



HoNOS-LD Guide for New Zealand Clinicians

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Acknowledgment for use of instruments

Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD) Royal College of Psychiatrists 1999.

HoNOS-LD key sources

Roy, A., Matthews, H., Clifford, P., Fowler, V., & Martin, D. (2002) Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD). *British Journal of Psychiatry*, 180, 61-66.

Roy, A., Matthews, H., Clifford, P., Fowler, V., & Martin, D. (2002) Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD). Glossary for HoNOS-LD score sheet. *British Journal of Psychiatry*, 180, 67-70.

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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<http://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/resources/honos/copyright.aspx>

Purpose of this guide

This guide is for HoNOS-LD, 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.

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Outcomes and HoNOS-LD

What is an outcome?

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

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

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

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

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

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

The benefits of collecting quality outcomes information

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

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

Sharing outcomes, such as HoNOS-LD 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

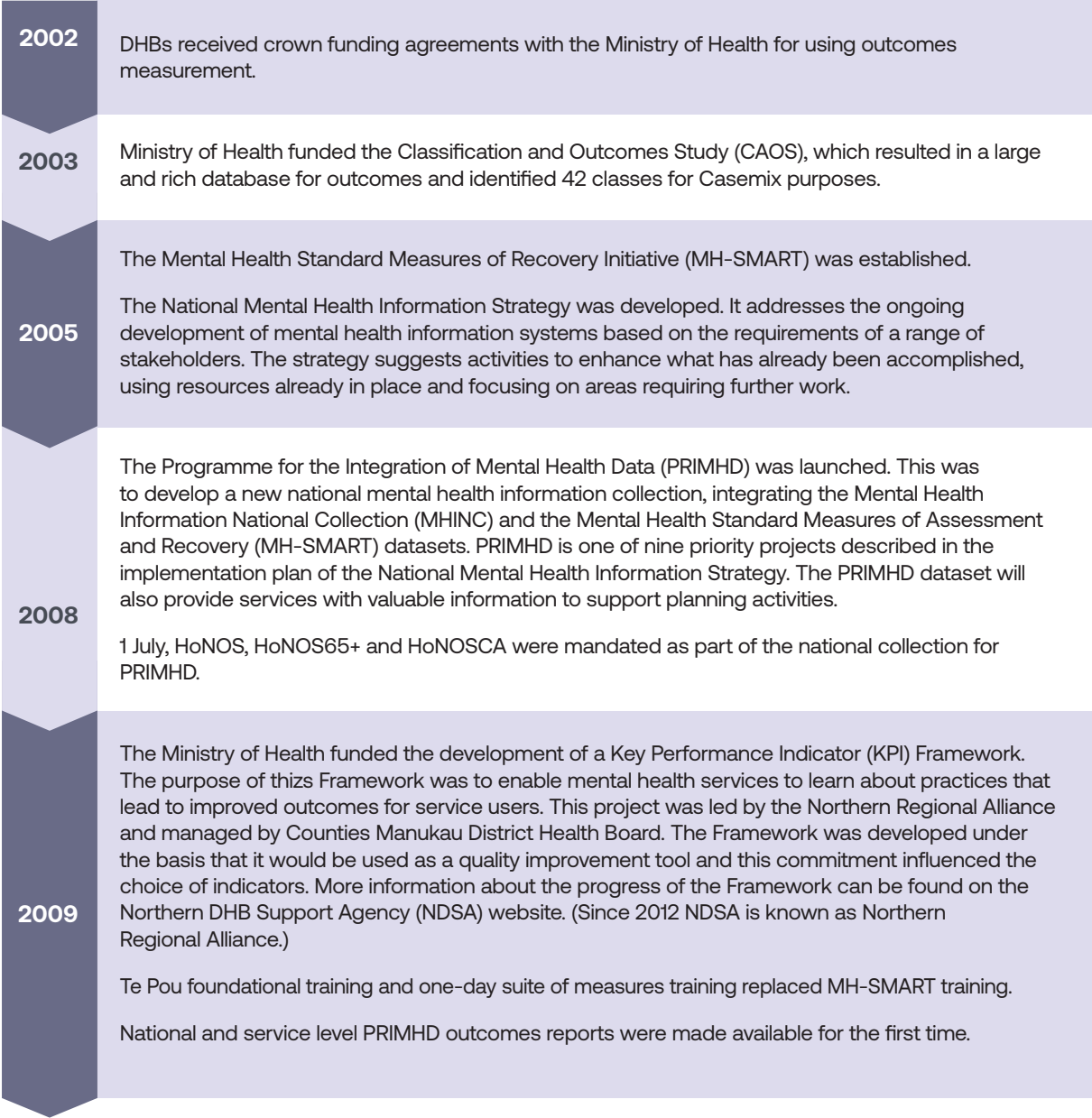
Health of the Nation Outcome Scales (HoNOS) in New Zealand

