



HoNOSCA



HoNOS



Guide for
New Zealand
Clinicians



Te Pou o te
Whakaaro Nui



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Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) © Royal College of Psychiatrists 1999.

HoNOSCA key sources

Gowers, S.G., Harrington, R.C., Whitton, A., Lelliott, P., Beevor, A., Wing, J. & Jezzard, R. (1999) Brief scale for measuring the outcomes of emotional and behavioural disorders in children. Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). The British Journal of Psychiatry, 174, 413-416.

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Wing, J.K., Curtis, R.H. & Beevor, A.S. (1999) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Glossary for HoNOS score sheet. The British Journal of Psychiatry, 174, 432-434.

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 HoNOSCA, 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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Contents

Outcomes and HoNOSCA	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 HoNOSCA?.....	7
When is HoNOSCA used?	8
HoNOSCA collection points	9
HoNOSCA collection rules for service users transferred between treatment settings	10
HoNOSCA rating guidelines and glossary	12
Important variations in rating guidelines	13
HoNOSCA glossary	14
Scale 1: Problems with disruptive, antisocial or aggressive behaviour	14
Scale 2: Problems with over-activity, attention or concentration	15
Scale 3: Non-accidental self-injury.....	16
Scale 4: Problems with alcohol, substance or solvent misuse	17
Scale 5: Problems with scholastic or language skills	18
Scale 6: Physical illness or disability problems	19
Scale 7: Problems associated with hallucinations, delusions or abnormal perceptions	20
Scale 8: Problems with non-organic somatic symptoms	21
Scale 9: Problems with emotional and related symptoms	22
Scale 10: Problems with peer relationships	23
Scale 11: Problems with self-care and independence	24
Scale 12: Problems with family life and relationships	25
Scale 13: Poor school attendance	26
Scale 14: Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the previous two weeks)	27
Scale 15: Problems with lack of information about services or management of the child or adolescent's difficulties	28
Clinical significance and recommended action	29
Rating reliably	30
Mental health outcomes information collection protocol (ICP) key concepts	31
Demonstrating change.....	31
ICP key concepts.....	31
HoNOS outcome measure ICP - key clinical and descriptive information	37
Key information routinely collected for PRIMHD	39
How we use outcomes information collected in clinical practice.....	40
Outcomes information as part of the bigger picture	44
Glossary of terms	44
Training and other resources	45

Outcomes and HoNOSCA

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 HoNOSCA 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

