



HoNOS-secure



HoNOS



Guide for
New Zealand
Clinicians

Te Pou o te
Whakaaro Nui



Acknowledgements

We would like to acknowledge a number of people who have contributed to the development of the resources.

- » For input into the development of the MH-SMART Initiative information collection protocol (ICP): Jennifer Chips, Malcolm Stewart and Verity Humberstone, first published 2006.
- » For input into version two of the National Outcomes Collection ICP (version 2.2) published in 2015: John Beveridge, Ryan Papps, Alison Bower and Mark Smith.
- » For development of the original e-booklets published in 2014: Alicia Yap, Cara Thomas and Mark Smith.

Acknowledgment for use of instruments

Health of the Nation Outcome Scales (HoNOS-secure) © 2009 International HoNOS-secure version, Royal College of Psychiatrists and St Andrew's Healthcare, UK.

HoNOS-secure key sources

Dr Philip Sugarman and Lorraine Walker, St Andrew's Hospital Trust, Northampton, UK.

For further information on HoNOS-related references please visit <http://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/resources/honos/references.aspx>.

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Purpose of this guide

This guide is for HoNOS-secure, a member of the HoNOS family of measures. This guide brings together resources that have previously been available as separate documents. These include the *Clinician's Reference Guide, Version 2.1, 2014*, the *Mental Health Outcomes Information Collection Protocol (ICP), Version 2.2, June 2015* and the *original e-booklets for each of the HoNOS measures, 2014*.

The booklet has been developed as a resource for:

- » clinicians and managers in mental health services
- » site coordinators and data quality personnel
- » outcomes trainers (to assist deliver training in their respective services).

How to use this guide

This guide is intended to be accessed electronically and includes clickable links. If it is printed, please ensure you check Te Pou's website regularly to ensure you are using the current version.



Orange boxes within each chapter contain links telling you where to get more information about that subject. You can either Ctrl + left mouse click on the link, or cut and paste the address into your browser's address bar.



We have also added handy hints which you will find in bold blue text.



You can also use the contents page to navigate within the response. Ctrl + left mouse click on the heading and you will be taken to the corresponding page.

Published April 2017

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Contents

| | |
|---|-----------|
| Outcomes and HoNOS-secure | 5 |
| What is an outcome?..... | 5 |
| The benefits of collecting quality outcomes information | 5 |
| Health of the Nation Outcome Scales (HoNOS) in New Zealand | 6 |
| Outcomes in New Zealand – key milestones | 6 |
| What is HoNOS-secure?..... | 7 |
| When is HoNOS-secure used? | 8 |
| HoNOS-secure collection points | 9 |
| HoNOS-secure collection rules for service users transferred between treatment settings..... | 10 |
| HoNOS-secure rating guidelines and glossary | 12 |
| Important variations in rating guidelines | 13 |
| HoNOS-secure glossary | 14 |
| Security scales A-G | 14 |
| Scale 1: Overactive, aggressive, disruptive or agitated behaviour | 16 |
| Scale 2: Non-accidental self-injury | 17 |
| Scale 3: Problem drinking or drug-taking | 18 |
| Scale 4: Cognitive problems..... | 19 |
| Scale 5: Physical illness or disability problems | 20 |
| Scale 6: Problems associated with hallucinations and delusions..... | 21 |
| Scale 7: Problems with depressed mood..... | 22 |
| Scale 8: Other mental and behavioural problems..... | 23 |
| Scale 9: Problems with relationships | 24 |
| Scale 10: Problems with activities of daily living | 25 |
| Scale 11: Problems with living conditions | 26 |
| Scale 12: Problems with occupation and activities | 27 |
| Clinical significance and recommended action..... | 28 |
| Rating reliably..... | 29 |
| Mental health outcomes information collection protocol (ICP) key concepts | 30 |
| Demonstrating change..... | 30 |
| ICP key concepts..... | 30 |
| Focus of care rating guidelines | 36 |
| HoNOS outcome measure ICP - key clinical and descriptive information | 37 |
| Key information routinely collected for PRIMHD | 40 |
| How we use outcomes information collected in clinical practice..... | 41 |
| Outcomes information as part of the bigger picture | 45 |
| Glossary of terms | 45 |
| Training and other resources | 46 |

Outcomes and HoNOS-secure

What is an outcome?

An outcome is a change in health, wellbeing and circumstances over time (Te Pou, 2012).

Outcome measures provide the ability for service users, clinicians, managers and organisations to measure change (improvement, deterioration or maintenance) in health, wellbeing and circumstances over time. Change between one collection to the next is known as an outcome.

An outcome measure collects information about a person's mental health and social functioning at set points throughout the person's journey to recovery. This can be at admission and discharge from mental health services, or at admission and review if the person is receiving services for longer than three months.

Outcome measures can focus on a range of different domains, such as clinical status, functioning, employment, living conditions and spiritual wellbeing. Outcome measures can also be rated from different perspectives, such as service user, clinician or health worker, whānau or significant other.

Outcome measures undergo psychometric testing to determine their quality and usefulness in the required setting. These properties identify the measure's reliability, validity and sensitivity to therapeutic change.

Outcome information is used at local, regional and national levels to assess the effectiveness of services. New Zealand has adopted an outcome measurement framework with five component areas: clinical, addictions, Māori, self-rated and functioning information. The clinical measures have been introduced first, based on the HoNOS family of measures – all mandated for collection in New Zealand mental health services.

The benefits of collecting quality outcomes information

Data quality is key to using outcomes information effectively. Clinicians are trained in the use of outcome measures to ensure consistent collection across individual clinicians, teams and services.

The primary use of outcomes data is at an individual level. Good quality outcomes data can help us in discussing outcomes information with service users. This is one way service users can participate in their care and treatment and it may allow for further conversations about recovery.

Sharing outcomes, such as HoNOS-secure ratings, with a service user as part of a collaborative care plan should be routine and may also improve opportunities for whānau involvement. Information about the use of outcomes at an individual level is discussed later in this guide.

The secondary use of outcome data is at an aggregate level. At this level, good quality outcomes data can help us to better understand changes in health, wellbeing and circumstances for people who access mental health and addiction services across all of New Zealand.

It can inform planning, service improvement activities and benchmarking initiatives, and provide an overview of organisational performance on those indicators over time.



For more information about outcome measurement used in mental health and addiction services in New Zealand see www.tepou.co.nz/outcomes-and-information/mental-health-outcome-measures/28

Health of the Nation Outcome Scales (HoNOS) in New Zealand

In [Rising to the Challenge](#): The Mental Health and Addiction Service Development Plan 2012–2017, the Ministry of Health directs a greater focus on outcome measurement and key performance indicators to help develop an outcomes culture in mental health and addiction services.

The Ministry's strategy for Health of the Nation Outcome Scales (HONOS) is to ensure good compliance with collections before introducing other mandated measures.

The overall collection rate, for 2016 onwards, for HoNOS is 80 per cent for both community and inpatient collections combined and 80 per cent for inpatient admissions and discharges. The ability to accurately reflect change at an aggregate level relies on obtaining a high percentage of collections.

Outcomes in New Zealand – key milestones

| | | | |
|------|---|------|--|
| 2002 | DHBs received crown funding agreements with the Ministry of Health for using outcomes measurement. | | |
| 2003 | Ministry of Health funded the Classification and Outcomes Study (CAOS), which resulted in a large and rich database for outcomes and identified 42 classes for Casemix purposes. | | |
| 2005 | <p>The Mental Health Standard Measures of Recovery Initiative (MH-SMART) was established.</p> <p>The National Mental Health Information Strategy was developed. It addresses the ongoing development of mental health information systems based on the requirements of a range of stakeholders. The strategy suggests activities to enhance what has already been accomplished, using resources already in place and focusing on areas requiring further work.</p> | 2009 | <p>Framework was to enable mental health services to learn about practices that lead to improved outcomes for service users. This project was led by the Northern Regional Alliance and managed by Counties Manukau District Health Board. The Framework was developed under the basis that it would be used as a quality improvement tool and this commitment influenced the choice of indicators. More information about the progress of the Framework can be found on the Northern DHB Support Agency (NDSA) website.</p> <p>(Since 2012 NDSA is known as Northern Regional Alliance.)</p> <p>Te Pou foundational training and one-day suite of measures training replaced MH-SMART training.</p> <p>National and service level PRIMHD outcomes reports were made available for the first time.</p> |
| 2008 | <p>The Programme for the Integration of Mental Health Data (PRIMHD) was launched. This was to develop a new national mental health information collection, integrating the Mental Health Information National Collection (MHINC) and the Mental Health Standard Measures of Assessment and Recovery (MH-SMART) datasets. PRIMHD is one of nine priority projects described in the implementation plan of the National Mental Health Information Strategy. The PRIMHD dataset will also provide services with valuable information to support planning activities.</p> <p>1 July, HoNOS, HoNOS65+ and HoNOSCA were mandated as part of the national collection for PRIMHD.</p> | 2012 | <p>July 1st, HoNOS-secure and HoNOS-LD were mandated as part of the national collection for PRIMHD.</p> <p>Release of <i>Rising to the Challenge</i> Service Development Plan.</p> |
| 2009 | The Ministry of Health funded the development of a Key Performance Indicator (KPI) Framework. The purpose of this | 2013 | National Mental Health and Addiction Information Reference Group established by Te Pou in response to the <i>Rising to the Challenge: The Mental Health and Addiction Service Plan 2012–2017</i> . |
| | | 2015 | July 1st, Alcohol and Drug Outcome Measure (ADOM) was mandated as part of the national collection for PRIMHD. |
| | | 2016 | 1 July collection of a supplementary consumer record (SCR) including indicators of social outcome (accommodation, employment and education status, and presence of a wellness plan) was mandated for DHB and NGO services as part of the national collection for PRIMHD. |

What is HoNOS-secure?

