15) Steps in Interpretation of case reports

(A sample report is attached in Item 20 under Support | Training Items under BCFPI's main menu)

Step 1: Consider Limits to the Tools.

It is important to remind yourself of the limits of this brief questionnaire or interview. As noted above, the tools do not constitute a comprehensive assessment or yield diagnoses, they reflect the perspective of a single informant, and the inevitably yield a certain percentage of false positive and false negative results. Parents, for example, may have more difficulty judging the severity of a child's anxiety or mood problems and may be unaware of antisocial behaviour such as theft or substance abuse. Other problems, such as Regulating Attention, Impulsivity, and Activity Level, are often most evident in classroom settings. Parental mood may influence child behaviour directly, or effect ratings indirectly by influencing parental perceptions of child problems (Boyle & Pickles, 1997a,b; Maoz et al., 2015).

Step 2: Review Narrative Description of Presenting Concerns *(interview only)*

Print the Standard Parent Report. Review the problems identified by the informant and accompanying narrative details recorded in the Comments section at the top of the Standard Parent Report. The Comments section should include important contextual information such as a recent divorce or custody dispute, additional concerns emerging during the interview, specific service requests, etc.

Step 3: Review Demographic Data

Review the demographic information summarized in the Standard Parent Report. Demographic measures often act as general risk or protective factors. Limited education, economic disadvantage, and single parent status, for example, may increase child risk (Jakovljevic et al., 2016; Lipman & Boyle, 2008; Offord, Boyle, & Racine, 1990) and reduce the likelihood of service utilization (Cunningham, et al., 2000; Offord et al., 1987; Santiago et al., 2013). Higher educational and economic levels, in contrast, may act as protective factors and may be linked to improved service utilization.

Step 4: Review the Composite Scores

Using the Standard Parent Report, review the composite Externalizing, Internalizing, and Total Problem T scores. Composite scores are more reliable measures of child functioning than individual subscales. They often constitute better estimates of overall risk, better measures of service outcome, and better predictors of the longer term course of child problems than individual subscales.

Step 5: Examine Patterns of Composite Scale Scores

Examine the pattern of composite Externalizing and Internalizing child problem T scores. Epidemiological research consistently yields three clusters of clinical problems: (1) High Externalizing problems and Low Internalizing problems, (2) High Internalizing problems and Low Externalizing problems, (3) a combination of High Externalizing and High Internalizing problems. These clusters are important to the estimation of risk, design of service plans, the measurement of outcome, and the prediction of long term outcome.

Step 6: Review Individual Mental Health Subscale Scores

Review individual Mental Health subscale scores (e.g. Cooperating, Managing Anxiety, Managing Mood, etc.). T scores of 70, higher than 98% of the norming population, are generally considered to be a significantly elevated score. A T score of 65 (greater than 93% of the population) might be considered a borderline score.

Step 7: Examine Patterns of Subscale Scores

Next, examine patterns of subscale T scores. Many children present with common combinations of elevated subscale scores (Agnew-Blais, 2017; Offord, et al., 1987). For example, approximately 40 to 50% of children who have difficulty regulating attention, impulsivity and activity level also have difficulty cooperating with adults and peers (Agnew-Blais, 2017; Szatmari, Boyle, & Offord, 1989). Children who have difficulty regulating attention, impulsivity and activity level also often evidence problems managing anxiety or mood (Agnew-Blais, 2017; March, et al., 2000). Combinations of problems influence risk, treatment selection, response to treatment (Agnew-Blais, 2017; March, et al., 2000), and long-term outcome.

Step 8: Review Item Responses

Examine responses to individual items and clusters of items. Which items contributed to subscale T scores above 70? Which items accounted for borderline scores?

Step 9: Review Contextual Narrative *(interview only)*

Read the contextual narrative comments recorded by the interviewer in the text box below each question. The contextual narrative may suggest other problems that need to be explored in follow-up

interviews, situational influences on child behaviour, precipitating factors, or clues regarding potentially useful interventions.

