HoNOSI

Health of the Nation Outcome Scales for Infants

(0-47 months)

Glossary

Ver 1.0

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The Health of the Nation Outcome Scales for Infants (HoNOSI)

Introduction

The early years are foundational for healthy social and emotional wellbeing across the lifespan. Early intervention can have a powerful impact on creating positive outcomes across this developmental trajectory.

The Health of the Nation Outcome Scales for Infants (HoNOSI) has been developed as a routine outcome measure to support clinicians who work to improve the emotional and social well-being of infants and young children in the 0 - 3 year old age group (i.e. 0-47 months). There is a broad range of development within this age band and where appropriate, the HoNOSI attempts to provide guidance for rating both those at the younger and those at the upper end of the age band. At the same time, HoNOSI is built on clinical judgement as to the level of severity to be rated. For further information on developmental stages, refer to:
https://wcwpds.wisc.edu/childdevelopment/resources/CompleteDevelopmentDetails.pdf
https://childdevelopmentinfo.com/ages-stages/#.WCqgZkbD92g
http://raisingchildren.net.au/
http://www.education.vic.gov.au/childhood/parents/health/Pages/default.aspx
and/or consult your colleagues and supervisor regarding developmental stages, how to rate clinical cases or how to use this instrument.

Therefore, underpinning the use of HoNOSI is considering the age and developmental stage of the infant or young child and the typical parameters of child development. For pre-term infants, the clinician is likely to consider whether developmental age is more relevant than birth age. Certain behaviours e.g. oppositional or disruptive behaviours are normal in the development of young children as they explore and begin to individuate, as are separation anxiety symptoms late in the first year. The capacity to learn to regulate their emotions and behaviour occurs within the context of their primary caregiving relationships.

The HoNOSI has been developed for use by clinicians working both in specialist perinatal and infant mental health units and for those who see infants and young children in child and adolescent mental health service settings. It is expected that knowledge of development and the impact of the early years on later development is central to all clinicians working with infants, pre-schoolers, children and adolescents although specialist infant mental health and generalist child and adolescent mental health service staff may have differing levels of familiarity and specialist knowledge. While the prime audience are clinicians within the specialist mental health sector (both infant and CAMHS), it is possible that HoNOSI may also be of use to clinicians in the primary mental health sector.

For clinicians, the HoNOSI aims to:

- inform treatment decisions by highlighting unexpected progress or deterioration for infants/young children;
- document the progress of the infant/young child and make overt changes, and;
- facilitate discussion of infants and young children's presentation among clinicians.

Services might also use the HoNOSI as an adjunct to:

- describing program or service effectiveness, and;
- contributing to examining the local implementation of evidence based treatments.

As with HoNOSI's companion instrument, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), rating the presence of difficulties on any HoNOSI scale does not necessarily indicate that the source of the difficulty, or the required intervention, is solely with the infant/young child. To interpret any clinical ratings as indicating the infant/young child is the sole locus of the psychopathology is to both misinterpret the instrument and misunderstand the interdependent nature of child development and the environment in which it occurs.

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Background to HoNOSI

HoNOSCA was developed in the UK by a team led by Dr Simon Gowers and Prof Richard Harrington in the late 1990s. The aim was to have an instrument that was brief, reliable and valid enough that it could be used routinely in Child and Adolescent Mental Health Services (CAMHS) to ascertain both a snapshot of children and adolescent's level of symptomatology as well as change over time. The first HoNOSCA paper was published in 1999 and since then HoNOSCA has been used widely (Adamis et al., 2011; Bilenberg, 2003; Brann, 2010; Duffy & Skeldon, 2014; Gowers et al., 1999; Hanssen-Bauer et al., 2010; Kisely et al., 2010; Lesinskiene, Senina, & Ranceva, 2007). Australian CAMHS trialled HoNOSCA in 1999 and by 2003, it was part of the National Outcomes and Casemix Collection (NOCC) implemented by all Australian State and Territory Governments (Department of Health and Ageing, 2009).

