Mental Health
Information Development

Mental Health National Outcomes and Casemix Collection

Technical specification of State and Territory reporting requirements

Version 2.0

ENDORSED BY THE MHISSC
March 2017

Prepared by the Australian Mental Health Outcomes and Classification Network for the Mental Health Information Strategy Standing Committee,
Mental Health, Drug and Alcohol Principal Committee,
Australian Health Ministers Advisory Council
July 2017
Document information

Title: Mental Health National Outcomes and Casemix Collection: Technical specification of State and Territory reporting requirements.

Version: 2.0

File: NOCC V2.0 Technical Specifications Main 20170717

Document history

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<th>Details</th>
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<td>Initial draft distributed to Drafting Group</td>
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<td>15/09/2003</td>
<td>Distributed to States and Territories for internal consultation and comment</td>
</tr>
<tr>
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<td>27/10/2003</td>
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<td>01/12/2003</td>
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<td>24/07/2008</td>
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<tr>
<td>1.6</td>
<td>08/08/2008</td>
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<td>20/02/2015</td>
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Acknowledgments

While this document is published under the authority of the Commonwealth, it was developed in collaboration with the States and Territories through the organisational arrangements for the implementation of the National Mental Health Strategy. The National Mental Health Information Strategy Standing Committee (MHISSC), a subcommittee of the Australian Health Ministers Advisory Council (AHMAC) Mental Health, Drug and Alcohol Principal Committee, served as the expert committee that provided guidance and advice with respect to the specification of the National Outcomes and Casemix Collection (NOCC).

Suggested citation for this document:

Previous version of the NOCC Technical Specifications:

Other related publications:

Comments on the document should be forwarded to:
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APPENDIX A: Record layouts

APPENDIX B: Defined data elements and concepts
1. **Background**

1.1. 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 of the 38 objectives outlined in the original 1992 National Mental Health Policy related specifically to outcomes, and stated that the Policy would:

- “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
- “encourage the development of national outcome standards for mental health services, and systems for assessing whether services are meeting these standards”.¹

1.2. These concepts were simple but ambitious in the context of the poor status of information in mental health services in the early 1990s. Most services did not routinely collect basic clinical and service delivery data nor have systems capable of timely analysis and reporting of such data to inform clinical care. Simple and reliable instruments for measuring consumer outcomes were not available at the commencement of the Strategy, nor was a set of candidate measures evident. Perhaps more significantly, there were few precedents to follow as no other country had established routine consumer outcome measures comprehensively across their publicly funded mental health services.

1.3. In response, a research and development program was initiated early in the Strategy to identify measures of outcome that were feasible for use in routine clinical practice with adult consumers, resulting in the selection of a small set of standard measures that were put to trial.²,³ Similar work was undertaken in relation to outcome measures for use in child and adolescent mental health services.⁴

1.4. Implementation of the selected measures in public sector mental health services commenced under the Second National Mental Health Plan (1998-2003). Recognising the complexity of the work required and its national significance, the Australian

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Government contributed substantial funding to assist States and Territories in implementing their plans and support a range of related quality and safety initiatives in specialist mental health care. This was made available through bilaterally negotiated ‘Information Development Agreements’, and later, ‘Quality Through Outcomes’ Agreements.

1.5. Implementation of the ‘simple concept’ articulated in 1992 has taken the mental health sector into a period of major industry re-development and involved all public mental health services. By June 2003, approximately 60% of Australian public mental health services had commenced the process of consumer outcome measurement and an estimated 10,000 clinicians had participated in training sessions for the collection and use of outcome information.

1.6. Since 2003, the work has advanced substantially. A national body has been established (the Australian Mental Health Outcomes and Classification Network) to support the initiative through a range of industry development activity, and national data analysis and reporting of the outcomes data. More widely, national mental health information development expert advisory panels have been set up to provide clinician, consumer and carer perspectives. Internationally, Australia is recognised as leading the field in the use of consumer outcome measures in mental health services.

1.7. Version 1 of the Mental Health National Outcomes and Casemix Collection (NOCC) specifications was released in August 2003, to guide States and Territories in the implementation of routine consumer outcomes measurement. Developed collaboratively between the jurisdictions, the NOCC specifications set the agreed ‘ground rules’ for how consumer outcomes should be collected locally and reported nationally. The document was later revised (version 1.5, released December 2003) to incorporate new measures for children and young people.

1.8. There have been five subsequent revisions (including the current revision):

- Version 1.60, released February 2009, and Version 1.70, released November 2013, were designed to: (i) align aspects of the NOCC collection with the National Minimum Data Sets for Mental Health Care that are also collected and reported nationally by all States and Territories; and (ii) remove inconsistencies, redundancies and errors in the earlier documentation.

