

About me

Teacher

- 2003 – 2010: Primary School Teacher

School Psychologist

- 2010 – 2022: School Psychologist – across a range of schools (primary, high school, senior high school)

PhD

- 2012 – 2020: Longitudinal experiment working with primary school students looking at improving executive function

Private Practice

- 2016 – 2018: Working with children and adolescents

NovoPsych

- 2021 – current: Head of Psychometrics

The Strengths & Difficulties Questionnaire (SDQ)



Why and when?

- Intake overview — a wide-angle first look across domains before much is known. Flags where a narrower measure is necessary.
- Outcome monitoring — brief enough to repeat and track change over time.

A broad, brief screen of child mental health

- 25 items
- 5 subscales:
 - emotional symptoms
 - conduct problems
 - hyperactivity/inattention
 - peer problems
 - prosocial behaviour
- Ages 2–17
- Self-report from 11
- 5 minutes to complete

Completed by three informants:

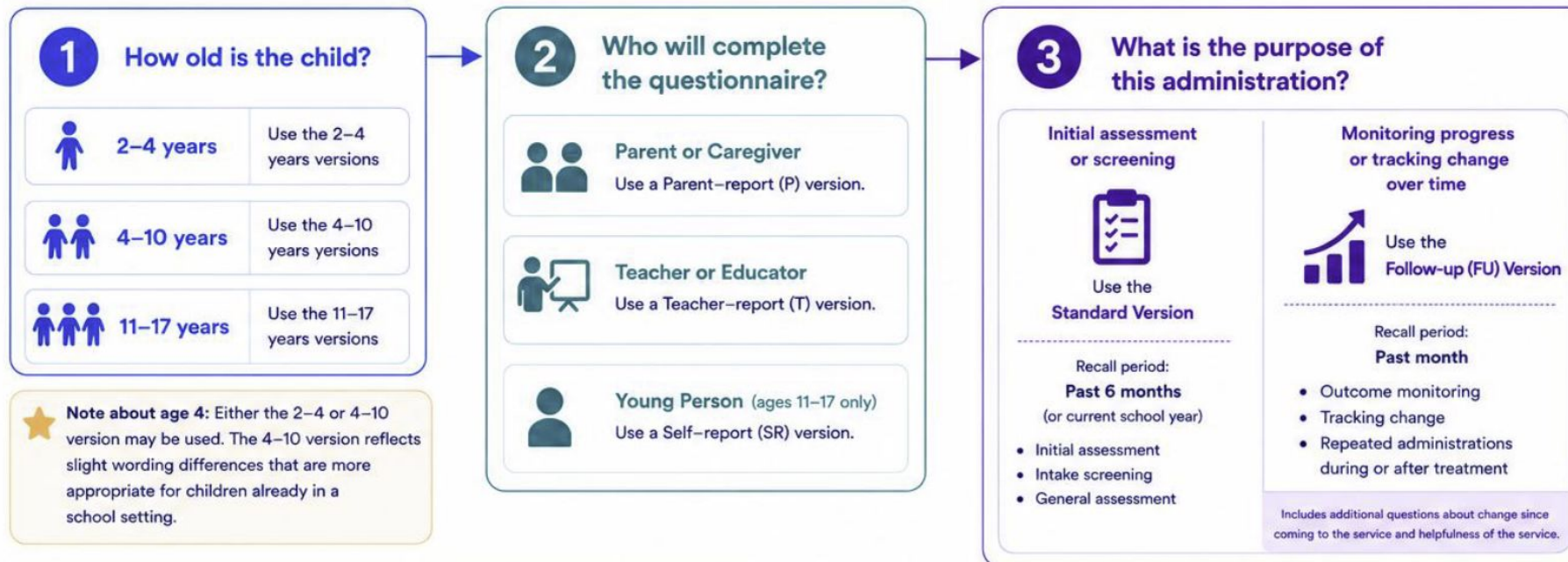
Parent

Teacher

Self-report

Which SDQ Version Should I Use?

A quick, 3-step guide to help you select the right SDQ for your client.



YOUR SDQ VERSION			
Respondent (Who will complete the questionnaire?)	Child's Age		
	2–4 years	4–10 years	11–17 years
 Parent or Caregiver (P)	SDQ P2–4	SDQ P4–10	SDQ P11–17
 Teacher or Educator (T)	SDQ T2–4	SDQ T4–10	SDQ T11–17
 Young Person (Self-report) (SR)	—	—	SDQ SR11–17
Add "FU" to the end of the version name if using the Follow-up version. Examples: SDQ P4–10 FU SDQ T11–17 FU SDQ SR11–17 FU			

USING MULTIPLE RESPONDENTS

The SDQ is designed to support multi-informant assessment.

Collect ratings from parents, teachers, and (when age appropriate) young people to get a more complete picture of the child or young person's strengths and difficulties.

Multi-informant data can be combined in NovoPsych reports to support comprehensive clinical insights.

FOR DETAILED INFORMATION ABOUT THE SDQ

Click here to read the full NovoPsych profile.

[View SDQ Profile](#)

SEND ASSESSMENTS TO INFORMANTS

Learn how to send parent, teacher, or informant rated assessments.

[View Help Article](#)



KEY POINTS



All SDQ versions contain the same 25 items (5 scales).



Choose the age band and respondent that best fit your client.



Use **Standard** for initial assessment; **Follow-up (FU)** for progress monitoring.



Young person (self-report) is available for ages 11–17 only.



Assessment powered by

NovoPsych

Strengths and limitations

STRENGTHS

- Reliable for a brief screen: mean Cronbach's $\alpha = .73$; test-retest $r = .62$ at 4–6 months.¹
- Strong discrimination: scores in High category and above carry a mean odds ratio of 15.7 (parent) and 15.2 (teacher) for a diagnosed disorder.¹
- Five-factor structure confirmed, and supported in 15 of 18 studies across a review of 48 studies ($N = 131,223$).^{1,3}
- High specificity when multi-informant: 94.6% (95% CI 94.1–95.1).²

LIMITATIONS

- Modest sensitivity as a standalone screen: 63.3% multi-informant (95% CI 59.7–66.9), and lower with a single informant.²
- Uneven across disorders: detects >70% of conduct, hyperactivity and depressive cases, but <50% of specific phobia, separation anxiety and eating disorders.²
- Subscale scores are less reliable than the total, and weaker for parent than teacher ratings.³
- Low cross-informant agreement (mean $r = .34$) — parent, teacher and self ratings often diverge.¹

References

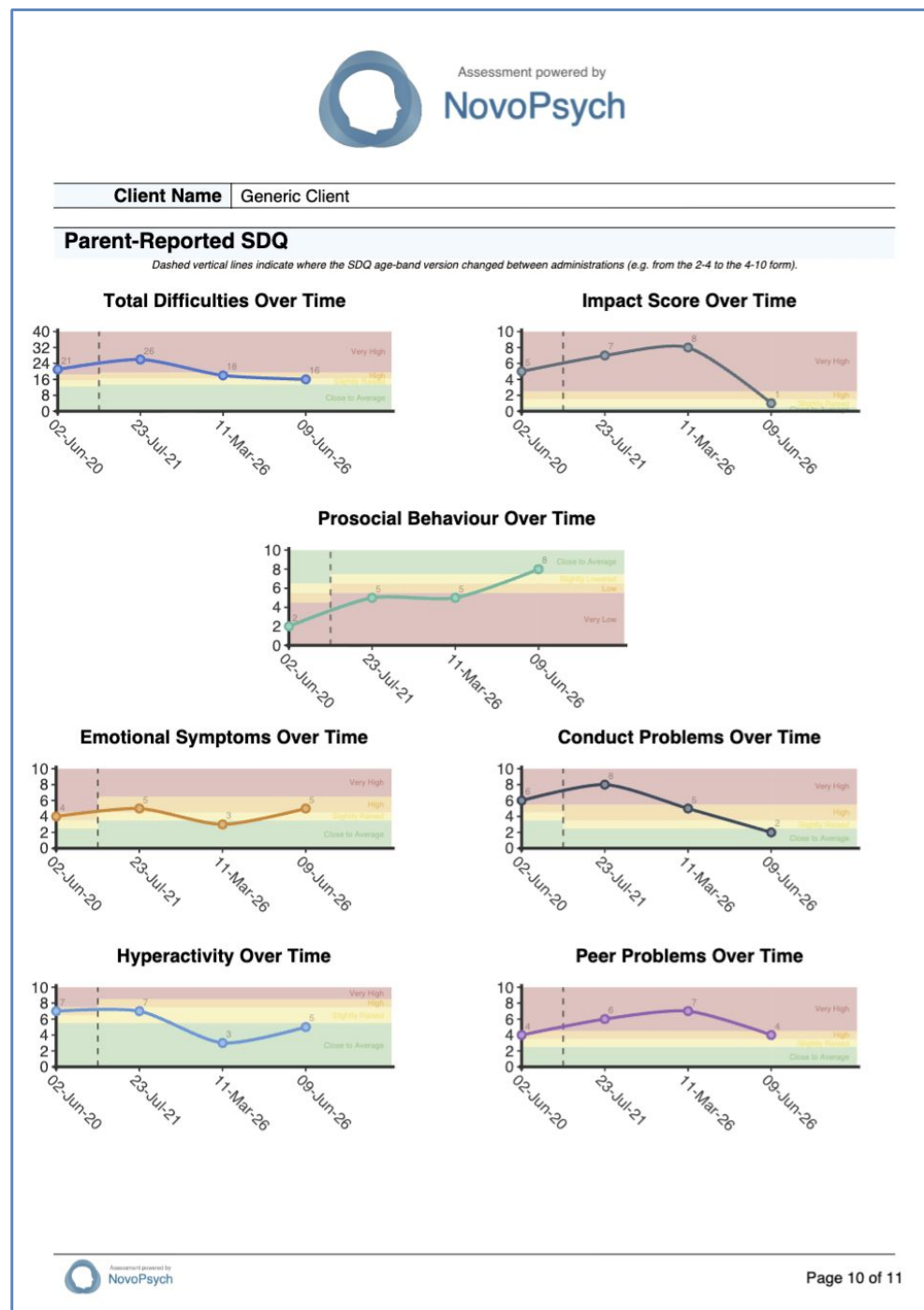
1. Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *J Am Acad Child Adolesc Psychiatry*, 40(11), 1337–1345 (figures, p. 1337).
2. Goodman, R., Ford, T., Simmons, H., Gatward, R., & Meltzer, H. (2000). Using the SDQ to screen for child psychiatric disorders in a community sample. *Br J Psychiatry*, 177, 534–539 (figures, p. 534).
3. Stone, L. L., Otten, R., Engels, R. C. M. E., Vermulst, A. A., & Janssens, J. M. A. M. (2010). Psychometric properties of the parent and teacher versions of the SDQ for 4- to 12-year-olds: A review. *Clin Child Fam Psychol Rev*, 13(3), 254–274 (figures, p. 254).

