Wellbeing Practitioner – Children and Young People (WP-CYP) Data Handbook

Version 1.0
Authors

Dr Joanne Woodford
Research Fellow, South West Collaborative Executive Group Committee Member

Dr Catherine Gallop
Director of CYP IAPT Programmes, South West Collaborative Executive Group Committee Member

Jonathan Parker
Clinical Lead, CYP-IAPT (South West Collaborative), South West Collaborative Executive Group Committee Member

Dr Fin Williams
CYP IAPT WP-CYP Academic Lead, South West Collaborative Executive Group Committee Member

Kate Sandel
Project Manager, CYP-IApT (South West Collaborative), South West Collaborative Executive Group

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INTRODUCTION
Welcome!
The following handbook has been compiled to assist you with data collection relevant to the Wellbeing Practitioner – Children and Young People (WP-CYP) role.

The handbook has been designed to support you with the collection of both sessional clinical outcomes as well as tracking children and young people through the care pathway, from referral through to discharge. As such, we hope this handbook will both increase awareness concerning the importance of routine data collection, as well as supplement the specific training WP-CYPs will be provided with by the University of Exeter.

This handbook contains:

• General background information concerning data monitoring and the wider WP-CYP evaluation
• Guidance on using and scoring measures
• Guidance on wider service data collection
• Copies of all measures relevant to the WP-CYP role, which can be copied and used freely

The handbook has been developed by the University of Exeter on behalf of the South West CYP-IAPT Collaborative, and also informed by the National WP-CYP Research and Evaluation Group. Instructions to using all clinical outcome measurements listed has been informed by the Child Outcomes Research Consortium (CORC) website (http://www.corc.uk.net/)

The approach may be subject to revision during the course of the WP-CYP programme, with new updated guidance provided. We would appreciate any comments or feedback on the handbook, which can be provided to Dr Joanne Woodford (j.woodford@exeter.ac.uk).
BACKGROUND TO DATA MONITORING AND THE WP-CYP EVALUATION

The new WP-CYP role will be monitored closely through ongoing data reporting, underpinning a national level evaluation of the role. The data collection protocol outlined within this handbook has been set by both the South West CYP-IAPT Collaborative Executive Group and the National WP-CYP Research and Evaluation Group.

Nationally, a 90% data completeness target has been set across all new WP-CYP services in England. Data collection will be closely monitored, with all data reported to the South West CYP-IAPT Collaborative on a quarterly basis. Data will also be reported to the National WP-CYP Research and Evaluation Group. This focus on data underpins CYP-IAPT more generally, with an increased focus on outcomes and improving service transparency, as well as being a key component of evidence based practice (Fonagy & Clark, 2015).

All data submitted will be analysed and interpreted, with reports provided to all services, including both individual service and wider service comparator data (Fleming, Jones, Bradley, & Wolpert, 2016). Data will be used to enhance learning across regional collaboratives as well as nationally (Wolpert et al., 2014) in order to further develop and enhance the WP-CYP role.

The routine clinical outcomes outlined in this handbook have been agreed upon by the WP-CYP Research and Evaluation Group, and have been informed by the Child Outcomes Research Consortium (CORC, http://corc.uk.net/). CORC outlines appropriate clinical outcome measurements to be used with children, young people, parents and carers with Child and Adolescent Mental Health Services (CAMHS; Wolpert et al., 2012). As well as practitioner/clinician reported outcomes (e.g., Current View) CORC outlines both patient-reported outcome measures (PROMs) and patient reported experience measures (PREMs) that underpin CYP IAPT more generally (Fleming et al., 2016).
IMPORTANCE OF ROUTINE DATA COLLECTION

Demonstrating the provision of quality care is both an ethical and legal obligation for any healthcare service (Svirydzenka, Ronzoni, & Dogra, 2017). As such, healthcare services are expected to routinely measure the quality of care provided (Care Quality Commission, 2010). Further, clinical commissioning groups (CCGs) use outcomes to demonstrate service (i) effectiveness; (ii) safety; and (iii) quality (Health & Social Act, 2012). As such, the collection of routine data is essential for the ongoing commissioning of healthcare providers, and thus sustaining the WP-CYP role. In addition, routine data collection is important to demonstrate both accountability and transparency regarding healthcare service provision across England (NHS England, 2015), providing important information concerning effectiveness, safety and quality to service users and the wider public (Hall et al., 2013).

CYP IAPT is underpinned by the principle of collaboration, where practitioners work alongside children, young people and their parents and carers to establish joint treatment goals, track progress together and adopt shared decision making. Outcomes-informed practice offers a key vehicle to support this core aim and embed these vital processes into clinical practice.

BENEFITS OF ROUTINE DATA COLLECTION

- Session-by-session monitoring and feedback of outcomes (for example, symptoms, functioning and therapeutic alliance) is an evidence based intervention of itself (Edbrooke-Childs, Gondek, Denington, Fonagy, & Wolpert, 2016). As such, it is an essential component of good clinical practice (Department of Health, 2011).
- Routine data collection is associated with enhanced communication between patient and practitioners, providing a way to monitor the impact of treatment, and to help inform subsequent treatment plans especially for non-responders (Carlier et al., 2012).
- Shared-decision making between patient and practitioner can be enhanced through the use of routine data collection (Law & Wolpert, 2014).
- Routine data collection can be used to inform supervision (Law & Wolpert, 2014) and is an essential component of WP-CYP case management supervision (Richards, Chellingsworth, Hope, Turpin, & Whtye, 2010).
- Session-by-session outcome measurement collection is associated with increased treatment effectiveness (Gondek et al., 2016).
- Session-by-session data is associated with increased data-completeness (Clark, 2011)
- Child, young people and families want routine data collection (Badham, 2011).
- The collection of routine service and clinical data can be used to inform improvements in service development (Fleming et al., 2016). Indeed, routine data collection has been essential in the ongoing implementation and development of Adult IAPT services across England (Clark, 2011; Gyani et al., 2013).
- Routine data collection is essential for ongoing service commissioning; with objective outcome measurement being crucial to secure future funding for all health services (Law & Wolpert, 2014).
USING PROMs AND PREMs WITH CHILDREN, YOUNG PEOPLE, PARENTS AND CARERS

This handbook is not designed to be a comprehensive guide to using patient-reported outcome measures (PROMs) and patient reported experience measures (PREMs) with children and young people. All WP-CYPs will be provided with training by the University of Exeter regarding the use of all routine outcomes, with a specific focus on developing awareness, competence and motivation to use routine outcomes collaboratively with children and young people. Further, WP-CYPs are encouraged to read the following extensive guidance to using clinical outcomes with children, young people, parents and carers:

http://www.corc.uk.net/media/1182/201404guide_to_using_outcomes_measures_and_feedback_tools.pdf

Although there are clear benefits to using clinical outcomes, it is essential that these outcomes are used in a collaborative way and supplement further context derived information (Law & Wolpert, 2014). Some specific “dos” and “don’ts” to using clinical outcomes with children, young people, parents and carers are provided in Table 1 below (Law & Wolpert, 2014).

Table 1: Dos and Don’ts to using clinical outcomes with children, young people, parents and carers

<table>
<thead>
<tr>
<th>SOME DOS AND DON'TS OF USING CLINICAL OUTCOME TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do</td>
</tr>
<tr>
<td>Do</td>
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<td>Do</td>
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<td>Do</td>
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<tr>
<td>Don’t</td>
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</tbody>
</table>

Taken from Law & Wolpert (2014), pp. 6
DATA COLLECTION AND ENTRY

Due to the nature of the WP-CYP role, children and young people may be seen in a variety of different locations. As such, WP-CYPs may be collecting session-by-session outcome measurements face-to-face or over the telephone. Where possible, the use of electronic devices (e.g., PCs, laptops, Padlets) may help facilitate data collection. However, the use of paper based questionnaires may also be required. It is important to always be prepared before each session, with all the resources you may need. All routine outcome measurements are in the Appendix of this handbook and separate PDFs of each outcome measure will also be provided. You can also access most outcome measurements listed in this handbook on the CORC website: http://www.corc.uk.net/

There is an acknowledgement that across the range of services within the South West Collaborative there is a significant variation in IT and data collection infrastructure. Where appropriate the CYP-IAPT team based at the University of Exeter are able to offer support and guidance in order to facilitate the consistent and coherent collection of data. Some services may wish to use an EXCEL spreadsheet specifically developed to collect all routine data. Other services may wish to develop their own database, for example using ACCESS, however it is essential any database developed for data entry mirrors the minimum data set outlined in this handbook (see pages 23-43).
WP-CYP ROUTINE CLINICAL OUTCOMES: A SUMMARY

A summary of the routine clinical outcomes can be found in Table 2. Specifically, clinical outcomes collected will be based on the main presenting difficulty experienced by the child/young person/parent/carer, as determined by the assessment and the collaborative decision made regarding ongoing treatment focus. Routine clinical outcomes should be collected on a session-by-session basis. If it is not possible for a clinical outcome measurement to be used this should be noted in clinical notes and the reporting tool with a clear reason for why this was the case.