- Version 1.80, released May 2015, and Version 1.90, released April 2016, were designed to: (i) incorporate changes to the collection of consumer-self report for Adults and Older Persons in inpatient settings; (ii) incorporate changes to clinician and consumer rated measures at discharge from ambulatory episodes; and (iii) incorporate new data elements (County of Birth, Indigenous Status & Area of Usual Residence) for the Collection Occasions Details Record. Several of these
changes were based upon recommendations arising from the *NOCC Strategic Directions 2014 – 2024 Final Report*, published October 2013, that were considered to make the collection more efficient and fit better with current clinical practice.

- The current revision (Version 2.0) has resulted from identification of the need to have closer alignment between the NOCC and the Australian Mental Health Care Classification, which was developed by the Independent Hospital Pricing Authority (IHPA) and is based upon the collection of the Mental Health Phase of Care (PoC). PoC was seen to be similar to the NOCC measure, Focus of Care (FoC). However FoC was a retrospective rating and PoC is a prospective rating. Given the broad collection of PoC for activity based finding purposes, the potential for confusion if both FoC and PoC were collected concurrently, and the limited uptake and use of the FoC, it was agreed that FoC would be removed from the NOCC suite of measures and PoC would be added as a data element.
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 Australian Government. The document provides details about the:

- *data content* of all items included in the Mental Health 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 Australian Government.

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. Whilst common issues continue to be faced by all States and Territories, solutions to many of those issues must address local requirements and system contexts. Accordingly, it is understood that all States and Territories will continue to develop and revise their local data collection protocols.

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 reporting arrangements. There have been many developments in the reporting of NOCC since the introduction several years ago of routine consumer outcomes data in specialised public mental health services in Australia. Readers are referred for further information to the national website (www.amhocn.org) managed by the Australian Mental Health Outcomes and Classification Network (AMHOCN).

2.4. The reporting requirements outlined in this document represent the agreed national minimum requirements and are not intended to limit the scope of data collections maintained by individual service agencies or States and Territories.
3. Overview of the clinical data to be collected


The specific clinical data to be collected depend on the type of *Episode of Mental Health Care* (inpatient, ambulatory, residential), the *Age Group* of the consumer, the *Episode 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 and consumer self-rated 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 compiled separately in a resource document. \(^5\)

This section provides an overview of each of the clinical and consumer self-rated measures and data items included in the Mental Health 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 consumer. 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.

**Key references**

*General adult version:*


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Older persons version:


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, prior to the introduction of the NOCC collection, was 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 Mental Health National Outcomes and Casemix Collection.

Key references

Original 39 item version of the LSP:


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

3.1.3. Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)

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 managing finances, social relationships, grooming)

6 The version listed here is recommended for use in Australia. A newer version (the HoNOS 65+ Version 3, Tabulated) is published on the UK Royal College of Psychiatrists website at http://www.rcpsych.ac.uk/cru/honoscales/honos65/ but is not recommended for use at this stage due to non-comparability with the general adult HoNOS.
are included in the LSP. The RUG-ADL is widely used in Australian nursing homes and other aged care residential settings. The RUG-ADL comprises 4 items only and is usually completed by nursing staff.

**Key reference**


### 3.1.4. Mental Health Phase of Care (PoC)

The Mental Health Phase of Care is a prospective description of the primary goal of care for a consumer at a point in time. While many factors can impact on the consumer’s mental health care plan, the mental health phase of care is intended to identify the primary goal of care by the treating professional(s) through engagement with the consumer.

**Key reference**


### 3.1.5. Consumer self-report outcome measure

While the original Information Priorities document released in 1999 proposed the national use of a specific self-report measure (the Mental Health Inventory – MHI), this was subsequently changed to allow States and Territories to introduce an ‘agreed’ alternative measure. This recognised that, at the time when the NOCC reporting arrangements were designed, limited Australian research had been undertaken on consumer rated measures to identify the most suitable measure for use routine use in service delivery.

Following consultations with consumers within their jurisdictions, States and Territories introduced one of the following:

- Mental Health Inventory (MHI-38);
- Behaviour and Symptoms Identification Scale (BASIS-32); or
- Kessler–10 Plus (K-10+).

Table 1 provides a summary of the consumer self-rated measure currently used with adult and older consumers within each of the States and Territories.
### Table 1: State and Territory selected adult consumer self-rated measures

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<tr>
<td>Tasmania</td>
<td>BASIS-32</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>BASIS 32</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>K10+</td>
</tr>
<tr>
<td>South Australia</td>
<td>K10+</td>
</tr>
<tr>
<td>Western Australia</td>
<td>K10+</td>
</tr>
<tr>
<td>Queensland</td>
<td>MHI-38</td>
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#### 3.1.5.1. Mental Health Inventory (MHI-38)

The Mental Health Inventory (MHI-38) was designed to measure general psychological distress and well-being in the RAND Health Insurance Experiment, a study designed to estimate the effects of different health care financing arrangements on the demand for services as well as on the health status of the patients in the study.