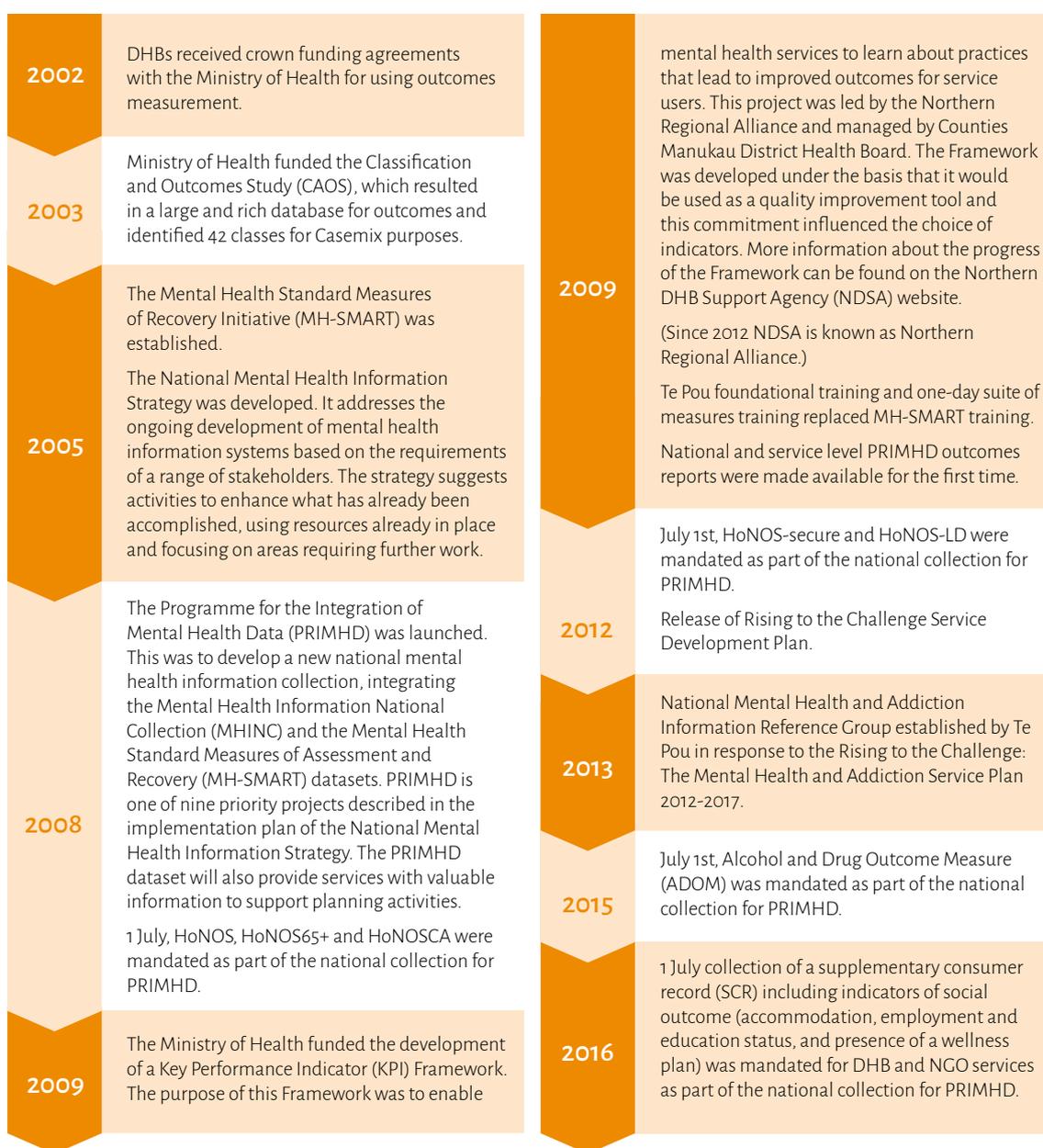
Health of the Nation Outcome Scales (HoNOS) in New Zealand

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



What is HoNOSCA?

Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) 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, HoNOSCA is the outcome measurement tool mandated by the Ministry of Health for to measure health and social functioning of children and adolescents (under the age of 18) accessing specialist child and adolescent mental health services.

HoNOSCA measures symptom severity and social functioning across time. It has 15 scales (also referred to as items) that measure behaviour, impairment, symptoms and social functioning. The items are rated, after routine clinical assessment, on a scale of 0 to 4. The results or changes in ratings between one collection and the next are known as outcomes.

HoNOSCA 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.

HoNOSCA is rated using a glossary which provides detailed descriptors for each level of severity and complexity. For all outcome collection occasions, scales are rated based on information from the last two weeks of a service user's presentation. The exception is for an end of episode in an inpatient setting, where the rating period is three days.

For scales 1 to 9, rate worst manifestation in a two week period. For scales 10 to 15, rate usual or typical in a two week period.

When is HoNOSCA used?

HoNOSCA is mandated for use with all people under 18 accessing specialist mental health services, in all district health boards (DHBs), in both inpatient and community settings.

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

HoNOSCA items

1. Problems with disruptive, antisocial or aggressive behaviour.
2. Problems with over-activity, attention or concentration.
3. Non-accidental self-injury.
4. Problems with alcohol, substance or solvent misuse.
5. Problems with scholastic or language skills.
6. Physical illness or disability problems.
7. Problems associated with hallucinations, delusions or abnormal perceptions.
8. Problems with non-organic somatic symptoms.
9. Problems with emotional and related symptoms.
10. Problems with peer relationships.
11. Problems with self-care and independence.
12. Problems with family life and relationships.
13. Poor school attendance.
14. Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the previous two weeks).
15. Problems with lack of information about services or management of the child or adolescent's difficulties.