Table 2: Summary of routine clinical outcomes

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Measurement Focus</th>
<th>Assessment</th>
<th>Treatment Sessions</th>
<th>Final Session</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Overview</td>
<td></td>
<td>Current View</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td>RCADS (47 items)</td>
<td>RCADS Depression (10 items)</td>
<td>RCADS (47 items)</td>
</tr>
<tr>
<td>Impact / Functioning</td>
<td></td>
<td>ORS/CORS (4 items)</td>
<td>ORS/CORS (4 items)</td>
<td>ORS/CORS (4 items)</td>
</tr>
<tr>
<td>Goals</td>
<td></td>
<td>Goal Based Outcomes (1-3 items)</td>
<td>Goal Based Outcomes (1-3 items)</td>
<td>Goal Based Outcomes (1-3 items)</td>
</tr>
<tr>
<td>Session Feedback</td>
<td></td>
<td>SFQ (4 items)</td>
<td>SFQ (4 items)</td>
<td>SFQ (4 items)</td>
</tr>
<tr>
<td>Service Feedback</td>
<td></td>
<td>ESQ (12 items)</td>
<td></td>
<td>ESQ (12 items)</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Overview</td>
<td></td>
<td>Current View</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td>RCADS (47 items)</td>
<td>RCADS Anxiety Disorder Subscale (6 – 9 items)</td>
<td>RCADS (47 items)</td>
</tr>
<tr>
<td>Impact / Functioning</td>
<td></td>
<td>ORS/CORS (4 items)</td>
<td>ORS/CORS (4 items)</td>
<td>ORS/CORS (4 items)</td>
</tr>
<tr>
<td>Goals</td>
<td></td>
<td>Goal Based Outcomes (1-3 items)</td>
<td>Goal Based Outcomes (1-3 items)</td>
<td>Goal Based Outcomes (1-3 items)</td>
</tr>
<tr>
<td>Session Feedback</td>
<td></td>
<td>SFQ (4 items)</td>
<td>SFQ (4 items)</td>
<td>SFQ (4 items)</td>
</tr>
<tr>
<td>Service Feedback</td>
<td></td>
<td>ESQ (12 items)</td>
<td></td>
<td>ESQ (12 items)</td>
</tr>
<tr>
<td><strong>Parenting / Behaviour</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Overview</td>
<td></td>
<td>Current View (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional &amp; behavioural difficulties</td>
<td></td>
<td>SDQ (25 items)</td>
<td>SDQ - Impact (8 items)</td>
<td>SDQ (25 items)</td>
</tr>
<tr>
<td>Parent Self-Efficacy</td>
<td></td>
<td>BP-SES (5 items)</td>
<td>BP-SES (5 items)</td>
<td>BP-SES (5 items)</td>
</tr>
<tr>
<td>Behaviour</td>
<td></td>
<td>ODDp (8 items)</td>
<td>ODDp (8 items)</td>
<td>ODDp (8 items)</td>
</tr>
<tr>
<td>Service Feedback</td>
<td></td>
<td>Experience of Service Questionnaire (12 items)</td>
<td></td>
<td>Experience of Service Questionnaire (12 items)</td>
</tr>
</tbody>
</table>
WP-CYP ROUTINE CLINICAL OUTCOMES: DEPRESSION/LOW MOOD

Table 3 provides a more detailed breakdown of the routine clinical outcomes to be collected for children and young people with depression/low mood as their main presenting difficulty. Versions of outcome measurements differ slightly dependent on the age of the child/young person.

Table 3: Routine clinical outcomes for depression/low mood

<table>
<thead>
<tr>
<th>Measurement Focus</th>
<th>Age Range (Guide)</th>
<th>Assessment</th>
<th>Treatment Sessions</th>
<th>Final Session</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Overview</strong></td>
<td>All</td>
<td>Current View</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Symptoms</strong></td>
<td>8+</td>
<td>RCADS (Full) self-reported</td>
<td>RCARDS (Depression subscale) self-reported</td>
<td>RCADS (Full) self-reported</td>
</tr>
<tr>
<td></td>
<td>Under 8</td>
<td>RCADS (Full) parent reported</td>
<td>RCADS (Depression subscale) parent reported</td>
<td>RCADS (Full) parent reported</td>
</tr>
<tr>
<td><strong>Impact/Functioning</strong></td>
<td>13+</td>
<td>ORS (13+)</td>
<td>ORS (13+)</td>
<td>ORS (13+)</td>
</tr>
<tr>
<td></td>
<td>6-12</td>
<td>CORS (6-12)</td>
<td>CORS (6-12)</td>
<td>CORS (6-12)</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>All</td>
<td>Goal Based Outcomes</td>
<td>Goal Based Outcomes</td>
<td>Goal Based Outcomes</td>
</tr>
<tr>
<td><strong>Session Feedback</strong></td>
<td>All (self or parent)</td>
<td>SFQ</td>
<td>SFQ</td>
<td>SFQ</td>
</tr>
<tr>
<td><strong>Service Feedback</strong></td>
<td>12+</td>
<td>ESQ (12-18))</td>
<td></td>
<td>ESQ (12-18)</td>
</tr>
<tr>
<td></td>
<td>9-11</td>
<td>ESQ (9-11)</td>
<td></td>
<td>ESQ (9-11)</td>
</tr>
<tr>
<td></td>
<td>Under 9</td>
<td>ESQ (Parent)</td>
<td></td>
<td>ESQ (Parent)</td>
</tr>
</tbody>
</table>
WP-CYP ROUTINE CLINICAL OUTCOMES: ANXIETY DISORDERS

Table 4 provides a more detailed breakdown of the routine clinical outcomes to be collected for children and young people with an anxiety disorder as their main presenting difficulty. Versions of outcome measurements differ slightly dependent on the age of the child/young person. The RCADS anxiety disorder specific subscale for treatment session collection should be informed by the main presenting anxiety disorder which is the focus of treatment.

**Table 4: Routine clinical outcomes for anxiety disorders**

<table>
<thead>
<tr>
<th>Measurement Focus</th>
<th>Age Range (Guide)</th>
<th>Assessment</th>
<th>Treatment Sessions</th>
<th>Final Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Overview</td>
<td>All</td>
<td>Current View</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Symptoms</td>
<td>8+</td>
<td>RCADS (Full) self-reported</td>
<td>RCADS (anxiety disorder specific subscale) self-reported</td>
<td>RCADS (Full) self-reported</td>
</tr>
<tr>
<td></td>
<td>Under 8</td>
<td>RCADS (Full) parent reported</td>
<td>RCADS (anxiety disorder specific subscale) parent reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(This may also be collected if feasible/desirable for young people 8+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact/Functioning</td>
<td>13+</td>
<td>ORS (13+)</td>
<td>ORS (13+)</td>
<td>ORS (13+)</td>
</tr>
<tr>
<td></td>
<td>6-12</td>
<td>CORS (6-12)</td>
<td>CORS (6-12)</td>
<td>CORS (6-12)</td>
</tr>
<tr>
<td>Goals</td>
<td>All</td>
<td>Goal Based Outcomes</td>
<td>Goal Based Outcomes</td>
<td>Goal Based Outcomes</td>
</tr>
<tr>
<td>Session Feedback</td>
<td>All (self or parent)</td>
<td>SFQ</td>
<td>SFQ</td>
<td>SFQ</td>
</tr>
<tr>
<td>Service Feedback</td>
<td>12+</td>
<td>ESQ (12-18))</td>
<td></td>
<td>ESQ (12-18)</td>
</tr>
<tr>
<td></td>
<td>9-11</td>
<td>ESQ (9-11)</td>
<td></td>
<td>ESQ (9-11)</td>
</tr>
<tr>
<td></td>
<td>Under 9</td>
<td>ESQ (Parent)</td>
<td></td>
<td>ESQ (Parent)</td>
</tr>
</tbody>
</table>
WP-CYP ROUTINE CLINICAL OUTCOMES: PARENTING/BEHAVIOURAL

Table 5 provides a more detailed breakdown of the routine clinical outcomes to be collected for children and young people whereby parenting/behavioural difficulties are the main focus of treatment. On the whole, these are parent/carer reported outcome measurements.