Interpreting the results

Read four things together

- Total difficulties (0–40) — the sum of the four problem subscales; the headline index.
- Subscale profile — emotional, conduct, hyperactivity/inattention and peer problems, plus prosocial behaviour as a strength.
- Impact supplement — distress and social impairment; often the clearest signal of clinical need.
- Norm-referenced bands — each score falls in a category (from close-to-average through to very high) against age and informant norms.

Interpret the total and impact scores with more confidence than any single subscale.



When informants disagree

Divergence between parent, teacher and self-report is common (and clinically informative)

Why it happens

- Children behave differently across settings, so agreement is modest by design (cross-informant mean $r = .34$).¹
- Divergence usually reflects context, not error — conduct seen at school but not home, or anxiety a parent sees but a teacher does not.

How I read it

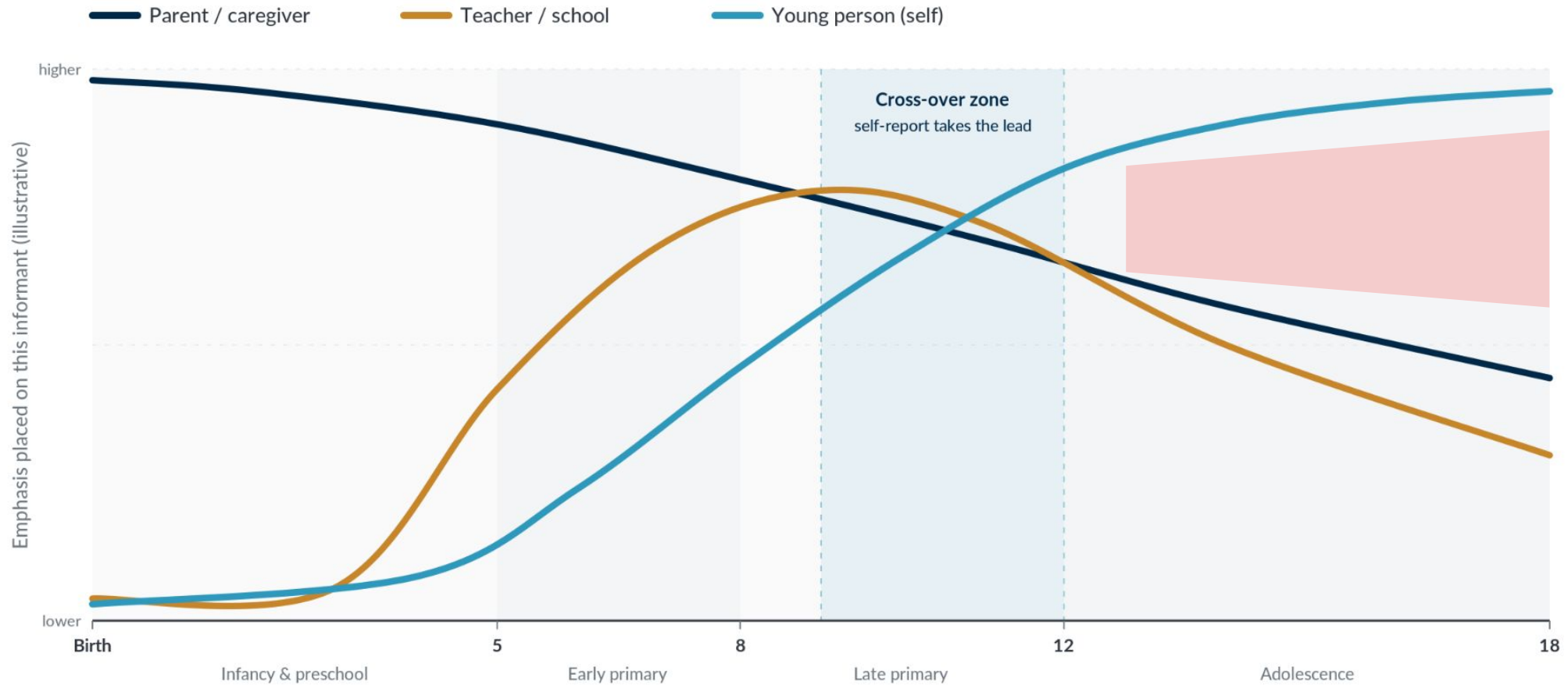
- Compare each informant against that informant's own norms, then compare the profiles side by side.
- Treat the discrepancy itself as data — it localises where and when difficulties show up.
- Multi-informant SDQs detect far more than any single rater, so gather more than one where you can.²

1. Goodman (2001), *J Am Acad Child Adolesc Psychiatry*, 40(11), 1337–1345, p. 1337. 2. Goodman et al. (2000), *Br J Psychiatry*, 177, 534–539, p. 534.



Whose report do we trust? Informants across development

The primary lens shifts from observer to self as children mature, earliest and strongest for internalising symptoms



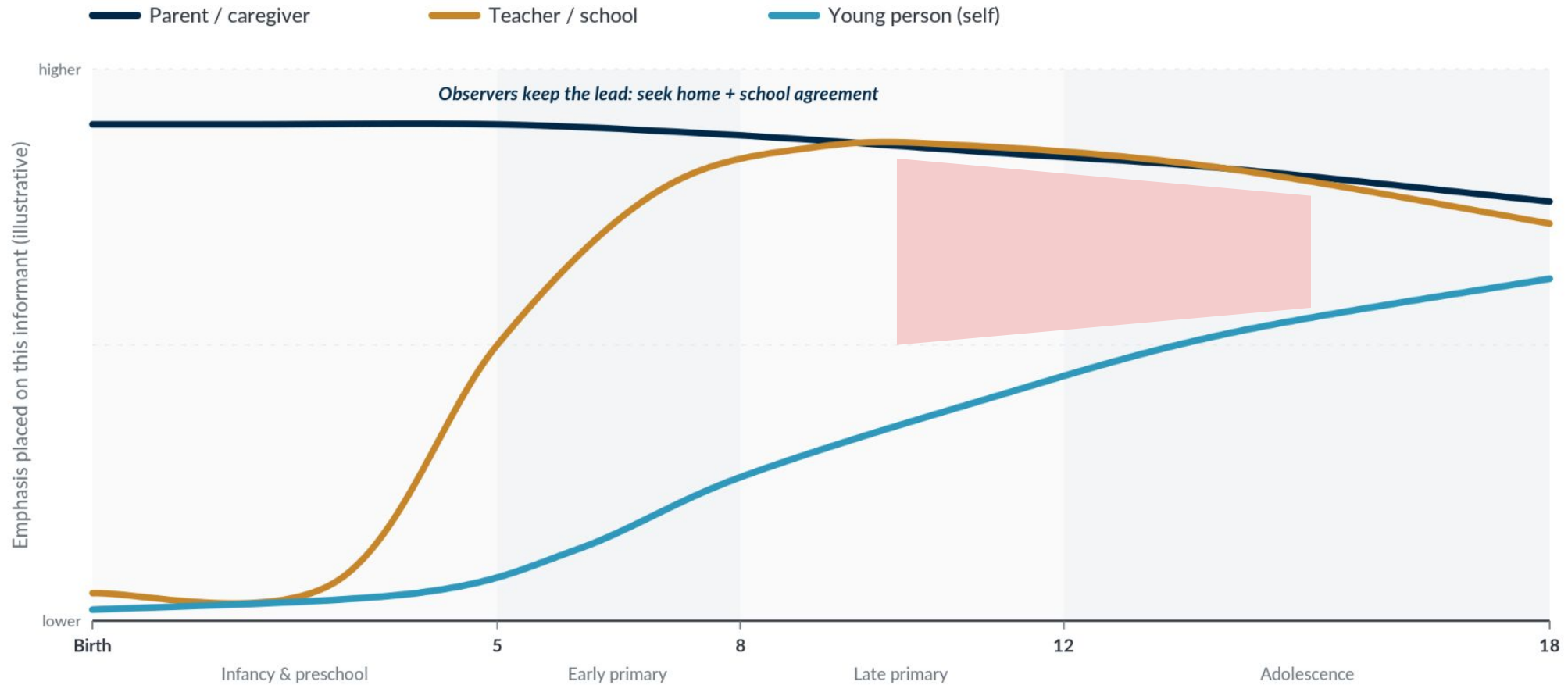
For internalising symptoms (anxiety, low mood), trust the young person's own report earlier; parents and teachers increasingly under-detect these, especially with camouflaging.

References: Achenbach, McConaughy & Howell (1987), *Psychological Bulletin*, 101(2), 213-232; De Los Reyes & Kazdin (2005), *Psychological Bulletin*, 131(4), 483-509;

De Los Reyes et al. (2015), *Psychological Bulletin*, 141(4), 858-900. Illustrative schematic, not measured values.

And when the behaviour is out in the open? Externalising symptoms

For observable behaviour (conduct, hyperactivity, defiance) the observers keep the lead, and the young person under-reports



For externalising / observable behaviour, weight observers and look for cross-setting agreement; the young person's own report is the least reliable single source, especially in childhood.

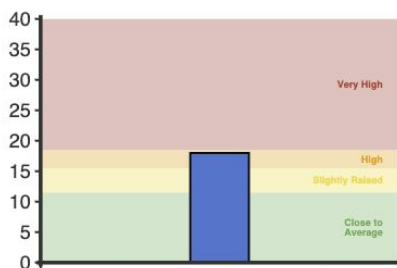
References: Achenbach, McConaughy & Howell (1987), *Psychological Bulletin*, 101(2), 213-232; Owens, Goldfine, Evangelista, Hoza & Kaiser (2007), *Clin Child Fam Psychol Rev*, 10(4), 335-351;

De Los Reyes et al. (2015), *Psychological Bulletin*, 141(4), 858-900. Illustrative schematic, not measured values.