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.

HoNOSCA collection points



HoNOSCA 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 36.

HoNOSCA 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 15.
- » Do not include information already rated in an earlier scale.
- » Rate the most severe problem that occurred in the previous four weeks.
- » 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 HoNOSCA. HoNOSCA 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 1-9	Always	Always
Scale 10-15	Based on usual or typical	Always

HoNOSCA glossary

Scale 1: Problems with disruptive, antisocial or aggressive behaviour

- ✓ **Include** behaviour associated with any disorder, such as hyperkinetic disorder, depression, autism, drugs or alcohol.
- ✓ **Include** physical or verbal aggression (e.g., pushing, hitting, vandalism, teasing), or physical or sexual abuse of other children.
- ✓ **Include** antisocial behaviour (e.g., stealing, lying, cheating) or oppositional behaviour (e.g., defiance, opposition to authority or tantrums).
- ✗ **Do not** include: over-activity rated at Scale 2; truancy, rated at Scale 13; self-harm rated at Scale 3.

Rating	Description
0	No problems of this kind during the period rated.
1	Minor quarrelling, demanding behaviour, undue irritability, lying, etc.
2	Mild but definitely disruptive or antisocial behaviour, lesser damage to property, or aggression, or defiant behaviour.
3	Moderately severe aggressive behaviour such as fighting, persistently threatening, very oppositional, more serious destruction of property, or moderately delinquent acts.
4	Disruptive in almost all activities, or at least one serious physical attack on others or animals, or serious destruction of property.

Additional notes for scale 1

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

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

Scale 2: Problems with over-activity, attention or concentration

- ✓ **Include** overactive behaviour associated with any disorder such as hyperkinetic disorder, mania, or arising from drugs.
- ✓ **Include** problems with restlessness, fidgeting, inattention or concentration due to any cause, including depression.

Rating	Description
0	No problem of this kind during the period rated.
1	Slight over-activity or minor restlessness, etc.
2	Mild but definite over-activity or attention problems, but can usually be controlled.
3	Moderately severe over-activity or attention problems that are sometimes uncontrollable.
4	Severe over-activity or attention problems that are present in most activities and almost never controllable.

Additional notes for scale 2

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

Scale 3: Non-accidental self-injury

- ✓ **Include** self-harm such as hitting self and self-cutting, suicide attempts, overdoses, hanging, drowning, etc.
- ✗ Do **not** include scratching, picking as a direct result of physical illness rated at Scale 6.
- ✗ Do **not** include accidental self-injury due, e.g., to severe learning or physical disability, rated at scale 6.
- ✗ Do **not** include illness or injury as a direct consequence of drug or alcohol use, rated at scale 6.

Rating	Description
0	No problems of this kind during the period rated.
1	Occasional thoughts about death, or of self-harm not leading to injury. No self-harm or suicidal thoughts.
2	Non-hazardous self-harm, such as wrist scratching, whether or not associated with suicidal thoughts.
3	Moderately severe suicidal intent (including preparatory acts, e.g., collecting tablets) or moderate non-hazardous self-harm (e.g., small overdose).
4	Serious suicidal attempt (e.g., serious overdose), or serious deliberate self-injury.

Additional notes for scale 3

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

Scale 4: Problems with alcohol, substance or solvent misuse

✓ **Include** problems with alcohol, substance or solvent misuse taking into account current age and societal norms.

✗ Do **not** include aggressive or disruptive behaviour due to alcohol or drug use, rated at Scale 1.

✗ Do **not** include physical illness or disability due to alcohol or drug use, rated at Scale 6.

Rating	Description
0	No problem of this kind during the period rated.
1	Minor alcohol or drug use, within age norms.
2	Mildly excessive alcohol or drug use.
3	Moderately severe drug or alcohol problems significantly out of keeping with age norms.
4	Severe drug or alcohol problems leading to dependency or incapacity.

