AMHOCN

Australian Private Hospitals Association

Comprehensive guidelines for the reliable and valid rating of the Health of the Nation Outcome Scales (HoNOS) in Australian Mental Health Services.

Version 1.0, August 2025

Preface

The Health of the Nation Outcome Scales (HoNOS) have now been implemented under nationally agreed data collection protocols across both the public and private specialist mental health service sectors in Australia, with that collection now having been in place for over 20 years.

This document has been developed as a comprehensive guide and reference for clinicians. It is also intended to support the future development of training resources. We have not aimed for brevity. Rather, our purpose has been to document our considered understanding of the HoNOS rating process, drawing on over fifty years of combined experience in training clinical staff.

Our aim has been to provide clarification grounded in that training experience. Rather than simply collating frequently asked questions with brief responses, we have sought to articulate the core concepts and rating principles that underpin accurate and clinically meaningful use of the HoNOS.

In developing this document, we have drawn extensively on insights gained from the original guidance prepared by Wing, J., Curtis, R., and Beevor, A. in their 1995 publication: ***HoNOS: Report on Research and Development***, Royal College of Psychiatrists, Research Unit and other work in the public domain. That foundational work has been central to the implementation and interpretation of HoNOS in Australia. However, this document does not replicate or revise that guidance. Instead, it reflects an independent synthesis shaped by our training experience, evolving clinical practice, and the specific requirements of the Australian context.

The guidance provided here applies to the version of the HoNOS currently implemented in Australia under agreed national protocols. Readers in other jurisdictions may need to consider any differences in the implementation of HoNOS in their setting.

About the authors

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Allen Morris-Yates is a research psychologist with over 35 years of experience in mental health research and information systems. Since the late 1990s, he has worked with the private psychiatric hospital sector to support the routine collection and analysis of outcome data. He has contributed to the development and implementation of national models for outcome reporting and has been involved in integrating outcome measures such as the HoNOS and MHQ–14 into service-level reporting systems.

Tim and Allen have both provided training in HoNOS to clinicians working in specialist mental health services, across both public and private sectors. Over the past 20 years, Tim has delivered face-to-face training to thousands of public sector clinicians, while Allen has worked with clinical staff in most of Australia's private psychiatric hospitals. They have consulted one another regularly over this time to

maintain a consistent interpretation of HoNOS rating guidelines and respond to emerging questions from the field.

Acknowledgements

The authors would like to acknowledge the valuable advice provided in reviews of an early draft of this document undertaken by Mr. Mick James (formerly HoNOS Adviser at the Royal College of Psychiatrists, UK), Dr Jon Painter (Senior Lecturer in Mental Health Nursing at Sheffield-Hallam University, UK), and Ms. Amanda Pickering (Senior Clinical Psychologist with extensive experience in the treatment of people with eating disorders, borderline personality disorders and related conditions).

Suggested citation

Coombs, T., & Morris-Yates, A. (2025) Comprehensive guidelines for the reliable and valid rating of the Health of the Nation Outcome Scales (HoNOS) in Australian Mental Health Services. Sydney: Australian Mental Health Outcomes and Classification Network; Canberra: Australian Private Hospitals Association.
DOI: https://doi.org/10.5281/zenodo.19656376

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Introduction and general guidelines

About the HoNOS

The Health of the National Outcome Scales, usually referred to as the "HoNOS", consists of a set of twelve rating scales designed by the UK Royal College of Psychiatrists (RCP) for use by specialist mental health services in monitoring progress towards the UK National Health Service's target which was stated as " ...to improve significantly the health and social functioning of mentally ill people" (Wing et al., 1998). The objectives were to develop a measure that was brief, comprehensive and clinically relevant. Although it is clearly difficult to combine all these attributes in a single 12–Item measure, the HoNOS does, to a greater extent than any other available instrument, meet those requirements.

In Australia, the HoNOS family of measures has been introduced in a wide variety of service settings and with people having a wider variety of presentations from those originally intended (Wing et al., 2000). The HoNOS has now been implemented as the standard clinician–completed rating scale in all public specialist mental health services and private hospital-based psychiatric services in Australia. This clinical reference aims to clarify the use of the measure in light of the experience of implementation of the HoNOS.

It is important to acknowledge that no document that aims to provide clarification will be perfect and there may still be variability in interpretation. However, this is to be expected because no mental health measure has perfect interrater reliability. Providing clarity will be a challenge because the measure is trying to achieve the almost impossible reduction of complexity and variability in the presentation of a person to a collection of twelve scales. However, it is important to recognise that the HoNOS provides over 60 different data points to describe the individual's unique presentation.

The content of the HoNOS

The HoNOS is based on the psychiatric assessment framework developed by Professor John Wing in the UK. Wing's view was that effective care must be based not just on the person's diagnoses, but on a comprehensive clinical assessment of the person's behaviours, symptoms, functioning and the environmental factors most relevant to their ongoing recovery or at least maintenance of functioning.[1]

The HoNOS is a multidimensional measure of problem severity capturing information across a broad spectrum of problem areas. It consists of 12 Items, rated in order from 1 to 12, with each

[1] ***SCAN*** or ***Schedules for Clinical Assessment in Neuropsychiatry*** is a set of tools created by the World Health Organisation aimed at diagnosing and measuring mental illness that may occur in adult life. It is not constructed explicitly for use with either the ICD-10 or DSM-IV but can be used for both systems. The SCAN system was originally called the *Present State Examination (PSE)*, but since version 10 (*PSE-10*), the commonly accepted name has been SCAN. The current version of SCAN is 2.1. For further information and references see Wing, J. "SCAN and the PSE tradition." Social Psychiatry & Psychiatric Epidemiology. 31.2 (1996): 50-54.

Item rated on a 5-point severity scale from 0-4. These Items will be familiar to trained mental health professionals as areas where people with a mental illness can commonly have problems and will be of interest because, for clinicians, they may be areas that are the focus of clinical interventions.

Items 1 to 8 focus on the person. Item 1 addresses Overactive, aggressive, disruptive or agitated behaviour; Item 2, Non-accidental self-injury and suicidal ideation; and Item 3, Problem drinking or drug-taking. This initial placement of the three behavioural scales reflects the view that these issues may be of first concern in any acute presentation.

Item 4 addresses Cognitive problems and Item 5, Physical illness or disability problems. This intermediate placement of these two items that address the person's cognitive and physical state, prior to items addressing psychiatric symptoms and social problems, reflects the view that the person's medical condition must be considered before contemplating their symptoms and social functioning.

Item 6 addresses Problems associated with hallucinations and delusions; Item 7, Problems with depressed mood; Item 8 Other mental and behavioural problems.

The remaining four Items 9 – 12 address social and role functioning together with the environmental factors that may support or inhibit the person's wellbeing and recovery. Item 9 addresses Problems with relationships; Item 10, Problems with activities of daily living; Item 11, Problems with living conditions; and Item 12, Problems with occupation and activities.

Items 9 through 12 may be difficult to rate in an emergency admission to an acute inpatient service setting if information about performance is unavailable elsewhere. Nevertheless, the issues addressed by Items 11 and 12 in particular, although possibly difficult to rate, are likely to be of significant importance in supporting the transfer of care, discharge planning, and in assisting the person's recovery once discharged.

Ratings are based on your clinical assessment

As was previously noted, the HoNOS is a summary of your clinical assessment of the person. The HoNOS is, however, not intended to structure the clinical assessment process or be used as an interview guide.

The HoNOS should usually be completed following a clinical assessment. Mindful that in routine practice, clinical assessment includes gathering information not only from interviews and observation, either face to face or via the telephone, but also the gathering of information from a range of possible informants.

Taken together, the ratings on the twelve items provide a description of the nature, severity and complexity of the patient's presentation at the specified point in their clinical path.

In clinical assessment you seek to obtain a wholistic understanding of the person's presentation and the relationship between the person's problems, strengths and treatment goals. This understanding occurs during the process of formulation of the treatment or care plan. Within this

context, HoNOS introduces a task that can feel counterintuitive: it asks you to break down that holistic understanding into distinct components, each aligned to one of the twelve HoNOS items.

HoNOS is intended to be grounded in clinical judgement and expertise, and when integrated into clinical practice, it can enhance the documentation and communication of clinical need and change over time. The quality of HoNOS ratings — their reliability and validity — reflects a range of factors, including the quality of clinical assessment, the rater's understanding of the HoNOS framework, and the extent to which the task is approached as a clinical rather than administrative activity. Support from colleagues and the broader organisation, along with a shared commitment to the meaningful use of outcome data, also plays an important role.

Use all available information

All information available to you when making a clinical judgement on the nature and severity of the person's problems should be used to guide the rating of the HoNOS.

Information should be gathered from:

- the person;
- direct observation;
- other clinical staff in your service (nurses, clinical psychologists, etc.);
- the person's psychiatrist or general practitioner;
- the clinical record;
- family and friends; and
- any other clinicians or agencies involved in the person's care.

It is best to complete ratings based on the information available at the time. Your objective should be to cover the domains addressed by the 12 HoNOS Items during your assessment. This will help ensure there is consistency in assessment practice.

Nevertheless, you may and should change your ratings if further information becomes available, indicating your initial rating of the problem during the period rated was incorrect.

Rating individuals who leave against clinical advice or are lost to care

In cases where a person has been lost to care, left the hospital, or stopped attending a day program against medical or clinical advice, it is still possible to score HONOS in absentia.

In some cases, the person may choose to call you or another clinician in the team to advise the hospital of their decision. In that case, you or that other clinician could take that opportunity to ask the person a few questions about how they were going and why they had decided to leave the hospital or quit the program. However, they might also wish to avoid that type of interaction and just make a brief call to the service's reception.

In either case, as mentioned above, it is assumed that in providing care in any service setting, the hospital's clinical staff work with the person's treating psychiatrist, general practitioner or case

manager and that within that context, in such circumstances, a brief discussion with the responsible clinician or other community care team members would be in order. It is on the basis of that discussion and any other available sources of information, that the HoNOS should be completed.

Where the HoNOS has not been completed, if the clinical notes are of sufficient quality, the rating may be completed retrospectively on that basis alone.

The rating of the HoNOS in absentia can be a contentious issue, but it is important to remember that clinical decisions about patient's health and well-being are often made based on limited information or third-party information. Completing the HoNOS based on this information is a legitimate summary of your assessment at that point in time. It also speaks to the importance and quality of clinical documentation of all practitioners so that documentation of disparate pieces of information can be used to inform ratings.

There may be occasions when adequate information is not available upon which to make a rating. These occasions will be rare because rating is based on all available information, including cross-informants.

Rate problems, not diagnoses; and do not take aetiology into account

When rating each HoNOS Item, your task is to describe the presence and severity of particular problems or behaviours. The rating should be based on what is observed or reported, regardless of why the problem might be occurring. This means that clinical hypotheses, diagnostic formulations, and assumptions about causation should not influence the rating.

For example, if a person is showing signs of depressed mood, that problem should be rated according to its current severity and impact, regardless of whether it is thought to stem from schizophrenia, bipolar disorder, trauma, or heavy use of alcohol or other drugs. In HoNOS, depressed mood is rated at Item 7 as a problem in its own right — not as a proxy for the diagnosis of Major Depression.

Each Item is designed to capture a specific type of clinical problem. It is incorrect to assume that an Item corresponds to a particular diagnosis. For instance, Item 3 is not a measure of the severity of an alcohol or drug use disorder, Item 6 is not a measure of schizophrenia, and Item 7 is not a measure of depression.

This approach is deliberate. Diagnosis is a complex and variable process influenced by clinical judgment, setting, and context. HoNOS avoids these complexities by focusing on the current expression of problems or distress, as seen or reported, rather than inferred causes or diagnostic labels.

Take culture and context into account

Take into account factors such as culture and context when assessing whether specific behaviours, experiences or beliefs are problematic.

With respect to cultural factors, take note of the following principles.

When possible, obtain information from culturally appropriate informants. Although the clinician provides the final ratings for the HoNOS, for people of Aboriginal and Torres Strait Islander backgrounds and for people of a Culturally and Linguistically Diverse background, it is extremely important to involve culturally appropriate informants when undertaking your clinical assessment. Ideally for Aboriginal and Torres Strait Islanders, that would mean an Aboriginal or Torres Strait islander health workers or healer, a member of the person's family, or a carer.

Reflect underlying social disadvantage. Objectively reflect any underlying social disadvantage experienced by the person in rating the scales, and thus avoid under-rating issues even when the level of disadvantage is widely experienced in the person's community.

Rate non-sanctioned behaviours. Objectively reflect non-sanctioned behaviours in rating the scales, and thus avoid under-rating socially and culturally unacceptable behaviours even when they are common in the community. In particular, for people having problems with alcohol or substance use and for people with eating disorders, be aware that the person may occupy a social environment where excessive use of alcohol or other drugs or objectively disordered behaviours related to eating are commonly accepted, encouraged or facilitated.

Do not rate culturally sanctioned behaviours. Where there is an indication that behaviours (e.g., deliberate self-harm), beliefs (e.g., in sorcery), and experiences (e.g., visions or voices) have a cultural basis, a clinician must determine whether these are consistent in form, intensity and duration with accepted local norms. If so, **do not** rate them. Only those that are **not** consistent with local norms should be rated. Any concurrent mental health problems or behaviours should always be rated where appropriate.

Issues of culture and subculture are often raised during HoNOS training. What is "normal", usual or typical behaviour, and how should that influence particular ratings? Understanding cultural differences is essential to engaging, communicating and understanding individual perspectives in a mental health assessment.

This presents a challenge because clinicians may hold varying opinions on what constitutes acceptable behavior across different age groups, subcultures, or ethnic communities within the wider society. As we previously discussed, cultural awareness plays a crucial role in assessment practices, and behaviours that are culturally accepted should not be classified as problems. Nonetheless, every culture has its own boundaries. If a behaviour is not accepted by the relevant subculture, age cohort, ethnicity, or the broader community, then it should be considered a problem and rated accordingly.

There are universal principles or standards; for example, excessive substance use that affects

functioning or assaulting people, regardless of culture, is seen as a problem and should be rated. The better your understanding of the person's culture, the more accurately the ratings will reflect the underlying issue for the individual.

Rate each item in order from 1 to 12

The order of the items is intended to reflect their clinical impact, with problems of behaviour and impairment taken earlier than problems with symptoms or social relations. The items are structured to reflect a general flow from acute clinical issues (such as behaviour and impairment) through to symptoms and then social functioning. Rating them in order helps maintain this conceptual structure and avoids biasing judgments of earlier items based on impressions formed in later domains. It also ensures that partially completed ratings still convey meaningful information.

Ensure the independence of ratings

Each item must be rated independently, and its content should not be rated again in a subsequent item. This ensures that overlapping issues are avoided, and each item contributes uniquely to the clinical profile. For example, aggression, overactivity, agitation, or disruptive behaviour should all be rated at Item 1 — regardless of cause, context, or diagnosis — and not taken into consideration again under other items.

Consider this example: a person gets into a fight (aggression rated at Item 1), is intoxicated (alcohol use rated at Item 3), and sustains physical injuries (injury rated at Item 5). Each item reflects a distinct aspect of the person’s presentation. When rating the alcohol problem at Item 3, you should not include the fact that the person got into a fight while intoxicated — that has already been rated at Item 1. The fact that alcohol use might contribute to aggression does not justify a higher severity rating at Item 3 unless there is independent evidence of a significant alcohol-related problem.

This rule may lead to apparent anomalies, as when a person having hallucinations acts violently, with a rating of 4 at Item 1, but is not concerned or distressed by the hallucinations, which occur only rarely and are not accompanied by (other) bizarre or incongruous behaviour. Item 6 is then rated at point 2. However, these ratings do actually reflect the reality of the current situation. The issue of possible future risk is not considered in HoNOS.

