

**Children & Young People's IAPT
Routine Outcome Monitoring**

Briefing Note

**Outcomes and Evaluation Task and Finish
Group (OEG)**

20th December 2011

NB supersedes note of October 17th 2011

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Membership of Outcomes and Evaluation Task and Finish Group (OEG)

With brief information on key relevant expertise

1. Dr Miranda Wolpert (Chair): CAMHS outcomes, data collection and analysis (National Informatics Advisor CYP IAPT)
2. Professor David Clark: Adult IAPT implementation and data analysis (National Informatics Advisor Adult IAPT)
3. Margaret Oates: Adult IAPT data collection and collation expertise
4. David Wells: Child and maternity data management and reporting
5. Bill Badham: Involvement of young people expertise
6. Dr Duncan Law: Clinical and outcome monitoring expertise in CAMHS
7. Dr Margaret Murphy: Clinical and outcome monitoring expertise in CAMHS
8. Dr Jessica Deighton: CAMHS measure review and psychometric analysis expertise
9. Dr Ann York: Expertise in Payment by Results currency development work and CAPA/service improvement in CAMHS
10. Amandeep Hothi: Voluntary sector expertise
11. Kathryn Pugh: project manager for Children & Young People's IAPT
12. Dr Paul Wilkinson: expertise in session by session monitoring in Cambridge IAPT
13. Claire Maguire: expertise in session by session monitoring in Bury IAPT and commissioning
14. Damian Hart: expertise in commissioning
15. Professor Paul Stallard: expertise in CBT and CAMHS
16. Professor Stephen Scott: expertise in conduct disorder and parenting
17. Dr Andy Fugard: psychometrics
18. Kevin Mullins: National IAPT Programme Lead
19. Dr Raphael Kelvin: DH advisor on CAMHS

Key principles

1. This is a new approach and is likely to benefit from refinement over time

The vision is that we work collaboratively and in particular that we learn from the sites that first adopt this approach and refine our thinking and practice over time.

We acknowledge up front that many aspects of this approach are new and, whilst we draw on experience from earlier pilots of session by session monitoring in Child and Adolescent Mental Health Settings both in the UK and abroad and from Adult IAPT, there is likely to be much for us to learn here and the approach may need refinement in light of this.

Our suggestion is that we review the approach in July 2012 after we have the first quarter of pilot data from the phase 1 implementer sites, and that the sites themselves are centrally involved in this review.

2. The views of children, young people and parents/carers are key

It is left to the practitioner to decide whether it is appropriate to give any individual measures to a parent/carer, a child or young person or both.

- Where only a parent/carer is involved in an intervention, it may make most sense to ask them only to complete measures (and where more than one parent/carer is involved it is up to practitioner's judgement if more than one parent/carer is asked to complete the measures).
- Where only a young person is in contact with services, it may make most sense for only them to complete measures.
- Where both a young person and a carer are involved, then again it is up to practitioner's judgement as to who should complete.

Most measures can be completed by a relatively able 8 year old.

If a service user chooses not to complete a form they should not be required to do so. The practitioner should note that they have chosen not to do so. From past trials it has been found it is very rare for service users to choose not to complete forms.

3. There should be no measurement without direct clinical utility

Any measure used as part of routine outcome monitoring (ROM) should directly contribute to the clinical work. In particular, when choosing the measures for use at each meeting, practitioners should look at the specific set of items/questions being asked and choose with the relevant service user that set of items which feels most meaningful to monitor.

The potential danger of the measures being seen as "tick box" or bureaucratic exercise, rather than a means to develop meaningful conversations is recognised as a major risk.

The vision of reviewing progress from the point of view of service users to aid direct work needs to be held in mind by practitioners and supported by supervisors and managers.

4. Good data and careful contextualized analysis are necessary for meaningful national reporting

To guarantee adequate data services need to ensure that 90% of all closed cases accepted for intervention within Tier 2 or 3 have post-assessment outcome data based on relevant service user report at, at least two time points (based on the same measure and the same informant).

This completion rate should be achieved by all IAPT trainees and supervisors from April 2012 and for those using the approach in the wider service by December 2012

These data will be collated nationally to report on reliable change and recovery rates and care will be taken to look at the best ways to analyse these data to take account of relevant contextual and other factors.

5. Routine Outcome Monitoring must be supported and resourced

Service managers must ensure:

- All cases have one nominated practitioner who is responsible for determining that ROM is meaningfully instituted for that case and make decisions about how this is to be managed when multiple practitioners and/or interventions are involved
- There are appropriate systems for collection of required data in their services

Supervisors/clinical leads must help support practitioners to:

- Determine collaboratively with service users the key things they want to work on and how to record and monitor these in each session
- introduce outcome evaluation to children and families and understand the rationale for the use of the measures
- Be cognizant of the strengths and limitations of different forms of outcome data and of how best to interpret information in the light of these
- Judge when it is appropriate for a client not to be asked to complete a scale
- Interpret what scored questionnaire results mean including what thresholds are and what they mean, and what counts as significant improvement
- Encourage open communication from clients including knowing how to make constructive use of negative or critical feedback
- Be able to use outcome data along with other information to decide on whether a change of therapy or change of techniques within that therapy is needed.

Key Elements of the Approach

The approach consists of 4 elements:

- 1) Assessment and review measures completed by relevant service users at the outset and at review/end of treatment (services to determine)

Purpose:

Assessment measures

Primary use: To ensure identification of key issues at outset and selection of appropriate symptom specific measures for regular monitoring.

