Australian Mental Health Outcomes and Classification Network

USING THE NOCC AND EXPERIENCE MEASURES TO MEET THE REQUIREMENTS OF THE NSQHS STANDARDS

Version 1.0
September 2025

www.amhocn.org

Acknowledgements

Acknowledgement of Country
We acknowledge the Traditional Owners of Country throughout Australia and recognise their continuing connection to lands, waters and communities. We pay our respect to the people, the cultures and Elders past and present.

Acknowledgment of Lived / Living Experience and Carers
We would like to recognise those with lived / living experience of mental health conditions in Australia. We acknowledge that we can only provide quality care through valuing, respecting and drawing upon the lived / living experience and expert knowledge of consumers, their families, carers and friends, staff and the local communities. We acknowledge their contribution to the development of AMHOCN resources.

Suggested citation for this document
Australian Mental Health Outcomes and Classification Network. (2025). Using the NOCC and experience measures to meet the requirements of the National Safety and Quality Health Service Standards. Sydney: Australian Mental Health Outcomes and Classification Network.

Contents

Introduction

The National Safety and Quality Health Service (NSQHS) Standards (Australian Commission on Safety and Quality in Health Care, 2021) were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The National Standards are important to ensure safety and quality in health care delivery. A system of accreditation is in place to demonstrate that organisations that deliver health care can demonstrate that they meet these standards.

This document aims to describe how the National Outcomes and Casemix Collection (including both the clinician rated and consumer self-assessment measures), the Your Experience of Service (YES) Survey and Carer Experience Survey (CES) can be used by services to identify evidence of actions aimed at meeting the standards, with a specific focus on the accreditation process from the perspective of mental health service organisations. It is by no means an exhaustive list but a tool to guide thinking about how the measures could be used. Quality managers may identify alternative uses and this type of innovation is strongly encouraged.

National Outcomes and Casemix Collection (NOCC) and Experience Measures

National Outcomes and Casemix Collection

Background

The National Outcomes and Casemix Collection (NOCC) was first implemented as part of the National Mental Health Strategy (Australian Health Ministers, 1992) (Australian Health Ministers, 1992) (Australian Health Ministers, 1998). The aim of the NOCC was to improve the quality of service provision through the use of measures to support consumer and clinician dialogue, support the evaluation of quality improvement activities in services and use information for services where benchmarking is the norm.

The NOCC includes both clinician-rated and consumer-rated measures and is specific to service setting (inpatient, residential, and ambulatory) and the consumers' age group (children and adolescents, adults, and older persons). All states and territories have implemented the collection, and the results are reported nationally in various ways.

Clinician rated measures

A range of clinician-rated measures have been introduced that can be used to understand not only the variability in the presentation of consumers but also the outcomes of care from the clinician's perspective.

The clinician-rated measures used in Adult and Older Person services are:

- Health of the Nation Outcome Scales (HoNOS)
- Health of the Nation Outcome Scales 65+ (HoNOS 65+)

- Life Skills Profile - 16 (LSP - 16)
- Resource Utilisation Groups - Activities of Daily Living (RUG – ADL)
- Mental Health Phase of Care (PoC)

The clinician-rated measures used in Child and Adolescent services are:

- Health of the Nation Outcome Scales - Child and Adolescent (HoNOSCA)
- Factors Influencing Health Status (FIHS)
- Mental Health Phase of Care (PoC)
- Children's Global Assessment Scale (CGAS)

Consumer self-assessment measures

Consumer self-assessment measures have also been implemented, which aim to gather the consumer's perspective about how they think, feel, and behave. These measures can be used by services to demonstrate the involvement of consumers in service provision and to demonstrate the change in their mental health from their perspective. The specific measure to be used has been decided by each state and territory.

The consumer self-assessment measures used in Adult and Older Person services are:

- Kessler - 10+ (K - 10+) (NSW, SA, NT, WA)
- Behavior and Symptom Identification Scale - 32 (BASIS - 32) (ACT, VIC, TAS)
- Mental Health Inventory - 38 (MHI - 38) (QLD)

The consumer self-assessment measures used in Child and Adolescent services are:

- Strengths and Difficulties Questionnaire (SDQ) – parent version and youth version

Both the clinician rated and consumer self-assessment measures can be used as a common language to support clinical communication, e.g., the Health of the Nation Outcome Scales family of measures (HoNOSCA/HoNOS/HoNOS 65+). Anything rated 2 or higher on the HoNOS measures is seen as clinically significant and should be reflected in the clinician's activity in relation to monitoring and their treatment and management planning.

Experience Measures

Your Experience of Service (YES)

Mental health consumers' experiences of health care have long been identified by services, consumers, carers and families as important in understanding how health services are performing and driving service quality improvement. Substantial work has been undertaken in Australia and internationally to establish processes that regularly capture information on the perspectives of consumers and their carers about the health care they receive.

At the national level, there was strong interest amongst the states and territories in the development of a standardised, national measure of mental health consumer experiences of care which could support quality improvement, service evaluation and benchmarking between services. The Your

Experience of Service (YES) Survey was subsequently developed to gather information from consumers about their experiences of care.

Carer Experience of Service (CES)

The Fourth National Mental Health Plan also recognised the role of carers in mental health service provision and the need for carers and families to receive information, within the bounds of privacy and confidentiality, about the treatment and care provided to the consumer. A national project was undertaken which resulted in the Mental Health Carer Experience Survey (CES). Carers developed the CES, which reflects issues that are important to them, such as a lack of information, recognition, and involvement in care.

By helping to identify specific areas where quality improvements can be made, both the YES and the CES can support collaboration between mental health services and consumers and carers to build better services.

National Standards

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of Safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, these NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The eight NSQHS Standards are:

Clinical Governance which describes the clinical governance and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve patient outcomes.

Partnering with Consumers which describes the systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that they are involved in the development and design of quality health care.

Preventing and Controlling Infections describes the systems and strategies to prevent infection, manage infections effectively when they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials, as part of effective antimicrobial stewardship.

Medication Safety which describes the systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.

Comprehensive Care which describes the integrated screening, assessment and risk identification processes for developing an individualised care plan to prevent and minimise the risks of harm in identified areas.

Communicating for Safety which describes the systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.

Blood Management which describes the systems and strategies for the safe, appropriate, efficient and effective care of patients' own blood, as well as other supplies of blood and blood products.

Recognising and Responding to Acute Deterioration which describes the systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

Each standard contains:

- a description of the standard;
- a statement of intent;
- a list of criteria that describe the key areas covered by the standard;
- explanatory notes on the content of the standard;
- item headings for groups of actions in each criterion; and
- actions that describe what is required to meet the standard.

What is accreditation?

The Australian Commission on Safety and Quality in Health Care notes:

> Accreditation provides assurances to the community that healthcare services meet the expected standards for safety and quality. It is a formal program where trained independent reviewers assess evidence of implementation for specified standards. (Australian Commission on Safety and Quality in Health Care, 2024)

What is evidence for accreditation?

This accreditation workbook includes specific and generic examples of evidence. Most of the examples of evidence in this workbook are listed as generic evidence by category. Examples of these categories of evidence are shown below.

Policy documents can include:

- Policies
- Procedure
- Protocols
- Guidelines
- Pathways.

A policy document may exist for a single action, a number of actions, parts of one or more standards, or a whole standard. The number of policies and detail in each policy will depend on the organisation's size, complexity and type of services.

Training documents can include:

- Orientation manuals
- Education calendars
- Training presentations
- Attendance records
- Online education modules
- Contracts with external education providers.

Organisations need to use a risk management approach to decide what training is required, which members of the workforce need to be trained and how often training needs to occur. Training can also include competency-based assessments and continuing professional development.

Committee and meeting records can include:

- Committee membership
- Committee terms of reference
- Agenda papers, minutes or actions arising from a meeting
- Dashboard reports
- Committee correspondence
- Reports submitted to a committee.

The number, structure and purpose of committees will vary across organisations. Smaller organisations may have one committee that covers one or a variety of standards, whereas larger organisations may have committees for specific actions in the standards, such as antimicrobial stewardship.

Audit results can include:

- Survey instruments, forms and tools used to conduct audits
- Analysis of data collected
- Reports on audits conducted
- Documents showing that audit results were benchmarked.

A risk management approach should be taken when determining what areas of a health service organisation are to be audited, how big the sample size will be, how often the area(s) will be audited, and how the audit results will be used to improve safety and quality of health care for patients.

Communication with the workforce, health service organisation or highest level of governance can include:

- Reports tabled at meetings
- Intranet content or online message boards
- Correspondence, such as broadcast emails
- Newsletters
- Posters.

Employment documents can include:

- Position descriptions
- Duty statements
- Employment contracts
- Performance review documentation
- Notification of scope of clinical practice.

Observations can be done for:

- The presence of a resource, such as signage, personal protective equipment or guidelines
- Clinical practice
- The inclusion of a specific tool or form in healthcare records.

Observations will be used by assessors from accrediting agencies but can also be used by organisations as part of an ongoing monitoring process.

PICMoRS

During the accreditation process, services will be assessed and assessors are encouraged to use the PICMoRS mnemonic guide for their assessment activities (Australian Commission on Saftey and Quality in Health Care, 2020). At least 60% of an assessor's time will be at the point of care, and they will observe and ask the workforce questions. Providing the workforce with an understanding of the PICMoRS and how the NOCC and experience measures can be part of the assessment process will help them provide the assessors with information demonstrating that the service meets the NSQHS Standards.

Process

When evaluating a particular process it is important to ensure that staff:

- Are aware of the process
- Understand all elements of the process
- Know what their role and responsibilities are as well as the roles of others involved
- Know where to find information about the process.

Examples of questions you could ask the workforce:

- How does this process work in your organisation?
- Is the process documented? How do you access this information?
- Who is responsible for the other parts of the process?
- Where else is this process used?
- Are there places where this process is not used? Why?
- Are there specific qualifications required to be able to carry out the process?
- Are you confident the information on this process is up to date and accurate?
- Can I see evidence of practice?

Improvement

In order to implement change it is important for the workforce to be made aware of, and participate in, quality improvement strategies and for results and recommendations to be widely reported. It is important to ensure staff:

- Are aware of changes to the process
- Receive information about any updates that are made to the process
- Participate in making changes if required
- Participate in evaluating the effectiveness of changes.

Examples of questions you could ask the workforce:

- Has the process been reviewed?
- What were the issues that led to the change?
- How would you get to know if there were changes?
- Who is responsible for making the changes?
- Have the changes been fully implemented?
- How did you determine if further changes are needed?

Consumers

To fully apply the NSQHS Standards in a health service organisation, governing bodies, management, patients, consumers, clinicians and clinical teams need to be engaged in implementing the actions set out in the NSQHS Standards. The Clinical Governance and Partnering with Consumers Standards set the overarching requirements for the effective implementation of all other standards.