The Australian Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP) recognised the need for related instruments for infants and young children under the age of 4 years as a clear gap in the NOCC protocol. The panel undertook a number of reviews of available outcome measures using both a rigorous process for assessing clinician and parent rated instruments and parameters for decision making. A significant gap in outcome measurement was identified. One option that ran as an ongoing subtext was to create a HoNOSCA like instrument for the under 4 year olds to fill this gap. This was not intended to replace any other instruments but rather to fill the gap in clinician-based instruments that exist in the public domain, and could readily be incorporated into the existing extensive collection and reporting infrastructure across the multiple governments and organisations that comprise the Australian mental health system.

Given the central importance of life-span approaches to mental health practice and service delivery and the emerging significance of the impact of the life cycle in mental health, addressing this gap is a national priority. With a collaborative relationship developed during an international examination of HoNOSCA (Hanssen-Bauer et al., 2007), the lead initiative occurred from Dr Sally Merry of New Zealand, with in principle support from key figures of the collaboration from the UK, Denmark, Norway as well as Australia. With the initial ideas scoped by Dr Merry, the CAMHIDEAP facilitated further development of HoNOSI. The working group included Dr Peter Brann, Dr Elisabeth Hoehn, Ms Margaret Hoyland, Dr Anne Sved Williams, Dr Nick Kowalenko, Ms Wendy Preston, Mr Tim Coombs and Ms Rosemary Dickson.

This version was developed to have a starting point for empirical testing and anticipated modification and parallels the HoNOSCA in so far as the quality of the ratings is more obviously a function of the knowledge of the rater and makes overt the rater's understanding of the infant or child's presentation. As with HoNOSCA, presentations do not differentiate aetiology. For example, an infant's apparent anxiety may be thought to be a reflection of the parent's anxiety but the anxiety will still be rated. No rating should ever be understood to comment on the cause or the solution. A clinical rating is simply shorthand for indicating there are difficulties: how best or who is best to deal with them, is a separate question.

For ease of reading, unless a specific term is required, 'infant' is used to refer to all children aged 0-47 months in this glossary. Unless specifically noted, parent should be read as including all caregivers. The term 'parents' may indicate plural or singular.

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The HoNOSI

Scale 1	Problems with disruptive behaviour/irritability/under controlled emotional regulation
Scale 2	Problems with activity levels, joint and/or sustained attention
Scale 3	Non accidental self-injury or lack of self-protective behaviours
Scale 4	Problems with feeding and eating behaviour
Scale 5	Problems with developmental delays
Scale 6	Problems with physical illness or disability
Scale 7	Problems associated with regulation and integration of sensory processing
Scale 8	Problems associated with sleep
Scale 9	Problems with emotional and related symptoms or over-controlled emotional regulation
Scale 10	Problems with social reciprocity
Scale 11	Problems with age appropriate self-care and environmental exploration
Scale 12	Problems with family life and relationships
Scale 13	Problems with attending care, education and socialisation settings
Scale 14	Problems with knowledge or understanding about the nature of the infant's difficulties
Scale 15	Problems with lack of information, understanding about services, or managing the infant's difficulties

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Key principles for rating the HoNOSI

- The rating period is the previous two weeks.
- Rate each scale in order from 1 to 15.
- Use all available information in making your rating. That is, HoNOSI ratings should reflect your judgement based on all sources of information available to you.
- Underlying problems may manifest across different scales but do not include a manifestation already rated in an earlier scale.
- Rate the most severe occurrence of the problem in the rating period, not the inferred cause.
- Clinically significant symptoms should be rated at a 2 or above.
- Ratings are informed by familiarity with, and a good understanding of, infant and child development. Good clinical practice recognises the role of supervision, team reviews, training and other resources as tools for reflecting on infant and child development. HoNOSI will not replace these. All examples in the glossary should be seen in a developmental context.
- The instrument is focussed on the infant but any rating may also reflect the relationship with the parent(s). Include the infant's temperament, parent's responses, interactions and level of distress regarding aspects of the infant's behaviour and presentation. As with HoNOSCA, the presence of a clinically significant rating (scoring 2, 3 or 4) does not imply that the source of the problem and/or the locus of intervention, is necessarily exclusively with the infant.
- When establishing a rating point, it can be useful to consider the underlying construct of a problem as a continuum.
- Differences between rating points may be influenced by the intensity of a problem, the presence of multiple problems, or the frequency of the problems.
- Each item is rated on a five-point scale of severity (0 to 4) as follows:

