HoNOSCA

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

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» Chris Hickson, Team Manager CAMHS, Nelson - Marlborough DHB.

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 - Child and Adolescent 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 HoNOSCA is to ensure good compliance with collections before introducing other mandated measures. The overall compliance target for HoNOSCA 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).

HoNOSCA collects information about a person’s mental health and social functioning using 15 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 HoNOSCA?

Health of the Nation Outcome Scale Child and Adolescent (HoNOSCA) 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. The tool is used specifically with individuals below the age of 18 years.

HoNOSCA measures the symptom severity and social functioning across time. It has 15 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.

HoNOSCA 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 HoNOSCA. Information from all available sources should be considered when completing ratings including the service user and 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 HoNOSCA training Te Pou provides at
www.tepou.co.nz/honos.
When is HoNOSCA used?

HoNOSCA 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).

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

The clinician that 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 at another DHB service are considered separate episodes of care. As such, a new episode of data collection should begin.
**HoNOSCA collection points**

**Episode start**

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

**Review**

**3 month review HoNOSCA**

**Ad hoc review HoNOSCA**
- 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**

**3 month review HoNOSCA**

**Episode end**

**Discharge HoNOSCA**
- Completed when people are discharged from a mental health service (community or inpatient setting).

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

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

**Episode end**
- Completed when people are discharged from a mental health service (community or inpatient setting).
HoNOSCA 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**

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 HoNOSCA, refresher training (minimum of every two years to keep certification), regular practice ratings and consistent use of the glossary.

Studies have shown HoNOSCA 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 HoNOSCA

» 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 15.

» 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 unable to rate.

» 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 HoNOSCA glossary. It is recommended that clinicians refer to the glossary consistently when completing HoNOSCA.

» HoNOSCA should be rated using information available from all sources.
HoNOSCA glossary

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

**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 such as pushing, hitting, vandalism, teasing; or physical or sexual abuse of other children.

Include antisocial behaviour such as thieving, lying, cheating; or oppositional behaviour such as defiance, opposition to authority or tantrums.

☒ Do not include over-activity rated at Scale 2, truancy rated at Scale 13 or self-harm 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 quarrelling, demanding behaviour, undue irritability, lying, etc.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definitely disruptive or antisocial behaviour, lesser damage to property, or aggression, or defiant behaviour.</td>
</tr>
<tr>
<td>3</td>
<td>Moderately severe aggressive behaviour such as fighting, persistently threatening, very oppositional, more serious destruction of property, or moderately delinquent acts.</td>
</tr>
<tr>
<td>4</td>
<td>Disruptive in almost all activities; or at least one serious physical attack on people or animals; or serious destruction of property.</td>
</tr>
</tbody>
</table>
Additional notes for Scale 1

This scale 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 overactivity, 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.

<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>Slight overactivity or minor restlessness, etc.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite overactivity or attention problems, but can usually be controlled.</td>
</tr>
<tr>
<td>3</td>
<td>Moderately severe overactivity or attention problems that are sometimes uncontrollable.</td>
</tr>
<tr>
<td>4</td>
<td>Severe overactivity or attention problems that are present in most activities and almost never controllable.</td>
</tr>
</tbody>
</table>

### Additional notes for Scale 2

This scale 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 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 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.

<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>Occasional thoughts about death, or of self-harm not leading to injury. No self-harm or suicidal thoughts.</td>
</tr>
<tr>
<td>2</td>
<td>Non-hazardous self-harm, such as wrist scratching, whether or not associated with suicidal thoughts.</td>
</tr>
<tr>
<td>3</td>
<td>Moderately severe suicidal intent including preparatory acts (e.g. collecting tablets) or moderate non-hazardous self-harm (e.g. small overdose).</td>
</tr>
<tr>
<td>4</td>
<td>Serious suicidal attempt (e.g. serious overdose), or serious deliberate self-injury</td>
</tr>
</tbody>
</table>

Additional notes for Scale 3

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 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 Scale 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.**

<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 alcohol or drug use, within age norms.</td>
</tr>
<tr>
<td>2</td>
<td>Mildly excessive alcohol or drug use.</td>
</tr>
<tr>
<td>3</td>
<td>Moderately severe drug or alcohol problems significantly out of keeping with age norms.</td>
</tr>
<tr>
<td>4</td>
<td>Severe drug or alcohol problems leading to dependency or incapacity.</td>
</tr>
</tbody>
</table>

### 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 Scale 1, whilst physical illness or disability due to alcohol or drug use would be rated at Scale 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.

