# Mental Health Information Development

# National Outcomes and Casemix Collection

**Technical specification of State and Territory reporting requirements for the outcomes and casemix components of 'Agreed Data' under National Mental Health Information Development Funding Agreements**

**Version 1.0**

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*Information Strategy Committee,*
*Australian Health Ministers Advisory Council*
*National Mental Health Working Group,*
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This document contains both original material and content taken from other sources.

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*National Outcomes and Casemix Collection: Overview of clinical measures and data items*. Commonwealth Department of Health and Ageing, Canberra, 2002.

*Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998 – 2003 (First Edition).* Commonwealth Department of Health and Aged Care, Canberra, June 1999

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# Foreword

The emphasis on health outcomes and information systems to support quality improvement has been gaining momentum in the wider health sector for several years. Increasing focus is being given to the responsibility of health care providers right across the world to use outcome measures to contribute to the ongoing review and development of clinical practice as well as to inform health service planning, policy development and the broader community. Many initiatives are underway throughout Australia's health system to achieve these ends.

In the field of mental health, the development of outcome measurement strategies has been slower, partly because of problems in defining and measuring mental health outcomes. However, the regular assessment of outcomes has been an aim of the National Mental Health Strategy since it was first agreed by all Australian Health Ministers in 1992. Two objectives of the Strategy related specifically to outcomes:

- to institute regular reviews of outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery; and
- to encourage the development of national outcome standards for mental health services, and systems for assessing whether services are meeting these standards.

Instruments for measuring consumer outcomes were not available when the National Mental Health Strategy commenced. In response to this need, a major research and development program was initiated under the first National Mental Health Plan (1993-98) to identify and field trial consumer outcome measures that would serve two needs. Firstly, the outcome measures had to be useful in routine clinical practice to allow monitoring of the health and wellbeing of the individual consumer. Secondly, the measures had to be suitable for monitoring outcomes at the broader service level. In a related national project, funded to develop a casemix classification for mental health services, significant experience was gained in the use of standardised scales for the measurement of 'clinical severity' in mental health services that could serve as the basis for the further development of casemix concepts in mental health. An understanding of variations in casemix is essential to interpreting outcome data. Current AR-DRG casemix models are widely agreed to be unsatisfactory for understanding variation in case complexity in mental health.

The Second National Mental Health Plan (1998-2003), agreed by all Australian Health Ministers in 1998, entails a national commitment to extend the research and development work by introducing the routine collection of outcome and casemix data in public mental health services. Under the Australian Health Care Agreements, all States and Territories have entered agreements with the Commonwealth that provide funds to support the workforce training and information system development needed to enable collection of an agreed 'outcomes and casemix' dataset. The scope of the initiative covers all specialised mental health services funded in the public sector.

A key aspect of the initiative is the agreement by States and Territories to provide data to the Commonwealth on an annual basis. The national data collected under this arrangement will be the focus of extensive research and development over future years, designed to further develop the application of outcomes and casemix concepts in mental health.

This document outlines the data reporting requirements that apply to the national outcomes and casemix collection. While its main purpose is to describe the technical aspects of the datasets to be prepared annually, it also presents an overview of the data to be collected and the key concepts underpinning the collection protocol. Although most States and Territories are not expected to be in a position to report data until 2003, the concepts and business rules covered in this document need to be understood now to guide the system development and workforce training currently being planned by all jurisdictions.

While every attempt has been made to simplify the content as much as possible and distil it to the common ground of the 'national minimum requirements', the document is detailed and technical in nature. Much of the detail in fact stems from the complexity of the mental health system being measured, and the need to develop common measurement tools that span inpatient and community-based care. Because many of the concepts and definitions used in Australia's standard health collections are centred on hospital care, development of a comprehensive reporting protocol for mental health services has been unable to draw on established precedents. This is particularly the case in the specification of 'counting rules' for episodes of community care, and processes for measuring outcomes in consumers who receive treatment across hospital and community settings.

To produce a coherent set of guidelines that are applicable across the hospital-community spectrum of care, it has been necessary to introduce a number of new concepts as well as, at times, depart from definitions that have become well established in Australia's hospital-oriented information collections. For example, under the current National Health Data Dictionary patients attending day hospitals or hospital-based day programs are defined as 'admitted patients' and counted in hospital statistics but in the current specifications, are grouped with ambulatory care. While this is believed to provide a better representation of the actual care provided, it is recognised that this may cause difficulties for some jurisdictions and not all may be able to implement every aspect of the specifications.

The reporting requirements outlined in this document represent the agreed national minimum requirements under Information Development Agreements and are not intended to limit the scope of data collections maintained by individual service agencies or State and Territory jurisdictions.

The current document represents 'Version 1' specification of requirements, developed collaboratively by all jurisdictions under the auspice of the AHMAC National Mental Health Working Group Information Strategy Committee. Further changes are expected over time, based on experience with the current version.

Dr Penny Gregory
Chair, AHMAC National Mental Health Working Group
August 2002

# CONTENTS

# 1. Background

1.1 Development of information to support mental health service delivery and planning is emphasised as a priority under the Second National Mental Health Plan. The Plan recognises that many of the goals of the National Mental Health Strategy depend on improving the quality of information available to guide decisions at all levels of the health system.

- At the *service delivery level*, clinicians need access to information that informs treatment decisions, contributes to evaluation of the effectiveness of interventions and the monitoring of client progress. Consumers and carers need information to evaluate the value of the treatments they receive and provide a structure that guides dialogue with the provider about treatment planning and personal progress.
- At the *service management level*, access to information is necessary to manage resources, monitor workflows, conduct clinical audits and monitor the overall efficiency and effectiveness of the service.
- At the *policy level*, information is necessary to assess the population needs for mental health services, plan and pay for services, determine priorities for the allocation of resources and inform value-for-money decisions in the allocation of funds.

1.2 The Second National Mental Health Plan acknowledged that information development in mental health services had lagged behind mainstream health services and that substantial work was required to enable the data needed to inform mental health service delivery and planning. To accelerate progress, the AHMAC National Mental Health Working Group released a statement of *National Mental Health Information Priorities* in June 1999 that outlined an ambitious plan to develop information infrastructure in all public mental health services.[1] The essence of the plan is the development of comprehensive, local clinical information systems within mental health services that:

- support and encourage good practice;
- regularly inform about consumer outcome;
- inform judgements about value for money; and
- produce national and State/Territory data as a by-product.

1.3 The current document represents a logical extension of the *National Mental Health Information Priorities* publication and should be reviewed in the context of the background, rationale and objectives outlined in that publication.

1.4 Under the Australian Health Care Agreements, a total of $38 million Commonwealth funding has been made available to the States and Territories to assist in achieving these objectives. All State and Territory jurisdictions have prepared Information

[1] *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998 – 2003 (First Edition).* Commonwealth Department of Health and Aged Care, Canberra, June 1999.

Development Plans (IDPs) and signed Information Development Agreements with the Commonwealth to participate in the national initiative.

1.5 The Information Development Agreements require participating States and Territories to provide to the Commonwealth de-identified, patient-level unit record data for the 'outcomes dataset' and the 'casemix dataset' specified in the *National Mental Health Information Priorities* document. Clause 2.1.16 within the Agreements states:

> *"Agreed Data" for the purposes of this Agreement means the following de-identified, patient-level unit record data described in the National Mental Health Information Priorities document:*
>
> *(i) the outcomes data set referred to in Module 1 of the document, comprising the Health of the Nation Outcomes Scales, the abbreviated Life Skills Profile and the Mental Health Inventory (or an agreed alternative consumer self rating measure);*
>
> *(ii) the casemix data set referred to in Module 3 of the document as identified in Table 12, page 49; and*
>
> *(iii) the patient-level components of the National Minimum Data Set – Mental Health Care as described in the most current version of the National Health Data Dictionary.*

For convenience, the combined outcomes and casemix datasets (i.e. (i) and (ii) above) are referred to as the *National Outcomes and Casemix Collection (NOCC)* throughout this document.

1.6 The data provided to the Commonwealth by the States and Territories will be reported nationally and used to inform further development of information to support mental health service delivery in Australia. The *National Mental Health Information Priorities* document outlined the broad process that entails:

- reporting of data by participating jurisdictions to an organisation contracted by the Commonwealth to perform the national data analysis and reporting function;
- development and preparation of standard reports for use by participating jurisdictions;
- publication of benchmarks and other national summary indicators to inform service development; and
- review of the data by a national expert committee established in collaboration with the States and Territories, with a view to further development and improvement of clinical measurement and related tools.

Specific details of the process and timetable for these activities are the subject of ongoing discussion between the Commonwealth, States and Territories.

1.7 The current document provides a 'version 1' technical specification of the outcomes and casemix data to be provided to the Commonwealth by States and Territories under the Information Development Agreements. Preparation of the document has taken account of the following considerations:

1.7.1 The NOCC dataset is a 'research and development' collection intended to supplement the basic data collected under the National Minimum Data Set – Mental Health Care. While future inclusion of outcomes and casemix data within the national minimum data set arrangements is anticipated, it is premature at this stage given the extensive industry development required within the mental health sector to establish the systems and workforce practices necessary to support routine collection.

1.7.2 Definitions developed for the purposes of the NOCC protocol elaborate concepts and data elements not currently covered by the National Health Data Dictionary as well as providing alternative definitions for items where current definitions do not provide an adequate basis for development in mental health services. Future work will be required to both incorporate definitions of new items and concepts which prove to be sufficiently robust and reconcile differences between the NHDD and the alternative NOCC definitions. Changes along these lines will be negotiated under the processes and structures of the National Health Information Agreement.

1.7.3 Successful introduction of the data set is dependent upon mental health organisations understanding the 'counting rules' for collecting and reporting data. There are many options and considerable ambiguity as the counting rules have not yet been established beyond a broad schema outlined in the *National Mental Health Information Priorities* document. The issues involved are considerably more complex than defining the list of data elements, particularly in regard to reporting of patient-level data for non-inpatient services for which there are few precedents in Australia's national health data collections. The new arrangements are therefore unable to draw on established reporting guidelines.

1.8 The document does not address reporting requirements in relation to the patient-level component of the National Minimum Data Set – Mental Health Care. Provision by States and Territories to the Commonwealth of these datasets is expected to conform with arrangements developed by the Australian Institute of Health & Welfare (AIHW).

1.9 Future revisions of the NOCC reporting specification are anticipated, based on experience with the current version. The specification will be reviewed annually and all revisions will be developed collaboratively between the Commonwealth and the States and Territories.

# 2. Purpose and scope of document

2.1 The purpose of this document is to outline the reporting requirements for provision of the NOCC dataset by States and Territories to the Commonwealth. The document provides details about the:

- *data content* of all items included in the National Outcomes and Casemix Collection;
- *business rules* to be followed in the reporting of those data items (i.e. what data are required when); and
- *extract format* to be used when preparing data files for submission to the Commonwealth.

2.2 The document limits its scope to the above and does not include detailed discussion of the data collection and system design issues that need to be resolved at State and Territory level to enable collection of NOCC data. While common issues will be faced by all jurisdictions, solutions will vary depending on local requirements and system contexts.[2]

2.3 Similarly, the document does not address issues concerning the analysis and interpretation of the outcomes and casemix data to be gathered under the IDP reporting arrangements. This will covered in separate papers.

2.4 The reporting requirements outlined in this document represent the agreed national minimum requirements under Information Development Agreements and are not intended to limit the scope of data collections maintained by individual service agencies or State and Territory jurisdictions.

2.5 Additional documentation will be prepared to address a range of issues relevant to the NOCC dataset and will cover:

- Rationale, key concepts and objectives;
- Privacy protocol; and
- National approach to data analysis and reporting.

[2] Individual jurisdictions may refer to New South Wales documentation as an example of an approach to the issues to be resolved in developing a local data collection protocol to guide service agencies. Copies of the documentation have been made available by the New South Wales Department of Health to all States and Territories.

# 3. Overview of the clinical data to be collected

- The agreed national requirements for outcomes and casemix data are outlined in the publication, *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003 (First Edition June 1999).*

- The specific clinical data to be collected depend on the type of *Episode of Mental Health Care* (inpatient vs ambulatory), the *Age Group* of the consumer, the *Mental Health Service Setting* and the *Reason for Collection.* Each of these concepts is discussed later in this document along with details on how they influence specific reporting requirements.

- Each of the standard clinical rating measures is subject to its own set of collection guidelines, documented in their respective glossaries. These are not included in the current document but have been packaged separately in a resource document for use by States and Territories.[3]

- This section provides an overview of each of the clinical measures and data items included in the *National Outcomes and Casemix Collection*.

## 3.1 Clinical data specific to adults and older people

### *3.1.1 Health of the Nation Outcome Scales (HoNOS & HoNOS65+)*

The Health of the Nation Outcome Scales (HoNOS) is a 12 item clinician-rated measure designed by the Royal College of Psychiatrists specifically for use in the assessment of consumer outcomes in mental health services. Ratings are made by clinicians based on their assessment of the patient or client. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

The 65+ variant of the HoNOS has been designed for use with adults aged older than 65 years. It consists of the same item set and is scored in the same way, however the accompanying glossary has been modified to better reflect the problems and symptoms likely to be encountered when rating older persons.

*References for versions used:*

*General adult version:*

Wing J, Beevor A, Curtis R, Park S, Hadden S, Burns A (1998) Health of the Nation Outcome Scales (HoNOS). Research and development. *British Journal of Psychiatry*, 172, 11-18.

Wing J, Curtis R, Beevor A (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432–434.

*Older persons version:*

Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). *British Journal of Psychiatry*, 174, 424-427.

[3] See *National Outcomes and Casemix Collection: Overview of clinical measures and data items.* Commonwealth Department of Health and Ageing, 2002

Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+): Glossary for HoNOS 65+ score sheet. *British Journal of Psychiatry*, 174, 435-438.

### *3.1.2 Abbreviated Life Skills Profile (LSP-16)*

The original LSP was developed by a team of clinical researchers in Sydney (Rosen et al 1989, Parker et al 1991) and is in fairly wide use in Australia as well as several other countries. It was designed to be a brief, specific and jargon free scale to assess a consumer's abilities with respect to basic life skills. It is capable of being completed by family members and community housing members as well as professional staff.

The original form of the LSP consists of 39 items. Work undertaken as part of the Australian Mental Health Classification and Service Costs (MH-CASC) study saw the 39 items reduced to 16 by the original designers in consultation with the MH-CASC research team. This reduction in item number aimed to minimise the rating burden on clinicians when the measure is used in conjunction with the HoNOS. The abbreviated 16-item instrument is the version to be reported under the National Outcomes and Casemix Collection.

*References for the LSP (original 39 item version)*

Rosen A, Hadzi-Pavlovic D, Parker G (1989) The Life Skills Profile: A measure assessing function and disability in schizophrenia. *Schizophrenia Bulletin*, 1989, 325-337.

Parker G, Rosen A, Emdur N, Hadzi-Pavlov D (1991) The Life Skills Profile: Psychometric properties of a measure assessing function and disability in schizophrenia Acta Psychiatrica Scandinavica 83 145-152.

Trauer T, Duckmanton RA, Chiu E (1995) The Life Skills Profile: A study of its psychometric properties. *Australian and New Zealand Journal of Psychiatry*, 29, 492-499.

*Reference for LSP-16 (abbreviated 16 item version):*

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials.* Canberra: Commonwealth Department of Health and Family Services.

### *3.1.3 Resource Utilisation Groups – Activities of Daily Living (RUGADL)*

Developed by Fries et al for the measurement of nursing dependency in skilled nursing facilities in the USA, the RUG-ADL measures ability with respect to 'late loss' activities – those activities that are likely to be lost last in life (eating, bed mobility, transferring and toileting). 'Early loss' activities (such as dressing and grooming) are included in the LSP. The RUG-ADL is widely used in Australia nursing homes and other aged care residential settings.

The RUG-ADL comprises 4 items only and is usually completed by nursing staff.

*Reference for version used:*

Fries BE, Schneider DP, et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). *Medical Care*, 32, 668-685.

### *3.1.4 Focus of Care*

Focus of Care is a data item developed in the Australian MH-CASC study that requires the clinician to make a judgement about each consumer's primary goal of care. It is a single item

requiring selection of one of four options: Acute; Functional Gain, Intensive Extended, and Maintenance.

*References for version used:*

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*. Canberra: Commonwealth Department of Health and Family Services.

### *3.1.5 Consumer self-report outcome measure*

While the Information Priorities document proposed the national use of a specific self-report measure (the Mental Health Inventory – MHI), this has been changed to allow States and Territories to introduce an 'agreed' alternative measure. This recognises that limited Australian research has been undertaken on consumer rated measures, and additional exploratory work in this area is important.

Most States and Territories are introducing one of the following:

- The Mental Health Inventory (MHI)
- The Behaviour and Symptoms Identification Scale (BASIS-32)
- The Kessler–10 (K-10)

Table 1 provides a summary of the consumer self rated measure to be utilised within each of the States and Territories.

**Table 1: State and Territory selected adult consumer self rated measures**

| Jurisdiction | Adult consumer self-rated outcome measure |
|---|---|
| Victoria | BASIS 32 |
| NSW | K10 |
| Tasmania | To be determined |
| ACT | BASIS 32 |
| NT | K10 |
| SA | To be determined |
| WA | MHI |
| Queensland | MHI |

## 3.2 Clinical data specific to children and adolescents

### *3.2.1 Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)*

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) is a 15 item clinician-rated measure modelled on the HoNOS and designed specifically for use in the assessment of child and adolescent consumer outcomes in mental health services. Ratings are made by clinicians based on their assessment of the patient. In completing their ratings, the clinician makes use of a specific glossary which details the meaning of each point on the scale being rated.

*References for version used:*

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

Gowers S, Harrington R, Whitton A, Beevor A, Lelliott P, Jezzard R, Wing J (1999b) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433.

### *3.2.2 Children's Global Assessment Scale (CGAS)*

The CGAS was developed by Schaffer and colleagues at the Department of Psychiatry, Columbia University to provide a global measure of severity of disturbance in children and adolescents. Similar to the HoNOSCA, it is designed to reflect the lowest level of functioning for a child or adolescent during a specified period. The measure provides a single global rating only, on a scale of 1–100.

*References for version used:*

Schaffer D, Gould MS, Brasic J, et al (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.

### *3.2.3 Factors Influencing Health Status (FIHS)*

The Factors Influencing Health Status (FIHS) measure is a checklist of seven 'psychosocial complications' based on the problems and issues identified in the chapter of ICD-10 regarding Factors Influencing Health Status. It is a simple checklist of the ICD factors, developed for use in the MH-CASC project.

*References for version used:*

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials.* Canberra: Commonwealth Department of Health and Family Services.

### *3.2.4 Strengths and Difficulties Questionnaire (SDQ)*

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire designed for 4-17 year olds and developed by Goodman et al in the United Kingdom. The SDQ has been recommended for routine use by the National Child and Adolescent Outcomes Expert Group but is not included in version 1 of the NOCC specification because most jurisdictions do not have the information system capacity to collect and report the data. It will however be included in Version 2 of the NOCC. Further information regarding the SDQ can be found in the Clinical Measures Overview document.

## 3.3 Other clinical data common to all consumer groups

### *3.3.1 Principal and Additional Diagnoses*[4]

The *Principal Diagnosis* is the diagnosis established after study to be chiefly responsible for occasioning the patient or client's care in the period of care preceding the *Collection Occasion. Additional Diagnoses* identify main secondary diagnoses that affected the person's care during the period in terms of requiring therapeutic intervention, clinical evaluation, extended management, or increased care or monitoring. Up to two *Additional Diagnoses* may be recorded.

### *3.3.2 Mental Health Legal Status*[5]

An indication that the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the period preceding the *Collection Occasion*.

## 3.4 Purpose of the clinical data

The standard measures will be used for the purpose of measuring consumer outcomes or casemix classification, or both. Table 2 summarises the data to be collected across the various consumer groups and the purposes of collection. In general, many of the measures will be used for both casemix development and outcome evaluation purposes.

[4] Although both *Principal Diagnosis* and *Additional Diagnosis* are collected as part of the NMDS-Admitted Patient Mental Health Care, and *Principal Diagnosis* (but not *Additional Diagnosis*) is included in the NMDS-Community Mental Health Care. Both data items are incorporated in the NOCC dataset because the NMDS definitions are not suitable for development of outcomes and casemix analysis. Specifically, the reporting under the NMDS-Admitted Patient Mental Health Care is based on the total hospital episode, while the NMDS-Community Mental Health requires the diagnosis at the point of each service contact. Under NOCC, the diagnoses assigned to the consumer is based on the *Period of Care* preceding the *Collection Occasion*.

[5] Like the diagnosis items, *Mental Health Legal Status* is also collected under the mental health minimum data set arrangements but also included in the NOCC requirements due to differences in the reporting period used as the basis for recording the data item.

