HoNOS

a New Zealand clinician’s guide to ratings and use
Acknowledgements

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Purpose of this booklet

This booklet has been developed to assist outcomes trainers to deliver training in their respective services. However, the content of this booklet should be of use to all clinicians and managers in mental health services.

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Health of the Nation Outcome Scale - 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 HoNOS is to ensure good compliance with collections before introducing other mandated measures. The overall compliance target for HoNOS for 2015 is 80 per cent and above for both inpatient and community settings.
What is an outcome?

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

HoNOS collects information about a person’s mental health and social functioning using 12 items (scales). We can measure change by using this standard rating tool at two set points in the service user’s journey.

This can, for example, be at admission and discharge from receiving mental health services, or at admission and review if the person is receiving services for longer than three months.

The benefits of collecting quality outcomes information

The collection of outcomes data helps us to:

» better understand changes in health, wellbeing and circumstances for people who access mental health services, across all of New Zealand

» more effectively plan activities at various levels such as individual, team, service and national.
What is HoNOS?

Health of the Nation Outcome Scale (HoNOS) is a clinician rated tool developed by the United Kingdom Royal College of Psychiatrist's Research Unit to measure the health and social functioning of people experiencing severe mental illness. This is an outcome tool mandated for use by specialist mental health services.

HoNOS measures the symptom severity and social functioning across time. It has 12 items that measure behaviour, impairment, symptoms and social functioning. The items are rated on a scale of 0–4 and the results or changes in ratings are known as outcomes and may be attributed to services provided. The rating is made using a glossary that has detailed descriptors of level of severity and complexity.

HoNOS is completed by a qualified mental health professional (clinician) to rate a range of health and social domains for people receiving services from specialist mental health services. The clinician will use information obtained from comprehensive mental health assessments and routine clinical work to complete HoNOS. Information from all available sources should be considered when completing ratings including the service user, their family/whanau and clinical notes.

Any clinician that has completed Te Pou’s foundational training and one-day specific measure training can become a trainer for that specific measure.

Learn more about the HoNOS training Te Pou provides at www.tepou.co.nz/honos.
When is HoNOS used?

HoNOS is:

» used when a person enters a specialist mental health service (admission) and when he/she exits (discharge) the service

» used at regular three monthly review periods while he/she continues to access the service provided

» completed when there are significant changes to the service user’s circumstances (ad hoc review).

HoNOS is mandated for use in all district health board (DHB) mental health services, in both inpatient and community settings.

The clinician who is most familiar with the individual service user should record the ratings taking into account all available information. Ideally the same team or clinician should make the follow up ratings as well. However, this may not always be possible, particularly in the case of inpatient treatment settings.

The completion of treatment at one DHB service, and commencement of treatment in another DHB service are considered separate episodes of care. As such, a new episode of data collection should begin.
**HoNOS collection points**

- **Assessment only collection** - Completed when people are not being admitted to a mental health service (community or inpatient setting).

- **Admission HoNOS** - Completed when people are admitted to a mental health service (community or inpatient setting).

- **Review HoNOS** - Completed after 3 months (91 days).

- **Ad hoc review** - Can be completed at any time at the discretion of the clinician. Recommended when anything clinically significant happens such as a change of clinician, change of medication, change to social or living situation.

- **Review HoNOS** - Completed after 3 months (91 days).

- **Episode end** - Completed when people are discharged from a mental health service (community or inpatient setting).
HoNOS collections when service users are transferred between treatment settings

By definition, a service user may only be the subject of one episode of mental health care at any given time. Where a person might be considered as receiving treatment in more than one service setting simultaneously, inpatient care will take precedence over community care. The diagram below illustrates this.

Community care with intervening inpatient admission

![Diagram showing information collection points for community and inpatient episodes]

Information collection
inpatient new episode

Information collection
inpatient end of episode

Information collection
community new episode

Information collection
community end of episode

Information collection
community new episode
Rating reliably

Rating reliably requires completed training in HoNOS, refresher training (minimum of every two years to keep certification), regular practice ratings and consistent use of the glossary.

Studies have shown HoNOS to have good inter-rater reliability and validity and sensitivity to therapeutic change. Te Pou’s technical review of the psychometric properties of HoNOS family of measures provides an outline of this, and can be downloaded from www.tepou.co.nz.

Challenge your practice

It is beneficial to practice completing ratings. You can do this by using some written vignettes and videos, found on the Te Pou website www.tepou.co.nz.

These have consensus ratings that you compare with your own. Consensus ratings are done by different clinicians/experts on the same vignette. The results are then discussed and relevant changes are made so that all clinician/expert raters agree on the final rating. This becomes the rationale for the ratings of each item and is provided with the written vignettes and video.