Health of the Nation Outcome Scales for use in secure and forensic mental health services (HoNOS-secure) is a member of the Health of the Nation Outcome Scales (HoNOS) family of measures. It is a clinician rated tool developed by the St Andrew's Healthcare Trust and the Royal College of Psychiatrist's Research Unit.

There are several variants in the HoNOS family of measures.

| | |
|--------------|--|
| HoNOS | for adults aged 18 to 65 years. |
| HoNOS65+ | for people aged 65 years and above. |
| HoNOSCA | for children and adolescents under 18 years. |
| HoNOS-LD | for adults who have a dual diagnosis, such as mental illness and an intellectual disability. |
| HoNOS-secure | for adults who are being supported by forensic services. |

In New Zealand, HoNOS-secure is the outcome measurement tool mandated by the Ministry of Health for use with people experiencing severe mental illness who are users of secure and forensic mental health services.

HoNOS-secure uses an amended version of the original 12 HoNOS scales (also referred to as items). The 12 HoNOS scales measure behaviour, impairment, symptoms and social functioning. The 7 additional security scales record the outcome of a clinical assessment of current need for secure/forensic care.

HoNOS-secure's 19 items are rated, after routine clinical assessment, on a scale of 0 to 4. The HoNOS-secure glossary provides detailed descriptions for each level of severity and complexity. The results or changes in ratings between one collection and the next are known as outcomes. Outcomes can then be used to measure and compare other service users and service related information.



The completed HoNOS-secure has 19 scales. The total score for the 7 security items and the total score for the 12 amended HoNOS scales are reported separately.

The original HoNOS 12 scales cannot be used instead of the HoNOS-secure 12 scales as there are differences in wording and descriptions between them.

HoNOS-secure is completed by a qualified mental health professional (clinician) using the information obtained in a comprehensive mental health assessment and from their routine clinical work. It is recommended information from all available sources be considered when completing ratings, including information provided by the service user, their whānau and also clinical notes.

HoNOS-secure is rated using the relevant glossary and is based on information from the last two weeks of a service user's presentation at all collection occasions. The exception is for an end of episode in an inpatient setting, where the rating period is three days.

Scales 11 and 12 can be rated beyond the two week period.

When is HoNOS-secure used?

HoNOS-secure is mandated for use with all people accessing secure and forensic mental health services, in all district health boards (DHBs), in both inpatient and community settings.

HoNOS-secure is completed:

- » as a person enters a specialist mental health service (admission/*episode start*) and when they exit (discharge/*episode end*) the service
- » at *three monthly review* periods while they continue to access services
- » when there are significant changes to the service user's health, wellbeing or circumstances (*ad hoc review*).

A clinician, who is most familiar with the individual service user, records the HoNOS-secure ratings, taking into account all available information. Ideally, the same clinician or team will rate the subsequent review or discharge HoNOS-secure. This may not always be possible, particularly in the case of inpatient treatment settings.

HoNOS-secure items

Security scales 7 items

- A. Risk of harm to adults or children.
- B. Risk of self-harm (deliberate or accidental).
- C. Need for building security to prevent escape.
- D. Need for a safely staffed living environment.
- E. Need for escort on leave (beyond secure perimeter).
- F. Risk to individual from others.
- G. Need for risk management procedures.

Amended HoNOS 12 items

- 1. Overactive, aggressive, disruptive or agitated behaviour.
- 2. Non-accidental self-injury.
- 3. Problem drinking or drug-taking.
- 4. Cognitive problems.
- 5. Physical illness or disability problems.
- 6. Problems associated with hallucinations and delusions.
- 7. Problems with depressed mood.
- 8. Other mental and behavioural problems.
- 9. Problems with relationships.
- 10. Problems with activities of daily living.
- 11. Problems with living conditions.
- 12. Problems with occupation and activities.

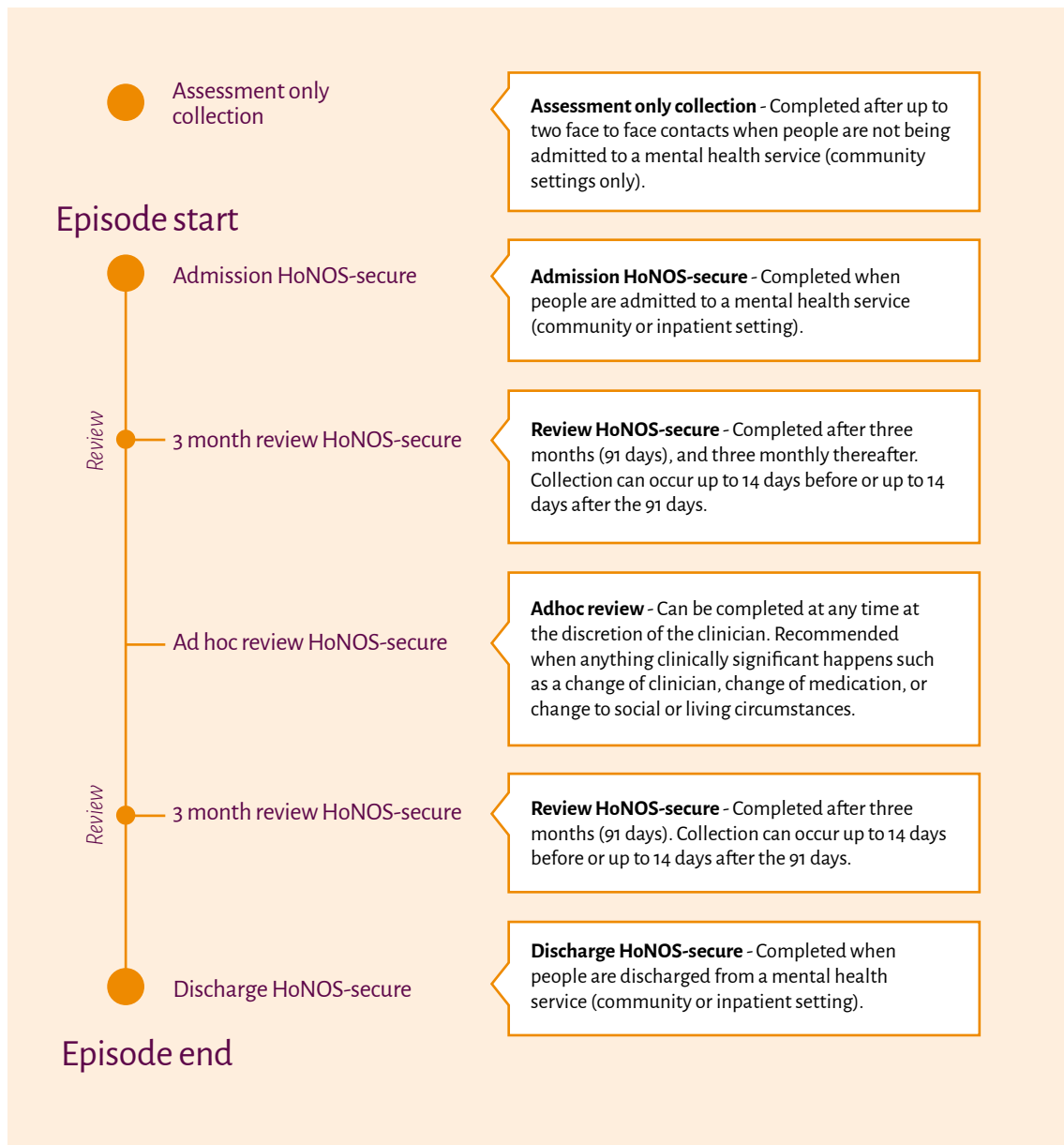


Note that the clinical significance and recommended actions for the 7 security scales are different to those for the HoNOS 12 scales. See page 25 and 26.

How each item is rated

- 0. No problem.
- 1. Minor problem requiring no action.
- 2. Mild problem but definitely present.
- 3. Moderately severe problem.
- 4. Severe to very severe problem.

HoNOS-secure collection points



HoNOS-secure collection rules for service users transferred between treatment settings

The completion of treatment at one DHB service and the commencement of treatment in another service in the same DHB are considered separate episodes of care. For example, transfer from an inpatient ward to a community service within the same DHB. As such, a new episode of data collection should begin.

The reason for this is that a service user may only be the subject of one episode of mental health care at any given time, either inpatient or community.

Community care with intervening inpatient admission





Guidelines for change of treatment setting scenarios

- » Where a person might be considered as receiving treatment in more than one service setting simultaneously, the inpatient care episode will take precedence over the community episode. Community involvement will be captured as usual and reported to Programme for the Integration of Mental Health Data (PRIMHD).
- » Where a person is discharged from a community episode for the purposes of inpatient admission, the ratings collected to end the community episode can be used, or electronically copied, to begin the inpatient episode.
- » Where a person is discharged from an inpatient episode to a community service, ratings cannot be copied to the community episode start. This is because the length of time between the inpatient discharge and admission to community treatment may render those inpatient discharge ratings out of date.
- » Where a person is receiving treatment in more than one community service, the clinician who knows the person the best should record the measure ratings, taking into account information from the full range of services with which the person is involved.
- » When a person is transferred from one DHB to another, an episode end collection should be completed by the transferring DHB. A new episode of care should begin with information shared between DHB providers informing the data collection in the process of transfer between the DHBs.
- » For requirements of the mental health outcomes information collection protocol (ICP) see the section headed mental health outcomes information collection protocol (ICP) key concepts.

For requirements of the mental health outcomes information collection protocol (ICP) see the section headed "[HoNOS outcome measure ICP - key clinical and descriptive information](#)" on page 37.