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

Outcomes in New Zealand – key milestones



Outcomes in New Zealand – key milestones

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 HoNOS-LD?

Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD) is a member of the Health of the Nation Outcome Scales (HoNOS) family of measures. It is a clinician rated tool developed by the Royal College of Psychiatrist’s Research Unit.

There are several variants in the HoNOS family of measures.

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

In New Zealand, HoNOS-LD is the outcome measurement tool mandated by the Ministry of Health for use with adults who have a dual diagnosis of intellectual disability and mental illness.

HoNOS-LD has 18 scales (also referred to as items) they measure behaviour, impairment, symptoms and social functioning. The items are rated, after routine clinical assessment, on a scale of 0 to 4. The glossary provides detailed descriptors for each level of severity and complexity. The results or changes in ratings between one collection and the next are known as outcomes. Outcomes can then be used to measure and compare other service users and service related information.

HoNOS-LD 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.

HoNOS-LD is rated using the relevant glossary and is based on information from the last two weeks of a service user’s presentation at all collection occasions. The exception is for an end of episode in an inpatient setting, where the rating period is three days.

When is HoNOS-LD used?

HoNOS-LD is mandated for use with all adults who have a dual diagnosis, such as a mental illness and an intellectual disability.

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

HoNOS-LD items

1. Behavioural problems – directed to others.
2. Behavioural problems – directed towards self (self-injury).
3. Other mental and behavioural problems.
4. Attention and concentration.
5. Memory and orientation.
6. Communication (problems with understanding).
7. Communication (problems with expression).
8. Problems associated with hallucinations and delusions.
9. Problems associated with mood changes.
10. Problems with sleeping.
11. Problems with eating and drinking.
12. Physical problems.
13. Seizures.
14. Activities of daily living at home.
15. Activities of daily living outside the home.
16. Level of self-care.
17. Problems with relationships.
18. Problems with occupation and activities.

