The French adaptation of the Health of the Nation Outcome Scale for Children and Adolescents Self-Rated Form (F-HoNOSCA-SR): Validation and clinical routine use

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Abstract

Objectives: The current study aimed to explore the validity of an adaptation into French of the self-rated form of the Health of the Nation Outcome Scales for Children and Adolescents (F-HoNOSCA-SR) and to test its usefulness in a clinical routine use.

Methods: One hundred and twenty nine patients, admitted into two inpatient units, were asked to participate in the study. One hundred and seven patients filled out the F-HoNOSCA-SR (for a subsample (N = 17): at two occasions, one week apart) and the strengths and difficulties questionnaire (SDQ). In addition, the clinician rated the clinician-rated form of the HoNOSCA (HoNOSCA-CR, N = 82).

Results: The reliability (assessed with split-half coefficient, item response theory (IRT) models and intraclass correlations (ICC) between the two occasions) revealed that the F-HoNSOCA-SR provides reliable measures. The concurrent validity assessed by correlating the F-HoNOSCA-SR and the SDQ revealed a good convergent validity of the instrument. The relationship analyses between the F-HoNOSCA-SR and the HoNOSCA-CR revealed weak but significant correlations. The comparison between the F-HoNOSCA-SR and the HoNOSCA-CR with paired sample t-tests revealed a higher score for the self-rated version.

Conclusions: The F-HoNOSCA-SR was reported to provide reliable measures. In addition, it allows us to measure complementary information when used together with the HoNOSCA-CR.

1. Introduction

Adolescents with serious mental health disorders sometimes require psychiatric care in an inpatient unit in order to provide optimal care to reduce the impact on their quality of life (Mathai and Bourne, 2009) as well as limiting the probability of long-term disability. The goal of such care is to reduce the difficulties to a level that is no longer problematic in daily life or at least treatable in an outpatient setting (Hanssen-Bauer et al., 2011). In this perspective, the assessment of treatment effectiveness requires an appropriate evaluation of the outcome such as the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA, Gowers et al., 1999). The rating of the HoNOSCA by a clinician (HoNOSCA-CR) is independent of the type of psychiatric illness involved and its psychometric properties are well established (Gowers et al., 1999; Pirkis et al., 2005). Furthermore, in the context of inpatient treatment, the HoNOSCA was demonstrated to be useful to assess the clinical outcomes and to have good discriminant validity between diagnoses (Swadi and Bobier, 2005; Lesinskiene et al., 2007; Urbena et al., submitted for publication).

Recently, Tiffin and Rolling (2012) conducted a confirmatory factor analysis on the HoNOSCA data of 1335 children and adolescents. They found a 3-factor model, namely “externalizing problems and associated problems” or behavioral difficulties; “emotional

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symptoms and associated problems\textsuperscript{2} which represent emotional and family disturbance, and “knowledge and information”\textsuperscript{3}. Their study was based on adolescent outpatients attending community-based Child and Adolescent Mental Health Services. In addition, Urben et al. (submitted for publication) extended the usefulness of these scores to adolescent inpatients and showed their discriminative value between diagnosed groups.

Nevertheless, few instruments are available to measure the difficulties from the adolescents’ point of view as the patient perspective is rarely taking into account as low agreement between clinician and patient’s rating was reported (Pierson & Boes, 1997). Nevertheless, the importance of patient perspective has been recently recognized (Kroenke et al., 2001). Therefore, Gowers et al. (2002) developed a self-rated form of the HoNOSCA (HoNOSCA-SR). Its psychometric properties and clinical usefulness were satisfactory and allow the taking into account of the patients’ point of view.

Within this context, the current study aimed to validate a French adaptation of the HoNOSCA-SR and to test its usefulness alongside the HoNOSCA-CR in a clinical routine use.

2. Method

2.1. Participants

All the patients attending the two psychiatric inpatient units were subject to participation, as the HoNOSCA rating was a part of the standard admission procedure. Exclusion criteria were either a lack of sufficient French language skills or severe mental retardation which would make the filling out of questionnaires impossible. Both inpatient units consisted of 10 beds, and accepted youths from 12 to 18 years of age. Intake of youths could be voluntary or against the will of the persons if necessary (if the life of the patient or other is in danger). It serves mainly as a crisis resolution unit.