Consider the impact of problems rated at items 1 to 8 when rating items 9 to 12

While Items 1–8 are rated independently, Items 9–12 explicitly incorporate the *impact* of problems rated earlier in the scale.

For Items 9 and 10 (social relationships and activities of daily living), the effect of problems rated in

Items 1–8 should be considered. For example, if a person's depressed mood (rated at Item 7) leads them to withdraw socially or strains their relationships, that impact should be reflected in the rating at Item 9.

Similarly, Items 11 and 12 (living conditions and occupational functioning) include the effects of problems in both the clinical domains (Items 1–8) and the social domains (Items 9 and 10). For example, a person with cognitive problems (Item 4) may have difficulty managing bills and other daily tasks (Item 10). If this results in the electricity being disconnected and the household falling into disrepair, those environmental consequences should be captured at Item 11.

This structured progression helps build a picture of how clinical problems manifest in functional and environmental difficulties, while still maintaining clarity and separation between the individual items.

Rating period

The rating period is typically the preceding two weeks, or the last three days for patients being discharged from acute inpatient care.

The standard two-week window allows clinicians to evaluate the most severe issues that patients have faced recently and enables clinicians to understand the patient's experiences and behaviours across different contexts and situations, leading to a more comprehensive understanding of the patient's mental health status. By concentrating on this timeframe, clinicians can effectively assess the patient's current state and capture the worst manifestations of the patient's symptoms and behaviour. This avoids averaging out their condition over a longer period of time, which may obscure significant fluctuations. While this holds true for Items 1 – 8, Items 9 – 12 can often require a more general rating over the rating period. This two-week rating period (three days on discharge from inpatient units) is long enough for symptoms or behaviour to manifest but short enough for events to be accurately recalled.

With respect to the exception of employing a three-day rating period at discharge from acute inpatient care, reports from clinical staff using the HoNOS in that service setting indicate that although the usual standard rating period for the HoNOS is the preceding two weeks, when completing the HoNOS at that point in the clinical path clinicians tend to rate the person's problems over the preceding two or three days, this being considered by them to be a more realistic indication of the person's clinical status at discharge. The person will generally not be discharged until their clinical status has stabilised or reached a point at which they can be safely discharged. The duration of the period of observation after which the responsible clinician would feel confident in making such a decision may vary from patient to patient but will usually range from two to five days. To align with actual clinical practice and for the sake of clarity and consistency, Australia's nationally agreed collection protocols state that at discharge from acute inpatient care, the rating period is the preceding three days.

Rate the MOST SEVERE problem that occurred during the period rated

You are asked to rate the “most severe problem” or the “worst manifestation of the problem” observed during the period rated. There are several reasons for this approach. First, the most severe instance of the behaviours, symptoms, or problems is usually the most clearly identifiable, allowing for a more objective and observable marker of the issue. Second, the most severe manifestation is likely to be the focus of your clinical attention. Third, this approach avoids the subjectivity involved in trying to estimate an average level of the person’s behaviour, symptoms, or problems across the entire period.

In assessing the “worst manifestation,” you should focus on the most severe instance observed during the rating period. In many cases, that severity will be determined by the intensity of the behaviour or symptom. However, frequency and duration may also inform your judgment — particularly where persistent moderate problems may, in clinical terms, represent a greater concern than isolated extreme ones. That said, where an acute or extreme event occurs, even if only once, it should be rated if it represents the most severe manifestation of the problem during the period.

In some cases, determining the “most severe” manifestation will require balancing intensity with persistence and functional impact. Use clinical judgment. The goal is to identify the manifestation most representative of the problem’s significance during the period rated. The focus is on clinical reality, not technicality.

Two examples may help illustrate this point.

[1] During the rating period, a person reports hearing distressing, derogatory voices on a daily basis. These voices interfere with their sleep, concentration, and interactions with others. The problem is persistent and clearly affects their functioning. On one day, they also describe a single, vivid episode in which they believed the television was sending them special messages. The experience was intense, but it was brief, did not recur, and the person was unsure afterward whether it had really happened. In this case, the rating for Item 6 (hallucinations and delusions) should reflect the ongoing impact of the daily auditory hallucinations. Although the delusional episode was more dramatic and may seem more severe in the moment, its ambiguity and singular nature make the persistent daily experiences the more clinically significant manifestation. The rating should therefore be based on the daily hallucinations.

[2] Throughout most of the rating period, a person appears stable and shows no signs of self-harming behaviour. However, during one day in that period, they make a serious suicide attempt, resulting in hospitalisation. Although the behaviour occurred only once, it is clearly the most severe manifestation of the problem during the period and must be rated accordingly at Item 2 (non-accidental self-injury). The rating reflects the seriousness of the event, not its frequency, in line with the instruction to rate the worst manifestation observed.

The “most severe problem” principle also applies when rating Item 1 (overactive, aggressive,

disruptive or agitated behaviour) and Item 8 (other mental and behavioural problems), where multiple relevant options may exist. It can sometimes feel reductive to select just one category when the person presents with several difficulties. However, identifying the most severe or prominent among them — the one with the greatest clinical impact during the period rated — helps ensure consistency in application. This may be the problem that has caused the most distress, impairment, or disruption, or the one that has most clearly required clinical attention.

Similarly, when choosing between multiple co-occurring problems that all warrant the same rating, you may find it helpful to consider which issue would be the immediate focus of clinical management. For example, if a person presents with both severe anxiety and severe sleep disturbance, your clinical judgment may prioritise improving sleep, particularly if the person is becoming medically compromised due to lack of rest. In this case, sleep disturbance may reasonably be considered the most severe problem for rating purposes, reflecting both clinical urgency and impact.

Items are designed to measure impact and distress, not just severity

The items are designed to measure the impact on the person's behaviour and distress caused by each problem, not just the severity of symptoms.

Further details regarding this advice are provided in the following explanation of the five points of the rating scale.

All items have a consistent scale of 0 – 4

All items have a consistent 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

Ratings of 2, 3 or 4 are described as “clinically significant”.

Ratings of 0 and 1 reflect sub-clinical or non-clinically significant problems.
A rating of **0** indicates that there is *no problem at all* in the area being rated. This means either the issue is completely absent, or the person’s functioning is entirely within normal limits. A rating of **1** is used when there is a *minor problem* that is evident but does not require any action or intervention. The issue may be transient, contextually appropriate, or so mild that it does not interfere with the person’s functioning. It may be something to note in clinical documentation, but

not something that calls for a specific treatment response. Examples include occasional restlessness or minor sleep disturbance, brief periods of low mood in response to everyday stress, or mild interpersonal tension that resolves quickly. Appropriate use of 0 and 1 ratings ensures that clinical attention is focused where it is most needed, while still capturing the full spectrum of a person's presentation.

Ratings of 2 indicate a mild problem that is definitely present. The problems or symptoms are clinically present but may come and go and may often be of relatively short duration; although somewhat bothered by them, with some effort, the person finds it relatively manageable, and it may not be immediately noticeable to others; there is minimal impact on functioning. Examples include: occasional anxiety or worry, feelings of irritability or sadness that persist for a few days, or mild difficulty concentrating or sleeping, none of which significantly impact on daily activities but should be monitored as part of routine clinical practice.

Ratings of 3 indicate a problem of moderate severity. Problems or symptoms are frequent and persistent, causing significant discomfort or distress, and are likely to be noticeable by others. They will have a significant impact on daily life, making it harder for the person to manage without some form of intervention, such as medication or structured support. Examples include relatively intense feelings of depressed mood or anxiety, occasional panic attacks, or intrusive thoughts.

Ratings of 4 indicate a severe or very severe problem. The problems or symptoms are intense and debilitating, often overwhelming and all-consuming. There is likely to be major interference with daily life, and there may be a requirement for immediate and intensive intervention. Examples include: constant, all-consuming depressed mood with cognitive slowing resulting in an inability to get out of bed or perform basic self-care; extreme anxiety or panic attacks that lead to avoidance of daily activities and significant impairment in functioning; or psychotic symptoms, such as hallucinations or delusions, that drastically impair reality perception and social interactions.

Common errors you should avoid

Do not treat the 5 points as a simple questionnaire scale where the middle option, 2, means the average

The HoNOS rating scale is not designed like a typical questionnaire where the midpoint (a rating of 2) represents "average." Interpreting it that way is a common misunderstanding, especially among those who are new to the HoNOS or unfamiliar with structured psychiatric assessment.

This misinterpretation often leads to consistent under-rating across multiple items, as problems that are clinically significant may be rated too low simply because they are viewed as common or typical in your practice setting. The effect is a general compression of ratings toward the middle, which can distort the clinical picture and reduce the usefulness of the data.

Instead, each point on the scale has a defined meaning and corresponds to a specific level of severity. Referencing the glossary and guidance for each item helps ensure that your ratings are aligned with the scale's intent, not just relative impressions.

Do not reserve a rating of 4 for the worst presentations you have seen

There will be times when several individuals — each with clearly different levels of severity — all warrant the same rating on a particular HoNOS scale. This is especially true for the most severe category: a rating of 4 for "severe to very severe" problems.

Even if these individuals differ in presentation, it is still correct to rate all of them as 4 if each meets the threshold for that category. An experienced clinician might still rank them in order, identifying one as the most severe, but this should not lead to giving the others a rating of 3. Doing so would understate the true severity of their problems.

A rating of 4 means the problem is severe. It does not mean the worst possible. The person's presentation could still be worse and would still be rated 4.

Avoid creating an artificial ceiling. Don't hold back a rating of 4 as if it must be saved for the most extreme case. If the person meets the criteria for a 4, then rate it a 4 — regardless of whether someone else's problems are even more severe.

A rating of 4 is a serious statement. It reflects substantial distress or impairment in that area, and it should be used when warranted.

Do not rate just within the range of problem severity seen in your service setting

Over time, clinicians working in a particular setting naturally become accustomed to the types and levels of problems commonly encountered there. This familiarity can shape your sense of what counts as "severe," potentially leading to unintentional under-rating of presentations that, while frequent in your setting, still meet the threshold for a high severity rating on the HoNOS scale.

To guard against this, it's helpful to revisit the glossary and the detailed scale guidance. These provide an external reference point to ensure that your ratings remain grounded in the scale definitions, not just in local norms.

Do not rate only in comparison to the person's past presentations

When rating someone you have assessed before — especially after repeated admissions or reviews — it's natural to compare their current presentation with what you remember as their worst. This is an understandable clinical habit, shaped by experience. However, it can unintentionally lead to ratings that reflect a *relative* improvement or deterioration, rather than an accurate assessment of the person's current presentation in absolute terms.

To maintain consistency, HoNOS ratings should reflect the severity of the person's problems during the current period rated, using the scale definitions — not a comparison to how they were at their best or worst on previous occasions.

In conclusion, take care to not rate within just your service's, hospital's, or service setting's range of problem severity or within the person's known range of problem severity, and don't reserve a rating of 4 for the most severe problems you have seen. There will often be occasions when

individuals with problems of clearly different severity all warrant the same rating on a given HoNOS scale.

The relationship between HoNOS ratings and interventions or care plans

The individual Items of the HoNOS provide a clear framework for describing the nature and severity, and taken together, the complexity of the person's presentation at key points in the clinical path.

Interventions should not be taken into consideration when rating the Items. Suppose that, in the current service setting, with the resources available, it is not possible to provide any treatment or intervention for some of the problems or issues covered by the HoNOS. In that case, those problems or issues, if present, must still be rated.

In other words, your rating of each Item should never depend on what you or your service intend to do or what care and interventions may or may not be provided.

However, the framework provided by the HoNOS ratings for describing the person's presentation can be used in thinking about and discussing the plan of care. This framework is illustrated in the table shown here.

Ratings of 0 and 1 are not clinically significant, requiring no specific action other than possible monitoring for change. Ratings of 2 and above are regarded as clinically significant and would warrant recording in the clinical record for ongoing monitoring. A rating of 2 may be incorporated in the care plan. Ratings 3 and 4 should always be incorporated in the care plan. Ratings of 2 or higher are areas that as a clinician you would monitor the person's presentation.

				Monitor?	**Active treatment or care plan?**
Clinically Significant	**4**	Severe to very severe problem	Most severe rating for this problem. Warrants recording in clinical file. Should be incorporated in care plan. *Note – problems can get worse.*	✓	✓
	3	Moderate problem	Warrants recording in clinical file. Should be incorporated in care plan.	✓	✓
	2	Mild problem	Warrants recording in clinical file. 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.	✗	✗

This link between HoNOS ratings, clinical monitoring, and care planning underscores the role of the HoNOS rating as part of everyday clinical work. The ratings can serve as a shared language for describing the severity of problems, guiding priorities for care, and communicating clearly within and across teams. When used in this way, HoNOS supports a structured, clinically grounded approach to understanding and responding to a person's needs.

The glossary provides guidance

The glossary for each Item provides a brief description with examples of the type(s) of behaviour that would be associated with each rating point.

These are just examples, NOT exhaustive lists of things to be considered. They are guides only, and the underlying rating scale is what you are rating to.

On occasions, you may find the glossary is not helpful. In those cases, always refer back to the underlying rating scale.

Remember the HoNOS ratings are made on a simple ordinal scale with 0 indicating no evidence of distress or disturbed behaviour in that area, 1 is a sub clinical issue that raises the suspicion of the clinician that an issue may be present and may or may not require intervention, while a rating of 2 or higher is an indication of a clinical significant issue that requires monitoring in clinical practice and some documentation of the interventions being undertaken to meet the person's need in this area. A rating of a 4 is not twice as bad as a rating of a 2 but we know that it is worse. Indeed, it may indicate a problem that is substantially more than twice as severe as that which a rating of 2 might indicate.

The glossary provides anchors for the scale rating points or brief descriptions of examples of the types of behaviour that would constitute a particular rating. Do not become overly focused on the wording of the glossary and feel that you cannot rate because the specific behaviour you observe is not directly reflected in the text. The challenge is to strike a balance between using the glossary to inform your ratings whilst ensuring that you are using the underlying ordinal structure of the scale.

Avoid missing any ratings

One of the main reasons HoNOS is used across services is to support consistency in assessment and communication. Every person, at every admission, review, and discharge, is assessed across the same twelve domains — areas where people with mental health needs commonly experience difficulties.

Even if you're unsure of the exact rating, it's still useful to record a score based on the information available. If a particular problem wasn't observed or mentioned, that in itself often provides a basis for a low or zero rating. If a problem was observed, then it's better to give an approximate rating than to leave the item blank. In most cases, having some information recorded is more useful — for

care planning, communication, and monitoring — than having none at all.

This approach helps build a fuller picture over time and supports consistent practice across teams and services.

Rating and use of the glossary for each individual item

The section provides more detailed discussion and clarification of what needs to be considered when rating each of the individual Items of the HoNOS.

The HoNOS glossary provides general guidance, offering examples of behaviours, signs, and symptoms to anchor the ordinal scale. These examples are illustrative rather than exhaustive and are not intended as fixed criteria. Rather, the glossary supports the translation of your clinical assessment into consistent and meaningful ratings. The glossary should not be treated as a checklist to be rigidly applied.