Step 10. Consider Child Functioning Scores

Review the Child Functioning Scale score. This score provides an estimate of the impact of the mental health problems on the child's social participation, social relationships, and school participation. Higher T scores reflect higher levels of functional impairment. These scores provide an important check on the severity of the problems noted in the mental health subscales.

The levels of child functioning impairment associated with different mental health problems vary considerably. For example, high T scores on the Managing Mood subscale are typically associated with higher levels of impairment than high T scores on the Managing Anxiety subscale.

Next, examine individual items on the Child Functioning Scale, as they may suggest important targets for intervention. A child whose social participation has been limited as a result of difficulties managing mood or anxiety, for example, may benefit from an intervention designed to increase participation in enjoyable extracurricular activities and establish new friendships.

Low T scores on the Child Functioning Scale may reflect child strengths. For example, a child whose school participation and achievement does not appear to have been affected by their mental health difficulties has assets that can be capitalized upon when planning interventions.

Step 11: Examine the Impact on Family Scale Score

This score provides an estimate of the impact of child mental health problems on family activities and functioning. Higher T scores reflect higher levels of family distress and risk. This score is important in understanding contextual factors that may influence service planning and outcome.

Next, examine the Impact on Family items, which describe the extent to which problems may be associated with a breakdown in family networks, conflict between partners, or overall distress regarding the child. Scores on these items provide clues regarding issues that need to be addressed in follow-up assessments, potential targets for intervention, and family strengths. For example, if the child's behaviour has become a source of conflict between partners, interventions (readings, books, videos, or workshops) designed to improve co-parenting communication, problem solving, and conflict resolution skills may be helpful.

Step 12: Check for Abuse *(interview only)*

Examine the 4 items on emotional abuse, physical abuse, sexual abuse, and exposure to domestic violence. Positive responses to these questions require narrative follow-up and may necessitate a report to child protection services.

Step 13: Examine Informant Mood

Examine Informant Mood T scores. Note that high T scores on this scale are associated with more depressed mood.

Step 14: Examine Family Functioning

Examine T score for Family Functioning. Note that the positively worded items on this subscale are reversed when the BCFPI software computes T scores. High T scores on this scale are associated with more ***dysfunctional*** family relationships.

Step 15: Other Items Available for Inquiry Problems *(interview only)*

Review responses to the Other Items Available for Inquiry questions. Determine whether other issues emerging during the interview must be followed up with more detailed clinical assessments. For example, in a proportion of children with difficulties managing anxiety, concerns regarding very specific fears or phobias may be noted. Some children who have difficulty regulating attention, impulsivity, and activity level may also have learning problems or in some cases movement problems such as tics or vocalizations.

Step 18: Consider Service Priorities

There is no simple formula for determining service priorities. However, a clinician with the training and experience needed to interpret the scores can use them, in combination with other available information, to consider service priorities. Several factors should be taken into account when considering service priorities.

- Higher T scores generally suggest a higher level of risk than lower T scores.

- With some notable exceptions, children with high T scores on several mental health subscales may be at higher risk than those with a high T score on a single subscale. For example, children with high T scores on both the Regulation of Attention, Impulsivity, and Activity level ***and*** Cooperating subscales may be at higher risk than those with high T score on either subscale alone.

- Children with high T scores on the Child Functioning Scale are at higher risk than those with lower scores. Within this scale, items indicating poor social relationships may be a particularly significant predictor of longer-term difficulties (Goodman et al., 2015; Hay, 2005; Offord et al., 1990; Offord et al., 1992). Note that some of the mental health subscales are correlated with higher functional impairment than others. Table 18 in Chapter 9, for example, shows that, in clinic samples, Managing Mood, Cooperating, and Regulating Attention, Impulsivity, and Activity Level are more closely linked to Child Functioning scores than Separation from Parents or Managing Anxiety.

- Children with high Impact on Family Scale scores may be at greater risk than those with low scores (Niccols et al., 2018; Offord, et al., 1990; Offord, et al., 1992). Table 19 in Chapter 9 shows that Externalizing problems seem to be associated with higher Impact on Family Scale scores (more family impairment). Among Internalizing problems, Managing Mood is associated with higher Impact on Family Scale scores.

