



HoNOS65+



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 for Elderly People (HoNOS65+) Royal College of Psychiatrists 1999.

### HoNOS65+ key sources

Burns, A., Beevor, A., Lelliott, P., Wing, J., Blakey, A., Orrell, M., Mulinga, J. & Hadden, S. (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). Glossary for HoNOS65+ score sheet. *The British Journal of Psychiatry*, 174, 435-438.

Burns, A., Beevor, A., Lelliott, P., Wing, J., Blakey, A., Orrell, M., Mulinga, J. & Hadden, S. (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS65+). *The British Journal of Psychiatry*, 174, 424-427.

MacDonald A.J.D. (1999) HoNOS 65+ glossary. *British Journal of Psychiatry*, 175, 192.

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 HoNOS65+, 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.

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*Published April 2017*

*Te Pou Limited trading as Te Pou o te Whakaaro Nui*

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# Contents

<b>Outcomes and HoNOS65+</b> .....	<b>5</b>
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 HoNOS65+?.....	7
When is HoNOS65+ used? .....	8
HoNOS65+ collection points .....	9
HoNOS65+ collection rules for service users transferred between treatment settings .....	10
HoNOS65+ rating guidelines and glossary.....	12
Important variations in rating guidelines .....	12
<b>HoNOS65+ glossary</b> .....	<b>13</b>
<b>Scale 1:</b> Overactive, aggressive, disruptive or agitated behaviour .....	13
<b>Scale 2:</b> Non-accidental self-injury .....	14
<b>Scale 3:</b> Problem drinking or drug-taking .....	15
<b>Scale 4:</b> Cognitive problems.....	16
<b>Scale 5:</b> Physical illness or disability problems .....	17
<b>Scale 6:</b> Problems associated with hallucinations and delusions.....	18
<b>Scale 7:</b> Problems with depressed mood.....	19
<b>Scale 8:</b> Other mental and behavioural problems.....	20
<b>Scale 9:</b> Problems with relationships .....	21
<b>Scale 10:</b> Problems with activities of daily living .....	22
<b>Scale 11:</b> Problems with living conditions .....	23
<b>Scale 12:</b> Problems with occupation and activities .....	24
Clinical significance and recommended action .....	25
Rating reliably .....	26
<b>Mental health outcomes information collection protocol (ICP) key concepts</b> .....	<b>27</b>
Demonstrating change.....	27
ICP key concepts.....	27
Focus of care rating guidelines .....	33
HoNOS outcome measure ICP - key clinical and descriptive information .....	34
Key information routinely collected for PRIMHD .....	36
How we use outcomes information collected in clinical practice.....	38
Outcomes information as part of the bigger picture .....	42
<b>Glossary of terms</b> .....	<b>42</b>
<b>Training and other resources</b> .....	<b>43</b>

# Outcomes and HoNOS65+

## 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 HoNOS65+ 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](http://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 HoNOS65+?

Health of the Nation Outcome Scales for Elderly People (HoNOS65+) is a member of the Health of the Nation Outcome Scales (HoNOS) family of measures. It is a clinician rated tool developed by 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, HoNOS65+ is the outcome measurement tool mandated by the Ministry of Health for use with people 65 years and over who are accessing specialist mental health services.

HoNOS65+ has 12 scales (also referred to as items) they measure behaviour, impairment, symptoms and social functioning. The items are rated, after routine clinical assessment, on a scale of 0 to 4. The glossary provides detailed descriptors 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.

HoNOS65+ 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.

HoNOS65+ 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 HoNOS65+ used?

HoNOS65+ is mandated for use with all people aged 65 years and over who are accessing specialist mental health services, in all district health boards (DHBs), in both inpatient and community settings.

HoNOS65+ 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 HoNOS65+ ratings, taking into account all available information. Ideally, the same clinician or team will rate the subsequent review or discharge HoNOS65+. This may not always be possible, particularly in the case of inpatient treatment settings.

