 The Data Collection Protocol	11
3 Collection of Clinician-rated Outcome Measures	13
3.1 Collection Occasions	15
4 Collection of the Consumer self report Measures:	
K10+ and Strengths and Difficulties Questionnaire	17
4.1 Good practice guide to offering a Consumer rated Measure	18
4.2 Administration and Completion of the Consumer self-rated Measure	19
4.3 Addressing Problems and questions	20
4.4 Collection Status	26
5 Child and Adolescent measures	27
5.1 Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA)	27
5.2 Children's Global Assessment Scale (CGAS)	38
5.3 Factors Influencing Health Status and Contact with Health Services	40
5.4 Interpreting SDQ Symptom Scores	41
6 Adult Measures	43
6.1 Health of the Nation Outcomes Scale (HoNOS)	43
6.2 Life Skills Profile (LSP-16)	51
6.3 Focus of Care: Item Clarifications and Elaborations	53
7 Older Persons 65+ Measures	55
7.1 Health of the Nation Outcomes Scale (HoNOS65+)	55
7.2 Life Skills Profile (LSP-16)	65
7.3 Focus of Care: Item Clarifications and Elaborations	67
7.4 RUGADL - Resource Utilisation Groups – Activities of Daily Living	69
8 Additional Data Items	71
8.1 Principal and Additional Diagnoses	71
8.2 Mental Health Legal Status	71
9 ICD-10 AM – International Statistical Classification of Diseases and related health problems, Australian Modification Code list	73
9.1 Mental Health Diagnosis (ICD-10-AM)	74
9.2 Other conditions from ICD-10 AM often associated with Mental and Behavioural disorders (A00 – Y98)	77
9.3 Factors Influencing Health Status and Contact with Health Services	80
10 Additional Resource Material	81

Reference Materials

There are numerous documents that should be read or referred to in conjunction with the clinicians' reference guide, some of which are listed below.

National documents:

- > National Mental Health Plan
- > National Mental Health Policy
- > National Practice Standards for the Mental Health workforce
- > National Standards for Mental Health Services
- > National Mental Health Information Priorities

Web site reference:

Australian Government, Department of Health and Ageing, National Mental Health publications, source the latest published versions of the above National documents:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs>

State documents:

- > SA Health Strategic Plan
<http://in.health.sa.gov.au/policyandintergovernmentrelations/Default.aspx?tabid=168>
- > Stepping Up Report
- > Stepping Up - A Social Inclusion Action Plan for Mental Health Reform 2007-2012
<http://www.health.sa.gov.au/mentalhealth/Default.aspx?tabid=36>
- > Code of Fair Information Practice
http://10.22.161.35:8080/policies/documents/Code_of_fair_info_practice.pdf
- > Mental Health Act 2009
- > The Mental Health Care Plan Information booklet
- > The Combined Regions Mental Health Assessment and Risk Assessment business rules
- > National Outcome and Casemix Collection - Mental Health Protocols for South Australia

Web site reference:

SA Mental Health Intranet, follow the links for Publications and for NOCC Resources:

<http://in.health.sa.gov.au/operations/Default.aspx?tabid=955>

Australian Mental Health Outcomes and Classification Network (AMHOCN)

Key documents, source the latest published versions from this site, including:

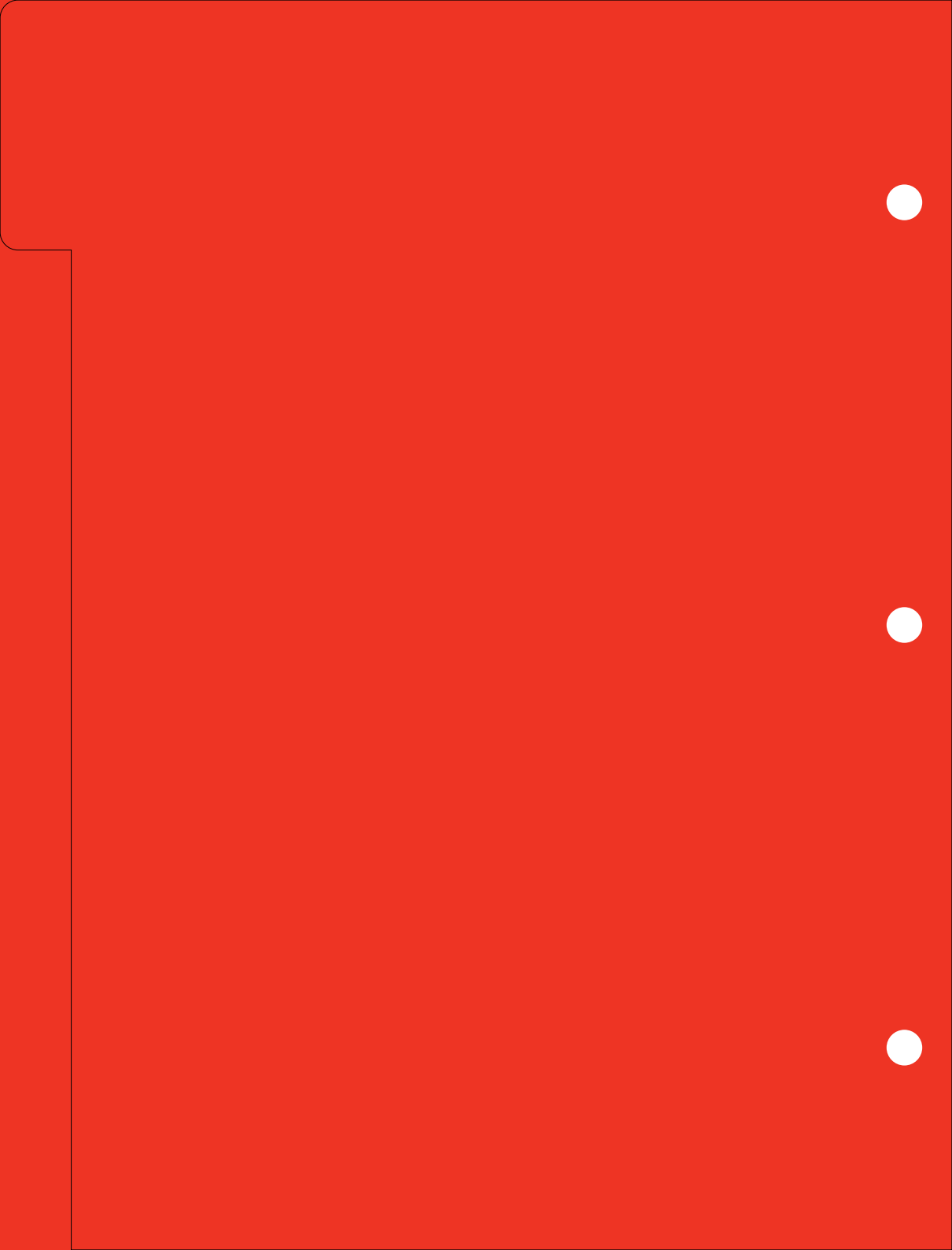
- > Mental Health National Outcomes and Casemix Collection - Technical specification of State and Territory reporting requirements
- > Mental Health National Outcomes and Casemix Collection - Overview of clinician rated and consumer self report measures and data items

Web site reference:

AMHOCN web site, follow the links for resources: <http://www.mhnocc.org/>

The Outcome Measures





1 The Outcome Measures

Outcome Measures and Rating Periods provides an overview of the outcome measures selected for introduction into routine clinical practice and the standard rating periods of the individual measures.

Outcome Measures and Rating Periods

Outcome measure	Usual rating period	Exceptions
K10+	Previous 4 Weeks	No exceptions
HoNOS / HoNOS 65+	Previous 2 weeks	3 days at Discharge from Inpatient psychiatric care
LSP	Previous 3 months (91 days) or the Preceding period	No exceptions
RUG-ADL	Current status	No exceptions
HoNOSCA	Previous 2 weeks	3 days at Discharge from Inpatient psychiatric care
CGAS	Previous 2 weeks	No exceptions
FIHS	Preceding period	No exceptions
SDQ	Last month	On admission to service – Last 6 months
Focus of Care	Preceding period	No exceptions

The Outcome Measures

Descriptions of Outcome Measures provides a brief description of each of the outcome measures.

Descriptions of Outcome Measures

Measures for Consumers of Child and Adolescent Mental Health Services	
HoNOS for Children & Adolescents (HoNOSCA)	Child and Adolescent equivalent to the HoNOS. Contains 15 items.
Children's' Global Assessment Scale (CGAS)	A single global measure of level of functioning, rated 0-100 in order of improved functioning.
ICD–10 Factors Influencing Health Status (FIHS)	Checklist of 'psychosocial complications' based on ICD–10 Factors Influencing Health Status
Strengths and Difficulties Questionnaire (SDQ)	A parent and child completed brief behavioural questionnaire administered on admission and follow up to health services for 4-17 year olds. It includes 25 items on psychological attributes for 5 scales: Emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and psychosocial behaviour. It also includes items on the impact of these attributes.
Measures for Consumers of Adult Mental Health Services	
Health of the Nation Outcome Scales (HoNOS)	An instrument developed in the United Kingdom for use by clinicians in their routine clinical work to measure consumer outcomes. Contains 12 items, across four outcome domains: Behaviour, Impairment, Symptoms and Social.
Life Skills Profile (LSP)	A clinician completed rating scale designed to assess abilities with respect to basic life skills over the preceding three months. Any of three versions of the LSP may be used, with 39, 20 or 16 items respectively.
The Kessler 10+ (K10+)	The Kessler 10 (K10) is a psychological distress measure with four additional items. A consumer-completed 10 item questionnaire designed to measure psychological distress. The recommended instrument also includes an additional 4 items rating impact and contribution of physical health problems.

Measures for Consumers of Older Persons Mental Health Services	
Health of the Nation Outcome Scales for Older People (HoNOS 65+)	A modified version of the HoNOS for people 65+
Life Skills Profile (LSP)	A clinician completed rating scale designed to assess abilities with respect to basic life skills over the preceding three months.
Resource Utilisation Groups-Activities Daily Living Scale (RUG-ADL)	An instrument for the measurement of nursing dependency in skilled nursing facilities. Measure the patient's needs for assistance in activities of daily living. (Eating, bed mobility, transferring and toileting).
The Kessler 10+ (K10+)	The Kessler 10 (K10) is a psychological distress measure with 4 additional items. A consumer-completed 10 item questionnaire designed to measure psychological distress. The recommended instrument also includes an additional 4 items rating impact and contribution of physical health problems.

The Outcome Measures

Copyright notices for outcome measures outlines the copyright for the outcome measures.

Copyright notices for outcome measures

Standardised Measure	Copyright Notice
Health of the Nation Outcome Scales (HoNOS) – adult, child and elderly persons versions	<p>The UK Department of Health and Her Majesty's Stationary Office has advised the Commonwealth that:</p> <p>"HoNOS may be reused in any format, free of charge under HMSO's new 'Click Use Licence' http://www.clickanduse.hmso.gov.uk</p> <p>Additionally, the principal authors of the HoNOS, HoNOSCA and HoNOS65+ have advised the Commonwealth that the instruments are in the public domain and may be used free of cost.</p>
Life Skills Profile	<p>Copyright on this instrument is held by the authors (Rosen A, Parker G, Hadzi-Pavlovic D) who have advised the Commonwealth as follows:</p> <p>"The authors of the LSP are pleased to give permission for the unlimited use of the LSP-16 to all mental health services in Australia, both public and private, for routine use, without cost."</p>
Focus of Care	<p>The Commonwealth holds copyright on this measure and grants permission for its use subject to the inclusion of an acknowledgment of the source and no commercial usage or sale.</p>
Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)	<p>The measure is used widely throughout the Australian Public Sector with no license costs attached. Usage should acknowledge the source: Fries BE, Schneider DP et al (1994). Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). Medical Care, 32, 668-685.</p>