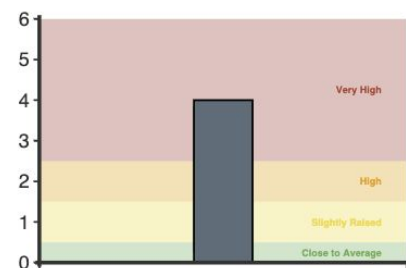
Reading the discrepancy: worked examples

SDQ T11-17

Total Difficulties Score

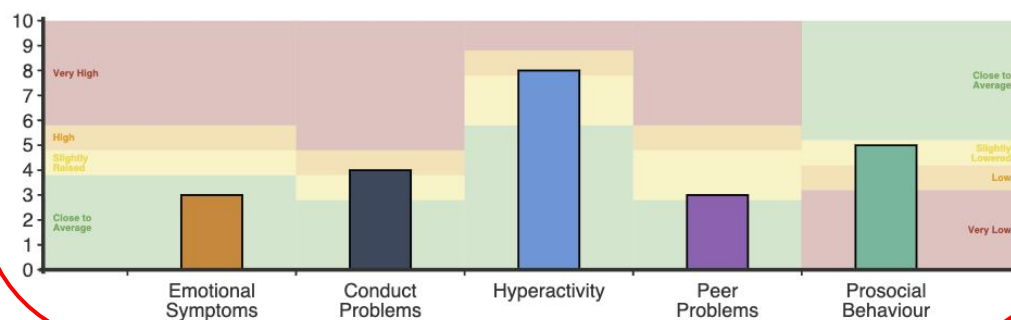


Impact Score



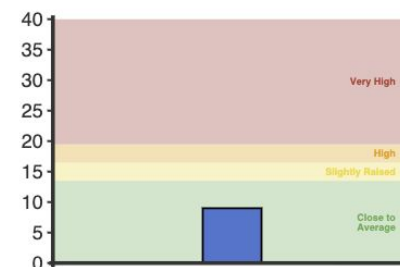
Difficulties reported to have been present for 6-12 months.

Subscale Scores



SDQ P11-17

Total Difficulties Score

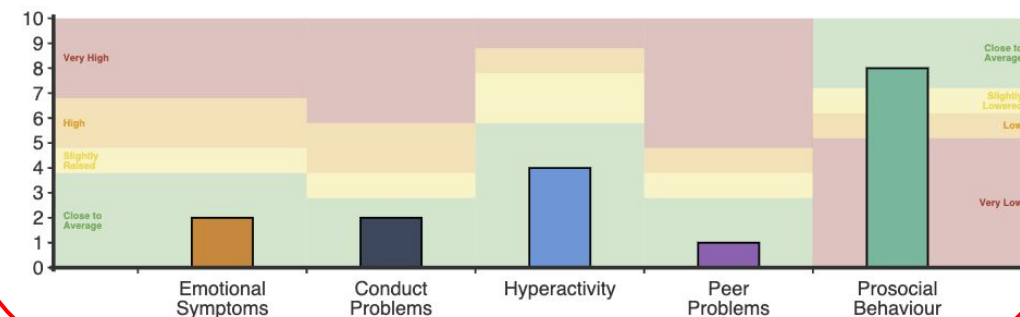


Impact Score



Difficulties reported to have been present for 1-5 months.

Subscale Scores

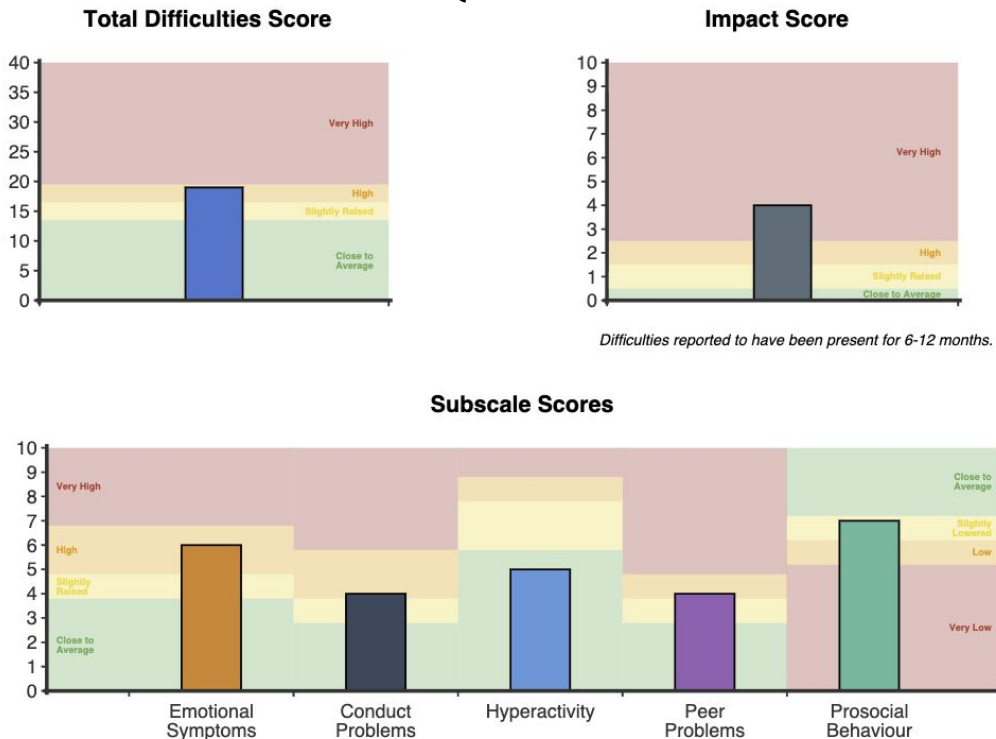
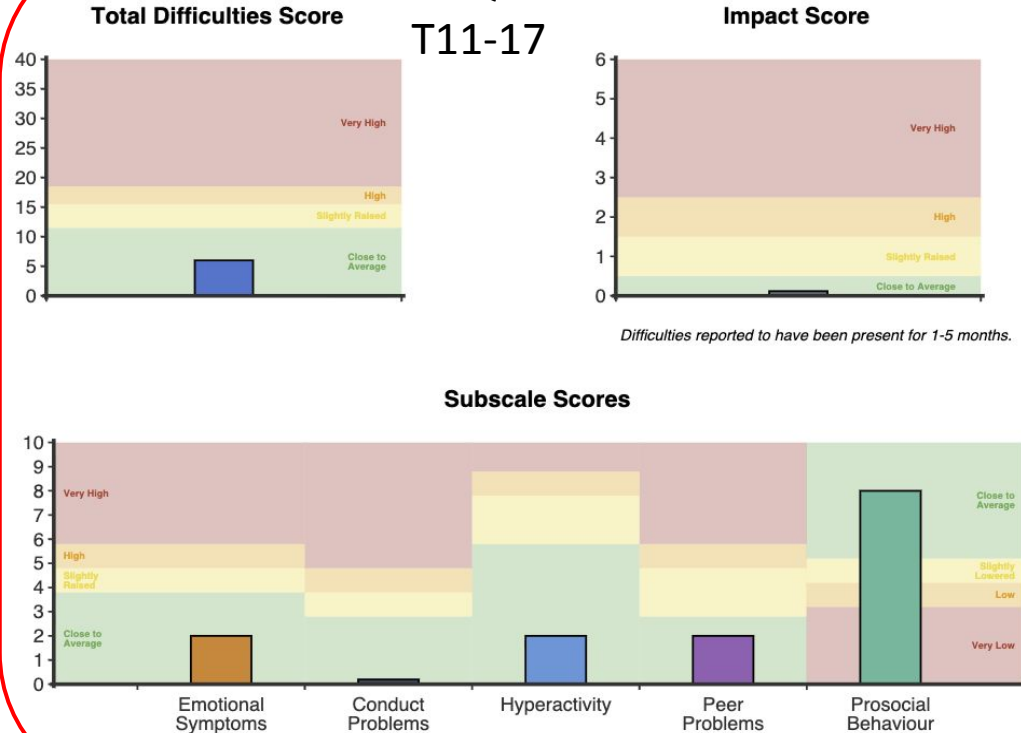


TEACHER HIGH · PARENT LOW

- Teacher's norm base: an experienced teacher has implicitly compared this child against hundreds of same-age peers.
- Context-specific load: classrooms tax sustained attention, group work and transitions in ways home does not.
- Parent blind spots: peer dynamics and on-task behaviour are hard to see from home.
- A narrower parent frame? Fewer same-age comparisons, or difficulties normalised over time.

Reading the discrepancy: worked examples

SDQ P11-17

SDQ
T11-17

PARENT HIGH • TEACHER LOW

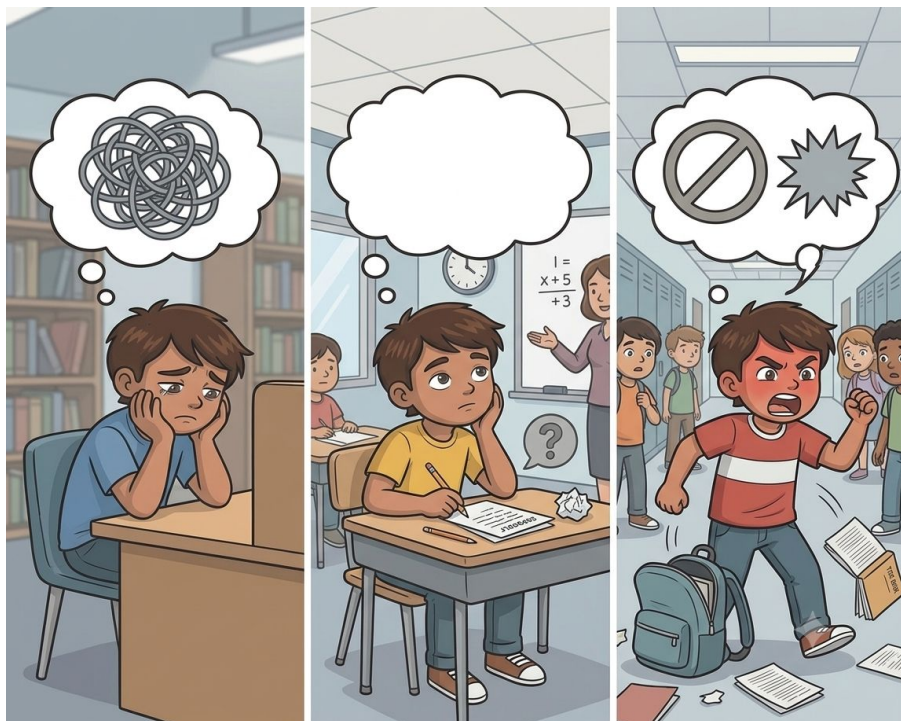
- “Holding it together, then letting go”: school restraint collapses at home, common in anxious or masking children.
- Parent norm base: a first or only child, or little exposure to same-age peers, can skew the reference point.
- Genuinely home-specific? Homework, siblings, bedtime and unstructured time load the home context.
- School under-detection: quiet, internalising presentations are easily missed in a busy class.

Take the home signal seriously; add self-report (11+) and probe internalising directly.

The discrepancy is the data.

Neither informant is wrong. Match the pattern to context, weight the better-normed observer, and let it steer the next assessment step.

The Pediatric Symptom Checklist-17 (PSC-17)



Why and when?

- As a fast first-line screen at intake or in routine care.
- To decide whether fuller, domain-specific assessment is warranted.