**Table 2: Data to be collected and purpose of collection**

| | Age Group | | | Purpose | |
|---|---|---|---|---|---|
| | Child & Adolescent | Adults | Older People | Outcomes Evaluation | Casemix Classification |
| **Clinical measurement scales** | | | | | |
| Health of the Nation Outcome Scales (HoNOS) | | ● | | ● | ● |
| Health of the Nation Outcome Scales for Older People (HoNOS 65+) | | | ● | ● | ● |
| Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) | ● | | | ● | ● |
| Life Skills Profile (LSP-16) | | ● | ● | ● | ● |
| Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL) | | | ● | | ● |
| Children's Global Assessment Scale (CGAS) | ● | | | | ● |
| Factors Influencing Health Status (FIHS) | ● | | | ○ | ● |
| Adult consumer self-rating measure | | ● | | ● | |
| Focus of Care | | ● | ● | ○ | ● |
| **Other clinical data** | | | | | |
| Mental Health Legal Status | ● | ● | ● | ○ | ● |
| Principal and Additional diagnosis | ● | ● | ● | ○ | ● |
| **Consumer self-report** | * | ● | ● | ● | |

*Note: See also Table 4 for details on when each of the above measures are to be collected.*

**Key to symbols**

- ● Indicates the data will be used for the specified purpose of building the casemix classification or measuring outcomes.
- ○ Indicates the data is not an outcomes measure as such but is important for the interpretation of outcome data.
- * The Strengths and Difficulties Questionnaire (SDQ) has been recommended for routine use by the National Child and Adolescent Outcomes Expert Group. It is however not included in version 1 of the NOCC specification because most jurisdictions do not have the information system capacity to collect and report the data. It will be included in version 2. Introduction of the SDQ at an earlier stage is at the discretion of individual States and Territories. Further information on the the version to be used can be found in the document *National Outcomes and Casemix Collection: Overview of clinical measures and data items*. Commonwealth Department of Health and Ageing, Canberra, 2002.

# 4. Scope of the NOCC collection

4.1 The scope of the NOCC reporting requirements covers all specialised mental health services managed or funded by the State and Territory health administrations. In general, the scope of the NOCC initiative is equivalent to the coverage of the annual *National Survey of Mental Health Services*.

4.2 Specialised mental health services include:

4.2.1 Public psychiatric hospitals and designated psychiatric units in general hospitals[6]

4.2.2 Community-based residential services

4.2.3 Ambulatory care mental health services

4.3 Recognising the variable development of information infrastructure in specialised mental health services, the timetable for implementation of NOCC has been negotiated separately by the Commonwealth with each jurisdiction. However, it is expected that the majority of State and Territory-funded specialised mental health services will be participating in the collection by June 2003.

4.4 Details of the implementation timetable are not provided in this document but outlined in each of the Information Development Agreements.

[6] Use of the term 'designated' to refer to mental health services in this document is not intended to imply any specific status under the State or Territory mental health legislation. Instead, it refers to the service as having as its primary function the delivery of treatment or care to people affected by mental illness. It is equivalent to the concept of 'specialised mental health service' as used in the annual National Survey of Mental Health Services.

# 5. Key concepts underpinning the NOCC protocol

Specification of the reporting protocol is based on five concepts: *Episode of Mental Health Care*; *Mental Health Service Setting; Collection Occasion, Age Group; and Mental Health Provider Entity.* Each of these is discussed below.

## 5.1 Episodes of Mental Health Care and Mental Health Service Setting

5.1.1 Concepts of episodes are used widely throughout the health system as a convenient method to describe the activities of health services and to organise data collection, reporting and analysis. In general, an episode of care is used to refer to a period of care with discrete start and end points.

5.1.2 Most work on defining episodes has been tied to acute hospital settings, where the principle is relatively simple – one episode per patient per hospital at any one time, with the episode beginning at admission and ending at discharge.

5.1.3 Significant problems arise when translating this concept to mental health services because no concept of episode has been agreed to quantify community services and many patients undergo care over extended periods. Additionally, multiple agencies or teams may be involved in providing care during a particular period, with each agency or team regarding their intervention as a discrete episode.

5.1.4 For the purposes of the current specification, an *Episode of Mental Health Care* will be defined as a more or less continuous period of contact between a consumer[7] and a *Mental Health Service Organisation* that occurs within the one *Mental Health Service Setting*.[8]

5.1.5 This formal concept of an episode should not be confused with either the clinical concept of an episode of care or the more narrowly defined, inpatient-centred definition currently used in the National Health Data Dictionary. Future research and development work using the data collected under the NOCC arrangements will explore the potential for more clinically meaningful definitions of episodes in mental health care.

5.1.6 Three broad episode types are identified which are based on the treatment setting – Inpatient, Community Residential and Ambulatory.[9]

[7] For the purposes of these specifications, the terms consumer and patient are used interchangeably and refer to a person for whom a *Mental Health Service Organisation* accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record.

[8] The concept of *Mental Health Service Setting* is defined in Appendix 1, along with its specified domain.

[9] Formal definitions of the three types of episodes are also provided in Appendix 1.

- *Inpatient episodes (Overnight admitted)* – refers to the period of care provided to a consumer who is admitted for overnight care to a designated psychiatric inpatient service.[10]
- *Community Residential episodes* – refers to the period of care provided to a consumer who is admitted for overnight care to a designated 24-hour community-based residential service.
- *Ambulatory episodes* – refers to all other types of care provided to consumers of a designated mental health service.[11]

5.1.7 Two business rules apply to episodes of mental health care:

- *One episode at a time:* While an individual may have multiple episodes of mental health care over the course of their illness, they may be considered as being in only one episode at any given point of time for a particular *Mental Health Service Organisation*. The practical implication is that the care provided by a *Mental Health Provider Entity* to an individual consumer at any point in time is subject to only one set of reporting requirements. Where a person might be considered as receiving concurrently two or more episodes of mental health care by virtue of being treated in more than one setting simultaneously the following order of precedence applies: Inpatient, Community Residential, Ambulatory.[12]
- *Change of setting = new episode*: A new episode is deemed to commence when a person's care is transferred between inpatient, community residential and ambulatory settings. A change of *Mental Health Service Setting* therefore marks the end of one episode and the beginning of another.

## 5.2 Collection Occasion

5.2.1 A *Collection Occasion* is defined as an occasion during an *Episode of Mental Health Care* when the required dataset is to be collected in accordance with a

[10] 'Inpatient episodes' as defined for the purpose of the NOCC protocol are confined to the category of *overnight admitted patients* as used in the National Health Data Dictionary and specifically exclude same day admitted patients. Same day admitted patients, which account for approximately one quarter of all separations from public sector psychiatric inpatient units, are included in Ambulatory episodes for NOCC purposes. This is consistent with the reporting practices that have been in place for the National Survey of Mental Health Services since 1994.

[11] Ambulatory episodes therefore include mental health treatment and care provided through a wide range of mental health programs including, for example, community-based crisis assessment and treatment teams, mental health day programs, psychiatric outpatient clinics provided by either hospital or community-based services, child and adolescent outpatient and community teams, social and living skills programs, psychogeriatric assessment services and so forth. For the purposes of the NOCC protocol, care provided by hospital-based consultation-liaison services to admitted patients in non-psychiatric and hospital emergency settings are also included under Ambulatory episodes.

[12] The 'one episode at a time' rule is simply an administrative device to facilitate data collection and development of business rules that clarify 'what should happen when'. It is not intended to undermine the important concept of *continuity of care* in mental health service delivery, nor to imply segregation in the service delivery roles of clinical staff working across inpatient and community-based settings.

standard protocol. The broad rule is that collection of data is required at both *episode start* and *episode end.*

5.2.2 In many cases, the beginning and end of episodes will be marked by some objective event such as admission or discharge from hospital or completion of community treatment. However, because episodes may extend over prolonged periods, it is desirable for outcomes and casemix data to also be collected at regular review points during that care, in order to monitor progress and determine if the consumer's condition has changed during the defined period.

5.2.3 For the purposes of the specification, the maximum interval between collection occasions will be based on the standard review period of 3 months (91 days) as promoted under the *National Standards for Mental Health Services.* Routine collection of patient outcome data at regular quarterly reviews was also foreshadowed in the *National Information Priorities* document.

5.2.4 Based on the above, three *Collection Occasions* are identified within an episode when the required data are to be collected:

- *Admission to mental health care*[13] – this refers to the beginning of an inpatient, ambulatory or community residential *Episode of Mental Health Care*. For the purposes of the NOCC protocol, episodes may start for a number of reasons. These include, for example, a new referral to community care, admission to an inpatient unit, transfer of care from an inpatient unit to a community team and so forth. Regardless of the reason, admission to a new episode should act as the 'trigger' for a specific set of data to be collected.
- *Discharge from mental health care*[14] – this refers to the end of an inpatient, ambulatory or community residential *Episode of Mental Health Care.* As per *Admission*, episodes may end for a number of reasons such as discharge from an inpatient unit, case closure of a consumer's community care, admission to hospital of a consumer previously under community care. Regardless of the reason, the end of an episode acts as a 'trigger' for a specific set of clinical data to be collected.
- *3 month (91-day) Review of mental health care* – this refers to the point at which the consumer has been under 13 weeks of continuous care since *Admission* to the episode, or 13 weeks has passed since the last *Review* was conducted during the current episode.

5.2.5 Specification of 3-monthly (91 day) reviews as the minimum requirement for consumers under ongoing care is not intended to restrict *Reviews* that may be

[13] 'Admission' and 'Discharge' are used as abbreviated generic terms throughout this document to refer to entry to or exit from care in all treatment settings. While it is recognised that for some mental health clinicians and consumers the terms are not 'community friendly', they are used here as economical ways of describing similar events in the cycle of mental health care. Alternative terms for Admission and Discharge are 'Episode Start' and 'Episode End', respectively.

[14] 'Discharge' is not formally defined in the National Health Data Dictionary which uses instead the term 'separation' defined as 'the process by which an episode of care for an admitted patient ceases.' The NOCC protocol uses the term 'discharge' by preference as a generic term to cover the completion of episodes across all treatment settings.

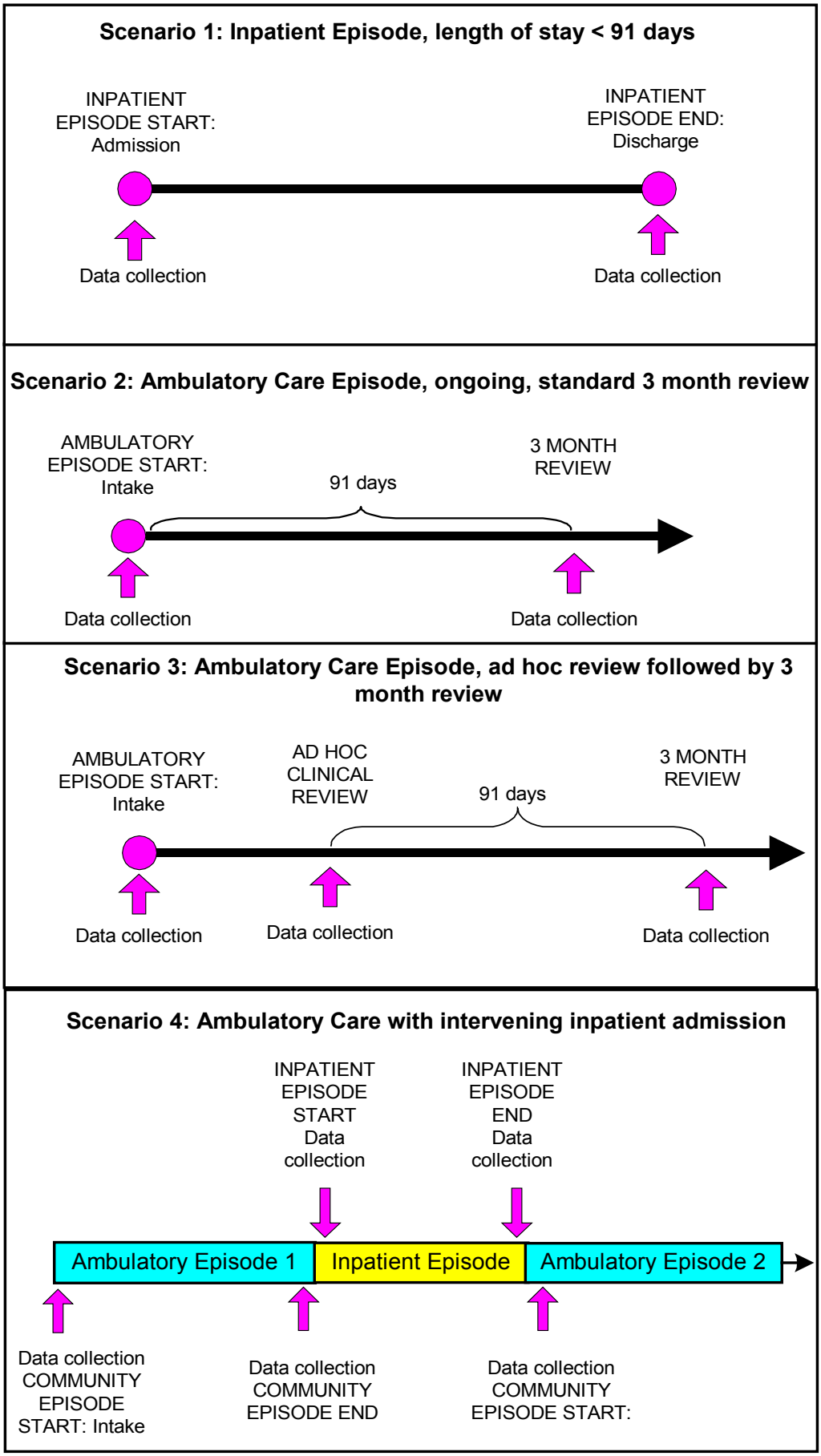
conducted at shorter intervals. Such *Reviews* of a consumer's status may occur for a number of reasons including, for example:

- in response to critical clinical events or changes in the consumer's status;
- in response to a change from voluntary to involuntary status or vice versa;
- following a transfer of care between community teams or change of case manager;
- transfers between inpatient wards within a multi-ward hospital;
- compliance with local agency or State-level requirements such as reviews conducted at the 35 day point within inpatient units;
- consumer or carer-requested reviews; and
- other situations where a review may be indicated

5.2.6 Where an ad hoc *Review* is conducted for any of the above reasons, it will also be deemed a *Collection Occasion* and included in the data reported. Such ad hoc *Reviews* move forward the next due *Collection Occasion* to 3 months (91 days) subsequently, or *Discharge*, whichever occurs sooner.

5.2.7 Figure 1 summarises the data collection points under various episode scenarios.

**Figure 1: Data collection requirements under four episode scenarios**



## 5.3 Age Group

5.3.1 The specific clinical measures to be reported at a particular *Collection Occasion* depend on the broad age group to which the consumer is assigned (Child & Adolescent, Adult, or Older people).

5.3.2 Generally, throughout mental health services, **Adults** are defined as persons between the age of 18 and 64 years inclusive, **Older people** are defined as persons aged 65 years and older and **Children and adolescents** are defined as persons under the age of 18 years.

5.3.3 States and Territories will be responsible for determining whether *Age Group* (and thus the clinical measures to be used) is determined on the basis of the actual age, condition and care needs of the consumer or deemed on the basis of the type of service providing the treatment and care, or a mixture of both. Currently, all mental health services in-scope are required under the National Survey of Mental Health Services to be classified according to the age group of their target population (General Adult, Child & Adolescent, Aged). Selection of the clinical measures to be applied by a given service can be based on this service classification.

5.3.4 Thus, in some circumstances a person may be assigned to a different *Age Group* to that in which they would assigned on the basis of their actual age, condition and care needs. For example, a person aged 60 years who was being cared for in an inpatient psychogeriatric unit may be assigned to the Older people age group. Similarly, a 15 year old admitted to an general adult psychiatric unit may be assigned to the Adult group if the adult measures are used.

5.3.5 The alternative option of determining which clinical measures to apply on the basis of the consumer's actual age, condition and care needs has more complex workforce training implications which can only be resolved at the State and Territory level.

5.3.6 Special issues arise in relation to Forensic Psychiatry Services which may cover all age groups and require additional measures to assessing outcomes. Future national developments in mental health outcome measures will consider options for the introducing an agreed set of supplementary measures for Forensic Psychiatry services. In the meantime, each jurisdiction should determine how the concept of *Age Group* will be interpreted for the Forensic Psychiatry services operating within its public sector.

## 5.4 Mental Health Provider Entity

5.4.1 A unique identifier to identify the *Mental Health Provider Entity* is essential for several reasons:

5.4.1.1 It allows the organisational and service provider contexts in which data are collected to be described.

5.4.1.2 When used in combination with the *Patient Identifier,* it provides the means to:

- assemble data collected at one or more *Collection Occasions* for a given consumer into higher-level *Episodes of Mental Health Care* which will be the subject of analysis and reporting; and
- link the outcomes and casemix data provided through the NOCC dataset to unit record data provided by States and Territories collected under related national data sets, in particular, the NMDS – Admitted Patient Mental Health Care and NMDS – Community Mental Health Care.

5.4.2 Complex issues are raised in designing a system to identify and classify mental health service providers. Services have diversified following the extensive structural reforms under the National Mental Health Strategy. Provider organisations typically provide an array of interlocking services through a number of discrete 'service units' or teams which include inpatient units, community-based residential facilities, hospital and community-based outpatient services and mobile assessment and treatment services. The clinical pathways between the various units are also complex. Patients may sometimes be transferred between inpatient facilities, depending on the intensity of care they require. Clients may often receive care from more than one ambulatory service within the organisation at a time, or be transferred between ambulatory care teams for more intensive care for short periods as their needs change.

5.4.3 The critical issue is at what level should we enumerate the mental health care provider to which the casemix and outcomes data will be attributed. Resolving the issue is fundamental to two aspects of the national reporting specification:

- it sets the boundaries for how the 'one episode at a time' rule is applied. For example, where two ambulatory care teams within an organisation share responsibility for the care of a consumer, are they each required to independently report outcomes and casemix data?
- it determines the level at which the consumer is identified uniquely (see section 5.5) below. For example, should the identifier be unique at the level of the service unit, the organisation, the region or beyond?

5.4.4 An additional complication is that it is desirable that the level at which the mental health care provider is specified matches or can be linked to the unit record data provided by States and Territories under NMDS arrangements.

5.4.5 A hierarchical approach is required to deal with this complexity in which the following levels are identified:

- State
- Region
- Mental health service organisation
- Service Unit

5.4.6 The current National Health Data Dictionary approach to identifying health care establishments is based on such a hierarchical model. The data item

'Establishment Identifier' is built from the following component parts: State, Establishment Type, Establishment Sector, Region and Establishment Number. An additional item 'Establishment Type' adds details of the type of service providing the health care. However, while the definitions for these items acknowledge the need to take a broad approach to defining and classifying health care provider organisations, the domain is inpatient-centred and based on 'bricks and mortar' concerns. Review of the concept is ongoing, but in its current form, it is not suitable for unmodified use in the current specification.

5.4.7 An alternative approach is offered by the method used to identify mental health services under the National Survey of Mental Health Services. Within this, States and Territories report establishment-level data aggregated around the concept of a *Mental Health Service Organisation* and further specify data relating to the various inpatient, ambulatory care and community residential service units that operate beneath the level of the 'parent' organisation. All mental health service organisations are grouped by regions.

5.4.8 In the early years of Survey reporting, the arrangement of mental health services into distinct organisational units was inherently local in character, being based on State/Territory and local needs with no guiding principle to ensure consistency. In particular, principles were not developed to guide complex, multi-agency organisations in how to report ambulatory care service data. Some organisations reported in aggregate terms, combining the activity and expenditure data of multiple community services while others reported at the detailed, individual service or team level. Despite these beginnings, greater stability and consistency within jurisdictions in how services are reported has been apparent in more recent Survey years.

5.4.9 The hierarchical model for describing services to the National Survey of Mental Health Services, and the flexibility it offers States and Territories, is regarded as providing a sensible first step in developing the concept of *Mental Health Provider Entity* under the NOCC reporting arrangements. In particular, it provides a basis for specifying the level at which the 'one episode at a time' rule and the associated patient-level unit record data are reported.[15]

***Specification***

5.4.10 Each *Collection Occasion* record reported as part of the NOCC extract should be assigned to a *Mental Health Provider Entity* which is identified by a unique *Mental Health Provider Entity Identifier*.

5.4.11 The *Mental Health Provider Entity Identifier* represents a hierarchically ordered, composite data element incorporating four levels of health service organisation:

- State
- Region

[15] This is in fact the approach being taken for reporting data under the NMDS - Community Mental Health Care which links reporting to the organisational entities which have previously responded to the National Survey of Mental Health Services.

- Mental health service organisation
- Service unit

The layout of the *Mental Health Provider Entity Identifier* is represented as follows.


5.4.12 During the introductory period of the NOCC dataset, States and Territories will have discretion in determining the level at which the concepts of *Region*, *Mental Health Service Organisation* and *Service Unit* are translated, subject to the guidelines outlined below. Future work will focus on further elaborating guidelines for describing the *Mental Health Provider Entity* based on experience, with a view to promoting consistency for benchmarking purposes.

5.4.13 The *Service Unit* represents a discrete service provider unit within a *Mental Health Service Organisation.* Two guidelines apply to the way in way an organisation's mental health services are reported as *Service Units*:

- Each hospital and community residential facility within the organisation should be identified as separate *Service Units*.
- Community-based ambulatory services provided by the organisation – whether organised into separate teams, specific programs or located at multiple sites – may be clustered and reported as a single *Service Unit* or identified as individual *Service Units* in their own right.

5.4.14 When assigning *Service Unit* to a *Collection Occasion*, the following reporting rules apply:

- Where the collection occurs in the context of an *inpatient episode*, the *Service Unit Identifier* should be the code assigned to the hospital to which the patient is currently admitted.[16]
- Where the collection occurs in the context of a *community residential episode*, the *Service Unit Identifier* reported should be the code assigned to the community residential facility to which the patient is admitted.
- Where the collection occurs in the context of an *ambulatory episode*, the *Service Unit Identifier* reported should be the code used to refer to the ambulatory care service which is primarily responsible for provision of treatment and care during the episode.