You can also find alternative online training options on the Australian Mental Health Outcomes and Classification Network website.
Quick guide to rating HoNOS

» Perform a full clinical assessment of the service user’s clinical history and current problems.
» Refer to glossary when completing ratings.
» Rate items in order from 1 to 12.
» Use all available information in making your rating.
» Do not include information already rated in an earlier item.
» Rate the most severe problem that occurred in the period rated.
» The rating period is generally the preceding two weeks, except at discharge from inpatient care, when it is the previous three days.
» Each item is rated on a 5-point item of severity (0 to 4 and 7):
  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 applicable.
» The use of rating point 7 should be avoided where possible. The resulting missing data make scores less comparable over time or between settings.
» Specific information on how to rate each point on each item is provided in the HoNOS glossary. It is recommended that clinicians refer to the glossary consistently when completing HoNOS.
» HoNOS should be rated using information available from all sources.
HoNOS glossary

Please note that not all examples may be relevant to the New Zealand context.

**Scale 1: Overactive, aggressive, disruptive or agitated behaviour**

- **✓** Include such behaviour due to any cause, such as drugs, alcohol, dementia, psychosis, depression, etc.
- **✗** Do not include bizarre behaviour, rated at scale 6.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems of this kind during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Irritability, quarrels, restlessness etc. not requiring action.</td>
</tr>
<tr>
<td>2</td>
<td>Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup or window); marked overactivity or agitation.</td>
</tr>
<tr>
<td>3</td>
<td>Physically aggressive to others or animals (short of rating 4); threatening manner more serious overactivity or destruction of property.</td>
</tr>
<tr>
<td>4</td>
<td>At least one serious physical attack on others or on animals; destruction of property (e.g. fire-setting); serious intimidation or obscene behaviour.</td>
</tr>
</tbody>
</table>

**Additional notes for Scale 1**

This scale is concerned with a spectrum of behaviours. The short title is ‘Aggression’, for convenience, but the full title is broader and more accurate. All four types of behaviour are included, whether or not there is intention, insight or awareness. However, the context must be considered since disagreement, for example, can be expressed more vigorously, but still acceptably, in some social contexts than in others.

Possible causes of the behaviour are not considered in the rating and diagnosis is not taken into account. For example, the severity of disruptive behaviour by someone with dementia or learning disability is rated here, as is aggressive overactivity associated with mania, or agitation associated with severe depression, or violence associated with hallucinations or personality problems. Bizarre behaviour is rated at scale 6.
Scale 2: Non-accidental self-injury

Do not include accidental self-injury (for example due to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.

Do not include illness or injury as a direct consequence of drug or alcohol use rated at Scale 3, (for example cirrhosis of the liver or injury resulting from drunk diving are rated at Scale 5).

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems of this kind during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Fleeting thoughts about ending it all, but little risk during the period rated; no self-harm.</td>
</tr>
<tr>
<td>2</td>
<td>Mild risk during period; includes non-hazardous self-harm, e.g. wrist-scratching.</td>
</tr>
<tr>
<td>3</td>
<td>Moderate to serious risk of deliberate self-harm during the period rated; includes preparatory acts, e.g. collecting tablets.</td>
</tr>
<tr>
<td>4</td>
<td>Serious suicidal attempt or serious deliberate self-injury during the period rated.</td>
</tr>
</tbody>
</table>

Additional notes for Scale 2

This scale deals with ideas or acts of self-harm in terms of their severity or impact. As in the clinical situation, the issue of intent during the period, though sometimes difficult to assess (for example when service user is slowed by depression), is part of the current risk assessment. Thus, severe harm caused by an impulsive overdose could be rated at severity point 4, even though the clinician judged that the service user had not intended more than a moderate demonstration.

In the absence of strong evidence to the contrary, clinicians should assume that the results of self-harm were all intended. Risk of future self-harm is not part of this rating; although it should be part of the wider clinical assessment.
Scale 3: Problem drinking or drug-taking

- Do not include aggressive or destructive 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 5.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems of this kind during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Some over-indulgence, but within social norm.</td>
</tr>
<tr>
<td>2</td>
<td>Loss of control of drinking or drug-taking; but not seriously addicted.</td>
</tr>
<tr>
<td>3</td>
<td>Marked craving or dependence on alcohol or drugs with frequent loss of control, risk taking under the influence, etc.</td>
</tr>
<tr>
<td>4</td>
<td>Incapacitated by alcohol or drug problems.</td>
</tr>
</tbody>
</table>

**Additional notes for Scale 3**

Consider characteristics such as craving or tolerance for alcohol or drugs, priority over other activities given to their acquisition and use, impaired capacity to control the quantity taken, frequency of intoxication and drunk driving or other risk-taking.