Score	**Rating**	***Suggested implications***
0	No problem.	In the clinician's considered opinion.
1	Minor problem requiring no formal action.	Sub-clinical problem, evidence of some behavioural disturbance or distress, unlikely to be monitored or included in care plan.
2	Mild problem.	Mild problem, clinically significant issue, evidence of distress and/or behaviour disturbance. Likely to be monitored or included in care plan.
3	Problem of moderate severity.	Moderate problem, clinically significant issue, evidence of greater distress and/or, behavioural impact. Definitely monitored and included in care plan.

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4	Severe to very severe problem.	Severe clinical problem, distress and/or behavioural disturbance dominant aspect of presentation, greater frequency and/or intensity of clinical activity as evidenced in care plan.
9	Not known or not applicable.	

- Higher ratings can be expected to accompany more severe, more frequent and more widespread presentations.

- As far as possible, the use of rating point 9 should be avoided, because missing data makes scores less comparable over time or between settings.

- The total score for HoNOSI is calculated by summing the first 13 scales. Missing data (i.e. '9') should be treated as zero for this purpose. A valid total score requires at least 11 of the first 13 scales to be rated in the range 0-4.

Specific information on how to rate each point on each item is provided in the Glossary.

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Scale 1: Problems with disruptive behaviour/irritability/under controlled emotional regulation	
Include	Oppositional and disruptive behaviours are normal in the development of young children as they explore and begin to individuate. This scale addresses problems with the age and developmentally appropriate capacity of the infant to manage strong feelings, without recourse to age inappropriate levels of overt disruptive behaviours. Clinically, the identification of age-inappropriate emotional regulation does not indicate the source of any difficulties. It may be expected, though not invariable, that regulating emotions connected to hunger, tiredness, and separation may be more prominent with younger infants while overt aggression or rage may be prominent with the older children. Include behaviour associated with any disorder (such as hyperkinetic disorder, depression, autism). Include the capacity to manage intense feelings of hunger, tiredness or separation from the primary caregiver. Include difficulty calming, demanding, whining, undue irritability, excessive crying, frequently arching back and stiffening coupled with turning away from all eye contact, physiological indicators of stress (hiccups, yawns, non-injurious scratching) and manifestations of under controlled emotional regulation. Include physical or verbal aggression (e.g. pushing, hitting, biting, kicking, teasing), to others (e.g. children, parents or other caregivers, siblings, familiar adults or strangers), animals or objects (e.g. toys). Include oppositional behaviour (e.g. defiance, opposition to authority or tantrums).
Exclude	Problems associated with feeding and sleeping rated at scale 4 (feeding) and scale 8 (sleeping). Problems directly associated with physical health illnesses or disability rated at scale 6. Problems associated with self-injury rated at scale 3. Problems associated with over-controlled emotional regulation or inhibited behaviours are rated at Scale 9. Problems associated with Sensory Processing that impact on adaptive interaction are rated at Scale 7.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action.
2	Mild problem. May be limited to one context.
3	Problem of moderate severity with disruptive or aggressive behaviour or under controlled emotional regulation. May be/likely to be in more than one context.
4	Severe to very severe problem with disruptive or aggressive behaviour or under controlled emotional regulation. May occur in almost all activities.

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Scale 2: Problems with activity levels, joint and/or sustained attention	
Include	Include problems with overactivity/underactivity, joint and sustained attention associated with any cause, including related to aspects of the caregiving environment (e.g. lack of appropriate stimulation, opportunities for motor development). Include problems with restlessness, fidgeting, jerkiness, distractibility, listlessness or concentration due to any cause, including depression. Include issues of sustained as well as joint attention. Activity and attention difficulties may manifest in altered levels of vigilance, impaired turn taking in behavioural interactions, pronounced startle reflexes and rigidity. Where two factors appear to negate each other (e.g. joint attention problematic but sustained attention is not problematic), rate the most severe occurrence.
Exclude	Problems directly associated with physical health illnesses or disability scored at scale 6.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action.
2	Mild problem with overactivity/underactivity or restlessness but with age-appropriate support/structure, the infant can modify their activity levels. Some vulnerability in joint and/or sustained attention however the infant's development is only mildly affected.
3	Problem of moderate severity with overactivity/underactivity. Activity levels may be difficult to control even with appropriate supports. May be significant issues with joint and/or sustained attention.
4	Severe to very severe problem with overactivity/underactivity. Likely to be impacting negatively on the infant's capacity to engage and achieve developmental milestones across multiple contexts. Consistent and severe limitations in joint and/or sustained attention.