[16] Where the *Service Unit* is a hospital or residential service, the *Service Unit Identifier* should be the Establishment Number used by the State or Territory to identify the unit in the National Minimum Data Set - Admitted Patient Mental Health Care. States should therefore ensure that the Service Unit identifiers used for ambulatory care services do not overlap with the range assigned to hospital and residential units reporting to the NMDS

***Note**: An implication of the above rules is that the Service Unit Identifier recorded for any given Collection Occasion will not necessarily refer to the Service Unit responsible for collecting the data. For example, where an ambulatory care service assists in the admission to hospital of a consumer and completes the required data items and standard measures, the Service Unit Identifier recorded for that Collection Occasion should refer to the hospital, not the ambulatory care service.*

5.4.15 The concept of *Mental Health Service Organisation* refers to a separately constituted health care organisation that is responsible for the clinical governance, administration and financial management of the *Service Unit* in which the *Episode of Mental Health Care* is provided. A *Mental Health Service Organisation* may consist of one or more *Service Units* based in different locations and providing services in inpatient, community residential and ambulatory settings.[17]

5.4.16 For most jurisdictions, the *Mental Health Service Organisation* is equivalent to the Area/District Mental Health Service. These are usually organised to provide a full range of inpatient, community residential and ambulatory services to a given catchment population. In the larger jurisdictions, they are referred to as Area/District Mental Health Services. However, the concept may also be used to refer to health care organisations which provide only one type of mental health service (e.g., acute inpatient care) or which serve a specialised or statewide function.

5.4.17 Where the *Mental Health Service Organisation* consists of multiple *Service Units*, those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and
- share medical records or, in the case where is more than one physical medical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

5.4.18 **The 'one episode at a time' business rule should be applied across the *Mental Health Service Organisation* not at the *Service Unit* level**. Thus, where multiple *Service Units* within the organisation are simultaneously involved in providing treatment and care to a consumer, that consumer is considered as receiving only one *Episode of Mental Health Care* using the order of precedence described in paragraph 5.1.7. A consumer may however be regarded as receiving more than one episode of care when each episode is provided by a separate *Mental Health Service Organisation.*

[17] Note that *Mental Health Service Organisation* is not equivalent to the concept of Health Establishment as defined in the National Health Data Dictionary. For example, multiple health care providers classified as individual Health Establishments may make up a single *Mental Health Service Organisation*. A formal definition of the *Mental Health Service Organisation* concept is provided in Appendix 1.

5.4.19 The *Region* component of the *Mental Health Provider Entity Identifier* refers to the geographic area in which the *Service Unit* is located. Most States and Territories have established a system for aggregating local areas to higher level regional groupings and use this to report data to the NMDS – Admitted Patient Mental Health Care, NMDS – Community Mental Health Care and the National Survey of Mental Health Services. Where the region concept is not applicable, jurisdictions report the State identifier as the Region code.[18]

## 5.5 Patient identifiers

5.5.1 Unique identification of the consumer is an essential requirement in clinical information systems, both for ensuring that local information collections support continuity of care, as well for State and national-level analysis.

5.5.2 All unit record data reported by States and Territories under the IDPs is to be assigned to an individual consumer, identified by the number that is unique at the level of the *Mental Health Service Organisation* and shared by all service units operating under the organisation.

5.5.3 States and Territories vary in the extent to which service units operating as components of a mental health service organisation share a unique identifier for patients under care. However, where these are not in place, jurisdictions are taking steps to establish such arrangements.

5.5.4 The unique identifier reported in the NOCC extract submitted to the Commonwealth should be in encrypted form and identical to that used in supplying unit record data for the *National Minimum Data Set – Community Mental Health Care* and the *National Minimum Data Set – Admitted Patient Mental Health Care.*

[18] The *Region* concept used in the *Mental Health Provider Entity Identifier* is therefore identical to the National Health Data Dictionary definition. The alternative option of defining *Region* as the catchment population served by the combination of *Mental Health Service Organisation* and *Service Unit* has potential for adding greater meaning and will be explored in future versions.

# 6. Unit of reporting

## 6.1 Basic unit of reporting – the *Collection Occasion*

6.1.1 Reporting of patient-level unit record data in current national collections is tied to 'episodes of care'. The principle is a simple one – one record per patient per episode. In inpatient services, patient-level data are reported in terms of hospital separations, with multiple records added for each separation over the annual reporting period.

6.1.2 For the purposes of NOCC reporting requirements, the unit of reporting will be the *Collection Occasion*. A specified data set is to be reported for three defined collection occasions (*Admission, Review, Discharge*).

6.1.3 The alternative option of reporting data at the level of the episode is not proposed because building episode-based data will create greater difficulty for State and Territory jurisdictions. The task of linking collection occasions and building episodes for analysis purposes will be conducted on an exploratory basis at the national level.

6.1.4 In resolving this, it is important to distinguish the *unit of reporting* from the *unit of analysis.* The units of reporting will serve as the building blocks to assemble higher level 'units of care' which will be the subject of analysis. For this there needs to be both:

- a capacity to link discrete collection occasion events, using as a primary key the data elements *Mental Health Provider Entity* and *Patient Identifier;*
- a conceptual framework to guide the bundling of those events into coherent units for analysis. Issues related to these aspects will be the subject of separate papers and do not need to delay development of the reporting specification.

## 6.2 Reporting context - *Reason for Collection*

6.2.1 Application of the reporting protocol requires that the defined *Collection Occasions* be mapped to a range of key events (i.e. admission to hospital, registration by community services, clinical review, transfer, discharge etc) which may occur within the context of an *Episode of Mental Health Care*.

6.2.2 Understanding the nature of the events triggering admission, discharge or review is necessary for subsequent informed analysis. For example, it will be desirable to separately analyse the differential outcomes of new consumers admitted to ambulatory care from those who commence an ambulatory episode following discharge from hospital.

6.2.3 These considerations will be captured within the data item *Reason for Collection.*[19] The domain of the *Reason for Collection* item is shown in Table 3 below.[20]

**Table 3: Domain and data definitions for *Reason for Collection***

| Collection Occasion | Reason for Collection | Definition |
|---|---|---|
| **Admission** to mental health care | 01. New referral | Admission to a new inpatient, community residential or ambulatory episode of care of a consumer not currently under the active care[21] of the *Mental Health Service Organisation*. |
| | 02. Admitted from other treatment setting | Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the active care of the *Mental Health Service Organisation*. |
| | 03. Admission - Other | Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above. |
| **Review** of mental health care | 04. 3-month review | Standard review conducted at 3 months (91 days) following admission to the current episode of care or 91 days subsequent to the preceding Review |
| | 05. Review – Other | Standard review conducted for reasons other than the above. |
| **Discharge** from mental health care | 06. No further care | Discharge from an inpatient, community residential or ambulatory episode of care of a consumer for whom no further care is planned by the *Mental Health Service Organisation*. |
| | 07. Discharge to change of treatment setting | Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the care of the *Mental Health Service Organisation*. |
| | 08. Death | Completion of an episode of care following the death of the consumer. |
| | 09. Discharge - Other | Discharge from an inpatient, community residential or ambulatory setting for any reason other than defined above. |

[19] This item incorporates and replaces the data items Reason for Episode Start and Reason for Episode End specified in Table 12 of the *National Information Priorities* document.

[20] It is noted that the *Reasons for Collection* item has some conceptual similarities to the National Health Data Dictionary data elements Mode of Admission, Mode of Separation and Reason for Cessation of Treatment. However, the items have different domains and purposes. The *Reasons for Collection* domain incorporates two concepts: 'Why is the information being collected now?' And 'where is the patient coming from/going to' in terms of the next step in their sequence of care.

[21] The concept of 'active care' is necessary to promote consistency in the development of guidelines for the regular review and closure of cases under ongoing community care. As an interim step, States and Territories have agreed to adopt the following business rule in their clinician training strategies.

"A person is defined as being under 'active care' at any point in time when:

- they have not been discharged from care AND
- some services (either direct to or on behalf of the consumer) have been provided over the previous 3 months AND
- a future appointment has been made to see the person within the next 3 months.

Thus, where no future services are planned in the next 3 months, the person is not considered to be under 'active care'."

6.2.4 Individual States and Territories have the option of specifying the domain in greater detail and are encouraged to do. For example, New South Wales uses a list of 39 hierarchically ordered *Reasons for Collection*, which accommodate a range of local service issues and State requirements super-numerary to the national requirements. However, where the domain is further specified, States and Territories should ensure a capacity to map to the national definitions. These represent the mandatory national conditions for collection of data at *Admission*, *Review* and *Discharge*.

## 6.3 Collection Occasion Date

6.3.1 The *Collection Occasion Date* is the reference date for all data collected at any given *Collection Occasion*.

6.3.2 For data collected at the **beginning** of an *Episode of Mental Health Care* the *Collection Occasion Date* is referred to as the *Admission Date*. For data collected at **end** of an *Episode of Mental Health Care,* the *Collection Occasion Date* is referred to as *Discharge Date.* For data collected at *Review* during an ongoing *Episode of Mental Health Care*, the *Collection Occasion Date* is referred to as the *Review Date*.

6.3.3 The *Collection Occasion Date* should be distinguished from the actual date of completion of individual measures that are required at the specific occasion. In practice, the various measures may be completed by clinicians and consumers over several days. For example, at *Review* during ambulatory care, the client's case manager might complete the HoNOS and LSP during the clinical case review on the scheduled date, but in order to include their client's responses to the consumer self-report measure, they would most likely have asked the client to complete the measure at their last contact with them. For national reporting and statistical purposes, a single date is required which ties all the standardised measures and other data items together in a single *Collection Occasion*.[22] The actual collection dates of the individual data items and standard measures may be collected locally but is not required in the national reporting extract.

6.3.4 A special requirement applies in the case of inpatient episodes to facilitate record matching with corresponding records collected under the NMDS – Admitted Patient Mental Health Care. For *Admission* to inpatient episodes, the *Collection Occasion Date* should be the date of admission as recorded in the NMDS data set. For *Discharge* from inpatient episodes, the *Collection Occasion Date* should be the date of separation as recorded in the NMDS data set.[23]

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[22] The implication is that each data item and standardised measure needs to 'belong' to a specific *Collection Occasion* and assumes the date properties of the *Collection Occasion*. Technical solutions will be needed within local information systems to group all relevant data items and standardised measures collected as part of the NOCC dataset and attach them to a specific, dated *Collection Occasion.*

[23] This requirement is workable for the vast majority of inpatient episodes but may not be appropriate for those episodes that include extended periods of leave. See Section 7.3 for proposed approach for dealing with such cases.

# 7. Collection protocol

- This section describes the protocol to be used to guide the collection of outcomes and casemix data. It focuses on what data is to be collected and when it is to be collected.

- The NOCC protocol defines the minimum requirements and should not be interpreted as confining participating jurisdictions to those requirements. Additionally, local services may elect to collect additional measures or to increase the frequency of ratings.

- Implementing the protocol within service delivery agencies requires consideration of how the required data collection will be integrated within agency-level clinical processes and broader information requirements. Local systems vary with different business processes, data collection forms and so forth that reflect differences in service delivery structures. Resolving these issues is beyond the scope of the current document but will need to be addressed by all jurisdictions.

## 7.1 Data requirements at each Collection Occasion

7.1.1 Design of the protocol needs to accommodate both the outcomes and casemix development objectives of the Information Development Agreements. These are not identical. Simply put, casemix requirements need key data to be collected only once during each episode to allow the episode to be adequately described and classified. From the casemix perspective, the only issue is to ensure that the information is collected at the most appropriate point within the overall episode of care. For example, assessment on the HoNOS at *Admission* would suffice for casemix purposes because it is the best measure of the level of severity of the condition presented by the consumer to the treatment system.

7.1.2 In comparison, measurement of consumer outcomes by definition presumes a comparison over time and requires data to be collected on at least two occasions in order to allow assessment of change in the consumer's health status. Thus, taking the same example of the HoNOS, a minimal requirement would be to collect the HoNOS at Admission and Discharge.

7.1.3 The national protocol take all these issues into account and requires that:

- clinical measures that are to be used for outcomes evaluation and casemix purposes be collected at the *Admission*, *Review* and *Discharge Collection Occasions* within episodes to allow change in the consumer's clinical status to be assessed; and
- items required only for casemix purposes be collected at points which are consistent with the MH-CASC classification to allow the classification to be further developed. In general, the decision about whether to collect these at episode start or episode end is based on using the *Collection Occasion* that best describes the consumer during the overall episode of care.

Table 4 brings together these considerations and provides summary details of the various measures to be collected at the three *Collection Occasions* during each episode of mental health care.

**Table 4: Data to be collected at each *Collection Occasion* within each *Mental Health Service Setting*, for consumers in each *Age Group***

| *Mental Health Service Setting* | INPATIENT | | | COMMUNITY RESIDENTIAL | | | AMBULATORY | | |
|---|---|---|---|---|---|---|---|---|---|
| *Collection Occasion* | A | R | D | A | R | D | A | R | D |
| ***Children and Adolescents*** | | | | | | | | | |
| HoNOSCA | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| CGAS | ● | ● | ✖ | ● | ● | ✖ | ● | ● | ✖ |
| FIHS | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● | ● |
| Principal and Additional Diagnoses | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● | ● |
| Mental Health Legal Status | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● | ● |
| ***Adults*** | | | | | | | | | |
| HoNOS | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| LSP-16 (1) | ✖ | ✖ | ✖ | ● | ● | ● | ✖ | ● | ● |
| Consumer self-report (2, 3) | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ● |
| Principal and Additional Diagnoses | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● | ● |
| Focus of Care (4) | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ● | ● |
| Mental Health Legal Status | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● | ● |
| ***Older persons*** | | | | | | | | | |
| HoNOS 65+ | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| LSP-16 (1) | ✖ | ✖ | ✖ | ● | ● | ● | ✖ | ● | ● |
| RUG-ADL | ● | ● | ✖ | ● | ● | ✖ | ✖ | ✖ | ✖ |
| Consumer self-report (2,3) | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ● |
| Principal and Additional Diagnoses | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● | ● |
| Focus of Care (4) | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ● | ● |
| Mental Health Legal Status | ✖ | ● | ● | ✖ | ● | ● | ✖ | ● | ● |

**Abbreviations and Symbols**

| | |
|---|---|
| **A** | Admission to Mental Health Care |
| **R** | Review of Mental Health Care |
| **D** | Discharge from Mental Health Care |
| ● | Collection of data on this occasion is mandatory |
| ✖ | No collection requirements apply |

**Notes**

(1) The LSP-16 is not included as a measure for use in inpatient settings as, in its current form, it requires ratings to be based on the consumer's functioning over the previous three months. This is difficult for the majority of inpatient episodes which are relatively brief.

(2) The classification of consumer self-report measures as mandatory is intended only to indicate the expectation that consumer's will be invited to complete self-report measures at the specified *Collection Occasions*, not that such measures will always be appropriate. Special considerations applying to the collection of self-report measures are described in section 7.4

(3) Introduction of consumer self-report measures in inpatient episodes is not included as a national requirement at this stage but will be reviewed in the future following experience in use of the measures in other settings. Individual jurisdictions or service agencies may however choose to trial these measures in inpatient settings.

(4) Restriction of the Focus of Care only to ambulatory care episodes for adults and older persons is based on experience in the MH-CASC study which found it be of limited value in inpatient and community residential settings and with child/adolescent patients.

## 7.2 Rating periods for the clinical measures and data items

Completion of each of the clinical measures and data items is based on a period of observation that is specific to each scale or item, and may vary according to the *Collection Occasion*. Table 5 identifies the usual rating periods and their exceptions for all clinical data.

**Table 5: Rating periods for each of the clinical measures and data items**

| Standardised measure or Data item | Usual rating period | Exceptions |
|---|---|---|
| HoNOS / HoNOS 65+ | Previous 2 weeks | At discharge from Inpatient psychiatric care, based on previous 3 days including day of discharge. |
| LSP | Previous 3 months | no exceptions |
| RUG-ADL | Current status | no exceptions |
| Adult Consumer Self rating measure | Depends on which measure is used. Usually based on previous 2-4 weeks. | no exceptions |
| HoNOSCA | Previous 2 weeks | At discharge from Inpatient psychiatric care, based on previous 3 days including day of discharge. |
| CGAS | Previous 2 weeks | no exceptions |
| FIHS | The period of care bound by the current *Collection occasion* and the preceding *Collection Occasion*. | no exceptions |
| Focus of Care | The period of care bound by the current *Collection occasion* and the preceding *Collection Occasion*. | no exceptions |
| Principal and Additional Diagnoses | The period of care bound by the current *Collection occasion* and the preceding *Collection occasion*. | no exceptions |
| Mental Health Legal Status | The period of care bound by the current *Collection Occasion* and the preceding *Collection Occasion*. | no exceptions |

## 7.3 Special issues in interpreting the protocol at service delivery level

7.3.1 The standard protocol is designed to fit most clinical situations without there being an expectation that the fit will be perfect. Based on experience to date, it is expected that implementation of the protocol for the majority of cases should be relatively straightforward once information systems are in place and clinician training in use of the instruments has been completed.

7.3.2 However, there is a range of special issues that will need to be resolved within each jurisdiction where application of the standard protocol is more complex. Most of these concern clarifying the interface between episodes in complex sequences of care and interpreting the two business rules which act as triggers to data collection (one episode at a time, change of setting = new episode).

7.3.3 It is beyond the scope of the current document to provide detailed guidelines on all potential complexities arising in the translation of the standard protocol to the many service delivery environments in which mental health services operate in Australia. However, a summary of the approach recommended to the main issues is provided in Table 6 as a basis for further discussion within jurisdictions and development of workforce training programs.

**Table 6: Recommended approach to special issues in interpreting the protocol at service delivery level**

| Scenario | Common Questions | National minimum requirement |
|---|---|---|
| 1. Movement between inpatient and community settings | Do ratings need to be recorded for the end of the community episode as well as the beginning of the inpatient episode when a consumer is transferred from ambulatory care to hospital? | Yes, because one episode has ended and another commenced. How this is achieved depends on the service structures established within the organisation. It does not necessarily imply that separate ratings are made by two independent clinicians. Potential to integrate the data requirements within a single rating should be explored. |
| 2. Transfer between two wards of the psychiatric unit | Is the transfer of a patient from one psychiatric ward to another within the same hospital campus a new episode and thus requiring new data collection? | No, because there has not been a change of treatment setting. However, there may be good clinical reasons to reassess the patient when transfer occurs e.g., when the transfer is from an acute to a rehabilitation ward, or from a general acute unit to a forensic ward within the hospital. Decisions about whether such additional ratings are required need to be resolved at the local level. Where they do occur, they should be reported and Reason for Collection coded as 'Review – Other'. |

| Scenario | Common Questions | National minimum requirement |
|---|---|---|
| 3. Transfer between psychiatric units from one hospital campus to another | Should a new inpatient episode be commenced when a consumer is transferred from one hospital to another within the same mental health care organisation? | Yes. Even though this is not technically a change in treatment setting, States and Territories have agreed that a inpatient episode should be recorded in these circumstances, with the associated data collection requirements. |
| 4. Transfer of care between community teams | Does a new cycle of data collection begin when case management is transferred from one ambulatory care team to another within the same organisation? | No, within the national episode model the consumer is regarded as remaining within the same episode of care. However, as in the example (2) above, there may be good clinical reasons to reassess the patient when between-team transfer occurs. e.g., transfer from crisis team to continuing care team. Decisions about whether such additional ratings are required need to be resolved at the local level. |
| 5. Multiple team involvement in case management | Is each team expected to complete ratings on the consumer? | No, the consumer is regarded as receiving only one episode of care at a time. Decisions about which team (or clinician) is responsible for completing the required ratings need to be at the local level. |
| 6. 'Intended' same day admissions: | Is each day of care a new inpatient episode, requiring a full set of ratings? | No. Definitions that have been developed under the *National Survey of Mental Health Services* since 1994 have regarded 'intended same day admissions' as a component of ambulatory care services. |
| 7. Discharge from hospital on indefinite leave | Does an inpatient episode continue when a patient is placed on extended leave but remains, legally, an inpatient? | This is a common but complex issue in mental health services. As a general rule, it is recommended that, for the purposes of the NOCC dataset, the inpatient episode be deemed to have ended when the patient is sent on leave and where there is no intention that he/she return for an overnight stay *within the next 7 day period*. |
| 8. Return to hospital from indefinite leave | Does a new inpatient episode begin when a patient returns to hospital after a period of extended leave? | This is the converse of the above. It is recommended that where an inpatient episode is deemed to have ended as a result of indefinite leave, and the patient returns unexpectedly, a new inpatient episode should be commenced. |
| 9. Brief inpatient episodes | Are discharge ratings required for very brief inpatient episodes? | Partly. Inpatient episodes of less than 3 days do not require the following ratings:<br>• Adults and Older Persons: HoNOS/HoNOS65+<br>• Child/adolescent: HoNOSCA and CGAS |

| Scenario | Common Questions | National minimum requirement |
|---|---|---|
| | | This is because the period that would be rated at discharge (previous 3 days) would overlap with the admission ratings.<br>However, all other aspects of the collection protocol are required. |
| 10. Rapid readmission to hospital | If a patient is discharged from an inpatient unit and is readmitted within a very short period, is this a new inpatient episode or a continuation of the previous one? | Where the readmission was unplanned, there are strong clinical grounds for recording a new episode and reassessing the patient. However, this issue remains unresolved and will be referred to a national expert committee for advice when established later in 2002. |
| 11. 'Assessment only' cases seen by community teams | Is outcomes and casemix data required on every person seen by community teams, regardless of whether they are accepted for treatment? | No, many people are seen only briefly by community teams and referred elsewhere following assessment. Similarly, community teams provide services on a consultation and shared care basis to many people, some of whom they do not assess directly. Collection of outcomes and casemix data in such instances is clearly impractical. Developing a nationally agreed process for registering this important aspect of mental health team work is yet to be developed (see Appendix 4). In the meantime, jurisdictions should develop guidelines to clarify that 'assessment only' cases are not expected to entail the full NOCC data requirements. |
| 12. Consumers seen regularly but at less than 3 monthly intervals | How should the 3 monthly (91 day) review 'rule' be applied in these cases? Does it mean that they will need to be seen more regularly? | No, definitely not, the collection protocol is intended to support good practice rather than dictate how services should be delivered. Where the needs of a consumer require that they be seen regularly but at less than 3 monthly intervals, then reviews using the standard instruments should be conducted on the next appointment that occurs after 3 months have elapsed since the last collection occasion. |

## 7.4 Special considerations applying to the collection of consumer self-report measures

7.4.1 In general, all consumers should be asked to complete self–report measures at the *Collection Occasions* indicated in Table 4. However, due to the nature and severity of their mental health or other problems, it is likely that some consumers should never be asked to complete self–report measures, others may not be able to complete the self–report measures at the scheduled occasion, whilst still others may sometimes find completion of the self–report measures to be difficult or stressful. Suggested criteria for defining the reasons why the collection of self–report measures would be contraindicated are outlined below.

