

## **Health of the Nation Outcome Scales (HoNOS) – Frequently Asked Questions**

### **1 Frequently asked questions**

#### **What is HoNOS?**

It is a set of 12 scales, each measuring groups of problems commonly presented by people with mental health problems.

#### **How is severity measured?**

All scales follow the same 5-point scale:

- 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

The glossary provides more detailed examples of each rating point for the 12 individual scales.

#### **What if there is insufficient information to make a rating?**

Rate 9 if Not Known. However, remember that rating 9 will impact on the ability to use the data to measure outcome, so wherever possible use your assessment to gather all of the information required to rate the HoNOS.

#### **How are outcomes measured using HoNOS?**

By comparing the severity of problems recorded at time 1 against time 2.

#### **Who can complete the HoNOS?**

Any trained mental health professional.

#### **When is HoNOS completed?**

The scales are completed after comprehensive assessment. Specific times are usually initial assessment, routine reviews, urgent re-assessments in response to changes in presentation and at the discharge of patients.

### **What questions do I ask the patient?**

It is not intended that the HoNOS structures your clinical assessment. You should undertake your usual clinical assessment and then use the information to complete the scales.

### **What information can be used to make the ratings?**

As well as your interview with the patient, use all available information and reports from other informants including carers and significant others. But remember, the rating is based on your clinical judgement.

### **What if two problems are present on the same scale but of different severity?**

This happens quite a lot because each scale represents a wide range of problems. Always rate the most severe problem that occurred during the period rated.

### **What time period do I rate?**

The HoNOS considers the worst problems that have occurred during the previous two weeks. If time 2 rating takes place **less** than two weeks after the time 1 rating, then you need to rate problems that have occurred over a shorter period of time (usually just one week). Otherwise you will be considering problems that occurred during the time rated at time 1.

### **When thinking or beliefs are thought to be inconsistent with a person's culture, how do I determine whether they are or not?**

It is vital that clinical assessments take account of the diverse needs of people, including their beliefs and cultural and religious heritage, as these have a major impact on understanding the way people present. It's always useful to check with relatives, carers or the person's peer group to establish their views on whether the person's beliefs are culturally normative.

### **Where can I rate 'elation' in HoNOS?**

Scale 8 'J' provides the opportunity to rate elation, but remember that any associated overactive, disruptive or agitated behaviours will have already been rated at scale 1.

### **How do I rate.....**

**.. a patient who hears hallucinatory voices telling them to harm people but who is not distressed by this and whose behaviour has not been affected during the period rated?**

Rate 0 on scale 1; 2 on Scale 6.

**.. violent ruminations with severe distress in a patient with obsessional-compulsive disorder but no manifestations in behaviour.**

Rate 0 on Scale 1; 4 on Scale 8C.

**.. a patient with personality problems who has markedly aggressive thoughts towards others and has problems in relationships, but has not acted aggressively during the period apart from a couple of quarrels.**

Rate 1 on Scale 1; 3 on Scale 9.

**.. a patient severely disabled after diving from a high window, who has not been suicidal during the period but has been severely depressed.**

Rate 0 on Scale 2; 4 on Scale 5; 4 on Scale 7.

**.. a patient with severe Korsakov's syndrome who has not been drinking or craving alcohol during the period.**

Rate 0 on Scale 3; 4 on Scale 4.

**.. a patient with severe tardive dyskinesia who has adapted well, is not bothered by it and, during the period under review, has had none of the psychotic symptoms for which medication was originally taken.**

Rate 4 on Scale 5 if justified by the severity of the dyskinesia; 0 on Scale 6.

### **What does not 'double counting' mean when rating HoNOS?**

Scales should be rated on the basis of content specific to that scale alone, without consideration of causes or associations with other scales. Risk of future problems is not considered in HoNOS but should be an item in any dataset of which HoNOS is a part.

### **Where can I rate thought disorder in HoNOS?**

In rating thought disorder there may be some aspects of thought disorder that present as delusional (e.g. thought insertion/broadcasting) and thus are rated at scale 6, whilst other phenomena such as knights move thinking will be rated at Scale 4.

### **How do I score long term illness (e.g. HIV) where this is not currently impacting on personal functioning?**

A patient in remission from (or who is not currently displaying any symptoms as a result of) a long-term illness is rated on the worst state in the period, not on the prospective level.

**Can I rate smoking/tobacco misuse at scale 3?**

This issue was not addressed in the initial guidance but has been subject to extensive international debate by HoNOS experts and the decision has been made to NOT include tobacco use here.

**Do I rate the misuse of psychoactive prescribed medicines and over the counter products such as codeine that can be misused at scale 3?**

Yes, where the substance being misused is psychoactive. This does not include the misuse of other substances such as laxatives in eating disorder presentations.