Secondary use: To enable severity and type of problems across services to be compared

Review measures

Primary use: To provide feedback on the experience of the service and to check no outstanding issues

Secondary use: If enough data to allow additional analysis of outcomes and service experience, including added value score on SDQ

- 2) Brief symptom specific measures completed by relevant service users weekly

Purpose:

Primary use: To help practitioner and service users track progress

Secondary use: To enable analysis of recovery and change rates. These will be the key information reported back in quarterly national reports

- 3) Feedback tools for use in meetings e.g. Goals Based Outcomes or Outcomes Rating Scale and feedback on the meeting itself from relevant service users

Purpose

Primary use: To aid meaningful conversations in the meeting/session

Secondary use: These will be analysed alongside symptom specific measures above and may be used in future refinements. These will not be used as part of quarterly national reports in the first instance.

- 4) Practitioner reported information including indication of description of problem, selected complexity factors and current educational/work status

Purpose

Primary use: To aid practitioner thinking about nature of issues and needs of relevant service users

Secondary use: To be used in analysis to try to ensure that comparisons are only made between similar sorts of cases and relevant complexity factors are taken into account.

Details of the Approach

1) Assessment and Review measures by relevant service users

Note: services can use whatever assessment protocols or additional measures are agreed locally but the measures below should be included

The relevant service user(s) should be asked to complete the following assessment measures:

- Strength & Difficulties Questionnaire – assessment (SDQ) (30 items)
- Revised Child Anxiety & Depression Scale (RCADS) (47 Items)

These should be repeated at a review period determined appropriate by the service (e.g. 6 months after first contact, or at case closure) along with the

- Experience of Service Questionnaire (ESQ) (12 items)

Details of all items for above shown in Appendix 1

2) Brief symptom specific measures by relevant service users

From second meeting onwards, relevant service user(s) should be asked to complete one or more of 11 symptom specific checklist (each ≤12 items).

Once a set of items are chosen they should continue to be completed by the same informant until either the case is closed or the scores drop below the clinical cut off point for that set of items (though the practitioner and service user may decide to continue using that set of items even when this is the case).

Additional sets of items can be completed if practitioner and service user feel relevant and not too burdensome.

It is noted that two of the symptom scales are for those young people who are best deemed as young adults and are in line with Adult IAPT measures.

For those non-IAPT cases where it is felt that none of the currently identified symptom specific measures are felt relevant, then the Regular monitoring scale (RMQ) can be used- this looks at the impact of difficulties generally.

These measures should be completed every session (weekly) wherever possible and will form the basis for national reporting.

Details of all items for above shown in Appendix 2

3) Feedback tools used in meeting with relevant service users

Relevant service users rate up to 3 uniquely agreed “goals/things agreed to work on” or use the Outcome Rating Scale (ORS) or Child Outcomes Rating Scale (CORS)

Towards the end of the meeting all those present may be asked to rate their experience of the meeting using either the 4 item feedback on session form or use the Session Rating Scale (SRS)

These are designed as aids to clinical work and should be completed as frequently as judged relevant. Where they are completed, this information should be included in recording on relevant databases. Research shows that frequent “checking in” and feedback can aid clinical work but it is left to clinical discretion, in discussion with supervisors as to which of the above tools are used and their exact frequency.

Details of these items shown in Appendix 3

4) Practitioner Information

Practitioner will be required to complete provisional views after first meeting

- Problem description (23 items)
- Selected contextual information (13 items)

Practitioners will have the opportunity to amend or update this information at each subsequent meeting but only need do so if they have new information or want to change their views.

In addition after each meeting the practitioner will complete a brief set of items:

- Who was in the meeting (checklist with Y/N)
- if there was a key crisis (Y/N)
- if measures were refused or not given (Y/N)
- CYP attendance at education or training (0-3)
- CYP attainment in education or training (0-3)

This information is essential to aid interpretation and reporting of outcomes so must be completed every meeting

Details of these items shown in Appendix 4

Worked examples are shown in Appendix 5

Details of problem descriptors are shown in Appendix 6

Appendix 1 Assessment Measures

SDQ assessment version (child version below but also parent version)

1. I try to be nice to other people. I care about their feelings
2. I am restless, I cannot stay still for long
3. I get a lot of headaches, stomach-aches or sickness
4. I usually share with others (food, games, pens etc.)
5. I get very angry and often lose my temper
6. I am usually on my own. I generally play alone or keep to myself
7. I usually do as I am told
8. I worry a lot
9. I am helpful if someone is hurt, upset or feeling ill
10. I am constantly fidgeting or squirming
11. I have one good friend or more
12. I fight a lot. I can make other people do what I want
13. I am often unhappy, down-hearted or tearful
14. Other people my age generally like me
15. I find it difficult to concentrate
16. I am nervous in new situations. I easily lose confidence
17. I am kind to younger children
18. I am often accused of lying or cheating
19. Other children or young people pick on me or bully me
20. I often volunteer to help others (parents, teachers, children)
21. I think before I do things
22. I take things that are not mine from home, school or elsewhere
23. I get on better with adults than with people my own age
24. I have many fears, I am easily scared
25. My attention is good
26. Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?
27. If yes: How long have these difficulties been present
28. Do the difficulties upset or distress you?
29. Do the difficulties interfere with your everyday life in the following areas?
 - a. Home Life
 - b. Friendships
 - c. Classroom learning
 - d. Leisure activities
30. Do the difficulties make it harder for those around you? (family, friends, teachers, etc.)