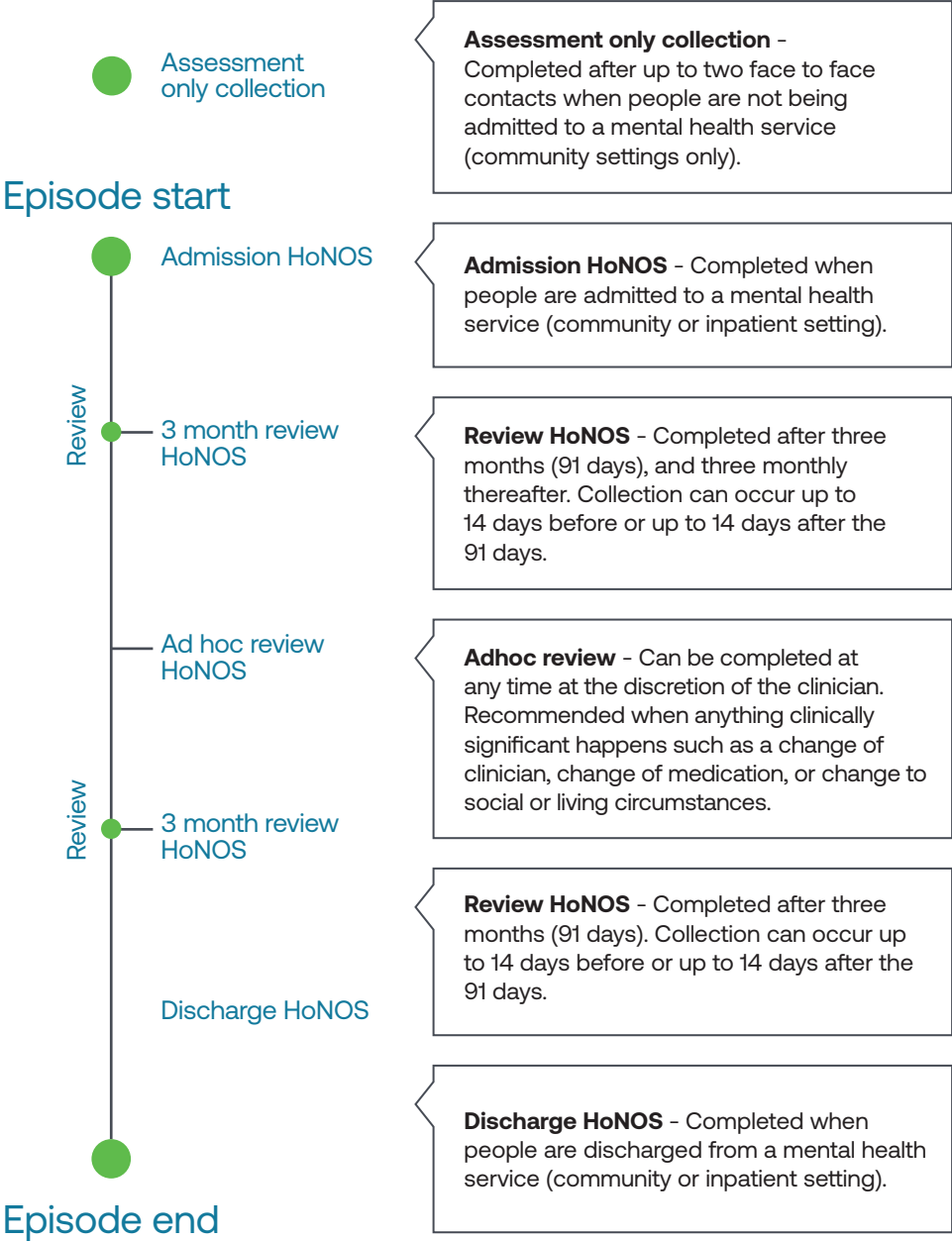
How each item is rated

0. No problem.
1. Mild problem.
2. Moderate problem.
3. Severe problem.
4. Very severe problem.



Note that the 5-point scale rating definitions in HoNOS-LD are slightly different than other HoNOS rating definitions (HoNOS, HoNOS65+, HoNOSCA and HoNOS-secure). This may have an impact on collection systems and should be considered at the time of analysis.

HoNOS-LD collection points



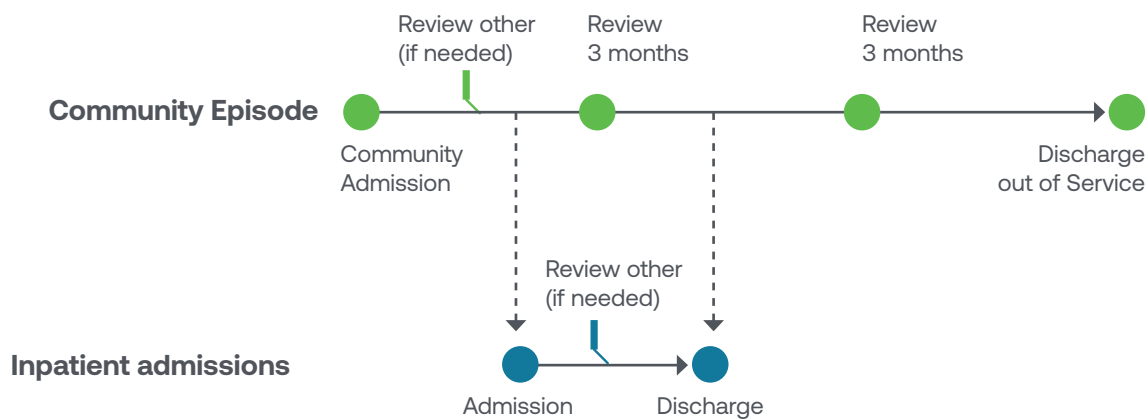
HoNOS-LD collection rules for service users

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 three 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 three monthly reviews.