Item 1 – Overactive, aggressive, disruptive or agitated behaviour

	HoNOS	*HoNOS 65+*
	Overactive or aggressive or disruptive or agitated behaviour	**Behavioural disturbance (e.g. overactive, aggressive, disruptive or agitated behaviour, uncooperative or resistive behaviour)**
	Include such behaviour due to any cause (e.g., drugs, alcohol, dementia, psychosis, depression, etc.) *Do not include bizarre behaviour rated at Item 6.*	*Include such behaviour due to any cause, e.g., dementia, drugs, alcohol, psychosis, depression, etc.* *Do not include bizarre behaviour, rated at Item 6.*
0	No problem of this kind during the period rated.	No problems of this kind during the period rated.
1	Irritability, quarrels, restlessness etc. not requiring action.	Occasional irritability, quarrels, restlessness etc., but generally calm and co–operative and not requiring any specific action.
2	Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g., broken cup, window); marked over-activity or agitation.	Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g., broken cup, window); significant over-activity or agitation; intermittent restlessness or wandering (day or night); uncooperative at times, requiring encouragement and persuasion.
3	Physically aggressive to others or animals (short of rating 4); threatening manner; more serious over-activity or destruction of property.	Physically aggressive to others or animals (short of rating 4); more serious damage to, or destruction of, property; frequently threatening manner, more serious or persistent over-activity or agitation; frequent restlessness or wandering; significant problems with co-operation, largely resistant to help or assistance.
4	At least one serious physical attack on others or on animals; destructive of property (e.g., fire-setting); serious intimidation or obscene behaviour.	At least one serious physical attack on others (over and above rating of 3); major or persistent destructive activity (e.g., fire–setting); persistent and threatening behaviour; severe over-activity or agitation; sexually disinhibited or other inappropriate behaviour (e.g., deliberate inappropriate urination or defecation); virtually constant restlessness or wandering; severe problems related to non–compliant or resistive behaviour.

Item 1, *Overactive, aggressive, disruptive or agitated behaviour,* encompasses observable behaviours that may be distressing to the person, hazardous to themselves or others, or disruptive to the social environment. All four kinds of behaviour are included in the rating, regardless of whether the person displays intention, insight, or awareness.

Context is important when evaluating such behaviour. For instance, expressions of disagreement may be more forceful in certain cultural or interpersonal settings and still remain within acceptable limits.

The rating focuses solely on the severity and impact of the behaviour itself, not on its underlying

causes or any associated diagnosis. For example, this item is used to rate disruptive behaviour in a person with dementia or intellectual disability, overactive aggression in the context of mania, severe agitation during major depression, or violent behaviour linked to hallucinations, delusions, or personality difficulties. Note that unusual or bizarre behaviour, where the issue is not primarily about aggression or disruption, should be rated instead at Item 6.

Detailed guidance

The following table provides detailed guidance regarding the rating of the severity and impact of mild, moderate and severe levels of the four kinds of behaviour addressed by this scale. Note that there is significant overlap between them. For example, a severely agitated person may also exhibit overactive and aggressive behaviour and the person's partner, relatives or friends may experience that constellation of behaviours as moderately or severely disruptive.

	Overactive	***Aggressive***	***Disruptive***	***Agitated***
2 – Mild	Appears more energetic, talkative, or restless than usual, but can still engage in daily activities with minimal impact.	Increased irritability or frustration.	Behaviour causes occasional frustration or annoyance, but it does not lead to significant emotional distress. Partners, friends, or relatives might feel mildly stressed but can usually cope.	Restlessness, fidgeting, pacing, or tapping fingers or feet; Increased talking, rapid speech, or agitation in speech tone; Difficulty sitting still, appearing tense or on edge.
3 – Moderate	Heightened levels of energy; Talking excessively and interrupting others; Increased restlessness.	Raised voice, expressing anger, frustration, or distress more intensely; Aggressive or confrontational behaviour, such as yelling, cursing, or making threatening gestures, throwing objects or hitting walls; Threatening behaviour without actual physical harm; Difficulty calming down after being provoked.	Behaviour leads to frequent stress or anxiety. Partners, friends, or relatives may feel emotionally drained or feel helpless. For example: Frequent arguments that take time to resolve and cause ongoing tension; Significant changes in plans or routines to avoid triggering the disruptive behaviour; Emotional withdrawal or distancing that affects the relationship's intimacy and support.	Increased muscle tension, clenching fists, pacing more rapidly, or exhibiting more pronounced signs of physical agitation; May have difficulty following directions or engaging in rational conversation.
4 – Severe to very severe	Overactive behaviour is highly disruptive and may include extreme levels of energy, incessant talking, rapid pressured speech that is difficult to interrupt, and severe restlessness or agitation.	Shouting, screaming, or making threats; Threatening or assaulting others, destroying property, or engaging in high-risk behaviours with little regard for consequences.	The behaviour causes severe emotional distress, including chronic stress or anxiety. Partners, friends, or relatives may feel overwhelmed, fearful, or hopeless, and their mental health might be significantly affected. For example: Constant arguments or conflicts that have led to long-term resentment or estrangement; Major disruptions to daily life caused by the need to cope with the person's behaviour.	Intense physical restlessness, pacing rapidly or erratically; May be incoherent or unable to communicate effectively.

Item 2 – Non-accidental self-injury (suicidal ideation and deliberate self-harm)

	HoNOS	*HoNOS 65+*
	Non-accidental self-injury	**Non-accidental self-injury**
	Do not include accidental self-injury (due e.g., to dementia or severe learning disability); the cognitive problem is rated at Item 4 and the injury at Item 5. Do not include illness or injury as a direct consequence of drug/alcohol use rated at Item 3 (e.g., cirrhosis of the liver) or injury resulting from drink driving which are rated at Item 5).	*Do not include accidental self–injury (due e.g., to dementia or severe learning disability); any cognitive problem is rated at Item 4 and the injury at Item 5. Do not include illness or injury as a direct consequence of drug or alcohol use rated at Item 3, (e.g., cirrhosis of the liver or injury resulting from drunk–driving are rated at Item 5).*
0	No problem of this kind during the period rated.	No problem of this kind during the period rated.
1	Fleeting thoughts about ending it all but little risk during the period rated; no self-harm.	Fleeting thoughts of self–harm or suicide; but little or no risk during the period rated.
2	Mild risk during the period rated; includes non-hazardous self-harm (e.g., wrist-scratching).	Mild risk during period; includes more frequent thoughts or talking about self–harm or suicide (including 'passive' ideas of self–harm such as not taking avoiding action in a potentially life–threatening situation, e.g., while crossing a road).
3	Moderate to serious risk of deliberate self-harm during the period rated; includes preparatory acts (e.g., collecting tablets).	Moderate to serious risk of deliberate self–harm during the period rated; includes frequent or persistent thoughts or talking about self–harm; includes preparatory behaviours, e.g., collecting tablets.
4	Serious suicidal attempt and/or serious deliberate self-injury during the period rated.	Suicidal attempt or deliberate self–injury during period.

Item 2 deals with ideas or acts of self-harm, rated according to their severity, the extent of physical harm or psychological distress caused, and the level of risk to the person's safety during the period rated.

While intent can be difficult to assess — for example, when the person's thinking is slowed by depression — it remains clinically relevant in judging the seriousness of a self-injurious act. For instance, significant harm caused by an impulsive overdose would still be rated at severity point 4, even if the clinician believes the person did not intend to cause serious harm, but rather to express distress.

Relatively mild self-injurious behaviour such as scratching, biting or cutting should also be rated. In the absence of strong evidence to the contrary, clinicians should assume that the results of self-harm were all intended.

Risk of future self-harm is not part of this rating. HoNOS ratings reflect observed or reported problems during the period rated, whereas clinical risk assessments include judgement about future risk.

Note also that this item is a rating of deliberate non-accidental self-injury and not self-injury that may be the passive result of the person's behaviour. For example, you would not rate the person who isn't eating or drinking because of delusional ideas about the safety of the available food or water. This type of behaviour may result in self-harm, but it is not rated here because it is not deliberate.

Detailed guidance

The following table provides detailed guidance regarding the rating of the severity and impact of mild, moderate and severe levels of the issues addressed by this scale.

	Suicidal ideation	***Deliberate self-harm***
2 – Mild	Thoughts of death or dying by suicide are present but are fleeting and not intense. They may occur sporadically and are more passive in nature, typically arising in response to stress or as a passing idea, rather than being a persistent preoccupation.	Occasional self-harm, that is infrequent and not part of a regular pattern. The methods employed are generally less severe, such as superficial cutting, scratching, or burning. The injuries are typically shallow and do not require medical attention. The primary intent is often emotional regulation or coping with distress rather than a desire to cause serious harm. There is usually no suicidal intent associated with the self-harm.
3 – Moderate	Suicidal thoughts are more frequent and intrusive. They likely cause significant distress and are harder to dismiss. Such thoughts might include more specific considerations of how one might end their life, though without a detailed plan or immediate intent. There may be a stronger sense of wanting to die or escape from pain. The person may begin to engage in some preparatory behaviours, such as giving away possessions or writing a will, but without an immediate plan to act.	Self-harm occurs more regularly, such as weekly or several times a month, and there is a more established pattern of behaviour. The methods employed are more severe, involving deeper cutting, more intense burning, or other forms of harm that cause more significant injury. There is a risk of infection or more serious complications which can require medical intervention. The intent may include a stronger drive for emotional relief and can sometimes be a means of punishing oneself. While not typically associated with suicidal intent, there is a higher risk of accidental severe harm.
4 – Severe to very severe	Suicidal thoughts are intense, persistent, and overwhelming. They dominate the individual's thinking and emotional state. There is a clear and specific plan for how to commit suicide, with a timeline and the means identified. The individual has strong intent and may have taken preparatory steps to enact their plan. They might actively isolate themselves and exhibit behaviours indicating imminent risk, such as acquiring the means to commit suicide or writing a suicide note. In the worst case, the individual may have attempted suicide during the period being rated.	Self-harm occurs frequently, often several times a week or daily. The behaviour is persistent and pervasive. The methods employed are very severe, such as deep cutting, significant burning, or other forms of harm that cause substantial injury. There may be a use of dangerous tools or methods that significantly increase the risk of severe harm. The injuries inflicted are severe and often require significant medical intervention. This might include frequent hospital emergency visits, stitches, or treatment for significant wounds. There is a high risk of severe complications, including life-threatening injuries. There may be an overlap with suicidal ideation, though the primary intent is still typically to cope with intense emotional pain. However, the risk of accidental severe injury or death is very high.

Item 3 – Problem drinking or drug-taking

	HoNOS	*HoNOS 65+*
	Problem drinking or drug-taking	**Problem drinking or drug-taking**
	Do not include aggressive/destructive behaviour due to alcohol or drug use, rated at Item 1. *Do not include physical Illness or disability due to alcohol or drug use, rated at Item 5.*	*Do not include aggressive/destructive behaviour due to alcohol or drug use, rated at Item 1.* *Do not include physical Illness or disability due to alcohol or drug use, rated at Item 5.*
0	No problem of this kind during the period rated.	No problem of this kind during the period rated.
1	Some over–indulgence but within social norm.	Some over–indulgence but within social norm.
2	Loss of control of drinking or drug-taking, but not seriously addicted.	Occasional loss of control of drinking or drug–taking; but not a serious problem.
3	Marked craving or dependence on alcohol or drugs with frequent loss of control; risk taking under the influence.	Marked craving or dependence on alcohol or drug use with frequent loss of control, drunkenness, etc.
4	Incapacitated by alcohol/drug problem.	Major adverse consequences or incapacitated due to alcohol or drug problems.

Item 3 addresses problems arising from the use, misuse, or dependence on alcohol or drugs. Consider patterns of behaviour such as frequent intoxication, escalating or compulsive use, difficulty limiting intake, and the extent to which substance use takes priority over other activities or responsibilities. Include risk-taking behaviours, such as driving while intoxicated, as well as short-term consequences like hangovers after alcohol use or comedowns or crashes after psycho-active substance use. Also rate signs of dependence, including craving, tolerance, or withdrawal, and persistent use despite harmful consequences.

In general, a rating of 1 or 2 refers to use or overuse of alcohol or other drugs, while a rating of 3 or 4 reflects signs of craving, dependence, or behavioural disruption. This item covers problems related to any psychoactive substance — including alcohol, illicit drugs, prescribed medications, and even substances like caffeine, nicotine, or laxatives — if their use is associated with distress, craving, compulsive behaviour, or harm.

The focus is on the person's relationship to the substance, rather than its legal status or medical use. For example, if a person is distressed when they cannot access their drug of choice, shows behaviour driven by substance use, or experiences significant negative impact from it, this should be rated.

Use of opioid replacement therapy (e.g. methadone or buprenorphine) may reflect continuing dependence or compulsive use. In such cases, if there is evidence of craving or behavioural disturbance associated with the substance, a rating may be appropriate. However, the use of prescribed medication for other mental health conditions — such as antidepressants or antipsychotics — is not rated here unless there is clear evidence of misuse, overuse, or

problematic behaviour related to the substance itself.

Longer-term cognitive effects such as loss of memory are rated at Item 4, physical disability (e.g., from accidents) or disease (e.g., liver damage) are rated at Item 5, mental effects at Items 6, 7 and 8, and problems with relationships are rated at Item 9.

Variability in clinicians' views of what constitutes use or overuse of drugs or alcohol is exposed by this item. This is often associated with different views by clinicians on the use of drugs and alcohol by different age cohorts, subcultures or ethnicities within the broader community. As we have discussed previously, cultural awareness is an important part of assessment practice, and problems should not be rated when they are perceived as cultural norms. However, excessive drug or alcohol use in a subculture or age cohort may be seen as a problem from the broader community's perspective and should be rated.

This item can be difficult to rate at review or discharge from overnight inpatient or residential care service settings which specialise in the rehabilitation of people with alcohol or drug use disorders. The individual will have been in a relatively safe environment where they would not have ready access to alcohol or drugs. So, there is unlikely to be evidence of problem drinking or drug taking. However, the rating should be based not just on overt evidence of dependence or harmful use but also on your clinical judgement as to the extent and severity of the person's remaining problems with alcohol or drugs, such as craving and dependence.

Detailed guidance

The following table provides detailed guidance regarding the rating of the severity and impact of mild, moderate and severe levels of the issues addressed by this scale.

	Harmful use	***Craving***	***Dependence***
2 – Mild	Occasional use, with amounts that exceed recommended limits. The person may experience minor health issues or risks, such as hangovers or minor injuries.	Occasional thoughts or desires to use the substance do not dominate the person's mind. Cravings are manageable and do not cause significant distress or disruption to daily activities. The person can easily resist the urge to use the substance and can distract themselves with other activities.	Substance use may not be daily and is generally less intense compared to moderate or severe dependence. The individual is usually aware of their substance use issue and might express concern or guilt about their inability to control their use. There may be early signs of developing tolerance (needing more of the substance to achieve the same effect) or experiencing mild withdrawal symptoms, but these are typically not as pronounced as in moderate or severe dependence. There is minimal disruption to daily activities, work, or social relationships.