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

- Include problems of memory, orientation and understanding associated with any disorder; learning disability, dementia, schizophrenia, etc.

- Do not include temporary problems (such as hangovers) resulting from drug or alcohol use, rated at Scale 3.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems of this kind during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Minor problems with memory or understanding, e.g. forgets names occasionally.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite problems, e.g. has lost way in a familiar place or failed to recognise a familiar person; sometimes mixed up about simple decisions.</td>
</tr>
<tr>
<td>3</td>
<td>Marked disorientation in time, place or person, bewildered by everyday events; speech is sometimes incoherent, mental slowing.</td>
</tr>
<tr>
<td>4</td>
<td>Severe disorientation, e.g. unable to recognise relatives, at risk of accidents, speech incomprehensible, clouding or stupor.</td>
</tr>
</tbody>
</table>

Additional notes for Scale 4

Intellectual and memory problems associated with any disorder, including dementia, learning disability, schizophrenia, very severe depression, etc., are taken into account, for example problems in naming or recognising familiar people or pets or objects; not knowing the day, date or time; difficulties in understanding or using speech (in own language); failure to remember important matters; not recognising common dangers (gas taps, ovens, crossing busy roads); clouding of consciousness and stupor.
Scale 5: Physical illness or disability problems

Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning.

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.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No physical health problem during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Minor health problem during the period (e.g. cold, non-serious fall, etc).</td>
</tr>
<tr>
<td>2</td>
<td>Physical health problem imposes mild restriction on mobility and activity.</td>
</tr>
<tr>
<td>3</td>
<td>Moderate degree of restriction on activity due to physical health problem.</td>
</tr>
<tr>
<td>4</td>
<td>Severe or complete incapacity due to physical health problem.</td>
</tr>
</tbody>
</table>

Additional notes for Scale 5

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

The rating at points 2 – 4 is made in terms of degree of restriction on activities, irrespective of the type of physical problem. Include impairments of the senses, unwanted side effects of medication, limitations on movement from whatever cause, injuries associated with the effects of drugs or alcohol, etc. The physical results of accidents or self-injury in the context of severe cognitive problems should also be rated here.
Scale 6: Problems associated with hallucinations and delusions

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of hallucinations or delusions during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Somewhat odd or eccentric beliefs not in keeping with cultural norms.</td>
</tr>
<tr>
<td>2</td>
<td>Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to service user or manifestation in bizarre behaviour, that is, moderately severe clinical problem.</td>
</tr>
<tr>
<td>3</td>
<td>Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, that is, moderately severe clinical problem.</td>
</tr>
<tr>
<td>4</td>
<td>Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on service user.</td>
</tr>
</tbody>
</table>

Additional notes for Scale 6

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

If the service user is distressed, or behaves bizarrely in accordance with the delusion (for example acting in a grandiose manner, running up large debts, dressing the part, expecting to be admitted to a royal palace, etc.) the rating is at points 3 or 4. Any violent, overactive and disruptive behaviour, however, has already been rated at Scale 1 and should not be included again. Similar considerations apply to other kinds of delusion and to hallucinations.
**Scale 7: Problems with depressed mood**

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems associated with depressed mood during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Gloomy; or minor changes in mood.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite depression and distress: e.g. feelings of guilt; loss of self-esteem.</td>
</tr>
<tr>
<td>3</td>
<td>Depression with inappropriate self-blame, preoccupied with feelings of guilt.</td>
</tr>
<tr>
<td>4</td>
<td>Severe or very severe depression, with guilt or self-accusation.</td>
</tr>
</tbody>
</table>

**Additional notes for Scale 7**

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

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

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any of these problems during period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Minor non-clinical problem.</td>
</tr>
<tr>
<td>2</td>
<td>A problem is clinically present at a mild level, e.g. service user has a degree of control.</td>
</tr>
<tr>
<td>3</td>
<td>Occasional severe attack or distress, with loss of control, e.g. has to avoid anxiety provoking situations altogether, call in a neighbour to help, etc. That is, a moderately severe level of problem.</td>
</tr>
<tr>
<td>4</td>
<td>Severe problem dominates most activities.</td>
</tr>
</tbody>
</table>

Additional notes for Scale 8

This Scale provides an opportunity to rate symptoms not included in the previous clinical Scales. Several types of problem are specified, distinguished by the capital letters A–J, as specified above. Only the single most severe problem occurring during the period is rated. This procedure is repeated at T2 (Time 2). In this way, the most severe problem is always rated for each succeeding time period and the contribution to the total score reflects severity at T1 and T2 even if the symptom type changes.
Scale 9: Problems with relationships