Who should complete HoNOS-LD 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.

HoNOS-LD 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 four weeks.
- › The exception is at discharge from acute inpatient care, in which case the rating period should be the preceding 72 hours or three days.
- › Each scale is rated on a 5-point item of severity (0 to 4) as follows:
 - 0 - no problem during the period rated
 - 1 - mild problem
 - 2 - moderate problem
 - 3 - severe problem
 - 4 - very severe problem
 - 7 - not known or not able to rate.
- › Specific help for rating each point on each scale is provided in the glossary.
- › As far as possible, the use of rating point 7 should be avoided, because missing data makes scores less comparable over time or between settings.



Note that the 5-point scale rating definitions for the HoNOS-LD are slightly different from the other HoNOS scales.

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

HoNOS-LD should be rated using information available from all sources.

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 glossary

Scale 1: Behavioural problems – directed to others



Include behaviour that is directed to other persons.



Do **not** include behaviour that is directed towards self (item 2) or primarily at property or other behaviours (item 3). Rate risk as it is **currently perceived**.

Rating	Description
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).

Scale 2: Behavioural problems – directed towards self (self-injury)



Include all forms of self-injurious behaviour.



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

Rating	Description
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.

Scale 3: Other mental and behavioural problems

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



Do **not** include behaviour directed towards others (item 1), or self-injurious behaviour (item 2).

Rating	Description
0	No behavioural problem(s) during the period rated.
1	Occasional behavioural problem(s) that are out of the ordinary or socially unacceptable.
2	Behaviour(s) sufficiently frequent and severe to produce some disruption of and impact on own or other people's functioning.
3	Behaviour(s) 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(s) producing major disruption of and impact on functioning requiring constant supervision or physical intervention for prevention.

Scale 4: Attention and concentration



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

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

Scale 5: Memory and orientation



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

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

Scale 6: Communication (problems with understanding)



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

Rating	Description
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.

Scale 7: Communication (problems with expression)



Include all attempts to make needs known and communicate with others (words, gestures, signs). Rate behaviour under items 1, 2 and 3.

Rating	Description
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.

Scale 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).

Rating	Description
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.

Scale 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).

Rating	Description
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).

Scale 10: Problems with sleeping



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



Do **not** rate intensity of behaviour disturbance — this should be included in item 3.

Rating	Description
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).

Scale 11: Problems with eating and drinking

✓ **Include** both increase and decrease in weight.

✗ Do **not** rate pica — which should be rated in Item 3.

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

Rating	Description
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.

Scale 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 items 1, 2 and 3 (e.g. constipation producing aggression).

Rating	Description
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).

Scale 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 items 1, 2 and 3).

Rating	Description
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.

Scale 14: Activities of daily living at home

- ✓ **Include** such skills as cooking, cleaning and other household tasks.
- ✓ **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.
- ✗ Do **not** rate problems with daily living outside the home (item 15).
- ✗ Do **not** rate problems with self-care (item 16).

Rating	Description
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.

Scale 15: Activities of daily living outside of 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 (item 14).
- ✗ Do **not** include problems with self-care (Item 16). Rate the current level with the existing support.

Rating	Description
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.

Scale 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.

Rating	Description
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).

Scale 17: Problems with relationships



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



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

Rating	Description
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.

Scale 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 (Item 16).

Rating	Description
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.

