

CGAS Rating Guide

The coding guidance notes and vignettes are provided to assist in the process of rating the clinical severity of all the young people who have been admitted to your service. The vignettes provided were originally developed for the 'Children and Young Persons In-patient Evaluation (CHYPIE) Study.

CODING THE CGAS

Code the CGAS on the basis of your patient's worst level of emotional and behavioural functioning in the past three months by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. The scores can range from 1, which is the very worst, to 100, which is the very best. Use intermediary levels (e.g. 35, 58, 62).

*Rate actual functioning regardless of treatment or prognosis.
Do not count functional physical impairments unless they are clearly related to emotional functioning, i.e. functional handicap due to cerebral palsy or blindness would not be coded, but difficulty as a consequence of soiling would be. (Note that the HoNOSCA coding differs here – cf area A6.)*

It will be helpful to take into account how your patient functions in four major areas:

1. *At home with family*
2. *At school*
3. *With friends*
4. *During leisure time*

The overall score will represent an overall rating from these four areas.

Locating the score

1. Locate a decile based on the descriptions that follow.
2. Consider the appropriate decile in thirds and locate the functioning in the upper middle or lower third of the decile.
3. Choose a score within that third as the overall score.

CHILDREN'S GLOBAL ASSESSMENT SCALE

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Adaptation of the Adult Global Assessment Scale
(Robert L. Spitzer, M.D., Nathan Gibbon, M.S.W., Jean Endicott, Ph.D.)

The examples of behaviour provided are only illustrative and are not required for a particular rating.

Specified time period: 1 month

100-91 DOING VERY WELL

Superior functioning in all areas (at home, at school and with peers), involved in a range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc.). Likeable, confident, everyday worries never get out of hand. Doing well in school. No symptoms.

90-81 DOING WELL

Good functioning in all areas. Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally "blow-ups" with siblings, parents or peers).

80-71 DOING ALL RIGHT –minor impairment

No more than slight impairment in functioning at home, at school, or with peers. Some disturbance of behaviour or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sib) but these are brief and interference with functioning is transient, such children are only minimally disturbing to others and are not considered deviant by those who know them.

70-61 SOME PROBLEMS - in one area only

Some difficulty in a single area, but generally functioning pretty well, (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky petty theft; consistent minor difficulties with school work, mood changes of brief duration, fears and anxieties which do not lead to gross avoidance behaviour; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60-51 SOME NOTICEABLE PROBLEMS – in more than one area

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

50-41 OBVIOUS PROBLEMS – moderate impairment in most areas or severe in one area.

Moderate degree of interference in functioning in most social areas or severe impairment functioning in one area, such as might result from for example , suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.

40-31 SERIOUS PROBLEMS – major impairment in several areas and unable to function in one area

Major impairment in functioning in several areas and unable to function in one of these areas, i.e., disturbed at home, at school, with peers, or in the society at large, e.g.,

persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30-21 SEVERE PROBLEMS - unable to function in almost all situations.

Unable to function in almost all areas, e.g., stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g., sometimes incoherent or inappropriate).

20-11 VERY SEVERELY IMPAIRED -considerable supervision is required for safety.

Needs considerable supervision to prevent hurting others or self, e.g., frequently violent, repeated suicide attempts OR to maintain personal hygiene! OR gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10-1 EXTREMELY IMPAIRED - constant supervision is required for safety.

Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

Summary Decile Descriptions for CGAS:	
100-91	DOING VERY WELL
90-81	DOING WELL
80-71	DOING ALL RIGHT –minor impairment
70-61	SOME PROBLEMS - in one area only
60-51	SOME NOTICEABLE PROBLEMS – in more than one area
50-41	OBVIOUS PROBLEMS – moderate impairment in most areas or severe in one area
40-31	SERIOUS PROBLEMS – major impairment in several areas and unable to function in one area
30-21	SEVERE PROBLEMS - unable to function in almost all situations
20-11	VERY SEVERELY IMPAIRED - so impaired that considerable supervision is required for safety
10-1	EXTREMELY IMPAIRED - so impaired that constant supervision is required for safety

ILLUSTRATIVE VIGNETTES

TINA

Tina is a small, sweet faced freckled 10 year old girl who was referred by a paediatrician who had been unsuccessful in treating her for refusing to go to school. Her difficulties began on the first day of school one year ago when she cried and hid in the basement. She only agreed to go to school when her mother promised to come with her and stay to have lunch with her at school. For the next three months on school days Tina had a variety of somatic complaints, such as headaches and tummy aches, and each day would go to school only reluctantly, after much cajoling by her parents. Soon thereafter she could be got to school only if her parents lifted her out of bed, dressed and fed her, and drove her to school. Often she would leave school during the day and return home. Finally in the spring the school social worker consulted Tina's paediatrician who instituted a behavioural program with the help of her parents. Because this program was of only limited help, the paediatrician referred Tina now, at the beginning of the school year. The symptoms continue with Tina missing on average 3 days / week of school.

