Frequently Asked Questions: The Clinician's FAQ to HoNOSCA in Australia

Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP)

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The final report of the Mental Health National Outcomes and Casemix Collection: NOCC Strategic Directions 2014 – 2024 project (National Mental Health Information Development Expert Advisory Panel, 2013) recommended that work should be undertaken "to supplement the HoNOSCA glossaries to optimise clarity for particular items (5, 7, 13, 14 and 15)".

These Frequently Asked Questions are intended to provide clinicians with guidance around the specific items identified by the NOCC Strategic Directions report plus other common issues that may not be answered in the HoNOSCA glossary (Gowers et al., 1999). They are not exhaustive and clinicians, policy makers, analysis and other interested parties are encouraged to forward additional questions to the national Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP) through their State/ Territory outcomes implementation teams.

While there are no objective 'experts' in the world of outcome measurement, these FAQs are intended to provide guidance based upon the author's experiences.

Reliability, validity and feasibility

Is HoNOSCA reliable? Across disciplines, across raters, across services?

Reliability tells you the confidence with which the results of an instrument can be used under specific circumstances. The reliability of HoNOSCA is good for a routinely-used instrument. HoNOSCA's reliability is higher if the same rater is used to follow the progress of one consumer over time, or if aggregated data are used for analysis of a number of consumers. Although there are some differences between disciplines, a key issue is that those clinicians who have worked in acute inpatient settings tend to rate community consumers slightly lower than community-based clinicians. Training is useful for highlighting clinician differences and improving inter rater

[1] CAMHIDEAP recognises earlier contributions to this work from Brann et al. (2003)

reliability.

In short, HoNOSCA is reliable enough. For further information see recent articles (Hanssen-Bauer et al., 2007; Hanssen-Bauer et al., 2010; J. Pirkis, Burgess, P., Kirk, P., Dodson, S., & Coombs, T., 2005).

Is HoNOSCA a valid instrument?

To date, in published studies, HoNOSCA has been demonstrated to have good discriminative and concurrent validity, good face validity and to be sensitive to change. For further information see recent articles (Hanssen-Bauer et al., 2010; J. Pirkis et al., 2005).

What is the clinical utility of HoNOSCA?

At the level of the individual, comparing previous and current HoNOSCA ratings as part of routine clinical practice in clinical review has been found to be clinically useful. This is because the HoNOSCA covers the range of issues that are likely to be of clinical significance. So it provides a useful structure for summarizing and considering the person's progress over time. The HoNOSCA can be used to assist clinical supervision including the practice of assessment and the process of case reviews. It has also been used to support efficient communication between clinicians by identifying key areas of clinical concern as well as supporting discussions between clinicians, consumers and families along with the process of joint care planning.

Collection of HoNOSCA ratings also meets the service's need for information about the nature of the consumer's difficulties and the changes in those difficulties over time. This need for information requires that clinicians routinely collect data about individual consumers so that services can derive aggregate statistics. The collection of this information is essential in effectively managing services, developing policy and learning how best to deliver effective care.

The need to collect, reflect and have mental health practice informed by the collection and use of standard outcome measures stems from both the National Mental Health Strategy and good clinical practice.

HoNOSCA doesn't go into enough detail with the problem we are treating.

HoNOSCA is not meant to deal with everything that may be occurring in a child or young person's life. This is a routine instrument and all services may choose to add other more specific instruments into their own practice. The benefit of HoNOSCA's generality is that it captures information about a variety of different aspects of the child or adolescents life. The HoNOSCA is not a diagnostic tool and can be supplemented with the completion of other instruments if you or

your service require. HoNOSCA is also part of suite of measures that, used together, provide information about a child or adolescent.

Implementation issues

What does my service need to do to make HoNOSCA most useful for consumers, clinicians or for my service?

Consumers and carers

- Provide user-friendly information that clinicians can share with young people and their families / carers in understanding problem areas, defining /agreeing on treatment goals, planning care and reviewing progress.

Clinicians

- Treating findings as hypotheses to be considered.
- Be open to feedback and reflection.
- Commit to sharing outcomes with young consumers and their families.
- Commit to using outcomes in clinical reviews, supervision and team quality improvement activities.

Services

- Provide clear protocols and procedures for data collection.
- Provide the resources required for data collection.
- Provide user-friendly, timely, individual consumer, clinician and team data.
- Use the data to inform clinical processes such as peer and case reviews, supervision, choices of interventions, and examining case progress.
- Use the data to inform team and service processes such as exploring relative strengths and weaknesses of the team, informing team and individual professional development.
- Demonstrate leadership through using the data in a sensitive and thoughtful manner.
- Dedicate time and resources to use the data and support clinicians in proactively exploring the data.
- Ensure that HoNOSCA (and all outcome measures) are included in routine processes rather than being conceptualised and treated as add-ons.
- Ensure that the emphasis remains on clinical utility and learning from our work.
- Encourage outcome data to be used in reflecting on all aspects of practice including the impact of management-initiated procedures and policies.