Rate the service user’s most severe problem associated with active or passive withdrawal from social relationships, and/or non-supportive, destructive or self-damaging relationships.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No significant problems during the period.</td>
</tr>
<tr>
<td>1</td>
<td>Minor non-clinical problems.</td>
</tr>
<tr>
<td>2</td>
<td>Definite problems in making or sustaining supportive relationships; service user complains and/or problems are evident to others.</td>
</tr>
<tr>
<td>3</td>
<td>Persisting major problems due to active or passive withdrawal from social relationships, and/or to relationships that provide little or no comfort or support.</td>
</tr>
<tr>
<td>4</td>
<td>Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social relationships.</td>
</tr>
</tbody>
</table>

Additional notes for Scale 9

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

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

If the service user is rather solitary, but self-sufficient, competent when with others, and satisfied with the level of social interaction, the rating would be 1. Near-total isolation (whether because the service user withdraws, or is shunned by other, or both) is rated 4. Take the degree of the service users’ distress about personal relationships, as well as degree of withdrawal or difficulty, into account when deciding between points 2 & 3. Aggressive behaviour by the service user towards another person is rated at Scale 1.
Scale 10: Problems with activities of daily living

Rate the overall level of functioning in activities of daily living (ADL), for example problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, organising where to live, occupation and recreation, mobility and use of transport, shopping, 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, rated at Scale 11 and Scale 12.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems during period rated; good ability to function in all areas.</td>
</tr>
<tr>
<td>1</td>
<td>Minor problems only e.g. untidy, disorganised.</td>
</tr>
<tr>
<td>2</td>
<td>Self-care adequate, but major lack of performance of one or more complex skills (see above).</td>
</tr>
<tr>
<td>3</td>
<td>Major problems in one or more areas of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills.</td>
</tr>
<tr>
<td>4</td>
<td>Severe disability or incapacity in all or nearly all areas of self-care and complex skills.</td>
</tr>
</tbody>
</table>
Additional notes for Scale 10

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

» first, a summary of the effects on personal and social functioning of the problems rated at Items 1 – 9
» second, a lack of opportunities in the environment to use and develop intact skills
» third, a lack of motivation or encouragement to use opportunities that is available.

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

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

» the basic level includes self-care activities such as eating, washing, dressing, toileting and simple occupations. If performance is moderately or seriously low, rate 3 or 4;
» the complex level includes the use of higher level skills and abilities in occupational and recreational activities, money management, household shopping, child care, etc., as appropriate to the service user’s circumstances. If these are normal or as adequate as they can be, rate 0 or 1. Ratings 2 and 3 are intermediate.
Scale 11: Problems with living conditions

Rate the overall severity of problems with the quality of living conditions and daily domestic routine.

✔ Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones?

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

NB Rate service user's usual accommodation. If in acute ward, rate the home accommodation. If information not obtainable, rate 7.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Item 10 to the lowest level possible, and supportive of self-help.</td>
</tr>
<tr>
<td>1</td>
<td>Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn’t like food, etc.).</td>
</tr>
<tr>
<td>2</td>
<td>Significant problems with one or more aspects of the accommodation and/or regime (e.g. restricted choice; staff or household have little understanding of how to limit disability, or how to help develop new or intact skills).</td>
</tr>
<tr>
<td>3</td>
<td>Distressing multiple problems with accommodation (e.g. some basic necessities absent); housing environment has minimal or no facilities to improve service user’s independence.</td>
</tr>
<tr>
<td>4</td>
<td>Accommodation is unacceptable (e.g. lack of basic necessities, patient is at risk of eviction, or 'roofless', or living conditions are otherwise intolerable making service user’s problems worse).</td>
</tr>
</tbody>
</table>
Additional notes for Scale 11

The scale requires knowledge of the service user’s usual domestic environment during the period rated, whether at home or in some other residential setting. If this information is not available, rate 7 (not known). Consider the overall level of performance this service user could reasonably be expected to achieve given appropriate help in an appropriate domestic environment.

Take into account the balance of skills and disabilities. How far does the environment restrict, or support, the service user’s optimal performance and quality of life? Do staff know (as they should) what the service user’s capacities are?

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

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

Between these poles, an overall judgement is required as to how far the environment restricts achievable autonomy during the period – 2 indicates moderate restriction and 3 indicates substantial.
Scale 12: Problems with occupation and activities

Rate the overall level of problems with quality of daytime 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 qualified staff, access to supportive facilities, for example staffing and equipment of day centres, workshops, social clubs, etc.

