HoNOSI Guide for New Zealand Clinicians

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Acknowledgements

We would like to acknowledge a number of people who have contributed to the development of the resources.

- For development of this e-booklet: Mark Smith, Sandra Baxendine, Fiona Dempster, Sarah Fitzpatrick
- This e-booklet reviewed by Dr Tanya Wright and Dr Denise Guy

Acknowledgment for use of instruments

Health of the Nation Outcome Scales for Infants (HoNOSI), Australian mental health and outcomes and classification network 2020

HoNOSI key sources

Gowers, S., Harrington, R., Whitton, A., Lelliott, P., Beevor, A., Wing, J., & Jezzard, R. (1999). Brief scale for measuring the outcomes of emotional and behavioural disorders in children: Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry, 174*(5), 413-416. doi:10.1192/bjp.174.5.413

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For further information on HoNOS-related references please visit https://www.rcpsych.ac.uk/events/in-house-training/health-of-nation-outcome-scales

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Purpose of this guide

This guide is for HoNOSI, a member of the HoNOS family of measures. This guide brings together resources that have previously been available as separate documents. These include the *Clinician's Reference Guide, Version 2.1, 2014,* the *Mental Health Outcomes Information Collection Protocol (ICP), Version 2.2, June 2015 and the original e-booklets for each of the HoNOS measures, 2014.*

The booklet has been developed as a resource for:

- clinicians and managers in mental health services
- site coordinators and data quality personnel
- outcomes trainers (to assist deliver training in their respective services).

How to use this guide

This guide is intended to be accessed electronically and includes clickable links. If it is printed, please ensure you check Te Pou's website regularly to ensure you are using the current version.

Purple boxes within each chapter contain links telling you where to get more information about that subject. You can either Ctrl + left mouse click on the link, or cut and paste the address into your browser's address bar.

We have also added handy hints which you will find next to the yellow lightbulb.

You can also use the contents page to navigate within the response. Ctrl + left mouse click on the heading and you will be taken to the corresponding page.

Published November 2022

Te Pou Limited trading as Te Pou

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Outcomes and HoNOSI

What is an outcome?

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

Outcome measures provide the ability for service users, clinicians, managers and organisations to measure change (improvement, deterioration or maintenance) in health, wellbeing and circumstances over time. Change between one collection to the next is known as an outcome.

An outcome measure collects information about a person's mental health and social functioning at set points throughout the person's journey to recovery. This can be at admission and discharge from mental health services, or at admission and review if the person is receiving services for longer than three months.

Outcome measures can focus on a range of different domains, such as clinical status, functioning, employment, living conditions and spiritual wellbeing. Outcome measures can also be rated from different perspectives, such as service user, clinician or health worker, whanau or significant other.

Outcome measures undergo psychometric testing to determine their quality and usefulness in the required setting. These properties identify the measure's reliability, validity and sensitivity to therapeutic change.

Outcome information is used at local, regional and national levels to assess the effectiveness of services. New Zealand has adopted an outcome measurement framework with five component areas: clinical, addictions, Māori, self-rated and functioning information. The clinical measures have been introduced first, based on the HoNOS family of measures – all mandated for collection in New Zealand mental health services.

The benefits of collecting quality outcomes information

Data quality is key to using outcomes information effectively. Clinicians are trained in the use of outcome measures to ensure consistent collection across individual clinicians, teams and services.

The primary use of outcomes data is at an individual level. Good quality outcomes data can help us in discussing outcomes information with service users. This is one way service users can participate in their care and treatment and it may allow for further conversations about recovery.

Sharing outcomes, such as HoNOSI ratings, with a service user as part of a collaborative care plan should be routine and may also improve opportunities for whānau involvement. Information about the use of outcomes at an individual level is discussed later in this guide.

The secondary use of outcome data is at an aggregate level. At this level, good quality outcomes data can help us to better understand changes in health, wellbeing and circumstances for people who access mental health and addiction services across all of New Zealand.

It can inform planning, service improvement activities and benchmarking initiatives, and provide an overview of organisational performance on those indicators over time.

For more information about outcome measurement used in mental health and addiction services in New Zealand see www.tepou.co.nz/initiatives/using-data-to-improve-outcomes

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

In Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017, the Ministry of Health directs a greater focus on outcome measurement and key performance indicators to help develop an outcomes culture in mental health and addiction services.

The Ministry's strategy for Health of the Nation Outcome Scales (HONOS) is to ensure good compliance with collections before introducing other mandated measures.

The overall collection rate for HoNOS, for 2016 onwards, is 80 per cent for both community and inpatient collections combined and 80 per cent for inpatient admissions and discharges. The ability to accurately reflect change at an aggregate level relies on obtaining a high percentage of collections.

Outcomes in New Zealand – key milestones

Year	Milestone
2002	DHBs received crown funding agreements with the Ministry of Health for using outcomes measurement.
2003	Ministry of Health funded the Classification and Outcomes Study (CAOS), which resulted in a large and rich database for outcomes and identified 42 classes for Casemix purposes.
2005	The Mental Health Standard Measures of Recovery Initiative (MH-SMART) was established. The National Mental Health Information Strategy was developed. It addresses the ongoing development of mental health information systems based on the requirements of a range of stakeholders. The strategy suggests activities to enhance what has already been accomplished, using resources already in place and focusing on areas requiring further work.
2008	The Programme for the Integration of Mental Health Data (PRIMHD) was launched. This was to develop a new national mental health information collection, integrating the Mental Health Information National Collection (MHINC) and the Mental Health Standard Measures of Assessment and Recovery (MH-SMART) datasets. PRIMHD is one of nine priority projects described in the implementation plan of the National Mental Health Information Strategy. The PRIMHD dataset will also provide services with valuable information to support planning activities. 1 July, HoNOS, HoNOS65+ and HoNOSCA were mandated as part of the national collection for PRIMHD.
2009	The Ministry of Health funded the development of a Key Performance Indicator (KPI) Framework. The purpose of thizs Framework was to enable mental health services to learn about practices that lead to improved outcomes for service users. This project was led by the Northern Regional Alliance and managed by Counties Manukau District Health Board. The Framework was developed under the basis that it would be used as a quality improvement tool and this commitment influenced the choice of indicators. More information about the progress of the Framework can be found on the Northern DHB Support Agency (NDSA) website. (Since 2012 NDSA is known as Northern Regional Alliance.) Te Pou foundational training and one-day suite of measures training replaced MH-SMART training. National and service level PRIMHD outcomes reports were made available for the first time.

Outcomes in New Zealand – key milestones

Year	Milestone
2012	July 1st, HoNOS-secure and HoNOS-LD were mandated as part of the national collection for PRIMHD. Release of Rising to the Challenge Service Development Plan.
2013	National Mental Health and Addiction Information Reference Group established by Te Pou in response to the Rising to the Challenge: The Mental Health and Addiction Service Plan 2012-2017.
2015	July 1st, Alcohol and Drug Outcome Measure (ADOM) was mandated as part of the national collection for PRIMHD.
2016	1 July collection of a supplementary consumer record (SCR) including indicators of social outcome (accommodation, employment and education status, and presence of a wellness plan) is mandated for DHB and NGO services as part of the national collection for PRIMHD. Marama Real-Time Feedback is launched to the sector.
2018	He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction released.
2021	New transfer rules for HoNOS family of measures introduced in PRIMHD.
2023	HoNOSI introduced into infant mental health services from 1 July, 2023 as a voluntary measure.
2024	HoNOSI mandated for collection by infant mental health services from 1 July, 2024.

What is HoNOSI?

Health of the Nation Outcome Scales for Infants (HoNOSI) is a member of the Health of the Nation Outcome Scales (HoNOS) family of measures. It is a clinician rated tool developed by the Australian mental health outcomes and classification network.

There are several variants in the HoNOS family of measures.

Measure	Description
HoNOS	for adults aged 18 to 65 years.
HoNOS65+	for people aged 65 years and above.
HoNOSCA	for children and adolescents under 18 years.
HoNOS-LD	for adults who have a dual diagnosis, such as mental illness and an intellectual disability.
HoNOS-secure	for adults who are being supported by forensic services.
HoNOSI	for infants aged 0 to 47 months.

In New Zealand, HoNOSI is the outcome measurement tool mandated by the Ministry of Health for measuring the health and social functioning of infants (under the age of 4) accessing specialist infant mental health services.

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

HoNOSI is completed by a qualified mental health professional (clinician) using the information obtained in a comprehensive mental health assessment and from their routine clinical work. It is recommended information from all available sources be considered when completing ratings, including information provided by the service user, their whānau and also clinical notes.

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

When is HoNOSI used?

HoNOSI is mandated for use with all people under 4 years of age accessing specialist mental health services, in both inpatient and community settings.

HoNOSI is completed:

- as a person enters a specialist mental health service (admission/episode start) and when they exit (discharge/*episode end*) the service
- at *three monthly review* periods while they continue to access services
- when there are significant changes to the service user's health, wellbeing or circumstances (*ad hoc review*).