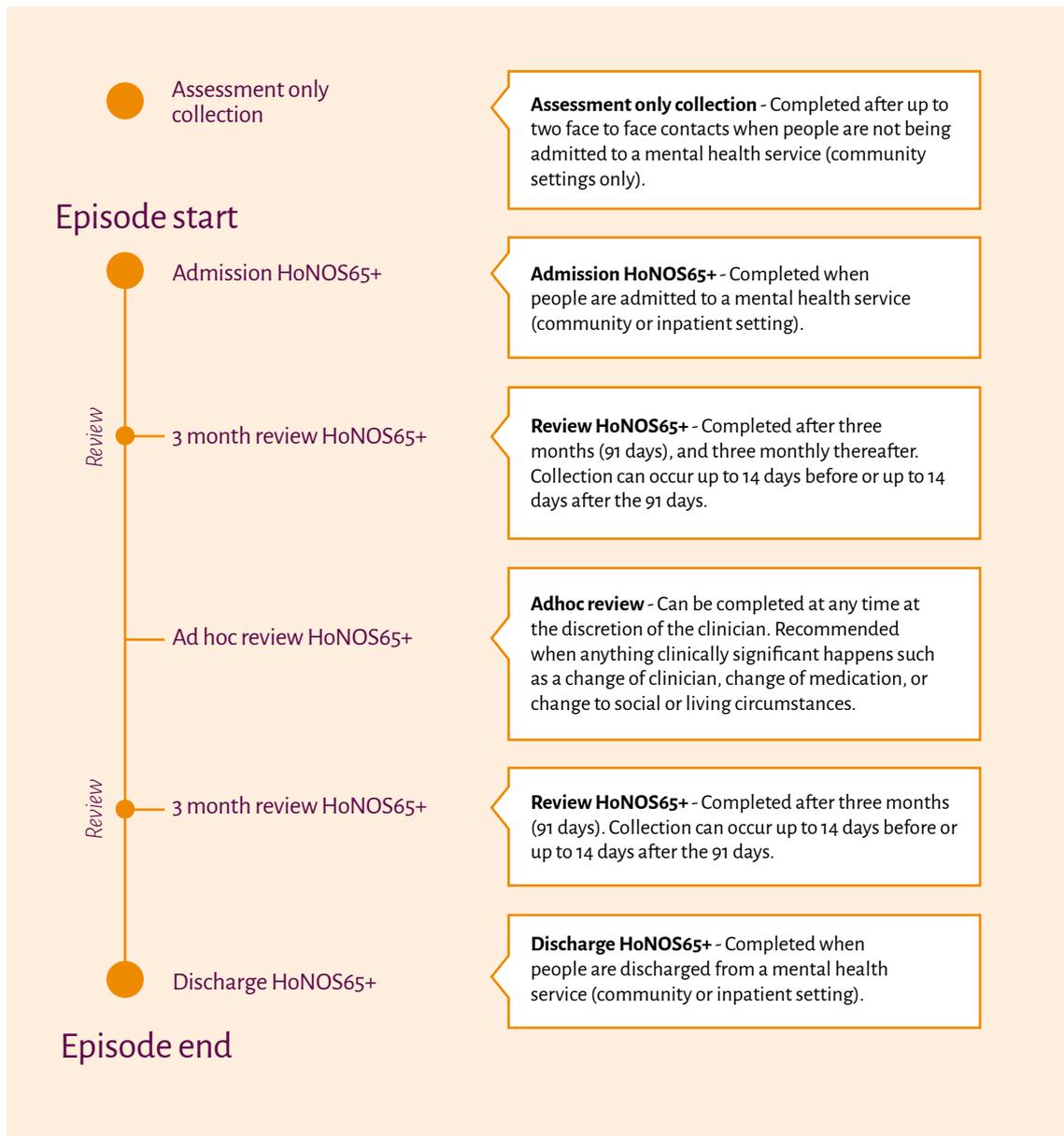
### HoNOS65+ items

1. Behavioural disturbance (e.g. overactive, aggressive, disruptive, or agitated behaviour, uncooperative or resistive 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 depressive symptoms.
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.