Data were collected on 107 patients (mean age = 15.07, S.D. = 1.64), 38.3% of males. The reasons of hospitalization or diagnoses included suicidal tendency or suicide attempt (19.0%), psychosis (2.5%), personality disorder (1.3%), eating disorder (7.6%), depression (19.0%), anxiety (16.5%), behavioral difficulties (27.8%) or pervasive developmental disorder (6.3%).

2.2. Measures

2.2.1. HoNOSCA clinician-rated (HoNOSCA-CR, Gowers et al., 1999; Holzer et al., 2006)

The assessment was carried out by trained psychiatrists, psychologists or nurses using the French version of the HoNOSCA-CR (Holzer et al., 2006) which is derived from the French version of the Health of the Nation Outcome Scales (HoNOS) for adults validated by Lauzon et al. (2001). The HoNOSCA-CR provides information about a variety of symptoms, as well as social and physical functioning. The HoNOSCA-CR is composed of 15 items scored on a 5-point severity scale listed as follows: “no problem”, “minor problem requiring no action”, “mild problem but definitely present”, “moderately severe problem” and “severe to very severe problem” (4). The HoNOSCA-CR was reported to have acceptable inter-rater reliability and face validity in inpatient and outpatient settings (Branin et al., 2001; Pirks et al., 2005). In this study, only the first 13 items were taken into account, focusing on the adolescent’s difficulties. Indeed, the last two items focused on the available information about pathology and care system and their inter-rater reliability is subject to debate (Pirks et al., 2005). In addition, using only the first 13 items allowed us to make a better comparison with the self-rated form of the HoNOSCA.

The measures provided by the HoNOSCA-CR were the following: firstly we computed the Total score by averaging the scores of items 1–13. Secondly, based on the factor structure proposed by Tiffin and Roling (2012), we computed the mean score of the externalizing problems (Ext score, by averaging the scores of the items 1, 2, 5 and 11) and of the emotional symptoms (Emo score, by averaging the scores of the items 3, 4, 6, 7, 8, 9, 10, 12, 13). As with all scores, higher scores represent higher difficulties.

2.2.2. French HoNOSCA self-rated (F-HoNOSCA-SR)

The F-HoNOSCA-SR refers to an adaptation of the HoNOSCA-SR proposed by Gowers et al. (2002). Some limitations of the HoNOSCA-SR made us think that an adaptation of the instrument was necessary. Indeed, from our point of view, the formulation of the questions was too difficult to be understood by adolescents with severe mental disorders. In the same vein, the fact that a clinician, not involved in care, has to help the patient to fill out the questionnaire is a severe limitation for a self-rated questionnaire and in its intended use in a clinical routine. It is noticeable that this problem is also acknowledged by the original authors of the HoNOSCA-SR themselves (Gowers et al., 2002). Regarding the objective of a self-rated questionnaire, which is to indicate information from patients’ point of view, we aimed to adapt the instrument in order for it to be filled out by the adolescents themselves.

Therefore, we formulated the questionnaire in order to be as close as possible to the English version of HoNOSCA-SR, but easier to understand for an adolescent with a severe mental disorder. In addition, we adapted the Likert-scale in order to refer to more simple concepts for youths and to stay close to the scale proposed in the French version of the HoNOSCA-CR (Holzer et al., 2006). Indeed, in the original version of the self-rated form, the response format was as follows: “not at all”, “insignificantly”, “mild but definitely”, “moderately”, and “severely”. Thus, the concepts “insignificantly” and “mild but definitely”, seemed hard to understand for youths. Therefore, the response format of the F-HoNOSCA-SR was replaced by the following: “not at all”, “almost not”, “not much”, “very much” and “extremely”.