According to her mother, despite Tina's many absences from school last year, she performed well. During this time she also happily participated in most other activities, including Girl Scout meetings, sleepovers with several friends (usually also with her sister), and family outings.

When Tina was interviewed she at first minimised any problems about school, insisting that "everything is okay", and that she gets good grades and likes all the teachers. When this was pursued she became angry. Eventually she said that kids tease her about her size, calling her "shrimp" and "shorty". She finally admitted that what bothers her is leaving home, she could not specify why that was, hinting that she was afraid something would happen, not stating to whom, or what, but that it makes her uncomfortable when all her family is out of sight.

CGAS code 46

HoNOSCA: 1=0/2=0/3=0/4=0/5=0/6=0/7=0/8=3/9=3/ 10=2/ 11=0/12=1/13=4

PETER

Peter was referred to the clinic by his GP at the age of 6 years. He had always been afraid of dogs but this fear was now preventing his mother from taking him out shopping with her and had also led to him running into the road heedless of traffic in order to avoid an encounter with a dog on the pavement.

Peter had been afraid of dogs since the age of a year. At that time and until he was 3 and a half they had lived next to a house where there were two noisy Scottish terriers. These dogs were usually out in the adjacent garden, and were often yapping and scrambling up against the wire fence. They never attacked Peter and never broke through into the family's house or garden.

Peter was often out in the garden but if the dogs suddenly came in to the next door garden, he would either stand and scream or else would run in to the house sobbing and afraid.

His fear of all dogs persisted after the family left the neighbourhood. At the time of referral, he would seem terrified if he saw an unleashed dog in the street and might then run out into the middle of the road regardless of the traffic. Sometimes he would refuse to leave home in case he should meet a dog in the street. His mother had difficulty taking him with her when she went to visit friends or went shopping. He could never be taken to the beach.

He would not mind looking at books with pictures of dogs in them or even reading or hearing stories about dogs. However, if he saw a film with a dog in it he would seem anxious and would

bite his nails. His mother had tried to get him used to small puppies but he had shied away from these although he once agreed to hold a puppy on a leash. His mother said that he was not afraid of cats, rabbits, squirrels or farm animals.

He had no other fears. He bit his nails frequently. He had temper tantrums 2 or 3 times a month. These were becoming less frequent. They usually lasted for less than 3 minutes. The last tantrum that mother could recall followed his brother accidentally kicking him.

Mother said that he was usually a happy boy. Although wilful, he was always obedient and respectful. He got on well with his younger brother and did not show any open jealousy. They played together often and happily.

His schoolteacher reported that he was a bright boy who did well at his lessons. When he had first gone to school 10 months before, he had refused to eat school dinners, but this difficulty only lasted for a few weeks. At that time he also used to wet himself but this too had stopped. The teachers reported that he was a solitary boy who did not have many friends. At school Peter was thought to be somewhat fearful of new situations. He displayed no fear of the school pets (rabbits) but showed no interest in them either.

Peter slept and ate well. Mother thought that he was a little clumsy and inept at jumping and climbing. He was never incontinent of urine or faeces. His vision, hearing, etc were normal.

CGAS code 46

HoNOSCA: 1=0/2= 0/3= 0/4=0/5-0/6=0/7= 0/8=0/9=3/10=2/11=0/12=0/13=0

GILLIAN

Gillian was referred at the age of 11. She had been incontinent of faeces for the previous three years and advice on treatment was being sought.

Toilet training had been easy and she was fully continent by the age of 2 and a half years. At the age of 4 and a-half years she accidentally locked herself in to the lavatory. For several weeks after that she insisted that the lavatory door be kept open while she was inside. However, this incident seemed to cause no other emotional upset and did not disturb her bowel routine. At the age of five there was a brief period of faecal incontinence. She started to soil again 3 years later at the age of 8 1/2 and she had been soiling continuously ever since, soiling her pants every night, and also several times a day both at school and at home. She would have a bath in the evening but before going to sleep a few hours later she would be dirty again and would have to have another bath. Her faeces were always loose and unformed. There was no pain on defaecation and there were no other physical symptoms.

She would sometimes hide her soiled underwear and would lie about having dirtied herself. Although she had two baths a day her father said that she was not a clean child, and that she did not wash her hands or teeth at all regularly. There were often faeces under her nails, and sometimes her sheets were smeared with faeces. On occasion she took her sister's underpants and wore these, staining them. However, she only ever defaecated in her clothes or bed, and never smeared faeces over other objects.

She got on badly with her only sibling, Irene, aged 19. She has always copied her and apparently envied her, and when she was younger had often said "I wish I could have been born first like Irene". Irene used to tease her and criticise her because of her "disgusting" habits. But if anything, the relationship had improved lately.

