

CAMHS Information Project

*A Resource Kit for Outcomes
Measurement in Kent Child
and Adolescent Mental Health
Services*

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INTRODUCTION AND CHECKLIST

The CAMHS Information Project (CIP) was commissioned as a county-wide response to the call for implementation of routine outcomes measurement (ROM), as indicated in both national and local level policies (Every Child Matters, 2004; National Standards Framework: Standard 9, 2004; CAMHS Commissioning Strategy for Kent, 2007; Kent Children and Young People's Plan, 2008-2011).

The aims of the CIP were to implement systems of ROM across Tier 2 and 3 CAMH services in Kent; and in doing so, promote a culture of learning and advancement through the proactive use of outcomes tools, and monitor, evaluate and ensure continual high-quality service provision to children, young people and families living in the county.

Furthermore, as ROM is considered an essential aspect of commissioning arrangements needed for service improvement, its implementation indicates a further example of good practice across the county's CAMH services. The CIP was therefore intended as more than a performance management measure, and instead was to make a strategic contribution to CAMH service development with improved outcomes for service users.

Terms of Reference – The CAMHS Information Group

The CAMHS Information Group acts as a steering group for the CIP and holds responsibility for a number of different functions which include;

- To coordinate and support implementation of the CAMHS Information Project across Kent
- To ensure consistent, routine and continual use of agreed core CAMHS outcomes measures
- To ensure links with the broader CAMHS Performance Management Framework are maintained
- To collect, analyse and interpret the information generated from the CAMHS Information Project
- To develop appropriate responses for services whose outcomes data is in question e.g. by providing direction and guidance on further investigation to assess outcomes in other ways
- To liaise with CORC and provide them with appropriate, quality data for in-depth analysis
- To support the CAMHS Information Officer

Accountability and Representation

The CAMHS Information Group is a sub-group of the CAMHS Strategy Group and is chaired by the CAMHS Strategy Commissioner. It meets regularly and members share additional contact via email. Included in the group is representation from CAMHS Providers at Tiers 2 through to 4, Commissioners

from PCTs and LAs, as well as members of the CAMHS Practice Improvement Programme, Canterbury Christ Church University. In addition, representation from Preventative Services Managers, the Voluntary Sector and other relevant stakeholders is continually sought.

- Outcomes

The CAMHS Information Group aims to achieve consistent and coordinated collection of routine outcomes data from all Targeted and Specialist Mental Health Providers across Kent.

The Group facilitates regular reporting of outcomes between Providers and Commissioners and provides regular feedback to the CAMHS Strategy Group.

The Group will identify services where outcomes data has indicated challenges potentially exist, and support them in the implementation of further measures to capture additional information. In such cases, the Group will encourage reflection on practice and use of resources at service level, and will work with Commissioners on behalf of services to address areas of need.

Collecting Outcomes Data in CAMHS: Checklist

(adapted from 'The IAPT Handbook' V 2.0.1, 2011)

Services may find it helpful to use this checklist when reviewing their information systems in relation to routine outcomes measurement.

1. Identify a 'Lead Clinician' and 'Lead Administrator' to oversee data collection and ensure data is used effectively in services. These roles may be allocated on a rotational basis.
2. Understand what information should be collected (see Chapter 2), including any local requirements.
3. Agree a data collection process (see Chapter 3).
4. Develop and agree local delivery arrangements with Clinicians, Administrative and Technical staff to ensure full participation.
5. Ensure Clinicians are trained in the importance of data collection and have access to this resource kit.
6. Begin data collection
 - a. What is your data collection process (who does what, when and how)
 - b. Ensure data collection systems (e.g. YiM, RIO) are in place
 - c. Review data collection to identify any adaptations that are needed
7. Ensure processes have been implemented for data analysis and dissemination of findings.

CHAPTER 1: THE IMPORTANCE OF COLLECTING OUTCOMES DATA

Systems of routine outcomes measurement are used to monitor and evaluate service provision. The information gathered can be used to improve services dedicated to promoting the mental health and emotional wellbeing of children and young people.

Within individual services outcomes data can be used to enhance clinical practice and service user experience by providing opportunity for individual and service level reflection, and gain service user feedback on experiences of contact with a service. Information can also be used to assist services in planning more effectively and therefore improve overall team performance.

More widely, information from outcomes measurement can be used to ensure clinical practice remains grounded in a strong evidence base and commissioning is informed in such a way as to promote positive outcomes for service users.



Uses of Outcomes Data

- To provide stakeholders with the opportunity to learn more about the successes and needs of practice at individual, team and service levels
- To generate suggestions for development and improvement of services
- To identify significant and emerging trends and patterns e.g. related to service user profile and future trajectory
- To underpin the grounding of practice in a strong evidence base
- To inform decisions over commissioning in response to what is identified by individual services
- To question service provision with the view to including additional and more complementary outcomes measures; where the need for further information is indicated (for example where core measures have only partially captured a particular service)

Clinicians and Practitioners

- Information from measures such as the Experience of Service Questionnaire (CHI ESQ) may be incorporated into supervision sessions in order to encourage reflection on individual performance and experience with a particular case. This in turn can lead to changes in clinical practice.
- Clinicians often report they feel having individual level feedback gives them a specific sense of the practice of ROM being relevant.

Service Users

- Some services utilise outcomes data to demonstrate quantifiable change to service users.
- Some Clinicians report that being able to objectify 'getting better' encourages service users to feel confident about leaving a service, or continue with an intervention when they may have felt pessimistic about their progress.

Provider Service

- At this level, outcomes data is most often used to inform commissioning and service planning by identifying where a service is experiencing success and where it may need to make changes.
- Demonstrable outcomes measurement activity supports the service in being a competitive provider.
- Specifically, outcomes data can be used to review the suitability of potential service users to the service by informing acceptance criteria / acting as a screening tool.
- Outcomes data can be used to describe the complexity and profile of cases seen by the service e.g. proportion of referrals for eating disorders, self harm, ADHD etc.

- Analysis of outcomes data can include information on intervention offered, in order to evidence how a particular treatment may be most effective for a particular client group.
- Many services aim to achieve triangulation of outcomes data with other sources of information such as demographics, in order to identify trends for particular groups of children and young people and highlight different pathways to getting better.

Commissioners

- Commissioners often rely on quantitative data to give them an overview of how services are performing.
- Although outcomes data alone cannot provide comprehensive insight into the functioning of a particular service, it is still one of the most powerful and accessible sources of information services have at their disposal for evidencing strategic development.
- Outcomes data enables Commissioners to make nation-wide and county-wide comparisons across services, which can more reliably inform decisions about funding and service development.

Considerations

The CAMHS Outcomes Research Consortium (CORC) recommends teams have regular periods of time to think about what they expect to see from their outcomes data, to remove any challenges to sharing the information once it is available e.g. apprehension to engage with findings that indicate the service is in need.

Where outcomes contradict what is expected, teams should consider factors such as;

- Suitability of the measures being used
- Small sample sizes
- The presence of outliers in the data
- Where data only represents one Clinician / specialism, case complexity
- Whether effect was due to receipt of an intervention or being on a waiting list
- Human error
- Cultural differences across respondents
- The remit of the service being offered (e.g. diagnostic or intervention)
- Suitability of referrals.

Teams should aim to formulate hypotheses to explain their outcomes data and target investigation of this.

From a Service Level point of view, data should be analysed year by year rather than accumulatively, as including 'old' data may mask more recent improvements. This also enables comparison across years which can more easily be linked to changes in service provision, team composition, referral criteria etc. At the Individual Level, data should be analysed case by case to illuminate change which has occurred in a particular young person.



CHAPTER 2: MEASUREMENT TOOLS AND THE CORC STANDARD

Outcomes measures utilised by CAMH teams will vary according to the profile of service users seen in each service however, as a minimum standard, services will be expected to use Parent (and where appropriate) Self rated Strengths and Difficulties Questionnaires (SDQs), Children's Global Assessment Scale (CGAS) and the Experience of Service Questionnaire (CHI-ESQ). Measures such as Strengths and Difficulties Questionnaire Teacher Version (SDQ-T) and Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) may also be included. This range of measures will ensure parents / carers, children and young people, clinicians and practitioners all have opportunity to become involved in the process of ROM.

Additional measures which may be used alongside the core measures are; the Goal Based Outcomes (GBOs), Nisonger Child Behaviour Rating Form (Nisonger CBRF), Sheffield Learning Disabilities Outcome Measure (SLDOM) and the CORC Consultation Feedback Questionnaire.

It is important to consider this is not an exhaustive list of measures and some services may need greater flexibility in terms of the 'core' measures they use due to issues with suitability for client group. In addition, these measures are not problem / issue specific, and are instead global indicators. Finally, consideration must be given to the training needs of

staff within services wishing to use particular measures such as HoNOSCA and the reliability and validity requirements of these.

Core Measures Factsheets *

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaires (SDQs) are widely used across CAMH services as a screening tool for emotional and behavioural disorders. The measure can be used with children aged 3-17 years and is available in Parent / Carer, Teacher and Self Report formats (self report is only suitable for use with children aged 11 years and above). The SDQ is composed of 25 statements relating to five domains of behaviour; Emotional Symptoms, Conduct Problems, Hyperactivity, Peer problems and Pro-social. The SDQ is recommended for use with all children within the designated age range apart from those with severe learning disabilities.

Administration:

The SDQ is first administered at assessment – this is the T1 measurement. It is then re-administered between 4 and 8 months later – this is the T2 measurement. To ensure the measure is valid, the T2 questionnaire must be administered in a +4 to 8 month time frame. SDQs can be given to parents and where appropriate children to complete in clinic by Administrative staff or their Clinician.

Alternatively, they can be sent to the family or teacher by post to complete and return. In some cases; usually more so for T2 collection, SDQs can be completed over the telephone.

* For 'Measures Guide' see Appendix A

Scoring:

Each of the five domains is scored using a likert scale consisting of three items; not true, somewhat true and certainly true. The value assigned to each item on the likert scale varies across the five domains (details of specific values across the domains can be found on the scoring information sheet accompanying the measure). For each of the five domains scores can range from 0-10 if all statements were answered (a score can be prorated if at least three statements in the domain were completed). A Total Difficulties Score (TDS) is then generated by summing the scores of four of the domains (all except the Pro-social), to give a score of between 0-40 (the TDS is counted as missing if one of the component domain scores is missing).

When using a version of the SDQ with an Impact Supplement, the scores of the statements on overall distress and social impairment can be summed to generate an impact score of between 0-10 on the Parent and Self Report versions (difficulties upset of distress the child / me, difficulties interfere with home life, difficulties interfere with friendships, difficulties interfere with classroom learning, difficulties interfere with leisure activities) and 0-6 on the Teacher version (difficulties upset or distress the child, difficulties interfere with peer relationships, difficulties interfere with classroom learning). Here;

Not at all	0	Quite a lot	1
Only a little	0	A great deal	2

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

Analysis:

Within the CIP, the SDQ is considered a treatment-outcome measure. Moreover, it is used to quantify change in the child's behaviour and how this impacts upon others following the implementation of an intervention, through quantifying difference in T1 and T2 scores. SDQs may also be used as part of clinical assessment whereby TDS and Impact score are classified into 'normal', 'borderline' and 'abnormal' ranges, with a score in the abnormal range being indicative of a possible mental health disorder (details of specific values of each classification range can be found on the scoring information sheet accompanying the measure).

References:

www.sdqinfo.org

www.corc.uk.net

Mathai, J., Anderson, P. & Bourne, A. (2003). Use of the Strengths and Difficulties Questionnaire as an Outcome Measure in a Child and Adolescent Mental Health Service. *Australasian Psychiatry*, 11:3, 334-337.

Children's Global Assessment Scale (CGAS)

The Children's Global Assessment Scale (CGAS) is a Clinician-rated measure of functioning in everyday life of children and young people aged 0-23 years. Scores on the CGAS are reported as specific raw scores e.g. 52, where zero is very poor functioning and 100 is the highest level of functioning. The CGAS is recommended for use with all clients within the designated age range.