3 – Moderate	More frequent use, with regular instances of consuming larger quantities than intended. More significant health issues, such as regular hangovers, increased risk of injuries, and early signs of liver damage or other organ harm.	More frequent thoughts about using the substance, which may arise in specific situations or in response to certain triggers. Cravings are stronger and may cause noticeable distress or preoccupation. The person may find it challenging to resist the urge to use the substance, requiring more effort and support to manage. There may be some impact on behaviour and decision-making, with the person possibly altering their routine to avoid triggers or situations where cravings are more likely.	Significant time is spent obtaining, using, or recovering from the substance's effects. This can interfere with daily responsibilities and routines. The individual continues to use the substance even when it causes or exacerbates recurring social or interpersonal issues. This can include conflicts with family members, friends, or colleagues. Important social, occupational, or recreational activities are reduced or abandoned due to substance use. The individual's life becomes increasingly centered around the substance, and other interests or activities are neglected.
4 – Severe to very severe	Daily or near-daily use, often with an inability to control the amount consumed. Recurrent use in physically hazardous situations, continued use despite physical or psychological problems. Severe disruption in daily activities, work, and social relationships. High likelihood of job loss, relationship breakdowns, and legal issues. Significant health problems, including chronic liver disease, pancreatitis, neurological damage, and mental health disorders.	Persistent and intrusive thoughts about using the substance, often occurring multiple times a day. Cravings are intense and overwhelming, causing significant distress and preoccupation. The person finds it very difficult to resist the urge to use the substance, often leading to a high risk of relapse.	The individual requires markedly increased amounts of the substance to achieve the desired effect. They experience withdrawal symptoms when they reduce or cease substance use (e.g., tremors, nausea, sweating, anxiety, irritability, and depression). The individual often takes the substance or a closely related substance to relieve or avoid withdrawal symptoms. There is loss of control that may be indicated by a persistent desire or unsuccessful efforts to cut down or control substance use, and use of the substance in larger amounts or over a longer period than intended. A considerable amount of time is spent in activities necessary to obtain, use, or recover from the effects of the substance. The individual continues to use the substance despite being aware of having persistent or recurrent physical or psychological problems likely caused or exacerbated by the substance. For example, continuing to drink heavily despite knowing it worsens a liver condition. Important social, occupational, or recreational activities are given up or reduced because of substance use.

Item 4 – Cognitive problems

	HoNOS	*HoNOS 65+*
	Cognitive problems	**Cognitive problems**
	Include problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia, etc. *Do not include temporary problems (e.g., hangovers) resulting from drug/alcohol use, rated at Item 3.*	*Include problems of orientation, memory, and language associated with any disorder: dementia, learning disability, schizophrenia, etc.* *Do not include temporary problems (e.g., hangovers) which are clearly associated with alcohol, drug or medication use, rated at Item 3.*
0	No problem of this kind during the period rated.	No problem of this kind during the period rated.
1	Minor problems with memory or understanding (e.g., forgets names occasionally).	Minor problems with orientation (e.g., some difficulty with orientation to time) or memory (e.g., a degree of forgetfulness but still able to learn new information), no apparent difficulties with the use of language.
2	Mild but definite problems (e.g., has lost the way in a familiar place or failed to recognise a familiar person); sometimes mixed up about simple decisions.	Mild problems with orientation (e.g., frequently disorientated to time) or memory (e.g., definite problems learning new information such as names, recollection of recent events; deficit interferes with everyday activities); difficulty finding way in new or unfamiliar surroundings; able to deal with simple verbal information but some difficulties with understanding or expression of more complex language.
3	Marked disorientation in time, place or person; bewildered by everyday events; speech is sometimes incoherent; mental slowing.	Moderate problems with orientation (e.g., usually disorientated to time, often place) or memory (e.g., new material rapidly lost, only highly learned material retained, occasional failure to recognise familiar individuals); has lost the way in a familiar place; major difficulties with language (expressive or receptive).
4	Severe disorientation (e.g., unable to recognise relatives); at risk of accidents; speech incomprehensible; clouding or stupor.	Severe disorientation (e.g., consistently disorientated to time and pace, and sometimes to person) or memory impairment (e.g., only fragments remain, loss of distant as well as recent information, unable to effectively learn any new information, consistently unable to recognise or to name close friends or relatives); no effective communication possible through language or inaccessible to speech.

Item 4, Cognitive problems, is used to rate difficulties with thinking, memory, or understanding that may occur in the context of a wide range of conditions, including dementia, intellectual disability, schizophrenia, and episodes of very severe depression. Problems may include: forgetting important information; confusion about time, date, or place; difficulty recognising familiar people, animals, objects, or places; impaired comprehension or expression of speech in the person's own first language; failure to perceive common dangers (such as leaving gas burners on, touching or mishandling hot appliances, or stepping into traffic); and marked clouding of awareness or episodes of stupor.

The signs and symptoms of formal thought disorder (e.g., circumstantiality, tangential thinking and

word salad) are also rated on Item 4. Note that, for people with schizophrenia, schizoaffective disorder and other psychoses, the severity and impact of the psychotic or delusional content of their thinking is rated at item 6, whilst the form of their thought as it is expressed is rated here on Item 4.

For people with major affective disorder, the effects of psychomotor slowing or mania on cognitive functioning are rated on this scale.

Remember that you are rating the underlying cognitive performance of the person on this item and not the impact of that cognitive performance, which is rated on later items.

Detailed guidance

The following table provides detailed guidance regarding the rating of the severity and impact of mild, moderate and severe levels of some of the issues addressed by this scale.

	Memory	***Attention and concentration***	***Language and communication***	***Processing speed***	***Executive functioning***	***Visuospatial skills***
2 – Mild	Occasional forgetfulness, such as misplacing items or forgetting names of acquaintances. Difficulty recalling recent events or conversations but able to remember with prompts or cues.	Occasional lapses in attention, such as momentarily losing track of a conversation. Ability to maintain focus for shorter tasks, but may become distracted with longer tasks.	Occasional trouble finding the right word but able to communicate effectively most of the time. Speech is generally coherent and fluent. Minor slips or pauses are noticeable but do not significantly impede communication.	The individual may take a little longer than usual to complete tasks that require quick thinking or responses. They might need extra time to understand instructions or to process new information.	May struggle slightly with planning or organising tasks but can generally manage with some effort or compensatory strategies. Mild difficulty in problem-solving, particularly with novel or complex problems, but they can usually come to a solution with time.	Slight difficulties with tasks requiring spatial awareness, such as navigating unfamiliar environments or assembling simple puzzles. Minor challenges in judging distances or the relative position of objects. Occasional errors in spatial orientation or depth perception, such as misplacing objects or bumping into things occasionally.
3 – Moderate	More consistent forgetfulness, such as regularly forgetting appointments or events. Increased difficulty recalling recent events, even with prompts. Might forget details of personal history.	Frequent lapses in attention, such as losing track of conversations or activities multiple times a day. Difficulty maintaining focus on tasks, leading to incomplete tasks or mistakes. Difficulty with tasks that require sustained concentration, such as reading or following complex instructions.	Frequent difficulty finding words, leading to noticeable pauses or the use of generic terms like "thing" or "it." Speech may become less fluent, with increased instances of repetition, circumlocution (talking around a word), or use of incorrect words.	There are more pronounced delays in completing cognitive tasks, such as problem-solving, decision-making, and learning new skills. The individual may frequently ask others to repeat information or clarify instructions.	More apparent struggles with planning, organising, and prioritising tasks. Greater difficulty in holding and manipulating information in mind, leading to challenges in following complex instructions or sequences. Significant challenges in approaching new or complex problems, often requiring assistance or more time to resolve issues.	Noticeable difficulties with more complex visuospatial tasks, such as interpreting maps, following detailed diagrams, or assembling more intricate objects. More frequent errors in spatial orientation, such as judging distances accurately. Increased difficulty in recognising familiar faces or places due to impaired spatial processing.

4 – Severe to very severe	Inability to recall recent events, names of close family members, or familiar tasks. Significant problems with both short-term and long-term memory. Unable to remember important aspects of life consistently.	Persistent and pervasive difficulties with attention, struggling to maintain focus even on simple tasks. Inability to complete tasks, frequent mistakes, and forgetting to start or finish activities. Very limited ability to concentrate on any task, easily distracted by the slightest interruptions.	Severe difficulty in finding words, leading to frequent and prolonged pauses. The person may often be unable to recall common words. Speech may become fragmented, with frequent errors, substitutions, or complete breakdowns in communication. The individual might rely heavily on gestures or non-verbal cues. Significant problems with comprehension. The individual may struggle to understand even simple instructions or everyday conversations.	The individual experiences significant delays in processing even simple information or completing basic tasks. They may take an exceptionally long time to respond to questions or follow simple instructions.	Major and consistent difficulties in all areas of executive function, including planning, organisation, task initiation, and problem-solving. Inability to initiate, plan, or complete tasks without significant assistance.	Profound difficulties with basic visuospatial tasks, such as recognising shapes, patterns, or faces, and understanding spatial relationships in simple contexts. Severe impairment in spatial orientation and depth perception, leading to frequent accidents or inability to navigate even familiar environments.

Item 5 – Physical illness or disability problems

	HoNOS	*HoNOS 65+*
	Physical illness or disability problems	**Physical illness or disability problems**
	Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning. *Include side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drink-driving, etc.* *Do not include mental/behavioural problems rated at Item 4.*	*Include illness or disability from any cause that limits mobility, impairs sight or hearing, or otherwise interferes with personal functioning (e.g., pain).* *Include side–effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self–harm associated with cognitive problems, drunk driving etc.* *Do not include mental or behavioural problems rated at Item 4.*
0	No physical health problem during the period rated.	No physical health, disability or mobility problems during the period rated.
1	Minor health problems during the period (e.g., cold, non-serious fall, etc.)	Minor health problem during the period (e.g., cold); some impairment of sight or hearing (but still able to function effectively with the aid of glasses or hearing aid).
2	Physical health problem imposes mild restriction on mobility and activity.	Physical health problem associated with mild restriction of activities or mobility (e.g., restricted walking distance, some degree of loss of independence); moderate impairment of sight or hearing (with functional impairment despite the appropriate use of glasses or hearing aid); some degree of risk of falling, but low and no episodes to date; problems associated with mild degree of pain.
3	Moderate degree of restriction on activity due to physical health problem.	Physical health problem associated with moderate restriction of activities or mobility (e.g., mobile only with an aid – stick or Zimmer frame – or with help); more severe impairment of sight or hearing (short of rating 4); significant risk of falling (one or more falls); problems associated with a moderate degree of pain.
4	Severe or complete incapacity due to physical health problem.	Major physical health problem associated with severe restriction of activities or mobility (e.g., chair or bed bound); severe impairment of sight or hearing (e.g., registered blind or deaf); high risk of falling (one or more falls) because of physical illness or disability; problems associated with severe pain; presence of impaired level of consciousness.

Item 5, Physical illness or disability problems, is used to rate the extent to which a physical health condition or disability has affected the person during the rating period. Minor, short-lived conditions that are expected to resolve quickly and have minimal impact on functioning—such as a cold or superficial bruising — should be rated at 0 or 1, depending on their effect. More serious conditions, even if temporary, should be rated according to the degree of functional impairment they cause. For example, a person with a broken leg and arm who cannot mobilise independently should receive a higher rating, despite the expectation of eventual recovery.

In cases involving fluctuating conditions—such as remission from a longer-term illness—the rating should reflect the most severe state experienced during the period, not the current level of recovery or anticipated outcome. Ratings at points 2 to 4 should reflect the extent to which the person's activities are limited by the physical health problem, regardless of its cause. This includes, for example, sensory impairments, medication side effects, and mobility limitations from any source. Injuries resulting from substance use, or physical harm occurring in the context of significant cognitive impairment, should also be included.

In short, Item 5 is concerned with functional impairment resulting from a physical illness or disability—not merely the presence of the condition itself. What is being rated is the degree to which the physical health problem limits the person's ability to function. For example, some Paralympians may have a missing limb, but if this does not restrict their functioning in any meaningful way, no rating is required. However, if the physical loss or condition does limit what they can do, then it should be rated here.

Item 5 focuses on the physical deficit and its direct impact on functioning, whereas Item 10 captures how that limitation affects the person's performance of daily activities. The two are related but distinct: Item 5 addresses the underlying physical problem; Item 10 addresses how that problem plays out in daily life.

As another example, a diagnosis of diabetes mellitus does not in itself justify a rating on Item 5. However, if the person experiences hypoglycaemic episodes that lead to confusion, collapse, or a temporary inability to function, then the impairment associated with those episodes *should* be rated.

Incapacity refers to a complete inability to perform or function due to a physical health condition. When rating Item 5, consider both the *severity* and *duration* of the problem over the period. As with all HoNOS items, the general rule is to rate the most severe presentation, not the average level of functioning. However, it's important to distinguish between brief or isolated episodes of incapacity and more sustained or recurrent limitations. For example, if a person was unable to mobilise independently for one day due to pain or fatigue, but otherwise functioned well, a high rating may not be warranted. In contrast, if the person was incapacitated for several days or had persistent or recurrent limitations, a higher score is appropriate. The rating should reflect how significantly and how persistently the physical illness or disability disrupted the person's functioning at its worst during the period.

Functional limitations due to physical pain, even in the absence of obvious disability, should also be rated under Item 5. Pain that restricts movement, interferes with concentration, or reduces the person's ability to function in daily life should be taken into account.

Emotional or psychological distress associated with illness, disability, or pain should only influence the rating if it contributes directly to reduced functioning. For example, if distress leads the person to avoid movement or withdraw from essential activities, this should be reflected in the rating. However, if the distress is present but does not impair function, it should be rated separately under Item 7 (Depressed mood) or Item 8 (Other emotional and behavioural problems),

as appropriate.

Item 6 – Problems with hallucinations and delusions

	HoNOS	*HoNOS 65+*
	Problems associated with hallucinations and/or delusions	**Problems associated with hallucinations and delusions**
	Include hallucinations and delusions irrespective of diagnosis. *Include odd and bizarre behaviour associated with hallucinations or delusions.* *Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at Item 1.*	*Include hallucinations and delusions irrespective of diagnosis.* *Include odd and bizarre behaviour associated with hallucinations or.* *Do not include aggressive, destructive or overactive behaviours attributed to hallucinations, delusions, rated at Item 1.*
0	No evidence of hallucinations or delusions during the period rated.	No evidence of delusions or hallucinations during the period rated.
1	Somewhat odd or eccentric beliefs not in keeping with cultural norms.	Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2	Delusions or hallucinations (e.g., voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e., clinically present but mild.	Delusions or hallucinations (e.g., voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, that is, a present, but mild clinical problem.
3	Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, i.e., moderately severe clinical problem.	Marked preoccupation with delusions or hallucinations, causing significant distress or manifested in obviously bizarre behaviour, that is, moderately severe clinical problem.
4	Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient.	Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with a major impact on patient or others.

Item 6, Problems with hallucinations, delusions and abnormal perceptions, is used to rate the presence and impact of these phenomena, irrespective of diagnosis.

Rating point 1 is reserved for minor oddities or harmless eccentricities that have little or no effect on the person's functioning. For example, if a person believes that a small device has been implanted in their body but shows no distress and does not act on this belief, a rating of 2 may be appropriate. However, if the person becomes distressed or modifies their behaviour in response—such as avoiding electronic devices, refusing to eat, covering their mouth when speaking, or attempting to remove the imagined implant—a higher rating of 3 or 4 would be justified.

Note that any violent, disruptive, or overactive behaviour associated with these symptoms should be rated at Item 1, and not counted again here. In Item 6, the focus is on the distress caused by the abnormal perceptions or the extent to which they shape the person's behaviour.

The person's thought form or coherence should be rated under Item 4, while bizarre behaviour—including unusual appearance, eccentric dress, abnormal body language, incongruent social interactions, or extreme emotional responses—should be rated here under Item 6 when these behaviours arise directly from delusions or hallucinations.

These principles apply to all types of delusions and hallucinations. For example, distorted perceptions of body size or shape, such as those commonly seen in anorexia nervosa, should also be rated under this item when they reflect a strongly held misperception that persists despite clear contradictory evidence and affects behaviour or emotional state.

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Detailed guidance

The following table provides detailed guidance regarding the rating of the severity and impact of mild, moderate and severe levels of the issues addressed by this scale.