A clinician, who is most familiar with the individual service user, records the HoNOSI ratings, taking into account all available information. Ideally, the same clinician or team will rate the subsequent review or discharge HoNOSI. This may not always be possible, particularly in the case of inpatient treatment settings.

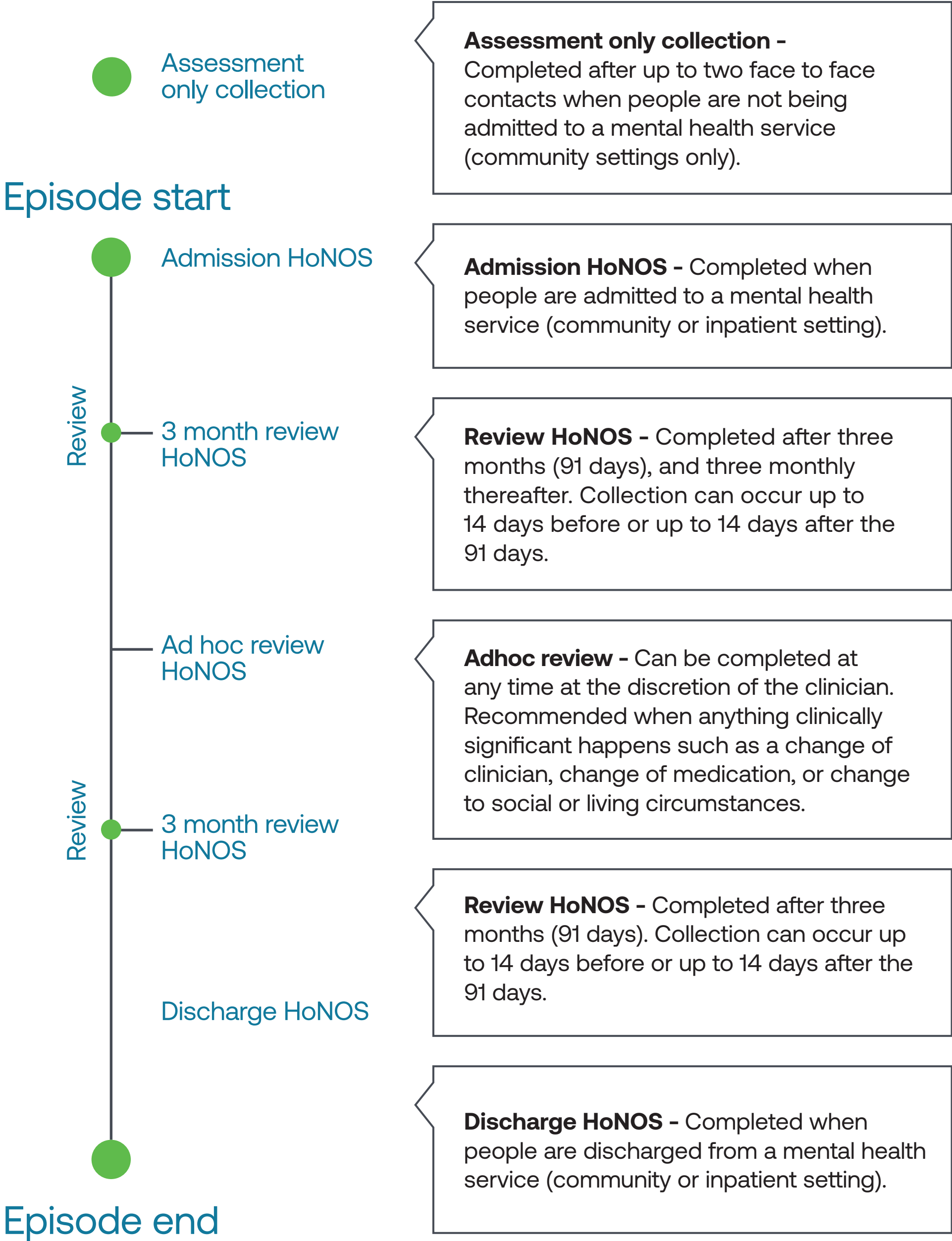
HoNOSI items

1. Problems with disruptive behaviour/irritability/ under controlled emotional regulation.
2. Problems with activity levels, joint and/or sustained attention.
3. Non accidental self-injury or lack of self-protective behaviours.
4. Problems with feeding and eating behaviour.
5. Problems with developmental delays.
6. Problems with physical illness or disability.
7. Problems associated with regulation and integration of sensory processing.
8. Problems associated with sleep.
9. Problems with emotional and related symptoms or over-controlled emotional regulation.
10. Problems with social reciprocity.
11. Problems with age-appropriate self-care and environmental exploration.
12. Problems with family life and relationships.
13. Problems with attending care, education and socialisation settings.
14. Problems with knowledge or understanding about the nature of the infant's difficulties.
15. Problems with lack of information, understanding about services, or managing the infant's difficulties

How each item is rated

0. No problem.
1. Minor problem requiring no action.
2. Mild problem but definitely present.
3. Moderately severe problem.
4. Severe to very severe problem.

HoNOS family collection points



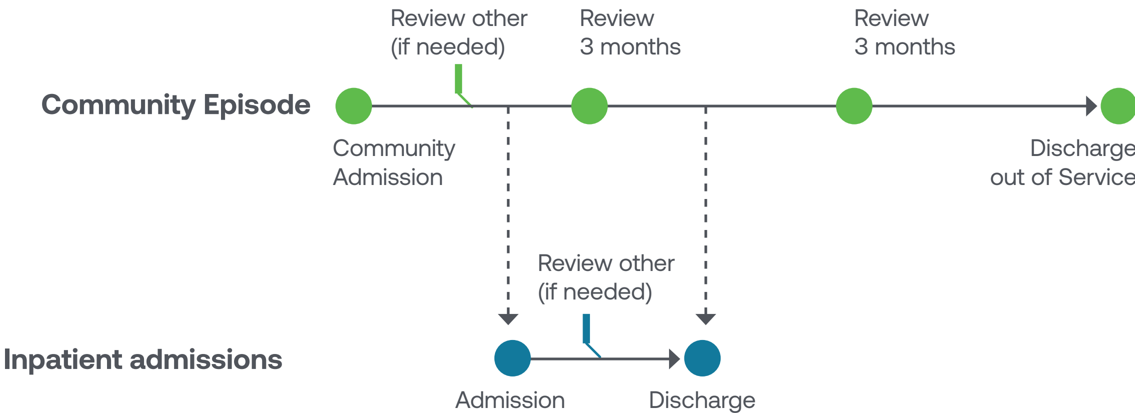
HoNOSI collection rules for service users

The community episode becomes the primary setting and the community episode remains open if there is an inpatient admission.

If someone is admitted to an inpatient unit when they are in the community services an admission and discharge collection for inpatient will still be required but the community episode is not closed. What this means is that the review date timing will be set by the community admission not the inpatient admission.

If 3 monthly review collections are due while someone is in the inpatient setting (as shown above) these would be completed by the community clinicians.

Review other collections can still be collected in inpatient and community settings with no change to the timing of the 3 monthly reviews.



Who should complete HoNOSI ratings

Community episodes– Completed by community clinician.

Transfer between community and inpatient settings – This can be completed by either the community clinician who organised the transfer or the admitting inpatient clinician.

Discharge from inpatient setting – Completed by inpatient clinician.

Inpatient setting – Review other collections completed by inpatient clinician. Collections over 3 months in an inpatient setting, completed by inpatient clinician.

HoNOSI rating guidelines and glossary

General rating guidelines

- The rating period is the previous two weeks.
- Rate each scale in order from 1 to 15.
- Use all available information in making your rating. That is, HoNOSI ratings should reflect your judgement based on all sources of information available to you.
- Underlying problems may manifest across different scales but do not include a manifestation already rated in an earlier scale.
- Rate the most severe occurrence of the problem in the rating period, not the inferred cause.
- Clinically significant symptoms should be rated at a 2 or above.
- Ratings are informed by familiarity with, and a good understanding of, infant and child development. Good clinical practice recognises the role of supervision, team reviews, training and other resources as tools for reflecting on infant and child development. HoNOSI will not replace these. All examples in the glossary should be seen in a developmental context.
- The instrument is focussed on the infant but any rating may also reflect the relationship with the parent(s). Include the infant's temperament, parent's responses, interactions and level of distress regarding aspects of the infant's behaviour and presentation. As with HoNOSCA, the presence of a clinically significant rating (scoring 2, 3 or 4) does not imply that the source of the problem and/or the locus of intervention, is necessarily exclusively with the infant.
- When establishing a rating point, it can be useful to consider the underlying construct of a problem as a continuum.
- Differences between rating points may be influenced by the intensity of a problem, the presence of multiple problems, or the frequency of the problems.

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

Score	Rating	Suggested implications
0	No problem.	In the clinician's considered opinion.
1	Minor problem requiring no formal action.	Sub-clinical problem, evidence of some behavioural disturbance or distress, unlikely to be monitored or included in care plan.
2	Mild problem.	Mild problem, clinically significant issue, evidence of distress and/or behaviour disturbance. Likely to be monitored or included in care plan.
3	Problem of moderate severity.	Moderate problem, clinically significant issue, evidence of greater distress and/or, behavioural impact. Definitely monitored and included in care plan.
4	Severe to very severe problem.	Severe clinical problem, distress and/or behavioural disturbance dominant aspect of presentation, greater frequency and/or intensity of clinical activity as evidenced in care plan.
7	Not known or not applicable.	

