

**HoNOSCA:  
HEALTH OF THE NATION OUTCOME SCALES  
(CHILD & ADOLESCENT MENTAL HEALTH)**

**Trainer's Guide**

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## HoNOSCA Trainers' Guide

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## **1. Introduction**

### **1.1 Purpose of the Trainers' Guide**

The Trainers' Guide is for clinically experienced Mental Health professionals who may wish to train raters often within their multidisciplinary team in the routine administration of HoNOSCA. Some may also be concerned with on-going quality assurance and the use of the data gathered. Trainers need to be fully familiar with the Raters' Pack, which contains answers to questions commonly asked by raters, the Glossary of definitions for each severity point of the 13 HoNOSCA items, the Chart of background data, and the Score Sheet.

### **1.2 Origins of HoNOSCA**

The Child and Adolescent Mental Health Scales are one of a second generation of Health of the Nation Outcome Scales which originate from the Health of the Nation strategy. This identified three targets for mental health, two concerned with a reduction in suicide rates. The first target was worded as follows:

"to improve significantly the health and social functioning of mentally ill people."

A set of scales was therefore needed that would measure the range of physical, personal and social problems associated with mental illness. These would be used by practitioners in the mental health field on a routine basis within the clinical context. This implied an eventual national system for data collection, usable across the whole range of professional-patient contacts at reasonable cost, with the new instrument as an important component.

It was clear that the generic HoNOS scales would not be appropriate for use in Child and Adolescent Mental Health thus the HoNOSCA scales represent a Child and Adolescent version based on the same principles.

### **1.3 Characteristics of HoNOSCA**

The key characteristics of a routine outcome instrument are as follows:

1. short, simple, acceptable and useful to clinicians;
2. adequate coverage of clinical and social problems;
3. sensitive to improvement, deterioration, or lack of change over time;
4. known reliability;
5. known relationship to more established scales;

6. one or more simple indicators for local and national use, including comparisons.

It is important that quality data are collected by clinicians who find information generated helpful for their own clinical purposes. When anonymised and aggregated within a minimum dataset, these data could be used for measuring national and local progress.

In addition to the general requirements of HoNOS, the Child and Adolescent version needs also to take account of:

1. developmental issues;
2. a relatively greater importance of family life and education;
3. the range of problems encountered in Child and Adolescent Mental Health and over the full age spectrum needs to be covered within a single set of scales

No brief set of items could hope to cover comprehensively all the above requirements but the 13-item HoNOSCA has been demonstrated to provide a good compromise for general use. The University of Manchester Department of Child and Adolescent Psychiatry, in conjunction with the College Research Unit (CRU) undertook a programme of development and assessment that included a consultation phase, a pilot trial (n = 90, 5 sites), main field trials (n = 1276, 36 sites), and trials of reliability and validity. In addition, satisfaction and acceptability were evaluated at debriefing meetings and a questionnaire administered through the field site co-ordinators. The results were very satisfactory and are summarised in the Brief Report. Field trials covered a full range of each diagnosis and type of service encountered in Child and Adolescent Mental Health.

## **2. Structure and Scoring of HoNOSCA**

### **2.1 Structure**

The table shows how the structure of HoNOSCA supports multiple functions.

1. Each of the 13 items in Section A, scored 0-4, covers a broad spectrum within one problem area.
2. Overlap between probable areas is restricted; each item makes a specific contribution (see descriptions at sections 3 and 4).
3. The content is based on problems, not diagnoses (which are available separately).
4. Items can be aggregated into 4 section scores: a,b, c, d.