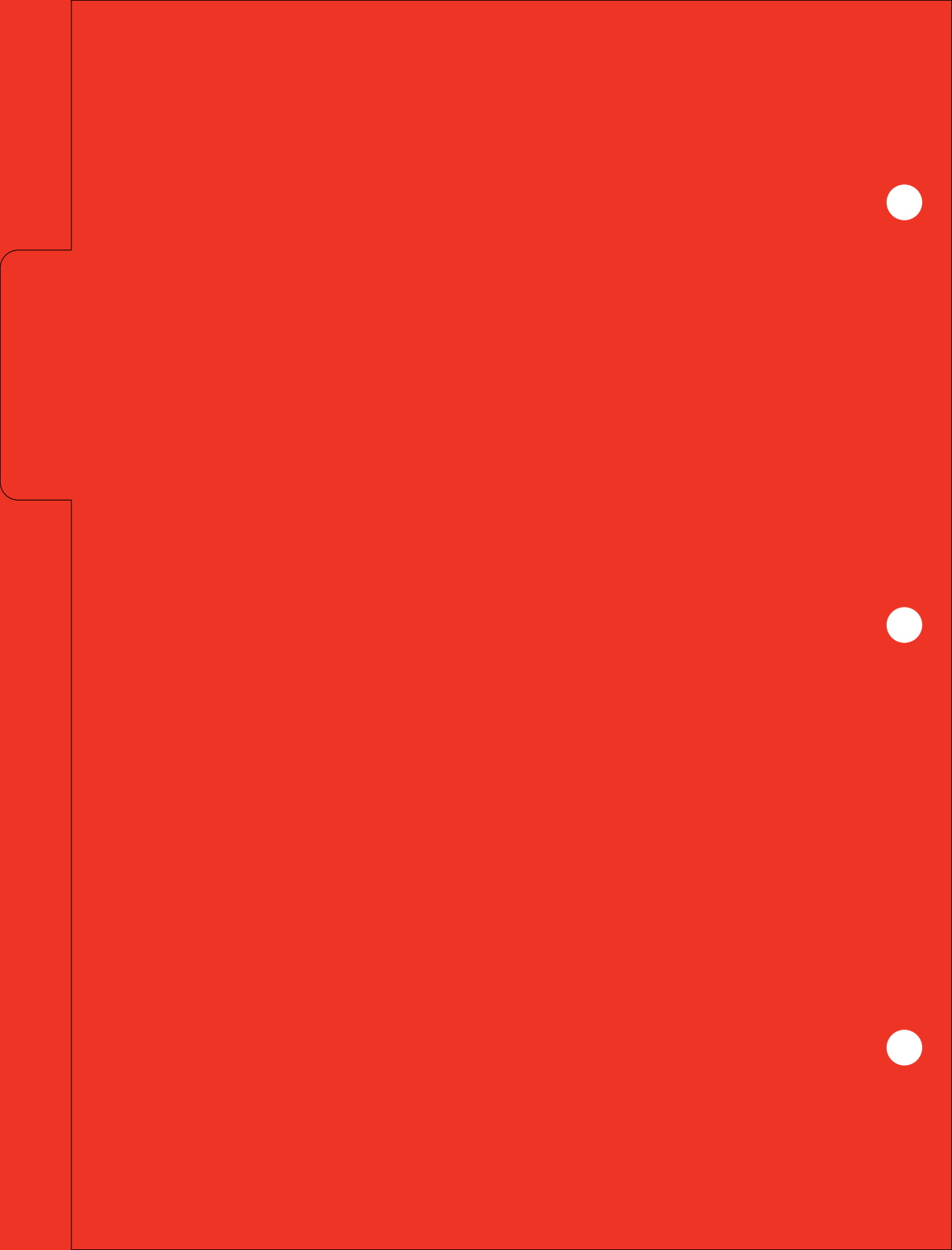
The Kessler 10+ (K10+)	Usage should acknowledge the following: "Professor Ronald C Kessler of the Department of Health Care Policy, Harvard Medical School is thanked for the use of research on the K10 funded by US Public Health Service Grants RO1 MH46376, R01 MH52861, RO1 MH49098, and K05 MH00507 and by the John D and Catherine T MacArthur Foundation Network on Successful Midlife Development (Gilbert Brim, Director)."
Children's Global Assessment Scale (CGAS)	Research instrument, used widely throughout child and adolescent mental health services. Usage should acknowledge the source: Schaffer D, Gould MS, Brasic J et al (1983). A Children's Global Assessment Scale (CGAS). Archives of General Psychiatry, 40, 1228-1231.
ICD-10 Factors Influencing Health Status (FIHS)	The Commonwealth holds copyright on this measure and grants permission for its use subject to the inclusion of an acknowledgment of the source and no commercial usage or sale.
Strengths and Difficulties Questionnaire (SDQ)	The author (Robert Goodman) holds copyright on this instrument. Approval for the use of this instrument in South Australia was negotiated with Dr Goodman in February 2004.





The Data Collection Protocol





2 The Data Collection Protocol

The data collection protocol provides guidelines for the collection of outcome measures in designated mental health facilities referred to as Inpatient mental health care, Community residential mental health care, and for Ambulatory mental health care. *Overview of Data Collection Protocol* outlines which measures are to be completed at different points in the delivery of care.

Overview of Data Collection Protocol

	Inpatient			Community residential			Ambulatory		
	A	R	D	A	R	D	A	R	D
Children and Adolescents									
HoNOS-CA	✓	✓	✓	✓	✓	✓	✓	✓	✓
Children's Global Assessment Scale	✓	✓		✓	✓		✓	✓	
Factors Influencing Health Status		✓	✓		✓	✓		✓	✓
SDQ	✓	✓	✓	✓	✓	✓	✓	✓	✓
Principal and Additional Diagnoses		✓	✓		✓	✓		✓	✓
Mental Health Legal Status		✓	✓		✓	✓		✓	✓
Adults									
HoNOS	✓	✓	✓	✓	✓	✓	✓	✓	✓
Life Skills Profile -16				✓	✓	✓		✓	✓
K10+				✓	✓	✓	✓	✓	✓
Focus of Care								✓	✓
Principal and Additional Diagnoses		✓	✓		✓	✓		✓	✓
Mental Health Legal Status		✓	✓		✓	✓		✓	✓
Older Persons 65+									
HoNOS 65+	✓	✓	✓	✓	✓	✓	✓	✓	✓
LSP-16				✓	✓	✓		✓	✓
Resource Utilisation Groups –Activities of Daily Living	✓	✓		✓	✓				
K10+				✓	✓	✓	✓	✓	✓
Focus of Care								✓	✓
Principal and Additional Diagnoses		✓	✓		✓	✓		✓	✓
Mental Health Legal Status		✓	✓		✓	✓		✓	✓

✓ Indicates this measure is completed at this time

Abbreviations and Symbols

A Admission to Mental Health care

R Review of Mental Health care

D Discharge from Mental Health care

The Data Collection Protocol

Data to be collected and purpose of collection

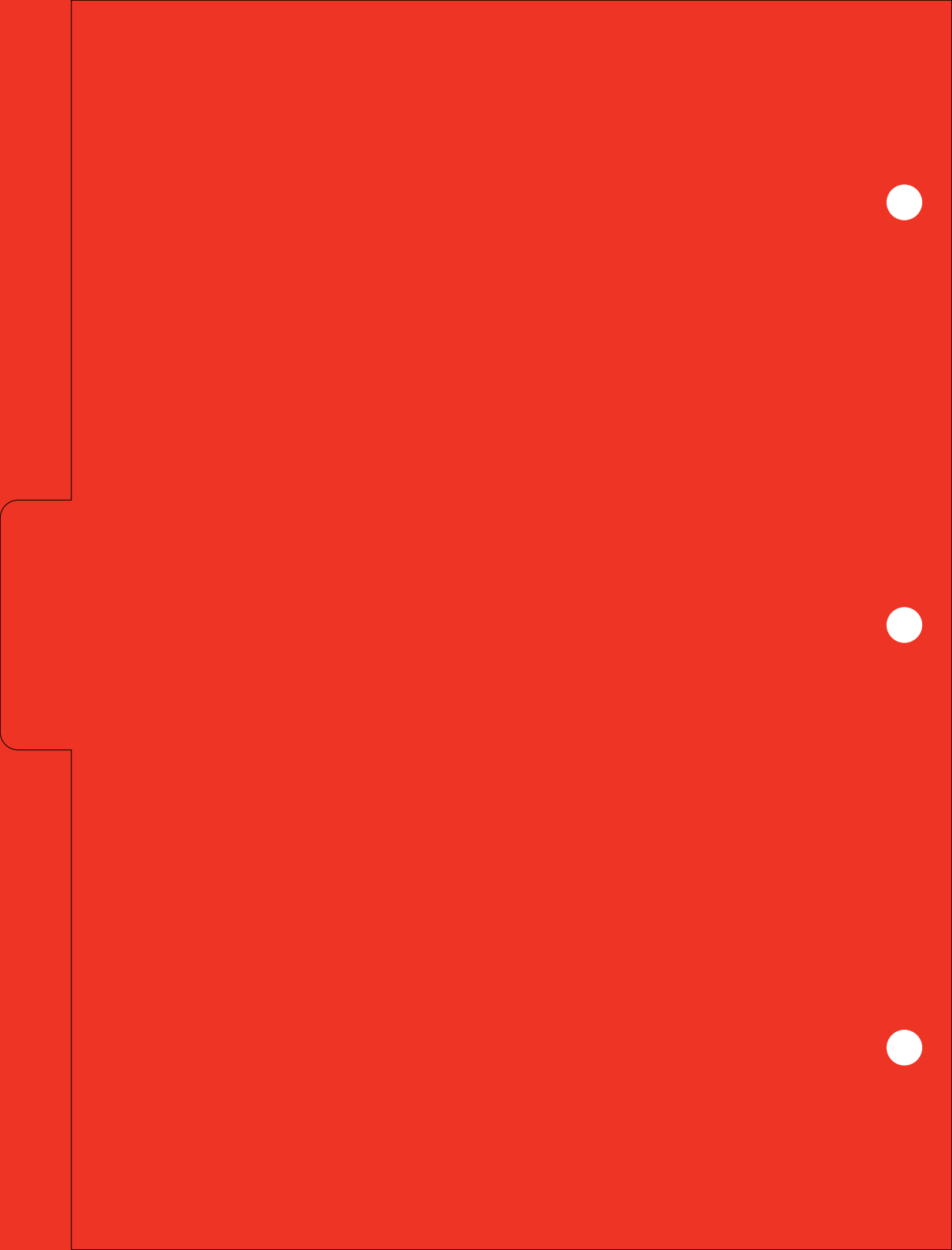
	Age Group			Purpose	
	Child & Adolescent	Adults	Older People	Outcomes Evaluation	Casemix Classification
Clinical measurement scales					
Health of the Nation Outcome Scales (HoNOS)		●		●	●
Health of the Nation Outcome Scales for Older People (HoNOS 65+)			●	●	●
Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)	●			●	●
Life Skills Profile (LSP-16)		●	●	●	●
Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL)			●		●
Children’s Global Assessment Scale (CGAS)	●				●
Factors Influencing Health Status (FIHS)	●			○	●
Other clinical data					
Mental Health Legal Status	●	●	●	○	●
Principal and Additional diagnosis	●	●	●	○	●
Focus of Care (FoC)		●	●	○	●
Consumer self-report					
Kessler 10 (K10+),		●	●	●	
Strengths and Difficulties Questionnaire (SDQ, all versions)	●			●	

Key to symbols

- Indicates the data will be used for the specified purpose of building the casemix classification or measuring outcomes.
- Indicates the data is not an outcomes measure as such but is important for the interpretation of outcome data.



Collection of Clinician-rated Outcome Measures



3 Collection of Clinician-rated Outcome Measures

The clinician rated outcome measures are collected according to a standard data collection protocol. The protocol outlining which instruments are to be completed at a particular point in time is based on the following concepts:

Program Type (Population group)

Children and Adolescents	0-17 years
Adults	18-64 years
Older Persons	65+ years

Mental Health Service Setting

Psychiatric Inpatient Service: This setting includes overnight care provided in public psychiatric hospitals and designated psychiatric units in public acute hospitals. Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Designated psychiatric units in a public acute hospital are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. For the purposes of NOCC specification, care provided by a Ambulatory mental health service team to a person admitted to a designated Special Care Suite or 'Rooming-In' facility within in a community general hospital for treatment of a mental or behavioural disorder is also included under this setting.

Community Residential Mental Health Service: A residential mental health service is a specialised mental health service that:

- > employs mental health-trained staff on site;
- > provides rehabilitation, treatment or extended care;
- > to residents provided with care intended to be on an overnight basis;
- > in a domestic-like environment; and
- > encourages the resident to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However all these services employ on-site mental health trained staff for some part of each day.

For non-24 hour staffed services to be included in NOCC data reporting, they must employ mental health trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day. This is consistent with the scope of the NMDS – Residential Mental Health Care.

Collection of Clinician-rated Outcome Measures

Ambulatory Care mental health Service: This setting includes all non-admitted, non-residential services provided by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include community-based crisis assessment and treatment teams, day programs, psychiatric outpatient clinics provided by either hospital or community-based services, child and adolescent outpatient and community teams, social and living skills programs, psychogeriatric assessment services and so forth. For the purposes of the NOCC protocol, care provided by hospital-based consultation-liaison services to admitted patients in non-psychiatric and hospital emergency settings is also included under this setting.

Refer to: <http://meteor.aihw.gov.au> for the latest definition on “Specialised Mental Health service setting”.

Collection Occasion

Admission to mental health care
Review of mental health care (91 days)
Discharge from mental health care

As a general rule, the clinician-rated outcome measures should be completed at the same time a formal clinical mental health assessment takes place and align to admission, review and discharge.

3.1 Collection Occasions

The following Reasons for Collection have been identified for the three primary Collection Occasions. The appropriate reason for collection is:

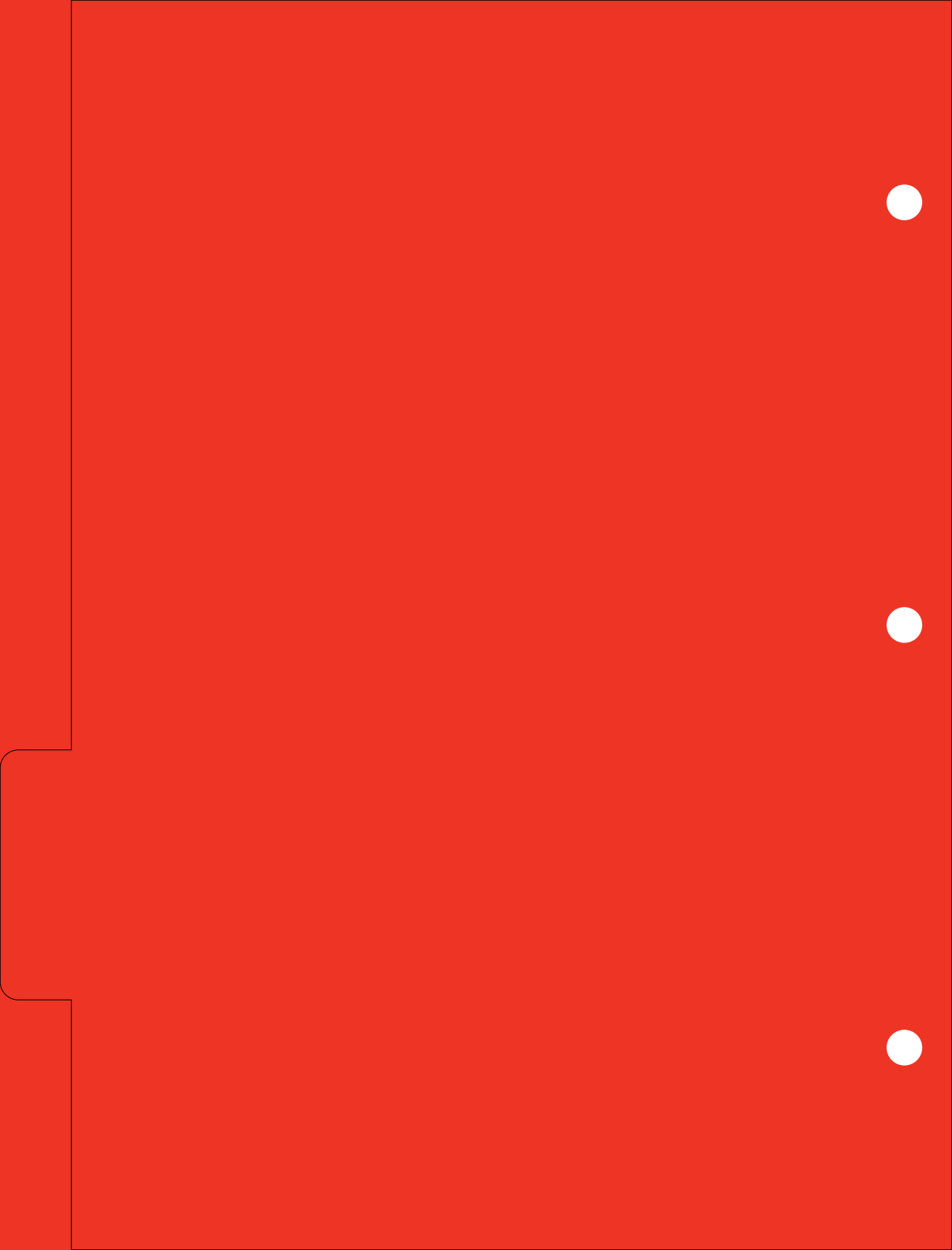
Collection Occasion	Reason for Collection	Definition
Admission	01. New referral	Admission to a new Psychiatric inpatient, community residential or ambulatory episode of care of a consumer not currently under the active care of the <i>Mental Health Service Organisation</i> . Notes: <i>New to the MH Service Organisation</i> or <i>New, having not been under 'active care' in the previous 3mths.</i>
	02. Admitted from other treatment setting	Transfer of care between a Psychiatric inpatient, community residential or ambulatory setting of a consumer currently under the active care of the <i>Mental Health Service Organisation</i> . Notes: <i>Admitted from other dedicated MH care treatment setting within the current MH Organisation</i>
	03. Admission - Other	Admission to a new Psychiatric inpatient, community residential or ambulatory episode of care for any reason other than defined above.
Review	04. 3-month review	Standard review conducted at 3 months (91 days) following admission to the current episode of care or 91 days subsequent to the preceding Review
	05. Review – Other	Standard review conducted for reasons other than the above. > in response to critical clinical events or changes in the consumer's status; > in response to a change from voluntary to involuntary status or vice versa; > following a transfer of care between community teams or change of case manager; > transfers between inpatient wards within a multi-ward hospital; > consumer or carer-requested reviews; and other situations where a review may be indicated

Collection of Clinician-rated Outcome Measures

Collection Occasion	Reason for Collection	Definition
Discharge	06. No further care	<p>Discharge from an inpatient, community residential or ambulatory episode of care of a consumer for whom no further care is planned by the <i>Mental Health Service Organisation</i>.</p> <p>Notes: <i>No further care in the current MH Service Organisation</i></p>
	07. Discharge to change of treatment setting	<p>Transfer of care between an inpatient and ambulatory setting of a consumer currently under the care of the <i>Mental Health Service Organisation</i>.</p> <p>Notes: <i>Discharge to change of treatment setting within the current MH Organisation</i></p>
	08. Death	<p>Completion of an episode of care following the death of the consumer.</p>
	09. Discharge - Other	<p>Discharge from an inpatient or ambulatory episode of care for any reason other than defined above.</p>



- Collection of the Consumer self report Measures



4 Collection of the Consumer self report Measures: K10+ and Strengths and Difficulties Questionnaire

When inviting the consumer to complete the self-report measure the clinician needs to explain that the measure will provide the opportunity for the consumer to monitor his/her own progress (journey to recovery?). Monitoring his/her own journey can then lead to the consumer being more involved in his/her own treatment and care.

Explain that the measure is not a test and that there are no right or wrong answers. Reassure the consumer that the information will be kept confidential in the same way as their medical record. Offer them assistance but do not force them or indirectly indicate that they must complete the questionnaire. Explain to the consumer that they can ignore any questions that they feel uncomfortable with. Finally, reassure the consumer that their completion of the self-report measure is voluntary and their care will not be affected if they refuse to complete the measure.

When the consumer returns the measure, check that it has been completed. If not complete, ask the consumer whether he or she had any difficulty or whether they accidentally missed a question(s), this process may give clinicians valuable insight into the consumers mental health status

In general, all consumers should be asked to complete the self-report measures at the same scheduled Collection occasions as the Clinicians Rated measures are completed (that is, admission, review and discharge).

However, some consumers may not be able to complete self-report measures for a variety of reasons including but not limited to

- > the consumer's cognitive functioning is insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability;
- > where the consumer's current clinical state is of sufficient severity to make it unlikely that their responses to a self-report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that they were a reasonable indication of person's feelings and thoughts about their current emotional and behavioural problems and wellbeing;
- > where an invitation to complete the measures is likely to be experienced as distressing or require a level of concentration and effort the person feels unable to give;
- > cultural or language issues make the self-report measure inappropriate.

Collection of the Consumer self report Measures

Given these considerations, clinical judgement should be used to determine if the consumer is invited to complete self-report measure. At all other times, the consumer should be invited to complete the consumer self report measure.

In many cases, the severity of the person's clinical state will diminish with appropriate treatment and care. It is suggested that, if within a period of up to **7 days** following the *Collection Occasion* in an ambulatory care setting the consumer is likely to be able to complete the self-report questionnaire then their responses should be sought at that time. Otherwise, no further attempt to administer the self-report questionnaire at that *Collection Occasion* should be made.

4.1 Good practice guide to offering a Consumer rated Measure

Admission

The following script (or a variation appropriately reworded to match your own style) is suggested for introducing the consumer self-rated report measure.

"We have standard questionnaires that we ask consumers to complete. The questionnaire asks about how you have been feeling and how this may have impacted on your life in the last few weeks. Completing the questionnaire is important as it can give you a record of where you have started with treatment and your progress over time. It can also mean that it gives you and I the opportunity to discuss current issues and future directions in treatment and care."

The information will be kept confidential and only those people involved in your care will have access to it. (Remember to emphasise that.) However, if you choose not to complete this questionnaire, it will in no way affect the treatment you receive.

This questionnaire should take about 10 minutes to complete. Please read the instructions before you start. Remember there are no right or wrong answers, just choose the response that best shows how you feel. Don't ask your friends or family to complete it, but myself or another member of staff will be here to answer any questions you may have."

Review

As all consumers will have completed the questionnaire on admission into the unit or service, a brief introduction is suitable. The following script is recommended.

"I would like you to fill out this questionnaire again. It was the same one you filled in when your first arrived (started seeing me). By filling this in now, we can compare it to the last one and see what has changed. There are no right or wrong answers. Remember, if you choose not to complete this questionnaire, it will in no way affect the treatment you receive."

Discharge

An introduction similar to that used at review should be offered. The following script is recommended.

"Before you leave we would like you to fill out the questionnaire again. By filling this out now, we can compare how things have changed for you. Remember there are no right or wrong answers and if you choose not to complete the questionnaire, it will in no way affect the treatment you receive."

4.2 Administration and Completion of the Consumer self-rated Measure

In all clinical settings and at all occasions, the consumer should be provided with privacy and be free from distractions. For both inpatient and ambulatory administration provide a firm writing surface such as a table or clipboard.

Closing

Closing should be the same regardless of setting and occasion. When the consumer returns the questionnaire, check that they have been completed. If not complete, ask the consumer whether he or she had any difficulty or whether they accidentally missed a question(s). Encourage them to complete the questionnaire. Offer them assistance, but **do not** force them or indirectly indicate that they must complete the questionnaire. **Finally, thank the consumer.**

When the questionnaire is returned to you, quickly browse through it to make sure that all the questions have been answered. If you notice there are missing items point this out to the consumer and try to elicit the reason in a casual, non-threatening fashion.

"Thanks for filling in the questionnaire, that's great. I'm really pleased you made the effort. I just wanted to check something with you because you've left this out. Did you leave it out because you don't want to fill it in or did you accidentally skip over it?"

Collection of the Consumer self report Measures

Encourage the consumer to complete the questionnaire. Your exact response should be determined by their reason for non-completion.

If consumers have missed questions accidentally, say:

*"That's okay. Would you mind filling them in now?
That would be really great."*

Ran out of time

If there are time constraints you may need to leave the questionnaire with them and collect it later.

In an outpatient setting you may need to arrange another time or alternatively let them take the questionnaire home with them. In the latter case give them an envelope and ask them to return the questionnaire at their next visit. Ask that they finish the questionnaire within the next day or two. Stress the importance of having information about how **they** are feeling now. Also remind them to complete the questionnaire on their own – you are interested in how they feel. Tell them that when they have finished they should put it in the envelope and then bring it back at their next visit.

After the questionnaire has been completed you may notice the consumer has circled more than one answer. If this has only occurred for one question – take the most extreme response. If several or all responses are answered in this fashion try to find out why, then help the consumer to correct their responses.

*"This is interesting. I've noticed that you've circled more than one response for these questions. Why have you answered in that way?
Would you like to tell me about it?"*

4.3 Addressing Problems and questions

Refusal to Complete the Questionnaire

Consumers must not be forced or ordered to fill out the questionnaire. If the consumer refuses, try to find out their reasons for refusal. Acknowledge that their reasons are valid and point out that **refusal will in no way affect their treatment**. Encourage them to fill in the questionnaire using the suggested scripts as outlined below. If the consumer still maintains refusal, take back the questionnaire.

Don't want to

A consumer may simply state that he or she does not want to fill in the questionnaire.

If the consumer refuses to complete the self-rated report measure, under codes for collection status rate **4 Not completed due to refusal by patient or client**.

If the consumer is hostile

It may be best to simply say:

"I can see you are a bit unsettled at the moment. Why don't we leave this for now?"

In an **ambulatory** care setting it is best to re-present at the next session. A suggested script may be:

"I'm sorry you were upset at the last session, I think it was a bad time to offer you the questionnaire. How would you feel about completing the questionnaire now? It would be really helpful for your treatment and care if you could fill it in for me."

If the clinician is unable to offer the self-rated report measure because of hostility, under codes for collection status rate **2 Not completed due to temporary contraindication**.

If the consumer is not hostile

Encourage him or her to complete the questionnaire. If the consumer still says no, discontinue (using the same response as that if the consumer is hostile) and try again at the next session or visit.

The following script is suggested.

"We are really doing this so we can get a good idea of how you are feeling. This questionnaire is really a useful tool for doing this".

If the consumer continues to refuse to complete the self-rated report measure, under codes for collection status rate **4 Not completed due to refusal by patient or client**.

Collection of the Consumer self report Measures

Trust

The consumer may not trust what you are trying to find out. If this happens, re-emphasise the purpose of the questionnaire and **how the information will help you to help them**. However, care must be taken because the more you re-present the more suspicious they may become. If the consumer is suspicious to the point of paranoia, there is very little you can do – the more you push the more they will become anxious and concerned about your motives. In this case it is best to discontinue and maybe try again at a later date when the consumer feels more settled and safe.

Time

If the consumer states he or she does not have the time, be understanding and encourage the consumer.

“Yes, I understand it can be seen as time consuming, but this information will give us a better understanding of how you feel, and this will help both of us in planning your treatment.”

If the consumer continues to refuse to complete the self-rated report measure, under codes for collection status rate **4 Not completed due to refusal by patient or client**.

Confidentiality

If the consumer is concerned about people seeing the information, re-emphasise that the information is confidential.

“Like all your medical records, we assure you that the information you provide will be kept in strict confidence. We follow very strict policies and procedures to make sure that only authorized people have access to the information.

If another clinician requires information about you we would only give them that information if you give us your consent. Also, if you are referred to another clinician, you will be asked to sign a consent form that allows us to talk to that clinician about your treatment”.

If the consumer refuses to complete the consumer self-rated report measure, because of concerns about confidentiality, under codes for collection status rate **4 Not completed due to refusal by patient or client**.

Content

If the consumer feels the questionnaire is irrelevant re-emphasise the purpose of the questionnaire. For example, you might say:

"You may not feel this questionnaire is relevant to you but it does provide us with very useful information about how you feel and how well you are able to cope with your daily activities. Remember the more information we have the more we will be able to help you."

If the consumer feels particular items are irrelevant the following scripts may be used:

"Although this question doesn't seem to apply to you at present, it has been found to be a useful question to ask people with problems like those you currently have. So that we get a clear and reliable picture of how you feel about your problems we need to ask you the same questions we ask everyone else. So it is important that you try to answer every question, even though some of them may not seem relevant."

Or

"This questionnaire may not be exactly appropriate for you but just answer it as best you can. Don't worry if some of the questions don't seem to apply to you but, your responses to them can still give us useful information."

If the consumer leaves some questions unanswered on the self-rated report measure because of concerns about content, under codes for collection status rate as **1 complete or partially complete**.

Comprehension

If a consumer has trouble understanding particular items, ask them which part of the items they are having trouble with. Re-read the question slowly and exactly as it is written. Do **not** rephrase the question. If the consumer is unfamiliar with, or does not know the meaning of a word, it is appropriate to provide a definition of that word. If they are still having trouble, say:

"Try your best, just put down what you feel. There is no right or wrong answer".

Collection of the Consumer self report Measures

If a consumer asks for clarification of an item so that they can better understand and respond to that question, assist the consumer by slowly re-reading the question exactly as it is written. If the consumer asks what the question means, do not try to explain it, but suggest that he or she:

“Use your own interpretation. We need you to answer the question based on what you think it means. As stated previously, it is appropriate to provide the definition of an unfamiliar or unknown word”.

If the consumer is unable to complete the self-rated report measure because of poor comprehension, under codes for collection status rate **2 Not completed due to temporary contraindication**.