A 17-item broadband psychosocial screen

- 17 items
- Parent report
- 3 subscales:
 - internalising
 - attention
 - externalising
- Total psychosocial score
- Ages 4–16
- 3 min
- Community Percentiles

Completed by:

Parent

Strengths and limitations

STRENGTHS

- Very brief (17 items, ~2–3 min) yet covers three domains.
- Reliable in a large national sample: internal consistency 0.89, test–retest 0.85.¹
- Stable three-factor structure confirmed across large, diverse samples.^{1,2}
- Screens as well as much longer measures for ADHD, externalising and depression.³
- Good discrimination in over 18,000 children: total sensitivity 82% and specificity 81% at the standard cut-off (≥ 15).⁴

LIMITATIONS

- Weaker for anxiety detection (AUC ≈ 0.68 versus ≥ 0.80 for other domains).³
- Single informant (parent); may miss what a teacher or the young person would report.
- Brevity trades away symptom-level detail.
- Keep in mind that percentiles might not be entirely accurate for 4–5-year-olds

References

1. Murphy et al. (2016). The PSC-17: subscale scores, reliability and factor structure in a new national sample. *Pediatrics*, 138(3), e20160038 (abstract).
2. Stoppelbein et al. (2012). Factor analyses of the PSC-17. *Journal of Pediatric Psychology*, 37(3), 348–357 (p. 348).
3. Gardner, Lucas, Kolko & Campo (2007). PSC-17 versus alternative screens in at-risk primary care. *J Am Acad Child Adolesc Psychiatry*, 46(5), 611–618 (p. 611).
4. Gardner, W., Murphy, M., Childs, G., et al. (1999). The PSC-17: a brief Pediatric Symptom Checklist with psychosocial problem subscales. *Ambulatory Child Health*, 5(3), 225–236 (Table 3, p. 230).

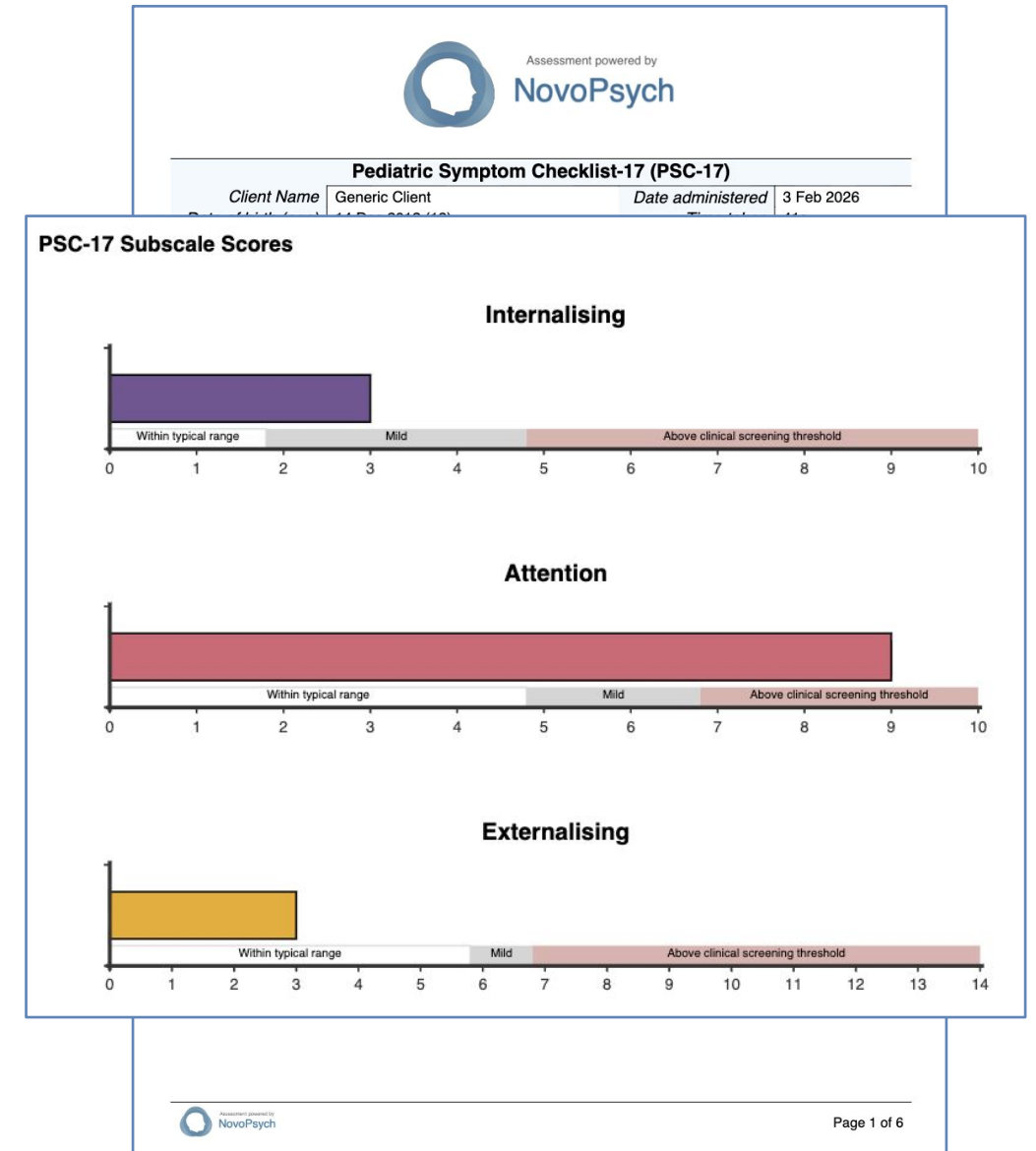
Fast, broadband triage

How I read it

- Check the total against the cut-off (≥ 15) for overall psychosocial risk.
- Then read the three subscales: each elevation points to a domain, not a diagnosis.
- Co-occurring elevations flag complexity and a broader work-up.

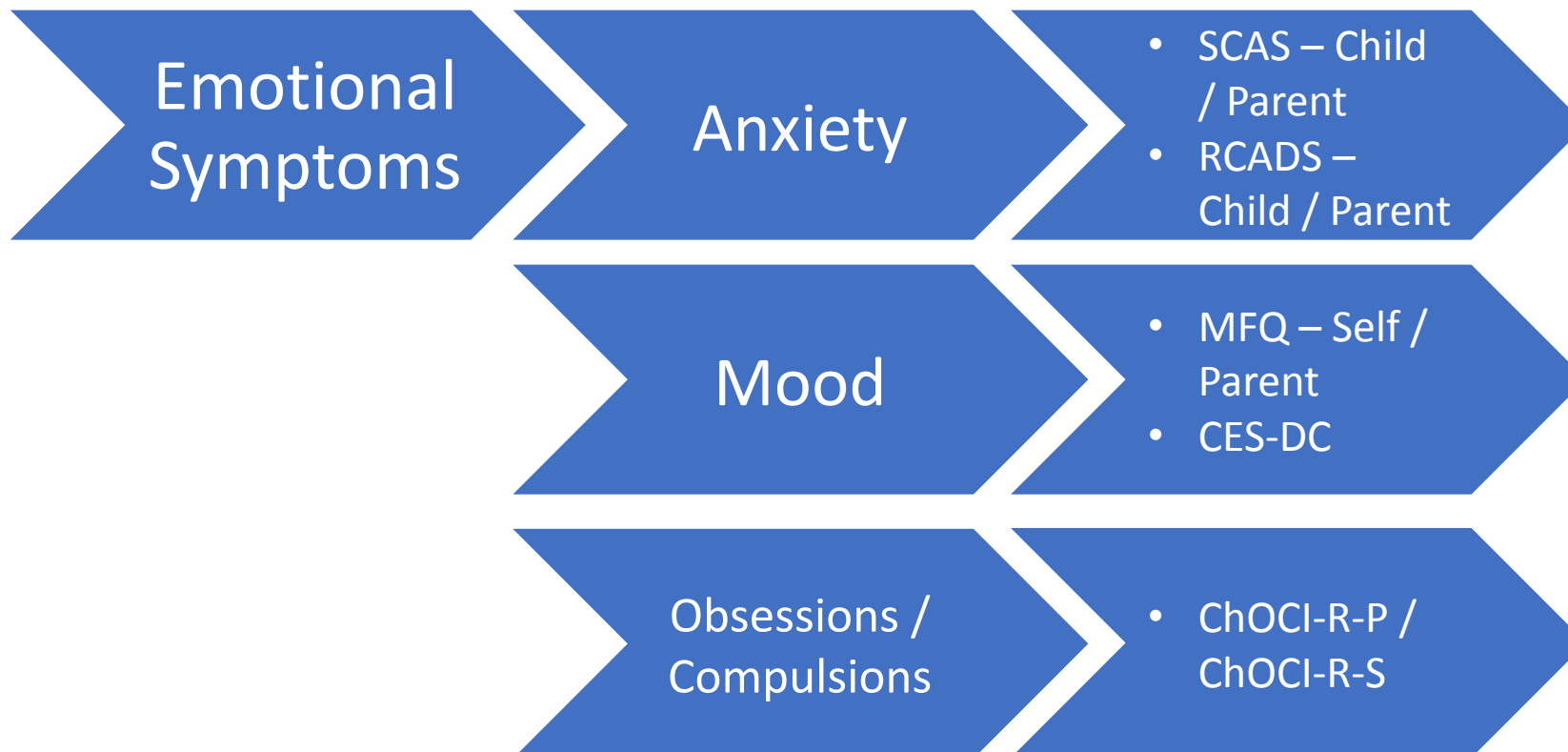
Where each elevation sends me

- Internalising ≥ 5 → an anxiety or mood measure
- Attention ≥ 7 → an ADHD-specific, teacher-inclusive tool
- Externalising ≥ 7 → a conduct and behaviour evaluation across settings