Can the HoNOSCA be used with different age groups?

HoNOSCA was designed for children and adolescents. As a starting point, the presumption is that it will be used with any child or young person using a CAMHS service irrespective of age. It should be useful for the majority of CAMHS consumers including 18 year olds. At the younger end it has been used with 3 years and up. While it has been used with 3 year olds, there appears more variability in reports of its usefulness. Clinical judgment should be used with this age group, and younger, to decide if it should not be recorded. Experience in the UK and Australia suggests that from 4 years old, the scale is typically useful.

As the important needs of infant mental health should not be ignored, further work is being undertaken in regards measurement for those aged 0- 47 months.

Is HoNOSCA useful with a range of cultural and linguistically diverse groups?

Your cultural competence as a clinician guides how you conduct your assessment and your understanding of the phenomena you observe. The cultural appropriateness of the HoNOSCA rating should reflect the cultural competence of the rater in understanding the nature of presentation in that group. For example, conceptualising 'hearing voices' as 'hallucinations' always requires interpretation within the applicable cultural context. Elders or specialist organisations may be of assistance in supporting that understanding. Cultural and social mores will also be relevant in understanding whether a phenomenon is, or is not, a symptom. The clinician rather than the instrument determines whether a phenomenon is a 'symptom'. The instrument provides a mechanism for producing a summary of your clinical assessment.

Is HoNOSCA a diagnostic instrument?

No. HoNOSCA focuses on symptoms and functioning. One child with ADHD may have their activity and concentration well treated and hence receives a low rating on Scale 2; while another with a psychotic disorder may have marked concentration difficulties and hence receives a high score on Scale 2.

General rating issues

If the score on any particular scale is greater or equal to 2, what do I do? How do you distinguish the rating points e.g. minor to mild, and moderate to severe?

HoNOSCA does not tell you what to do; it describes the child. What you do is a clinical decision. As

a guide, MH-OAT (NSW) and Dr Peter Brann (CAMHIDEAP Chair) encourage clinicians to consider the information in the table below.

While HoNOSCA is not a binary scale, it can be helpful to firstly consider whether the problem is clinically significant or not. After this, the next question is your judgment regarding the severity of the problem.

Not clinically significant	**0**	**No problem**	**Problem not present.**
	1	Minor problem	May require further assessment, monitoring or no intervention. May or may not be recorded in clinical file.
Clinically significant	2	Mild problem	Warrants recording in clinical notes. May or not be incorporated in care plan.
	3	Moderate problem	Warrants recording in clinical file. Should be incorporated in care plan.
	4	Severe to very severe problem	Warrants recording in clinical file. Should be incorporated in care plan. Note – child or young person can get worse.

I can't decide on what scale to rate a particular behaviour/problem. What should I do?

The key is to remember to only rate a particular behaviour or symptom once. For example, a drunk adolescent gets into a fight and suffers a broken arm. The aggression would be rated at Scale 1, the alcohol at Scale 4 and the physical injury at Scale 6. As the aggression has been rated at Scale 1, it would not be used to inflate or create a rating at Scale 4. Another example, which can cause concern, is the weight loss from an eating disorder which would be rated at Scale 6, while the vomiting would be rated at Scale 8 and the anxiety around eating would be rated at Scale 9.

Perhaps a helpful guideline is to remember that one diagnosis does not equate to one scale only and that one behaviour/symptom can only be scored on one scale.

We work as a team, so how should we do the rating?

Teams may discuss the consumer but one person from the team should be primarily responsible (e.g. case manager, key person). This also applies to any situation where multiple staff members are involved with one consumer.

Disagreements between team members on ratings are certainly worth exploring as they may reveal more about different experiences and perspectives which can enrich the team's shared understanding about the child. Disagreements may also reveal more about team members' perspectives than the instrument per se.

How do we deal with different views? For example, what if the mum and dad or the parent and child disagree or provide different views?

Great question! This is a common occurrence. All information from all sources, including case notes, other informants etc. is taken into account and the ratings are based on your integrated clinical judgment. In all clinical assessments, we weigh up different informants. This is the same. HoNOSCA provides a record of your clinical judgment based on information available at that point in time.

Can I rate the HoNOSCA if I haven't seen the child or the adolescent?

CAMHIDEAP is of the opinion that it is necessary to have seen the child or adolescent in order to have first-hand information about the previous 2 weeks for them. Without this information, the ratings are too dependent on the perceptions of others and it is difficult to have an informed clinical judgement.

HoNOSCA records clinicians' judgment which is strengthened by contact with the young person. With this in mind, there will be situations where a clinical judgment that further investigation is required is rightly formed based on the perspectives of others (e.g. a young person who is itinerant and is reported by others to be self-harming). In this case, clinical judgment will be required to determine whether HoNOSCA can be completed prior to seeing the young person followed by an ad hoc review of the young person when contact is established. If interventions are planned and implemented through others (e.g. parents) even though the young person refuses to participate, then clinical judgments are likely to have been made.