- Certain demographic factors are associated with risk for childhood mental health problems. For example, economic disadvantage, limited maternal education, and single parent status appear to be associated with higher risk and poorer outcomes (Jakovljevic et al., 2016; Lipman & Boyle, 2008; Offord, Boyle, & Racine, 1990; Offord, et al, 1992) and a lower probability of service utilization (Cunningham, et al.,1995, 2000; Offord et al., 1987; Santiago et al., 2013).

- Other variables may act as ***protective factors***. For example, while economic disadvantage or limited maternal education may constitute risk factors, higher income and maternal education may represent protective factors. Similarly, while poor peer relationships are a significant risk factor, good peer relationships appear to act as a protective factor (Goodman et al., 2015; Hay, 2005; Offord, et al., 1990). Other evidence suggests that participation in sports and extracurricular activities may act as protective factors.

Step 19: Plan Follow-up Assessments

Reviewing the Brief Child and Family Intake and Outcome System data for an individual client prior to conducting follow-up clinical assessments allows interviewers to plan questions or select assessment tools that pursue concerns previously identified. This approach contributes to a comprehensive service delivery process and uses valuable clinical time efficiently. For example, composite scores, subscale scores, and combinations of scores may suggest problems that should be pursued in more detailed differential diagnostic assessments. The possibility of a depressive disorder, for example, should be considered when parents report high T scores on the Managing Mood subscale.

Step 20: Consider Potential Comorbid Problems

Given the literature on childhood behavioural and emotional problems, mental health subscale scores may suggest potential comorbid difficulties not addressed in these brief tools but that should be considered when planning follow-up assessments. For example, children with high T scores on the Regulating Attention, Impulsivity, and Activity Level subscale may be at increased risk of Tourettes syndrome. Clinicians should be alert to the possibility of these potential comorbid difficulties.

The mental health subscale scores also may suggest potentially comorbid family problems that need to be pursued in follow-up assessments. The types of oppositional behaviours measured in the Cooperating subscale and the antisocial behaviours reflected in the Regulating Conduct subscale, for example, may be associated with ineffective discipline, marital conflict, domestic violence, or parental depression. One question regarding quarreling between parents in the Impact on Family Scale may provide clues regarding difficulties in this area. The Family Functioning scale provides additional information regarding family functioning. Concerns in these areas should be pursued in follow-up clinical assessments and considered in the development of service plans.

Step 21: Consider Interim Service Plans

In many cases, clients must wait for more comprehensive assessments and services. In the interim, however, the Readiness subscale may suggest resources that parents can use while waiting. These resources might include books on child development, videotapes on child behaviour management, community-based parenting groups (Cunningham, Bremner, & Boyle, 1995; Ryan, O'Farrelly, & Ramchandani, 2017), local parent support groups, or websites. Accumulating evidence suggests that these types of resources can make a meaningful contribution to client change (Andrews, Swank, Foorman, & Fletcher, 1995; Ryan, O'Farrelly, & Ramchandani, 2017). Developing interim service plans capitalizes on the readiness for change and momentum that is often present when families initiate service contacts.

Step 22: Consider Service Plan Options

Mental health subscale scores also may suggest different interventions that might be considered when developing more detailed assessment and service plans. Much of the literature on evidenced-based treatment is linked to the effectiveness of interventions for specific groups of children and their families (Kazdin & Weisz, 1998; Schwartz, Waddell, Barican, & Gray-Grant, 2015). Many of the most promising evidenced-based interventions are manualized for specific problem clusters included in the mental health subscales (Chambless & Hollon, 1998; Schwartz et al., 2015). For example, clinical trials suggest that different cognitive-behavioural, family, and pharmacological interventions are helpful for children with ADHD (MTA Cooperative Group, 1999; Schwartz et al., 2015), conduct disorder, anxiety disorders (Labellarte, et al., 1999; Schwartz et al., 2015; Silverman, et al., 1999), and mood disorders (Kolko, Bren, Baugher, Bridge, & Birmaher, 2000; Schwartz et al., 2015).