<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 impairment within the normal range of variation.</td>
</tr>
<tr>
<td>2</td>
<td>Minor but definite impairment of clinical significance.</td>
</tr>
<tr>
<td>3</td>
<td>Moderately severe problems, below the level expected on the basis of mental age, past performance, or physical disability.</td>
</tr>
<tr>
<td>4</td>
<td>Severe impairment, much below the level expected on the basis of mental age, past performance, or physical disability.</td>
</tr>
</tbody>
</table>

Additional notes for Scale 5

This scale 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.

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

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.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of abnormal thoughts or perceptions 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>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).</td>
</tr>
<tr>
<td>3</td>
<td>Moderate preoccupation with abnormal thoughts or perceptions or delusions; hallucinations, causing much distress, or manifested in obviously bizarre behaviour.</td>
</tr>
<tr>
<td>4</td>
<td>Mental state and behaviour is seriously and adversely affected by delusions or hallucinations or abnormal perceptions, with severe impact on the person or others.</td>
</tr>
</tbody>
</table>
Additional notes for Scale 7

This scale addresses all hallucinations, delusion 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 Scale 1). Overactive behaviour, for example, in hypomania should also be rated elsewhere (Scale 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 Item 6
- Do not include physical illnesses that complicate non-organic somatic symptoms, 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>Slight problems only, such as occasional enuresis, minor sleep problems, headaches or stomach aches without organic basis.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite problem with non-organic somatic symptoms.</td>
</tr>
<tr>
<td>3</td>
<td>Moderately severe, symptoms produce a moderate degree of restriction in some activities.</td>
</tr>
<tr>
<td>4</td>
<td>Very severe problems or symptoms persist into most activities. The child or adolescent is seriously or adversely affected.</td>
</tr>
</tbody>
</table>

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 Scale 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 overactivity behaviours attributed to fears of phobias, rated at Scale 1.

Do not include physical complications of psychological disorders, such as severe weight loss, rated at Scale 6.

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

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 Scale 1. Physical complications of psychological disorders such as severe weight loss should be rated at Scale 6. If a child has two or more symptoms in this category, choose only the most severe.

Scale 10 to 13 (ratings of social functioning and autonomy) unlike Scale 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 (Scale 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.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No significant problems during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Either transient or slight problems, occasional social withdrawal.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite problems in making or sustaining peer relationships. Problems causing distress due to social withdrawal, over-intrusiveness, rejection or being bullied.</td>
</tr>
<tr>
<td>3</td>
<td>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).</td>
</tr>
<tr>
<td>4</td>
<td>Severe social isolation with hardly any friends due to inability to communicate socially or withdrawal from social relationships.</td>
</tr>
</tbody>
</table>

### 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 Scale 1. Difficulties within the family or with siblings are rated under Scale 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, for example 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.

<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; good ability to function in all areas</td>
</tr>
<tr>
<td>1</td>
<td>Minor problems (e.g. untidy, disorganised).</td>
</tr>
<tr>
<td>2</td>
<td>Self-care adequate, but major inability to perform one or more complex skills (see above).</td>
</tr>
<tr>
<td>3</td>
<td>Major problems in one or more areas of self-care (e.g. eating, washing, dressing) or major inability to perform several complex skills.</td>
</tr>
<tr>
<td>4</td>
<td>Severe disability in all or nearly all areas of self-care or complex skills.</td>
</tr>
</tbody>
</table>

**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.
HoNOSCA – a New Zealand clinician's guide to ratings and use

Scale 12: Problems with family life and relationships

 ✓ Include parent-child and sibling relationship problems.

 Include relationships with foster parents, social workers 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.

 X Do not include aggressive behaviour by the child or adolescent, rated at Scale 1.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems during the period rated.</td>
</tr>
<tr>
<td>1</td>
<td>Slight or transient problems.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite problem (e.g. some episodes of neglect or hostility or enmeshment or overprotection).</td>
</tr>
<tr>
<td>3</td>
<td>Moderate problems, e.g. neglect, abuse, hostility. Problems associated with family or carer breakdown or reorganisation.</td>
</tr>
<tr>
<td>4</td>
<td>Serious problems with the child or adolescent feeling or being victimised, abused or seriously neglected by family or carer.</td>
</tr>
</tbody>
</table>
Additional notes for Scale 12

Usually this scale 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 institutions and with the 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 reorganisation 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 Scale 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, for example hospital school, home tuition, etc. If school holiday, rate the last two weeks of the previous term.