Assessors will evaluate consumer participation in all areas of safety and quality systems and processes. The method of consumer participation used will vary depending on the safety and quality process or system.

Examples of questions you could ask the workforce:

- How were consumers involved in designing, improving or evaluating the process?
- How do you provide consumers with feedback on this process?
- How do you engage consumers in their own care? How is this documented?
- Do you collect feedback from consumers on this process? How?

Monitoring

It is important to check that the workforce who are involved in a process understand how it is monitored. For instance, through the collection and analysis of data to:

- Identify areas of under and high-performance
- Prioritise areas for improvement
- Measure changes over time
- Evaluate the effectiveness of changes that are introduced.

Examples of questions you could ask the workforce:

- How is this process monitored? Where is this documented?
- Do you use national, jurisdictional or local measures to monitor this process or system? Why?
- How would you know if the process is not being used or not working?
- Can you describe what prompted the process to be changed?

Reporting

It is important to check that data is collected, analysed and reported appropriately to all levels of an organisation, key stakeholders and consumers. There should be systems in place to ensure that reporting on processes and systems occurs to those involved, which may include:

- The individual or committee with accountability
- The governing body
- Management
- The workforce
- Consumers
- The community
- Other health services.

Examples of questions you could ask the workforce:

- Where is information on the process reported?
- Where is this documented?
- How often does this occur?
- Does the information go to the consumers, workforce, management or governing body?
- Do you get feedback on information that you report?

Systems

The Systems element of PICMoRS aims to encourage actions, and therefore changes/improvements at the overarching level of the organisation, rather than only at the local level. It is a systemic change that is required. For example, collecting, analysing and reporting incident related data using the organisation's incident management system should inform policy, training and risk management systems.

Examples of questions you could ask the workforce:

- Is the information from this process or system used to change other processes, such as risk management, policy development, training and quality improvement?

- Does the information from any other process or system influence how you use or change this process?
- Where is this documented?

Follow this link to a video which gives a brief overview on the Role of the Assessor in accrediting against the NSQHS Standards.

NSQHS Standards

The NOCC and experience measures cannot be used for all the NSQHS Standards but certainly lend themselves to specific actions as evidence of meeting the Standards. The following tables are intended to guide thinking, and services may have developed other innovative practices to support quality improvement and accreditation processes.

Clinical Governance

Follow this link to a video which gives a brief overview of the Clinical Governance standard.

Action	Evidence
1.01 The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews, reports and monitors the organisation's progress on safety and quality performance	Does your organisation's governing body provide leadership by ensuring the NOCC and/or experience measures are used to inform collaborative decision-making on the service's planning, design, monitoring and evaluation? Does your governing body have a standard item on meeting agendas to discuss results of NOCC and experience measures? Does the governing body receive regular reports of the NOCC and experience measures and use those reports to monitor performance, progress and report on strategies for safe and high-quality clinical care? For example, the proportion of consumers with positive experiences on YES and the CES are reported and discussed. Are items of the YES and CES that have the lowest ratings discussed, and have actions been initiated to address the issues? Are the NOCC and experience measures used to support the evaluation of quality improvement activities within your organisation? Are the collection and use of NOCC and experience measures included in policy documents and in employment documents? For example, does your organisation's executive, directors or leadership positions include job descriptions, duty statements or performance review documentation that make reference to the use of the outcomes or experience measures for clinical governance or quality improvement purposes? Does your organisation have documentation of training activities that describe the use of the NOCC and experience measures to support development of strategic priorities and improvements in the quality of care? Does your organisation communicate the results of the collection of the NOCC and experience measures to staff and consumers/carers e.g., notice boards, ward-based patient-facing information boards, newsletters, or updates from the leadership team?

Action	Evidence
1.05 The health service organisation considers the safety and quality of health care for patients in its business decision-making.	Does your organisation report the NOCC or experience measures by variables such as age group and service setting, and at a total score or individual item score level? Is there evidence of how that information has been used to inform business decision-making?

Action	Evidence
1.08 The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	Are NOCC and experience measure included in your organisation-wide quality improvement framework or quality improvement policy? Is there evidence of actions taken as a result of reviewing the reporting of the NOCC and/or experience measures?

Action	Evidence
1.09 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	Is there a regular schedule of reporting the results of the consumer rated outcome measures (e.g., K-10+, BASIS-32, MHI-38 or SDQ) or carer rated outcome measure (parent version of SDQ) and the YES and CES to the leadership group and particularly the consumer and carer consultative committee?

Action	Evidence
1.10 The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	Ratings on the NOCC measures provide an indication of the level of risk associated with behavioural disturbance or symptomatology (e.g. HoNOSCA/HoNOS/HoNOS65+), functioning (e.g. LSP-16 / CGAS) and self-reported distress (K-10+, BASIS-32, MHI-38, SDQ). Does your organisation report items from these measures to identify risk for the population under care within the service and then implement and evaluate strategies to ameliorate this risk? For example, clinically significant ratings (rating of 2 or more) on HoNOS Scale 1 *Overactive, aggressive, disruptive or agitated behaviour* are used to monitor the extent of this behaviour within the organisation. Is there evidence of actions to manage this type of behaviour, such as training to de-escalate violence and aggression?

Action	Evidence
1.13 The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	All NOCC and experience measure items can be used to meet this action. Does your organisation use the consumer-rated outcome measures (K-10+, BASIS-32, MHI-38, SDQ) to support care planning? Do you have examples of how the information collected from the YES and the CES is being used to inform and evaluate service quality improvement activities?

Action	Evidence
1.14 The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	The YES and the CES have specific items to better understand the patients' and carers' experience of how to make a complaint. (YES Q.9 *You believe that you would receive fair treatment if you made a complaint* and Q.18 *Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)*, CES Q.18 *An explanation of how to make a compliment or complaint about the mental health service)* Is there evidence that your organisations is reporting this information and it is being used in decision making by the governing body to understand and monitor organisation-wide complaint management systems? Are the results of these YES and CES questions used to monitor improvements in the quality and effectiveness of your organisation’s complaints management system?

Action	Evidence
1.15 The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	The NOCC measures (HoNOSCA/HoNOS/HoNOS65+) can be used to support the identification of consumers who are at higher risk of harm (e.g., HoNOS/65+ Scale 2/HoNOSCA Scale 3 *Non accidental self-injury*), MHI-38 Item 21 *How often have you felt that others would be better off if you were dead*, BASIS-32 Item 9 *Isolation or feelings of loneliness*, Item 17 *Depression, hopelessness*, Item 18 *Suicidal feeling*, K-10+ Item 4 *How often did you feel hopeless*, Item 7 *How often did you feel depressed*, Item 10 *How often did you feel worthless.* Is there reporting of this information within your organisation at team or service level to support the planning and delivery of care?

Action	Evidence
1.16 The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	The organisation has health care record systems in place that support the systematic audit of clinical documentation. The HoNOS is the primary measure of problem severity within the NOCC, and during training participants are encouraged to recognise that any rating above 2 should be considered clinically significant and reflected in the care plan. The HoNOS Quality Assessment Tool (H-QAT) is an audit tool provided in Appendix 1 and can be used to monitor the relationship between ratings and care plans, ensuring that ratings accurately reflect the needs of the patient and associated care plan activities. Accuracy in the use of the HoNOS, HoNOS 65+, and HoNOSCA is also critical for supporting Activity-Based Funding, as these measures capture consumers' clinical needs and associated resource requirements. A systematic audit of HoNOS ratings is therefore an essential component in ensuring that an organisation maintains accurate and complete health care records.

Action	Evidence
1.20 The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	Is there evidence that the NOCC measures and the YES/CES measures are included within training and workforce development activities within your organisation? Does the training involve consumer and carer educators, representatives or peer support workers? Is this training mandatory within your organisation? Are records kept of the NOCC and YES/CES training activities?

Action	Evidence
1.28 The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	Are the results of the NOCC and YES/CES used to monitor the performance of your organisation, including the outcomes of care? Is the NOCC and YES/CES information used to understand and explore clinical variation through a process of internal benchmarking? For example, are total scores or individual item scores on HoNOSCA/HoNOS/HoNOS65+ used to understand variation in the complexity of consumers across teams or services? Is the identification of variation used to implement and monitor improvements in team/service performance within your organisation?

Action	Evidence
1.33 The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	The YES (Q.6 *Your individuality and values were respected (such as your culture, faith or gender identity, etc.)*, Q.16 *There were activities you could do that suited you)*; and the CES (*Q.4 Your personal values, beliefs and circumstances were taken into consideration*, Q.5 *You were able to obtain cultural or language support (such as an interpreter) when you needed*, Q.12 *You were given the opportunity to enhance your abilities as a carer*, Q.14 *Staff worked in a way that supported your relationship with your family member, partner or friend*) relate to a consumer's or carer's perspective of whether their individuality, such as values, beliefs, culture, were respected. Is this information used within your organisation to demonstrate your organisation's recognition of Aboriginal and Torres Strait Islander or Culturally and Linguistically Diverse beliefs? Is this reported information used by your organisation to monitor improvements in performance and the creation of a welcoming environment that recognises the importance of cultural beliefs and practices?

Partnering with Consumers

Follow this link to a video which gives a brief overview of the Partnering with Consumers standard.

Action	Evidence
2.02 The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	Does your organisation use the NOCC and YES and CES measures to monitor and improve partnering with consumers? For example: • Completion rates of the NOCC consumer self-assessment measures (K-10+, BASIS-32, MHI-38, SDQ) or the YES and CES measures can be used as evidence of your organisation's commitment to engaging with consumers. • Completion rates of the CES can be used as an indication of the service's commitment to engaging with carers e.g., CES Q.20 *Information on opportunities to participate in improving this mental health service*. • Completion rates of the YES and CES can be used to monitor quality improvement activities with regards to partnering with consumers and carers.