5. The total score, range 0-52, represents overall severity.

**Table: HoNOSCA Structure and Scoring (Section A)**

<b>Section title and brief item name</b>	<b>Range of item scores</b>	<b>Range of section scores</b>
a. Behavioural Problems  1. Aggressive/antisocial 2. Overactivity,attention 3. Self-harm 4. Substance misuse	  0-4 0-4 0-4 0-4	0-16
b. Impairment  5. Scholastic/language skills 6. Physical disability	  0-4 0-4	0-8
c. Symptomatic Problems  7. Hallucinations & delusions 8. Non-organic somatic symptoms 9. Emotional & related symptoms	  0-4 0-4 0-4	0-12
d. Social Problems  10. Peer relationships 11. Self care & independence 12. Family life & relationships 13. Poor school attendance	  0-4 0-4 0-4 0-4	0-16
e. Total score (1-13)		0-52

The *section scores* tend to show different patterns of outcome. For children with acute presentations, improvement may be expected in the order c, a, d, b. Subsection d offers the possibility of change when clinical problems have reached a steady level of severity.

The *total score* represents the summed severity of individual items and can therefore be used to measure outcome for national and local purposes (see section 6).

## **2.2 Scoring**

Each item is rated on a 5-point scale of severity (0 to 4):

- 0 No problem.
- 1 Minor problem requiring no action.
- 2 Mild problem but definitely present.
- 3 Problem of moderate severity.
- 4 Severe to very severe problem.
- 9 Not known.

Specific guidance for rating each point on each item is provided in the Glossary. The Glossary should be referred to on each occasion for guidance about the specific items to be included or excluded in each scale, as well as guidance about severity. As far as possible, the use of rating point 9 should be avoided, because missing data make scores less comparable over time or between settings.

## **3. Key Principles for Rating**

### **3.1 Qualifications of Trainers**

The chief requirement for trainers is substantial experience of Child and Adolescent Mental Health Services. Some knowledge of measuring instruments and their uses is an advantage for those involved in the supervision and quality assurance of data collection, and applications for public health purposes.

### **3.2 Qualifications of Raters**

HoNOSCA is designed for the assessment of children and adolescents in contact with Child and Adolescent Mental Health Services in either hospital or community settings. In principle, any well-trained mental health professional can learn to use the instrument. In the field trials professionals from all the disciplines represented in CAMHS rated cases including doctors, nurses, psychologists, social workers, art and occupational therapists and teachers. There did not appear to be any substantial difference in rating style between these groups.

### **3.3 HoNOSCA is not an interview but a Clinical Assessment**

HoNOSCA is not intended to structure a full clinical assessment. It will normally be completed following a routine assessment or review with child and informant. Sometimes a team meeting will be an appropriate forum for completing HoNOSCA ratings but they may be completed by an



individual clinician using all sources of information, including case notes, family members, other professional or reports etc.

### **3.4 Rate Health and Social Problems, not interventions**

HoNOSCA is concerned with 'health outcomes' not 'health care outcomes'. Interventions should not be taken into consideration when rating items. However, a rating of 1 does mean that, although a problem is present and should be recorded, its severity is minimal and no intervention is needed. Ratings of 2-4 on any item should be considered regularly for decision as to whether intervention is required.

### **3.5 Length of Period and Frequency of Rating**

#### ***The Period Rated:***

Usually, the two-week period preceding the first contact (T1) is rated. If the most severe problem leading to the assessment occurred rather more than a fortnight earlier it would usually be appropriate to include it in the rating. The period rated likewise at the second assessment (T2) should be the previous two weeks in order to optimise the sensitivity of HoNOSCA to change.

#### ***Frequency of Rating:***

HoNOSCA ratings will usually be made at the beginning and end of treatment. Interim assessments can be made at any frequency that is appropriate for the purposes of the clinician or for routine record keeping. Children and adolescents admitted to hospital could be rated twice at admission and discharge even if admission has only lasted a few days. After discharge, the intervals between ratings will depend on the care plan. These suggestions are general clinical guidelines but local contractual arrangements may offer alternative guidelines.

### **3.6 Rating the Severity of Problems**

For Items 1 - 9, the worst problem occurring during the chosen period is rated to give a measure of 'present state'. The rater should not attempt to rate each item as an average over the period. Items 10 - 13, however, require a more general rating over the chosen period.