Table 5: Routine clinical outcomes for parenting/behavioural difficulties

<table>
<thead>
<tr>
<th>Measurement Focus</th>
<th>Age Range (Guide)</th>
<th>Assessment</th>
<th>Treatment Sessions</th>
<th>Final Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Overview</td>
<td>All</td>
<td>Current View</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional &amp; behavioural difficulties</td>
<td>All</td>
<td>SDQ–Parental</td>
<td>SDQ-Parental</td>
<td>SDQ-Parental</td>
</tr>
<tr>
<td></td>
<td>11-17 (Optional)</td>
<td>SDQ-Child</td>
<td>SDQ-Child</td>
<td>SDQ-Child</td>
</tr>
<tr>
<td>Parent Self-Efficacy</td>
<td>All</td>
<td>BP-SES</td>
<td>BP-SES</td>
<td>BP-SES</td>
</tr>
<tr>
<td>Behaviour</td>
<td>All</td>
<td>ODDp</td>
<td>ODDp</td>
<td>ODDp</td>
</tr>
<tr>
<td>Service Feedback</td>
<td>All</td>
<td>ESQ (Parent)</td>
<td></td>
<td>ESQ (Parent)</td>
</tr>
<tr>
<td></td>
<td>12+ (Optional)</td>
<td>ESQ (12-18)</td>
<td></td>
<td>ESQ (12-18)</td>
</tr>
<tr>
<td></td>
<td>9-11 (Optional)</td>
<td>ESQ (9-11)</td>
<td></td>
<td>ESQ (9-11)</td>
</tr>
</tbody>
</table>
CURRENT VIEW

Background
The aim of Current View is to record assessment information in a standardised way, including main presenting problems, impact and risk. A Current View should be completed post initial assessment for all children/young people assessed by WP-CYPs. Although the Current View tool is completed post initial assessment, if new information is derived during treatment, the Current View form may be updated.

Scoring
Full guidance concerning how to measure impact, define contextual problems and attendance and attainment difficulties is provided with the Current View form.

Full online training regarding the use of Current View can be found on the following link, including worked examples to practice with: http://pbrcamhs.org/training/current-view-tool-training/

Administration
Practitioner completed at the end of all initial assessment sessions, regardless of main presenting difficulty.

Versions
Current View (Appendix A)
REVISED CHILDREN’S ANXIETY AND DEPRESSION SCALE (RCADS) AND PARENT VERSION (RCADS-P)

Background
The Revised Children’s Anxiety and Depression Scale (RCADS) and the RCADS – Parent Version (RCADS-P) are 47-item questionnaires designed to measure the self or parent reported frequency of depression/low mood and anxiety (Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000; Chorpita, Moffitt, & Gray, 2005). Both versions measure the following disorders from the Diagnostic and Statistical Manual of Mental Disorders (DSM) as published by the American Psychiatric Association (APA) (standard criteria for the classification of mental disorders): Major Depressive Disorder (MDD); Generalised Anxiety Disorder (GAD); Obsessive Compulsive Disorder (OCD); Panic Disorders (PD); Separation Anxiety Disorder (SAD); and Social Phobia (SOP). The item can either be used as a full 47-item questionnaire, or specific subscales can be used for the aforementioned DSM disorders. Both the RCADS and RCADS-P have been found to have good levels of internal consistency, test-retest reliability, and good convergent/divergent validity (Chorpita et al., 2000; Chorpita et al., 2005; Ebesutani et al., 2010; Ebesutani et al., 2011).

Administration
The RCADS is designed as a self-report tool for children/young people aged between 8-18 years. Either the child-report or parent-report can be self-completed, or questionnaires can be administered by a practitioner verbally.

The RCADS should be administered in the following situations:

- The full RCADS should be administered in the initial assessment if the main presenting problem is depression or anxiety. If the child/young person is aged 8-18, the child reported version will be used. For those under 8, or for children/young people who cannot complete the measure, the RCADS-P should be administered. If feasible, the RCADS-P can also be collected if you have a child reported version complete (however this is optional).
- The RCADS-Subscale only should be administered in each subsequent treatment session, dependent on main presenting difficulty and treatment focus. For example, if the main presenting difficulty, and focus of treatment, is depression/low mood, the Depression Subscale will be administered in each subsequent treatment session.
- The full RCADS should be administered again in the final treatment session if the main presenting problem is depression or anxiety.

Scoring
Respondents are asked to rate the frequency of each symptom experienced currently, with the following options: ‘never = 0’; ‘sometimes = 1’; ‘often = 2’ or ‘always =3’. Both a total score and sum score for each of the DSM disorders can be calculated. Scoring aids are provided within this handbook (pages xx-xx). However, in order to interpret the score, scoring programs available from the questionnaire developer should be used (http://www.childfirst.ucla.edu/Resources.html). This allows you to enter the raw score and transform the score based on age (school year group) and will inform you as to whether the child/young person scores above the clinical cut off for each of the DSM disorders based on population data from young people of the same age not experiencing mental health difficulties. The United States (US) school grade equivalent needs to be entered, as per Table 6 on the following page:
Table 6: US school grade equivalents for age ranges

<table>
<thead>
<tr>
<th>US School Grade</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
<td>4-5 years</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>5-6 years</td>
</tr>
<tr>
<td>1st Grade</td>
<td>6-7 years</td>
</tr>
<tr>
<td>2nd Grade</td>
<td>7-8 years</td>
</tr>
<tr>
<td>3rd Grade</td>
<td>8-9 years</td>
</tr>
<tr>
<td>4th Grade</td>
<td>9-10 years</td>
</tr>
<tr>
<td>5th Grade</td>
<td>10-11 years</td>
</tr>
<tr>
<td>6th Grade</td>
<td>11-12 years</td>
</tr>
<tr>
<td>7th Grade</td>
<td>12-13 years</td>
</tr>
<tr>
<td>8th Grade</td>
<td>13-14 years</td>
</tr>
<tr>
<td>9th Grade</td>
<td>14-15 years</td>
</tr>
<tr>
<td>10th Grade</td>
<td>15-16 years</td>
</tr>
<tr>
<td>11th Grade</td>
<td>16-17 years</td>
</tr>
<tr>
<td>12th Grade</td>
<td>17-18 years</td>
</tr>
</tbody>
</table>

Transforming raw scores will need to be carried out post-session given the time limited nature of the WP-CYP role. However, raw scores can be feedback to the child/young person/parent/carer and transformed scores presented in the subsequent treatment session.

Versions

Versions applicable to the WP-CYP role are listed below:

- RCADS Child Self-Reported (8-18 years) (Appendix B)
- RCADS Patent-Reported (Appendix C)
- RCADS Scoring Guide Child Self-Reported (8-18 years) (Appendix B)
- RCADS Scoring Guide Patent-Reported (Appendix C)
- Depression Child Self-Reported (Appendix F)
- Depression Parent-Reported (Appendix G)
- Generalised Anxiety Child Self-Reported (Appendix H)
- Generalised Anxiety Parent-Reported (Appendix I)
- OCD Child Self-reported (Appendix J)
- OCD Parent-reported (Appendix K)
- Panic Child Self-reported (Appendix L)
- Panic Parent-reported (Appendix M)
- Social Anxiety Child Self-reported (Appendix N)
- Social Anxiety Parent-reported (Appendix O)
OUTCOME RATING SCALE (ORS) AND CHILD OUTCOME RATING SCALE (CORS)

Background

The Outcome Rating Scale (ORS) (Miller & Duncan, 2000) and Child Outcome Rating Scale (CORS) (Duncan, Miller & Sparks, 2003) are short four-item measures of general functioning and impact. The ORS specifically measures how well children and young people are doing in the following areas: individually (personal wellbeing); interpersonally (family, close relationships); socially (work, school, friendships) and overall (general sense of wellbeing). The CORS uses slight variations in language and format (for example, smiley faces) to ensure the measure is child friendly. The ORS has good levels of internal consistency, test-retest reliability and concurrent validity (Bringhurst, Watson, Miller, & Duncan, 2006; Duncan et al., 2003; Miller, Duncan, Brown, Sparks & Claud, 2003). The CORS has also been demonstrated to have moderate validity and good reliability (Duncan, Sparks, Miller, Bohanske, & Claud, 2006).

Administration

The ORS is designed as a self-report tool for children/young people aged between 13-18 years. The CORS is designed for children age 6-12. The tool can be self-completed, or administered by a practitioner verbally. Parents/carers can also complete the ORS/CORS, however this should be in addition to the child/young person reports.