RCADs (child version below but is also parent version)

1. I worry about things
2. I feel sad or empty
3. When I have a problem, I get a funny feeling in my stomach
4. I worry when I think I have done poorly at something
5. I would feel afraid of being on my own at home
6. Nothing is much fun anymore
7. I feel scared when I have to take a test
8. I feel worried when I think someone is angry with me
9. I worry about being away from my parents

10. I get bothered by bad or silly thoughts or pictures in my mind
11. I have trouble sleeping
12. I worry that I will do badly at my school work
13. I worry that something awful will happen to someone in my family
14. I suddenly feel as if I can't breathe when there is no reason for this
15. I have problems with my appetite
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)
17. I feel scared if I have to sleep on my own.
18. I have trouble going to school in the mornings because I feel nervous or afraid
19. I have no energy for things
20. I worry I might look foolish
21. I am tired a lot
22. I worry that bad things will happen to me
23. I can't seem to get bad or silly thoughts out of my head.
24. When I have a problem, my heart beats really fast
25. I cannot think clearly
26. I suddenly start to tremble or shake when there is no reason for this
27. I worry that something bad will happen to me
28. When I have a problem, I feel shaky
29. I feel worthless
30. I worry about making mistakes
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening.
32. I worry what other people think of me
33. I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)
34. All of a sudden I feel really scared for no reason at all
35. I worry about what is going to happen
36. I suddenly become dizzy or faint when there is no reason for this
37. I think about death
38. I feel afraid if I have to talk in front of my class
39. My heart suddenly starts to beat too quickly for no reason
40. I feel like I don't want to move
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)
43. I feel afraid that I will make a fool of myself in front of people
44. I have to do some things in just the right way to stop bad things from happening
45. I worry when I go to bed at night
46. I would feel scared if I had to stay away from home overnight
47. I feel restless

Review measures

SDQ Items – Follow Up – as for assessment but following replace items 26–30

26. Since coming to the clinic, are your problems: Much better / A bit better / About the same / A bit worse / Much worse

27. Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?
28. Over the last month, have you had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?
29. If you have answered "Yes", please answer the following questions about these difficulties: Do the difficulties upset or distress you?
30. Do the difficulties interfere with your everyday life in the following areas?
- Home Life
 - Friendships
 - Classroom learning
 - Leisure activities
31. Do the difficulties make it harder for those around you? (family, friends, teachers etc.)

RCADS as above

ESQ:

- I feel that the people who saw me listened to me
- It was easy to talk to the people who saw me
- I was treated well by the people who saw me
- My views and worries were taken seriously
- I feel the people here know how to help me
- I have been given enough explanation about the help available here
- I feel that the people who have seen me are working together to help me
- The facilities here are comfortable (e.g. waiting area)
- My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)
- It is quite easy to get to the place where I have my appointments
- If a friend needed this sort of help, I would suggest to them to come here
- Overall, the help I have received here is good

Appendix 2 – Symptom specific measures: “How are things ...?”

Problem description (source of question items)	Items to be used each meeting (or weekly as relevant)
<p>1. Depression / low mood</p> <p>(RCADs) Never = 0 Sometimes =1 Often =2 Always =3</p>	<ul style="list-style-type: none"> • I feel sad or empty • Nothing is much fun anymore • I have trouble sleeping • I have problems with my appetite • I have no energy for things • I am tired a lot • I cannot think clearly • I feel worthless • I feel like I don't want to move • I feel restless
<p>2. Out of control behaviour child view</p> <p>(Me & My School) Never = 0 Sometimes = 1 Always = 2</p>	<ul style="list-style-type: none"> • I get very angry • I lose my temper • I hit out when I am angry • I do things to hurt people • I am calm • I break things on purpose • I bully others
<p>3. Out of control behavior-parent/carer view</p> <p>(Scott adapted DSM IV items – for parent report) Never = 0 Sometimes = 1 Always = 2</p>	<ul style="list-style-type: none"> • often loses temper • often argues with adults • often actively defies or refuses to comply with adults' requests or rules • often deliberately annoys people • often blames others for his or her mistakes or misbehaviour • is often touchy or easily annoyed by others • is often angry and resentful • is often spiteful or vindictive
<p>4 Anxious away from home (Separation anxiety)</p> <p>(RCADs) Never = 0 Sometimes =1 Often =2 Always =3</p>	<ul style="list-style-type: none"> • I would feel afraid of being on my own at home • I worry about being away from my parents • I feel scared if I have to sleep on my own • I have trouble going to school in the mornings because I feel nervous or afraid • I am afraid of being in crowded places (shopping centres, the movies, buses, busy playgrounds) • I worry when I go to bed at night • I would feel scared if I had to stay away from home overnight
<p>5 Anxious in social situations (Social anxiety or phobia)</p> <p>RCADs Never = 0 Sometimes =1 Often =2 Always =3</p>	<ul style="list-style-type: none"> • I worry when I think I have done poorly at something • I feel scared when I have to take a test • I feel worried when I think someone is angry with me • I worry that I will do badly at my school work • I worry I might look foolish • I worry about making mistakes • I worry what other people think of me • I feel afraid if I have to talk in front of my class • I feel afraid that I will make a fool of myself in front of people
<p>6. Anxious generally (Generalized anxiety)</p> <p>RCADs Never = 0 Sometimes =1 Often =2 Always =3</p>	<ul style="list-style-type: none"> • I worry about things • I worry that something awful will happen to someone in my family • I worry that bad things will happen to me • I worry that something bad will happen to me • I worry about what is going to happen • I think about death
<p>7. Disturbed by traumatic event</p>	<ul style="list-style-type: none"> • I thought about it when I didn't mean to