Action	Evidence
2.03 The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	Does your organisation use the results of the YES and CES to support identification of how well the service provides care across the categories of the Australian Charter of Healthcare Rights? For example: • Access ○ YES Q.8 *You had access to your treating doctor or psychiatrist when you needed*, Q.15 *You had opportunities to discuss your progress with the staff caring for you*, Q.17 *You had opportunities for your family and carers to be involved in your treatment and care if you wanted*, Q.20 *Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)*, Q.22 *Convenience of the location for you (such as close to family and friends, transport, parking, community services you use, etc.*) ○ CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend*, Q.8 *You were involved in decisions affecting your family member, partner or friend*, Q.10 *You were given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of*

Action	Evidence
	confidentiality, you could not be told specific information), Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend*, Q.16 *You had opportunities to communicate confidentially with the treating doctor if you needed (such as by phone, email or in person)*, Q.21 *A number you could call after hours for the service* • Safety ○ YES Q.3 *You felt safe using this service*, Q.9 *You believe that you would receive fair treatment if you made a complaint*, Q.11 *The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)* • Respect ○ YES Q.1 *You felt welcome at this service*, Q.2 *Staff showed respect for how you were feeling*, Q.4 *Your privacy was respected*, Q.5 *Staff showed hopefulness for your future*, Q.6 *Your individuality and values were respected (such as your culture, faith or gender identity, etc.)*, Q.7 *Staff made an effort to see you when you wanted*, Q.12 *You were listened to in all aspects of your care and treatment* ○ CES Q.4 *Your personal values, beliefs and circumstances were taken into consideration*, Q.5 *You were able to obtain cultural or language support (such as an interpreter) when you needed*, Q.7 *Your opinion as a carer was respected*, Q.9 *You were identified as a carer of your family member, partner or friend*, Q.13 *Staff conveyed hope for the recovery of your family member, partner or friend* • Partnership ○ YES Q.10 *Your opinions about the involvement of family or friends in your care were respected*, Q.13 *Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff)*, Q.14 *Staff discussed the effects of your medication and other treatments with you*, Q.15 *You had opportunities to discuss your progress with the staff caring for you*, Q.17 *You had opportunities for your family and carers to be involved in your treatment and care if you wanted*, Q.21 *Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)* ○ CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend*, Q.8 *You were involved in decisions affecting your family member, partner or friend*, Q.10 *You were given opportunities to discuss the care,*

Action	Evidence
	treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information), Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend*, Q.16 *You had opportunities to communicate confidentially with the treating doctor if you needed (such as by phone, email or in person)* • Information ○ YES *Q.14 Staff discussed the effects of your medication and other treatments with you*, Q.18 *Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)*, Q.19 *Explanation of your rights and responsibilities*, Q.20 *Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)*, Q.21 *Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)* ○ CES Q.1 *You understood what you could expect from the mental health service for yourself and your family member, partner or friend*, Q.2 *You were given an explanation of any legal issues that might affect your family member, partner or friend*, Q.3 *You understood your rights and responsibilities*, Q.15 *You were given information about services and strategies available if your family member, partner or friend became unwell again*, Q.17 *A brochure or other material about your rights and responsibilities*, Q.18 *An explanation of how to make a compliment or complaint about the mental health service*, Q.19 *Information about carer support services (such as local groups, carer consultants, counsellors)*, Q.20 *Information on opportunities to participate in improving this mental health service*, Q.21 *A number you could call after hours for the service*, Q.22 *Information about taking a support person to meetings or hearings if you wished* • Privacy ○ YES Q.3 *You felt safe using this service*, Q.4 *Your privacy was respected*, Q.9 *You believe that you would receive fair treatment if you made a complaint*, Q.11 *The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)* ○ CES Q.16 *You had opportunities to communicate confidentially with the treating doctor if you needed (such as by phone, email or in person)* • Give feedback ○ YES Q.9 *You believe that you would receive fair treatment if you made a complaint*

Action	Evidence
	○ CES Q.18 *An explanation of how to make a compliment or complaint about the mental health service*, Q.20 *Information on opportunities to participate in improving this mental health service*

Action	Evidence
2.05 The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	Does your organisation use the completion of the YES Q.10 *Your opinions about the involvement of family or friends in your care were respected,* and the CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend,* as evidence of the involvement of carers/ family and friends as substitute decision makers?

Action	Evidence
2.06 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	The YES and the CES have specific questions to identify if the consumer or carer felt that they were involved in care planning: • YES Q.10 *Your opinions about the involvement of family or friends in your care were respected*, Q.14 *Staff discussed the effects of your medication and other treatments with you*, Q.15 *You had opportunities to discuss your progress with the staff caring for you*, Q.17 *You had opportunities for your family and carers to be involved in your treatment and care if you wanted* • CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend*, Q.7 *Your opinion as a carer was respected*, Q.8 *You were involved in decisions affecting your family member, partner or friend*, Q.9 *You were identified as a carer of your family member, partner or friend*, Q.10 *You were given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)*, Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend*, Q.16 *You had opportunities to communicate confidentially with the treating doctor if you needed (such as by phone, email or in person)*

Action	Evidence
	Does your organisation report these results as evidence of consumer and carer participation in care planning?

Action	Evidence
2.07 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	Does your organisation use the NOCC consumer self-assessment measures (K-10+, BASIS-32, MHI-38, SDQ) as evidence of the involvement of consumers in care planning processes? Does your service have evidence of training in the use of the NOCC consumer self-assessment measures to support care planning? Does your organisation use the YES and the CES as evidence of the involvement of consumers and carers in the care planning process?

Action	Evidence
2.08 The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	Does your organisation have evidence of the distribution and availability of translations of the NOCC consumer self-assessment measure (K-10+, BASIS-32, MHI-38, SDQ) and the YES and CES?

Action	Evidence
2.09 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	Does your organisation use the YES and CES as evidence of the involvement of consumers and carers in the evaluation of internally developed health and health service information? In particular: • YES Q.18 *Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)* • CES Q.15 *You were given information about services and strategies available if your family member, partner or friend became unwell again*, Q.19 *Information about carer support services (such as local groups, carer consultants, counsellors)*, Q.20 *Information on opportunities to*

Action	Evidence
	participate in improving this mental health service, Q.22 *Information about taking a support person to meetings or hearings if you wished*

Action	Evidence
2.10 The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	Does your organisation use the YES and YES questions as evidence of supporting clinicians, consumers and carers in meeting their information needs. In particular: • YES Q.18 *Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)*, Q.19 *Explanation of your rights and responsibilities*, Q.20 *Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)* • CES Q.17 *A brochure or other material about your rights and responsibilities*, Q.18 *An explanation of how to make a compliment or complaint about the mental health service*, Q.19 *Information about carer support services (such as local groups, carer consultants, counsellors)*, Q.20 *Information on opportunities to participate in improving this mental health service*, Q.21 *A number you could call after hours for the service*, Q.22 *Information about taking a support person to meetings or hearings if you wished*

Action	Evidence
2.11 The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	Does your organisation use the results of the NOCC, the YES and the CES as evidence for the involvement of consumers and carers in the evaluation of organisational performance? Are the results of the NOCC, YES and CES reported at consumer and carer committees? For example, are the outcomes of care reported such as: • for aggregate data, the extent to which people change during their time with the service, AMHOCN suggests that a statistically significant improvement is a HoNOS total change score of 4 or more; • the distribution of people in the different phases of care – Acute, Functional Gain, Intensive Extended, Consolidating Gain;

Action	Evidence
	• the highest or lowest rated YES or CES questions or domains; • CES Q.20 *Information on opportunities to participate in improving this mental health service*, as evidence that carers had an opportunity to participate in improving the mental health service?

Action	Evidence
2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	Does your organisation use the results of the YES and the CES by Aboriginal and Torres Strait Islander status as evidence to better understand any variation of experience between different population groups and use this information for quality improvement purposes?

Preventing and Controlling Infections

Follow this link to a video which gives a brief overview of the Preventing and Controlling Infections standard.

Action	Evidence
3.13 The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy	Does your organisation use the YES Q.11 *The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)* as evidence of the consumer's perspective on the provision of a clean, safe and hygienic environment?

Action	Evidence
3.14 The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning	Does your organisation use the YES Q.11 *The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)* as evidence of the consumer's perspective on the provision of a clean, safe and hygienic environment?

Medication Safety

Follow this link to a video which gives a brief overview of the Medication Safety standard.

Action	Evidence
4.03 Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Shared decision-making	Does your organisation use YES Q.14 *Staff discussed the effects of your medication and other treatments with you* as evidence of the involvement of consumer in medication management? Does your organisation use YES and CES as evidence of your organisation's commitment to shared decision making? Evidence of shared decision could include: • YES Q.10 *Your opinions about the involvement of family or friends in your care were respected*, Q. 12 *You were listened to in all aspects of your care and treatment*, Q. 15 *You had opportunities to discuss your progress with the staff caring for you,* Q. 21 *Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)* • CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend,* Q.7 *Your opinion as a carer was respected*, Q.8 *You were involved in decisions affecting your family member, partner or friend,* Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend*

Action	Evidence
4.11 The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	Does your organisation use YES Q.14 *Staff discussed the effects of your medication and other treatments with you* as evidence of the provision of information on medication and its risks?

Comprehensive Care

Follow this link to a video which gives a brief overview of the Comprehensive Care standard.

Action	Evidence
5.03 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Shared decision-making	Does your organisation use the NOCC consumer self-assessment measures (K-10+, BASIS-32, MHI-38, SDQ) and the YES and CES to demonstrate partnering with consumers in the provisions of comprehensive care? This could include: • Reporting completion rates of the consumer self-assessment measure (K-10+, BASIS-32, MHI-38 or SDQ) • Reporting completion rates of the YES and CES • Use of specific experience measures items as evidence of meeting the consumer's information needs ○ YES Q.18 *Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.),* Q.19 *Explanation of your rights and responsibilities*, Q.20 *Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)* ○ CES Q.1 *You understood what you could expect from the mental health service for yourself and your family member, partner or friend,* Q.2 *You were given an explanation of any legal issues that might affect your family member, partner or friend,* Q.3 *You understood your rights and responsibilities*, Q.15 *You were given information about services and strategies available if your family member, partner or friend became unwell again*, Q.17 *A brochure or other material about your rights and responsibilities,* Q.18 *An explanation of how to make a compliment or complaint about the mental health service*, Q.19 *Information about carer support services (such as local groups, carer consultants, counsellors)*, Q.20 *Information on opportunities to participate in improving this mental health service*, Q.21 *A number you could call after hours for the service,* Q.22 *Information about taking a support person to meetings or hearings if you wished)* • Use of specific experience measure items as evidence of shared decision-making ○ YES Q.10 *Your opinions about the involvement of family or friends in your care were respected,* Q.12 *You were listened to in all aspects of your care and treatment,* Q.15 *You had opportunities to discuss your progress with the staff caring for you*, Q.21

Action	Evidence
	Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.) ○ CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend,* Q.7 *Your opinion as a carer was respected* Q.8 *You were involved in decisions affecting your family member, partner or friend*, Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend*

Action	Evidence
5.04 The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	Does your organisation use NOCC measures and YES and CES to demonstrate that it provides care in a setting that best meets the consumer's clinical needs? For example: • NOCC measures ○ Scores on the consumer self-assessment measures (K-10+, BASIS-32, MHI-38 or SDQ) can reflect the consumer's perspective on the need for treatment ○ HoNOSCA/HoNOS/HoNOS65+ problem severity scores can be used to reflect the need for inpatient care, compared to community care or the need for transfer of care. Higher total scores on the HoNOSCA/HoNOS/HoNOS65+ indicate greater problem severity. (Prowse & Coombs, 2009) ○ Scores on functional measures (LSP-16, CGAS) may reflect the need for longer term rehabilitation in comparison to acute care. For the LSP-16, the total score can range from 0 to 48. Higher scores indicate greater levels of functional impairment. For the CGAS, the total score can range from 0-100. Lower scores indicate greater functional impairment. • Experience measures ○ YES Q.11 *The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.),* Q.22 *Convenience of the location for you (such as close to family and friends, transport, parking, community services you use, etc.*) ○ CES Q.5 *You were able to obtain cultural or language support (such as an interpreter) when you needed*