The ORS/CORS should be administered in the following situations:

- The ORS/CORS should be administered in the initial assessment if the main presenting problem is depression or anxiety.
- The ORS/CORS should also be administered in each subsequent treatment session, and the final treatment session, if the main presenting problem is depression or anxiety.

Scoring

A visual analogue scale is used, with the child/young person instructed to place a mark on a 10cm line under each of the four areas of functioning measured. Low scores are made towards the left and high score towards the right (Duncan et al., 2006), with the child/young person asked to place a mark on each scale to represent how they feel they have been doing in each area. The given score corresponds to the measurement of length on the ruler e.g., a mark placed at 7.5 cm would be a score of 7.5. Each item score is summed, with a maximum total score of 10 possible. The cut off scores are as follows (see http://www.corc.uk.net/outcome-experience-measures/outcome-rating-scale/)

ORS (ages 13 and over):
- Cut off for 13–17 year olds = 28
- Cut off for 18 and over = 25

CORS (ages 12 and under):
- Child Self Reporting = 32
- Carer Reporting on Child = 28

As this outcome measurement relies on accurate measurement it is important that the visual analogue scales on all printed copies measures 10cms exactly.

Versions

- ORS (13+ years) (Appendix P)
- CORS (6-12 years) (Appendix Q)
SESSION FEEDBACK QUESTIONNAIRE (SFQ)

Background

The Session Feedback Questionnaire (SFQ) is a short four-item measurement to gain session-by-session feedback. It is a measurement of therapeutic alliance and can be used to track whether children/young people feel listened to, understood, given the opportunity to discuss what they wanted to and whether the session has given the child/young person ideas to work on (Law & Wolpert, 2014). Positive and negative feedback are both important for the development and maintenance of therapeutic alliance and can help identify any changes/setbacks that may lead to poorer outcomes or drop out (Law & Wolpert, 2014).

Administration

The SFQ is designed as a self-report tool for children/young people, with no specific age restrictions. The SFQ should be used with the child/young person at the end of every session, with results discussed and explored. If necessary, feedback can be provided by a parent/carer.

The SFQ should be administered in the following situations:

- The SFQ should be administered in the initial assessment if the main presenting problem is depression or anxiety.
- The SFQ should also be administered in each subsequent treatment session, and the final treatment session, if the main presenting problem is depression or anxiety.

Scoring

There are four items, and each item is rated on a 5 point scale: ‘Not at all – 1’; ‘Only a little – 2’; ‘Somewhat – 3’; ‘Quite a bit – 4’ and ‘Totally – 5’.

Versions

- SFQ (Appendix R)
GOAL BASED OUTCOMES

Background
To supplement the collection of standardised PROMs, goal-based outcomes take a idiographic approach, allowing the measurement of attainment of up to three goals set collaboratively between children/young people, families and practitioners (Wolpert et al., 2012; Law, 2006). Research demonstrates significant correlations between standardised PROMs and Goal Based Outcomes (Wolpert et al., 2012). Further, the use of idiographic PROMs provides a focus on particular difficulties patients have identified, thus improving treatment acceptability (Weisz et al., 2011).

Administration
Goal Based Outcomes are designed to be used as part of treatment. For those children/young people considered suitable for WP-CYP support, up to three goals should be set collaboratively between children/young people/parents/carers towards the end of assessment. Attainment towards these goals will be monitored throughout treatment. For some children/young people it may take a few sessions to be able to decide on up to three goals. Time 1 goal ratings should not be recorded until three goals are fixed. As such, there may be missing data initially. However, given the time limited nature of WP-CYP working, it is important to support the child/young person to fix three goals as early in treatment as possible.

Goal Based Outcomes should be administered in the following situations:

- Ideally three goals should be set in the initial assessment if the child/young person is suitable for ongoing treatment and support and their main presenting problem is depression or anxiety.
- Progress towards goal attainment should be measured in each subsequent treatment session, and the final towards the main presenting problem is depression or anxiety.

Scoring
Progress towards goals is measured at each contact by asking the child/young person to rate progress towards their goal on a scale from 0 (no progress) to 10 (goal fully reached).

Versions
- Goal Based Outcomes (Appendix S)
EXPERIENCE OF SERVICE QUESTIONNAIRE (ESQ)

Background
The ESQ (Attride-Stirling, 2002) is a 12-item questionnaire, specifically developed to measure satisfaction in CAMHs services. The questionnaire also includes three free text sections to examine what was liked about the service, what needs improving and also any other comments (www.corc.net).

Administration
Either child self-reported, and/or, parent/carer reported ESQs should be completed by all WP-CYP service users at the following time points, regardless of main presenting difficulty.

- End of initial assessment session with a WP-CYP, regardless of service suitability
- Treatment completion (regardless of onward referral)

The questionnaire may be filled out by children/young people/parents/carers on their own, or with support if required. However, an envelope should be provided to enable the questionnaire to be completed confidentially if wanted. If a child/young person/parent/carer drops out of treatment attempts should be made to collect ESQ data by post, e.g., copies of the questionnaire should be sent via post with a stamped addressed envelope (SAE).

Scoring
Each of the 12 items are rated using a Likert Scale, ranging from “Certainly True = 3”; “Partly True = 2” and “Not True = 1”. There is a slight variation in response options for younger children, dependent on the question being asked, however the responses are scored in the same way (Brown et al., 2014)

Responses can be grouped into two constructs (Brown et al., 2014):
Satisfaction with Care - items 1, 2, 3, 4, 5, 6, 7, 11 and 12
Satisfaction with Environment - items 8, 9 and 10

Versions
- ESQ Child Self-Report for 9-11 year olds (Appendix T)
- ESQ Child Self-Report for 12-18 year olds (Appendix U)
- ESQ Parent/Carer Report (Appendix V)
STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)

Background

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a 25 item questionnaire to measure emotional and behavioural difficulties experienced by children and young people aged between 3 and 16 years old. The SDQ comprises of 5 scales (5 items each) measuring: emotional symptoms; conduct problems; hyperactivity-inattention; peer problems and prosocial behaviour (Stone et al., 2015). Psychometric properties of the measure differ within the research literature (see Hawes & Dadds, 2004; Stone et al., 2010; Mieloo et al., 2012; Yao et al., 2009). The SDQ also has a supplement section, with an additional 8 items, examining overall difficulties, length of time difficulties have been experienced and 6 items examining impact. These 6 impact supplement items examine overall upset/distress and impact on home life, friendships, classroom learning and leisure activities.

Administration

The SDQ Patient Report can be completed by parents for children/young people aged 4-17 years. There is a Child Report version for children/young people aged 11-17. The SDQ is designed to be self-completed, with support provided if required.

The SDQ should be administered in the following situations:

- The SDQ Initial Parent Report should be collected in the initial assessment if the main presenting problem is parental or behavioural difficulties for children of all ages. If the child/young person is aged between 11-17 years, the SDQ Initial Child Report should also be collected if feasible.
- The SDQ Parent Report Impact Supplement only should be taken in each subsequent treatment session if the main presenting problem is parental or behavioural difficulties for children of all ages. If the child/young person is aged between 11-17 years, the SDQ Child Report Impact Supplement should also be collected if feasible.
- The SDQ Follow-Up Parent Report should be collected in the final treatment session if the main presenting problem is parental or behavioural difficulties for children of all ages. If the child/young person is aged between 11-17 years, the SDQ Follow-Up Child Report should also be collected if feasible.

Scoring

A full guide to scoring the SDQ by hand can be found in Appendix AA. Each of the initial 25 items are answered by the responses “Not True”; “Somewhat True” and “Certain True”. “Somewhat True” is always scored as 1, however the other two items are scored “0” or “2” dependent on the item. Each of the scales have a score ranging from 0-10, with a maximum score possible of 40 as the prosocial scale is not summed.

The 6 item impact supplement generates a total score ranging from 0-10. Each item is scored “Not at all = 0”; “Only a little = 0; “A medium amount = 1” and “A great deal = 2”.

Versions

- SDQ Parent Report (4-17) (Appendix W)
- SDQ Child Report (11-17) (Appendix X)
- SDQ Parent Report Impact Supplement (4-17) (Appendix Y)
- SDQ Child Report Impact Supplement (11-17) (Appendix Z)
BRIEF PARENTAL SELF EFFICACY SCALE (BP-SES)

Background
The BP-SES is a short 5-item measure of parental self-efficacy.

Administration
The BP-SES is completed by the parent/carer. The BP-SES is designed to be self-completed, with support provided if required.

The BP-SES should be administered in the following situations:

- The BP-SES should be collected in the initial assessment if the main presenting problem is parental or behavioural difficulties for children of all ages.
- The BP-SES should be taken in each subsequent treatment session and the final treatment session if the main presenting problem is parental or behavioural difficulties for children of all ages.