Administration:

CGAS should be administered by the Clinician who has undertaken the consultation with the child, young person and / or their family. CGAS is first administered at assessment – this is the T1 measurement. It is then re-administered 6 months later or at case closure if this is sooner – this is the T2 measurement. The assigned score should not count functional physical impairments unless they are clearly related to emotional functioning.

Scoring:

The rating given by the Clinician should be based on the actual, lowest level of functioning shown within the past month regardless of treatment or prognosis.

It may be helpful to locate a decile based on the descriptions given in the CGAS, consider this in thirds and locate the child / young person's functioning in the upper, middle or lower third of

the decile, and finally choose a score within that third as the overall score.

CGAS decile descriptions are;

100-91	Superior functioning in all areas / doing very well
90-81	Good functioning / doing well
80-71	No more than a slight impairment in functioning / doing all right (minor impairment)
70-61	Some difficulty in a single area / some problems (in one area only)
60-51	Variable functioning with sporadic difficulties / some noticeable problems (in more than one area)
50-41	Moderate degree of interference in functioning / obvious problems (moderate impairment in most areas or severe impairment in one)
40-31	Major impairment in functioning in several areas / serious problems (major impairment in several areas and unable to function in one area)
30-21	Unable to function in almost all areas / severe problems
20-11	needs considerable supervision / very severely impaired
10-1	Needs constant supervision / extremely impaired (constant supervision is required for safety)

Further descriptions of level of functioning of each decile can be found on the scoring information sheet.

Analysis:

Within the CIP, the CGAS is considered a treatment-outcome measure. Moreover, it is used to quantify change in the child / young person's ability to function following the implementation of an

intervention, through quantifying difference in T1 and T2 scores.

References:

www.rcpsych.ac.uk/pdf/CGAS%20Ratings%20Guide.pdf

www.corc.uk.net

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H. R. & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). Archives of General Psychiatry, 40:11, 821-1231

The Experience of Service Questionnaire (CHI ESQ)

The Commission for Health Improvement (now the Health Care Commission) Experience of Service Questionnaire (CHI ESQ) is a measure of service satisfaction within CAMHS. The CHI ESQ is used as part of a battery of routine outcomes measures, so that a family's experiences with the service can be linked to the child's difficulties and symptom reduction. There are Parent and Self Report (suitable for use with young people aged 9-11 years or 12-18 years) formats of the questionnaire, as well as a Parent rated ESQ Addendum. The CHI ESQ is recommended for use with all clients seen by the service.

Administration:

The CHI ESQ is a T2 measure only as it is looking at a family's experience of the service and so should be administered at 6 months / case closure if this is sooner. The CHI ESQ can be given to parents and where appropriate children / young people to complete in clinic by Administrative staff or their Clinician. Alternatively, it can be sent to the family by post to complete and return.

Scoring:

Both Parent and Child / Young Person formats of the CHI ESQ consist of 13 items rated Not True (1), Partly True (2), or Certainly True (3). There are also three free text questions looking at what the respondent liked about the service, what they felt needed improving and any other comments. CORC

are currently researching ways of presenting and analysing the free text comments from the CHI ESQ in order to include more qualitative data in reports.

The ESQ Addendum consists of 3 items rated Not True (1), Partly True (2) or Certainly True (3).

Analysis:

Within the CIP, the CHI ESQ is considered a service satisfaction outcome measure. Moreover, the higher the score obtained on the CHI ESQ, the better the respondents experience with the service.

References:

<http://www.corc.uk.net/index.php?contentkey=33>

(If you are a registered member of CORC you can access the excel data drop for the three free text questions on the CHI ESQ using this link)

www.corc.uk.net

Attride-Stirling, J. (2002). Development of Methods to Capture Users' Views of Child and Adolescent Mental Health Services in Clinical and Governance Reviews. Commission for Health Improvement.

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

HoNOSCA is a Clinician-rated measure used to assess severity of difficulties. It is suitable for use with young people aged 9 years and older. It is not recommended for use with younger children or those with less severe difficulties. Section A of the measure consists of 13 items relating to different types of problems. Section B (which is optional) consists of 2 items relating to the parent or young person's knowledge of the nature of the young person's difficulties and their information about the services available.

Administration:

HoNOSCA should be completed by the Clinician who has undertaken a consultation with the young person and / or their family. If the young person is seen by more than one clinician in the service, each can complete a HoNOSCA at each time point; however CORC will only collect data on one Clinician per questionnaire. HoNOSCA is first completed at assessment – this is the T1 measurement. It is then re-administered 6 months later or at case closure if this is sooner – this is the T2 measurement (for longer cases, it is repeated annually until case closure).

Scoring:

Section A: each of the 13 items are rated between 0-4 where;

No Problem	0	Minor Problem (no action)	1
Minor Problem (definitely present)	2	Moderately severe problem	3
Severe to very severe problem	4	Information unknown	9

Clinicians must rate the most severe problem that occurred during the period rated (usually the past 2 weeks). Further details to assist in rating each of the 13 items are given on the score sheet. The scores from each of the 13 items are then added together to give a Total Score for section A.

Section B: each of the items are rated between 0-4 where;

No Problem	0	Minor Problem (no action)	1
Minor Problem (definitely present)	2	Moderately severe problem	3
Severe to very severe problem	4	Information unknown	9

Further details to assist in rating each of the items are given on the score sheet. The scores from each of the items are then added together to give a Total Score for section B.

Analysis:

Within the CIP, HoNOSCA is considered a treatment-outcome measure. Moreover, it is used to quantify change in the severity of the young person's difficulties following the implementation of an

intervention, through quantifying difference in T1 and T2 scores.

References:

www.liv.ac.uk/honosca

www.corc.uk.net

Gowers, S.G., Harrington, R.C., Whitton, A., Lelliott, P., Beevor, A., Wing, J. & Jezzard, R. (1999). Brief Scale for Measuring the Outcomes of Emotional and Behavioural Disorders in Children: Health of the Nation Outcomes Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry*, 174:5, 413-416

Gowers, S.G., Harrington, R.C., Whitton, A., Lelliott, P., Beevor, A., Jezzard, R. & Wing, J.K. (1999). Health of the Nation Outcomes Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174:5, 428-431

Garralda, E., Yates, P. & Higginson, I. (2000). Child and Adolescent Mental Health Service Use: HoNOSCA as an outcome measure. *British Journal of Psychiatry*, 177, 52-58

Strengths and Difficulties Questionnaire – Teacher Version (SDQ-T)

The Strengths and Difficulties Questionnaires (SDQs) are widely used across CAMH services as a screening tool for emotional and behavioural disorders. The SDQ is composed of 25 statements relating to five domains of behaviour; Emotional Symptoms, Conduct Problems, Hyperactivity, Peer problems and Pro-social. The SDQ is recommended for use with all children within the designated age range apart from those with severe learning disabilities.

Administration:

The SDQ-T is first sent to Teachers when the child has their assessment – this is the T1 measurement. It is sent again between 4 and 8 months later – this is the T2 measurement. To ensure the measure is valid, T2 questionnaire must be completed between the +4 to 8 month time frame. In some cases services may wish to attempt completion of the SDQ-T over the telephone.

Scoring:

Each of the five domains is scored using a Likert scale consisting of three items; not true, somewhat true and certainly true. The value assigned to each item on the Likert scale varies across the five domains (details of specific values across the domains can be found on the scoring information sheet accompanying the measure). For each of the

five domains scores can range from 0-10 if all statements were answered (a score can be prorated if at least three statements in the domain were completed). A Total Difficulties Score (TDS) is then generated by summing the scores of four of the domains (all except the Pro-social), to give a score of between 0-40 (the TDS is counted as missing if one of the component domain scores is missing).

When using a version of the SDQ with an impact supplement, the scores of the statements on overall distress and social impairment can be summed to generate an impact score of between 0-6 on the Teacher version (difficulties upset or distress the child, difficulties interfere with peer relationships, difficulties interfere with classroom learning). Here;

Not at all	0	Quite a lot	1
Only a little	0	A great deal	2

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

Analysis:

Within the CIP, the SDQ-T is considered a treatment-outcome measure. Moreover, it is used to quantify

change in the child's behaviour and how this impacts upon others following the implementation of an intervention, through quantifying difference in T1 and T2 scores. SDQs may also be used as part of clinical assessment whereby TDS and Impact score are classified into 'normal', 'borderline' and 'abnormal' ranges, with a score in the abnormal range being indicative of a possible mental health disorder (details of specific values of each classification range can be found on the scoring information sheet accompanying the measure).

References:

www.sdqinfo.com

www.corc.uk.net

Mathai, J., Anderson, P. & Bourne, A. (2003). Use of the Strengths and Difficulties Questionnaire as an Outcome Measure in a Child and Adolescent Mental Health Service. *Australasian Psychiatry*, 11:3, 334-337.

Additional Measures Factsheets

Goal Based Outcomes (GBOs)

GBOs were developed to identify what children, young people and parents wanted to achieve from their contact with a service, and they measure how far these goals have been met. GBOs are suitable for use with parents of all children / young people seen by the service. The measure is also suitable for young people aged between 11-16years. Although it is recommended that goals are set by those most directly involved in the intervention e.g. parents if the intervention is parent training, child if the intervention is individual child work, ratings given to each goal should be formulated from a joint perspective including those of the child / young person, parent / carer and Clinician. However ultimately, the person setting the goal is the person doing the work – the person working towards the goal needs to agree and own it themselves, in order to ensure it is their desired outcome that gets measured.

Administration:

Within the first three sessions with the Clinician, the respondent is asked to identify and list up to 3 goals they would like to achieve from their contact with the service. They are then asked to rate how close they feel they are to reaching these at the present time – this is the T1 measure (more goals can be set however only the first three will be evaluated by CORC). At 6 months following T1 or at case closure,

whichever is soonest, respondents are asked to re-rate how close they feel they are to reaching their 3 goals – this is the T2 measure.

Scoring:

Rating how close a respondent feels to reaching an identified goal at both T1 and T2 is done using a 10 point scale where 0 = the furthest away from reaching the goal and 10 = achieving the goal.

Analysis:

Within the CIP, GBOs are considered a treatment-outcome measure. Moreover, they are used to quantify the degree of change in how able a child/young person and/or family feels they can achieve their identified goals, following the implementation of an intervention. This is calculated by quantifying difference in T1 and T2 scores. The greater the score, the greater the effect of the intervention in terms of how far the respondent feels they have come in being able to reach their goals.

References:

www.corc.uk.net

[http://www.corc.uk.net/index.php?contentkey=81#](http://www.corc.uk.net/index.php?contentkey=81#GBO)

[GBO](#) (to access a presentation on GBOs by Dr Duncan Law, Consultant Clinical Psychologist & CAMHS Service Manager, Hertfordshire Partnership NHS Trust).

Nisonger Child Behaviour Rating Form (Nisonger CBRF)

The Nisonger CBRF is a validated measure for assessing behaviour in children and young people aged 3-16 years with mild to severe learning disabilities, including autistic spectrum disorder. There is a parent / carer version and a teacher version. The measure is comprised of three sections; (1) a free text item on recent circumstances which may affect the rating of the questionnaire, (2) social competence and (3) problem behaviours.

Administration:

The measure should firstly be completed at the point of assessment – this is the T1 measurement. It can be completed by parents / carers in clinic or posted to them with the first appointment letter. The measure is re-administered 6 to 8 months after T1, or at case closure, whichever is sooner – this is the T2 measurement.

Scoring:

Section (2) on social competence contains 10 items on pro-social behaviour. Items are scored on a 4 point Likert scale from 0 (not true) to 3 (completely / always true). These create 2 factors; 'compliant / calm' (ranging from 0-18) and 'adaptive / social' (ranging from 0-12).

Section (3) on problem behaviours contains 66 items addressing a range of symptoms. Items are scored on a 4 point Likert scale from 0 (behaviour did not occur / was not a problem) to 3 (behaviour occurred

a lot / was a severe problem). These items create 6 factors; 'conduct problem' (ranging from 0-48), 'insecure / anxious' (ranging from 0-45), 'hyperactive' (ranging from 0-27), 'self injury / stereotypic' (ranging from 0-21), 'self isolated / ritualistic' (ranging from 0-24), and 'overly sensitive' (ranging from 0-15).