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Scale 3: Non accidental self-injury or lack of self-protective behaviours	
Include	With infants and pre-schoolers, the question of intentionality is less clear than with older children. While intention should be considered, it will not always be apparent and the clinician may draw on clinical experience to infer intentionality. Behaviours included here are essentially those that result in self-harm that are not the consequence of an accident. However, self-injurious behaviours and actions are rated here irrespective of any indication of intent. May include self-soothing behaviour that results in injury or harm e.g. hitting, biting, hair pulling, head banging, rocking, cutting, scratching, excessive sucking leaving marks, skin scratching or picking. May include lack of self-protective reflexes, inhibition of pain and reassurance responses e.g. when an infant is clearly hurt yet inhibits a response where other infants of the same age would be expected to cry, flinch and look to parent(s) for reassurance. Include attempts to stab self with a pen or other non-lethal object, cutting self with knives or scissors, deliberately jumping from a height with injurious intent, frequently discussing intent to self-injure. May include consideration of behaviours during play.
Exclude	Self-injurious behaviour secondary to a medical condition. Accidental self-injury unless clearly from a lack of self-protective reflexes.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action with lack of self-protective reflexes or self-injurious behaviours.
2	Mild problem with self-injury or a lack of self-protective reflexes. May include rubbing, scratching, rocking or play which leads to mild levels of physical injury. Play that regularly involves self-injury. Occasional episodes where self-protective reflex is inhibited.
3	Problem of moderate severity with potential or actual self-injury. May include moderately severe problems with a lack of self-protective behaviours that lead to, or potentially lead to injury. May be preoccupation, repeated episodes, or inhibition of pain responses to self-injury.
4	Severe to very severe self-injury occurs. Episodes of physical self-injury. May include inhibition of response to pain/discomfort and lack of self-protection and self-soothing leading to severe self-injury.

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Scale 4: Problems with feeding and eating behaviour	
Include	Feeding behaviours progress with development. The acknowledgement of problems in this area will be influenced by the duration, distress and incongruence of the concerning behaviours with the infant's age and age appropriate development. Include problems related to difficulties with breast feeding, bottle feeding and solids. Include all feeding difficulties irrespective of potential cause or solution. Nutritional difficulties may not always be present but should be considered. Include behaviours such as reluctance, resistance or refusing to feed; tiring or sleeping readily during feeding; feeding related distress (e.g. fussiness or crying); maintaining adequate nutrition which may result in nasogastric/gastrostomy tube feedings; sensory adversity; vomiting and difficulty in achieving developmentally appropriate food or feeding skills e.g. limited diet, consistent refusal of certain foods, groups, or types (e.g. solids), or modes of eating e.g. refusal to eat independently; little recognition of the relationship between hunger, feeding and satiety. Include under- and over-eating. Include feeding problems related to prematurity, physiological problems and gastrointestinal symptoms.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Problems may be transient and may be expected at the infant's developmental stage.
2	Mild problem with feeding or eating. Nutritional intake is likely to be within expected parameters.
3	Problem of moderate severity with feeding or eating. Some risk of nutritional problems.
4	Severe to very severe problem with feeding or eating.

SAMPLE

Scale 5: Problems with developmental delays.	
Include	Include problems with developmental delays not rated at other scales. Delays may occur in areas such as cognitive, motor, language, or communication development. Concerns should be rated both irrespective of cause and whether additional professional assessment or intervention has occurred (e.g. paediatrics, speech pathology). It may be difficult to distinguish one domain from another. Cognitive, motor and communication difficulties may manifest in balance, coordination, proprioception, problem solving, articulation, comprehension, sentence structure, vocabulary, communication pragmatics, gestures, vocal quality or range, interference with vocalisation (e.g. dummy, fingers). Difficulties in these areas may impact on ability to interact effectively with the environment and themselves in the areas of communication, motor and cognitive skills. While corrected age is a useful construct with premature infants, chronological age may be the more useful in identifying potential need for intervention.
Exclude	Physical illness or disability problems such as vision and hearing problems (rated at scale 6).

