

CHILDREN AND YOUNG PEOPLE'S TRACKING OUTCOMES

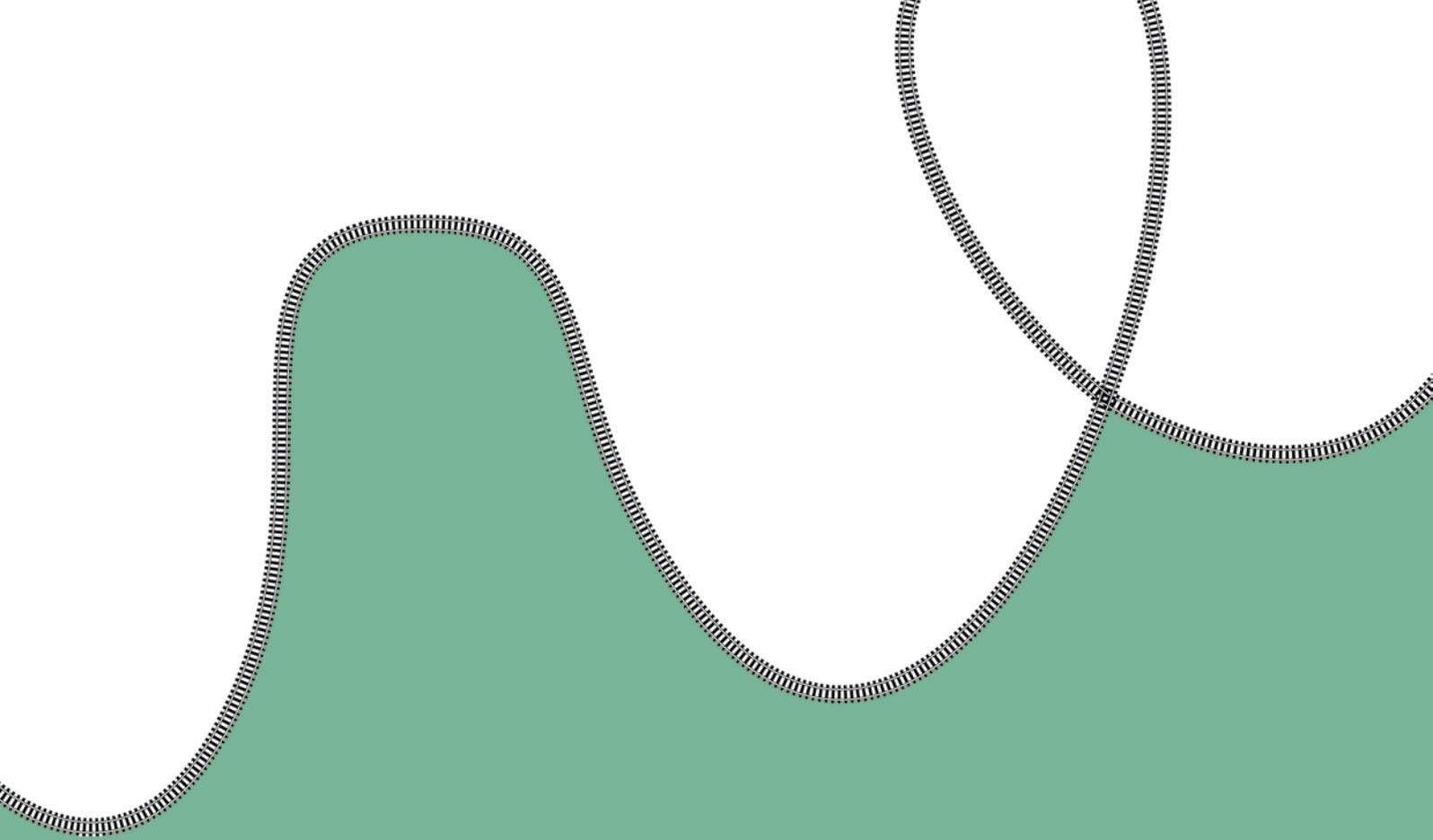
Resource Pack

Version 1.3.2

Child/Young Person Measures

Parent/Carer Measures

Practitioner Resources



CHILDREN AND YOUNG PEOPLE'S TRACKING OUTCOMES

Resource Pack

Version 1.3.2

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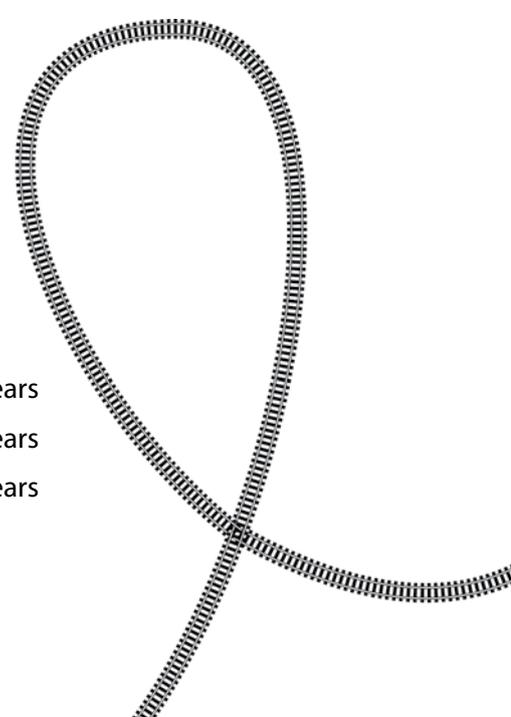
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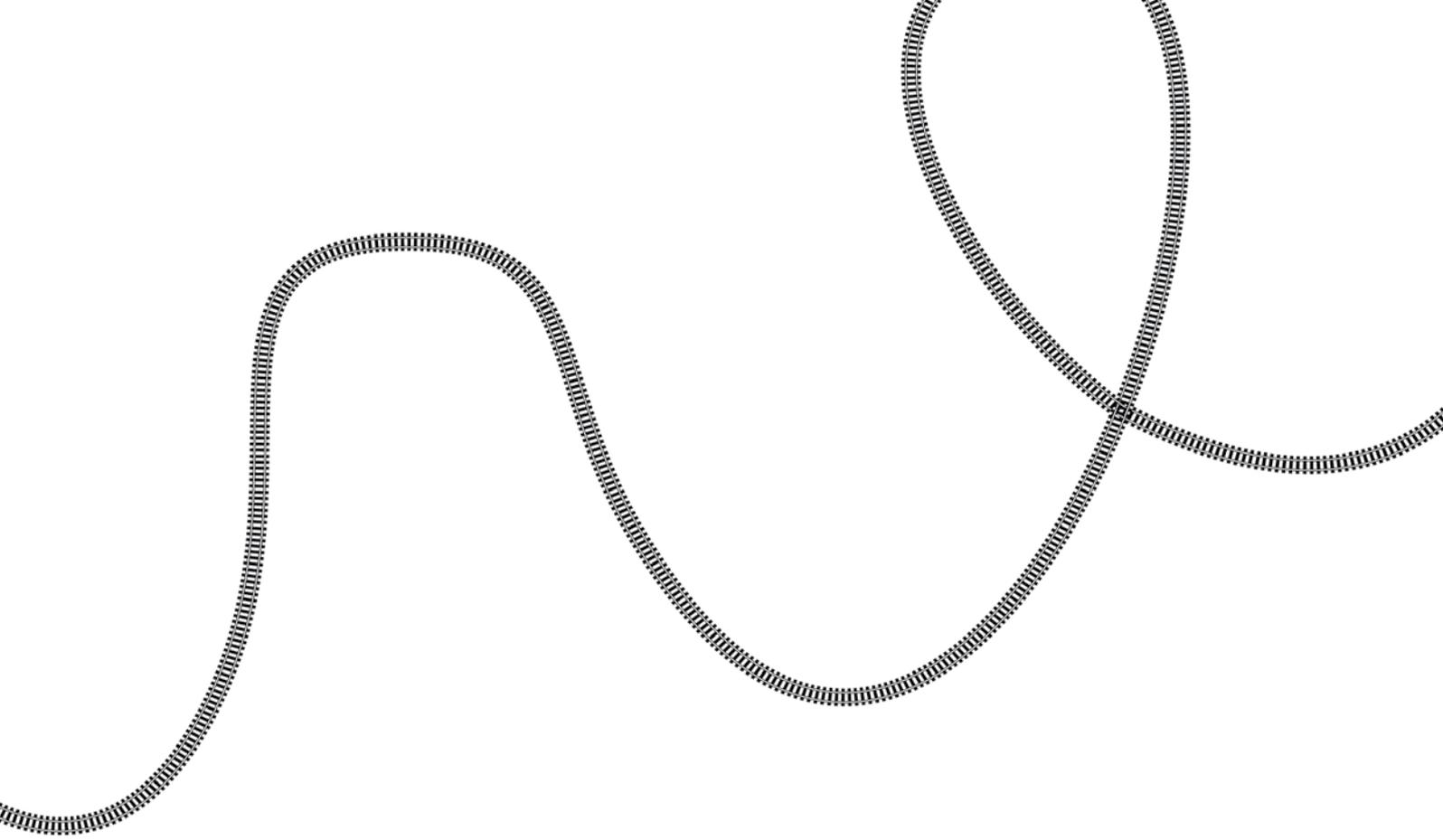
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WELCOME

Welcome

The Children and Young People's Improving Access to Psychological Therapies – Tracking Outcomes Resource Pack

This pack contains:

- Copies of measures for use at initial assessment, session by session and at review.
- Guidance on scoring measures
- Information on interpreting the scores in terms of clinical bands (where appropriate)
- Consent forms (to be completed by relevant family members when questionnaire first sent out or at first meeting as deemed most relevant)

All forms can be printed and copied freely.

Note on tracking change and experience for children, young people and families

The aim is to help clinicians understand and track change from the point of view of those they are working with, in order to help guide clinical interventions. The set of tools are chosen to provide information that can complement other information, and service users feedback, gained through clinical conversations.

Evidence shows us that if we get our approach to monitoring outcomes right, children and young people feel more involved in their treatment and together we achieve better outcomes. The role and attitude of the therapist when giving children and young people or their parents these tools is critically important – this is more than an add-on to your session. The forms for children, young people and parents in this pack are designed to be completed direct by service users but can also be used as prompts or aids for discussion and completed in conversation in the session (e.g. in particular the feedback on sessions questions) and the form filled out afterwards to capture the scores .

This approach was developed by the Outcomes and Evaluation Group (December 2011) and will be reviewed by them in July 2012. This pack should be used along the lines laid out by the Outcomes and Evaluation Group Briefing Note (December 2011) and in conjunction with the CYP IAPT Outcomes Orientated Practice Group (CO-OP) guide and other guidelines on the CYP IAPT web pages <http://www.iapt.nhs.uk/cyp-iapt/>

We welcome any comments on the approach or feedback as to how you have found it please [email iapt@dh.gsi.gov.uk](mailto:iapt@dh.gsi.gov.uk).

Miranda Wolpert

Chair of Outcome and Evaluation Group CYP IAPT

February 2012

Membership of Outcomes and Evaluation Task and Finish Group (OEG) *With brief information on key relevant expertise*

Dr Miranda Wolpert (Chair)

CAMHS outcomes, data collection and analysis (National Informatics Advisor CYP IAPT)

Professor David Clark

Adult IAPT implementation and data analysis (National Informatics Advisor Adult IAPT)

Margaret Oates

Adult IAPT data collection and collation expertise

David Wells

Child and maternity data management and reporting

Bill Badham

Involvement of young people expertise

Dr Duncan Law

Clinical and outcome monitoring expertise in CAMHS

Dr Margaret Murphy

Clinical and outcome monitoring expertise in CAMHS

Dr Jessica Deighton

CAMHS measure review and psychometric analysis expertise

Dr Ann York

Expertise in Payment by Results currency development work and CAPA/service improvement in CAMHS

Amandeep Hothi

Voluntary sector expertise

Kathryn Pugh

Project manager for Children & Young People's IAPT

Dr Paul Wilkinson

expertise in session by session monitoring in Cambridge IAPT

Claire Maguire

Expertise in session by session monitoring in Bury IAPT and commissioning

Damian Hart

Expertise in commissioning

Professor Paul Stallard

expertise in CBT and CAMHS

Professor Stephen Scott

Expertise in conduct disorder and parenting

Dr Andy Fugard

Psychometrics

Kevin Mullins

National IAPT Programme Lead

Dr Raphael Kelvin

DH advisor on CAMHS

Using information from clinical tools to improve clinical practice

Overview of Measures

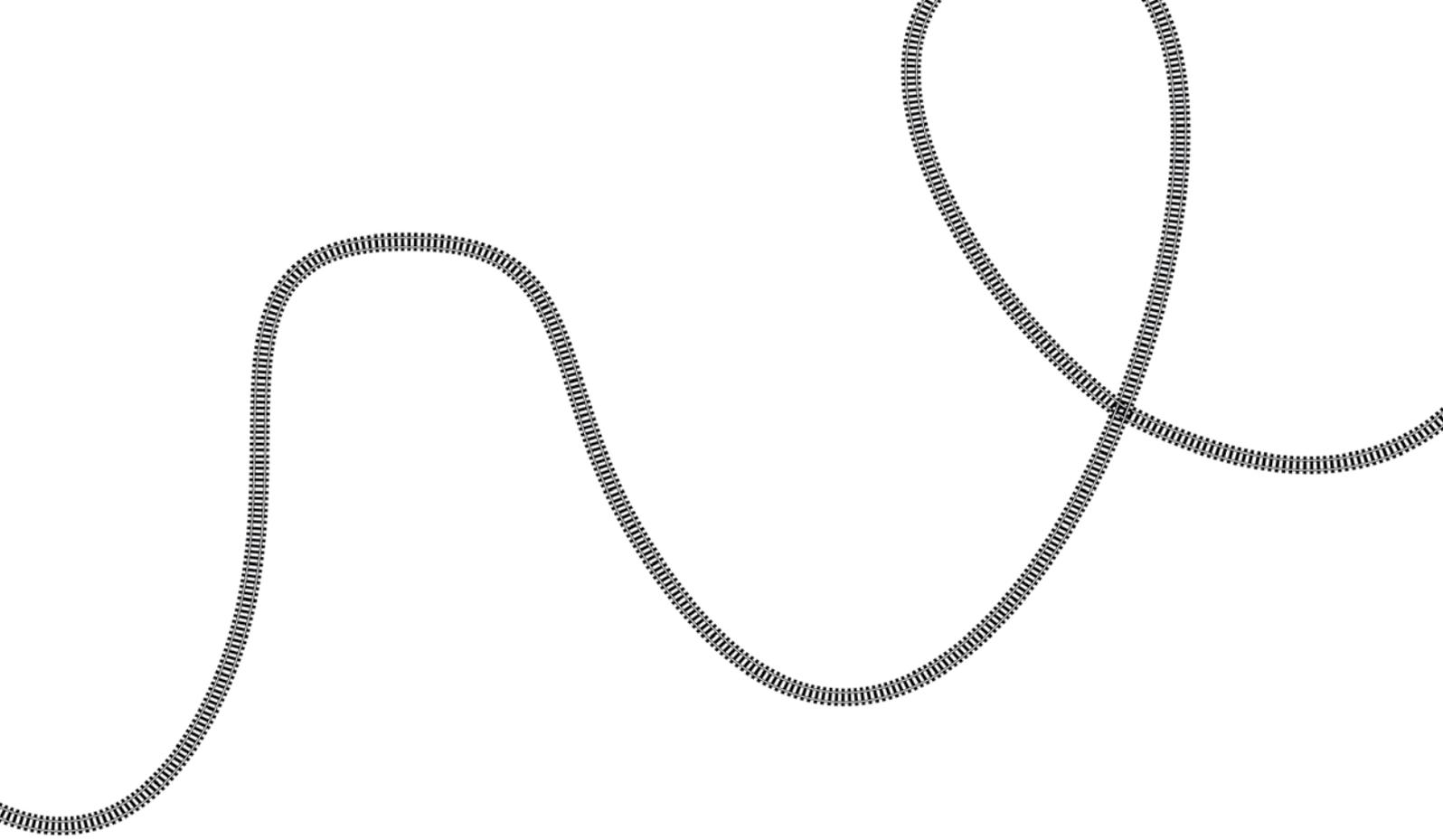
All measure can be completed by parent only, young person only or both as judged relevant

Assessment Measures:	
MEASURES	Notes
SDQ	Seek consent to share data- either at first meeting or with initial letter
RCADS	
Session-by-session Measures:	
MEASURES	Notes
Goals tracking	Use review of goals to check progress against agreed focus
General wellbeing tracking	Use Outcomes Rating Scale to track general wellbeing
Symptom tracking	Use one of the brief session specific measures as relevant to the specific difficulties being focused on NB 90% of all cases must have at least two time points of symptom tracking data from same category of respondent by time of case closure
Impact tracking	Use "how are you doing" measure instead of symptom tracking only if none of symptom measures above are suitable
Feedback tracking	Use four questions or session rating scale towards end of meeting to discuss how the meeting was experienced by those present
Review Measures:	
MEASURES	Notes
SDQ	Completed every six months or as service protocol demands (some services may choose to do more or less frequently)
RCADS	
CHI- ESQ	

Some Do's and Don'ts of using clinical outcome tools

1	DO	Make sure you have the questionnaires you need, ready before the session
2	DO	Always explain why you are asking anyone to fill out a questionnaire
3	DO	Look at the answers
4	DO	Discuss the answers with service users
5	DO	Share the information in supervision
6	DO	Always use information from outcomes in conjunction with other clinical information
1	Don't	Give out a questionnaire if you think the person doesn't understand why they are being asked to complete them
2	Don't	Give out any outcome measure if you don't understand why you are using it
3	Don't	Use the tools if the service users is too distressed
4	Don't	See the numbers generated from outcome tools as an absolute fact
5	Don't	See your clinical judgement as an absolute fact

Taken from CO-OP guide V1.3 Feb 2012 p.16



CONSENT TO SHARE INFORMATION

Gaining Consent to share data: information for practitioners

The CYP IAPT project has agreed an “opt in” approach to data sharing. This means asking children, young people or their parents/guardians as relevant, for permission to share their data.

This permission covers: answers to questionnaires and some key personal details such as name and address, so that different pieces of information can be linked to allow meaningful analysis (e.g. a child’s questionnaire responses can be linked to the number of sessions they were seen for and the sort of treatment they received).

Before we analyse the data we will delete all personal details and only use the anonymised data for analysis and reporting

The approach we are taking

We have been advised to follow the process used for gaining consent for use of Patient Reported Outcomes Measures in elective surgery. This involves asking the first time a questionnaire is completed for permission to use the data from this and subsequent questionnaires.

Who gives consent?

If a young person is over the age of 16 they can give independent consent without parental input unless there are exceptional circumstances (such as where they are deemed unable to make independent decisions for some reason)

If a young person is under the age of 16 but judged “Gillick competent” i.e. able to understand and retain the information about the decision they are making and can weigh up and use this information in coming to their decision, then they too can legal give consent without parent or guardian authorization.

If a young person is under the age of 16 and not judged Gillick competent, i.e. not able to understand and retain the information about the decision they are making and can weigh up and use this information in coming to their decision, then parent or guardian authorization is required

Who completes the form?

There are two consent forms- one for young people and one for their parents/guardians. Only **ONE** needs to be completed. Please ask for the **ONE** to be completed that you deem relevant

- If the young person is judged “Gillick competent” and completes the young person form, but they and you would like the parent to sign the form also that is fine –just ask the parent/guardian to add their signature to the bottom of the form for young people.
- If the parent is the one giving authorization but you and they feel it makes sense for the “non-Gillick” competent child to sign that is also fine –they can add their signature on the form for parents.

Participation is voluntary

If authorization is not given or withdrawn at any time please ensure this is recorded on your relevant database so that the information in question can be excluded from data sharing.

Consent to share information:

Improving Access to Psychological Therapy for Children & Young People

During treatment, you will be asked to complete questionnaires about how you feel and how much progress you are making towards achieving treatment goals. Your therapist will regularly check these with you to make sure they are helping the best they can.

Our request

We are asking your permission to use answers to these questionnaires to collect information about the quality of the services provided for children, young people and their families

Our promise

Nationally, we will report only group information, for instance how many people with particular problems have recovered by the end of treatment.

It will not be possible to identify you personally from these analyses and reports.

By signing this consent form you are agreeing that:

Your personal details and questionnaire responses will be held securely by MegaNexus who are providing secure data storage for the Improving Access to Psychological Therapies for Children and Young People.

All the information will be handled securely (no unauthorized person can see it). Any identifying information, such as your name, address etc, will be removed before analysis and before any publication. This anonymised data will be used by The CAMHS Outcomes Research Consortium (CORC) who are analysing the data and may be used by other research groups to help make services as good as they can be.

No one involved in the project will release your personal information unless required by law or where there is a clear overriding public interest.

Your participation is voluntary

You may withdraw your consent for this information to be shared up to the point at which data are analysed and personal details removed. Please talk to the person working with you if you have any concerns or queries

I agree for my information to be part of the database for the
Children and Young People' Improving Access to Psychological Therapies Project

Yes

OR

(please circle)

Name: _____

Signature: _____ Date _____

Parental Consent to share information:

Improving Access to Psychological Therapy for Children & Young People

During treatment, you and your child may be asked to complete questionnaires about how you and they feel and how much progress you are making towards achieving treatment goals. The therapist will regularly check these with you to make sure they are helping the best they can.

Our request

We are asking your permission to use answers to these questionnaires to collect information about the quality of the services provided for children, young people and their families

Our promise

Nationally, we will report only group information, for instance how many people with particular problems have recovered by the end of treatment.

It will not be possible to identify you or your child personally from these analyses and reports.

By signing this consent form you are agreeing that:

Your child's personal details and questionnaire responses will be held securely by MegaNexus who are providing secure data storage for the Improving Access to Psychological Therapies for Children and Young People.

All the information will be handled securely (no unauthorized person can see it). Any identifying information, such as your child's name and address etc will be removed before analysis and before any publication. This anonymised data will be used by The CAMHS Outcomes Research Consortium (CORC) who are analysing the data and may be used by other research groups to help make services as good as they can be.

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You may withdraw your consent for this information to be shared up to the point at which data are analysed and personal details removed. Please talk to the person working with you if you have any concerns or queries.