7.4.2 In all cases, clinical judgement as to the appropriateness of inviting the consumer to complete the measures should be the determining factor at any given *Collection Occasion*. Where collection of consumer self–report measures is contraindicated, the reasons should be recorded.

***General exclusions***

7.4.3 Some consumers may not be able to complete self–report measures at any time and should not be asked to do so. A definitive list of circumstances in which a general exclusion applies is beyond the scope of this document but broadly it would include situations where:

- the consumer's cognitive functioning is insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability;
- cultural or language issues make the self-report measure inappropriate.[24]

***Temporary contraindications***

7.4.4 Under certain conditions, a consumer may not be able to complete the self-report measure at a specific *Collection Occasion*. Circumstances where it may be appropriate to refrain from inviting the consumer to complete the self-report measure include:

- where the consumer's current clinical state is of sufficient severity to make it unlikely that their responses to a self–report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that they were a reasonable indication of person's feelings and thoughts about their current emotional and behavioural problems and wellbeing;
- where an invitation to complete the measures is likely to be experienced as distressing or require a level of concentration and effort the person feels unable to give.

[24] Substantial development work is required in the future to address cultural issues in the use and interpretation of self-report outcome measures. See Appendix 4.

7.4.5 It is suggested that consumers in this group need not be invited to complete self–report measures at the time when they meet the specified criteria. At all other times, an attempt should be made to obtain their responses.

7.4.6 In many cases, the severity of the person's clinical state will be diminish with appropriate treatment and care. It is suggested that, if within a period of up to 7 days following the *Collection Occasion* in an ambulatory care setting the consumer likely to be able to complete the self–report questionnaire then their responses should be sought at that time. Otherwise, no further attempt to administer the self–report questionnaire at that *Collection Occasion* should be made.

## 7.5 Future development of the protocol

7.5.1 This version 1 of the National Outcomes and Casemix Collection has been prepared from the research and development undertaken to date under the National Mental Health Strategy and the early experiences by several jurisdictions in introducing standard outcome measurement into routine clinical practice. Much remains to be learnt through trial and application over the coming years.

7.5.2 The protocol represents an attempt to achieve a compromise between the desirable and the achievable. A range of issues remain unresolved and specific areas require further development (e.g., measures for child & adolescent services). Appendix 3 outlines an indicative agenda for future development.

7.5.3 Much of the input to future development will come from day-to-experience in using the measures and the protocol governing their collection. Experience from the technical side of system development will also inform future revisions, along with analysis of the national data and formal research studies of the measurement instruments themselves.

7.5.4 Expert groups have been established for Adult (inclusive of Aged Persons and Forensic settings) and Child & Adolescent Services. These groups will advise on future revisions and ensure that they are compatible with good clinical and management practice. The Child and Adolescent Outcomes Expert Group became operational in February 2002, and the Adult Outcomes Expert Group is to be convened for the first time in July 2002.

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# 8. NOCC data extract and file layout specification

This section identifies the layout and format of NOCC data files to be submitted by States and Territories to the Commonwealth Mental Health & Special Programs Branch. Section 10 provides details of the supplementary Mental Health Provider Entity Reference Files also required to be submitted by States and Territories.

## 8.1 Overview of data model for NOCC extract

8.1.1 The basic design of the extract consists of a set of data records for each *Collection Occasion*. The structure of the data to be reported can be represented in the data model shown in Figure 2. In the model, a Person may have standardised measures and associated data items collected at one or more Collection Occasions. At each Collection Occasion zero or one each of the HoNOS, LSP, RUG-ADL, HoNOSCA, CGAS, FIHS, consumer self-rated measure and other individual data items (Principal diagnosis, Additional Diagnosis, Focus of Care, Mental health legal status) may be recorded.

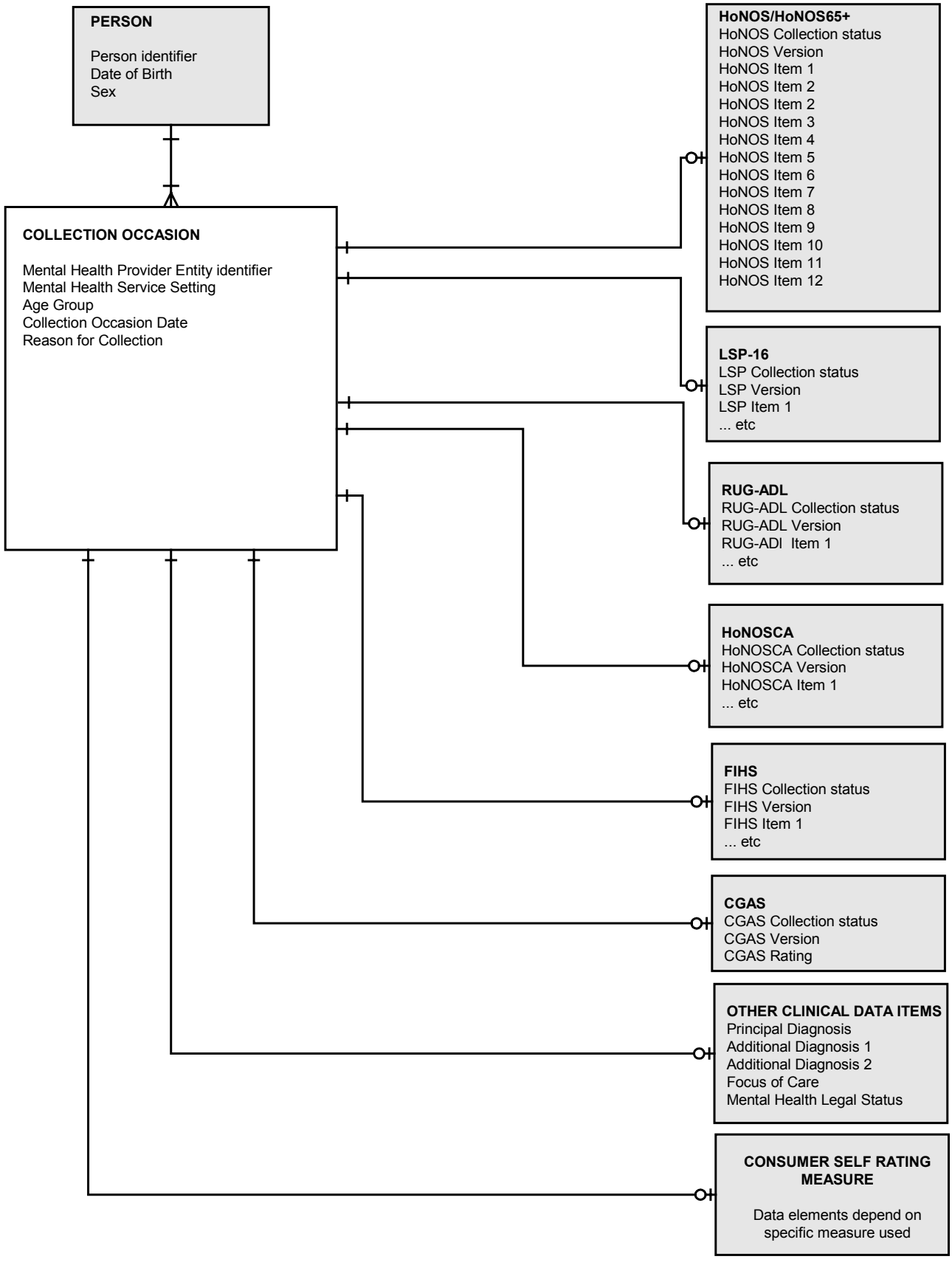
8.1.2 Three advantages of the model of the model should be noted

- First, neither the concept of an *Episode of Mental Health Care* or the concept of a *Period of Care* are represented as entities in the model. Information regarding either entity may be derived for statistical purposes from sequential instances of *Collection Occasions*.

- Second, the suggested model separates the record for each individual standardised measure from the *Collection Occasion*, even though the measures have a one-to-one relationship with it. This enables additional measures to be more easily added as the need arises. For example, as further measures for children and adolescents are identified these will need to be added to the extract. It also makes the process of accommodating the different consumer self-report instruments that will be used by States and Territories less complex for all parties.

- Third, the model provides a logical grouping of the NOCC data measures. In particular, the four individual data items that are collected at the same points within episodes and based the preceding *Period of Care* (*Principal Diagnosis, Additional Diagnosis, Focus of Care. Mental Health Legal Status*) are grouped into the category ‘Other Clinical Data Items’.

**Figure 2 : Data model underlying the NOCC data extract**



## 8.2 File type and naming convention

8.2.1 Data submitted to the Commonwealth should be formatted as a Fixed Format data file, with each record in the file being terminated with Carriage Return (CR) and Line Feed (LF) characters.

8.2.2 The data file will have the naming convention of NOCC*SNNNNN*.DAT. Where *S* is the State identifier and *NNNNN* represents an incremental batch number (leading zeros present). Note that resubmitted files should have a batch number greater than the file they replace. For example, the first NOCC data file submitted by the Australian Capital Territory would be named 'NOCC8000001.DAT'.

## 8.3 Reporting period and delivery date

8.3.1 Files are to be prepared on an annual basis and sent each December (Commonwealth suggests by c.o.b. 5 December each year, or closest working day).

8.3.2 Each annual file will include data for the preceding financial year e.g., December 2002 file should include data for the 2001-2 financial year.

## 8.4 File structure

8.4.1 The extract format consists of a set of *Data Records* for each *Collection Occasion*. Each record in the set has a different record type but must have the same unique *Collection Occasion Identifier*.

8.4.2 In each extract file for any given period the Data records must be preceded by a single *File Header Record* having the structure outlined below.

8.4.3 In each extract file for any given period the Data records must be followed by a single *File Terminator Record* having the structure outlined below:

8.4.4 There is one *Data Record* for each of the following:

- Collection Occasion Details
- Each of the standard rating measures i.e. HoNOS/HoNOS65+, LSP-16, RUGADL, HoNOSCA, CGAS, FIHS, Consumer Self Rated Measure.[25]
- Other Clinical Data items

8.4.5 All *Data Records* should include the following elements in the order shown:

- Record type
- Collection occasion identifier
- Specific data in the format specified for the given record type.

[25] Specific extract formats for each type of consumer self–rated measure reported will be developed in consultation with the State's and Territories intending to report the measure.

8.4.6 The specific data within each *Data Record* type, other than the Collection Occasion Details and Other Clinical Data Items records, consists of the data elements detailing the collection of the measure (Collection Status, Version) followed by the actual data elements constituting the measure. Where summary scores are derived from individual scores, these are not required in the national extract as they will be derived from the individual item scores.

8.4.7 The order of fields in a record must be the same as the order they are specified in the Record Layouts specified below. Field values should be formatted as specified in the Record Layouts.

8.4.8 The first field in each record must be *Record Type.* Valid values are shown below.

**Table 7: Valid values for *Record Type***

| Record Type | Description |
|---|---|
| HR | File Header Record |
| COD | Collection Occasion Details |
| OCDI | Other Clinical Data items |
| HONOS | HoNOS or HoNOS65+ |
| LSP16 | LSP–16 |
| RUGADL | RUG–ADL |
| HONOSCA | HoNOSCA |
| CGAS | CGAS |
| FIHS | FIHS |
| MHI38 | MHI (Standard 38 item version) (Consumer Self–Rated Measure) |
| BASIS32 | BASIS (Standard 32 item version) (Consumer Self–Rated Measure) |
| K10LM | K–10–LM (Last Month version of the K–10 proposed for use in NSW) (Consumer Self–Rated Measure) |
| K10L3D | K–10–L3D (Last 3 Days version of the K–10 proposed for use in NSW) (Consumer Self–Rated Measure) |
| ZZZZZZZZ | File Terminator Record |

## 8.5 Data integrity

8.5.1 Values in **Date** fields must be recorded in compliance with ISO 8601, specifically; dates must be of fixed 8 column width in the format CCYYMMDD, with leading zeros used when necessary to pad out a value. e.g., , 13th March 2001 would appear as 20010313.

8.5.2 Values in **Numeric** fields must be zero-filled and right-justified.

8.5.3 Values in **Character** fields must be left justified and space-filled.

## 8.6 File header and termination records

8.6.1 The first record of the extract file must be a File Header Record (Record type = 'HR'), and it must be the only such record in the file.

8.6.2 The File Header Record is a quality control mechanism, which uniquely identifies each file that is sent to the Commonwealth. (i.e. who sent the file, what date the file was sent, how many records are in the file etc). The information contained in the header fields will be checked against the actual details of the file to ensure that the file received has not been corrupted.

8.6.3 The last record of the data file must be a File Termination Record (Record type = 'ZZZZZZZZ'), and it must be the only such record in the file.

8.6.4 The Record Count field must contain the exact number of records in the file including the File Header Record and the File Termination Record.

8.6.5 The proposed layout of the File Header Record is shown in Table 8.

**Table 8: Record Layout for *File Header Record* within the data extract**

| Data Element | Type [Length] | Start | Notes |
|---|---|---|---|
| Record type | Char [8] | 1 | Value = HR |
| State identifier | Char [1] | 9 | Domain = 1 New South Wales; 2 Victoria; 3 Queensland; 4 South Australia; 5 Western Australia; 6 Tasmania; 7 Northern Territory; 8 Australian Capital Territory. |
| Report period start date | Date [8] | 10 | |
| Report period end date | Date [8] | 18 | |
| Data file generation date | Date [8] | 26 | |
| Record count | Number [8] | 34 | |
| Data file type | Char [4] | 42 | Value = NOCC |
| NOCC reporting specification version | Char [3] | 46 | Value = 010 |
| *Record length* = | 49 | | |

## 8.7 Data records

8.7.1 The extract format for the *Data records* is specified in detail in Table 9.

8.7.2 The order of fields in each record must be the same as the order they are shown in below. Field values should be formatted as specified.

**Table 9: Data record layout — *Collection Occasion Details***

| Data Element | Type [Length] | Start | Notes |
|---|---|---|---|
| Record type | Char [8] | 1 | Value = COD |
| Collection occasion identifier | Char [30] | 9 | |
| Person identifier | Char [20] | 39 | |
| Date of birth | Date [8] | 59 | |
| Sex | Char [1] | 67 | |
| Mental health service setting | Char [1] | 68 | |
| Age group | Char [1] | 69 | |
| Collection occasion date | Date [8] | 70 | |
| Reason for collection | Char [2] | 78 | |
| Mental health provider entity identifier | Char [10] | 80 | |
| *Record length* = | 90 | | |

**Table 10: Data record layout — *Other Clinical Data Items***

| Data Element | Type [Length] | Start | Notes |
|---|---|---|---|
| Record type | Char [8] | 1 | Value = OCDI |
| Collection occasion identifier | Char [30] | 9 | |
| Principal diagnosis | Char [8] | 39 | |
| Additional diagnosis 1 | Char [8] | 47 | |
| Additional diagnosis 2 | Char [8] | 55 | |
| Focus of care | Char [1] | 63 | |
| Mental health legal status | Char [1] | 64 | |
| *Record length* = | 65 | | |

**Table 11: Data record layout — *HoNOS/HoNOS65+***

| Data Element | Type (Length) | Start | Notes |
|---|---|---|---|
| Record type | Char [8] | 1 | Value = HONOS |
| Collection occasion identifier | Char [30] | 9 | |
| HoNOS version | Char [2] | 39 | |
| HoNOS collection status | Char [1] | 41 | |
| HoNOS item 01 | Number [1] | 42 | |
| HoNOS item 02 | Number [1] | 43 | |
| HoNOS item 03 | Number [1] | 44 | |

| Data Element | Type (Length) | Start | Notes |
|---|---|---|---|
| HoNOS item 04 | Number [1] | 45 | |
| HoNOS item 05 | Number [1] | 46 | |
| HoNOS item 06 | Number [1] | 47 | |
| HoNOS item 07 | Number [1] | 48 | |
| HoNOS item 08 | Number [1] | 49 | |
| HoNOS item 08a | Char [1] | 50 | |
| HoNOS item 09 | Number [1] | 51 | |
| HoNOS item 10 | Number [1] | 52 | |
| HoNOS item 11 | Number [1] | 53 | |
| HoNOS item 12 | Number [1] | 54 | |
| *Record length* = | 55 | | |

**Table 12: Data record layout — *LSP–16***

| Data Element | Type (Length) | Start | Notes |
|---|---|---|---|
| Record Type | Char [8] | 1 | Value = LSP16 |
| Collection occasion identifier | Char [30] | 9 | |
| LSP-16 version | Char [2] | 39 | |
| LSP-16 Collection status | Char [1] | 41 | |
| LSP-16 item 01 | Number [1] | 42 | |
| LSP-16 item 02 | Number [1] | 43 | |
| LSP-16 item 03 | Number [1] | 44 | |
| LSP-16 item 04 | Number [1] | 45 | |
| LSP-16 item 05 | Number [1] | 46 | |
| LSP-16 item 06 | Number [1] | 47 | |
| LSP-16 item 07 | Number [1] | 48 | |
| LSP-16 item 09 | Number [1] | 49 | |
| LSP-16 item 10 | Number [1] | 50 | |
| LSP-16 item 11 | Number [1] | 51 | |
| LSP-16 item 12 | Number [1] | 52 | |
| LSP-16 item 13 | Number [1] | 53 | |
| LSP-16 item 14 | Number [1] | 54 | |
| LSP-16 item 15 | Number [1] | 55 | |
| LSP-16 item 16 | Number [1] | 56 | |
| *Record length* = | 57 | | |

**Table 13: Data record layout — *RUG–ADL***

| Data Element | Type [Length] | Start | Notes |
|---|---|---|---|
| Record Type | Char [8] | 1 | Value = RUGADL |
| Collection occasion identifier | Char [30] | 9 | |
| RUGADL version | Char [2] | 39 | |
| RUGADL collection status | Char [1] | 41 | |
| RUGADL item 1 | Number [1] | 42 | |
| RUGADL item 2 | Number [1] | 43 | |
| RUGADL item 3 | Number [1] | 44 | |
| RUGADL item 4 | Number [1] | 45 | |
| *Record length* = | 46 | | |

**Table 14: Data record layout — *HoNOSCA***

| Data Element | Type [Length] | Start | Notes |
|---|---|---|---|
| Record type | Char [8] | 1 | Value = HONOSCA |
| Collection occasion identifier | Char [30] | 9 | |
| HoNOSCA version | Char [2] | 39 | |
| HoNOSCA collection status | Char [1] | 41 | |
| HoNOSCA item 01 | Number [1] | 42 | |
| HoNOSCA item 02 | Number [1] | 43 | |
| HoNOSCA item 03 | Number [1] | 44 | |
| HoNOSCA item 04 | Number [1] | 45 | |
| HoNOSCA item 05 | Number [1] | 46 | |
| HoNOSCA item 06 | Number [1] | 47 | |
| HoNOSCA item 07 | Number [1] | 48 | |
| HoNOSCA item 08 | Number [1] | 49 | |
| HoNOSCA item 09 | Number [1] | 50 | |
| HoNOSCA item 10 | Number [1] | 51 | |
| HoNOSCA item 11 | Number [1] | 52 | |
| HoNOSCA item 12 | Number [1] | 53 | |
| HoNOSCA item 13 | Number [1] | 54 | |
| HoNOSCA item 14 | Number [1] | 55 | |
| HoNOSCA item 15 | Number [1] | 56 | |
| *Record length* = | 57 | | |

**Table 15: Data record layout — *CGAS***

| Data Element | Type [Length] | Start | Notes |
|---|---|---|---|
| Record type | Char [8] | 1 | Value = CGAS |
| Collection occasion identifier | Char [30] | 9 | |
| CGAS version | Char [2] | 39 | |
| CGAS collection status | Char [1] | 41 | |
| CGAS rating | Number [3] | 42 | |
| *Record length* = | 45 | | |

**Table 16: Data record layout — *FIHS***

| Data Element | Type [Length] | Start | Notes |
|---|---|---|---|
| Record type | Char [8] | 1 | Value = FIHS |
| Collection occasion identifier | Char [30] | 9 | |
| FIHS version | Char [2] | 39 | |
| FIHS collection status | Char [1] | 41 | |
| FIHS item 01 | Number [1] | 42 | |
| FIHS item 02 | Number [1] | 43 | |
| FIHS item 03 | Number [1] | 44 | |
| FIHS item 04 | Number [1] | 45 | |
| FIHS item 05 | Number [1] | 46 | |
| FIHS item 06 | Number [1] | 47 | |
| FIHS item 07 | Number [1] | 48 | |
| *Record length* = | 49 | | |

# 9. Data validation process

9.1 Validation of NOCC data files is planned to be conducted at 5 levels, each level representing a higher level of complexity. A brief description of the validation levels planned for the national data is provided in Table 17.