HoNOS-secure rating guidelines and glossary

Security scales

The security scales are completed first. Work through scales A to G in alphabetical order. Choose a severity rating for each scale.

- » Update the service user's clinical history and risk assessment.
- » Review past incidents, behaviours, attitudes held, current progress.
- » Assess the most serious potential problem in the 'near future' (weeks or months). Where relevant, consider if living unsupported in the community. 'Potential' implies significant likelihood. Where the outcome is unpredictable (eg overdose, fire), assess in proportion to the degree of risk likely to occur.
- » Rate the conclusions of the risk assessment and the current need for secure care. Note: this may or may not be the same as the care currently provided.



The fundamental consideration when rating the 7 security scales is that we are rating the current need for care and clinical risk management, and not current placement. For example, a HoNOS-secure rating of a service user in prison is not about the current placement (prison), it is about their need for care and clinical risk management outside of that environment.

Once the 7 security scales have been rated, continue to rate the HoNOS scales in order from 1 to 12.

General rating guidelines

- » Perform a full clinical assessment of the service user's clinical history and current problems.
- » Rate scales in order from 1 to 12.
- » Do not include information already rated in an earlier scale.
- » Rate the most severe problem that occurred in the period rated.
- » The rating period is generally the preceding two weeks for inpatients at admission, for hospital outpatients and for all clients of community based services. The exception is at discharge from acute inpatient care, in which case the rating period should generally be the preceding 72 hours or three days.
- » Each scale is rated on a 5-point item of severity (0 to 4) as follows:
 - 0 - no problem
 - 1 - minor problem requiring no formal action
 - 2 - mild problem, should be recorded in a care plan or other case record
 - 3 - problem of moderate severity
 - 4 - severe to very severe problem
 - 7 - not known or not able to rate.
- » Specific help for rating each point on each scale is provided in the glossary.
- » As far as possible, the use of rating point 7 should be avoided, because missing data makes scores less comparable over time or between settings.



It is recommended that clinicians refer to the glossary consistently when completing the HoNOS-secure. HoNOS-secure should be rated using information available from all sources.

Important variations in rating guidelines

| Core rules | | |
|-------------|------------------------------|---|
| Scale | Rate the worst manifestation | Rate over the past two weeks |
| Scale 1-8 | Always | Always |
| Scale 9-10 | Based on usual or typical | Always |
| Scale 11-12 | Based on usual or typical | May need to go back beyond two weeks to establish the usual situation |

HoNOS-secure glossary

Security scales A-G

The security scale ratings are completed first. Work through scales A to G in alphabetical order. Choose a severity rating for each scale.

A. Rate risk of harm to adults or children

0. Nil significant.
1. 'Minor' e.g. altercation: non-contact sex offence; damage to property; waste bin fire.
2. Significant injury; major fire; sex assault.
3. Serious - wounding; arson endangering life; rape; disability.
4. Grave – including homicide, near-fatal injury, profound trauma.

B. Rate risk of self-harm (deliberate or accidental)

0. Nil significant.
1. For example minor self-harm/overdose; marked neglect of hygiene, undernourished.
2. Significant injury or disfigurement; inpatient medical treatment for overdose; burns; starvation, etc.
3. Disability by any form of self-harm.
4. Actual or near suicide; jumping from height.

C. Rate need for building security to prevent escape

0. Open community residence.
1. Open facility on psychiatric campus.
2. Low security; PICU; high dependency; restricted exit with security features.
3. Medium security; airlock; secure building design and compound.
4. High security, security features comparable to closed prison.

D. Rate need for a safely staffed living environment

0. No need, unstaffed residence appropriate.
1. Day care; home treatment; 24 hour staff or inpatient care, but with unescorted community leave.
2. 24 hour staff or inpatient care, without unescorted community leave.
3. Enhanced, continuous or special observation measures.
4. Occasional or frequent seclusion; more than one staff continuously.

E. Rate need for escort on leave (beyond secure perimeter).

Do not include need for a driver.

- 0. No inclination to abscond; alert individual; behave appropriately.
- 1. One escort as may wander, fall, get run over, return late or behave inappropriately.
- 2. Maximum two escorts to contain behaviour or deter absconsion.
- 3. Maximum three escorts to contain behaviour or deter absconsion.
- 4. Requires special arrangements; four escorts, special vehicle; police assistance.

F. Rate risk to individual from others

- 0. Nil significant.
- 1. Bullying; disempowerment; unwanted attention; disadvantage.
- 2. Abuse; assault; swindle; serious harassment; prostitution.
- 3. Serious victimisation or injury; rape; severe media hostility.
- 4. Death, serious disability, profound trauma.

G. Rate the need for risk management procedures

- 0. Basic care planning.
- 1. Ongoing team clinical risk assessment.
- 2. Specialist clinical risk management; relapse prevention or other special therapy.
- 3. Requires **compulsory** check, search or test regarding drugs, weapons, visits, mail, phone.
- 4. Invasive or intensive checks, searches, tests or similar restriction.

Scale 1: Overactive, aggressive, disruptive or agitated behaviour

- ✓ **Include** such behaviour due to any cause, such as drugs, alcohol, dementia, psychosis, depression, etc.
- ✗ Do **not** include bizarre behaviour, rated at Scale 6. Rate sexual behaviours at Scale 8 (I) but rate any violence/intimidation here.

| Rating | Description |
|--------|---|
| 0 | No problems of this kind during the period rated. |
| 1 | Some irritability, quarrels, restlessness, disruptive behaviour, etc. |
| 2 | Includes occasional aggressive gestures, pushing, pestering or provoking others; threats or verbal aggression; lesser damage to property (e.g. broken cup or window, cigarette burns); marked over-activity or agitation. |
| 3 | Physically aggressive to others or animals (short of rating 4); persistently threatening manner; more serious over-activity or destruction of property (e.g. broken doors, minor fire setting to bins/ashtrays etc.). |
| 4 | At least one serious physical attack on others or on animals; destruction of property (e.g. dangerous fire-setting); use of weapons; persistent serious intimidation behaviour. |

Additional notes for scale 1

This scale is concerned with a spectrum of behaviours. The short title is 'Aggression', for convenience, but the full title is broader and more accurate. All four 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, the severity of disruptive behaviour by someone with dementia or learning disability is rated here, as is aggressive overactivity associated with mania, or agitation associated with severe depression, or violence associated with hallucinations or personality problems. Bizarre behaviour is rated at Scale 6.

Scale 2: Non-accidental self-injury

- X** Do **not** include **accidental** self-injury (due e.g. to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.
- X** Do **not** include illness or injury as a direct consequence of drug or alcohol use rated at Scale 3, (e.g. cirrhosis of the liver or injury resulting from drunk driving are rated at Scale 5).

| Rating | Description |
|--------|--|
| 0 | No problem of this kind during the period rated. |
| 1 | Fleeting thoughts about self-harm or suicide, but little risk; no self-harm. |
| 2 | Mild risk during period; includes non-hazardous self-harm e.g. wrist-scratching, not requiring physical treatment); persistent or worrying thoughts about self-harm. |
| 3 | Moderate to serious risk of deliberate self-harm; includes preparatory acts (e.g. collecting tablets, secreting razor blade, making nooses, suicide notes). |
| 4 | Serious suicidal attempt and/or serious deliberate self-harm during period (i.e. person seriously harmed self, or intended to, or risk death by their actions). |

Additional notes for scale 2

This scale 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 (e.g. when consumer is slowed by depression), is part of the current risk assessment. Thus, severe harm caused by an impulsive overdose could be rated at severity point 4, even though the clinician judged that the consumer had not intended more than a moderate demonstration.

In the absence of strong evidence to the contrary, clinicians should assume that the results of self-harm were all intended. Risk of future self-harm is not part of this rating; although it should be part of the wider clinical assessment.

Scale 3: Problem drinking or drug-taking

- X** Do **not** include aggressive or destructive behaviour due to alcohol or drug use, rated at Scale 1.
- X** Do **not** include physical illness or disability due to alcohol or drug use, rated at Scale 5.

| Rating | Description |
|--------|---|
| 0 | No problem of this kind during the period rated (e.g. minimal cannabis use, drinking within health guidelines). |
| 1 | Some over-indulgence, but within social norm (e.g. significant cannabis use, other low risk activity). |
| 2 | Loss of control of drinking or drug-taking; but not seriously addicted (e.g. regular cannabis use, drinking above health guidelines); (in controlled settings – occasional positive urine tests, loss of leave or delayed discharge on account of attitude or behaviour towards drink and drugs). |
| 3 | Marked dependence on alcohol or drugs with frequent loss of control, drunk driving; (in controlled settings – drug debts, frequent attempts to obtain drugs; persistent pre-occupation with drink/drugs; repeated intoxication or positive urine tests). |
| 4 | Incapacitated by alcohol or drug problems. |

Additional notes for scale 3

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 drunk driving or other risk-taking.

Temporary effects such as hangovers should also be included here. Longer-term cognitive effects such as loss of memory are rated at Scale 4, physical disability (e.g. from accidents) or disease (e.g. liver damage) at Scale 5, mental effects at Scales 6, 7 and 8, problems with relationships at Scale 9.