Action	Evidence
5.06 Clinicians work collaboratively to plan and deliver comprehensive care	Does your organisation use the YES as evidence that clinicians have worked collaboratively to deliver care? For example: • Reported completion rates of the NOCC consumer self-assessment measures (K-10+, BASIS-32, MHI-38, SDQ) • YES Q.13 *Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff)*

Action	Evidence
5.07 The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	Does your organisation use the NOCC measures as evidence of the identification of risks of harm (Pressure injuries, falls, nutrition, cognitive impairment, self-harm and suicide, violence and aggression)? For example: • Clinically significant ratings on the problem severity measures i.e., items that have ratings of 2 or more) (Burgess, Trauer, Coombs, McKay, & Pirkis, 2009): ○ HoNOS /HoNOS65+ (Scale 1 *Overactive, aggressive, disruptive or agitated*, Scale 2 *Non-accidental self-injury*, Scale 4 *Cognitive problems*, Scale 5 *Physical illness or disability*) ○ HoNOSCA (Scale 1 *Disruptive, antisocial, aggres*sive, Scale 3 *Non-accidental self-injury*, Scale 5 *Scholastic or language skills problems*, Scale 6 *Physical illness or disability problems*) • Scores on the functioning measures ○ LSP-16 (adult and older persons) higher scores (Item 1 *Difficulty initiating and responding to conversation*, Item 7 *Violent to others*, Item 9 *Maintain adequate diet*, Item 14 *Behaves offensively*) indicating risk of harm ○ CGAS (children and adolescents) with score lower than 40 (40-31 *Major impairment of functioning in several areas,* 30-21 *Unable to function in almost all areas,* 20-11 *Needs considerable supervision,* 10-1 *Needs constant supervision*) were identified as individuals requiring intensive support. • Scores on the consumer self-assessment measures ○ BASIS-32 higher scores (Item 9 *Isolation or feelings of loneliness*, Item 17 *Depression, hopelessness*, Item 18 *Suicidal feeling or behaviour*, Item 19 *Physical symptoms (for*

Action	Evidence
	example, headaches, aches and pains, sleep disturbance, stomach aches, dizziness), Item 21 *Confusion, concentration, memory*, Item 26 *Uncontrollable, compulsive behaviour (for example, eating disorder, hand-washing, hurting yourself)*, Item 28 *Drinking alcoholic beverages*, Item 29 *Taking illegal drugs misusing*, Item 30 *Controlling temper, outbursts of anger, violence*, Item *31 Impulsive, illegal or reckless behaviour* ○ MHI 38 higher scores (Item 8 *Had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory*, Item 9 *Feel depressed*, Item 14 *Been in firm control of your behaviour, thoughts, emotions or feelings*, Item 16 *Feel that you had nothing to look forward to*, Item 18 *Felt emotionally stable*, Item 19 Felt downhearted and blue, Item 20 *Felt like crying*, Item 21 *Felt that others would be better off if you were dead*, Item 24 *Feel that nothing turned out for you the way you wanted it to*, Item 27 *Felt so down in the dumps that nothing could cheer you up*, Item 28 *Think about taking your own life*, Item 30 *Been moody or brooded about things*, Item 36 *Been in low or very low spirits*); lower scores (Item 2 *Felt lonely*, Item 4 *Felt that the future looks hopeful and promising*) ○ K-10+ higher scores (Item 4 *Feel hopeless*, Item 7 *Feel depressed*, Item 10 *Feel worthless*) ○ SDQ higher scores (Item 12 *Often fights with other children or bullies them*)

Action	Evidence
5.10 Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	Does your organisation use the NOCC consumer self-assessment measure (K-10+, BASIS-32, MHI-38 or SDQ) as a screening tool? For example: • K-10+ was originally designed as a screening tool (Kessler, et al., 2002) Population reference material indicates that scores higher than 30 are consistent with a diagnosis of severe anxiety and depression, with higher scores indicating greater psychological distress. https://www.abs.gov.au/ausstats/abs@.nsf/ProductsbyReleaseDate/4D5BD324FE8B415FCA2579D500161D57 • BASIS-32 was developed for use in outcome assessment and covers the major symptoms and functioning difficulties often experienced by people as a result of a mental illness. (Eisen, Dickey, & Sederer, 2000) • MHI-38 has its roots in measurement in the general population and was designed to measure general psychological distress and well-being. (Veit & Ware, 1983) • SDQ is a brief behavioural screening measure designed for 4-17 year olds. Scales are summed to generate the total difficulties score. (Goodman, Ford, Simmons, Gatward, & Meltzer, 2000).

Action	Evidence
5.12 Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	Does your organisation regularly report and review the completion of all the required NOCC measures collected at admission, review and discharge? Are the results reported as evidence of the documentation of screening and assessment practice within your organisation? Does your organisation use the NOCC measures as evidence of alerts in the health care record?

Action	Evidence
5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	Does your organisation use NOCC and YES and CES measures as evidence of shared decision making. For example: • Experience measures ○ YES Q.10 *Your opinions about the involvement of family or friends in your care were respected*, Q.12 *You were listened to in all aspects of your care and treatment*, Q.15 *You had opportunities to discuss your progress with the staff caring for you,* Q.21 *Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)* ○ CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend,* Q.7 *Your opinion as a carer was respected,* Q.8 *You were involved in decisions affecting your family member, partner or friend,* Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend* • NOCC measures ○ Does your organisation use the NOCC measure as evidence of consumer involvement in care planning and shared decision making. For example, are the rates of collection of the consumer self-assessment measures reported? ○ Does your organisation's policy and procedure documents call for the offering and discussion of the consumer self-assessment measure as part of the assessment and care planning process? ○ Does your organisations policy and procedure documents call for discussion with the consumer the results of the clinician rated measures as part of the assessment and care planning process?

Action	Evidence

5.14 The workforce, patients, carers and families work in partnership to:
a. Use the comprehensive care plan to deliver care
b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care
c. Review and update the comprehensive care plan if it is not effective
d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur
	Does your organisation use NOCC and experience measures to provide evidence of the effectiveness of the comprehensive care plan? For example:
	• Experience measures (specifically questions where consumers and carers report the outcomes of care)
	  ○ YES Q.23 *The effect the service had on your hopefulness for the future*, Q.24 *The effect the service had on your ability to manage your day to day life*, Q.25 *The effect the service had on your overall well-being*
	  ○ CES Q.23 *Your relationship with the person for whom you care,* Q.24 *Your hopefulness for your future,* Q.25 *Your overall wellbeing*
	• NOCC measures are used to demonstrate change in the presentation of the consumer from the clinician's and consumer's perspective and are used to demonstrate change and monitor the effectiveness of care.
	  ○ Scores on HoNOS/HoNOSCA/HoNOS65+
	  ○ Scores on LSP-16/CGAS
	  ○ Change in allocated Phase of Care
	  ○ Scores on K-10+/BASIS-32/MHI-38/SDQ

Action	Evidence

5.31 The health service organisation has systems to support collaboration with patients, carers and families to:
a. Identify when a patient is at risk of self-harm
b. Identify when a patient is at risk of suicide
c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
	Does your organisation use NOCC and experience measures to provide evidence of the identification of the risks of self-harm and suicide? For example:
	• Clinically significant ratings i.e., items that have ratings of 2 or more (Burgess, Trauer, Coombs, McKay, & Pirkis, 2009) on the problem severity measures:
	  ○ HoNOS /HoNOS65+ (Scale 2 *Non-accidental self-injury*, Scale 7 *Depressed mood*)
	  ○ HoNOSCA (Scale 3 *Non-accidental self-injury*, Scale 9 *Emotional and related symptoms*)
	• While no specific items on the LSP-16 measure self-harm certain items may be indirect indicators of the potential for self-harm in particular items 3 is violent to others an indicator of emotional instability, item 7 is well groomed indicating poor self-care an indicator of depressed mood or low self-esteem, item 8 has problems with people who live with him/her an indicator of interpersonal conflict contributing to emotional distress and item 9

Action	Evidence

	• While no specific items on the self-assessment measures reflect self-harm certain items may be indirect indicators of the potential for self-harm
	  ○ BASIS-32 higher scores (Item 9 *Isolation or feelings of loneliness*, Item 17 *Depression, hopelessness*, Item 18 *Suicidal feeling or behaviour*,
	  ○ MHI 38 higher scores (Item 9 *Feel depressed*, Item 16 *Feel that you had nothing to look forward to*, Item 21 *Felt that others would be better off if you were dead*, Item 28 *Think about taking your own life*);
	  ○ K-10+ higher scores (Item 4 *Feel hopeless*, Item 7 *Feel depressed*, Item 10 *Feel worthless*)
	  ○ SDQ higher scores (Item 13 *Often unhappy, depressed or tearful*, Item 19 *Picked on or bullied*)

Action	Evidence

5.34 The health service organisation has processes to support collaboration with patients, carers and families to:
a. Identify patients at risk of becoming aggressive or violent
b. Implement de-escalation strategies
c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce
	Does your organisation use the NOCC measures to provide evidence of the identification of the risks of aggression and violence? For example:
	• Clinically significant ratings i.e., items that have ratings of 2 or more (Burgess, Trauer, Coombs, McKay, & Pirkis, 2009) on the problem severity measures:
	  ○ HoNOS /HoNOS65+ (Scale 1 *Overactive, aggressive, disruptive or agitated*, Scale 2 *Non-accidental self-injury*)
	  ○ HoNOSCA (Scale 1 *Disruptive, antisocial or aggressive*, Scale 3 *Non-accidental self-injury)*
	• Higher scores on the functioning measure for adults and older persons
	  ○ LSP-16 (Item 7 *Violent to others*)
	• While no specific items on the self-assessment measure identify aggression or violence certain items may be indirect indicators of the potential for aggression.
	  ○ BASIS-32 higher scores (Item 28 *Drinking alcoholic beverages*, Item 29 *Taking illegal drugs misusing*, Item 30 *Controlling temper, outbursts of anger, violence*, Item *31 Impulsive, illegal or reckless behaviour*)
	  ○ MHI-38 higher scores (Item 14 *Been in firm control of your behaviour, thoughts, emotions or feelings*)

Action	Evidence
	○ K-10+ (Item 5 *Feel restless or fidgety,* Item 6 *Feel so restless you could not sit still*) ○ SDQ (Item 5 *Get very angry and often lose temper*)

Communicating for Safety

Follow this link to a video which gives a brief overview of the Communicating for Safety standard.