Analysis:

Section (2) Pro-social: Raw scores are translated into a percentile. **Lower scores** reflect greater difficulty. The cut off percentile is the 85th **below** which identifies problematic behaviour e.g. greater problems adapting socially in terms of social competence and problematic behaviour.

Section (3) Problem behaviour: Raw scores are translated into a percentile (6 of the items do not score; irritable, repeatedly flaps or waves hands etc..., sudden changes in mood, engages in meaningless, repetitive body movements, underactive / slow and unhappy or sad). **Higher scores** reflect greater difficulty. The cut off percentile is the 85th **above** which significant pathology exists.

The Nisonger CBRF can be used to look at total problem score or an individual problem area. A positive outcome is considered if there is a shift in one or more problem area(s) to a non problem area e.g. a score above the 85th percentile for Section (2) or below the 85th percentile for Section (3).

References:

www.psychmed.osu.edu/ncbrf.htm

www.corc.uk.net

Aman, M.G., Tasse, M.J., Rojahn, J. & Hammer, D. (1996). The Nisonger CBRF: A Child Behaviour Rating Scale Form for Children with Developmental Disabilities. *Research in Developmental Disabilities*, 17:1, 41-57.

Sheffield Learning Disabilities Outcome Measure (SLDOM)

The SLDOM looks at symptom severity and parents' ability to cope with their child's difficulties. It is suitable for use with parents of children aged 3-16 years with learning disabilities. The measure was developed to evaluate services for children and young people with a severe to profound level of learning disability, by measuring the changes in the way carers gain confidence in understanding and managing the child's behaviour, in addition to symptom behaviour change. The SLDOM is comprised of three sections; two with a 6 point scale (strongly agree, agree, unsure, disagree, strongly disagree and not applicable) and one involving qualitative responses.

Administration:

Part 1 of the measure should be completed at the point of assessment – this is the T1 measurement. Parts 1, 2 and 3 of the measure are administered 6 to 8 months after T1, or at case closure, whichever is sooner – this is the T2 measurement. If the case is still open at Time 1 + 6 to 8 months, Part 1 only should be completed again. If the case is closed at T1 + 6 to 8 months, parts 1, 2 and 3 will need completing.

Scoring:

Part 1 contains 8 items relating to understanding of the child's behaviour and it looks at the relationship between parent /carer and child, parental level of

confidence and parental views about the future. These items use a 5 point Likert scale where 5 = strongly agree and 1 = strongly disagree (0=n/a). Scores for items 2, 4 and 7 are reversed so here, 1=strongly agree and 5= strongly disagree. Maximum score for this section is 40 and minimum score is 8.

Part 2 contains 10 items which ask about how the team works and how the service is delivered (and is applicable to services delivered in people's homes as well as in a clinic setting). These items use a 5 point Likert scale where 5 = strongly agree and 1 = strongly disagree (0=n/a). Scores for items 2, 4, 7 and 10 are reversed so here, 1=strongly agree and 5= strongly disagree. Maximum score for this section is 50 and minimum score is 10.

Part 3 captures qualitative feedback as free text. The questions in this section ask about the positives for the child and the family, the negatives for the child and the family, and any suggestions the parents have for the improvement of the service they had received.

Analysis:

Part 1 is scored out of 40. Positive outcomes are indicated by a score of 25 or above.

Part 2 is scored out of 50. Positive outcomes are indicated by a score of 30 or above.

References:

www.corc.uk.net/index.php?contentkey=91

CORC Consultation Feedback Questionnaire

This questionnaire is designed to monitor the impact of consultation / liaison work carried out by CAMHS practitioners. Specifically, it measures service satisfaction and confidence in dealing with child mental health issues. It is completed by professionals who have sought information from CAMHS about child mental health. The questionnaire is not suitable for very casual consultations, e.g. requests for information / contact details of other services, or for referrals.

Administration:

The CORC Consultation Feedback Questionnaire is administered following consultation work and so is a T2 measure only. It can be used for face to face and telephone consultations. It is also suitable for one off or a series of consultations. On-going consultations can be monitored at routine intervals to map how a group of professionals rate service satisfaction and their own confidence in dealing with child mental health issues, over a continuous period of liaison with the CAMHS professional.

The Consultant completes questions 1-6 themselves and the Consultee answers the remaining questions;

The consultation was about...

What I wanted from this consultation was...

What was the outcome...

Are you happy with the outcome...

Has the consultation reduced your concerns...

How easy was it to arrange a consultation when you needed to...

Is there anything that could improve the consultation service...

Scoring:

This is done manually at present although CORC are developing the CORC Consultation Database in order for services to send their data for central collation and analysis.

Analysis:

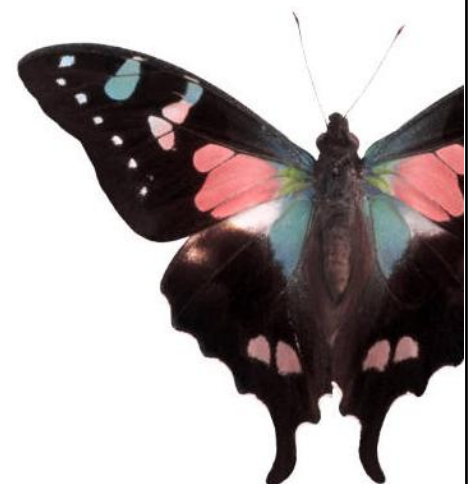
Within the CIP, the CORC Consultation Questionnaire is used as a service satisfaction outcome measure.

References:

<http://www.corc.uk.net/media/File/Measures/Consultation/CORC-Consultation-Questionnaire.pdf>

<http://www.corc.uk.net/media/File/documents/Information%20Sheets/Information%20Sheet%2025%20-%20Consultation.pdf>

www.corc.uk.net



CHAPTER 3: INFORMATION SYSTEMS

Outcomes Data Collection Process

In order to achieve a coherent, consistent and ultimately successful implementation of ROM, a clearly defined process must be established within each service.

The process used to carry out ROM will vary from service to service. Therefore, the example given below is intended to serve only as a guide to the steps and practicalities involved. Each service will need to formulate and refine their own process according to individual factors such as staffing, record keeping systems and referral / screening / assessment procedures etc.

General Tips

- It is useful to have measures packs made up in advance so that these are easily distributed to the rest of the team as and when needed. They are particularly useful for urgent risk assessments (URAs) where Clinicians have to leave the service at very short notice and so need access to all the measures quickly.
- It is useful to colour code measures to distinguish between T1 and T2 and respondents e.g. green for Parental SDQ at T1 and yellow for Parental SDQ at T2, pink for Self

rated SDQ at T1 and blue for Self rated SDQ at T2 etc.

- Tracking labels can be placed on the front cover of the measures packs to provide a summary of where the case is in the process of outcomes measurement (see Appendix B).
- Services should aim to employ a system whereby they schedule six month follow up appointments with families at the point of initial assessment, as a matter of routine practice. This will aim to ensure T2 measures are completed within the designated time frame required to validate them (T1 + 4 to 8 months for SDQs).

Who does what?

Where a number of different staff members are taking on roles in the collection of outcomes data, it may be of use to highlight their specific responsibilities within the service's process of implementation. In the process example detailed below, Clinician responsibility has been highlighted in blue and Administrative staff responsibility has been highlighted in green. This example represents the kinds of tasks different staff members may undertake in collecting outcomes data. However, it is not exhaustive and some services may be in a position whereby they have the resource of an Assistant Psychologist / Research Assistant who may

share, if not take on entirely, the role depicted by Administrative staff.

For those services where administrative resource is a major concern, it may be worth exploring the possibility of employing an 'Honorary Research Assistant / Assistant Psychologist' to support outcomes work. Alternatively, many university students are keen to get work experience within a CAMHS setting and so provide another resource which could be utilised to support the implementation of ROM. Both graduate and undergraduate psychologists will possess the analytical skills needed to conduct statistical and qualitative analyses of the data collected (see Appendix C).

CASE OPENS

- The child is offered an Initial Assessment appointment
- The tracking database is updated to log details of the case and a UPIN is generated
- A measures pack is put together
- UPIN is written on the measures and the pack is given to the Clinician / made available to the IAS clinic.

TIME 1

- Measures are completed and returned to the measures pack: Clinician completes the CGAS/ HoNOSCA / GBOs with the family and the family complete SDQs *
- Clinician gives the completed measures pack back to administrative staff / data input staff
- The tracking database is updated with details of when the Time 1 measures were taken
- The data from the measures is inputted into YIM or another storage database
- The pack is returned to the child's file / a separate filing system ready for Time 2.

TIME 2 (+ 6 months / case closure)

- The tracking database is reviewed monthly to identify those cases where Time 2 measures are due to be taken
- Measures are completed: Clinician completes the CGAS / HoNOSCA /GBOs with the family and the family completes SDQs & CHI ESQ **
- Clinician gives the completed measures pack back to administrative staff / data input staff
- The tracking database is updated with details of when the Time 2 measures were taken
- The data from the measures is inputted into YIM or another storage database
- Analysis is conducted / reports produced for complete 'whole cycle' data (e.g. T1 and T2)
- Completed measures are returned to the child's file.

* Some services may wish to post Parental and where appropriate Self rated SDQs to the family with their initial appointment letter for completion in advance. Alternatively, the family can complete the SDQs in clinic (see Appendix D) or during a break in the first appointment.

** In some instances, services may find it more appropriate to administer measures via the telephone or send them out in the post, if families are not due to return to clinic within the designated time frame for T2 collection. However, it should be noted postal and telephone data collection methods are often not as reliable as face to face data collection and response rates are usually much lower.

Tracking Databases

A form of tracking system should be utilized in each service to assist in monitoring the use of outcomes measures and ensure this is done in a comprehensive and coherent way.

A tracking database is one such system which is used to record details about the administration, completion and inputting of outcomes measures for each patient.

The database is constructed using an Excel spreadsheet and employs the conditional formatting and formulae functions of the software. Formulas are used to automatically calculate age of the child / young person and predicted Time 2 dates. Conditional Formatting is used to colour code the immediacy of Time 2 dates, so that whoever is inspecting the database can see at a glance which cases are due for Time 2 data collection in the given month (see Appendix E for details of the formulas recommended for use).

The database enables services to generate Unique Patient Identification Numbers (UPINs – see below) for each patient with whom outcome measures have been used. As a minimum, tracking databases should contain the following core information;

- UPINs, first name, surname and demographic information
- when Time 1 measures were administered and/or received, and inputted for analysis
- when Time 2 measures **are due to be** administered
- when Time 2 measures were administered and/or received, and inputted for analysis
- date of case closure

The fields for inclusion in the tracking database listed above are not exhaustive and merely represent the essential, core information which is needed to monitor the use of outcomes measures. It is entirely feasible for individual services to extend this list of fields to capture further information they feel may be relevant to their service and systems e.g. Clinicians involved, administration method (post / face to face / telephone), if the case Did Not Attend or was URA etc. The tracking database can also include more individualised information to map completed stages of the service's process of outcomes measurement e.g. 'measures pack put together', 'measures pack given to Clinician', 'completed measures handed to Administrator for inputting' and so on.

How to use

As the tracking database contains details of when T2 measures are due to be completed, it is recommended Administrative staff, or those responsible for preparing the measures packs, have a system in place whereby they regularly review the tracking database, in order to identify those cases where T2 questionnaires need to be administered.

Services intending to post out SDQs to families at T2 may wish to do this at 4 months after the completion of T1 SDQs (as opposed to 6 months), to allow for additional reminders to be sent if families do not return them. This will maximize opportunity for T2 SDQs to be completed within the T1 + 4 to 8 months time frame.