I agree for my child's information to be part of the database for the
Children and Young People' Improving Access to Psychological Therapies Project

Yes

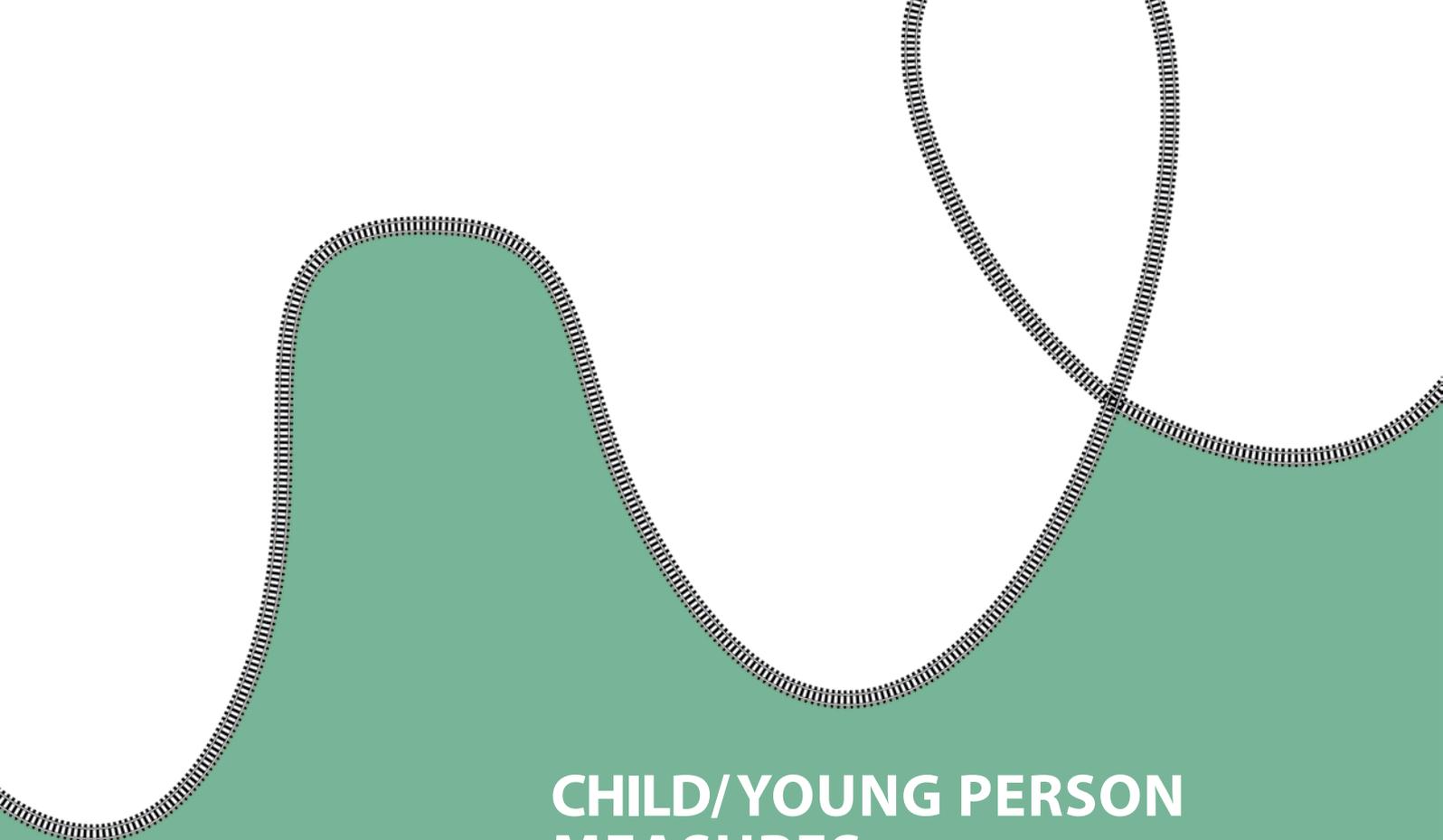
OR

No

(please circle)

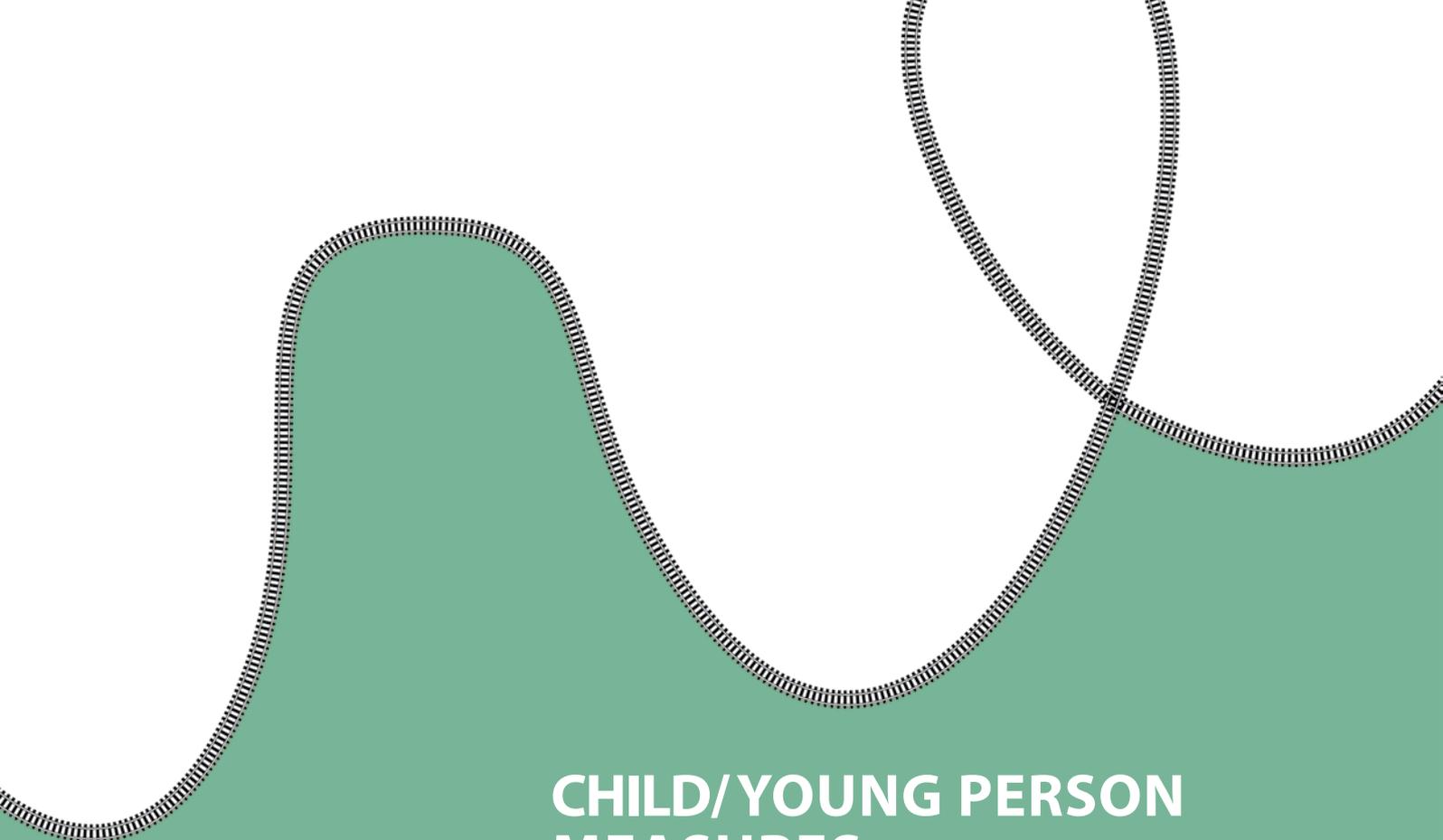
Name: _____

Signature: _____ Date _____



CHILD/YOUNG PERSON MEASURES

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GOAL OR GLOBAL TRACKING
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- 28 How are things?
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- 50 RCADS
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Day Services (9-11)
- 54 CHI Experience of Service Questionnaire
Day Services (12-18)



CHILD/YOUNG PERSON MEASURES

ASSESSMENT

Strengths and Difficulties Questionnaire

S 11-17

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

Your Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

	No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

• How long have these difficulties been present?

	Less than a month	1-5 months	6-12 months	Over a year
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress you?

	Not at all	Only a little	Quite a lot	A great deal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

	Not at all	Only a little	Quite a lot	A great deal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature

Today's Date

Thank you very much for your help



RCADS

NHS ID:

Child/ Young Person's NAME:

Date: / / 20

Time: ^h

Please put a circle around the word that shows how often each of these things happens to you.
There are no right or wrong answers.

1	I worry about things	Never	Sometimes	Often	Always
2	I feel sad or empty	Never	Sometimes	Often	Always
3	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4	I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always

6	Nothing is much fun anymore	Never	Sometimes	Often	Always
7	I feel scared when I have to take a test	Never	Sometimes	Often	Always
8	I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9	I worry about being away from my parent	Never	Sometimes	Often	Always
10	I am bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always

11	I have trouble sleeping	Never	Sometimes	Often	Always
12	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
13	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15	I have problems with my appetite	Never	Sometimes	Often	Always

16	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
18	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19	I have no energy for things	Never	Sometimes	Often	Always
20	I worry I might look foolish	Never	Sometimes	Often	Always

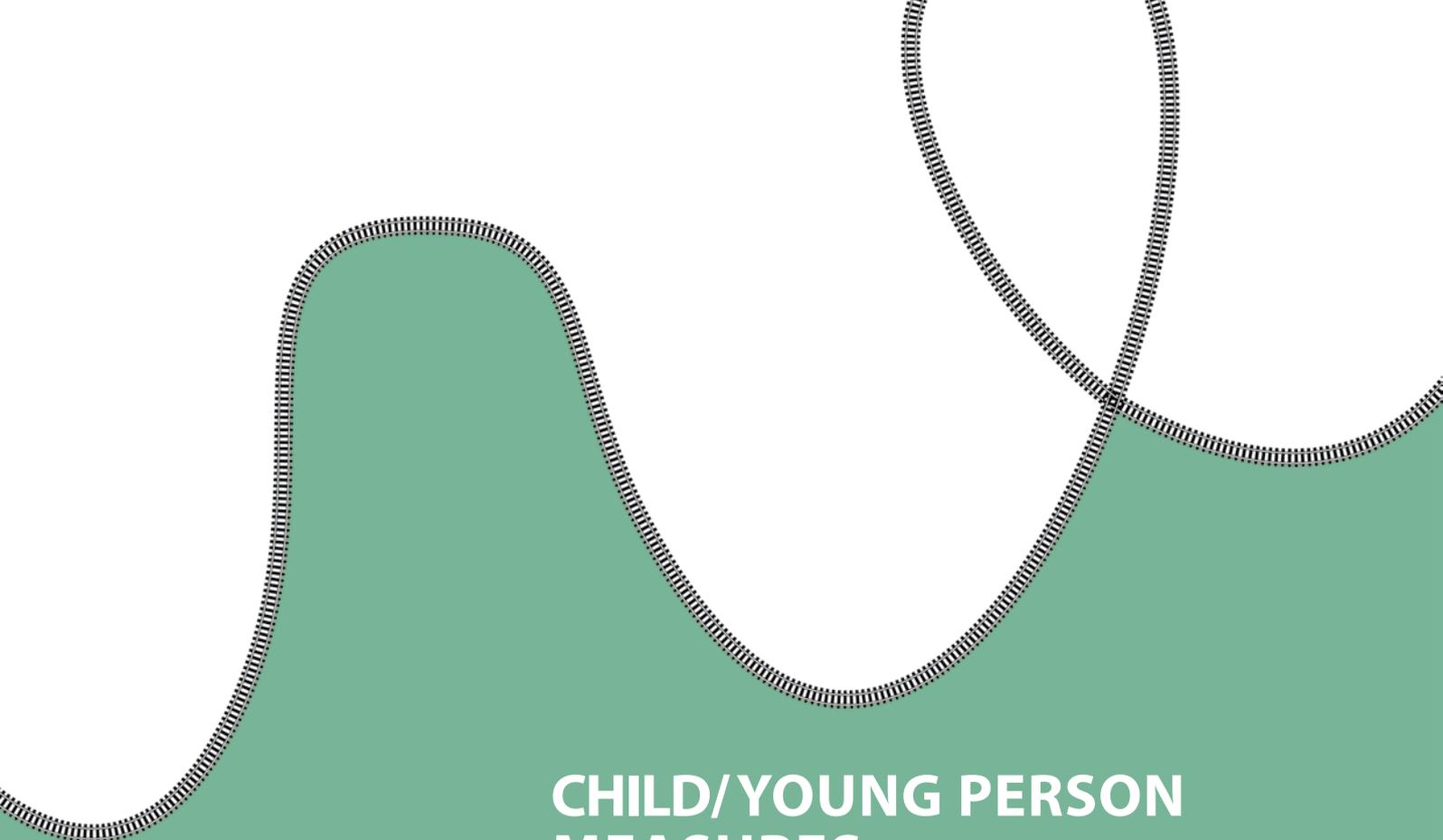
21	I am tired a lot	Never	Sometimes	Often	Always
22	I worry that bad things will happen to me	Never	Sometimes	Often	Always
23	I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
24	When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25	I cannot think clearly	Never	Sometimes	Often	Always

26	I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27	I worry that something bad will happen to me	Never	Sometimes	Often	Always
28	When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29	I feel worthless	Never	Sometimes	Often	Always
30	I worry about making mistakes	Never	Sometimes	Often	Always

31	I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32	I worry what other people think of me	Never	Sometimes	Often	Always
33	I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34	All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
35	I worry about what is going to happen	Never	Sometimes	Often	Always

36	I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37	I think about death	Never	Sometimes	Often	Always
38	I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
39	My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40	I feel like I don't want to move	Never	Sometimes	Often	Always

41	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
43	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
44	I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45	I worry when I go to bed at night	Never	Sometimes	Often	Always
46	I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
47	I feel restless	Never	Sometimes	Often	Always



CHILD/YOUNG PERSON MEASURES

**SESSION BY SESSION -
GOAL OR GLOBAL TRACKING**



Goal progress chart

Goal N°



You can turn this chart on its side for a quick look at progress over the sessions.

GOAL:

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
Remember a score of zero means no progress has been made towards a goal , a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two												
1		0	1	2	3	4	5	6	7	8	9	10
2		0	1	2	3	4	5	6	7	8	9	10
3		0	1	2	3	4	5	6	7	8	9	10
4		0	1	2	3	4	5	6	7	8	9	10
5		0	1	2	3	4	5	6	7	8	9	10
6		0	1	2	3	4	5	6	7	8	9	10
7		0	1	2	3	4	5	6	7	8	9	10
8		0	1	2	3	4	5	6	7	8	9	10
9		0	1	2	3	4	5	6	7	8	9	10
10		0	1	2	3	4	5	6	7	8	9	10
11		0	1	2	3	4	5	6	7	8	9	10
12		0	1	2	3	4	5	6	7	8	9	10

Who agreed this goal (tick below):

Child/young person

Family members

Practitioner

Other (please specify):



NHS ID:

Service allocated
case ID

.....

.....

Outcome Rating Scale (ORS)

(Ages 13 to Adult)

Name _____ Age (Yrs): _____ Session # _____ Date: _____
Who is filling out this form? Please check one: Self _____ Other _____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

Individually

(Personal well-being)

Interpersonally

(Family, close relationships)

Socially

(Work, school, friendships)

Overall

(General sense of well-being)

SCORING

Each line is 10cm.

Score with ruler
e.g. 3.5cm = score
of 3.5.

Write the scores
for each of the four
lines here in the
margin.

Add the four scores
for a total score.

Plot overall score
on the graph

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"Performance Metrics" to download the measure

Child Outcome Rating Scale (CORS)

(Ages 6 to 12)

Name _____ Age (Yrs): _____ Session # _____ Date: _____
Who is filling out this form? Please check one: Child _____ Caretaker _____
If caretaker, what is your relationship to this child? _____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*

Me
(How am I doing?)



Family
(How are things in my family?)



School
(How am I doing at school?)



Everything
(How is everything going?)



SCORING

Each line is 10cm.

Score with ruler
e.g. 3.5cm = score
of 3.5.

Write the scores
for each of the
four lines here in
the margin.

Add the four
scores for a total
score.

Plot overall score
on the graph

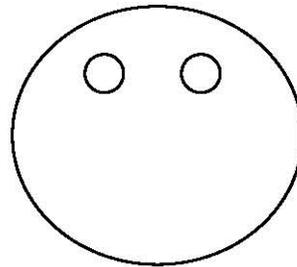
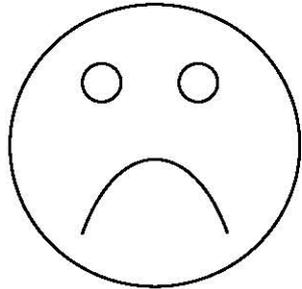
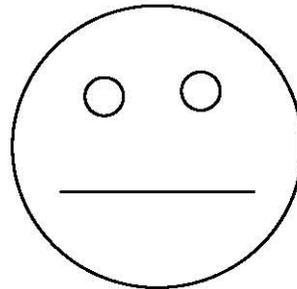
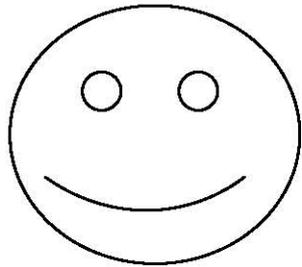
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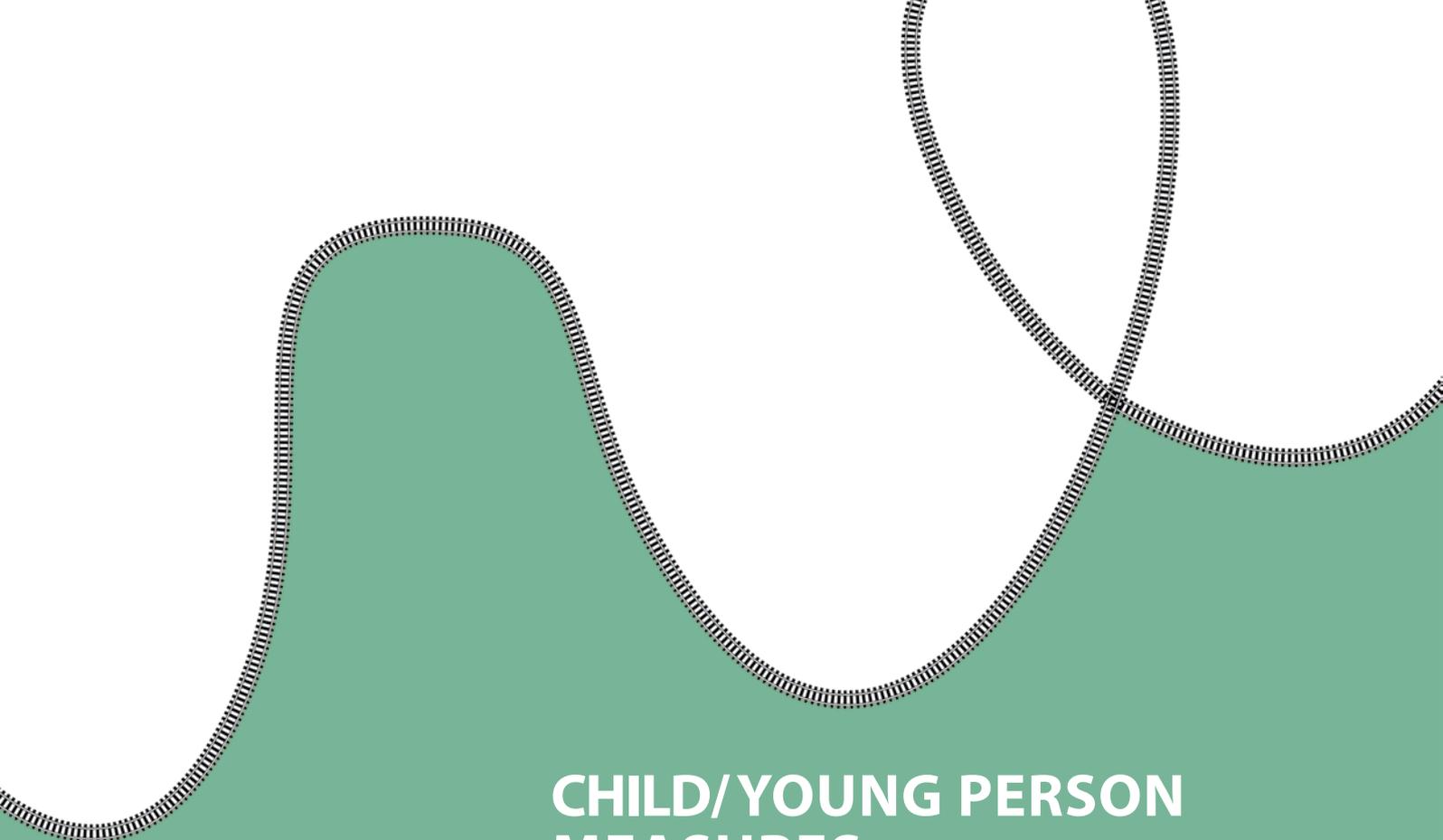
Young Child Outcome Rating Scale (YCORS)

(Age 5 and under)

Name _____	Age (Yrs): _____	Session # _____	Date: _____
------------	------------------	-----------------	-------------

Choose one of the faces that shows how things are going for you. Or, you can draw one below that is just right for you.





CHILD/YOUNG PERSON MEASURES

SESSION BY SESSION - SYMPTOM TRACKING



How are things?

Session N°



Date: / / 20

Time: ^h

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

		0	1	2	3
1	I feel sad or empty	Never	Sometimes	Often	Always
2	Nothing is much fun anymore	Never	Sometimes	Often	Always
3	I have trouble sleeping	Never	Sometimes	Often	Always
4	I have problems with my appetite	Never	Sometimes	Often	Always
5	I have no energy for things	Never	Sometimes	Often	Always
6	I am tired a lot	Never	Sometimes	Often	Always
7	I cannot think clearly	Never	Sometimes	Often	Always
8	I feel worthless	Never	Sometimes	Often	Always
9	I feel like I don't want to move	Never	Sometimes	Often	Always
10	I feel restless	Never	Sometimes	Often	Always

SUM:



NHS ID:

Service allocated case ID:



How are things?

Session N°



Date: / / 20

Time: ^h

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

		0	1	2	3
1	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
2	I worry about being away from my parents	Never	Sometimes	Often	Always
3	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
4	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
5	I am afraid of being in crowded places (shopping centres, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
6	I worry when I go to bed at night	Never	Sometimes	Often	Always
7	I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always

SUM:



NHS ID:

Service allocated case ID



How are things?

Session N°



Date: / / 20

Time: ^h

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

		0	1	2	3
1	I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
2	I feel scared when I have to take a test	Never	Sometimes	Often	Always
3	I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
4	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
5	I worry I might look foolish	Never	Sometimes	Often	Always
6	I worry about making mistakes	Never	Sometimes	Often	Always
7	I worry what other people think of me	Never	Sometimes	Often	Always
8	I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
9	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always

SUM:



NHS ID:

Service allocated case ID:



How are things?

Session N°



Date: / / 20

Time: ^h [']

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

		0	1	2	3
1	I worry about things	Never	Sometimes	Often	Always
2	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
3	I worry that bad things will happen to me	Never	Sometimes	Often	Always
4	I worry that something bad will happen to me	Never	Sometimes	Often	Always
5	I worry about what is going to happen	Never	Sometimes	Often	Always
6	I think about death	Never	Sometimes	Often	Always

SUM:



NHS ID:

Service allocated case ID:



How are things?

Session N°



Date: / / 20

Time: ^h

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

		0	1	2	3
1	I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
2	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
3	I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
4	I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
5	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
6	I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always

SUM:



NHS ID:

Service allocated case ID:



How are things?

Session N°



Date: / / 20

Time: ^h

Please put a circle around the word that shows how often each of these things happen to you.
There are no right or wrong answers.

		0	1	2	3
1	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
2	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
3	When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
4	I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
5	When I have a problem, I feel shaky	Never	Sometimes	Often	Always
6	All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
7	I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
8	My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
9	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always

SUM:



NHS ID:

Service allocated case ID:



How are things?

Session N°



Date: / / 20

Time: ^h [']

Below is a list of comments made by people after stressful life events. Please mark each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time please mark the 'not at all' box.

Frequency during the last week:		0	1	3	5
1	I thought about it when I didn't mean to	Not at all	Rarely	Sometimes	Often
2	I tried to remove it from memory	Not at all	Rarely	Sometimes	Often
3	I had waves of strong feelings about it	Not at all	Rarely	Sometimes	Often
4	I stayed away from reminders of it	Not at all	Rarely	Sometimes	Often
5	I tried not to talk about it	Not at all	Rarely	Sometimes	Often
6	Pictures about it popped into my mind	Not at all	Rarely	Sometimes	Often
7	Other things kept making me think about it	Not at all	Rarely	Sometimes	Often
8	I tried not to think about it	Not at all	Rarely	Sometimes	Often

SUM:



NHS ID:

Service allocated case ID:



How are things?

Session N°



Date: / / 20

Time: ^h

Below is a questionnaire which is going to ask you how you feel. There are no right or wrong answers. You should just pick the answer which is best for you. For example, we might ask "I feel happy", and then you will have to mark one of the options that say "Never", "Sometimes" or "Always"

		0	1	2
1	I get very angry	Never	Sometimes	Always
2	I lose my temper	Never	Sometimes	Always
3	I hit out when I am angry	Never	Sometimes	Always
4	I do things to hurt people	Never	Sometimes	Always
5	I am calm*	Always	Sometimes	Never
6	I break things on purpose	Never	Sometimes	Always
7	I bully others	Never	Sometimes	Always

*This item needs to be scored in reverse, i.e. Always =2, Sometimes=1, Never=0
Clinical banding is based on scoring of first 6 items only.

SUM:



NHS ID:

Service allocated case ID:



How are things?

Session N^o



Date: / / 20

Time: ^h

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Over the last 2 weeks, how often have you been bothered by any of the following problems?		0	1	2	3
1	Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
2	Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day
3	Trouble falling or staying asleep, or sleeping too much	Not at all	Several days	More than half the days	Nearly every day
4	Feeling tired or having little energy	Not at all	Several days	More than half the days	Nearly every day
5	Poor appetite or overeating	Not at all	Several days	More than half the days	Nearly every day
6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	Not at all	Several days	More than half the days	Nearly every day
7	Trouble concentrating on things, such as reading the newspaper or watching television	Not at all	Several days	More than half the days	Nearly every day
8	Moving or speaking so slowly that other people could have noticed/ Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	Not at all	Several days	More than half the days	Nearly every day
9	Thoughts that you would be better off dead or of hurting yourself in some way	Not at all	Several days	More than half the days	Nearly every day

SUM:



NHS ID:

Service allocated case ID



How are things?

Session N°



Date: / / 20

Time: ^h

Over the last 2 weeks, how often have you been bothered by any of the following problems?