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

Rate the service user’s usual situation. If in an acute ward, rate activities during the period before admission. If information is not available, use the rating 7.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Service user’s daytime environment is acceptable; helpful in keeping any disability rated at Item 10 to the lowest level possible, and supportive of self-help.</td>
</tr>
<tr>
<td>1</td>
<td>Minor or temporary problems e.g. late pension cheques, reasonable facilities available but not always at desired times etc.</td>
</tr>
<tr>
<td>2</td>
<td>Limited choice of activities e.g. there is lack of reasonable tolerance (e.g. unfairly refused entry to public library or baths etc.); or handicapped by lack of a permanent address; or insufficient carer or professional support; or helpful day setting available but for very limited hours.</td>
</tr>
<tr>
<td>3</td>
<td>Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access.</td>
</tr>
<tr>
<td>4</td>
<td>Lack of any opportunity for daytime activities makes service user’s problem worse.</td>
</tr>
</tbody>
</table>
Additional notes for Scale 12

The principles considered at Scale 11 also apply to the outside environment. Consider arrangements for encouraging activities such as: shopping; using local transport; amenities such as libraries; understanding local geography; possibly physical risks in some areas; use of recreational facilities.

Take into account accessibility, hours of availability, and suitability of the occupational environment provided for the service user at day hospital, drop-in or day centre, sheltered workshop, etc. Are specific (for example educational) courses available to correct deficits or provide new skills and interests? Is a sheltered outside space available if the service user is vulnerable in public (for example, because of odd mannerisms such as talking to themselves)? For how long is the service user unoccupied during the day? Do staff know what the service users capacities are?

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

» If the level of autonomy in daytime activities is not restricted, rate 0. A less full but adequate regime is rated 1.

» If minimal conditions for daytime activities are not met (with the service user severely neglected and/or with virtually nothing constructive to do), rate 4.

» Between these poles, a judgement is required as to how far the environment restricts achievable autonomy; 2 indicates moderate restriction and 3 indicates substantial.
## Important variations in rating guidelines

<table>
<thead>
<tr>
<th>Scale</th>
<th>Rate the worst manifestation</th>
<th>Rate over the past two weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale 1-8</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>Scale 9-10</td>
<td>Based on usual or typical</td>
<td>Always</td>
</tr>
<tr>
<td>Scale 11-12</td>
<td>Based on usual or typical</td>
<td>May need to go back beyond two weeks to establish the usual situation</td>
</tr>
</tbody>
</table>
Clinical significance and recommended action

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

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

<table>
<thead>
<tr>
<th>Clinically Significant</th>
<th>Monitor</th>
<th>Active treatment or management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe to very severe problem</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 3 | Moderate problem | ✓ | ✓ |
| Warrants recording in clinical file. Should be incorporated in care plan. |

| 2 | Mild problem | ✓ | Maybe |
| Warrants recording in clinical notes. May or may not be incorporated in care plan. |

<table>
<thead>
<tr>
<th>Not clinically significant</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minor problem</td>
<td></td>
</tr>
<tr>
<td>Requires no formal action. May or may not be recorded in clinical file.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 0 | No problem |      |      |
| Problem not present |      |      |
The outcomes training model and guide

**Refresher training for clinicians**
Minimum of two yearly attendance after basic training. Emphasis on inter-rater reliability and clinical pathways.

**Basic outcome training at DHB level for clinicians**
Minimum of one day training. The extent of regional support will depend on DHB/MoH resourcing.

**Refresher training**
Minimum of two yearly to keep certification.

- HoNOS
- HoNOSCA
- HoNOS-LD
- HoNOS-secure
- HoNOS65+

**Foundational training (regional)**
One day modular training. Certification based on *Let's get real*.

**Content**
- Key messages
- Outcomes and recovery
- Engagement
- Feedback
- Inter-rater reliability
- Training skills
- Training resources

**Trainer pre-requisite**
- Clinician familiar with outcome measure
- Minimum of one year using the measure

**7 Real Skills**
- Working with service users
- Working with Māori
- Working with families
- Working with communities
- Challenging stigma/discrimination
- Law, policy and practice
- Professional and personal development

**Prerequisite**
- Foundational training (regional)
  - One day modular training. Certification based on *Let's get real*.