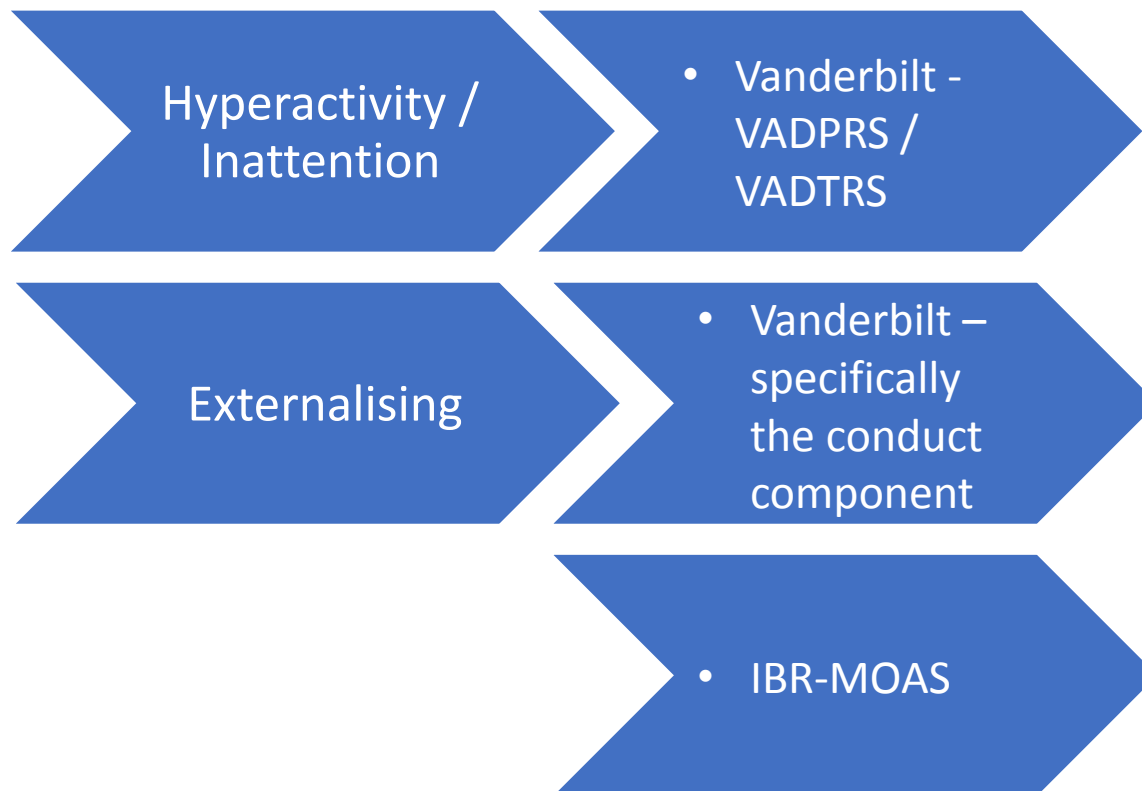


Elevated Subscales?

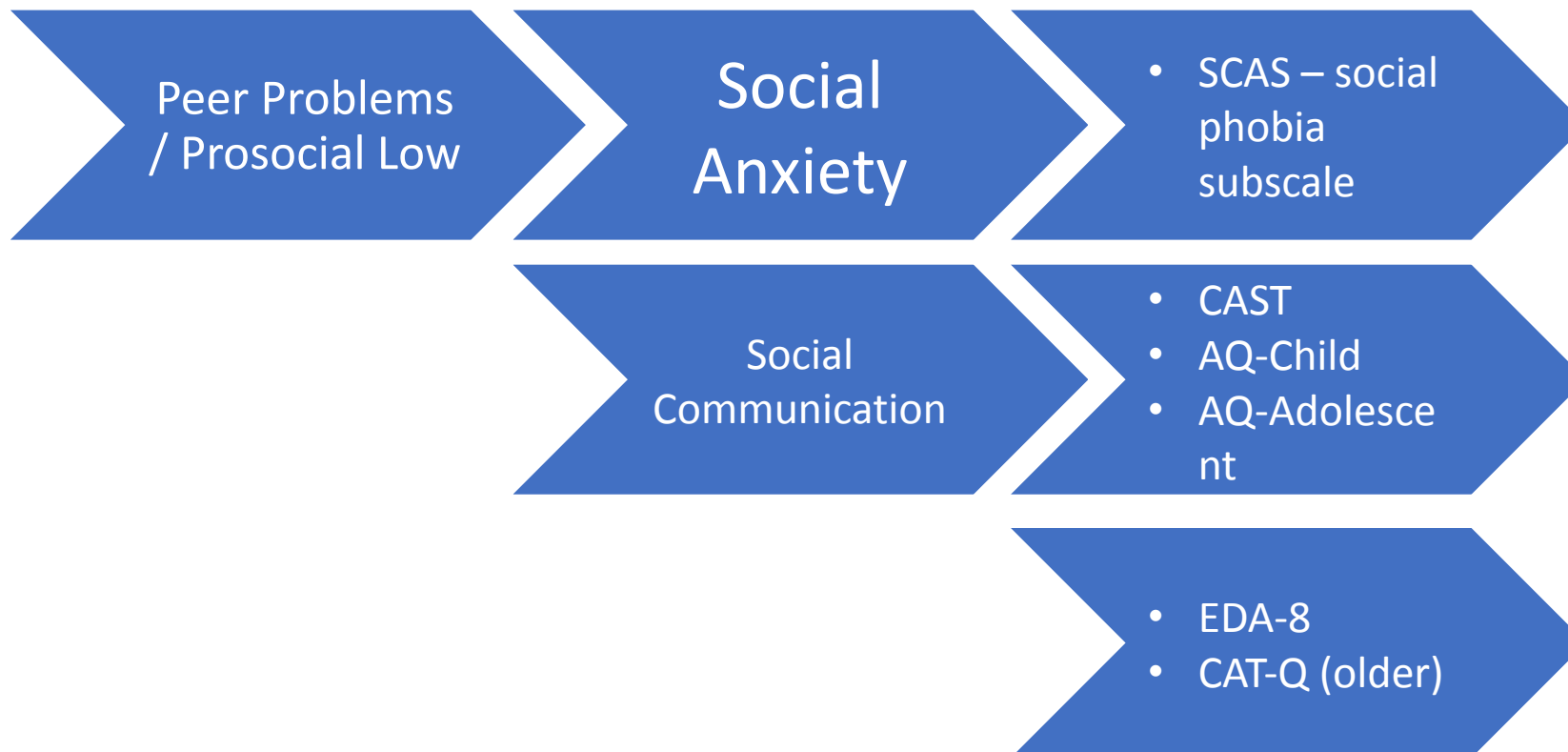
Thinking specifically about the SDQ...



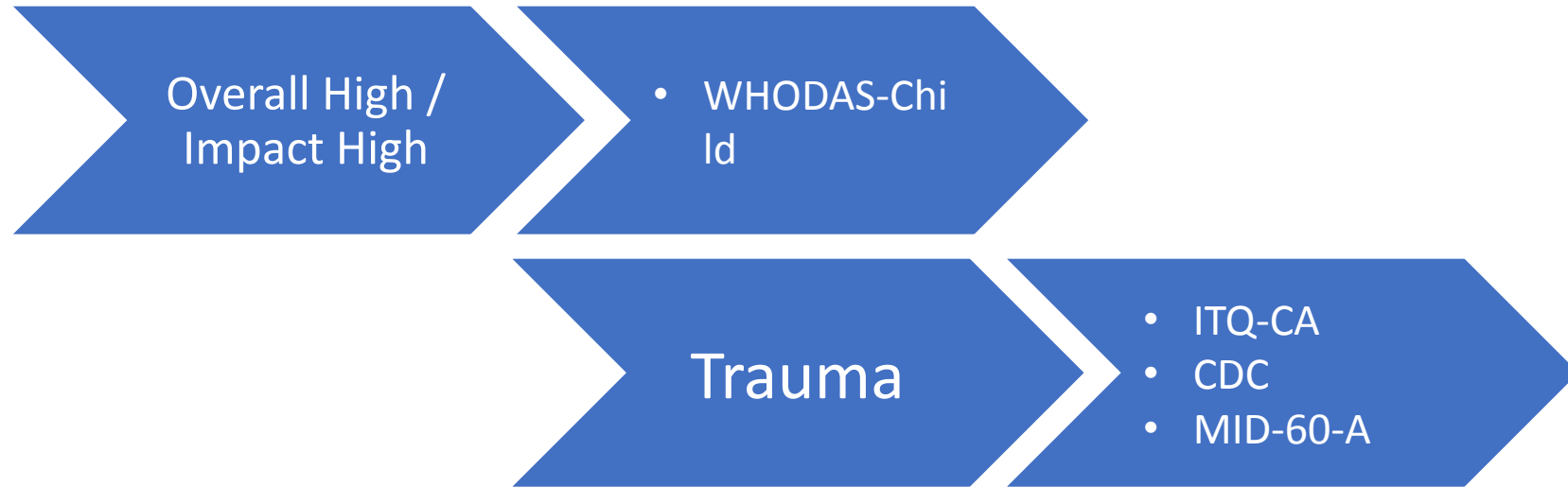
Elevated Subscales?



Elevated Subscales?



Elevated Subscales?



The Spence Children's Anxiety Scale (SCAS)



Why and when?

- When anxiety is the concern and need to know which type, not just how much.
- To profile symptom clusters, target intervention, and track anxiety over care.

A multidimensional profile of childhood anxiety

- 38 (parent) or 44 (child) items
- 6 subscales:
 - separation anxiety
 - social phobia
 - obsessive-compulsive
 - panic / agoraphobia
 - physical-injury fears
 - generalised anxiety
- Child 8–15 / Parent 7–13
- 8 minutes
- Community Percentiles

Completed by:

Child

Parent

Strengths and limitations

STRENGTHS

- Robust six-factor structure confirmed across large samples and cross-culturally.^{1,2,4}
- Discriminates specific anxiety disorders; subscale peaks match the presenting disorder.^{1,3}
- Strong internal consistency for the total and most subscales; retest acceptable to satisfactory.^{1,2}
- Parallel child and parent forms enable multi-informant assessment.³

LIMITATIONS

- The Generalised Anxiety subscale discriminates least well between disorders.³
- The Physical Injury Fears subscale is the weakest for internal consistency.⁵
- Parent-child agreement is modest ($r \approx .23-.66$).³