- Higher ratings can be expected to accompany more severe, more frequent and more widespread presentations.
- As far as possible, the use of rating point 7 should be avoided, because missing data makes scores less comparable over time or between settings.
- The total score for HoNOSI is calculated by summing the first 13 scales. Missing data (i.e. '7') should be treated as zero for this purpose. A valid total score requires at least 11 of the first 13 scales to be rated in the range 0-4.

Specific information on how to rate each point on each item is provided in the Glossary.

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

HoNOS should be rated using information available from all sources.

HoNOSI glossary

Scale 1: Problems with disruptive behaviour/irritability emotional regulation

Include

This scale addresses problems with the age and developmentally appropriate capacity of the infant to manage strong feelings, without recourse to age-inappropriate levels of overtly oppositional, dysregulated behaviours.

Clinically, the identification of age-inappropriate emotional regulation does not indicate the source of any difficulties. It may be expected, though not invariable, that regulating emotions connected to hunger, tiredness, and separation may be more prominent with younger infants while overt aggression or rage may be prominent with the older children.

Include behaviour associated with any disorder (such as hyperkinetic disorder, depression, autism).

Include the capacity to manage intense feelings of hunger, tiredness or separation from the primary caregiver.

Include difficulty calming, demanding, whining, undue irritability, excessive crying, frequently arching back and stiffening coupled with turning away from all eye contact, physiological indicators of stress (hiccups, yawns, non-injurious scratching) and manifestations of under controlled emotional regulation.

Include physical or verbal aggression (e.g. pushing, hitting, biting, kicking, teasing), to other (e.g. children, parents or other caregivers, siblings, familiar adults or strangers), animals or objects (e.g. toys).

Include oppositional behaviour (e.g. defiance, opposition to authority or tantrums).

Exclude

Problems associated with feeding and sleeping rated at scale 4 (feeding) and scale 8 (sleeping).

Problems directly associated with physical health illnesses or disability rated at scale 6.

Problems associated with self-injury rated at scale 3.

Problems associated with over-controlled emotional regulation or inhibited behaviours are rated at Scale 9.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action.
2	Mild problem. May be limited to one context.
3	Problem of moderate severity with disruptive or aggressive behaviour or under controlled emotional regulation. May be/likely to be in more than one context.
4	Severe to very severe problem with disruptive or aggressive behaviour or under controlled emotional regulation. May occur in almost all activities.

Scale 2: Problems with activity levels, joint and/or sustained attention

Include

Include problems with overactivity/underactivity, joint and sustained attention associated with any cause, including related to aspects of the caregiving environment (e.g. lack of appropriate stimulation, opportunities for motor development).

Include problems with restlessness, fidgeting, jerkiness, distractibility, listlessness or concentration due to any cause, including depression. Include issues of sustained as well as joint attention. Activity and attention difficulties may manifest in altered levels of vigilance, impaired turn taking in behavioural interactions, pronounced startle reflexes and rigidity.

Where two factors appear to negate each other (e.g. joint attention problematic but sustained attention is not problematic), rate the most severe occurrence.

Exclude

Problems directly associated with physical health illnesses or disability scored at scale 6.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action.
2	Mild problem with overactivity/underactivity or restlessness but with age-appropriate support/structure, the infant can modify their activity levels. Some vulnerability in joint and/or sustained attention however the infant's development is only mildly affected.
3	Problem of moderate severity with overactivity/underactivity. Activity levels may be difficult to control even with appropriate supports. May be significant issues with joint and/or sustained attention.
4	Severe to very severe problem with overactivity/underactivity. Likely to be impacting negatively on the infant's capacity to engage and achieve developmental milestones across multiple contexts. Consistent and severe limitations in joint and/or sustained attention.

Scale 3: Non accidental self-injury or lack of self-protective behaviours

Include

With infants and pre-schoolers, the question of intentionality is less clear than with older children. While intention should be considered, it will not always be apparent and the clinician may draw on clinical experience to infer intentionality. Behaviours included here are essentially those that result in self-harm that are not the consequence of an accident. However, self-injurious behaviours and actions are rated here irrespective of any indication of intent.

May include self-soothing behaviour that results in injury or harm e.g. hitting, biting, hair pulling, head banging, rocking, cutting, scratching, excessive sucking leaving marks, skin scratching or picking.

May include lack of self-protective reflexes, inhibition of pain and reassurance responses e.g. when an infant is clearly hurt yet inhibits a response where other infants of the same age would be expected to cry, flinch and look to parent(s) for reassurance.

Include attempts to stab self with a pen or other non-lethal object, cutting self with knives or scissors, deliberately jumping from a height with injurious intent, frequently discussing intent to self-injure. May include consideration of behaviours during play.

Exclude

Self-injurious behaviour secondary to a medical condition.

Accidental self-injury unless clearly from a lack of self-protective reflexes.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action with lack of self-protective reflexes or self-injurious behaviours.
2	Mild problem with self-injury or a lack of self-protective reflexes. May include rubbing, scratching, rocking or play which leads to mild levels of physical injury. Play that regularly involves self-injury. Occasional episodes where self-protective reflex is inhibited.
3	Problem of moderate severity with potential or actual self-injury. May include moderately severe problems with a lack of self-protective behaviours that lead to, or potentially lead to injury. May be preoccupation, repeated episodes, or inhibition of pain responses to self-injury.
4	Severe to very severe self-injury occurs. Episodes of physical self-injury. May include inhibition of response to pain/discomfort and lack of self-protection and self-soothing leading to severe self-injury.

Scale 4: Problems with feeding and eating behaviour

Include

Feeding behaviours progress with development. The acknowledgement of Problems in this area will be influenced by the duration, distress and incongruence of the concerning behaviours with the infant's age and age-appropriate development.

Include problems related to difficulties with breast feeding, bottle feeding and solids. Include all feeding difficulties irrespective of potential cause or solution. Nutritional difficulties may not always be present but should be considered.

Include behaviours such as reluctance, resistance or refusing to feed; tiring or sleeping readily during feeding; feeding related distress (e.g. fussiness or crying); maintaining adequate nutrition which may result in nasogastric/gastrostomy tube feedings; sensory adversity; vomiting and difficulty in achieving developmentally appropriate food or feeding skills e.g. limited diet, consistent refusal of certain foods, groups, or types (e.g. solids), or modes of eating e.g. refusal to eat independently; little recognition of the relationship between hunger, feeding and satiety. Include under- and over-eating.

Include feeding problems related to prematurity, physiological problems and gastrointestinal symptoms.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Problems may be transient and may be expected at the infant's developmental stage.
2	Mild problem with feeding or eating. Nutritional intake is likely to be within expected parameters.
3	Problem of moderate severity with feeding or eating. Some risk of nutritional problems.
4	Severe to very severe problem with feeding or eating.

Scale 5: Problems with developmental delays

Include

Include problems with developmental delays not rated at other scales. Delays may occur in areas such as cognitive, motor, language, or communication development. Concerns should be rated both irrespective of cause and whether additional professional assessment or intervention has occurred (e.g. paediatrics, speech pathology).

It may be difficult to distinguish one domain from another. Cognitive, motor and communication difficulties may manifest in balance, coordination, proprioception, problem solving, articulation, comprehension, sentence structure, vocabulary, communication pragmatics, gestures, vocal quality or range, interference with vocalisation (e.g. dummy, fingers). Difficulties in these areas may impact on ability to interact effectively with the environment and themselves in the areas of communication, motor and cognitive skills. While corrected age is a useful construct with premature infants, chronological age may be the more useful in identifying potential need for intervention.

Exclude

Physical illness or disability problems such as vision and hearing problems (rated at scale 6).

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. These may be expected to be within the typical range of development.
2	Mild problem that may be noted across more than one setting and in comparison to similar aged peers.
3	Problem of moderate severity that may be noted across settings compared with similar aged peers.
4	Severe to very severe problem with cognitive, motor or communication skills. Likely to cause significant distress for the infant and/or family. May be severe delays compared to similar aged peers.

Scale 6: Problems with physical illness or disability

Include

Physical health problem or disability which limits or prevents movement, impairs sight or hearing or otherwise interferes with functioning. Problems in this area may be observed or based on reports from others.

Include side effects from medication, physical effects from drug/alcohol exposure, or physical complications of psychological disorders.

Include physical complications or disability as consequence of self-injury.

Ratings will be influenced by consideration of impact of illness on everyday functioning.

Exclude

Problems with cognitive, motor or communication skills already rated at scale 5.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action (e.g. cold, non-serious fall, teething). Parent voices concern about transient physical illness or physical symptoms but these are not considered serious by the parent or clinician.
2	Mild problem with physical illness or disability, which may occasionally prevent or challenge engagement in usual activities. Overall structure of their day is typically preserved and activities such as the ability to play are only mildly affected.
3	Problem of moderate severity with physical illness or disability, resulting in some ongoing distress and loss of function. Typically, there is some time each day, in which they are able to engage in usual activities, such as play.
4	Severe to very severe problem with physical illness or disability that result in serious distress and/or loss of function. Normal everyday routines and activities, including play, are seriously impacted because of the physical problem. Considerable input of effort and resources may be required to care for the infant and support the parent.