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. These may be expected to be within the typical range of development.
2	Mild problem that may be noted across more than one setting and in comparison to similar aged peers.
3	Problem of moderate severity that may be noted across settings compared with similar aged peers.
4	Severe to very severe problem with cognitive, motor or communication skills. Likely to cause significant distress for the infant and/or family. May be severe delays compared to similar aged peers.

SAMPLE

Scale 6: Problems with physical illness or disability	
Include	Physical health problem or disability which limits or prevents movement, impairs sight or hearing or otherwise interferes with functioning. Problems in this area may be observed or based on reports from others. Include side effects from medication, physical effects from drug/alcohol exposure, or physical complications of psychological disorders. Include physical complications or disability as consequence of self-injury. Ratings will be influenced by consideration of impact of illness on everyday functioning.
Exclude	Problems with cognitive, motor or communication skills already rated at scale 5.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action (e.g. cold, non-serious fall, teething). Parent voices concern about transient physical illness or physical symptoms but these are not considered serious by the parent or clinician.
2	Mild problem with physical illness or disability, which may occasionally prevent or challenge engagement in usual activities. Overall structure of their day is typically preserved and activities such as the ability to play are only mildly affected.
3	Problem of moderate severity with physical illness or disability, resulting in some ongoing distress and loss of function. Typically, there is some time each day, in which they are able to engage in usual activities, such as play.
4	Severe to very severe problem with physical illness or disability that result in serious distress and/or loss of function. Normal everyday routines and activities, including play, are seriously impacted because of the physical problem. Considerable input of effort and resources may be required to care for the infant and support the parent.

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Scale 7: Problems associated with regulation and integration of sensory processing	
Include	Problems associated with processing, regulating and integrating information from sensory stimuli which interfere with the sensory regulation required for adaptive interaction with and exploration of the world. While problems with sensory organs are rated at scale 6, this scale is more concerned with the processing of otherwise apparently intact sensory organs. Problems associated with sensory processing can reflect hypersensitivity (over-reactive therefore avoidant or fearful/cautious) and/or hyposensitivity (under reactive therefore seeking or impulsive) to one or more normal sensory stimuli. Sensory stimuli include vision, touch, hearing, taste, smell and spatial awareness including the sensation of movement and awareness of body position in space. Problems associated with the regulation and integration of sensory processing usually occur across multiple settings and within multiple relationships. Intensity, frequency, duration and location of problematic sensory stimuli may impact on the infant's presentation. Examples of the manifestation of sensory regulation difficulties may include responsiveness to fabrics, movement, travel, focus on apparently irrelevant objects and an avoidance of play. They may appear to have a preference for swaddling, or to seeking or avoiding certain fabrics.
Exclude	Problems with disruptive behaviour/under controlled emotional regulation rated at scale 1. Problems with activity and attention levels rated at scale 2. Problems with feeding rated at scale 4. Problems associated with cognitive, motor or communication difficulties rated at scale 5. Problems with physical illness or disability rated at scale 6. Problems with anxiety and depression and over controlled emotional regulation rated at scale 9.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action with sensory processing (over or under responding to normal sensory stimuli). However, the impact on adaptive daily functioning and exploration of the world is typically minor.
2	Mild problem with sensory processing identified and impacting on the infant. The infant and/or family may be showing signs of distress but maintaining appropriate developmental milestones. Definite and minor impact on functioning in daily tasks or in maintaining interactions in primary care-giving relationships. May become agitated, distressed, or disengaged when exposed to specific sensory stimuli.
3	Problem of moderate severity with sensory processing that are impacting on the infant's capacity to engage with their environment. May manifest as diminished exploration and play. Expect a definite and moderate impact on daily functioning.

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4	Severe to very severe problem related to sensory processing directly impacting the infant's social, emotional and physical wellbeing. Definite and severe impact that is typically ongoing.