Additional notes for scale 4

Consider characteristics such as craving or tolerance for alcohol or drugs, priority over other activities given to their acquisition and use, impaired capacity to control the quantity taken, frequency of intoxication and risk-taking. Dependence on alcohol and drugs is rare in children and adolescents thus this item addresses substance misuse out with the norms for a child's age. Aggressive and disruptive behaviour due to alcohol or drug use should not be included here as they are rated at Item 1, whilst physical illness or disability due to alcohol or drug use would be rated at Item 6.

Scale 5: Problems with scholastic or language skills

- ✓ **Include** problems in reading, spelling, arithmetic, speech or language associated with any disorder or problem, such as specific developmental learning problems, or physical disability such as hearing problems.
- ✓ **Include** reduced scholastic performance associated with emotional or behavioural problems.
- ✗ Children with generalised learning disability should **not be included** unless their functioning is below the expected level.
- ✗ Do **not** include temporary problems resulting purely from inadequate education.

Rating	Description
0	No problems of this kind during the period rated.
1	Minor impairment within the normal range of variation.
2	Minor but definite impairment of clinical significance.
3	Moderately severe problems, below the level expected on the basis of mental age, past performance, or physical disability.
4	Severe impairment, much below the level expected on the basis of mental age, past performance, or physical disability.

Additional notes for scale 5

This item is concerned with problems with reading, spelling, arithmetic, speech or language associated with any disorder or problem such as a specific developmental learning problem or physical disability such as a hearing problem. Emphasis is on under-performance with respect to expectation thus, children with generalised learning disability should not be included unless their functioning is less than optimal. It is often helpful to take into account past performance in deciding the appropriate rating, for example, a child achieving at average level could be rated as having a problem if his prior performance was in the superior range.

Scale 6: Physical illness or disability problems

- ✓ **Include** physical illness or disability problems that limit or prevent movement, impair sight or hearing, or otherwise interfere with personal functioning.
- ✓ **Include** movement disorder, side effects from medication, physical effects from drug or alcohol use, or physical complications of psychological disorders such as severe weight loss.
- ✓ **Include** self-injury due to severe learning disability or as of consequence of self-injury such as head banging.
- ✗ Do **not** include somatic complaints with no organic basis, rated at scale 8.

Rating	Description
0	No incapacity as a result of physical health problems during the period rated.
1	Slight incapacity as a result of a health problem during the period (e.g., cold, non-serious fall, etc.).
2	Physical health problem that imposes mild but definite functional restriction.
3	Moderate degree of restriction on activity due to physical health problems.
4	Complete or severe incapacity due to physical health problems.

Additional notes for scale 6

Consider the impact of physical disability or disease on the child 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 child 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. Include also physical complications of psychological disorders such as severe weight loss in anorexia nervosa.

Scale 7: Problems associated with hallucinations, delusions or abnormal perceptions

- ✓ **Include** hallucinations, delusions or abnormal perceptions irrespective of diagnosis.
- ✓ **Include** odd and bizarre behaviour associated with hallucinations and delusions.
- ✓ **Include** problems with other abnormal perceptions such as illusions or pseudo-hallucinations, or overvalued ideas such as distorted body image, suspicious or paranoid thoughts.
- ✗ Do **not** include disruptive or aggressive behaviour associated with hallucinations or delusions, rated at Scale 1.
- ✗ Do **not** include overactive behaviour associated with hallucinations or delusions, rated at Scale 2.

Rating	Description
0	No evidence of abnormal thoughts or perceptions during the period rated.
1	Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2	Abnormal thoughts or perceptions are present (e.g., paranoid ideas, illusions or body image disturbance), but there is little distress or manifestation in bizarre behaviour, i.e., clinically present but mild.
3	Moderate preoccupation with abnormal thoughts or perceptions or delusions; hallucinations, causing much distress, or manifested in obviously bizarre behaviour.
4	Mental state and behaviour is seriously and adversely affected by delusions or hallucinations or abnormal perceptions, with severe impact on the person or others.

Additional notes for scale 7

This item addresses all hallucinations, delusions or abnormal perceptions irrespective of diagnosis, as well as odd and bizarre behaviours associated with psychotic symptoms. Problems with other abnormal perceptions should also be included here such as illusions or pseudo-hallucinations or over-valued ideas such as suspicious or paranoid thoughts or abnormalities of body image in eating disorders. Disruptive or aggressive behaviour associated with hallucinations or delusions should not be rated here (see Item 1). Overactive behaviour, for example in hypomania should also be rated elsewhere (Item 2).