	Hallucinations	***Delusions***	***Abnormal perceptions of body image***
2 – Mild	Hallucinations occur infrequently, possibly only a few times a month or during periods of significant stress. The hallucinations are usually less intense and might be vague or fleeting. For example, hearing a faint voice that is difficult to understand. The individual might be able to recognise the hallucinations as not real and can often maintain daily functioning with minimal disruption. There may be some mild distress, but it doesn't significantly impair social, occupational, or personal activities.	Delusions are present but infrequent, are less intense and may be more easily questioned by the person. The delusions may not significantly impair daily functioning or social interactions. The person may still be able to maintain some insight into the irrationality of their beliefs. For example, a person might believe that a neighbour is watching them but can be reassured that this is not the case.	The individual experiences occasional dissatisfaction with their body shape or size, accompanied by distorted or unrealistic perceptions that are mildly incongruent with their actual appearance. These concerns are focused on specific body parts perceived as problematic, but the misperceptions are not constant and do not dominate their thinking. While the individual may avoid certain clothing styles or social situations that draw attention to these areas, their overall social and occupational functioning remains largely intact. Some mild restrictive eating behaviours or dieting may be present, but they are not rigid or extreme. Exercise routines, if any, are influenced to a degree by body image concerns but are moderate and do not reflect compulsive or driven behaviour. The key feature is that while the person's body image is distorted, the impact is limited and does not substantially impair daily life.
3 – Moderate	Hallucinations occur more regularly, such as a few times a week. The hallucinations are more pronounced and can be disturbing or distressing. For example, hearing clear, distinct voices that give commands or commentary. The individual experiences noticeable interference with daily activities. Social interactions, work performance, and personal care might be affected. There might be moderate distress and difficulty distinguishing hallucinations from reality at times.	Delusions are more frequent and persistent. Delusions are stronger and more firmly held, with the person often resistant to contrary evidence. The delusions interfere with daily functioning, causing noticeable difficulties in work, social interactions, and personal care. For example, a person might believe that they are being spied on by a government agency and this belief affects their ability to leave the house or interact with others normally.	The individual frequently feels unhappy with their body shape or size, and these thoughts occupy a significant portion of their time. They may frequently check their appearance in mirrors or avoid mirrors altogether to prevent negative feelings. The individual often perceives themselves as overweight or larger than they actually are, even if they are underweight. This distorted perception affects their self-esteem and confidence levels. These perceptions lead to more pronounced restrictive eating behaviours, such as skipping meals, avoiding certain food groups, or eating very small portions. There may be a noticeable increase in exercise, often driven by a desire to change their body shape or size.

4 – Severe to very severe	Hallucinations are frequent, often occurring daily or multiple times a day. The hallucinations are intense, vivid, and persistent. They might involve multiple senses and can be very frightening or commanding. The content of the hallucinations often includes threatening, derogatory, or highly distressing material. The individual's ability to function in daily life is severely impaired. They might be unable to maintain employment, manage personal care, or sustain relationships. There is significant distress, and the person might have difficulty distinguishing hallucinations from reality, leading to potential safety risks or bizarre behaviour.	Delusions are constant or nearly constant. Delusions are extremely intense and deeply held. The person has no insight into the irrationality of their beliefs. The delusions severely disrupt all aspects of daily life, including work, social interactions, and personal care. The person might be unable to distinguish delusions from reality, and their behaviour may be significantly influenced by these false beliefs. For example, a person may believe that they are a historical figure on a critical mission, leading to actions based on this belief that can result in harm to themselves or others, such as refusing necessary medical treatment or engaging in dangerous activities.	The individual experiences constant and intense dissatisfaction with their body shape or size. These thoughts dominate their daily life and significantly affect their mental well-being. There is a profound and persistent belief that they are overweight or have a distorted view of specific body parts, regardless of their actual body weight or shape. This severe distortion is resistant to reassurance or evidence to the contrary. The individual engages in extreme restrictive eating behaviours, such as fasting, extreme calorie counting, or eliminating entire food groups. Excessive exercise becomes compulsive and is done to an extent that it can harm physical health.

Item 7 – Problems with depressed mood

	HoNOS	*HoNOS 65+*
	Problems with depressed mood	**Problems with depressive symptoms**
	Do not include over-activity or agitation, rated at Item 1. Do not include suicidal ideation or attempts, rated at Item 2. Do not include delusions or hallucinations, rated at Item 6.	*Do not include overactivity or agitation, rated at Item 1. Do not include suicidal ideation or attempts, rated at Item 2. Do not include delusions or hallucinations, rated at Item 6. Rate associated problems (e.g., changes in sleep, appetite or weight; anxiety symptoms) at Item 8.*
0	No problem associated with depressed mood during the period rated.	No problems associated with depression during the period rated.
1	Gloomy; or minor changes in mood.	Gloomy; or minor changes in mood only.
2	Mild but definite depression and distress (e.g., feelings of guilt; loss of self-esteem).	Mild but definite depression on subjective or objective measures (e.g., loss of interest or pleasure, lack of energy, loss of self–esteem, feelings of guilt).
3	Depression with inappropriate self-blame; preoccupied with feelings of guilt.	Moderate depression on subjective or objective measures (depressive symptoms more marked).
4	Severe or very severe depression, with guilt or self-accusation.	Severe depression on subjective or objective grounds (e.g., profound loss of interest or pleasure, preoccupation with ideas of guilt or worthlessness).

Item 7 focuses on symptoms of depressed mood, not on the whole syndrome identified as Major Depression. What is rated here are the signs and symptoms associated with low mood — such as persistent sadness, loss of interest or pleasure (anhedonia), feelings of guilt or worthlessness, and reduced self-esteem — regardless of the underlying diagnosis.

It's important to follow the core HoNOS principle: **rate the problem, not the diagnosis**. Depressed mood can occur across a wide range of mental disorders, including schizophrenia, post-traumatic stress disorder, personality disorders, and substance use disorders. What matters for Item 7 is the presence and severity of these mood-related symptoms during the period rated.

In general, the more such symptoms are present — and the more they interfere with functioning or cause distress — the higher the severity rating should be.

Remember also that the person's affect or how the person's mood is expressed can differ from their underlying mood. So, a person can look happy but feel sad, or look sad and feel happy and have an incongruent affect. The HoNOS is your perspective, so even if someone says they feel fine but your observations of their appearance and behaviour, and perhaps also reports from family or other caregivers, lead you to think they are in fact depressed, then you should rate your perspective.

Other phenomena associated with the diagnosis of Major Depression are rated on other scales.

For example, the vegetative or physical signs and symptoms associated with depression: problems

with sleep, sleeping too much or not being able to sleep; or problems with appetite, not being hungry and not eating or eating too much, are rated at Item 8.

Similarly, overactivity and agitation are rated at Item 1; self-harm at Item 2; stupor or slowed cognitive functioning at Item 4; delusions and hallucinations at Item 6.

For a person with severe Major Depression, the rating on Item 7 does not stand on its own as the overall rating of the severity of their full presentation. Rather, as emphasised above, Item 7 just captures your rating of the severity of the person's problems with depressed mood. A person with severe depression would, at admission to psychiatric inpatient care, be very likely to have clinically significant ratings on a range of other problems together with a rating of at least 3 on Item 7. In this way, the person's HoNOS item profile captures both the severity and complexity of their current presentation.

Detailed guidance

The following table provides detailed guidance regarding the rating of the severity and impact of mild, moderate and severe levels of the issues addressed by this scale.

	Sadness	***Anhedonia***	***Worthlessness***	***Guilt***
2 – Mild	Feelings of sadness are present but manageable. The individual can often distract themselves or find brief periods of relief.	The individual experiences a noticeable decrease in enjoyment or interest in some activities but can still find pleasure in others. This loss of interest is relatively mild and may not be pervasive across all activities. Feelings of dissatisfaction or mild disinterest occur, but the individual can still feel joy and satisfaction at times.	Feelings of worthlessness are present but not overwhelming. They may surface occasionally and are often related to specific situations or failures. These feelings may manifest as occasional self-critical thoughts, mild self-doubt, and a general feeling of being less capable or competent than others. These feelings are not pervasive and can often be challenged or mitigated with reassurance or positive experiences.	Feelings of guilt are present but relatively mild. They may arise occasionally and are often linked to specific events or actions that the individual perceives as minor mistakes or shortcomings. Occasional thoughts of self-blame or regret, but these thoughts are usually transient and can often be reassured or dismissed. The individual might feel responsible for minor issues but does not dwell excessively on these feelings.
3 – Moderate	Sadness is more pervasive and persistent. It is harder for the individual to find relief and it often interferes with concentration and decision-making.	The decrease in pleasure and interest is more pronounced and affects a broader range of activities. The individual finds it increasingly difficult to feel motivated to engage in activities that were once enjoyable. The individual may actively avoid many activities they previously enjoyed and participate in fewer social engagements. They might show less initiative in starting or continuing activities. Feelings of boredom, disinterest, and a sense of emotional numbness or flatness are more pervasive.	More pervasive and persistent feelings of worthlessness. These feelings occur more frequently and may be generalised beyond specific situations. Frequent self-critical thoughts, significant self-doubt, and persistent feelings of inadequacy. The person may have difficulty accepting compliments or positive feedback and may often ruminate on perceived failures and shortcomings.	More pervasive and persistent feelings of guilt. The individual feels guilty more frequently and may have difficulty letting go of these feelings, even when reassured by others. Frequent thoughts of self-blame and regret, often about past actions or perceived failures. The individual may ruminate on these thoughts, leading to increased anxiety and distress. They might have difficulty accepting that their guilt is disproportionate to the situation.

4 – Severe to very severe	Feelings of sadness are overwhelming and incapacitating. The individual is likely to also feel intense hopelessness, helplessness, or worthlessness.	The loss of pleasure is profound and pervasive. The individual finds little to no joy or interest in almost all activities, including those that are fundamentally necessary or routine. The individual often avoids almost all activities and shows a marked decrease in social and occupational participation. They may spend most of their time inactive or disengaged. Profound emotional numbness, a persistent sense of emptiness, and a complete lack of enjoyment in life. They may also experience significant distress over their inability to feel pleasure.	Overwhelming and constant feelings of worthlessness. These feelings are deeply held and dominate the individual's thoughts and emotions. Persistent and pervasive self-critical and self-blaming thoughts. The individual may feel completely useless, undeserving of love or respect, and believe they are a burden to others. These feelings can lead to significant emotional distress and may contribute to suicidal ideation or self-harm.	Overwhelming and constant feelings of guilt. These feelings dominate the individual's thoughts and emotions and are often irrational or disproportionate to the actual events. Persistent and pervasive self-blame and feelings of profound guilt, often for events outside of their control or for trivial matters. The individual may believe they are fundamentally flawed or responsible for causing significant harm. These feelings can lead to severe emotional distress and may contribute to suicidal ideation or self-harm.

Item 8 – Other mental and behavioural problems

	HoNOS	*HoNOS 65+*
	Other mental and behavioural problems	**Other mental and behavioural problems**
	Rate only the most severe clinical problem not considered at scales 6 and 7 as follows. *Specify the type of problem by entering the appropriate letter: A phobic; B anxiety; C obsessive-compulsive; D mental strain/tension; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify.*	*Rate only the most severe clinical problem not considered at Items 6 and 7 as follows: specify the type of problem by entering the appropriate letter: A phobic: B anxiety; C obsessive–compulsive; D stress; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify…*
0	No evidence of any of these problems during period rated.	No evidence of any of these problems during period rated.
1	Minor problems only.	Minor non–clinical problems.
2	A problem is clinically present at a mild level (e.g., patient has a degree of control).	A problem is clinically present, but at a mild level, for example the problem is intermittent, the patient maintains a degree of control or is not unduly distressed.
3	Occasional severe attack or distress, with loss of control (e.g., has to avoid anxiety provoking situations altogether, call in a neighbour to help, etc.) i.e., moderately severe level of problem.	Moderately severe clinical problem, for example, more frequent, more distressing or more marked symptoms.
4	Severe problem dominates most activities.	Severe persistent problems which dominates or seriously affects most activities.
A	Phobic	Phobic
B	Anxiety	Anxiety
C	Obsessive-compulsive	Obsessive-compulsive
D	Mental strain/tension	Mental strain/tension
E	Dissociative	Dissociative
F	Somatoform	Somatoform
G	Eating	Eating
H	Sleep	Sleep
I	Sexual	Sexual
J	Other	Other

Item 8, Other mental and behavioural problems, enables the rating of symptoms that fall outside the scope of the earlier clinical items. The following categories are provided to guide the rating of this item:

:

A **Phobias**. That is, fear or avoidance behaviour in response to specific situations or objects that is out of proportion to the actual threat, including fear of leaving home, crowds, public places,

travelling, social phobias and specific phobias.

B **Anxiety and panics**. Includes generalised anxiety, panic or similar experiences.

C **Obsessional and compulsive problems**. Recurrent obsessions or compulsive acts that are distressing and typically perceived by the person as irrational.

D **Reactions to severely stressful events and traumas**.

E **Dissociative ('conversion') problems.** Mental process where the person disconnects from their thoughts, feelings, memories or sense of identity.

F **Somatisation**. Persisting perceived physical complaints in spite of full investigation and reassurance that no disease is present.

G **Eating or appetite**. Includes excessive intake or persistent restriction of food intake; related disordered behaviours to manage weight e.g., purging, excessive exercise, dieting etc.

H **Sleep**. Problems with the quality, timing or duration of sleep that impact on sense of fatigue, cognitive function or mood.

I **Sexual problems**. Disturbance of the person's ability to respond sexually or experience sexual pleasure or heightened libido that is distressing or unwanted.

J **Problems not specified elsewhere**. Any other mental or behavioural problem, not elsewhere identified. Includes emotional dysregulation or an expansive or elated mood, for example.

Only the single most severe problem occurring during the period is rated. This procedure is repeated at subsequent occasions. In this way, the most severe problem is always rated at each succeeding occasion. The rating reflects the severity of *other mental and behavioural problems* at each occasion, even if the symptom type changes.

Sometimes clinicians assume that they should continue rating the same problem across time — for example, to show improvement or resolution. However, Item 8 is not designed to follow a specific problem across the clinical path. Instead, it captures whichever "other" problem is currently most severe. The coding of the type of problem simply helps identify which issue was rated most prominently at that time.

When two or more problems warrant an equally high rating, consider which problem you would address first and note that.

As with the other scales, a rating of 1 indicates a sub-clinical problem. You are aware that there is an issue, but there is no specific need to monitor it and no requirement for a specific intervention. If you rate 0 then you do not have to identify a specific behaviour.

Simply because Item 8 exists does not mean that it has to be rated. If there are no other mental and behavioural problems, then your rating on this item would be 0 and you would not select any type of problem.

Additional details

Additional details regarding the commonly rated other mental and behavioural problems are given below and in the following sub-section.

A – Anxiety and panics

Symptoms of anxiety include panic attacks and a range of physical, behavioural, emotional, and cognitive symptoms.

Panic attacks are characterized by an abrupt surge of intense fear or discomfort that peaks within minutes, often accompanied by a feeling of detachment from reality or oneself, or intense fear of going crazy or losing control. The person may also experience a strong feeling that they are about to die, even when there is no real danger.

Physical symptoms of anxiety may include:

- a persistent feeling of the heart racing or pounding;
- excessive sweating even if not physically active; uncontrollable shaking of the hands or other parts of the body;
- feelings of breathlessness;
- discomfort or pain in the chest that may be mistaken for a heart problem;
- dizziness or lightheadedness;
- stomach pain, nausea, diarrhea or other digestive problems;
- persistent muscle tension, aching or pain;
- constant feelings of tiredness or fatigue.

Behavioural symptoms of anxiety include: avoiding situations or places that trigger anxiety; compulsive engagement in repetitive behaviours or rituals to reduce anxiety; difficulty sleeping, indicated by insomnia, trouble falling asleep, or waking up frequently during the night. Note that if one of these kinds of behavioural symptoms are a predominant feature of the issues to be rated here at Item 8, then they may be identified as the issue being rated. Avoidance is coded as A, compulsive behaviours as C, and difficulty sleeping as H.