### 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.

## HoNOS65+ collection points



## HoNOS65+ 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 34.

# HoNOS65+ rating guidelines and glossary

## 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 HoNOS65+. HoNOS65+ 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

# HoNOS65+ glossary

## Scale 1: Behavioural disturbance

(e.g. overactive, aggressive, disruptive or agitated behaviour, uncooperative or resistive 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.

Rating	Description
0	No problems of this kind during the period rated.
1	Occasional irritability, quarrels, restlessness etc., but generally calm and co-operative and not requiring any specific action.
2	Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); significant overactivity or agitation; intermittent restlessness or wandering (day or night); uncooperative at times, requiring encouragement and persuasion.
3	Physically aggressive to others or animals (short of rating 4); more serious damage to, or destruction of, property; frequently threatening manner, more serious or persistent overactivity or agitation; frequent restlessness or wandering; significant problems with co-operation, largely resistant to help or assistance.
4	At least one serious physical attack on others (over and above rating of 3); major or persistent destructive activity (e.g. fire-setting); persistent and threatening behaviour; severe overactivity or agitation; sexually disinhibited or other inappropriate behaviour (e.g. deliberate inappropriate urination or defecation); virtually constant restlessness or wandering; severe problems related to non-compliant or resistive behaviour.

## 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 more frequent thoughts or talking about self-harm or suicide (including 'passive' ideas of self-harm such as not taking avoiding action in a potentially life-threatening situation, e.g. while crossing a road).
3	Moderate to serious risk of deliberate self-harm during the period rated; includes frequent or persistent thoughts or talking about self-harm; includes preparatory behaviours, e.g. collecting tablets.
4	Suicidal attempt or deliberate self-injury during period.

## 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	Occasional loss of control of drinking or drug-taking; but not a serious problem.
3	Marked craving or dependence on alcohol or drug use with frequent loss of control, drunkenness, etc.
4	Major adverse consequences or incapacitated due to alcohol or drug problems.

## 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) which are clearly associated with alcohol, drug or medication use, rated at Scale 3.

Rating	Description
0	No problem of this kind during the period rated.
1	Minor problems with orientation (e.g. some difficulty with orientation to time) or memory (e.g. a degree of forgetfulness but still able to learn new information), no apparent difficulties with the use of language.
2	Mild problems with orientation (e.g. frequently disorientated to time) or memory (e.g. definite problems learning new information such as names, recollection of recent events; deficit interferes with everyday activities); difficulty finding way in new or unfamiliar surroundings; able to deal with simple verbal information but some difficulties with understanding or expression of more complex language.
3	Moderate problems with orientation (e.g. usually disorientated to time, often place) or memory (e.g. new material rapidly lost, only highly learned material retained, occasional failure to recognise familiar individuals); has lost the way in a familiar place; major difficulties with language (expressive or receptive).
4	Severe disorientation (e.g. consistently disorientated to time and place, and sometimes to person) or memory impairment (e.g. only fragments remain, loss of distant as well as recent information, unable to effectively learn any new information, consistently unable to recognise or to name close friends or relatives); no effective communication possible through language or inaccessible to speech.