The questionnaire is composed of 13 items. Identically to the scores computed for HoNOSCA-CR, we computed the following scores for the F-HoNOSCA-SR: the Total score by averaging the scores of items 1–13. Second, we computed the mean score of the externalizing problems (Ext score, by averaging the scores of the items 1, 2, 5 and 11) and of the emotional symptoms (Emo score, by averaging the scores of the items 3, 4, 6, 7, 8, 9, 10, 12, 13). As with all scores, higher scores represent higher difficulties.

The factorial structure of the F-HoNOSCA-SR was assessed using confirmatory factor analyses (CFA). In accordance with the above, we tested a bifactor model in which all items, in addition to loading on one sub-dimension (Ext or Emo), also loaded on a general factor (Total). Because of the limited number of participants, we used a post-hoc Monte Carlo simulation of 5000 trials to estimate the cutoff values of the fit indices as well as the mean bias in the parameters estimates. The fit cutoffs at P = 0.05 were acceptable for the bifactor model (χ²(51) = 71.78, CFI = 0.93, RMSEA = 0.06, SRMR = 0.06) and the mean bias of the parameter estimates was not exceedingly high (12.8% on the average).

2.2.3. Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997; d’Acremont and Van der Linden, 2008)

The SDQ is a self-rated questionnaire allowing us to measure difficulties of adolescents. The questionnaire is composed of 25 items rated on a three-point Likert scale: “not true”, “somewhat true”, and “certainly true”. The SDQ total difficulty score is computed by averaging the 20 items referring to difficulties such as emotional symptoms, hyperactivity/inattention, conduct and peer problems. Moreover, in compliance with Goodman et al. (2010), we computed the Total difficulties score of the SDQ, namely externalizing and externalizing problems. Higher scores refer to higher difficulties.

2.3. Procedure

All adolescents admitted to both units (N = 129), were proposed on a voluntary basis (informed consent was thus obtained), to fill out both the F-HoNOSCA-SR and the French version of the SDQ. All was explained to the patients that the response on the questionnaires would not be read by the clinician (assuring anonymity and reducing social desirability bias), but only by the research team. After completion of the questionnaires, the patient put it in an envelope and closed it (N = 107 valid data for F-HoNOSCA-SR). Meanwhile, on a specific form, the clinician rated the HoNOSCA-CR (N = 82 valid data including F-HoNOSCA-SR and HoNOSCA-CR) and filled out the age and gender of the patients and diagnosis or reason for hospitalization. For a subsample of adolescents (N = 17), we asked them to fill out once again the F-HoNOSCA-SR after 1 week (7 days) of hospitalization.

2.4. Data analyses

The data were explored revealing no outliers and that it suited a Gaussian distribution allowing the use of parametric tests. Different validity criteria were assessed in this study. First, we assessed general reliability using McDonald’s (1999) omega coefficient for the whole test and split-half coefficients for the three scores of the F-HoNOSCA-SR namely, the Total score, the Ext score, and the Emo score. We further analyzed our data with Item Response Theory (IRT) methods. For the latter, we opted for Samejima’s Graded Response Model (1997) because of its suitability for analyzing ordered, polytomous data and because it can be used to produce information curves for the whole test and for each of its dimensions. Then, we assessed the test–retest reliability by computing Intraclass Correlation Coefficients (ICC) between both occasions where the F-HoNOSCA-SR was rated by the
adolescents. Then, to assess the concurrent validity of the F-HoNOSCA-SR we computed Pearson’s correlations with the SDQ. First, convergent validity was assessed by computing correlations between the F-HoNOSCA-SR scores and the corresponding SDQ scores. To assess the divergent validity, the Emo score of the F-HoNOSCA-SR showed a correlation between odd and even-numbered of 0.832. McDonald’s omega coefficient for the Ext score the split-half coefficient is of 0.640 and for the Emo score of 0.269. Regarding item by item, the ICC revealed coefficients (see Table 1) ranging from 0.287 (item 8: somatic disturbance) to 0.920 (item 7: hallucinations).

