Comparison of the Current View Tool with The Paddington Complexity Scale and HoNOSCA

Briefing Note by PbR Project Group 27.03.13

Background

We have received two written enquiries questioning why we have chosen the Current View tool as central to data collection in PbR pilot work and asking how the Current View form compares with other assessment scales, in particular the Paddington Complexity Scale (PCS) and HoNOSCA. Below we give some context, explain our reasoning, lay out the differences and overlap between these measures and explain our rationale for using the Current View as part of CAMHS PbR development.

Executive summary

- The Current View is consistent with the CYP IAPT dataset and it was agreed to use the CYP IAPT dataset as the basis for data collection in PbR to minimise burden on services
- The Current View tool is not intended to be an assessment tool but rather a one page snapshot data collection tool to capture key information that is hypothesised to be relevant to understand outcomes and interpret resource use
- The Current View does expand on both the HoNOSCA and PCS by covering contextual/environmental factors, key complexity factors that are not addressed elsewhere, and certain problem descriptions. These were derived from extensive clinician consultation. We realise they are not perfect but they seemed to have widespread clinician buy-in.
- The Current View terms and language were agreed in consultation with young people and their representatives so that it could be used without the necessity of diagnostic categorisation and with young people and their families
- Training materials have been developed to ensure that clinicians use the Current View in consistent ways across the country. Inter-rater reliabilities are high and feedback is positive
- If services choose to use HoNOSCA or PCS these data can be included in the PbR pilot alongside the Current View

Rationale for use of Current View Tool

It is important to note that we are at least two years away from the possible implementation of PbR in CAMHS. We are currently collecting and analysing data to determine potential clusters for CAMHS. It is important to stress from the outset that the use of the Current View tool for the purposes of this pilot data collection work does not mean the Current View will be used as a clustering tool, it is just a convenient and non-burdensome way of gathering information for the pilot as part of much wider dataset capture.

Because assessment information (including problem type, severity, complexity and context) is not routinely collected in a standardised way across CAMH services, it is difficult to devise a system of predicting resource need without measuring this information in a way that is comparable from one service to another.

Retrospective analysis of several large CAMHS data sets has provided an indication of the information that is needed to make these predictions and has informed our approach to prospective

data collection. Our hypothesis is that along with problem type and severity, comorbidity, complexity and context will allow for differentiation between children and young people with different levels of resource need. Therefore a tool that captures all of this information will provide stronger and more reliable predictors of resource need than are currently possible. For the CAMHS PbR pilot, the Current View tool is primarily a data collection device and may or may not form the basis for the eventual 'clustering tool'. Either way, our iterative approach to data collection and analysis means that the tool is likely to go through a number of revisions, depending on what is found to be useful in predicting resource need. We acknowledge that the Current View tool does not cover every possible problem seen in CAMHS and the range of problem descriptions could be broader, but we believe that the benefits of using a tool that is aligned with the CYP IAPT project data collection requirements is, on balance, a good trade-off at this stage of data-gathering. We have made our best effort to balance the usefulness (both clinical and for our purposes) of the Current View with ease of use and minimal burden.

The Current View tool was developed through expert consultation. The problems listed are representative of the common mental health problems experienced by young people (e.g. Ford, Goodman, & Meltzer, 2003) as well as the rarer problems. The data collection needed to inform a needs-based clustering system must necessarily capture both common and rare problems. Although we acknowledge a particular emphasis on differentiation of anxiety problems which relates to the focus of wave one CYP IAPT, we feel that this is appropriate as anxiety problems are seen at all levels of CAMHS (tier 2-4) and are commonly comorbid with a variety of other diagnoses (e.g. Lewinsohn, Zinbarg, Seeley, Lewinsohn, & Sack, 1997). We think it is important to understand the impact of these comorbidities and differing severities on the resource needs across a range of CAMHS populations. We will take care in the analysis of data to ensure there is not an overemphasis on anxiety. When we do analysis of this as part of this project we may well collapse some of these categories in light of this.

It is important that the Current View tool should be used in conjunction with the Current View completion guide, which has definitions for each item on the tool.

The complexity factors were selected via expert consultation and analysis of retrospective data as being likely to imply additional resource when they are present alongside a problem. Often the range of developmental difficulties present is unclear at initial intake, and therefore cannot yet be described as complexity factors. The need for clarification can be flagged in the problem list using the 'unexplained developmental difficulties' indicator. In some cases clarification of developmental status (LD, SpLD, ASD) will form the larger part of a CAMHS episode of care.