## Scale 5: Physical illness or disability problems

- ✓ **Include** illness or disability from any cause that limits mobility, impairs sight or hearing, or otherwise interferes with personal functioning (e.g. 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); some impairment of sight or hearing (but still able to function effectively with the aid of glasses or hearing aid).
2	Physical health problem associated with mild restriction of activities or mobility (e.g. restricted walking distance, some degree of loss of independence); moderate impairment of sight or hearing (with functional impairment despite the appropriate use of glasses or hearing aid); some degree of risk of falling, but low and no episodes to date; problems associated with mild degree of pain.
3	Physical health problem associated with moderate restriction of activities or mobility (e.g. mobile only with an aid – stick or Zimmer frame – or with help); more severe impairment of sight or hearing (short of rating 4); significant risk of falling (one or more falls); problems associated with a moderate degree of pain.
4	Major physical health problem associated with severe restriction of activities or mobility (e.g. chair or bed bound); severe impairment of sight or hearing (e.g. registered blind or deaf); high risk of falling (one or more falls) because of physical illness or disability; problems associated with severe pain; presence of impaired level of consciousness.

## Scale 6: Problems associated with hallucinations and delusions

- ✓ **Include** hallucinations and delusions (or false beliefs) irrespective of diagnosis.
- ✓ **Include** odd and bizarre behaviour associated with hallucinations or delusions, (or false beliefs).
- ✗ Do **not** include aggressive, destructive or overactive behaviours attributed to hallucinations, delusions or false beliefs, 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.

## Scale 7: Problems with depressive symptoms

**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.

**NB** Rate associated problems (e.g. changes in sleep, appetite or weight; anxiety symptoms) at Scale 8.

Rating	Description
0	No problems associated with depressed mood during the period rated.
1	Gloomy or minor changes in mood only.
2	Mild but definite depression on subjective or objective measures (e.g. loss of interest or pleasure, lack of energy, loss of self-esteem, feelings of guilt).
3	Moderate depression on subjective or objective measures (depressive symptoms more marked).
4	Severe depression on subjective or objective grounds (e.g. profound loss of interest or pleasure, preoccupation with ideas of guilt or worthlessness).

## 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; **J** other, specify.

Rating	Description
0	No evidence of any of these problems during period rated.
1	Minor non–clinical problems.
2	A problem is clinically present, but at a mild level, for example the problem is intermittent, the consumer maintains a degree of control or is not unduly distressed.
3	Moderately severe clinical problem, for example, more frequent, more distressing or more marked symptoms.
4	Severe persistent problems that dominates or seriously affects most activities.

## Scale 9: Problems with relationships



**Rate** the patient's most severe problem associated with active or passive withdrawal from, or tendency to dominate, social relationships, and/or non-supportive, destructive or self-damaging relationships.

Rating	Description
0	No significant problems during the period.
1	Minor non-clinical problems.
2	Definite problems in making, sustaining or adapting to supportive relationships (e.g. because of controlling manner, or arising out of difficult, exploitative or abusive relationships), definite but mild difficulties reported by consumer or evident to carers or others.
3	Persisting significant problems with relationships; moderately severe conflicts or problems identified within the relationship by the consumer or evident to carers or others.
4	Severe difficulties associated with social relationships (e.g. isolation, withdrawal, conflict, abuse); major tensions and stresses (e.g. threatening breaking down of relationship).

## 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 effectively in all basic activities (e.g. continent – or able to manage incontinence appropriately, able to feed self and dress) and complex skills (e.g. driving or able to make use of transport facilities, able to handle financial affairs appropriately).
1	Minor problems only without significantly adverse consequences, for example, untidy, mildly disorganised, some evidence to suggest minor difficulty with complex skills but still able to cope effectively.
2	Self-care and basic activities adequate (though some prompting may be required), but difficulty with more complex skills (e.g. problem organising and making a drink or meal, deterioration in personal interest especially outside the home situation, problems with driving, transport or financial judgements).
3	Problems evident in one or more areas of self-care activities (e.g. needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted) as well as inability to perform several complex skills.
4	Severe disability or incapacity in all or nearly all areas of basic and complex skills (e.g. full supervision required with dressing and eating, frequent urinary or faecal incontinence).

## Scale 11: Problems with living conditions

✓ **Rate** the overall severity of problems with the quality of living conditions; accommodation and daily domestic routine, taking into account the consumer's preferences and degree of satisfaction with circumstances.

