

National outcomes collection

Mental health outcomes information collection protocol (ICP)

Version 2.2, June 2015.



Document control

References	Name
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Version control

For detailed changes see ‘What’s new’ section for changes since the last version

Version	Date	Status	Description of changes
Draft 0.5	07 May 2008	Initial document drafted	<ul style="list-style-type: none"> John Beveridge & Ryan Papps.
Draft 1.0	27 June 2008	Updated	<ul style="list-style-type: none"> inclusion of comments from site coordinators and ICP review group.
Draft 1.5	01 July 2008	Updated	<ul style="list-style-type: none"> inclusion of acknowledgements and modification of content of section on PRIMHD.
Release version 1.2	31 July 2008	Final amendments	<ul style="list-style-type: none"> note this release version is prepared for the website and is identified as version 1.2 to align with the PRIMHD file specification.
Draft 1.3	02 February 2011	Additions	<ul style="list-style-type: none"> of HoNOS secure and HoNOS-LD measures glossaries for review by expert group clarification of RFC brief episode of care for inpatient settings being “three consecutive days or less”.
Release version 2.0	23 March 2011	Amendments	<ul style="list-style-type: none"> to clarify use of HoNOS secure glossary.
2.1	June 2012	Updated	<ul style="list-style-type: none"> update branding and format.
2.2	June 2015	Updated	<ul style="list-style-type: none"> update branding and format remove ICP change log - same information captured in version control update ‘what’s new in version 2.2’ move and consolidate ‘General rating guidelines’ and ‘2009 international version’ information to beginning of glossary in HoNOS secure move clinical significance and recommended actions tables for ‘security scales A-G’ and ‘12 items’ in HoNOS secure check and update all references and links to websites add HoNOS copyright information from RCPsych.

Acknowledgments

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- MH-SMART Initiative Information Collection Protocol, V1.2, October 2006
- Queensland Health Outcomes Collection Protocol, V1.5, July 2005
- HoNOS-LD: Dr Ashok Roy, Psychiatrist, North Warwickshire NHS trust; Dr Helen Matthews, Psychiatrist, Pembrokeshire and Derwen NHS Trust; Dr Paul Clifford, Director, CORE, British Psychological Society; David Martin, Clinical audit coordinator, North Warwickshire NHS Trust and Vanessa Fowler, Psychologist, Kingston and District Community NHS Trust
- HoNOS secure: Dr Philip Surgarman and Lorraine Walker, St Andrews Healthcare and Royal College of Psychiatrists, UK

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About this document

The aim of this document is to provide a guide to staff involved with the collection of mental health outcome information (formerly known as MH-SMART information) to be reported under the Programme for the Integration of Mental Health Data (PRIMHD) mental health information programme.

This document outlines the outcome information required to be collected (including the first outcome tool, the HoNOS suite of measures), when it is required to be collected, and includes a frequently asked questions section covering common questions about the collection process.

Note that this document outlines only the minimum set of data required to be collected for national outcomes reporting. District health boards (DHBs) may collect more information as part of this process.

Technical information or documentation about the full PRIMHD data set, along with PRIMHD reporting requirements is available from the PRIMHD website: <http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data>.

The ICP document may be downloaded in PDF format for printing but is uncontrolled unless viewed electronically from its original location.

What's new in version 2.2

No new content has been added in this version.

Further information on the implementation of HoNOS in New Zealand can be found on Te Pou's website, www.tepou.co.nz. Background on the development of the HoNOS family of measures in the United Kingdom can be found on the Royal College of Psychiatrists website <http://www.rcpsych.ac.uk/>.

Programme for the Integration of Mental Health Data (PRIMHD)

PRIMHD is about developing a national integrated mental health information collection. The integration of two former separate data collections, *Mental Health Information National Collection (MHINC)* and the *Mental Health Standard Measures of Assessment and Recovery (MH-SMART)*, has enabled the sector to link information on service user service provision (MHINC) with outcomes (MH-SMART).

The vision is to assist in the improvement of health outcomes for all mental health service users in New Zealand by providing a single rich data source of national mental health information.

PRIMHD¹ is one of nine priority projects described in the implementation plan of the *National Mental Health Information Strategy (2006)*².

The collection of quality outcome data will progress the development of a national dataset that supports a better and more detailed **understanding of changes in health, wellbeing and circumstances** for those accessing mental health services.

The dataset will also provide services with valuable information to support planning activities. For this reason, it is important that the sector continues to maintain momentum embedding the collection of outcome measures into routine practice and, at the same time, works on integrating that information with the current national data collection, MHINC.

Who receives what services, by whom, with what effect (outcome)

Question	Answer	Former information source
Who receives?	Demographic and clinical characteristics of mental health service users	<ul style="list-style-type: none">• MHINC• MH-SMART
What services?	Details of mental health services delivered	<ul style="list-style-type: none">• MHINC for volume and service type
From whom?	Service characteristics	<ul style="list-style-type: none">• MHINC for team type
With what effect?	Service user outcome data such as severity of symptoms	<ul style="list-style-type: none">• MH-SMART• MHINC• Knowing the People Planning (KPP)

¹<http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data>

²<http://www.health.govt.nz/publication/national-mental-health-information-strategy-implementation-plan-2006>

Scope of information collection protocol (ICP)

The scope of the Mental Health Outcomes Information Collection Protocol (ICP) currently covers all DHB mental health services (with NGO services to be added at a later date). This includes all DHB mental health inpatient services and community services, as well as forensic mental health services and intellectual disability mental health services. Some exclusion may apply – see frequently asked questions.

Purpose of outcome data to be collected

The protocol accommodates both the outcomes and case complexity (casemix) objectives of the *National Mental Health Information Strategy (2006)*³. These are not identical.

- Measurement of service user outcomes by definition presumes a comparison over time and requires information to be collected on at least two occasions in order to allow assessment of change in the service user's health status.
- Case complexity requirements need key information items to be collected during each episode to allow each period of care within the episode to be adequately described and classified. From a case complexity perspective, the only issue is to ensure that information is collected at the most appropriate point within the overall episode of care.

The standard measures will be used for the purpose of measuring service user outcomes or case complexity, or both. The following table summarises the data to be collected across the various service user groups and the purposes for collection. In general, many of the measures will be used for both outcomes evaluation purposes and case complexity.

Information to be collected and the purpose of collection	Age group			Purpose	
	Child and youth	Adults	Older adults	Outcomes evaluation	Case complexity
Clinical measurement scales					
Health of the Nation outcomes scales (HoNOSCA, HoNOS, HoNOS65+, HoNOS Secure and HoNOS-LD)	•	•	•	•	•
Focus of care		•	•	○	•
Other clinical items available in PRIMHD data set					
Mental health legal status	•	•	•	○	•
Principal and additional diagnosis	•	•	•	○	•

- indicates the information will be used for the specific purpose of building casemix classification or measuring outcomes.
- indicates the information is not an outcomes measure as such, but is important for the interpretation of outcome data.

³<http://www.health.govt.nz/publication/national-mental-health-information-strategy-implementation-plan-2006>

Key concepts underpinning the ICP

The ICP is based on a number of key concepts.

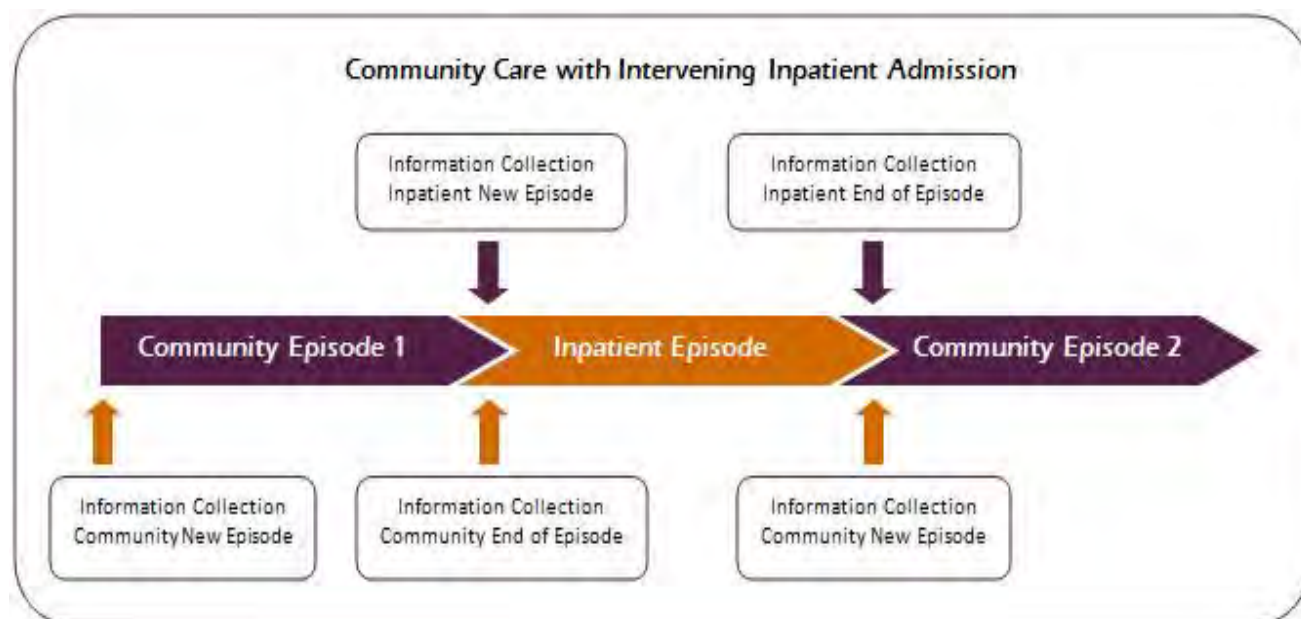
Service setting

The service setting denotes the setting in which the mental health service is provided. This can either be *inpatient* or *community*.