Scoring
Each of the 5 items are answered by the responses “Strongly disagree = 1”; “Disagree=2” and “Neutral=3”; “Agree=4” and “Strongly Agree=5”. A maximum score of 25 can be generated, with higher scores indicating greater parental self-efficacy.

Versions
- BP-SES (Appendix BB)
OPPOSITIONAL DEFIANT DISORDER – PARENT REPORTED (ODDp)

Background
The ODDp is a short 8-item measure of behavioural difficulties.

Administration
The ODDp is completed by the parent/carer. The ODDp is designed to be self-completed, with support provided if required.
The ODDp should be administered in the following situations:

- The ODDp should be collected in the initial assessment if the main presenting problem is parental or behavioural difficulties for children of all ages.
- The ODDp should be taken in each subsequent treatment session and the final treatment session if the main presenting problem is parental or behavioural difficulties for children of all ages.

Scoring
Each of the 8 items are answered by the responses “Not true = 0”; “Somewhat true = 1” and “Certainly true = 2”. A maximum score of 16 can be generated, with higher scores indicating greater behavioural difficulties.

Versions
- ODDp (Appendix CC)
WP-CYP MINIMUM DATASET USER GUIDANCE

Background

The WP-CYP minimum dataset (MDS) includes key components from the following datasets:

- Adult IAPT ([http://content.digital.nhs.uk/iapt](http://content.digital.nhs.uk/iapt))
- Mental Health MDS ([http://content.digital.nhs.uk/mhsds](http://content.digital.nhs.uk/mhsds))

This guide is designed to provide standards concerning how the WP-CYP MDS should be collected by WP-CYPs and services. This covers both tracking services users through the care pathway and entering clinical outcome measurements throughout treatment.

The MDS comprises of four main components:

- Personal and demographic data for the child/young person
- Referral details (including tracking children/young people through the service)
- Appointment details (including treatment received and routine clinical outcomes)
- Waiting time paused (to ensure any children/young people whereby activity is temporarily suspended is recorded so not to impact on waiting list time and treatment duration)

Data Collection and Entry

As previously outlined, services are likely to have different data entry systems. Some services may use IAPTUS. Other services may use an Excel spreadsheet, specifically developed for data collection. Other services may develop their own data collection system. However, it is essential all data collected matches the data items set explicitly set out in this guide. Item options (where relevant) have been based on the NHS Data Model in order to aim for consistency in data collection across services, regardless of setting. Full instructions concerning how to collect the MDS are listed in Tables 7, 8, 9 and 10 on the following pages.

Table 7: Personal and Demographic Data

<table>
<thead>
<tr>
<th>Personal and Demographic Data</th>
<th>Description</th>
<th>Item Options (Where relevant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td>Description</td>
<td>Item Options (Where relevant)</td>
</tr>
<tr>
<td>NHS Number</td>
<td>The patients NHS number should be recorded if know. If unknown, the NHS number should be traced</td>
<td>1. Number present and verified</td>
</tr>
<tr>
<td>Status Identifier Code</td>
<td>This item is used to specify whether the NHS number is known.</td>
<td>2. Number present but not traced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Trace required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Trace attempted - No match or multiple match found</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Trace needs to be resolved - (NHS Number or PATIENT detail conflict)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Trace in progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Number not present and trace not required</td>
</tr>
<tr>
<td><strong>IAPT Local Patient Identifier</strong></td>
<td>This is the identification number provided to the child/young person by the service</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Organisation Code (Provider)</strong></td>
<td>This is the organisation code of your service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It you do not have an NHS identification code, please enter your full service name (or agreed abbreviation; however this must be used a standard across all CP-PWPs within service).</td>
<td></td>
</tr>
<tr>
<td><strong>Organisation Code (Educational Establishment)</strong></td>
<td>This is the organisation code of the education establishment the child/young person attends. Education codes are free to access on the Department for Education Website</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please enter the Unique Reference Number (URN)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(NB: This is currently not an option on CYP-IAPTUS however we will be examining whether this item could be added. For those WPs using IAPTUS, please enter the URN number in general clinical notes)</td>
<td></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td>Please provide the date of birth in the following format Day/Month/Year (00/00/0000)</td>
<td></td>
</tr>
</tbody>
</table>
| Gender (Patient Stated, Current) | Enter stated gender | 1. Not Known  
2. Male  
3. Female  
4. Where the patient does not classify themselves as either male or female. |
|----------------------------------|---------------------|------------------------------------------------|
| Postcode of Usual Address | Please enter postcode of usual address, which should be 5 – 7 digits. Follow one of the following formats (as appropriate), always leaving a space between the outward and inward code: A9 9AA  
A99 9AA  
AA9 9AA  
AA99 9AA | 1. Owner occupier  
2. Settled mainstream housing with family/friends  
3. Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)  
4. Tenant - Local Authority/Arms Length Management Organisation/Registered Landlord  
5. Tenant - Housing Association  
6. Tenant - Private landlord  
7. Other mainstream housing  
8. Rough sleeper  
9. Squatting  
10. Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)  
11. Sofa surfing (sleeps on different friends floor each night)  
12. Placed in temporary accommodation by Local Authority (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation  
13. Staying with friends/family as a short term guest  
14. Other homeless  
15. Supported accommodation (accommodation supported by staff or resident caretaker)  
16. Supported lodgings (lodgings supported by staff or resident caretaker)  
17. Supported group home (supported by staff or resident caretaker)  
18. Other accommodation with mental health care and support |
<p>| Accommodation Status | This is the accommodation status of the child/young person. Option 2 should be selected if living with family. Other options would be selected if the young person is living on their own/homeless/supported accommodation. IAPTUS users will have a longer drop down item option list, however inappropriate items have been removed from the Excel spreadsheet for ease of data collection. |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.</td>
<td>Independent hospital/clinic</td>
</tr>
<tr>
<td>20.</td>
<td>Specialist rehabilitation/recovery</td>
</tr>
<tr>
<td>21.</td>
<td>Other NHS facilities/hospital</td>
</tr>
<tr>
<td>22.</td>
<td>Foyer - accommodation for young people aged 16-25 who are homeless or in housing need</td>
</tr>
<tr>
<td>23.</td>
<td>Refuge</td>
</tr>
<tr>
<td>24.</td>
<td>Non-Mental Health Registered Care Home</td>
</tr>
<tr>
<td>25.</td>
<td>Other accommodation with care and support (not specialist mental health)</td>
</tr>
<tr>
<td>26.</td>
<td>Bail/Probation hostel</td>
</tr>
<tr>
<td>27.</td>
<td>Other accommodation with criminal justice support such as ex-offender support</td>
</tr>
<tr>
<td>28.</td>
<td>Extra care sheltered housing (also known as 'very sheltered housing'). For people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between schemes, but meals and some personal care are often provided.</td>
</tr>
<tr>
<td>29.</td>
<td>Other sheltered housing</td>
</tr>
<tr>
<td>30.</td>
<td>Mobile accommodation</td>
</tr>
<tr>
<td>31.</td>
<td>Not elsewhere classified</td>
</tr>
</tbody>
</table>

| General Medical Practice Code (GMPC) | Enter general practice code | See: [https://www.nhsbsa.nhs.uk/node/583](https://www.nhsbsa.nhs.uk/node/583) |

<table>
<thead>
<tr>
<th>Ethnic Category</th>
<th>Enter ethnic category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>British</td>
</tr>
<tr>
<td>2.</td>
<td>Irish</td>
</tr>
<tr>
<td>3.</td>
<td>Any other White background</td>
</tr>
<tr>
<td>4.</td>
<td>White and Black Caribbean</td>
</tr>
<tr>
<td>5.</td>
<td>White and Black African</td>
</tr>
<tr>
<td>6.</td>
<td>White and Asian</td>
</tr>
<tr>
<td>7.</td>
<td>Any other mixed background</td>
</tr>
<tr>
<td>8.</td>
<td>Indian</td>
</tr>
<tr>
<td>9.</td>
<td>Pakistani</td>
</tr>
<tr>
<td>10.</td>
<td>Bangladeshi</td>
</tr>
<tr>
<td>11.</td>
<td>Any other Asian background</td>
</tr>
<tr>
<td>12.</td>
<td>Caribbean</td>
</tr>
<tr>
<td>13.</td>
<td>African</td>
</tr>
<tr>
<td>14.</td>
<td>Any other Black background</td>
</tr>
<tr>
<td>15.</td>
<td>Chinese</td>
</tr>
<tr>
<td>16.</td>
<td>Any other ethnic group</td>
</tr>
<tr>
<td>17.</td>
<td>Not stated</td>
</tr>
</tbody>
</table>