✓ Are the **basic necessities** met (heat, light, hygiene)? Does the physical environment contribute to maximising independence and minimising risk, and provide a choice of opportunities to facilitate the use of existing skills and develop new ones?

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

**NB** Rate patient's **usual** accommodation. If in acute ward, 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 minimising any risk, and supportive of self-help; the consumer is satisfied with their accommodation.
1	Accommodation is reasonably acceptable with only minor or transient problems related primarily to the consumer's preferences rather than any significant problems or risks associated with their environment (e.g. not ideal location, not preferred option, doesn't like food).
2	Basics are met but significant problems with one or more aspects of the accommodation or regime (e.g. lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems of access); may be associated with risk to consumer (e.g. injury) which would otherwise be reduced.
3	Distressing multiple problems with accommodation e.g. some basic necessities are absent (unsatisfactory or unreliable heating, lack of proper cooking facilities, inadequate sanitation); clear elements of risk to the consumer resulting from aspects of the physical environment.
4	Accommodation is unacceptable: e.g. lack of basic necessities, insecure, or living conditions are otherwise intolerable, contributing adversely to the consumer's condition or placing them at high risk of injury or other adverse consequences.

## 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 maximising autonomy.
1	Minor or temporary problems e.g. good facilities available but not always at appropriate times for the consumer.
2	Limited choice of activities; e.g. insufficient carer or professional support, useful day setting available but for very limited hours.
3	Marked deficiency in skilled services and support available to help optimise activity level and autonomy, little opportunity to use skills or to develop new ones; unskilled care difficult to access.
4	Lack of any effective opportunity for daytime activities makes the consumer's problems worse or consumer refuses services offered which might improve their situation.

## Clinical significance and recommended action

It is important clinicians correlate their clinical practice, actions and interventions to reflect findings in the completed HoNOS65+ 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.

		Monitor	Active treatment or management plan
Clinically Significant	<b>4</b> 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.	✓	✓
	<b>3</b> Moderate problem Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	<b>2</b> Mild problem Warrants recording in clinical notes. May or may not be incorporated in care plan.	✓	Maybe
Not clinically significant	<b>1</b> Minor problem Requires no formal action. May or may not be recorded in clinical file.	Maybe	✗
	<b>0</b> No problem Problem not present	✗	✗

## 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](http://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](http://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](http://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 team providing services to people 65 years and over would generally use HoNOS65+ 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 HoNOS65+ 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
<b>1. Acute:</b> 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).
<b>2. Functional gain:</b> 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).
<b>3. Intensive extended:</b> 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.
<b>4. Maintenance:</b> 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.
<b>5. Assessment only:</b> 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"> <li>» 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).</li> <li>» A service user is under shared care and is being reviewed for the first time in three months.</li> </ul>
<b>Episode start collection occasions</b>	
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"> <li>» self-referrals</li> <li>» referrals from family members or other caregivers</li> <li>» referrals from private medical practitioners, including general practitioners (GPs) and private psychiatrists.</li> </ul>
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 <b>not</b> include:</p> <ul style="list-style-type: none"> <li>» transfers between acute psychiatric inpatient units and specialised, high acuity inpatient facilities <i>within the same hospital</i></li> <li>» instances when a person in a community setting receives more intensive treatment for several days or weeks from a second community mental health team.</li> </ul> <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>
<b>Review collection occasions</b>	
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><b>Note:</b> 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"> <li>» DHBs may choose to generate local rules, consistent with this national ICP, about completion of ad hoc reviews.</li> <li>» 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.</li> </ul>