References

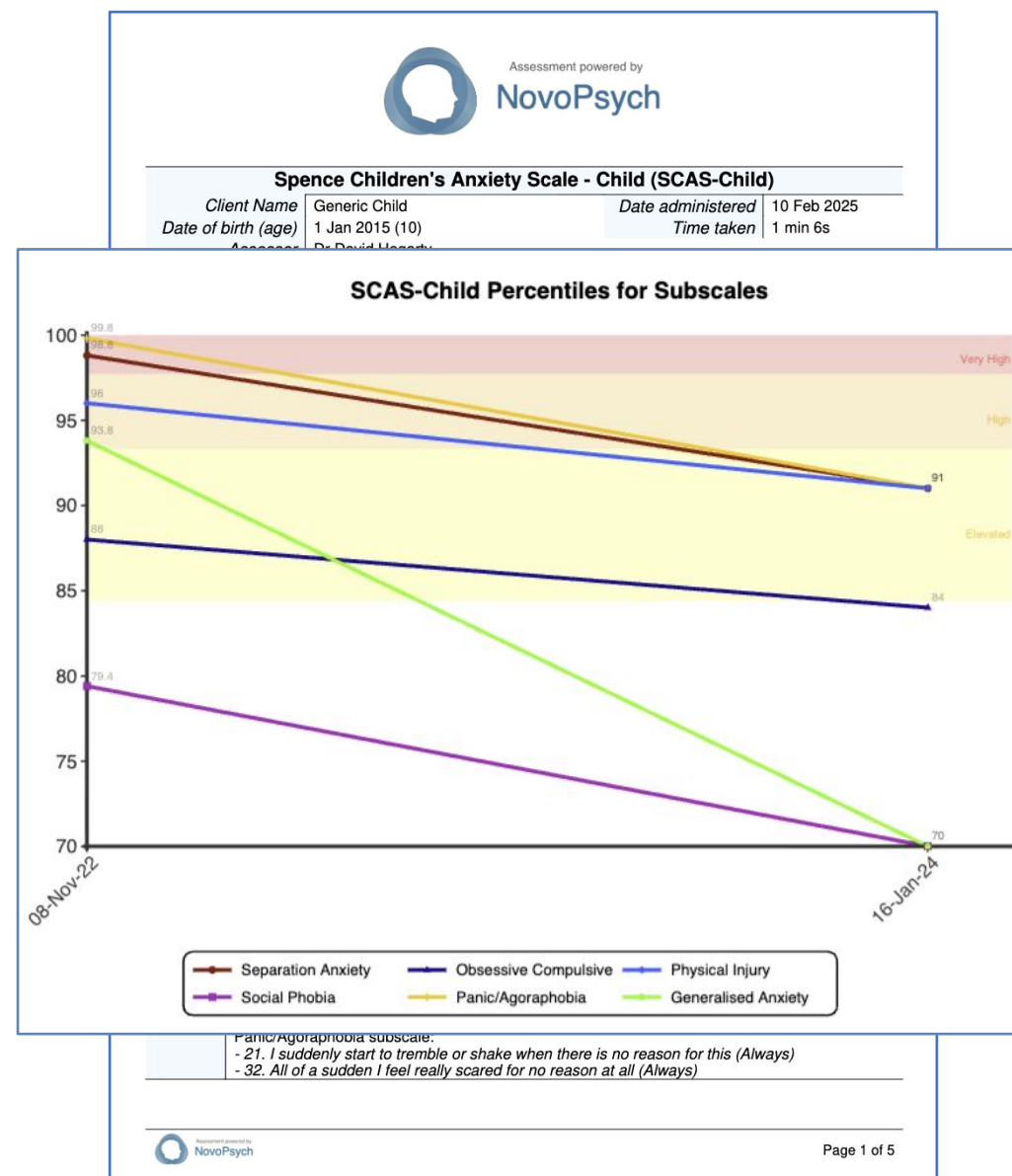
1. Spence, S. H. (1998). A measure of anxiety symptoms among children. *Behaviour Research and Therapy*, 36(5), 545–566 (p. 545).
2. Spence, Barrett & Turner (2003). Psychometric properties of the SCAS with young adolescents. *J Anxiety Disord*, 17(6), 605–625 (p. 605).
3. Nauta et al. (2004). A parent-report measure of children's anxiety. *Behaviour Research and Therapy*, 42(7), 813–839 (p. 813).
4. Orgilés et al. (2016). Factor structure and reliability of the SCAS: a systematic review. *J Affective Disorders*, 190, 333–340 (p. 333).
5. Arendt, Hougaard & Thastum (2014). Child and parent SCAS in a Danish community and clinical sample. *J Anxiety Disord*, 28(8), 947–956 (p. 947).

Interpreting the results

How I read it

- The total anxiety score against age and gender norms, shown as a percentile.
- The six-domain profile: which subscales are elevated tells you the type of anxiety.
- Bands: Normal (≤ 84 th percentile), Elevated (85–93rd), High (94–97th), Very High (≥ 98 th).
- Reliable change: about 14 points (child) or 13 (parent) on the total signals real change.

A percentile at or above 85 on the total or any subscale is clinically noteworthy.



Reading the anxiety profile

Why the profile matters

- A broad screener tells you anxiety is present; the SCAS tells you where it lives.
- It covers domains brief screeners miss, notably OCD and panic/agoraphobia.
- The elevated subscale steers the formulation and the intervention (exposure targets obviously differ).

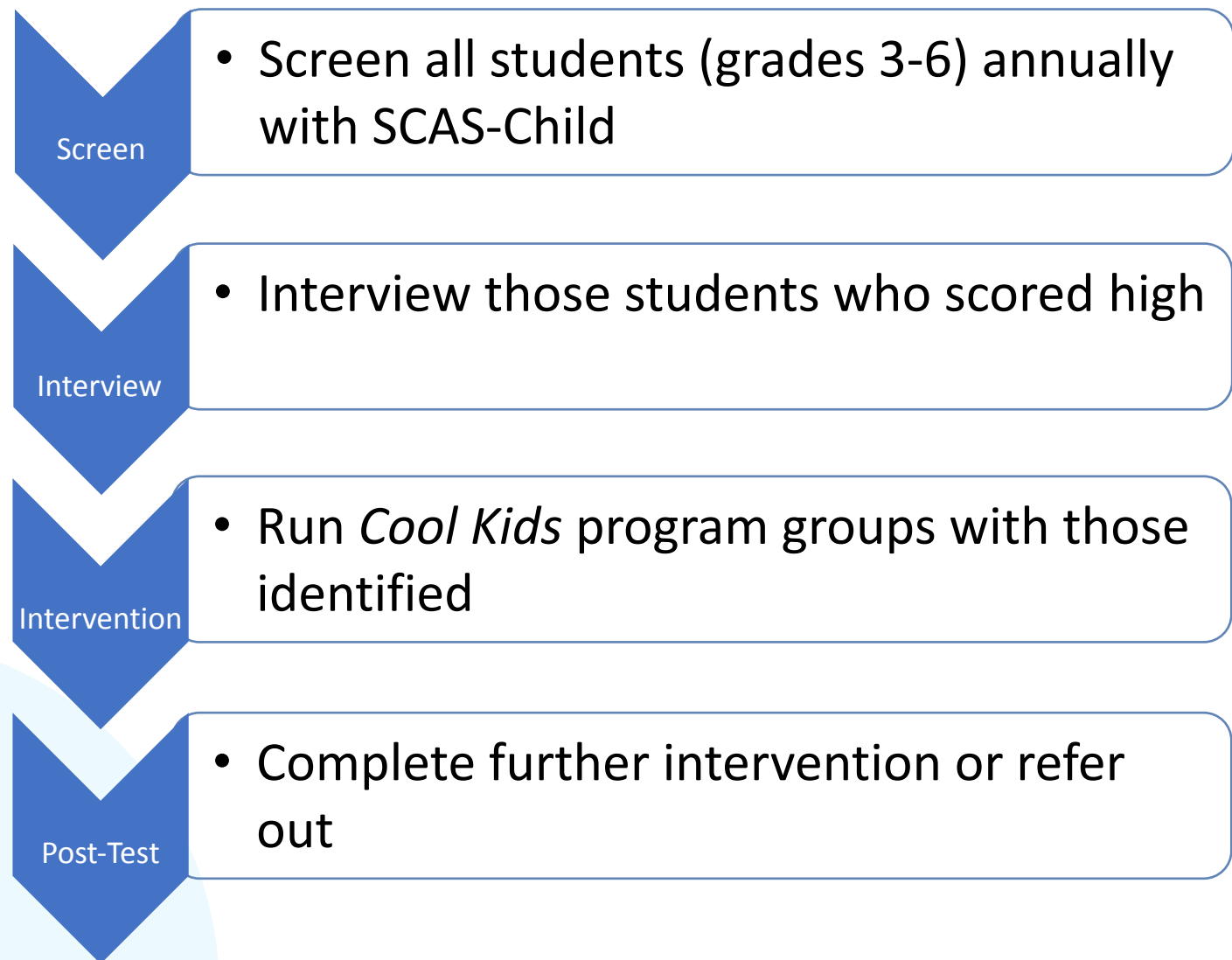
Using child and parent together

- Compare the two forms; agreement is modest by design.
- Children often report internalising symptoms parents underestimate, so a low parent form does not cancel a high child form.
- Weight the informant closest to the feared situation.

Social Phobia Items

		Never	Sometimes	Often	Always
6	I feel scared when I have to take a test	0	1	2	3
7	I feel afraid if I have to use public toilets or bathrooms	0	1	2	3
9	I feel afraid that I will make a fool of myself in front of people	0	1	2	3
10	I worry that I will do badly at my school work	0	1	2	3
29	I worry what other people think of me	0	1	2	3
35	I feel afraid if I have to talk in front of my class	0	1	2	3

Cohort screening using the SCAS-Child?



Anxiety Management Skills for Anxious Children and Teens (aged 7-17 years)

The Emotional Health Clinic in the Macquarie University Lifespan Health and Wellbeing Research Centre offers evidence-based assessment and psychological treatment for emotional disorders across the lifespan. This clinic offers access to our flagship treatment programs that have been developed using scientific research, evaluated in clinical trials, and are used nationally and internationally.

ABOUT THE COOL KIDS PROGRAM

Cool Kids (nicknamed Chilled for teens) is a structured program that treats anxiety in young people. It uses a cognitive behavioural approach which means that it focuses on teaching skills to manage anxiety. The program was authored by the team at the Emotional Health Clinic, has a 30 year research history and is used by Cool Kids Accredited Providers in more than 20 countries.

Core skills for young people in the Cool Kids and Chilled programs include;

- how to identify anxious thoughts, feelings, and behaviours,
- discovering realistic thoughts and expectations (detective thinking), and,
- gradually building independence and confidence by facing fears (stepladders).

If needed, additional skills such as problem solving, social confidence and relaxation are introduced to help manage difficult situations.

Parents are shown how to support their child in the use of these new skills and a section of the program focuses on parenting strategies that encourage children to self-manage anxiety.



COOL KIDS AND CHILLED THROUGH MACQUARIE UNIVERSITY

Although Cool Kids can be run for individual families or in a group for multiple families, at Macquarie the program is offered in individual sessions only. The sessions can be delivered at our clinic in North Ryde (Sydney, Australia) or can be delivered over telehealth (Zoom).

Sessions include time with a young person and parents together, time with the young person alone and time with parents alone. The amount of time with each varies each session and with the age of a young person.

The Revised Child Anxiety and Depression Scale (RCADS)



RCADS Anxiety items $\approx$ SCAS

Why and when?

- When need to know low mood in addition to anxiety.