**Table 17: Overview of levels of validation planned for NOCC data files**

| Level | Type | Description |
|---|---|---|
| 1 | Pre-processing checks | Pre-processing is performed to ensure that data file received can be read, has not been corrupted during transmission, that it is in the format specified and that the header record data matches the actual contents of the file. |
| 2 | Record referential checks | Record referential checks ensure that 'parent records' exist for each 'child record' e.g., a Collection Occasion Details record must exists for each HoNOS Data Record. |
| 3 | Field value checking | Field value checking ensures that each field has valid values as specified in the NOCC data dictionary. |
| 4 | Field referential checks | Field referential checks ensure that the value of a field is consistent with the values in other relevant fields on the same or different records. For example, the combination of Age Group = Child & Adolescent and Date of Birth = 01.06.1919 is inconsistent. |
| 5 | Record sequences | Record sequence checks assess the overall sequence of Collection Occasion Details records to ensure they occur in the expected order. For example, a Collection Occasion Details (COD)record where Setting = Inpatient, Reason for Collection = Admission immediately followed (by date order) by another COD record where Setting = Ambulatory, Reason for Collection = Discharge implies miscoding or missing records. |

9.2 Upon receipt, the NOCC data file will be subjected to an initial series of checks that cover Levels 1-3 above to ensure that the file has not been corrupted during transmission, that it is in the format specified, and that the data contained in each record is valid. Further work is required in specifying Level 4-5 checks and will be deferred pending review of the quality of data received under this version 1 specification.

9.3 The various Level 1-3 validation checks to be performed are defined in detail in Table 18 below.

9.4 The process for performing the validation will be as follows:

9.4.1 All records in the file are read, with a sequential record number being assigned to each record by the input program.

9.4.2 Records are checked in sequence, beginning with the first record which must be a valid File Header Record.

9.4.3 Where a validation check fails, an error report entry will be generated. The error report will give the Error code, the record number of the Record which failed the validation check and, where the record is a duplicate of a preceding record, the record number of that preceding record.

9.4.4 Where the Action following a failed validation check indicates that the File is to be rejected, then no further processing of the records in that file will be attempted.

9.4.5 Where the Action following a failed validation check indicates that the Record is to be rejected then the consequences of that rejection will depend on the Type of record.

9.4.6 If a record of Collection Occasion Details (Record type = 'COD') is to be rejected, then all other data records linked to that record by the shared Collection occasion identifier will also be rejected. (This rule is necessary to maintain the referential integrity of the resulting data set.)

9.4.7 If any other type of data record other than a Collection Occasion Details record is to be rejected then only that record will be rejected.

9.4.8 Where the Action following a failed validation check indicates only that the error is to be reported, then the record will be retained. In most cases this kind of error will require recording of invalid data to the standard missing value for the particular data item.

9.5 The error reports generated by the initial validation procedure will be returned to the responsible State or Territory.

9.6 It is expected that States and Territories will re-submit a corrected NOCC data file to the Commonwealth as soon as possible.

**Table 18: Error codes, brief descriptions, details and actions to be taken in initial data validation checks performed at initial input processing of NOCC data files.**

| Code | Description | Details | Action |
|---|---|---|---|
| NOCC010001 | Record type of File header record is not valid | Record type is not 'HR'. | Reject file |
| NOCC010002 | State identifier in File Header Record not valid | Recorded value is not within the specified domain of valid values. | Report |
| NOCC010003 | Report period start date not valid | Recorded value is not a valid date OR recorded date is inconsistent (earlier or later than expected, as defined by the period for which the extract was believed to have been submitted) | Reject file |
| NOCC010004 | Report period end date not valid | Recorded value is not a valid date OR recorded date is inconsistent (earlier or later than expected, as defined by the period for which the extract was believed to have been submitted) | Reject file |
| NOCC010005 | Extract generation date is not valid | Recorded value is not a valid date OR recorded date is inconsistent (eg, earlier than the Report period end date) | Report |
| NOCC010006 | Record count is not valid | Recorded value is 0, is blank, or includes illegal characters. | Reject file |
| NOCC010007 | National report identifier is not valid | Recorded value is not 'NOCC'. | Reject file |
| NOCC010008 | National reporting specification version is not valid | Recorded value is not consistent with the report specification version expected for data submitted in the period identified by the Report period start date and Report period end date (ie, currently '010'). | Reject file |
| NOCC010009 | Number of records in file not equal to Record count | The number of records in the file, including the File header record and the File terminator record must equal the number recorded as the Record count. | Reject file |
| NOCC010010 | Unable to read file | On reading the first 51 characters in the file no valid File Header Record could be extracted. This includes the occurrence of any of the preceding errors resulting in a Reject file action. | Reject file |
| NOCC020001 | Record type of Data record is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC020002 | Collection occasion identifier in Collection Occasion Details record is not valid. | Recorded value is blank or includes illegal characters. | Reject record |
| NOCC020003 | Collection occasion identifier in Collection Occasion Details record is a duplicate of the Collection occasion identifier of a preceding Collection Occasion Details record. | Duplicate records of Collection Occasions are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC020004 | Person identifier in Collection Occasion Details record is not valid. | Recorded value is blank or includes illegal characters. | Reject record |
| NOCC020005 | Date of birth is not valid. | Recorded value is not a valid date. Date of birth is deemed to be missing (ie, 09/09/9999). | Report |
| NOCC020006 | Sex is not valid. | Recorded value is not within the specified domain of valid values. Sex is deemed to be missing (ie, 9). | Report |
| NOCC020007 | Mental health service setting is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC020008 | Age group is not valid. | Recorded value is not within the specified domain of valid values. Age group is deemed to be missing (ie, 9). | Report |

| Code | Description | Details | Action |
|---|---|---|---|
| NOCC020009 | Collection occasion date is not valid. | Recorded value is not a valid date. | Reject record |
| NOCC020010 | Collection occasion date is out of range specified by the Report period start date and Report period end date. | | Reject record |
| NOCC020011 | Reason for collection is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC020012 | The identified Collection Occasion is a duplicate of a preceding record of a Collection Occasion. | The primary key of the Collection Occasion, formed by the union of the data elements Patient identifier, Mental health service setting, Reason for collection and Mental health provider entity identifier, is not unique. | Reject record |
| NOCC020013 | The Region code within the Mental Health Provider Entity Identifier does not have a corresponding record in the Mental Health Provider Entity Reference File. | Recorded value is not within the specified domain of valid values for Regions as provided in the supplementary Mental Health Provider Entity Reference File. | Reject record |
| NOCC020014 | The Mental Health Service Organisation Number within the Mental Health Provider Entity Identifier does not have a corresponding record in the Mental Health Provider Entity Reference File. | Recorded value is not within the specified domain of valid values for Mental Health Service Organisations as provided in the supplementary Mental Health Provider Entity Reference File. | Reject record |
| NOCC020015 | The Service Unit Identifier within the Mental Health Provider Entity Identifier does not have a corresponding record in the Mental Health Provider Entity Reference File. | Recorded value is not within the specified domain of valid values for Service Unit as provided in the supplementary Mental Health Provider Entity Reference File. | Reject record |
| NOCC030001 | Collection occasion identifier in Other Clinical Data Items record is not valid. | Recorded value is not among the set of Collection occasion identifiers found within the set of records of Collection Occasion Details included in the current file, or is blank. | Reject record |
| NOCC030002 | Collection occasion identifier in Other Clinical Data Items record is a duplicate of the Collection occasion identifier of a preceding Other Clinical Data Items record. | Duplicate records of LSP–16 are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC030003 | Principal diagnosis is not valid. | Recorded value is not within the specified domain of valid values. | Report |
| NOCC030004 | Additional diagnosis 1 is not valid. | Recorded value is not within the specified domain of valid values. Additional diagnosis 1 is deemed to be missing. | Report |
| NOCC030005 | Additional diagnosis 2 is not valid. | Recorded value is not within the specified domain of valid values. Additional diagnosis 2 is deemed to be missing. | Report |
| NOCC030006 | Focus of care is not valid. | Recorded value is not within the specified domain of valid values. Focus of care is deemed to be missing (ie, 9). | Report |
| NOCC030007 | Mental health legal status is not valid. | Recorded value is not within the specified domain of valid values. Mental health legal status is deemed to be missing (ie, 9). | Report |
| NOCC040001 | Collection occasion identifier in HoNOS/HoNOS65+ record is not valid. | Recorded value is not among the set of Collection occasion identifiers found within the set of records of Collection Occasion Details, or is blank. | Reject record |

| Code | Description | Details | Action |
|---|---|---|---|
| NOCC040002 | Collection occasion identifier in HoNOS/HoNOS65+ record is a duplicate of the Collection occasion identifier of a preceding HoNOS/HoNOS65+ record. | Duplicate records of HoNOS/HoNOS65+ are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC040003 | HoNOS version is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC040004 | HoNOS collection status is not valid. | Recorded value is not within the specified domain of valid values. HoNOS collection status is deemed to be missing (ie, 9). | Report |
| NOCC040005 | HoNOS item 01 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 01 is deemed to be missing (ie, 7). | Report |
| NOCC040006 | HoNOS item 02 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 02 is deemed to be missing (ie, 7). | Report |
| NOCC040007 | HoNOS item 03 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 03 is deemed to be missing (ie, 7). | Report |
| NOCC040008 | HoNOS item 04 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 04 is deemed to be missing (ie, 7). | Report |
| NOCC040009 | HoNOS item 05 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 05 is deemed to be missing (ie, 7). | Report |
| NOCC040010 | HoNOS item 06 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 06 is deemed to be missing (ie, 7). | Report |
| NOCC040011 | HoNOS item 07 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 07 is deemed to be missing (ie, 7). | Report |
| NOCC040012 | HoNOS item 08 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 08 is deemed to be missing (ie, 7). | Report |
| NOCC040013 | HoNOS item 08a is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 08a is deemed to be missing (ie, Z). | Report |
| NOCC040014 | HoNOS item 09 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 09 is deemed to be missing (ie, 7). | Report |
| NOCC040015 | HoNOS item 10 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 10 is deemed to be missing (ie, 7). | Report |
| NOCC040016 | HoNOS item 11 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 11 is deemed to be missing (ie, 7). | Report |
| NOCC040017 | HoNOS item 12 is not valid. | Recorded value is not within the specified domain of valid values. HoNOS item 12 is deemed to be missing (ie, 7). | Report |
| NOCC050001 | Collection occasion identifier in LSP–16 record is not valid. | Recorded value is not among the set of Collection occasion identifiers found within the set of records of Collection Occasion Details, or is blank. | Reject record |
| NOCC050002 | Collection occasion identifier in LSP–16 record is a duplicate of the Collection occasion identifier of a preceding LSP–16 record. | Duplicate records of LSP–16 are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC050003 | LSP–16 version is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC050004 | LSP–16 collection status is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 collection status is deemed to be missing (ie, 9). | Report |

| Code | Description | Details | Action |
|---|---|---|---|
| NOCC050005 | LSP–16 item 01 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 01 is deemed to be missing (ie, 9). | Report |
| NOCC050006 | LSP–16 item 02 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 02 is deemed to be missing (ie, 9). | Report |
| NOCC050007 | LSP–16 item 03 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 03 is deemed to be missing (ie, 9). | Report |
| NOCC050008 | LSP–16 item 04 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 04 is deemed to be missing (ie, 9). | Report |
| NOCC050009 | LSP–16 item 05 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 05 is deemed to be missing (ie, 9). | Report |
| NOCC050010 | LSP–16 item 06 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 06 is deemed to be missing (ie, 9). | Report |
| NOCC050011 | LSP–16 item 07 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 07 is deemed to be missing (ie, 9). | Report |
| NOCC050012 | LSP–16 item 08 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 08 is deemed to be missing (ie, 9). | Report |
| NOCC050013 | LSP–16 item 09 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 09 is deemed to be missing (ie, Z). | Report |
| NOCC050014 | LSP–16 item 10 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 10 is deemed to be missing (ie, 9). | Report |
| NOCC050015 | LSP–16 item 11 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 11 is deemed to be missing (ie, 9). | Report |
| NOCC050016 | LSP–16 item 12 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 12 is deemed to be missing (ie, 9). | Report |
| NOCC050017 | LSP–16 item 13 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 13 is deemed to be missing (ie, 9). | Report |
| NOCC050018 | LSP–16 item 14 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 14 is deemed to be missing (ie, 9). | Report |
| NOCC050019 | LSP–16 item 15 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 15 is deemed to be missing (ie, 9). | Report |
| NOCC050020 | LSP–16 item 16 is not valid. | Recorded value is not within the specified domain of valid values. LSP–16 item 16 is deemed to be missing (ie, 9). | Report |
| NOCC060001 | Collection occasion identifier in RUG–ADL record is not valid. | Recorded value is not among the set of Collection occasion identifiers found within the set of records of Collection Occasion Details, or is blank. | Reject record |
| NOCC060002 | Collection occasion identifier in RUG–ADL record is a duplicate of the Collection occasion identifier of a preceding RUG–ADL record. | Duplicate records of RUG–ADL are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC060003 | RUG–ADL version is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC060004 | RUG–ADL collection status is not valid. | Recorded value is not within the specified domain of valid values. RUG–ADL collection status is deemed to be missing (ie, 9). | Report |

| Code | Description | Details | Action |
|---|---|---|---|
| NOCC060005 | RUG–ADL item 01 is not valid. | Recorded value is not within the specified domain of valid values. RUG–ADL item 01 is deemed to be missing (ie, 9). | Report |
| NOCC060006 | RUG–ADL item 02 is not valid. | Recorded value is not within the specified domain of valid values. RUG–ADL item 02 is deemed to be missing (ie, 9). | Report |
| NOCC060007 | RUG–ADL item 03 is not valid. | Recorded value is not within the specified domain of valid values. RUG–ADL item 03 is deemed to be missing (ie, 9). | Report |
| NOCC060008 | RUG–ADL item 04 is not valid. | Recorded value is not within the specified domain of valid values. RUG–ADL item 04 is deemed to be missing (ie, 9). | Report |
| NOCC070001 | Collection occasion identifier in HoNOSCA record is not valid. | Recorded value is not among the set of Collection occasion identifiers found within the set of records of Collection Occasion Details, or is blank. | Reject record |
| NOCC070002 | Collection occasion identifier in HoNOSCA record is a duplicate of the Collection occasion identifier of a preceding HoNOSCA record. | Duplicate records of HoNOSCA are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC070003 | HoNOSCA version is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC070004 | HoNOSCA collection status is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA collection status is deemed to be missing (ie, 9). | Report |
| NOCC070005 | HoNOSCA item 01 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 01 is deemed to be missing (ie, 7). | Report |
| NOCC070006 | HoNOSCA item 02 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 02 is deemed to be missing (ie, 7). | Report |
| NOCC070007 | HoNOSCA item 03 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 03 is deemed to be missing (ie, 7). | Report |
| NOCC070008 | HoNOSCA item 04 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 04 is deemed to be missing (ie, 7). | Report |
| NOCC070009 | HoNOSCA item 05 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 05 is deemed to be missing (ie, 7). | Report |
| NOCC070010 | HoNOSCA item 06 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 06 is deemed to be missing (ie, 7). | Report |
| NOCC070011 | HoNOSCA item 07 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 07 is deemed to be missing (ie, 7). | Report |
| NOCC070012 | HoNOSCA item 08 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 08 is deemed to be missing (ie, 7). | Report |
| NOCC070013 | HoNOSCA item 09 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 09 is deemed to be missing (ie, Z). | Report |
| NOCC070014 | HoNOSCA item 10 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 10 is deemed to be missing (ie, 7). | Report |
| NOCC070015 | HoNOSCA item 11 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 11 is deemed to be missing (ie, 7). | Report |
| NOCC070016 | HoNOSCA item 12 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 12 is deemed to be missing (ie, 7). | Report |

| Code | Description | Details | Action |
|---|---|---|---|
| NOCC070017 | HoNOSCA item 13 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 13 is deemed to be missing (ie, 7). | Report |
| NOCC070018 | HoNOSCA item 14 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 14 is deemed to be missing (ie, 7). | Report |
| NOCC070019 | HoNOSCA item 15 is not valid. | Recorded value is not within the specified domain of valid values. HoNOSCA item 15 is deemed to be missing (ie, 7). | Report |
| NOCC080001 | Collection occasion identifier in CGAS record is not valid. | Recorded value is not among the set of Collection occasion identifiers found within the set of records of Collection Occasion Details, or is blank. | Reject record |
| NOCC080002 | Collection occasion identifier in CGAS record is a duplicate of the Collection occasion identifier of a preceding CGAS record. | Duplicate records of CGAS are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC080003 | CGAS version is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC080004 | CGAS collection status is not valid. | Recorded value is not within the specified domain of valid values. CGAS collection status is deemed to be missing (ie, 9). | Report |
| NOCC080005 | CGAS rating is not valid. | Recorded value is not within the specified domain of valid values. CGAS rating is deemed to be missing (ie, 999). | Report |
| NOCC090001 | Collection occasion identifier in FIHS record is not valid. | Recorded value is not among the set of Collection occasion identifiers found within the set of records of Collection Occasion Details, or is blank. | Reject record |
| NOCC090002 | Collection occasion identifier in FIHS record is a duplicate of the Collection occasion identifier of a preceding FIHS record. | Duplicate records of FIHS are rejected. Only the first record is accepted. The report should include the record number of the accepted first instance and the rejected subsequent instance. | Reject record |
| NOCC090003 | FIHS version is not valid. | Recorded value is not within the specified domain of valid values. | Reject record |
| NOCC090004 | FIHS collection status is not valid. | Recorded value is not within the specified domain of valid values. FIHS collection status is deemed to be missing (ie, 9). | Report |
| NOCC090005 | FIHS item 01 is not valid. | Recorded value is not within the specified domain of valid values. FIHS item 01 is deemed to be missing (ie, 9). | Report |
| NOCC090006 | FIHS item 02 is not valid. | Recorded value is not within the specified domain of valid values. FIHS item 02 is deemed to be missing (ie, 9). | Report |
| NOCC090007 | FIHS item 03 is not valid. | Recorded value is not within the specified domain of valid values. FIHS item 03 is deemed to be missing (ie, 9). | Report |
| NOCC090008 | FIHS item 04 is not valid. | Recorded value is not within the specified domain of valid values. FIHS item 04 is deemed to be missing (ie, 9). | Report |
| NOCC090009 | FIHS item 05 is not valid. | Recorded value is not within the specified domain of valid values. FIHS item 05 is deemed to be missing (ie, 9). | Report |
| NOCC090010 | FIHS item 06 is not valid. | Recorded value is not within the specified domain of valid values. FIHS item 06 is deemed to be missing (ie, 9). | Report |
| NOCC090011 | FIHS item 07 is not valid. | Recorded value is not within the specified domain of valid values. FIHS item 07 is deemed to be missing (ie, 9). | Report |

# 10. Mental Health Provider Entity Reference File

10.1 In addition to the NOCC data files specified in section 8, States and Territories should submit to the Commonwealth Mental Health & Special Programs Branch a supplementary Mental Health Provider Entity Reference File. This is a simple file outlining the code domain used in each component of the composite data element *Mental Health Provider Entity*.

10.2 The file may be presented as 3 tables that provide details of the entities reported under each of the fields *Region, Mental Health Service Organisation and Service Unit.* The details required in each table are shown below.

**Table 19: Region details**

| Region Code | Region Name |
|---|---|
| A1 | (text description of common name used to refer to the region) |
| A2 | |
| etc | |

**Table 20: Mental Health Service Organisation details**

| Organisation Number | Organisation Name | National Health Data Dictionary Establishment identifier (if applicable) |
|---|---|---|
| 01 | (text description of common name used to refer to the organisation) | (NHDD Establishment identifier - if there is a 1:1 relationship. Otherwise – not applicable) |
| 02 | | |
| etc | | |

**Table 21: Service Unit details**

| Service Unit Identifier | Service Unit Name | Service Type | National Health Data Dictionary Establishment identifier (if applicable) |
|---|---|---|---|
| 0001 | (text description of common name used to refer to the service unit) | Code as per Mental Health Service Setting i.e. 1= Inpatient, 2 = Community Residential; 3 = Ambulatory | (NHDD Establishment identifier. Mandatory if Service Type = Inpatient. For Ambulatory, provide code if there is a 1:1 relationship with the Establishment Identifier used in reporting the NMDS – Community Mental Health Care. |
| 0002 | | | |
| etc | | | |

10.3 Details of the format of the Mental Health Provider Entity Reference File will be negotiated individually with each State and Territory.

# APPENDIX 1 Data Dictionary

## Defined Data Elements and Concepts

## Active Care {concept}

*Definition:* "A person is defined as being under 'active community care' at any point in time when:

- they have not been discharged from care AND
- some services (either direct to or on behalf of the consumer) have been provided over the previous 3 months AND
- a future appointment has been made to see the person within the next 3 months.

Thus, where no future services are planned in the next 3 months, the person is not considered to be an 'active case'

*AIHW Knowledgebase ID:* -

## Admission to Mental Health Care {concept}

*Definition:* Refers to the beginning of an inpatient, ambulatory or community residential *Episode of Mental Health Care*. For the purposes of the NOCC protocol, episodes may start for a number of reasons. These include, for example, a new referral to community care, admission to an inpatient unit, transfer of care from an inpatient unit to a community team and so forth. Regardless of the reason, admission to a new episode should act as the 'trigger' for a specific set of data to be collected.

*AIHW Knowledgebase ID:* -

*(*Note: *Admission* is defined under AIHW KB item 000007 as the 'the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.')