Clinical significance and recommended action

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

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

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

Rating reliably

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

To rate reliably we recommend you complete HoNOS training refreshers a minimum of every two years (this is required to maintain certification as a HoNOS trainer). Regular practice rating HoNOS and consistent use of the glossary will also aid 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, HoNOS-LD, HoNOS-secure and HoNOSI) are detailed in this section.

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

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

Demonstrating change

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

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

ICP key concepts

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

Service-related descriptors:

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

Service setting

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

Mental health service team

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

The team can also be an indicator of which HoNOS measure should be used, for example, a team working with people with joint learning difficulties and mental illness would generally use HoNOS-LD 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 the age of 4 years.

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

Episode descriptors:

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

Episode of care

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

As discussed earlier, a person can only be the subject of one outcomes *episode of care* within the same DHB at any given time. A set of guidelines in “*When is HoNOS-LD used?*” identify the requirements for a number of scenarios that describe transfer between services.

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



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

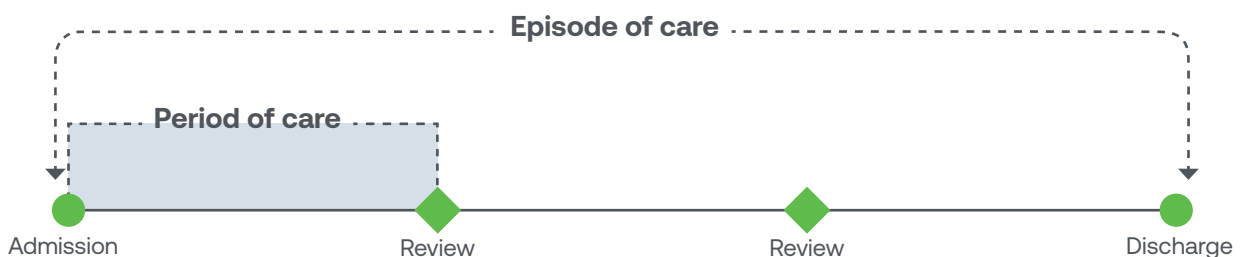
A *period of care* is the interval within an *episode of care* between one collection and the next. For example, the period of care may start with an *episode start* and end with a *review*. Primarily the period of care provides ‘bookends’ that allow us to measure outcomes.

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 another setting, or another DHB, only then the episode of care ends.

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

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

Period of care within a community episode of care



HoNOS-LD 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 three 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)

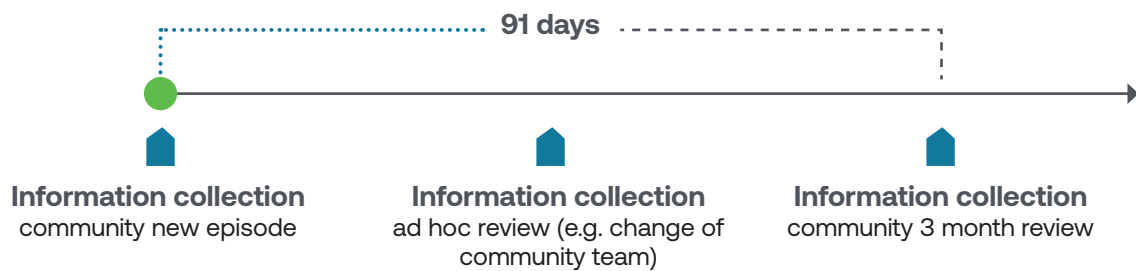
An *ad hoc review* may be triggered in response to a significant event and occur earlier than the 91 day standard *review*. This can be done in both inpatient and community. This may include when a person:

- › 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 DHB may also have its own local rules about when to complete *ad hoc reviews*.

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

Community episode of care



End of episode or inpatient discharge

The *end of episode* occurs when:

- › there is no further care planned in the current DHB or service setting. For example, a service user is discharged from an inpatient team, and/or when a person no longer requires treatment from a community service.
- › there is a change in mental health service setting 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-LD is not required.

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 retrospective global clinical judgment.

Focus of care is not collected for:

- › admission or episode start collections
- › child and youth episodes where HoNOSCA is used.
- › infant episodes where HoNOSI is used.