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Scale 8: Problems associated with sleep	
Include	Sleep disturbance is common for infants. Include difficulties in both settling and maintaining sleep irrespective of where the locus of the difficulty is thought to be (infant, parent, living arrangements). Include excessive sleep (e.g. which interferes with opportunities for skills or social development), insufficient sleep (e.g. periods of awakenings or reduced sleep time), disturbed sleep (e.g. sleep talking, sleep walking, night terrors, or any other disturbance during sleep when the infant does not seem to respond to the parents) or difficulties resettling. Include snoring or loud mouth breathing with breath holding or gasping.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Typically within expected developmental norms, infrequent and where the family appear to have some approaches that successfully address the problem.
2	Mild problem which is intermittent. The family appear to have some success in addressing the problem for the infant.
3	Problem of moderate severity. The infant's sleeping pattern is of concern to the parents or family or it is likely to be interfering with functioning or development. The sleep disturbance occurs frequently and may be significantly out of keeping with age expectations.
4	Severe to very severe problem. The sleeping pattern is a cause for great distress in the parents and family and may be significantly out of keeping with age norms. The sleep disturbance is present nearly all the time and significantly interferes with functioning or development.

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Scale 9: Problems with emotional and related symptoms or over-controlled emotional regulation	
Include	Symptoms of depression, anxiety and phobias. Problems with negative or inhibited affect in the infant suggestive of low mood, anxiety, fear, emotional withdrawal, or over-controlled emotional regulation. May include fears, anxiety or emotional withdrawal from parents and others. Include incongruent lack of emotional expression. May be expressed with changes in curiosity, clinging, masking face, incongruent emotional expression, crying, anger, hypnotic gaze, withdrawal and blank expression, exaggerated positive or negative emotional responses. May include excessive stillness, frozen watchfulness, quiet rage and restrictions in affect range. An apparent increased tolerance for aversive adult behaviour, or problems seeking appropriate comfort or safety should be considered. Include age or developmentally inappropriate lack of wariness, or avoidance of parents.
Exclude	Physical sequelae of psychological disorders or medication – rated at scale 6. Disruptive behaviours resulting from emotional distress – rated at scale 1. The emotion associated with the disruptive behaviour is rated here at scale 9.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action, or transient mood, anxiety and emotional symptoms or changes.
2	Mild problem with emotional symptoms.
3	Problem of moderate severity with emotional symptoms which are preoccupying, intrude into some activities and are uncontrollable at least sometimes.
4	Severe to very severe problems with emotional symptoms which intrude into all activities and may be nearly always uncontrollable.

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Scale 10: Problems with social reciprocity	
Include	This scale addresses the infant's engagement in, and engagement of others in, age and developmentally appropriate interactions. There may be problems with seeking, engaging and enjoying interactions with familiar adults and children, including development of the social smile at 6 weeks. Responses to social engagement or social intrusion from others may not be responded to appropriately e.g. ambiguous half smiles. Problems may manifest with reciprocity in communication, play, and games. Reciprocity may be expressed both pre-verbally and verbally, as well as behaviourally. Problems may manifest as indiscriminate and overfamiliar social interactions as well as withdrawn and disengaged social interactions. Problems rated in this scale may include the infant's capacity to manage appropriate eye contact e.g. the infant may not gaze at the parent's face or at an interesting object when shown. Problems may include not socially referencing others, brief glances without sustained looking (difficulty gaining and sustaining eye contact); avoidant gaze; no eye contact (but no active avoidance either) and unfocused eyes. Problems with vocalisations relating to reciprocity of interactions, such as turn taking, engagement attempts, and vocal mirroring may also be relevant indicators of social reciprocity issues.
Exclude	Difficulties with communication separate to the social reciprocity function are rated at Scale 5. Difficulties with the emotional attunement of parent's and carers to the infant and misalignment between the infant's needs and the parents' or carers' responses should be rated at Scale 12.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Transient or mild problems in the infant's developing capacity to engage in social relationships.
2	Mild problem.
3	Problem of moderate severity with social reciprocity.
4	Severe to very severe issues with social reciprocity. Problems likely to occur in many areas, over time and intrude across most interactions.