| Religious or other Belief system affiliation | Enter religious or other belief system. Please be as specific as possible. A full drop down list is available on IAPTUS or other systems set up for data collection. | There are 159 items for Religious or Belief system, as such they are not all listed in this document. |
| Long Term Physical Condition | Enter whether the child/young person has a known physical health condition | 1. Yes  
2. No  
3. Unknown (Person asked and does not know or is not sure)  
4. Not Stated (Person asked but declined to provide a response) |
|-------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|
| Language Code (Preferred)     | This item is only completed for children/young people with visual or hearing impairments | 1. Braille - for people who are unable to see  
2. American Sign Language  
3. Australian Sign Language  
4. British Sign Language  
5. Makaton - devised for children and adults with a variety of communication and Learning Disabilities |
| Person Relationship (Main Carer) | Enter the relationship of the main carer to the child/young person | 1. Biological mother  
2. Biological father  
3. Step-Parent  
4. Stepmother  
5. Stepfather  
6. Grandmother  
7. Grandfather  
8. Aunt  
9. Uncle  
10. Sister  
11. Brother  
12. Other relative  
13. Adoptive mother  
14. Adoptive father  
15. Foster mother  
16. Foster father  
17. Residential Carer  
18. Other  
19. None - Lives Alone |
| Looked After Child Indicator | Is the child/young person a looked after child | 1. Yes - is a Looked After Child  
2. No - is not a Looked After Child |
| Safeguarding Vulnerability Factors Indicator | Indicate whether there are any Child Safeguarding vulnerability factors. | 1. Yes - Child Safeguarding vulnerability factors present  
2. No - Child Safeguarding vulnerability factors not present |
| Constant Supervision and Care Required due to Disability Indicator | Indicate whether the child/young person requires constant (round the clock) care and/or supervision for maintenance of their safety and/or wellbeing. | 1. Yes - PERSON requires constant care and/or supervision  
2. No - PERSON does not require constant care and/or supervision |
| Young Carer Indicator | Indicate whether the child/young person is | 1. Yes - child or young PERSON has a caring role for an ill or disabled parent, Carer or sibling |
a young carer e.g., do they have a caring role for an ill or disabled parent, carer or sibling.

2. No - child or young PERSON does not have a caring role for an ill or disabled parent, Carer or sibling

3. Not Stated (PERSON asked but declined to provide a response)

### Child Protection Plan Indication Code
Indicate whether the child/young person is, or has previously been, subject to a Child Protection Plan (CPP)

1. Has never been subject to a Child Protection Plan
2. Has previously been subject to a Child Protection Plan
3. Is currently subject to a Child Protection Plan

---

**Table 8: Referral Details**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Item Options (Where relevant)</th>
</tr>
</thead>
</table>
| NHS Number                        | The patients NHS number should be recorded if known. If unknown, the NHS number should be traced | 1. Number present and verified  
2. Number present but not traced  
3. Trace required  
4. Trace attempted - No match or multiple match found  
5. Trace needs to be resolved - (NHS Number or PATIENT detail conflict)  
6. Trace in progress  
7. Number not present and trace not required  
8. Trace postponed (baby under six weeks old) |
<p>| NHS Number Status Identifier Code | This item is used to specify whether the NHS number is known.                 |                                                                                              |
| IAPT Local Patient Identifier     | This is the identification number provided to the child/young person by the service |                                                                                              |
| Organisation Code (Provider)     | This is the organisation code of your service.                                | See: <a href="https://digital.nhs.uk/organisation-data-service">https://digital.nhs.uk/organisation-data-service</a> |
| Referral Request Received Date    | Enter the date the referral is received, rather than the date on the referral letter |                                                                                              |</p>
<table>
<thead>
<tr>
<th>Referral Request Received Time</th>
<th>Enter using the 24 hour clock. Please use the following format: XX:XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Referral for Mental Health</td>
<td>Enter the type of referring organisation. This is the referral agency/person/professional who originally referred the child/young person into the service. IAPTUS users will have a longer drop down item option list, however inappropriate items have been removed from the Excel spreadsheet for ease of data collection.</td>
</tr>
<tr>
<td>1. General Medical Practitioner Practice</td>
<td>2. Health Visitor</td>
</tr>
<tr>
<td>3. Other Primary Health Care</td>
<td>4. Self</td>
</tr>
<tr>
<td>5. Carer</td>
<td>6. Social Services</td>
</tr>
<tr>
<td>7. Education Service</td>
<td>8. Employer</td>
</tr>
<tr>
<td>11. Probation Service</td>
<td>12. Court Liaison and Diversion Service</td>
</tr>
<tr>
<td>15. Community-based Paediatrics</td>
<td>16. Other Independent Sector Mental Health Services</td>
</tr>
<tr>
<td>17. Voluntary Sector</td>
<td>18. Accident and Emergency Department</td>
</tr>
<tr>
<td>19. Other secondary care specialty</td>
<td>20. Temporary transfer from another Mental Health NHS Trust</td>
</tr>
<tr>
<td>21. Permanent transfer from another Mental Health NHS Trust</td>
<td>22. Community Mental Health Team (Learning Disabilities) ***</td>
</tr>
<tr>
<td>23. Community Mental Health Team (Child and Adolescent Mental Health) ***</td>
<td>24. Inpatient Service (Child and Adolescent Mental Health) ***</td>
</tr>
<tr>
<td>25. Inpatient Service (Learning Disabilities) ***</td>
<td>26. Asylum Services</td>
</tr>
<tr>
<td>27. Telephone or Electronic Access Service</td>
<td>28. Out of Area Agency</td>
</tr>
<tr>
<td>31. Other SERVICE or agency</td>
<td>32. Single Point of Access Service ****</td>
</tr>
<tr>
<td>33. Stepped up from low intensity Improving Access to Psychological Therapies Service *</td>
<td>34. Stepped down from high intensity Improving Access to Psychological Therapies Service *</td>
</tr>
</tbody>
</table>
| Referring Care Professional Staff Group | Enter the type of referring care professional staff group.  
Two additional items have been added to the Excel spreadsheet:  
• School Staff  
• Community Youth Worker  
We will aim to have these items added to IAPTUS, however in the meanwhile, IAPTUS users can select the following options instead:  
• School Nurse  
• Voluntary care worker | 35. Improving Access to Psychological Therapies Service ****  
36. Internal Referral ****  
1. Art Therapist  
2. Clinical Psychologist  
3. Dietitian  
4. Drama Therapist  
5. Music Therapist  
6. Occupational Therapist  
7. Orthoptist  
8. Physiotherapist  
9. Podiatrist  
10. Prosthetist  
11. Psychotherapist  
12. Radiographer  
13. Speech and Language Therapist  
14. Orthoptist  
15. Community Dentist  
16. CONSULTANT  
17. GENERAL MEDICAL PRACTITIONER  
18. General Practitioner With A Special Interest  
19. MIDWIFE  
20. District NURSE  
21. Health Visitor  
22. Macmillan NURSE  
23. School Nurse  
24. Specialist Nursing - Active Case Management (Community Matrons)  
25. Specialist Nursing - Arthritis Nursing/Liaison  
26. Specialist Nursing - Asthma and Respiratory Nursing/Liaison  
27. Specialist Nursing - Breast Care Nursing/Liaison  
28. Specialist Nursing - Cancer Related  
29. Specialist Nursing - Cardiac Nursing/Liaison  
30. Specialist Nursing - Children's Services  
31. Specialist Nursing - Community Cystic Fibrosis  
32. Specialist Nursing - Continence Services  
33. Specialist Nursing - Diabetic Nursing/Liaison  
34. Specialist Nursing - Enteral Feeding Nursing Services  
35. Specialist Nursing - Haemophilia Nursing Services  
36. Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)  
37. Specialist Nursing - Infectious Diseases  
38. Specialist Nursing - Intensive Care Nursing  
39. Specialist Nursing - Palliative/Respite Care |
| Primary Reason for Referral (Mental Health) | 1. Depression  
2. Anxiety  
3. Obsessive compulsive disorder  
4. Phobias  
5. Self-harm behaviours  
6. Conduct disorders  
8. Neurodevelopmental conditions  
9. Relationship difficulties  
10. Self - care issues  
11. Sleep difficulties  
12. Difficulties self-organising  
13. Behavioural and emotional regulatory difficulties  
14. Anger  
15. Self-esteem  
16. Stress/tension |
|-------------------------------------------|------------------------------------------------------------|
| The primary presenting condition or symptom for which the child/young person was referred to the service.  
IAPTUS users will have a longer drop down item option list, however inappropriate items have been removed from the Excel spreadsheet for ease of data collection. The following items have been added to the Excel | 40. Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison  
41. Specialist Nursing - Rehabilitation Nursing  
42. Specialist Nursing - Stoma Care Services  
43. Specialist Nursing - Tissue Viability Nursing/Liaison  
44. Specialist Nursing - Transplantation Patients Nursing Service  
45. Specialist Nursing - Treatment Room Nursing Services  
46. Specialist Nursing - Tuberculosis Specialist Nursing  
47. Specialist Nursing - Other Specialist Nursing  
48. Specialist Nursing - Safeguarding  
49. Practice Nursing  
50. Staff NURSE  
51. Other Registered NURSE  
52. Public Health NURSE  
53. Appliances Technician  
54. Audiologist  
55. Counsellor  
56. Nursery Nurse  
57. Play Therapist  
58. Social Worker  
59. Voluntary Care Worker  
60. Screener (in a National Screening Programme)  
61. Health Trainer (Non Clinical) *  
62. Health Trainer (Clinical) *  
63. Health Care Assistant *  
64. Health Care Support Worker *  
65. School Staff  
66. Community Youth Worker |
<table>
<thead>
<tr>
<th>Organisational Code (Referral)</th>
<th>The organisational code of the referring organisation. If you do not have access to NHS Digital, please enter the full name, or service wide agreed standard abbreviation, or the referring organisation.</th>
<th>See: <a href="https://digital.nhs.uk/organisation-data-service">https://digital.nhs.uk/organisation-data-service</a></th>
</tr>
</thead>
</table>
| Service Request Acceptance Indicator | Select the appropriate option; this is **following** the initial APPOINTMENT with the CY-PWP | 1. Yes  
2. No |
| Previous Symptom Indicator | An indication of whether this is a recurrence of a previously diagnosed condition as stated by a person. This should be determined in assessment | 1. Yes  
2. No  
3. Unknown (PERSON asked and does not know or is not sure)  
4. Not Stated (PERSON asked but declined to provide a response) |
| Spell End Code (Reason Terminating Treatment) | Please write the reason for terminating WP-CYP support. This includes those children/young people assessed by WP-CYPs but not deemed suitable for support, or declined support. | 1. Not suitable for Improving Access to Psychological Therapies Service - no action taken or directed back to referrer  
2. Not suitable for the Improving Access to Psychological Therapies Service - signposted elsewhere with mutual agreement of PATIENT  
3. Discharged by mutual agreement following advice and support  
4. Referred to another therapy service by mutual agreement  
5. Suitable for Improving Access to Psychological Therapies Service, but |
| End Date | Please enter the end date of service support. Use the day/month/year format. |
|——— | ———— |
| Organisational Code (Signposting) | Organisation code if child/young person referred onto another organisation/service. This can include internal service referrals. If you do not have access to NHS digital, please use service wide agreed name or acronym for the organisation. | See: [https://digital.nhs.uk/organisation-data-service](https://digital.nhs.uk/organisation-data-service) |