The *focus of care* is based on the intensity and purpose of the services provided during the preceding *period of care*. As an example, being in an acute setting does not mean there is an acute *focus of care*.

It has implications for the kinds of outcomes that might be expected for each of the four alternative domains: acute, functional gain, intensive extended and maintenance. These are 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. Admission to an acute unit does not necessarily mean the focus of care will be 'acute'.

Functional gain: The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a person 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 person 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 person has stabilised and functions relatively independently.

Focus of care rating guidelines

Service user characteristics			Service requirements		
Symptoms	Functioning	Primary goal	Indicative time to achieve primary goal	Indicative treatment intensity	Examples of typical documentation in care plan to support the rating
1. Acute: Short-term reduction in severity of symptoms and/or personal distress associated with recent onset of exacerbation of psychiatric disorder.					
High and of recent onset	Low–high	Reduce symptoms	Days to weeks	Daily contact over a short period	Interventions designed to reduce the intensity of positive symptoms (e.g. reduce severity of depressive symptoms or the level of anxiety, manage hostile or aggressive behaviour related to mental illness).
2. Functional gain: Improve personal, social or occupational functioning or promote psychosocial adaptation in a client with impairment arising from a psychiatric disorder.					
Low	Low–medium	Improve functioning	Weeks to months	Weekly contact, or more multiple attendances per week in a structured rehabilitation programme	Interventions designed to result in a significant improvement in the service user’s personal, social and/or occupational functioning in the short-term (weeks to months). This may include the development of basic ‘community survival’ skills (e.g. shopping, cooking), social skills (e.g. conversation) or vocational skills (e.g. job seeking or job maintenance).
3. Intensive extended: Prevent or minimise further deterioration and reduce risk of harm in a client who has a stable pattern of severe symptoms/frequent relapses/severe inability to function independently, and is judged to require care over an indefinite period.					
High and unremitting	Low	Reduce risk that arises from symptoms and/or low functioning	Months to years	Minimum of multiple weekly contacts, more frequent as required; delivered over an indefinite period	Inpatient or outreach-based interventions (the latter typically in the service user’s own environment) aimed to (1) minimise the risks and handicaps associated with the on-going symptoms and psychosocial dysfunctions arising from a psychiatric disorder (2) strengthen the service user’s capacity to use supportive professional and non-professional networks.
4. Maintenance: Maintain level of functioning, minimise deterioration or prevent relapse where the client has stabilised and functions relatively independently.					
Low	Low–high	Improve functioning	Months to years	Scheduled weekly to monthly contact	Interventions designed to consolidate the service user’s current functioning (at least in the short-term) while working toward improvement in the long-term or planning for the service user’s exit from the service.
5. Assessment only: The primary goal is only to assess the client.					
High–low	Low–high	Assessment	Days	Assessment only	Assessment documentation only

HoNOS-LD outcome measure ICP – key clinical and descriptive information

Admission date

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

Collection occasion date

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

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

Completion date

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

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

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

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

Reason for collection (RFC)