3.2. Validity of the F-HoNOSCA-SR

The convergent and divergent validity of the F-HoNOSCA-SR was explored by correlating it with the SDQ. The SDQ total difficulty score correlated significantly and positively with the Total score, \( r = 0.703, P < 0.001 \), the Ext score, \( r = 0.683, P < 0.001 \), and the Emo score, \( r = 0.614, P < 0.001 \), of the F-HoNOSCA-SR. More precisely, to assess convergent validity, we computed the correlations between the Internalizing score of the SDQ and the Emo score of the F-HoNOSCA-SR (\( r = 0.542, P < 0.001 \)) and between the externalizing score of the SDQ and the Ext score of the F-HoNOSCA-SR (\( r = 0.607, P < 0.001 \)). To assess divergent validity, correlations between the Internalizing score of the SDQ and the Ext score of the F-HoNOSCA-SR (\( r = 0.413, P < 0.001 \)) and between the externalizing score of the SDQ and the Emo score of the F-HoNOSCA-SR (\( r = 0.440, P < 0.001 \)) were computed. Fisher’s r-to-z transformation analyses showed that the correlations were significantly lower for the divergent analyses of the Ext score (\( P_{\text{one-tailed}} = 0.03 \)) but not for the Emo score.

3.3. Agreement between clinician-rated and self-rated instruments

In addition, to test the cross-validity between the self-rated instrument and the correlations were computed between the F-HoNOSCA-SR and the HoNOSCA-CR (see Table 2). The correlations between clinician-rated and self-rated forms of HoNOSCA were high and positive, with ICCs ranging from 0.554 (Emotion) to 0.876 (Physical illness). The ICCs for the Ext score were slightly lower (ranging from 0.520 to 0.630) compared to the Emo score (ranging from 0.620 to 0.778), indicating slightly higher agreement for the Emo score.

Table 1
Test–retest reliability for the self-HoNOSCA (N=17).

<table>
<thead>
<tr>
<th>Scale item</th>
<th>ICC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aggression</td>
<td>0.804</td>
</tr>
<tr>
<td>2. Concentration</td>
<td>0.696</td>
</tr>
<tr>
<td>3. Self-injury</td>
<td>0.739</td>
</tr>
<tr>
<td>4. Substance misuse</td>
<td>0.826</td>
</tr>
<tr>
<td>5. Language</td>
<td>0.822</td>
</tr>
<tr>
<td>6. Physical illness</td>
<td>0.876</td>
</tr>
<tr>
<td>7. Hallucinations</td>
<td>0.920</td>
</tr>
<tr>
<td>8. Somatic disturbance</td>
<td>0.278</td>
</tr>
<tr>
<td>9. Emotion</td>
<td>0.554</td>
</tr>
<tr>
<td>10. Peer relationships</td>
<td>0.837</td>
</tr>
<tr>
<td>11. Independence</td>
<td>0.791</td>
</tr>
<tr>
<td>12. Family relationships</td>
<td>0.593</td>
</tr>
<tr>
<td>13. School attendance</td>
<td>0.794</td>
</tr>
</tbody>
</table>

Note: ICC: Intraclass correlation coefficients.

Table 2
Pearson’s correlations between self-rated and clinician-rated HoNOSCA (N=82).

<table>
<thead>
<tr>
<th>HoNOSCA-CR</th>
<th>Total score</th>
<th>Ext score</th>
<th>Emo score</th>
</tr>
</thead>
<tbody>
<tr>
<td>F-HoNOSCA-SR</td>
<td>0.307**</td>
<td>0.090</td>
<td>0.351**</td>
</tr>
<tr>
<td>Ext score</td>
<td>0.308**</td>
<td>0.206</td>
<td>0.285**</td>
</tr>
<tr>
<td>Emo score</td>
<td>0.269*</td>
<td>0.010</td>
<td>0.149**</td>
</tr>
</tbody>
</table>

Note: F-HoNOSCA-SR: French Health of the Nation Outcome Scale for Children and Adolescents Self-rated Form; HoNOSCA-CR: French Health of the Nation Outcome Scale for Children and Adolescents clinician-rated Form; Total score: mean of all items, Ext score: Externalizing problems score, Emo score: Emotional symptoms score.