Emotional symptoms that may be rated at Item 8 include:

- Intense fear or panic in response to specific situations or objects
- A general sense of unease or dread
- Feeling constantly on edge or overwhelmed

Emotional symptoms that are better rated at **Item 1 (agitation)** include restlessness, being unable to relax, or irritability (e.g., becoming easily frustrated or angered).

Cognitive symptoms that may be rated at Item 8 include:

- Persistent and uncontrollable worry about various aspects of life, even when there is no clear reason for concern
- Intrusive thoughts — recurrent and unwanted thoughts that are distressing or upsetting
- Hypervigilance — excessive alertness to potential danger or threat, often resulting in an

exaggerated startle response
- Racing thoughts — a rapid, scattered flow of thoughts across different topics, often described as overwhelming or difficult to control

Cognitive symptoms of anxiety that should instead be rated at Item 4 – Cognitive problems (and which should not then be rated again here at item 8) include difficulty concentrating, difficulty remembering things, or experiencing "brain fog".

Note also that if intrusive thoughts or hypervigilance occur as part of a broader response to trauma or extreme stress, the problem should be rated under code D (reaction to severely stressful events), rather than code B (anxiety and panic).

Racing thoughts, in particular, can appear across a range of mental disorders and may need to be rated under different HoNOS items depending on their features. The following example illustrates how to determine the appropriate rating:

> A person describes lying awake at night with their mind "going a million miles an hour," jumping between thoughts about work, finances, relationships, and world events. The thoughts come rapidly and feel difficult to control but are recognisably grounded in real concerns. They report feeling overwhelmed but not euphoric, grandiose, or disorganised. *This would be rated at Item 8 as a cognitive symptom of anxiety.*

In contrast, racing thoughts in mania are often accompanied by rapid speech, flight of ideas, distractibility, and inflated self-esteem. When these features reflect disorganisation or impaired mental control, they should be rated at Item 4 (cognitive problems). If the content of the thoughts is delusional — such as grandiose beliefs or psychotic ideas — that content should be rated at Item 6 (hallucinations and delusions). This is not considered double counting, as Items 4 and 6 refer to different aspects of mental functioning.

D – Reactions to severely stressful events and traumas

Reactions to stressful events and trauma can manifest in various ways, affecting physical, emotional, cognitive, and behavioural aspects of a person's current presentation. Many of these symptoms overlap with the symptoms experienced by people with other Anxiety disorders, whilst other typical symptoms, although identified here, will have already been rated at earlier Items and should not be taken into account here.

Physical symptoms may include: chronic fatigue, sleep disturbance, muscle tension, frequent headaches or migraines, gastrointestinal problems, elevated heart rate, and excessive sweating.

Emotional symptoms may include some phenomena that should be rated here at Item 8, together with other symptoms that should be rated at either Item 7 or Item 1. Symptoms rated here at Item 8 include: hyperarousal (i.e., a constant state of high alert, easily startled, and having difficulty relaxing); dissociation (i.e., feeling disconnected from oneself or the surroundings, experiencing depersonalization or derealization); or intense episodes of anxiety, fear or panic triggered by reminders of the traumatic event. Emotional symptoms that should have been rated at Item 7 include: emotional numbness, that is difficulty experiencing positive emotions, feeling detached

from others, or lacking interest in activities previously enjoyed; feelings of guilt or shame about the event, even when not at fault; and persistent negative beliefs about oneself, others, or the world. Symptoms that should have been rated at Item 1 include: increased irritability, and outbursts of frustration or anger.

Cognitive symptoms include: intrusive thoughts (i.e., recurrent, unwanted, and distressing thoughts about the traumatic event); and flashbacks (i.e., vivid and disturbing memories or re-experiencing the traumatic event as if it is happening again). Other cognitive symptoms that commonly occur in people having moderate to severe reactions to severely stressful events or traumas, but which should be rated on Item 4 and not considered again here include: difficulty concentrating, trouble focusing or maintaining attention; and difficulty remembering details of the traumatic event or general memory issues.

G – Problems with eating

Problems with eating principally characterize disorders such Anorexia nervosa, Bulimia nervosa, Binge eating disorder, Avoidant or restrictive food intake disorder, Emotional eating, and Orthorexia. There might be significant weight gain or weight loss and a change in eating patterns in the last two weeks. Problems with eating may also occur in Major depressive disorder, Anxiety disorders, Psychotic disorders, Alcohol and other substance use disorders, and Dementia.

H – Problems with sleep

Problems with eating principally characterize disorders such as Insomnia, Hypersomnia, Sleep apnea, Restless legs syndrome; Nightmares and night terrors, and Sleep-wake cycle disorders. Problems with sleep may also occur in Major depressive disorder, Anxiety disorders, Bipolar disorder, and Post-traumatic stress disorder. Poor sleep can be distressing for the individual and impact on their behaviour.

Detailed rating guidance

The following table provides detailed guidance regarding the rating of the severity and impact of mild, moderate and severe levels of the issues most commonly rated on this scale.

	Anxiety and panic	***Reactions to stressful events and trauma***	***Eating***	***Sleep***
2 – Mild	Mild feelings of nervousness, worry, or unease that are manageable. Occasional episodes of anxiety or panic attacks that occur infrequently or in specific situations. Symptoms are short-lived, lasting for a brief period and resolving on their own, with no significant disruption to social and role functioning.	Occasional intrusive thoughts, mild anxiety or irritability, mild physical symptoms, some avoidance behaviour. Symptoms are occasional, are manageable without assistance, and have minimal impact on daily life.	Occasional emotional eating or loss of appetite. Mild preoccupation with food, dieting, or body image. Slight deviations from regular eating patterns, such as skipping meals or eating more when stressed. Some feelings of guilt or shame about eating behaviours, but not overwhelming.	Occasional difficulty falling asleep, staying asleep, or waking up too early, occurring less than three nights per week.

3 – Moderate	More pronounced feelings of nervousness, worry, or apprehension that interfere with daily activities and functioning. Symptoms persist for an extended period, lasting for several days or weeks. The individual's quality of life and functioning is significantly affected: they may have difficulty concentrating, sleeping, or performing tasks at work or school; social interactions may be challenging, and they may avoid certain situations or activities due to fear or discomfort. While they may still be able to function, it is often with increased effort and difficulty.	Frequent intrusive thoughts, moderate anxiety or mood swings, persistent somatic symptoms, increased avoidance behaviour. Symptoms are frequent, pronounced and distressing, and have a moderate impact on daily life.	Frequent emotional eating, binge eating, or restrictive eating. More significant preoccupation with food, dieting, or body image. Noticeable changes in weight, either gain or loss. Avoidance of social situations involving food. Regular feelings of distress, guilt, or shame related to eating behaviours.	Sleep disturbances occur on a more frequent basis, affecting sleep quality on three to five nights per week. These problems with sleep may significantly impact daytime functioning and overall quality of life. The individual may experience moderate fatigue, difficulty concentrating, mood disturbances, and irritability during the day.
4 – Severe to very severe	Intense and overwhelming feelings of fear, panic, or dread that are difficult to control and may feel debilitating. Episodes of anxiety are persistent and frequent, occur on most days, with symptoms often present even in the absence of specific triggers. Symptoms are chronic and enduring, lasting for an extended duration without significant relief, and may escalate rapidly in response to stressors. The individual's ability to function in daily life is severely impaired.	Persistent intrusive thoughts, severe anxiety or panic attacks, severe somatic symptoms, extensive avoidance behaviour, and possible dissociation. Symptoms occur very frequently, possibly daily, are intense and overwhelming, and have a significant impact on daily life.	Persistent and severe emotional eating, binge eating, or restrictive eating. Extreme preoccupation with food, dieting, or body image, often leading to other severe mental health issues. Significant and possibly rapid weight changes, leading to underweight or obesity. Chronic feelings of distress, guilt, or shame, often resulting in isolation and withdrawal from social activities. Physical symptoms such as malnutrition, electrolyte imbalances, gastrointestinal problems, or other health complications.	Persistent and severe sleep disturbances occur on most nights, affecting sleep quality on five to seven nights per week. These problems have a profound impact on daytime functioning and overall well-being. The individual may experience severe fatigue, cognitive impairment, mood disturbances (such as depression or anxiety), and significant impairment in work, school, or social functioning

Item 9 – Problems with relationships

	HoNOS	*HoNOS 65+*
	Problems with relationships	**Problems with relationships**
	Rate the patient's most severe problem associated with active or passive withdrawal from social relationships, and/or non-supportive, destructive or self-damaging relationships.	*Problems associated with social relationships, identified by the patient or apparent to carers or others. Rate the patient's most severe problem associated with active or passive withdrawal from, or tendency to dominate, social relationships or non–supportive, destructive or self–damaging relationships.*
0	No significant problem during the period.	No significant problems during the period.
1	Minor non-clinical problems.	Minor non–clinical problems.
2	Definite problem in making or sustaining supportive relationships; patient complains and/or problems are evident to others.	Definite problems in making, sustaining or adapting to supportive relationships (e.g., because of controlling manner, or arising out of difficult, exploitative or abusive relationships), definite but mild difficulties reported by patient or evident to carers or others.
3	Persisting major problem due to active or passive withdrawal from social relationships and/or to relationships that provide little or no comfort or support.	Persisting significant problems with relationships; moderately severe conflicts or problems identified within the relationship by the patient or evident to carers or others.
4	Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social relationships.	Severe difficulties associated with social relationships (e.g., isolation, withdrawal, conflict, abuse); major tensions and stresses (e.g., threatening breaking down of relationship).

This item (and also Item 10) refers to functioning and disability rather than symptoms.

Item 9, Problems with relationships, concerns both the quality and quantity of the person's communication and social relationships. Consider both active and passive relationships, including difficulties arising from intrusive, withdrawn, or otherwise problematic social behaviours. The person's broader social environment, including family, household, residential, and community contexts, should also be taken into account.

Remember to draw on all available sources of information when making the rating. Reports by a spouse, friend, caregiver, or case worker may reveal important concerns, such as social withdrawal, clinginess, or misinterpretation of social cues, that are not apparent in direct observation.

Ask whether the person is able to gain emotional support from others. For example, a person with dementia or an intellectual or developmental disability (including autism spectrum conditions) may be overly friendly, or may struggle to interpret or use verbal and non-verbal communication effectively — resulting in impaired social relationships. Similarly, individuals with moderate to severe mental illness or with enduring personality difficulties may find it hard to retain supportive friendships or develop mutual trust with others.

If the person is solitary but self-sufficient, socially competent, and content with their level of engagement, a rating of 1 is appropriate. While most people seek some level of social connection, it is important to recognise the context and meaning of the person's social behaviour. Periods of solitude that are voluntary, culturally sanctioned, or spiritually motivated — and do not cause distress or impair function — should not be considered problematic.

In contrast, near-total social isolation — especially when it reflects a significant inability or unwillingness to engage with others — may warrant a rating of 4, particularly if it is unwanted or distressing. This includes cases where the person actively withdraws, is persistently excluded or rejected by others, or both. When choosing between ratings of 2 and 3, consider both the degree of relational difficulty and the extent of distress or dissatisfaction the person experiences in their social life.

It is also important to consider how harmful or complex social environments may contribute to relational difficulties. Some individuals have personal relationships characterised by emotional abuse, neglect, or intimate partner violence, or work in hostile or isolating settings. This may also extend to online environments, where individuals can be exposed to harmful interactions, manipulation, or exploitation, or may struggle to form genuine and supportive connections. These relationships can undermine the person's ability to form and maintain safe, trusting, or reciprocal relationships.

While the objective characteristics of the environment — such as interpersonal conflict, unsupportive conditions, or danger — should be captured under Item 11 (Problems with living conditions) or Item 12 (Problems with occupation and activities), the person's emotional and relational responses to those environments should be rated here, under Item 9. This includes the internalised effects of sustained relational harm, such as mistrust, social withdrawal, emotional detachment, or difficulty establishing healthy interpersonal boundaries.

For example, a person who has lived with ongoing emotional abuse or intimate partner violence may find it difficult to feel safe in new relationships, even outside the immediate environment. Rating these impacts is not a form of victim-blaming, but a recognition of how destabilising environments can impair relational functioning. By acknowledging these effects as part of the person's emotional and social response patterns, clinicians can ensure that the impact is addressed in the clinical formulation and considered in care planning.

Detailed guidance

The following sections provide structured guidance for rating the severity and impact of the most frequently observed interpersonal and relational difficulties associated with social functioning. Each theme—such as impaired communication, emotional numbing, or identity disturbance—is described with a progression of HoNOS severity ratings (1 to 4) to support consistent and clinically informed decision-making. These themes reflect common challenges encountered in mental health settings, particularly in the context of complex trauma, personality vulnerabilities, and long-term psychiatric illness.

The issues are presented in an order that moves from basic interpersonal engagement and affective capacity (e.g., the ability to communicate or emotionally connect) to increasingly complex patterns of relational insecurity and identity-based disturbance (e.g., mistrust, dependency, and role confusion). In effect, this represents a conceptual progression from individuals who cannot engage socially, to those who cannot engage stably or safely. This structure is intended to support clinicians in formulating the nature of social difficulties more clearly and mapping them to appropriate intervention strategies.

Impaired Communication

Impaired communication can be a significant contributor to social relationship problems and should be rated according to its impact on the person's ability to engage with others.

A rating of 1 is appropriate when the person is generally able to communicate effectively but may occasionally be misunderstood or struggle to express more complex thoughts. These difficulties are minor, infrequent, and have little or no impact on their social functioning.

A rating of 2 should be used when communication problems are more noticeable and occur with some regularity—such as difficulty following conversations, expressing needs clearly, or understanding others. These issues may cause some strain or awkwardness in relationships but do not prevent meaningful participation in social life.

A rating of 3 indicates more frequent and disruptive communication difficulties that interfere with the person's ability to sustain relationships. The individual may have trouble maintaining conversations, frequently misinterpret others, or respond inappropriately in social situations, leading to distress, withdrawal, or conflict.

A rating of 4 is warranted when communication is so severely impaired that the person is largely unable to engage in meaningful social interaction. This may include minimal or disorganised speech, marked difficulty comprehending others, or a level of dysfunction that results in near-total isolation or rejection.

As always, ratings should reflect both the severity of the communication difficulty and its functional impact on the person's social relationships.

Anhedonia and Emotional Numbing

Anhedonia and emotional numbing refer to a diminished capacity to experience or express emotional connection in social relationships. The person may appear detached, emotionally flat, or unresponsive to positive or emotionally meaningful interactions. This can affect their ability to form or maintain close relationships and may be observed in various clinical contexts, including depression, post-traumatic stress, or negative symptoms of psychosis.

A rating of 1 is appropriate when the person appears emotionally subdued or detached in some settings, but can still connect with familiar people or in situations that feel safe or predictable. Their emotional engagement may be limited, but they retain the capacity for warmth and responsiveness.

A rating of 2 should be used when emotional flatness or numbing is more consistently evident. The person rarely expresses enjoyment, affection, or emotional interest, and others may describe them as distant, disengaged, or hard to reach. While some relationships are maintained, the emotional quality of those relationships is reduced.

A rating of 3 is warranted when there is a persistent and noticeable inability to relate emotionally to others, even in close relationships. The person may acknowledge feeling emotionally "shut down," struggle to recognise or respond to others' emotions, or avoid emotionally charged situations. This can be distressing both to the person and to those around them, leading to social withdrawal or relationship strain.