Episode of care

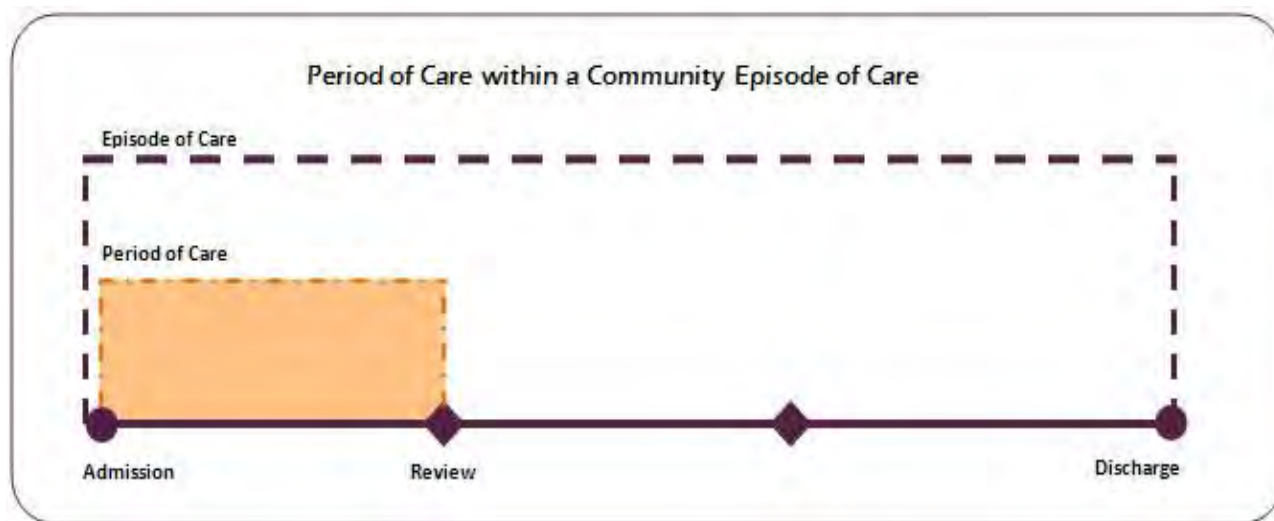
The concept of episodes is widely used throughout the health system as a method to describe the activities of health services. An episode of mental health care for the purposes of outcomes collection is used to refer to a period of contact between a service user and mental health service within the same setting, and has discrete start and end points. It is defined as a more or less continuous period of contact within a mental health service setting.

By definition, a service user may only be the subject of one such 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.



Period of care

The period of care is the interval within an episode of care between one collection occasion and the next.



Collection occasion

A collection occasion is defined as 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.

Collection occasions generally occur at the following times.

New episode

Commencing within a service setting. The new episode of mental health care begins when the service user commences treatment with a mental health service setting. This may be marked by an objective event like service user admission to an inpatient unit. In the community, a new episode would be recorded if:

- a service user currently receiving no mental health service care is admitted into a mental health service, or
- when a service user moves between settings and begins a new episode of care.

The beginning of a new episode acts as a 'trigger' for a specific set of information to be collected.

Note: If an assessment of a new service user in the community determines that no further mental health service care will be provided, then an assessment only collection occasion is required.

Review - three month (standard 91 days)

This collection occasion refers to the point at which the service user has been under three months' of continuous care within the same service setting, either since the episode commenced, or since the last review was completed within the current episode.

Review other (ad hoc)

This collection occasion identifies other situations which may trigger a review earlier than the 91 day standard review occasion. These may include when a service user:

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

District health boards (DHBs) may choose to generate local rules about when to complete ad hoc reviews.

Ad hoc collections will not reset the standard three month review process, unless the ad hoc review occurs within the required timeframe for a three month review (refer RFC 05), where they may be considered as the planned three month review.



End of episode

Within a mental health service setting. End of episode occurs when no further treatment or care is planned in the current service setting. This includes discharge from an inpatient team, and/or when the service user no longer requires treatment or care from a community team. Regardless of the reason, the end of an episode acts as a 'trigger' for a specific set of clinical data to be collected. A change in mental health service setting marks the end of one episode and the beginning of another.

Age group

The outcome measures to be reported at a particular collection occasion depend on the broad age group to which the service user is assigned (child and youth, adult or older person). The exception is for children under the age of four years, who are currently not in scope for the collection of outcome measures.

Generally, throughout mental health services, adults are defined as persons between the age of 18 and 64 years inclusive, older people are defined as persons aged 65 years and older and children and youth are defined as persons under the age of 18 years.

However, clinical or organisational factors sometimes require that a service user be assigned to a different age group to that which they would be assigned on the basis of their biological age. For example, a person aged 60 years who was being cared for in an inpatient psychogeriatric unit may be assigned to the older people age group. Similarly, a 15 year old in full time employment, living alone or similar, admitted to a general mental health unit, may be assigned to the adult group.

Mental health service team

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.

Admission date

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

Collection occasion date

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

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

Reason for collection

Application of the ICP requires that the defined collection occasion be mapped to a range of key events (such as admission to an inpatient unit or community team, review and discharge) which may occur within the context of an episode of mental health care.

Understanding the nature of the events triggering new episode, end of episode and review is necessary for subsequent informed analysis. For example, it will be desirable to separately analyse the differential outcomes of new service users admitted to community services from those who are admitted to community services following discharge from an inpatient service.

These considerations will be captured within the data item reason for collection (RFC). An explanation for each RFC is outlined below.

Assessment only (RFC 01)

This collection occasion is utilised in the community setting only, and applies in the following situations.

- 1) A person is seen for a maximum of two face-to-face occasions for the purpose of assessment only and the outcome of the assessment was that the person received no further intervention by the health care agency (DHB). Services also delivered 'on behalf of' the service user are not counted as face to face contacts.

- 2) A person is a shared care service user who is being reviewed and whose previous contact with the mental health community service occurred more than 91 days previously. The measures will be collected by the community team worker. Assessment only collections are required to be completed within one week of assessment.

Outcomes episode start collection occasions

New referral (RFC 02)

This applies in any case where a person is admitted into care in a mental health service setting which does not involve their transfer from care from another mental health service setting within the same DHB mental health service. It includes self-referrals, referrals from family members or other caregivers, referrals from private medical practitioners, including General Practitioners (GPs) and private psychiatrists.

New referral collections are required to be completed within two weeks of assessment in the community, or within 24 hours in an inpatient setting.

Transfer (admission) from other setting (RFC 03)

This category principally refers to the start of an episode when transfers between mental health service settings occur, for example, community to inpatient, or, inpatient to community within the same health care agency (DHB).

It does not include transfers from acute psychiatric inpatient units to specialised, high acuity inpatient facilities and transfers from specialised, high acuity inpatient facilities to acute psychiatric inpatient units within the same hospital.

It does not include cases where a person in community mental health care has responsibility for their care taken over by a second service team providing more intensive community mental health care for several days or weeks.

Complete referral documentation, including the appropriate standard measures, may be made available to the admitting unit at the time the transfer takes place. The staff member responsible for the completion of the first comprehensive clinical assessment is responsible for ensuring that the standard measures are collected and recorded as required. Information provided by the referring service may be used to inform the comprehensive admission assessment.

Transfer (admission) from other setting collections are required to be completed within two weeks of assessment in the community, or within 24 hours in an inpatient setting.

Episode start other (RFC 04)

The decision to ascertain and record information in response to an admission not classifiable under the preceding alternatives should be treated as an episode start other. This may include transfers from other mental health service settings outside the admitting DHB, including from private psychiatric hospitals. Episode start other collections can be completed as required.

Outcomes episode review collection occasions

Review - three month (RFC 05)

This is the standard mandatory review to be conducted at intervals of 13 weeks (91 days) in all DHB mental health service settings. This interval of 13 weeks is identified as the routine clinical review interval and is also the standard interval for the collection of outcomes and casemix information.

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

Review - other (RFC 06)

The decision to ascertain and record information at a clinical review conducted in response to any other event not classifiable under the preceding alternatives needs to be addressed by local policies. This can include any of the reviews identified in the National Mental Health Standards 2001, Standard 16.11.

Review - other collections can be completed as required.

Outcomes episode end collection occasions

No further care (RFC 07)

This category refers to occasions where a person is discharged from a mental health service setting without referral for further treatment in any mental health service setting in any DHB. Included under this category are instances where a person is referred to a private medical practitioner, or is simply discharged to their usual residence.

The clinical staff member responsible for the discharge of the service user is responsible for ensuring that the standard measures to be collected at discharge are completed and recorded as required. This includes both clinician-rated and the associated individual data items.

No further care collections are required to be completed within one week of episode end in the community, and within three days in an inpatient setting.

Transfer (discharge) to other setting (RFC 08)

This category principally refers to the end of an episode when transfers between service settings occur, for example, community to inpatient, or, inpatient to community

It does not include cases where a service user already in community mental health care has responsibility for their care taken over by a second service team providing more intensive community mental health care for several days or weeks. It also does not include transfers from general acute psychiatric inpatient units to specialised high-acuity inpatient facilities and vice versa.

The clinical staff member responsible for the discharge and referral of the service user should complete the required clinician-rated measures and period of care data.

Transfer (discharge) to other setting collections is required to be completed within one week of episode end in the community, or three days in an inpatient setting.

Lost to care (including AWOL and discharged at own risk) (RFC 09)

In inpatient psychiatric care settings this category refers to the case where a service user has left care against advice, has been discharged at their own risk, or has otherwise been “lost to care”. The need for ongoing care may be probable but not clear because the person cannot be contacted.

The clinical staff member responsible for the discharge of the service user lost to care should complete the required clinician-rated measures and period of care data items.

In a community mental health care setting, this category refers to cases where a service user in need of ongoing care either has been discharged at their own risk due to their having refused such care, or their current whereabouts are unknown and there is no reasonable expectation that they will be located within 13 weeks of their last service contact.

The clinical staff member responsible for the discharge of the service user lost to care should complete the required clinician-rated measures and data items relating to the preceding period of care. Standard measures should be completed where the responsible staff member was able to validly ascertain the service user’s clinical status at the time. If this information is not available then valid ratings cannot be made.

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

Deceased (RFC 10)

The clinical staff member responsible for the discharge of the deceased service user should not complete the required clinician-rated measures but only complete the individual data items identifying the collection occasion and the period of care data.

Note: that this category is not to be used where the client is determined to have been “lost to care” and it is subsequently determined that they have died. However, if the service user is lost to care and dies within three days of being “lost to care” – that should be recorded as (RFC10).

Deceased collections are required to be completed within one week of episode end.

HoNOS, HoNOS65+, HoNOSCA, HoNOS secure and HoNOS-LD is not required to be collected for this RFC.

Brief episode of care (RFC 11)

A very brief episode of inpatient psychiatric mental health care is defined as a length of stay of three consecutive days (72 hours) or less.

A very brief episode of community mental health care is defined as one during which contacts, including either face-to-face or by telephone, have taken place over a period less than 14 days.

Whilst standard measures are not required to be completed, individual data items identifying the collection occasion and the preceding period of care are.

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

HoNOS, HoNOS65+, HoNOSCA, HoNOS secure and HoNOS-LD is not required to be collected for this RFC.

Episode end other (RFC 12)

This category is set aside for instances where the DHB mental health service's policy indicates that there is a definite clinical or administrative need to consider other clinical events not classifiable under the preceding alternatives as constituting the discharge of a service user from an episode of care.

This category includes the discharge of a service user from any mental health service setting in one DHB to any setting in another DHB, for example, transfer from an inpatient unit in one DHB to an inpatient unit in another DHB.

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

Focus of care

The focus of care identifies the principal clinical intent of the care provided during the period of care preceding the collection occasion. It is a global clinical judgment based on the intensity and purpose of the services provided during the period of care. It has implications for the kinds of outcomes that might be expected.

The domain of the focus of care covers four alternatives – acute, functional gain, intensive extended and maintenance – defined as follows.

Acute: The primary goal is the short-term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder.