The ICP requires that each collection occasion is mapped to a range of key events (such as admission, review or discharge) and triggers a set of information to be collected. There are 12 *reasons for collection* in the protocol to describe the nature of each collection, allowing analysis of outcomes of new service users from those who are admitted following transfer from 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)	<p>Use for community settings only, where:</p> <ul style="list-style-type: none"> » A person is seen for a maximum of two face-to-face sessions for the purpose of assessment only and with the outcome of no further treatment by the DHB. Services delivered 'on behalf of' the service user are not counted as face to face contacts (i.e. phone call or notes made when service user is not present). » A service user is under shared care and is being reviewed for the first time in three months.
Episode start collection occasions	
New referral (RFC02)	<p>Use for new referrals which do not involve a transfer from another mental health service setting within the same DHB.</p> <p>This includes:</p> <ul style="list-style-type: none"> » self-referrals » referrals from family members or other caregivers » referrals from private medical practitioners, including general practitioners (GPs) and private psychiatrists.
Transfer (admission) from other setting (RFC03)	<p>Use for transfers between mental health service settings, community to inpatient</p> <p>Does not include:</p> <ul style="list-style-type: none"> » transfers between acute psychiatric inpatient units and specialised, high acuity inpatient facilities (eg physical health) <i>within the same hospital</i> » instances when a person in a community setting receives more intensive treatment for several days or weeks from a second community mental health team. <p>Referral and assessment documentation should be shared with the receiving service at the time of transfer and may be used to inform the comprehensive admission assessment.</p>
Episode start other (RFC04)	<p>Use for admissions for any reason not defined above. This may include transfers from other external mental health and addiction services and settings including transfers from other DHBs and private psychiatric hospitals.</p>
Review collection occasions	
Review – three month (RFC05)	<p>This is the standard mandatory review to be completed at intervals of three months (91 days) in all DHB mental health service settings where a person is in ongoing treatment for three months (91) days. In community the review is set from time community admission or last three months review and is not affected by inpatient admission.</p> <p>Note: Assessments can be completed up to 14 days prior and 14 days following the three month review date, allowing 28 days to schedule the review.</p>
Review – other (RFC06)	<p>Use when a decision is made to complete a clinical review in response to a significant event. This may include when a person moves to another mental health and addiction service team within the same setting; when a case manager changes; when the person declines treatment or support, injures themselves or another person or requests a review; when a person receives compulsory assessment or treatment.</p> <ul style="list-style-type: none"> » DHBs may choose to generate local rules, consistent with this national ICP, about completion of ad hoc reviews. » If an ad hoc review occurs within the required three month review timeframe (14 days either side of the scheduled review), it can be used as the three month review.

Episode end collection occasions

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

Episode end – no further care (RFC07)	Use when a person is discharged from a mental health and addiction service to their usual residence without referral for further treatment in a mental health and addiction setting in any DHB. Included are instances where a person is referred to a private medical practitioner, or a GP in a PHO.
Episode end – transfer (discharge) to other treatment setting (RFC08)	Use when transfers between service settings occur, 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: <ul style="list-style-type: none">» 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. <ul style="list-style-type: none">» Collection identifiers and period of care data should be completed for instances where a service user has died.» Outcome measure data is not required.
Brief episode of care (RFC11)	A very brief episode of inpatient psychiatric mental health care is defined as a length of stay of three days (72 hours) or less . A very brief episode of community mental health care is defined as one during which contacts, including either face to face or by telephone, have taken place over a period less than 14 days . <ul style="list-style-type: none">» Collection occasion identifiers and period of care data should be completed for brief episodes of care.» Outcome measure data is not required.
Episode end – other (RFC12)	Use when a person is discharged from any mental health service setting in one DHB to any setting in another DHB, for example, transfer from an inpatient unit in one DHB to an inpatient unit in another DHB. May also be used for instances where the DHB mental health service's policy indicates that there is a definite clinical or administrative need to consider other clinical events not classifiable under the preceding alternatives as constituting the discharge of a service user.

Key information routinely collected for PRIMHD

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

Mental health principal diagnosis

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

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

Mental health legal status

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



Things to remember

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

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

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



For further information on PRIMHD mental health data

www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

Mental health service activity

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

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



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

How we use outcomes information collected in clinical practice

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

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

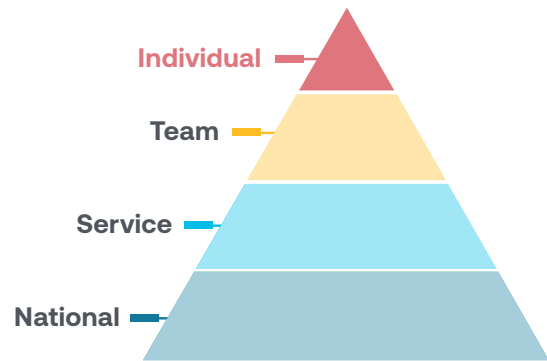
The team level involves staff in a team working directly with the service user, their whānau and significant others. At this level an individual's information is used for some purposes and aggregated data (or data from groups of service users) is used for other purposes.