## Admission Date

*Definition:* The date on which the *Episode of Mental Health Care* is deemed to have commenced within the specified *Mental Health Service Setting*. In inpatient and community residential settings this is the actual or statistical date of admission. In ambulatory settings this is the date on which the *Episode of Mental Health Care* within that setting was initiated, as defined under the standard NOCC protocol. It may or may not be equivalent to the original date of 'entry to care' within the ambulatory service.

*Domain:* Any valid date expressed as dd/mm/ccyy.
09/09/9999 Not stated / Missing

*Comment:* Note that this data element is derived from the *Collection Occasion Date* and is not specifically required under NOCC reporting arrangements.

*Field:* AdmnDt (Date [8] formatted in extract as CCYYMMDD)

*AIHW Knowledgebase ID:* -

(Note: *Admission date* is defined under AIHW KB item 000008 as the 'Date on which an admitted patient commences an episode of care.')

## Age Group

Definition: The *Age Group* to which the patient or client has been assigned for the purposes of the data collection protocol. Generally, throughout mental health services, **Adults** are defined as persons between the age of 18 and 64 years inclusive, **Older people** are defined as persons aged 65 years and older and **Children and adolescents** are defined as persons under the age of 18 years. States and Territories will be responsible for determining whether *Age Group* (and thus the clinical measures to be used) is determined on the basis of the actual age, condition and care needs of the consumer or deemed on the basis of the type of service providing the treatment and care, or a mixture of both.

*Domain:*
1 Child or adolescent (0–17)
2 Adult (18–64)
3 Older person (65+)

*Comment:* In some circumstances a person may be legitimately assigned to a different *Age group* to that in which they would assigned on the basis of their actual age. For example, a person aged 60 years who was being cared for in an inpatient psychogeriatric unit may be assigned to the Older person's *Age group*.

*Field:* AgeGrp (Char [1])
*AIHW Knowledgebase ID:* -

## CGAS Collection Status

*Definition:* See the specification under *Collection Status {generic data element}*.
*Domain:* See the specification under *Collection Status {generic data element}*.
*Comment:*
*Field:* CgasCS (Char [1])
*AIHW Knowledgebase ID:* -

## CGAS Rating

*Definition:* Rating on the Children's Global Assessment Scale.
*Domain:*

| | |
|---|---|
| 1 – 10 | Needs constant supervision |
| 11 – 20 | Needs considerable supervision |
| 21 – 30 | Unable to function in almost all areas |
| 31 – 40 | Major impairment of functioning in several areas and unable to function in one of these areas |
| 41 – 50 | Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area |
| 51 – 60 | Variable functioning with sporadic difficulties or symptoms in several but not all social areas |
| 61 – 70 | Some difficulty in a single area but generally functioning pretty well |
| 71 – 80 | No more than slight impairments in functioning |
| 81 – 90 | Good functioning in all areas |
| 91 – 100 | Superior functioning |
| 997 | Unable to rate |
| 998 | Not applicable (collection not required due to protocol exclusion) |
| 999 | Not stated / Missing |

*Comments:*
*Field:* Cgas (Number [3])
*AIHW Knowledgebase ID:* -

## CGAS Version

*Definition:* The version of the CGAS completed.
*Domain:*

| | |
|---|---|
| 01 | Version as described in Schaffer D, Gould MS, Brasic J, et al (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231. |

*Comment:*
*Field:CgasVer* (Char [2])
*AIHW Knowledgebase ID:* -

## Collection Occasion Date

*Definition:* The reference date for all data collected at any given *Collection Occasion,* defined as the date on which the *Collection Occasion (Admission, Review, Discharge)* occurred.
*Domain:* Any valid date expressed as dd/mm/ccyy
09/09/9999 Not stated / Missing
*Comment:* The *Collection Occasion Date* should be distinguished from the actual date of completion of individual measures that are required at the specific occasion. In practice, the various measures may be completed by clinicians and consumers over several days. For example, at *Review* during ambulatory care, the client's case manager might complete the HoNOS and LSP during the clinical case review on the scheduled date, but in order to include their client's responses to the consumer self-report measure, they would most likely have asked the client to complete the measure at their last contact with them. For national reporting and statistical purposes, a single date is required which ties all the standardised measures and other data items together in a single *Collection Occasion*. The actual collection dates of the individual data items and standard measures may be collected locally but is not required in the national reporting extract.
*Field:* ColDt (Date [8] formatted in extract as CCYYMMDD)

*AIHW Knowledgebase ID:* -

## Collection Occasion {concept}

*Definition:* A *Collection Occasion* is defined as an occasion during an *Episode of Mental Health Care* when the required dataset is to be collected in accordance with a standard protocol. The broad rule is that collection of data is required at both episode start and episode end. Three *Collection Occasions* within an *Episode of Mental Health Care* are identified: *Admission*, *Review*, and *Discharge*.
*Comment:* See also *Reason for Collection*
*AIHW Knowledgebase ID:* -

## Collection Status {generic data element}

*Definition:* The status of the data recorded and, if missing data is recorded, the reason for the non–completion of the measure.
*Domain:*
1 Complete or Partially complete
2 Not completed due to temporary contraindication (applies only to self–report measures)
4 Not completed due to general exclusion (applies only to self–report measures)
5 Not completed due to refusal by patient or client (applies only to self–report measures)
7 Not completed for reasons not elsewhere classified
8 Not completed due to protocol exclusion (e.g. Collection not required at admission immediately following inpatient discharge)
9 Not stated / Missing
*Instances:* HoNOS Collection Status,
HoNOSCA Collection Status,
CGAS Collection Status,
FIHS Collection Status,
Adult Consumer self-rating Collection Status,
LSP Collection Status,
RUGADL Collection Status.
*Field:* See the specification given for each instance.
*AIHW Knowledgebase ID:* -

## Data File Generation Date

*Definition:* The date on which the current file was created.
*Domain:* Any valid date. Identification of this date is mandatory in the NOCC extract file.
*Field:* GenDt (Date [8] formatted in extract as CCYYMMDD)
*Relevant AIHW Knowledgebase ID:* -

## Data File Type

*Definition:* A constant value inserted in the file header record to indicate that the file contains NOCC data.
*Domain:* NOCC
*Comment:* This indicator is included so that even if the file is renamed in such a way that its purpose is obscured, the nature of its contents can still be determined through simple visual examination of the first record in the file.
*Field:* FileType (Char [4])
*AIHW Knowledgebase ID:* -

## Date of Birth

*Definition:* The consumer's date of birth.
*Domain:* Any valid date expressed as dd/mm/ccyy.
09/09/9999 Not stated / Missing
*Field:* DoB (Date [8] formatted in extract as CCYYMMDD)
*AIHW Knowledgebase ID:* 000036

## Discharge from Mental Health Care {concept}

*Definition:* Refers to the end of an inpatient, ambulatory or community residential *Episode of Mental Health Care*. As per *Admission*, for the purposes of the NOCC protocol episodes may end for a number of reasons such as discharge from an inpatient unit, case closure of a consumer's community care, admission to hospital of a consumer previously under community care. Regardless of the reason, the end of an episode acts as a 'trigger' for a specific set of clinical data to be collected

*AIHW Knowledgebase ID:* -

*(*Note: *Separation* is a related concept defined under AIHW KB item 000148 as the 'the process by which an episode of care for an admitted patient ceases'. A separation may be formal or statistical.')

## Discharge Date

*Definition:* The date on which the *Episode of Mental Health Care* is deemed to have ended within the specified *Mental Health Service Setting*. In inpatient and community residential settings this is the actual or statistical date of separation. In ambulatory settings this is the date on which the *Episode of Mental Health Care* within that setting ceased, as defined under the standard NOCC protocol. It may or may not be equivalent to the actual date of case closure by the ambulatory service

*Domain:* Any valid date expressed as dd/mm/ccyy.
01/01/9999 Episode not yet ended
09/09/9999 Not stated / Missing

*Comment:* Note that this data element is derived from the *Collection Occasion Date*

*Field:* DschDt (Date [8] formatted in extract as CCYYMMDD)

*AIHW Knowledgebase ID:* -

(Note: *Separation date* is defined under AIHW KB item 000043 as the 'Date on which an admitted patient completes an episode of care.')

## Episode of Mental Health Care {concept}

*Definition:* An *Episode of Mental Health Care* is defined as a more or less continuous period of contact between a consumer and a *Mental Health Service Organisation* that occurs within the one *Mental Health Service Setting.* The episode begins when the person is admitted into care within the given setting and ends when he/she is discharged from care within that setting. An episode also ends if the person is transferred into care in a different service setting. By definition, a person may only be the subject of one such *Episode of Mental Health Care* at any given time while under the care of a given *Mental Health Service Organisation.* Note that this formal concept of an episode should not be confused with the clinical concept of an episode of care

*AIHW Knowledgebase ID:* -

(Note: *Episode of Care* is defined under AIHW KB item 000445 as the 'The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.')

## Episode of Mental Health Care Type {concept}

*Definition:* The type of *Episode of Mental Health Care*. Three broad episode types are identified which are based on the *Mental Health Service Setting* – Inpatient, Community Residential and Ambulatory.

- *Inpatient episode (Overnight admitted)* – refers to the period of care provided to a consumer who is admitted for overnight care to a designated psychiatric inpatient service.
- *Community Residential episode* – refers to the period of care provided to a consumer who is admitted for overnight care to a designated 24-hour community-based residential service.
- *Ambulatory episode* – refers to all other types of care provided to consumers of a designated mental health service.

*AIHW Knowledgebase ID:* -

(Note: *Care Type* is defined under AIHW KB item 000168 as the 'The care type defines the overall nature of a clinical service provided to an admitted patient during an episode of

care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care)'. The domain includes Acute care; Rehabilitation care; Palliative care; Geriatric evaluation and management ; Psychogeriatric care ; Maintenance care; Newborn care; Other admitted patient care; Organ procurement - posthumous; Hospital boarder.)

## FIHS Collection Status

*Definition:* See the specification under *Collection Status {generic data element}*.
*Domain:* See the specification under *Collection Status {generic data element}*.
*Field:* FihsCS (Char [1])
*AIHW Knowledgebase ID:* -

## FIHS Item 1

*Definition:* Maltreatment syndromes.
*Domain:*
1 Yes, the person had one or more of these factors influencing their health status
2 No, none of these factors were present
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion)
9 Not stated / Missing
*Comment:* Includes: Neglect or abandonment; Physical abuse; Sexual abuse; Psychological abuse.
*Field:* Fihs1 (Number [1])
*AIHW Knowledgebase ID:* -

## FIHS Item 2

*Definition:* Problems related to negative life events in childhood.
*Domain:* See the domain of *FIHS Item 1* above.
*Comment:* Includes: Loss of love relationship in childhood; Removal from home in childhood; Altered pattern of family relationships in childhood; Problems related to alleged sexual abuse of child by person within primary support group; Problems related to alleged sexual abuse of child by person outside primary support group; Problems related to alleged physical abuse of child; Personal frightening experience in childhood; Other negative life events in childhood.
*Field:* Fihs2 (Number [1])
*AIHW Knowledgebase ID:* -

## FIHS Item 3

*Definition:* Problems related to upbringing.
*Domain:* See the domain of *FIHS Item 1* above.
*Comment:* Includes: Inadequate parental supervision and control; Parental overprotection; Institutional upbringing; Hostility towards and scapegoating of child; Emotional neglect of child; Other problems related to neglect in upbringing; Inappropriate parental pressure and other abnormal qualities of upbringing; Other specified problems related to upbringing.
*Field:* Fihs3 (Number [1])
*AIHW Knowledgebase ID:* -

## FIHS item 4

*Definition:* Problems related to primary support group, including family circumstances.
*Domain:* See the domain of *FIHS Item 1* above.
*Comment:* Includes: Problems in relationship with spouse or partner; Problems in relationship with parents and in-laws; Inadequate family support; Absence of family member; Disappearance or death of family member; Disruption of family by separation and divorce; Dependant relative needing care at home; Other stressful life events affecting family and household; Other problems related to primary support group.
*Field:* Fihs4 (Number [1])
*AIHW Knowledgebase ID:* -

## FIHS Item 5

*Definition:* Problems related to social environment.
*Domain:* See the domain of *FIHS Item 1* above.
*Comment:* Includes: Problems of adjustment to lifecycle transitions; Atypical parenting situation; Living alone; Acculturation difficulty; Social exclusion and rejection; Target of perceived adverse discrimination and rejection.
*Field:* Fihs5 (Number [1])
*AIHW Knowledgebase ID:* -

## FIHS item 6

*Definition:* Problems related to certain psychosocial circumstances.
*Domain:* See the domain of *FIHS Item 1* above.
*Comment:* Includes: Problems related to unwanted pregnancy; Problems related to multiparity; Seeking or accepting physical, nutritional or chemical interventions known to be hazardous or harmful; Seeking or accepting behavioural or psychological interventions known to be hazardous or harmful; Discord with counsellors.
*Field:* Fihs6 (Number [1])
*AIHW Knowledgebase ID:* -

## FIHS Item 7

*Definition:* Problems related to other psychosocial circumstances.
*Domain:* See the domain of *FIHS Item 1* above.
*Comment:* Includes: Conviction in civil and criminal proceedings without imprisonment; Imprisonment or other incarceration; Problems related to release from prison; Problems related to other legal circumstances; Victim of crime or terrorism; Exposure to disaster, war or other hostilities.
*Field:* Fihs7 (Number [1])
*AIHW Knowledgebase ID:* -

## FIHS Version

*Definition:* The version of the FIHS completed.
*Domain:*
01 Version as described in Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*. Canberra: Commonwealth Department of Health and Family Services

*Comment:*
*Field:* *FihsVer* (Char [2])
*AIHW Knowledgebase ID:* -

## Focus of Care

*Definition:* The focus of care identifies the principal clinical intent of the care provided during the period of care preceding the collection occasion.
*Domain:*
1 Acute
The focus of care is on the immediate reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of psychiatric disorder. Interventions are focused on symptom reduction with a reasonable expectation of substantial improvement in the short-term.
2 Functional Gain
The focus of care is the improvement of personal, social or occupational functioning or the promotion of psychosocial adaptation in a patient with impairment arising from psychiatric disorder. Interventions are focused on disability and the promotion of personal recovery, with an expectation of substantial improvement over the short to medium term. At this stage the person will generally have a relatively stable pattern of clinical symptoms, with treatment being focused on the prevention of any relapse of the illness.
3 Intensive Extended
The focus of care is on the prevention or minimisation of further deterioration and the reduction of risk of harm (to self or others) in a patient who has a stable pattern

of severe symptoms, frequent relapses, and/or a severe inability to function independently, and is judged to require care over an indefinite period.

4 Maintenance
Care provided over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

8 Not applicable (collection not required due to protocol exclusion)

9 Not stated / Missing

*Field:* FoC (Char [1])
*AIHW Knowledgebase ID:* -

## HoNOS Collection Status

*Definition:* The Collection status of the HoNOS (or HoNOS 65+), whichever was required by the protocol. See the specification under *Collection Status {generic data element}*.
*Domain:* See the specification under *Collection Status {generic data element}*.
*Field:* HnosCS (Char [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 01

*Definition:* Overactive, aggressive, disruptive or agitated behaviour.
*Domain:*

0 No problem within the period rated
1 Minor problem requiring no formal action
2 Mild problem. Should be recorded in a care plan or other case record
3 Problem of moderate severity
4 Severe to very severe problem
7 Not stated / Missing
8 Collection not required due to protocol exclusion
9 Unable to rate because not known or not applicable to the consumer

*Comments:*
*Field:* Hnos01 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 02

*Definition:* Non–accidental self–injury.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos02 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 03

*Definition:* Problem drinking or drug–taking.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos03 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 04

*Definition:* Cognitive problems.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos04 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 05

*Definition:* Physical illness or disability problems.
*Domain:* See the domain of *HoNOS item 1* above.

*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos05 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 06

*Definition:* Problems associated with hallucinations and delusions.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos06 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 07

*Definition:* Problems with depressed mood.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos07 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 08

*Definition:* Other mental and behavioural problems.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos08 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 08a

*Definition:* The type or kind of problem rated in Item 8.
*Domain:*

| | |
|---|---|
| A | Phobias – including fear of leaving home, crowds, public places, travelling, social phobias and specific phobias |
| B | Anxiety and panics |
| C | Obsessional and compulsive problems |
| D | Reactions to severely stressful events and traumas |
| E | Dissociative ('conversion') problems |
| F | Somatisation – Persisting physical complaints in spite of full investigation and reassurance that no disease is present |
| G | Sleep problems |
| H | Problems with appetite, over– or undereating |
| I | Sexual problems |
| J | Problems not specified elsewhere: an expansive or elated mood, for example. |
| X | Not applicable (Item 8 rated 0, 7, or 8) |
| Z | Not stated / Missing |

*Field:* Hnos8a (Char [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 09

*Definition:* Problems with relationships.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos09 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 10

*Definition:* Problems with activities of daily living.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos10 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 11

*Definition:* Problems with living conditions.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos11 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Item 12

*Definition:* Problems with occupation and activities.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOS item 1* above.
*Field:* Hnos12 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOS Version

*Definition:* The version of the HoNOS completed.
*Domain:*
A1 General adult version as described in Wing J, Curtis R, Beevor A (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432–434.
G1 HoNOS 65+ as described in Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). *British Journal of Psychiatry*, 174, 424-427.
*Comment:*
*Field:* *HnosVer* (Char [2])
*AIHW Knowledgebase ID:* -

## HoNOSCA Collection Status

*Definition:* See the specification under *Collection Status {generic data element}*.
*Domain:* See the specification under *Collection Status {generic data element}. }*.
*Field:* HnosCCS (Char [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 01

*Definition:* Disruptive, antisocial, or aggressive behaviour.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* When rating the HoNOSCA clinicians should refer to the appropriate entry in the glossary (rather than simply basing their ratings on the brief scale descriptors.
*Field:* HnosC01 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 02

*Definition:* Problems with overactivity, attention or concentration.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC02 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 03

*Definition:* Non-accidental self-injury.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC03 (Number [1])

## HoNOSCA Item 04

*Definition:* Alcohol, substance or solvent misuse.
*Domain:* See the domain of *HoNOS item 1* above.

*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC04 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 05

*Definition:* Problems with scholastic or language skills.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC05 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 06

*Definition:* Physical illness or disability problems.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC06 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 07

*Definition:* Problems associated with hallucinations, delusions, or abnormal perceptions.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC07 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 08

*Definition:* Problems with non-organic somatic symptoms.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC08 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 09

*Definition:* Problems with emotional and related symptoms.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC09 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 10

*Definition:* Problems with peer relationships.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC10 (Number [1])

## HoNOSCA Item 11

*Definition:* Problems with self-care and independence.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC11 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 12

*Definition:* Problems with family life and relationships.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.

*Field:* HnosC12 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 13

*Definition:* Poor school attendance.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC13 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 14

*Definition:* Problems with lack of knowledge or understanding about the nature of the child or adolescent's difficulties.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC14 (Number [1])
*AIHW Knowledgebase ID:* -

## HoNOSCA Item 15

*Definition:* Problems with lack of information about services or management of the child or adolescent's difficulties.
*Domain:* See the domain of *HoNOS item 1* above.
*Comments:* See the comments under *HoNOSCA item 1* above.
*Field:* HnosC15 (Number [1])
*Comments:* Items 14 and 15 are excluded from the calculation of the Total Score because they describe the patient or client's parent's knowledge about the person's problems and the services available rather than aspects of the child or adolescent's problems.
*Field:* HnosCT13 (Number [2])
*AIHW Knowledgebase ID:* -

## HoNOSCA Version

*Definition:* The version of the HoNOSCA completed.
*Domain:*
01 Gowers S, Harrington R, Whitton A, Beevor A, Lelliott P, Jezzard R, Wing J (1999b) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433.

*Comment:*
*Field:* *HnosCVer* (Char [2])
*AIHW Knowledgebase ID:* -

## LSP-16 Collection Status

*Definition:* See the specification under *Collection Status {generic data element}*.
*Domain:* See the specification under *Collection Status {generic data element}*.
*Field:* LspCS (Char [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 01

*Definition:* Does this person generally have any difficulty with initiating and responding to conversation.
*Domain:*
0 No difficulty with conversation
1 Slight difficulty with conversation
2 Moderate difficulty with conversation
3 Extreme difficulty with conversation
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Comment:* The order of coding of domain for each LSP-16 item shows increasing levels of disability with increasing scores. No disability is coded as 0 whilst the most severe level of disability is coded as 3. This scoring is consistent with the scoring used by the other clinician–rated measures. However, the original 39 item version of the LSP employed the reverse of this convention, with high levels of disability being coded 0.
*Field:* Lsp01 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 02

*Definition:* Does this person generally withdraw from social contact.
*Domain:*
0 Does not withdraw at all
1 Withdraws slightly
2 Withdraws moderately
3 Withdraws totally or near totally
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing
*Field:* Lsp03 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 03

*Definition:* Does this person generally show warmth to others.
*Domain:*
0 Considerable warmth
1 Moderate warmth
2 Slight warmth
3 No warmth at all
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing
*Field:* Lsp04 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 04

*Definition:* Is this person generally well groomed (e.g., neatly dressed, hair combed).
*Domain:* 0 Well groomed
*Domain:*
0 Well groomed
1 Moderately well groomed
2 Poorly groomed
3 Extremely poorly groomed
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing
*Field:* Lsp05 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 05

*Definition:* Does this person wear clean clothes generally, or ensure that they are cleaned if dirty.
*Domain:*
0 Maintains cleanliness of clothes
1 Moderate cleanliness of clothes
2 Poor cleanliness of clothes
3 Very poor cleanliness of clothes
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field:* Lsp06 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 06

*Definition:* Does this person generally neglect their physical health.
*Domain:*
0 No neglect
1 Slight neglect of physical problems
2 Moderate neglect of physical problems
3 Extreme neglect of physical problems
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing
*Field:* Lsp07 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 07

*Definition:* Is this person violent to others.
*Domain:*
0 Not at all
1 Rarely
2 Occasionally
3 Often
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing
*Versions:* Appears as item 7 in the LSP-16
*Field:* Lsp08 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 08

*Definition*: Does this person generally make and/or keep up friendships.
*Domain:*
0 Friendships made or kept well
1 Friendships made or kept with slight difficulty
2 Friendships made or kept with considerable difficulty
3 No friendships made or none kept
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing
*Field:* Lsp09 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 09

*Definition:* Does this person generally maintain an adequate diet.
*Domain:*
0 No problem
1 Slight problem
2 Moderate problem
3 Extreme problem
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing
*Field:* Lsp09 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 10

*Definition:* Does this person generally look after and take their own prescribed medication (or attend for prescribed injections) on time.