Scale 4: Cognitive problems

- ✓ **Include** problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia, etc.
- ✗ Do **not** include temporary problems (e.g. hangovers) resulting from drug or alcohol use, rated at Scale 3.

| Rating | Description |
|--------|---|
| 0 | No problem of this kind during the period rated. |
| 1 | Minor problems with memory or understanding (e.g. forgets names occasionally). |
| 2 | Mild but definite problems (e.g. has lost the way in a familiar place or failed to recognise a familiar person); sometimes mixed up about simple decisions; major impairment of long term memory. |
| 3 | Marked disorientation in time, place or person, bewildered by everyday events; speech is sometimes incoherent, mental slowing. |
| 4 | Severe disorientation (e.g. unable to recognise relatives, at risk of accidents, speech incomprehensible); clouding or stupor. |

Additional notes for scale 4

Intellectual and memory problems associated with any disorder, including dementia, learning disability, schizophrenia, very severe depression, etc., are taken into account, e.g. problems in naming or recognising familiar people or pets or objects; not knowing the day, date or time; difficulties in understanding or using speech (in own language); failure to remember important matters; not recognising common dangers (gas taps, ovens, crossing busy roads); clouding of consciousness and stupor.

Scale 5: Physical illness or disability problems

- ✓ **Include** illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning (eg pain).
- ✓ **Include** side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drunk driving etc.
- ✗ Do **not** include mental or behavioural problems rated at Scale 4.

| Rating | Description |
|--------|---|
| 0 | No physical health problem during the period rated. |
| 1 | Minor health problem during the period (e.g. cold, non-serious fall, etc.). |
| 2 | Physical health problem imposes mild restriction on mobility and activity (eg sprained ankle, breathlessness). |
| 3 | Moderate degree of restriction on activity due to physical health problem (eg has to give up work or leisure activity). |
| 4 | Severe or complete incapacity due to physical health problems. |

Additional notes for scale 5

Consider the impact of physical disability or disease on the consumer in the recent past. Problems likely to clear up fairly rapidly, without longer term consequences (e.g. a cold or bruising from a fall), are rated at point 0 or 1. A consumer in remission from a possibly long-term illness is rated on the worst state in the period, not on the prospective level.

The rating at points 2-4 is made in terms of degree of restriction on activities, irrespective of the type of physical problem. Include impairments of the senses, unwanted side effects of medication, limitations on movement from whatever cause, injuries associated with the effects of drugs or alcohol, etc. The physical results of accidents or self-injury in the context of severe cognitive problems should also be rated here.

Scale 6: Problems associated with hallucinations and delusions

- ✓ **Include** hallucinations and delusions irrespective of diagnosis.
- ✓ **Include** odd and bizarre behaviour associated with hallucinations or delusions, such as thought disorder.
- ✗ Do **not** include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at Scale 1.

| Rating | Description |
|--------|---|
| 0 | No evidence of hallucinations or delusions during the period rated. |
| 1 | Somewhat odd or eccentric beliefs not in keeping with cultural norms. |
| 2 | Delusions or hallucinations (eg. voices, visions) present, but there is little distress to patient or manifestation in bizarre behaviour (ie, clinically present but mild). |
| 3 | Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour (ie, moderately severe clinical problem). |
| 4 | Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient/others. |

Additional notes for scale 6

Rate such phenomena irrespective of diagnosis. Rating point 1 is reserved for harmless eccentricity or oddness. If a consumer has a delusional conviction of royal descent but does not act accordingly and is not distressed, the rating is at point 2.

If the consumer is distressed, or behaves bizarrely in accordance with the delusion (e.g. acting in a grandiose manner, running up large debts, dressing the part, expecting to be admitted to a royal palace, etc.) the rating is at points 3 or 4. Any violent, overactive and disruptive behaviour, however, has already been rated at Scale 1 and should not be included again. Similar considerations apply to other kinds of delusion and to hallucinations.

Scale 7: Problems with depressed mood

- X** Do **not** include overactivity or agitation, rated at Scale 1.
- X** Do **not** include suicidal ideation or attempts, rated at Scale 2
- X** Do **not** include delusions or hallucinations, rated at Scale 6.

| Rating | Description |
|--------|--|
| 0 | No problems associated with depressed mood during the period rated. |
| 1 | Gloomy or minor changes in mood (not regarded as “depression”). |
| 2 | Mild but definite depression and distress: (eg. feelings of guilt; loss of self-esteem, but not amounting to a clinical episode of depression); troublesome mood swings. |
| 3 | Depression with inappropriate self-blame, preoccupied with feelings of guilt, at a level likely to attract diagnosis and treatment; clinically problematic swings of mood. |
| 4 | Severe or very severe depression, with guilt or self-accusation. |

Additional notes for scale 7

Depressed mood and symptoms closely associated with it often occur in disorders other than depression. Consider symptoms only: e.g. loss of self-esteem and guilt. These are rated at Scale 7 irrespective of diagnosis. The more such symptoms there are the more severe the problems tend to be.

Overactivity and agitation are rated at Scale 1; self-harm at Scale 2; stupor at Scale 4; delusions and hallucinations at Scale 6. Note that the rule is followed that symptoms, not diagnoses, are rated. Sleep and appetite problems are rated separately at Scale 8.

Scale 8: Other mental and behavioural problems



Rate only the most severe clinical problem **not** considered at Scales 6 and 7 as follows: Specify the type of problem by entering the appropriate letter: **A** phobic; **B** anxiety; **C** obsessive–compulsive; **D** stress; **E** dissociative; **F** somatoform; **G** eating; **H** sleep; **I** sexual (for sexual behaviour problem, see guidance in brackets); **J** other, specify.

| Rating | Description |
|--------|---|
| 0 | No evidence of any of these problems during period rated. |
| 1 | Minor non-clinical problems (<i>impolite sexual talk/gestures</i>). |
| 2 | A problem is clinically present, but there are relatively symptom-free intervals and service user has degree of control i.e., mild level; (excessively tactile or non-contact sexual offence or very provocative, e.g., exposes self, walks around semi-naked, peeping into bedrooms, etc.). |
| 3 | Constant preoccupation with problem; occasional severe attack or distress, with loss of control e.g. avoids anxiety provoking situations, calls neighbour to help, etc.; moderately severe level of problem; (<i>sexual assault, e.g., touching breast/buttock/genitals over clothing</i>). |
| 4 | Severe, persistent problem dominates most activities; (<i>more serious sexual assault, i.e., genital contact, sexual touching under clothing</i>). |

Additional notes for scale 8

This scale provides an opportunity to rate symptoms not included in the previous clinical scales.

Several types of problem are specified, distinguished by the capital letters A to J, as specified above. Only the single most severe problem occurring during the period is rated. This procedure is repeated at Time 2 (T2). In this way, the most severe problem is always rated for each succeeding time period and the contribution to the total score reflects severity at T1 and T2 even if the symptom type changes.



- » If there are no problems score 0 and do not complete a letter score.
- » clinical diagnoses and conditions from a recognised classification system such as ICD or DSM should be used to inform scale 8.

Scale 9: Problems with relationships



Rate the patient's most severe problem associated with active or passive withdrawal from social relationships, and/or non-supportive, destructive or self-damaging relationships. Take into account limited access to outside relationships in secure settings, include patients/inmates/staff relationships.

| Rating | Description |
|--------|--|
| 0 | No significant problems during the period. |
| 1 | Minor non-clinical problems. |
| 2 | Definite problems in making or sustaining supportive relationships: patient complains and/or problems are evident to others. |
| 3 | Persisting major problems due to active or passive withdrawal from social relationships, and/or to relationships that provide little or no comfort or support. |
| 4 | Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social relationships. |

Additional notes for scale 9

This scale concerns the quality as well as the quantity of consumers' communications and social relationships with others. Both active and passive relationships are considered, as are problems arising from consumers' own intrusive or withdrawn behaviour. Take into account the wider social environment as well as the family or residential scene. Is the consumer able to gain emotional support from others?

If consumers with dementia or learning disability (including the autistic spectrum) are over-friendly, or unable to interpret or use language (including body language) effectively, communication and relationships are likely to be affected. People with personality problems (rated independently of diagnosis) can find it difficult to retain supportive friendships or make useful allies.

If the consumer is rather solitary, but self-sufficient, competent when with others, and satisfied with the level of social interaction, the rating would be 1. Near-total isolation (whether because the consumer withdraws, or is shunned by others, or both) is rated 4. Take the degree of the consumer's distress about personal relationships, as well as degree of withdrawal or difficulty, into account when deciding between points 2 & 3. Aggressive behaviour by the consumer towards another person is rated at Scale 1.

Scale 10: Problems with activities of daily living

- ✓ **Rate** the overall level of functioning in activities of daily living (ADL): (e.g. problems with **basic activities of self-care** such as eating, washing, toilet); also **complex skills** such as budgeting, organising where to live, recreation, mobility and use of transport, self-development, etc.
- ✓ **Include** any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.
- ✗ Do **not** include lack of opportunities for exercising intact abilities and skills (e.g., in secure settings), rated at Scales 11 and 12.

| Rating | Description |
|--------|--|
| 0 | No problems during period rated; good ability to function in all areas. |
| 1 | Minor problems only (e.g. untidy, disorganised). |
| 2 | Self-care adequate, but major lack of performance of one or more complex skills (see above); needs occasional prompting. |
| 3 | Major problems in one or more areas of self-care (eating, washing, dressing, toilet, etc.) has a major inability to perform several complex skills; needs constant prompting or supervision. |
| 4 | Severe disability or incapacity in all or nearly all areas of self-care and complex skills. |

Additional notes for scale 10

Consider the overall level of functioning achieved by the consumer during the period rated. Rate the level of actual performance, not potential competence. The rating is based on the assessment of three kinds of problem:

- » First, a summary of the effects on personal and social functioning of the problems rated at Scales 1-9
- » Second, a lack of opportunities in the environment to use and develop intact skills
- » Third, a lack of motivation or encouragement to use opportunities that is available.

The overall level of performance rated may therefore be due to lack of competence, to lack of opportunities in the environment, to lack of motivation, or to a combination of all these.