I am discharging the child/young person and I haven't seen them in some time. Can I still rate the HoNOSCA?

This question presumes that you have seen the child and provided an assessment rating. It is not uncommon for young consumers and their families/carers to complete their contact with CAMHS without a formal closure session. You would rate the discharge HoNOSCA based upon all sources

of information including what your own experience indicates the child's state is likely to have been in the 2 weeks prior to the discharge rating. The act of discharging that child/young person indicates that you have formed a view that this, rather than proactive follow up, is the appropriate clinical course of action. For example if a youth worker colleague raises concerns about the young person's suicidality, then you would be unlikely to discharge the young person. Again, HoNOSCA is a means for documenting your clinical judgment, based on all sources of information and a discharge reflects your clinical judgment.

Can something be a symptom if nearly everyone does it? For example, all the kids in my town smoke.

The challenge in using a glossary that refers to current societal and age norms is that these may vary across the country. There is a range of important discussions to be held between clinicians as to what constitutes clinically significant behaviour. One of the benefits of standard outcome measures is that they help bring out differences of opinion and should provide a basis for examining differences between regions and clinicians. This issue reminds us to ensure that comparative results using any outcome measure are treated as valuable hypotheses rather than as definite conclusions about population differences. In the first instance, they provide an opportunity to have these kinds of discussions within our teams.

Does the cause of a disorder matter in knowing how to rate HoNOSCA?

HoNOSCA does not ask for causation. Symptoms, behaviours and functioning are rated at their appropriate scale. The only time this may seem to become an issue concerns Scales 6 and 8. If a symptom is presumed to be non-organic it will be rated at Scale 8 but if it is presumed to be organic (i.e. an aspect of a physical illness) then it would be rated at Scale 6. In practice, this does not seem to be a huge problem, particularly if as suggested, the same clinician rates at each rating period.

Specific scale rating issues

What if there is only one example or incident of aggressive behaviour (Scale 1) during the rating period?

Rate the worst manifestation of the behaviour. Some clinicians have been reluctant to rate one incident as they believe it may imply that the child has a particular disorder when the behaviour may be contextually understandable. However, HoNOSCA is a descriptive tool. If a rating is recorded on this scale, it doesn't mean the child has a particular diagnosis. The presumed cause of the behaviour/symptom is not relevant to whether it is rated. It may only influence the scale on which it is rated.

For example, a child punches another child in the school grounds at lunch time. The punching is rated even though it turns out that the apparent 'aggressor' has been bullied over a long period by the apparent 'victim'. Targeting the aggressive behaviours may be focused on environmental rather than individual interventions. Irrespective of the 'cause', change in this behaviour is an important issue that should be tracked by routine outcome measurement.

How do we distinguish self-harm from suicide on Scale 3?

As with all risk assessment, the clinician's task is to assess intent and likelihood of harm and this can be applied to both self-harm and suicidality. Reading of the glossary makes it clear that the scale does not consider self-harm to be less severe than suicidality. Both a serious suicide attempt and serious self-harm can receive a rating of 4.

What if the child or young person has autism and so has always had language problems – how do I rate that on Scale 5?

Children with intellectual disability would not be rated unless their functioning is below the expectation / overall cognitive functioning for that child/adolescent. Specific developmental delays in scholastic or language skills should always be scored because a specific delay is below the level expected on the basis of the child's mental age; hence language disorder in autism would be rated.

The guiding principle is the expected level for that child/adolescent. This feature would also permit the rating of a child with average language or scholastic skills whose prior performance was at a higher level. Prior performance should be conceptualised as the average overall impression rather than any specific high or low.

What would constitute a rating of 2 or more in regard to eating disorders on Scale 7?

To give an example, consider a girl who has been actively losing weight and is objectively underweight, who says she is fatter than most girls her age and "losing a bit more weight will only be good". This type of thinking would be rated and the girl is seen as having a clinically significant perceptual problem on this scale.

How do you rate a child not in school on Scale 13?

This item is best understood as tapping into the prime vocational setting for this age group. School is the prime opportunity for this group. However there are other options available and they should be the reference point. The underlying construct is the engagement in the expected vocational activity at that age.

It is not about whether the expected option is good or desired (e.g. mutual obligation). Rate against their usual vocational or educational setting (e.g. TAFE, employment, preschool, education in a correctional setting). For those who are unemployed, the target vocational setting at that time may be considered to be Centrelink and its requirements.

What is the difference between Scales 14 and 15?

Scale 14 is about the difficulties being experienced by the child or young person and how those children or young people, and their parents or carers, understand the nature of the problem, its cause or prognosis. Scale 15 is about the degree of understanding the child or adolescent, or their parent or carer, has about managing any difficulties being experienced by the child or young person e.g. where to go and what to do.

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