If the consumer leaves some questions unanswered on the self-rated report measure because of poor comprehension, under codes for collection status rate as **1 complete or partially complete**.

Confusion

Some consumers may find some questions confusing, repetitive or similar. They may feel they've already answered a question and then don't know how to answer one that is similar. If this occurs, explain that:

“Yes, some of the questions are (seem) a bit the same, but asking things in different ways can sometimes give us more reliable information about the way you feel. Just answer it as best you can. Remember there is no right or wrong answer – this is purely to monitor how you are feeling about your problems. If some of the questions are similar, that's okay. Don't think about it too hard – you'll probably have an immediate reaction – so if that's how you feel when you read it, that's what you should answer.”

If the consumer is unable to complete the self-rated report measure because of confusion, under codes for collection status rate **2 Not completed due to temporary contraindication**.

Poor memory

Some consumers may have difficulty with their memory. By the time they have read through all the response alternatives to a question they can't remember what the first one was, or, what the question was. A consumer may inform you of this difficulty or you may notice it yourself. In either case, it may be best to sit with him or her and work through the questionnaire with them. Read the questions aloud to them. In this way you can act as a memory prompt. Ask the consumer:

"Would you like me to sit with you? We can work through the questions together."

If the consumer is unable to complete the self-rated report measure because of poor memory, under codes for collection status, rate **3 Not completed due to general exclusion**.

Poor eyesight

If a consumer has forgotten his or her glasses, offer to sit with them and read the questions aloud for them. In settings where consumers commonly forget their reading glasses, it may be useful to keep on hand one or two old pairs of reading glasses.

If the consumer is unable to complete the self-rated report measure because of poor eyesight, under codes for collection status rate **2 - Not complete due to temporary contraindication**.

Uncertainty

Consumers may feel uncertainty as to how to answer. Try to ease their uncertainty and encourage them. Often their uncertainty is focused around the limited responses available to them in a particular question. In those cases you need to help them stop worrying too much about accuracy and encourage them to make their best guess.

If the consumer says something like "I'm sort of half this - half that, what should I put down?" you may say:

"Do the best you can – just answer how you most feel – whichever one suits you best."

If the consumer is unable to complete the self-rated report measure because of uncertainty, under codes for collection status rate **2 Not complete due to temporary contraindication**.

If the consumer leaves some questions unanswered on the self-rated report measure because of uncertainty, under codes for collection status rate **1 Complete or partially complete**.

Don't think the questions were relevant – it's a waste of time.

If the consumer feels the questionnaire or some questions in a questionnaire are irrelevant choose one of the following responses:

"Although this question doesn't seem to apply to you at present, it has been found to be a useful question to ask people with problems like those you currently have. So it is important that you try to answer every question, even though some of them may not seem relevant."

Collection of the Consumer self report Measures

Or

This questionnaire may not be exactly appropriate for you but just answer it as best you can. Don't worry if some of the questions don't seem to apply to you but, your responses to them can still give useful information.

If the consumer is unable to complete the self-rated report measure because they feel it is a waste of time, under codes for collection status rate **2 Not complete due to temporary contraindication**.

If the consumer leaves some questions unanswered on the self-rated report measure because they feel it is a waste of time, under codes for collection status rate **1 Complete or partially complete**.

Too long

If a consumer indicates he/she did not complete the questionnaire because it is too long, say:

"Sorry about that, but it does provide useful information for you and I so that we can use it to work together on the issues you have currently."

If the consumer is unable to complete the self-rated report measure because they feel it is too long, under codes for collection status rate **2 Not complete due to temporary contraindication**.

If the consumer leaves some questions unanswered on the self-rated report measure because they feel it is too long, under codes for collection status rate **1 Complete or partially complete**.

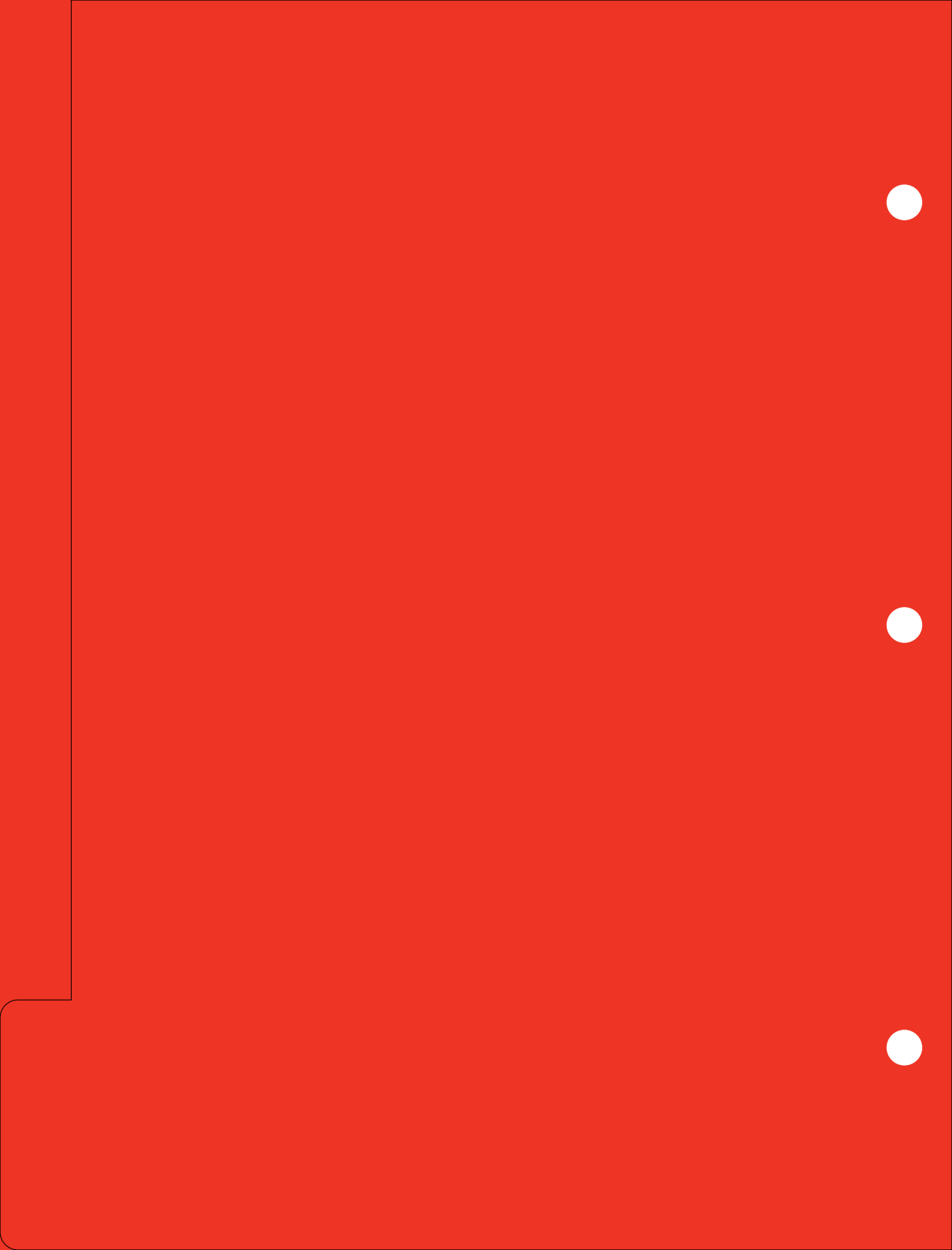
4.4 Collection Status

There are a number of indicators of the status of data collection. These codes describe the way measures were completed, or the reasons why measures were not completed.

1. Complete or Partially complete
2. Not completed due to temporary contraindication (applies only to self-report measures)
3. Not completed due to general exclusion (applies only to self-report measures)
4. Not completed due to refusal by patient or client (applies only to self-report measures)
7. Not completed for reasons not elsewhere classified
9. Not stated / Missing



Child and Adolescent measures



5 Child and Adolescent measures

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

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

The Strengths and Difficulties Questionnaire (SDQ) is a voluntary consumer rated scale which can be filled out by a client/parent/carer/teacher and is used in conjunction with the above clinician rated scales. Scores from the SDQ questionnaire are entered into the Information system by the clinician. While the SDQ is a voluntary measure it is the clinician's responsibility to ensure the SDQ is offered to the consumer and an explanation given as to its usefulness to their care and treatment.

5.1 Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA)

General rating guidelines

1. Rate items in order from 1 to 15.
2. Do not include information already rated in an earlier item.
3. Rate the most severe problem that occurred in the period rated.
4. The rating period is generally the preceding two weeks for inpatients at admission, for hospital outpatients, and for all patients of community based services. The exception is at discharge from inpatient care, in which case the rating period should generally be the preceding 72 hours.

Each item is rated on a 5-point scale of severity (0 to 4) as follows:

0 No problem

1 Minor problem requiring no formal action

2 Mild problem. Should be recorded in a care plan or other case record

3 Problem of moderate severity

4 Severe to very severe problem

7 Not Stated / Missing

9 Not known / Unable to rate. *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.*

Child and Adolescent measures

Specific help for rating each point on each item is provided in the Glossary and this should be referred to when making a rating.

The HoNOSCA does not set targets or interventions. The instrument is used to rate **health outcome** not **health care outcomes**, so interventions are not considered when rating items.

The following table provides guidelines to interpreting scores achieved on the HoNOSCA distinguishing between clinically and not clinically significant scores. These are general rules for clinicians using the HoNOSCA scores in day to day clinical practice.

More detailed reports on an individuals HoNOSCA score can be printed from within the Information system..

			Monitor	Active treatment or management plan?	
Not clinically significant		Problem not present.	×	×	
	1	Minor problem	Requires no formal action. May or may not be recorded in clinical file.	Maybe	×
Clinically significant	2	Mild problem	Warrants recording in clinical notes. May or not be incorporated in care plan.	✓	Maybe
	3	Moderate problem	Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	4	Severe to very severe problem	Most severe category for patients with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <i>Note – patient can get worse.</i>	✓	✓

Glossary HoNOSCA

1. Problems with disruptive, antisocial or aggressive behaviour

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

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

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

Do not include: Overactivity 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 overactivity, 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 overactivity or minor restlessness, etc.

2 Mild but definite overactivity or attention problems, but can usually be controlled.

3 Moderately severe overactivity or attention problems those are sometimes uncontrollable.

4 Severe overactivity or attention problems that are present in most activities and almost never controllable.

Child and Adolescent measures

3. Non-accidental self-injury

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

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

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

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

0 No problems of this kind during the period rated.

1 Occasional thoughts about death, or of self-harm not leading to injury. No self-harm or suicidal thoughts.

2 Non-hazardous self-harm, such as wrist scratching, whether or not associated with suicidal thoughts.

3 Moderately severe suicidal intent (including preparatory acts, eg. collecting tablets) or moderate non-hazardous self-harm (eg. small overdose).

4 Serious suicidal attempt (eg. serious overdose), or serious deliberate self-injury.

4. Problems with alcohol, substance or solvent misuse

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

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

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

0 No problems of this kind during the period rated.

1 Minor alcohol or drug use, within age norms.

2 Mildly excessive alcohol or drug use.

3 Moderately severe drug or alcohol problems significantly out of keeping with age norms.

4 Severe drug or alcohol problems leading to dependency or incapacity.

5. Problems with scholastic or language skills

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

Include reduced scholastic performance associated with emotional or behavioural problems.

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

Do not include temporary problems resulting purely from inadequate education.

0 No problems of this kind during the period rated.

1 Minor impairment within the normal range of variation.

2 Minor but definite impairment of clinical significance.

3 Moderately severe problems, below the level expected on the basis of mental age, past performance, or physical disability.

4 Severe impairment, much below the level expected on the basis of mental age, past performance, or physical disability.

6. Physical illness or disability problems

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

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

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

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

0 No incapacity as a result of physical health problems during the period rated.

1 Slight incapacity as a result of a health problem during the period (eg. cold, non-serious fall, etc.).

2 Physical health problem that imposes mild but definite functional restriction.

3 Moderate degree of restriction on activity due to physical health problems.

4 Complete or severe incapacity due to physical health problems.

Child and Adolescent measures

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

Include hallucinations, delusions or abnormal perceptions irrespective of diagnosis.

Include odd and bizarre behaviour associated with hallucinations and delusions.

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

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

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

0 No evidence of abnormal thoughts or perceptions during the period rated.

1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.

2 Abnormal thoughts or perceptions are present (eg. paranoid ideas, illusions or body image disturbance), but there is little distress or manifestation in bizarre behaviour, 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, and phobias. obsessions or compulsions, arising from any clinical condition including eating disorders.

Do not include aggressive, destructive or overactivity 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.

Child and Adolescent measures

10. Problems with peer relationships

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

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

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

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

0 No significant problems during the period rated.

1 Either transient or slight problems, occasional social withdrawal.

2 Mild but definite problems in making or sustaining peer relationships. Problems causing distress due to social withdrawal, over-intrusiveness, rejection or being bullied.

3 Moderate problems due to active or passive withdrawal from social relationships, over-intrusiveness, or to relationships that provide little or no comfort or support, eg. as a result of being severely bullied.

4 Severe social isolation with hardly any friends due to inability to communicate socially or withdrawal from social relationships.

11. Problems with self-care and independence

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

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

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

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

0 No problems of this kind during the period rated; good ability to function in all areas.

1 Minor problems, eg. untidy, disorganised.

2 Self-care adequate, but major inability to perform one or more complex skills (see above).

3 Major problems in one or more areas of self-care (eating, washing, dressing) or major inability to perform several complex skills.

4 Severe disability in all or nearly all areas of self-care or complex skills.

12. Problems with family life and relationships

Include parent-child and sibling relationship problems.

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

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

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

Include problems with enmeshment and overprotection.

Include problems with family bereavement leading to reorganisation.

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

0 No problems during the period rated.

1 Slight or transient problems.

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

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

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

Child and Adolescent measures

13. Poor school attendance

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

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

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

NB 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 period rated)

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.