* \( P < 0.05 \)
** \( P < 0.01 \)
were weaker than those between both self-rated instruments. However, the correlation between the Total score of both forms of HoNOSCA is significant.

In addition to this, we modeled the information curve of the complete HoNOSCA-CR with the same unconstrained graded response model that we used for its self-rated form (see Fig. 2).

3.4. Comparison between clinician and patient point of view on the severity

In order to assess the severity of the rating between the clinician-rated and self-rated version of the HoNOSCA, t-test for paired-samples were computed (see Fig. 3). In general, patients rated significantly higher difficulties than the clinician regarding the Total score ($N=82$; Self-rated: $M=1.74$, S.D. 0.73; clinician-rated: $M=1.24$, S.D. 0.48; $t=6.13$, d.f.=81, $P<0.001$), the Ext score (Self-rated: $M=1.87$, S.D. 0.94; Clinician-rated: $M=1.00$, S.D. 0.69; $t=7.55$, d.f.=81, $P<0.001$) and the Emo score (Self-rated: $M=1.34$, S.D. 0.52; Clinician-rated: $M=1.00$, S.D. 0.69; $t=4.03$, d.f.=81, $P<0.001$). More specifically, almost all items differed between both versions (except peer relationships and school attendance). The clinician rated higher difficulties than patients regarding scores on emotion and family relationship items. In contrast, patients rated higher difficulties than clinician on aggression, concentration, self-injury, substance misuse, language, physical illness, hallucinations, somatic disturbance, and independence items.

4. Discussion

It is important to have a valid instrument to assess the services and individual treatment response. One such valid instrument is the HoNOSCA-CR which is a well-established and simple instrument used worldwide in clinical routines (Gowers et al., 1999; Garralda et al., 2000; Brann et al., 2001). However, patients’ points of view bring supplementary data, which are important and deserve to be taken into account. Therefore, Gowers et al. (2002) developed a self-rated HoNOSCA with good psychometric properties and clinical usefulness. From this perspective, we developed a French adaption of the HoNSOCA-SR and found that the instrument has good psychometric properties, as well as having the advantage of being administrable in a clinical routine bringing supplementary data to the HoNSOCA-CR.

4.1. Reliability of the instruments

The reliability of the scores, explored with the split-half procedure alongside with test information curves, revealed a satisfactory validity. Indeed, both omega and split-half coefficients were satisfactory for all scores (Webb et al., 2007) and the latter were comparable to those observed by Gowers et al. (2002) for the Total score referring to global difficulties of youths. The information curves point out that, for the complete test and for the emotional symptoms dimension, the maximum amount of information is near the center of the distribution (at 0.27 and 0.19 logits, respectively) and that the information functions show a smooth decrease as one strays from this center. The whole test and its two dimensions provide a substantial amount of information that remains quite constant across a broad range of the symptoms (between plus or minus one standard deviation). Only the externalizing problems dimension shows a distinct fall off beyond these limits, indicating a loss of precision for extreme cases (around two standard deviations on the scale).

In addition, the ICC coefficients assessing the test–retest validity indicated that the three scores were satisfactory. Regarding the analyses item by item, it was shown that only item 8 (somatic disturbance) seems to have a lower level of consistency over time. Thus, both analyses revealed that the F-HoNOSCA-SR has a reliable measure, at least when using the three main scores proposed in the literature for the HoNOSCA-CR (Gowers et al., 1999;...
Tiffin and Rolling, 2012). Furthermore, to assess the concurrent validity we observed the relationships between the F-HoNOSCA-SR and the SDQ. According to the global score, the analyses revealed that the F-HoNOSCA-SR possesses a good convergent validity as the correlations between both instruments were even higher than those observed in the sample of Gowers et al. (2002). In addition, the analyses with the subscales revealed a satisfactory convergent validity. Regarding the divergent validity, we observed a satisfactory divergent validity for the Ext score of the F-HoNOSCA-SR but not for the Emo score of the F-HoNOSCA-SR.