<p>(PTSD) IES 8</p>	<ul style="list-style-type: none"> • I tried to remove it from memory • I had waves of strong feelings about it • I stayed away from reminders of it • I tried not to talk about it • Pictures about it popped into my mind • Other things kept making me think about it • I tried not to think about it
<p>8. Compelled to do or think things (OCD) RCADs Never = 0 Sometimes =1 Often =2 Always =3</p>	<ul style="list-style-type: none"> • I get bothered by bad or silly thoughts or pictures in my mind • I have to keep checking that I have done things right (like the switch is off, or the door is locked) • I can't seem to get bad or silly thoughts out of my head • I have to think of special thoughts (like numbers or words) to stop bad things from happening • I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order) • I have to do some things in just the right way to stop bad things from happening
<p>9. Panic RCADs Never = 0 Sometimes =1 Often =2 Always =3</p>	<ul style="list-style-type: none"> • When I have a problem, I get a funny feeling in my stomach • I suddenly feel as if I can't breathe when there is no reason for this • When I have a problem, my heart beats really fast • I suddenly start to tremble or shake when there is no reason for this • When I have a problem, I feel shaky • All of a sudden I feel really scared for no reason at all • I suddenly become dizzy or faint when there is no reason for this • My heart suddenly starts to beat too quickly for no reason • I worry that I will suddenly get a scared feeling when there is nothing to be afraid of

Symptom specific measures for those whose maturity/life circumstances are that of a young adult (~16+)

Problem description	Items to be used each meeting (or weekly as relevant)
<p>Depression / low mood (PHQ-9) Not at all = 0 Several days = 1 More than half the days = 2 Nearly every day = 3</p>	<p>Over the last 2 weeks, how often have you been bothered by any of the following problems?</p> <ul style="list-style-type: none"> • Little interest or pleasure in doing things • Feeling down, depressed, or hopeless • Trouble falling or staying asleep, or sleeping too much • Feeling tired or having little energy • Poor appetite or overeating • Feeling bad about yourself or that you are a failure or have let yourself or your family down • Trouble concentrating on things, such as reading the newspaper or watching television • Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual • Thoughts that you would be better off dead or of hurting yourself in some way
<p>Anxious generally (Generalized anxiety) (GAD-7) Not at all = 0 Several days = 1 More than half the days = 2 Nearly every day = 3</p>	<p>Over the last 2 weeks, how often have you been bothered by any of the following problems?</p> <ul style="list-style-type: none"> • Feeling nervous, anxious or on edge • Not being able to stop or control worrying • Worrying too much about different things • Trouble relaxing • Being so restless that it is hard to sit still • Becoming easily annoyed or irritable • Feeling afraid as if something awful might happen

Note for those who are using this approach in wider CAMHS with difficulties that are not relevant to any of the problem descriptions above then use RMQ (regular monitoring scale): 5 pt scale

Since coming last time, are your difficulties.....

How much have your difficulties been upsetting or distressing you? (5 pt scale)

How much have your difficulties been interfering with your everyday life in the following areas?

- a. Home life
- b. Friendships
- c. Ability to learn or work
- d. Leisure activities

Thinking about the future: How much better do you think you will be in one month's time?

Appendix 3 Feedback tools for use in session

Goal monitoring/checking general progress:

Practitioner has choice of tools

- **Goals:**

“We agreed to work on X. How would you score this today on a scale of 0–10 where 0 is not begun to achieve goal and 10 is really good/goal achieved”

- **Outcome Rating Scales (ORS)/ Child Outcome Rating Scale (CORS)**

“Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels” [using 10cm visual analogue scale]

- Individually (Personal well-being)
- Interpersonally (Family, close relationships)
- Socially (Work, school, friendships)
- Overall (General sense of well-being)

Feedback at end of meeting:

Practitioner has choice of tools

- **Feedback Questions (asked as part of general conversation and scores noted by practitioner rather than given as sheet)- 4 pt scale**
 - Did you feel listened to?
 - Did you understand what was said in the meeting?
 - Did you talk about what you wanted to talk about?
 - Did the meeting give you ideas for the future?
- **Session Rating Scale (SRS)**
Please rate today's session by placing a mark on the line nearest to the description that best fits your experience. [Using 10cm visual analogue scale with the following anchors]
- **Relationship** (I did not feel heard, understood, and respected - I felt heard, understood, and respected)
- **Goals and Topics** (We did *not* work on or talk about what I wanted to work on and talk about - we worked on and talked about what I wanted to work on and talk about).
- **Approach or Method** (The therapist's approach is not a good fit for me. The therapist's approach is a good fit for me).
- **Overall** (There was something missing in the session today - Overall, today's session was right for me).

Appendix 4 Practitioner Information (NB Can update every session)

Problem descriptions

(NB not diagnosis, rather is problem categorization to help identify relevant intervention and regular monitoring items).

no problem, mild problem, moderate some impact, severe - effects life a lot, not known

- 1) Depression or low mood (Depression)
- 2) Out of control behaviour (ODD or CD)
- 3) Anxious away from home (Separation anxiety)
- 4) Anxious in social situation (Social anxiety/phobia)
- 5) Anxious generally (Generalized anxiety)
- 6) Disturbed by traumatic event (PTSD)
- 7) Compelled to do or think things (OCD)
- 8) Panics (Panic disorder)
- 9) Afraid of going out (Agoraphobia)
- 10) Afraid of specific things (Specific phobia)
- 11) Difficulties sitting still or concentrating (ADHD/Hyperactivity)
- 12) Does not speak (Selective mutism)
- 13) Eating issues (Eating disorder)
- 14) Repetitive problematic behaviours (Habit disorder)
- 15) Doesn't get to toilet in time (Elimination problems)
- 16) Drug and alcohol difficulties (Substance abuse)
- 17) Severe mental health issues (Psychosis or bipolar disorder)
- 18) Severe relationship difficulties (Emerging personality disorder)
- 19) Self harm (Self injury or self harm)
- 20) Gender discomfort issues (Gender identity disorder)
- 21) Problems in attachment to parent/carer (Attachment problems)
- 22) Carer management of CYP behaviour (eg Management of child with challenging behaviour)
- 23) Family relationship difficulties