Child and Adolescent measures

5.2 Children’s Global Assessment Scale (CGAS)

The CGAS is used as the key measure of level of functioning for consumers of child and adolescent mental health services. It provides 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.

General rating guidelines

Rate the consumer’s most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. Use exact scores (eg 35, 58, 62).

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

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

Child and Adolescent measures

5.3 Factors Influencing Health Status and Contact with Health Services

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.

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.

General rating guidelines

By using the following rating scale, indicate whether any of the factors listed below are present or have required special clinical evaluation, therapeutic treatment, diagnostic procedures or increased clinical care or monitoring during the preceding period of care.

- 1 Yes
- 2 No
- 7 Unable to rate (insufficient information)
- 9 Not stated/ Missing

Rate more than one item if appropriate.

Glossary

1. Maltreatment syndromes

Includes: Neglect or abandonment; Physical abuse; Sexual abuse; Psychological abuse.

2. Problems related to negative life events in childhood

Includes: Loss of love relationship in childhood; Removal from home in childhood; Altered pattern of family relationships in childhood; Problems related to alleged sexual abuse of child by person within primary support group; Problems related to alleged sexual abuse of child by person outside primary support group; Problems related to alleged physical abuse of child; Personal frightening experience in childhood; Other negative life events in childhood.

3. Problems related to upbringing

Includes: 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; Other specified problems related to upbringing.

4. Problems related to primary support group, including family circumstances

Includes: Problems in relationship with spouse or partner; Problems in relationship with parents and in-laws; Inadequate family support; Absence of family member; Disappearance or death of family member; Disruption of family by separation and divorce; Dependant relative needing care at home; Other stressful life events affecting family and household; Other problems related to primary support group.

5. Problems related to social environment

Includes: Problems of adjustment to lifecycle transitions; Atypical parenting situation; Living alone; Acculturation difficulty; Social exclusion and rejection; Target of perceived adverse discrimination and rejection.

6. Problems related to certain psychosocial circumstances

Includes: Problems related to unwanted pregnancy; Problems related to multiparity; Seeking or accepting physical, nutritional or chemical interventions known to be hazardous or harmful; Seeking or accepting behavioural or psychological interventions known to be hazardous or harmful; Discord with counsellors.

7. Problems related to other psychosocial circumstances

Includes: Conviction in civil and criminal proceedings without imprisonment; Imprisonment or other incarceration; Problems related to release from prison; Problems related to other legal circumstances; Victim of crime or terrorism; Exposure to disaster, war or other hostilities.

5.4 Interpreting SDQ Symptom Scores

Although SDQ scores can often be used as continuous variables, it is sometimes convenient to classify scores in the bands as set out in the Table below. Using the comments, a "substantial risk of clinical significant problems" score on the Total Difficulties Score can be used to identify likely 'cases' with mental 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 'substantial risk of clinically significant' band on any given score with a further 10% scoring in the 'may reflect clinically significant problems' band. The exact proportions vary according to country, age and gender – normative SDQ data are available from the website <http://www.sdqinfo.com/b8.html>. Banding and caseness criteria for these characteristics can be adjusted, setting the threshold higher when avoiding false positives is of paramount importance, and setting the threshold lower when avoiding false negatives is more important.

Child and Adolescent measures

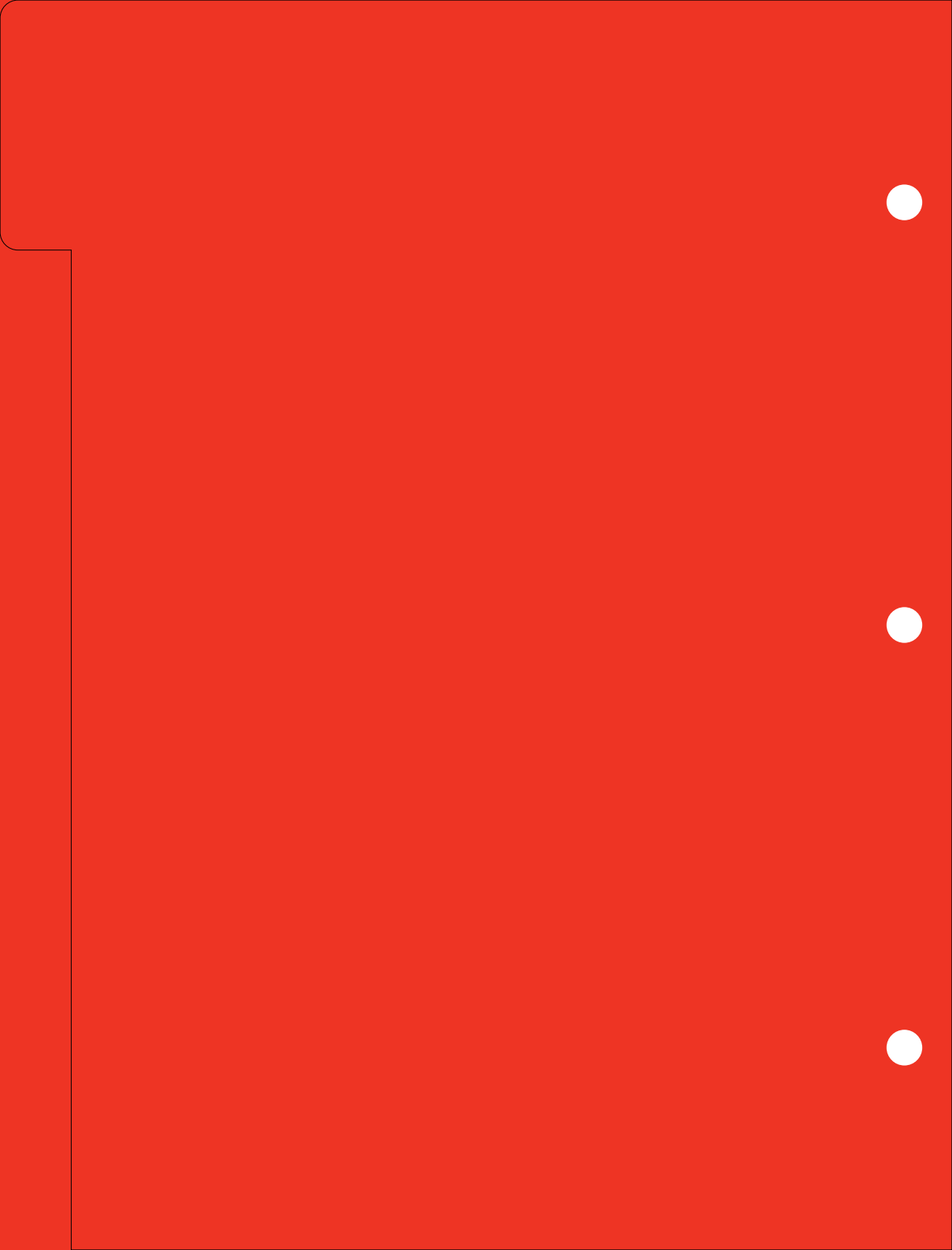
	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Parent			
Total Difficulties Score	0-13	14-16	17-40
Emotional Symptoms Score	0-3	4	5-10
Conduct Problem Score	0-2	3	4-10
Hyperactivity Score	0-5	6	7-10
Peer Problem Score	0-2	3	4-10
Self Completed			
Total Difficulties Score	0-15	16-19	20-40
Emotional Symptoms Score	0-5	6	7-10
Conduct Problem Score	0-3	4	5-10
Hyperactivity Score	0-5	6	7-10
Peer Problem Score	0-3	4-5	6-10
Parent and Self Completed			
	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly low, which may reflect clinically significant problems'	'This score is low - there is a substantial risk of clinically significant problems in this area'
Prosocial Behaviour Score	6-10	5	0-4

Note: This broad classification is based on information from the www.sdqinfo.com web site (c) R Goodman. It is used with permission, and is intended to provide a general reference range only, while more detailed clinical interpretations are being developed with Dr. Goodman.

Graphical reports of an individual consumers SDQ scores can be printed from within the Information system.

Adult Measures





6. Adult Measures

6.1 Health of the Nation Outcomes Scale (HoNOS)

General rating guidelines

Rate items in order from 1 to 12.

Do not include information rated in an earlier scale.

Rate the most severe problem that occurred in the period rated.

The rating period is generally the preceding two weeks for inpatients at admission, for hospital outpatients, and for all patients of community-based services. The exception is at discharge from inpatient care, in which case the rating period should generally be the preceding 72 hours.

Each item is rated on a 5-point scale of severity (0 to 4) as follows:

0 No problem

1 Minor problem requiring no formal action

2 Mild problem. Should be recorded in a care plan or other case record

3 Problem of moderate severity

4 Severe to very severe problem

7 Not stated/missing

9 Not known / Unable to rate

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 help for rating each point on each item is provided in the Glossary and this should be referred to when making a rating. The table below provides outlines additional information that can guide rating.

Adult Measures

				Monitor	Active treatment or management plan?
Not clinically significant	0	No problem	Problem not present.	×	×
	1	Minor problem	Requires no formal action. May or may not be recorded in clinical file.	Maybe	×
Clinically significant	2	Mild problem	Warrants recording in clinical notes. May or not be incorporated in care plan.	✓	Maybe
	3	Moderate problem	Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	4	Severe to very severe problem	Most severe category for patients with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <i>Note – patient can get worse.</i>	✓	✓

Glossary HoNOS

1. Overactive, aggressive, disruptive or agitated behaviour

***Include** such behaviour due to any cause, eg. 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 overactivity or agitation.

3 Physically aggressive to others or animals (short of rating 4); threatening manner; more serious overactivity 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 eg. 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, (eg. cirrhosis of the liver or injury resulting from drunk driving are rated at Scale 5).*

0 No problem of this kind during the period rated.

1 Fleeting thoughts about ending it all, but little risk during the period rated; no self-harm.

2 Mild risk during period; includes non-hazardous self-harm eg. wrist-scratching.

3 Moderate to serious risk of deliberate self-harm during the period rated; includes preparatory acts eg. collecting tablets.

4 Serious suicidal attempt or serious deliberate self-injury during the period rated.

Adult Measures

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 (eg. 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 eg. forgets names occasionally.
- 2 Mild, but definite problems, eg. 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, eg. 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 (eg. 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 a moderately severe clinical problem.
- 4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient.

Adult Measures

7. Problems with depressed mood

Do **not** include overactivity 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: eg. 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, eg. patient/client has a degree of control.

3 Occasional severe attack or distress, with loss of control eg. 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): eg. 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 eg. 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 (eg. not ideal location, not preferred option, doesn't like food, etc.).

Adult Measures

- 2 Significant problems with one or more aspects of the accommodation and/or regime (eg. 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 (eg. some basic necessities absent); housing environment has minimal or no facilities to improve patient's independence.
- 4 Accommodation is unacceptable (eg. 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, eg. 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 eg. late pension cheques, reasonable facilities available, but not always at desired times etc.
- 2 Limited choice of activities; eg. there is a lack of reasonable tolerance (eg. 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.

6.2 Life Skills Profile (LSP-16)

General rating guidelines

- > Complete on day of or within 24 hours of three monthly reviews in ambulatory care.
- > The rating period is the preceding 3 months
- > Assess the consumer's general functioning over the past three months
- > Do not assess functioning during crisis when the consumer was ill or becoming ill
- > Rate each scale in order from 1-16
- > Each item is noted on a 4-point scale of severity (0-3)

Glossary

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?

Adult Measures

8	<p>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?</p>
9	<p>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?</p>
10	<p>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?</p>
11	<p>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?</p>
12	<p>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?</p>
13	<p>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?</p>
14	<p>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?</p>
15	<p>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?</p>
16	<p>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?</p>

6.3 Focus of Care: Item Clarifications and Elaborations

Focus of care

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

Indicate main focus of care over the preceding period

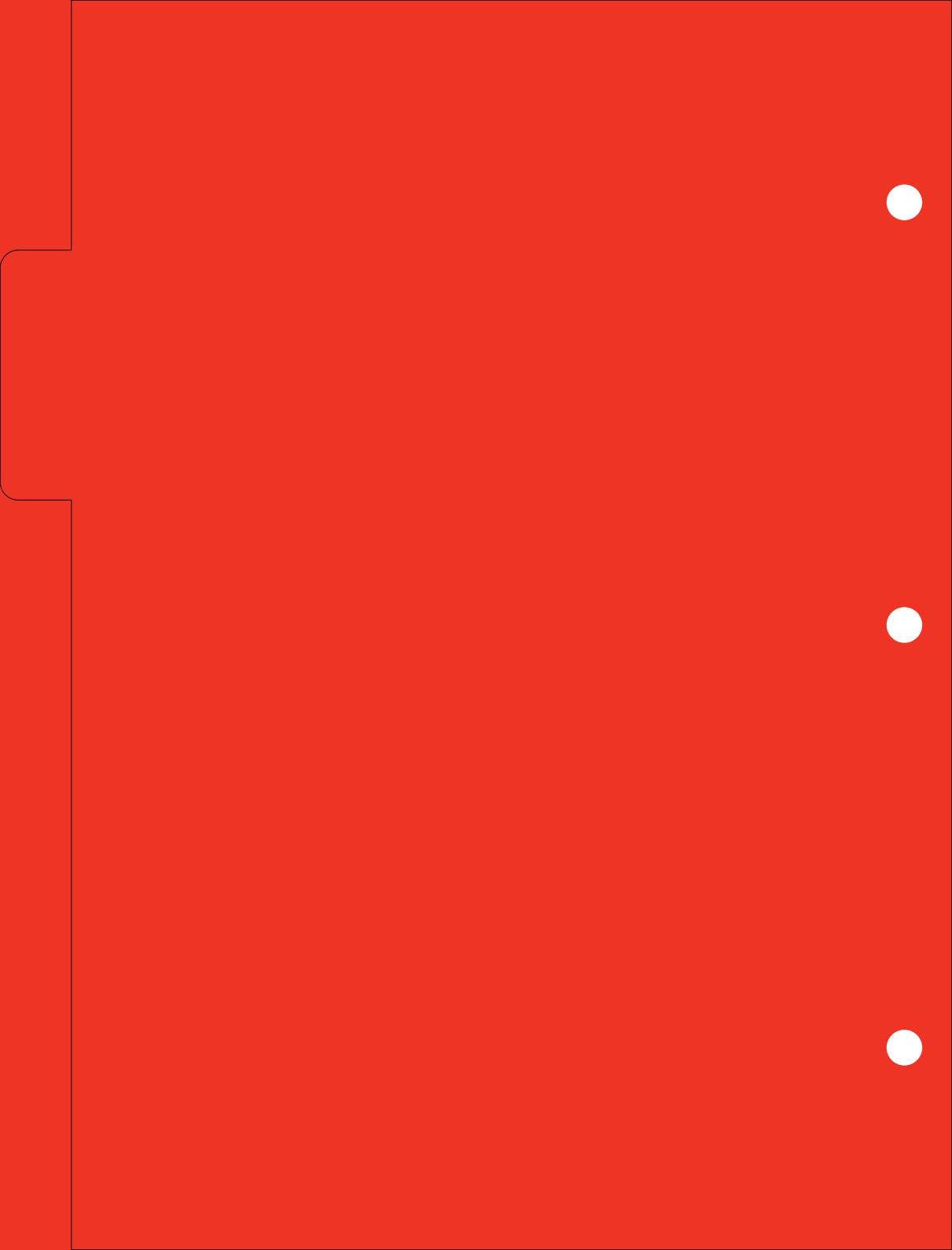
Adult Measures

		Consumer Characteristics			Service Requirements		Examples of typical documentation in care plan to support the rating
		Symptoms	Functioning	Primary Goal	Indicative time to achieve Primary Goal	Indicative treatment intensity	
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.