Regarding the cross-validity between the F-HoNOSCA-SR and the HoNOSCA-CR, only weak but significant correlations were observed. It is noticeable that Gowers et al. (2002) found correlations in the same vein in their inpatient sample at admission. More specifically, for the emotional symptoms scales, we found weak but significant correlation, whereas for the externalizing problems the correlation is weak and not significant. Thus, it seems that the agreement between patients and caregivers is weak. These results are in line with literature comparing results of clinician-rated and self-rated instruments in people with severe mental disorders (Mattila-Evenden et al., 1996; Kramer et al., 2003; Dorz et al., 2004; Bondolfi et al., 2010). One possible interpretation of the discrepancies might lay in the referential population used to rate the HoNOSCA. Indeed, the caregiver might compare the severity of the patient's problem to other patients with severe mental disorders that are admitted to the inpatient unit. In contrast, patients rated the F-HoNOSCA-SR comparing their difficulties to peers of their age without severe mental disorders. Thus, the two referential groups were not comparable, and in such it could have influenced the rating of the HoNOSCA resulting in poor relationships between the HoNOSCA-CR and the F-HoNOSCA-SR.

In the same vein, the IRT analyses revealed that the clinicians (HoNOSCA-CR) are more precise in evaluating severely ill rather than less ill patients. The IRT analyses on the patients' scale (F-HoNOSCA-SR) revealed that the precision is slightly more extended. Thus, these differences might give a possible explanation of the weak correlations observed between both HoNOSCA forms. Finally, our adaptation of the response format, made in order to have simpler concepts for youths, could also have influenced the relationships between both HoNOSCA forms. Nevertheless, both patients and clinicians used the full-range scale indicating that the weak correlations could not be attributed to a bias in the use of the rating scale.

4.2. Severity comparison between clinician-rated and self-rated HoNOSCA

The severity revealed by both forms of HoNOSCA differed greatly as it was similarly observed in the study of Gowers et al. (2002). In particular, clinician rated the items emotion and family relationships higher than adolescents do. It might be explained by the fact that the clinician usually took into account the information of the family to rate the emotional items, which often revealed that the youth suffered from flat affect or from relationship difficulties. The adolescent patients, in contrast, might find it hard to recognize such difficulties or have a more positive view of their family relationships.

In contrast, adolescents reported more difficulties than clinicians in aggression, concentration, self-injury, substance misuse, language, physical illness, hallucinations, somatic disturbance, and independence difficulties. Thus, in self-rated form, adolescents are more prone to report their aggressive or antisocial behaviors which is a less confrontational experience than the one they go through in the admission interview. This reasoning might be applied to substance misuse and hallucination. In the context of F-HoNOSCA-SR, the adolescents seem to be less defensive and therefore more appropriately revealed their substance consumption or hallucinations. It is understandable as these refer to very difficult themes to discuss from the patient's perspective. Therefore, adolescent patients prefer to reveal it in the F-HoNOSCA-SR, rather than in the admission interview. Furthermore, adolescent patients seem to be more occupied by their attentional and concentration abilities than the clinician does. From the same perspective, self-injury might be less questioned on admission in the inpatient units when no signs could be observed. Thus, the adolescents more precisely report their behaviors regarding self-injury on the F-HoNOSCA-SR.

An alternative interpretation could lay in a misattribution of behavioral/concentration difficulties. Indeed, taking into account the great proportion of adolescents with behavioral problems or depression difficulties, the clinicians might under-rate behavioral/concentration difficulties because they can be attributed to emotional problems. This interpretation could also explain the higher proportion of emotional problems reported by clinicians compared to patients' report. In contrast, patients reported higher behavioral problems than emotional symptoms, which seem to be more consistent with the repartition of the diagnoses. This interpretation could also allow us to understand the great correlation observed between externalizing problems reported in the self-rated form and emotional symptoms rated on the clinician-rated form.

Concerning physical illness, it represents a less important point from the point of view of the clinician, who perhaps owes it more thought in order to be able to rate it more adequately. The somatic difficulties also are more important from the patient's point of view than from the clinician's one. The last item that is more severely rated from the patient's perspective is the one of independence. This might be explained by the fact that a majority of patients have difficulties in taking public transportation, for example, which does not appear to always be taken into account by the clinician. An explanation, in terms of reference group, might also help to understand this last difference. Indeed, whereas the adolescent rated themselves not as independent as their peer, the clinician, when comparing to other adolescents with severe mental health disorders, might have found them more independent.