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

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

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

Identifying the status of the collection

Completion date

The date the measure was actually completed.

Collection status

The status of the data recorded and, if missing information is recorded, the reason for the non-completion of the measure. Collection of this information will facilitate the monitoring of adherence to the data collection protocol.

01 - Complete or partially complete.

07 - Not completed for reasons not elsewhere classified.

08 - Not completed due to protocol exclusion.

09 - Not stated/missing.

Mode of administration

An indicator of the procedure or method used in the ascertainment and recording of the standard measure. For clinician-rated measures it enables ratings completed in the context of a comprehensive clinical assessment to be distinguished from those which were not. Collection of this information will also facilitate the monitoring of adherence to the information collection protocol.

01 - Clinical rating completed following clinical assessment.

02 - Clinical rating completed without clinical assessment (for example, service user unable to be located).

08 - Not applicable (collection not required due to protocol exclusion or not collected for other reasons).

09 - Not stated/missing.

Outcome measure

HoNOS - An instrument developed in the United Kingdom, rated by clinicians to measure change across 12 domains for people using **adult** mental health services.

HoNOS65+ - A modified version of HoNOS for people aged 65 years and above.

HoNOSCA - The child and adolescent equivalent of HoNOS, 15 domains.

HoNOS-LD - Designed for use in measuring types of problems commonly presented by adult service users who have an intellectual disability with mental health needs.

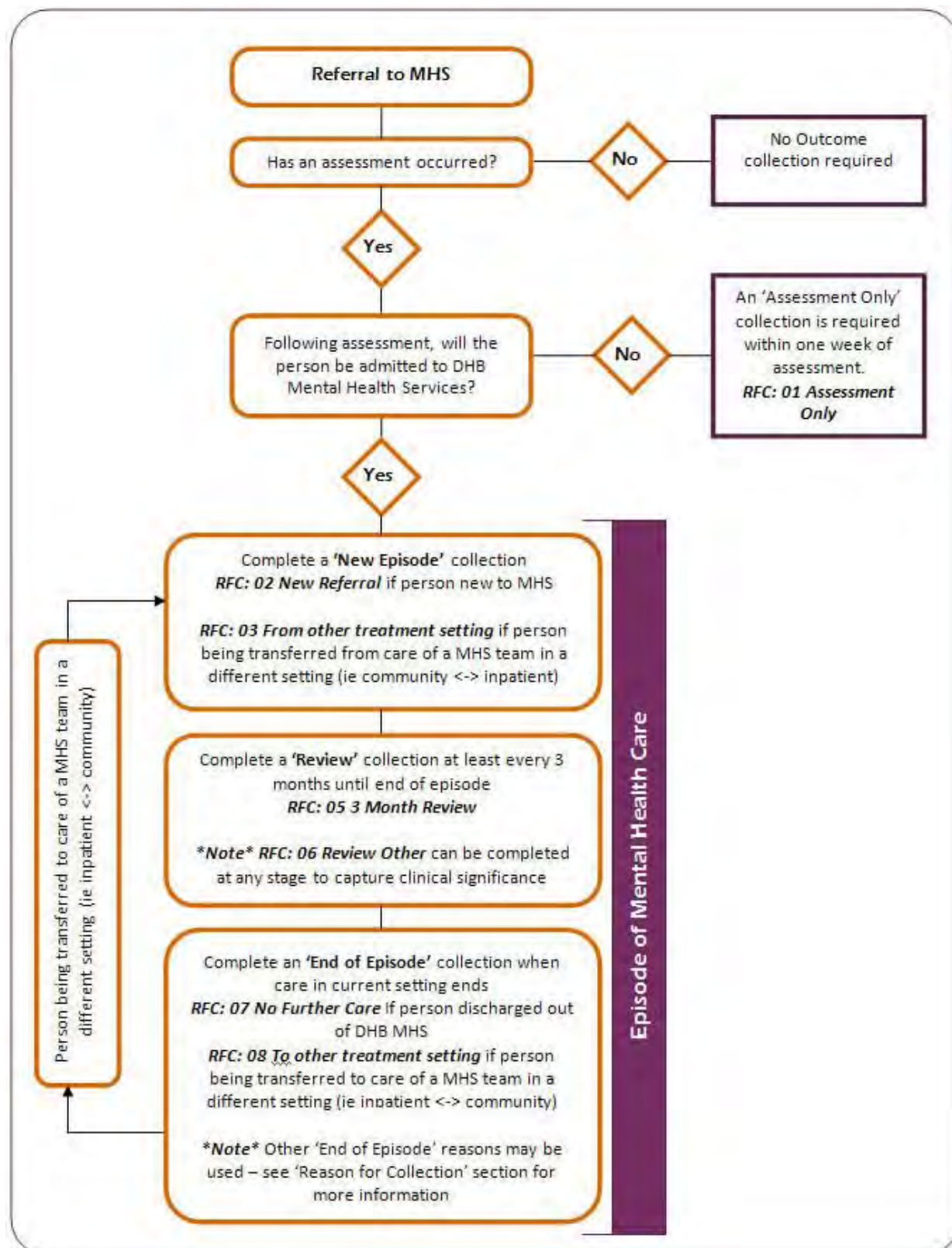
HoNOS secure - Designed for adult service users who are being supported by forensic services.

The HoNOS suite of measures are rated, using the relevant glossary, based on the last **two weeks (with the exception of HoNOS-LD which is rated based on the previous 4 weeks)** of a service users presentation at **all collection occasions. A global exception to this rule is at the end of episode in an inpatient setting, where the rating period is three days for all measures.**

Measures are not required to be collected if the episode end reason for collection is either 10 - Deceased or 11 - Brief episode of care.

Detailed rating rules and glossaries can be viewed for each measure in the appendices.

Information collection protocol (ICP) flow



Glossary

Service user	A person who experiences or has experienced mental illness and who uses or has used mental health services. It covers the term consumer, patient, client, tangata whai ora.
Clinician	Includes all mental health professionals - doctors, nurses and allied health staff working in mental health who are in the scope for collecting outcome measures.
Recovery	Defined as “the ability to live well in the presence or absence of one’s mental illness (or whatever people choose to name their experience)” Blueprint 1998.
Standard measures of outcome	Standard tools or instruments that are used to obtain a number or classification with sufficient reliability and precision from or about an individual or population that is indicative of an outcome. When a standard measure is used twice to measure change it is used as an outcome measure. The first standard measure to be introduced will be the HoNOS family of measures. As the MH-SMART initiative progresses, further outcome measures may be introduced, including a service user rated measure, Hua Oranga (a Māori specific measure), a functioning measure and a measure specific to alcohol and other drug services.
Health of the Nation Outcome Scales (HoNOS)	<p>HoNOS is a clinical outcome measure used to measure the health status of service users who use mental health services. It is not an assessment in itself, but rather is completed following an assessment, using all available information. The HoNOS family includes HoNOS (for adults), HoNOSCA (for child and youth), HoNOS65+ (for adults over 65), HoNOS-LD (for those with intellectual and learning disability) and HoNOS secure (forensic). HoNOS measures are rated with the use of an accompanying glossary</p> <p>HoNOS</p> <p>A 12 item scale used by clinicians to measure behaviour, impairment, symptoms and social functioning in adults.</p> <p>HoNOSCA</p> <p>A 15 item scale, modelled on the adult HoNOS, specifically for use in the assessment of child and adolescent service user outcomes in mental health services. <i>See separate Reference Guide for Child and Adolescent Services.</i></p> <p>HoNOS65+</p> <p>The same 12 item scale as the adult HoNOS, however, a glossary specifically developed for older adults is used to rate HoNOS65+. <i>See separate Reference Guide for Older Adult Services.</i></p> <p>HoNOS LD</p> <p>An 18 item scale designed for use in measuring types of problems commonly presented by adult service users who have an intellectual disability with mental health needs.</p> <p>HoNOS secure</p> <p>A 19 item scale designed for adult service users who are being supported by forensic services.</p>
Episode of care	A more or less continuous period of contact between a service user and a contracted DHB mental health service that occurs within one mental health service setting – either inpatient or community .
Period of care	The interval within an episode of care between one collection occasion and the next.

Frequently asked questions

Recommended approach to special issues in interpreting the protocol at service delivery level.

Note: These frequently asked questions are in general related to adult, older adult and child & youth measures but may also be applicable to the use of the HoNOS secure and HoNOS-LD.

The standard protocol is designed to accommodate most clinical situations. It is recognised that there are a number of special issues where the application of the standard collection protocol is more complex. Many of these are associated with the interface between episodes in complex sequences of care and interpreting the two business rules which act as triggers to information collection (one episode at a time, change in service setting = new episode).

The following table details the recommended approach to special issues in interpreting the protocol at the service delivery level.

Issue	Question	Suggested response
Movement between services.	Do ratings need to be recorded for the end of the community episode, as well as at the beginning of the inpatient episode, when a service user is transferred from community care to inpatient care?	YES. Information provided by the community worker may be utilised to complete the inpatient admission collection (RFC 02). Collection occasion should be recorded within 24 hours from admission. Acceptable for one set of data to fill both community discharge and inpatient admission collection occasions. Where a collection is used twice in this way, each collection must identify the CPN of the clinician who completed the ratings.
	Can one set of data fill an inpatient episode end and community episode start?	NO. These two collection occasions are seen as different, and therefore are required to be distinct sets of data.
	Do ratings need to be recorded for the end of the community episode, or inpatient episode, when a service user is transferred to NGO services?	YES. If the person is discharged from inpatient or community care and will have no further care in either of those settings, a no further care (RFC07) collection is required.
	What happens when care is transferred between teams within the same service setting? Are ratings required?	NO (but useful to do so). Transfer of a service user between teams within the same service setting does not constitute a change in episode, therefore no ratings are required. This transfer can be 'marked' by completion of a review other (RFC06), as the change of teams can be seen as a clinically significant event.

Issue	Question	Suggested response
Multiple team involvement in case management.	Is each team expected to complete separate ratings for the service user?	NO. The service user is regarded as receiving only one episode of care at a time. Decisions about which team (or clinician) is responsible for completing the required ratings need to be made at the local level, however, generally the principle team (or clinician) is responsible for ensuring collection is completed.
Brief episodes of care.	Do brief episodes of care require ratings to be completed?	YES. Admission and discharge collections are required to be completed, however, if discharge occurs less than 14 days in the community, or less than three days in an inpatient setting, HoNOS, HoNOS65+, HoNOSCA are not required in the episode end collection. Note: If a service user receiving MHS care in a community setting has an admission into an inpatient setting, but does not stay overnight (same day admissions), this should be considered part of the community episode.
Unregistered service users.	When service user is not registered – not admitted to service – should the ratings be completed?	Has an assessment occurred? <ul style="list-style-type: none"> • NO. If person received information only or is being triaged for urgency only, no ratings are completed. • YES. An assessment was completed, with the result determining the person requires no further MHS input. An assessment only (RFC01) collection is required.
Discharge from hospital on indefinite leave.	Does an inpatient episode of mental health end when a service user is placed on extended leave (with the intention that they won't return) but remains, legally, an inpatient – and therefore require discharge ratings?	YES. If it is intended that the person would not return, the current episode ends and a new episode starts. This needs to be treated as any other discharge to the community service setting with a three monthly review when due.
Return to hospital from indefinite leave.	Does a new inpatient episode begin when a service user on leave is admitted to hospital?	YES. This should be treated as a new inpatient episode. Note: Local PMS systems may prevent this from occurring.
Rapid readmission to psychiatric hospital or inpatient unit.	If a service user is discharged from an inpatient unit and is readmitted within a very short period, is this a new inpatient?	YES. It is a <i>new episode</i> – standard information collection requirements apply.