Older Persons 65+ Measures





7 Older Persons 65+ Measures

7.1 Health of the Nation Outcomes Scale (HoNOS65+)

General rating guidelines

- > *Rate items in order from 1 to 12.*
- > *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 for inpatients at admission, for hospital outpatients, and for all consumers of community-based services. The exception is at discharge from inpatient care, in which case the rating period should generally be the preceding 72 hours.*

Each item is rated on a 5-point scale of severity (0 to 4) as follows:

- 0 No problem
- 1 Minor problem requiring no formal action
- 2 Mild problem. Should be recorded in a care plan or other case record
- 3 Problem of moderate severity
- 4 Severe to very severe problem
- 7 Not stated/ Missing
- 9 Not known/ unable to rate

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 help for rating each point on each item is provided in the Glossary and this should be referred to when making a rating. The table below provides outlines additional information that can guide rating.

Older Persons 65+ Measures

				Monitor	Active treatment or management plan?
Not clinically significant	0	No problem	Problem not present.	×	×
	1	Minor problem	Requires no formal action. May or may not be recorded in clinical file.	Maybe	×
Clinically significant	2	Mild problem	Warrants recording in clinical notes. May or not be incorporated in care plan.	✓	Maybe
	3	Moderate problem	Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	4	Severe to very severe problem	Most severe category for consumers with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <i>Note – consumer can get worse.</i>	✓	✓

Glossary HoNOS 65+

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

***Include** such behaviour due to any cause, eg. dementia, drugs, alcohol, psychosis, depression, etc.*

***Do not** include bizarre behaviour, rated at Scale 6.*

0 No problems of this kind during the period rated.

1 Occasional irritability, quarrels, restlessness etc, but generally calm and co-operative and not requiring any specific action.

2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); significant overactivity 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 overactivity 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 overactivity 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.

Older Persons 65+ Measures

2. Non-accidental self-injury

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

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

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

3. Problem drinking or drug-taking

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

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

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

4. Cognitive problems

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

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

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

5. Physical illness or disability problems

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

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

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

- 0 No physical health, disability or mobility problems during the period rated.
- 1 Minor health problem during the period (e.g. cold); some impairment of sight or hearing (but still able to function effectively with the aid of glasses or hearing aid).

Older Persons 65+ Measures

- 2 Physical health problem associated with mild restriction of activities or mobility (eg. restricted walking distance, some degree of loss of independence); moderate impairment of sight or hearing (with functional impairment despite the appropriate use of glasses or hearing aid); some degree of risk of falling, but low and no episodes to date; problems associated with mild degree of pain.
- 3 Physical health problem associated with moderate restriction of activities or mobility (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 (eg. voices, visions) are present, but there is little distress to consumer 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 consumer or others.

7. Problems with depressive symptoms

***Do not** include overactivity or agitation, rated at Scale 1.*

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

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

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

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

8. Other mental and behavioural problems

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

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

Older Persons 65+ Measures

9. Problems with relationships

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

- 0 No significant problems during the period.
- 1 Minor non-clinical problems.
- 2 Definite problems in making, sustaining or adapting to supportive relationships (eg. because of controlling manner, or arising out of difficult, exploitative or abusive relationships), definite, but mild difficulties reported by patient or evident to carers or others.
- 3 Persisting significant problems with relationships; moderately severe conflicts or problems identified within the relationship by the patient or evident to carers or others.
- 4 Severe difficulties associated with social relationships (eg. isolation, withdrawal, conflict, abuse); major tensions and stresses (eg. threatening breaking down of relationship).

10. Problems with activities of daily living

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

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

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

- 0 No problems during period rated; good ability to function effectively in all basic activities (eg. continent – or able to manage incontinence appropriately, able to feed self and dress) and complex skills (eg. driving or able to make use of transport facilities, able to handle financial affairs appropriately).
- 1 Minor problems only without significantly adverse consequences, for example, untidy, mildly disorganised, some evidence to suggest minor difficulty with complex skills, but still able to cope effectively.

- 2 Self-care and basic activities adequate (though some prompting may be required), but difficulty with more complex skills (eg. problem organising and making a drink or meal, deterioration in personal interest especially outside the home situation, problems with driving, transport or financial judgements).
- 3 Problems evident in one or more areas of self-care activities (eg. needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted) as well as inability to perform several complex skills.
- 4 Severe disability or incapacity in all or nearly all areas of basic and complex skills (eg. full supervision required with dressing and eating, frequent urinary or faecal incontinence).

11. Problems with living conditions

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

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

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

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

- 0 Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible and minimising any risk, and supportive of self-help; the patient is satisfied with their accommodation.
- 1 Accommodation is reasonably acceptable with only minor or transient problems related primarily to the patient's preferences rather than any significant problems or risks associated with their environment (eg. not ideal location, not preferred option, doesn't like food).
- 2 Basics are met, but significant problems with one or more aspects of the accommodation or regime (eg. lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems of access); may be associated with risk to patient (eg. injury) which would otherwise be reduced.

Older Persons 65+ Measures

- 3 Distressing multiple problems with accommodation; eg. some basic necessities are absent (unsatisfactory or unreliable heating, lack of proper cooking facilities, inadequate sanitation); clear elements of risk to the patient resulting from aspects of the physical environment.
- 4 Accommodation is unacceptable: eg. lack of basic necessities, insecure, or living conditions are otherwise intolerable, contributing adversely to the patient's condition or placing them at high risk of injury or other adverse consequences.

12. Problems with occupation and activities

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

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

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

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

7.2 Life Skills Profile (LSP-16)

General rating guidelines

- > Complete on day of or within 24 hours of three monthly reviews in ambulatory care.
- > The rating period is the preceding 3 months
- > Assess the consumer's general functioning over the past three months
- > Do not assess functioning during crisis when the consumer was ill or becoming ill
- > Rate each scale in order from 1-16
- > Each item is noted on a 4-point scale of severity (0-3)

Glossary

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?

Older Persons 65+ Measures

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?

7.3 Focus of Care: Item Clarifications and Elaborations

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

Focus of care



Indicate main focus of care over the preceding period

Older Persons 65+ Measures

	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.

7.4 RUGADL - Resource Utilisation Groups – Activities of Daily Living

General 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 unless the person is deceased.

It is essential that the rater knows what behaviours and tasks are contained within each scale and has a “working knowledge” of the scale.

Note that a rating of “2” is not included in the domain of valid ratings.

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 two assistants to readjust position, and perform own pressure area relief.

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.

Older Persons 65+ Measures

- 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.

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 persons to perform any transfer in the day or night.

4. Eating

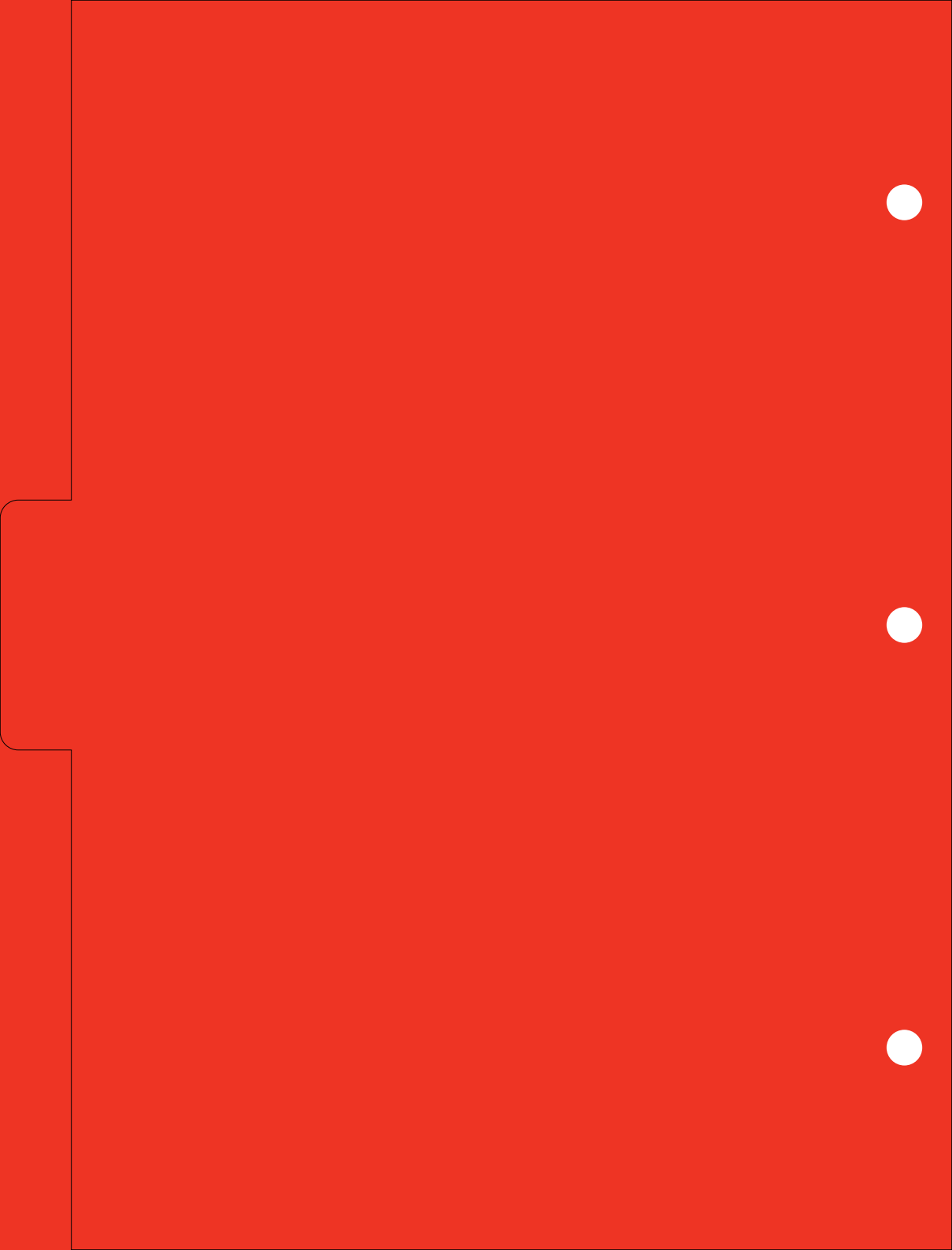
Includes the tasks of cutting food, bringing food to the mouth and the chewing and swallowing of food. Does not include preparation of the meal.

- 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 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.



Additional Data Items





8 Additional Data Items


8.1 Principal and Additional Diagnoses

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

8.2 Mental Health Legal Status

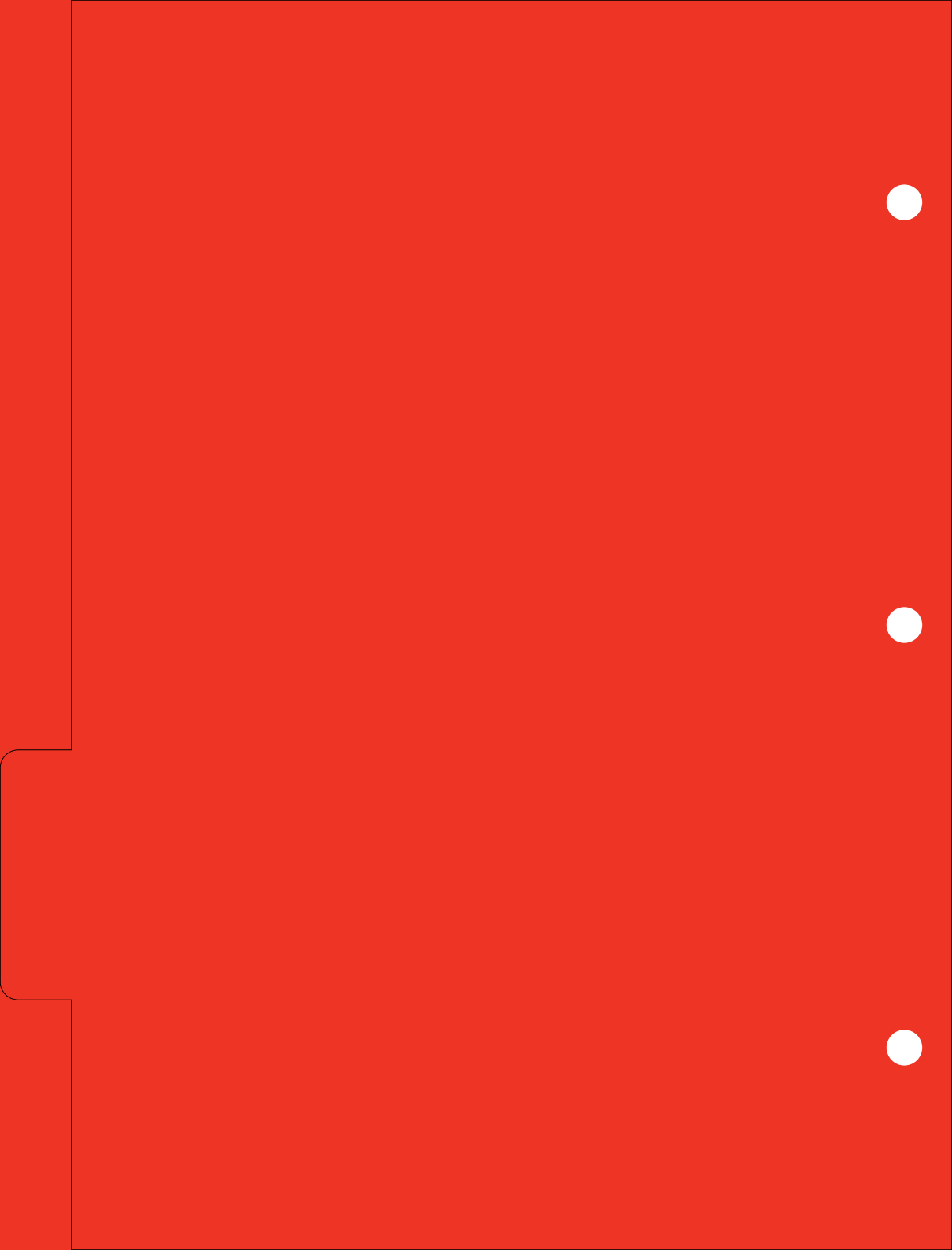
This item is used to indicate whether the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the period preceding the *Collection Occasion*.