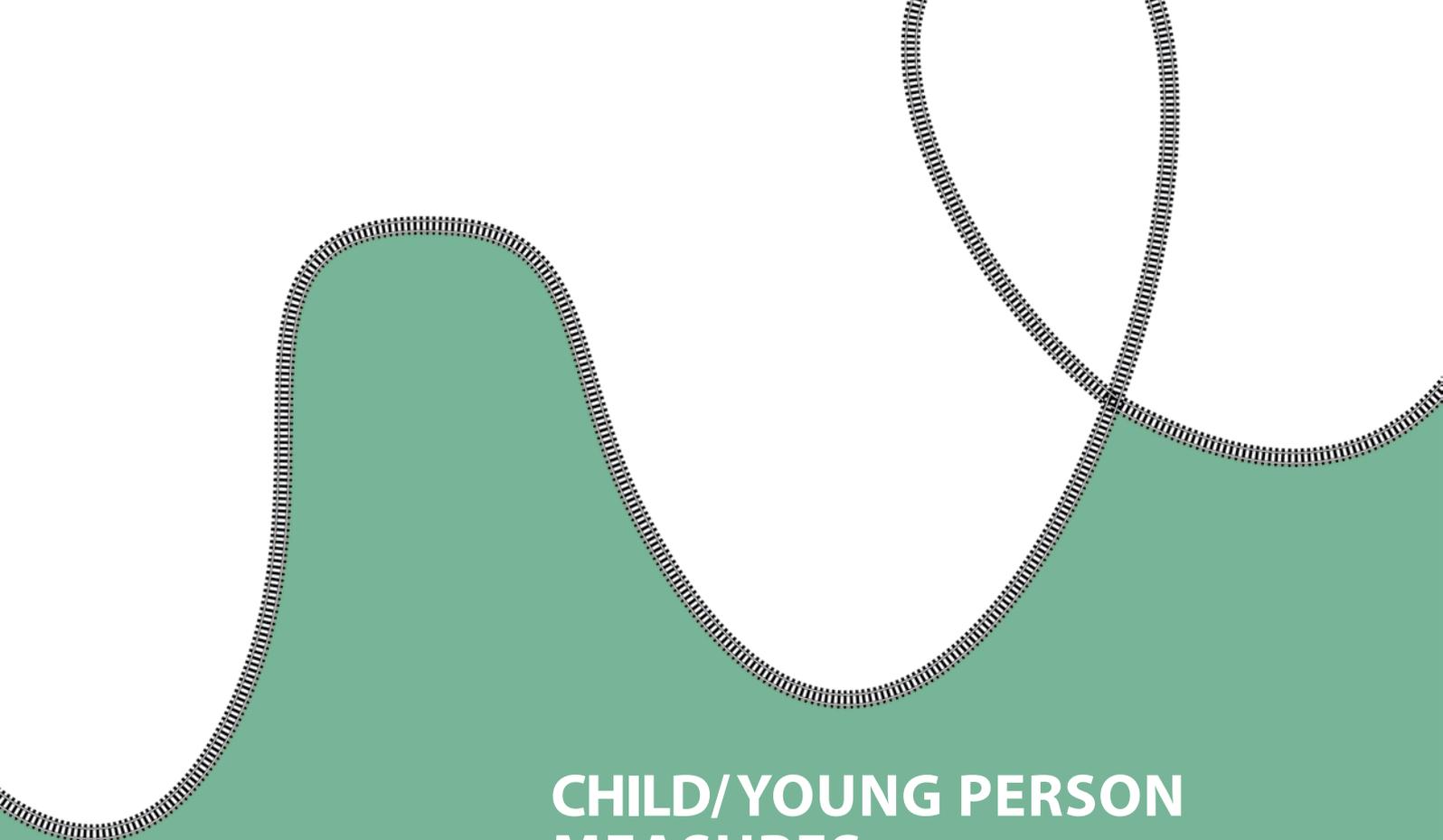
Over the last 2 weeks, how often have you been bothered by any of the following problems?		0	1	2	3
1	Feeling nervous, anxious or on edge	Not at all	Several days	More than half the days	Nearly every day
2	Not being able to stop or control worrying	Not at all	Several days	More than half the days	Nearly every day
3	Worrying too much about different things	Not at all	Several days	More than half the days	Nearly every day
4	Trouble relaxing	Not at all	Several days	More than half the days	Nearly every day
5	Being so restless that it is hard to sit still	Not at all	Several days	More than half the days	Nearly every day
6	Becoming easily annoyed or irritable	Not at all	Several days	More than half the days	Nearly every day
7	Feeling afraid as if something awful might happen	Not at all	Several days	More than half the days	Nearly every day

SUM:



NHS ID:

Service allocated case ID:



CHILD/YOUNG PERSON MEASURES

SESSION BY SESSION - IMPACT TRACKING

How are you doing?

Thinking about the recent past:

Since coming last time, are your difficulties:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>				

- How much have your difficulties been upsetting or distressing you?

Not at all	A little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Not at all	A little	A medium amount	A great deal
Your home life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your ability to learn or work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thinking about the future:

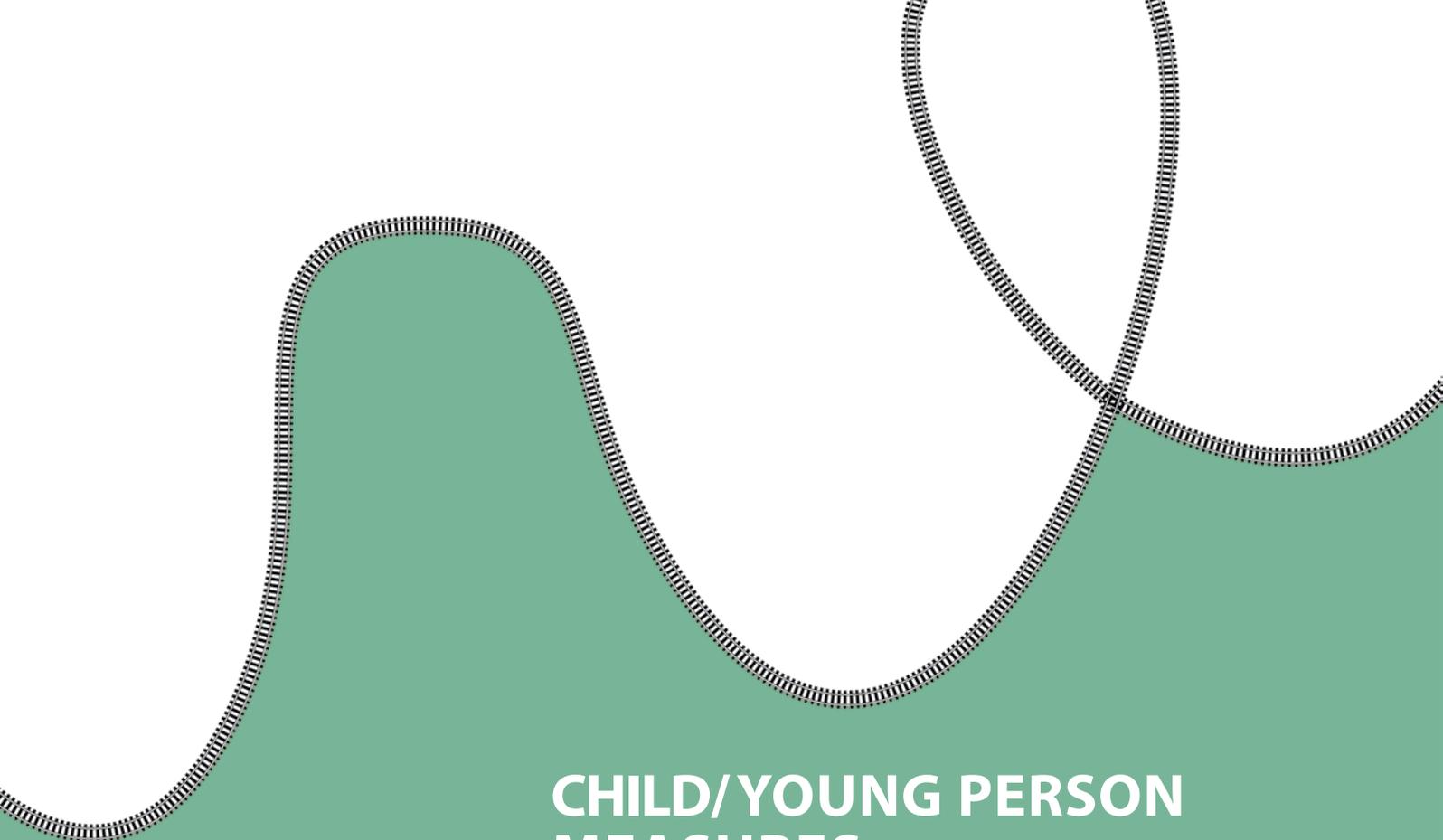
- How much better do you think you will be in one month's time?

No better, maybe worse	Only a little better	Quite a lot better	A great deal better
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your name

Today's date

Thank you very much for your help



CHILD/YOUNG PERSON MEASURES

SESSION BY SESSION - FEEDBACK TRACKING



How was this meeting?

Session N°

Date: // 20

Time: ^h[']

		0	1	2	3	4
1	Did you feel listened to?	Not at all	Only a little	Somewhat	Quite a bit	Totally
2	Did you talk about what you wanted to talk about?	Not at all	Only a little	Somewhat	Quite a bit	Totally
3	Did you understand the things said in the meeting?	Not at all	Only a little	Somewhat	Quite a bit	Totally
4	Did you feel the meeting gave you ideas for what to do?	Not at all	Only a little	Somewhat	Quite a bit	Totally

Who gave this feedback (tick below):

Child/young person

Mother

Father

Professional

Other (please specify):

.....

NHS ID:

.....

Service allocated
case ID

.....

SUM:

Session Rating Scale (SRS V.3.0)

(Ages 13 to Adult)

Name _____ Age (Yrs): _____ Session # _____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected.

I felt heard, understood, and respected.

Goals and Topics

We did not work on or talk about what I wanted to work on and talk about.

We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me.

The therapist's approach is a good fit for me.

Overall

There was something missing in the session today.

Overall, today's session was right for me.

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Child Session Rating Scale (CSRS)

(Ages 6 to 12)

Name _____ Age (Yrs): _____ Session # _____ Date: _____

How was our time together today? Please put a mark on the lines below to let us know how you feel.

Listening

_____ did not always listen to me.



_____ listened to me.

How Important

What we did and talked about was not really that important to me.



What we did and talked about were important to me

What We Did

I did not like what we did today.



I liked what we did today.

Overall

I wish we could do something different



I hope we do the same kind of things next time.

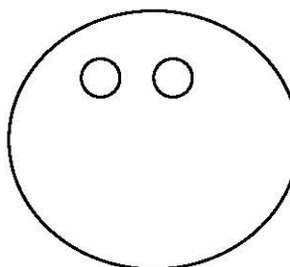
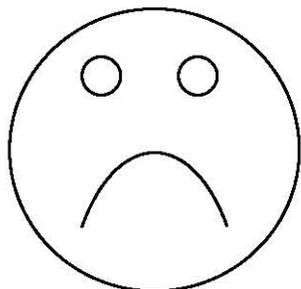
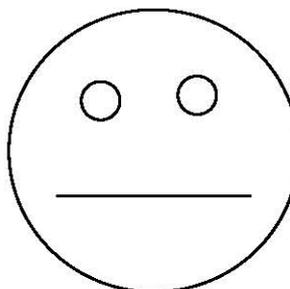
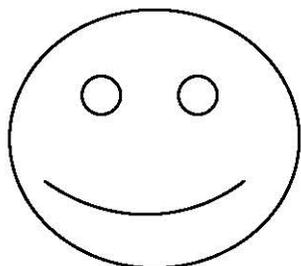
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Young Child Session Rating Scale (YCSRS)

(Age 5 and under)

Name _____ Age (Yrs): ____ Session # ____ Date: _____

Choose one of the faces that shows how it was for you to be here today. Or, you can draw one below that is just right for you.



Group Session Rating Scale (GDRC)

(Ages 13 to Adult)

Name _____ Age (Yrs): _____ Session # _____ Date: _____

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

I did not feel understood, respected, and/or accepted by the leader and/or the group.

Relationship

I felt understood, respected, and accepted by the leader and the group.

We did not work on or talk about what I wanted to work on and talk about.

Goals and Topics

We worked on and talked about what I wanted to work on and talk about.

The leader and/or the group's approach is a not a good fit for me.

Approach or Method

The leader and group's approach is a good fit for me.

There was something missing in group today—I did not feel like a part of the group.

Overall

Overall, today's group was right for me—I felt like a part of the group.

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Child Group Session Rating Scale (CGSRS)

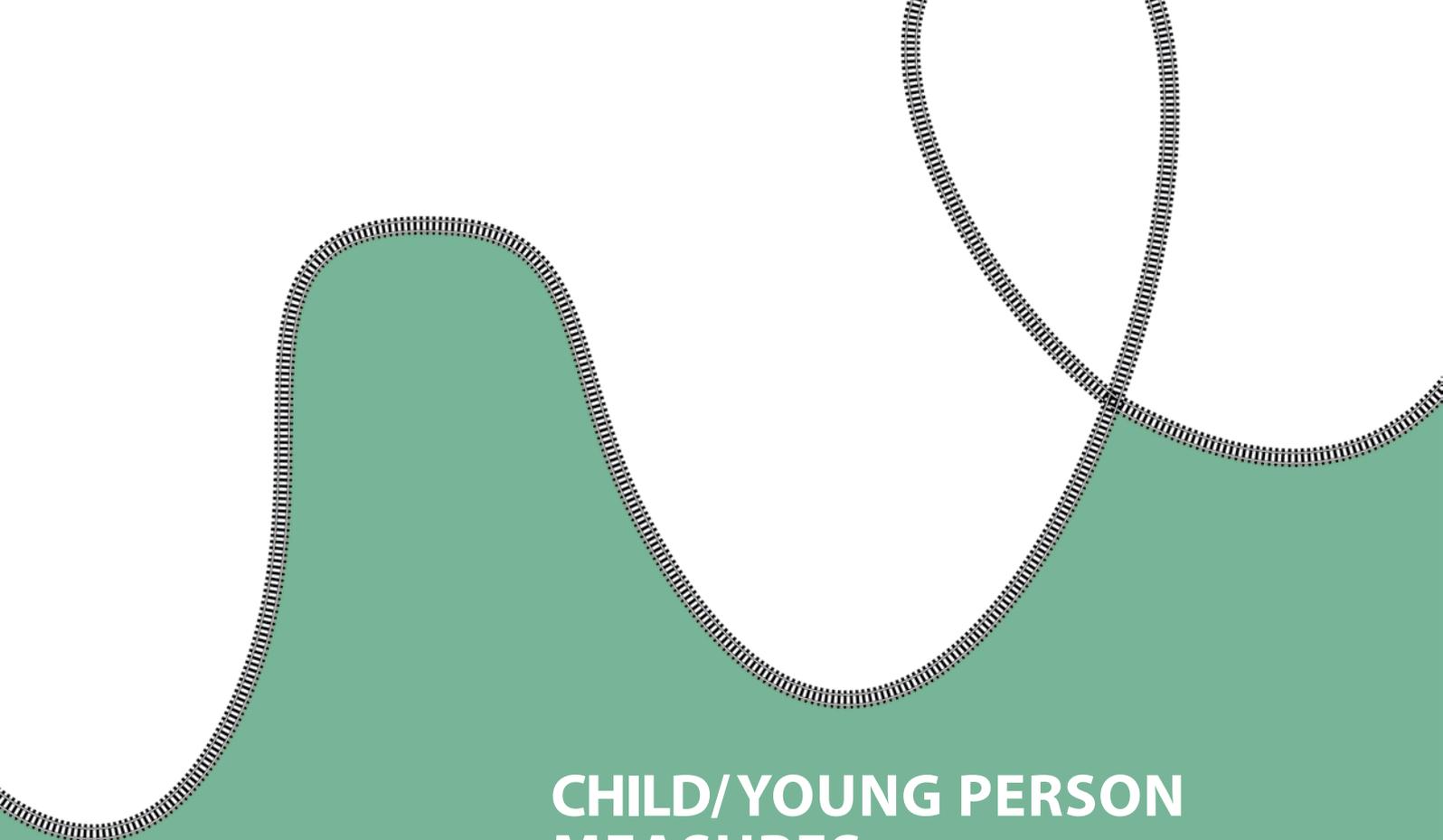
(Ages 6 to 12)

Name _____ Age (Yrs): _____ Session # _____ Date: _____

How was our group today? Please put a mark on the lines below to let us know how you feel.

The leader or group did not listen to me or like me.	Listening -----  ----- 	The leader and group listened to me and liked me.
We did not talk about or do important things.	How Important -----  ----- 	We talked about and did important things.
I did not like what we did today.	What We Did -----  ----- 	I liked what we did today.
Today was not good for me—I did not feel like a part of this group.	Overall -----  ----- 	Today was good for me—I felt like a part of this group.

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CHILD/YOUNG PERSON MEASURES

REVIEW

Strengths and Difficulties Questionnaire

S11-17
FOLLOW-UP

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

Your Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Since coming to the clinic, are your problems:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>				

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, have you had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

• Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do your difficulties make it harder for those around you (family, friends, teachers etc.)?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your signature

Today's date

Thank you very much for your help



RCADS

NHS ID:

Child/ Young Person's NAME:

Date: / / 20

Time: ^h

Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.

1	I worry about things	Never	Sometimes	Often	Always
2	I feel sad or empty	Never	Sometimes	Often	Always
3	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4	I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always

6	Nothing is much fun anymore	Never	Sometimes	Often	Always
7	I feel scared when I have to take a test	Never	Sometimes	Often	Always
8	I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9	I worry about being away from my parent	Never	Sometimes	Often	Always
10	I am bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always

11	I have trouble sleeping	Never	Sometimes	Often	Always
12	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
13	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15	I have problems with my appetite	Never	Sometimes	Often	Always

16	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
18	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19	I have no energy for things	Never	Sometimes	Often	Always
20	I worry I might look foolish	Never	Sometimes	Often	Always

21	I am tired a lot	Never	Sometimes	Often	Always
22	I worry that bad things will happen to me	Never	Sometimes	Often	Always
23	I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
24	When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25	I cannot think clearly	Never	Sometimes	Often	Always

26	I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27	I worry that something bad will happen to me	Never	Sometimes	Often	Always
28	When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29	I feel worthless	Never	Sometimes	Often	Always
30	I worry about making mistakes	Never	Sometimes	Often	Always

31	I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32	I worry what other people think of me	Never	Sometimes	Often	Always
33	I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34	All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
35	I worry about what is going to happen	Never	Sometimes	Often	Always

36	I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37	I think about death	Never	Sometimes	Often	Always
38	I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
39	My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40	I feel like I don't want to move	Never	Sometimes	Often	Always

41	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
43	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
44	I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45	I worry when I go to bed at night	Never	Sometimes	Often	Always
46	I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
47	I feel restless	Never	Sometimes	Often	Always

EXPERIENCE OF SERVICE QUESTIONNAIRE

Day services (9-11)

What do you think about coming to this service or clinic.

For each item, please circle the answer that is closest to what **you** think

Did the people who saw you listen to you?	 Yes	 Only a little	 Not really	 Don't Know	1
Was it easy to talk to the people who saw you?	 Yes	 Only a little	 Not really	 Don't Know	2
How were you treated by the people who saw you?	 Very well	 Ok	 Not very well	 Don't Know	3
Were your views and worries taken seriously?	 Yes	 Only a little	 Not really	 Don't Know	4
Do you feel that the people here know how to help you?	 Yes	 A little	 Not really	 Don't Know	5
Were you given enough explanation about the help available here?	 Yes	 Only a little	 Not really	 Don't Know	6
Do you feel that the people here are working together to help you?	 Yes	 Only a little	 Not really	 Don't Know	7
The facilities here (like the waiting area) are	 Comfortable	 Ok	 Uncomfortable	 Don't Know	8
The time of my appointments was	 Convenient	 Ok	 Not convenient	 Don't Know	9
The place where I had my appointments was	 Easy to get to	 Ok to get to	 Hard to get to	 Don't Know	10
If a friend needed this sort of help, do you think they should come here?	 Yes	 Maybe	 Not really	 Don't Know	11
Has the help you got here been good?	 Yes	 Only a little	 Not really	 Don't Know	12

NOW TURN OVER...

What was really good about your care?

13

Was there anything you didn't like or anything that needs improving?

14

Is there anything else you want to tell us about the service you received?

15

I am _____ years old	I am a: Girl <input type="checkbox"/> Boy <input type="checkbox"/>
I consider myself: White <input type="checkbox"/>	Black or Black British <input type="checkbox"/> Asian or Asian British <input type="checkbox"/>
Mixed <input type="checkbox"/>	Other <input type="checkbox"/>
Are you registered disabled (e.g. hearing impaired)?	No <input type="checkbox"/> Yes <input type="checkbox"/>

THANKS FOR HELPING US

Now place this form in the envelope provided and put it in the box marked CHI in the reception

For administration purposes	
Trust: _____	
Service: _____	Code: _____
Tier: _____	DB No: _____

EXPERIENCE OF SERVICE QUESTIONNAIRE



Day services (12-18)

Please think about the appointments you have had at this service or clinic.

For each item, please tick the circle that best describes what you think or feel (e.g.)

	Certainly True	Partly True	Not True	Don't know	
I feel that the people who saw me listened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	1
It was easy to talk to the people who saw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	2
I was treated well by the people who saw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	3
My views and worries were taken seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	4
I feel the people here know how to help me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	5
I have been given enough explanation about the help available here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	6
I feel that the people who have seen me are working together to help me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	7
The facilities here are comfortable (e.g. waiting area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	8
My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	9
It is quite easy to get to the place where I have my appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	10
If a friend needed this sort of help, I would suggest to them to come here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	11
Overall, the help I have received here is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	12

PLEASE TURN OVER...

What was really good about your care?

13

Was there anything you didn't like or anything that needs improving?

14

Is there anything else you want to tell us about the service you received?

15

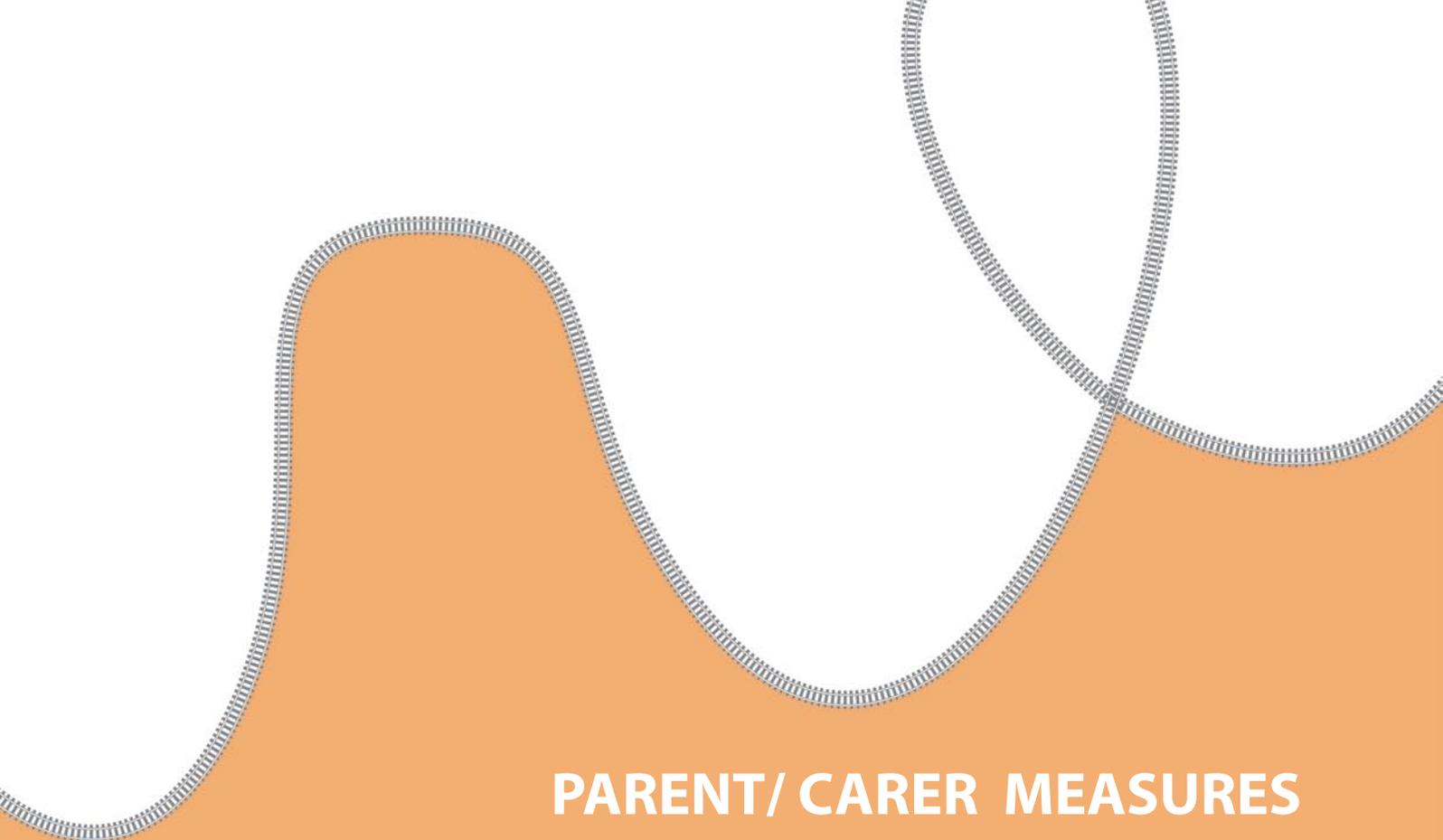
I am _____ years old	I am: Female <input type="checkbox"/>	Male <input type="checkbox"/>	
I consider myself:	White <input type="checkbox"/>	Black or Black British <input type="checkbox"/>	Asian or Asian British <input type="checkbox"/>
	Mixed <input type="checkbox"/>	Other <input type="checkbox"/>	
Are you registered disabled (e.g. hearing impaired)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	

If you don't want to take part, please tick this box and return the blank questionnaire in the envelope provided.