Issue	Question	Suggested response
A service user is transferred to another ward or unit within the same hospital for medical or surgical care, with a definite expectation that they will return within the following seven days.	Do ratings need to be recorded?	NO. Not if their management continues with the inpatient unit. If the consultation/liaison service is involved then they may complete a review - other (RFC06). Local processes may have an impact on this issue and will need to be addressed accordingly.
Service users in ward for overnight stays on a regular basis.	Service users are admitted to the unit for overnight stays as part of the management plans on a regular basis – does each of these admissions count as a new episode?	These service users are treated as being in the community treatment setting and are reviewed under the community protocol (three monthly reviews).
Service user seen regularly, but at more than three monthly intervals. For example, Clozapine service users, shared care GP service users, shared private psychiatrist service users.	How should the three monthly (91 day) review 'rule' be applied in these cases?	These service users will be seen as 'shared care service users' and ratings are required. If the service user remains in an open community episode of MHS care, review - other (RFC06) should be completed each time they are seen. If the service user has a new MHS community episode each time they are seen, assessment only (RFC01) collections should be completed following each contact.
Age protocol.	Does the age group or the type of unit (for example, adult inpatient unit) determine which measures are collected? For example, a 17 year old admitted to adult unit?	Age group determines the measures to be collected. Child and youth measures are collected, but this can be overwritten by clinician as long as the measure is clearly identified.
Lost to care.	If a service user/tangata whai ora is lost to care are the standard measures completed?	Inpatient: If service user has left care against advice or is discharged at own risk the clinical staff member responsible for the discharge should complete the standard measures. Community: Standard measures should only be completed where valid information is available. If not enough information is available to rate – indicate unable to rate. It is also important to consider the local protocol which may dictate the no contact/no rating period.

Issue	Question	Suggested response
Forensic service user.	How do we treat service users under the Mental Health Act who return for arranged overnight stay in hospital?	These are treated as community episodes.
A service user is transferred from one DHB mental health service to a mental health service in another DHB.	Is the reason for collection 07 no further care or 12 discharges other?	RFC12 - discharge other. RFC07 has implications about the service user's need for further services.
Sub-acute inpatient units.	Is movement between an acute and sub-acute inpatient unit or a step down unit a new episode of care?	NO. Not within the same hospital. It is recommended that a review is completed. RFC06 determined by clinical need.
Admission of service user to a regional psychiatric hospital.	Should a new inpatient episode be commenced when a service user is transferred to a regional hospital when this hospital is in the same DHB?	YES. The transfer to a regional psychiatric hospital is seen as transfer is to a different mental health organisational setting.

Appendix 1: HoNOS rating guidelines and glossary

General rating guidelines

- Perform a full clinical assessment of the service user's clinical history and current problems.
- Rate scales in order from 1 to 12.
- Do not include information already rated in an earlier scale.
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks for inpatients at admission, for hospital outpatients, and for all clients of community based services. The exception is at discharge from acute inpatient care, in which case the rating period should generally be the preceding 72 hours or three days.

Each scale is rated on a 5-point scale of severity (0 to 4) as follows:

0. No problem.
 1. Minor problem requiring no formal action.
 2. Mild problem. Should be recorded in a care plan or other case record.
 3. Problem of moderate severity.
 4. Severe to very severe problem.
 7. Not known or unable to rate.
- Specific help for rating each point on each scale is provided in the glossary.
 - As far as possible, the use of rating point 7 should be avoided, because missing data make scores less comparable over time or between settings.

HoNOS scores: Clinical significance and recommended actions

Not clinically significant	0	No problem	<ul style="list-style-type: none"> Problem not present
	1	Minor problem	<ul style="list-style-type: none"> Requires no formal action. May or may not be recorded in clinical file.
Clinically significant	2	Mild problem	<ul style="list-style-type: none"> Warrants recording in clinical file. May or may not be incorporated in care plan.
	3	Moderate problem	<ul style="list-style-type: none"> Warrants recording in clinical file. Should be incorporated in care plan.
	4	Severe to very severe problem	<ul style="list-style-type: none"> Most severe category for service user's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <p>Note: Client can get worse</p>

HoNOS glossary

1. Overactive, aggressive, disruptive or agitated behaviour

Include such behaviour due to any cause, e.g. drugs, alcohol, dementia, psychosis, depression, etc.

Do not include bizarre behaviour, rated at scale 6.

0. No problems of this kind during the period rated.
1. Irritability, quarrels, restlessness etc. not requiring action.
2. 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.
3. Physically aggressive to others or animals (short of rating 4); threatening manner; more serious overactivity or destruction of property.
4. At least one serious physical attack on others or on animals; destruction of property (e.g. fire-setting); serious intimidation or obscene behaviour.

Additional notes for scale 1

This scale is concerned with a spectrum of behaviours. The short title is 'Aggression', for convenience, but the full title is broader and more accurate. All four types of behaviour are included, whether or not there is intention, insight or awareness. However, the context must be considered since disagreement, for example, can be expressed more vigorously, but still acceptably, in some social contexts than in others. Possible causes of the behaviour are not considered in the rating and diagnosis is not taken into account. For example, the severity of disruptive behaviour by someone with dementia or learning disability is rated here, as is aggressive overactivity associated with mania, or agitation associated with severe depression, or violence associated with hallucinations or personality problems. Bizarre behaviour is rated at scale 6.

2. Non-accidental self-injury

Do not include **accidental** self-injury (due e.g. to dementia or severe learning disability); the cognitive problem is rated at scale 4 and the injury at scale 5.

Do not include illness or injury as a direct consequence of drug or alcohol use rated at scale 3, (e.g. cirrhosis of the liver or injury resulting from drunk driving are rated at scale 5).

0. No problem of this kind during the period rated.
1. Fleeting thoughts about ending it all, but little risk during the period rated; no self-harm.
2. Mild risk during period; includes non-hazardous self-harm e.g. wrist-scratching.
3. Moderate to serious risk of deliberate self-harm during the period rated; includes preparatory acts e.g. collecting tablets.
4. Serious suicidal attempt or serious deliberate self-injury during the period rated.

Additional notes for scale 2

This scale deals with ideas or acts of self-harm in terms of their severity or impact. As in the clinical situation, the issue of intent during the period, though sometimes difficult to assess (e.g. when 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.

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.

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

Additional notes for scale 3

Consider characteristics such as craving or tolerance for alcohol or drugs, priority over other activities given to their acquisition and use, impaired capacity to control the quantity taken, frequency of intoxication, and drunk driving or other risk-taking. Temporary effects such as hangovers should also be included here. Longer-term cognitive effects such as loss of memory are rated at scale 4, physical disability (e.g. from accidents) or disease (e.g. liver damage) at scale 5, mental effects at scales 6, 7 and 8, problems with relationships at scale 9.

4. Cognitive problems

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

Do not include temporary problems (e.g. hangovers) resulting from drug or alcohol use, rated at scale 3.

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

Additional notes for scale 4

Intellectual and memory problems associated with any disorder, including dementia, learning disability, schizophrenia, very severe depression, etc., are taken into account. 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.

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.

0. No physical health problem during the period rated.
1. Minor health problem during the period (e.g. cold, non-serious fall, etc.).
2. Physical health problem imposes mild restriction on mobility and activity.
3. Moderate degree of restriction on activity due to physical health problem.
4. Severe or complete incapacity due to physical health problem.

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 (e.g. 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 to 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.

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.

0. No evidence of hallucinations or delusions during the period rated.
1. Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2. Delusions or hallucinations (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.
3. Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, that is, moderately severe clinical problem.
4. Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on service user.

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

7. Problems with depressed mood

*Do **not** include overactivity or agitation this is rated at scale 1*

*Do **not** include suicidal ideation or attempts this is rated at scale 2*

*Do **not** include delusions or hallucinations this is rated at scale 6*

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

Additional notes for scale 7

Depressed mood and symptoms closely associated with it often occur in disorders other than depression. Consider symptoms only: e.g. loss of self-esteem and guilt. These are rated at scale 7 irrespective of diagnosis. The more such symptoms there are the more severe the problems tend to be. Overactivity and agitation are rated at scale 1; self-harm at scale 2; stupor at scale 4; delusions and hallucinations at scale 6. Note that the rule is followed that symptoms, not diagnoses, are rated. Sleep and appetite problems are rated separately at scale 8.

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.

0. No evidence of any of these problems during period rated.
1. Minor non-clinical problems.
2. A problem is clinically present at a mild level, e.g. service user has a degree of control.
3. 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.
4. Severe problem dominates most activities.

Additional notes for scale 8

This scale provides an opportunity to rate symptoms not included in the previous clinical scales. Several types of problem are specified, distinguished by the capital letters A to J. Only the single most severe problem occurring during the period is rated. This procedure is repeated at Time 2 (T2). In this way, the most severe problem is always rated for each succeeding time period and the contribution to the total score reflects severity at Time 1(T1) and T2 even if the symptom type changes.

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.

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

Additional notes for scale 9

This scale concerns the quality as well as the quantity of 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 others, or both) is rated 4. Take the degree of the service user's distress about personal relationships, as well as degree of withdrawal or difficulty, into account when deciding between points 2 and 3. Aggressive behaviour by the service user towards another person is rated at scale 1.

10. Problems with activities of daily living (ADL)

Rate the overall level of functioning in activities of daily living (ADL): e.g. problems with **basic activities of self-care** such as eating, washing, 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.

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

Additional notes for scale 10

Consider the overall level of functioning achieved by the 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 scales 1 to 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.

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.

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

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

Additional notes for scale 11

This scale requires knowledge of the 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 to 10, and information on the following points:

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

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

12. Problems with occupation and activities

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

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

Note: Rate the service user's **usual** situation. If in acute ward, rate activities during period before admission. If information not available, rate 7.

0. Service user's day-time environment is acceptable; helpful in keeping any disability rated at scale 10 to the lowest level possible, and supportive of self-help.
1. Minor or temporary problems e.g. late pension cheques, reasonable facilities available but not always at desired times etc.
2. Limited choice of activities; e.g. there is a 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.
3. 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.
4. Lack of any opportunity for daytime activities makes service user's problem worse.

Additional notes for scale 12

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

The rating is based on an overall assessment of the extent to which the daytime environment brings out the best abilities of the 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 substantial.