-
-
-

ICD-10 AM – International Statistical Classification of Diseases and related health problems



9 ICD-10 AM – International Statistical Classification of Diseases and related health problems, Australian Modification Code list

The following Internet links can be accessed for a complete current code list of the ICD-10 AM code list:

The World Health Organisation (WHO):

<http://www.who.int/classifications/icd/en/>

The South Australian code list endorsed by SA Health Integrated South Australian Activity Collection (ISAAC):

<http://www.dh.sa.gov.au/isaac/>

The NCCH (National Centre for Classification in Health) is responsible for producing and updating ICD-10-AM in Australia under contract from The Australian Department of Health and Ageing, holder of the WHO licence to create an Australian version of ICD-10.

http://nis-web.fhs.usyd.edu.au/ncch_new/

Whilst DSM is not endorsed nor the National Diagnosis standard, for historical reference the following link is provided for information:

<http://www.nzhis.govt.nz/moh.nsf/pagesns/255?Open>

This link provides mapping tables between DSM-IV, ICD-9-CM-A and ICD-10-AM, as signed off by the New Zealand Health Authorities and is therefore for information only.

9.1 Mental Health Diagnosis (ICD-10-AM)

These codes, primarily from ICD10-AM will only be used as a statistical grouping and not as an indication of clinical diagnosis on which to make clinical decisions. These represent the most often-used mental health diagnosis groups (from the ICD-10 code list, sixth edition, June 2008) and are not intended as a comprehensive list of codes.

More detailed diagnostic codes are available later in this Section and for additional information refer to ICD10-AM Mental Health Manual.

Where the code has been identified in the ICD-10 listing as an unacceptable Primary diagnosis code then this is indicated in the list to follow with an asterix.

The information systems may not contain all the codes as listed here as they currently have the most commonly used codes. However if there is a need for a code to be added this can be done by making a request to the information system administrator.

Mental and behavioural disorders (F00-F99)

It is expected that a Principal diagnosis will be a "F" code.

F00-F09

Organic, including symptomatic, mental disorders

F00 Dementia in Alzheimers disease
F00.0* Early dementia in Alzheimers dis
F00.1* Late dementia in Alzheimers dis
F00.2* Alzheimers dementia atypic / mixed
F00.9* Alzheimers dementia unsp
F01 Vascular dementia
F01.9 Vascular dementia unspecified
F02 Dementia in oth dis classified elsewhere
F03 Unspecified dementia
F04 Orgnc amnes synd not dt alco & oth subs
F05 Delirium not dt alco & oth psyact subs
F06 Oth ment disrd dt brain damage dysf dis
F07 Person & beh disrd dt brain dis dam dysf
F09 Unsp orgnc or symptomatic mental disrd

F10-F19

Mental and Behavioural disorders due to psychactive substance abuse

F10 Mental & behavioural disrd dt alcohol
F10.0 Ment & beh disrd dt alcohol use ac intox
F10.5 Ment & beh disrd dt alco use psych disrd

F10.9 Ment beh disrd dt alco ? ment beh disrd
F11 Mental & behavioural disrd dt opioid use
F11.0 Ment & beh disrd dt opioid use ac intox
F11.5 Ment & beh disrd dt opioids psych disrd
F11.9 Ment & beh disrd dt opd ? ment beh disrd
F12 Ment & beh disrd dt use of cannab
F12.0 Ment & beh disrd dt cannab use ac intox
F12.5 Ment & beh disrd dt cannab psych disrd
F12.9 Ment & beh disrd cannab ? ment beh disrd
F13 Ment & beh disrd dt sedatives hypnotics
F13.0 Ment & beh disrd dt sed hypn ac intox
F13.5 Ment & beh disrd dt sed hypn psych dis
F13.9 Ment beh disrd sed hypn ? ment beh disrd
F14 Ment & beh disorders dt use cocaine
F14.0 Ment & beh disrd dt use cocaine ac intox
F14.5 Ment & beh disrd dt cocaine psych disrd
F14.9 Ment beh disrd cocaine ? ment beh disrd
F15 Ment & beh disrd dt stimt incl cafeine
F15.0 Ment & beh disrd dt stimulants ac intox
F15.5 Ment & beh disrd dt stimt psych disrd
F15.9 Ment beh disrd dt stimt ? ment beh disrd
F16 Ment & beh disrd dt use hallucinogens
F16.0 Ment & beh disrd dt hallucin ac intox

F16.5 Ment & beh disrd dt hallucin psych dis
 F16.9 Ment beh disrd hallucin ? ment beh disrd
 F17 Ment & beh disrd dt use tobacco
 F17.0 Ment & beh disrd dt use tobacco ac intox
 F17.5 Ment & beh disrd dt tobacco psych disrd
 F17.9 Ment beh disrd dt tbcc ? ment beh disrd
 F18 Ment & beh disrd dt use volatile solv
 F18.0 Ment & beh disrd dt vol solv ac intox
 F18.5 Ment & beh disrd vol solv psych disrd
 F18.9 Ment beh disrd vol solv ? ment beh disrd
 F19 Ment & beh disrd mult drug & psyact subs
 F19.0 Ment & beh disrd mult dr psyact ac intox
 F19.5 Ment & beh dis mult dr psyact psych dis
 F19.9 Ment beh disrd mult dr psyact ? ment beh

F20-F29

Schizophrenia, schizotypal and delusional disorders

F20 Schizophrenia
 F20.0 Paranoid schizophrenia
 F20.1 Hebephrenic schizophrenia
 F20.2 Catatonic schizophrenia
 F20.3 Undifferentiated schizophrenia
 F20.4 Post-schizophrenic depression
 F20.5 Residual schizophrenia
 F20.6 Simple schizophrenia
 F20.8 Other schizophrenia
 F20.9 Schizophrenia unspecified
 F21 Schizotypal disorder
 F22 Persistent delusional disorders
 F22.0 Delusional disorder
 F22.9 Persistent delusional disorder unsp
 F23 Acute and transient psychotic disorders
 F23.2 Ac schizophrenia-like psychotic disorder
 F23.9 Acute & transient psychotic disrd unsp
 F24 Induced delusional disorder
 F25 Schizoaffective disorders
 F25.0 Schizoaffective disorder manic type
 F25.1 Schizoaffective disrd depressive type
 F25.2 Schizoaffective disorder mixed type

F25.8 Other schizoaffective disorders
 F25.9 Schizoaffective disorder unspecified
 F28 Other nonorganic psychotic disorders
 F29 Unspecified nonorganic psychosis

F30-F39

Mood affective disorders

F30 Manic episode
 F30.0 Hypomania
 F30.9 Manic episode unspecified
 F31 Bipolar affective disorder
 F31.0 Bipolar affective disrd curr hypomanic
 F31.1 Bipol aff disrd curr manic wo psych sym
 F31.2 Bipol aff disrd curr manic w psych sym
 F31.3 Bipol aff disrd curr mild / mod depres
 F31.4 Bipol aff disrd sev depres wo psych sym
 F31.7 Bipolar aff disrd curr in remission
 F31.9 Bipolar affective disorder unspecified
 F32 Depressive episode
 F32.00 Mild depres ep not in postnatal period
 F32.1 Moderate depressive episode
 F32.20 Sev depres ep wo psych sym not postnatal
 F32.30 Sev depres ep w psych sym not postnatal
 F32.90 Depres ep not in the postnatal period
 F33 Recurrent depressive disorder
 F33.9 Recurrent depressive disorder unsp
 F34 Persistent mood [affective] disorders
 F34.0 Cyclothymia
 F34.1 Dysthymia
 F34.9 Persistent mood [affective] disrd unsp
 F38 Other mood [affective] disorders
 F39 Unspecified mood [affective] disorder

F40-F48

Neurotic, stress related and somatoform disorders

F40 Phobic anxiety disorders
 F40.0 Agoraphobia
 F40.00 Agoraphobia wo mention panic disorder
 F40.01 Agoraphobia with panic disorder
 F40.1 Social phobias

ICD-10 AM – International Statistical Classification

- F40.2 Specific (isolated) phobias
- F40.8 Other phobic anxiety disorders
- F40.9 Phobic anxiety disorder unspecified
- F41 Other anxiety disorders
- F41.0 Panic disrd [ep paroxysmal anxiety]
- F41.1 Generalized anxiety disorder
- F41.8 Other specified anxiety disorders
- F41.9 Anxiety disorder unspecified
- F42 Obsessive-compulsive disorder
- F42.9 Obsessive-compulsive disorder unsp
- F43.0 Acute stress reaction
- F43.1 Post traumatic stress disorder
- F43.2 Adjustment disorders
- F43.8 Other reactions to severe stress
- F43.9 Reaction to severe stress unspecified

F44.4-F44.7

Dissociative disorders of movement and sensation

- F44 Dissociative [conversion] disorders
- F45.0 Somatization disorder
- F45.1 Undifferentiated somatoform disorder
- F45.2 Hypochondriacal disorder
- F45.3 Somatoform autonomic dysfunction
- F45.8 Other somatoform disorders
- F45.9 Somatoform disorder unspecified
- F48 Other neurotic disorders
- F48.9 Neurotic disorder unspecified

F50-F59

Behavioural syndromes associated with physiological disturbances

- F50 Eating disorders
- F50.9 Eating disorder unspecified
- F51 Nonorganic sleep disorders
- F52 Sexual dysf not dt organic disrd or dis
- F53 Ment & beh disrd ass w puerperium NEC
- F54 Psychol & beh fct ass w disrd dis cl/e
- F55 Harmful use nondependence substances
- F59 Unsp beh synd w physl disturb phys fct

F60-F69

Disorders of adult personality and behaviour

- F60.0 Paranoid personality disorder
- F60.1 Schizoid personality disorder
- F60.2 Dissocial personality disorder
- F60.3 Emotionally unstable personality disrd
- F60.30 Emotion unstable person disrd impulsive
- F60.31 Emotion unstable person disrd borderline
- F60.4 Histrionic personality disorder
- F60.5 Anankastic personality disorder
- F60.6 Anxious [avoidant] personality disorder
- F60.7 Dependent personality disorder
- F60.8 Other specific personality disorders
- F60.9 Personality disorder unspecified
- F61 Mixed and other personality disorders
- F62 Enduring person changes not dt br damage
- F63 Habit and impulse disorders
- F63.0 Pathological gambling
- F63.9 Habit and impulse disorder unspecified
- F64 Gender identity disorders
- F65 Disorders of sexual preference
- F66 Psychol beh disrd ass sex devt orientn
- F68 Oth disrd adult personality & behaviour
- F69 Unsp disrd adult personality & behaviour

F70-F79

Mental retardation

- F70 Mild mental retardation
- F70.8 Mild mental retard other impaired beh
- F71 Moderate mental retardation
- F72 Severe mental retardation
- F73 Profound mental retardation
- F78 Other mental retardation
- F79 Unspecified mental retardation

F80-F89

Disorders of psychological development

- F80 Spec development disrd speech & language

- F81 Spec development disrd scholastic skills
- F81.9 Development disrd scholastic skills unsp
- F82 Spec development disorder
motor function
- F83 Mixed specific developmental disorders
- F84 Pervasive developmental disorders
- F84.5 Aspergers syndrome
- F88 Oth disorders psychological development
- F89 Unsp disorder psychological development
- F90-F98
Behavioural and emotional disorders with
onset usually occurring in childhood
- F90 Hyperkinetic disorders
- F91 Conduct disorders
- F91.3 Oppositional defiant disorder
- F92 Mixed disorders of conduct and emotions
- F93 Emotional disorders childhood onset
- F93.9 Childhood emotional disorder unsp
- F94 Disrd social function child & adol onset
- F95 Tic disorders
- F98 Oth beh & emot disrd child & adol onset
- F98.9 Unsp beh & emot disrd child &
adol onset
- Unspecified Mental disorder
- F99 Mental disorder not otherwise specified

9.2 Other conditions from ICD-10 AM often associated with Mental and Behavioural disorders (A00 – Y98)

A00-B99

Certain Infectious and Parasitic diseases

- A50 Congenital syphilis
- A52 Late syphilis
- A81 Atypical virus infections of CNS