Unique Patient Identification Numbers & Movement Across Services

Unique Patient Identification Numbers (UPINs) are given to each patient with whom outcomes measures have been used. UPINs are necessary to;

- Identify the service to which a patient 'belongs'
- Avoid duplication of patient identification numbers across different services
- Map the movement of a patient across different tiers and services

The UPINs used in the CIP take the form of an 8 digit code comprised of three segments. For Tier 3 services this consists of two initials to represent the service, followed by the initials CIP (which identified the case is included in the CIP dataset), followed by three numbers. The final three numbers are unique to the patient e.g. GT CIP 001. For Tier 2 services, the only difference is that the first segment of the UPIN is comprised of two numbers rather than initials e.g. 01 CIP 001.

The CORC 'Youthinmind' storage database cannot hold UPINs of more than 10 characters in length.

When a referral is accepted by a service the patient's details are inputted on a tracking system such as the outcomes measures tracking database used in the CIP. At this point, the UPIN for that case will be

generated and linked to the patient's name and other details. When the outcomes measures are administered to the patient / family at T1 and T2, their UPIN should be written in the top right hand corner of the measure to ensure it corresponds with that on the tracking system.

In the event that a case moves from one service to another between T1 and T2 measurements, the patient keeps their existing UPIN and it is this number that is entered into the tracking system used at the T2 service. At the point of analysis, cases which have experienced movement across services are identified as having a different UPIN to the majority of those present in the T2 dataset (the original UPIN generated and used at T1 will have a different prefix compared to the others).

When a T1 service refers a case to another service, it is their responsibility to;

- alert the receiving service to the fact Time 1 measures have already been taken
- record the date at which Time 1 measures were collected
- alert the receiving service as to when the Time 2 measures are due

The service making the referral can do this by noting the necessary details on a hard copy of the T1 measure itself, which should then be included in the

referral / case notes sent to the service receiving the referral.

Similarly, it is necessary for the service receiving the referral (and so collecting the T2 measures), to document the following;

- the name of the service from which the case was referred
- the name of the service which delivered any intervention between Time 1 and Time 2

The service receiving the referral can do this by noting the necessary details on a hard copy of the T2 measure itself.

This system ensures that any change signified in the difference between T1 and T2 measures is attributed to the service that provided the main treatment. It also enables the following analysis to be conducted;

- Quantification of the number of cases which have moved from one service to another
- Extraction of information about where cases have come from and where they go to (this information may serve as a useful indication of outcome in its own right)
- Identification and explanation of missing Time 2 data in the Time 1 service dataset
- Identification and explanation of missing Time 1 data in the Time 2 service dataset

- Location of services where the data needed to conduct Time 1 and Time 2 comparisons are held.

YouthInMind (YiM)

The Youthinmind Database (YiM) is an Access database available from the CORC website. It is freely downloadable to members of CORC and can be used to score and produce reports for the following core outcomes measures;

- SDQ
- CGAS
- CHI ESQ
- HoNOSCA
- GBOs

YiM is not designed to be accessed by multiple users at one time and so it is not suitable for use on a shared network. YiM does not hold clinical data and has limited scope for demographic data. It is therefore not intended for use as an electronic patient record system.

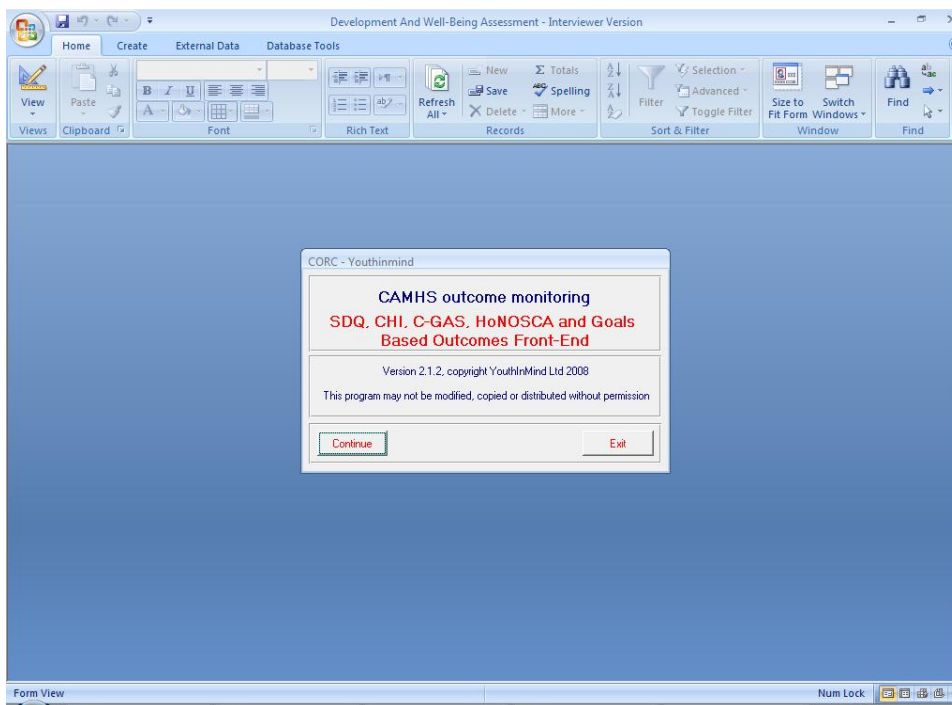
Downloading the database

The database is comprised of two parts, a 'blank end' and a 'front end'. Details on how to download and link the two ends are available on the CORC website at

<http://www.corc.uk.net/media/File/documents/Information%20Sheets/June%202008/Information%20sheet%20->

[%20Getting%20Started%20with%20%20New%20YiM-final.pdf](#)

For those services already using an older version of the YiM database, this will become the 'blank end' to which a new 'front end' can be attached (details on how to link the two ends are also available on the CORC website).



Inputting Data

Services are encouraged to explore the YiM database in order to familiarise themselves with how to input their own data. Use of the database is relatively straightforward with most steps being clearly explained and signposted. The database has the

utility to alert the person inputting to any missing data to help increase accuracy.

Development And Well-Being Assessment - Interviewer Version

Enter Initial Parent SDQ for DRAFT001 - Anna Neal

Strengths and Difficulties Questionnaire

How well does each statement describe how your child has been over the LAST 6 MONTHS?

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Press Ctrl/R to remove a selection

Continue Back Close

Development And Well-Being Assessment - Interviewer Version

Enter initial C-GAS for DRAFT001 - Anna Neal

C-GAS at initial assessment

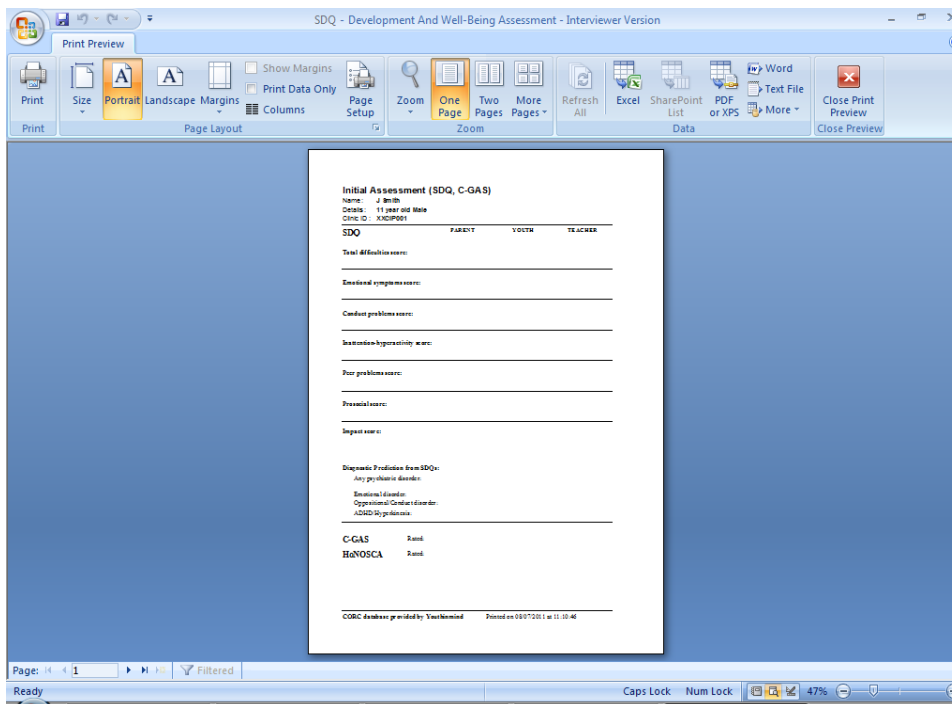
Superior functioning	100
Good functioning in all areas	90
No more than slight impairment in functioning	80
Some difficulty in a single area, but generally functioning pretty well	70
Variable functioning with sporadic difficulties or symptoms	60
Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area	50
Major impairment in functioning in several areas and unable to function in one of these areas	40
Unable to function in almost all areas	30
Needs considerable supervision	20
Needs constant supervision	10

Rated on: Rated by:

Close

Generating reports

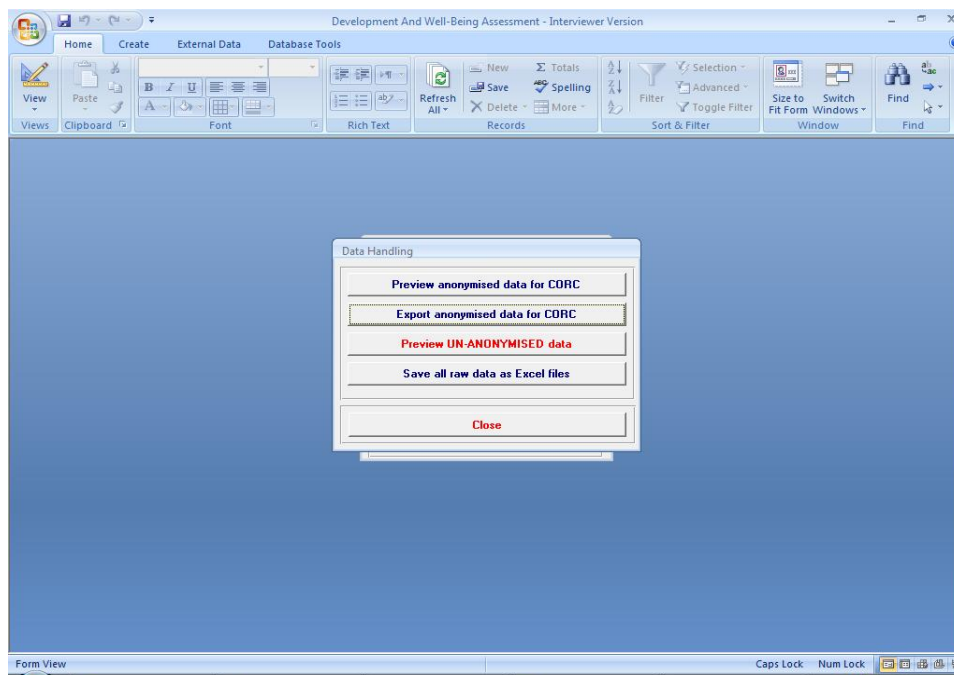
YiM can produce three types of report; Initial Assessment Reports, Follow-Up Assessment Reports and Change Score Reports. The Initial Assessment Report shows scores for all completed T1 questionnaires, the Follow-Up Report shows scores for all completed T2 questionnaires and the Change Score Report shows the difference between T1 and T2 scores, as well as the SDQ Problem Improvement and Service Helpfulness items. Each report also has a page on GBOs. The reports are designed to provide a snapshot of what the main issues are and where there are variations between respondents.



Exporting data

There are two ways users can export data to other programmes from the YiM Database;

Users can save tables holding data on demographics, T1 questionnaires, and T2 questionnaires as separate Excel spreadsheets (the 'save all raw data as Excel files' option under Data Handling). These tables can be opened in Excel or imported to other Access databases or an SPSS file. Once data from YiM has been exported, users will be prompted to save the files to a specific location on their computer (usually the C drive).