<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>Slight problems (e.g. late for two or more lessons).</td>
</tr>
<tr>
<td>2</td>
<td>Definite but mild problems (e.g. missed several lessons because of truancy or refusal to go to school).</td>
</tr>
<tr>
<td>3</td>
<td>Marked problems, absent several days during the period rated.</td>
</tr>
<tr>
<td>4</td>
<td>Severe problems, absent most or all days. Include school suspension, exclusion or expulsion for any cause during the period rated.</td>
</tr>
</tbody>
</table>

**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 scales, future intentions should not be rated, thus a school refusing a child expressing intention to return after the school holidays would score on this scale until satisfactory school attendance had been achieved.

*The above 13 items in Section A are generally summed to give a total score. The additional two 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.*
**Scale 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.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems during the period rated. Parents and carers have been adequately informed about the child or adolescent’s problems.</td>
</tr>
<tr>
<td>1</td>
<td>Slight problems only.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite problems.</td>
</tr>
<tr>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>Very severe problems. Parents have no understanding about the nature of their child or adolescent’s problems.</td>
</tr>
</tbody>
</table>

### Additional notes for Scale 14

This scale 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.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems during the period rated. The need for all necessary services has been recognised.</td>
</tr>
<tr>
<td>1</td>
<td>Slight problems only.</td>
</tr>
<tr>
<td>2</td>
<td>Mild but definite problems.</td>
</tr>
<tr>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>Very severe problems. Parents have no information about appropriate services or professionals do not know where a child should be managed.</td>
</tr>
</tbody>
</table>

### Additional notes for Scale 15

This scale 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 education provision.
### 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 1-9</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>Scale 10-15</td>
<td>Based on usual or typical</td>
<td>Always</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 HoNOSCA ratings.

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

<table>
<thead>
<tr>
<th>Clinical Significance</th>
<th>Monitor</th>
<th>Active treatment or management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4</strong> 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>
<tr>
<td><strong>3</strong> Moderate problem</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Warrants recording in clinical file. Should be incorporated in care plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> Mild problem</td>
<td>✓</td>
<td>Maybe</td>
</tr>
<tr>
<td>Warrants recording in clinical file. May or may not be incorporated in care plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1</strong> Minor problem</td>
<td>Maybe</td>
<td>x</td>
</tr>
<tr>
<td>Requires no formal action. May or may not be recorded in clinical file.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>0</strong> No problem</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Problem not present</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

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
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 certificate they will be required to have completed one refresher day training in a two year time period. They will be required to provide a minimum of one training to their 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 is 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 HoNOSCA with the service user present or after the clinical interview. Important to note, the HoNOSCA 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 HoNOSCA.

**Session 1**

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

**Session 2**

» Introducing HoNOSCA.
» Background to the measure.
» Items structure
» 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.

Te Pou provides HoNOSCA training online on their website, www.tepou.co.nz.

This is an online training tool that has been designed to assist clinicians to become more proficient in using HoNOSCA 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.

HoNOSCA feedback scenario videos are available on Te Pou’s website, www.tepou.co.nz. The scenario videos depict clinicians providing feedback on HoNOSCA 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 HoNOSCA scores or where the service user requests to see their HoNOSCA 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 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 HoNOSCA 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 handy way to show service user their HoNOSCA 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. HoNOSCA 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 HoNOSCA 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.

HoNOSCA 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 HoNOSCA can include both individual and aggregated HoNOSCA information. This is the only level that can benefit from both individual and aggregated information. Te Pou has resources about how HoNOSCA 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
» workforce planning
» service performance and accountability framework
» research
» quality initiatives
» service development.

Use of HoNOSCA 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 HoNOSCA 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 HoNOSCA 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](http://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>
</tbody>
</table>
| 2008 | 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 |
| 2009 | The Ministry of Health funded the development of 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.) |
2009

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.

2012

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

Release of Rising to the Challenge Service Development Plan.

2013


2015

1 July, 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>
</tbody>
</table>
### Information Collection Protocol (ICP) key concepts

<table>
<thead>
<tr>
<th>Key concepts</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<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>
</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 HoNOSCA is used for children and adolescents aged 3-18 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.


If a service user is seen by more than one service within the same DHB area, should each service complete a HoNOS65+?

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; HoNOSCA is not a performance management tool. HoNOSCA 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 HoNOSCA trainer for my DHB?

Trainers need a certificate in Part A and B to be able to train other clinicians in the use of HoNOSCA. After completing Part A training, trainers will then attend a one day modular training on HoNOSCA (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.