B20-B94

Human immunodeficiency virus (HIV) disease

- B22 HIV resulting in other spec diseases

C00-D48

Neoplasms

- C70 Malignant neoplasm of meninges
- C71 Malignant neoplasm of brain
- C72 Malg neoplasm spin cd cran nerve &
oth CNS
- D33 Benign neoplasm brain & other parts CNS
- D42 Neoplasm uncertain or unknown
beh meninges
- D43 Neoplasm unc / unk beh brain & CNS

E00-E90

Endocrine nutritional and metabolic diseases

- E00 Congenital iodine-deficiency syndrome
- E01 Iodine-def-rel thyroid disrd allied cond
- E02 Subclinical iodine-def hypothyroidism
- E03 Other hypothyroidism
- E05 Thyrotoxicosis [hyperthyroidism]
- E15 Nondiabetic hypoglycaemic coma
- E22 Hyperfunction of pituitary gland
- E23 Hypofunction & oth disrd pituitary gland
- E24 Cushings syndrome
- E30 Disorders of puberty NEC
- E34 Other endocrine disorders
- E51 Thiamine deficiency
- E64 Sequelae maln & oth nutritional def
- E66 Obesity
- E70 Disorders aromatic amino-acid
metabolism
- E71 Disrd br-chain amn-acid & fatty acid metab

ICD-10 AM – International Statistical Classification

E74 Other disorders carbohydrate metabolism

E80 Disord porphyrin & bilirubin metabolism

G00-G99

Diseases of the nervous system

G00 Bacterial meningitis NEC

G02 Meningitis in oth infect & parasit dis c/e

G03 Meningitis dt other & unspecified causes

G04 Encephalitis, myelitis encephalomyelitis

G06 Intracranial intraspinal abs & granuloma

G10 Huntingtons disease

G11 Hereditary ataxia

G20 Parkinsons disease

G21 Secondary parkinsonism

G24 Dystonia

G25 Oth extrapyramidal & movement disorders

G31 Other degenerative dis nervous sys NEC

G32 Oth degen disrd nervous sys in dis c/e

G35 Multiple sclerosis

G37 Other demyelinating diseases of CNS

G40 Epilepsy

G41 Status epilepticus

G43 Migraine

G44 Other headache syndromes

G45 TIAs (cerebral) & related syndromes

G47 Sleep disorders

G70 Myasthenia gravis & oth myoneural disrd

G91 Hydrocephalus

G92 Toxic encephalopathy

G93 Other disorders of brain

G97 Postproc disorders of nervous system NEC

H60-H95

Diseases of the ear and mastoid process

H93 Other disorders of ear NEC

I00-I99

Diseases of the circulatory system

I10 Essential (primary) hypertension

I60 Subarachnoid haemorrhage

I61 Intracerebral haemorrhage

I62 Oth nontraumatic intracranial haem

I63 Cerebral infarction

I64 Stroke not spec haemorrhage or infrcrct

I65 Occlus precereb art no cereb infrcrct

I66 Occlus stenosis cereb art no cereb infrcrct

I67 Other cerebrovascular diseases

I69 Sequelae of cerebrovascular disease

I95 Hypotension

J00-J99

Diseases of the respiratory system

J10 Influenza dt other id influenza virus

J11 Influenza virus not identified

J42 Unspecified chronic bronchitis

J43 Emphysema

J45 Asthma

K00-K93

Diseases of the digestive system

K25 Gastric ulcer

K26 Duodenal ulcer

K27 Peptic ulcer site unspecified

K29 Gastritis and duodenitis

K30 Dyspepsia

K58 Irritable bowel syndrome

K59 Other functional intestinal disorders

K70 Alcoholic liver disease

K71 Toxic liver disease

K86 Other diseases of pancreas

L00-L99

Diseases of the skin and subcutaneous tissue

L20 Atopic dermatitis

L98 Oth disrd skin & subcutaneous tis NEC

M00-M99

Diseases of the musculoskeletal system and connective tissue

M32 Systemic lupus erythematosus

M54 Dorsalgia

N00-N99

Diseases of the Genitourinary system

- N48 Other disorders of penis
- N91 Absent scanty and rare menstruation
- N94 Pain & cond ass w femle gen org menst
- N95 Menopausal & oth perimenopausal disrd

O00-O99

Pregnancy, childbirth and the puerperium

- O04 Medical abortion
- O35 Mat care known or suspect fetal abn
- O99 Oth mat dis cl/e comp preg brth puerp

Q00-Q99

Congenital malformations, deformations and chromosomal abnormalities

- Q02 Microcephaly
- Q03 Congenital hydrocephalus
- Q04 Other congenital malformations of brain
- Q05 Spina bifida
- Q75 Oth cong malform skull & face bones
- Q85 Phakomatoses not elsewhere classified
- Q86 Cong malform synd dt exog cause NEC
- Q90 Downs syndrome
- Q91 Edwards syndrome and Patau syndrome
- Q93 Monosomies deletions from autosomes NEC
- Q96 Turners syndrome
- Q97 Oth sex chromsm abn femle phntype NEC
- Q98 Oth sex chromsm abn male phenotype NEC
- Q99 Other chromosome abnormalities NEC

R00-R99

Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

- R55 Syncope and collapse
- R56 Convulsions not elsewhere classified
- R62 Lack expected normal physiological devt
- R63 Symptoms concerning food fluid intake
- R78 Drugs & oth subs not normally in blood

- R83 Abnormal findings in cerebrospinal fluid
- R90 Abn findings on dx imaging of CNS
- R94 Abnormal results of function studies

S00-S99

Injury, poisoning and certain other consequences of external causes

- S06 Intracranial injury

X40-X49

Accidental poisoning by and exposure to noxious substances

X60-X84 Intentional self harm

- X60* Intent self poison anlgsc antipyr antirhm
- X61* Intent selfpoison antiep sed-hyp psytrp
- X62* Intent selfpoison narc psychdyslpt NEC
- X63* Intent selfpoison oth aut nrv sys dr
- X64* Intent selfpoison oth & unsp dr biol sub
- X65* Intentional selfpoisoning alcohol
- X66* Intent selfpoison orgnc solv hydcarb
- X67 Intent selfpoison oth gases & vapours
- X68* Intentional selfpoison pesticides
- X69* Intent selfpoison oth unsp chem nox sub
- X70 Intent selfharm hanging strangltn suffn
- X71 Intentional selfharm by drowning
- X72* Intentional selfharm by handgun disch
- X73 Intent self harm by rifle shotgun disch
- X74 Intent selfharm oth & unsp firearm
- X75* Intent selfharm by explosive material
- X76* Intent selfharm by smoke fire & flames
- X77* Intent selfharm steam vapour hot obj
- X78 Intentional selfharm by sharp object
- X79* Intentional selfharm by blunt object
- X80* Intent selfharm jump from a high place
- X81* Intent selfharm - before moving object
- X82 Intentional self-harm by crashing of MV
- X83* Intentional selfharm by oth spec means
- X84* Intentional selfharm by unsp means

X85-Y09 Assault

- X93 Assault by handgun discharge

ICD-10 AM – International Statistical Classification

X99 Assault by sharp object
Y00 Assault by blunt object
Y04 Assault by bodily force
Y05 Sexual assault by bodily force
Y06 Neglect and abandonment
Y07 Other maltreatment syndromes

Y40-Y59

Adverse medicaments and biological substances causing adverse effects in therapeutic use

Y46 Antiepileptic drugs adv eff Rx use

Y47 Sed-hyp antianxiety dr adv eff Rx use
Y49 Psychotropic adverse effects Rx use
Y50 CNS stimulants NEC adv eff Rx use
Y51 Dr aff aut nervous system adv eff Rx use
Y57 Oth & unsp dr medicaments adv eff Rx

Y85-Y89

Sequelae of external causes of morbidity and mortality

Y90-Y98

Supplementary factors related to causes of morbidity and mortality classified elsewhere

9.3 Factors Influencing Health Status and Contact with Health Service

Z00 – Z99

Factors influencing health status and contact with health services

Z00 General examination and investigation of persons without complaint or reported diagnosis
Z02 Examination and encounter for administrative purposes
Z03 Medical observation and evaluation for suspected diseases and conditions
Z04 Examination and observation for other reasons
Z50 Care inv use of rehab procedure
Z54 Convalescence
Z55 Problems rel to education and literacy
Z56 Problems related to employment and unemployment
Z59 Problems related to housing and economic circumstances
Z60 Problems related to social environment
Z61 Problems related to negative life events in childhood
Z62 Other problems related to upbringing
Z63 Other problems related to primary support group, including family circumstances

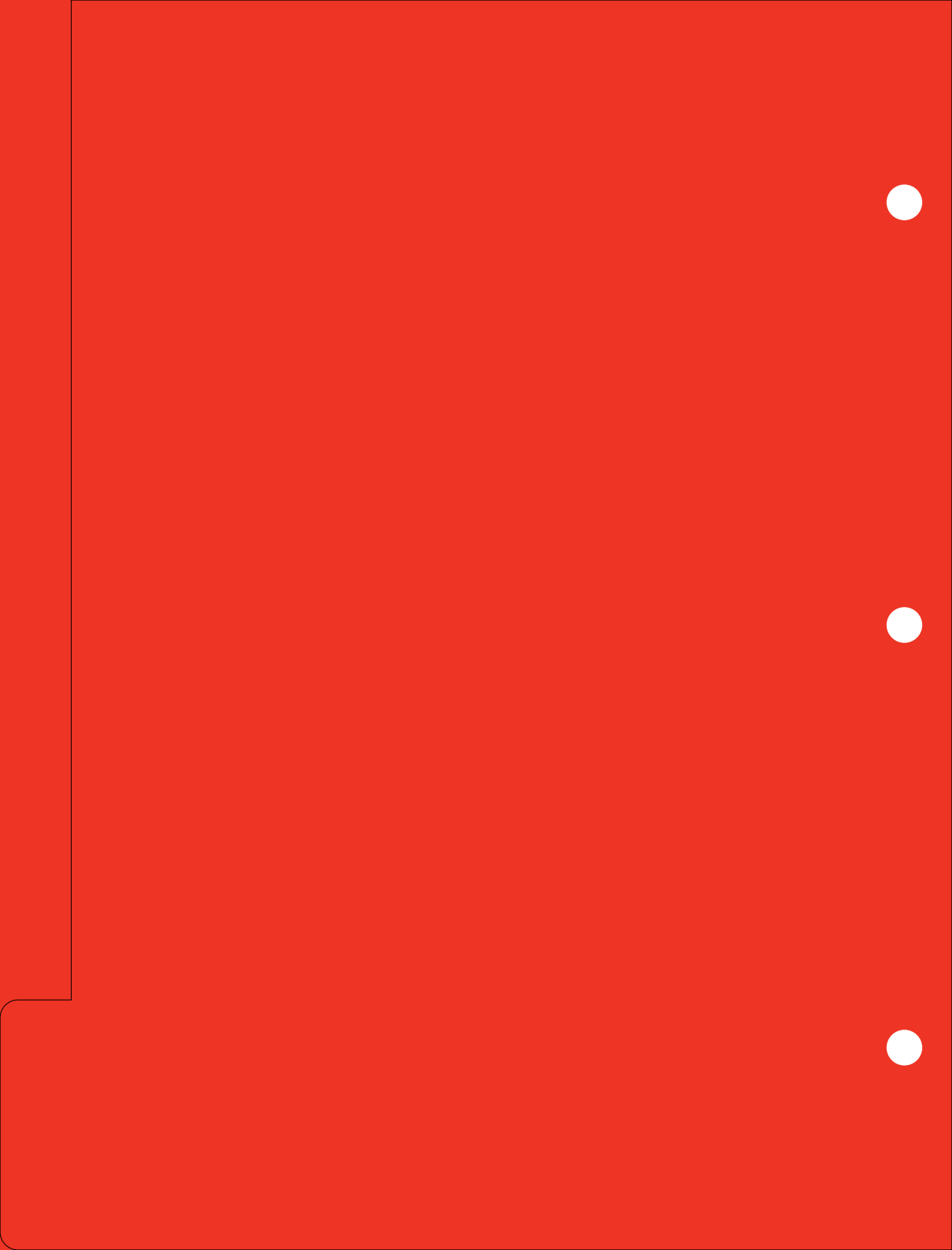
Z63.4* Disappearance and death of family member

Z64 Problems related to certain psychosocial circumstances
Z65 Problems related to other psychosocial circumstances
Z70 Counselling rel sex attitude beh orientn
Z71 Encntr hlth service oth advice NEC
Z72 Problems related to lifestyle
Z73 Problems related to life-management difficulty
Z75 Problems related to medical facilities and other health care
Z76 Persons encountering health services in other circumstances
Z81 Family history of mental and behavioural disorders
Z82 Family history of certain disabilities and chronic diseases leading to disablement
Z85 Personal history of malignant neoplasm
Z86 Personal history of certain other diseases
Z87 Personal history of other diseases and conditions
Z91 Personal history of risk-factors, not elsewhere classified



Additional Resource Material





10 Additional Resource Material

AMHOCN Internet site for information on training resources, materials, reports and other links which may be useful: <http://www.mhnocc.org/>

There is also AMHOCN online training available:
http://www.mhnocc.org/amhocn/Online_NOCC_Training/

The Transcultural Mental Health Centre has proudly developed booklets and CDs on wellbeing issues in a number of community languages. The booklets and CDs focus on the importance of obtaining and maintaining mental health and wellbeing, and encourage communities and individuals to reflect on these matters.

The K-10 is available in a number of languages from this site: <http://www.dhi.gov.au/Transcultural-Mental-Health-Centre/Information-for-Consumers-Carers-and-Community/Consumers/Translations/default.aspx>

The SA Mental Health Intranet has many documents and forms relevant to Outcome Measurement, user guides for Mental Health Information systems and a link for the SA Mental Health training calendar:
<http://in.health.sa.gov.au/operations/Default.aspx?tabid=784>

Additional reference notes:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Additional Resource Material

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