The full form contains 38 items. Each item includes a description of a particular symptom or state of mind. The MHI can be completed either as a self-report measure or as part of an interview.

**Key references**


#### 3.1.5.2. Behavior and Symptom Identification Scale (BASIS-32)

The Behavior and Symptom Identification Scale (BASIS-32) was developed in the early 1990’s by a team in the United States for use in outcome assessment. The BASIS-32 asks the consumer to respond to 32 questions that assess the extent to which the person has been experiencing difficulties on a range of dimensions.

**Key references**


3.1.5.3. **Kessler 10 Plus (K10+)**

Originally developed in 1992 by Kessler & Mroczek\(^7\) for use in the United States National Health Interview Survey, the K10 is a ten-item self-report questionnaire designed to yield a global measure of ‘non-specific psychological distress’ based on questions about the level of nervousness, agitation, psychological fatigue and depression in the relevant rating period.

The K10+ contains additional questions to assess functioning and related factors, and it is this instrument which is being used by four States and Territories (New South Wales, Western Australia, South Australia, Northern Territory) in the NOCC. Overall, the K10+ is an extremely brief symptoms and functioning measure, validated against diagnosis that is intended to be supplemented with additional measures of domains relevant to consumers.

**Key references**


**Note:** Additional resource material is being prepared by the Centre for Mental Health, New South Wales Health Department and will be made available to all States and Territories. See also [http://www.health.nsw.gov.au/policy/cmh/mhos](http://www.health.nsw.gov.au/policy/cmh/mhos)

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.

\(^7\) Kessler R, Mroczek D. *Final versions of our Non-Specific Psychological Distress Scale.* Ann Arbor MI: Survey Research Centre of the Institute for Social Research, University of Michigan, Memo dated March 10, 1994
Key references


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.

Key reference


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, originally developed for use in the MH-CASC project.

Key reference


3.2.4. Parent and Consumer self-report measure – the 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. It exists in several versions to meet the needs of researchers, clinicians and educationalists. General documentation of the SDQ is available on the website: www.sdqinfo.com.

Please note that the versions labelled ‘English (Austral)’ currently on the SDQ website are not the versions specified for use in Australia. The versions for use in Australia can be found in the document: Mental Health National Outcomes and Casemix Collection: Overview of clinician rated and consumer self-report measures, Version 1.50.
Key references


3.3. Other clinical data common to all consumer groups

3.3.1. Principal and Additional Diagnoses

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.

Both Principal Diagnosis and Additional Diagnosis are collected as part of the Admitted Patient Mental Health Care NMDS, and Principal Diagnosis (but not Additional Diagnosis) is included in the Community Mental Health Care NMDS. Nevertheless, both data items are incorporated in the NOCC because the NMDS definitions are not suitable for development of outcomes and casemix analysis. Specifically, the reporting under the Admitted Patient Mental Health Care NMDS is based on the total hospital episode, while the Community Mental Health Care NMDS requires the diagnosis at the point of each service contact.

Under the NOCC protocol, the diagnoses assigned to the consumer are based on the Period of Care preceding the Collection Occasion, that is, the interval between the current Collection Occasion and that immediately preceding it within the current Episode of Mental Health Care.

3.3.2. Mental Health Legal Status

This item is used to indicate whether 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.

Like the diagnosis items, Mental Health Legal Status is also collected under the National 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.

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.
### Table 2: Data to be collected and purpose of collection

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<td>Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)</td>
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<td>Life Skills Profile (LSP-16)</td>
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<td>Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL)</td>
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<td>Children’s Global Assessment Scale (CGAS)</td>
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<tr>
<td>Factors Influencing Health Status (FIHS)</td>
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<td>Other clinical data</td>
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<td>Mental Health Legal Status</td>
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<td>Principal and Additional diagnosis</td>
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<td>Phase of Care (PoC)</td>
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<td>Consumer self-report</td>
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</tbody>
</table>

**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.
4. **Scope of the NOCC collection**

Two features define the scope of the National Outcomes and Casemix Collection reporting requirements.

- They are designed to cover *specialised mental health services* managed by, or in receipt of funds from, State or Territory health authorities.
- Within specialised mental health services, the focus of the collection is on the activities of *Mental Health Service Organisations*.

Both of these features also define the scope of long established data collections on mental health services in Australia, being central to the current NMDS – Mental Health Establishments and its predecessor, the annual National Survey of Mental Health Services that was conducted between 1994 and 2005.