Scale 7: Problems associated with regulation and integration of sensory processing

Include

Problems associated with processing, regulating and integrating information from sensory stimuli which interfere with the sensory regulation required for adaptive interaction with and exploration of the world.

While problems with sensory organs are rated at scale 6, this scale is more concerned with the processing of otherwise apparently intact sensory organs.

Problems associated with sensory processing can reflect hypersensitivity (over-reactive therefore avoidant or fearful/cautious) and/or hyposensitivity (under reactive therefore seeking or impulsive) to one or more normal sensory stimuli. Sensory stimuli include vision, touch, hearing, taste, smell and spatial awareness including the sensation of movement and awareness of body position in space.

Problems associated with the regulation and integration of sensory processing usually occur across multiple settings and within multiple relationships. Intensity, frequency, duration and location of problematic sensory stimuli may impact on the infant's presentation.

Examples of the manifestation of sensory regulation difficulties may include responsiveness to fabrics, movement, travel, focus on apparently irrelevant objects and an avoidance of play. They may appear to have a preference for swaddling, or to seeking or avoiding certain fabrics.

Exclude

Problems with disruptive behaviour/under controlled emotional regulation rated at scale 1.

Problems with activity and attention levels rated at scale 2.

Problems with feeding rated at scale 4.

Problems associated with cognitive, motor or communication difficulties rated at scale 5.

Problems with physical illness or disability rated at scale 6.

Problems with anxiety and depression and over controlled emotional regulation rated at scale 9.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action with sensory processing (over or under responding to normal sensory stimuli). However, the impact on adaptive daily functioning and exploration of the world is typically minor.
2	Mild problem with sensory processing identified and impacting on the infant. The infant and/or family may be showing signs of distress but maintaining appropriate developmental milestones. Definite and minor impact on functioning in daily tasks or in maintaining interactions in primary care-giving relationships. May become agitated, distressed, or disengaged when exposed to specific sensory stimuli.
3	Problem of moderate severity with sensory processing that are impacting on the infant's capacity to engage with their environment. May manifest as diminished exploration and play. Expect a definite and moderate impact on daily functioning.
4	Severe to very severe problem related to sensory processing directly impacting the infant's social, emotional and physical wellbeing. Definite and severe impact that is typically ongoing.

Scale 8: Problems associated with sleep

Include

Sleep disturbance is common for infants.

Include difficulties in both settling and maintaining sleep irrespective of where the locus of the difficulty is thought to be (infant, parent, living arrangements).

Include excessive sleep (e.g. which interferes with opportunities for skills or social development), insufficient sleep (e.g. periods of awakenings or reduced sleep time), disturbed sleep (e.g. sleep talking, sleep walking, night terrors, or any other disturbance during sleep when the infant does not seem to respond to the parents) or difficulties resettling.

Include snoring or loud mouth breathing with breath holding or gasping.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Typically within expected developmental norms, infrequent and where the family appear to have some approaches that successfully address the problem.
2	Mild problem which is intermittent. The family appear to have some success in addressing the problem for the infant.
3	Problem of moderate severity. The infant's sleeping pattern is of concern to the parents or family or it is likely to be interfering with functioning or development. The sleep disturbance occurs frequently and may be significantly out of keeping with age expectations.
4	Severe to very severe problem. The sleeping pattern is a cause for great distress in the parents and family and may be significantly out of keeping with age norms. The sleep disturbance is present nearly all the time and significantly interferes with functioning or development.

Scale 9: Problems with emotional and related symptoms or emotional regulation

Include

Symptoms of depression, anxiety and phobias. Problems with negative or inhibited affect in the infant suggestive of low mood, anxiety, fear, emotional withdrawal, or emotional regulation.

May include fears, anxiety or emotional withdrawal from parents and others. Include incongruent lack of emotional expression. May be expressed with changes in curiosity, clinging, masking face, incongruent emotional expression, crying, anger, hypnotic gaze, withdrawal and blank expression, exaggerated positive or negative emotional responses. May include excessive stillness, frozen watchfulness, quiet rage and restrictions in affect range. An apparent increased tolerance for aversive adult behaviour, or problems seeking appropriate comfort or safety should be considered.

Include age or developmentally inappropriate lack of wariness, or avoidance of parents.

Exclude

Physical sequelae of psychological disorders or medication – rated at scale 6.

Disruptive behaviours resulting from emotional distress – rated at scale 1. The emotion associated with the disruptive behaviour is rated here at scale 9.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action, or transient mood, anxiety and emotional symptoms or changes.
2	Mild problem with emotional symptoms.
3	Problem of moderate severity with emotional symptoms which are preoccupying, intrude into some activities and are uncontrollable at least sometimes.
4	Severe to very severe problems with emotional symptoms which intrude into all activities and may be nearly always uncontrollable.

Scale 10: Problems with social reciprocity

Include

This scale addresses the infant's engagement in, and engagement of others in, age and developmentally appropriate interactions.

There may be problems with seeking, engaging and enjoying interactions with familiar adults and children, including development of the social smile at 6 weeks. Responses to social engagement or social intrusion from others may not be responded to appropriately e.g. ambiguous half smiles. Problems may manifest with reciprocity in communication, play, and games. Reciprocity may be expressed both pre-verbally and verbally, as well as behaviourally. Problems may manifest as indiscriminate and overfamiliar social interactions as well as withdrawn and disengaged social interactions.

Problems rated in this scale may include the infant's capacity to manage-appropriate eye contact e.g. the infant may not gaze at the parent's face or at an interesting object when shown. Problems may include not socially referencing others, brief glances without sustained looking (difficulty gaining and sustaining eye contact); avoidant gaze; no eye contact (but no active avoidance either) and unfocused eyes. Problems with vocalisations relating to reciprocity of interactions, such as turn taking, engagement attempts, and vocal mirroring may also be relevant indicators of social reciprocity issues.

Exclude

Difficulties with communication separate to the social reciprocity function are rated at Scale 5.

Difficulties with the emotional attunement of parent's and carers to the infant and misalignment between the infant's needs and the parents' or carers' responses should be rated at Scale 12. a

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Transient or mild problems in the infant's developing capacity to engage in social relationships.
2	Mild problem.
3	Problem of moderate severity with social reciprocity.
4	Severe to very severe issues with social reciprocity. Problems likely to occur in many areas, over time and intrude across most interactions.

Scale 11: Problems with age-appropriate self-care and environmental exploration

Include

This scale addresses age-appropriate self-care and exploration of the environment.

Self-care is more likely to be a prominent consideration with older children. Self-care is likely to include age-appropriate levels of assistance with bathing, feeding, dressing, playing etc. Problems with self-care and environmental exploration may exist due to environmental restrictions, including parent's comfort, concerns or control.

Include problems with activities of self-care such as washing, dressing, toileting.

Exploration may include visual, tactile, verbal as well as physical exploration (under or over exploration). Include problems with complex skills such as play, autonomous activities or separating from parents, taking into account the norm for the infant's age and developmental stage. Difficulties may be indicated by regression to an earlier stage of development. The impact on exploration and self-care resulting from separation problems with parents when the infant is attending structured socialisation settings (e.g. day care, pre-school) may be rated here although actual attendance issues are rated at scale 13.

Include poor levels of functioning arising from apparent lack of motivation, mood, environmental restriction or any other issue whether it is considered to arise from the infant, parents or the environment.

Exclude

Do not include feeding problems rated at scale 4.

Do not include sleeping problems rated at scale 8.

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 the outcome of limited environmental exploration on structured socialisation settings rated at scale 13.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action with self-care or exploration of the environment.
2	Mild problem with self-care or exploration of the environment.
3	Problem of moderate severity with self-care or exploration of the environment.
4	Severe to very severe problem with self-care or exploration of the environment that is likely to be intruding across settings, activities and persons.

Scale 12: Problems with family life and relationships

Include

This scale addresses problems in family life that are thought to impact on the infant. If the parents are separated, consider the relationship with each parent and the separated parents' ability to co-parent where appropriate.

Include relationships with significant others – grandparents, siblings, extended family members, child care providers. Include instances of neglect including physical (e.g. lack of sufficient access to appropriate food, shelter and clothing) and emotional (e.g. lack of warmth, comfort and age-appropriate regulation of the infant's affect). Parental reflective capacity; the availability of access to caring, attentive and empathic adults and the ability to keep the infant in mind, should be considered.

Include parent or family irritability with the infant. Difficulties in managing powerful emotions or any consequent harmful behaviour by those in the infant's immediate environment should be considered.

Include instances of physical or verbal hostility or abuse towards the infant, as well as family hostility or conflict which impacts on the infant. Consider capacity for significant others to contain powerful negative emotions towards the infant.

Issues such as parental or sibling mental health, substance use and personality problems should be included if they have an effect on the infant.