Two levels of functioning are considered when deciding the severity of problems:

- » The basic level includes self-care activities such as eating, washing, dressing, toileting and simple occupations. If performance is moderately or seriously low, rate 3 or 4.
- » The complex level includes the use of higher level skills and abilities in occupational and recreational activities, money management, household shopping, child care, etc., as appropriate to the consumer's circumstances. If these are normal or as adequate as they can be, rate 0 or 1. Ratings 2 and 3 are intermediate.

Scale 11: Problems with living conditions

- ✓ **Rate** the overall severity of problems with the quality of living conditions and daily domestic routine.
- ✓ Are the **basic necessities** met (heat, light, hygiene)? If so, is there help to cope with disabilities and a **choice of opportunities to use skills and develop new ones?**
- ✗ Do **not** rate the level of functional disability itself, rated at Scale 10.

NB Rate patient's **usual** accommodation whether community, open or secure setting (hospital or prison). If in acute ward/other temporary care, rate the home accommodation. If information not obtainable, rate 7.

| Rating | Description |
|--------|--|
| 0 | Accommodation and living conditions are acceptable; helpful in keeping any disability rated at scale 10 to the lowest level possible, and supportive of self-help. |
| 1 | Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn't like food, etc.). |
| 2 | Significant problems with one or more aspects of the accommodation and/or regime (e.g. restricted choice; staff or household have little understanding of how to limit disability, or how to help develop new or intact skills). |
| 3 | Distressing multiple problems with accommodation (e.g. some basic necessities absent); housing environment has minimal or no facilities to improve service user's independence |
| 4 | Accommodation is unacceptable (e.g. lack of basic necessities, patient is at risk of eviction, or 'roofless', or living conditions are otherwise intolerable making service user's problems worse) |

Additional notes for scale 11

This scale requires knowledge of the consumer's usual domestic environment during the period rated, whether at home or in some other residential setting. If this information is not available, rate 7 (not known). Consider the overall level of performance this consumer could reasonably be expected to achieve given appropriate help in an appropriate domestic environment. Take into account the balance of skills and disabilities. How far does the environment restrict, or support, the consumer's optimal performance and quality of life? Do staff know (as they should) what the consumer's capacities are?

The rating must be realistic, taking into account the overall problem level during the period, ratings on Scales 1–10, and information on the following points:

- » Are the basics provided for – heat, light, food, money, clothes, security and dignity? If the basic level conditions are not met, rate 4
- » Consider the quality and training of staff; relationships with staff or with relatives or friends at home; degree of opportunity and encouragement to improve motivation and maximise skills, including: interpersonal problems; provision for privacy and indoor recreation; problems with other residents; helpfulness of neighbours. Is the atmosphere welcoming? Are there opportunities to demonstrate and use skills: e.g., to cook, manage money, exercise talents and choice, and maintain individuality?
- » If full autonomy has been achieved, i.e., the environment does not restrict optimum performance overall, rate as 0. A less full, but adequate regime is rated 1

Between these poles, an overall judgement is required as to how far the environment restricts achievable autonomy during the period – 2; indicates moderate restriction and 3 substantial.

Scale 12: Problems with occupation and activities

✓ **Rate** the overall level of problems with quality of day–time environment. Is there help to cope with disabilities, **and opportunities for maintaining or improving occupational and recreational skills and activities**? Consider factors such as stigma, lack of appropriate qualified staff, access to supportive facilities, (e.g. staffing and equipment at Day Centres, workshops, social clubs) etc.

✗ Do **not** rate the level of functional disability itself, rated at Scale 10.

NB Rate the patient's **usual** situation, whether in community, open or secure setting (hospital or prison). If patient is in acute ward/temporary care, rate activities during period before admission. If information not available, rate 7.

| Rating | Description |
|--------|---|
| 0 | Patient's day–time environment is acceptable; helps to keep any disability rated at Scale 10 to the lowest level possible, and supportive of self–help |
| 1 | Minor or temporary problems (e.g. late pension cheques, reasonable facilities available but not always at desired and appropriate times, etc.) |
| 2 | Limited choice of activities; e.g. lack of reasonable tolerance (e.g. unfairly refused entry to public library/baths; lack of day areas); lack of facilities in large establishment; handicapped by lack of a permanent address; insufficient carer/professional support; or helpful day setting available but for very limited hours |
| 3 | Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or develop new ones; unskilled care difficult to access; no activity areas available; leave withheld from small establishment causes restriction |
| 4 | Lack of opportunity for daytime activities makes patient's problem worse; long periods of enforced inactivity each day (e.g. prison cell) |

Additional notes for scale 12

The principles considered at Scale 11 also apply to the outside environment. Consider arrangements for encouraging activities such as: shopping; using local transport; amenities such as libraries; understanding local geography; possible physical risks in some areas; use of recreational facilities. Take into account accessibility, hours of availability, and suitability of the occupational environment provided for the consumer at day hospital, drop-in or day centre, sheltered workshop, etc. Are specific (e.g. educational) courses available to correct deficits or provide new skills and interests? Is a sheltered outside space available if the consumer is vulnerable in public (e.g. because of odd mannerisms, talking to self, etc.)? For how long is the consumer unoccupied during the day? Do staff know what the consumer's capacities are?

The rating is based on an overall assessment of the extent to which the daytime environment brings out the best abilities of the consumer during the period rated, whatever the level of disability rated at Scale 10. This requires a judgement as to how far changing the environment is likely to improve performance and quality of life and whether any lack of motivation can be overcome.

- » If the level of autonomy in daytime activities is not restricted, rate 0. A less full but adequate regime is rated 1
- » If minimal conditions for daytime activities are not met (with the consumer severely neglected and/or with virtually nothing constructive to do), rate 4
- » Between these poles, a judgement is required as to how far the environment restricts achievable autonomy; 2 indicates moderate restriction and 3 substantial

Clinical significance and recommended action

It is important clinicians correlate their clinical practice, actions and interventions to reflect findings in the completed HoNOS-secure ratings.

Where scales are of clinical significance, rated 2 to 4, it is important to ensure that this is recorded in clinical notes, and action points are considered in individual treatment or management plans and recovery planning processes.

| HoNOS security scale scores | | Monitor | Active treatment or management plan |
|-----------------------------|--|---------|-------------------------------------|
| Clinically Significant | 4 Severe to very severe problem Most severe category for service users with this problem. Warrants recording in clinical file. Should be incorporated in care plan. Note: Service user can get worse. | ✓ | ✓ |
| | 3 Moderate problem Warrants recording in clinical file. Should be incorporated in care plan. | ✓ | ✓ |
| | 2 Mild problem Warrants recording in clinical notes. May or may not be incorporated in care plan. | ✓ | Maybe |
| | 1 Minor problem May be recorded in clinical file. | Maybe | ✗ |
| Not clinically significant | 0 No problem Problem not present | ✗ | ✗ |

| Amended HoNOS scale scores | | Monitor | Active treatment or management plan |
|----------------------------|--|---------|-------------------------------------|
| Clinically Significant | 4 Severe to very severe problem Most severe category for service users with this problem. Warrants recording in clinical file. Should be incorporated in care plan. Note: Service user can get worse. | ✓ | ✓ |
| | 3 Moderate problem Warrants recording in clinical file. Should be incorporated in care plan. | ✓ | ✓ |
| | 2 Mild problem Warrants recording in clinical notes. May or may not be incorporated in care plan. | ✓ | Maybe |
| Not clinically significant | 1 Minor problem Requires no formal action. May or may not be recorded in clinical file. | Maybe | ✗ |
| | 0 No problem Problem not present | ✗ | ✗ |



Note that there can only be total scores for the 7 security items and the 12 HoNOS items separately. There is no total score for the 19 items in HoNOS-secure.

Rating reliably

Studies show HoNOS to have good inter-rater *reliability*, excellent *validity* and have *sensitivity to therapeutic change*. Te Pou's technical review of the psychometric properties of HoNOS family of measures provides an outline of this.

To rate reliably we recommend you complete HoNOS training refreshers a minimum of every two years (this is required to maintain certification as a HoNOS trainer). Regular practice rating HoNOS and consistent use of the glossary will also aide your rating reliability.

Challenge your practice

Practice completing ratings by accessing Te Pou's HoNOS training online. Online training provides you with written vignettes (stories) and videos to practice your scoring and then compare them against consensus ratings.

Many clinicians and experts rate each vignette. The results are then discussed and relevant changes are made to the vignette, so all clinicians and expert raters agree on the final rating scores. This becomes the 'consensus' for the rating of each scale. Consensus scores or ratings are provided with the written vignettes and video.



The outcomes training model and guide

www.tepou.co.nz/resources/the-outcomes-training-model-and-guide/166

HoNOS training online

www.tepou.co.nz/outcomes-and-information/honos-training-online/33

The HoNOS family of measures: A technical review of their psychometric properties

www.tepou.co.nz/resources/the-honos-family-of-measures-a-technical-review-of-their-psychometric-properties/327

Find alternative online training options on the Australian Mental Health Outcomes and Classification Network (AMHOCN) website <http://www.amhocn.org/>

Mental health outcomes information collection protocol (ICP) key concepts

Not only do clinicians need to understand how to use HoNOS, you also require an understanding of the rules. When and what should be collected alongside HoNOS are additional elements that will help you relate to the context for the episode, and provide the ability to more meaningfully compare episodes and their outcome.

These rules, about when and what to collect, are known as the mental health outcomes information collection protocol (ICP), or protocol. Key concepts behind the HoNOS family of measures ICP (for HoNOS, HoNOS65+, HoNOSCA, HoNOS-LD and HoNOS-secure) are detailed in this section.

The mental health outcomes ICP sets the standards for all specialist DHB inpatient and community mental health services, as well as forensic and intellectual disability mental health services.