### **3.7 Serial Ratings Should be Made by the Same Rater if possible**

HoNOSCA ratings should, if possible, be made by the same Rater, since this is good clinical practice and makes for consistency. Although comparisons weren't made in the HoNOSCA field trials of ratings of different-Rater pairs compared with same-Rater pairs, the HoNOS field trials suggested that there was no major difference between them when setting was controlled for.

### **3.8 Measuring Outcomes and Targets**

Each HoNOSCA rating provides a profile and measure of severity. The difference between the severity measured at two timepoints provides an estimate of outcome. HoNOSCA can also be used to provide serial ratings, allowing the measurement of trends and fluctuations over time. Aggregating scores across groups of patients provides a measure of group outcomes, e.g. between children with different clinical or social characteristics, or treated in different ways or in different settings, or living in different areas, or nationally from one year to the next in order to measure whether a target specified in terms of HoNOSCA is met.

### **3.9 Avoid Overlap Between Ratings**

The content of each item should be rated only once, thus eliminating overlap and double-counting as far as possible. The order of items is intended to reflect their clinical impact, with problems of behaviour and impairment taken earlier than problems with symptoms or social relations. Items should be rated in numerical order to promote consistency and comparability. Thus any example of disruptive, anti-social or aggressive behaviour, whatever the apparent diagnosis, cause of context, should be rated at Item 1 and not taken into consideration again.

Example: A teenager gets into a fight (severity of aggression rated at Item 1), when drunk (severity of alcohol problem rated at Item 3), and suffers physical injury (severity of injury rated at Item 5). Ratings on these three items might well be a different levels of severity.

The issue of possible *future risk* is not considered in HoNOSCA. Risk could be a separate item in a minimum data set of which HoNOSCA could be a part.

### **3.10 Clinical Judgement**

All judgements recorded in HoNOSCA are those of the clinician, not of the child or parent. (The User version of HoNOSCA for adolescents, which will allow comparison with professional ratings, is being piloted). Clinicians deal with uncertainty in their everyday interpretation of evidence from the literature and training. The development of consistency by single raters (who, with help from a supervisor, come to recognise their own styles of rating), and also between raters within teams, enhances the quality and clinical interpretability of the data. Item profiles will be interpreted locally in the light of this understanding. It is also important that a degree of supervision and help should continue after training, not only for the first 20 or so patients (when queries will be more common) but also to prevent drift thereafter.

## **4. Systematic Run Through the Items**

The HoNOSCA Glossary has been refined by taking account of the comments and questions of supervisors and raters during the course of

the trials. Some of the answers are specified in the section on 'Common Queries' in the Raters' Pack. The following commentary provides a consecutive description of the principles of rating as applied to each item in turn. For Items 1 - 9, the worst problem occurring during the chosen period is rated to give a measure of 'present state'. The rater does not attempt to rate each item as an average over the period. Items 10 - 13, by definition, do require a more general rating over the chosen period.

## **Section A**

### **Item 1                      Disruptive, antisocial or aggressive behaviour**

This item is concerned with a spectrum of behaviours. All three types of behaviour are included, whether or not there is intention, insight or awareness. However, the context must be considered since disagreement, for example, can be expressed more vigorously, but still acceptably, in some social contexts than in others.

Possible causes of the behaviour are not considered in the rating and diagnosis is not taken into account. For example, severity of disruptive behaviour by a child with hyperactivity is rated here, as is aggressive overactivity associated with psychotic disorder or violence associated with conduct disorder.

### **Item 2                      Problems with attention, overactivity or concentration**

This item is concerned with all attentional problems associated with any cause such as hyperkinetic disorder, mood disorder or arising from drugs. Although children with Attention Deficit Disorder, with Hyperactivity are likely to score highly here, this scale is not intended to refer to a narrow range of diagnoses, restlessness or inattention due to obsessional ruminations for example, should also be rated here.