*Domain:*
0 Reliable with medication
1 Slightly unreliable
2 Moderately unreliable
3 Extremely unreliable
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field Name:* Lsp10

*AIHW Knowledgebase ID:* -

## LSP-16 Item 11

*Definition:* Is the person willing to take psychiatric medication when prescribed by a doctor.

*Domain:*
0 Always
1 Usually
2 Rarely
3 Never
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field:* Lsp11 (Number [1])

*AIHW Knowledgebase ID:* -

## LSP-16 Item 12

*Definition:* Does this person co-operate with health services (e.g., doctors and/or other health workers).

*Domain:*
0 Always
1 Usually
2 Rarely
3 Never
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field:* Lsp12 (Number [1])

*AIHW Knowledgebase ID:* -

## LSP-16 Item 13

*Definition:* Does this person generally have problems (e.g., friction, avoidance) living with others in the household.

*Domain:*
0 No obvious problem
1 Slight problems
2 Moderate problems
3 Extreme problems
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field:* Lsp13 (Number [1])

## LSP-16 Item 14

*Definition:* Does this person behave offensively (includes sexual behaviour).

*Domain:*
0 Not at all
1 Rarely

2 Occasionally
3 Often
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field:* Lsp14 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 15

*Definition:* Does this person behave irresponsibly.
*Domain:*
0 Not at all
1 Rarely
2 Occasionally
3 Often
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field:* Lsp15 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Item 16

*Definition:* What sort of work is this person capable of (even if unemployed, retired or doing unpaid domestic duties).
*Domain:*
0 Capable of full-time work
1 Capable of part-time work
2 Capable of sheltered work
3 Totally incapable of work
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion or item not included in the version collected)
9 Not stated / Missing

*Field:* Lsp16 (Number [1])
*AIHW Knowledgebase ID:* -

## LSP-16 Version

*Definition:* The version of the LSP-16 completed.
*Domain:*
01 Version as described in Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*. Canberra: Commonwealth Department of Health and Family Services.

*Comment:*
*Field:* *Lsp16Ver* (Char [2])
*AIHW Knowledgebase ID:* -

## Mental Health Consumer {concept}

*Definition:* The terms consumer and patient are used interchangeably in the NOCC specification and refer to a person for whom a *Mental Health Service Organisation* accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record.
*Comment:*
*AIHW Knowledgebase ID:* -

## Mental Health Legal Status

*Definition:* An indication that the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the *Period of Care* preceding the *Collection Occasion*.
*Domain:*
1 Person was an involuntary patient for all or part of the period of care

2 Person was not an involuntary patient at any time during the period of care
8 Not applicable (collection not required due to protocol exclusion)
9 Not stated / Missing

*Field:* Invlntry (Char [1])

## Mental Health Service Setting

*Definition:* The setting within which the *Episode of Mental Health Care* takes place, as defined by the specified domain.

*Domain:*

1 Psychiatric inpatient service

Refers to public psychiatric hospitals and designated psychiatric units in public acute hospitals. Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Designated psychiatric units in a public acute hospital are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. For the purposes of NOCC specification, care provided by Ambulatory mental health service team to a person admitted to a community general hospital for treatment of a mental or behavioural disorder is also included under this setting.

2 Community residential mental health service

Refers to residential units staffed on a 24-hour basis by health professionals with specialist mental health qualifications or training and established in a community setting which provides specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Psychogeriatric hostels and psychogeriatric nursing homes are included in this category.

3 Ambulatory mental health service

Refers to non-admitted, non-residential services provided by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include community-based crisis assessment and treatment teams, day programs, psychiatric outpatient clinics provided by either hospital or community-based services, child and adolescent outpatient and community teams, social and living skills programs, psychogeriatric assessment services and so forth. For the purposes of NOCC specification, care provided by hospital-based consultation-liaison services to admitted patients in non-psychiatric and hospital emergency settings is also included under this setting.

Special Notes:

a. This item will be used to derive the type of *Episode of Mental Health Care* provided to the consumer.
b. A single *Mental Health Provider Entity* may provide care in all three settings. For example, a psychiatric hospital may provide group programs tailored for people living in the community who attend on a regular basis, or run a community nursing outreach service that visits people in the homes. It is essential that these programs be differentiated when reporting the *Mental Health Service Setting* that is providing the episode of care, even though all programs may share the same *Mental Health Provider Entity Identifier*. For example, in the above scenario, where a consumer who is not currently an overnight admitted patient attends the hospital-based group program, the *Mental Health Service Setting* should be recorded as Ambulatory mental health service, **not** Psychiatric inpatient service.
c. Where a person might be considered as receiving concurrently two or more episodes of mental health care by virtue of being treated in more than one setting simultaneously the following order of precedence applies: Inpatient, Community Residential, Ambulatory

*Field:* MhSrvSet (Char [1])
*AIHW Knowledgebase ID:* -

## Mental Health Service Organisation {concept}

*Definition:* The concept of a *Mental Health Service Organisation* refers to a separately constituted health care organisation that is responsible for the clinical governance, administration and financial management of the *Service Unit* in which the *Episode of Mental Health Care* is provided. A *Mental Health Service Organisation* may consist of one or more *Service Units* based in different locations and providing services in inpatient, community residential and ambulatory settings. For example, a *Mental Health Service Organisation* may consist of several hospitals or two or more community centres, each of which is a separate 'bricks and mortar' facility.

Where the *Mental Health Service Organisation* consists of multiple *Service Units*, those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and
- share medical records or, in the case where is more than one physical medical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

For most jurisdictions, the *Mental Health Service Organisation* concept is equivalent to the Area/District Mental Health Service. These are usually organised to provide the full range of inpatient, community residential and ambulatory services to a given catchment population. However, the concept may also be used to refer to health care organisations which provide only one type of mental health service (e.g., acute inpatient care) or which serve a specialised or statewide function.

Note that *Mental Health Service Organisation* is not equivalent to the concept of Health Establishment as defined in the National Health Data Dictionary. For example, multiple health care providers classified as individual Health Establishments may make up a single *Mental Health Service Organisation.*

Recognising the variation that exists between jurisdictions in the way in which mental health services are organised, each State and Territory has discretion in how the concept is translated for NOCC reporting purposes with a view to further developing the concept in future years.

*Comment*: *Mental Health Service Provider Organisation* is a critical concept in the NOCC reporting arrangements as it is a key field used to uniquely identify each *Episode of Mental Health* care for each consumer. While an individual may receive services from multiple *Service Units* concurrently, they a may only be considered as being in one episode at any given point of time. Where a patient is being treated by the organisation in two settings simultaneously the following order of precedence applies: Inpatient, Community Residential, Ambulatory.

*AIHW Knowledgebase ID:* -

## Mental Health Service Organisation Number

*Definition:* The identifier for the *Mental Health Service Organisation* which is responsible for providing the current *Episode of Mental Health* care in which the *Collection Occasion* occurs. Each *Mental Health Service Organisation* to have a unique identifier at the State or Territory level.

*Domain:* Domain values to be specified by individual States and Territories

*Comment:* Is a component of the composite element *Mental Health Provider Entity Identifier*

*Field:* MHSON (Char [3])

*AIHW Knowledgebase ID:* -

## Mental Health Provider Entity Identifier

*Definition:* A composite data element that concatenates the data elements *State, Region Code, Mental Health Service Organisation Number* and *Service Unit Identifier*. The composite identifier should be unique at the national level..

*Domain:* Concatenation of:
N - State identifier
AA - Region code
NNN - Mental Health Service Organisation Number
NNNN - Service Unit identifier
*Comment:*
*Field:* MHPEI (Char [10])
*AIHW Knowledgebase ID:* -

## NOCC Reporting Specification Version

*Definition:* The version of the National Outcomes and Casemix Collection (NOCC) reporting specification under which the data has been collected and submitted.
*Domain:* 010 Version 1.0
*Comment:*
*Field:* NSpecVer (Char [3])
*AIHW Knowledgebase ID:* -

## Period of Care {concept}

*Definition:* The period bound by one *Collection Occasion* and another and immediately preceding the current *Collection Occasion.*
*Comment:*
*AIHW Knowledgebase ID:* -

## Person Identifier

Definition: Person identifier unique within the *Mental Health Service Organisation*.
*Domain:* Any valid identifier as defined by the *Mental Health Service Organisation.*
*Comment:*
*Field:* PID (Char [20])
*AIHW Knowledgebase ID:* 000127

## Principal and Additional Diagnoses

*Definition:* The Principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the patient or client's care during the *Period of Care* preceding the *Collection Occasion*. Additional diagnoses identify secondary diagnoses that affected the person's care during the period in terms of requiring therapeutic intervention, clinical evaluation, extended management, or increased care or monitoring.
*Domain:* ICD-10-AM.
Although any ICD-10-AM diagnosis may be identified, a subset of diagnoses which should cover most cases is identified below. This subset is based on the ICD–PC (the Primary Care version of Chapter V of ICD–10) with some additional ICD–10–AM codes.
*Comments:* The National Centre for Classification and Coding in Health has developed simplified ICD-10-AM Mental Health Subset for use in community-based mental health service settings that describes diagnoses at the 3 digit level. Services may use this subset as the basis for coding.
Note that the *Principal* and *Additional Diagnoses* must not be confused with the patient or client's current clinical diagnoses or with the reasons for contact with respect to any given Service contact. Also note that definition given here is conceptually consistent but not identical with that given in the NHDD. The NHDD definition refers to the preceding Episode of care. In episodes of acute inpatient care, the Episode of care and the Period of care will almost always refer to the same interval. In extended episodes of care, the reference interval is different.
*Field:* Dx1, Dx2, Dx3 (Char [8] formatted as ANNNNNN)
*AIHW Knowledgebase ID:* 000136

## Reason for Collection

*Definition:* The reason for the collection of the standardised measures and individual data items on the identified *Collection Occasion*.
*Domain:*

| | |
|---|---|
| 01. New referral | Admission to a new inpatient, community residential or ambulatory *Episode of Mental Health Care* of a consumer not currently under the active care of the *Mental Health Service Organisation.* |
| 02. Admitted from other treatment setting | Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the active care of the *Mental Health Service Organisation*. |
| 03. Admission - Other | Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above. |
| 04. 3-month (91 day) review | Standard review conducted at 91 days following admission to the current *Episode of Mental Health Care* or 91 days subsequent to the preceding *Review.* |
| 05. Review – Other | Standard review conducted for reasons other than the above. |
| 06. No further care | Discharge from an inpatient, community residential or ambulatory episode of care of a consumer for whom no further care is planned by the *Mental Health Service Organisation*. |
| 07. Discharge to change of treatment setting | Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the care of the *Mental Health Service Organisation*. |
| 08. Death | Completion of an *Episode of Mental Health Care* following the death of the consumer. |
| 09. Discharge - Other | Discharge from an inpatient, community residential or ambulatory *Episode of Mental Health Care* for any reason other than defined above. |

*Field:* CollRsn (Char [2])
*AIHW Knowledgebase ID:* -

## Record Type

*Definition:* A code indicating the type of each record included in an NOCC data file.
*Domain:*

| | |
|---|---|
| HR | File Header Record |
| COD | Collection Occasion Details |
| OCDI | Other Clinical Data items |
| HONOS | HoNOS or HoNOS65+ |
| LSP16 | LSP–16 |
| RUGADL | RUG–ADL |
| HONOSCA | HoNOSCA |
| CGAS | CGAS |
| FIHS | FIHS |
| MHI38 | MHI (Standard 38 item version) (Consumer Self–Rated Measure) |
| BASIS32 | BASIS (Standard 32 item version) (Consumer Self–Rated Measure) |
| K10LM | K–10–LM (Last Month version of the K–10 proposed for use in NSW) (Consumer Self–Rated Measure) |
| K10L3D | K–10–L3D (Last 3 Days version of the K–10 proposed for use in NSW) (Consumer Self–Rated Measure) |
| ZZZZZZZZ | File Terminator Record |

*Comment:*
*Field:* RecTyp (Char [8])
*AIHW Knowledgebase ID:* -

## Record Count

*Definition:* The exact number of records in the file including the file header record and the file terminator record.
*Domain:* Integer values between 2 and 99,999,999.

*Comment:* This data is used in initial validation of the file contents. Disagreement between the recorded Record count and the actual number records in the file indicate serious corruption of the file.
*Field:* RecCount (Number [8])
*AIHW Knowledgebase ID:* -

## Region Code

*Definition:* An identifier to describe the location in which the *Service Unit* is located in an area.
*Domain:* Domain values to be specified by individual States and Territories.
*Comment:* Is a component of the composite element *Mental Health Service Organisation Identifier*
*Field:* Reg (Char [2])
*AIHW Knowledgebase ID:* 000378

## Report Period End Date

*Definition:* The date of the finish of the period to which the data included in the current file refers.
*Domain:* Any valid date. Identification of this date is mandatory.
*Field:* RepEnd (Char [8] formatted in extract as CCYYMMDD)
*AIHW Knowledgebase ID:* -

## Report Period Start Date

*Definition:* The date of the start of the period to which the data included in the current file refers.
*Domain:* Any valid date. Identification of this date is mandatory.
*Field:* RepStart (Char [8] formatted in extract as CCYYMMDD)
*AIHW Knowledgebase ID:* -

## Review of Mental Health Care {concept}

*Definition:* Refers to a *Collection Occasion* occurring within an *Episode of Mental Health Care.* A review may be a standard 3-month (91 day) review occurring at the point at which the consumer has been under 13 weeks of continuous care since Admission to the episode, or 13 weeks has passed since the last review was conducted during the current episode, or an ad hoc review.
*AIHW Knowledgebase ID:* -

## RUGADL Collection Status

*Definition:* See the specification under *Collection status {generic data element}*.
*Domain:* See the specification under *Collection status {generic data element}*.
*Field:* RugAdlCS (Char [1])
*AIHW Knowledgebase ID:* -

## RUGADL Item 1

*Definition:* Bed Mobility: Ability to move in bed after the transfer into bed has been completed.
*Domain:*
1 Independent or supervision only
3 Limited physical assistance
4 Other than 2 – person physical assistance
5 2 – person physical assistance
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion)
9 Not stated / Missing
Not that a rating of 2 is not included in the domain of valid ratings.
*Comments:*
*Field:* RugAdl1 (Number [1])
*AIHW Knowledgebase ID:* -

## RUGADL Item 2

*Definition:* Toileting: Includes mobilising to the toilet, adjustment of clothing before and after toileting, and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes.

*Domain:* See the domain of *RUGADL item 1* above.
*Comments:* See the comments under *RUGADL item 1* above.
*Field:* RugAdl2 (Number [1])
*AIHW Knowledgebase ID:* -

## RUGADL Item 3

*Definition:* Transfer: Includes the transfer in and out of bed, bed to chair, in and out of shower or tub.
*Domain:* See the domain of *RUGADL item 1* above.
*Comments:* See the comments under *RUGADL item 1* above.
*Field:* RugAdl3 (Number [1])
*AIHW Knowledgebase ID:* -

## RUGADL Item 4

*Definition:* Eating: Includes the tasks of cutting food, bringing food to the mouth and the chewing and swallowing of food. Does not include preparation of the meal.
*Domain:*
1 Independent or supervision only
2 Limited assistance
3 Extensive assistance / Total dependence / Tube fed
7 Unable to rate (insufficient information)
8 Not applicable (collection not required due to protocol exclusion)
9 Not stated / Missing

Ratings of 4 and 5 are not included in the domain of valid ratings.
*Comments:* See the comments under *RUGADL item 1* above.
*Field:* RugAdl4 (Number [1])
*AIHW Knowledgebase ID:* -

## RUGADL Version

*Definition:* The version of the RUGADL completed.
*Domain:*
01 The version described in Fries BE, Schneider DP, et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). *Medical Care*, 32, 668-685.

*Comment:*
*Field:* *RugAdlVer* (Char [2])
*AIHW Knowledgebase ID:* -

## Service Unit {concept}

*Definition:* A *Service Unit* is defined as a discrete service provider unit within the *Mental Health Service Organisation*. Each hospital and community residential facility within the organisation should be identified as separate *Service Units.* Community-based ambulatory services provided by the organisation – whether organised into separate teams, specific programs or located at multiple sites – may be clustered and reported as a single unit or regarded as individual *Service Units* in their own right.

Note: Ideally, where a mental health facility provides mixed services (e.g., overnight inpatient care as well as ambulatory care), each component will be defined as a separate *Service Unit* and assigned a unique *Service Unit Identifier.*

## Service Unit Identifier

*Definition:* The unique identifier for the *Service Unit* of the *Mental Health Service Organisation* primarily responsible for providing the treatment and care during the *Episode of Mental Health Care.*
*Domain:* Domain values to be specified by individual States and Territories

**Note**: Where the *Service Unit* is a hospital or community residential service, the *Service Unit Identifier* should be the Establishment Number used by the State or Territory to identify the unit in the National Minimum Data Set -Admitted Patient Mental Health

Care.[26] States should therefore ensure that the *Service Unit identifiers* used for ambulatory care services do not overlap with the range assigned to hospital and community residential units reporting to the NMDS.

*Comment:* The *Service Unit Identifier* reported at each *Collection Occasion* is a component of the composite element *Mental Health Service Provider Entity Identifier*.

- Where the collection occurs in the context of an inpatient episode, the Service unit identifier reported should be the code assigned to the hospital to which the patient is currently admitted.
- Where the collection occurs in the context of a community residential episode, the Service unit identifier reported should be the code assigned to the community residential facility to which the patient is currently admitted.
- Where the collection occurs in the context of an ambulatory episode, the Service unit identifier reported should be the code used to refer to the ambulatory care service unit which is primarily responsible for provision of treatment and care during the episode.

*Field:* ServUn (Char [4])
*AIHW Knowledgebase ID:* -

## Sex

*Definition:* The sex of the person.
*Domain:*
1 Male
2 Female
3 Indeterminate
9 Not stated / Missing
*Field:* Sex (Char [1])
*AIHW Knowledgebase ID:* 000149

## State Identifier

*Definition:* An identifier indicating the State or Territory responsible for the collection and submission of the NOCC data file.
*Domain:*
1 New South Wales
2 Victoria
3 Queensland
4 South Australia
5 Western Australia
6 Tasmania
7 Northern Territory
8 Australian Capital Territory
*Field:* State (Char [1])
*AIHW Knowledgebase ID:* 000380

[26] Establishment Number is one of three elements that make up the Establishment Identifier used to identify all admitted patient records within the National Minimum Data Set -Admitted Patient Mental Health Care. The format and layout of Establishment Identifier is represented in the National Health Data Dictionary as NNANNN where N = State Identifier, N = Establishment Sector, A = Region Code and NNN = Establishment Number.

# APPENDIX 2 Relationship between National Outcomes and Casemix Collection and National Minimum Data Sets for Mental Health

The data collected under the arrangements of the Mental Health Information Development Plans is designed to supplement the patient-level data of the National Minimum Data Sets – Mental Health Care reported by States and Territories. These comprise two separate collections, described below, each of which is provided directly by jurisdictions to the Commonwealth and the AIHW.

Both the NOCC dataset and the NMDS collections essentially cover the same health events – the treatment and care of persons provided by public sector specialised mental health services. The NMDS collection captures a range of sociodemographic, service-related and clinical data for each episode. The NOCC collection is more explicitly clinically focused and collects information about the nature of the disorders experienced by consumers of mental health services and the outcomes of care. Minimal overlap exists between the NOCC and NMDS collections and where it does occur, is necessary for record identification purposes or because definitions of data domains vary.

A brief description of the two patient-level collections that form the National Minimum Data Sets – Mental Health Care is provided below.

**National Minimum Data Set – Admitted Patient Mental Health Care**

This collection represents a subset of the broader NMDS – Admitted Patient Health Care which is collected annually for all hospital separations and compiled as electronic records. Each record contains the agreed set of data that make up the NMDS – Admitted Patient Health Care comprising demographics and diagnosis data, data on procedures undertaken, length of stay and the AR-DRG classification for each hospital separation.

The scope of this NMDS - Admitted Patient Mental Health Care is restricted to admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. Patients receiving specialised psychiatric care are identified through the field *Psychiatric Care Days* which indicates the number of days they spent within a specialised psychiatric hospital, unit or ward. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

The mental health subset adds 9 items to the broader NMDS – Admitted Patient Care. Data elements that make up the NMDS – Admitted Patient Mental Health Care are shown Table 22.