<b>Episode end collection occasions</b> All collections are required to be completed within one week of episode end in the community, and within three days in an inpatient setting.	
<b>Episode end – no further care (RFC07)</b>	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.
<b>Episode end – transfer (discharge) to other treatment setting (RFC08)</b>	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 <b>not</b> include: <ul style="list-style-type: none"> <li>» 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</li> <li>» transfers from general acute psychiatric inpatient units to specialised high-acuity inpatient facilities and vice versa.</li> </ul>
<b>Lost to care (RFC09)</b>	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.
<b>Deceased (RFC10)</b>	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"> <li>» Collection identifiers and period of care data should be completed for instances where a service user has died.</li> <li>» Outcome measure data is not required.</li> </ul>
<b>Brief episode of care (RFC11)</b>	A very brief episode of inpatient psychiatric mental health care is defined as a length of stay of <b>three days (72 hours) or less</b> . 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 <b>less than 14 days</b> . <ul style="list-style-type: none"> <li>» Collection occasion identifiers and period of care data should be completed for brief episodes of care.</li> <li>» Outcome measure data is not required.</li> </ul>
<b>Episode end - other (RFC12)</b>	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](http://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](http://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.

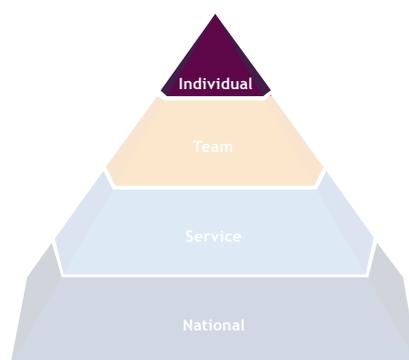
**The team level** involves staff in a team working directly with the service user, their whānau and significant others. At this level an individual's information is used for some purposes and aggregated data (or data from groups of service users) is used for other purposes.

**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>

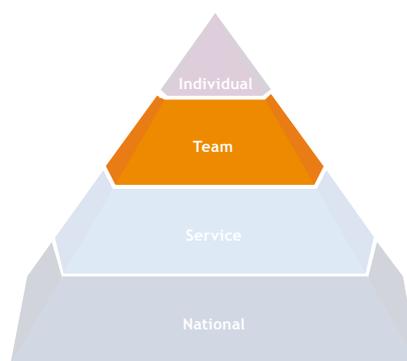
The Story of Change 'Nothing about us without us' profiles the West Coast DHB and their efforts to share information with service users <http://www.tepou.co.nz/news/nothing-about-us-without-us-the-benefits-of-informing-service-users-about-honos/175>

## 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

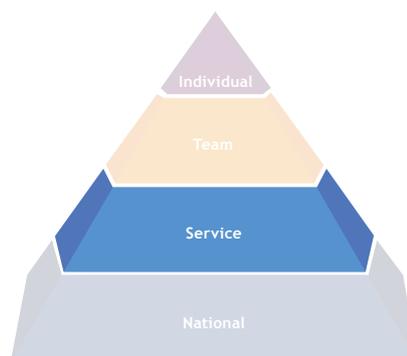
<http://www.tepou.co.nz/resources/using-honosca-in-multi-disciplinary-teams/246>

## 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.

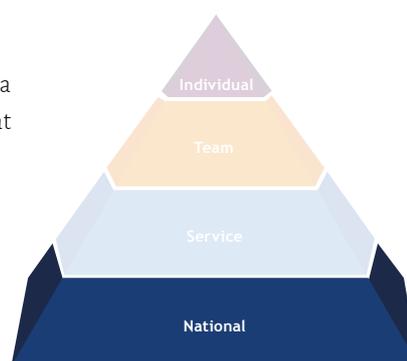


## National level – aggregated data

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](http://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](http://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](http://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](http://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](http://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](http://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](http://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](http://www.tepou.co.nz/events)

## Become a HoNOS65+ trainer for your DHB

Are you interested in becoming a HoNOS65+ 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

## HoNOS65+ 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.



HoNOS65+ e-learning refresher

[www.tepou.co.nz/outcomes-and-information/honos-training-online/33](http://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](http://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](http://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](http://www.tepou.co.nz/honos)