### **Item 3                      Non-accidental self injury**

This item deals with ideas or acts of self-harm in terms of their severity or impact. As in the clinical situation, the issue of intent during the period, though sometimes difficult to assess is part of the current risk assessment. Thus, harm caused by an impulsive overdose could be rated at severity point 3 rather than 4 if the clinician judged that the child had not intended more than a moderate demonstration. Conversely, an adolescent who acquired a gun with clear intent to commit suicide, but was prevented in time, would be rated at point 4 (although rated 0 at Item 6). However, in the absence of strong evidence to the contrary, clinicians will usually assume that the results of self-harm were all intended. Non hazardous self-harm without suicidal intent should also be included here with the exception of scratching or picking as a direct result of a physical illness.

### **Item 4                      Problems with alcohol, substance or solvent misuse**

Consider characteristics such as craving or tolerance for alcohol or drugs, priority over other activities given to their acquisition and use, impaired capacity to control the quantity taken, frequency of intoxication and risk-taking. Dependence on alcohol and drugs is rare in children and adolescents thus this item addresses substance misuse out with the norms for a child's age. Aggressive and disruptive behaviour due to alcohol or drug use should not be included here as they are rated at Item

1, whilst physical illness or disability due to alcohol or drug use would be rated at Item 6.





## **Item 9                      Problems with emotional and related symptoms**

Only the most severe clinical problem not considered previously should be rated here. This might include depression, anxiety, worries, fears, phobias, obsessions or compulsions arising from any clinical condition including eating disorders. Aggressive destructive or overactive behaviours attributed to fears or phobias should be rated at Item 1. Physical complications of psychological disorders such as severe weight loss should be rated at Item 6. If a child has two or more symptoms in this category, choose only the most severe.

This procedure is repeated at T2. Items 10 to 13 (ratings of social functioning and of autonomy) unlike Items 1 to 9 which are concerned with the most severe example of difficulty occurring in the time period, address the mean level of functioning during the rating period. For example, in considering peer relationships (Item 10) the general level of friendships should be considered rather than giving undue weight to a child who has fallen out with one friend.

## **Item 10            Peer relationship problems**

This should include problems with school friends and the social network. This item is concerned with absence of friendships or social contacts with peers, as well as problems with over-intrusiveness and inappropriate play. Aggressive behaviour and bullying by the child however, should not be rated here but under Item 1. Difficulties within the family or with siblings are rated under Item 12. Difficulties making or sustaining friendships should be included as well as passive withdrawal from social relationships.

## **Item 11            Problems with self care and independence**

The overall level of functioning should be rated here, taking into account the norm for the child's chronological age. The child's actual performance should be rated not their potential competence.

## **Item 12            Problems with family life and relationships**

Usually this item will refer to relationships with parents and siblings in the family home but if the normal home is with foster parents or in residential placements, relationships there should be rated. Where the child is living away from home, relationships within the institution and with separated parents and siblings should both be rated. Parental personality problems, mental illnesses and marital difficulties should only be rated here if they have an effect on the child, though this will usually be the case. Problems associated with physical, emotional or sexual abuse should be included but this scale is not intended to address abusive or neglectful features alone. Difficulties arising from overinvolvement and overprotection should be included, as well as difficulties arising from family re-organisation as a result of relocation or bereavement. Sibling jealousy or physical coercion



by a sibling should be included but aggressive behaviour by the child should be rated under Item 1.

### **Item 13      Poor school attendance**

School non-attendance for any reason should be included. This will include truancy, school refusal, school withdrawal or suspension for any cause. Where the child is an inpatient or day patient, attendance at the appropriate educational facility at the time of rating should be recorded. This may include the hospital school or home tuition. During school holidays, the last two weeks of the previous term should be rated. As with other items, future intentions should not be rated, thus a school refusing a child expressing intention to return after the school holidays would score on this item until satisfactory school attendance had been achieved.

The above 13 items in Section A are generally summed to give a total score. The additional 2 items (Section B) may be used for children seen for brief interventions, where the main problem is of diagnostic uncertainty or lack of familiarity with appropriate services.