Action	Evidence
6.03 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Shared decision-making	Does your organisation use the NOCC and YES and CES measures as evidence of the work undertaken to actively partner with consumers. For example: • Reporting completion rates of the consumer self-assessment measure/s (K-10+/BASIS-32/MHI-38/SDQ) can demonstrate the involvement of consumers in their own care. • Identification of the consumer's information needs: ○ YES Q.18 *Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.),* Q.19 *Explanation of your rights and responsibilities*, Q.20 *Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)* ○ CES Q.1 *You understood what you could expect from the mental health service for yourself and your family member, partner or friend,* Q.2 *You were given an explanation of any legal issues that might affect your family member, partner or friend,* Q.3 *You understood your rights and responsibilities*, Q.15 *You were given information about services and strategies available if your family member, partner or friend became unwell again*, Q.17 *A brochure or other material about your rights and responsibilities,* Q.18 *An explanation of how to make a compliment or complaint about the mental health service,* Q.19 *Information about carer support services (such as local groups, carer consultants, counsellors)*, Q.20 *Information on opportunities to participate in improving this mental health service,* Q.21 *A number you could call after hours for the service,* Q.22 *Information about taking a support person to meetings or hearings if you wished* • Evidence of shared decision making: ○ YES Q.12 *You were listened to in all aspects of your care and treatment*, Q.15 *You had opportunities to discuss your progress with the staff caring for you*, Q.21 *Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)* ○ CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend,* Q.7 *Your opinion as a carer was respected,* Q.8 *You were involved in decisions affecting your family member, partner or friend,* Q.11 *You were*

Action	Evidence
	involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend)

Action	Evidence
6.04 The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	Does your organisation use the clinically significant ratings on the NOCC clinician rated measures (specifically HoNOS/HoNOSCA/HoNOS 65+) to support clinical communication on critical information about the consumer's care? For example: • HoNOS/HoNOS65+ ratings of 2 or more on Scale 2 (*Non accidental self-injury*) are used to support clinical communication regarding consumer risk (Mater Health Services and Australian Commission on Safety and Quality in Health Care, 2009) • HoNOSCA: Scale 3 *Non accidental self-injury*

Action	Evidence
6.07 The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	Does your organisation use the NOCC measures to support clinical handover? The NOCC measures can strengthen the clinical handover process by ensuring that both the clinician's assessment and the consumer's perspective are communicated. This provides a consistent, structured foundation for safe and person-centred care. For example, the measures can be used as: • Minimum information for handover – ensuring that key domains such as symptoms, functioning, and consumer experience are consistently covered. • A tool for risk identification – highlighting clinically significant areas (e.g., self-harm risk, aggression, functional impairment) that require ongoing monitoring or intervention. • A shared language – supporting multidisciplinary understanding and integrating the consumer's voice into the handover discussion.

Action	Evidence
6.08 Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	Does your organisation use the NOCC consumer and clinician rated measures as part of a structured clinical handover. For example: • Discussion of clinically significant ratings (i.e., items that have ratings of 2 or more), on the clinician rated measures (HoNOS/HoNOSCA/HoNOS65+) • Discussion of the consumer's perspective as evidenced by the ratings of the consumer self-assessment measure (K-10+/BASIS-32/MHI-38/SDQ). Does your organisation use the YES and the CES as evidence of the involvement of the consumer and carer in clinical handover? • Consumer involvement in clinical handover could be demonstrated by specific items of the YES Q.12 *You were listened to in all aspects of your care and treatment*, Q.13 *Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff),* Q.15 *You had opportunities to discuss your progress with the staff caring for you* • Carer involvement in clinical handover could be demonstrated by specific items of the CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend,* Q.7 *Your opinion as a carer was respected,* Q.8 *You were involved in decisions affecting your family member, partner or friend,* Q.9 *You were identified as a carer of your family member, partner or friend,* Q.10 *You were given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information),* Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend*

Action	Evidence
6.09 Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	Does your organisation use clinically significant ratings (i.e., items that have ratings of 2 or more) on the HoNOS/HoNOSCA/HoNOS65+ to communicate critical information about the consumer's needs as they emerge or change?

Action	Evidence
6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	Does your organisation use the YES and CES as evidence that consumers, families or carers have an opportunity to directly communicate critical information during care? For example: • YES Q.7 *Staff made an effort to see you when you wanted,* Q.8 *You had access to your treating doctor or psychiatrist when you needed*, Q.10 *Your opinions about the involvement of family or friends in your care were respected*, Q.12 *You were listened to in all aspects of your care and treatment*, Q.14 *Staff discussed the effects of your medication and other treatments with you*, Q.15 *You had opportunities to discuss your progress with the staff caring for you* • CES Q.6 *You were given the opportunity to provide relevant information about your family member, partner or friend*, Q.7 *Your opinion as a carer was respected,* Q.8 *You were involved in decisions affecting your family member, partner or friend*, Q.10 *You were given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)* Q.11 *You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend,* Q.16 *You had opportunities to communicate confidentially with the treating doctor if you needed (such as by phone, email or in person*)

Action	Evidence
6.11 The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	Does your organisation include clinically significant ratings (i.e., items that have ratings of 2 or more) on the clinician rated measures (HoNOS/HoNOSCA/HoNOS65+) as evidence of the documentation of critical information? Does your organisation use the NOCC measure or the YES and CES as evidence of monitoring the outcomes of care from the consumers' perspective? Does your organisation use changes in the allocation of the Mental Health Phase of Care as evidence of changes to the care plan?

Blood Management

Mental Health Services are usually exempt from assessment for this standard. However, the NOCC measures and/or experience measures can still be used for accreditation purposes under this standard. Follow this link to a video which gives a brief overview of the Blood Management standard.

Action	Evidence
7.03 Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Shared decision-making	Does your organisation use the YES to demonstrate inclusion of the consumer in all aspects of care including blood transfusions? Does the Mental Health Service use YES Q.12 (*You were listened to in all aspects of your care and treatment*) as evidence for meeting this action?

Recognising and Responding to Acute Deterioration

Follow this link to a video which gives a brief overview of the Recognising and Responding to Acute Deterioration standard.

Action	Evidence
8.03 Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	Does your organisation use completion rates of the consumer self-assessment measure (K-10+/BASIS-32/MHI-38/SDQ) as evidence of involving patients in their own care? Does your organisation use YES Q.12 *You were listened to in all aspects of your care and treatment*, Q.15 *You had opportunities to discuss your progress with the staff caring for you*, Q.21 *Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)* as evidence of shared decision making?

Action	Evidence
8.05 The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	Does your organisation use the ratings of the consumer self-assessment measure (K-10+/BASIS-32/MHI-38/SDQ) as evidence of the monitoring and recognition of acute deterioration in mental state? For example: • A specific score is used as a prompt to identify specific actions to meet the consumer's mental health care needs such as the level of observation required. For example, scores on the K-10+ higher than 30 are an indication of severe anxiety and distress. Does your organisation use the ratings of the clinician-rated measures (HoNOSCA/HoNOS/HoNOS65+) as evidence of the monitoring and recognition of acute deterioration in mental state? For example: • A specific score is used as a prompt to identify specific actions to meet the consumer's mental health care needs such as the level of observation required. Such as, scores of 3 or more on items I or 2 of the HoNOS/HoNOS65+ specific change in scores are used as a prompt to identify specific actions to meet the consumer's mental health care needs such as the level of observation required. Such, as score on HoNOS scales that move from the not clinically significant (rating 0 or 1) to the clinically significant range (ratings of 2, 3 or 4)

Action	Evidence
8.06 The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	Does your organisation use the NOCC measures as indicators for the escalation of care? For example: • Rating of the consumer self-assessment measure (K-10+/BASIS-32/MHI-38/SDQ) • A specific score is used as a prompt to identify specific actions to escalate care and this is included in policy or procedure documentation. • A specific change in scores is used as a prompt to identify specific actions to escalate care and this is included in policy or procedure documentation. • Ratings of the clinician rated measures (HoNOS/HoNOSCA/HoNOS65+) • A specific score is used as a prompt to identify specific actions to escalate care and this is included in policy or procedure documentation • A specific change in scores is used as a prompt to identify specific actions to escalate care and this is included in policy or procedure documentation • A change in Phase of Care from Consolidating Gain to Acute or Intensive Extended is used as a trigger for specific interventions, observations or approaches to service delivery. Does your organisation use specific YES and CES items to prompt quality improvement activities in protocols to escalate care? • YES Q.8 *You had access to your treating doctor or psychiatrist when you needed* • CES Q.15 *You were given information about services and strategies available if your family member, partner or friend became unwell again*, Q.21 *A number you could call after hours for the service*

Action	Evidence
8.09 The workforce uses the recognition and response systems to escalate care	Does your organisation report on completion of the consumer self-assessment measures, clinician rated measures, YES and CES measures as evidence of how your organisation is supporting the identification of improvements on processes for escalating care? Does your service have training records of how staff have been trained in the use of the NOCC and YES and CES measures to support the process of recognising and responding to the need for the escalation of care?

Conclusion

The NSQHS Standards provide a nationally consistent statement about the standard of care consumers can expect from their health service organisations. Significant information about consumers and the care provided to them is collected by the NOCC and experience measures. Making full use of this information in areas such as consumer and carer engagement, clinical care, management of teams and the exploration of variations in clinical practice or outcomes provides the foundations to improving the quality of health service provision. This document has shown how the measures that make up the National Outcomes and Casemix Collection and Experience measurement, using the YES and the CES, can support quality improvement and accreditation.

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Appendix 1 HoNOS Quality Assessment Tool (H-QAT)

Overview

A clinical audit in mental health is an essential tool for improving the quality and safety of care. Clinical audits promote accountability, support continuous quality improvement, and ultimately enhance patient outcomes.

During all Health of the Nation Outcomes Scales (HoNOS) training, the relationship between clinical practice and the rating in the HoNOSCA/HoNOS/HoNOS65+ is emphasised. Any rating equal to or higher than 2 is considered clinically significant and reflects an area of the consumer's presentation that warrants monitoring and should be incorporated into treatment and management planning. To support quality improvement initiatives in rating of the HoNOS measures, AMHOCN has developed the HoNOS Quality Audit Tool (H-QAT), which incorporates key training points into an audit process that specifically assesses the alignment between clinical ratings and the documentation of observations of the consumer's presentation, as well as the associated interventions.

The H-QAT enables the systematic evaluation of clinical ratings against the criterion of clinical significance. By using this tool routinely, organisations can identify gaps and areas for improvement in the accuracy of HoNOS ratings and the quality of associated clinical documentation.
The audit focuses on two key aspects of the alignment between HoNOS ratings and documentation quality - specifically Clinically Significant Ratings and Zero, Unable to Rate, Missing ratings.

Part 1: Clinically Significant Ratings (scores => 2)
This section evaluates ratings that indicate Clinically Significant problems. It audits clinical documentation for:

- **Observations** of the consumer's behaviours and presentation.
- **Monitoring** to track the issue over time.
- **Interventions** provided to address the consumer's needs in that area.