A rating of 4 should be used when the person shows little or no emotional engagement across virtually all settings, including with close family or carers. They may appear indifferent, disconnected, or emotionally unreachable, and experience a profound sense of emptiness or isolation. Relationships may collapse due to the absence of emotional reciprocity, and the person may report being unable to feel or care, even when recognising that this is distressing.

Mistrust of Safety and Boundaries

Mistrust of safety and boundaries refers to difficulties forming secure, trusting relationships due to a pervasive sense that others may be unsafe, intrusive, or unreliable. The construct overlaps with—but is distinct from—paranoia or rejection sensitivity. It concerns the person's capacity to feel safe in relational settings, to trust others appropriately, and to negotiate interpersonal boundaries without fear, hypervigilance, or emotional withdrawal. This pattern often arises in individuals with histories of trauma, neglect, or betrayal, and may manifest as guardedness, avoidance of closeness, or rigid self-protection in social interactions.

A rating of 1 is appropriate when the person is somewhat cautious or slow to trust but ultimately able to establish safe and respectful connections. These tendencies may reflect personality style rather than clinical concern and do not cause significant interpersonal difficulty.

A rating of 2 should be used when the person's mistrust leads them to avoid emotional intimacy or vulnerability, even with people they know well. They may maintain excessive emotional distance, resist support, or set rigid interpersonal boundaries that reduce the depth and quality of their relationships.

A rating of 3 is warranted when mistrust is persistent and more entrenched, making it difficult for the person to form or sustain meaningful bonds. They may perceive others as unpredictable or threatening, struggle to allow closeness even in safe contexts, and their social world may be marked by conflict, emotional detachment, or absence of close relationships.

A rating of 4 should be used when the person is unable to engage in close relationships at all due to an overwhelming and pervasive sense that others are unsafe. They may isolate themselves entirely, reject supportive gestures, or interpret ordinary social interactions as intrusive or dangerous. This level of mistrust results in profound interpersonal disconnection and severe impairment in social functioning.

Distrust and Paranoia

Distrust and paranoia can create substantial barriers to forming and maintaining healthy social relationships. In this context, paranoia should be understood broadly and is not limited to delusional beliefs as seen in psychotic disorders. While clinical paranoia may involve fixed false beliefs of persecution or harm (e.g., being watched, followed, or conspired against), milder or subclinical forms are common and can include persistent mistrust, hypervigilance, or exaggerated sensitivity to perceived criticism or rejection. The person may frequently suspect others of bad intentions, interpret neutral remarks as hostile, or assume that they are being judged, ridiculed, or excluded. These patterns can occur across a range of mental health conditions and should be rated based on the impact on social relationships, not merely on diagnostic labels.

A rating of 1 is appropriate when the person is occasionally wary or mistrustful but this does not interfere meaningfully with their social functioning.

A rating of 2 should be used when distrust or guardedness is more frequent or pronounced, leading to noticeable interpersonal tension, hesitancy in forming connections, or a reluctance to confide in others. Relationships may be somewhat strained, but social participation is still generally maintained.

A rating of 3 reflects more pervasive suspiciousness or paranoid thinking that causes active avoidance, repeated misunderstandings, or conflict with others. The person may withdraw socially or interpret others' actions as deliberately harmful, leading to significant disruption in their ability to sustain relationships.

A rating of 4 is warranted when the person's paranoia is severe, persistent, and substantially impairs their capacity for meaningful interaction. They may be consumed by fears of persecution or betrayal, isolate themselves completely, or display behaviour that others find irrational or threatening. The key consideration is the degree to which paranoid thinking affects interpersonal functioning and contributes to social disconnection or distress.

Hypersensitivity to Rejection

Hypersensitivity to rejection refers to heightened emotional responses to perceived criticism, disapproval, or abandonment, even when these cues are subtle, ambiguous, or unintended. The person may misinterpret neutral or minor interpersonal signals—such as delayed responses, disagreements, or changes in tone—as signs of rejection, leading to distress or maladaptive responses. This heightened sensitivity can contribute to tension, misunderstanding, and instability in relationships.

A rating of 1 is appropriate when the person appears emotionally reactive or self-doubting in response to mild criticism or perceived slights, but this does not cause major interpersonal disruption. They may seek reassurance or feel hurt easily, but their key relationships remain stable.

A rating of 2 should be used when this sensitivity is more regular or pronounced, leading to frequent misunderstandings, excessive reassurance-seeking, or clingy behaviour that others find burdensome. Relationships may be strained, with patterns of emotional dependency or

withdrawal, but there is still ongoing engagement.

A rating of 3 is warranted when emotional reactions to perceived rejection are intense and recurring, leading to significant interpersonal difficulties. The person may oscillate between closeness and withdrawal, or respond with distress, anger, or impulsivity that destabilises relationships.

A rating of 4 should be used when the person reacts to minor or imagined slights with extreme emotional intensity—such as despair, rage, or dependency—that overwhelms or drives away others. Relationships are often chaotic, short-lived, or unsustainable, and the person's functioning is significantly impaired as a result.

Emotional Dysregulation and Instability

Emotional dysregulation and instability can significantly disrupt a person's ability to form and sustain stable social relationships. This refers to patterns of intense, rapidly shifting, or poorly controlled emotional responses—such as anger, sadness, anxiety, or elation—that are difficult to manage and may appear disproportionate to the situation. These emotional reactions may escalate quickly, be difficult to calm, and may not align with social expectations or context. The impact is particularly relevant when these fluctuations cause distress to others or lead to unstable, volatile, or short-lived relationships.

A rating of 1 is appropriate when the person occasionally displays heightened emotional responses, such as being easily frustrated or tearful, but these are short-lived, contextually understandable, and do not meaningfully affect their social interactions.

A rating of 2 should be used when emotional lability—such as sudden mood shifts or overreactions—leads to occasional conflict or distress in relationships. Others may find the person unpredictable or emotionally reactive, but some relational stability is maintained.

A rating of 3 is warranted when emotional instability is more frequent or intense, causing significant and ongoing difficulties in relationships. The person may have emotional outbursts, become overwhelmed easily, or react impulsively in ways that strain or damage their connections with others. Relationships may be characterised by repeated conflict, distancing, or reconciliation cycles.

A rating of 4 should be used when emotional dysregulation is pervasive and severe, leading to chaotic, unstable, or unsustainable social relationships. The person may have frequent, intense emotional outbursts, sudden and extreme shifts in behaviour or mood, or reactions that are bewildering or distressing to others. Social functioning is seriously impaired, and meaningful interpersonal connections are difficult or impossible to maintain.

Identity Disturbance and Dependency

Identity disturbance and dependency refer to difficulties in maintaining a stable sense of self or an appropriate level of autonomy within relationships. This may manifest as an unstable or poorly defined self-image, shifting values or goals, and an over-reliance on others for decision-making,

validation, or emotional regulation. Individuals may assume inconsistent roles in relationships, struggle to assert boundaries, or become excessively dependent or compliant. These difficulties are commonly observed in individuals with borderline personality disorder, complex trauma histories, or other conditions marked by attachment disruption.

A rating of 1 is appropriate when the person occasionally appears uncertain about their preferences, boundaries, or role in relationships, but generally maintains adequate autonomy and consistency. They may rely on others for reassurance or direction at times, but these tendencies do not significantly disrupt functioning.

A rating of 2 should be used when there is a pattern of blurred interpersonal boundaries, inconsistent roles, or difficulty sustaining a stable sense of identity in relationships. The person may shift between submissiveness and assertiveness, or between dependence and withdrawal, in ways that are confusing or frustrating to others. While some relationships are maintained, they are often strained or marked by role confusion.

A rating of 3 is warranted when identity instability or dependency leads to frequent dysfunction in relationships. The person may form intense attachments that quickly shift, fear abandonment excessively, or exhibit extreme compliance, jealousy, or neediness that others find overwhelming. Relationships may become volatile, one-sided, or emotionally exhausting, and the person may struggle to function independently in key areas of life.

A rating of 4 should be used when there is a pervasive lack of a coherent sense of self and a disabling level of dependency or instability in relationships. The person may have no clear personal identity or values, assume extreme or contradictory relational roles, and be unable to tolerate any real or perceived separation. These patterns severely impair their ability to sustain relationships or function autonomously, and may lead to repeated crises, emotional dysregulation, or self-destructive behaviours within interpersonal contexts.

Item 10 – Problems with activities of daily living

	HoNOS	*HoNOS 65+*
	Problems with activities of daily living	**Problems with activities of daily living**
	Rate the overall level of functioning in activities of daily living (ADL) (e.g., problems with basic activities of self-care such as eating, washing, dressing, toilet; also, complex skills such as budgeting, organising where to live, occupation and recreation, mobility and use of transport, shopping, self-development, etc.). *Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.* *Do not include lack of opportunities for exercising intact abilities and skills, rated at Items 11-12.*	*Rate the overall level of functioning in activities of daily living (ADL): e.g., problems with basic activities of self–care such as eating, washing, dressing, toilet; also, complex skills such as budgeting, recreation and use of transport, etc.* *Include any lack of motivation for using self–help opportunities, since this contributes to a lower overall level of functioning.* *Do not include lack of opportunities for exercising intact abilities and skills, rated at Items 11 and 12.*
0	No problem during period rated; good ability to function in all areas.	No problems during period rated; good ability to function effectively in all basic activities (e.g., continent – or able to manage incontinence appropriately, able to feed self and dress) and complex skills (e.g., driving or able to make use of transport facilities, able to handle financial affairs appropriately).
1	Minor problems only (e.g., untidy, disorganised).	Minor problems only without significantly adverse consequences, for example, untidy, mildly disorganised, some evidence to suggest minor difficulty with complex skills but still able to cope effectively.
2	Self-care adequate, but major lack of performance of one or more complex skills (see above).	Self–care and basic activities adequate (though some prompting may be required), but difficulty with more complex skills (e.g., problem organising and making a drink or meal, deterioration in personal interest especially outside the home situation, problems with driving, transport or financial judgements).
3	Major problem in one or more areas of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills.	Problems evident in one or more areas of self–care activities (e.g., needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted) as well as inability to perform several complex skills.
4	Severe disability or incapacity in all or nearly all areas of self-care and complex skills.	Severe disability or incapacity in all or nearly all areas of basic and complex skills (e.g., full supervision required with dressing and eating, frequent urinary or faecal incontinence).

Item 10 summarises the severity of personal and social impairment associated with problems rated at Items 1 to 9, together with any direct effects of impaired motivation. It concerns the person's ability to manage everyday activities required for independent or semi-independent living.

Ratings should reflect the person's functioning during the period rated, taking into account both what the person is required or expected to do in their current setting, and how they go about doing it. Focus on observable performance, not hypothetical potential.

Areas of functioning to consider include:

- **Basic self-care** – hygiene, dressing, eating, toileting, and medication
- **Domestic/practical tasks** – cooking, shopping, cleaning, managing money
- **Social and occupational responsibilities** – attending appointments, managing transport, communicating effectively, and parenting

The manner of performance should also be considered, including:

- **Efficiency** – Does the person complete tasks without unnecessary delay or confusion?
- **Reliability** – Are tasks done consistently or only sporadically?
- **Initiative** – Does the person begin tasks on their own or require prompting?

These factors interact: for instance, someone may have the necessary skills (the "what") but fail to act on them due to apathy, low mood, or cognitive difficulty (the "how").

When considering the effects of Items 1–9, focus on whether symptoms such as disorganisation, cognitive problems, low energy, anxiety, or social withdrawal interfere with the person's ability to initiate, carry out, or complete daily activities. These effects often underlie real-world impairments in functioning.

Environmental context and rating of observed functioning

Do not rate a problem solely because the person is in an environment where certain tasks (e.g., cooking, cleaning) are not expected of them — for example, in a residential setting where meals and domestic tasks are provided. The mere absence of opportunity to perform a task does not indicate a problem in functioning.

However, if clinical observation or collateral information indicates that the person would be unable to perform essential tasks independently if supports were removed, this should be rated. In such cases, the structured environment may be compensating for impaired functioning rather than reflecting intact ability.

If the person has no opportunity to demonstrate a skill, and there is no evidence of skill loss, poor motivation, or distress, then a rating is not required.

Conversely, if the person does not currently perform certain tasks (e.g., budgeting, cooking) and lacks the necessary skills — even if motivated to learn — the rating should reflect their actual level of performance, not their potential. Environmental limitations on the development or demonstration of functioning are rated at Items 11 and 12, not Item 10.

Detailed guidance regarding rating levels

Rating 0 – No problems
The person is fully independent across all relevant domains. Tasks are performed efficiently, reliably, and on their own initiative. No supervision or support is required.

Rating 1 – Minor problems requiring no action
There are occasional lapses (e.g., missed meals, undone laundry). Initiative may be slightly reduced, but the person functions independently and safely, without need for intervention.

Rating 2 – Mild but clinically significant problems
The person is inefficient or inconsistent in task completion and may avoid certain activities due to anxiety or low confidence. Independence is mildly affected.

Rating 3 – Moderately severe problems
There are regular difficulties across several domains. The person may neglect important responsibilities (e.g., missing meals or bills). Follow-through is unreliable, and initiative is poor.

Rating 4 – Severe to very severe problems
The person shows pervasive inability to manage daily activities. Self-care may be minimal or absent, and functioning is fully dependent or associated with high risk if left unsupported.

In summary, if the person's performance of basic self-care is moderately or seriously low, rate 3 or 4. If the person's use of higher level skills and abilities in the performance of more complex domestic and practical tasks and the conduct of their social and occupational responsibilities, as appropriate to the person's circumstances, are normal or as adequate as they can be, rate 0 or 1. Ratings of 2 and 3 are intermediate.

Items 11 and 12 – Problems with the person's environment

In mental health contexts, people often experience **multiple and interacting difficulties**. Even so, the same principle applies: **Item 10 captures actual functioning**, as observed during the rating period. **Items 11 and 12** invite a broader perspective: *to what extent is the person's functioning being limited by the world around them?* These items ask you to consider whether the person could achieve a better quality of life—greater autonomy, stronger relationships, or a more fulfilling role—if their social or environmental context were different.

This shift in viewpoint may feel different from the clinical focus of Items 1–10, but the underlying question remains consistent: **how serious is the restriction on what the person could reasonably achieve, and how much of that restriction is due to their environment?**

If there is **no such restriction**, Items 11 and 12 should be rated **0**. If there is a **very substantial restriction**—for example, a person is unable to participate meaningfully in life despite intact skills or motivation—then a rating of **4** is appropriate.

Items 11 and 12 require knowledge of the person's **usual domestic and daytime situation**, and an understanding of both their **potential and current level of performance**. If the person is newly admitted in acute crisis and this information is not yet available, you may indicate that you are unable to rate these items. However, the preference is to **gather contextual information** from the person or from collateral sources, including family, caregivers, or other service providers.

Rating Items 11 and 12 involves considering the complex interplay between the person's **abilities**, their **potential**, the **environment they are currently in**, and the **possibility of an environment that better supports skill development and autonomy.**

The following example may help illustrate these points.

A person with a diagnosis of schizophrenia is living in supported accommodation. Their symptoms are well controlled with medication, and they are capable of cooking, managing money, and using public transport independently. However, their current environment is socially isolating and offers no structured opportunities for employment, volunteering, or recreational activity. Staff interactions are limited, and the person has little meaningful contact with others.

During the rating period, they attend to basic self-care and manage essential tasks, but spend most of their time alone and disengaged. This functional performance would warrant a **rating of 2 on Item 10**, reflecting mild but clinically significant problems in daily living.

However, if this person were living in a more stimulating environment with access to supported employment, group activities, or structured peer interaction, they might be able to engage more fully and lead a richer, more autonomous life. Because the current environment is constraining their autonomy despite intact skills and motivation, **a rating of 2 or 3 on Items 11 and/or 12** may be appropriate—depending on the extent and impact of the restriction.