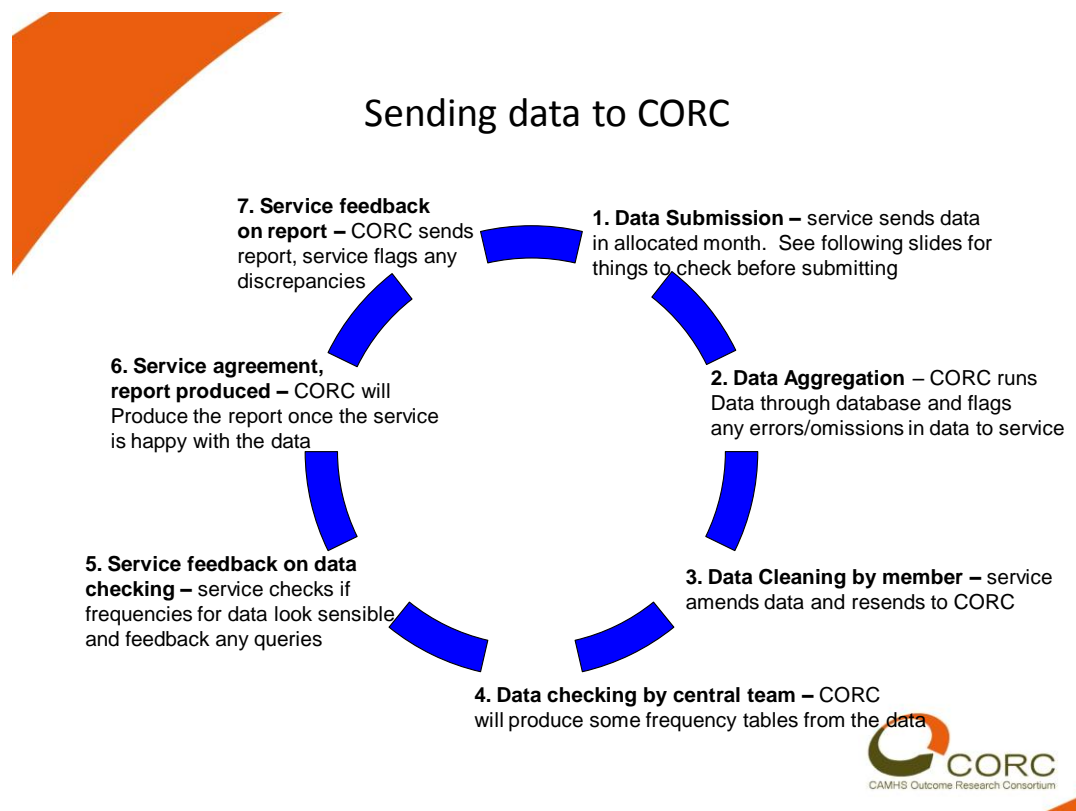
- Users can export all the demographic, T1 questionnaire and T2 questionnaire data as a single file (the 'export anonymised data for

CORC' option under Data Handling). This file can be opened in Excel or imported to other Access databases or an SPSS file.

Once the exported file(s) have been saved, they can be emailed to CORC for analysis. However, all data must be anonymised and 'cleaned' prior to being sent. Further details on how to do this are available from the CORC website at

<http://www.corc.uk.net/index.php?contentkey=33>

Select the '7 steps' and the '7 steps appendix' pdf documents.



Slide from the CORC Central Team presentation to Kent, June 2011.

CORC Log-In and Submitting Data for Analysis

The month allocated to Kent for submission of data is January. Individual services hold responsibility for submitting their own data following the protocols outlined on the CORC website (see Appendix F for a copy of the proforma needed for submission of data).

Services are required to register under the Kent Membership Log in, in order to access the resources on the website and submit data for analysis. This can be achieved by following these steps;

- Look up www.corc.uk.net
- On the top left corner of the home page select 'register here'
- Select 'register now'
- Enter registration information, profile information and preferences
- Submit details

These details can then be used to download the YiM database in the first instance, and access the live 'drop in' forum where member services can post queries and seek advice from the CORC Central Team and other members. The forum is currently available on Tuesdays between 10am and 12pm and on Fridays between 2pm and 4pm.

RIO

At present, the RIO system is being rolled out across West Kent and Medway CAMH services. In view of the forthcoming launch, the following guidance has been written for services to consider. However, it is important to note that as RIO becomes incorporated into services and practice is modified around its use, some of this information may become inaccurate or redundant.

Data Inputting

- The system is currently set up in such a way that only clinicians will have the necessary access to input scores from outcomes measures. This means clinicians will have greater ownership of and accessibility to data, which will hopefully encourage greater usage of the information gathered. However, clinicians may feel the responsibility of inputting scores is a burden and something which may be more appropriately managed by administrative staff
- One particular issue to consider is linked to the possibility of having to post out some outcomes measures to families at T2 – those who are not due to be seen in a face to face appointment (e.g. where cases have closed before T1 + 6months). If administrative staff

were to be responsible for posting measures rather than clinicians, they would need access to the outcomes measurement section on RIO in order to identify families

Measures

- The facility for entering SDQ data (and possibly that for the other core measures) relies on the paper copies having been scored in advanced of inputting – subscale scores rather than individual question scores are entered (a Total Difficulties Score is automatically calculated and classified into clinical / borderline / non-clinical is given)
- Where HoNOSCA is used as the clinician rated outcome measure as part of the CIP, measurements are taken at two time points (T1 = initial assessment / first appointment following allocation to a clinician, and T2 = + 6 months from Time 1 or at case closure; whichever comes first). However, this protocol somewhat contravenes guidance given by the Kent and Medway NHS and Social Care Partnership Trust on when to administer HoNOSCA (at initial appointment / if there is a major change in treatment plan or the client's difficulties / annually / at case closure). This contravention means it is possible HoNOSCA may only be administered at initial

appointment and annually thereafter, which would miss out the T2 (T1 + 6 month) data collection which forms part of the usual CIP protocol

- Services need to ensure all versions of the CHI ESQ are available on the RIO system and not just the Parent / Carer version

Report Production / Data Analysis

- It appears the system currently offers a similar level of functionality to that of YIM (inputting of scores from the core suite of outcome measures and report production summarising scores at T1 and T2 - although these may have to be produced as separate documents and compared manually). However, it is unclear as to the exact form exported data would take and if this would be suitable for the kinds of statistical analysis expected to be undertaken by CORC (e.g. as Excel or SPSS files)

'Tracking' Functionality

- One particularly important aspect of the process of ROM is an alert to T2 date based on a calculation using the T1 date (usually this is T1 date + 6 months).
- In order to avoid using an additional tracking database, the current RIO system would need to be used in such a way as to provide such an

alert for T2 dates. The most logical way to manage this may be to utilise the clinician diary function (when entering the scores of outcome measures administered at T1, clinicians would simultaneously calculate a provisional T2 date (T1 + 6 months) and enter this into the diary facility). However, there are several issues to consider here;

- Clinicians may be absent or do not use RIO at the point when the T2 date is highlighted in their diary, and so will be unaware the T2 measure is due
- Cases may close prior to T2. In this eventuality, CGAS / HoNOSCA and CHI ESQ need to be administered at case closure rather than the scheduled T2 date (SDQs can only be administered between +4 to 8 months in order to validate the 'added value' score)
- To overcome these issues Service Managers may decide to access the diaries of the clinicians in the team, in order to review T2 dates on a monthly basis. If this practice is employed Service managers will be able to;
 - Identify cases (including those that have closed before the originally scheduled T2 date) that may require T2 measures to be sent out in the post

- Alert clinicians via written memo / email / verbal instruction to cases that are due for T2 measures in a particular month (this would serve as an additional method of alerting / reminding clinicians of T2 measures needing administration)
- Identify those clinicians whom consistently fail to obtain T2 data, and act upon this to improve response rates.



CHAPTER 4: REPORTING OF DATA

Analysis of Data

In order for CAMH services across Kent to become compliant with CORC it is expected that data will be sent to them for a more in-depth analysis including comparison with their national dataset. However, within a single CORC membership, the number of full reports which can be generated is currently capped at eight.

CORC allocate each member service a particular month of the year in which to send data. For Kent, this is **January**. CORC have specific requirements as to the form datasets take when they are sent, as well as a strict protocol for 'cleaning' datasets – this involves ensuring all variable names are compatible with their database, any errors are identified and changed etc. Details on what exactly is required and how to send data to CORC is available from their website at

<http://www.corc.uk.net/index.php?contentkey=33>

and under Chapter 3 Section 3.4 of this document.

Questions to ask of the data

The purpose of undertaking routine outcomes measurement is to generate reliable data which can be used to;

- Facilitate informed commissioning on the basis of 'real' data which depicts the current challenges facing modern day CAMH services across Kent.
- Equip teams with the information and evidence they will need for strategic development of their service into the future.
- Identify areas of good practice and success within Kent CAMHS.
- Embed areas of good practice in a solid evidence-base.
- Identify emerging trends in the Kent CAMHS dataset.
- Enable individual practitioner level reflection of work for professional development.
- Enable services to reflect upon their whole-team performance in a county-wide context, in order that they are able to identify and respond to areas where development, support, additional measurement and review are indicated.

Examples of how outcomes datasets can be analysed include;

- Illuminating the complexity of cases referred to the service:
 - T1 or pre-treatment scores e.g. average scores across domains of the SDQ / HoNOSCA / CGAS in the context of 'clinical cut-off' points
 - Comparison of T1 scores across different respondents e.g. Parent / Self / Teacher SDQ and correlates with Clinician based scores from CGAS / HoNOSCA
 - Use of qualitative descriptions / in-house measures of background and risk factors

- Quantifying the impact of intervention(s) in terms of presenting problems:
 - Quantification of change in T1 and T2 scores with significance testing and review of 'clinical cut off' points. Comparisons across respondents and different measures
 - Analysis of data from GBOs including qualitative information
 - Calculation of the Added Value Score for SDQ data

- Quantifying patient's experience of service satisfaction:
 - CHI ESQ ratings and comments.
Qualitative analysis to identify themes
 - Feedback from the CORC Consultation Questionnaire
 - Usefulness of service value from SDQ data

Use of Demographics

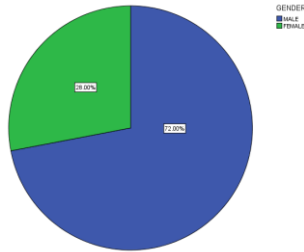
Demographic data can include;

- Age mix
- Gender mix
- Ethnic mix
- Family composition
- SEN
- LAC
- Source of referral
- Duration of treatment
- Presenting problem(s)
- Number of professionals involved
- Type of intervention

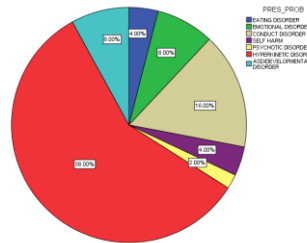
To conduct analysis of outcomes data meaningfully, services are encouraged to consider what they want to gain from their generated dataset and how they want to use this information in order to develop provision for children, young people and families.