Selected Contextual Factors (can update each meeting)

Indicate if any of following true (and indicate if not known):

1. Looked after child
2. Young carer status
3. Learning Disability
4. Serious physical health issues (including Chronic Fatigue)
5. Pervasive Developmental disorder (including autism and Asperger's)
6. Neurological issues such as tics or Tourette's
7. Current protection plan
8. Deemed "child in need" of social service input
9. Refugee or asylum seeker
10. Experience of war, torture or trafficking

Home

- No contextual issues
- Some issues e.g. some family MH issues or difficulties with housing
- Significant issues: more than one issue e.g. substance abuse and MH issues
- Severe issues; wide range issues or one severe issue e.g. severe parental MH
- Not known

School

- No contextual issues
- Some issues e.g. one incident bullying
- Significant issues e.g. ongoing bullying or problems with one teacher
- Severe issues e.g. severe bullying or breakdown in relationship with school
- Not Known

Community

- No contextual issues
- Some issues e.g. issues with housing or community engagement
- Significant issues e.g. area of some violence with frequent police involvement
- Severe issues e.g. area of high violence
- Not Known

Practitioner report after each meeting (Practitioner)

Tick who took part in the meeting: Young person/Caregiver/Other Young People (as part of group work) /Other caregivers (as part of group work)/Other
Tick as many as relevant

Has there been a key crisis or issue that needs to be taken into account at this point (eg newly revealed self harm, bereavement, trauma)? Y/N

Did you ask for a measure(s) to be completed that PC refused to complete? Y/N

Did you ask for a measure(s) to be completed that CYP refused to complete? Y/N

Clinician decided not to give one or more measures Y/N

Choose which most applies for CYP re education, employment or training (EET)

Attendance

- No problem.
- Some problems: attending part-time or missing some days / truanting/refusal
- Significant problems: Rarely attending; at high risk of exclusion/dismissal
- Excluded or not in EET.

Attainment

- No problems
- Some problems. eg: in school well below year level in at least one subject in work some problems (timekeeping, workrate, etc)
- Significant problems (e.g. fails key exams, below year group in all subjects), received formal warnings from employer.
- Severe problems: Dropped out of school or employment

Appendix 5 Worked examples; Alex, Jamal and Maisy¹

Alex (8) – referred for school refusal

Time point	Clinical activity	Data requested & collected	Data recorded	Use of data
January 10 th 2012	<p>8 year old Alex referred to CAMHS by GP</p> <p>Referral notes following: Alex is very anxious Alex won't go to school Alex has "learning disability" Alex lives with both biological parents and older sister Alex is in mainstream school but has additional support</p>	<p>Relevant members of CAMHS discuss referral and agree appropriate to offer appt</p> <p>Offered initial appointment and sent SDQ, RCADS for parents to complete with rationale as below and request to bring to first meeting:</p> <p>"Please find attached questionnaires for parents to be completed before you come to your first appointment. These can be completed by both parents together or each can complete one separately."</p>	<p>Alex logged on system</p> <p>Key demographics logged on system: age, DOB, etc.</p> <p>Information from referral entered on system including: provisional categorization of contextual factor "learning disability"</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>To support clinician planning and formulation</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>To ensure relevant contextual and demographic information available on each case</p>
February 12 th 2012	<p>Alex and mother attend first appointment</p>	<p>Alex's mother has completed questionnaires but left at home by mistake</p> <p>All feel Alex not able to complete questionnaires but is asked to contribute views in session</p> <p>Questionnaires completed in session. Too little time to sum scores but a selection of item responses examined and discussed as part of wider clinical interview</p> <p>Clinical interview reveals potential bullying at school</p>	<p>Alex's mother's questionnaire scores entered on system</p> <p>Demographics and other details now amended</p> <p>Including noting psychosocial factor: "School context mild (e.g. bullying)"</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Provisional thoughts on key issues/problem formulation shared with family</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Key contextual factors considered in analysis and interpretation of outcomes</p>

¹ CORS/ORS/SRS not shown in these examples but could be used instead of goals and session feedback or in addition as relevant

<p>February 24th 2012</p>	<p>Alex and mother attend second appt</p>	<p>Further clinical interview undertaken</p> <p>Information gathered so far is pulled together into a formulation explaining the current difficulties and shared with Alex and the mother</p> <p>Alex and family agree goals a) aim to get back in school b) aim to feel less scared all the time</p> <p>agreed on CBT for Alex with his mother present</p> <p>Set up school meeting to help agree plan with teachers to tackle bullying</p> <p>Clinician completes CGAS</p>	<p>Provisional presenting problems recorded as “separation anxiety” and “general anxiety”</p> <p>Record Goals : a) get back in school b) feel less scared all the time</p> <p>(☹ 0–10 ☺)</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Used to agree next steps for treatment</p> <p>Help focus treatment plan</p> <p>Used to determine measures to be used each session – in this case relevant items from parent RCADS for separation anxiety (see Appendix 2 above)</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>To review recovery and reliable change rates in specified problem area in this case in relation to separation anxiety</p>
<p>March 15th 2012</p>	<p>Alex seen by CAMHS clinician with mother</p>	<p>Review goals i.e. getting back to school and feeling scared all the time – Alex centrally involved in these ratings</p> <p>Alex’s mother completes RCADS items for separation anxiety each time</p> <p>Fear thermometer used with Alex</p>	<p>Rates goals a) 3 b) 5</p> <p>RCADS for separation anxiety above the clinical cut off</p> <p>At end of meeting Alex and his mother complete feedback form (see Appendix 2 above) – fine generally but Alex indicates not understanding everything.</p> <p>Clinician agrees with Alex’s mother strategies how to make clearer to Alex</p> <p>Clinician completes end of meeting measures</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>RCADS used to monitor progress</p> <p>Experience of session used to inform next session planning</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Data available to model change over time</p> <p>Able to track reliable change and recovery rates on standardized measure</p>
<p>CONTINUE with interventions and use of measures at each meeting</p>				