4.3. Use of the F-HoNOSCA-SR in clinical routine

The HoNOSCA-CR is a well-established instrument (Gowers et al., 1999; Pirkis et al., 2005) able to briefly assess the global functioning of patients presenting mental health disorder. In addition, it allows us to make a reliable assessment given arguments for public policy regarding the health care system. In this perspective, taking into account the patient's point of view is a crucial factor (Kroenke and West, 2001). Indeed, recently it was demonstrated that in order to predict the psychiatric outcomes and the readmission rate, it is more powerful to use both self-rated and clinician-rated instruments together, rather than only one (Clements et al., 2006). Thus, this highlights the importance to take into account both information sources. More generally, there is potential benefits and disadvantages in taking into account clinician and patients point of view (Ford, 2005). Potential problems with the patient's point of view include concerns about social desirability, for example. However, recent government policy noticed the importance of taking into account the patient's point of view in making a policy decision and such partnership and shared decision-making are becoming a key feature (Bower et al., 2006). In this perspective, Callaly and Hallebone (2001) stressed that it is important to take into account the patient's perspective in order to propose appropriate treatment development. In the same vein, Dickey (2001) proposed a multidimensional approach including the patient's, the clinician's and the
family’s point of view which incorporates the subjective experiences of the patients and not only those of the professional.

In this perspective, the F-HoNOSCA-SR filled a gap by providing a brief and reliable assessment of the global functioning of the patients. However, regarding the great amount of differences in the severity of both forms of HoNOSCA, it might be very useful in a clinical routine to rate both forms of HoNOSCA, in both the clinician-rated and the self-rated. Indeed, it seems that adolescents will reveal a lot of information in the F-HoNOSCA-SR which could be compared with the HoNOSCA-CR in order to set up the care objectives, for example. In addition, regarding the amount of items that are rated higher in the F-HoNOSCA-SR in comparison to the HoNOSCA-CR, we could assume that adolescent patients revealed information that they would not otherwise do in alternate settings. In this context, all the discrepancies between the F-HoNOSCA-SR and the HoNOSCA-CR reported above stressed the importance of therapy engagement in identifying difficulties and increasing common treatment aims (Gowers et al., 2002).

4.4. Limitations

Some limitations should be acknowledged. Firstly, the study was conducted in two inpatients facilities, therefore in order to generalize the use of the F-HoNOSCA-SR for outpatients attending community-based Child and Adolescent Mental Health Services, further studies are needed. The adaptation of the response format of the F-HoNOSCA-SR, made in order to render the questionnaire more understandable and to make the filling out easier for youths with severe mental disorders, could be seen as a potential limitation. This adaptation could have led to the weak correlations observed between both HoNOSCA forms. Indeed, this could have led to slightly different ways of responding between youths and clinicians. However, it should be noted that the correlations observed in our study are in the same range as those of Gowers et al. (2002) and are in line with previous literature (Mattila-Evenden et al., 1996; Kramer et al., 2003; Dorz et al., 2004; Bondolfi et al., 2010) which made us think that the F-HoNOSCA-SR is a useful tool, complementary to the HoNOSCA-CR. However, regarding the lack of consistency between the F-HoNOSCA-SR and the HoNOSCA-CR, it could be useful to assess the relationships between the F-HoNOSCA-SR and the HoNOSCA-CR at the end of hospitalization or between patients and clinician that are used to work together.

4.5. Conclusions

The present study aims to assess the validity and the use of the F-HoNOSCA-SR in a clinical routine. We reported that the F-HoNOSCA-SR is a reliable measure with good validity. Thus, it allows us to measure supplementary useful information compared to the HoNOSCA-CR. In addition, it was reported that the use of the F-HoNOSCA-SR in a clinical routine provided important information about the patient difficulties.

Conflict of interest

None.

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