The protocol standardises the collection of the HoNOS family of measures. It contains both outcomes and case complexity objectives, allowing the information you collect to be compared across service users and teams or services. It also ensures the information used for benchmarking and service improvement activities has integrity.

Demonstrating change

At a minimum, the protocol requires the following collections to be made in order to demonstrate change.

- » At least two collections, at the start and at the end of each episode of mental health care <91 days. This allows a comparison of the change in a person's outcomes over time.
- » Reviews at three monthly (91 day) intervals for people in ongoing care.
- » Key clinical and descriptive information to be recorded alongside each HoNOS measure to adequately describe each collection occasion.

ICP key concepts

The key concepts underpinning the ICP are detailed below. This is followed by the key clinical and descriptive information that is collected alongside the HoNOS measure.

Service-related descriptors:

- » service setting
- » mental health service team
- » age group.

Service setting

- » The *service setting* denotes the setting in which the mental health service is provided. The setting can be *inpatient* or *community*.
- » Inpatient – where the service user is admitted to a bed within a psychiatric inpatient unit with an expectation that he/she will stay overnight.
- » Community – all other instances where the service user is not an inpatient:
 - ⌘ inpatients of general medical units seen on a consultation liaison basis
 - ⌘ prisoners treated in correctional facilities
 - ⌘ people living in the community who attend inpatient day programmes
 - ⌘ people living in NGO residential facilities treated by a DHB community mental health team.

Mental health service team

Identifying a person's primary *mental health service team* is important when tracking their movement within an *episode of care*, and essential for comparing their outcomes within each team.

The team can also be an indicator of which HoNOS measure should be used, for example, a forensic team would generally use HoNOS-secure rather than HoNOS.

Age group

Outcome measures to be reported at a particular collection occasion depend on the broad *age group* to which the service user is assigned, for example, adult, older person or child and youth.

As a general rule, HoNOS is for use with adults aged 18 to 64 years accessing services from specialist mental health services.

- » Adults are defined as people between the age of 18 and 64 years inclusive.
- » Older people are defined as people aged 65 years and older.
- » Children and youth are defined as people under the age of 18 years.

Age restrictions can be overridden by clinicians where the use of another measure may be more appropriate. For example a 60 year old receiving treatment in an older person's service.

Episode descriptors:

- » episode of care
- » period of care
- » collection occasion
- » focus of care.

Episode of care

An *episode of care*, for the purposes of outcomes collection, is used to refer to a continuous period of contact between a person and a mental health service within the same setting. It has a discrete start and end point, beginning with a referral and admission to a mental health service, and ending when the person is discharged from that setting.

As discussed earlier, a person can only be the subject of one outcomes *episode of care* within the same DHB at any given time. A set of guidelines in “*When is HoNOS-secure used?*” identify the requirements for a number of scenarios that describe transfer between services.

An *episode of care* (admission to discharge) may include one or more *period of care*.

Period of care

A *period of care* is the interval within an *episode of care* between one collection and the next. For example, the period of care may start with an *episode start* and end with a *review*. Primarily the period of care provides ‘bookends’ that allow us to measure outcomes.

For people who are not discharged, a subsequent period of care begins with a review collection three months (91 days) from the date of the episode start. Review collections then continue at three monthly intervals until the service user is discharged or transferred to another setting, or another DHB, only then the episode of care ends.

Outcomes can be viewed over *periods of care* as well as over *episodes of care* (admission to discharge or episode start to episode end).

In cases where a person is admitted and discharged in less than 91 days, and no review is completed, an episode of care and a period of care are the same.

Period of care within a community episode of care



HoNOS collection occasion

A *collection occasion* is a point during an *episode of care* where the outcome measures and case complexity information are collected in accordance with the protocol:

- » outcomes episode start
- » outcomes episode review – three month (91 days) or ad hoc reviews
- » outcomes episode end.

Each *collection occasion* acts as a ‘trigger’ for a specific set of *key clinical information* to be collected.

Episode start

A new *episode start* is when a person commences treatment with a mental health service. This may be a *new referral*, a *transfer from another setting* or an *admission for another reason*.

- » For inpatient settings, the *episode start* is the date of admission.
- » In community settings, the episode start is the date the service user is first seen by the service, or the date a service user moves from an inpatient setting and begins a new episode of care in the community.



Assessment only

If an assessment identifies that no further mental health service care will be provided, an *assessment only* collection is required. *Assessment only* collections are useful to teams and services to determine volumes and complexity of people who are not accepted into the service. *Assessment only* collections do not require any follow up collections - they are effectively a combined admission and discharge.

Review – three month (schedule 91 days)

Reviews are required for all service users in ongoing care three months from their *episode start*, or three months since the last *review* was completed.

Three month *reviews* can be scheduled up to 14 days prior to and 14 days after the 91 day period. Giving you 28 days to complete the *review*.



If an ad hoc review falls within the timeframe of a scheduled review, the ad hoc review can take the place of the scheduled review.

Review other (ad hoc)

An *ad hoc review* may be triggered in response to a significant event and occur earlier than the 91 day standard *review*. This may include when a person:

- » moves to another mental health service team within the same service setting
- » changes case manager
- » declines treatment or support
- » requests a review
- » injures themselves or another person
- » receives compulsory assessment or treatment.

Your DHB may also have its own local rules about when to complete *ad hoc reviews*.

Ad hoc reviews will not reset the standard three month *review* process, unless the *ad hoc review* occurs within the required timeframe for a three month *review*. In this case they can be considered as a planned three month *review*.

Community episode, *ad hoc review*, followed by 3 month review



End of episode

The *end of episode* occurs when:

- » there is no further care planned in the current DHB or service setting. For example, a service user is discharged from an inpatient team, and/or when a person no longer requires treatment from a community service.
- » there is a change in mental health service setting (i.e. inpatient to community or community to inpatient). This is also known as a *transfer to another setting* and marks the end of one episode and the beginning of another.
- » a service user is lost to care or is deceased.
- » there is a very brief episode of care; less than 72 hours in inpatient services or less than 14 days in community services. Outcome measures are not required to be collected in this instance.

Regardless of the reason, the *end of episode* acts as a 'trigger' for a specific set of clinical data to be collected.



When a service user is lost to care or dies, or when there is a very brief episode of care (as described above) contextual and episode descriptors must be collected to end the episode, but collection of HoNOS is not required.

Focus of care

The *focus of care* identifies the principal clinical intent of the care provided during the *period of care* preceding the collection occasion.

It is a retrospective global clinical judgment.

Focus of care is not collected for

- » admission or episode start collections.
- » child and youth episodes where HoNOSCA is used.

The *focus of care* is based on the intensity and purpose of the services provided during the preceding *period of care*. As an example, being in an acute setting does not mean there is an acute *focus of care*.

It has implications for the kinds of outcomes that might be expected for each of the four alternative domains: acute, functional gain, intensive extended and maintenance. These are defined as follows.

Acute: The primary goal is the short-term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder. Admission to an acute unit does not necessarily mean the focus of care will be 'acute'.

Functional gain: The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a person with impairment arising from a psychiatric disorder.

Intensive extended: The primary goal is the prevention or minimisation of further deterioration and the reduction of risk of harm in a person who has a stable pattern of severe symptoms, frequent relapses, and/or a severe inability to function independently, and is judged to require care over an indefinite period.

Maintenance: The primary goal is to maintain the level of functioning, minimise deterioration or prevent relapse where the person has stabilised and functions relatively independently.

Focus of care rating guidelines

| Service user characteristics | | | Service requirements | | |
|--|-------------|--|---|---|---|
| Symptoms | Functioning | Primary goal | Indicative time to achieve primary goal | Indicative treatment intensity | Examples of typical documentation in care plan to support the rating |
| 1. Acute: Short-term reduction in severity of symptoms and/or personal distress associated with recent onset of exacerbation of psychiatric disorder. | | | | | |
| High and of recent onset | Low–high | Reduce symptoms | Days to weeks | Daily contact over a short period | Interventions designed to reduce the intensity of positive symptoms (e.g. reduce severity of depressive symptoms or the level of anxiety, manage hostile or aggressive behaviour related to mental illness). |
| 2. Functional gain: Improve personal, social or occupational functioning or promote psychosocial adaptation in a client with impairment arising from a psychiatric disorder. | | | | | |
| Low | Low–medium | Improve functioning | Weeks to months | Weekly contact, or more multiple attendances per week in a structured rehabilitation programme | Interventions designed to result in a significant improvement in the service user's personal, social and/or occupational functioning in the short-term (weeks to months). This may include the development of basic 'community survival' skills (e.g. shopping, cooking), social skills (e.g. conversation) or vocational skills (e.g. job seeking or job maintenance). |
| 3. Intensive extended: Prevent or minimise further deterioration and reduce risk of harm in a client who has a stable pattern of severe symptoms/frequent relapses/severe inability to function independently, and is judged to require care over an indefinite period. | | | | | |
| High and unremitting | Low | Reduce risk that arises from symptoms and/or low functioning | Months to years | Minimum of multiple weekly contacts, more frequent as required; delivered over an indefinite period | Inpatient or outreach-based interventions (the latter typically in the service user's own environment) aimed to (1) minimise the risks and handicaps associated with the on-going symptoms and psychosocial dysfunctions arising from a psychiatric disorder (2) strengthen the service user's capacity to use supportive professional and non-professional networks. |
| 4. Maintenance: Maintain level of functioning, minimise deterioration or prevent relapse where the client has stabilised and functions relatively independently. | | | | | |
| Low | Low–high | Improve functioning | Months to years | Scheduled weekly to monthly contact | Interventions designed to consolidate the service user's current functioning (at least in the short-term) while working toward improvement in the long-term or planning for the service user's exit from the service. |
| 5. Assessment only: The primary goal is only to assess the client. | | | | | |
| High–low | Low–high | Assessment | Days | Assessment only | Assessment documentation only |

HoNOS outcome measure ICP - key clinical and descriptive information

Admission date

- » In inpatient settings, this is the actual date of admission.
- » In community settings, this is the date that the service user was first seen by the service.