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

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

Individual level

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



Uses at individual level

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

- › discussion with people about their HoNOS-LD scores
- › discussion with people about any changes to their scores – as part of their recovery planning
- › completion of adhoc HoNOS-LD 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.

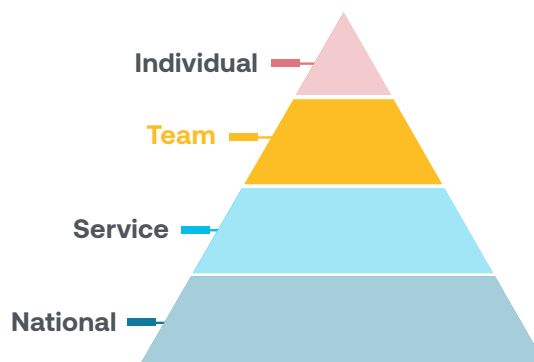


HoNOS outcomes information at this level can be used between clinician and service user through a feedback process. Videos that demonstrate the feedback process are available at www.tepou.co.nz/initiatives/honos-family-of-measures/honos-feedback-scenario-videos

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 HONOS-LD can include both individual and aggregated HoNOS-LD information. This is the only level that can benefit from both individual and aggregated information. Te Pou have resources on how HoNO-LD 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

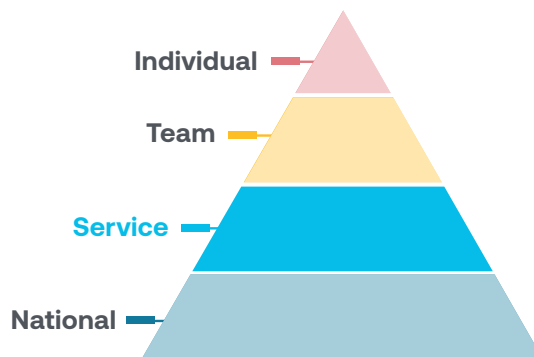


Using HoNOS in multi-disciplinary teams videos
www.tepou.co.nz/initiatives/honos-family-of-measures/using-the-honos-family-of-measures-in-multidisciplinary-teams

- › Discharge planning.

Service level – aggregated data

Te Pou provides three monthly outcome reports which are sent to each of the 20 DHBs. If you wish to view these reports, please contact your site coordinator or service manager. These reports may contribute to service level uses.



Uses at service level

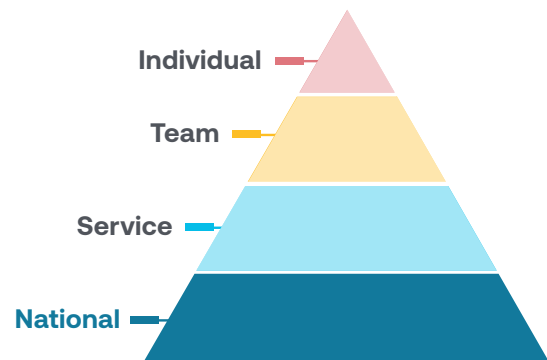
- › Benchmarking with other DHBs
- › Service planning
- › Workforce planning
- › Service performance and accountability framework
- › Research
- › Quality initiatives
- › Service development.

National level – aggregated data

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

Uses at national level

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



As well as providing DHB outcome reports, Te Pou provides national reports. These national reports use outcome data collected as part of clinical practice within all 20 DHBs to provide an overall picture of data quality, indicating what has changed for service users and how DHBs perform.



View the latest national PRIMHD outcomes summary reports
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, DHBs and NGOs, to inform benchmarking activity, service planning, funding of services and changes in policy.

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



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 DHB clinicians in collecting HoNOS ratings. These trainers are responsible for supporting and training clinicians locally.

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



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 HoNOS-LD trainer for your DHB

Are you interested in becoming a HoNOS-LD trainer for your DHB?

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

Once you’ve completed Part A and Part B training, you will be able to provide minimum one day basic outcomes training at your DHB.

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

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

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 five 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