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Scale 11: Problems with age appropriate self-care and environmental exploration	
Include	This scale addresses age-appropriate self-care and exploration of the environment. Self-care is more likely to be a prominent consideration with older children. Self-care is likely to include age appropriate levels of assistance with bathing, feeding, dressing, playing etc. Problems with self-care and environmental exploration may exist due to environmental restrictions, including parent's comfort, concerns or control. Include problems with activities of self-care such as washing, dressing, toileting. Exploration may include visual, tactile, verbal as well as physical exploration (under or over exploration). Include problems with complex skills such as play, autonomous activities or separating from parents, taking into account the norm for the infant's age and developmental stage. Difficulties may be indicated by regression to an earlier stage of development. The impact on exploration and self-care resulting from separation problems with parents when the infant is attending structured socialisation settings (e.g. day care, pre-school) may be rated here although actual attendance issues are rated at scale 13. Include poor levels of functioning arising from apparent lack of motivation, mood, environmental restriction or any other issue whether it is considered to arise from the infant, parents or the environment.
Exclude	Do not include feeding problems rated at scale 4. Do not include sleeping problems rated at scale 8. Do not include lack of opportunities for exercising intact abilities and skills, as might occur in an over-restrictive family rated at scale 12. Do not include the outcome of limited environmental exploration on structured socialisation settings rated at scale 13.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action with self-care or exploration of the environment.
2	Mild problem with self-care or exploration of the environment.
3	Problem of moderate severity with self-care or exploration of the environment.
4	Severe to very severe problem with self-care or exploration of the environment that is likely to be intruding across settings, activities and persons.

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Scale 12: Problems with family life and relationships	
Include	This scale addresses problems in family life that are thought to impact on the infant. If the parents are separated, consider the relationship with each parent and the separated parents' ability to co-parent where appropriate. Include relationships with significant others – grandparents, siblings, extended family members, child care providers. Include instances of neglect including physical (e.g. lack of sufficient access to appropriate food, shelter and clothing) and emotional (e.g. lack of warmth, comfort and age appropriate regulation of the infant's affect). Parental reflective capacity; the availability of access to caring, attentive and empathic adults and the ability to keep the infant in mind, should be considered. Include parent or family irritability with the infant. Difficulties in managing powerful emotions or any consequent harmful behaviour by those in the infant's immediate environment should be considered. Include instances of physical or verbal hostility or abuse towards the infant, as well as family hostility or conflict which impacts on the infant. Consider capacity for significant others to contain powerful negative emotions towards the infant. Issues such as parental or sibling mental health, substance use and personality problems should be included if they have an effect on the infant.
Exclude	Do not include disruptive behaviour by infant, rated at scale 1. Do not include problems with social reciprocity rated at scale 10.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Some concerns about family relationships may be evident but effect on infant mitigated through adequate parental reflective capacity and action are apparent.
2	Mild problem with family relationships. Some impact on the infant's development is apparent.
3	Problem of moderate severity with family relationships. Considerable impact on infant development apparent.
4	Severe to very severe problem in family relationships with severe impact on the infant.

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Scale 13: Problems with attending care, education and socialisation settings	
Include	This scale addresses attendance at the prime socialisation setting outside of the immediate family. Include attendance at any type of regular socialisation and care activity at the time of rating e.g. regular care with extended family or formal early childhood education (sometimes called kindergarten or pre-school). Include activities irrespective of location or whether a family member is present (e.g. regular play group sessions at infant's home). Include refusal of, or withdrawal from early childhood education, childcare, play group or similar regular socialisation activity, irrespective of cause. Include limited or minimal opportunities to attend socialisation activities appropriate to the infant's age. Include consideration of additional supports such as reassurance, transitional objects, required to settle the infant in the setting. If early childhood education, childcare etc. is in holiday break, rate the last two weeks of the previous open period. Note: Infants and young children will communicate their reluctance and distress at attending these settings through a range of symptoms. These may include problems in feeding, toileting, eating, playing, communicating and sleeping both at the settings and around the transition time. These symptoms in themselves are likely to be rated at different HoNOSI scales and are not the sole source of rating at this scale. However, it is acknowledged that the reluctance to attend may be conveyed to the clinician through these symptoms. The actual attendance problems are rated at this scale. Note: Reluctance to attend a socialisation setting may reflect problems in that setting for the infant. Reluctance to attend may also occur in the dyadic relationship or simply from parental concerns. To reiterate, acknowledging a problem does not mean that the source of the problem or the required solution necessarily lies with the infant. HoNOSI is agnostic as to the locus of any intervention.
Exclude	Many infants have not attended a socialisation setting outside the family and the clinician will typically not consider this a problem. However, a clinician may decide to rate this non-attendance as a problem; for example, where non-attendance has been considered to reflect extended separation difficulties. All behaviours and emotional expressions or consequences of problems associated with attendance or separation are rated at their respective scales (e.g. Disruptive at scale 1, Feeding at scale 4, Emotional at scale 9, Environmental exploration at scale 11). Absences due to illness of infant or parents requiring them to be absent from the setting. This typically includes medical conditions, such as fevers, contagious illnesses or infections which would be rated at scale 6.