Example Slides from Mock Outcomes Reports

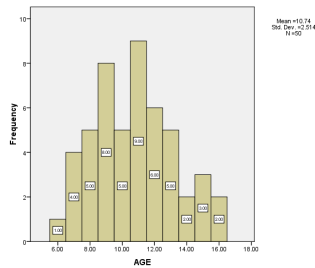
Outcomes Data Activity Demographics



Outcomes Data Activity Demographics



Outcomes Data Activity Demographics

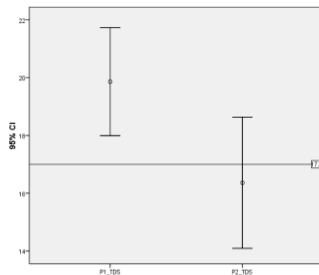


Outcomes Data Activity SDQ Data

Descriptive Statistics

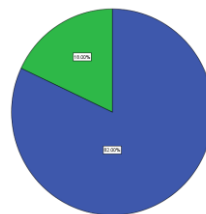
	N	Min	Max	Mean	Std. Deviation
P1_TDS	50	9.00	28.00	20.1800	5.41611
P2_TDS	36	6.00	29.00	16.3611	6.70672

Outcomes Data Activity SDQ Data



The mean TDS value has fallen from 20 at Time 1 to 16 at Time 2 (T1 + 4 to 6 months)
Time 2 mean TDS is now below the point of clinical significance for parent rated SDQ (17)

Outcomes Data Activity SDQ Data



The number of children with 'significant difficulties' includes those cases with a **Total Difficulties Score of 14 or more and a Total Impact Score of 2 or more using the parent view only**. This formula was devised by Robert Goodman; Goodman, R., Ford, T. & Meltzer, H. (2002). Mental Health problems of Children in the Community: 18 month Follow Up. *British Medical Journal*, 324, 1496-1497

Outcomes Data Activity SDQ Data

- **Added Value = 2.3 + 0.8 * T1 Total + 0.2 * T1 Impact – 0.3 * T1 Emotion – T2 Total**
 - This is then divided by 5 to give a standardised effect size
 - $(2.3 + (0.8 * 20.2) + (0.2 * 4.1) - (0.3 * 3.8) - 16.4) / 5 =$ **0.35**
- Scores at 0 suggest there has been no impact of service as compared to what would be expected if the child received no intervention
- Scores above 0 suggest the impact of service is positive and greater than if the child had received no intervention
- Score below 0 suggest the impact of service is negative and greater than if the child had received no intervention
- This calculation is designed for application to data from children with significant mental health problems. It is not appropriate to assess the impact of prevention projects or intervention for children with minor or transient difficulties.

Outcomes Data Activity CGAS Data

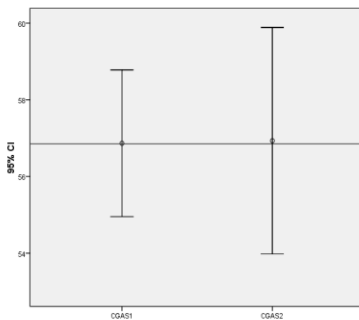
Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
CGAS1	50	48.00	65.00	56.7000	5.02341
CGAS2	30	45.00	69.00	56.9333	7.90867

CGAS score 51-60:

Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

Outcomes Data Activity CGAS Data

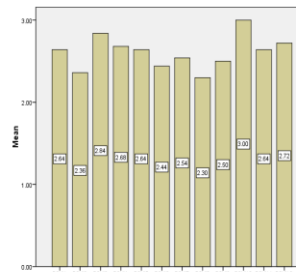


Mean Time 1 CGAS
Rating = 56.7

Mean Time 2 CGAS
Rating = 56.9

No statistically
significant
difference between
Time 1 and Time 2
Ratings

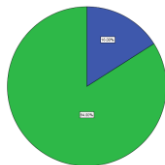
Outcomes Data Activity CHI ESQ Data



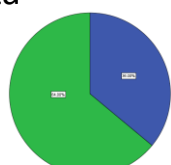
A rating of 3 = Certainly True
A rating of 2 = Somewhat True
A rating of 1 = Not True

PCHI 1 = I feel that the people who have seen my child have listened to me
PCHI 2 = It was easy to talk to the people who have seen my child
PCHI 3 = I was treated well by the people who have seen my child
PCHI 4 = My views and worries were taken seriously
PCHI 5 = I feel the people here know how to help with the problem I came for
PCHI 6 = I have been given enough explanation about the help available here
PCHI 7 = I feel that the people who have seen my child are working together to help with the problem(s)
PCHI 8 = The facilities here are comfortable
PCHI 9 = The appointments are usually at a convenient time
PCHI 10 = It is quite easy to get to the place where the appointments are
PCHI 11 = If a friend needed similar help, I would recommend that he or she come here
PCHI 12 = Overall, the help I received here is good

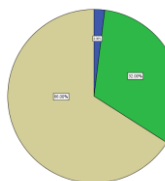
Outcomes Data Activity CHI ESQ Data



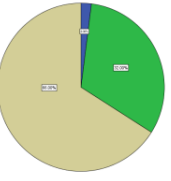
I was treated well by the people who have seen my child



I feel the people here know how to help with the problem I came for



If a friend needed similar help, I would recommend that he or she come here



Overall, the help I received here is good



CHAPTER 5: FREQUENTLY ASKED QUESTIONS

Since the implementation of the CIP a number of scenarios have been identified by Clinicians, Managers and Researchers as potentially challenging in terms of conducting routine outcomes measurement.

In response to these challenges, members from the Psychology Department of East Kent Hospitals University Foundation Trust (EKHUFT) have worked alongside the CIP Information Officer to devise a list of 'Frequently Asked Questions'. The FAQs detail these particular scenarios and how best they can be managed, utilising the knowledge gleaned from Clinicians and Managers working in CAMH settings day to day.

URGENT RISK ASSESSMENTS (URAs)

Services should aim to collect outcomes data from patients and their families wherever possible and this includes those seen at URAs. Here, the Clinician attending will be required to use their professional judgment as to whether it is appropriate to administer the full suite of outcomes measures in use (Parent / Carer rated SDQs and Self rated SDQs for young people aged 11 years or older). **However, as a minimum they are expected to complete the Clinician-rated CGAS** as part of their contact with the patient.

Due to the need to attend URAs relatively quickly, Clinicians have often found it useful to have a batch of ready-made packs of measures located in reception which they can easily access as they leave the building. The measures packs should contain copies of all the measures and their various versions, so that the Clinician can select exactly what they need once they meet the patient and family.

The service receives a request to attend an URA > Clinician attends (hospital / family home):

- Clinician picks up a measures pack on their way to the URA
- Clinician completes the CGAS
- Clinician calculates when a potential Time 2 date would fall (+ 6 months from the current date) and notes this on the front of the measures pack and in their diary.
- Clinician decides whether it is appropriate to administer Self and / or Parent rated SDQs (if this is deemed inappropriate, Clinician notes that these measures were not given)
- Clinician returns the completed measures to the measures pack which is placed in the file
- Clinician returns to the service and the file is given to admin for typing / stored separately (dependent on process used in the given service)

If the case is formally referred to the service after the URA or if the child / young person / family attend for follow up, SDQs and CHI ESQ can be administered at this point utilising the usual outcomes process for the given service.

Internal Wait Lists

It is not uncommon for cases to be placed on an internal waiting list. Indeed, this can happen at several points after the case has been accepted into the service. Consequently, deciding when to undertake T1 data collection can be made increasingly complex.

As a general rule, T1 data collection occurs at Initial Assessment. However, it is recognised that for some services, cases will often be placed on an internal waiting list following Initial Assessment. If this occurs, a decision must be made as to whether T1 data needs to be collected again when intervention begins at the First Therapy Session, or whether the pre-existing T1 data remains valid.

There is no concrete answer to this question. However, **the factor that most likely dictates whether T1 data needs to be collected again is the amount of time between Initial Assessment and First Therapy Session.** Using scores from outcomes measures completed at an Initial Assessment more than 3 months prior to any intervention commencing, will likely only reflect change which has occurred through being on a wait list rather than receiving treatment.

It is therefore pivotal that Clinicians inspect any completed measures located in the patient's file, to find out when the T1 data was collected. From this, they should be able to ascertain whether T1 collection will need repeating, or whether the existing data remains valid.

If a case is closed following the Initial Assessment and it is not referred to another service or the patient / family disengages following the Initial Assessment, only T1 measures are completed. Date of case closure is usually recording on the tracking system used by the service. As this would be the same as the date of Initial Assessment, it is indicated that the case was closed straight away and hence there will not be any T2 or follow up data for that particular case.

If the case is referred to another service following the Initial Assessment, T1 measures are taken as usual, and the date they were administered is recorded. The measures are then forwarded on to the service receiving the referral.

Internal waiting list is known to be ≤ 3 months, collect Time 1 data at the Initial Assessment

Internal waiting list is known to be > 3 months, collect Time 1 data at the First Therapy Session

Brief Interventions and Consultations

Planned short term interventions

On occasions where a Clinician has planned a short term intervention with a patient; for example 1-3 sessions, it is not suitable to use the SDQ as a parent / self rated outcome measure. This is essentially because there will be a time lag of approximately three months before follow up data could be collected (due to the strict time frame for T2 SDQ data collection of T1 + 4 to 8 months).

During that time lag, the family may have moved on and do not see the need to complete a follow up measure as their intervention had finished some time ago. Contrastingly, the family may be in crisis and want to access the service again but a referral may not have been made. Also, there are practical issues around whether the contact details for the family are still relevant.

In this situation, it is advisable to use the CHI ESQ as a stand-alone T2 measure of service user satisfaction, completed at the end of the intervention. However, if the Clinician would like to try to capture elements of change over the course of the intervention despite it being brief, they may use the GBOs measure (see Chapter 2 Section 2.2.2).

Cases Closed or Referred Elsewhere at Initial Assessment

If a case is closed following the Initial Assessment and it is not referred to another service, only T1 measures are completed. Date of case closure is usually recording on the tracking system used by the service. As this would be the same as the date of Initial Assessment, it is indicated that the case was closed straight away and hence there will not be any T2 or follow up data for that particular case.

If the case is referred to another service following the Initial Assessment, T1 measures are taken as usual, and the date they were administered is recorded. The measures are then forwarded on to the service receiving the referral (see Chapter 3 Section 3.3).

Unplanned short term interventions

Of course, it is not always possible to know how long the course of an intervention will last as there are many factors affecting this outside of the Clinician's control. In this situation, where an intervention ends unexpectedly and T1 data was collected in the usual way, it will be necessary to record that contact ended abruptly or in an unplanned manner e.g. because the family did not attend further appointments.

If the Clinician does not see the patient again, they will be unable to collect T2 CGAS data. However, attempts can be made to gather T2 SDQ and the CHI ESQ data by posting these measures to families to complete and return to the service. This would be done within the designated T2 SDQ time frame of 4 to 8 months post T1 data collection.

It is useful to note that if the family has disengaged the likelihood of them returning completed postal measures is extremely low. Therefore, the service may wish to make a team decision over whether it is cost effective to administer T2 measures, in light of the size of their existing T2 dataset and the circumstances under which the family disengaged from the service.

Planned brief interventions > CHI ESQ (at closure only) and GBOs (Time 1 and Time 2)

Unplanned brief interventions > Postal Time 2 SDQs and CHI ESQ sent to the family (CGAS cannot be measured if the Clinician no longer has contact with the patient)

Consultation work

A number of CAMH services offer consultation as part of their work. In anticipation of increasing demand for this, it may be useful to consider using outcomes measurement to document consultation work supplied by the service.

The CORC Consultation Feedback Questionnaire is designed to monitor the impact of consultation work carried out by CAMHS practitioners. It is completed by professionals who have sought information from CAMHS about child mental health. The questionnaire is not suitable for very casual consultations, e.g. requests for information / contact details of other services, or for referrals.

The questionnaire is administered following consultation work and so is a T2 measure only. It can be used for face to face and telephone consultations. It is also suitable for one off or a series of consultations. On-going consultations can be monitored at routine intervals to map how a group of professionals rate service satisfaction and their own confidence in dealing with child mental health issues, over a continuous period of liaison with the CAMHS professional.

Complex Cases – LAC

Often a family's circumstances can affect the decision over whether or not to administer outcomes measures. An example which commonly generates much discussion is when a child has become Looked After between T1 and T2 data collection. There appears to be at least two main issues that need addressing in this scenario, 1) the reliability of the data and 2) the ethical position of clinicians in these cases.

In terms of reliability of data, there is some published guidance available from the Department for Education website on the administration of SDQs for LAC;

'The questionnaire must be completed by the child's main carer. For most looked after children and young people this will be either a foster carer or their residential care worker where the child is in residential accommodation. However it is possible for the questionnaire to be completed by a parent or other family member if they are looking after the child'.

'For children who have changed carers during the course of the year, local authorities should assess which carer is best placed to carry out the assessment'.

Department for Education (2011). SDQ Guidance Update. Retrieved from;

http://media.education.gov.uk/assets/files/pdf/s/statistical%20returns_sdq%20guidance%20update%20dec%202008.pdf

However, this guidance is not explicitly relevant to CAMHS and does not address administration of other outcomes measures that may be in used within the service.