<p>May 20th 2012</p>	<p>Case closed</p>	<p>Alex back in school and anxiety reduced – plan for how to cope with relapses in place – decide to end intervention</p> <p>Alex's mother completes SDQ, full RCADS and CHI ESQ, Alex helped to complete CHI ESQ where possible</p> <p>Clinician completes CGAS and rates outcome of treatment</p>	<p>Rates goals a) 8 b) 8</p> <p>RCADS for separation anxiety and for GAD within the non clinical range</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Used to review case with family and in supervision</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Data available to model change over time</p> <p>Able to track reliable change and recovery rates on standardized measure</p>
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Jamal 10- referred for OCD

Time point	Clinical activity	Data requested & collected	Data recorded	Use of data
January 10 th 2012	<p>Jamal: 10 year old referred to CAMHS by school</p> <p>Referral notes washes hands all the time</p> <p>Jamal lives with his mother and step father</p> <p>Jamal's mother does not speak English</p>	<p>Relevant members of CAMHS discuss referral</p> <p>Offered appointment and sent SDQ and RCADS, with rationale as below, and request to bring to first meeting:</p> <p>“Please find attached questionnaires for both Jamal and you to complete before you come to your first appointment. These can be completed by both parents together or each can complete one separately. If there is anything you don't understand we can discuss when we meet.”</p> <p>NB Questionnaires sent in relevant language where possible e.g., SDQ has 59 languages to choose from</p>	<p>Key demographics logged on system including age, DOB, etc.</p> <p>Information from referral entered on system</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>To support clinician planning and formulation</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>To ensure relevant contextual and demographic information available on each case</p>
January 20 th 2012	<p>Jamal, his mother and step father and translator attend first appointment</p>	<p>Translator helps Jamal's mother complete questionnaires</p> <p>Service unable to score immediately – Jamal's family are told will comment on scores when next meet</p> <p>Clinical interview reveals potential OCD – hand washing</p>	<p>Questionnaire scores (after session) entered on system</p> <p>Demographics and other details now amended</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Provisional thoughts towards formulation shared but may require further thought and interview</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Contextual factors taken into account in analysis of outcomes</p>
January 29 th 2012	<p>Jamal and his mother attend second appt</p>	<p>Scores from questionnaires reported back and discussed</p> <p>Further clinical interview undertaken</p>	<p>Provisional presenting problem recorded as OCD</p> <p>Record Goal: Reduce amount of hand-washing</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Used to agree next steps for treatment and focus treatment plan</p>

		<p>Jamal and family agree goals</p> <p>agreed on CBT for Jamal with mum present</p>		<p>Agree measures to be used each session- in this case parent and child RCADS for OCD (see appendix 2 above):</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Data available to model change over time</p> <p>Able to track reliable change and recovery rates on standardized measure</p>
February 15th 2012	Jamal seen by CAMHS clinician with mother	<p>Review goal re hand washing rituals; Jamal centrally involved in these ratings</p> <p>All attending complete RCADS for OCD each time and these reviewed at start of session</p>	<p>Hand-washing goal rated</p> <p>RCADS for OCD above the clinical cut off</p> <p>Jamal and parents complete experience of session question- say 'fine'</p> <p>Clinician completes end of meeting measures</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Rating of goals and RCADS used to monitor progress</p> <p>Experience of session used to inform next session planning</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Data available to model change over time</p> <p>Able to track reliable change and recovery rates on standardized measure</p>
CONTINUE with therapy and use of measures at each meeting				
May 20 th 2012	Case closed	<p>Jamal OCD reduced – decide to end intervention</p> <p>Mother and father complete SDQ and CHI ESQ, Jamal helped to complete CHI ESQ where possible</p> <p>Clinician rates outcome of treatment</p>	<p>Goal re hand-washing 10</p> <p>RCADs for OCD put Jamal in the non- clinical range</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Used to review case with family and in supervision</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Data available to model change over time</p> <p>Able to track reliable change and recovery rates on standardized measure</p>

Maisy 15 referred for self harm

Time point	Clinical activity	Data requested & collected	Data recorded	Use of data
January 10 th 2012	<p>15 year old Maisy referred to CAMHS by GP</p> <p>Referral notes following: Maisy very challenging to foster carers.</p> <p>Maisy reports disrupted sleep and hearing voices in her head and her foster family have noticed cuts on her fore-arms</p> <p>Maisy lives with her foster mother and foster father and their two younger children (6 and 7 years old)</p> <p>Maisy has been placed with them for the last 3 moths She has a history of broken placements and was put into care at 6 years old following sexual abuse by her stepfather</p>	<p>Relevant members of CAMHS discuss referral</p> <p>Agreed to offer very rapid appointment given severity of concerns- foster parents contacted by phone and appointment arranged for next day</p> <p>Team debate if appropriate to ask to complete questionnaires or not - decide to send SDQ and RCADS and explain on phone the reasons for sending these: <i>"to help us get a better understanding of the nature of the difficulties, we use these standard questionnaires which we send to everyone seen here. We use the information from these along with a detailed interview when you come, to understand the nature of the difficulties and any differences between people in their perspective on these. We will discuss our ideas on this with you and refine them in the light of your view and together we will reach agreement as to how best to help. Some of the questions may not be at all relevant to you or Maisy, and other things that may feel very important may not be covered. We can discuss these when you come. If anyone really feels they do not want to complete any or all of the question,s that is fine and feel free to leave anything you don't understand or want to discuss with us first, but if all (foster mother and foster father and Maisy) could have a go at answering the questions to</i></p>	<p>Key demographics logged on system</p> <p>Including age, dob, and fact that Maisy is "Looked After" (LAC)</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>To support clinician planning and formulation</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>To ensure relevant contextual and demographic information available on each case</p>