Scale 8: Problems with non-organic somatic symptoms

- ✓ **Include** problems with gastrointestinal symptoms such as non-organic vomiting or cardiovascular symptoms or neurological symptoms or non-organic enuresis and encopresis or sleep problems or chronic fatigue.
- ✗ Do **not** include movement disorders such as tics, rated at Scale 6.
- ✗ Do **not** include physical illnesses that complicate non-organic somatic symptoms, rated at Scale 6.

Rating	Description
0	No problems of this kind during the period rated.
1	Slight problems only, such as occasional enuresis, minor sleep problems, headaches or stomach aches without organic basis.
2	Mild but definite problem with non-organic somatic symptoms.
3	Moderately severe, symptoms produce a moderate degree of restriction in some activities.
4	Very severe problems or symptoms persist into most activities. The child or adolescent is seriously or adversely affected.

Additional notes for scale 8

This should include difficulties with gastro-intestinal symptoms such as non-organic vomiting or cardio-vascular symptoms or neurological symptoms without demonstrable organic cause. Non-organic enuresis or encopresis should also be included here. Include also sleep symptoms and those related to chronic fatigue. Movement disorders such as tics or those related to the side-effects of medication should not be included and should be rated under Item 6.

Scale 9: Problems with emotional and related symptoms

- ✓ **Rate** only the most severe clinical problem not considered previously.
- ✓ **Include** depression, anxiety, worries, fears, phobias, obsessions or compulsions, arising from any clinical condition including eating disorders.
- ✗ Do **not** include aggressive, destructive or over-activity behaviours attributed to fears or phobias, rated at Scale 1.
- ✗ Do **not** include physical complications of psychological disorders, such as severe weight loss, rated at Scale 6.

Rating	Description
0	No evidence of depression, anxiety, fears or phobias during the period rated.
1	Mildly anxious, gloomy, or transient mood changes.
2	A mild but definite emotional symptom is clinically present, but is not preoccupying.
3	Moderately severe emotional symptoms, which are preoccupying, intrude into some activities, and are uncontrollable at least sometimes.
4	Severe emotional symptoms which intrude into all activities and are nearly always uncontrollable.

Additional notes for scale 9

Only the most severe clinical problem not considered previously should be rated here. This might include depression, anxiety, worries, fears, phobias, obsessions or compulsions arising from any clinical condition including eating disorders. Aggressive destructive or overactive behaviours attributed to fears or phobias should be rated at Item 1. Physical complications of psychological disorders such as severe weight loss should be rated at Item 6. If a child has two or more symptoms in this category, choose only the most severe. Items 10 to 13 (ratings of social functioning and of autonomy) unlike Items 1 to 9 which are concerned with the most severe example of difficulty occurring in the time period, address the mean level of functioning during the rating period. For example, in considering peer relationships (Item 10) the general level of friendships should be considered rather than giving undue weight to a child who has fallen out with one friend.

Scale 10: Problems with peer relationships

- ✓ **Include** problems with school mates and social network. Problems associated with active or passive withdrawal from social relationships or problems with over intrusiveness or problems with the ability to form satisfying peer relationships.
- ✓ **Include** social rejection as a result of aggressive behaviour or bullying.
- ✗ Do **not** include aggressive behaviour, bullying, rated at Scale 1.
- ✗ Do **not** include problems with family or siblings rated at Scale 12.

Rating	Description
0	No significant problems during the period rated.
1	Either transient or slight problems, occasional social withdrawal.
2	Mild but definite problems in making or sustaining peer relationships. Problems causing distress due to social withdrawal, over-intrusiveness, rejection or being bullied.
3	Moderate problems due to active or passive withdrawal from social relationships, over-intrusiveness, or to relationships that provide little or no comfort or support, e.g., as a result of being severely bullied.
4	Severe social isolation with hardly any friends due to inability to communicate socially or withdrawal from social relationships.