Exclude

Do not include disruptive behaviour by infant, rated at scale 1.

Do not include problems with social reciprocity rated at scale 10.

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. Some concerns about family relationships may be evident but effect on infant mitigated through adequate parental reflective capacity and action are apparent.
2	Mild problem with family relationships. Some impact on the infant's development is apparent.
3	Problem of moderate severity with family relationships. Considerable impact on infant development apparent.
4	Severe to very severe problem in family relationships with severe impact on the infant.

Scale 13: Problems with attending care, education and socialisation settings

Include

This scale addresses attendance at the prime socialisation setting outside of the immediate family. Include attendance at any type of regular socialisation and care activity at the time of rating e.g. regular care with extended family or formal early childhood education (sometimes called kindergarten or pre-school). Include activities irrespective of location or whether a family member is present (e.g. regular play group sessions at infant's home).

Include refusal of, or withdrawal from early childhood education, childcare, play group or similar regular socialisation activity, irrespective of cause.

Include limited or minimal opportunities to attend socialisation activities appropriate to the infant's age.

Include consideration of additional supports such as reassurance, transitional objects, required to settle the infant in the setting.

If early childhood education, childcare etc. is in holiday break, rate the last two weeks of the previous open period.

Note: Infants and young children will communicate their reluctance and distress at attending these settings through a range of symptoms. These may include problems in feeding, toileting, eating, playing, communicating and sleeping both at the settings and around the transition time. These symptoms in themselves are likely to be rated at different HoNOSI scales and are not the sole source of rating at this scale. However, it is acknowledged that the reluctance to attend may be conveyed to the clinician through these symptoms. The actual attendance problems are rated at this scale.

Note: Reluctance to attend a socialisation setting may reflect problems in that setting for the infant. Reluctance to attend may also occur in the dyadic relationship or simply from parental concerns. To reiterate, acknowledging a problem does not mean that the source of the problem or the required solution necessarily lies with the infant. HoNOSI is agnostic as to the locus of any intervention.

Exclude

Many infants have not attended a socialisation setting outside the family and the clinician will typically not consider this a problem. However, a clinician may decide to rate this non-attendance as a problem; for example, where non-attendance has been considered to reflect extended separation difficulties.

All behaviours and emotional expressions or consequences of problems associated with attendance or separation are rated at their respective scales (e.g. Disruptive at scale 1, Feeding at scale 4, Emotional at scale 9, Environmental exploration at scale 11).

Absences due to illness of infant or parents requiring them to be absent from the setting. This typically includes medical conditions, such as fevers, contagious illnesses or infections which would be rated at scale 6.

Rating	Description
0	No problem. Infant displays age-appropriate behaviour on separation from their parents and settles readily when comforted in the environment.
1	Minor problem requiring no formal action with attending and may display reluctance for brief periods. Responds with small amount of support additional to that typically required at this age.
2	Mild problem with some sessions missed or refusal to participate in activities when attending.
3	Problem of moderate severity with several days missed during rating period due to infant's reluctance to attend.
4	Severe to very severe problem with infant absent for most of the days or sessions during the rating period.

Scale 14: Problems with knowledge or understanding about the nature of the infant's difficulties

Include

Include lack of useful information or understanding available to the parents, caregivers, referrers or support system about the nature of the difficulties.

Include problems with capacity or knowledge to understand the infant's difficulties.

Include limited or incorrect understanding of the infant's developmental stage and needs.

Include misunderstanding, minimising, elaborating or exaggerating the difficulties, impact or distress as well as inaccurate attribution of the infant's difficulties.

Include lack of explanation about the difficulty/diagnosis, the cause of the problem or understanding of the prognosis or the impact on the infant.

Rating a problem here does not exclude the service system revising their understanding of the infant's difficulties. In many ways, problems rated here may indicate a lack of congruence between the parent's and other's views about the nature of the difficulties and the views of the clinician (or the assessing or treating system.)

Rating	Description
0	No problem. Parents, referrers or carers demonstrate a good level of understanding about the difficulties.
1	Minor problem requiring no formal action. For example, parents essentially understand infant's difficulties but with occasional misunderstandings such as sometimes downplaying, or exaggerating the infant's difficulty or distress.
2	Mild problem in understanding infant's difficulties.
3	Problem of moderate severity. Parents have very little or very poor knowledge about the nature of their infants' problems.
4	Severe to very severe problem. For example, parents have no understanding about the nature of their infant's problems. Significant disagreement between the parents, or the referrer's or the carer's views and the views of the assessing or treating system.

Scale 15: Problems with lack of information, understanding about services, or managing the infant's difficulties

Include

Include lack of useful information available to the parents, caregivers, or referrers, or a lack of understanding regarding services or management of the difficulties.

Include parental willingness or ability to utilise services or interventions to support the infant. The consistency with which parent's understand or use appropriate strategies and the extent to which supports are required to help the parent's use optimal approaches may be considered.

Include parents, referrers or carers use and implementation of information and appropriate and feasible strategies. Include problems with accessing available services appropriate to the infant's difficulties (e.g. early childhood nursing, child protection, family support).

Rating a problem here does not exclude the service system revising their understanding of the optimal approach to managing the infant's difficulties. In many ways, problems rated here may indicate a lack of congruence between the family, carer's or referrer's views about the management of the infant's difficulties and the views of the clinician (or the assessing or treating system's views).

Rating	Description
0	No problem.
1	Minor problem requiring no formal action. For example, parents have an adequate understanding of how best they and other resources can help their infant, or they are actively seeking appropriate information, support or access to services.
2	Mild problem in understanding or willingness to use the appropriate services, approaches, resources and supports for the infant's difficulties.
3	Problem of moderate severity in understanding or willingness to use the appropriate services, approaches, resources and supports for the infant's difficulties.
4	Severe to very severe problem in understanding or willingness to use the appropriate services, approaches, resources and supports for the infant's difficulties.

Clinical significance and recommended action

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

Where scales are of clinical significance, rated 2 to 4, it is important to ensure that this is recorded in clinical notes, and action points are considered in individual treatment or management plans and recovery planning processes.

	Rating		Monitor	Active treatment or management plan
Clinically Significant	4	**Severe to very severe problem** Most severe category for service users with this problem. Warrants recording in clinical file. Should be incorporated in care plan. Note: Service user can get worse.	✓	✓
	3	**Moderate problem** Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	2	**Mild problem** Warrants recording in clinical notes. May or may not be incorporated in care plan.	✓	*Maybe*
Not clinically significant	1	**Minor problem** Requires no formal action. May or may not be recorded in clinical file.	*Maybe*	✗
	0	**No problem** Problem not present	✗	✗

Rating reliably

Studies show HoNOSI to have good inter-rater *reliability, validity* and have *sensitivity to therapeutic* change. Te Pou's technical review of the psychometric properties of HoNOS family of measures provides an outline of this.

To rate reliably we recommend you complete HoNOS training refreshers a minimum of every two years (this is required to maintain certification as a HoNOS trainer). Regular practice rating HoNOS and consistent use of the glossary will also aide your rating reliability.

Challenge your practice

Practice completing ratings by accessing Te Pou's HoNOS training online. Online training provides you with written vignettes (stories) and videos to practice your scoring and then compare them against consensus ratings.

Many clinicians and experts rate each vignette. The results are then discussed and relevant changes are made to the vignette, so all clinicians and expert raters agree on the final rating scores. This becomes the 'consensus' for the rating of each scale. Consensus scores or ratings are provided with the written vignettes and video.

The outcomes training model and guide
www.tepou.co.nz/resources/the-outcomes-training-model-and-guide

HoNOS training online
www.tepou.co.nz/initiatives/honos-family-of-measures/honos-training

The HoNOS family of measures: A technical review of their psychometric properties
www.tepou.co.nz/resources/the-honos-family-of-measures-a-technical-review-of-their-psychometric-properties

Find alternative online training options on the Australian Mental Health Outcomes and Classification Network (AMHOCN) website
www.amhocn.org

Mental health outcomes information collection protocol (ICP) key concepts

Not only do clinicians need to understand how to use HoNOS, you also require an understanding of the rules. When and what should be collected alongside HoNOS are additional elements that will help you relate to the context for the episode, and provide the ability to more meaningfully compare episodes and their outcome.

These rules, about when and what to collect, are known as the mental health outcomes information collection protocol (ICP), or protocol. Key concepts behind the HoNOS family of measures ICP (for HoNOS, HoNOS65+, HoNOSCA, HoNOSI, HoNOS-LD and HoNOS-secure) are detailed in this section.

The mental health outcomes ICP sets the standards for all specialist Te Whatu Ora inpatient and community mental health services, as well as forensic and intellectual disability mental health services.

The protocol standardises the collection of the HoNOS family of measures. It contains both outcomes and case complexity objectives, allowing the information you collect to be compared across service users and teams or services. It also ensures the information used for benchmarking and service improvement activities has integrity.

Demonstrating change

At a minimum, the protocol requires the following collections to be made in order to demonstrate change.