**Table 22: Data elements included in the NMDS – Admitted Patient Mental Health Care[27]**

- **IDENTIFIERS**
  - Establishment identifier (made up of)
    - *State identifier*
    - *Establishment sector*
    - *Region code*
    - *Establishment number*
  - Person Identifier
- **SOCIODEMOGRAPHIC ITEMS**
  - Sex
  - Date of birth
  - Country of birth
  - Indigenous status
  - Marital status *
  - Employment status *
  - Area of usual residence
  - Pension status *
  - Type of usual accommodation *
- **SERVICE AND ADMINISTRATIVE ITEMS**
  - Care type (previously Type of episode of care)
  - Previous specialised treatment
  - Admission date
  - Separation date
  - Total leave days
  - Mode of admission (previously Source of referral to acute hospitals or private psychiatric hospital) *
  - Mode of separation
  - Source of referral to public psychiatric hospital *
  - Referral to further care *
  - Total psychiatric care days *
  - Mental health legal status *
- **CLINICAL ITEMS**
  - Principal diagnosis
  - Additional diagnosis
  - Diagnostic Related Group
  - Major Diagnostic Category
  - Intended length of hospital stay

* Indicates items specific to specialised mental health care

[27] Source: National Health Data Dictionary, Version 10, Australian Institute of Health and Welfare, Canberra, July 2001

## National Minimum Data Set – Community Mental Health Care

This collection represents a set of data elements collected at each service contact in ambulatory mental health care. The scope of the collection covers all specialised mental health dedicated to the assessment, treatment or care of non-admitted patients. community settings. The scope includes:[28]

- only ambulatory public community mental health establishments;
- both adult and adolescent and child community mental health services; and
- non-admitted services in hospitals such as specialised psychiatric outpatient services.

The scope excludes:

- admitted patient mental health services;
- support services that are not specialised mental health care services; and
- services provided by non-government organisations and residential services.

Data elements that make up the NMDS – Community Mental Health Care are shown in Table 23.

**Table 23: Data elements included in the NMDS – Community Mental Health Care[29]**

- Establishment identifier (made up of)
  - *State identifier*
  - *Establishment sector*
  - *Region code*
  - *Establishment number*
- Person Identifier
- Sex
- Date of birth
- Country of birth
- Indigenous status
- Area of usual residence
- Marital status
- Mental health legal status
- Principal diagnosis
- Service contact date

[28] Source: Mental Health Services in Australia 1999-2000. AIHW (final pre-publication draft), February 2002

[29] Source: National Health Data Dictionary, Version 10, Australian Institute of Health and Welfare, Canberra, July 2001

# APPENDIX 3 Priority Future Development Issues

In preparing version 1 of this specification, the drafting group was aware that a range of issues remain unresolved and specific areas require further development. As indicated earlier, future revisions of the NOCC reporting specification are anticipated, based on day-to-day experience in the use of the various clinical measures. The specification will be reviewed annually and all revisions will be developed collaboratively between the Commonwealth and the States and Territories

Much of the input to future development will come from day-to-experience in using the measures and the protocol governing their collection. Experience from the technical side of system development will also inform future revisions, along with review of the national data and formal research studies of the measurement instruments themselves. Development will also be guided by the needs of States and Territories and the views of expert groups established to advise on overall implementation and development issues.

This Appendix provides an indicative outline of the issues likely to receive priority focus in future years.

### 1. Outcome Measures for Child and Adolescent populations

Standard outcome measures recommended in the *National Priorities* document were confined to adults although the casemix development module outlined the requirement to begin collection of several measures by child & adolescent services (HoNOSCA, CGAS, FIHS, Principal and Additional Diagnosis and Mental Health Legal Status). Further development of outcome measures specific to child/adolescent populations was foreshadowed to occur in subsequent years.

The first steps commenced in May 2001 when an ad hoc group of child and adolescent clinicians met to review available measures. The group recommended use of the HoNOS and CGAS as outcomes measures which was subsequently accepted by the AMHAC Mental Health Working Group. In addition, the group recommended the Strengths and Difficulties Questionnaire (SDQ) for consideration as a self-report tool. The SDQ, developed by Goodman et al in the United Kingdom, is a brief behavioural screening questionnaire about 3-16 year olds and is presented in several versions to meet the needs of researchers, clinicians and educationalists. The basic version comprises a 25 item scale measure.[30]

The SDQ has been excluded from Version 1 of the NOCC protocol but is anticipated to be included in the future subject to national agreement on the version(s) to be used and the collection protocol. Individual jurisdictions may chose however to introduce at an earlier stage.[31]

The ad hoc group has more recently been formally constituted as the National Child and Adolescent Outcomes Expert Group which will develop formal recommendations to the

[30] See http://www.sdqinfo.com for details of the SDQ.

[31] For example, New South Wales has incorporated the SDQ in its standard measures for collection by child/adolescent services.

AHMAC National Mental Health Working Group on implementation and further development of routine outcome measures in child and adolescent services.

**2. Outcome Measures for Older persons**

Similar issues apply here. Version 1 of the NOCC dataset includes several measures specific to older people (HoNOS65+, RUGADL in inpatient episodes) while also extending the basic adult reporting requirements to people aged over 65 years. These arrangements have been agreed to by the AMHAC Mental Health Working Group. Additional issues specific to the measurement of outcomes of older people who are consumers of mental health services, and casemix classification development for this client group, will be considered within the advisory structures and as part of the review of data planned to be conducted to support the basic NOCC initiative.

**3. Outcome Measures for Forensic Psychiatry Services**

As noted in section 5.3, special issues arise in relation to Forensic Psychiatry Services which may cover all age groups and require additional measures to assessing outcomes. Future national developments in mental health outcome measures will consider options for the introducing supplementary measures for Forensic Psychiatry Services. As a first step, Victoria is undertaking a national project under its IDP funding to investigate the appropriateness of the existing adult suite of outcome measures for this sector, the need for any supplementary measures and, to devise appropriate implementation protocols and training resources. The project will:

- evaluate the appropriateness of outcome measures to be implemented across adult mental health services for application in the forensic context;
- determine the need for supplementary measures;
- recommend implementation protocols for outcome measures in forensic mental health services with a focus on issues of scope, in particular:
  - when should supplementary measures apply should they be needed?
  - should a forensic suite of measures have application to all forensic clients including those receiving treatment within the mainstream adult mental health system?
- develop training resources specific to the forensic mental health context; and
- inform the introduction of outcome measurement into forensic mental health services across all jurisdictions and to facilitate the adoption of a uniform national approach.

The results of the Victorian project will provide the basis for future decisions regarding possible refinements of the standard measures to meet the needs of Forensic Psychiatry services.

**4. Cultural issues in the use of outcome measures**

Little work has been completed in the formal evaluation of the appropriateness of the standard instruments in the measurement of consumer outcomes for people from different cultures. The most pressing issue concerns the appropriateness of the standard suite of instruments for indigenous consumers of mental health services. Under the IDP funding arrangements, the Northern Territory will undertake a preliminary project to gather data on

the use of the standard measures with Aboriginal and Torres Strait Islander consumers. Results from the project are expected to be available in 2003 and will inform the next steps. Consultation within national expert committees will consider the results of the Northern Territory project as well as advise on broader directions for improving the capacity of measures to assess the outcomes of mental health consumers from culturally and linguistically diverse backgrounds.

### 5. Consumer self-rated measures of outcome

Version 1 of the NOCC requirements allows each State and Territory to select its own consumer self-rated measure of outcome rather than there being a uniform measure adopted by all jurisdictions. The flexibility offered to States and Territories recognises that the various 'candidate' instruments have different strengths and that further research and consultation is required prior to setting a particular measure as the national standard.

As at 31 May 2002, six jurisdictions had selected a measure for routine use, these are listed below.

**Table 24: State and Territory selected adult consumer self rated measures**

| State/Territory | Consumer Self Rated Outcome Measure |
|---|---|
| Victoria | BASIS 32 |
| NSW | K10 |
| Tasmania | to be decided |
| ACT | BASIS 32 |
| NT | K10 |
| SA | to be decided |
| WA | MHI |
| Queensland | MHI |

As a part of its IDP funding, Victoria will undertake a comparative analysis of existing consumer self rating measures in use across the different jurisdictions including BASIS 32, MHI, K10, and SF36 with a view to developing a national uniform approach to the use of a consumer self report instrument. Additionally, the project will make clear recommendations in relation to the most suitable existing measures and the possible development of a new Australian self report measure.

### 6. Further development of the episode model for community episodes (Assessment only, Consultation-Liaison and Shared Care)

As noted in section 7.3, considerable complexity exists in applying the NOCC protocol to ambulatory mental health care. Two key issues require guidelines for clinicians as to what, if any, data should be collected.

- How to deal with 'assessment only' episodes where the person may only be seen for assessment and then referred elsewhere or is deemed not to require services.

- How to deal with the different patterns of care that are apparent in community mental health services, where the agency may be the only service provider for the consumer or

may share service provision with another provider through shared care or consultation-liaison modalities.

There is broad agreement across jurisdictions that collection of outcomes data is not appropriate or practical in these circumstances although clearly the work needs to be recognised in any casemix model developed to describe the work of mental health services. Ideally, the concept of 'model of care' is incorporated in all recording systems to enable the various service types to be distinguished. However, there is inconsistency across the jurisdictions in recording practices and most information systems do not have the capacity to introduce the model of care concept at this stage. Adoption of a national approach has therefore been deferred for future development (post 2003) due to the significant system implications.

Appendix 4 further outlines the issues to be addressed in developing a more sophisticated episode model that recognises the diversity of services included under 'ambulatory mental health care'.

## 7. Resolving differences in definitions used under NMDS and NOCC

Definitions developed for the purposes of the NOCC protocol elaborate concepts and data elements not currently covered by the National Health Data Dictionary as well as providing alternative definitions for items where current definitions do not provide an adequate basis for development in mental health services. Future work is required to both incorporate definitions of new items and concepts which prove to be sufficiently robust and reconcile differences between the NHDD and the alternative NOCC definitions. Changes along these lines will be negotiated under the processes and structures of the National Health Information Agreement.

# APPENDIX 4 Future development of the Episode Model for Ambulatory Mental Health Care

*A key issue unresolved in the NOCC protocol is 'Are all ambulatory episodes 'in scope' for outcomes and casemix reporting?'. In preparing this Version 1, it was clear that broad agreement existed across jurisdictions that collection of outcomes data is not appropriate or practical in a number of circumstances, particularly for people seen for 'assessment only' and services provided to people on a shared care or consultation-liaison basis. Incorporation of these concepts within the episode model underpinning the protocol was however deferred for future years (post 2003), recognising that there will be significant system implications for all jurisdictions.*

*The text that follows present the discussion notes used by States and Territories in considering the issue. They are replicated here both for convenience and to keep the issue 'on notice' in the preparation of future versions of the protocol.*

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The definition of ambulatory care is all embracing. This raises the issue of whether it is appropriate to identify a subset of ambulatory care episodes which should be deemed out of scope for outcomes and casemix reporting requirements. Two groups need to be considered.

## *Assessment only episodes*

These concern situations where the person is seen only for assessment and is then referred elsewhere (i.e. external to the Mental Health Service Organisation), or is assessed as not currently requiring further ambulatory care services. Good practice suggests that all such cases be 'registered' or recorded in some way if the assessment is 'significant' and involves face-to-face contact. However, it is inappropriate to expect that such cases be subject to the full outcomes and casemix collection (e.g. the concept of episode end/discharge is inapplicable). Analysis of available data suggests that 'assessment only' cases are significant in volume and comprise up to 20% of individuals seen by the 'average' community mental health team, and up to 40% for some teams such as crisis services. Clarifying the exclusion of this group is an important point to promote clinician acceptance of the overall NOCC initiative.

There is an additional reason to distinguish these cases from those consumers who are assessed and accepted for treatment and care. To do otherwise would confound the analysis of outcomes and casemix data by confusing individuals who receive 'partial services' from those receiving full treatment services. 'Assessment only' cases are best considered to be a separate product of mental health services. They need to be 'counted' but excluded from the more demanding data reporting aspects.

The outcomes assessment protocol developed by Victoria explicitly excludes such cases from data collection but the issue is not addressed in the NSW specification nor featured in the collections designed by other jurisdictions. Note that the need to specify the business rules for 'assessment only' cases is equally important to the data provided by States and Territories

under the National Minimum Data Set - Community Mental Health Care but specific rules have not been established at this stage.

A possible definition is offered by work currently being undertaken in New Zealand in a major casemix and outcomes project based on the Australian MH-CASC study.[32]

> *"Assessment only episodes refer to episodes of mental health care where the person was seen on a face-to-face basis in the community for a maximum of two occasions only for assessment and the outcome of the assessment was:*
>
> - *The person was admitted to a psychiatric inpatient unit;*
>
> *OR*
>
> - *No further intervention by this health care agency was planned;*
>
> *OR*
>
> - *For child and adolescent clients only, the person is placed on a waiting list and no further appointment is scheduled within the next 3 months.*

Note:

- The requirement for face-to-face contact assists in clarifying the reporting requirements in relation to the telephone-based triage and referral work of mental health agencies. This work becomes out of scope for outcomes and casemix purposes.

- The 2-session rule is designed as a sensible threshold, based on consultations with clinicians. However, it could be modified subject to acceptance of the overall concept.

- The 'waiting list' rule for child/adolescent reflects the styles of practice in those services where consumers are seen, assessed as requiring further care, and placed in a virtual queue as a means to manage demand.

- If Assessment Only is accepted as a necessary data element, it would need to be collected at the Admission Collection occasion.

- Resolving that 'assessment only' episodes are excluded from outcome and casemix reporting requirements does not imply that they are also exempt from the basic occasion of service reporting requirements under the National Minimum Data Set - Community Mental Health Care. This would be counterproductive. Occasion of service data are essential to future analysis of level of service provision direct to the assessment and triage functions of mental health provider agencies.

- A decision on acceptance of this item needs to separated from deciding an implementation timetable. Given that it may not be possible for most jurisdictions to implement now, it may be practical to propose in principal agreement to collect post June 2003. Earlier adoption by some jurisdictions could be optional.

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[32] Gaines P, Bower A & Buckingham W. *Mental Health Classification and Outcomes Study: Study Resource Manual*. Health Research Council of New Zealand: Auckland, 2001

## *Consultation-liaison and Shared Care episodes*

Questions about the inclusion/exclusion of each of these 'models of care' are frequent when information collection requirements are discussed with clinicians. Each causes difficulty in interpreting how the collection and reporting protocol might apply.

A 'model of care' data item is required to distinguish these cases and is being trialed in the New Zealand national study, with the following domain:

- *Direct care – where the mental health agency is the primary mental health provider for the consumer and delivers care in the inpatient setting, the community setting or both.*
- *Shared care - in which the mental health agency works with other care providers (usually the patient's General Practitioner) and the care is shared on a formal basis between the various agencies or providers.*
- *Consultation/liaison - where the consumer remains under the clinical care of another provider (typically a general practitioner in the community setting, or a specialist physician in a general hospital setting) and a specialist mental health provider provides consultation and liaison services such as a 'second opinion' or advice on a particular problem such as medication management or psychological treatment. Like Shared Care, in consultation/liaison models a provider other than the mental health service is the primary provider of the mental health care.*

Distinguishing these different models is necessary to provide a coherent set of rules to clinicians about which consumers are 'in scope' for outcomes and casemix data. Early considerations that drove the Information Development Plan were focused on Direct Care service delivery, and gave little attention to the applicability of the collection to the newer shared care and consultation- liaison models. Practicalities suggest that it is not appropriate to impose a cycle of regular outcomes and casemix reporting for cases seen only through shared care or consultation-liaison arrangements.

A recognition of these various models of care is fundamental to understanding differences in the outcomes, quality and cost of different services. Like 'assessment only' cases, both shared care and consultation/liaison models have significant capacity to confound the interpretation of outcome and casemix data. Patients with similar levels of need will appear to be receiving different levels of service depending on whether they are participating in a shared care scheme. Such understanding is also required for the successful introduction of output-based funding models.

Proposal: Apply the same solution as 'assessment only' – i.e. Consultation/liaison and shared care cases to be 'counted' but excluded from outcomes and casemix reporting.

Note:

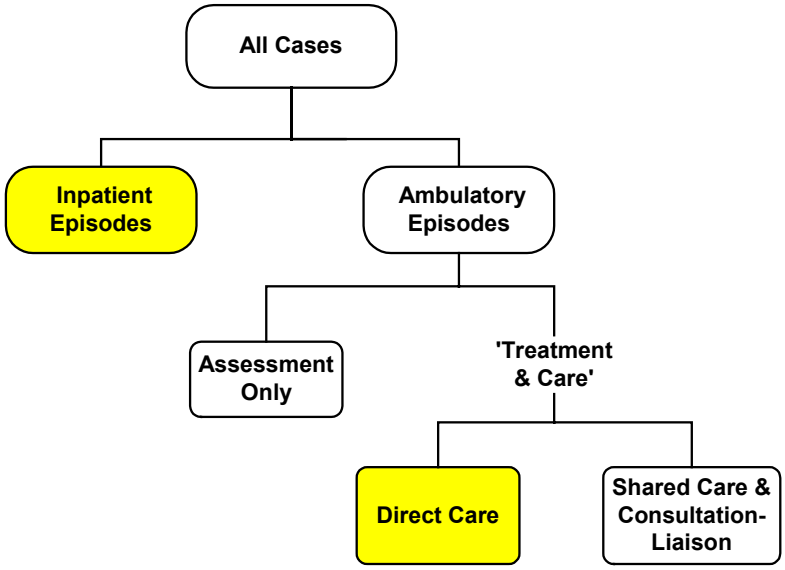
- If agreed, the data element 'Model of Care' would need to be introduced as a further splitting variable for ambulatory episodes.

- Model of Care would be required at all three Collection Occasions. While it is best based on retrospective judgement (i.e. at Review and Discharge), recording at admission would be necessary because it influences the subsequent reporting requirements.

- Exclusion from outcome and casemix reporting requirements does not imply exemption from occasion of service reporting requirements under the National Minimum Data Set - Community Mental Health Care. The same arrangement as per Assessment Only should apply.

## *Implications of 'Assessment Only' and 'Model of Care' for episode model*

Putting all this together implies that a more sophisticated model of episodes is required to recognise the reality of current mental health practices in Australia. A summary of the model that would underpin the protocol is shown below. Shaded boxes indicate those episode types subject to outcomes and casemix reporting requirements.




Summary of issues to be resolved in future versions of the NOCC protocol:

1. Should special provision be made to identify and exclude 'Assessment only' episodes? If so:

   - Is the proposed definition agreed?
   - When should this item be implemented?

2. Should special provision be made to identify and exclude Shared Care and Assessment Only Episodes through the introduction of the item 'Model of care'? If so:

   - Are the proposed definitions agreed?
   - When should this item be implemented?

# APPENDIX 5 Membership of Information Strategy Committee

| | |
|---|---|
| Dr Peggy Brown (Chair) | Director, Mental Health, Mental Health Unit<br>Queensland Health |
| Ms Lorna Payne (Deputy Chair) | Manager, Service Monitoring and Review, Mental Health Branch, Department of Human Services, Victoria |
| Ms Carolyn Muir | Principal Information Officer, Centre for Mental Health, NSW Health Department |
| Mr Terry Barker | Section Head, Mental Health, Social and Emotional Wellness Branch, Department of Health and Community Services, Northern Territory |
| Ms Ruth Catchpoole | Manager, Systems and Outcomes, Mental Health Unit, Queensland Health |
| Ms Danuta Pawelek | Director, Systems Development, Mental Health Division, Department of Health, Western Australia |
| Mr Mike Melino | Manager, Mental Health Unit, Department of Human Services, South Australia |
| Dr Graeme Vaughan | Manager, Mental Health Information and Evaluation Unit, Department of Health and Human Services, Tasmania |
| Mr Ian Bull | Manager, Health Informatics and Business Systems, Health Information Service, Department of Health, Housing and Community Care, ACT |
| Ms Jenny Hargreaves | Head, Patient Morbidity and Mental Health Services Unit, Australian Institute of Health and Welfare |
| Ms Marelle Rawson | Director, Health Section, Australian Bureau of Statistics |
| Ms Helen Connor | Consumer Representative, Mental Health Council of Australia |
| Ms Judy Hardy | Carer Representative, Mental Health Council of Australia |
| Ms Penny Taylor | Research Manager, Steering Committee for the Review of Commonwealth/State Service Provision (SCRCSSP), Productivity Commission |
| Mr Allen Morris-Yates | Principal Information Officer, National Secretariat, Strategic Planning Group for Private Psychiatric Services |
| Mr Mick O'Hara | Director, Quality and Effectiveness Section, Mental Health and Special Programs Branch,Commonwealth Department of Health and Ageing |
| Mr Bill Buckingham | Buckingham & Associates Pty Ltd, Consultant to Commonwealth Department of Health and Ageing |
| Ms Kim Walker (Technical Advisor to Chair) | Assistant Director, Quality and Effectiveness Section, Mental Health & Special Programs Branch, Commonwealth Department of Health and Ageing |
| Ms Janet Graney (Secretariat) | Quality and Effectiveness Section, Mental Health & Special Programs Branch, Commonwealth Department of Health and Ageing |
| Mr David Braddock (Observer) | Senior Analyst, Australian Institute of Health and Welfare |

# APPENDIX 6 Membership of Technical Drafting Group

| | |
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| Mr Michael O'Hara | Commonwealth Department of Health and Ageing |
| Ms Kim Walker | Commonwealth Department of Health and Ageing |
| Ms Carolyn Muir | New South Wales Health Department |
| Ms Lorna Payne | Victorian Department of Human Services |
| Ms Jenny Hargreaves | Australian Institute of Health & Welfare |
| Mr David Braddock | Australian Institute of Health & Welfare |
| Mr Bill Buckingham | Consultant to Commonwealth Department of Health and Ageing |
| Mr Allen Morris-Yates | Strategic Planning Group for Private Psychiatric Services |
| Ms Kristen Breed (secretariat) | Commonwealth Department of Health and Ageing |

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