Purpose: To provide assurance that clinically significant HoNOS scores **are reflected** in clinical documentation and that practice aligns with the ratings.

Part 2: Zero, Unable to Rate, Missing Ratings
This section evaluates ratings of **Zero, Unable to Rate and Missing**. It reviews clinical records for evidence of:

- **Observations** of the consumer's behaviours and presentation.
- **Monitoring** to track the issue over time.
- **Interventions** provided to address the consumer's needs in that area.

Purpose: To identify instances where documentation justifies a HoNOS rating that is greater than Zero or rated as Unable to Rate or Missing. This part of the audit identifies potential **under-rating** of HoNOS items to improve both rating accuracy and documentation quality.

For the auditor, the process is exactly the same for both Part 1 and Part 2. They are looking for documentation of observations / monitoring and interventions associated with the individual HoNOS items. It is the interpretation of the results that reflects aspects of the quality of the HoNOS ratings.

The H-QAT requires a systematic review of the medical records. To begin, a random sample of individual admission HoNOS ratings is identified for a service unit. The clinical documentation associated with the admission and the HoNOS ratings is then reviewed. These documents could include triage documentation, admission records, and initial care or management plans. Note that in longer-term settings, you may wish to audit the HoNOS rating made at review. In that case, you should adjust your inspection of the documentation to focus on care plans and mental health review documentation.

Systematically, the individual HoNOS items are identified as either clinically significant (>/=2) or not clinically significant (<=1).

For items rated as clinically significant, Part 1 “Clinically Significant Ratings” of the H-QAT is completed. If the reviewed file includes a description of behaviours or evidence of monitoring related to that item, the documentation of observations is marked 'yes'; if there is no such documentation, it is marked 'no'. Similarly, if there is evidence of interventions related to this item in the treatment, initial management, or care plan, the documentation of intervention is marked 'yes'; if there is no evidence of intervention, it is marked 'no'.

While the clinically significant audit assesses the quality of clinically significant ratings, it does not attempt to determine whether differences between scores of 2, 3, and 4 are reflected in the documentation - only that a clinically significant rating is supported by the notes. A more detailed audit, aimed at assessing the accuracy of the ordinal scale itself and its correspondence with documentation, will be developed as further experience with the H-QAT is gained.

For the items rated Zero, Unable to Rate or Missing, then Part 2 “Zero, Unable to Rate, Missing Ratings” of the H-QAT is completed. Here again, if the reviewed documentation includes a description of behaviours or evidence of monitoring activities related to that item, the documentation of observations is marked 'yes'; if there is no such documentation, it is marked 'no'. Similarly, if there is evidence of interventions related to this item in the treatment, initial management, or care plan, the documentation of intervention is marked 'yes'; if there is no evidence of intervention, it is marked 'no'.

Note that the H-QAT includes examples of the types of observations or interventions that may be considered when completing the audit. These examples are by no means exhaustive and additional material may provide evidence of observation or interventions. Additional examples may be added with more use of the H-QAT.

Scoring the H-QAT

Scoring the H-QAT is straightforward, as the audit generates two different scores, one for Clinically Significant Ratings (Part 1) and the other for Zero, Unable to Rate, Missing Ratings (Part 2).

For the HoNOS being audited, the rating for each item is entered into the HoNOS rating column. The auditor systematically reviews each HoNOS item and determines if the rating is either Clinically Significant (=>2) or a rating of Zero, Unable to Rate or Missing. Scores of 1 are not considered in this auditing process. If the rating is clinically significant, then the auditor completes Part 1 but does not complete Part 2. If the rating is Zero, Unable to Rate or Missing then the auditor does not complete Part 1 but completes Part 2. This process is followed until all items have been reviewed.

For Part 1 Clinically Significant Ratings, each HoNOS item is reviewed. If the clinical documentation includes a clear observation of signs, symptoms, or behaviours related to that item, this is scored as a 'yes' (numerical value of 0.5). If there is documentation of the interventions associated with the observed signs, symptoms or behaviour, then this is scored as 'yes' (numerical value 0.5). Both scores are added together for each item. Therefore, each item has a potential maximum score of 1.

For example, HoNOS Item 3 (Problem drinking or drug-taking) receives a clinically significant rating of 3. In the documentation, there is evidence of craving and dependence on alcohol (so scored as a 'yes' with numerical value of 0.5) and there is evidence of interventions aimed at reducing alcohol consumption (controlled drinking) (so scored as a 'yes' with numerical value of 0.5). The score for this item is therefore 1.

To obtain the H-QAT total score, each item's combined score is then summed. The H-QAT has a potential total score of 12 if all items are clinically significant, with clear documentation of observations and interventions. To calculate the Part 1 H-QAT score for a clinically significant ratings, the numerator is the total score of 'yes' ratings for Part 1 H-QAT, divided by the number of clinically significant ratings, and then multiplied by 100. This produces a percentage that reflects the proportion of clinically significant ratings supported by adequate documentation. In this case, higher scores indicate better quality documentation that more accurately reflects clinical significance.

For example, a HoNOS collection has two clinically significant ratings for Items 1 and 6. For Item 1, there is documentation of observed agitated behaviour (score 0.5) and documentation of interventions, including the use of de-escalation techniques (0.5). Similarly, for Item 6 there is documentation of delusional thinking (0.5) and documentation of interventions associated with this type of thinking, such as medication (0.5). For this, given that both clinically significant items have good documentation, the score is 100%

For Zero, Unable to Rate or Missing ratings, a similar process is used. Each HoNOS item with a Zero, Unable to Rate or Missing rating is reviewed to determine if documentation indicates any observation of behaviour assigned a 'yes' (numerical value of 0.5) and if documentation indicates interventions associated with those observations, then this is assigned a 'yes' (numerical value 0.5). Again, both scores are added together for each item. Therefore, each item has a potential maximum score of 1 for a total possible score of 12, if all items have clear documentation of observations and interventions associated with the HoNOS item.

To calculate the score for Zero, Unable to Rate and Missing ratings, the numerator is the total score of 'yes' ratings for Part 2 H-QAT, divided by the denominator, the total number of Zero, Unable to Rate and Missing ratings, and then multiplied by 100. This produces a percentage that indicates how

many Zero, Unable to Rate and Missing ratings may have been inaccurate. In this case, higher scores suggest under-rating on the HoNOS.

For example, a HoNOS collection has Zero ratings for Items 4 and 10. For Item 4, observations of cognitive problems, such as thought disorder, are documented; however, no communication strategies are in place to mitigate these issues. This Item would attract a total score of 0.5. While for Item 10, there are documented observations of problems with simple and complex activities of daily living, but no documentation of interventions to improve functioning. This item would also attract a score of 0.5. Using the H-QAT calculation (i.e., the numerator is the total score of 'yes' ratings for Part 2 Zero, Unable to Rate, Missing Ratings, divided by the denominator, the total number of Zero, Unable to Rate, Missing ratings, and then multiplied by 100), this gives a Zero, Unable to Rate, Missing rating score of 50%.

Combining these two examples, we can see that clinically significant issues were accurately rated (Items 1 and 6). However, for Items 4 and 10, the scores suggest that the ratings provided were not accurate and were, in fact, under-rated. This two-part scoring approach allows the H-QAT to identify both the accuracy of clinically significant ratings and the potential presence of under-rating.

Scoring the H-QAT in this way enables the monitoring of the quality of HoNOS ratings, supports the identification of trends, and guides the development and implementation of improvement strategies. These strategies may include additional training in the use of the measure, targeted training in documentation, or education on the relationship between assessment, documentation, and care planning. Monitoring quality may also highlight the need for specific staff development in managing particular issues such as drug and alcohol use, relationship difficulties, or cognitive problems.

H-QAT Scoring Guide

The H-QAT produces **two scores**:

1. **Clinically Significant Ratings**
2. **Zero, Unable to Rate, Missing Ratings**

Part 1 – Clinically Significant Ratings

1. **Identify items** on the HoNOS with clinically significant ratings (>2).
2. **Review documentation** for each item.
    - If documentation includes observations of signs, symptoms, or behaviours that justify the rating → score **Yes = 0.5**.
    - If documentation is missing or inadequate → score **No = 0**.
    - If documentation includes interventions associated with observed signs, symptoms, or behaviours that justify the rating → score **Yes = 0.5**.
    - If documentation is missing or inadequate → score **No = 0**.
3. **Assign scores**: Each item can score up to 1 (based on the rating + documentation).
4. **Calculate total score**: Add all item scores → maximum possible = 12.
5. **Calculate percentage score**:

$$\text{Score} = \frac{Total\ Yes\ ratings}{Number\ Clinically\ Significant\ ratings}\ X100$$

6. **Interpretation**: Higher scores = better documentation quality (accurately reflecting clinically significant ratings).

Part 2 – Zero, Unable to Rate, Missing Ratings

1. **Identify items** on the HoNOS rated Zero, Unable to Rate, Missing.
2. **Review documentation** for each item rated Zero, Unable to Rate, Missing.
    - If documentation includes observations of signs, symptoms, or behaviours that justify the rating → score **Yes = 0.5**.
    - If documentation is missing or inadequate → score **No = 0**.
    - If documentation includes interventions associated with observed signs, symptoms, or behaviours that justify the rating → score **Yes = 0.5**.
    - If documentation is missing or inadequate → score **No = 0**.
3. **Assign scores**: Each item can score up to 1.
4. **Calculate total score**: Add all item scores → maximum possible = 12.
5. **Calculate percentage score**:

$$\text{Score} = \frac{Total\ Yes\ ratings}{Number\ of\ Zero,\ \ Unable\ to\ Rate,\ \ Missing\ ratings}\ X100$$

6. **Interpretation**: Higher scores = greater evidence of **under-rating** on the HoNOS.

Worked Example: H-QAT Scoring

Part 1 – Clinically Significant Ratings

- Suppose a HoNOS assessment has **10 clinically significant ratings** (items scored =>2).
- When reviewing documentation, **8 of these items** have clear notes describing signs, symptoms, or behaviours justifying the score and interventions associated with problem area.
- Calculation:

$$\text{Score} = \frac{8}{10}\ X100 = 80\%$$

Interpretation:
An 80% score means that **most clinically significant ratings were well-documented**, but 20% lacked adequate supporting evidence.