- At least two collections, at the start and at the end of each episode of mental health care <91 days. This allows a comparison of the change in a person's outcomes over time.
- Reviews at three monthly (91 day) intervals for people in ongoing care.
- Key clinical and descriptive information to be recorded alongside each HoNOS measure to adequately describe each collection occasion.

ICP key concepts

The key concepts underpinning the ICP are detailed below. This is followed by the key clinical and descriptive information that is collected alongside the HoNOS measure.

Service-related descriptors:

- Service setting
- Mental health service team
- Age group.

Service setting

- The *service setting* denotes the setting in which the mental health service is provided. The setting can be *inpatient* or *community*.
- Inpatient – where the service user is admitted to a bed within a psychiatric inpatient unit with an expectation that he/she will stay overnight.
- Community – all other instances where the service user is not an inpatient:
  - inpatients of general medical units seen on a consultation liaison basis
  - prisoners treated in correctional facilities
  - people living in the community who attend inpatient day programmes
  - people living in NGO residential facilities treated by a Te Whatu Ora community mental health team.

Mental health service team

- Identifying a person's primary *mental health service team* is important when tracking their movement within an *episode of care,* and essential for comparing their outcomes within each team.

The team can also be an indicator of which HoNOS measure should be used, for example, a Child and Adolescent Mental Health Service (CAMHS) team providing services to people under 18 years of age would generally use HoNOSCA or HoNOSI rather than HoNOS.

Age group

- Outcome measures to be reported at a particular collection occasion depend on the broad *age group* to which the service user is assigned, for example, adult, older person or child and youth.

As a general rule, HoNOS is for use with adults aged 18 to 64 years accessing services from specialist mental health services.

- Adults are defined as people between the age of 18 and 64 years inclusive.
- Older people are defined as people aged 65 years and older.
- Children and youth are defined as people under the age of 18 years.
- Infants are defined as people under 4years

Age restrictions can be overridden by clinicians where the use of another measure may be more appropriate. For example a 60 year old receiving treatment in an older person's service.

Episode descriptors:

- Episode of care
- Period of care
- Collection occasion
- Focus of care.

Episode of care

An *episode of care*, for the purposes of outcomes collection, is used to refer to a continuous period of contact between a person and a mental health service within the same setting. It has a discrete start and end point, beginning with a referral and admission to a mental health service, and ending when the person is discharged from that setting.

A community and inpatient episode can be open at one time in Te Whatu Ora.

An *episode of care* (admission to discharge) may include one or more *period of care*.

Find out more about transfer rules in PRIMHD for the HoNOS family of measures www.tepou.co.nz/initiatives/honos-family-of-measures/change-of-transfer-rules-in-primhd-for-the-honos-family-of-measures

Period of care

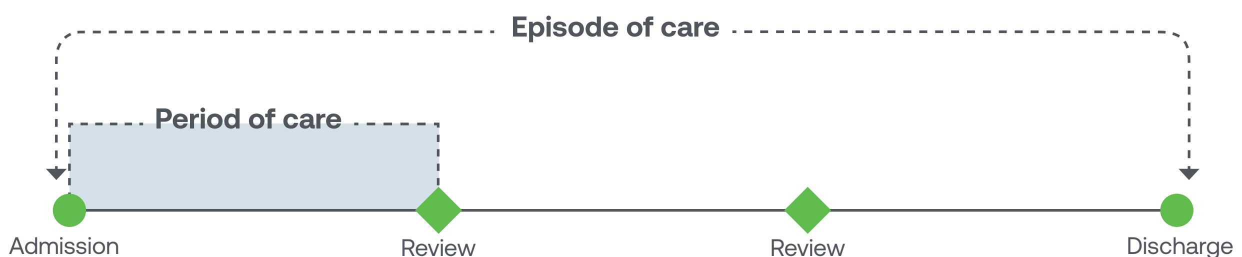
A *period of care* is the interval within an *episode of care* between one collection and the next. For example, the period of care may start with an episode start and end with a *review*. Primarily the period of care provides 'bookends' that allow us to measure outcomes.

For people who are not discharged, a subsequent period of care begins with a review collection three months (91 days) from the date of the episode start. Review collections then continue at three monthly intervals until the service user is discharged or transferred to community setting, or another Te Whatu Ora, only then the episode of care ends.

Outcomes can be viewed over *periods of care* as well as over *episodes of care* (admission to discharge or episode start to episode end).

In cases where a person is admitted and discharged in less than 91 days, and no review is completed, an episode of care and a period of care are the same.

Period of care within a community episode of care



Focus of care

Focus of care is not collected for HoNOSI or HoNOSCA collections.

HoNOSI collection occasion

A *collection occasion* is a point during an *episode of care* where the outcome measures and case complexity information are collected in accordance with the protocol:

- outcomes episode start
- outcomes episode review – three month (91 days) or ad hoc reviews
- outcomes episode end.

Each *collection occasion* acts as a 'trigger' for a specific set of *key clinical information* to be collected.

Episode start

A new *episode start* is when a person commences treatment with a mental health service. This may be a *new referral, a transfer from another setting* or an *admission for another reason*.

For inpatient settings, the *episode start* is the date of admission.

- In community settings, the episode start is the date the service user is first seen by the service.

Assessment only

If an assessment identifies that no further mental health service care will be provided, an *assessment only* collection is required. *Assessment only* collections are useful to teams and services to determine volumes and complexity of people who are not accepted into the service. *Assessment only* collections do not require any follow up collections - they are effectively a combined admission and discharge.

Review – three month (schedule 91 days)

Reviews are required for all service users in ongoing care three months from their *episode start*, or three months since the last *review* was completed.

Three month *reviews* can be scheduled up to 14 days prior to and 14 days after the 91 day period. Giving you 28 days to complete the *review*. In community the review is set from time community admission or last 3 months review and is not affected by inpatient admission.

If an ad hoc review falls within the timeframe of a scheduled review, the ad hoc review can take the place of the scheduled review.

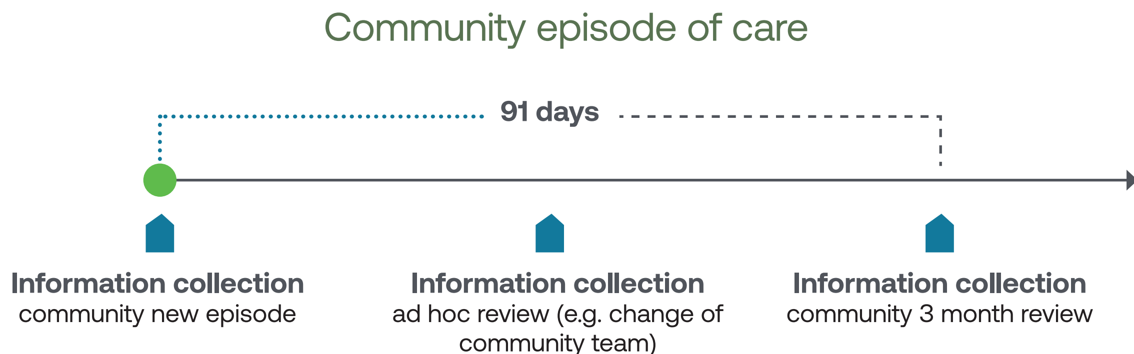
Review other (ad hoc)

An *ad hoc review* may be triggered in response to a significant event and occur earlier than the 91 day standard *review*. This can be done in both inpatient and community. This may include when a person:

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

Your Te Whatu Ora may also have its own local rules about when to complete *ad hoc reviews*.

Ad hoc reviews will not reset the standard three month *review* process, unless the *ad hoc review* occurs within the required timeframe for a three month *review*. In this case they can be considered as a planned three month *review*.



End of episode or inpatient discharge

The *end of episode* occurs when:

- there is no further care planned in the current Health NZ service setting. For example, a service user is discharged from an inpatient team, and/or when a person no longer requires treatment from a community service.
- there is a change in mental health service setting from inpatient to community. This is also known as a *transfer to another setting*.
- a service user is lost to care or is deceased.
- there is a very brief episode of care; less than 72 hours in inpatient services or less than 14 days in community services. Outcome measures are not required to be collected in this instance.

Regardless of the reason, the *end of episode* acts as a 'trigger' for a specific set of clinical data to be collected.

When a service user is lost to care or dies, or when there is a very brief episode of care (as described above) contextual and episode descriptors must be collected to end the episode, but collection of HoNOS is not required.

HoNOSI outcome measure ICP - key clinical and descriptive information

Admission date

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

Collection occasion date

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

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

Completion date

Completion date is the date the *collection occasion was completed*.

Episode start collections are required to be completed within two weeks of assessment *(collection occasion date)* in the community, or within 24 hours in an inpatient setting.

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

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

Reason for collection (RFC)

Important note

While the following RFC apply to the use of HoNOSI, in working with infants the relationship between clinicians and parents/caregivers is critical. Therefore, when mention is made of the service user in these RFC it should be understood we are also referring to the involvement of parents/caregivers in the life of the infant.

The ICP requires that each collection occasion is mapped to a range of key events (such as admission, review or discharge) and triggers a set of information to be collected. There are 12 *reasons for collection* in the protocol to describe the nature of each collection, allowing analysis of outcomes of new service users from those who are admitted following transfer from a community service, for example. The table below is a guide to identifying the correct reason for collection and any associated rules.