In terms of ethical responsibility, the decision over whether or not to administer measures in this scenario should be based on clinical judgment. In order to support the decision making process, the following may be useful to consider;

- How long ago was the child placed in care?
- Has the child been placed in care previously?
 - If the child was recently placed in care or was placed in care for the first time, they may be unsettled, upset and anxious. Therefore, asking them to complete a self report measure of their difficulties is likely to be insensitive and to cause more distress. The child's responses are also likely to be unrepresentative of how they are feeling more generally.
- Who will be completing informant rated measures?
 - Biological Parents may under-rate the severity of difficulties at follow up, in order to encourage the return of the child to the family home, or contrastingly over-

rate the severity of difficulties in order to maintain separation. Parents may become distressed at being asked to give details about their child, if that child has been removed from the family home. The Parent may currently be attending a Parenting Group in order to comply with a Court Order.

- Foster Parent / Respite Carers may under rate the severity of difficulties or over rate improvement at follow up; as they feel the outcome of the measures reflect their ability as carers.
- Social / Residential Worker; if a child has only recently been placed in care, the social or residential worker may not know them sufficiently well to give reliable answers to outcomes questions.

Ultimately, Clinicians have an ethical responsibility to ensure minimal distress is caused to service users. This responsibility must be weighed up against the professional responsibility to collect outcome measures wherever possible, for the development of the service and benefit of the children, young people and families it serves.



GLOSSARY OF TERMS

CAMHS – Child and Adolescent Mental Health Services: The term is often used broadly to encompass all services and agencies that contribute to the mental health and emotional wellbeing of children and young people. However, it can also be used to refer to *Specialist CAMHS*; services generally provided by Health operating at Tier 2, 3 and 4.

CGAS – A routine outcome measurement tool developed to provide a global measure of everyday functioning in children and young people.

CHI ESQ – A routine outcomes measurement tool used to measure service user satisfaction with CAMHS.

Clinician – in this document is used to refer to any mental health professional involved in a child or young person's assessment or care.

CORC Consultation Questionnaire – A routine outcomes measurement tool used to capture information around child mental health consultation and advice services offered by CAMHS to other professionals.

GBOs – A routine outcomes measurement tool used to capture the degree of movement towards goals set by the service user in collaboration with their Clinician and family.

HoNOSCA – Health of the Nation Outcome Scales for Children and Adolescents: a routine outcomes measurement tool that assesses the behaviours, impairments, symptoms and social functioning of children and young people with mental health problems.

Human Error – Errors in action, planning or execution of a particular task

Intervention – in this document is used to refer to any therapies or medical treatments that form part of a child or young person’s assessment or care.

LAC – Looked After Child: a child or young person (less than 18 years old) who is in the care of a local authority under a care order by the courts, or accommodated under a voluntary arrangement as a result of there being no person who has parental responsibility, s/he is lost or abandoned, or the person caring for her/him being prevented from providing suitable accommodation or care.

Nisonger CBRF – Nisonger Child Behaviour Rating Form: A routine outcomes measurement tool that assesses social competence and problem behaviours in children and young people with learning disabilities and autistic spectrum disorder.

Outlier – A score or data point which differs substantially from the other scores or data points.

SDQ – Strengths and Difficulties Questionnaire: A routine outcomes measurement tool used to assess emotional and behavioural symptoms in children and young people with mental health problems.

SLDOM – Sheffield learning Disabilities Outcome Measure: A routine outcomes measurement tool used to evaluate services for children and young people with severe to profound learning disabilities.

Tiers – A CAMHS four tier model representing a strategic and functional framework and / or an organizational structure. Tier 1: universally accessible primary contact services. Professionals working in these services include; GPs, Health Visitors and Teachers. Tier 2: interventions offered by individual staff within Specialist CAMHS (PMHWs, Psychiatric Nurses, Clinical Psychologists, Psychotherapists, Psychiatrists). Tier 3: interventions offered by teams or staff from Specialist CAMHS. These often centre around particularly complex needs. Tier 4: very specialized CAMHS interventions and care including inpatient CAMHS, secure mental health services, specialist neuro-psychiatric services and highly specialist outpatients services for young people with complex disorders.

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APPENDICES

- A. Measures Guide
- B. Tracking Sticker Template
- C. Example Honorary Research Assistant Person Specification and Job Description
- D. ROM Letter to Families
- E. Recommended Formulas and Conditional Formatting Rules for Excel Tracking Databases
- F. CORC Data Submission Proforma
- G. Outcomes Data Collection Information Sheets for Parent / Carers and Young People

Appendix A: Measures Guide

SDQs (Time 1 and Time 2)

Parent rated SDQs are given to all families attending the service.

There are three parent rated versions, one for parents of children aged 3-4 years, one for parents of children aged 4-16 years and another for parents of young people aged 11 -17 years.

Self rated SDQs are only given to young people aged 11-17 years.

Denoted on the top right corner of the measure is it's designation as parent / self rated, Time 1 / Time 2, and age range e.g.

- P 3-4= parent rated Time 1 SDQ for parents of children aged 3-4 years.
- P 4-16 = parent rated Time 1 SDQ for parents of children aged 4-16 years.
- P 11-17= parent rated Time 1 SDQ for parents of young people aged 11-17 years.
- P (follow up) 3-4= parent rated Time 2 SDQ for parents of children aged 3-4 years.
- P (follow up) 4-16 = parent rated Time 2 SDQ for parents of children aged 4-16 years.

- P (follow up) 11-17 = parent rated Time 2 SDQ for parents of young people aged 11-17 years.
- S 11-17 = self rated Time 1 SDQ for young people aged 11-17 years.
- S (follow up) 11-17 = self rated Time 2 SDQ for young people aged 11-17 years.

CGAS (Time 1 and Time 2)

A Clinician rated measure completed for all children attending the service.

Clinicians must give a specific raw score e.g. 57 as opposed to a decile score e.g. 51-60

CHI ESQ (Time 2 Only)

Parent rated CHI ESQ and ESQ ADDENDUM are given to all families who have attended the service.

Self rated CHI ESQ is only given to young people aged 9 years or above.

There are two self rated versions, one for children aged 9-11 years and another for young people aged 12-18 years.

Denoted in the left corner of the measure is it's designation as parent / self rated and age range e.g.

- Day Services (Parent / Carer) = parent rated CHI ESQ or ESQ ADDENDUM for parents of all children.
- Day Services (9-11) = self rated CHI ESQ for children aged 9-11 years.
- Day Services (12-18) = self rated CHI ESQ for young people aged 12-18 years.

Nisonger CBRF (Time 1 and Time 2)

This measure is given to all parents of children aged 3-16 years attending the service.

Although the same version of the measure is used at Time 1 and Time 2, it may be useful to colour code them so Clinicians can ensure they have copies for each time point, e.g.

- T1 = Time 1 (first appointment after allocation) Nisonger CBRF (BLUE).
- T2 = Time 2 (+6mths or at case closure – whichever is soonest) Nisonger CBRF (GREEN).

SLDOM (Time 1 and Time 2)

This measure is given to all parents of children aged 3-16 years attending the service.

Time 1 and Time 2 versions of this measure differ and so it may be useful to colour code them so Clinicians can ensure the correct version is used at each time point, e.g.

- T1 = Time 1 (first appointment after allocation) SLDOM (BLUE).
- T2 = Time 2 (+6mths or at case closure – whichever is soonest) SLDOM (GREEN).

Goal Based Outcomes (GBOs) (Time 1 and Time 2)

Within the first 3 sessions with the Clinician, the respondent (usually parent) is asked to identify and list up to 3 goals they would like to achieve from their contact with the service.

At each time point, the respondent is asked to rate how close they feel they are to reaching these goals.

- T1 = Time 1 rating (within the first three appointments after allocation).
- T2 = Time 2 rating (+6mths or at case closure – whichever is soonest).

Appendix B: Tracking Sticker Template

Name:

ID Number:

D.O.B:

Time 1 Date:

Predicted Time 2 Date (Time 1 date + 6 months):

Appendix C: Example Honorary Research Assistant Person Specification and Job Description

JOB DESCRIPTION: HONORARY RESEARCH ASSISTANT CAMHS (Part – time)

	Essential (E) / Desirable (D)	Application (APP) / Interview (I) / References (R)
QUALIFICATIONS		
Undergraduate degree in Psychology (2:1 or above) (Applications from undergraduate students in their final year of study expected to gain a 2:1 or above are also welcome)	D	APP
Postgraduate / masters degree in a relevant area e.g. child mental health / development, research methodology, statistics	D	APP
EXPERIENCE		
Computer literate with knowledge of SPSS and Excel	E	APP / I
Possess sufficient breadth and depth of knowledge of research methods and data analysis to work within the given area	E	APP / I
Experience of managing large datasets	E	APP / I
Knowledge of child and adolescent mental health services	D	APP / I
Knowledge / experience of service evaluation	D	APP / I
SKILLS AND ATTRIBUTES		
Good interpersonal and team working skills	E	I / R
Good organisational skills	E	I / R
Excellent written and oral communication skills	E	APP / I / R
Data coding and analysis skills	E	APP / I
QUALITIES		
Willingness to learn new skills	E	APP / I

Ability to work on own initiative as well as part of a team	E	R
Ability to communicate with a variety of stakeholders including service managers, clinicians, commissioners and service users	E D	I / R APP / I
Commitment to the post for 9 months		

MAIN PURPOSE OF THE JOB

The overall aim of the role is to coordinate and support the collection of routine outcomes measures datasets from individual CAMH services in Kent and undertake analysis of these in line with guidance from Service Managers, the CAMHS Strategy Group and the CAMHS Outcomes Research Consortium (CORC).

DUTIES

Support the service in their implementation of systems to collect the required datasets, which will include overseeing data collation and input, and tracking the administration of measures.

Regularly reporting back to the rest of the team on progress and what outcomes data is showing.

Work with the team to overcome challenges which arise in conducting routine outcomes measurement.

Liaise with various Kent based expert groups and external groups such as CORC.

Present information on progress and outcomes to supervising bodies, e.g. steering groups.

Liaise with support staff on routine matters.

Attend and participate in relevant meetings.

Co-ordinate own work with that of others to avoid conflict or duplication of effort.

Contribute to the planning of research projects which stem from the outcomes data.

Appendix D: ROM Letter to Families

Postal Time 2 Measures

Dear (*insert name of family member*)

As you may remember when you attended your first appointment you were asked to fill out a 'Strengths and Difficulties Questionnaire' (SDQ). I am now sending you another copy of the SDQ. We would be very grateful if you could take a few moments to complete it, answering each question on your own and as truthfully as possible. It is also very important that the parent or guardian that completed the original SDQ fills in this one, if at all possible.

By comparing these questionnaires to those you filled in previously, we will be able to explore how we are doing as a service and look at the progress we have made together. I have also enclosed another questionnaire called the 'Experience of Service' questionnaire. Again, we would be very grateful if you could take a few minutes to complete this also. By looking at the feedback you are able to provide we can look at how we are doing as a service and make changes that can benefit you and your family should you use the service in the future.

Please send the completed questionnaires to us in the stamped addressed envelope provided.

Information from the questionnaires may be used for audit, research, teaching and publication purposes, but it will be presented in such a way that neither you nor your family can be identified. If you have any concerns about how we propose to use the information please discuss them with *(insert name/title and contact details of relevant contact in local service e.g. clinical governance or audit officer)*.

Thank you for taking the time to complete these questionnaires. It is very much appreciated.

Yours sincerely

(Insert name of clinician/administrator)

Request to arrive early for first appointment

Dear *(insert name of family member)*

When you arrive for your appointment *(insert date and time)*, you will be asked to complete a questionnaire called the Strengths and Difficulties Questionnaire (SDQ). The questionnaire has 25 items about different aspects of your child's behaviour. We would be very grateful if you could take a few moments to complete this questionnaire in reception just before attending the appointment, answering each question on your own and as truthfully as possible. We will also ask you to complete the same questionnaire in 6 months time. This will give us an idea of the progress that we have made together and will be used to help us evaluate our services. This process can make a real difference to your family because the person who saw you or your child can get your feedback and change what they do for the better.