Part 2 – Zero, Unable to Rate, Missing Ratings

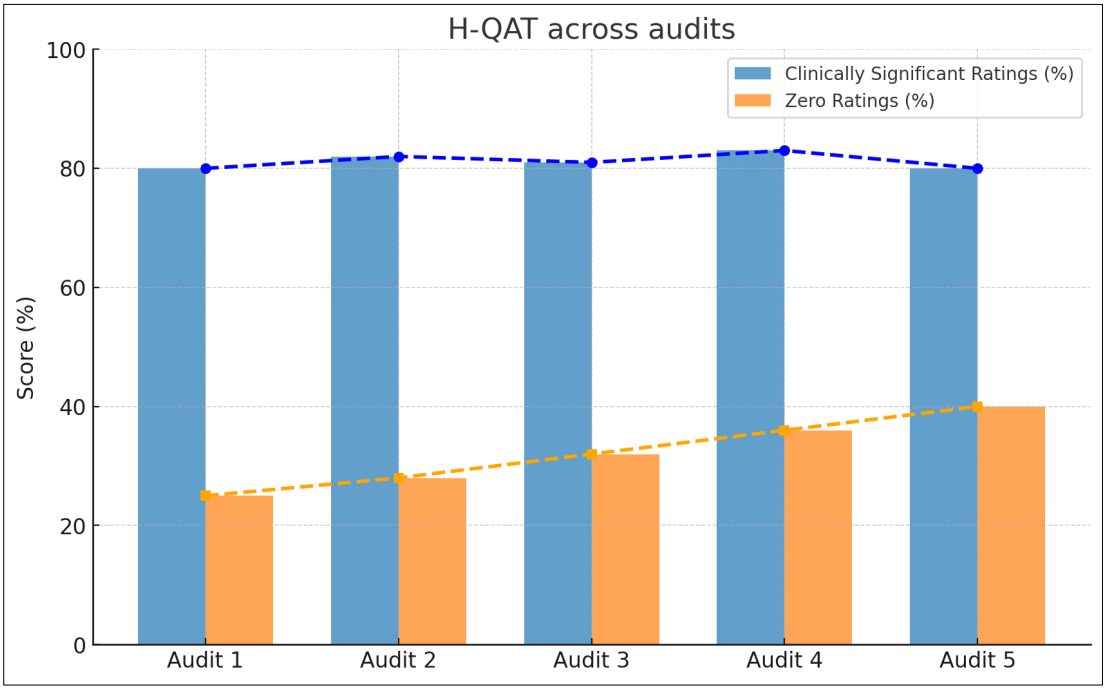
- In the same HoNOS, assume there are **12 items scored as Zero, Unable to Rate, Missing**.
- On review, **3 of these items** actually had evidence in the notes of both behaviours and interventions relevant to that domain.
- Calculation:

$$\text{Score} = \frac{3}{12}\ X100 = 25\%$$

Interpretation:
A 25% score suggests that **a quarter of the Zero, Unable to Rate, Missing ratings may have been**

under-rated, as documentation indicated relevant observations and interventions despite a Zero, Unable to Rate, Missing score.

These results can be trended to produce a report such as the example below.



In the example above, the documentation associated with clinically significant ratings is consistently well-documented 80% of the time; in contrast to rising scores on the Zero, Unable to Rate, Missing ratings, which indicate continued deterioration in the quality of ratings.

Examples of the HoNOS /HoNOS65+ H-QAT and the HoNOSCA H-QAT, along with a glossary of terms, follow.

HoNOS/ HoNOS 65+ Quality Audit Tool

		Part 1: Clinically Significant Ratings (2 or Higher)					Part 2: Zero, Unable to Rate, Missing Ratings				
HoNOS/HoNOS 65+ Scale	HoNOS Rating	Possible observations	Documentation of observations	Possible interventions	Documentation of interventions	H-QAT Clinically Significant Ratings	Possible observations	Documentation of observations	Possible interventions	Documentation of interventions	H-QAT Zero, Unable to Rate, Missing Ratings
1. Overactive, aggressive, disruptive or agitated behaviour		• Physical indicators • Verbal indicators • Emotional indicators	Yes ☐ No ☐	• De-escalation techniques • Behavioural contracts • Social or environmental modifications • Medication	Yes ☐ No ☐		• Physical indicators • Verbal indicators • Emotional indicators	Yes ☐ No ☐	• De-escalation techniques • Behavioural contracts • Social or environmental modifications • Medication	Yes ☐ No ☐	
2. Non-accidental self-injury		• Actions/thoughts/ plans or intent related to suicide are described • Actions/thoughts/ plans or intent to self-harm are described	Yes ☐ No ☐	• Safety planning • Skill building, emotional self-regulation • Psychotherapy • CBT • DBT • ACT • Mindfulness	Yes ☐ No ☐		• Actions/thoughts/ plans or intent related to suicide are described • Actions/thoughts/ plans or intent to self-harm are described	Yes ☐ No ☐	• Safety planning • Skill building, emotional self-regulation • Psychotherapy • CBT • DBT • ACT Mindfulness	Yes ☐ No ☐	
3. Problem drinking or drug-taking		• Use of drug or alcohol is described	Yes ☐ No ☐	• Drug and alcohol focused psychotherapy • Psychoeducation • Psychotherapy • CBT • MI • ACT • Mindfulness • Medication including opioid replacement therapy	Yes ☐ No ☐		• Use of drug or alcohol is described	Yes ☐ No ☐	• Drug and alcohol focused psychotherapy • Psychoeducation • Psychotherapy • CBT • MI • ACT • Mindfulness	Yes ☐ No ☐	

				• Participation in recovery programs/ peers support groups • Referral to AOD services/ participation in detox					• Medication including opioid replacement therapy • Participation in recovery programs/ peers support groups • Referral to AOD services/ participation in detox		
4. Cognitive problems		• Memory or concentration issues described	Yes ☐ No ☐	• Structured routines/ simplified tasks • Reminders • Environmental modifications • Medication	Yes ☐ No ☐		• Memory or concentration issues described	Yes ☐ No ☐	• Structured routines/ simplified tasks • Reminders • Environmental modifications • Medication	Yes ☐ No ☐	
5. Physical illness or disability problems		• Description of physical illness or disability. The functional restrictions are described	Yes ☐ No ☐	• Engagement of physical health care providers • Goal setting/ problem solving to overcome functional restrictions • Environmental modifications or adaptive technology	Yes ☐ No ☐		• Description of physical illness or disability. The functional restrictions are described	Yes ☐ No ☐	• Engagement of physical health care providers • Goal setting/ problem solving to overcome functional restrictions • Environmental modifications or adaptive technology	Yes ☐ No ☐	
6. Problems associated with hallucinations and delusions		• Hallucinations or delusional ideas are described, their frequency and intensity	Yes ☐ No ☐	• Medication (see additional notes) • Psychotherapy • CBT • Mindfulness Psychoeducation	Yes ☐ No ☐		• Hallucinations or delusional ideas are described, their frequency and intensity	Yes ☐ No ☐	• Medication (see additional notes) • Psychotherapy • CBT • Mindfulness • Psychoeducation	Yes ☐ No ☐	
7. Problems with depressed mood		• Description of mood	Yes ☐ No ☐	• Medication • Psychotherapy • CBT • ACT	Yes ☐ No ☐		• Description of mood	Yes ☐ No ☐	• Medication • Psychotherapy • CBT • ACT	Yes ☐ No ☐	

8. Other mental and behavioural problems		• Symptoms or signs of other mental and behavioural problem described	Yes ☐ No ☐	• Psychoeducation • Goal setting • Individual or group psychotherapy • CBT • DBT • SFT • Medication	Yes ☐ No ☐		• Symptoms or signs of other mental and behavioural problem described	Yes ☐ No ☐	• Psychoeducation • Goal setting • Individual or group psychotherapy • CBT • DBT • SFT • Medication	Yes ☐ No ☐	
9. Problems with relationships		• Quality and quality of relationships are described	Yes ☐ No ☐	• Psychoeducation • Family relationship therapy • Individual or group psychotherapy • CBT • DBT • Goal setting/ problem solving	Yes ☐ No ☐		• Quality and quality of relationships are described	Yes ☐ No ☐	• Psychoeducation • Family relationship therapy • Individual or group psychotherapy • CBT • DBT • Goal setting/ problem solving	Yes ☐ No ☐	
10. Problems with activities of daily living		• Observations would include basic self-care abilities and how independently the person can manage them	Yes ☐ No ☐	• Engagement of Occupational Therapist • Behavioural activation • Prompting, cueing or positive reinforcement	Yes ☐ No ☐		• Observations would include basic self-care abilities and how independently the person can manage them	Yes ☐ No ☐	• Engagement of Occupational Therapist • Behavioural activation (BA) • Prompting, cueing or positive reinforcement	Yes ☐ No ☐	
11. Problems with living conditions		• Living conditions are described	Yes ☐ No ☐	• Engagement of social worker • Liaison with Community Managed Organisation • Liaison with NDIS support services • Liaison with Accommodation service provider	Yes ☐ No ☐		• Living conditions are described	Yes ☐ No ☐	• Engagement of social worker • Liaison with Community managed Organisation • Liaison with NDIS support services • Liaison with Accommodation service provider	Yes ☐ No ☐	

12. Problems with occupation and activities		• Occupation and leisure activities are described	Yes ☐	No ☐	• Engagement of social worker • Goal setting • Liaison with Community Managed Organisation • Liaison with NDIS support services • Liaison with Accommodation service provider	Yes ☐	No ☐		• Occupation and leisure activities are described	Yes ☐	No ☐	• Engagement of social worker • Goal setting • Liaison with Community Managed Organisation • Liaison with NDIS support services • Liaison with Accommodation service provider	Yes ☐	No ☐
Count of Clinically Significant Items					**Clinically Significant Ratings Score**				**Count of Zero, Unable to Rate, Missing items**			**Zero, Unable to Rate, Missing Ratings Score**
Clinically Significant Ratings Score / Count of Clinically Significant Items X 100 = Total Score Clinically Significant Ratings									**Zero, Unable to Rate, Missing ratings score / Count of Zero, Unable to Rate, Missing items X 100 = Total Score Zero, Unable to Rate, Missing Ratings**			

HoNOSCA Quality Audit Tool

		Part 1: Clinically Significant Ratings (2 or Higher)					Part 2: Zero, Unable to Rate, Missing Ratings				
HoNOSCA Scale	HoNOSCA Rating	Possible observations	Documentation of observations	Possible interventions	Documentation of interventions	H-QAT Clinically Significant Ratings	Possible observations	Documentation of observations	Possible interventions	Documentation of interventions	H-QAT Zero, Unable to Rate, Missing Ratings
1. Problems with disruptive, antisocial or aggressive behaviour		• Physical indicators • Verbal indicators • Emotional indicators	Yes ☐ No ☐	• De-escalation techniques • Behavioural contracts • Social or environmental modifications • Medication	Yes ☐ No ☐		• Physical indicators • Verbal indicators • Emotional indicators	Yes ☐ No ☐	• De-escalation techniques • Behavioural contracts • Social or environmental modifications • Medication	Yes ☐ No ☐	
2. Problems with overactivity, attention or concentration		• Physical indicators • Verbal indicators • Emotional indicators	Yes ☐ No ☐	• Behavioural strategies (structured routines, clear expectations, reward systems • Psychological therapies • CBT • Social skills training • Mindfulness	Yes ☐ No ☐		• Physical indicators • Verbal indicators • Emotional indicators	Yes ☐ No ☐	• Behavioural strategies (structured routines, clear expectations, reward systems) • Psychological therapies • CBT • Social skills training • Mindfulness	Yes ☐ No ☐	
3. Non-accidental self-injury		• Actions/thoughts/ plans or intent related to suicide described • Actions/thoughts/ plans or intent to self-harm are described	Yes ☐ No ☐	• Safety planning • Skill building, emotional self-regulation • Psychotherapy • CBT • DBT • ACT • Mindfulness	Yes ☐ No ☐		• Actions/thoughts/ plans or intent related to suicide described • Actions/thoughts/ plans or intent to self-harm are described	Yes ☐ No ☐	• Safety planning • Skill building, emotional self-regulation • Psychotherapy • CBT • DBT • ACT • Mindfulness	Yes ☐ No ☐	

