## 10) Understanding BCFPI Scores, Scales and Response Patterns

(A sample report is available as item # 20 in BCFPI's Main menu, under BCFPI Support | Training Items:
20) Sample Case report

### Who Should Interpret the Case Reports?

As tools with standardized scores, they are designed to be *interpreted by mental health professionals who have a graduate degree*. Graduate coursework should have provided a knowledge of child development, an in-depth understanding of childhood behavioural and emotional problems, training in the psychometric principles on which these measures are based, and knowledge of evidence-based service options for the types of problems they address. Individuals interpreting the interview must be certified as a BCFPI interviewer and all users must have access to supervision, consultation, and support. The Brief Child and Family Intake and Outcomes System tools are best interpreted by a team with expertise in children's mental health difficulties, psychometric measures, and evidence-based best practices.

### Limitations to Interpretation of the Tools

It is important that several limitations be considered when interpreting the scores:

- ***The subscales are not diagnostic***

In labeling the subscales, we have used terms that describe the behaviours and processes measured by the questions composing the subscales. For example, the Managing Anxiety subscale reflects the extent to which the child worries about a variety of situations. High scores reflect more difficulty with the management of anxiety. The individual subscales do not yield sufficient information to make a diagnosis. The diagnosis of childhood disorders requires more comprehensive information, data from multiple informants, evidence regarding the duration of these problems, an estimate of the functional impact of symptoms, and the exclusion of other potential explanations for the child's difficulties. In the Province of Ontario, the communication of a diagnosis is a protected act reserved for Registered Psychologists and Physicians.

- ***The subscales are descriptive measures***

The subscales provide descriptive information that does not reflect assumptions regarding the etiology or cause of the child's problems. High scores on the Regulation of Attention, Impulsivity, and Activity level, for example, may reflect disruptions in the child's life (e.g., change in schools), learning disabilities, anxiety disorders, depressive disorders, medical conditions, or ADHD. Follow-up assessments are necessary to establish a diagnosis, formulate hypotheses regarding the etiology of the child's problems, and to consider the best available service options.

- ***The tools do not provide a comprehensive assessment***

The items are designed to screen for common referral concerns, estimate their impact on child and family functioning, consider interim service options, and anticipate barriers which might prevent a family from using a potentially helpful services. The items will not detect all potential referral problems. For example, there are no items regarding thought disorders or Tourette's syndrome. These problems are often identified during discussions regarding the client's general concerns or may emerge in the context of an interview. Many of these problems can be recorded in the interview's Other Concerns Checklist and noted in the Comments section.

.● ***The subscale results may yield both false positive and false negative results***

Like all standardized measurement tools (and clinical interviews), both ***false positive*** and ***false negative*** results are possible. Some children with t-scores below 70 on an individual subscale may well have difficulties in that area. This situation is referred to as a ***false negative*** result. For example, a percentage of children with t-scores below 70 on the Managing Anxiety subscale may actually have significant difficulties with anxiety.

On the other hand, children with t-scores above 70 on an individual subscale may not have difficulties in that area. This situation is referred to as a ***false positive*** result. For example, a child with a t-score of 70 or above on the Managing Mood subscale may not have difficulties with mood. The percentage of children showing false positive and false negative results may vary across ages, subscales, or organizational settings. These tools should ***NOT*** be used as a stand-alone screening, triaging, or treatment decision-making tool.

- ***The scores reflects the perspective of the informant completing the tool***

Mothers, fathers, and other raters observe children in different situations. The activities, rules, and people present in different settings vary. Mothers, fathers, and other raters may have different perspectives regarding the types of behaviours that are common at different stages in the child's development.

Moreover, youth completing a self-report tool often have a different perspective on their feelings and behaviour. Parents, for example, may not be aware of issues that are a source of anxiety to youth. The reports of mothers, fathers, and youth, therefore, may vary and should often be considered in follow-up clinical assessments.

- ***The tools are normed on infants 8-17 months, toddlers 18-36 months, preschoolers 3-5 years, children 6-12 years, and adolescents 13-18.99 years old***

The norms were derived from studies conducted with nationally representative samples of parents of Canadian children (e.g., Niccols et al., 2018). BCFPI software calculates scores on the basis of age-appropriate comparison data.

## Interpreting T-Scores

The ***Standard Parent Report*** (see example at the end of this chapter) compares an individual child's scores to a nationally representative sample of parents of Canadian children (e.g., Niccols et al., 2018). These norms should be used when interpreting the subscale scores.

- A child's score is compared to those of boys or girls who are in their same age range (8-17 months, 18-36 months, 3-5 years, 6-12 years, or 13-18 years).

- The subscale results are summarized as T scores. T scores are standardized measures based on a distribution with a mean of 50 and a standard deviation of 10. The average T score for the normative sample on which the score is based is 50.

- A T score of 50 corresponds to a percentile score of 50. The scores of 50% of the population are lower than a T score of 50. On the graphical reports, a T score of 50 is depicted by a bolded horizontal line.

- The scores of approximately 84% of the population are lower than a T score of 60.

- The scores of approximately 93% of the population are below a T score of 65. When a T score is below 65, the title of the subtest is depicted in green.

- A score at or above the 65$^{th}$ but below the 70$^{th}$ percentile is considered a ***borderline*** score. On the graphical reports, a T score of 65 is depicted by a dashed blue line.

- When a T score is above 65 and below 70, the title of the subtest is depicted in blue.

- The scores of approximately 98% of the population are lower than a T score of 70. On the graphical reports, a T score of 70 is depicted by a dashed red line. When a child's score reaches a T score of 70, the title of the subtest is depicted in red.