If you could therefore **arrive ten minutes prior to your appointment time** in order to complete the questionnaire, it would be very much appreciated.

Information from this questionnaire may be used for audit, research, teaching and publication purposes, but it will be presented in such a way that neither you nor your family can be identified. If you have any concerns about how we propose to use the

information please discuss them with *(insert name/title and contact details of relevant contact in local service e.g. clinical governance or audit officer)*.

Thank you very much in advance for taking the time to complete the questionnaire.

(If you do not wish to complete the questionnaire, we completely understand and it will in no way affect the treatment your family receives).

Yours sincerely

(Insert name of clinician/administrator)

Appendix E: Recommended Formulas and Conditional Formatting Rules for Excel Tracking Databases

Excel 1997-2003:

- 1) *Folding the spreadsheet (allows you to keep particular columns of information in view while you work on others e.g. patient name, UPIN, DOB...)*
 - a. Click on the column to the right of where you want to fold the sheet
 - b. Window > freeze panes (keep rows and columns visible while the rest of the worksheet scrolls [based on current selection])

- 2) *Formula to calculate the current date*
 - a. Enter into the formula bar: =TODAY()

- 3) *Formula to calculate Age (in years) from DOB*
 - a. Enter into the formula bar: =(\$A\$1-E4)/365
 - b. Here, '\$A\$1' references the current date cell and 'E' references the DOB column

- 4) *Formula to calculate T2 date from T1 date for **Parent** rated measures*
 - a. Enter into the formula bar: = (T1 cell ref. + 120 or 180) for 4 or 6 months respectively

- 5) *Formula to calculate T2 date from T1 date for the **Child** rated SDQ*
 - a. Enter into the formula bar: =IF((child age cell ref.)<=10, "NA", (T1 cell ref.+120 or 180)) for 4 or 6 months respectively. This rule will calculate the T2 date where the child is old enough to complete a self report SDQ.

- 6) To copy a formula into the other cells in the column (instead of having to re-type it in each individual cell), place the cursor over the bottom right hand corner of the cell and click. Then drag the cursor down across all the cells you want to apply the formula to (*).

- 7) *Conditional Formatting to colour code T2 dates according to urgency*
 - a. Click on the T2 column where you wish to apply the rule (highlighting the whole column)

 - b. Format > Conditional formatting > Cell value is > between

 - c. Enter the appropriate time frame:
 - i. =\$A\$1-60 and =\$A\$1-31 **RED**
 - ii. =\$A\$1-30 and =\$A\$1+30 **ORANGE**

- iii. Cell value is > greater than =\$A\$1+31 GREEN
- d. Select 'Format' and the 'colour' you wish to assign to the time frame, e.g.
 - i. A time frame which has already passed (and is more than 6 months ago) and 'red'
 - ii. Repeat the above process for a current time frame (e.g. 30 days + or – the current date) and 'orange'
 - iii. Repeat the above process for a future time frame (e.g. one month or more after the current month) and 'green'
 - iv. Click 'OK'.
- e. This conditional formatting will allow you to see when T2 dates are late and when they are due, using a traffic light colour system.
- f. To apply the conditional formatting to all columns where T2 dates are entered, use the 'Format Painter' function. This icon is located in the tool bar (and looks like a paint brush).
 - i. Select the first cell in the column which has already been conditionally formatted, then click on the Format Painter icon,
 - ii. Click on the first cell of the next column you want to format.
 - iii. Use the same process as used to apply a formula across all cells in a column (*) to apply the conditional formatting rule across all the cells in the column.
 - iv. Repeat for other columns.

8) *Printing selected cells*

- a. In order to print a list to share at team meetings of those cases where T2 measures are due to be administered, the easiest thing to do is take a screen shot.
- b. Position the database in the window so you can see all the relevant information (ensure you fold the spreadsheet so you can capture name, UPIN and T2 date all on the same page).
- c. Click 'Ctrl' and 'Prt Scr SysRq' keys together.
- d. Open a blank word document
- e. Click 'paste'
- f. The screen shot of the database page should appear and can be printed off for use in the team meeting.

9) *Establishing links between workbooks*

- a. Create a second workbook which will become the 'target' into which information from an existing workbook can be linked.
- b. Ensure both workbooks are open and saved.
- c. Select and copy the source content in the existing workbook (e.g. whether case is closed field) – this becomes the linked object.
- d. Move to the target workbook, select the cell where you want the linked data to be entered.
- e. Select Edit, Paste Special to open the Paste Special Dialogue Box

- f. In most cases, use the 'All' option that is selected by default when creating a paste link (although you can change selections pertaining to the content and formatting you want to include in the pasted material).
- g. Click the Paste Link button; this will immediately execute the link.
- h. After linking a source and target workbooks, test the link by switching to the source cells and making a change to their content – this should be reflected in the target workbook.
- i. If you paste link blank cells, Excel displays 0 for the blank cell in the target workbook. To suppress the display of zeros, choose Tools, Options, click the View tab, and deselect the Zero Values option.

Appendix F: CORC Data Submission Proforma

Proforma completed by member grouping on submission of data

Please note your data cannot be analysed unless you send us this completed checklist

- 1) Please check that there are no patient IDs which are longer than 10 characters in length
- 2) Please check that there are no duplicate IDs in your dataset

e.g. “Tommy Smith” must have only one ID for any one period of intervention. If you give Tommy ID CC3215 when he is seen in 2007 by Service A and then you give Jane Jones ID CC3215 when she is seen in Service A in 2008, we will not be able to recognise this as a different child. I.e. they will be considered as the same child and one set of data will be lost or corrupted.

If you see Tommy Smith again in 2008 for a different intervention he will need to have a different ID for us to be able to capture the different work in each “episode of care”

- 3) Please check that you have included all of our essential variables in your data. These are as follows:
 - Patient ID
 - Member Name
 - Team Name (if applicable)
 -
- 4) Please note that it is now important that you send us the date variable for each of the questionnaires that you send into us.

e.g. “P_SDQ_DATE_T1” and “P_SDQ_DATE_T2” (Parent SDQ Time 1 and Parent SDQ Time 2). This information is included in our list of variables, the most updated list can be found at: <http://www.corc.uk.net/index.php?contentkey=33>, and is called, “Information to send to CORC Central Team- Advice for Members”

We ask that members do their very best to collect this information and send it to us, however, if you do not have this information, please let us know and we will discuss ways forward

5) Please provide some background information on the teams you have sent data from.

	<u>Team Name as written in Data File</u>	<u>Team Name</u>	<u>What Sort of Team is this?</u>	<u>What Tier is this team?</u> (If your team does not fall into the a specific Tier, please indicate which you would most liken it to)	<u>Groupings within the report?</u> (Within the report the teams are likely to be put together on graphs in groups of 4, please indicate if there are certain groupings you would prefer)
	<i>e.g. ADHDN</i>	<i>ADHD Team North</i>	<i>This is our ADHD specialist team in the North</i>	<i>Tier 4</i>	<i>Would like grouped with teams 3, 4, 5</i>
1					
2					
3					
4					
5					
6					
7					
8					

*Please add additional rows if you are submitting data for more than 8 teams (we will only be able to offer graphs for the first 8 teams, and tables for any additional)

6) Number of children seen during reporting period

	<u>Service Level</u>	<u>Team Level</u>							
		1	2	3	4	5	6	7	8
a) Number of referred children who were themselves or a family seen for at least one appointment									
b) Number of referred children who were themselves or a family seen for at least one appointment where the referred child was over 11									
c) Number of referred children who were themselves or a family seen for at least one appointment where the referred child was over 9									

* Please add additional columns if you are submitting data for more than 8 teams

7) How did you collect measures from children and families?

Please give the rough balance in percentage terms of what methods were used for each of the questionnaires, using the key below – for your Service and split by Teams (you can choose more than one method)

	Name	Method of Data Collection					
		SDQ Parent T1	SDQ Parent T2	SDQ Child T1	SDQ Child T2	Parent CHI-ESQ	Child CHI-ESQ
Service	<i>e.g. Erinsborough</i>	<i>A 50% B 50%</i>	<i>F 100%</i>	<i>C 100%</i>	<i>F 100%</i>	<i>C 75% B 25%</i>	<i>A 80% B 20%</i>
Teams	<i>e.g. Team A</i>	<i>A 50% B 50%</i>	<i>G 100%</i>	<i>C 100%</i>	<i>G 100%</i>	<i>C 75% B 25%</i>	<i>A 80% B 20%</i>
1							
2							
3							
4							
5							
6							
7							
8							

KEY - Method of Data Collection

A	Phone by the practitioner
B	Phone by someone else, e.g. admin or research asst., other practitioner)
C	Face to face with the practitioner
D	Face to face with someone else (eg admin)
E	In waiting room
F	Post
G	Post with incentive
H	Online
free text	Other, (please state)

8) What reporting period would you like this report to be based on?

All Data held in the CORC database so far for your service

OR

A specific reporting period: from

to

9) Please indicate whether you would like your demographic information included in your report?

Yes

No

If you answered “Yes”, please list which demographics you would want included:

10) When are T1 family measures completed?

Have you got systems in place to ensure that the SDQ for parents and children (where relevant) is administered within the first few meetings after the T1 measure is given?

Yes

No

Other (please state)

If you answered “No”, when are the T1 measures generally administered?

- after assessment is completed and when treatment begins
- other - please specify
- don't know

11) When are you generally collecting time 2 SDQ?

Have you got systems in place to ensure that the SDQ T2 for parents and children (where relevant) is administered at no less than 4 months and no more than 8 months after the T1 measure is given?

Yes

No

Other (please state)

If you answered “No”, when is the SDQ T2 generally given out?

- at case closure whenever that is
- later than 8 months
- other - please specify
- don't know

12) When are you generally collecting CHI-ESQ?

Have you got systems in place to ensure that the CHI- ESQ for parents and children (where relevant) is administered at around 6 months (or case closure if sooner) after the T1 measure is given.

- Yes
- No

Other (please state)

If you answered “No”, when is the CHI-ESQ generally given out?

- at case closure whenever that is
- later than 6 months
- other - please specify
- don't know

Appendix G: Outcomes Data Collection Information Sheets for Parents / Carers and Young People

Parent / Carer

Outcomes measurement is an activity routinely undertaken by Child and Adolescent Mental Health Services throughout the UK. It is undertaken in order to monitor how efficiently and successfully services are being delivered to children, young people and families. It also serves to record how the child, young person and family progress through the service, and helps inform changes that can be made to improve the service and therefore the experience of those using it.

The process of outcomes measurement involves young people, families and clinicians working together to complete a small number of questionnaires during the course of contact with the service. The information from these questionnaires may be used for audit, research, teaching and publication purposes, as well as to directly monitor the progress of individual children, young people and families.

The information from the completed questionnaires will always be presented in such a way that no person or family can be identified. If you have

concerns about how we propose to use the information, please discuss them with (*insert name / title and contact details of relevant contact in the local service e.g. clinical governance or audit officer, or name / title of the clinician leading the case*). If you do not wish to complete any questionnaires, this will in no way affect the treatment you or your family receives.

Young Person

Questionnaires are often given to young people and families who use a service like ours which aims to help people.

The information you give allows us to keep track of how well we are doing our job. It also tells us about how young people and families feel about their problems, and lets us know what changes we can make to improve our service and the experience of those using it.

Young people, families and the staff working here, are all asked to complete some questionnaires. The information from these questionnaires can be used in research and to teach staff how to do things better.

When we use information to teach staff or do some research about our service, no one is ever able to know from which person the information came from, because we never use your name.

If you want to talk to someone more about how we use information you give us, you can ask to speak with *(insert name / title and contact details of relevant contact in the local service e.g. clinical governance or audit officer, or name / title of the clinician leading the case)*.

You do not have to complete any questionnaires if you do not want to. Whether you decide to complete the questionnaires or not, you will be treated in exactly the same way.



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