Additional notes for scale 10

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

Scale 11: Problems with self-care and independence

- ✓ **Rate** the overall level of functioning, e.g., problems with basic activities of self-care such as feeding, washing, dressing, toilet, and also complex skills such as managing money, travelling independently, shopping etc.; taking into account the norm for the child's chronological age.
- ✓ **Include** poor levels of functioning arising from lack of motivation, mood or any other disorder.
- ✗ Do **not** include lack of opportunities for exercising intact abilities and skills, as might occur in an over-restrictive family, rated at Scale 12.
- ✗ Do **not** include enuresis and encopresis, rated at Scale 8.

Rating	Description
0	No problems of this kind during the period rated; good ability to function in all areas.
1	Minor problems, e.g., untidy, disorganised.
2	Self-care adequate, but major inability to perform one or more complex skills (see above).
3	Major problems in one or more areas of self-care (eating, washing, dressing) or major inability to perform several complex skills.
4	Severe disability in all or nearly all areas of self-care or complex skills.

Additional notes for scale 11

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

Scale 12: Problems with family life and relationships

- ✓ **Include** parent-child and sibling relationship problems.
- ✓ **Include** relationships with foster parents, social works or teachers in residential placements. Relationships in the home with separated parents and siblings should both be included. Parental personality problems, mental illness, marital difficulties should only be rated here if they have an effect on the child or adolescent.
- ✓ **Include** problems such as poor communication, arguments, verbal or physical hostility, criticism and denigration, parental neglect or rejection, over-restriction, sexual or physical abuse.
- ✓ **Include** sibling jealousy, physical or coercive sexual abuse by sibling.
- ✓ **Include** problems with enmeshment and overprotection.
- ✓ **Include** problems with family bereavement leading to reorganisation.
- ✗ Do **not** include aggressive behaviour by the child or adolescent, rated at Scale 1.

Rating	Description
0	No problems during the period rated.
1	Slight or transient problems.
2	Mild but definite problem, e.g., some episodes of neglect or hostility or enmeshment or overprotection.
3	Moderate problems, e.g., neglect, abuse, hostility. Problems associated with family or carer breakdown or reorganisation.
4	Serious problems with the child or adolescent feeling or being victimised, abused or seriously neglected by family or carer.

Additional notes for scale 12

Usually this item will refer to relationships with parents and siblings in the family home but if the normal home is with foster parents or in residential placements, relationships there should be rated. Where the child is living away from home, relationships within the institution and with separated parents and siblings should both be rated. Parental personality problems, mental illnesses and marital difficulties should only be rated here if they have an effect on the child, though this will usually be the case. Problems associated with physical, emotional or sexual abuse should be included but this scale is not intended to address abusive or neglectful features alone. Difficulties arising from over-involvement and overprotection should be included, as well as difficulties arising from family re-organisation as a result of relocation or bereavement. Sibling jealousy or physical coercion by a sibling should be included but aggressive behaviour by the child should be rated under Item 1.

Scale 13: Poor school attendance

- ✓ **Include** truancy, school refusal, school withdrawal or suspension for any cause.
- ✓ **Include** attendance at type of school at time of rating, e.g., hospital school, home tuition, etc. If school holiday, rate the last two weeks of the previous term.

Rating	Description
0	No problems of this kind during the period rated.
1	Slight problems, e.g., late for two or more lessons.
2	Definite but mild problems, e.g., missed several lessons because of truancy or refusal to go to school.
3	Marked problems, absent several days during the period rated.
4	Severe problems, absent most or all days. Include school suspension, exclusion or expulsion for any cause during the period rated.

Additional notes for scale 13

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



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

Scales 14 and 15 are concerned with problems for the child, parent or carer relating to lack of information or access to services. These are not direct measures of the child's mental health but changes here may result in long-term benefits for the child.

Scale 14: Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the previous two weeks)

- ✓ **Include** lack of useful information or understanding available to the child or adolescent, parents or carers.
- ✓ **Include** lack of explanation about the diagnosis or the cause of the problem or the prognosis.