4. Problems with alcohol, substance or solvent misuse		• Use of drug or alcohol described • Memory or concentration issues described	Yes ☐ No ☐	• Drug and alcohol focused psychotherapy • Psychoeducation • Psychotherapy • CBT • MI • ACT • Mindfulness • Medication including opioid replacement therapy • Participation in recovery programs/ peers support groups • Referral to AOD services/ participation in detox	Yes ☐ No ☐		• Use of drug or alcohol described • Memory or concentration issues described	Yes ☐ No ☐	• Drug and alcohol focused psychotherapy • Psychoeducation • Psychotherapy • CBT • MI • ACT • Mindfulness • Medication including opioid replacement therapy • Participation in recovery programs/ peers support groups • Referral to AOD services/ participation in detox	Yes ☐ No ☐	
5. Problems with scholastic or language skills		• Speech, vocabulary, reading, writing, comprehension, following instructions, academic performance	Yes ☐ No ☐	• Speech and language therapy • Individualised learning support or education plans • Assistive technology • Positive reinforcement	Yes ☐ No ☐		• Speech, vocabulary, reading, writing, comprehension, following instructions, academic performance	Yes ☐ No ☐	• Speech and language therapy • Individualised learning support or education plans • Assistive technology • Positive reinforcement	Yes ☐ No ☐	
6. Physical illness or disability problems		• Description of physical illness or disability. The functional restrictions are described	Yes ☐ No ☐	• Engagement of physical health care providers • Goal setting/ problem solving to overcome functional restrictions • Environmental modifications or adaptive technology	Yes ☐ No ☐		• Description of physical illness or disability. The functional restrictions are described	Yes ☐ No ☐	• Engagement of physical health care providers • Goal setting/ problem solving to overcome functional restrictions • Environmental modifications or adaptive technology	Yes ☐ No ☐	

7. Problems associated with hallucinations, delusions or abnormal perceptions		• Hallucinations or delusional ideas are described, their frequency and intensity	Yes ☐	No ☐	• Medication (see additional notes) • Psychotherapy • CBT • Mindfulness Psychoeducation	Yes ☐	No ☐		• Hallucinations or delusional ideas are described, their frequency and intensity	Yes ☐	No ☐	• Medication (see additional notes) • Psychotherapy • CBT • Mindfulness • Psychoeducation	Yes ☐	No ☐
8. Problems with non-organic somatic symptoms		• Physical complaints such as pain, fatigue, sleep or illness without identifiable medical causes	Yes ☐	No ☐	• Psychoeducation • Goal setting • Individual or group psychotherapy • CBT • DBT • SFT • Medication	Yes ☐	No ☐		• Physical complaints such as pain, fatigue, sleep or illness without identifiable medical causes	Yes ☐	No ☐	• Psychoeducation • Goal setting • Individual or group psychotherapy • CBT • DBT • SFT • Medication	Yes ☐	No ☐
9. Problems with emotional and related symptoms		• Persistent sadness, anxiety, irritability, mood swings, or heightened emotional responses	Yes ☐	No ☐	• Psychoeducation • Goal setting • Individual or group psychotherapy • CBT • DBT • SFT • Medication	Yes ☐	No ☐		• Persistent sadness, anxiety, irritability, mood swings, or heightened emotional responses	Yes ☐	No ☐	• Psychoeducation • Goal setting • Individual or group psychotherapy • CBT • DBT • SFT • Medication	Yes ☐	No ☐
10. Problems with peer relationships		• Identification of peers • Quality and quality of relationships with peers	Yes ☐	No ☐	• Social skills training • Mentoring and peer support • Psychotherapy • Reinforcement positive social interaction	Yes ☐	No ☐		• Identification of peers, Quality and quality of relationships with peers	Yes ☐	No ☐	• Social skills training (SST) • Mentoring and peer support • Psychotherapy • Reinforcement positive social interaction	Yes ☐	No ☐
11. Problems with self-care and independence		• Basic self-care abilities and how independently the person can manage them	Yes ☐	No ☐	• Visual schedules or prompts • Positive reinforcement • Graded responsibility • Assistive or adaptive technology	Yes ☐	No ☐		• Observations would include basic self-care abilities and how independently the person can manage them	Yes ☐	No ☐	• Visual schedules or prompts • Positive reinforcement • Graded responsibility • Assistive or adaptive technology	Yes ☐	No ☐

12. Problems with family life and relationships		• Quality and quality of family relationships	Yes ☐	No ☐	• Family therapy aimed at improved communications • Parenting support and education • Structured family routines • Stress management	Yes ☐	No ☐		• Quality and quality of family relationships	Yes ☐	No ☐	• Family therapy aimed at improved communications • Parenting support and education • Structured family routines • Stress management	Yes ☐	No ☐	
13. Poor school attendance		• Attendance at school, frequency, missed days, sessions	Yes ☐	No ☐	• Addressing underlying issues (anxiety, bullying, academic catch-up) • Attendance plan • Graded return to school • Positive reinforcement	Yes ☐	No ☐		• Attendance at school, frequency, missed days, sessions	Yes ☐	No ☐	• Addressing underlying issues (anxiety, bullying, academic catch-up) • Attendance plan • Graded return to school • Positive reinforcement	Yes ☐	No ☐	
14. Problems with knowledge or understanding about the nature of the child or adolescent's difficulties		• Limited awareness of condition, unrealistic expectations, difficulty recognising impact on daily life	Yes ☐	No ☐	• Psychoeducation • Written and visual resources • Collaboration, realistic expectations	Yes ☐	No ☐		• Limited awareness of condition, unrealistic expectations, difficulty recognising impact on daily life	Yes ☐	No ☐	• Psychoeducation • Written and visual resources • Collaboration, realistic expectations	Yes ☐	No ☐	
15. Problems with lack of information about services or management of the child or adolescent's difficulties		• Uncertainty about available supports, confusion about treatment options, reliance on incorrect information, or difficulty navigating	Yes ☐	No ☐	• Clear information, written and visual resources, service directories or resource packs, regular communication	Yes ☐	No ☐		• Uncertainty about available supports, confusion about treatment options, reliance on incorrect information, or difficulty navigating	Yes ☐	No ☐	• Clear information, written and visual resources, service directories or resource packs, regular communication	Yes ☐	No ☐	
Count of Clinically Significant Items					**Clinically Significant Ratings Score**				**Count of Zero, Unable to Rate, Missing items**			**Zero, Unable to Rate, Missing Ratings Score**		
Clinically Significant Ratings Score / Count of Clinically Significant Items X 100 = Total Score Clinically Significant Ratings									**Zero, Unable to Rate, Missing ratings score / Count of Zero, Unable to Rate, Missing items X 100 = Total Score Zero, Unable to Rate, Missing Ratings**					

H-QAT Glossary of Terms

Acceptance and Commitment Therapy (ACT): A therapy that encourages acceptance of difficult thoughts and feelings while committing to actions aligned with personal values. It helps individuals build psychological flexibility and live more meaningfully.

Behavioural Activation (BA): Encourages individuals to engage in meaningful, enjoyable, or goal-directed activities to counter low mood and withdrawal. By increasing positive experiences and reducing avoidance, BA helps improve motivation, mood, and overall functioning.

Behavioural Contracts: Written or verbal agreements that clearly outline expected behaviours, responsibilities, and rewards or consequences to encourage positive change.

Basic Self Care: Essential tasks needed to maintain health and hygiene, such as bathing, dressing, eating, and toileting independently.

Cognitive Behavioural Therapy (CBT): A structured, goal-oriented therapy that helps individuals identify and challenge unhelpful thoughts and behaviours. It teaches practical strategies to manage problems such as anxiety, depression, or stress.

Complex Activities of Daily Living: Managing finances, cooking, shopping, using transportation, taking medications, and maintaining a household, which support independent living in the community.

De-escalation Techniques: Using calm, respectful communication and non-threatening body language to reduce agitation and prevent escalation. Strategies include active listening, validating the person's feelings, offering choices, and creating space to promote a sense of safety and control. These approaches help build trust, lower tension, and support a return to constructive problem-solving.

Dialectical Behaviour Therapy (DBT): A form of CBT that combines acceptance and change strategies, focusing on skills like distress tolerance, emotional regulation, and interpersonal effectiveness. It is particularly effective for individuals with intense emotions or self-harming behaviours.

Emotional Indicator: Irritability, frustration, anger, low tolerance for distress, rapid mood shifts, heightened sensitivity to perceived provocation, and difficulty calming down once aroused.

Mindfulness: The practice of paying attention to the present moment with curiosity and without judgment. It reduces stress, improves self-awareness, and enhances emotional regulation.

Motivational Interviewing: An approach that helps individuals explore and resolve ambivalence, strengthening their motivation and commitment to positive behaviour change.

Psychoeducation: Providing clear, accurate information about mental health conditions, symptoms, and treatments. It helps improve understanding, enhance coping strategies, and support active participation in care and recovery.

Psychotherapy: A therapeutic process that uses structured conversations to explore thoughts, feelings, and behaviours. It aims to improve mental health, resolve difficulties, and support personal growth.

Physical Indicators: Restlessness, pacing, rapid movements, clenched fists or jaw, flushed face, glaring, invading personal space, sweating, trembling, and rapid breathing.

Skill Building - Emotional Self-regulation: Development of practical skills such as problem-solving, communication, and coping strategies to manage emotions effectively.

Social Skills Training (SST): Teaches individuals practical skills for effective communication, relationship-building, and problem-solving in social situations. It often uses modelling, role-play, and feedback to build confidence and improve interactions with others.

Solution-Focused Therapy (SFT): A short-term, goal-oriented therapeutic approach that emphasises an individual's strengths and resources rather than focusing on problems. It helps clients identify solutions, set achievable goals, and build practical steps toward positive change.

Verbal Indicators: Shouting, raised or pressured speech, threats, hostile or abusive language, sarcasm, excessive interruptions, and argumentative or confrontational tone.