Anxiety and depression in one DSM-aligned measure

- 47 items
- 6 subscales:
 - separation anxiety
 - social phobia
 - generalised anxiety
 - panic disorder
 - obsessive-compulsive
 - major depression
- Total Anxiety + Total Internalising
- Ages 8–18
- 8 min
- Community Percentiles

Completed by:

Child

Parent

Strengths and limitations

STRENGTHS

- Revised the SCAS to add major depression and remove the poorly performing Physical Injuries subscale, with the factor structure supported in a sample of 1,641 youth.¹
- In a clinical sample of 513 referred youth, showed greater correspondence to specific diagnostic syndromes than traditional anxiety and depression measures.²
- Parent version: high internal consistency, test–retest reliability and good convergent/divergent validity in a school sample of 967.³

LIMITATIONS

- Descriptors depend on the norm set: NovoPsych uses Australian norms for the Child version and US norms for the Parent version.
- Separation anxiety is developmentally uncommon in older adolescents, so read that subscale with age in mind.
- Parent–child agreement is modest ($r \approx .28$), so informants diverge.⁴
- Anxiety and depression share substantial general-distress variance, so the subscales are highly intercorrelated and the separation is relative.⁵

References

1. Chorpita, Yim, Moffitt, Umemoto & Francis (2000). A revised child anxiety and depression scale. *Behaviour Research and Therapy*, 38(8), 835–855 (p. 835).
2. Chorpita, Moffitt & Gray (2005). Psychometric properties of the RCADS in a clinical sample. *Behaviour Research and Therapy*, 43(3), 309–322 (p. 309).
3. Ebesutani et al. (2011). A psychometric analysis of the RCADS – parent version. *J Abnormal Child Psychology*, 39(2), 173–185 (p. 173).
4. Achenbach, McConaughy & Howell (1987). Cross-informant correlations for child/adolescent behavioural and emotional problems. *Psychological Bulletin*, 101(2), 213–232.
5. Clark & Watson (1991). Tripartite model of anxiety and depression: psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology*, 100(3), 316–336.

Interpreting the results

Interpretation

- Total Internalising for overall severity; Total Anxiety for the anxiety composite.
- The subscale profile: which of the six dimensions is elevated.
- NovoPsych reports percentiles against norms, in four bands: Normal (Mild, Elevated, Clinical).
- Reliable change: a shift of about 15 points signals clinically significant change.

Norms are age-based (8-12 and 13-18)



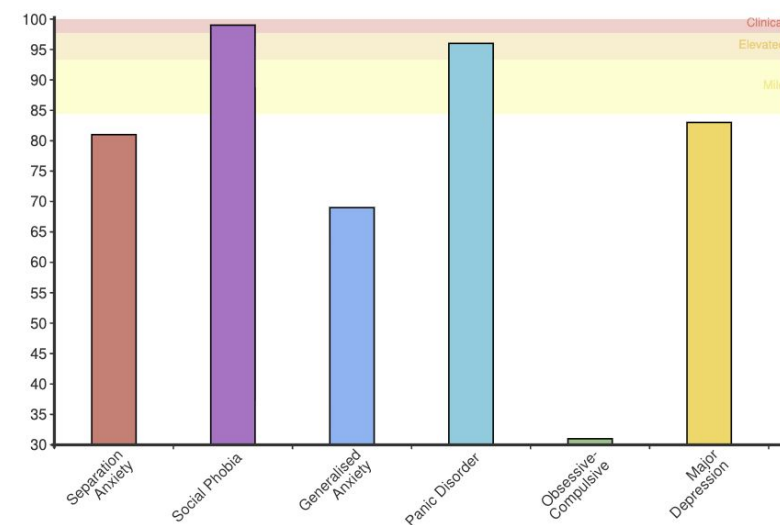
Revised Child Anxiety and Depression Scale - Child version (RCADS-Child)

Client Name	Generic Child	Date administered	25 Jun 2024
Date of birth (age)	1 Jan 2013 (11)	Time taken	1 min 6s
Assessor	Dr David Hegarty		

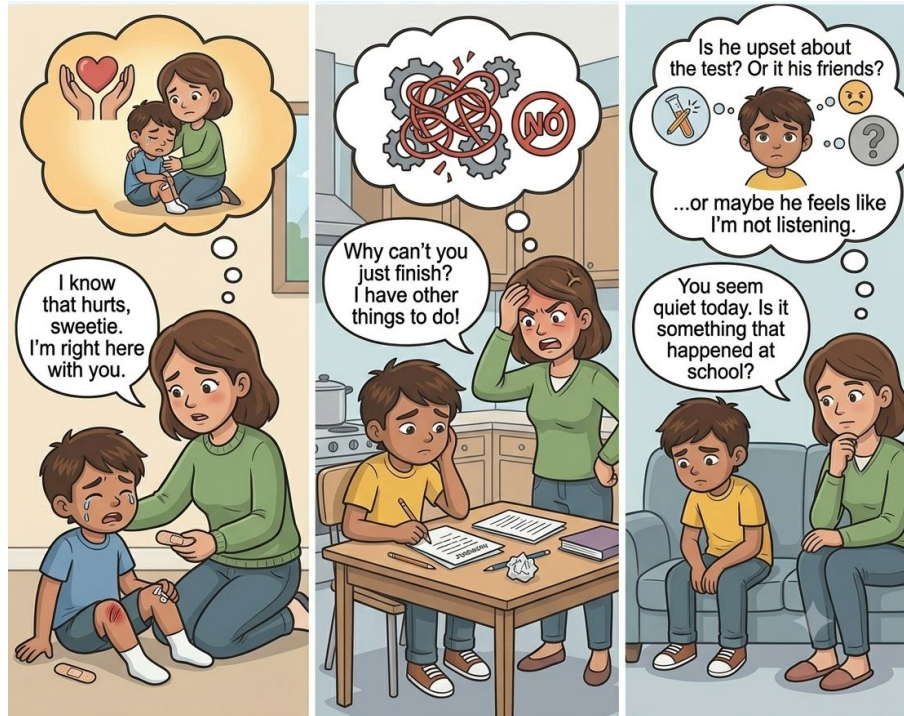
Results

	Raw Score	Normative Percentile	Descriptor
Total Internalising Scale Score (Range 0-141)	68	87	Mild
Total Anxiety Scale Score (Range 0-111)	55	87	Mild
Separation Anxiety (Range 0-21)	8	81	Normal
Social Phobia (Range 0-27)	22	99	Clinical
Generalised Anxiety (Range 0-18)	8	69	Normal
Panic Disorder (Range 0-27)	14	96	Elevated
Obsessive-Compulsive (Range 0-18)	3	31	Normal
Major Depression (Range 0-30)	13	83	Normal

Percentiles for Subscales



The Composite Caregiving Questionnaire (CCQ)



Why and when?

- To assess the caregiving context and the parent's capacities, not the child.
- For formulation, treatment planning, and tracking attachment-based work.

Measuring the caregiving relationship, not the child's symptoms

- 42 items • caregiver self-report
- 5 caregiving scales:
 - self-efficacy: empathy
 - self-efficacy: affection & emotion
 - caregiving helplessness
 - hostile perceptions
 - parent mentalisation
- Children aged 0–6
- 7 min
- Non-diagnostic
- Community percentiles

Completed by:

Caregiver

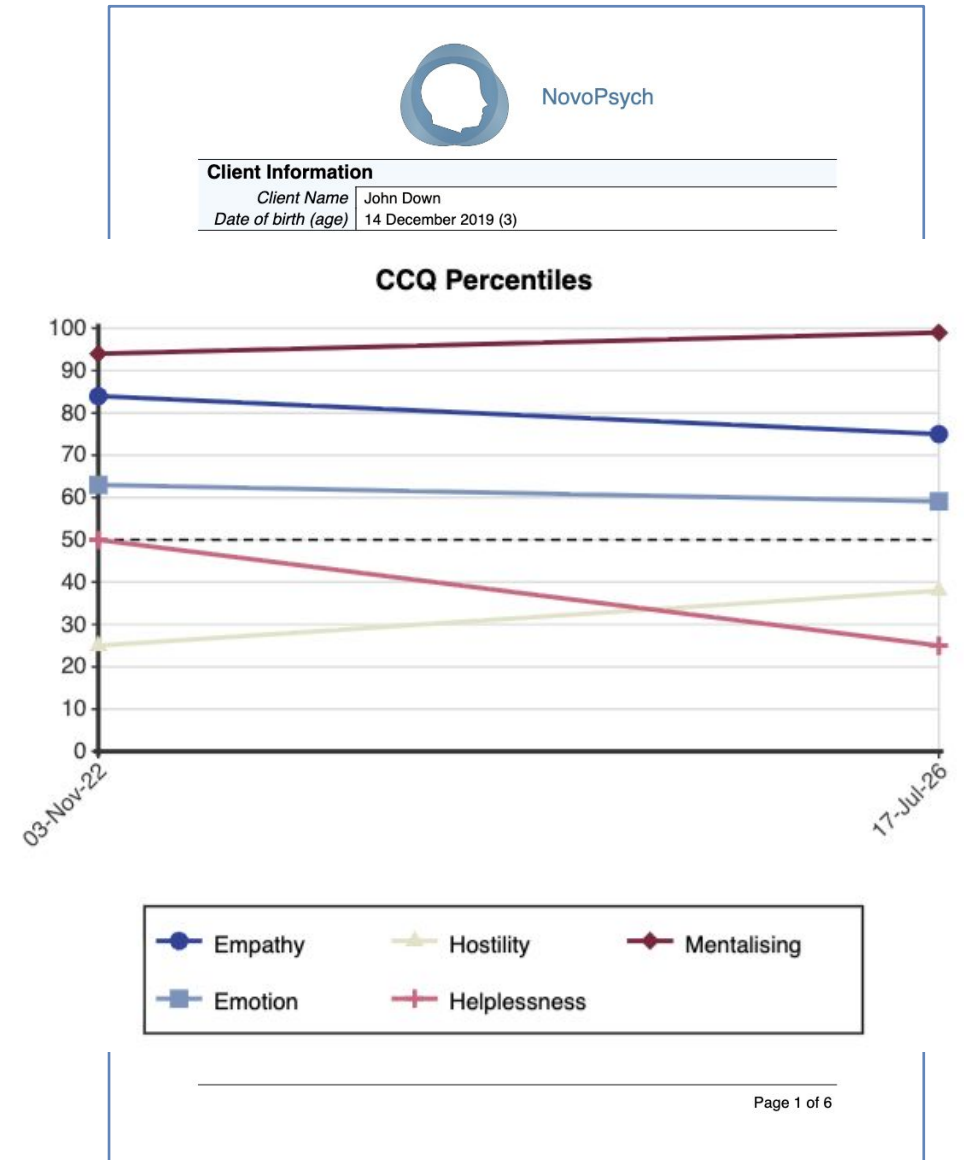
Interpreting the results

Five scales, read one at a time

Read each scale on its own

- Every scale has its own score, percentile and clinical-concern flag; there is no total score.
- Direction differs: higher is healthier for the two self-efficacy scales and mentalisation; higher is a concern for hostile perceptions and caregiving helplessness.
- Percentiles compare the caregiver against a community reference sample (Byron & Hawkins, 2022).
- Each scale carries its own clinical-concern threshold, so read the profile scale by scale.