Her parents reported that Gillian made friends with other girls in her class at school visiting them occasionally and also at times being visited by them. However, she was not very happy at

school, disliking some subjects and some teachers. Her general health was good, she was not enuretic and her reading and speech were quite normal.

Her parents described her as a cheerful little girl, but generally very bossy and also jealous and resentful of her sister. She got on well and easily with other grown ups. She nagged a lot at home and always tried to get her own way. She would always be prepared to do a household chore, but only if paid for it.

CGAS Code 42

HoNOSCA: 1=1/2=0/3=0/4=0/5=0/6=0/7=0/8=4/9=0/10=1/11=0/12=1/13=0/

JACK

A bright 9 year old boy was taken to the paediatric emergency room after his mother found him in the bathroom pressing a knife to his stomach. On examination there was no more than a minor scratch. Upon questioning, the child told the psychiatric resident that he wanted to die because he didn't want to continue to live the way he did. When specifically questioned he reported that he was feeling sad, bad and angry most of the time, that he wasn't having any fun anymore, and that he felt very tired all the time. He had no difficulty falling asleep but regularly wakes up about 3.00 am and then again at 5.30 am and can't fall asleep again.

He also reported he has heard a single voice talking to him telling him to kill himself with a knife in his belly. He identified the voice as his grandfather's who had died four years ago from a stroke. He had been hearing such a voice for the last month. His mother corroborated the child's report from her observations and added that the onset was about six months ago and that he had got progressively worse. Four months ago he began to steal from her and became quite disobedient and had temper tantrums. During the last two weeks he resisted going to school and cried all the way there. She also reported that he has been very preoccupied with the separation of his parent's two years ago and feels that it was all his fault. The teacher had reported to her that his attention span was rapidly decreasing and that he has withdrawn from friends and appeared quite sluggish.

CGAS code 33

HoNOSCA: 1=1/2=3/3=3/4=0/5=0/6=0/7=2/8=3/9=4/10=3/11=0/12=0/13=3

TIMOTHY

Timmy is a ten year-old boy who lives at home with his parents. He has attended CAMHS in the past because he will not go to school. Despite their best endeavours he continued to refuse to attend school and any attempt to make him do so would result in extreme anxiety and aggressive behaviour towards his parents. Timmy was referred to the child psychiatry inpatient service. Further history from his parents revealed that Timmy was bullied at school to a minor degree about two years ago. Since then his attendance was sporadic for about six months but he then could not be induced to return to school. At home he spends long periods of time alone in his bedroom whatever the parents try to do to get him to join family activities. However periodically, he will decide that he wants to go out with his father or with his cousins and can then go shopping or attend a football game, apparently without difficulty. Trying the same outing at another time will produce an intensely aversive reaction from him. There does not seem to be much logic to this behaviour.

He had never been very good at making friends and only plays with other children who are three years younger than himself although he is known to be an intelligent boy. He refused to be admitted and his parents did not feel that they could insist. They agreed to strongly encourage

him to attend as a day patient. With the help of pets in the hospital classroom, He was encouraged to come to the inpatient unit but immediately retreated to a room set aside for him and would not move from there even to eat with other children. He was curious about them and wanted to join in their activities but could not bring himself to do so. He was suspicious of any attempt to include him in activities. His parents maintained his attendance over several weeks but were not willing to encourage him to take medication that he thought would poison him. Eventually a state of impasse was recognised and he returned home to the care of his mother but no effective educational strategy in place; he refused to co-operate with a home tutor. He continued his pattern before admission of spending much time in his bedroom but was able to have successful outings about once or twice a week.

CGAS code 26

HoNOSCA: 1=0 (no aggression in last3months)/2=0/3=0/4=0/5=0/6=0/7=0/
8=0/9=4/10=4 (because no friends)/11=3/12=2/13=4

STEPHEN

Stephen was referred to the clinic at the age of 6 by a psychiatrist attached to a special school for emotionally disturbed children that he had been attending for the previous 8 weeks. The headmistress of this special school for children with behavioural difficulties had found Stephen to be the “worst case” she had ever seen. More specifically her complaints were overactivity, poor concentration, and aggressive behaviour to teachers and other children. There was a long history of similar behaviour in other settings and Stephen had received psychiatric treatment at another hospital before going to her school. Because of the severity of his disturbance and the disruptive effect it was having on his home the referral was accompanied by a request for his admission to a children’s in-patient unit.

His mother said he was at his best between 4 and 6 pm, when he was alone with her, whilst she read him stories. At other times he was “always on the go – never sitting still”. He was clumsy and broke things frequently.

When taken out for a walk he would often dash into the middle of the road, heedless of any danger. He would open car doors on the roadside and pull at or manipulate their controls. At times he had wandered into neighbour’s houses. He had egged on some of the neighbour’s children to destructive behaviour and at other times had been rough and aggressive towards them. The neighbours now no longer allowed their children to play with him.