**Refresher training**
Minimum of two yearly to keep certification.

- HoNOS
- HoNOSCA
- HoNOS-LD
- HoNOS-secure
- HoNOS65+

**Link to information use training**
Guide to the training model

Foundational training – Part A

Te Pou will provide the foundational one day training. This training will have a regional focus, in order to indicate to district health boards how they can cooperate and share resources. The training will focus on key messages, engagement, providing service user feedback on outcome scores, inter-rater reliability, training skills and understanding key resources such as the Information Collection Protocol and the clinician rating glossary. All trainers participating in the one day training will need to have familiarity with the outcome tools and at least one year using the measure(s). Te Pou will certify all trainers successfully completing the foundational training at practitioner level using the Let’s get real framework to enable them to complete the specific one day modular courses for the HoNOS family of measures.

Current trainers

Current Mental Health Standard Measures of Assessment and Recovery Initiative (MH-SMART) trainers will be eligible to have their current MH-SMART certification rolled over automatically.

To retain their outcomes training certification they will be required to have completed one refresher training in a two year time period. They will be required to provide a minimum of one training to clinical staff in the same two year period.

Specific outcome measure training – Part B

To attend the specific outcome measure training it is a pre-requisite that trainers have attended the foundation training This training will be certificated to enable trainers to provide training in the specific outcome measure to their clinical staff.
Refresher training for trainers

All trainers will be required to attend a refresher training once every two years. This training will reflect the needs of participants by focusing on the outcome tools of participating individuals. In time, dependant on demand, there may be a need for refresher training for specific outcomes measures.

DHB/regional level training to clinicians

Trainers will be expected to provide training at their local level (DHB or regional dependant on resourcing), using the resources provided from the foundation, specific outcome measure training and refresher training. This training should aim to be at least one day in length. Te Pou will make available expected content for this training to provide guidance to trainers.

Refresher training to clinicians

All clinicians are expected to attend some form of refresher training within a two year period following their basic training. This training needs to be provided by certified trainers. Te Pou’s online training resource may prove invaluable for this.

There is currently a variation in the way refresher training is provided. Te Pou will provide some guidance to trainers on the content of this refresher training.
Information use training

Connected to the outcome training model (available from www.tepou.co.nz) is the need for training in using information. Te Pou are contracted to provide training to specific sector groups in using information. A strong focus of this training will be using outcomes information. The sector groups are clinicians, service users, non-government organisations (NGO’s), managers and family facilitators as indicated in the simple model on the right.

Best practice training model

The best practice training model is one which has training provided by clinicians and service users jointly where practicable. Collaboration between clinicians and service users is fundamental to modelling best practice.

It is a matter of clinical judgement how clinicians collaborate with service users, for example scoring the HoNOS with the service user present or after the clinical interview. Important to note, the HoNOS is not itself sufficient as the basis for a comprehensive clinical interview but it can be part of an interview.
What are my responsibilities as a trainer?

Trainers are responsible for organising basic training and refresher training sessions at their respective DHBs. Please note that access to the Trainers’ Forum is only available to those who are certified trainers. DHB Site Coordinators are also available to provide support to trainers. Here is a suggested outline for delivering the one day clinician training for HoNOS.

Session 1
» Background/context to outcomes in New Zealand.
» Inter-rater reliability.

Session 2
» Introducing HoNOS.
» Background to the measure.
» Items structure/focus of care.
» Rating rules/clinically significant issues.

Session 3
» Practicing working through the scales.

Session 4
» Practicing scoring a vignette with DVD.

As for refresher training, trainers can cover the Clinicians’ Reference Guide, ICP and Glossary and have a practice rating. Trainers can use the written vignettes and films available on Te Pou’s online training webpage for the practice ratings.
Training information and other resources

Trainers can register for the online ‘Trainers’ Forum at [www.tepou.co.nz/forum](http://www.tepou.co.nz/forum).

Te Pou provides HoNOS training online on their website, [www.tepou.co.nz](http://www.tepou.co.nz).

This is an online training tool that has been designed to assist clinicians to become more proficient in using HoNOS through the use of case studies. The case studies consist of a written vignette and a short video/film. This online training tool is an excellent resource for refresher training. Clinicians can use the tool by following a four step process:

1. read a case study
2. watch the video
3. complete the rating form
4. check the results.

**HoNOS feedback scenario videos** are available on Te Pou’s website, [www.tepou.co.nz](http://www.tepou.co.nz). The 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.

**Te Pou’s HoNOS tool** is available online and for iOS and Android devices. This free tool was developed to integrate information into your clinical practice, anytime, anywhere. Use the tool to collect ratings for any of the HoNOS family of measures. You can then view past collections, compare results over time, share a service user’s results with them and track when collections are due. The dashboard feature helps you to quickly understand your caseload numbers and severity, plus other useful snapshot statistics about your work. Visit [www.tepou.co.nz/honos](http://www.tepou.co.nz/honos) to learn more.
An Outcomes Graph Builder is available on Te Pou’s website, www.tepou.co.nz. This is a simple 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 a service user 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.