THANK YOU FOR YOUR HELP

Now place this form in the envelope provided and put it in the box marked CHI in the reception

For administration purposes	
Trust: _____	
Service: _____	Code: _____
Tier: _____	DB No: _____



PARENT/ CARER MEASURES

56 ASSESSMENT

57 Strengths and Difficulties Questionnaire P 3/4

59 Strengths and Difficulties Questionnaire P 4-16

61 RCADS

63 SESSION BY SESSION - GOAL OR GLOBAL TRACKING

64 Goal progress chart

65 Outcome Rating Scale (ORS)

66 SESSION BY SESSION - SYMPTOM TRACKING

67 How are things?

68 How are things?

74 SESSION BY SESSION - IMPACT TRACKING

75 How is your child doing?

76 SESSION BY SESSION - FEEDBACK TRACKING

77 How was this meeting?

78 Session Rating Scale (SRS V.3.0)

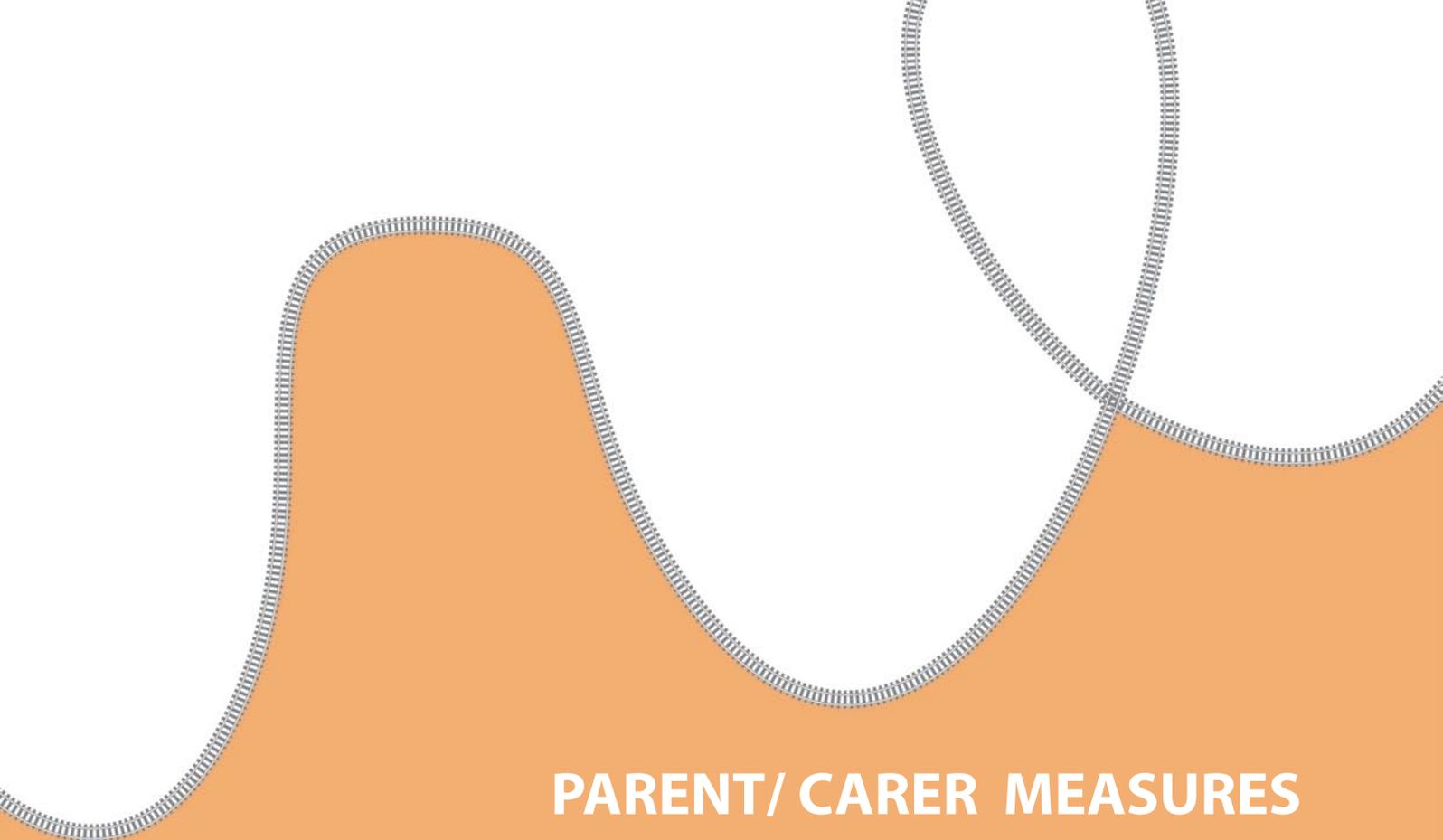
79 REVIEW

80 Strengths and Difficulties Questionnaire P 3/4 Follow- up

82 Strengths and Difficulties Questionnaire P 4-16 Follow- up

84 RCADS

86 CHI Experience of service questionnaire

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PARENT/ CARER MEASURES

ASSESSMENT

Strengths and Difficulties Questionnaire

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

Child's Name

Male/Female

Date of Birth.....

	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"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

	No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

● How long have these difficulties been present?

	Less than a month	1-5 months	6-12 months	Over a year
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

● Do the difficulties upset or distress your child?

	Not at all	Only a little	Quite a lot	A great deal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

● Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

● Do the difficulties put a burden on you or the family as a whole?

	Not at all	Only a little	Quite a lot	A great deal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire

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

Child's Name

Male/Female

Date of Birth.....

	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"/>
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Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

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

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

● Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

● Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

Child/ Young Person's NAME:

.....

Relationship to Child/Young Person :

Date: / / 20

Time: ^h [']

*Please put a circle around the word that shows how often each of these things happens to your child.
There are no right or wrong answers.*

1	My child worries about things	Never	Sometimes	Often	Always
2	My child feels sad or empty	Never	Sometimes	Often	Always
3	When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
4	My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5	My child feels afraid of being alone at home	Never	Sometimes	Often	Always

6	Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7	My child feels scared when taking a test	Never	Sometimes	Often	Always
8	My child worries when he/she thinks someone is angry with him/her	Never	Sometimes	Often	Always
9	My child worries about being away from me	Never	Sometimes	Often	Always
10	My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always

11	My child has trouble sleeping	Never	Sometimes	Often	Always
12	My child worries about doing badly at school work	Never	Sometimes	Often	Always
13	My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14	My child suddenly feels as if he/she can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15	My child has problems with his/her appetite	Never	Sometimes	Often	Always

16	My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17	My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18	My child has trouble going to school in the mornings because of feeling nervous or afraid	Never	Sometimes	Often	Always
19	My child has no energy for things	Never	Sometimes	Often	Always
20	My child worries about looking foolish	Never	Sometimes	Often	Always

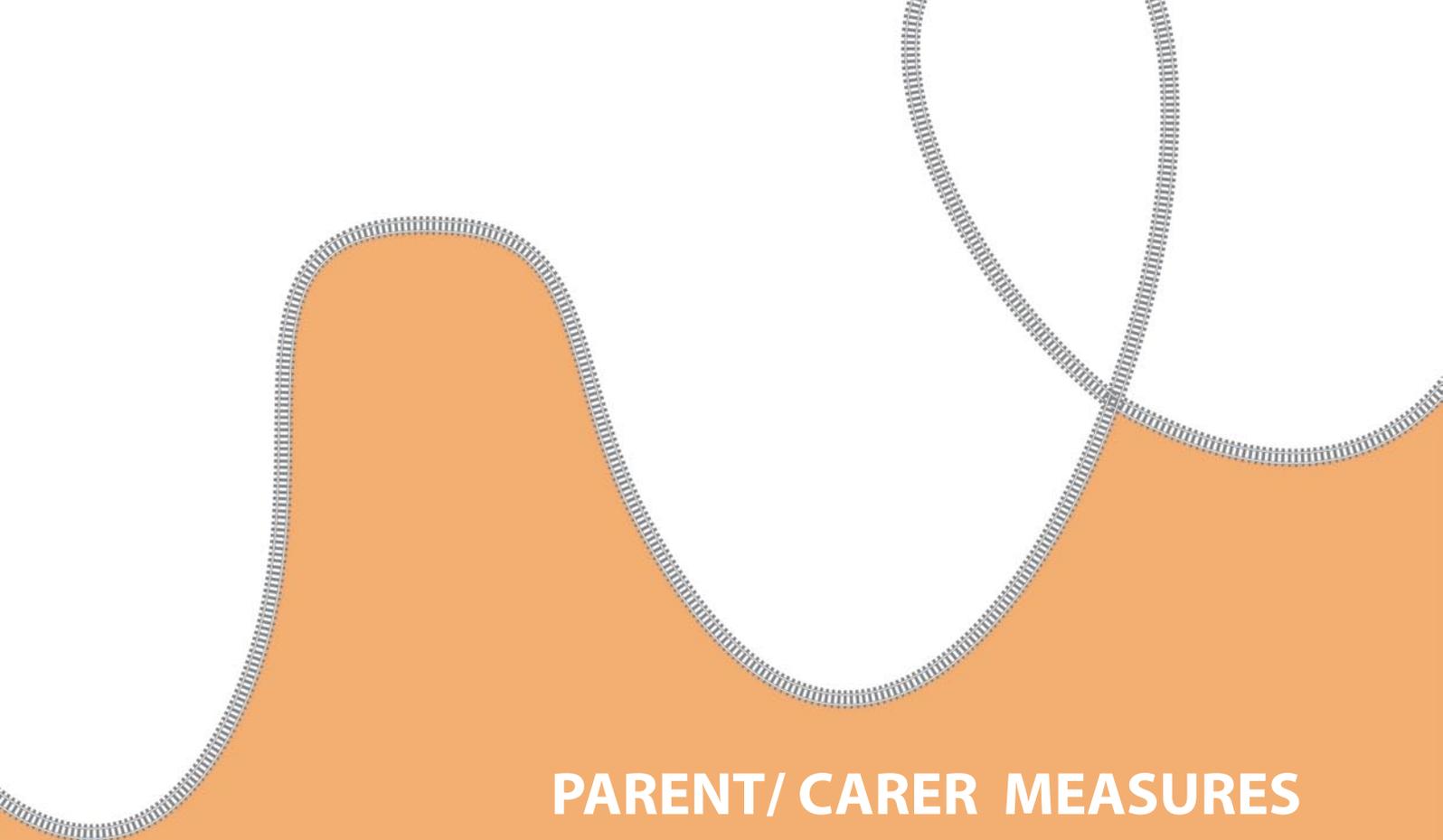
21	My child is tired a lot	Never	Sometimes	Often	Always
22	My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23	My child can't seem to get bad or silly thoughts out of his/her head	Never	Sometimes	Often	Always
24	When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
25	My child cannot think clearly	Never	Sometimes	Often	Always

26	My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27	My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28	When my child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29	My child feels worthless	Never	Sometimes	Often	Always
30	My child worries about making mistakes	Never	Sometimes	Often	Always

31	My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32	My child worries what other people think of him/her	Never	Sometimes	Often	Always
33	My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34	All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35	My child worries about what is going to happen	Never	Sometimes	Often	Always

36	My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37	My child thinks about death	Never	Sometimes	Often	Always
38	My child feels afraid if he/she has to talk in front of the class	Never	Sometimes	Often	Always
39	My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40	My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always

41	My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42	My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43	My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44	My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45	My child worries when in bed at night	Never	Sometimes	Often	Always
46	My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47	My child feels restless	Never	Sometimes	Often	Always

A decorative wavy line composed of small, repeating geometric patterns, resembling a stylized wave or a series of overlapping loops, positioned at the top of the page.

PARENT/ CARER MEASURES

**SESSION BY SESSION -
GOAL OR GLOBAL TRACKING**

Goal progress chart

Goal N°



You can turn this chart on its side for a quick look at progress over the sessions.

GOAL:

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
Remember a score of zero means no progress has been made towards a goal , a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two												
1		0	1	2	3	4	5	6	7	8	9	10
2		0	1	2	3	4	5	6	7	8	9	10
3		0	1	2	3	4	5	6	7	8	9	10
4		0	1	2	3	4	5	6	7	8	9	10
5		0	1	2	3	4	5	6	7	8	9	10
6		0	1	2	3	4	5	6	7	8	9	10
7		0	1	2	3	4	5	6	7	8	9	10
8		0	1	2	3	4	5	6	7	8	9	10
9		0	1	2	3	4	5	6	7	8	9	10
10		0	1	2	3	4	5	6	7	8	9	10
11		0	1	2	3	4	5	6	7	8	9	10
12		0	1	2	3	4	5	6	7	8	9	10

Who agreed this goal (tick below):

Child/young person

Family members

Practitioner

Other (please specify):



NHS ID:

Service allocated
case ID

.....

.....

Outcome Rating Scale (ORS)

(Ages 13 to Adult)

Name _____ Age (Yrs): _____ Session # _____ Date: _____
Who is filling out this form? Please check one: Self _____ Other _____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

Individually

(Personal well-being)

Interpersonally

(Family, close relationships)

Socially

(Work, school, friendships)

Overall

(General sense of well-being)

SCORING

Each line is 10cm.

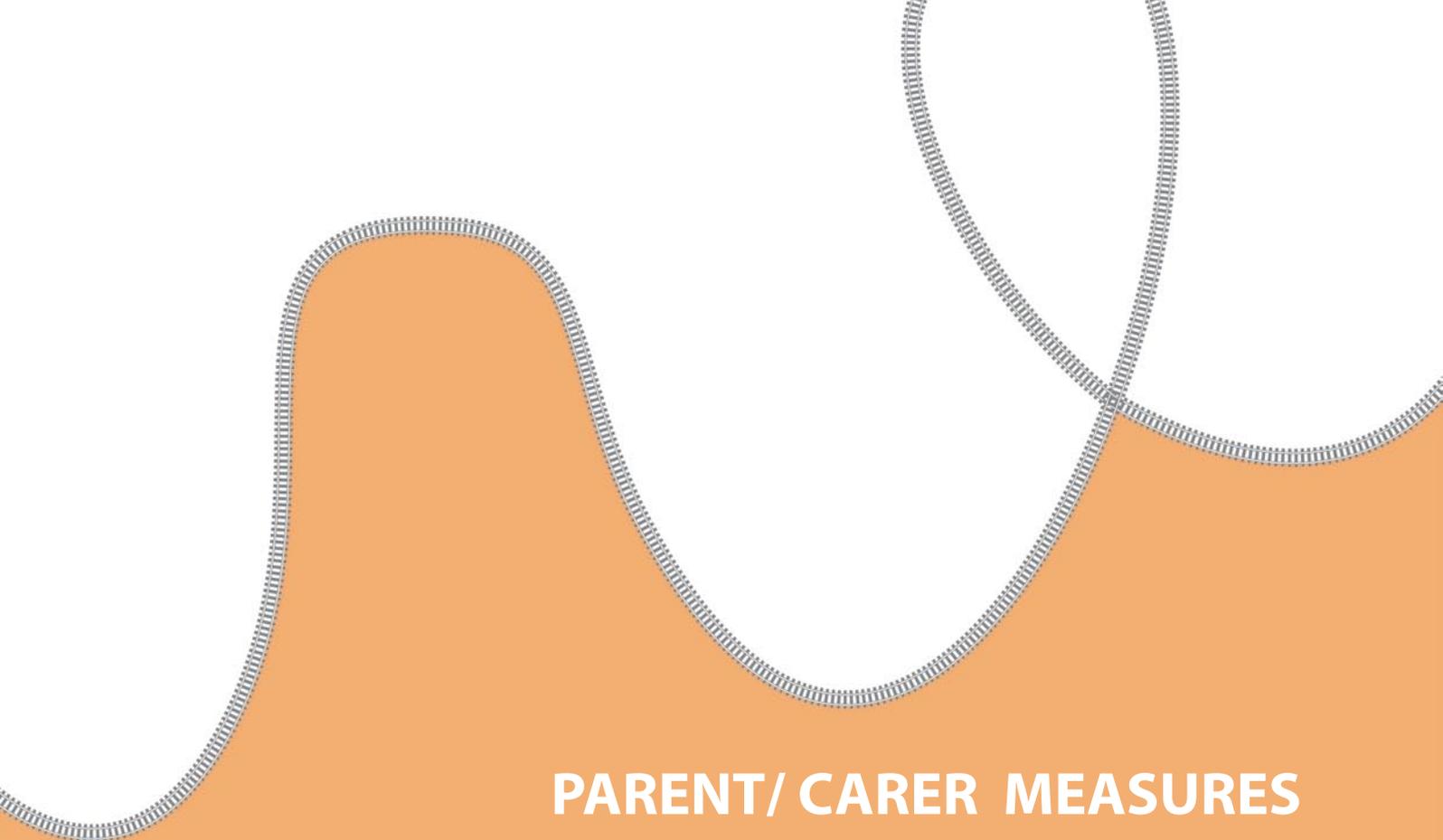
Score with ruler
e.g. 3.5cm = score
of 3.5.

Write the scores
for each of the
four lines here in
the margin.

Add the four
scores for a total
score.

Plot overall score
on the graph.

The information on this page is for illustration purposes only.
Please go to <http://scottdmiller.com> and follow the link for
"Performance Metrics" to download the measure



PARENT/ CARER MEASURES

**SESSION BY SESSION -
SYMPTOM TRACKING**

How are things?

Session N°



Date: day, month, year.

Time: hour, minutes.

Please put a circle around the word that shows how often each of these things happen to your child. There are no right or wrong answers.

		0	1	2	3
1	My child feels sad or empty	Never	Sometimes	Often	Always
2	Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
3	My child has trouble sleeping	Never	Sometimes	Often	Always
4	My child has problems with his/her appetite	Never	Sometimes	Often	Always
5	My child has no energy for things	Never	Sometimes	Often	Always
6	My child is tired a lot	Never	Sometimes	Often	Always
7	My child cannot think clearly	Never	Sometimes	Often	Always
8	My child feels worthless	Never	Sometimes	Often	Always
9	My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
10	My child feels restless	Never	Sometimes	Often	Always

SUM:



Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

.....

NHS ID:

.....

Service allocated
case ID

.....

How are things?

Session N°



Date: day, month, year.

Time: hour, minutes.

Please put a circle around the word that shows how often each of these things happen to your child.
There are no right or wrong answers.

		0	1	2	3
1	My child feels afraid of being alone at home	Never	Sometimes	Often	Always
2	My child worries about being away from me	Never	Sometimes	Often	Always
3	My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
4	My child has trouble going to school in the mornings because of feeling nervous or afraid	Never	Sometimes	Often	Always
5	My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
6	My child worries when in bed at night	Never	Sometimes	Often	Always
7	My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always

SUM:



Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

.....

NHS ID:

.....

Service allocated
case ID

.....

How are things?

Session N°



Date: day, month, year.

Time: hour, minutes.

Please put a circle around the word that shows how often each of these things happen to your child. There are no right or wrong answers.

		0	1	2	3
1	My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
2	My child feels scared when taking a test	Never	Sometimes	Often	Always
3	My child worries when he/she thinks someone is angry with him/her	Never	Sometimes	Often	Always
4	My child worries about doing badly at school work	Never	Sometimes	Often	Always
5	My child worries about looking foolish	Never	Sometimes	Often	Always
6	My child worries about making mistakes	Never	Sometimes	Often	Always
7	My child worries what other people think of him/her	Never	Sometimes	Often	Always
8	My child feels afraid if he/she have to talk in front of the class	Never	Sometimes	Often	Always
9	My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always

SUM:



Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

.....

NHS ID:

.....

Service allocated case ID

.....

How are things?

Session N°



Date: day, month, year.

Time: hour, minutes.

Please put a circle around the word that shows how often each of these things happen to your child.
There are no right or wrong answers.

		0	1	2	3
1	My child worries about things	Never	Sometimes	Often	Always
2	My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
3	My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
4	My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
5	My child worries about what is going to happen	Never	Sometimes	Often	Always
6	My child thinks about death	Never	Sometimes	Often	Always

SUM:



Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

.....

NHS ID:

.....

Service allocated
case ID

.....

How are things?

Session N°



Date: day, month, year.

Time: hour, minutes.

Please put a circle around the word that shows how often each of these things happen to your child. There are no right or wrong answers.

		0	1	2	3
1	My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always
2	My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
3	My child can't seem to get bad or silly thoughts out of his/her head	Never	Sometimes	Often	Always
4	My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
5	My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
6	My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always

SUM:



Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

.....

NHS ID:

.....

Service allocated
case ID

.....

How are things?

Session N°



Date: day, month, year.

Time: hour, minutes.

Please put a circle around the word that shows how often each of these things happen to your child.
There are no right or wrong answers.

		0	1	2	3
1	When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
2	My child suddenly feels as if he/she can't breathe when there is no reason for this	Never	Sometimes	Often	Always
3	When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
4	My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
5	When my child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
6	All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
7	My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
8	My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
9	My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always

SUM:



Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

.....

NHS ID:

.....

Service allocated
case ID

.....

How are things?

Session N°



Date: day, month, year.

Time: hour, minutes.

Please put a circle around the word that shows how often each of these things happen to your child.
There are no right or wrong answers.

		0	0	1
1	My child loses their temper	Not true	Somewhat true	Certainly true
2	My child argues with adults	Not true	Somewhat true	Certainly true
3	My child actively defies or refuses to comply with adults' requests or rules	Not true	Somewhat true	Certainly true
4	My child deliberately annoys people	Not true	Somewhat true	Certainly true
5	My child blames others for his or her mistakes or misbehaviour	Not true	Somewhat true	Certainly true
6	My child is touchy or easily annoyed by others	Not true	Somewhat true	Certainly true
7	My child is angry and resentful	Not true	Somewhat true	Certainly true
8	My child is spiteful or vindictive	Not true	Somewhat true	Certainly true

SUM:



Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

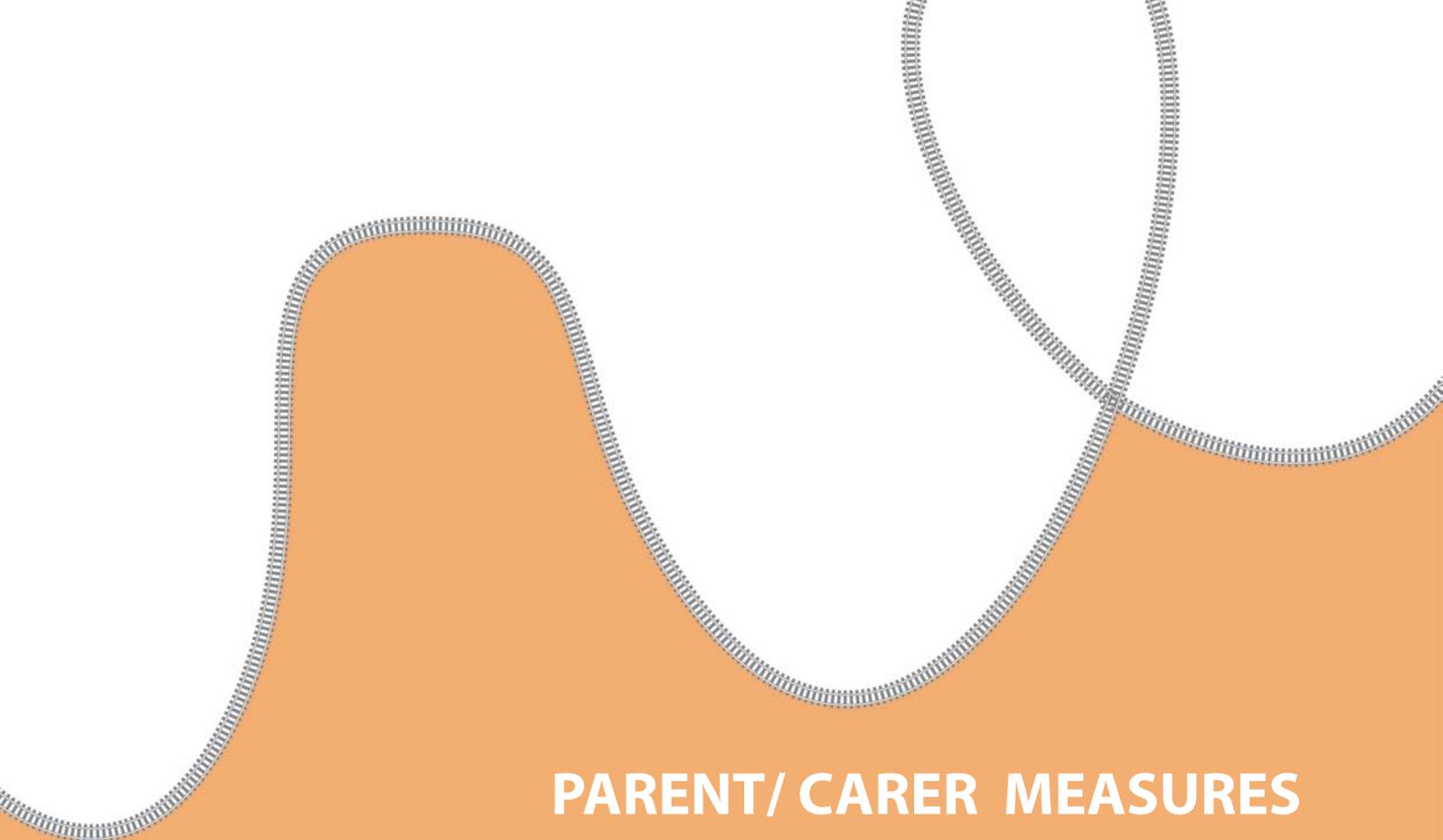
.....