Rating	Description
0	No problem. Infant displays age appropriate behaviour on separation from their parents and settles readily when comforted in the environment.
1	Minor problem requiring no formal action with attending and may display reluctance for brief periods. Responds with small amount of support additional to that typically required at this age.

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2	Mild problem with some sessions missed or refusal to participate in activities when attending.
3	Problem of moderate severity with several days missed during rating period due to infant's reluctance to attend.
4	Severe to very severe problem with infant absent for most of the days or sessions during the rating period.

SAMPLE

Scale 14: Problems with knowledge or understanding about the nature of the infant's difficulties	
Include	Include lack of useful information or understanding available to the parents, caregivers, referrers or support system about the nature of the difficulties. Include problems with capacity or knowledge to understand the infant's difficulties. Include limited or incorrect understanding of the infant's developmental stage and needs. Include misunderstanding, minimising, elaborating or exaggerating the difficulties, impact or distress as well as inaccurate attribution of the infant's difficulties. Include lack of explanation about the difficulty/diagnosis, the cause of the problem or understanding of the prognosis or the impact on the infant. Rating a problem here does not exclude the service system revising their understanding of the infant's difficulties. In many ways, problems rated here may indicate a lack of congruence between the parent's and other's views about the nature of the difficulties and the views of the clinician (or the assessing or treating system.)

Rating	Description
0	No problem. Parents, referrers or carers demonstrate a good level of understanding about the difficulties.
1	Minor problem requiring no formal action. For example, parents essentially understand infant's difficulties but with occasional misunderstandings such as sometimes downplaying, or exaggerating the infant's difficulty or distress.
2	Mild problem in understanding infant's difficulties.
3	Problem of moderate severity. Parents have very little or very poor knowledge about the nature of their infants' problems.
4	Severe to very severe problem. For example, parents have no understanding about the nature of their infant's problems. Significant disagreement between the parents, or the referrer's or the carer's views and the views of the assessing or treating system.

SAMPLE

Scale 15: Problems with lack of information, understanding about services, or managing the infant's difficulties	
Include	Include lack of useful information available to the parents, caregivers, or referrers, or a lack of understanding regarding services or management of the difficulties. Include parental willingness or ability to utilise services or interventions to support the infant. The consistency with which parent's understand or use appropriate strategies and the extent to which supports are required to help the parent's use optimal approaches may be considered. Include parents, referrers or carers use and implementation of, information and appropriate and feasible strategies. Include problems with accessing available services appropriate to the infant's difficulties (e.g. early childhood nursing, child protection, family support). Rating a problem here does not exclude the service system revising their understanding of the optimal approach to managing the infant's difficulties. In many ways, problems rated here may indicate a lack of congruence between the family, carer's or referrer's views about the management of the infant's difficulties and the views of the clinician (or the assessing or treating system's views).

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. For example, parents have an adequate understanding of how best they and other resources can help their infant, or they are actively seeking appropriate information, support or access to services.
2	Mild problem in understanding or willingness to use the appropriate services, approaches, resources and supports for the infant's difficulties.
3	Problem of moderate severity in understanding or willingness to use the appropriate services, approaches, resources and supports for the infant's difficulties.
4	Severe to very severe problem in understanding or willingness to use the appropriate services, approaches, resources and supports for the infant's difficulties.

SAMPLE