**How do you rate self harm at scale 2 in someone whose behaviour is caused by their psychosis?**

When considering this issue it is important to remember that the scale looks at non-accidental (i.e. deliberate) self harm. So it is important to assess the level of insight and control that the individual has over their behaviour. If the behaviours are definitely caused by delusions and/or hallucinations then they should be considered at scale 6. However, where a patient uses self harm as a means of trying to cope with distress caused by hallucinations and delusions this could be considered as deliberate self harm and rated at scale 2.

**Patients with an eating disorder may have physical illness caused directly by their mental illness, but this may not stop them functioning physically. Indeed many may carry on doing what they have always done physically and add a lot of extra physical exertion as part of their mental illness. Consequently, their physical health can become very serious, but this is not immediately apparent in their presentation. If it is not apparent, then how should scale 5 be rated?**

You should rate the current level NOT the potential level of ill health and/or disability. Some examples are related to more obvious examples like Hepatitis or HIV where someone can present as perfectly OK despite the obvious potential hazards to health associated with the diagnosis. Similarly you may have some form of long term degenerative condition that may ultimately be fatal but it is the previous 2 weeks that provide the sample health profile to inform the rating. So the patient may have been relatively well in the 2 week period and so would be rated quite low. They may subsequently experience a deterioration but this is only rated if the patients

needs to be reassessed. Some of the issues raised by Eating Disorders can be difficult to rate as there is often a sense that the client will carry on doing things despite the risks and continued harm that their lifestyle might cause, but it has to be rated on current function/level of disability.

## **2. Systematic run through the HoNOS scales**

The HoNOS Glossary has been refined by taking account of the comments and questions of supervisors and raters during the course of the field trials. The following commentary provides a consecutive description of the principles of rating as applied to each scale in turn. For scales 1-9, the worst problem occurring during the chosen period is rated to give a measure of 'present state'. The rater does not attempt to rate each scale as an average over the period. Scales 10-12, by definition, do require a more general rating over the chosen period.

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

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

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

### ***Scale 2 Non-accidental self-injury***

This scale deals with ideas or acts of self-harm in terms of their severity or impact. As in the clinical situation, the issue of intent during the period, though sometimes difficult to assess (e.g. when patient is slowed by depression), is part of the current risk assessment. Thus, severe harm caused by an impulsive overdose could be rated at severity point 3 rather than 4 if the clinician judged that the patient had not intended more than a moderate demonstration. Conversely, a patient who acquired a gun with clear intent to commit suicide, but was prevented in time, would be rated at point 4 (although rated 0 at scale 5). However, in the absence of strong evidence to the contrary, clinicians will usually assume that the results of self-harm were all intended. Risk of *future* self-harm is not part of this rating; it should be part of the wider dataset.

### ***Scale 3 Problem drinking or drug taking***

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

be included here. Longer term cognitive effects such as loss of memory are rated at scale 4, physical disability (e.g. from accidents) or disease (e.g. liver damage) at scale 5, mental effects at scales 6-8, problems with relationships at scale 9.

#### ***Scale 4 Cognitive problems***

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

#### ***Scale 5 Physical illness or disability problems***

Consider the impact of physical disability or disease on the patient in the recent past. Problems likely to clear up fairly rapidly, without longer term consequences (e.g. a cold or bruising from a fall), are rated at point 0 or 1. A patient in remission from a possible long-term illness is rated on the worst state in the period, not on the prospective level. The rating at points 2-4 is made in terms of degree of restriction on activities, irrespective of the type of physical problem. Include impairments of the senses, unwanted side effects of medication, limitations on movement from whatever cause, injuries associated with the effects of drugs or alcohol, etc. The physical results of accidents or self-injury in the context of severe cognitive problems should also be rated here.

#### ***Scale 6 Problems associated with hallucinations and delusions***

Rate such phenomena irrespective of diagnosis. Rating point 1 is reserved for harmless eccentricity or oddness. If a patient has a delusional conviction of royal descent but does not act accordingly and is not distressed, the rating is at point 2. If the patient is distressed, or behaves bizarrely in accordance with the delusion (e.g. acting in a grandiose manner, running up large debts, dressing the part, expecting to be admitted to a royal palace, etc.) the rating is at 3 or 4. Any violent overactive and disruptive behaviour, however, has already been rated at scale 1 and should not be included again. Similar considerations apply to other kinds of delusion and to hallucinations.

#### ***Scale 7 Problems with depressed mood***

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

### ***Scale 8 Other mental and behavioural problems***

This scale provides an opportunity to rate symptoms not included in the previous clinical scales. Several types of problem are specified, distinguished by the capital letters A-J, as specified below. Only the single most severe problem occurring during the period is rated. This procedure is repeated at future points (e.g. review). In this way, the most severe problem is always rated for each succeeding time period and the contribution to the total score reflects severity at Time1 and Time2 even if the symptom type changes. (The outcome of the problem rated at T1 can be recorded separately if needed.)