Alternative online training options are available on the Australian Mental Health Outcomes and Classification Network (AMHOCN) website.

Te Pou provides an annual National Trainers’ Day which is a one day workshop for existing trainers. Te Pou also provides occasional forums (mini conferences) and conferences about outcomes information. More information about these various workshops, forums and conferences can be found on Te Pou’s training calendar.

The Australasian Mental Health Outcomes and Information Conference (AMHOIC) This event is jointly hosted by Te Pou and Australasian Mental Health Outcomes and Classification Network (AMHOCN). The AMHOIC is a bi-annual conference to explore the various research and training that is currently being done around outcomes information within New Zealand and Australia. Te Pou provides video links to keynote speakers from the AMHOIC which can be found at www.tepou.co.nz.
Outcomes information use

Outcome information can be used in many ways.

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:

» assists with developing clinical pathways
» supports quality mental health assessments, intervention and recovery planning
» improves service delivery and clinician responsiveness to Maori
» improves opportunities for whanau/family 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 to view at www.tepou.co.nz.

The Story of Change ‘Nothing about us without us’ profiles the West Coast DHB and their efforts to share information with service users, available at www.tepou.co.nz.
**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 has resources about how HoNOS outcomes information can be used within a team setting, which can be found on the website [www.tepou.co.nz](http://www.tepou.co.nz).

Uses at team level:
- allocation of referrals
- severity of caseloads across the team
- workforce planning
- discharge planning.

**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.

Uses at service level:
- benchmarking with other DHBs
- PRIMHD outcome reports ([see page 39](#))
- workforce planning
- service performance and accountability framework
- research
- quality initiatives
- service development.

Use of HoNOS information at a service level can help to inform service and workforce planning.
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.
How we use outcomes data collected in clinical practice

PRIMHD (pronounced ‘primed’) is the programme for the integration of mental health data. It is The Ministry of Health’s national collection of activity and outcomes data, in mental health and addictions.

Every three months, Te Pou provides each DHB with reports based on HoNOS from PRIMHD data. These DHB reports use outcomes data collected as part of clinical practice to provide an overall picture of data quality and show how the DHB is performing against national targets.

Each summary is made up of:

1. collection completion and validity – shows teams and services the quality of the data
2. outcomes related information – gives signals of what has changed over time for service users
3. service related information – looks at how a service performs.

You can view the latest national PRIMHD outcomes summary reports on the Te Pou website, www.tepou.co.nz.

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.
## Outcomes in New Zealand - Key milestones

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>DHBs received crown funding agreements with the Ministry of Health for using outcomes measurement.</td>
</tr>
<tr>
<td>2003</td>
<td>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.</td>
</tr>
<tr>
<td>2005</td>
<td>The Mental Health Standard Measures of Recovery Initiative (MH-SMART) was established. 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.</td>
</tr>
<tr>
<td>2008</td>
<td>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. 1 July, HoNOS, HoNOS65+ and HoNOSCA were mandated as part of the national collection for PRIMHD.</td>
</tr>
<tr>
<td>2009</td>
<td>The Ministry of Health funded the development of a Key Performance Indicator (KPI) Framework. The purpose of this 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. (Since 2012 NDSA is known as Northern Regional Alliance.)</td>
</tr>
</tbody>
</table>
Te Pou foundational training and one-day suite of measures training replaced MH-SMART training.

National and service level PRIMHD outcomes reports were made available for the first time.

July 1st, HoNOS-secure and HoNOS-LD were mandated as part of the national collection for PRIMHD.

Release of Rising to the Challenge Service Development Plan.


July 1st, Alcohol and Drug Outcome Measure (ADOM) is to be mandated as part of the national collection for PRIMHD.