**Table 9: Appointment Details**

**Appointment Details**

To be entered for every contact with the child/young person / parent / carer

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Item Options (Where relevant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number</td>
<td>The patients NHS number should be recorded if know. If unknown, the NHS number should be traced</td>
<td>1. Number present and verified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Number present but not traced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Trace required</td>
</tr>
</tbody>
</table>

**PATIENT declined treatment that was offered**

6. Deceased (Assessed Only)

7. Not Known (Assessed Only)

8. Stepped up from low intensity Improving Access to Psychological Therapies Service

9. Stepped down from high intensity Improving Access to Psychological Therapies Service

10. Completed scheduled treatment

11. Dropped out of treatment (unscheduled discontinuation)

12. Referred to non-Improving Access to Psychological Therapies Service

13. Deceased (Assessed and Treated)

14. Not Known (Assessed and Treated)
<table>
<thead>
<tr>
<th>IAPT Local Patient Identifier</th>
<th>This is the identification number provided to the child/young person by the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation Code (Provider)</td>
<td>This is the organisation code of your service</td>
</tr>
<tr>
<td>Appointment Date</td>
<td>Enter the date of the appointment. Use the following date format: Day/Month/Year</td>
</tr>
<tr>
<td>Appointment Time</td>
<td>Enter using the 24 hour clock. Please use the following format: XX:XX</td>
</tr>
<tr>
<td>Care Professional Role</td>
<td>The WP-CYP specific options are not currently on IAPTUS. IAPTUS users should use the PWP option for now, however we will be requesting Wellbeing Practitioner – Children &amp; Young People (WP-CYP) is added to IAPTUS</td>
</tr>
<tr>
<td>1. Psychological Well-being Practitioner (PWP) - Trainee</td>
<td></td>
</tr>
<tr>
<td>2. Psychological Well-being Practitioner (PWP) – Qualified</td>
<td></td>
</tr>
<tr>
<td>3. Wellbeing Practitioner – Children &amp; Young People (WP-CYP) - Trainee</td>
<td></td>
</tr>
<tr>
<td>4. Wellbeing Practitioner – Children &amp; Young People (WP-CYP) - Qualified</td>
<td></td>
</tr>
<tr>
<td>Attend or Did not Attend Code</td>
<td>1. Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT</td>
</tr>
<tr>
<td>2. Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen</td>
<td></td>
</tr>
<tr>
<td>3. PATIENT arrived late and could not be seen</td>
<td></td>
</tr>
<tr>
<td>4. APPOINTMENT cancelled by, or on behalf of, the PATIENT</td>
<td></td>
</tr>
<tr>
<td>5. Did not attend - no advance warning given</td>
<td></td>
</tr>
<tr>
<td>6. APPOINTMENT cancelled or postponed by the Health Care Provider</td>
<td></td>
</tr>
<tr>
<td>7. Not applicable - APPOINTMENT occurs in the future *</td>
<td></td>
</tr>
<tr>
<td>Clinical Contact Duration of Appointment (minutes)</td>
<td>Please enter the total duration of the appointment in minutes. This does not include administration or travel time.</td>
</tr>
</tbody>
</table>
| Appointment Type (IAPT) | Please enter the type of appointment. | 1. Assessment  
2. Treatment  
3. Assessment and Treatment  
4. Review Only  
5. Review and Treatment  
6. Follow-up APPOINTMENT after treatment end  
7. Other |
|---|---|---|
| Appointment Location Type | Please enter the location of the appointment. This item is only necessary if the appointment is delivered in a location outside of your standard service premises. IAPTUS users will have a longer drop down item option list, however inappropriate items have been removed from the Excel spreadsheet for ease of data collection. | 1. PATIENT's Home  
2. Carer's Home  
3. PATIENT's Workplace  
4. Other PATIENT Related Location  
5. Primary Care Health Centre  
6. Polyclinic  
7. General Medical Practitioner Practice  
8. Dental Practice  
9. OPHTHALMIC MEDICAL PRACTITIONER Premises  
10. Walk In Centre  
11. Out of Hours Centre  
12. Emergency Community Dental Service  
13. Out-Patient Clinic  
14. WARD  
15. Day Hospital  
16. Accident and Emergency or Minor Injuries Department  
17. Other Departments  
18. Children's Home  
19. Day Centre  
20. Resource Centre  
21. Sure Start Children’s Centre  
22. Child Development Centre  
23. School  
24. Further Education College  
25. University  
26. Nursery Premises  
27. Other Childcare Premises  
28. Training Establishments  
29. Other Educational Premises  
30. Probation Service Premises  
31. Police Station / Police Custody Suite  
32. Immigration Removal Centre  
33. Street or other public open space  
34. Other publicly accessible area or building  
35. Voluntary or charitable agency premises  
36. Dispensing Optician Premises  
37. Dispensing Pharmacy Premises  
38. Other locations not elsewhere classified |
<table>
<thead>
<tr>
<th>Consultation Medium Used</th>
<th>Face to face communication mode</th>
<th>Therapy Type (IAPT)</th>
</tr>
</thead>
</table>
| 1. Face to face communication  
2. Telephone  
3. Telemedicine web camera  
4. Talk type for a PERSON unable to speak  
5. Email **  
6. Short Message Service (SMS) - Text Messaging **  
7. Other * | If the appointment was face-to-face, please enter the type of face-to-face contact.  
The following options are not currently available on IAPTUS but are on the Excel spreadsheet:  
1. Parent/Carer Only  
2. Accompanied by Parent/Carer  
We will look to have these items added to IAPTUS in the longer term. For now, IAPTUS users should add whether Parent/Carer only, or Accompanied by Parent/Carer to clinical notes. | For all treatment / support session, please add the type of treatment delivered.  
The following items have been added to the Excel spreadsheet and we will request these are added to IAPTUS. For now, if IAPTUS users are supporting one of these interventions, please select “Other Low Intensity” and add exact treatment delivered to clinical notes:  
1. Parenting / SLT strategies for sleeping, toileting and feeding  
1. Guided Self Help (Book)  
2. Non-guided Self Help (Book)  
3. Guided Self Help (Computer)  
4. Non-Guided Self Help (Computer)  
5. Behavioural Activation (Low Intensity)  
6. Psychoeducational peer support  
7. Other Low Intensity  
8. Parenting / SLT strategies for sleeping, toileting and feeding  
9. Behavioural experiments  
10. Problem Solving (Depression)  
11. Problem Solving & Worry Time (GAD)  
12. Exposure and habituation  
13. Exposure and response prevention  
14. Cognitive Restructuring  
15. Sleep Hygiene  
16. Parent led-CBT  
17. Behavioural and Emotional Regulation Strategies |
| 2. Behavioural experiments          | 18. Lifestyle Management          |
| 3. Problem Solving (Depression)     | 19. Coping Cat                    |
| 4. Problem Solving & Worry Time (GAD) | 20. Timd 2 Tiger                 |
| 5. Exposure and habituation         |                                 |
| 6. Exposure and response prevention |                                 |
| 7. Cognitive Restructuring          |                                 |
| 8. Sleep Hygiene                    |                                 |
| 9. Parent led-CBT                   |                                 |
| 10. Behavioural and Emotional Regulation Strategies | |
| 11. Lifestyle Management            |                                 |
| 12. Coping Cat                      |                                 |
| 13. Timd 2 Tiger                    |                                 |