The language used in the Current View tool was developed in consultation with young people; the problems listed are described in terms that were acceptable to them, hence the use of terms such as 'issues'. Involving service users in decisions about their care and sharing thoughts on their problems or diagnoses has been shown to have a positive impact on user satisfaction, treatment adherence and outcomes (Drake & Deegan, 2009).

It is likely that a purely 'primary diagnosis' led clustering system would not differentiate between low and high resource need; this is demonstrated in our retrospective data analysis, which showed that while some disorders (e.g. Psychosis and Eating Disorders) were indicative of high levels of resource use, other problems were less easily distinguishable (appearing to be distributed across all

levels of resource use). In order to reflect the full range and comorbidity of problems seen in CAMHS, it was thought prudent to use descriptors rather than diagnostic codes to allow the tool to capture a broader range of symptoms. This allows practitioners to categorise children with similar levels of impairment and difficulties in groupings and, if they are using diagnostic categories to know where these should be placed.

The aim is to capture assessment information as early as possible, thus we are not expecting a formal diagnosis to have been made when the Current View is completed; the form is designed to represent the clinician's view at that point in time. The Current View tool is broadly comparable with the HoNOSCA and Paddington Complexity Scale (PCS) in terms of the problems and complexities covered (see table below) as well as attempting to capture information about the young person's environment, which is not well covered by the HoNOSCA or PCS. The Current View has the added benefit of all information being captured on a single form, thus increasing the likelihood of both 'problem' and 'complexity' information being collected.

We acknowledge that the Current View tool is not perfect. Our aim was to develop a tool that can be used to capture a reasonable range of problems and complexities seen in CAMHS that can also be completed quickly and easily by clinicians and that is aligned with other data collection movements currently happening in CAMHS (CYP-IAPT and the CAMHS minimum dataset) so as to avoid overburdening clinicians with new measures. The PbR pilot team has received consistent feedback from clinicians at participating pilot sites (tiers 2-4, including specialist services) that the Current View tool represents their case loads and appears clinically useful.

We welcome comments from the CAMHS community as to how it can be refined and improved further.

Summary of items covered by the three scales

Current View	Covered on HoNOSCA	Covered on PCS
Complexity Items		
Looked after child	No	Yes
Young carer status	No	No
Learning disability	No	Yes
Serious physical health issues (inc. chronic fatigue)	Yes, score 6	Yes
PDD (autism/Asperger's)	No	Yes
Neurological Issues (tics/Tourettes)	No	? Yes partially ("physical illness with brain involvement")
Current Protection Plan	No	Yes
Child in need of social service input	No	Yes partially (recorded as current involvement with other agencies)
Refugee or asylum seeker	No	No
Experience of war, torture and trafficking	No	No
Experience of abuse or neglect	No	No
Parental health issues	No	No
Contact with Youth Justice System	No	Yes partially (recorded as involvement with other

		agencies)
Living in financial difficulty	No	No
Contextual Problems and Employment Education and Training (EET)	**Covered on HoNOSCA**	**Covered on PCS**
Home	No	No
School, work or training	No	No
Community	No	No
Service Engagement	Yes- HoNOSCA score B2	Yes partially, related to carers attitude and cooperation with assessment and treatment
Attendance (EET)	Yes- score 13	Yes partially ("No school" (excluded) item)
Attainment (EET)	Yes- score 5	No
Problem Descriptions	**Covered on HoNOSCA**	**Covered on PCS**
Anxious away from caregivers (Separation anxiety)	Partially covered by HoNOSCA score 9- emotional and related symptoms "Have you been feeling in a low or anxious mood or troubled by fears, obsessions or rituals?"	Partial- "anxiety disorders"
Anxious in social situations (Social anxiety/phobia)		Partial- "anxiety disorders"
Anxious generally (Generalized anxiety)		Partial- "anxiety disorders"
Compelled to do or think things (OCD)		Partial- "anxiety disorders"
Panics (Panic disorder)		Partial- "anxiety disorders"
Avoids going out (Agoraphobia)		Partial- "anxiety disorders"
Avoids specific things (Specific phobia)		Partial- "anxiety disorders"
Repetitive problematic behaviours (Habit problems)		Partial- "anxiety disorders"
Depression/low mood (Depression)		Yes- "Mood/affective disorders"
Self-Harm (Self injury or self-harm)	Yes, score 3 *(Does not include suicidal ideation)*	No
Extremes of mood (Bipolar disorder)	Not directly- mood and psychosis covered separately.	Would be recorded as "Other primary psychiatric condition"
Delusional beliefs and hallucinations (Psychosis)	Yes, score 7	Yes, "Schizophrenia"
Drug and alcohol difficulties (Substance abuse)	Yes, score 4	No
Difficulties sitting still or concentrating	Yes, score 2	Yes- "hyperkinetic disorder or ADHD"
Behavioural difficulties (CD or ODD)	Yes, score 1	Yes, "Oppositional Defiant disorder" and Conduct disorder
Poses risk to others	?Partial- score 1 "problems related to disruptive,antisocial and aggressive behaviour"	No
Carer management of CYP behaviour(e.g., management of child)	No	?Partial, "Carer's attitude and cooperation with assessment and treatment"
Doesn't get to toilet in time (Elimination problems)	No	Partial, "Nonorganic encopresis"