Collection occasion date

- » At *episode start* and *review* - this is the date assessment and outcome measure information was *collected*.
- » At *end of episode* - this is the date the episode ended (the date of discharge in inpatient settings, or the date of last contact or discharge from community settings).

The *collection occasion date* should be distinguished from the *completion date* of any of the individual standard measures.

Completion date

Completion date is the date the *collection occasion* was *completed*.

Episode start collections are required to be completed within two weeks of assessment (*collection occasion date*) in the community, or within 24 hours in an inpatient setting.

Review collections are required to be completed within two weeks (14 days) either side of the review due date.

Episode end collections are required to be completed within one week of the episode end in the community, and within three days in an inpatient setting.

Reason for collection (RFC)

The ICP requires that each collection occasion is mapped to a range of key events (such as admission, review or discharge) and triggers a set of information to be collected. There are 12 *reasons for collection* in the protocol to describe the nature of each collection, allowing analysis of outcomes of new service users from those who are admitted following transfer from an inpatient service, for example. The table below is a guide to identifying the correct reason for collection and any associated rules.

| Reason code | Guide for use |
|---|--|
| Assessment only (RFCo1) | <p>Use for community settings only, where:</p> <ul style="list-style-type: none"> » A person is seen for a maximum of two face-to-face sessions for the purpose of assessment only and with the outcome of no further treatment by the DHB. Services delivered 'on behalf of' the service user are not counted as face to face contacts (i.e. phone call or notes made when service user is not present). » A service user is under shared care and is being reviewed for the first time in three months. |
| Episode start collection occasions | |
| New referral (RFCo2) | <p>Use for new referrals which do not involve a transfer from another mental health service setting within the same DHB.</p> <p>This includes:</p> <ul style="list-style-type: none"> » self-referrals » referrals from family members or other caregivers » referrals from private medical practitioners, including general practitioners (GPs) and private psychiatrists. |
| Transfer (admission) from other setting (RFCo3) | <p>Use for transfers between mental health service settings, for example, community to inpatient, or inpatient to community, within the same DHB.</p> <p>Does not include:</p> <ul style="list-style-type: none"> » transfers between acute psychiatric inpatient units and specialised, high acuity inpatient facilities <i>within the same hospital</i> » instances when a person in a community setting receives more intensive treatment for several days or weeks from a second community mental health team. <p>Referral and assessment documentation should be shared with the receiving service at the time of transfer and may be used to inform the comprehensive admission assessment.</p> |
| Episode start other (RFCo4) | <p>Use for admissions for any reason not defined above. This may include transfers from other external mental health and addiction services and settings including transfers from other DHBs and private psychiatric hospitals.</p> |
| Review collection occasions | |
| Review – three month (RFCo5) | <p>This is the standard mandatory review to be completed at intervals of three months (91 days) in all DHB mental health service settings where a person is in ongoing treatment for three months (91) days.</p> <p>Note: Assessments can be completed up to 14 days prior and 14 days following the three month review date, allowing 28 days to schedule the review.</p> |
| Review – other (RFCo6) | <p>Use when a decision is made to complete a clinical review in response to a significant event. This may include when a person moves to another mental health and addiction service team within the same setting; when a case manager changes; when the person declines treatment or support, injures themselves or another person or requests a review; when a person receives compulsory assessment or treatment.</p> <ul style="list-style-type: none"> » DHBs may choose to generate local rules, consistent with this national ICP, about completion of ad hoc reviews. » If an ad hoc review occurs within the required three month review timeframe (14 days either side of the scheduled review), it can be used as the three month review. |

| Episode end collection occasions All collections are required to be completed within one week of episode end in the community, and within three days in an inpatient setting. | |
|---|---|
| Episode end – no further care (RFC07) | Use when a person is discharged from a mental health and addiction service to their usual residence without referral for further treatment in a mental health and addiction setting in any DHB. Included are instances where a person is referred to a private medical practitioner, or a GP in a PHO. |
| Episode end – transfer (discharge) to other treatment setting (RFC08) | Use when transfers between service settings occur, for example, community to inpatient or inpatient to community. This category principally refers to the end of an episode when transfers between service settings occur, for example, community to inpatient, or, inpatient to community. It does not include: <ul style="list-style-type: none"> » cases where a person already in community mental health care has responsibility for their care taken over by a second service team providing more intensive community mental health care for several days or weeks » transfers from general acute psychiatric inpatient units to specialised high-acuity inpatient facilities and vice versa. |
| Lost to care (RFC09) | In inpatient settings this includes cases where a person has left care against advice, has been discharged at their own risk, or has otherwise been 'lost to care'. The need for ongoing care may be probable but not clear because the person cannot be contacted. In a community setting, this includes cases where a person in need of ongoing care either has been discharged at their own risk due to their having refused such care, or their current whereabouts are unknown and there is no reasonable expectation that they will be located within 13 weeks of their last service contact. Collection identifiers and period of care data should be completed for service users lost to care. Outcome measures to be completed where the responsible clinician is able to validly ascertain the service user's clinical status at the time. Otherwise valid ratings cannot be made. |
| Deceased (RFC10) | Use to end an episode of care following the death of a service user. Do not use where a person is recorded to have been lost to care, and it is subsequently found to have died, unless the person died within three days of being lost to care. <ul style="list-style-type: none"> » Collection identifiers and period of care data should be completed for instances where a service user has died. » Outcome measure data is not required. |
| Brief episode of care (RFC11) | A very brief episode of inpatient psychiatric mental health care is defined as a length of stay of three days (72 hours) or less . A very brief episode of community mental health care is defined as one during which contacts, including either face to face or by telephone, have taken place over a period less than 14 days . <ul style="list-style-type: none"> » Collection occasion identifiers and period of care data should be completed for brief episodes of care. » Outcome measure data is not required. |
| Episode end - other (RFC12) | Use when a person is discharged from any mental health service setting in one DHB to any setting in another DHB, for example, transfer from an inpatient unit in one DHB to an inpatient unit in another DHB. May also be used for instances where the DHB mental health service's policy indicates that there is a definite clinical or administrative need to consider other clinical events not classifiable under the preceding alternatives as constituting the discharge of a service user. |

Key information routinely collected for PRIMHD

In addition to the outcome measure information collected above in PRIMHD, the national dataset collects activity, clinical and descriptive information about an episode of care. This contributes to a better understanding, and more meaningful analysis, of episodes of mental health care and their outcomes.

Mental health principal diagnosis

PRIMHD requires a diagnosis for all mental health and addiction service users within 91 days of their first contact with the service or by the time of discharge.

Due to the nature of mental health and addiction diagnoses, sometimes it is not possible to provide a definitive diagnosis at initial assessment. If this is the case a provisional diagnosis may be made, and as treatment progresses a principal diagnosis allocated. PRIMHD maintains a history of diagnoses.

Mental health legal status

Directors of Area Mental Health Services (DAMHS) are responsible for recording legal status under the appropriate section of any Act that may result in admission or treatment by mental health services.



Things to remember

- » A service user may come under more than one Act at any one particular time.
- » A legal status record must be provided to PRIMHD when assigned to a service user.

When assessing outcomes, it is important to know whether a service user has been treated on an involuntary basis under the relevant legislation during their episode, or period, of care.

For PRIMHD, this includes any legal status under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Criminal Procedure (Mentally Impaired Persons) Act 2003, or the Criminal Justice Act 1985.



For further information on PRIMHD mental health data

www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

Mental health service activity

The need for sound information on what activity is currently being provided is required so local, regional and national decision makers can make informed decisions about the provision of mental health and addiction services.

If activity information is incomplete, and is not linked to clinical measures (diagnosis, treatment and outcomes), decision makers will not be properly informed.



Guide to PRIMHD activity collection and use

www.health.govt.nz/publication/guide-primhd-activity-collection-and-use

How we use outcomes information collected in clinical practice

Outcome information can be used in many ways and at many different levels. Stakeholders of mental health and addiction services can be divided into four different levels. People involved at each level will primarily be interested in, and will have access to, different kinds of information. The levels are:

The individual level involves the service user, their whānau, significant others, as well as the staff working with them. At this level the individual's own information is primarily used.

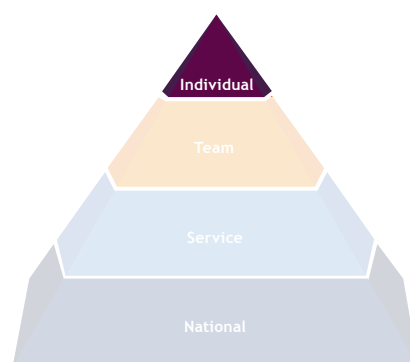
The team level involves staff in a team working directly with the service user, their whānau and significant others. At this level an individual's information is used for some purposes and aggregated data (or data from groups of service users) is used for other purposes.

The service level involves organisations. These often consist of multiple teams and can be a DHB or a larger NGO. At this level aggregated data will primarily be used.

The national level involves government departments or other organisations that consider the national picture, and/or compare across multiple organisations. They will mostly be interested in aggregated data.

Individual level

A collaborative approach should be used to collect outcome measures. Discussing ratings with service users is one way they can participate in their care and treatment, and it may allow for further conversations about recovery. HoNOS ratings are done by the clinician following an assessment as part of maintaining a service user's record, so the service user doesn't participate in the rating process, nor does the clinician use it as a structured interview. However, sharing HoNOS ratings with the service user as part of a collaborative care plan should be routine.