He would often scream or screech, or bang on surfaces making a loud noise. If father should ever attempt to punish or correct Stephen he would set up a loud screech. Father felt that Stephen was well aware that the noise he made had an upsetting effect on both his parents. His behaviour towards his mother varied considerably. He might torment her or swear at her, but he would love to be cuddled by her or have her to himself in a room. His relationship with his younger sib was somewhat tense. He had tipped him out of his high chair on two occasions, and if the younger brother ever touched any of his toys he would slap him.

He was often destructive and would break his own toys. He had been cruel to animals and had squeezed a goldfish to death. He lied quite openly, but rarely to defend himself from anticipated punishment.

He often seemed unhappy and tearful. He was afraid of thunder and loud noises – when upset he would beat his head with his fist. He sucked his thumb and bit his fingernails and toenails. He was frequently incontinent of faeces. He was usually continent of urine at night. He slept poorly, waking at 5.30 am. On waking his bed would be in disarray. He had masturbated openly since the age of 18 months and continued to do so many times a day. He had no food fads, but was messy at table. About 2 or 3 times a month he would vomit during a meal.

When he attended for initial assessment as an outpatient he was impish and mischievous, running around the waiting room turning the lights on and off. He ran into several offices and picked up the telephones, apparently oblivious to the occupant's reaction. When he came into the examiner's room he demanded toys, but handled them for only a momentary period before putting them down again. There was no obvious organisation in his use of play material. He threw sand around the room. He ignored requests put to him to stop doing these things. His speech was difficult to understand. He spoke in a loud unmodulated voice with the words bunched together in a jerky way. He did not enunciate final consonants.

After admission to the children's psychiatric ward his behaviour was initially very disturbed and extremely overactive.

He soiled himself frequently and ate the faeces. In class he also ate chalk and rabbit droppings, he had frequent tantrums when distressed. He seemed especially upset by his poor manual ability. When asked to thread a bead necklace he threw it away crying out "I can't do it, I can't do it, you must do it for me". He then overturned one of the desks. He seemed depressed at the separation from his mother. He would sometimes stand by the ward window and wail for her.

He never lied and never seemed to be in any way distressed at his own destructive or aggressive activity and he seemed undeterred by punishment.

To his teacher he seemed to be insatiably curious. He would often sniff people. He repeatedly asked to be shown the teacher's nurse's and doctor's sex organs and breasts. He did this without apparent mischievousness or humour.

He was found tearing a butterfly apart and also pulling with force at the leg of a pet rabbit.

He was unsettled at meal times and on occasion threw his utensils at other children.

CGAS code 10

HoNOSCA: 1=4 (aggression to people and animals) /2=4 /3=1/4=0/5=0 (no evidence for this area)/6=0/7=0/8=3/9=1/10=4 (intrusive and sexualised)/ 11=4/12=0 (no evidence for this area)/13=0

GEORGE

George is a 16 year old boy who was admitted to the hospital from a juvenile detention centre following a serious suicide attempt. He had in some way, wrapped shoelaces and tape around his neck causing respiratory impairment. When found he was cyanotic and semi-conscious. He had been admitted to the detention centre earlier that day where he was noted to be quite withdrawn.

On admission he was reluctant to speak, other than to say that he would kill himself and nobody could stop him. However, he did admit to a two week history of depressed mood, difficulty sleeping, decreased appetite, decreased interest, guilt feelings and suicidal ideation.

According to his parents, George was without emotional difficulties until at the age of 13 he became involved in drugs, primarily LSD, marijuana and other non-opioid substances. His grades dropped drastically, he ran away from home on several occasions after arguments with his parents, and he made a suicide gesture by overdosing on aspirin. A year later he was expelled from school after an argument with the principle. Unable to control his behaviour, his parents had him declared a child in need of assistance. He was then evaluated in a mental health clinic and a recommendation was made for placement in a group home.

He apparently did well in the group home and his relationships with his parents improved immensely with family counselling. He was quite responsible in holding his job and attending school and was involved in no illegal activities, including use of drugs. However, six months ago he again became involved in drugs and over a course of two weeks was involved in ten 'breaking-and-enterings', all of which he did alone. At this time he remembers being depressed but cannot recall whether the mood was prior to or after re-involvement with drugs. He was then sent to the juvenile detention centre where he did well so that he was discharged to his parent's three weeks ago. On day after returning home he impulsively left with friends in a stolen car for a trip to Scotland. His depression began shortly thereafter and, according to him, his guilt over what he had done to his parents led to his suicide attempt.

CGAS code 9

HoNOSCA: 1=3 (stealing)/2=0/3=4/4=4/5=0/6=0/7=0/8=0/9=4/10=0/11=0/12=0/13=0