NHS ID:

.....

Service allocated
case ID

.....



PARENT/ CARER MEASURES

**SESSION BY SESSION -
IMPACT TRACKING**

How is your child doing?

Since coming last time

Are your child's difficulties now:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>				

Are you and the family now coping with these difficulties:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>				

- Since coming last time, how much have your child's difficulties been upsetting or distressing him or her?

Not at all	A little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Since coming last time, how much have your child's difficulties been interfering with his or her everyday life in the following areas?

	Not at all	A little	A medium amount	A great deal
Home life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to learn or work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thinking about the future:

- How much better do you think he or she will be in one month's time?

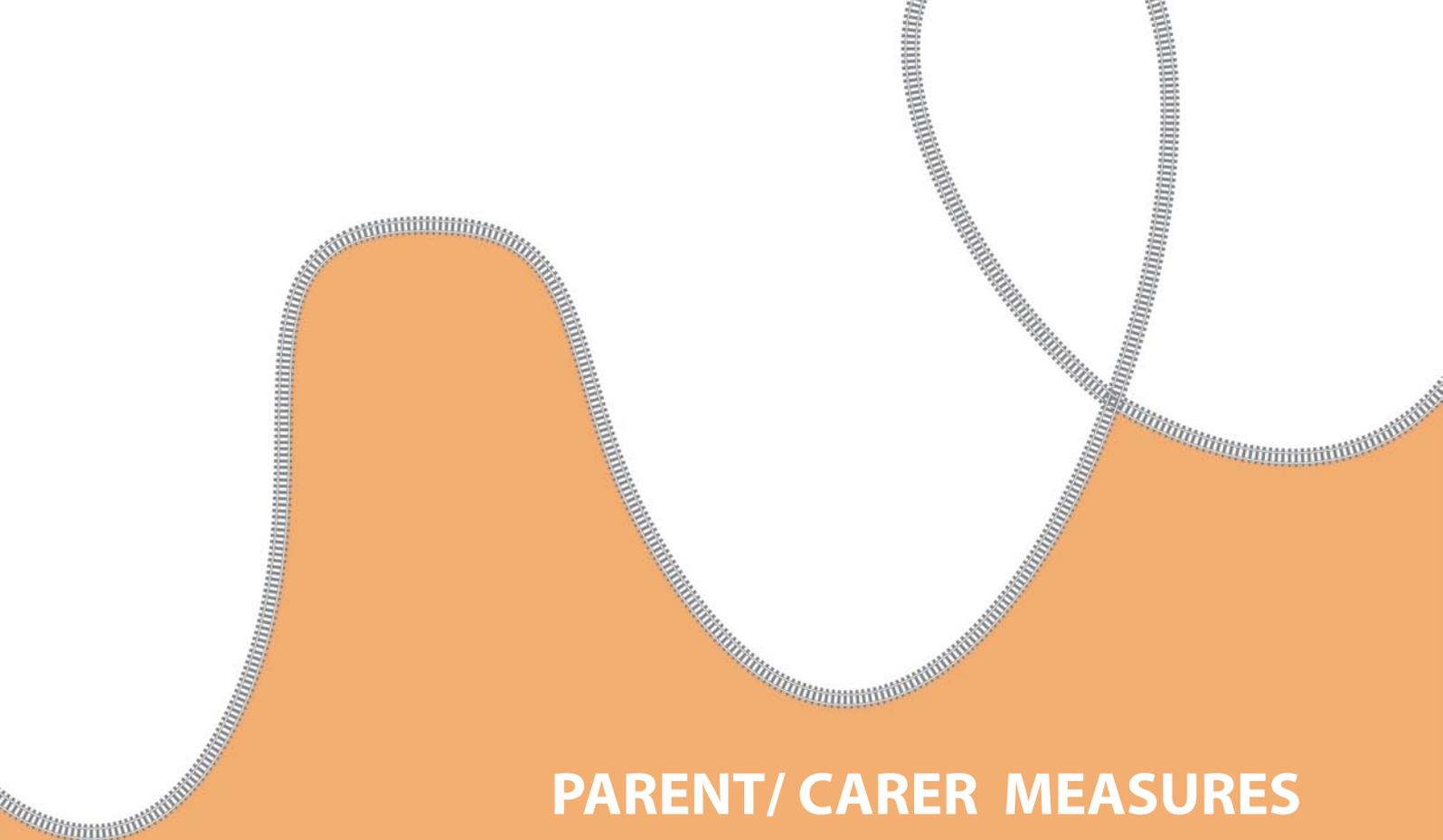
No better, maybe worse	Only a little better	Quite a lot better	A great deal better
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother / Father / Other (please specify:)

Thank you very much for your help



PARENT/ CARER MEASURES

**SESSION BY SESSION -
FEEDBACK TRACKING**

How was this meeting?

Date: / / 20

Time: ^h [']

Session N^o



		0	1	2	3	4
1	Did you feel listened to?	Not at all	Only a little	Somewhat	Quite a bit	Totally
2	Did you talk about what you wanted to talk about?	Not at all	Only a little	Somewhat	Quite a bit	Totally
3	Did you understand the things said in the meeting?	Not at all	Only a little	Somewhat	Quite a bit	Totally
4	Did you feel the meeting gave you ideas for what to do?	Not at all	Only a little	Somewhat	Quite a bit	Totally

Who gave this feedback (tick below):

Child/young person



Mother



Father



Professional



Other (please specify):

.....

NHS ID:

.....

Service allocated
case ID

.....

SUM:



Session Rating Scale (SRS V.3.0)

(Ages 13 to Adult)

Name _____ Age (Yrs): _____ Session # _____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected.

I felt heard, understood, and respected.

Goals and Topics

We did not work on or talk about what I wanted to work on and talk about.

We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me.

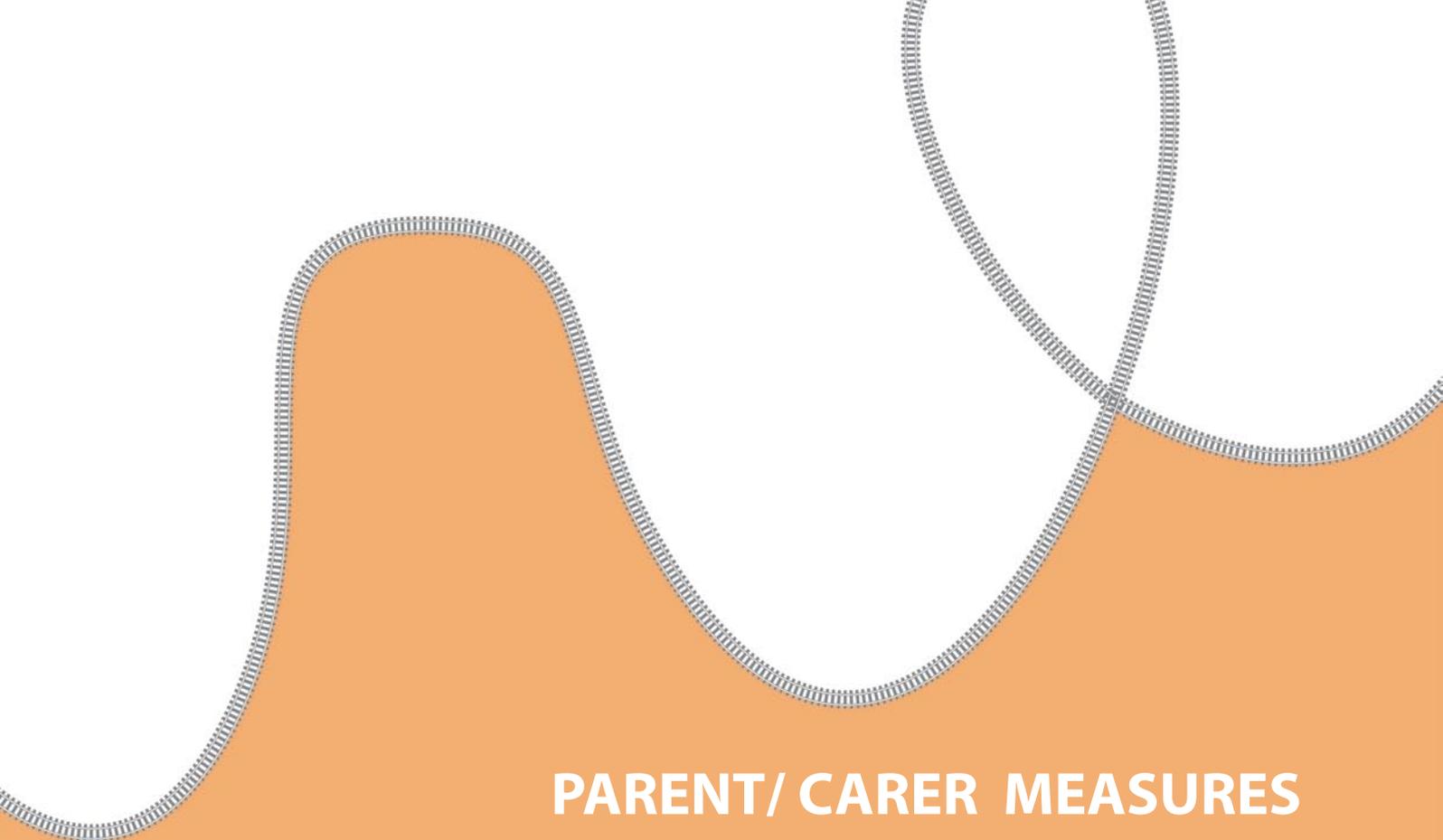
The therapist's approach is a good fit for me.

Overall

There was something missing in the session today.

Overall, today's session was right for me.

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PARENT/ CARER MEASURES

REVIEW

Strengths and Difficulties Questionnaire

P 3/4
FOLLOW-UP

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

Child's Name

Male/Female

Date of Birth.....

	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"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

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

Since coming to the clinic, are your child's problems:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>				

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire

P4-16
FOLLOW-UP

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

Child's Name

Male/Female

Date of Birth.....

	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"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

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

Since coming to the clinic, are your child's problems:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>				

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

Child/ Young Person's NAME:

.....

Relationship to Child/Young Person :

Date: / / 20

Time: ^h [']

Please put a circle around the word that shows how often each of these things happens to your child. There are no right or wrong answers.

1	My child worries about things	Never	Sometimes	Often	Always
2	My child feels sad or empty	Never	Sometimes	Often	Always
3	When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
4	My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5	My child feels afraid of being alone at home	Never	Sometimes	Often	Always

6	Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7	My child feels scared when taking a test	Never	Sometimes	Often	Always
8	My child worries when he/she thinks someone is angry with him/her	Never	Sometimes	Often	Always
9	My child worries about being away from me	Never	Sometimes	Often	Always
10	My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always

11	My child has trouble sleeping	Never	Sometimes	Often	Always
12	My child worries about doing badly at school work	Never	Sometimes	Often	Always
13	My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14	My child suddenly feels as if he/she can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15	My child has problems with his/her appetite	Never	Sometimes	Often	Always

16	My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17	My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18	My child has trouble going to school in the mornings because of feeling nervous or afraid	Never	Sometimes	Often	Always
19	My child has no energy for things	Never	Sometimes	Often	Always
20	My child worries about looking foolish	Never	Sometimes	Often	Always

21	My child is tired a lot	Never	Sometimes	Often	Always
22	My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23	My child can't seem to get bad or silly thoughts out of his/her head	Never	Sometimes	Often	Always
24	When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
25	My child cannot think clearly	Never	Sometimes	Often	Always

26	My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27	My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28	When my child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29	My child feels worthless	Never	Sometimes	Often	Always
30	My child worries about making mistakes	Never	Sometimes	Often	Always

31	My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32	My child worries what other people think of him/her	Never	Sometimes	Often	Always
33	My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34	All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35	My child worries about what is going to happen	Never	Sometimes	Often	Always

36	My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37	My child thinks about death	Never	Sometimes	Often	Always
38	My child feels afraid if he/she have to talk in front of the class	Never	Sometimes	Often	Always
39	My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40	My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always

41	My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42	My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43	My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44	My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45	My child worries when in bed at night	Never	Sometimes	Often	Always
46	My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47	My child feels restless	Never	Sometimes	Often	Always

EXPERIENCE OF SERVICE QUESTIONNAIRE

Day services (Parent or Carer)

Please think about the appointments you, your child and/or your family have had at this service or clinic.

For each item, please tick the box that best describes what you think or feel about the service (e.g.).

	Certainly True	Partly True	Not True	Don't know	
I feel that the people who have seen my child listened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	1
It was easy to talk to the people who have seen my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	2
I was treated well by the people who have seen my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	3
My views and worries were taken seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	4
I feel the people here know how to help with the problem I came for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	5
I have been given enough explanation about the help available here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	6
I feel that the people who have seen my child are working together to help with the problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	7
The facilities here are comfortable (e.g. waiting area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	8
The appointments are usually at a convenient time (e.g. don't interfere with work, school)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	9
It is quite easy to get to the place where the appointments are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	10
If a friend needed similar help, I would recommend that he or she come here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	11
Overall, the help I have received here is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?	12

PLEASE TURN OVER...

What was really good about your care?

13

Was there anything you didn't like or anything that needs improving?

14

Is there anything else you want to tell us about the service you received?

15

Child's age: _____	Child's gender: Female <input type="checkbox"/> Male <input type="checkbox"/>
Child's ethnicity: White <input type="checkbox"/>	Black/Black British <input type="checkbox"/> Asian/Asian British <input type="checkbox"/>
Mixed <input type="checkbox"/>	Other <input type="checkbox"/>
Is your child registered disabled (e.g. hearing-impaired)?	No <input type="checkbox"/> Yes <input type="checkbox"/>

If you don't want to take part, please tick this box and return the blank questionnaire in the envelope provided.

THANK YOU FOR YOUR HELP

Now place this form in the envelope provided and put it in the box marked CHI in the reception

For administration purposes	
Trust: _____	
Service: _____	Code: _____
Tier: _____	DB No: _____

PRACTITIONER RESOURCES

90 PRACTITIONER FORMS

- 91 Demographics
- 92 Current View
- 93 Education, Employment or Training
- 94 Goal progress chart
- 95 Session Details
- 96 Interventions and Medications

97 PRACTITIONER SCORING AIDS

98 SDQ SCORING AIDS

- 99 SDQ Scoring aid - Child/ Parent/Carer report

101 RCADS SCORING AIDS

- 102 RCADs Scoring aid -
Creating sub scales for child self report
- 104 RCADs Scoring aid -
Creating sub scales for parent report

106 CLINICAL BANDS

107 CLINICAL BANDS ASSESSMENT- CHILD

- 108 Clinical Bands - Self Report : 8 to 10 year olds
- 109 Clinical Bands - Self Report : 11 to 12 year olds
- 110 Clinical Bands -Self Report : 13 to 14 year olds
- 111 Clinical Bands - Self Report : 15 to 16 year olds
- 112 Clinical Bands - Self Report : 17 to 18 year olds

113 CLINICAL BANDS ASSESSMENT- PARENT/CARER

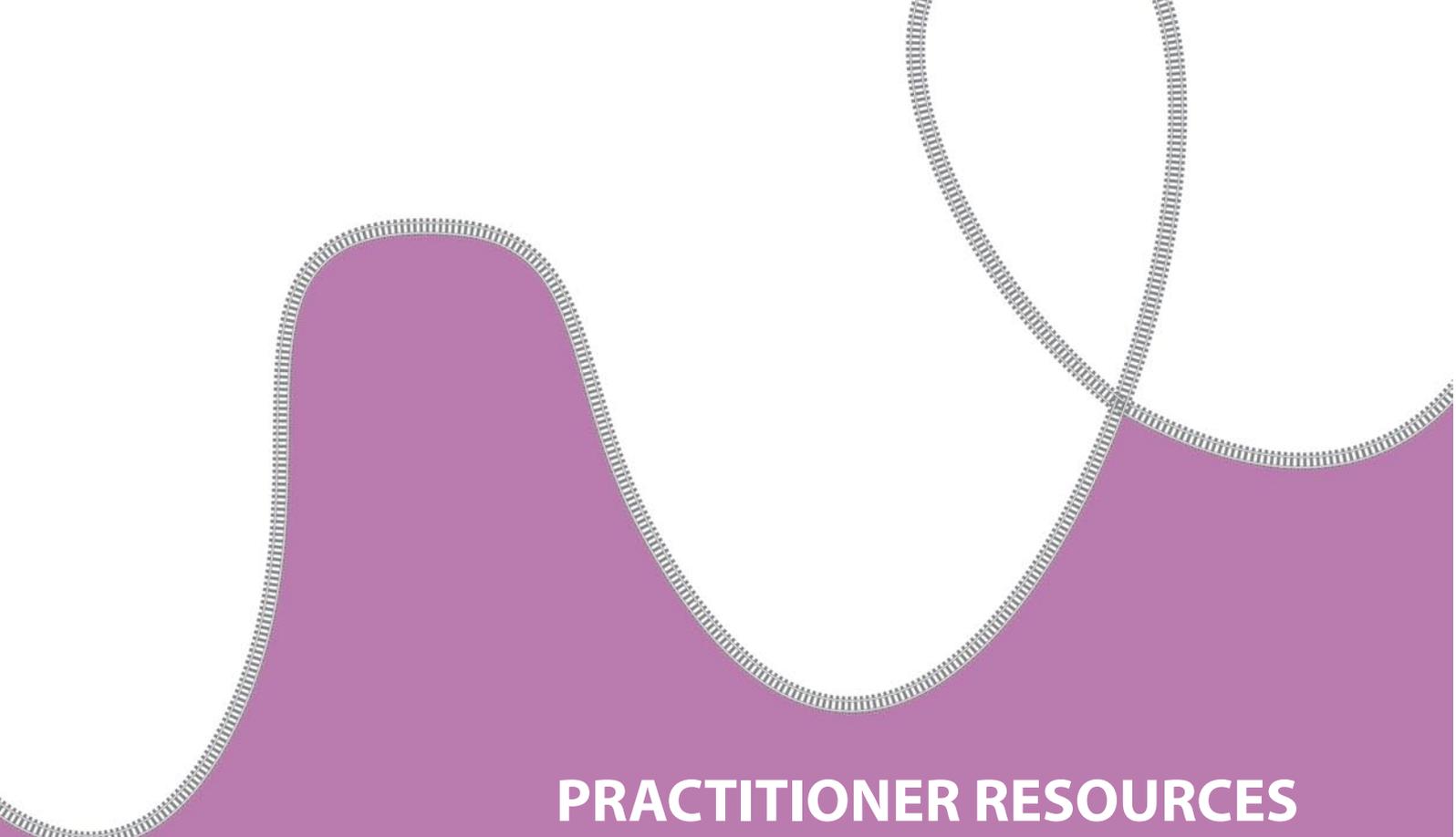
- 114 Clinical Bands - Parent of Child age: 3 to 4 years
- 115 Clinical Bands - Parent of Child age: 4 to 8 years
- 116 Clinical Bands - Parent of Child age: 8 to 10 years
- 117 Clinical Bands - Parent of Child age: 11 to 12 years

121 CLINICAL BANDS SESSION BY SESSION- CHILD

- 122 Clinical Bands - Self Report : 8 to 10 year olds
- 123 Clinical Bands - Self Report : 11 to 12 year olds
- 124 Clinical Bands -Self Report : 13 to 14 year olds
- 125 Clinical Bands - Self Report : 15 to 16 year olds
- 126 Clinical Bands - Self Report : 17 to 18 year olds
- 127 Clinical Bands - Self Report : adult 16+

128 CLINICAL BANDS SESSION BY SESSION- PARENT/CARER

- 129 Clinical Bands - Parent of Child age: 8 to 10 years
- 130 Clinical Bands - Parent of Child age: 11 to 12 years
- 131 Clinical Bands -
Parent of Young Person age: 13 to 14 years
- 132 Clinical Bands -
Parent of Young Person age: 15 to 16 years
- 133 Clinical Bands -
Parent of Young Person age: 17 to 18 years

The top of the page features a decorative graphic consisting of several overlapping, wavy lines. These lines are composed of a series of small, closely spaced vertical dashes, creating a textured, chain-link-like appearance. The lines are white and set against a solid purple background.