Because the scales point in different directions, do not read the profile as one “higher is better” bar.



Strengths and what to keep in mind

A relational lens, with an honest evidence note

STRENGTHS

- Shifts attention to the caregiving relationship, which symptom screeners miss.
- Non-diagnostic and clinician-facing, so it supports engagement, formulation and treatment planning.
- Built on constructs from established measures (parenting self-efficacy, caregiving helplessness, reflective functioning).
- Suited to monitoring outcomes of attachment-based treatments such as Circle of Security.

KEEP IN MIND

- The composite's own normative data are unpublished (Byron & Hawkins, 2022), and stand-alone peer-reviewed validation is limited.
- Self-report about one's own caregiving is open to social-desirability effects.
- Designed to inform, not to categorise attachment or serve as a diagnostic or forensic instrument.
- Interpret each scale against its own threshold, alongside history and observation.

References

Underlying constructs draw on: Kendall & Bloomfield (2005), parenting self-efficacy (TOPSE), *J Advanced Nursing*, 51(2), 174–181; Huth-Bocks et al. (2016), Caregiving Helplessness Questionnaire, *Infant Mental Health Journal*, 37(3), 208–221; George & Solomon (2011), caregiving helplessness (in *Disorganized Attachment and Caregiving*, pp. 133–166); Diamond et al. (2013), Maternal Reflective Function Scale.

CCQ normative data: Byron & Hawkins (2022), unpublished. Stand-alone peer-reviewed validation of the composite is limited at present.

The Vanderbilt ADHD Rating Scales



Why and when?

- When ADHD is the question and need symptoms rated against DSM criteria across home and school.
- To screen the common comorbidities (ODD, conduct, anxiety/depression) in the same pass.

DSM-aligned ADHD assessment across home and school

- Parent (VADPRS) 55 items
- Teacher (VADTRS) 43 items
- Ages 5–12
- 7–9 min
- Core ADHD dimensions:
 - inattention
 - hyperactivity / impulsivity
 - combined
- Comorbidity screens:
 - oppositional defiant • conduct
 - anxiety / depression
- Plus functional-impairment questions
- Maps directly to DSM criteria
- Community Percentiles

Completed by:

Parent

Teacher

Strengths and limitations

STRENGTHS

- Maps item-by-item onto DSM criteria; internal consistency and factor structure acceptable and DSM-consistent in a referred sample.¹
- Endorsed by the American Academy of Pediatrics in its ADHD clinical practice guideline.³
- Teacher version validated in over 8,000 children, with DSM-aligned dimensions stable across two years.²
- Parent and teacher forms give the cross-setting evidence DSM requires, and screen comorbidities at the same time.

LIMITATIONS

- The comorbidity screens (anxiety/depression, conduct) are weaker than the core ADHD dimensions; criterion correlations ranged .25–.66.²
- A symptom-and-impairment rating scale, not a diagnosis; the cut-off needs both symptom count and functional impairment.
- Normed for ages 5–12, not adolescents or preschoolers.

References

1. Wolraich, Lambert, Doffing, Bickman, Simmons & Worley (2003). Psychometric properties of the VADPRS in a referred population. *J Pediatric Psychology*, 28(8), 559–567 (p. 559).
2. Wolraich, Feurer, Hannah, Baumgaertel & Pinnock (1998). Obtaining systematic teacher reports of disruptive behaviour disorders utilizing DSM-IV. *J Abnormal Child Psychology*, 26(2), 141–152 (p. 141).
3. Wolraich et al. (2011). ADHD: clinical practice guideline for the diagnosis, evaluation and treatment of ADHD. *Pediatrics*, 128(5), 1007–1022.
4. Yuki, Bhagia, Mrazek & Jensen (2016). How does a real-world child psychiatric clinic diagnose and treat ADHD? *World Journal of Psychiatry*, 6(1), 118–127 (p. 118).

Interpreting the results

How I read it

- Each dimension is a symptom count: items rated “often” or “very often” (2 or 3) count towards that dimension’s DSM threshold.
- Read the ADHD dimensions first (inattention, hyperactivity/impulsivity, combined), then the comorbidity screens.

Symptoms without impairment, or impairment without symptoms, do not meet the cut-off on their own.

Cutoffs require symptoms **AND** impairment



Assessment powered by
NovoPsych

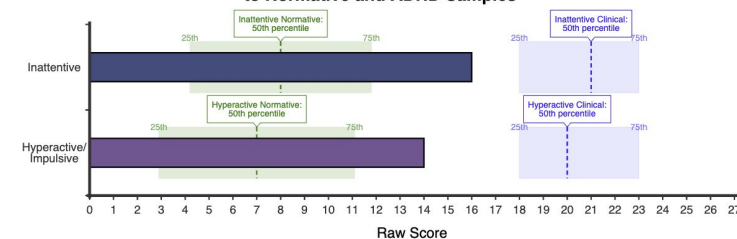
Vanderbilt ADHD Diagnostic Parent Rating Scale (VADPRS)

Client Name	Generic Child	Date administered	1 Apr 2025
Date of birth (age)	1 Jan 2015 (10)	Time taken	1 min 48s
Assessor	Dr David Hegarty		

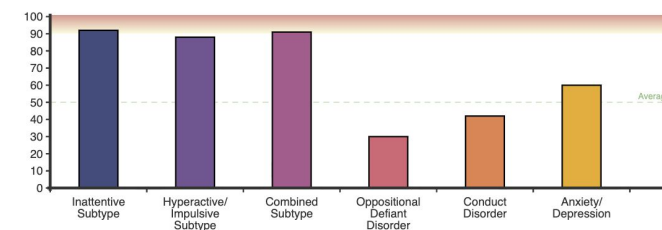
Results

	Raw Score	Above clinical cutoff?	Normative Percentile
Inattentive Subtype	16	Yes	92
Hyperactive/Impulsive Subtype	14	No	88
Combined Subtype	30	No	91
Oppositional Defiant Disorder	3	No	30
Conduct Disorder	1	No	42
Anxiety/ Depression	4	No	60

VADPRS ADHD Subscale Scores Compared to Normative and ADHD Samples



VADPRS Subscale Normative Percentiles



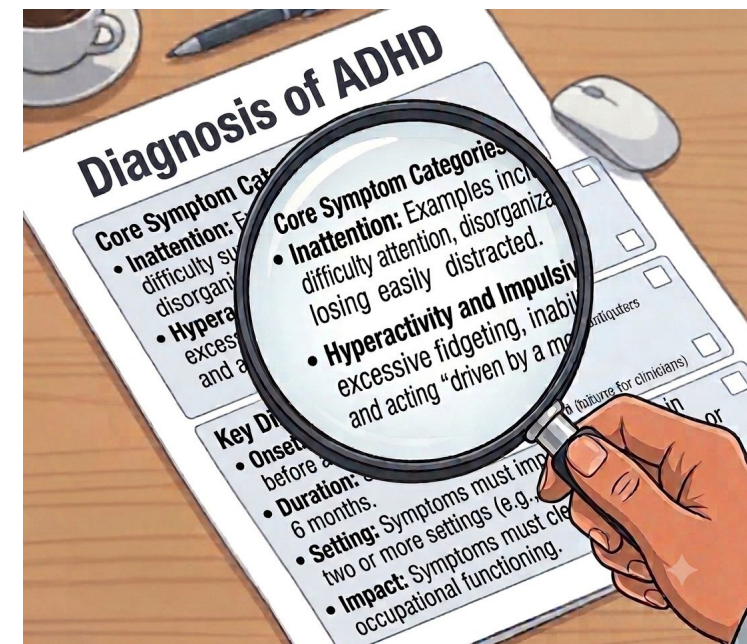
A different view: DSM criteria, across settings

Why it's a different view

- Multi-informant by design to test pervasiveness, not just to add a perspective: DSM requires symptoms in two or more settings, so the parent and teacher forms establish cross-situational presence.

Using it after a broad screen

- Unlike the SDQ, you're looking for agreement across settings: cross-setting corroboration supports an ADHD picture.
- Symptoms in one setting only (school but not home, or the reverse) can fail the pervasiveness test and point to a situational cause, a specific classroom, a learning difficulty, a home stressor, rather than ADHD.



The discrepancy is the data.

Neither informant is wrong. Match the pattern to context, weight the better-normed observer, and let it steer the next assessment step.

The rest of the NovoPsych child toolkit

Everything else flagged for children that we didn't cover in detail today

Domain	Assessment	Ages	Informant	What it measures
Anxiety	• SCARED (Child & Parent)	8–18	Child & parent	Anxiety-disorder symptom screen
	• Preschool Anxiety Scale (PAS)	2½–6½	Parent / guardian	Anxiety in young children
Mood	• Mood & Feelings Questionnaire (Self & Parent)	6–17	Self & parent	Recent depressive symptoms
	• Center for Epidemiological Studies Depression Scale for Children (CES-DC)	6–17	Self	Depression
OCD	• ChOCI-R (Self & Parent)	7–17	Self & parent	Obsessive–compulsive symptoms & severity
Autism / neurodevelopmental	• Childhood Autism Spectrum Test (CAST)	4–11	Parent, carer or teacher	Autism screen
	• Autism Spectrum Quotient Children's Version (AQ-Child)	4–11	Parent	Autistic traits
	• Extreme Demand Avoidance-8 (EDA-8)	5–17	Parent / caregiver	Extreme demand avoidance (PDA)
Trauma / dissociation	• International Trauma Questionnaire – Child and Adolescent Version (ITQ-CA)	7–17	Self	Trauma & complex PTSD
	• Child Dissociative Checklist (CDC)	5–12	Observer (parent/carers)	Dissociative symptoms
Behaviour	• Institute for Basic Research – Modified Overt Aggression Scale (IBR-MOAS)	6+	Clinician / observer	Overt aggression: type & severity
Eating	• Children's Eating Attitudes Test (ChEAT)	8–15	Self	Disordered-eating attitudes
Distress / monitoring	• Depression Anxiety Stress Scales – Youth Version (DASS-Y)	7–18	Self	Depression, anxiety & stress
	• Young Person's CORE (YP-CORE)	11–16	Self	Global distress; outcome monitoring
	• Strengths & Stressors (SAS)	1–17	Clinician	Family functioning & development
Functioning	• World Health Organisation Disability Assessment Schedule – Children and Youth version (WHODAS-Child)	10–17	Self	Functioning & disability
	• Multidimensional Assessment of Interoceptive Awareness – Youth Version (MAIA-Y)	7–17	Self	Interoceptive awareness

All are on the NovoPsych child assessment list. Child and parent (or self) forms are combined where both exist.