Important variations in rating guidelines

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

HoNOS summary scores

The individual HoNOS scales (items) constituting both variants (HoNOS and HoNOS65+) of the measure and the summary scores.

Data element	HoNOS item number and description	Item score	Summary score
HoNOS behavioural problems summary score		2 items	0 -8
HoNOS item 01	1. Overactive, aggressive, disruptive or agitated behaviour	0 – 4	
HoNOS item 03	3. Problem drinking or drug-taking	0 – 4	
HoNOS impairment summary score		2 items	0 – 8
HoNOS item 04	4. Cognitive problems	0 – 4	
HoNOS item 05	5. Physical illness or disability problems	0 – 4	
HoNOS delusions/hallucinations problems summary score		1 item	0 – 4
HoNOS item 06	6. Problems associated with hallucinations and delusions	0 – 4	
HoNOS depression problems summary score		4 items	0 – 16
HoNOS item 02	2. Non-accidental self-injury	0 – 4	
HoNOS item 07	7. Problems with depressed mood	0 – 4	
HoNOS item 08	8. Other mental and behavioural problems	0 – 4	
HoNOS item 09	9. Problems with relationships	0 – 4	
HoNOS social problems summary score		4 items	0 – 16
HoNOS item 09	9. Problems with relationships	0 – 4	
HoNOS item 10	10. Problems with activities of daily living	0 – 4	
HoNOS item 11	11. Problems with living conditions	0 – 4	
HoNOS item 12	12. Problems with occupation and activities	0 – 4	
HoNOS total (12-item) score		12 items	0 – 48

Appendix 2: HoNOS65+ rating guidelines and glossary

General rating guidelines

- Perform a full clinical assessment of the service user's clinical history and current problems.
- Rate scales in order from 1 to 12.
- Do not include information already rated in an earlier scale.
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks for inpatients at admission, for hospital outpatients, and for all clients of community based services. The exception is at discharge from acute inpatient care, in which case the rating period should generally be the preceding 72 hours or three days.

Each scale is rated on a 5-point scale of severity (0 to 4) as follows:

0. No problem.
 1. Minor problem requiring no formal action.
 2. Mild problem. Should be recorded in a care plan or other case record.
 3. Problem of moderate severity.
 4. Severe to very severe problem.
 7. Not known or unable to rate.
- Specific help for rating each point on each scale is provided in the glossary.
 - As far as possible, the use of rating point 7 should be avoided, because missing data make scores less comparable over time or between settings.

HoNOS65+ scores: Clinical significance and recommended actions

Not clinically significant	0	No problem	<ul style="list-style-type: none"> Problem not present
	1	Minor problem	<ul style="list-style-type: none"> Requires no formal action. May or may not be recorded in clinical file.
Clinically significant	2	Mild problem	<ul style="list-style-type: none"> Warrants recording in clinical file. May or may not be incorporated in care plan.
	3	Moderate problem	<ul style="list-style-type: none"> Warrants recording in clinical file. Should be incorporated in care plan.
	4	Severe to very severe problem	<ul style="list-style-type: none"> Most severe category for service user's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <p>Note: Client can get worse</p>

HoNOS65+ glossary

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

Include such behaviour due to any cause, e.g. dementia, drugs, alcohol, psychosis, depression, etc.

Do not include bizarre behaviour, rated at scale 6.

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

2. Non-accidental self-injury

Do not include **accidental** self-injury (due for example to dementia or severe learning disability), any 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, (e.g. cirrhosis of the liver or injury resulting from drunk-driving are rated at scale 5).

0. No problem of this kind during the period rated.
1. Fleeting thoughts of self-harm or suicide; but little or no risk during the period rated.
2. Mild risk during period; includes more frequent thoughts or talking about self-harm or suicide (including 'passive' ideas of self-harm such as not taking avoiding action in a potentially life threatening situation, e.g. while crossing a road).
3. Moderate to serious risk of deliberate self-harm during the period rated; includes frequent or persistent thoughts or talking about self-harm; includes preparatory behaviours, e.g. collecting tablets.
4. Suicidal attempt or deliberate self-injury during period.

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.

0. No problem of this kind during the period rated.
1. Some over-indulgence but within social norm.
2. Occasional loss of control of drinking or drug taking; but not a serious problem.
3. Marked craving or dependence on alcohol or drug use with frequent loss of control, drunkenness, etc.
4. Major adverse consequences or incapacitated due to alcohol or drug problems.

4. Cognitive problems

Include problems of orientation, memory, and language associated with any disorder: dementia, learning disability, schizophrenia, etc.

Do not include temporary problems (e.g. hangovers) which are clearly associated with alcohol, drug or medication use, rated at scale 3.

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

5. Physical illness or disability problems

Include illness or disability from any cause that limits mobility, impairs sight or hearing, or otherwise interferes with personal functioning (e.g. pain).

Include side effects from medication, effects of drug/alcohol use, physical disabilities resulting from accidents or self-harm associated with cognitive problems, drunk driving etc.

Do not include mental or behavioural problems rated at scale 4.

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

6. Problems associated with hallucinations and delusions

Include hallucinations and delusions (or false beliefs) irrespective of diagnosis.

Include odd and bizarre behaviour associated with hallucinations or delusions (or false beliefs).

Do not include aggressive, destructive or overactive behaviours attributed to hallucinations, delusions or false beliefs, rated at scale 1.

0. No evidence of delusions or hallucinations during the period rated.
1. Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2. Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to service user or manifestation in bizarre behaviour, that is, a present, but mild clinical problem.
3. Marked preoccupation with delusions or hallucinations, causing significant distress or manifested in obviously bizarre behaviour, that is, moderately severe clinical problem.
4. Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with a major impact on service user or others.

7. Problems with depressive symptoms

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.

Rate associated problems (e.g. changes in sleep, appetite or weight, anxiety symptoms) at scale 8.

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

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.

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

9. Problems with relationships

Problems associated with social relationships, identified by the service user or apparent to carers or others. **Rate** the service user's most severe problem associated with active or passive withdrawal from, or tendency to dominate, social relationships or non-supportive, destructive or self-damaging relationships.

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

10. Problems with activities of daily living (ADL)

Rate the overall level of functioning in activities of daily living (ADL): e.g. problems with **basic activities of self-care** such as eating, washing, dressing, toilet; also **complex skills** such as budgeting, recreation and use of transport, 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 scales 11 and 12.

0. No problems during period rated; good ability to function effectively in all basic activities (e.g. continent or able to manage incontinence appropriately, able to feed self and dress) and complex skills (e.g. driving or able to make use of transport facilities, able to handle financial affairs appropriately).
1. Minor problems only without significantly adverse consequences, for example, untidy, mildly disorganised, some evidence to suggest minor difficulty with complex skills but still able to cope effectively.
2. Self-care and basic activities adequate (though some prompting may be required), but difficulty with more complex skills (e.g. problem organising and making a drink or meal, deterioration in personal interest especially outside the home situation, problems with driving, transport or financial judgements).
3. Problems evident in one or more areas of self-care activities (e.g. needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted) as well as inability to perform several complex skills.
4. Severe disability or incapacity in all or nearly all areas of basic and complex skills (e.g. full supervision required with dressing and eating, frequent urinary or faecal incontinence).

11. Problems with living conditions

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

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

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

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

0. Accommodation and living conditions are acceptable; helpful in keeping any disability rated at scale 10 to the lowest level possible and minimising any risk, and supportive of self-help; the service user is satisfied with their accommodation.
1. Accommodation is reasonably acceptable with only minor or transient problems related primarily to the service user's preferences rather than any significant problems or risks associated with their environment (e.g. not ideal location, not preferred option, doesn't like food).
2. Basics are met but significant problems with one or more aspects of the accommodation or regime (e.g. lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems of access); may be associated with risk to service user (e.g. injury) which would otherwise be reduced.
3. Distressing multiple problems with accommodation; e.g. some basic necessities are absent (unsatisfactory or unreliable heating, lack of proper cooking facilities, inadequate sanitation); clear elements of risk to the service user resulting from aspects of the physical environment.
4. Accommodation is unacceptable: e.g. lack of basic necessities, insecure, or living conditions are otherwise intolerable, contributing adversely to the service user's condition or placing them at high risk of injury or other adverse consequences.

12. Problems with occupation and activities

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

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

Note: Rate the service user's **usual** situation. If in acute ward, rate activities during period before admission. If information not available, rate 7.

0. Service user's day-time environment is acceptable; helpful in keeping any disability rated at scale 10 to the lowest level possible, and maximising autonomy.
1. Minor or temporary problems, e.g. good facilities available but not always at appropriate times for the service user.
2. Limited choice of activities e.g. insufficient carer or professional support, useful day setting available but for very limited hours.
3. Marked deficiency in skilled services and support available to help optimise activity level and autonomy, little opportunity to use skills or to develop new ones; unskilled care difficult to access.
4. Lack of any effective opportunity for daytime activities makes the service user's problems worse or service user refuses services offered which might improve their situation.

Important variations in rating guidelines

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

HoNOS65+ summary scores

The individual HoNOS scales (items) constituting both variants (HoNOS and HoNOS65+) of the measure and the summary scores.

Data element	HoNOS item number and description	Item score	Summary score
HoNOS behavioural problems summary score		2 items	0 - 8
HoNOS item 01	1. Overactive, aggressive, disruptive or agitated behaviour	0 - 4	
HoNOS item 03	3. Problem drinking or drug-taking	0 - 4	
HoNOS impairment summary score		2 items	0 - 8
HoNOS item 04	4. Cognitive problems	0 - 4	
HoNOS item 05	5. Physical illness or disability problems	0 - 4	
HoNOS delusions/hallucinations problems summary score		1 item	0 - 4
HoNOS item 06	6. Problems associated with hallucinations and delusions	0 - 4	
HoNOS depression problems summary score		4 items	0 - 16
HoNOS item 02	2. Non-accidental self-injury	0 - 4	
HoNOS item 07	7. Problems with depressed mood	0 - 4	
HoNOS item 08	8. Other mental and behavioural problems	0 - 4	
HoNOS item 09	9. Problems with relationships	0 - 4	
HoNOS social problems summary score		4 items	0 - 16
HoNOS item 09	9. Problems with relationships	0 - 4	
HoNOS item 10	10. Problems with activities of daily living	0 - 4	
HoNOS item 11	11. Problems with living conditions	0 - 4	
HoNOS item 12	12. Problems with occupation and activities	0 - 4	
HoNOS total (12-item) score		12 items	0 - 48

Appendix 3: HoNOSCA rating guidelines and glossary

General rating guidelines

- Perform a full clinical assessment of the service user's clinical history and current problems.
- Rate scale in order from 1 to 15.
- Do not include information already rated in an earlier scale.
- Rate the most severe problem that occurred in the period rated.
- The rating period is generally the preceding two weeks for inpatients at admission, for hospital outpatients, and for all clients of community based services. The exception is at discharge from acute inpatient care, in which case the rating period should generally be the preceding 72 hours or three days.