PRACTITIONER RESOURCES

PRACTITIONER FORMS

Demographics

ABOUT CONTACT/ PATIENT

CONTACT START Date: / / 20

CONTACT END Date: / / 20

PATIENT POSTCODE/ADDRESS

CONSENT OBTAINED FOR SECONDARY USES yes no

CASE STATUS	<input type="checkbox"/> Closed	<input type="checkbox"/>
	<input type="checkbox"/> Open	<input type="checkbox"/>
	<input type="checkbox"/> Missing	<input type="checkbox"/>
CLOSURE REASON	<input type="checkbox"/> Discharged on professional advice	<input type="checkbox"/>
	<input type="checkbox"/> Discharged against professional advice	<input type="checkbox"/>
	<input type="checkbox"/> Patient non-attendance	<input type="checkbox"/>
	<input type="checkbox"/> Transferred to other HC provider medium secure unit	<input type="checkbox"/>
	<input type="checkbox"/> Transferred to other health care provider high secure unit	<input type="checkbox"/>
	<input type="checkbox"/> Transferred to other HC provider not medium/high secure	<input type="checkbox"/>
	<input type="checkbox"/> Transferred to adult mental health service*	<input type="checkbox"/>
	<input type="checkbox"/> Patient moved out of area	<input type="checkbox"/>
<input type="checkbox"/> Patient died	<input type="checkbox"/>	

ABOUT SERVICE

SERVICE COLLABORATION ID

SERVICE ID

TEAM ID

GP PRACTICE CODE

GP PRACTICE POSTCODE

LOCAL AUTHORITY

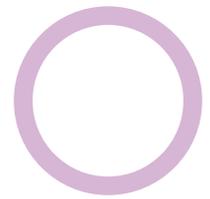
ABOUT REFERRAL

REFERRAL DATED Date: / / 20

REFERRAL RECEIVED BY CAMHS Date: / / 20

REFERRAL SOURCE

Primary Health Care	<input type="checkbox"/> GP	<input type="checkbox"/>
	<input type="checkbox"/> Health Visitor	<input type="checkbox"/>
	<input type="checkbox"/> Other Primary Health Care	<input type="checkbox"/>
Self Referral	<input type="checkbox"/> Self	<input type="checkbox"/>
	<input type="checkbox"/> Carer	<input type="checkbox"/>
Local Authority Services	<input type="checkbox"/> Social Services	<input type="checkbox"/>
	<input type="checkbox"/> Education Services	<input type="checkbox"/>
Employer	<input type="checkbox"/> Employer	<input type="checkbox"/>
	<input type="checkbox"/> Police	<input type="checkbox"/>
Justice System	<input type="checkbox"/> Courts	<input type="checkbox"/>
	<input type="checkbox"/> Probation Service	<input type="checkbox"/>
	<input type="checkbox"/> Prison	<input type="checkbox"/>
Child Health	<input type="checkbox"/> Court Liaison and Diversion Service	<input type="checkbox"/>
	<input type="checkbox"/> School Nurse	<input type="checkbox"/>
	<input type="checkbox"/> Hospital-based Paediatrics	<input type="checkbox"/>
Independent/ Voluntary Sector	<input type="checkbox"/> Community-based Paediatrics	<input type="checkbox"/>
	<input type="checkbox"/> Independent Sector - Medium Secure Inpatients	<input type="checkbox"/>
	<input type="checkbox"/> Independent Sector - Medium Low Inpatients	<input type="checkbox"/>
Acute Secondary Care	<input type="checkbox"/> Other Independent Sector MH Services	<input type="checkbox"/>
	<input type="checkbox"/> Voluntary Sector	<input type="checkbox"/>
	<input type="checkbox"/> A&E Department	<input type="checkbox"/>
Other Mental Health NHS Trust	<input type="checkbox"/> Other secondary care specialty	<input type="checkbox"/>
	<input type="checkbox"/> Temporary transfer from another MH NHS Trust	<input type="checkbox"/>
Internal referrals from Community Mental Health Team (within own NHS Trust)	<input type="checkbox"/> Permanent transfer from another MH NHS Trust	<input type="checkbox"/>
	<input type="checkbox"/> Community MH Team (Adult MH)	<input type="checkbox"/>
	<input type="checkbox"/> Community MHTeam (Learning Disabilities)	<input type="checkbox"/>
Internal referrals from Inpatient Service (within own NHS Trust)	<input type="checkbox"/> Community MHTeam (Child and Adolescent MH)	<input type="checkbox"/>
	<input type="checkbox"/> Inpatient Service (Adult Mental Health)	<input type="checkbox"/>
	<input type="checkbox"/> Inpatient Service (Forensics)	<input type="checkbox"/>
Other	<input type="checkbox"/> Inpatient Service (Child and Adolescent MH)	<input type="checkbox"/>
	<input type="checkbox"/> Inpatient Service (Learning Disabilities)	<input type="checkbox"/>
	<input type="checkbox"/> Asylum Services	<input type="checkbox"/>
	<input type="checkbox"/> NHS Direct	<input type="checkbox"/>
	<input type="checkbox"/> Out of Area Agency	<input type="checkbox"/>
	<input type="checkbox"/> Drug Action Team/Drug Misuse Agency	<input type="checkbox"/>
	<input type="checkbox"/> Other service or agency	<input type="checkbox"/>



CYP Name NHS ID:

Practitioner's Name Practitioner's ID

	PROBLEM DESCRIPTION	None	Mild	Moderate	Severe	Do not know
1	Depression/low mood (Depression)					
2	Behavioural difficulties (CD or ODD)					
3	Anxious away from home (Separation anxiety)					
4	Anxious in social situations (Social anxiety/phobia)					
5	Anxious generally (Generalized anxiety)					
6	Disturbed by traumatic event (PTSD)					
7	Compelled to do or think things (OCD)					
8	Panics (Panic disorder)					
9	Avoids going out (Agoraphobia)					
10	Avoids specific things (Specific phobia)					
11	Difficulties sitting still or concentrating (ADHD/Hyperactivity)					
12	Eating issues (Eating disorder)					
13	Gender discomfort issues (Gender identity disorder)					
14	Severe relationship difficulties (Emerging personality disorder)					
15	Problems in attachment to parent/carer (Attachment problems)					
16	Doesn't get to toilet in time (Elimination problems)					
17	Severe mental health issues (Psychosis or bipolar disorder)					
18	Self harm (Self injury or self harm)					
19	Drug and alcohol difficulties (Substance abuse)					
20	Repetitive problematic behaviours (Habit problems)					
21	Does not speak (Selective mutism)					
22	Carer management of CYP behaviour (e.g., Management of child with challenging behaviour)					
23	Family relationship difficulties					

Choose which most applies for CYP re. Home, School and Community context					
	None	Mild	Moderate	Severe	Don't know
HOME ISSUES e.g. family substance abuse					
SCHOOL ISSUES e.g. bullying					
COMMUNITY ISSUES e.g. violence					

SELECTED COMPLEXITY FACTORS		YES	NO	DO NOT KNOW
1	Looked after child			
2	Young carer status			
3	Learning Disability			
4	Serious physical health issues (including Chronic Fatigue)			
5	Pervasive Developmental disorder (including autism and Asperger's)			
6	Neurological issues such as tics or Tourette's			
7	Current protection plan			
8	Deemed "child in need" of social service input			
9	Refugee or asylum seeker			
10	Experience of war, torture or trafficking			

Education, Employment or Training

Session N°



Date: / / 20

Time: ^h [']

Please indicate which is most true currently

ATTENDANCE		
No problem	<input type="text"/>	0
Some problems: attending part-time or missing some days / truanting / refusal	<input type="text"/>	1
Significant problems: Rarely attending; at high risk of exclusion/dismissal	<input type="text"/>	2
Excluded or not in EET	<input type="text"/>	3
Not known	<input type="text"/>	

ATTAINMENT		
No problem	<input type="text"/>	0
Some problems e.g., in school well below year level in at least one subject, in work some problems (timekeeping, work rate, etc.)	<input type="text"/>	1
Significant problems (e.g., fails key exams, below year group in all subjects), received formal warnings from employer	<input type="text"/>	2
Severe problems: Dropped out of education or employment	<input type="text"/>	3
Not known	<input type="text"/>	

.....

NHS ID:

Service allocated case ID

Goal progress chart

Goal N°



You can turn this chart on its side for a quick look at progress over the sessions.

GOAL:

Session	Date	Today I would rate progress to this goal: (please circle the appropriate number below)										
Remember a score of zero means no progress has been made towards a goal , a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two												
1		0	1	2	3	4	5	6	7	8	9	10
2		0	1	2	3	4	5	6	7	8	9	10
3		0	1	2	3	4	5	6	7	8	9	10
4		0	1	2	3	4	5	6	7	8	9	10
5		0	1	2	3	4	5	6	7	8	9	10
6		0	1	2	3	4	5	6	7	8	9	10
7		0	1	2	3	4	5	6	7	8	9	10
8		0	1	2	3	4	5	6	7	8	9	10
9		0	1	2	3	4	5	6	7	8	9	10
10		0	1	2	3	4	5	6	7	8	9	10
11		0	1	2	3	4	5	6	7	8	9	10
12		0	1	2	3	4	5	6	7	8	9	10

Who agreed this goal (tick below):

Child/young person

Family members

Practitioner

Other (please specify):



NHS ID:

Service allocated
case ID

.....

.....

Session Details

EVENT/SESSION TYPE (Please tick only one)		
Session (e.g., assessment/treatment)	Mail contact	<input type="checkbox"/>
Missed appointment (DNA)	Email contact	<input type="checkbox"/>
Phone contact	Other	<input type="checkbox"/>

COMPLETION POINT <small>Point in period of contact when event occurred</small>		
Pre-therapy – Waiting list	Follow-up – 6-monthly	<input type="checkbox"/>
Assessment	Follow-up – Case closure	<input type="checkbox"/>
During therapy	Other	<input type="checkbox"/>

DATE and TIME of the EVENT Event/session date (e.g. Therapy session, home-completed questionnaire, telephone follow-up). Date and the time of event rather than of data entry.

Date: / / 20

Time: ^h [']

Please tick as many as needed

YOUNG PERSON AND FAMILY ATTENDANCE

Child or young person	<input type="checkbox"/>
Caregiver	<input type="checkbox"/>
Other CYP (in a group)	<input type="checkbox"/>
Other caregiver (in a group)	<input type="checkbox"/>
Others	<input type="checkbox"/>

ABOUT QUESTIONNAIRES

Did the practitioner give out at least one questionnaire?	<input type="checkbox"/>
Did a parent/carer refuse to complete a questionnaire (at least one)?	<input type="checkbox"/>
Did a child/young person refuse to complete a questionnaire (at least one)?	<input type="checkbox"/>

DESCRIBE ATTENDING PROFESSIONAL(S)

Nursing professional	<input type="checkbox"/>
Medical professional	<input type="checkbox"/>
Psychology professional	<input type="checkbox"/>
Primary mental health professional	<input type="checkbox"/>
Child and adolescent psychotherapy professional	<input type="checkbox"/>
Family therapy professional	<input type="checkbox"/>
Counselling professional	<input type="checkbox"/>
Occupational therapy professional	<input type="checkbox"/>
Social work professional	<input type="checkbox"/>
Other therapy qualified professional	<input type="checkbox"/>
Creative therapy professional	<input type="checkbox"/>
Educational psychology professional	<input type="checkbox"/>
Other education professional	<input type="checkbox"/>
Other qualified staff	<input type="checkbox"/>
Other unqualified staff	<input type="checkbox"/>

Indicate here if consent to share data has been withdrawn

Has there been a key crisis or issue that needs to be taken into account at this point (e.g., newly revealed self harm, bereavement, trauma?)	yes	no
---	-----	----

Please provide ID numbers of attending practitioners and select the level of their IAPT Training

PRACTITIONER 1 (LEAD)	PRACTITIONER 2	PRACTITIONER 3
ID:	ID:	ID:
IAPT trained	IAPT trained	IAPT trained
In training	In training	In training
Not IAPT trained	Not IAPT trained	Not IAPT trained

Interventions and Medications

Date: / / 20

Time: ^h [']

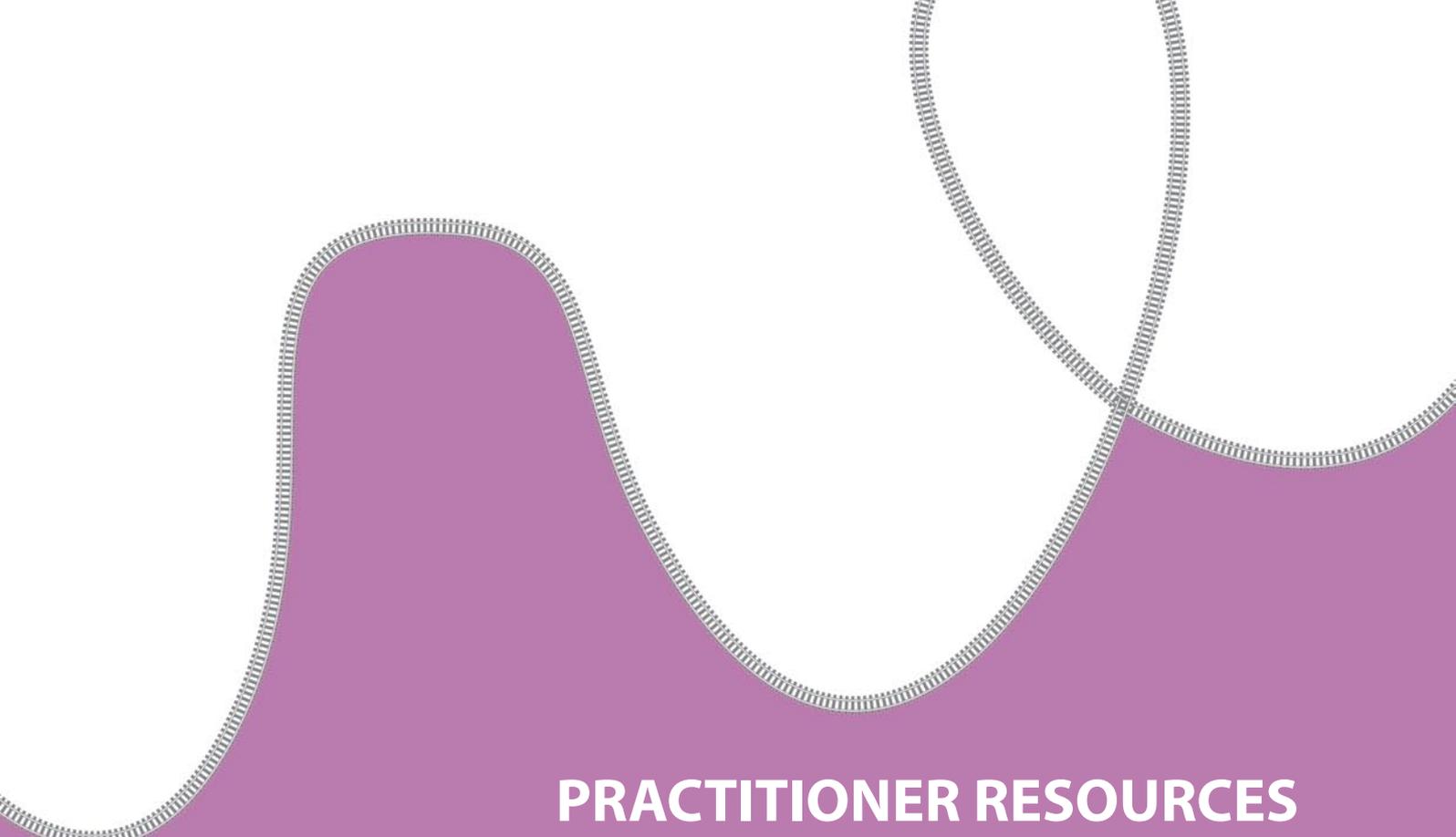
CYP Name NHS ID:

Practitioner's Name Practitioner's ID

Please tick as many as needed

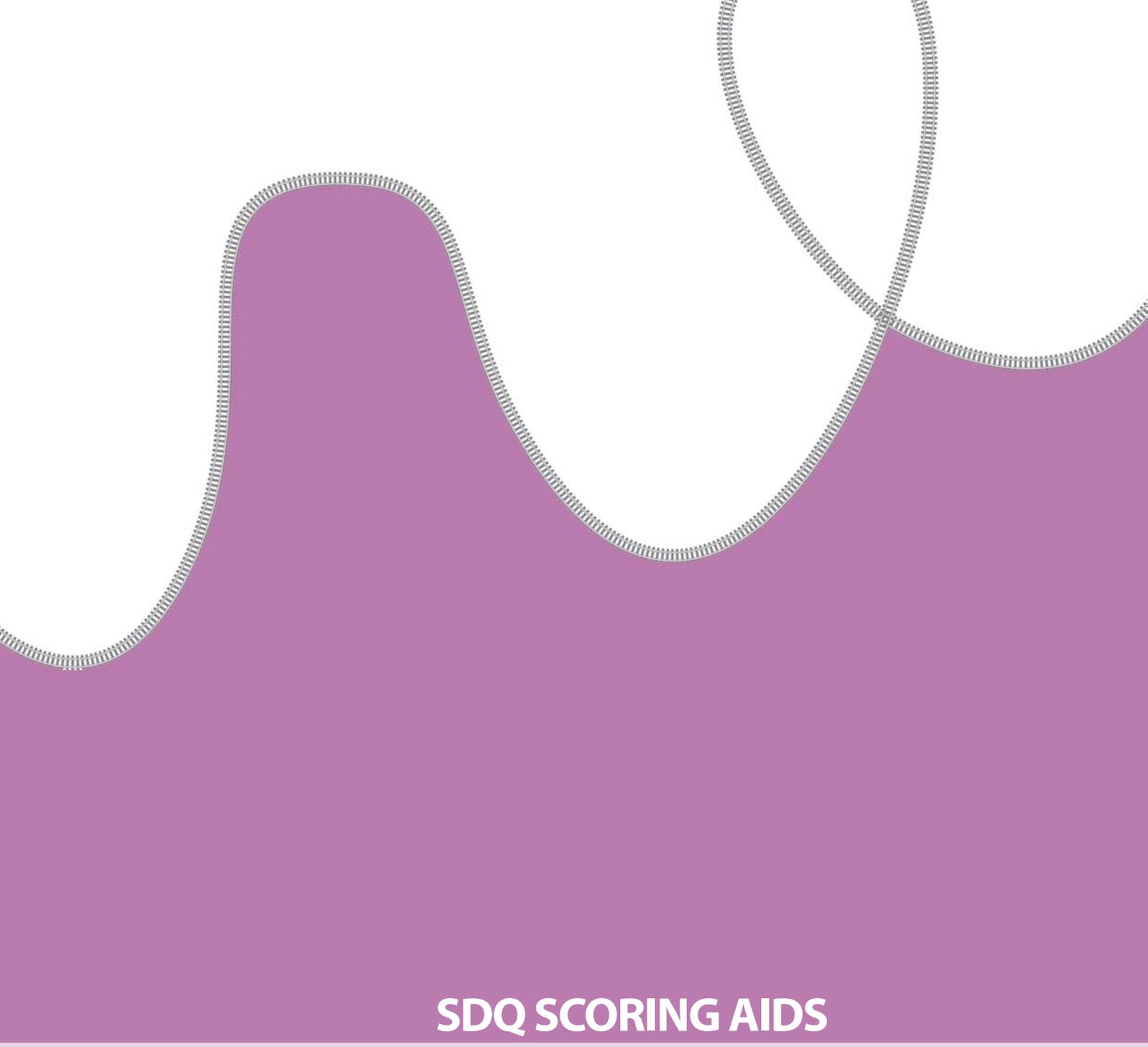
INTERVENTIONS			
Interpersonal Therapy (IPT)	<input type="checkbox"/>	Eye Movement Desensitization and Reprocessing EMDR	<input type="checkbox"/>
Cognitive Behavioural Therapy (CBT)	<input type="checkbox"/>	Family Work	<input type="checkbox"/>
Multimodal and Integrated Therapy approaches	<input type="checkbox"/>	Creative Therapies	<input type="checkbox"/>
Brief Solution Focussed Therapy	<input type="checkbox"/>	Pharmacological Advice	<input type="checkbox"/>
Psychodynamic Psychotherapy	<input type="checkbox"/>	Parent Training	<input type="checkbox"/>
Psychoanalytic Psychotherapy	<input type="checkbox"/>	Parent Other	<input type="checkbox"/>
Dialectical Behaviour Therapy (DBT)	<input type="checkbox"/>	Neuropsychological	<input type="checkbox"/>
Multi-Systemic Therapy (MST)	<input type="checkbox"/>	Counselling	<input type="checkbox"/>
Group Therapy	<input type="checkbox"/>	Child Psychotherapy	<input type="checkbox"/>
Family/Systemic Therapy	<input type="checkbox"/>	Other Therapy	<input type="checkbox"/>

MEDICATION				
TYPE OF UPDATE	Initial entry	<input type="checkbox"/>	Monoamine-oxidase inhibitors	<input type="checkbox"/>
	Update after change in medication	<input type="checkbox"/>	Selective serotonin re-uptake inhibitors	<input type="checkbox"/>
Hypnotics	<input type="checkbox"/>	Other antidepressant drugs	<input type="checkbox"/>	
Anxiolytics	<input type="checkbox"/>	Atomoxetine	<input type="checkbox"/>	
Barbiturates	<input type="checkbox"/>	Dexamfetamine sulphate	<input type="checkbox"/>	
Antipsychotic drugs	<input type="checkbox"/>	Methylphenidate Hydrochloride	<input type="checkbox"/>	
Antipsychotic depot injections	<input type="checkbox"/>	Modafinil	<input type="checkbox"/>	
Antimanic drugs	<input type="checkbox"/>	Nicotine	<input type="checkbox"/>	
Tricyclic antidepressant drugs	<input type="checkbox"/>	Other	<input type="checkbox"/>	



PRACTITIONER RESOURCES

PRACTITIONER SCORING AIDS



SDQ SCORING AIDS

SDQ Scoring aid - Child/Parent/Carer report

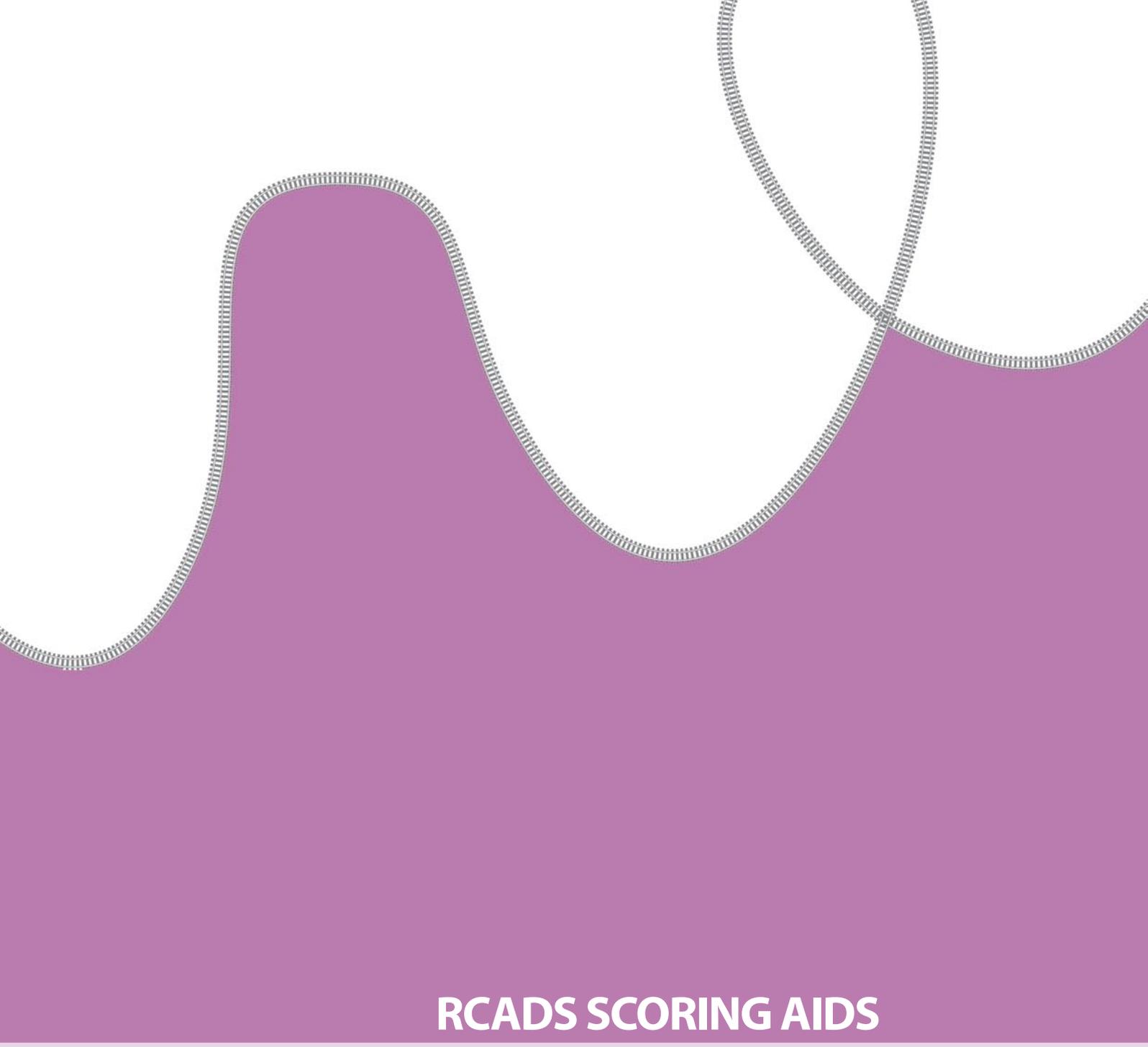
ITEMS		SCALE			Indicate here score given				
		Not true	Somewhat true	Certainly true	Emotional	CD	HYP	Peer	Prosocial
1	Considerate (Prosocial)	0	1	2					
2	Restless (HYP)	0	1	2					
3	Aches (Emo)	0	1	2					
4	Shares (Prosocial)	0	1	2					
5	Tempers (CD)	0	1	2					
6	Solitary (Peer)	0	1	2					
7	Obedient (CD)*	2	1	0					
8	Worries (Emo)	0	1	2					
9	Helpful (Prosocial)	0	1	2					
10	Fidgety (HYP)	0	1	2					
11	Friend (Peer)*	2	1	0					
12	Fights (CD)	0	1	2					
13	Unhappy (Emo)	0	1	2					
14	Popular (Peer)*	2	1	0					
15	Distractible (HYP)	0	1	2					
16	Clingy (Emo)	0	1	2					
17	Kind (Prosocial)	0	1	2					
18	Lies or cheats (CD)	0	1	2					
19	Victimized (Peer)	0	1	2					
20	Volunteers (Prosocial)	0	1	2					
21	Reflective (HYP)*	2	1	0					
22	Steals (CD)	0	1	2					
23	Better with adults (Peer)	0	1	2					
24	Fears (Emo)	0	1	2					
25	Attention (HYP)*	2	1	0					
		SUMS							

SDQ Scoring aid - Impact Scale- Child Self Report

IMPACT SUPPLEMENT		No	Minor	Definite	Severe
Impact 1	Problem?	Impact scores not calculated		Impact scores calculated from the below (Impact 3 to Impact 7)	

IMPACT SUPPLEMENT		<1 month	1-5 mo.	6-12 mo.	1 yr +
Impact 2	Duration	Not added to impact scores			

		No	Little	Medium	Great deal
Impact 3	Distress	0	0	1	2
Impact 4	Home life	0	0	1	2
Impact 5	Friendship	0	0	1	2
Impact 6	Learning	0	0	1	2
Impact 7	Leisure	0	0	1	2
Impact 8	Burden	Not added to impact scores			