		<p><i>help us understand how each of you see things that would be helpful."</i></p> <p>Since family have internet access and appt next day agreed to email the questionnaires across for family to print out complete and bring to meeting. NB if did not have internet access might suggest arriving 15 mins early to complete</p>		
January 11 th 2012	Maisy, her foster mother and foster father attend first appt	<p>Maisy's foster mother completes all questionnaires before session and brings to session</p> <p>Maisy's Foster father wants to discuss first in session</p> <p>Maisy does not want to complete</p> <p>In session clinician answers further questions re measures and what individual items aim to capture Maisy's Foster father completes in meeting Maisy still chooses not to complete</p> <p>Questionnaires from both foster parents rated by support staff and given to clinician to aid discussion- pointed out that they suggest Maisy very low mood and behaviour very challenging</p> <p>Scores suggest Maisy's foster mother more worried than foster father and feels going on longer... These differences explored in session and Maisy invited to comment also</p> <p>Mental state exam carried out as part of full clinical interview - both foster</p>	<p>Foster mothers' and foster fathers' scored measures entered on system</p> <p>Demographics and other details now amended</p> <p>Contextual factors recorded</p> <p>Provisional presenting problem recorded as self harm</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Disparities in views between foster parents discussed and Maisy's views checked</p> <p>Provisional thoughts towards formulation shared but explained want further thought and interview</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>To allow appropriate analysis of case complexity in relation to outcomes</p>

		<p>parents and Maisy acknowledge self harm</p> <p>View is that no active psychosis but may be a risk of developing</p> <p>Risk assessment undertaken as part of clinical interview determines no current suicide risk and not serious risk to parents or younger children, as Maisy has not directed any aggression towards them and foster parents are very protective of them both physically and emotionally. Safety plan agreed</p> <p>Agree contact with social services and further meeting with child psychiatrist to continue assessment</p> <p>Agree measures to use each time - depression measures</p>		
Jan 19 th 2012	Maisy and Foster Mother attend appt	<p>Further clinical interview undertaken</p> <p>Information gathered so far is pulled together into a formulation explaining the current difficulties and shared with Maisy and the foster family</p> <p>Maisy and her foster family agree goals a) reduce amount of self cutting b) improve relationship of Maisy with her foster mother</p> <p>To achieve these goals agree CAMHS Clinician will offer some individual work for Maisy</p> <p>Another CAMHS Clinician will work with foster family</p>	<p>Rating of goals</p> <p>Completion of RCADs depression</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Used to agree next steps for treatment</p> <p>Help focus treatment plan</p> <p>Used to monitor progress</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Data available to model change over time</p> <p>Able to track reliable change and recovery rates on</p>

		to help them support Maisy Clinician completes HoNOSCA		standardized measure
February 1st 2012	Maisy seen by CAMHS clinician - her foster mother brings her and waits outside	Review key things to work on ie self cutting and relationship with foster mother Complete RCADS depression measures Start therapeutic input	Rates goals a) 3 b) 1 Complete RCAD items Maisy completes experience of session question- says 'not happy' – this discussed in session and consider how to resolve and encourage return for next session Clinician completes end of meeting measures	<u>Primary use as aid for clinical contact</u> Maisy saying not happy with clinical encounter used to explore what been difficult RCAD items scored to show baseline and monitor progress Clinician looks at Maisy's experience and their sense of session in supervision <u>Secondary use to explore outcomes across services</u> Data available to model change over time Able to track reliable change and recovery rates on standardized measure
February 22 nd 2012	Appt for Maisy	Maisy did not attend	Record Non attendance	<u>Primary use as aid for clinical contact</u> Explore in supervision <u>Secondary use to explore outcomes across services</u> Note DNAs for analysis

<p>March 10th 2012</p>	<p>Appt for Maisy</p>	<p>Maisy attends (her foster mother waits outside)</p> <p>Mental state exam suggest psychosis</p>	<p>Rates goals a) 1 b) 1</p> <p>Maisy will not complete RCAD items or experience of session</p> <p>Her foster mother completes RCADs</p> <p>Clinician amends provisional diagnosis to include Psychosis</p> <p>Clinician completes end of meeting measures</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Review measures in light of amended categorization of problems – in this instance decide not to add further measures</p> <p>Explore in supervision</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Note refusal to complete measures to inform analysis</p>
<p>March 15th 2012</p>	<p>Both foster parents and Maisy seen together</p>	<p>Review key things - self cutting and relationship but also focus on diagnosis of psychosis</p>	<p>Goals rated a) 1 b) 1</p> <p>Both foster parents complete relevant RCADs items</p> <p>Foster parents rate experience of session positively</p> <p>Clinician completes end of meeting measures</p>	<p><u>Primary use as aid for clinical contact</u></p> <p>Explore any disparities in views and monitor progress</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Note refusal of Maisy to complete measures to inform analysis</p> <p>Data available from foster parents to model change over time</p> <p>Able to track reliable change and recovery rates on standardized measure from perspective of foster parents</p>