Each scale is rated on a 5-point scale of severity (0 to 4) as follows:

0. No problem.
 1. Minor problem requiring no formal action.
 2. Mild problem. Should be recorded in a care plan or other case record.
 3. Problem of moderate severity.
 4. Severe to very severe problem.
 7. Not known or unable to rate.
- Specific help for rating each point on each scale is provided in the glossary.
 - As far as possible, the use of rating point 7 should be avoided, because missing data make scores less comparable over time or between settings.

HoNOSCA scores: Clinical significance and recommended actions

Not clinically significant	0	No problem	<ul style="list-style-type: none"> Problem not present
	1	Minor problem	<ul style="list-style-type: none"> Requires no formal action. May or may not be recorded in clinical file.
Clinically significant	2	Mild problem	<ul style="list-style-type: none"> Warrants recording in clinical file. May or may not be incorporated in care plan.
	3	Moderate problem	<ul style="list-style-type: none"> Warrants recording in clinical file. Should be incorporated in care plan.
	4	Severe to very severe problem	<ul style="list-style-type: none"> Most severe category for service user's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <p>Note: Client can get worse</p>

HoNOSCA glossary

1. Problems with disruptive, antisocial or aggressive behaviour

Include behaviour associated with any disorder, such as hyperkinetic disorder, depression, autism, drugs or alcohol.

Include physical or verbal aggression (e.g. pushing, hitting, vandalism, teasing), or physical or sexual abuse of other children.

Include antisocial behaviour (e.g. thieving, lying, cheating) or oppositional behaviour (e.g. defiance, opposition to authority or tantrums).

Do not include: over-activity rated at scale 2, truancy rated at scale 13, self-harm rated at scale 3.

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

Additional notes for scale 1

This 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.

2. Problems with over-activity, attention or concentration

Include overactive behaviour associated with any disorder such as hyperkinetic disorder, mania, or arising from drugs.

Include problems with restlessness, fidgeting, inattention or concentration due to any cause, including depression.

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

Additional notes for scale 2

This 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 also be rated here.

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, for example, 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.

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

Additional notes for scale 3

This 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.

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.

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

Additional notes for scale 4

Consider characteristics such as craving or tolerance for alcohol or drugs, priority over other activities given to their acquisition and use, impaired capacity to control the quantity taken, frequency of intoxication and risk-taking. Dependence on alcohol and drugs is rare in children and adolescents thus this scale 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.

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.

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

Additional notes for scale 5

This 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 prior performance was in the superior range.

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.

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

Additional notes for scale 6

Consider the impact of physical disability or disease on the child in the recent past. Problems likely to clear up fairly rapidly, without longer term consequences (e.g. a cold or bruising from a fall), are rated at point 0 or 1. A child in remission from a possibly long-term illness is rated on the worst state in the period, not on the prospective level. The rating at points 2 to 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.

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.

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

Additional notes for scale 7

This scale addresses all hallucinations, delusions or abnormal perceptions irrespective of diagnosis, as well as odd and bizarre behaviours associated with psychotic symptoms. Problems with other abnormal perceptions should also be included here such as illusions or pseudo-hallucinations or over valued ideas such as suspicious or paranoid thoughts or abnormalities of body image in eating disorders.

Disruptive or aggressive behaviour associated with hallucinations or delusions should not be rated here (see scale 1). Overactive behaviour, for example in hypomania should also be rated elsewhere (scale 2).

8. Problems with non-organic somatic symptoms

Include problems with gastrointestinal symptoms such as non-organic vomiting or cardiovascular symptoms or neurological symptoms or non-organic enuresis and encopresis or sleep problems or chronic fatigue.

Do not include movement disorders such as tics, rated at scale 6.

Do not include physical illnesses that complicate non-organic somatic symptoms, rated at scale 6.

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

Additional notes for scale 8

This should include difficulties with gastro-intestinal symptoms such as non-organic vomiting or cardiovascular 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.

9. Problems with emotional and related symptoms

Rate only the most severe clinical problem not considered previously.

Include depression, anxiety, worries, fears, phobias, obsessions or compulsions, arising from any clinical condition including eating disorders.

Do not include aggressive, destructive or over-activity behaviours attributed to fears or phobias, rated at scale 1.

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

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

Additional notes for scale 9

Only the most severe clinical problem not considered previously should be rated here. This might include depression, anxiety, worries, fears, phobias, obsessions or compulsions arising from any clinical condition including eating disorders.

Aggressive destructive or overactive behaviours attributed to fears or phobias should be rated at 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. Scales 10 to 13 (ratings of social functioning and of autonomy) unlike scales 1 to 9 (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.

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.

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

Additional notes for scale 10

This should include problems with school friends and the social network. This scale 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.

11. Problems with self-care and independence

Rate the overall level of functioning, e.g. problems with basic activities of self-care such as feeding, washing, dressing, toilet, and also complex skills such as managing money, travelling independently, shopping etc.; taking into account the norm for the child's chronological age.

Include poor levels of functioning arising from lack of motivation, mood or any other disorder.

Do not include lack of opportunities for exercising intact abilities and skills, as might occur in an over-restrictive family, rated at scale 12.

Do not include enuresis and encopresis, rated at scale 8.

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

Additional notes for scale 11

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

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.

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

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

Additional notes for Scale 12

Usually this 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 institution and with separated parents and siblings should both be rated. Parental personality problems, mental illnesses and marital difficulties should only be rated here if they have an effect on the child, though this will usually be the case. Problems associated with physical, emotional or sexual abuse should be included but this scale is not intended to address abusive or neglectful features alone. Difficulties arising from over involvement and overprotection should be included, as well as difficulties arising from family 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.

13. Poor school attendance

Include truancy, school refusal, school withdrawal or suspension for any cause.

Include attendance at type of school at time of rating, e.g. hospital school, home tuition, etc. If school holiday, rate the last two weeks of the previous term.

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

Additional notes for scale 13

School non-attendance for any reason should be included. This will include truancy, school refusal, school withdrawal or suspension for any cause. Where the child is an inpatient or day service user, 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.

Note

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

Scales 14 and 15

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

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.

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

Additional notes for scale 14

This 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.

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.

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

Additional notes for scale 15

This 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 educational provision.

Important variations in rating guidelines

Core rules		
Scale	Rate the worst manifestation	Rate over the past two weeks
Scales 1-9	Always	Always
Scales 10-15	Based on usual or typical	Always

HoNOSCA summary scores

The individual HoNOSCA scales (items) of the measure and the summary scores.

Data element	HoNOSCA item number and description	Item score	Summary score
HoNOSCA behavioural problems summary score		4 items	0 – 16
HoNOSCA item 01	1. Disruptive, antisocial, or aggressive behaviour.	0 – 4	
HoNOSCA item 02	2. Problems with overactivity, attention or concentration.	0 – 4	
HoNOSCA item 03	3. Non-accidental self-injury.	0 – 4	
HoNOSCA item 04	4. Alcohol, substance or solvent misuse.	0 – 4	
HoNOSCA impairment summary score		2 items	0 – 8
HoNOSCA item 05	5. Problems with scholastic or language skills.	0 – 4	
HoNOSCA item 06	6. Physical illness or disability problems.	0 – 4	
HoNOSCA symptomatic problems summary score		3 items	0 – 12
HoNOSCA item 07	7. Problems associated with hallucinations, delusions, or abnormal perceptions.	0 – 4	
HoNOSCA item 08	8. Problems with non-organic somatic symptoms.	0 – 4	
HoNOSCA item 09	9. Problems with emotional and related symptoms.	0 – 4	
HoNOSCA social problems summary score		4 items	0 – 16
HoNOSCA item 10	10. Problems with peer relationships.	0 – 4	
HoNOSCA item 11	11. Problems with self-care and independence.	0 – 4	
HoNOSCA item 12	12. Problems with family life and relationships.	0 – 4	
HoNOSCA item 13	13. Poor school attendance.	0 – 4	
HoNOSCA information summary score		2 items	0 – 8
HoNOSCA item 14	14. Problems with lack of knowledge or understanding about the nature of the child or adolescent's difficulties.	0 – 4	
HoNOSCA item 15	15. Problems with lack of information about services or management of the child or adolescent's difficulties.	0 – 4	
HoNOSCA total (13-item) score		0-13	0-52
HoNOSCA total (15-item) score		0-15	0-60

Appendix 4: HoNOS-LD⁴ rating guidelines and glossary

General rating guidelines

- Perform a full clinical assessment of the service user's clinical history and current problems.
- Rate scales in order from 1 to 18.
- Do not include information already rated in an earlier scale.
- Rate the most severe problem that occurred in the previous 4 weeks.
- The exception is at discharge from acute inpatient care, in which case the rating period should generally be the preceding 72 hours or three days.

Each scale is rated on a 5-point scale of severity (0 to 4) as follows:

0. No problem during period rated.
1. Mild problem.
2. Moderate problem.
3. Severe problem.
4. Very severe problem.
7. Not known or unable to rate.

Note: The 5-point scale definitions in the HoNOS-LD documentation from the UK are slightly different than the existing HoNOS scales (See HoNOS). This may mean systems which display definitions will need to be modified for the HoNOS-LD. It will also require different combinations of values for analysis as it has potential impact on clinical significance and how this is defined for HoNOS-LD.

- Specific help for rating each point on each scale is provided in the glossary.
- As far as possible, the use of rating point 7 should be avoided, because missing data make scores less comparable over time or between settings.

⁴HoNOS-LD: Dr Ashok Roy, Psychiatrist, North Warwickshire NHS trust; Dr Helen Matthews, Psychiatrist, Pembrokeshire and Derwen NHS Trust; Dr Paul Clifford, Director, CORE, British Psychological Society; David Martin, Clinical audit coordinator, North Warwickshire NHS Trust and Vanessa Fowler, Psychologist, Kingston and District Community NHS Trust.

HoNOS-LD glossary

1. Behavioural problems - directed to others

Include behaviour that is directed to other persons. Do **not** include behaviour that is directed towards self (scale 2) or primarily at property or other behaviours (scale 3).

Rate risk as it is **currently perceived**.

0. No behavioural problems directed to others during the period rated.
1. Irritable, quarrelsome, occasional verbal abuse.
2. Frequent verbal abuse, verbal threats, occasional aggressive gestures, pushing or pestering (harassment).
3. Risk, or occurrence of, physical aggression resulting in injury to others requiring simple first aid, or requiring close monitoring for prevention.
4. Risk, or occurrence of, physical aggression producing injury to others serious enough to need casualty treatment and requiring constant supervision or physical intervention for prevention (e.g. restraint, medication or removal).

2. Behavioural problems - directed towards self (self-injury)

Include all forms of self-injurious behaviour.

Do **not** include behaviour directed towards others (scale 1), or behaviour primarily directed at property, or other behaviours (scale 3).