Item 11 – Problems with living conditions

	HoNOS	*HoNOS 65+*
	Problems with living conditions	**Problems with living conditions**
	Rate the overall severity of problems with the quality of living conditions and daily domestic routine. Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones? *Do not rate the level of functional disability itself, rated at Item 10.* *NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.*	*Rate the overall severity of problems with the quality of living conditions, accommodation and daily domestic routine, taking into account the patient's preferences and degree of satisfaction with circumstances. Are the basic necessities met (heat, light, hygiene)? If so, does the physical environment contribute to maximising independence and minimising risk, and provide a choice of opportunities to facilitate the use of existing skills and develop new ones?* *Do not rate the level of functional disability itself, rated at Item 10.* *NB: Rate patient's usual accommodation. If in acute ward, rate the home accommodation.*
0	Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Item 10 to the lowest level possible, and supportive of self-help.	Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Item 10 to the lowest level possible and minimising any risk, and supportive of self–help; the patient is satisfied with their accommodation.
1	Accommodation is reasonably acceptable although there are minor or transient problems (e.g., not ideal location, not preferred option, doesn't like the food, etc.)	Accommodation is reasonably acceptable with only minor or transient problems related primarily to the patient's preferences rather than any significant problems or risks associated with their environment (e.g. not ideal location, not preferred option, doesn't like food).
2	Significant problem with one or more aspects of the accommodation and/or regime (e.g., restricted choice; staff or household have little understanding of how to limit disability or how to help use or develop new or intact skills).	Basics are met but significant problems with one or more aspects of the accommodation or regime (e.g., lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems of access); may be associated with risk to patient (e.g., injury) which would otherwise be reduced.
3	Distressing multiple problems with accommodation (e.g., some basic necessities absent); housing environment has minimal or no facilities to improve patient's independence.	Distressing multiple problems with accommodation; e.g., some basic necessities are absent (unsatisfactory or unreliable heating, lack of proper cooking facilities, inadequate sanitation); clear elements of risk to the patient resulting from aspects of the physical environment.
4	Accommodation is unacceptable (e.g., lack of basic necessities, patient is at risk of eviction, or 'roofless', or living conditions are otherwise intolerable) making patient's problems worse.	Accommodation is unacceptable: e.g., lack of basic necessities, insecure, or living conditions are otherwise intolerable, contributing adversely to the patient's condition or placing them at high risk of injury or other adverse consequences.

Item 11 requires some knowledge of the person's usual domestic environment during the period rated, whether at home or in some other residential setting. If this information is not available, rate as "not known".

Consider the overall level of social and role functioning the person 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 their social and role functioning, quality of life and recovery? Do family and other caregivers know what the person's capacities are? Do they understand the nature of their mental health problems and how their own behaviour can support or hinder the person's recovery? If not, are they willing and able to learn?

The rating must be realistic, taking into account the overall problem level during the period, ratings on Items 1-10, and information on the following points:

Assess whether essential living needs are consistently met — including safe shelter, warmth, adequate lighting, food, financial resources, clothing, personal safety, and a sense of dignity. If any of these fundamentals are absent or clearly at risk — for example, if the person faces eviction despite otherwise stable housing — this would warrant a maximum severity rating of 4.

Consider the quality of the person's social relationships in their domestic environment. A person living alone in a state of social isolation with little or no opportunity for contact with relatives, friends or neighbours would warrant a rating of 4 on this item. Similarly, a person living in a relationship where they were subject to physical or emotional abuse from which they felt unable to escape would warrant a rating of 4 on this scale.

Consider the extent to which the person's partner, family or house mates understand the nature of the person's illness. Do they have insight into and understanding of the difficulties the person has? Has psychoeducation targeted to the specifics of the person's illness been made available to their partner, family members or close friends?

For example, for a person having problems with emotional dysregulation, have resources been provided to their partner on how to manage that relationship? If the partner or someone close was unwilling to participate in that psychoeducation, to learn and understand what was going on for their partner and learn how to respond differently, then, that would be something that could warrant a rating of at least 2. Their environment is actually not supportive and their partner is not being supportive of them and the person's particular needs.

Active disengagement from, or even hostility towards the person's therapeutic regimen by their partner or others with whom they live, may warrant a rating of 3 or even 4 depending on how much that impacts the person's recovery.

For individuals living in supported accommodation, assign a rating of 0 when the person is able to function freely and independently in their living situation, without environmental barriers. If the environment is somewhat limited but still sufficiently supportive, a rating of 1 is appropriate. Use scores of 2 or 3 when there is clear evidence that the home environment imposes moderate or substantial constraints on the person's ability to function at their potential. Consider the quality of relationships with others in the home in relation to the support they provide to develop new skills or prevent the deterioration of existing skills. The quantity and quality of the person's relationships have been rated at Item 9. In rating Item 11, reflect on how the home environment influences the

person's skill development and emotional wellbeing. Are relationships in the household constructive or strained? Is there adequate privacy and space for leisure? Do residents support or hinder one another? Is the setting one in which the person feels safe, welcomed, and encouraged to make choices, engage socially, and practise everyday skills such as cooking, budgeting, or expressing personal identity?

Although you may not have any capacity or responsibility for making changes to these aspects of the person's environment, if those problems are present they should be rated.

Item 12 – Problems with occupation and activities

	HoNOS	*HoNOS 65+*
	Problems with occupation and activities	**Problems with occupation and activities**
	Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities e.g., staffing and equipment of day centres, workshops, social clubs, etc. Do not rate the level of functional disability itself, rated at Item 10. *NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission.*	*Rate the overall level of problems with quality of day–time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, lack of access to supportive facilities, e.g., staffing and equipment of day centres, social clubs, etc.* *Do not rate the level of functional disability itself, rated at Item 10.* *NB: Rate the patient's usual situation. If in acute ward, rate activities during period before admission.*
0	Patient's day-time environment is acceptable: helpful in keeping any disability rated at Item 10 to the lowest level possible, and supportive of self-help.	Patient's day–time environment is acceptable; helpful in keeping any disability rated at Item 10 to the lowest level possible, and maximising autonomy.
1	Minor or temporary problems (e.g., late pension cheques): reasonable facilities available but not always at desired times, etc.	Minor or temporary problems, e.g., good facilities available but not always at appropriate times for the patient.
2	Limited choice of activities; lack of reasonable tolerance (e.g., unfairly refused entry to public library or baths, etc.); handicapped by lack of a permanent address; insufficient carer or professional support; helpful day setting available but for very limited hours.	Limited choice of activities; e.g., insufficient carer or professional support, useful day setting available but for very limited hours.
3	Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access.	Marked deficiency in skilled services and support available to help optimise activity level and autonomy, little opportunity to use skills or to develop new ones; unskilled care difficult to access.
4	Lack of any opportunity for daytime activities makes patient's problems worse.	Lack of any effective opportunity for daytime activities makes the patient's problems worse.

Item 12, Problems with occupation and activities, applies the principles considered at Item 11 to the potential occupation and leisure activities available to the person. In this sense, occupations are a broad range of activities that make a person's life meaningful and have purpose and are not limited to jobs or employment.

Base your rating on how effectively the person's daytime setting supports them in using their skills and engaging in meaningful roles — regardless of the level of disability rated in Item 10.. This requires a judgement about whether a change in environment is likely to improve the person's quality of life and support the recovery of social and role functioning, bearing in mind that this also depends on whether any lack of motivation can be overcome.For patients suffering an acute episode of mental illness who have had to take time off work or study or who are currently unable to fulfil the tasks they would normally be expected to undertake in that context, consider the support provided by their place of work or study and the level of understanding and support the patient receives in that environment. Do employers and other staff know what the person's

capacities and limitations are? If they do not, then this should be rated as an issue. The rating does not denote any moral blame but simply reflects that the environment can sometimes not provide the support that may be needed.

This Item considers the availability of specific programs to support skills development, but this program must meet the person's specific needs. It is one thing to have a rehabilitation program but another for that program to specifically meet the individual needs of the person, and this is what is considered here.

For patients with severe mental illness and associated high levels of disability the rating is based on an overall assessment of the extent to which the daytime environment brings out the best abilities of the person during the period rated, whatever the level of disability rated at Item 10.

Evaluate how well the person’s environment enables them to take part in meaningful daytime activities. Are there supports in place to help them access public spaces and services, such as shops, transport, libraries, community centres, or recreational areas? Consider also whether any safety concerns in the area pose barriers to participation.

For patients living in supported accommodation or in residential care settings: consider whether the person has access to educational or rehabilitation programs that are tailored to their needs and interests. Are there structured, safe options available for those who might find public settings overwhelming or unsafe? Also assess how much of the person’s day is spent without access to constructive activity, stimulation, or purpose.

- If the person is free and able to organise and take part in daytime activities without restriction, rate 0. A less full but still adequate routine is rated 1.
- A rating of 4 is appropriate when the person is left without meaningful daytime activity or support — for example, when they are routinely neglected or spend most of the day inactive, unstimulated, and unsupported.
- Between these poles, a judgement is required about how much the environment limits the person’s freedom and ability to organise and take part in achievable daytime activities. A rating of 2 indicates moderate restriction; 3 indicates substantial restriction.

Although you may not have any capacity or responsibility for making changes to these aspects of the person’s environment, if those problems are present they should be rated.

Patterns of HoNOS ratings in common syndromes

The ratings on the individual items are intended to be a summary of the clinician's understanding of the person's clinical status. Taken together, ratings on the twelve items provide a description of the nature, severity and complexity of the person's presentation, regardless of their diagnosis, at the specified point in their clinical path. Some examples of where specific features of common syndromes may be rated on the HoNOS are given below. Note that the issues identified are illustrative only and are not intended to be exhaustive. We discuss these here, not to suggest that diagnosis should precede your rating of the HoNOS, but to illustrate how the common features observed in various syndromes are represented across the full spectrum of issues addressed by the twelve HoNOS items.

Psychosis

For people with Psychotic illnesses, positive symptoms such as hallucinations and delusions are rated on Item 6; disorganised thinking and other cognitive problems are rated on Item 4; whilst agitation or overactive or disruptive behaviour, if present, is rated on Item 1. Negative symptoms such as anhedonia, that is, the reduced ability to experience pleasure or enjoyment from activities that were previously rewarding, are rated on Item 7; affective flattening, including emotional blunting, limited facial expression, and monotone speech, if marked, may be considered for rating at Item 8; whilst lack of social responsiveness and social withdrawal are rated on Item 9. Problems in maintaining personal hygiene, bathing or dressing (simple activities of daily living) or managing finances or meal preparation (complex activities of daily living) are rated at Item 10.

Depression

For people with Depression, the severity and impact of feelings of sadness, hopelessness or despair, loss of interest or pleasure in activities that once were enjoyable, and feelings of worthlessness or guilt, are rated at Item 7; low energy and fatigue, disturbed sleep patterns and changes in appetite or weight are rated at Item 8; difficulties concentrating, making decisions, or marked slowing of cognition and speech are rated at Item 4; agitation and restlessness are rated at Item 1; and social withdrawal or other problems with social relationships caused by negative cognitive biases and increased interpersonal sensitivity are rated at Item 9. Problems in washing hair or brushing teeth (simple activities of daily living) or housekeeping or managing public transport (complex activities of daily living) are rated at Item 10.

Trauma–related presentations

For people with Trauma–related presentations (e.g., Post-Traumatic Stress Disorder (PTSD), Adjustment Disorders and Complex PTSD) symptoms such as flashbacks, nightmares, intrusive thoughts, and hyper-vigilance are rated on Item 8; persistent feelings of sadness, guilt, or hopelessness, and anhedonia or diminished interest in activities are rated at Item 7; irritability and

aggression are rated at Item 1; difficulties with concentration at Item 4; feeling emotionally detached from others, or difficulty maintaining close relationships, are rated at Item 9; and alcohol or substance abuse at Item 3. Problems in grooming (simple activities of daily living) or shopping for groceries or supplies (complex activities of daily living) are rated at Item 10.

Borderline personality disorder

For people with a primary or secondary diagnosis of Borderline Personality Disorder, thoughts of self-harm, or behaviours associated with planning or intent to self-harm, are rated at Item 2 Non-accidental self-injury. Also rated at this Item are cutting, scratching, burning and other self-harming behaviours. The severity and impact of problems with depressed mood, particularly feelings of worthlessness, self-hatred, and despair, are rated at Item 7. Emotional dysregulation is rated at Item 8. Issues in terms of overvalued or hostile relationships and behaviour consequent on fears of abandonment are rated on Item 9 Problems with relationships. Problems in maintaining personal cleanliness (simple activities of daily living) or managing parental responsibilities (complex activities of daily living) are rated at Item 10.

Alcohol or substance dependence

For a person with Alcohol or substance dependence, the severity and impact of their craving and dependence is rated at Item 3. Behavioural disturbances including aggression, agitation, or disruptive behaviour, regardless of whether that is due to intoxication, withdrawal, or are acts committed in order to obtain alcohol or other drugs, are rated at Item 1. Disorientation or impaired judgment are rated at Item 4. If present, drug-induced hallucinations and delusions are rated at Item 6. Problems in maintaining oral hygiene (simple activities of daily living) or managing finances and paying rent (complex activities of daily living) are rated at Item 10.

Eating disorders

For people with an Eating Disorder, the severity and impact of the core problems with eating, including fasting and food restriction, bingeing and vomiting are rated under Item 8 and coded as G. Abnormal or delusional thinking about body image should be rated at Item 6. Cognitive problems related to starvation, including extreme rigidity and fixation on detail are rated at Item 4. Markers of acute physical risk and chronic medical problems (e.g., osteoporosis), together with physical problems arising from starvation, bingeing and purging, and obesity are rated at Item 5. Note that a BMI of less than 15 or greater than 35 is indicative of a severe problem with the person's weight.

Physical restlessness, overactivity, and pathological exercise should be rated at Item 1. Behaviours that disturb family life or cause distress to others (e.g., not letting others eat, cook, store or prepare food in the kitchen and intrusive exercise regimes), temper tantrums, etc. should also be rated at Item 1. These kinds of behaviours may also cause problems in relationships resulting in conflict, passive or active withdrawal. The severity of these relationship difficulties should be rated at Item 9.

The misuse of drugs or medicines that are associated with psychological or physical harm,

addictive behaviour of the type associated with psychoactive substance misuse, and psychological or physical effects from withdrawal, should all be rated at Item 3. Examples include laxatives, thyroxine, caffeine, metabolic stimulants, etc. This type of drug or medicine misuse is rated here rather than at Item 2 (non-accidental self-injury) because these behaviours are habitual and addictive in quality and the types of interventions likely being offered will more closely resemble those associated with substance misuse than deliberate self-harm. In clinical practice, people will have both problems associated with drug or medicine misuse and deliberate self-harm, while others may not, indicating the need for different types of interventions depending on their presentation. There is, therefore, clear clinical utility in separating the scoring of these different behaviours between Items 2 and 3.

Problems or lack of relationships with family or friends or intimate partners are rated at Item 9. At Item 10, consider such things as difficulties with shopping for, storing or preparing food; inability to eat socially; requirements for rigid routines around eating; and the clinical need to have a supervised or supported eating regime.

For people with an Eating Disorder, problems with living conditions rated at Item 11 may include family or friends accommodating and enabling the disordered behaviour and other symptoms by reassurance, turning a blind eye to unacceptable behaviours, or by being overly protective, permissive, or authoritarian. Problems with occupation and activities rated at Item 12 may include “toxic” work environments such as those encountered by ballerinas, models, actors, jockeys, etc.

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