Reason code	Guide for use
Assessment only (RFC01)	Use for community settings only, where: » A person is seen for a maximum of two face-to-face sessions for the purpose of assessment only and with the outcome of no further treatment by the Te Whatu Ora. Services delivered 'on behalf of' the service user are not counted as face to face contacts (i.e. phone call or notes made when service user is not present). » A service user is under shared care and is being reviewed for the first time in three months.
Episode start collection occasions	
New referral (RFC02)	Use for new referrals which do not involve a transfer from another mental health service setting within the same Te Whatu Ora. This includes: » self-referrals » referrals from family members or other caregivers » referrals from private medical practitioners, including general practitioners (GPs) and private psychiatrists.
Transfer (admission) from other setting (RFC03)	Use for transfers between mental health service settings, community to inpatient Does **not** include: » transfers between acute psychiatric inpatient units and specialised, high acuity inpatient facilities (eg physical health) *within the same hospital* » instances when a person in a community setting receives more intensive treatment for several days or weeks from a second community mental health team. Referral and assessment documentation should be shared with the receiving service at the time of transfer and may be used to inform the comprehensive admission assessment.
Episode start other (RFC04)	Use for admissions for any reason not defined above. This may include transfers from other external mental health and addiction services and settings including transfers from other Te Whatu Ora and private psychiatric hospitals.
Review collection occasions	
Review – three month (RFC05)	This is the standard mandatory review to be completed at intervals of three months (91 days) in all Te Whatu Ora mental health service settings where a person is in ongoing treatment for three months (91) days. In community the review is set from time community admission or last three months review and is not affected by inpatient admission. **Note**: Assessments can be completed up to 14 days prior and 14 days following the three month review date, allowing 28 days to schedule the review.
Review – other (RFC06)	Use when a decision is made to complete a clinical review in response to a significant event. This may include when a person moves to another mental health and addiction service team within the same setting; when a case manager changes; when the person declines treatment or support, injures themselves or another person or requests a review; when a person receives compulsory assessment or treatment. » Te Whatu Ora may choose to generate local rules, consistent with this national ICP, about completion of ad hoc reviews. » If an ad hoc review occurs within the required three month review timeframe (14 days either side of the scheduled review), it can be used as the three month review.

Episode end collection occasions All collections are required to be completed within one week of episode end in the community, and within three days in an inpatient setting.	
Episode end – no further care (RFC07)	Use when a person is discharged from a mental health and addiction service to their usual residence without referral for further treatment in a mental health and addiction setting in any Te Whatu Ora. Included are instances where a person is referred to a private medical practitioner, or a GP in a PHO.
Episode end – transfer (discharge) to other treatment setting (RFC08)	Use when transfers between service settings occur, inpatient to community. This category principally refers to the end of an inpatient admission when transfers between service settings occur from inpatient to community. It does **not** include: » transfers from general acute psychiatric inpatient units to specialised high–acuity inpatient facilities (eg physical health) and vice versa.
Lost to care (RFC09)	In inpatient settings this includes cases where a person has left care against advice, has been discharged at their own risk, or has otherwise been 'lost to care'. The need for ongoing care may be probable but not clear because the person cannot be contacted. In a community setting, this includes cases where a person in need of ongoing care either has been discharged at their own risk due to their having refused such care, or their current whereabouts are unknown and there is no reasonable expectation that they will be located within 13 weeks of their last service contact. Collection identifiers and period of care data should be completed for service users lost to care. Outcome measures to be completed where the responsible clinician is able to validly ascertain the service user's clinical status at the time. Otherwise valid ratings cannot be made.
Deceased (RFC10)	Use to end an episode of care following the death of a service user. Do not use where a person is recorded to have been lost to care, and it is subsequently found to have died, unless the person died within three days of being lost to care. » Collection identifiers and period of care data should be completed for instances where a service user has died. » Outcome measure data is not required.
Brief episode of care (RFC11)	A very brief episode of inpatient psychiatric mental health care is defined as a length of stay of **three days (72 hours) or less**. A very brief episode of community mental health care is defined as one during which contacts, including either face to face or by telephone, have taken place over a period **less than 14 days**. » Collection occasion identifiers and period of care data should be completed for brief episodes of care. » Outcome measure data is not required.
Episode end - other (RFC12)	Use when a person is discharged from any mental health service setting in one Te Whatu Ora to any setting in another Te Whatu Ora, for example, transfer from an inpatient unit in one Te Whatu Ora to an inpatient unit in another Te Whatu Ora. May also be used for instances where the Te Whatu Ora mental health service's policy indicates that there is a definite clinical or administrative need to consider other clinical events not classifiable under the preceding alternatives as constituting the discharge of a service user.

Key information routinely collected for PRIMHD

In addition to the outcome measure information collected above in PRIMHD, the national dataset collects activity, clinical and descriptive information about an episode of care. This contributes to a better understanding, and more meaningful analysis, of episodes of mental health care and their outcomes.

Mental health principal diagnosis

PRIMHD requires a diagnosis for all mental health and addiction service users within 91 days of their first contact with the service or by the time of discharge.

Due to the nature of mental health and addiction diagnoses, sometimes it is not possible to provide a definitive diagnosis at initial assessment. If this is the case a provisional diagnosis may be made, and as treatment progresses a principal diagnosis allocated. PRIMHD maintains a history of diagnoses.

Mental health legal status

Directors of Area Mental Health Services (DAMHS) are responsible for recording legal status under the appropriate section of any Act that may result in admission or treatment by mental health services.

Things to remember

- A service user may come under more than one Act at any one particular time.
- A legal status record must be provided to PRIMHD when assigned to a service user.

When assessing outcomes, it is important to know whether a service user has been treated on an involuntary basis under the relevant legislation during their episode, or period, of care.

For PRIMHD, this includes any legal status under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Criminal Procedure (Mentally Impaired Persons) Act 2003, or the Criminal Justice Act 1985.

For further information on PRIMHD mental health data
www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

Mental health service activity

The need for sound information on what activity is currently being provided is required so local, regional and national decision makers can make informed decisions about the provision of mental health and addiction services.

If activity information is incomplete, and is not linked to clinical measures (diagnosis, treatment and outcomes), decision makers will not be properly informed.

Guide to PRIMHD activity collection and use
www.health.govt.nz/publication/guide-primhd-activity-collection-and-use

How we use outcomes information collected in clinical practice

Outcome information can be used in many ways and at many different levels. Stakeholders of mental health and addiction services can be divided into four different levels. People involved at each level will primarily be interested in, and will have access to, different kinds of information. The levels are:

The individual level involves the service user, their whānau, significant others, as well as the staff working with them. At this level the individual's own information is primarily used.

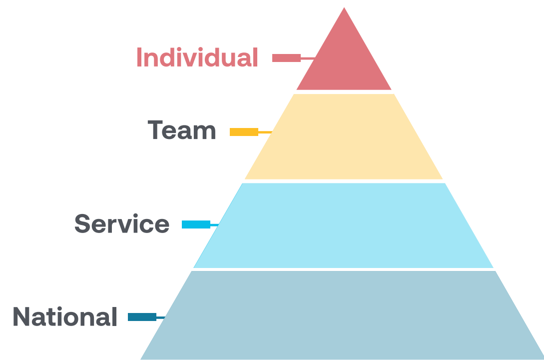
The team level involves staff in a team working directly with the service user, their whānau and significant others. At this level an individual's information is used for some purposes and aggregated data (or data from groups of service users) is used for other purposes.

The service level involves organisations. These often consist of multiple teams and can be a Te Whatu Ora or a larger NGO. At this level aggregated data will primarily be used.

The national level involves government departments or other organisations that consider the national picture, and/or compare across multiple organisations. They will mostly be interested in aggregated data.

Individual level

A collaborative approach should be used to collect outcome measures. Discussing ratings with service users and their parents/caregivers is one way they can participate in their care and treatment, and it may allow for further conversations about recovery. HoNOSI ratings are done by the clinician following an assessment as part of maintaining a service user's record, so the service user doesn't participate in the rating process, nor does the clinician use it as a structured interview. However, sharing HoNOSI ratings with the service users and their parents/caregivers as part of a collaborative care plan should be routine.



Uses at individual level

HoNOSI information can be used to support individual recovery planning and treatment goals. It is a useful tool to monitor progress, the outcomes people want to achieve and to help focus on their recovery. Ways to do this include:

- discussion with infants caregiver about their HoNOSI scores
- discussion with infants caregivers about any changes to their scores – as part of their recovery planning
- completion of adhoc HoNOSi ratings when people experience positive or challenging changes or circumstances
- encouraging people to keep a copy of their ratings over time and track their own progress.