### **Section B**

#### **Item 14      Lack of knowledge - nature of difficulties**

This item is concerned with difficulties the child might be experiencing due to a lack of understanding within the family, about the nature of his difficulties. Difficulties may arise because the parents ascribe a wrong diagnosis or attribute problems to the wrong cause.

#### **Item 15      Lack of information about management of the child's difficulties**

This item is concerned with difficulties arising out of a lack of knowledge of appropriate services or management. Included here would be a child with a learning difficulty whose family were unaware of routes to special educational provision.

## **5. Clinical Vignettes**

During the first training sessions a number of queries were made by participants concerning rating problems that they had experienced. Many of these involved issues of causation and risk, as well as difficulties in disentangling the various features of psychosomatic presentations. For example:

*Q:      Violent ruminations with severe distress in a boy with obsessive compulsive disorder but no manifestations in behaviour.*

*A:      Rate 0 on Item 1; 4 on Item 9.*

*Q:      A girl with anorexia nervosa who vomits to control her weight when she feels bloated but has no other physical symptoms.*

A: Rate 0 on Item 6; 3 or 4 on Item 8 depending on frequency of vomiting.

Q: *A boy with developing personality problems who has marked aggressive thoughts towards others and has problems in peer relationships, but does not act aggressively during the period apart from a couple of quarrels.*

A: Rate 1 on Item 1; 3 on Item 10.

Q: *A girl severely injured six weeks after jumping from a high window, who has not been suicidal during the period but has been severely depressed.*

A: Rate 0 on Item 3; 4 on Item 6; 4 on Item 9.

## 6. Uses of HoNOSCA

HoNOSCA is intended to support two kinds of use:

- the first is clinical and 'bottom-up'; to provide an instrument that will be useful to those using it as part of their routine clinical work. Without that motivation, it is unlikely to be used widely and consistently;
- the second is to provide a minimum basis of relevant clinical information for the measurement of outcomes, in order to inform public health and planning decisions and provide an indicator for comparisons locally and nationally.

### 6.1 Clinical Uses

Two kinds of health and social gain should be specified as the target against which to measure outcome:

- improvement in mental and physical health and social functioning, over and above what would be expected without intervention;
- maintenance of an optimal state of health and social functioning by preventing, slowing and/or mitigating deterioration.

Changes in HoNOSCA ratings over time might provide a valuable source of information for discussion within clinical reviews and aggregated data could show trends that might not be evident when considering individual cases in isolation.

It should be noted that the total score should always be considered together with the full profile of 13 items when using the results for clinical decisions.

***In summary, the clinical advantages of the routine use of HoNOSCA include:***

- a standard record of progress across 13 common types of problem;
- a quick checklist for clinical notes;
- comparison of outcome against expectation based on interventions or natural course;
- a tool for audit and case reviews;
- a method for matching patients' needs to practitioner skills in casemix and caseload;
- a standard record for clinical research

## **6.2 Administrative Uses**

After anonymisation and aggregation, HoNOSCA data can be used to inform the commissioning process by addressing questions of health gain, and contributing to a more definitive estimation of the outcome of severe mental health problems. Where mental health service providers (and/or commissioners) wish to target specific groups or problem areas, HoNOSCA data would contribute by providing a criterion measure. For example, high severity score profiles could contribute to decision making about the allocation of respite care places in order to maximise support to carers.

The administrative advantages of HoNOSCA include:

- high quality information for local and national public health planning;
- comparison with other parts of the clinical and service minimum data set;
- quantified expression of the first mental health target;
- monitor progress towards local, regional and national targets;
- clinical comparison (under conditions of equivalence) of patient groups, settings, costs, districts or geographical areas, sociodemographic indices.

## **6.3 Research Uses**

HoNOSCA is potentially a useful tool for research. At local level, projects are already incorporating it in service evaluations; for example monitoring the progress of inpatients at six weekly reviews in an Adolescent Unit, evaluating a new outpatient service.