Disturbed by traumatic event (PTSD)	No	Would be recorded as "Other primary psychiatric condition"
Eating issues (Anorexia/Bulimia)	Partial, score 8 "Self-induced vomiting"	Yes
Family relationship difficulties	Yes, score 12	?Partial, "Carer's attitude and cooperation with assessment and treatment"
Problems in attachment to parent/carer(Attachment problems)	No	No
Peer relationship difficulties	Yes, score 10	No
Persistent difficulties managing relationships with others (includes emerging personality disorder)	No	Partial, "Personality disorders"
Does not speak (Selective mutism)	No	Would be recorded as "Other primary psychiatric condition
Gender discomfort issues (Gender identity disorder)	No	Would be recorded as "Other primary psychiatric condition
Unexplained physical symptoms	Yes, score 8	Yes, "Somatoform disorders"
Unexplained developmental difficulties	No	Partial, "Sleep and feeding", "pervasive developmental disorder"
Self-care Issues(includes medical care management, obesity)	Yes, score 11	Yes, "sleep and feeding disorders"
Adjustment to Health Issues	No	Yes, "Acute stress reaction/Adjustment disorder"

Items covered by PCS that the Current View does not cover:

- Whether it is the first contact with MH services
- Who the child's main carers are
- **Mild** learning disability (see CV definitions which only include moderate and severe)
- Duration of condition

Items covered by HoNOSCA that the Current View does not cover:

- Lack of knowledge about nature of difficulties (?although this could be part of Service Engagement issues)

Items covered by Current View not covered by PCS or HoNOSCA:

Complexity Factors

- Refugee or asylum seeker
- Experience of war, torture and trafficking
- Experience of abuse or neglect
- Parental health issues
- Living in financial difficulty

Contextual Factors

- Home
- School, work or training
- Community

Problem Descriptions

- Extremes of Mood (Bipolar disorder)*
- Carer management of CYP behaviour*
- Doesn't go to the toilet in time*
- Disturbed by traumatic event
- Problems in attachment to parent/carer(Attachment problems)
- Does not speak (Selective mutism)
- Gender discomfort issues (Gender identity disorder)

**These items may be partially covered by the HoNOSCA or PCS, please see notes on these items in table above.*

Considerations going forward

- It is recognised that the Current View form currently has many descriptions around anxiety and fewer subcategories around other problems. This reflects its origins in the phase one of CYP IAPT. When we do analysis of this as part of this project we may well collapse some of these categories in light of this.
- The Current View will be iteratively refined by feedback from both PbR and CYP IAPT pilot sites, a preliminary consultation in July 2012 (link) led to one set of changes, there may be further refinements in July 2013.
- We welcome further feedback on how this form can be used.

Drake, M. D. P. D. R., & Deegan, P. D. P. (2009). Shared Decision Making Is an Ethical Imperative. *Psychiatric Services, 60*(8), 1007-1007.

Ford, T., Goodman, R., & Meltzer, H. (2003). The British Child and Adolescent Mental Health Survey 1999: The Prevalence of DSM-IV Disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(10), 1203-1211.

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