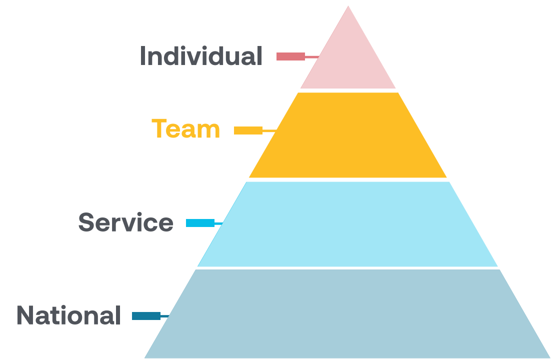
It also:

- supports quality mental health assessments, intervention and recovery planning
- improves opportunities for whānau involvement.

HoNOS outcomes information at this level can be used between clinician and service user through a feedback process. Videos that demonstrate the feedback process are available at www.tepou.co.nz/initiatives/honos-family-of-measures/honos-feedback-scenario-videos

Information about HoNOS ratings for service users www.tepou.co.nz/resources/information-about-honos-and-honos65-for-service-users

Team level



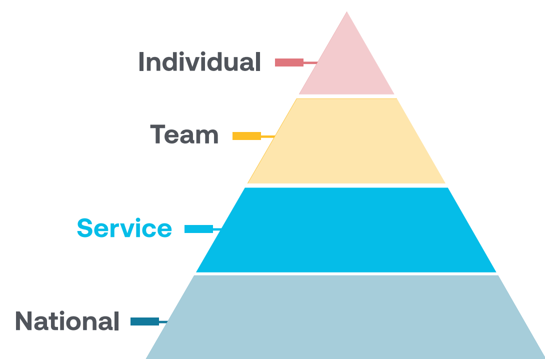
Team level use of HoNOSI can include both individual and aggregated HoNOSI information. This is the only level that can benefit from both individual and aggregated information. Te Pou have resources on how HoNOSI outcomes information can be used within a team setting.

Uses at team level

- To inform and guide multi-disciplinary team discussion
- Allocation of referrals
- Severity of caseloads across the team
- Workforce planning
- Discharge planning.

Using HoNOS in multi-disciplinary teams videos
www.tepou.co.nz/initiatives/honos-family-of-measures/using-the-honos-family-of-measures-in-multidisciplinary-teams

Service level – aggregated data

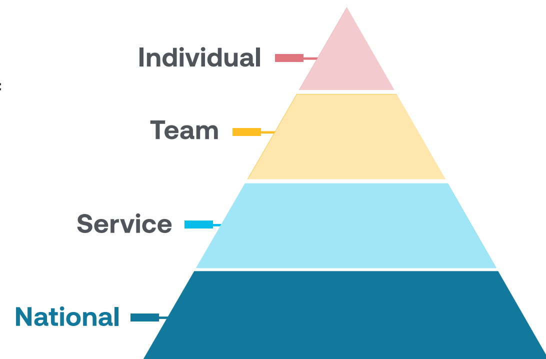


Te Pou provides three monthly outcome reports which are sent to each Health NZ service. If you wish to view these reports, please contact your site coordinator or service manager. These reports may contribute to service level uses. These reports will be made available via a reporting portal in the next year.

Uses at service level

- Benchmarking with other Te Whatu Ora
- Service planning
- Workforce planning
- Service performance and accountability framework
- Research
- Quality initiatives
- Service development.

National level – aggregated data



At an aggregated national level, data collected about HoNOSI contributes to a performance and accountability framework. This can be used to ensure that the quality of services continues to improve.

Uses at national level

- Research
- Understanding trends
- Patterns in outcomes at a national level
- Comparison with other jurisdictions
- Informing policy and mental health strategy.

As well as providing Health NZ service outcome reports, Te Pou provides national reports. These national reports use outcome data collected as part of clinical practice within all Health NZ services to provide an overall picture of data quality, indicating what has changed for service users and how services perform.

View the latest national PRIMHD outcomes summary reports
www.tepou.co.nz/initiatives/honos-family-of-measures/national-honos-reports

PRIMHD information and utility resource: Influencing the broader sector and workforce to improve the quality of the data collected in PRIMHD
www.tepou.co.nz/resources/primhd-information-and-utility-resource

Outcomes information as part of the bigger picture

The programme for the integration of mental health data, PRIMHD (pronounced 'primed'), is the Ministry of Health's national collection of activity and outcomes data in mental health and addictions. It includes service user referrals, activities and outcomes, such as HoNOS, ADOM and social outcome indicators.

PRIMHD's vision is to contribute to the improvement of health outcomes for all mental health and addiction service users in New Zealand. The intent is to provide a single rich data source of national mental health and addiction information which can be used by a range of different stakeholders, including the Ministry of Health, Health NZ services and NGOs, to inform benchmarking activity, service planning, funding of services and changes in policy.

The collection of quality outcome data allows PRIMHD to offer a more detailed understanding of changes in health, wellbeing and circumstances for people accessing mental health and addiction services.

For further information about PRIMHD
www.tepou.co.nz/initiatives/primhd

PRIMHD information and utility resource
www.tepou.co.nz/resources/primhd-information-and-utility-resource

Glossary of terms

Psychometric definitions	
Term	**Definition**
Reliability	Consistency of a set of items or a measure. The extent to which we can be sure that the score received on a test is consistent over time and across conditions. It is used to describe how good the test is at eliminating confounding error.
Validity	Whether the test actually measures what it is intended to measure. Validity testing is concerned with what the test measures and how well it does this.
Sensitivity to therapeutic change	The measure's ability to measure change across time. Feasibility is the degree to which the measure is acceptable to stakeholders or in this case useful in clinical practice. Feasibility is covered in training for the use of the measures in New Zealand.

Training and other resources

Te Pou uses a 'train the trainer' model which supports Te Whatu Ora clinicians in collecting HoNOS ratings. These trainers are responsible for supporting and training clinicians locally.

Each Health NZ service has identified trainers who have been certified by Te Pou after foundational and outcome measure-specific training. Please contact your local site coordinator or outcomes champion to determine trainer availability and for more information.

The outcomes training model and guide
www.tepou.co.nz/resources/the-outcomes-training-model-and-guide

Find out about training, workshops, forums and conferences
www.tepou.co.nz/events

Become a HoNOSI trainer for your service

Are you interested in becoming a HoNOSI trainer for your Health NZ service?

Trainers need a certificate in Part A (foundational training) and B (modular training) to be able to train other clinicians in the use of HoNOSI. After completing Part A training, you can attend one day modular training (Part B) for one or more of the HoNOS measures.

Once you've completed Part A and Part B training, you will be able to provide minimum one day basic outcomes training at your Te Whatu Ora.

Trainers are required to have two-yearly refresher training (at a minimum) to retain their certification.

Te Pou has created online training tools to assist clinicians to become more proficient in using HoNOS. Trainers also have access to a secure site which has presentations, videos and other resources.

Introductory HoNOS family e-learning for clinicians

This is an introductory e-learning for clinicians. It covers the essential information clinicians require to understand, complete and use any of the six HoNOS family measures.

HoNOS refresher training

Clinicians can complete refresher training online by reviewing and rating a series of case studies. Case studies consist of a written vignette and a short video, followed by a rating form and opportunity to check the results.

HoNOS training and e-learning modules
www.tepou.co.nz/initiatives/honos-family-of-measures/honos-training

HoNOS feedback scenario videos

HoNOS feedback scenario videos depict clinicians providing feedback on HoNOS scores (deterioration, improvement or no change/little change) to service users. Examples include offered and requested scenarios in which either the clinician offers to show the service user their HoNOS scores or where the service user requests to see their HoNOS scores. This content is relevant and transferable to all measures in the HoNOS family.

HoNOS feedback scenario videos
www.tepou.co.nz/initiatives/honos-family-of-measures/honos-feedback-scenario-videos

Outcomes graph builder

Te Pou's outcomes graph builder is a Microsoft Excel tool that can be used to generate HoNOS outcomes graphs for individual service users. This tool graphically presents information for up to three time periods, with the ability to store up to 12 individual collections of information. This tool is a handy way to show someone their HoNOS scores and/or for use in team discussions. The graphs can also be used during training to show clinicians an easy option for providing feedback to service users.

Outcomes graph builder
www.tepou.co.nz/resources/honos-outcomes-graph-builder-microsoft-excel-2007-or-later

Marama Real-Time Feedback

Marama Real-Time Feedback is a simple survey for whānau and tāngata whai ora to complete. It consists of seven questions that gauge how satisfied whānau and tāngata whai ora are with services.

Marama Real-Time Feedback
www.marama.co.nz

The Australasian Mental Health Outcomes and Information Conference (AMHOIC)

Te Pou and the Australasian Mental Health Outcomes and Classification Network (AMHOCN) jointly host AMHOIC, a biennial conference that explores outcomes information research and training within New Zealand and Australia.

Let's get real

In addition to outcomes training, Te Pou provides a range of training to services, including *Let's get real*.

The outcomes training is based on the competencies identified in *Let's get real*, a framework that supports people working in mental health and addiction to develop the right knowledge, skills, values and attitudes to effectively support people using services.

There are seven Real Skills for the mental health and addiction workforce.

- Working with service users.
- Working with Māori.
- Working with families.
- Working with communities.
- Challenging stigma and discrimination.
- Law, policy and practice.
- Professional and personal development.

Let's get real
www.tepou.co.nz/initiatives/lets-get-real

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