## Psychometric definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliability</td>
<td>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.</td>
</tr>
<tr>
<td>Validity</td>
<td>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.</td>
</tr>
<tr>
<td>Sensitivity to therapeutic change</td>
<td>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.</td>
</tr>
<tr>
<td>Key concepts</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Service setting</td>
<td>Setting in which the mental health service is provided, either inpatient or community.</td>
</tr>
<tr>
<td>Episode of care</td>
<td>An episode of mental health care for the purposes of outcomes collection is used to refer to a period of contact between a service user and mental health service within the same setting and has discrete start and end points.</td>
</tr>
<tr>
<td>Period of care</td>
<td>Interval within an episode of care between one collection occasion and the next.</td>
</tr>
<tr>
<td>Collection occasion</td>
<td>An occasion during an episode of mental health care when the outcome measures and case complexity information set are collected in accordance with the collection protocol.</td>
</tr>
<tr>
<td>Age group</td>
<td>Outcome measures to be reported at a particular collection occasion depend on the broad age group to which the service user is assigned, i.e. child and youth, adult or older person.</td>
</tr>
<tr>
<td>Mental health service team</td>
<td>Identifying the service user’s primary mental health service team is important when tracking a service user’s movement within an episode of care and essential for comparing service user data within each team.</td>
</tr>
<tr>
<td>Admission date</td>
<td>Either actual date of admission (inpatient service) or date the service user was first seen by the service (community service).</td>
</tr>
<tr>
<td>Collection occasion date</td>
<td>Start of episode, review of episode, end of episode.</td>
</tr>
<tr>
<td>Reason for collection</td>
<td>Understanding the nature of events triggering new episode, end of episode and review is necessary for subsequent informed analysis and these considerations will be captured within the reason for collection.</td>
</tr>
<tr>
<td>Focus of care</td>
<td>Identifies the principal clinical intent of the care provided during the period of care preceding the collection occasion and cover four alternatives; acute, functional gain, intensive extended and maintenance.</td>
</tr>
</tbody>
</table>
Frequently asked questions (FAQs)

**What are psychometric properties?**

The psychometric properties of instruments and measures are used to determine their quality and usefulness in the required setting. These properties are split into reliability, validity and sensitivity to therapeutic change.

**Which tool do I use and when?**

The age related measures are collected based on age. This age restriction can be overridden by clinicians where use of other measures may be more appropriate. However, as a general rule HoNOS is used for adults aged 18-65 years.

HoNOS-LD is collected when there is a team type identified in PRIMHD who are working with people who have an intellectual disability plus mental health problems.

HoNOS-secure is collected when there is a forensic team identified in PRIMHD who are working with people with recognised forensic problems.

Refer to the Information Collection Protocol for further detail, [www.tepou.co.nz](http://www.tepou.co.nz).

**If a service user is seen by more than one service within the same DHB area, should each service complete a HoNOS?**

No – the clinician who knows the service user the best should record the ratings, taking into account information from the full range of services with which the service user is involved. In inpatient care the measures are completed by the inpatient service. In community services, the key worker should complete the rating or alternately a decision is made as to which service would be responsible for completing the rating.

**If a service user is transferred from one DHB to another, should a new episode of care be collected?**

Yes – the completion of treatment at one DHB and the commencement of treatment at another are considered separate episodes of care, therefore a new episode of data collection should begin. In the process of transfer information shared between DHB providers will ultimately inform the data collection.
Can information obtained through outcome measures be used to compare individual staff performance?

No – outcomes information will not be used to compare individual staff performance, HoNOS is not a performance management tool. HoNOS ratings on their own say little about the care provided by an individual clinician, the treatment setting, diagnosis, available intervention used, changes recorded and improvements made.

How do I become a HoNOS trainer for my DHB?

Trainers need a certificate in Part A and B to be able to train other clinicians in the use of HoNOS. After completing Part A training, trainers will then attend a one day modular training on HoNOS (Part B). Trainers can then provide a minimum one day basic outcomes training at their respective DHBs. Trainers are required to have a minimum of a two yearly refresher training to keep certification.

What about Let’s get real?

The outcomes training is based on the competencies identified in Let’s get real. There are seven Real Skills.

» Working with service users.
» Working with Māori.
» Working with families.
» Working with communities.
» Challenging stigma/discrimination.
» Law, policy and practice.
» Professional and personal development.
What is the mental health outcomes Information Collection Protocol (ICP)?

The ICP outlines the collection of outcome information, and should be referred to and followed. The ICP details the minimum set of data required to be collected for reporting. DHBs may collect more information. An electronic version of the ICP can be found on the Te Pou website, www.tepou.co.nz.

Do you always rate over the past two weeks?

Yes, generally for all the HoNOS measures except for HoNOS-LD. Please refer to the ICP for further detail.

Where can I locate more information about PRIMHD?

Technical information/documentation about the full PRIMHD data set, along with PRIMHD reporting requirements is available from the PRIMHD website.
Integrate information into clinical practice, anytime, anywhere.

» Collect your HoNOS, HoNOSCA, HoNOS65+, HoNOS-LD and HoNOS-secure ratings.

» Understand your caseload with the dashboard snapshot statistics, invaluable for meetings with your team or manager – input your entire caseload to get the full benefit of the dashboard features.

» Compare an individual’s outcome ratings over time.

» Share individual results with service users – a great way to have meaningful conversations about outcomes with the people you support.

» See when HoNOS collections are due or overdue at a glance.

Visit www.tepou.co.nz/honos to learn more.