## **7. Plan for a Training Course**

Training in the use of HoNOSCA will generally require only a few hours. Experience shows that most clinicians find the 13 main scales quite easy to understand and use but continued learning continues with use. Speed and confidence improve rapidly as the scales are used in routine practice, particularly if a supervisor is available with whom to discuss queries as they arise. Most raters find that after completing 10+ score sheets they feel confident of recording HoNOSCA profiles that represent their overall clinical assessments. Even so, there can be a problem of 'drift' with any instrument. It is important in routine use to continue supervision, with retraining as necessary. Supervisors should also note that a few clinicians are unwilling to accept (or in very few cases unable to understand) the underlying principles of HoNOSCA. Such data would be unsuitable for pooling.

Training sessions should be designed by the supervisor to suit local circumstances. The pattern of trainers' courses, suitably simplified, may be appropriate as a general plan, under the following headings;

1. the reasons for creating HoNOSCA, against the background of a current system of information collection that is generally regarded as unhelpful to clinicians;
2. the structure and scoring of HoNOSCA;
3. key principles for rating;
4. systematic run through the items;
5. clinical uses (this may be the most important message);
6. after aggregation and anonymisation, use to make comparisons and monitor targets.

Following this introduction one or both of the following exercises can be suggested:

1. ask each trainee to write down a description of a patient they have recently seen;  
  
ask them then to rate HoNOSCA on this patient;  
  
address problems in rating HoNOSCA discovered during this process.
2. organise the trainees into pairs or groups, all of whom know a particular patient;  
  
ask them to write down a description of the patient;

ask them to rate HoNOSCA on this patient;

address problems in rating HoNOSCA discovered during this process.

## **8. In Conclusion**

Training and subsequent supervision are essential for the most effective use of HoNOSCA. Trainees respond well to learning HoNOSCA skills in a group and being given an opportunity to try out the technique. Training requires more scrutiny of detail than will eventually be required in routine use, because the underlying principles need to be explained. Once these are grasped, completion of the score sheet is relatively easy, since it depends on skills that trainees should already possess. Time spent on training and subsequent supervision should produce a good consensus and continued reliability. This in turn will maintain the quality of HoNOSCA data which, because realistically based in the ordinary clinical process, will provide good support for clinical and administrative decisions.

## **9. Other HoNOSCA Materials in the Trainers' Pack**

As well as this Guide, trainers will need:

- ***HoNOSCA: Brief Report on Research and Development<sup>1</sup>***

With minor amendments, this is identical to the Executive Summary of the main report to the Department of Health

- ***Raters' Pack***

Comprising an introduction, HoNOSCA Glossary, Chart and Score Sheet, and answers to questions commonly asked by Rater.

## **10. Definitions**

**Item** - HoNOSCA has 13 items.

**Severity Point** - each item has 5 severity points ranging from 'no problem' to 'very severe problem'.

**Subsections** - the 13 main HoNOSCA items can be divided into four sections: Behaviour (Items 1-4), Impairment (Items 5-6), Symptoms (Items 7-9) and Social Functioning (Items 10-13).

**Section Scores**- the totals of items in the subsection: a. Behaviour (Items 1-4, section score range 0-16), b. Impairment (Items 5-6, section score range 0-8), c. Symptoms (Items 7-9, section score range 0-12), d. Social Functioning (Items 10-13, section score range 0-16).

**Rater** - clinician (trained child mental health professional) who completes HoNOSCA.

**Supervisor** - clinician trained to train and supervise others to rate HoNOSCA.

**Time 1, Time 2 (T1, T2) etc** - A completed HoNOSCA score sheet is a numerical record of 'present state'. The first such assessment is a 'Time 1 (T1), the second at Time 2 (T2) etc. When the second assessment is made, the profile of item scores, section scores and total score can be compared with those from the first assessment, this comparison provides a measure of outcome. A series of assessments (T1, T2, T3, T4 etc) provides a description of the course.

<sup>1</sup> Gowers S.G., Harrington R., Whitton A., Lelliott P., Wing J. & Beevor A.,(1997) HoNOSCA: Health of the Nation Outcome Scales for Children and Adolescents, Brief Report on research and development. September 1995 - March 1997.

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