0. No self-injurious behaviour during the period rated.
1. Occasional self-injurious behaviour (e.g. face-tapping); occasional fleeting thoughts of suicide.
2. Frequent self-injurious behaviour not resulting in tissue damage (e.g. redness, soreness, wrist-scratching).
3. Risk or occurrence of self-injurious behaviour resulting in reversible tissue damage and no loss of function (e.g. cuts, bruises, hair loss).
4. Risk or occurrence of self-injurious behaviour resulting in irreversible tissue damage and permanent loss of functions (e.g. limb contractures, impairment of vision, permanent facial scarring) or attempted suicide.

3. Other mental and behavioural problems

This is a global rating to include behavioural problems not described in scales 1 or 2.

Do **not** include behaviour directed towards others (scale 1), or self-injurious behaviour (scale 2). Rate the **most prominent** behaviours present. Include:

A behaviour destructive to property; **B** problems with personal behaviours, for example, spitting, smearing, eating rubbish, self-induced vomiting, continuous eating or drinking, hoarding rubbish, inappropriate sexual behaviour; **C** rocking, stereotyped and ritualistic behaviour; **D** anxiety, phobias, obsessive or compulsive behaviour; **E** others.

0. No behavioural problems during the period rated.
1. Occasional behavioural problems that are out of the ordinary or socially unacceptable.
2. Behaviour sufficiently frequent and severe to produce some disruption of and impact on own or other people's functioning.
3. Behaviour sufficiently frequent and severe to produce significant disruption and impact on own or other people's functioning, requiring close monitoring for prevention.
4. Constant, severe problem behaviour producing major disruption of and impact on functioning requiring constant supervision or physical intervention for prevention.

4. Attention and concentration

Include problems that may arise from underactivity, overactive behaviour, restlessness, fidgeting or inattention, hyperkinesis or arising from drugs.

0. Can sustain attention and concentration in activities or programmes independently during the period rated.
1. Can sustain attention and concentration in activities or programmes with occasional prompting and supervision.
2. Can sustain attention and concentration in activities or programmes with regular prompting and supervision.
3. Can sustain attention and concentration in activities or programmes briefly with constant prompting and supervision.
4. Cannot participate in activities and programmes even with constant prompting and supervision.

5. Memory and orientation

Include recent memory loss and worsening of orientation for time, place and person in addition to previous difficulties.

0. Can reliably find their way around familiar surroundings and relate to familiar people.
1. Mostly familiar with environment and/or person, but with some difficulty in finding their way.
2. Can relate to environment and/or person with occasional support and supervision.
3. Can relate to environment and/or person with regular support and supervision.
4. Not apparently able to recognise or relate to people and environments.

6. Communication (problems with understanding)

Include all types of responses to verbal, gestural and signed communication, supported if necessary with environmental cues.

0. Able to understand first language (mother tongue) about personal needs and experience during the period rated.
1. Able to understand a group of words, short phrases, signed communication about most needs.
2. Able to understand some signs, gestures and single words about basic needs and simple commands (food, drink, come, go, sit, etc.).
3. Able to acknowledge and recognise attempts at communication with little specific understanding (pattern of response is not determined by nature of communication).
4. No apparent understanding or response to communication.

7. Communication (problems with expression)

Include all attempts to make needs known and communicate with others (words, gestures, signs).

Rate behaviour under scales 1, 2 and 3.

0. Able to express needs and experience during the period rated.
1. Able to express needs to familiar people.
2. Able to express basic needs only (food, drink, toilet, etc.).
3. Able to express presence of needs, but cannot specify (e.g. cries or screams when hungry, thirsty or uncomfortable).
4. Unable to express need or presence of need.

8. Problems associated with hallucinations and delusions

Include hallucinations and delusions irrespective of diagnosis.

Include all manifestations suggestive of hallucinations and delusions (responding to abnormal experiences, e.g. invisible voices when alone).

0. No evidence of hallucinations or delusions during period rated.
1. Occasional odd or eccentric beliefs or behaviours suggestive of hallucinations or delusions.
2. Manifestations of hallucinations or delusions with some distress or disturbance.
3. Manifestations of hallucinations or delusions with significant distress or disturbance.
4. Mental state and behaviour are seriously and adversely affected by hallucinations or delusions with severe distress or disturbance.

9. Problems associated with mood changes

Include problems associated with low mood states, elated mood states, mixed moods and mood swings (alternating between unhappiness, weeping and withdrawal on one hand and excitability and irritability on the other).

0. No evidence of mood change during period rated.
1. Mood present but with little impact (e.g. gloom).
2. Mood change producing significant impact on self or others (e.g. weeping spells, decrease in skills, withdrawal and loss of interest).
3. Mood change producing major impact on self or others (e.g. severe apathy and unresponsiveness, severe agitation and restlessness).
4. Depression, hypomania or mood swings producing severe impact on self and others (e.g. severe weight loss from anorexia or overactivity, agitation too severe to allow time to be engaged in meaningful activity).

10. Problems with sleeping

Do **not** rate intensity of behaviour disturbance, this should be included in scale 3.

Include daytime drowsiness, duration of sleep, frequency of waking and diurnal variation of sleep pattern.

0. No problem during the period rated.
1. Occasional mild sleep disturbance with occasional waking.
2. Moderate sleep disturbance with frequent waking, or some daytime drowsiness.
3. Severe sleep disturbance or marked daytime drowsiness (e.g. restlessness, overactivity, waking early) on some nights.
4. Very severe sleep disturbance with disturbed behaviour (e.g. restlessness, overactivity, waking early most nights).

11. Problems with eating and drinking

Include both increase and decrease in weight. Do **not** rate pica, which should be rated in scale 3.

This scale **does not include** problems experienced by people who cannot feed themselves (e.g. people with severe physical disability).

0. No problem with appetite during the period rated.
1. Slight alteration to appetite.
2. Severe alteration in appetite with no significant weight change.
3. Severe disturbance with some weight change during the period rated.
4. Very severe disturbance with significant weight change during the period rated.

12. Physical problems

Include illnesses from any cause that adversely affects mobility, self-care, vision and hearing (e.g. dementia, thyroid dysfunction, tremor affecting dexterity).

Do **not** include relatively stable physical disability (e.g. cerebral palsy, hemiplegia).

Behavioural disorders caused by physical problems should be rated under scales 1, 2 and 3 (e.g. constipation producing aggression).

0. No increased incapacity due to physical problems during the period rated.
1. Mildly increased incapacity, for example, viral illness, sprained wrist.
2. Significant incapacity requiring prompting and supervision.
3. Severe incapacity requiring some assistance with basic needs.
4. Total incapacity requiring assistance for most basic needs such as eating and drinking, toileting (fully dependent).

13. Seizures

Include all types of fits (partial, focal, generalised, and mixed, etc.) to rate the short term effect on the individual's daily life. **Rate** the effects of the fits.

Do **not** include behavioural problems caused by, or associated with, fits (use scales 1, 2 and 3).

0. No increased incapacity due to physical problems during the period rated.
1. Occasional seizures with minimal immediate impact on daily activities (e.g. resumes after seizures).
2. Seizures of sufficient frequency or severity to produce a significant immediate impact on daily activities (e.g. resumes activity after a few hours).
3. Seizures of sufficient frequency or severity producing a severe immediate impact on daily activities requiring simple first aid for injuries etc. (e.g. resumes activities next day).
4. Frequent poorly controlled seizures (may be accompanied by episodes of status epilepticus) requiring urgent clinical attention.

14. Activities of daily living at home

Include such skills as cooking, cleaning and other household tasks.

Do **not** rate problems with daily living outside the home (scale 15).

Do **not** rate problems with self-care (scale 16).

Rate what is seen regardless of cause, for example, disability, motivation etc.

Rate **performance not potential**.

Rate the **current level** achieved with the existing support.

0. Performs or contributes towards activities of daily living at home.
1. Some limitations in performing or contributing towards household tasks.
2. Significant limitations in performing or contributing towards household tasks (e.g. failure to wash or tidy up, difficulty in preparing meals).
3. Major limitations in performing or contributing towards household tasks (e.g. home neglected, dirty, untidy; no domestic routine).
4. Gross neglect or danger resulting from no apparent contribution to daily living activities.

15. Activities of daily living outside the home

Include skills such as budgeting, shopping, mobility and the use of transport, etc.

Do **not** include problems with activities of daily living at home (scale 14).

Do **not** rate problems with self-care (scale 16).

Rate the current level with the existing support.

0. Regular use of facilities and public amenities (e.g. shopping).
1. Some limitation in activity (e.g. difficulty with the use of public amenities or transport).
2. Significant limitations of activity relating to any one of: shopping, use of transport, public amenities.
3. Major restrictions in activity relating to more than any one of: shopping, use of transport, public amenities.
4. Severe restrictions in the use of shops, transport, facilities, etc.

16. Level of self-care

Rate the overall level of functioning in activities of self-care such as eating, washing, dressing and toileting.

Rate the current level achieved with the existing support.

Rate appearance not motivation.

0. Appearance and personal hygiene maintained.
1. Some deficits in personal appearance, personal hygiene or attention to health (e.g. poor grooming).
2. Significant deficits in personal appearance, personal hygiene or attention to health causing a problem with social acceptability, but not sufficient to pose a health risk (e.g. body odour, unkempt hair or nails).
3. Major deficits in personal appearance, personal hygiene or attention to health posing a health risk (e.g. skin rashes, gum infection, not fully dressed).
4. Gross self-neglect with severe difficulties relating to appearance, hygiene and diet posing a major health risk (e.g. pressure sores).

17. Problems with relationships

Include effects of problems with relationships with family, friends and carers (in residential and day or leisure settings).

Measure what is occurring regardless of cause, for example, somebody who is known to have good relationships may still display problems.

0. Positive and frequent contact with family or friend or carers.
1. Generally positive relationships, but some strain or limitations in contact.
2. Some positive relationships, but current disruptions of contact or worsening of relationships.
3. Difficulties in relationships with risk of breakdown or infrequent contact.
4. Significant relationships broken down with no current contact.

18. Occupation and activities

Rate the overall level of problems with quality of daytime environment.

Take account of **frequency and appropriateness** of, and engagement with, daytime activities. **Consider** factors such as lack of qualified staff, equipment and appropriateness with regard to age and clinical condition.

Do **not** rate problems with self-care (scale 16).

0. Fully engaged with acceptable range of activities.
1. Uses reasonable range of activities, but some limitation of access or appropriateness.
2. Uses limited range of activities, limited availability or appropriateness.
3. Attends daytime activity irregularly.
4. No engagement with daytime activity.

Important variations in rating guidelines

Unlike other HoNOS measures which are rated over the past two weeks (with the exception of those at the end of an inpatient episode), the HoNOS-LD requires rating the most severe problem that occurred in the previous four weeks.