Uses at individual level

HoNOS information can be used to support individual recovery planning and treatment goals. It is a useful tool to monitor progress, the outcomes people want to achieve and to help focus on their recovery. Ways to do this include:

- » discussion with people about their HoNOS scores
- » discussion with people about any changes to their scores – as part of their recovery planning
- » completion of adhoc HoNOS ratings when people experience positive or challenging changes or circumstances
- » encouraging people to keep a copy of their ratings over time and track their own progress.

It also

- » supports quality mental health assessments, intervention and recovery planning
- » improves opportunities for whānau involvement.



HoNOS outcomes information at this level can be used between clinician and service user through a feedback process. Videos that demonstrate the feedback process are available at <http://www.tepou.co.nz/resources/honos-feedback-scenario-videos/658>

Information about HoNOS ratings for service users <http://www.tepou.co.nz/resources/information-about-honosca-honos-and-honos-65-for-people-who-use-mental-health-services/428>

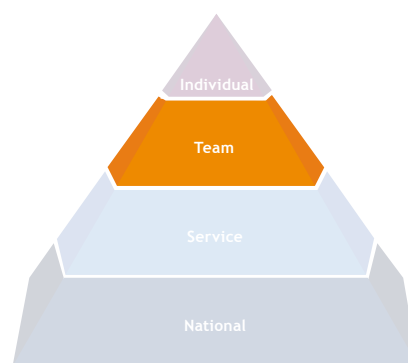
The Story of Change 'Nothing about us without us' profiles the West Coast DHB and their efforts to share information with service users <http://www.tepou.co.nz/news/nothing-about-us-without-us-the-benefits-of-informing-service-users-about-honos/175>

Team level

Team level use of HoNOS can include both individual and aggregated HoNOS information. This is the only level that can benefit from both individual and aggregated information. Te Pou have resources on how HoNOS outcomes information can be used within a team setting.

Uses at team level

- » to inform and guide multi-disciplinary team discussion.
- » allocation of referrals
- » severity of caseloads across the team
- » workforce planning
- » discharge planning.



Using HoNOS in MDTs

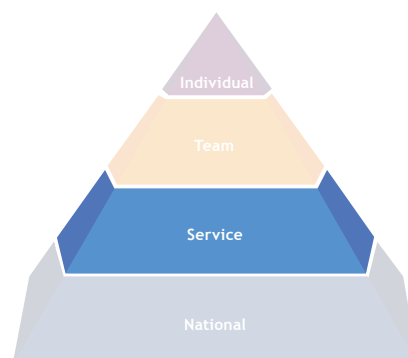
<http://www.tepou.co.nz/resources/using-honosca-in-multi-disciplinary-teams/246>

Service level – aggregated data

Te Pou provides three monthly outcome reports which are sent to each of the 20 DHBs. If you wish to view these reports, please contact your site coordinator or service manager. These reports may contribute to service level uses.

Uses at service level

- » benchmarking with other DHBs
- » service planning
- » workforce planning
- » service performance and accountability framework
- » research
- » quality initiatives
- » service development.

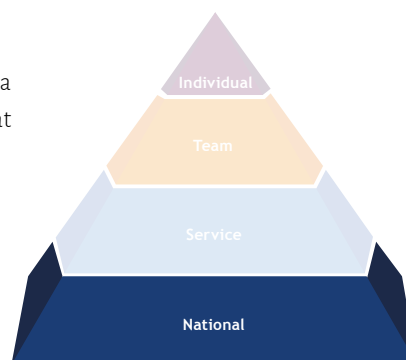


National level – aggregated data

At an aggregated national level, data collected about HoNOS contributes to a performance and accountability framework. This can be used to ensure that the quality of services continues to improve.

Uses at national level

- » research
- » understanding trends
- » patterns in outcomes at a national level
- » comparison with other jurisdictions
- » informing policy and mental health strategy



As well as providing DHB outcome reports, Te Pou provides national reports. These national reports use outcome data collected as part of clinical practice within all 20 DHBs to provide an overall picture of data quality, indicating what has changed for service users and how DHBs perform.



View the latest national PRIMHD outcomes summary reports, as well as a variety of other resources on outcomes and PRIMHD information use at

www.tepou.co.nz/outcomes-and-information/national-primhd-reports/112

From data to information – data use guidelines for standard measures collected in the New Zealand mental health system www.tepou.co.nz/resources/from-data-to-information-data-use-guidelines-for-standard-measures-collected-in-the-new-zealand-mental-health-system/68

PRIMHD information and utility resource: Influencing the broader sector and workforce to improve the quality of the data collected in PRIMHD

www.tepou.co.nz/resources/primhd-information-and-utility-resource/719

Outcomes information as part of the bigger picture

The programme for the integration of mental health data, PRIMHD (pronounced 'primed'), is the Ministry of Health's national collection of activity and outcomes data in mental health and addictions. It includes service user referrals, activities and outcomes, such as HoNOS, ADOM and social outcome indicators.

PRIMHD's vision is to contribute to the improvement of health outcomes for all mental health and addiction service users in New Zealand. The intent is to provide a single rich data source of national mental health and addiction information which can be used by a range of different stakeholders, including the Ministry of Health, DHBs and NGOs, to inform benchmarking activity, service planning, funding of services and changes in policy.

The collection of quality outcome data allows PRIMHD to offer a more detailed understanding of changes in health, wellbeing and circumstances for people accessing mental health and addiction services.



For further information about PRIMHD www.tepou.co.nz/outcomes-and-information/primhd/34

PRIMHD information and utility resource

www.tepou.co.nz/resources/primhd-information-and-utility-resource/719

Glossary of terms

| Psychometric definitions | |
|-----------------------------------|---|
| Term | Definition |
| Reliability | Consistency of a set of items or a measure. The extent to which we can be sure that the score received on a test is consistent over time and across conditions. It is used to describe how good the test is at eliminating confounding error. |
| Validity | Whether the test actually measures what it is intended to measure. Validity testing is concerned with what the test measures and how well it does this. |
| Sensitivity to therapeutic change | The measure's ability to measure change across time. Feasibility is the degree to which the measure is acceptable to stakeholders or in this case useful in clinical practice. Feasibility is covered in training for the use of the measures in New Zealand. |

Training and other resources

Te Pou uses a 'train the trainer' model which supports DHB clinicians in collecting HoNOS ratings. These trainers are responsible for supporting and training clinicians locally.

Each DHB has identified trainers who have been certified by Te Pou after foundational and outcome measure-specific training. Please contact your local DHB site coordinator or outcomes champion to determine trainer availability and for more information.



List of DHB site coordinators www.tepou.co.nz/outcomes-and-information/site-coordinators/116

The outcomes training model and guide www.tepou.co.nz/resources/the-outcomes-training-model-and-guide/166

Find out about training, workshops, forums and conferences www.tepou.co.nz/events

Become a HoNOS-secure trainer for your DHB

Are you interested in becoming a HoNOS-secure trainer for your DHB?

Trainers need a certificate in Part A (foundational training) and B (modular training) to be able to train other clinicians in the use of HoNOS. After completing Part A training, you can attend one day modular training (Part B) for one or more of the HoNOS measures.

Once you've completed Part A and Part B training, you will be able to provide minimum one day basic outcomes training at your DHB.

Trainers are required to have two-yearly refresher training (at a minimum) to retain their certification.

Te Pou has created online training tools to assist clinicians to become more proficient in using HoNOS. Trainers also have access to a secure site which has presentations, videos and other resources

HoNOS-secure refresher training

Clinicians can complete refresher training online by reviewing and rating a series of case studies. Case studies consist of a written vignette and a short video, followed by a rating form and opportunity to check the results.



HoNOS-secure e-learning refresher

www.tepou.co.nz/outcomes-and-information/honos-training-online/33

HoNOS feedback scenario videos

HoNOS feedback scenario videos depict clinicians providing feedback on HoNOS scores (deterioration, improvement or no change/little change) to service users. Examples include offered and requested scenarios in which either the clinician offers to show the service user their HoNOS scores or where the service user requests to see their HoNOS scores. This content is relevant and transferable to all measures in the HoNOS family.



HoNOS feedback scenario videos www.tepou.co.nz/resources/honos-feedback-scenario-videos/658

Outcomes graph builder

Te Pou's outcomes graph builder is a Microsoft Excel tool that can be used to generate HoNOS outcomes graphs for individual service users. This tool graphically presents information for up to three time periods, with the ability to store up to 12 individual collections of information. This tool is a handy way to show someone their HoNOS scores and/or for use in team discussions. The graphs can also be used during training to show clinicians an easy option for providing feedback to service users.



Outcomes graph builder www.tepou.co.nz/resources/outcomes-graph-builder-microsoft-excel-2007-or-later/245

The Australasian Mental Health Outcomes and Information Conference (AMHOIC)

Te Pou and the Australasian Mental Health Outcomes and Classification Network (AMHOCN) jointly host AMHOIC, a biennial conference that explores outcomes information research and training within New Zealand and Australia.



For further information about AMHOIC visit <http://www.tepou.co.nz/outcomes-and-information/amhoic/35>

Let's get real

In addition to outcomes training, Te Pou provides a range of training to services, including *Let's get real*.

The outcomes training is based on the competencies identified in *Let's get real*, a framework that supports people working in mental health and addiction to develop the right knowledge, skills, values and attitudes to effectively support people using services.

There are seven Real Skills for the mental health and addiction workforce.

- » Working with service users.
- » Working with Māori.
- » Working with families.
- » Working with communities.
- » Challenging stigma and discrimination.
- » Law, policy and practice.
- » Professional and personal development.



Let's get real <http://www.tepou.co.nz/initiatives/lets-get-real/107>

**Te Pou o te
Whakaaro Nui**

www.tepou.co.nz/honos