Rating	Description
0	No problems during the period rated. Parents and carers have been adequately informed about the child or adolescent's problems.
1	Slight problems only.
2	Mild but definite problems.
3	Moderately severe problems. Parents and carers have very little or incorrect knowledge about the problem which is causing difficulties such as confusion or self-blame.
4	Very severe problems. Parents have no understanding about the nature of their child or adolescent's problems.

Additional notes for scale 14

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

Scale 15: Problems with lack of information about services or management of the child or adolescent's difficulties

- ✓ **Include** lack of useful information or understanding available to the child or adolescent, parents or carers or referrers.
- ✓ **Include** lack of information about the most appropriate way of providing services to the child or adolescent, such as care arrangements, educational placements, or respite care.

Rating	Description
0	No problems during the period rated. The need for all necessary services has been recognised.
1	Slight problems only.
2	Mild but definite problems.
3	Moderately severe problems. Parents and carers have been given very little information about appropriate services, or professionals are not sure where a child should be managed.
4	Very severe problems. Parents have no information about appropriate services or professionals do not know where a child should be managed activities.

Additional notes for scale 15

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

Clinical significance and recommended action

It is important clinicians correlate their clinical practice, actions and interventions to reflect findings in the completed HoNOSCA 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	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	✗	✗

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 Child and Adolescent Mental Health Service (CAMHS) team providing services to people under 18 years of age would generally use HoNOSCA 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 HoNOSCA 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.



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.

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.

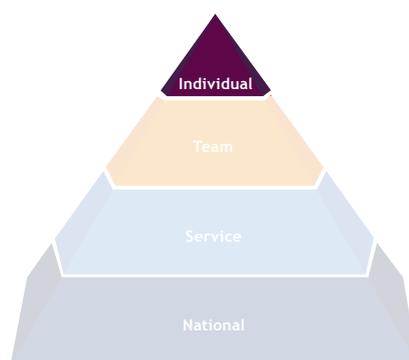
The team level involves staff in a team working directly with the service user, their whānau and significant others. At this level an individual's information is used for some purposes and aggregated data (or data from groups of service users) is used for other purposes.

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

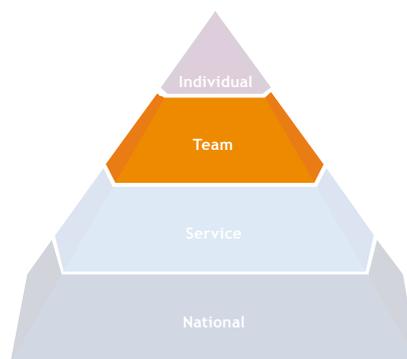
The Story of Change 'Nothing about us without us' profiles the West Coast DHB and their efforts to share information with service users <http://www.tepou.co.nz/news/nothing-about-us-without-us-the-benefits-of-informing-service-users-about-honos/175>

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

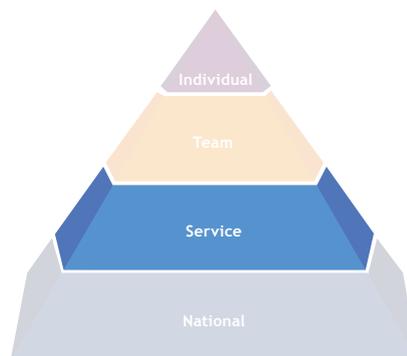
<http://www.tepou.co.nz/resources/using-honosca-in-multi-disciplinary-teams/246>

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.

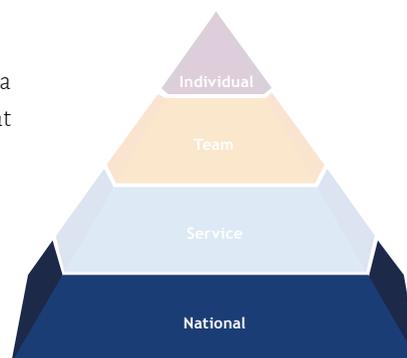


National level – aggregated data

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.

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.



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

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 HoNOSCA trainer for your DHB

Are you interested in becoming a HoNOSCA 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

HoNOSCA 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.



HoNOSCA 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