HoNOS-LD total score

Data element	HoNOS-LD item number and description	Item score	Summary score
HoNOS-LD total (18-item) score			0 – 72

Appendix 5: HoNOS secure rating guidelines and glossary

General rating guidelines

- Perform a full clinical assessment of the service user's clinical history and current problems.
- Do not include information already rated in an earlier scale, unless stated otherwise.
- Rate the **most severe** problem that occurred in the previous two weeks.
- The exception is at discharge from acute inpatient care, in which case the rating period should generally be the preceding 72 hours or three days.

Each scale is rated on a 5-point scale of severity (0 to 4) as follows:

0. No problem.
 1. Minor problem requiring no formal action.
 2. Mild problem. Should be recorded in a care plan or other case record.
 3. Problem of moderate severity.
 4. Severe to very severe problem.
 7. Not known or unable to rate.
- Specific help for rating each point on each scale is provided in the glossary.
 - As far as possible, the use of rating point 7 should be avoided, because missing data make scores less comparable over time or between settings.

2009 International version⁵

- Update clinical history and risk assessment of the service user.
- Review past incidents, behaviours, attitudes held, current progress etc.
- Assess the most serious potential problem in the “near future” (weeks or months). **Where relevant, consider if living unsupported in the community.** ‘Potential’ implies significant likelihood. Where outcome is unpredictable (e.g. overdose, fire), assess in proportion to degree of risk likely to occur.
- Rate the conclusions of the risk assessment and the **current** need for secure care. **Note:** This may or may not be the same as care currently provided.
- Rate 7 if unable to rate or no information available.

⁵ HoNOS Secure 2009 International Version – (excludes CPA). Authors: Philip Sugarman and Lorraine Walker, St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG. Development from HoNOS (Royal College of Psychiatrists Research Unit, London) and HoNOS-MDO (Philip Sugarman and Hazel Everest) originally commissioned by the UK Department of Health.

HoNOS security scale scores: Clinical significance and recommended actions

Not clinically significant	0	No problem	<ul style="list-style-type: none"> Problem not present
Clinically significant	1	Minor problem	<ul style="list-style-type: none"> May be recorded in clinical file.
	2	Mild problem	<ul style="list-style-type: none"> Warrants recording in clinical file. May or may not be incorporated in care plan.
	3	Moderate problem	<ul style="list-style-type: none"> Warrants recording in clinical file. Should be incorporated in care plan.
	4	Severe to very severe problem	<ul style="list-style-type: none"> Most severe category for service user's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <p>Note: Client can get worse</p>

HoNOS secure 12 scales: clinical significance and recommended actions

Not clinically significant	0	No problem	<ul style="list-style-type: none"> Problem not present
	1	Minor problem	<ul style="list-style-type: none"> Requires no formal action. May or may not be recorded in clinical file.
Clinically significant	2	Mild problem	<ul style="list-style-type: none"> Warrants recording in clinical file. May or may not be incorporated in care plan.
	3	Moderate problem	<ul style="list-style-type: none"> Warrants recording in clinical file. Should be incorporated in care plan.
	4	Severe to very severe problem	<ul style="list-style-type: none"> Most severe category for service user's with this problem. Warrants recording in clinical file. Should be incorporated in care plan. <p>Note: Client can get worse</p>

HoNOS secure glossary - Security scales A-G

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

A. Rate risk of harm to adults or children

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

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

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

C. Rate need for building security to prevent escape

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

D. Rate need for a safely staffed living environment

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

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

Do not include need for a driver.

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

F. Rate risk to individual from others

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

G. Rate the need for risk management procedures

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

HoNOS secure glossary

1. Overactive, aggressive, disruptive or agitated behaviour

Include behaviour due to any cause, e.g. drugs, alcohol, dementia, psychosis, depression, etc.

Do not include bizarre behaviour, rated at scale 6. Rate sexual behaviours at scale 8 (I) but rate any violence or intimidation here.

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

Additional notes for scale 1

This scale is concerned with a spectrum of behaviours. The short title is 'Aggression', for convenience, but the full title is broader and more accurate. All four types of behaviour are included, whether or not there is intention, insight or awareness. However, the context must be considered since disagreement, for example, can be expressed more vigorously, but still acceptably, in some social contexts than in others. Possible causes of the behaviour are not considered in the rating and diagnosis is not taken into account. For example, the severity of disruptive behaviour by someone with dementia or learning disability is rated here, as is aggressive overactivity associated with mania, or agitation associated with severe depression, or violence associated with hallucinations or personality problems. Bizarre behaviour is rated at scale 6.

2. Non-accidental self-injury

Do not include **accidental** self-injury (due for example 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, (e.g. cirrhosis of the liver or injury resulting from drunk driving are rated at scale 5).

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

Additional notes for scale 2

This scale deals with ideas or acts of self-harm in terms of their severity or impact. As in the clinical situation, the issue of intent during the period, though sometimes difficult to assess (e.g. when 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.

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.*

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

Additional notes for scale 3

Consider characteristics such as craving or tolerance for alcohol or drugs, priority over other activities given to their acquisition and use, impaired capacity to control the quantity taken, frequency of intoxication, and drunk driving or other risk taking. Temporary effects such as hangovers should also be included here. Longer term cognitive effects such as loss of memory are rated at scale 4, physical disability (e.g. from accidents) or disease (e.g. liver damage) at scale 5, mental effects at scales 6, 7 and 8, problems with relationships at scale 9.

4. Cognitive problems

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

*Do **not** include temporary problems (e.g. hangovers) resulting from drug or alcohol use, rated at scale 3.*

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

Additional notes for scale 4

Intellectual and memory problems associated with any disorder, including dementia, learning disability, schizophrenia, very severe depression, etc. are taken into account. 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.

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 (e.g. pain).

Include side effects from medication; effects of drug and/or 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.

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

Additional notes for scale 5

Consider the impact of physical disability or disease on the service user 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 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 to 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.

6. Problems associated with hallucinations and delusions

Include hallucinations and delusions irrespective of diagnosis.

Include odd and bizarre behaviour associated with hallucinations or delusions, such as thought disorder.

Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at scale 1.

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

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

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.

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

Additional notes for scale 7

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

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

8. Other mental and behavioural problems

Rate only the most severe clinical problem **not** considered at scales 6 and 7 as follows: Specify the type of problem by entering the appropriate letter:

A phobic; **B** anxiety; **C** obsessive–compulsive; **D** stress; **E** dissociative; **F** somatoform; **G** eating; **H** sleep; **I** sexual (for sexual behaviour problem, see guidance in brackets); **J** other, specify.

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

Additional notes for scale 8

This scale provides an opportunity to rate symptoms not included in the previous clinical scales. Several types of problem are specified, distinguished by the capital letters A to J, as specified above. Only the single most severe problem occurring during the period is rated. This procedure is repeated at Time 2 (T2). In this way, the most severe problem is always rated for each succeeding time period and the contribution to the total score reflects severity at Time 1 (T1) and T2 even if the symptom type changes.

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. Take into account limited access to outside relationships in secure settings, include service users, inmates, staff relationships.

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

Additional notes for scale 9

This scale concerns the quality as well as the quantity of 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 others, or both) is rated 4. Take the degree of the service user's distress about personal relationships, as well as degree of withdrawal or difficulty, into account when deciding between points 2 and 3. Aggressive behaviour by the service user towards another person is rated at scale 1.

10. Problems with activities of daily living (ADL)

Rate the overall level of functioning in activities of daily living (ADL): (e.g. problems with **basic activities of self-care** such as eating, washing, toilet); also complex skills such as budgeting, organising where to live, recreation, mobility and use of transport, self-development, etc.

Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.

Do not include lack of opportunities for exercising intact abilities and skills (e.g. in secure settings), rated at scales 11 and 12.

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

Additional notes for scale 10

Consider the overall level of functioning achieved by the 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 scales 1 to 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.

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

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

0. Accommodation and living conditions are acceptable; help to keep disability rated at scale 10 to the lowest level possible, and supportive of self-help.
1. Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn't like food, etc.).
2. Significant problems with one or more aspects of the accommodation and/or regime (e.g. restricted choice; inflexible programme; staff or household have little understanding of how to limit disability, or how to help develop new or intact skills).
3. Distressing multiple problems with accommodation or regime (e.g. some basic necessities absent, environment has minimal, no facilities to improve service user's independence); unnecessarily restrictive physical security (e.g. no access to outdoors, awaiting transfer to less secure facilities).
4. Environment unacceptable (e.g. lack of basic necessities or service user at risk of eviction, arbitrary transfer); 'roofless' or highly restrictive living conditions otherwise intolerable making service user's problems worse; severe physical confinement (e.g. much of daytime locked in room or cell, confined unnecessarily in seclusion or unfurnished room).

Additional notes for scale 11

This 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 to 10, and information on the following points:

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

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

12. Problems with occupation and activities

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

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

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

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

Additional notes for scale 12

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

The rating is based on an overall assessment of the extent to which the daytime environment brings out the best abilities of the 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 substantial.

Important variations in rating guidelines

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

HoNOS secure summary scores

When reporting on total scores for HoNOS secure, the HoNOS security scales A to G and the 12 scale HoNOS secure items need to be reported separately rather than as an aggregated total score.

Data element	HoNOS item number and description	Item score	Summary score
HoNOS behavioural problems summary score		2 items	0 - 8
HoNOS item 01	1. Overactive, aggressive, disruptive or agitated behaviour	0 - 4	
HoNOS item 03	3. Problem drinking or drug-taking	0 - 4	
HoNOS impairment summary score		2 items	0 - 8
HoNOS item 04	4. Cognitive problems	0 - 4	
HoNOS item 05	5. Physical illness or disability problems	0 - 4	
HoNOS delusions/hallucinations problems summary score		1 item	0 - 4
HoNOS item 06	6. Problems associated with hallucinations and delusions	0 - 4	
HoNOS depression problems summary score		4 items	0 - 16
HoNOS item 02	2. Non-accidental self-injury	0 - 4	
HoNOS item 07	7. Problems with depressed mood	0 - 4	
HoNOS item 08	8. Other mental and behavioural problems	0 - 4	
HoNOS item 09	9. Problems with relationships	0 - 4	
HoNOS social problems summary score		4 items	0 - 16
HoNOS item 09	9. Problems with relationships	0 - 4	
HoNOS item 10	10. Problems with activities of daily living	0 - 4	
HoNOS item 11	11. Problems with living conditions	0 - 4	
HoNOS item 12	12. Problems with occupation and activities	0 - 4	
HoNOS secure total (12-item) score		12 items	0 - 48
HoNOS secure items		7 items	0 - 28
HoNOS secure item	A Risk of harm to adults or children	0 - 4	
HoNOS secure item	B Risk of self-harm	0 - 4	
HoNOS secure item	C Need for building security	0 - 4	
HoNOS secure item	D Need for a safely-staffed environment	0 - 4	
HoNOS secure item	E Need for escort on leave	0 - 4	
HoNOS secure item	F Risk to individuals from others	0 - 4	
HoNOS secure item	G Need for risk management procedures	0 - 4	
HoNOS secure	Total score (7-item secure scale)	7 items	0 - 28