RCADS SCORING AIDS

RCADs Scoring aid - Creating sub scales for child self report

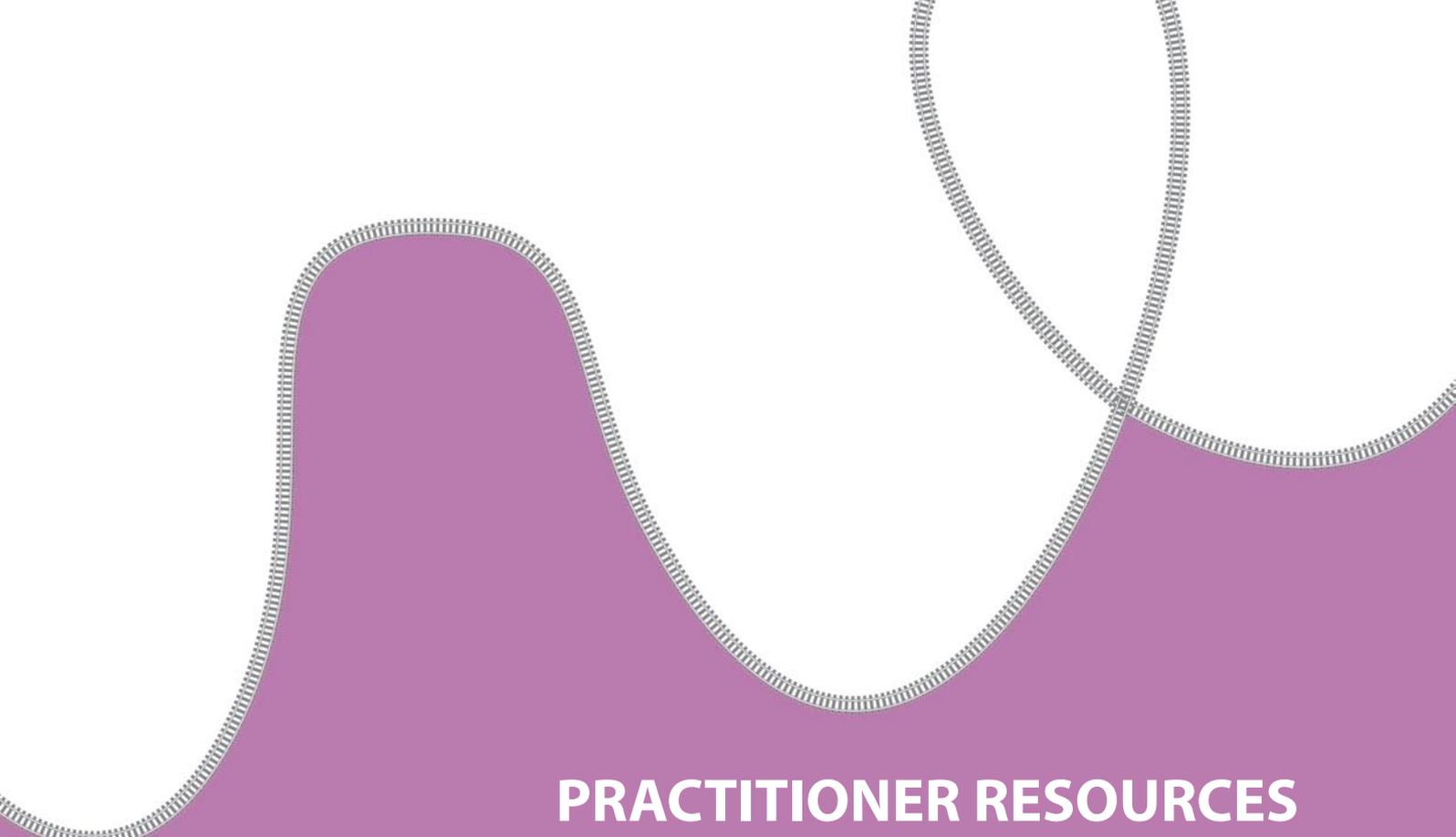
		Never	Sometimes	Often	Always	Social Phobia	Panic Disorder	Major Depression	Separation Anxiety	Generalized Anxiety	Obsessive-Compulsive
1	I worry about things	0	1	2	3						
2	I feel sad or empty.....	0	1	2	3						
3	When I have a problem, I get a funny feeling in my stomach.....	0	1	2	3						
4	I worry when I think I have done poorly at something.....	0	1	2	3						
5	I would feel afraid of being on my own at home	0	1	2	3						
6	Nothing is much fun anymore....	0	1	2	3						
7	I feel scared when I have to take a test	0	1	2	3						
8	I feel worried when I think someone is angry with me.....	0	1	2	3						
9	I worry about being away from my parents	0	1	2	3						
10	I get bothered by bad or silly thoughts or pictures in my mind.....	0	1	2	3						
11	I have trouble sleeping.....	0	1	2	3						
12	I worry that I will do badly at my school work	0	1	2	3						
13	I worry that something awful will happen to someone in my family....	0	1	2	3						
14	I suddenly feel as if I can't breathe when there is no reason for this.....	0	1	2	3						
15	I have problems with my appetite....	0	1	2	3						
16	I have to keep checking that I have done things right (like the switch is off, or the door is locked).....	0	1	2	3						
17	I feel scared if I have to sleep on my own..	0	1	2	3						
18	I have trouble going to school in the mornings because I feel nervous or afraid....	0	1	2	3						
19	I have no energy for things.....	0	1	2	3						
20	I worry I might look foolish.....	0	1	2	3						
21	I am tired a lot.....	0	1	2	3						
22	I worry that bad things will happen to me	0	1	2	3						

		Never	Sometimes	Often	Always	Social Phobia	Panic Disorder	Major Depression	Separation Anxiety	Generalized Anxiety	Obsessive-Compulsive
23	I can't seem to get bad or silly thoughts out of my head.....	0	1	2	3						
24	When I have a problem, my heart beats really fast.....	0	1	2	3						
25	I cannot think clearly.....	0	1	2	3						
26	I suddenly start to tremble or shake when there is no reason for this.....	0	1	2	3						
27	I worry that something bad will happen to me	0	1	2	3						
28	When I have a problem, I feel shaky...	0	1	2	3						
29	I feel worthless.....	0	1	2	3						
30	I worry about making mistakes....	0	1	2	3						
31	I have to think of special thoughts (like numbers or words) to stop bad things from happening	0	1	2	3						
32	I worry what other people think of me...	0	1	2	3						
33	I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds).....	0	1	2	3						
34	All of a sudden I feel really scared for no reason at all.....	0	1	2	3						
35	I worry about what is going to happen...	0	1	2	3						
36	I suddenly become dizzy or faint when there is no reason for this.....	0	1	2	3						
37	I think about death.....	0	1	2	3						
38	I feel afraid if I have to talk in front of my class	0	1	2	3						
39	My heart suddenly starts to beat too quickly for no reason.....	0	1	2	3						
40	I feel like I don't want to move....	0	1	2	3						
41	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of...	0	1	2	3						
42	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order).....	0	1	2	3						
43	I feel afraid that I will make a fool of myself in front of people.....	0	1	2	3						
44	I have to do some things in just the right way to stop bad things from happening....	0	1	2	3						
45	I worry when I go to bed at night...	0	1	2	3						
46	I would feel scared if I had to stay away from home overnight.....	0	1	2	3						
47	I feel restless.....	0	1	2	3						
Please, insert the number of the box you have marked in the box under the letters that is left blank. Then sum up the numbers for each letter's column.						SUMS					

RCADs Scoring aid - Creating sub scales for parent report

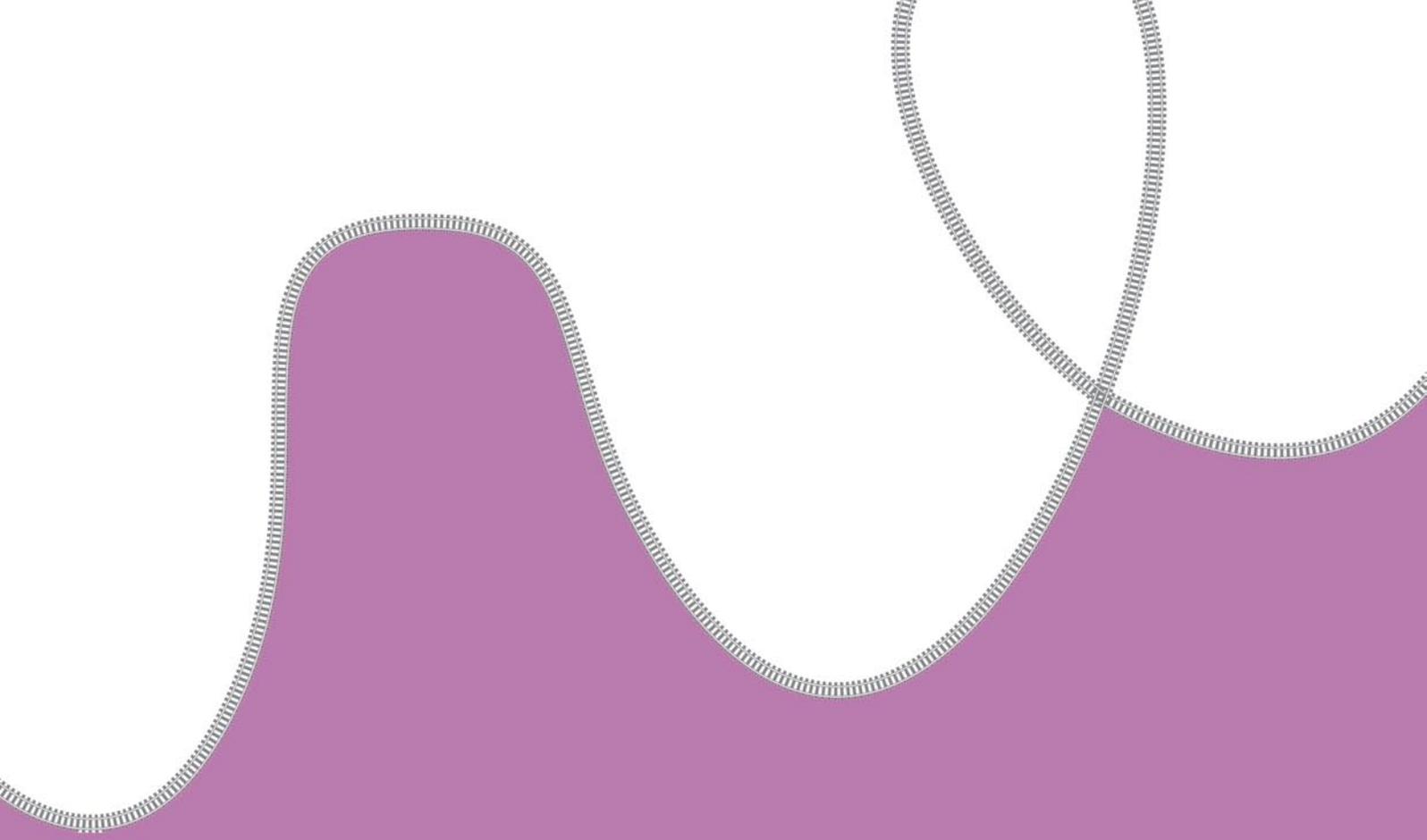
		Never	Sometimes	Often	Always	Social Phobia	Panic Disorder	Major Depression	Separation Anxiety	Generalized Anxiety	Obsessive-Compulsive
1	My child worries about things	0	1	2	3						
2	My child feels sad or empty	0	1	2	3						
3	When my child has a problem, he/she gets a funny feeling in his/her stomach	0	1	2	3						
4	My child worries when he/she thinks he/she has done poorly at something	0	1	2	3						
5	My child feels afraid of being alone at home	0	1	2	3						
6	Nothing is much fun for my child anymore	0	1	2	3						
7	My child feels scared when taking a test	0	1	2	3						
8	My child worries when he/she thinks someone is angry with him/her	0	1	2	3						
9	My child worries about being away from me	0	1	2	3						
10	My child is bothered by bad or silly thoughts or pictures in his/her mind	0	1	2	3						
11	My child has trouble sleeping	0	1	2	3						
12	My child worries about doing badly at school work	0	1	2	3						
13	My child worries that something awful will happen to someone in the family	0	1	2	3						
14	My child suddenly feels as if he/she can't breathe when there is no reason for this	0	1	2	3						
15	My child has problems with his/her appetite	0	1	2	3						
16	My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	0	1	2	3						
17	My child feels scared to sleep on his/her own	0	1	2	3						
18	My child has trouble going to school in the mornings because of feeling nervous or afraid	0	1	2	3						
19	My child has no energy for things	0	1	2	3						
20	My child worries about looking foolish	0	1	2	3						
21	My child is tired a lot	0	1	2	3						
22	My child worries that bad things will happen to him/her	0	1	2	3						
23	My child can't seem to get bad or silly thoughts out of his/her head	0	1	2	3						

		Never	Sometimes	Often	Always	Social Phobia	Panic Disorder	Major Depression	Separation Anxiety	Generalized Anxiety	Obsessive-Compulsive
24	When my child has a problem, his/her heart beats really fast	0	1	2	3						
25	My child cannot think clearly	0	1	2	3						
26	My child suddenly starts to tremble or shake when there is no reason for this	0	1	2	3						
27	My child worries that something bad will happen to him/her	0	1	2	3						
28	When my child has a problem, he/she feels shaky	0	1	2	3						
29	My child feels worthless	0	1	2	3						
30	My child worries about making mistakes	0	1	2	3						
31	My child has to think of special thoughts (like numbers or words) to stop bad things from happening	0	1	2	3						
32	My child worries what other people think of him/her	0	1	2	3						
33	My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	0	1	2	3						
34	All of a sudden my child will feel really scared for no reason at all	0	1	2	3						
35	My child worries about what is going to happen	0	1	2	3						
36	My child suddenly becomes dizzy or faint when there is no reason for this	0	1	2	3						
37	My child thinks about death	0	1	2	3						
38	My child feels afraid if he/she have to talk in front of the class	0	1	2	3						
39	My child's heart suddenly starts to beat too quickly for no reason	0	1	2	3						
40	My child feels like he/she doesn't want to move	0	1	2	3						
41	My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	0	1	2	3						
42	My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	0	1	2	3						
43	My child feels afraid that he/she will make a fool of him/herself in front of people	0	1	2	3						
44	My child has to do some things in just the right way to stop bad things from happening	0	1	2	3						
45	My child worries when in bed at night	0	1	2	3						
46	My child would feel scared if he/she had to stay away from home overnight	0	1	2	3						
47	My child feels restless	0	1	2	3						
Please, insert the number of the box you have marked in the box under the letters that is left blank. Then sum up the numbers for each letter's column.						SUMS					



PRACTITIONER RESOURCES

CLINICAL BANDS



**CLINICAL BANDS
ASSESSMENT- CHILD**

Clinical Bands - Self Report : 8 to 10 year olds

ASSESSMENT

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 8-10 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possible (Borderline)	Probably (Clinical)	
1	Sad or anxious							Emotional symptoms scale
2	Behavioural Difficulties							Conduct problems scale
3	Hyperactivity							Hyperactivity scale
4	Not getting on with others							Peer problems scale
5	Helping others							Prosocial scale
6	Overall difficulties							Total difficulties scale
7	Negative impact on life							Impact scale
<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: 0 auto;"> The SDQ not recommended for self-report for under 11 years old. </div>								
RCADs 47								
1	Depression/Low mood	0-14	15-16	17-30	0-15	16-18	19-30	Major depression
2	Anxious away from home	0-10	11-12	13-21	0-13	14-15	16-21	Separation anxiety
3	Anxious in social situations	0-16	17-18	19-27	0-18	19-21	22-27	Social phobia
4	Anxious generally	0-11	12-13	14-18	0-13	14-15	16-18	Generalized anxiety
5	Compelled to do or think things	0-10	11-12	13-18	0-11	13-14	15-18	OCD
6	Panic	0-11	12-13	14-27	0-13	14-15	16-27	Panic disorder
7	Overall anxiety	0-54	55-61	62-111	0-65	66-74	75-111	Total anxiety scale
8	Total anxiety and depression mixed	0-65	66-74	75-141	0-79	80-90	91-141	Total internalizing scale

Clinical Bands - Self Report : 11 to 12 year olds

ASSESSMENT

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 11-12 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possible (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-5	6	7-10	0-5	6	7-10	Emotional symptoms scale
2	Behavioural Difficulties	0-3	4	5-10	0-3	4	5-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-3	4-5	6-10	0-3	4-5	6-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-15	16-19	20-40	0-15	16-19	20-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-12	13-14	15-30	0-13	14-15	16-30	Major depression
2	Anxious away from home	0-7	8-9	10-21	0-10	11-12	13-21	Separation anxiety
3	Anxious in social situations	0-17	18-19	20-27	0-20	21-23	24-27	Social phobia
4	Anxious generally	0-10	11-12	13-18	0-13	14-15	16-18	Generalized anxiety
5	Compelled to do or think things	0-10	11-12	13-18	0-11	12-13	14-18	OCD
6	Panic	0-9	10-11	12-27	0-11	12-13	14-27	Panic disorder
7	Overall anxiety	0-48	49-55	56-111	0-61	62-69	70-111	Total anxiety scale
8	Total anxiety and depression mixed	0-61	62-69	70-141	0-72	73-82	83-141	Total internalizing scale

Clinical Bands -Self Report : 13 to 14 year olds

ASSESSMENT

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 13-14 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possible (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-5	6	7-10	0-5	6	7-10	Emotional symptoms scale
2	Behavioural Difficulties	0-3	4	5-10	0-3	4	5-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-3	4-5	6-10	0-3	4-5	6-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-15	16-19	20-40	0-15	16-19	20-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-11	12-13	14-30	0-13	14-15	16-30	Major depression
2	Anxious away from home	0-5	6-7	8-21	0-6	7-8	9-21	Separation anxiety
3	Anxious in social situations	0-17	18-20	21-27	0-20	21-22	23-27	Social phobia
4	Anxious generally	0-10	11-12	13-18	0-12	13	14-18	Generalized anxiety
5	Compelled to do or think things	0-10	11	12-18	0-9	10-11	12-18	OCD
6	Panic	0-8	9-10	11-27	0-10	11-12	13-27	Panic disorder
7	Overall anxiety	0-47	48-54	55-111	0-53	54-60	61-111	Total anxiety scale
8	Total anxiety and depression mixed	0-58	59-65	66-141	0-65	66-73	74-141	Total internalizing scale

Clinical Bands - Self Report : 15 to 16 year olds

ASSESSMENT

How likely is it that based on these scores the young person has clinically significant problems?

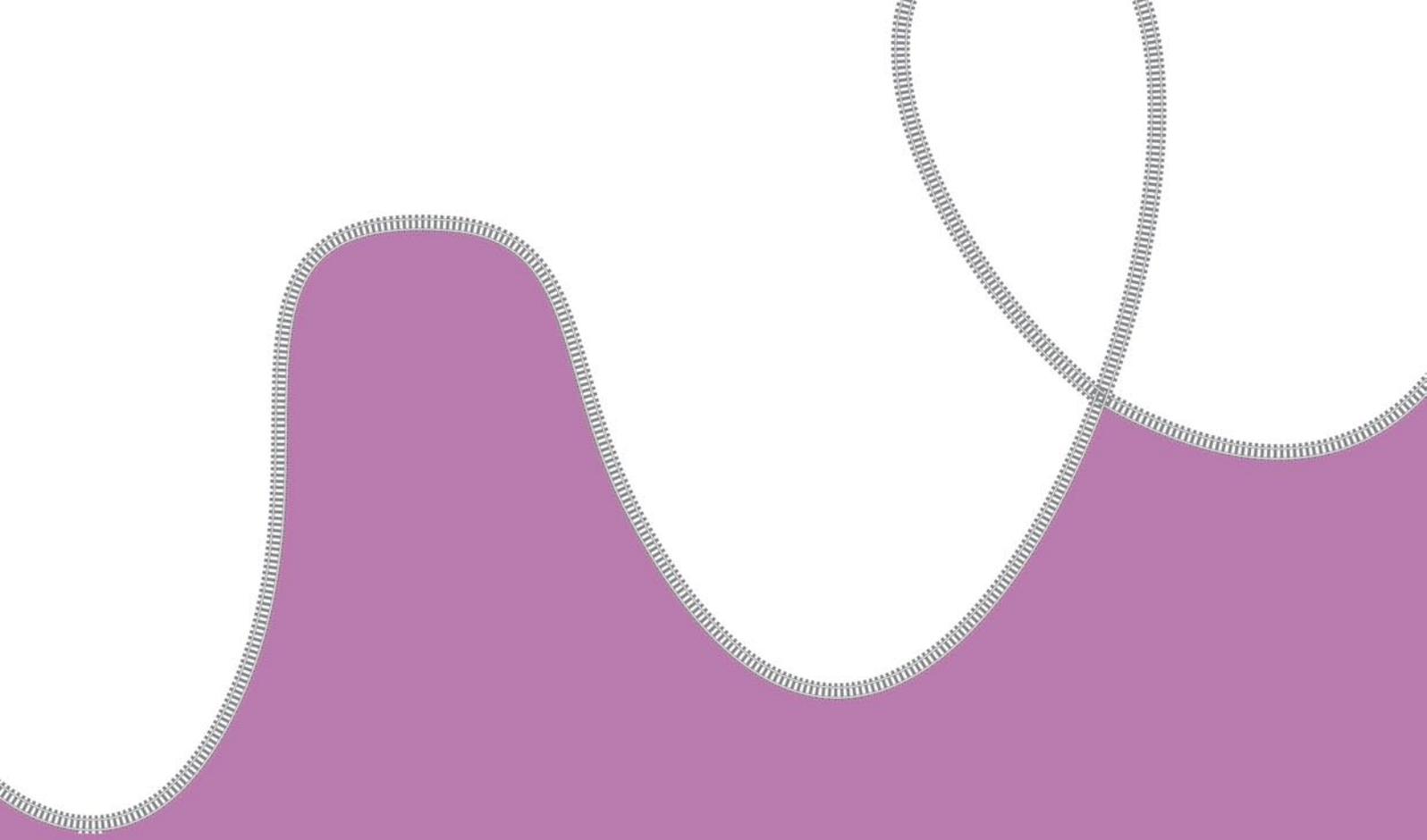
		CLINICAL BANDS FOR 15-16 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possible (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-5	6	7-10	0-5	6	7-10	Emotional symptoms scale
2	Behavioural Difficulties	0-3	4	5-10	0-3	4	5-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-3	4-5	6-10	0-3	4-5	6-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-15	16-19	20-40	0-15	16-19	20-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-13	14-15	16-30	0-12	13-14	15-30	Major depression
2	Anxious away from home	0-6	7	8-21	0-5	6	7-21	Separation anxiety
3	Anxious in social situations	0-18	19-20	21-27	0-19	20-22	23-27	Social phobia
4	Anxious generally	0-11	12	13-18	0-12	13	14-18	Generalized anxiety
5	Compelled to do or think things	0-8	9-10	11-18	0-8	9	10-18	OCD
6	Panic	0-8	9-10	11-27	0-8	9-10	11-27	Panic disorder
7	Overall anxiety	0-48	49-54	55-111	0-48	49-54	55-111	Total anxiety scale
8	Total anxiety and depression mixed	0-59	60-67	68-141	0-59	60-66	67-141	Total internalizing scale

Clinical Bands - Self Report : 17 to 18 year olds

ASSESSMENT

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 17-18 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possible (Borderline)	Probably (Clinical)	
1	Sad or anxious							Emotional symptoms scale
2	Behavioural Difficulties							Conduct problems scale
3	Hyperactivity							Hyperactivity scale
4	Not getting on with others							Peer problems scale
5	Helping others							Prosocial scale
6	Overall difficulties							Total difficulties scale
7	Negative impact on life							Impact scale
National norms for SDQ do not exist for over 17 years old.								
RCADs 47								
1	Depression/Low mood	0-12	13-14	15-30	0-15	16-18	19-30	Major depression
2	Anxious away from home	0-4	5	6-21	0-6	7-8	9-21	Separation anxiety
3	Anxious in social situations	0-17	18-19	20-27	0-20	21-22	23-27	Social phobia
4	Anxious generally	0-11	12-13	14-18	0-13	14-15	16-18	Generalized anxiety
5	Compelled to do or think things	0-9	10-11	12-18	0-11	12	13-18	OCD
6	Panic	0-7	8-9	10-27	0-7	8-9	10-27	Panic disorder
7	Overall anxiety	0-45	46-51	52-111	0-46	47-53	54-111	Total anxiety scale
8	Total anxiety and depression mixed	0-56	57-63	64-141	0-70	71-79	80-141	Total internalizing scale



**CLINICAL BANDS
ASSESSMENT-
PARENT/CARER**

Clinical Bands - Parent of Child age: 3 to 4 years

ASSESSMENT

		CLINICAL BANDS FOR 3-4 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-3	4	5-10	0-3	4	5-10	Emotional symptoms scale
2	Behavioural Difficulties	0-2	3	4-10	0-2	3	4-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-2	3	4-10	0-2	3	4-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-13	14-16	17-40	0-13	14-16	17-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale

Clinical Bands - Parent of Child age: 4 to 8 years

ASSESSMENT

		CLINICAL BANDS FOR 5-8 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-3	4	5-10	0-3	4	5-10	Emotional symptoms scale
2	Behavioural Difficulties	0-2	3	4-10	0-2	3	4-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-2	3	4-10	0-2	3	4-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-13	14-16	17-40	0-13	14-16	17-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale

Clinical Bands - Parent of Child age: 8 to 10 years

ASSESSMENT

		CLINICAL BANDS FOR 8-10 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-3	4	5-10	0-3	4	5-10	Emotional symptoms scale
2	Behavioural Difficulties	0-2	3	4-10	0-2	3	4-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-2	3	4-10	0-2	3	4-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-13	14-16	17-40	0-13	14-16	17-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-7	8-9	10-30	0-8	9-10	11-30	Major depression
2	Anxious away from home	0-8	9-10	11-21	0-8	9-10	11-21	Separation anxiety
3	Anxious in social situations	0-14	15-16	17-27	0-13	14-15	16-27	Social phobia
4	Anxious generally	0-8	9	10-18	0-8	9	10-18	Generalized anxiety
5	Compelled to do or think things	0-5	6	7-18	0-5	6-7	8-18	OCD
6	Panic	0-4	5	6-27	0-5	6	7-27	Panic disorder
7	Overall anxiety	0-36	37-41	42-111	0-37	38-43	44-111	Total anxiety scale
8	Total anxiety and depression mixed	0-42	43-48	49-141	0-44	45-51	52-141	Total internalizing scale

Clinical Bands - Parent of Child age: 11 to 12 years

ASSESSMENT

		CLINICAL BANDS FOR 11-12 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-3	4	5-10	0-3	4	5-10	Emotional symptoms scale
2	Behavioural Difficulties	0-2	3	4-10	0-2	3	4-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-2	3	4-10	0-2	3	4-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-13	14-16	17-40	0-13	14-16	17-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-7	8-9	10-30	0-9	10	11-30	Major depression
2	Anxious away from home	0-6	7-8	9-21	0-7	8-9	10-21	Separation anxiety
3	Anxious in social situations	0-13	14-15	16-27	0-16	17-19	20-27	Social phobia
4	Anxious generally	0-7	8	9-18	0-8	9-10	11-18	Generalized anxiety
5	Compelled to do or think things	0-5	6	7-18	0-5	6-7	8-18	OCD
6	Panic	0-4	5	6-27	0-5	6	7-27	Panic disorder
7	Overall anxiety	0-32	33-37	38-111	0-37	38-43	44-111	Total anxiety scale
8	Total anxiety and depression mixed	0-38	39-44	45-141	0-47	48-54	55-141	Total internalizing scale

Clinical Bands - Parent of Young Person age: 13 to 14 years

ASSESSMENT

		CLINICAL BANDS FOR 13-14 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-3	4	5-10	0-3	4	5-10	Emotional symptoms scale
2	Behavioural Difficulties	0-2	3	4-10	0-2	3	4-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-2	3	4-10	0-2	3	4-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-13	14-16	17-40	0-13	14-16	17-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-8	9	10-30	0-8	9-10	11-30	Major depression
2	Anxious away from home	0-5	6	7-21	0-5	6	7-31	Separation anxiety
3	Anxious in social situations	0-13	14-15	16-27	0-15	16-17	18-27	Social phobia
4	Anxious generally	0-7	8	9-18	0-6	7-8	9-18	Generalized anxiety
5	Compelled to do or think things	0-4	5	6-18	0-4	5	6-18	OCD
6	Panic	0-3	4	5-27	0-4	5	6-27	Panic disorder
7	Overall anxiety	0-30	31-35	36-111	0-32	33-37	38-111	Total anxiety scale
8	Total anxiety and depression mixed	0-36	37-42	43-141	0-39	40-46	47-141	Total internalizing scale

Clinical Bands - Parent of Young Person age: 15 to 16 years

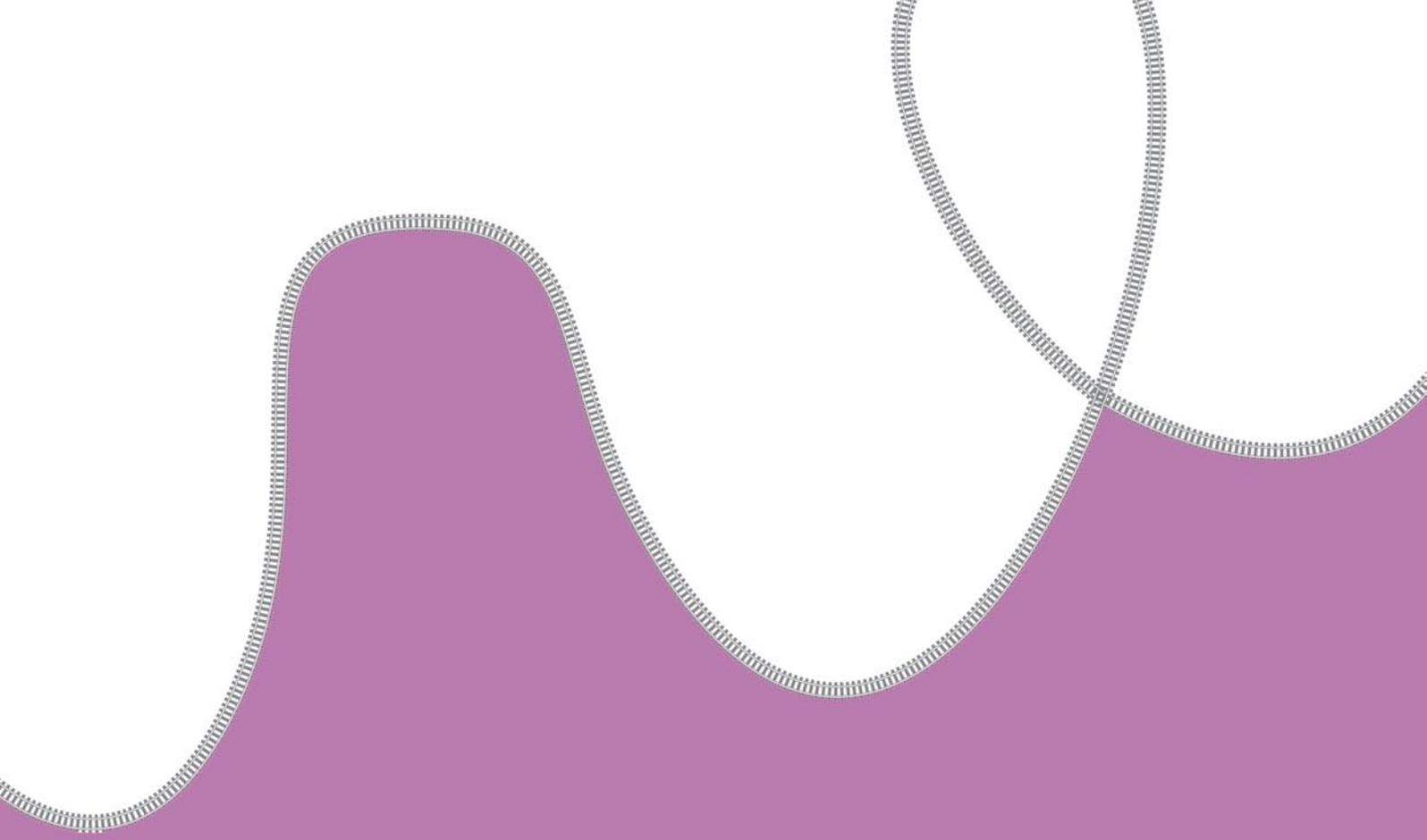
ASSESSMENT

		CLINICAL BANDS FOR 15-16 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-3	4	5-10	0-3	4	5-10	Emotional symptoms scale
2	Behavioural Difficulties	0-2	3	4-10	0-2	3	4-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-2	3	4-10	0-2	3	4-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-13	14-16	17-40	0-13	14-16	17-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-10	11-12	13-30	0-8	9-10	11-30	Major depression
2	Anxious away from home	0-14	5	6-21	0-5	6	7-21	Separation anxiety
3	Anxious in social situations	0-4	15-16	17-27	0-15	16-18	19-27	Social phobia
4	Anxious generally	0-7	8-9	10-18	0-7	8-9	10-18	Generalized anxiety
5	Compelled to do or think things	0-6	7-8	9-18	0-5	6	7-18	OCD
6	Panic	0-5	6	7-27	0-4	5	6-27	Panic disorder
7	Overall anxiety	0-33	34-39	40-111	0-35	36	42-111	Total anxiety scale
8	Total anxiety and depression mixed	0-42	43-48	49-141	0-42	43-49	50-141	Total internalizing scale

Clinical Bands - Parent of Young Person age: 17 to 18 years

ASSESSMENT

		CLINICAL BANDS FOR 17-18 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
SDQ		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Sad or anxious	0-3	4	5-10	0-3	4	5-10	Emotional symptoms scale
2	Behavioural Difficulties	0-2	3	4-10	0-2	3	4-10	Conduct problems scale
3	Hyperactivity	0-5	6	7-10	0-5	6	7-10	Hyperactivity scale
4	Not getting on with others	0-2	3	4-10	0-2	3	4-10	Peer problems scale
5	Helping others	6-10	5	0-4	6-10	5	0-4	Prosocial scale
6	Overall difficulties	0-13	14-16	17-40	0-13	14-16	17-40	Total difficulties scale
7	Negative impact on life	0	1	2-10	0	1	2-10	Impact scale
RCADs 47								
1	Depression/Low mood	0-9	10-11	12-30	0-9	10-11	12-30	Major depression
2	Anxious away from home	0-3	4	5-21	0-4	5	6-21	Separation anxiety
3	Anxious in social situations	0-12	13-14	15-27	0-14	15-16	17-27	Social phobia
4	Anxious generally	0-6	7-8	9-18	0-7	8	9-18	Generalized anxiety
5	Compelled to do or think things	0-3	4	5-18	0-5	6	7-18	OCD
6	Panic	0-3	4	5-27	0-5	6	7-27	Panic disorder
7	Overall anxiety	0-28	29-33	34-111	0-33	34-38	39-111	Total anxiety scale
8	Total anxiety and depression mixed	0-36	37-43	44-141	0-41	42-47	48-141	Total internalizing scale



**CLINICAL BANDS
SESSION BY SESSION-
CHILD**

Clinical Bands - Self Report : 8 to 10 year olds

SESSION BY SESSION - HOW ARE THINGS?

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 8-10 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-14	15-16	17-30	0-15	16-18	19-30	Major depression
2	Anxious away from home	0-10	11-12	13-21	0-13	14-15	16-21	Separation anxiety
3	Anxious in social situations	0-16	17-18	19-27	0-18	19-21	22-27	Social phobia
4	Anxious generally	0-11	12-13	14-18	0-13	14-15	16-18	Generalized anxiety
5	Compelled to do or think things	0-10	11-12	13-18	0-12	13-14	15-18	OCD
6	Panic	0-11	12-13	14-27	0-13	14-15	16-27	Panic disorder
7	Behavioural difficulties*	0-5	6	7-12	0-5	6	7-12	Conduct problem*
8	Disturbed by traumatic event	0-16	–	17-40	0-16	–	17-40	PTSD
9	General distress	32.1-40	–	0-32	32.1-40	–	0-32	Outcome Rating Scale

*Scored on first 6 items only.

Clinical Bands - Self Report : 11 to 12 year olds

SESSION BY SESSION - HOW ARE THINGS?

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 11-12 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-12	13-14	15-30	0-13	14-15	16-30	Major depression
2	Anxious away from home	0-7	8-9	10-21	0-10	11-12	13-21	Separation anxiety
3	Anxious in social situations	0-17	18-19	20-27	0-20	21-23	24-27	Social phobia
4	Anxious generally	0-10	11-12	13-18	0-13	14-15	16-18	Generalized anxiety
5	Compelled to do or think things	0-10	11-12	13-18	0-11	12-13	14-18	OCD
6	Panic	0-9	10-11	12-27	0-11	12-13	14-27	Panic disorder
7	Behavioural difficulties*	0-5	6	7-12	0-5	6	7-12	Conduct problem
8	Disturbed by traumatic event	0-16	–	17-40	0-16	–	17-40	PTSD
9	General distress	32.1-40	–	0-32	32.1-40	–	0-32	Outcome Rating Scale

*Scored on first 6 items only.

Clinical Bands -Self Report : 13 to 14 year olds

SESSION BY SESSION - HOW ARE THINGS?

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 13-14 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-11	12-13	14-30	0-13	14-15	16-30	Major depression
2	Anxious away from home	0-5	6-7	8-21	0-6	7-8	9-21	Separation anxiety
3	Anxious in social situations	0-17	18-20	21-27	0-20	21-22	23-27	Social phobia
4	Anxious generally	0-10	11-12	13-18	0-12	13	14-18	Generalized anxiety
5	Compelled to do or think things	0-10	11	12-18	0-9	10-11	12-18	OCD
6	Panic	0-8	9-10	11-27	0-10	11-12	13-27	Panic disorder
7	Behavioural difficulties*	0-5	6	7-12	0-5	6	7-12	Conduct problem
8	Disturbed by traumatic event	0-16	–	17-40	0-16	–	17-40	PTSD
9	General distress	28.1-40	–	0-28	28.1-40	–	0-28	Outcome Rating Scale

*Scored on first 6 items only.

Clinical Bands - Self Report : 15 to 16 year olds

SESSION BY SESSION - HOW ARE THINGS?

How likely is it that based on these scores the young person has clinically significant problems?

		CLINICAL BANDS FOR 15-16 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-13	14-15	16-30	0-12	13-14	15-30	Major depression
2	Anxious away from home	0-6	7	8-21	0-5	6	7-21	Separation anxiety
3	Anxious in social situations	0-18	19-20	21-27	0-19	20-22	23-27	Social phobia
4	Anxious generally	0-11	12	13-18	0-12	13	14-18	Generalized anxiety
5	Compelled to do or think things	0-8	9-10	11-18	0-8	9	10-18	OCD
6	Panic	0-8	9-10	11-27	0-8	9-10	11-27	Panic disorder
7	Behavioural difficulties*	No norms on this group. Use norm for 13-14 year olds.						Conduct problem
8	Disturbed by traumatic event	0-16	–	17-40	0-16	–	17-40	PTSD
9	General distress	28.1-40	–	0-28	28.1-40	–	0-28	Outcome Rating Scale

*Scored on first 6 items only.

Clinical Bands - Self Report : 17 to 18 year olds

SESSION BY SESSION - HOW ARE THINGS?

How likely is it that based on these scores the young person has clinically significant problems?

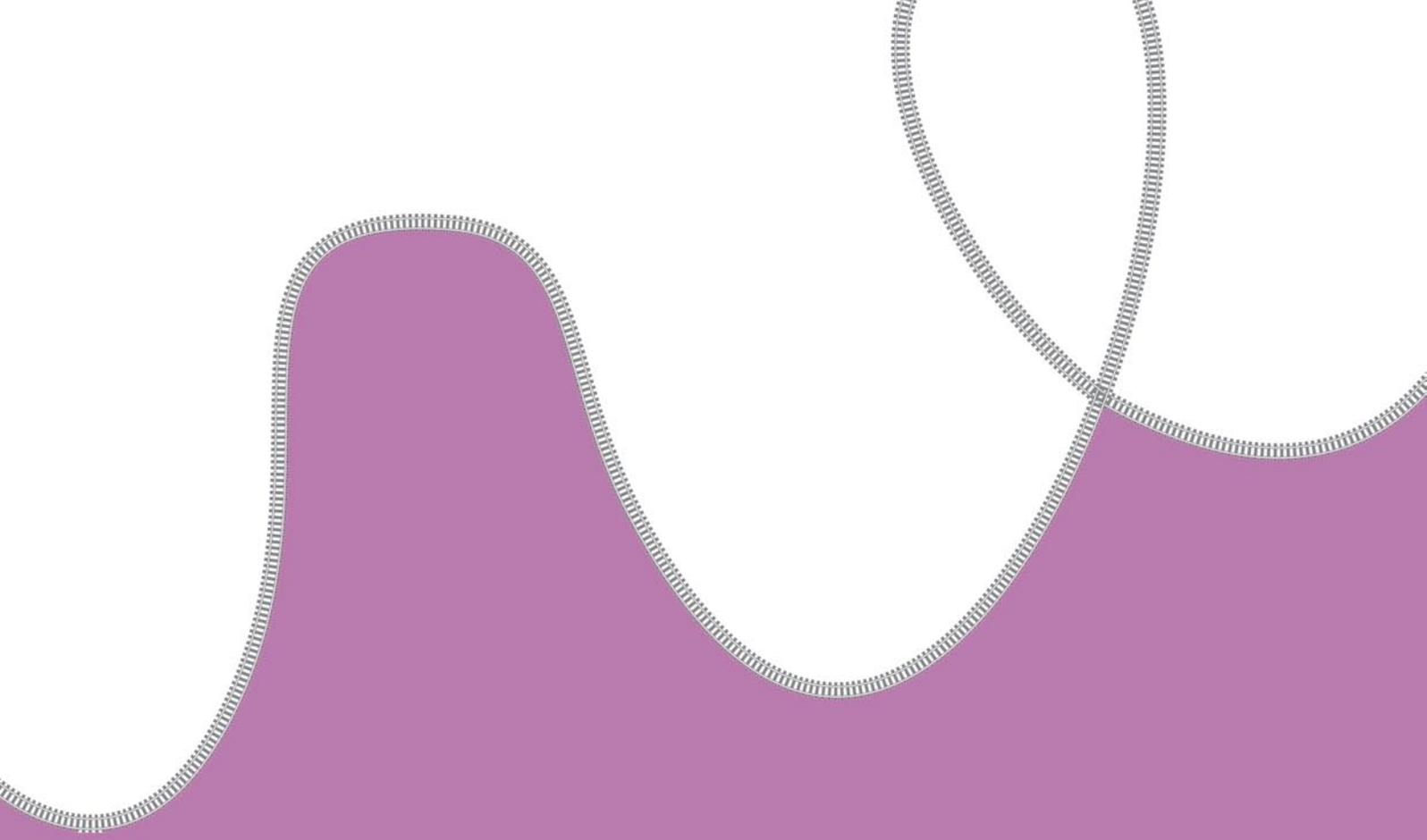
		CLINICAL BANDS FOR 17-18 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-12	13-14	15-30	0-15	16-18	19-30	Major depression
2	Anxious away from home	0-4	5	6-21	0-6	7-8	9-21	Separation anxiety
3	Anxious in social situations	0-17	18-19	20-27	0-20	21-22	23-27	Social phobia
4	Anxious generally	0-11	12-13	14-18	0-13	14-15	16-18	Generalized anxiety
5	Compelled to do or think things	0-9	10-11	12-18	0-11	12	13-18	OCD
6	Panic	0-7	8-9	10-27	0-11	12-13	14-27	Panic disorder
7	Behavioural difficulties*	No norms on this group. Use norm for 13-14 year olds.						Conduct problem
8	Disturbed by traumatic event	0-16	–	17-40	0-16	–	17-40	PTSD
9	General distress (age 17)	28.1-40	–	0-28	28.1-40	–	0-28	Outcome Rating Scale
10	General distress (age 18)	25.1-40	–	0-25	25.1-40	–	0-25	Outcome Rating Scale

*Scored on first 6 items only.

Clinical Bands - Self Report : adult 16+

SESSION BY SESSION - HOW ARE THINGS?

CLINICAL BANDS FOR ADULT 16+									
PROBLEM DESCRIPTION		MALE /FEMALE							SCALE DEFINITIONS
		SEVERITY RATING				CLINICAL BAND			
		Mild	Moderate	Moderately Severe	Severe	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Anxious generally	5-9	10-14	-	15-21	0-7	-	8-21	Generalized anxiety
2	Depression/Low mood	5-9	10-14	15-19	20-27	0-9	-	10-21	Major depression



**CLINICAL BANDS
SESSION BY SESSION-
PARENT/CARER**

Clinical Bands - Parent of Child age: 8 to 10 years

SESSION BY SESSION - HOW ARE THINGS?

PROBLEM DESCRIPTION		CLINICAL BANDS FOR 8-10 YEAR OLDS						SCALE DEFINITIONS
		BOYS			GIRLS			
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-7	8-9	10-30	0-8	9-10	11-30	Major depression
2	Anxious away from home	0-8	9-10	11-21	0-8	9-10	11-21	Separation anxiety
3	Anxious in social situations	0-14	15-16	17-27	0-13	14-15	16-27	Social phobia
4	Anxious generally	0-8	9	10-18	0-8	9	10-18	Generalized anxiety
5	Compelled to do or think things	0-5	6	7-18	0-5	6-7	8-18	OCD
6	Panic	0-4	5	6-27	0-5	6	7-27	Panic disorder
7	Behavioural difficulties	0-3	–	4-8	0-3	–	4-8	Conduct problem*
8	General distress	28.1-40	–	0-28	28.1-40	–	0-28	Outcome Rating Scale

Clinical Bands - Parent of Child age: 11 to 12 years

SESSION BY SESSION - HOW ARE THINGS?

PROBLEM DESCRIPTION		CLINICAL BANDS FOR 11-12 YEAR OLDS						SCALE DEFINITIONS
		BOYS			GIRLS			
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-7	8-9	10-30	0-9	10	11-30	Major depression
2	Anxious away from home	0-6	7-8	9-21	0-7	8-9	10-21	Separation anxiety
3	Anxious in social situations	0-13	14-15	16-27	0-16	17-19	20-27	Social phobia
4	Anxious generally	0-7	8	9-18	0-8	9-10	11-18	Generalized anxiety
5	Compelled to do or think things	0-5	6	7-18	0-5	6-7	8-18	OCD
6	Panic	0-4	5	6-27	0-5	6	7-27	Panic disorder
7	Behavioural difficulties	0-3	–	4-8	0-3	–	4-8	Conduct problem
8	General distress	28.1-40	–	0-28	28.1-40	–	0-28	Outcome Rating Scale

Clinical Bands - Parent of Young Person age: 13 to 14 years

SESSION BY SESSION - HOW ARE THINGS?

PROBLEM DESCRIPTION		CLINICAL BANDS FOR 13-14 YEAR OLDS						SCALE DEFINITIONS
		BOYS			GIRLS			
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-8	9	10-30	0-8	9-10	11-30	Major depression
2	Anxious away from home	0-5	6	7-21	0-5	6	7-21	Separation anxiety
3	Anxious in social situations	0-13	14-15	16-27	0-15	16-17	18-27	Social phobia
4	Anxious generally	0-7	8	9-18	0-6	7-8	9-18	Generalized anxiety
5	Compelled to do or think things	0-4	5	6-18	0-4	5	6-18	OCD
6	Panic	0-3	4	5-27	0-4	5	6-27	Panic disorder
7	Behavioural difficulties	0-3	–	4-8	0-3	–	4-8	Conduct problem
8	General distress	28.1-40	–	0-28	28.1-40	–	0-28	Outcome Rating Scale

Clinical Bands - Parent of Young Person age: 15 to 16 years

SESSION BY SESSION - HOW ARE THINGS?

PROBLEM DESCRIPTION		CLINICAL BANDS FOR 15-16 YEAR OLDS						SCALE DEFINITIONS
		BOYS			GIRLS			
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-10	11-12	13-30	0-8	9-10	11-30	Major depression
2	Anxious away from home	0-4	5	6-21	0-5	6	7-21	Separation anxiety
3	Anxious in social situations	0-14	15-16	17-27	0-15	16-18	19-27	Social phobia
4	Anxious generally	0-7	8-9	10-18	0-7	8-9	10-18	Generalized anxiety
5	Compelled to do or think things	0-6	7-8	9-18	0-5	6	7-18	OCD
6	Panic	0-5	6	7-27	0-4	5	6-27	Panic disorder
7	Behavioural difficulties	0-3	–	4-8	0-3	–	4-8	Conduct problem
8	General distress	28.1-40	–	0-28	28.1-40	–	0-28	Outcome Rating Scale

Clinical Bands - Parent of Young Person age: 17 to 18 years

SESSION BY SESSION - HOW ARE THINGS?

		CLINICAL BANDS FOR 17-18 YEAR OLDS						
PROBLEM DESCRIPTION		BOYS			GIRLS			SCALE DEFINITIONS
		Unlikely	Possibly (Borderline)	Probably (Clinical)	Unlikely	Possibly (Borderline)	Probably (Clinical)	
1	Depression/Low mood	0-9	10-11	12-30	0-9	10-11	12-30	Major depression
2	Anxious away from home	0-3	4	5-21	0-4	5	6-21	Separation anxiety
3	Anxious in social situations	0-12	13-14	15-27	0-14	15-16	17-27	Social phobia
4	Anxious generally	0-6	7-8	9-18	0-7	8	9-18	Generalized anxiety
5	Compelled to do or think things	0-3	4	5-18	0-5	6	7-18	OCD
6	Panic	0-3	4	5-27	0-5	6	7-27	Panic disorder
7	Behavioural difficulties	0-3	–	4-8	0-3	–	4-8	Conduct problem
8	General distress (age 17)	28.1-40	–	0-28	28.1-40		0-28	Outcome Rating Scale
9	General distress (age 18)	25.1-40	–	0-25	25.1-40	–	0-25	Outcome Rating Scale