- A Phobic
- B Anxiety
- C Obsessional-compulsive
- D Mental strain/tension
- E Dissociative ('conversion') problems
- F Somatoform
- G Eating (Problems with appetite, over- or undereating)
- H Sleep
- I Sexual
- J Other - Problems not specified elsewhere: e.g. expansive or elated mood

### ***Scale 9 Problems with relationships***

This scale concerns the quality as well as the quantity of patients' communications and social relationships with others. Both active and passive relationships are considered, as are problems arising from patients' own intrusive or withdrawn behaviour. Take into account the wider social environment as well as the family or residential scene. Is the patient able to gain emotional support from others? If patients with dementia or learning disability (including the autistic spectrum) are over-friendly or unable to interpret or use language (including body language) effectively, communication and relationships are likely to be affected. People with personality problems (rated independently of diagnosis) can find it difficult to retain supportive friendships or make useful allies. If the patient is rather solitary, but self-sufficient, competent when with others, and satisfied with the level of social interaction, the rating would be 1. Near-total isolation (whether because the patient withdraws, or is shunned by others, or both) is rated 4. Take the degree of the patients' distress about personal relationships, as well as degree of withdrawal or difficulty, into account when deciding between points 2 and 3. Aggressive behaviour by the patient towards another person is rated at scale 1.

### ***Scales 10 to 12 Ratings of functioning and of personal autonomy***

Repeated ratings at scales 10 – 12 provide an assessment of change in:

- overall personal and social handicap (which clinicians hope to minimise), and

- personal autonomy; i.e. the ability to use intact abilities and skills, which clinicians hope to maximise.

The rating at scale 10 summarises the severity of personal and social handicap associated with problems rated at scales 1-9 and with the patient's motivation.

Ratings at scales 11 and 12 summarise the degree to which the patient's ability to use intact functions is restricted by the residential or the daytime environment. Note that ratings on these two scales are independent of each other; they may well differ. It will usually be appropriate to assess all three scales on the whole of the period under consideration.

### ***Scale 10 Problems with activities of daily living***

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

- 1) a summary of the effects on personal and social functioning of the problems rated at scales 1-9;
- 2) a lack of opportunities in the environment to use and develop intact skills;
- 3) a lack of motivation or encouragement to use opportunities that are available.

The overall level of performance rated may therefore be due to lack of competence, to lack of opportunities in the environment, to lack of motivation, or to a combination. Two levels of functioning are considered when deciding the severity of problems:

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

### ***Scale 11 Problems with living conditions***

This scale requires a knowledge of the patient's usual domestic environment during the period rated, whether at home or in some other residential setting. If this information is not available (usually because someone is in an acute setting who has not previously been in contact with services), rate 9 (not known). Where a patient is in a longer term placement such as a long stay rehabilitation setting, if the plan of care is for that person to remain in that setting for at least 6 months then it is that environment that should be rated.



Consider the overall level of performance this patient could reasonably be expected to achieve given appropriate help in an appropriate domestic environment. Take into account the balance of skills and disabilities. How far does the environment restrict, or support, the patient's optimal performance and quality of life? Do staff know (as they should) what the patient's capacities are? The rating must be realistic, taking into account the overall problem level during the period, ratings on scales 1-10, and information on the following points:

- are the *basics* provided for - heat, light, food, money, clothes, security and dignity? If the basic level conditions are not met, rate 4;
- consider the quality and training of staff relationships with staff or with relatives or friends at home; degree of opportunity and encouragement to improve motivation and maximise skills, including: interpersonal problems; provision for privacy and indoor recreation; problems with other residents; helpfulness of neighbours. Is the atmosphere welcoming! Are there opportunities to demonstrate and use skills: e.g. to cook, manage money, exercise talents and choice, and maintain individuality? If full autonomy has been achieved, i.e. the residential environment does not restrict optimum performance overall, rate 0;
- a less full but adequate regime is rated 1. Between these poles, an overall judgement is required as to how far the environment restricts achievable autonomy during the period - 2 indicates moderate restriction and 3 substantial.

### ***Scale 12 Problems with occupation and activities***

The principles considered at scale 11 also apply to the outside environment. This scale requires a knowledge of the patient's usual day time environment during the period rated, whether at home or in some other residential setting. If this information is not available (usually because someone is in an acute setting who has not previously been in contact with services), rate 9 (not known). Where a patient is in a longer term placement such as a long stay rehab setting, if the plan of care is for that person to remain in that setting for at least 6 months then it is the environment around that placement that should be rated.

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

environment brings out the best abilities of the patient during the period rated, whatever the level of disability rated at scale 10. This requires a judgement as to how far changing the environment is likely to improve performance and quality of life and whether any lack of motivation can be overcome.

- If the level of autonomy in daytime activities is not restricted, rate 0. A less full but adequate regime is rated 1.
- If minimal conditions for daytime activities are not met (with the patient severely neglected and/or with virtually nothing constructive to do), rate 4.
- Between these poles, a judgement is required as to how far the environment restricts achievable autonomy - 2 indicates moderate restriction and 3 substantial.