CONTINUE

Maisy and family stop coming to sessions and cannot be contacted - social services informed but no further contact - after some months decided to close case

<p>May 20th 2012</p>	<p>Case closed</p>	<p>Clinicians involved each rate outcome and complete HoNOSCA based on last information available about Maisy</p>		<p><u>Primary use as aid for clinical contact</u></p> <p>Review in supervision</p> <p><u>Secondary use to explore outcomes across services</u></p> <p>Review change over time</p>
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Appendix 6

Problem descriptors- further information to aid categorisation

1	Depression or low mood (Depression)	<p>Feeling worthless, lonely, guilty, preoccupation with death, social isolation or withdrawal.</p> <p>May become uninterested in topics previously enjoyed, school work may deteriorate, sleep fitful or a lot</p> <p>May have headaches or stomach aches</p>
2	Out of control behaviour (ODD or CD)	<p>Involved in physical or verbal aggression, cruel behaviour toward people and pets, destructive behaviour, lying, truancy, vandalism or stealing.</p>
3	Anxious away from home (Separation anxiety)	<p>Excessive anxiety regarding separation from home or to parents/cares/important others</p> <p>May refuse to go to certain places (e.g. school)</p> <p>May refuse to sleep alone, experience nightmares</p> <p>May experience physical complaints (e.g. headaches, body-aches, nausea)</p>
4	Anxious in social situation (Social anxiety/phobia)	<p>Intense fear in social situations either specific or general</p> <p>May feel fear of being judged and of being embarrassed</p> <p>Physical symptoms include excessive blushing, sweating, trembling, palpitations, nausea, and stammering.</p>
5	Anxious generally (Generalized anxiety)	<p>Excessive worry typically involving anticipation of disaster re health issues, family, friends, or work</p> <p>May include physical symptoms, such as fatigue, headaches, nausea, muscle aches, difficulty swallowing or breathing, difficulty concentrating, trembling, twitching, irritability, agitation, over 6 months duration</p>
6	Disturbed by traumatic event (PTSD)	<p>Re-experiencing of a trauma through flashbacks or nightmares</p> <p>Avoidance of anything associated with the trauma</p> <p>Increased arousal e.g. difficulty falling or staying asleep, anger, and hyper vigilance</p>
7	Compelled to do or think things (OCD)	<p>Obsessive intrusive thoughts or images that enter the mind often recognized by the person as unrealistic and unwelcome but feel powerless to stop them.</p> <p>Compulsive behaviours are repetitive that CYP feels must be carried out, e.g. checking, washing, rumination, rituals</p>
8	Panics (Panic disorder)	<p>Repeated periods of intense fear or apprehension.</p> <p>Usually begin abruptly, reach a peak within 10 minutes, and subside over the next several hours.</p>
9	Afraid of going out	<p>Avoidance of public places/going out</p>

	(Agoraphobia)	
10	Afraid of specific things (Specific phobia)	Extreme or irrational fear related to exposure to specific objects or situations. Tends to actively avoid direct contact with the objects or situations
11	Difficulties sitting still or concentrating (ADHD/Hyperactivity)	Have some or all of following: <ul style="list-style-type: none"> • restless, fidgety and overactive • continuously chatter and interrupt people • easily distracted and do not finish things • inattentive and cannot concentrate on tasks • impulsive, suddenly doing things without thinking first • have difficulty waiting their turn in games, in conversation or in a queue.
12	Does not speak (Selective mutism)	Capable of speech feels unable to speak in given situations, or to specific people. Often co-exists with shyness or and/or social anxiety
13	Eating issues (Eating disorder)	Insufficient or excessive food intake. Includes Bulimia nervosa, anorexia nervosa and binge eating
14	Repetitive problematic behaviours (Habit disorder)	Tension-discharging phenomena, such as head banging, body rocking, thumb sucking, nail biting, hair pulling , teeth grinding, hitting or biting parts of one's own body, body manipulations, repetitive vocalizations, and air swallowing
15	Doesn't get to toilet in time (Elimination problems)	Repeatedly having bowel movements in inappropriate places after the age when bowel control is normally expected. (encopresis) Micturation after age of toilet training (bed-wetting) (enuresis)
16	Drug and alcohol difficulties (Substance abuse)	Use of alcohol or drugs in such a way as negative impact on life
17	Severe mental health issues (Psychosis or bipolar disorder)	May involve one or more of: Thought disorder – not being able to think straight - ideas jumbled Delusions – strong beliefs with no objective evidence, inconsistent with general cultural beliefs Hallucinations – hearing or seeing things not there that cause distress
18	Severe relationship difficulties (Emerging personality disorder)	Unusually high levels of instability in mood; black and white thinking, or splitting; chaotic and unstable interpersonal relationships, self-image, identity, and behaviour May involve periods of dissociation.
19	Self harm (Self injury or self harm)	Skin-cutting burning, scratching, banging or hitting body parts, interfering with wound healing and the ingestion of toxic substances or objects
20	Gender discomfort issues	Significant discontent with their biological sex and/or the gender

	(Gender identity disorder)	they were assigned at birth
21	Problems in attachment to parent/carer (Attachment problems)	Disturbed attachment between young person and those close to them. May be different at different ages e.g. younger child unable to gain comfort from parents/carers when in distress.
22	Carer management of CYP behaviour (eg Management of child with challenging behaviour)	Focus is on managing difficult behaviour
23	Family relationship difficulties	Focus is on relationship difficulties