**Psychotropic Medication Usage**

| 1. Prescribed but not taking          |                                 |
| 2. Prescribed and taking              |                                 |
| 3. Not Prescribed                     |                                 |
| 4. Unknown (PERSON asked and does not know or is not sure) | |
| 5. Not Stated (PERSON asked but declined to provide a response) | |

**Current View**

Entered for every assessment conducted

**Full RCADS – Self-Reported**

Entered if:
- Main presenting problem depression and/or anxiety
- 8 years or above

Taken in:
- Assessment
- Final treatment session

**Full RCADS – Parent/Carer Reported**

Entered if:
- Main presenting problem depression and/or anxiety
- Under 8 years
- Optionally collected for 8 years and above (if feasible/desirable)

Taken in:
- Assessment
- Final treatment session
| RCADS GAD Subscale – Self-Report | Entered if:  
• Main presenting problem GAD  
• 8 years or above  

Taken in:  
• Every treatment session accept final when full RCADS taken |
|---|---|
| RCADS GAD Subscale – Parent/Carer Report | Entered if:  
• Main presenting problem GAD  
• Under 8 years  

Taken in:  
Every treatment session accept final when full RCADS taken |
| RCADS Panic Subscale – Self-Report | Entered if:  
• Main presenting problem Panic  
• 8 years or above  

Taken in:  
Every treatment session accept final when full RCADS taken |
| RCADS Panic Subscale – Parent/Carer Report | Entered if:  
• Main presenting problem Panic  
• Under 8 years  

Taken in:  
Every treatment session accept final when full RCADS taken |
| RCADS Social Anxiety Disorder Subscale – Self-Report | Entered if:  
• Main presenting problem Social Anxiety Disorder  
• 8 years or above  

Taken in:  
Every treatment session accept final when full RCADS taken |
<p>| RCADS Social Anxiety Disorder Subscale – | Entered if: |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Carer Report</td>
<td>- Main presenting problem Social Anxiety Disorder</td>
</tr>
<tr>
<td></td>
<td>- Under 8 years</td>
</tr>
<tr>
<td>Taken in:</td>
<td>Every treatment session accept final when full RCADS taken</td>
</tr>
<tr>
<td>RCADS OCD Subscale – Self-Report</td>
<td>Entered if:</td>
</tr>
<tr>
<td></td>
<td>- Main presenting problem OCD</td>
</tr>
<tr>
<td></td>
<td>- 8 years or above</td>
</tr>
<tr>
<td>Taken in:</td>
<td>Every treatment session accept final when full RCADS taken</td>
</tr>
<tr>
<td>RCADS OCD Subscale – Parent/Carer Report</td>
<td>Entered if:</td>
</tr>
<tr>
<td></td>
<td>- Main presenting problem OCD</td>
</tr>
<tr>
<td></td>
<td>- Under 8 years</td>
</tr>
<tr>
<td>Taken in:</td>
<td>Every treatment session accept final when full RCADS taken</td>
</tr>
<tr>
<td>RCADS Depression Subscale – Self-Report</td>
<td>Entered if:</td>
</tr>
<tr>
<td></td>
<td>- Main presenting problem Depression</td>
</tr>
<tr>
<td></td>
<td>- 8 years or above</td>
</tr>
<tr>
<td>Taken in:</td>
<td>Every treatment session accept final when full RCADS taken</td>
</tr>
<tr>
<td>RCADS Depression Subscale – Parent/Carer Report</td>
<td>Entered if:</td>
</tr>
<tr>
<td></td>
<td>- Main presenting problem Depression</td>
</tr>
<tr>
<td></td>
<td>- Under 8 years</td>
</tr>
<tr>
<td>Taken in:</td>
<td>Every treatment session accept final when full RCADS taken</td>
</tr>
<tr>
<td>Goal Based Outcomes</td>
<td>Entered if:</td>
</tr>
<tr>
<td></td>
<td>- Main presenting problem depression and/or anxiety</td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **ORS** | Entered if:  
- Main presenting problem depression and/or anxiety  
- 13 years or above  
  
Taken in:  
- Assessment  
- Every treatment session |
| **CORS** | Entered if:  
- Main presenting problem depression and/or anxiety  
- Aged 6-12  
  
Taken in:  
- Assessment  
- Every treatment session |
| **SFQ** | Entered if:  
- Main presenting problem depression and/or anxiety  
- Parent/carer, or child/young person reported.  
  
Taken in:  
- Assessment  
- Every treatment session  
- The Session Feedback Questionnaire is not currently on IAPTUS. IAPTUS users should keep paper copies of the measure to be entered when this questionnaire has been added to IAPTUS. |
| **ESQ** | Taken in:  
- Assessment (regardless of suitability for treatment)  
- Every treatment session |
| **SDQ—Parental - Full** | Entered if:  
- Main presenting problem behavioural/parental  
  
Taken in:  
- Assessment  
- Final treatment session |
<p>| <strong>SDQ – Child - Full</strong> | Entered if: |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Entered if:</th>
<th>Taken in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDQ – Parental – Impact</td>
<td>• Main presenting problem behavioural/parental</td>
<td>• Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Final treatment session</td>
</tr>
<tr>
<td>SDQ – Child – Impact</td>
<td>• Main presenting problem behavioural/parental</td>
<td>• Every treatment session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(except final, where full SDQ taken)</td>
</tr>
<tr>
<td>BP-SES</td>
<td>• Main presenting problem behavioural/parental</td>
<td>• Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Every treatment session</td>
</tr>
<tr>
<td>ODDp</td>
<td>• Main presenting problem behavioural/parental</td>
<td>• Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Every treatment session</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>Item Options (Where relevant)</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| NHS Number                 | The patients NHS number should be recorded if know. If unknown, the NHS number should be traced | 9. Number present and verified  
10. Number present but not traced  
11. Trace required  
12. Trace attempted - No match or multiple match found  
13. Trace needs to be resolved - (NHS Number or PATIENT detail conflict)  
14. Trace in progress  
15. Number not present and trace not required  
16. Trace postponed (baby under six weeks old) |
| NHS Number Status Identifier Code | This item is used to specify whether the NHS number is known. |  |
| IAPT Local Patient Identifier | This is the identification number provided to the child/young person by the service |  |
| Organisation Code (Provider) | This is the organisation code of your service | See: [https://digital.nhs.uk/organisation-data-service](https://digital.nhs.uk/organisation-data-service) |
| ACTIVITY SUSPENSION START DATE | The date activity suspension starts. Use day/month/year format |  |
| ACTIVITY SUSPENSION END DATE  | The date activity suspension ends. Use day/month/year format |  |
| ACTIVITY SUSPENSION REASON   | PATIENT unavailable due to holiday PATIENT unavailable due to other health needs PATIENT stated not available - other reason |  |
REFERENCES


SAMSHA’s National Registry of Evidence-Based Programs and Practices. (2015). *Partners for change outcome management system (PCOMS)*. International Centre for Clinical Excellence