4.1. **The definition of specialised mental health services**

4.1.1. Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The concept of a specialised mental health service is not dependent on the inclusion of the service within the State or Territory mental health budget.

A service is not defined as a specialised mental health service solely because its clients include people affected by a mental illness or psychiatric disability. The definition excludes specialist drug and alcohol services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.

These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc).

4.1.2. Specialised mental health services include:

- Public psychiatric hospitals and designated psychiatric units in general hospitals;\(^9\)

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\(^9\) 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.
• Community-based residential services\(^\text{10}\); and
• Ambulatory care mental health services.

## 4.2. The definition of a Mental Health Service Organisation

### 4.2.1. Within specialised mental health services, the focus of the collection is on the activities of Mental Health Service Organisations. This concept was first defined in NOCC Version 1.0, and subsequently, formally recognised under the National Health Data Dictionary (as an object class with the METeOR identifier 286449) and used to guide all national mental health data collections.

### 4.2.2. For the purposes of the current specifications, the definition of a Mental Health Service Organisation is identical to that given under the NHDD. That definition is summarised below.

### 4.2.3. A Mental Health Service Organisation is a separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised mental health care.

### 4.2.4. A Mental Health Service Organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings. For example, a Mental Health Service Organisation may consist of several hospitals or two or more community centres.

### 4.2.5. 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 clinical records or, in the case where is more than one physical clinical 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.

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\(^\text{10}\) Aged care residential services (eg, psychogeriatric nursing homes) in receipt of funding under the Aged Care Act and subject to Australian Government reporting requirements (ie, report to the System for the Payment of Aged Residential Care (SPARC) collection) are considered to be ‘out of scope’ for reporting under NOCC on the condition that they are accredited or are formally engaged in a quality improvement process aimed at achieving accreditation under Aged Care standards.
4.2.6. For most States and Territories, the Mental Health Service Organisation is equivalent to the Area or District Mental Health Service. These are usually organised to provide the full range of admitted patient, residential and ambulatory services to a given catchment population. However, the term may also be used to refer to health care organisations which provide only one type of mental health service (e.g. acute admitted patient care) or which serve a specialised or state-wide function.

4.2.7. As noted in the next section, Mental Health Service 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.
5. Key concepts underpinning the NOCC protocol

Under the NOCC protocols the required data is collected at key Collection Occasions within an Episode of Mental Health Care provided by a Mental Health Service Organisation within a specific Episode Service Setting. The specific clinical measures and other data elements that should or may be collected at any given Collection Occasion are determined by the Episode Service Setting within which the occasion occurs, the Collection Age Group to which the patient or client has been assigned, and whether the Collection Occasion itself is defined as an Admission, a Review or a Discharge.

The key concepts: Episode of Mental Health Care; Episode Service Setting; Collection Occasion; Collection Age Group; and Mental Health Service Provider Entity are each discussed in detail below.

5.1. Episodes of Mental Health Care

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. In the original planning for introduction of NOCC, significant problems arose when translating this concept to community-based mental health services. No concept of episode had been agreed to quantify these types of services. There are several issues that make the definition of an episode in that setting particularly difficult. First, whilst the initiation of community–based mental health care is usually accompanied by formal well–defined processes, its termination often is more difficult to define, either clinically or administratively. Second, many patients undergo care over extended periods. Finally, multiple agencies or teams, working in either the same or different service settings, 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 NOCC specification, an Episode of Mental Health Care is defined as a more or less continuous period of contact between a
consumer\textsuperscript{11} and a \textit{Mental Health Service Organisation} that occurs within the one \textit{Episode Service Setting}.

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.

5.1.6. Three broad episode types are identified which are based on the Episode Service Setting – Psychiatric Inpatient, Community Residential and Ambulatory.

- \textit{Psychiatric Inpatient episodes (Overnight admitted)} – refers to the period of care provided to a consumer who is admitted for overnight care to a public sector specialised psychiatric inpatient service.

- \textit{Community Residential episodes} – refers to the period of care provided to a consumer who is admitted for overnight care to a public sector specialised community-based residential service.

- \textit{Ambulatory episodes} – refers to all other types of care provided to consumers of a public sector specialised community-based ambulatory mental health service.

Note that Psychiatric inpatient episodes’ as defined for the purpose of the NOCC protocol are confined to the category of \textit{overnight admitted patients} as used in the National Health Data Dictionary and specifically exclude same day admitted patients. Same day admitted patient episodes, which account for approximately one quarter of all separations from public sector psychiatric inpatient units, are defined as occasions of service within Ambulatory care 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, and its successor, the NMDS – Mental Health Establishments.

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

- \textit{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 \textit{Mental Health Service Organisation}. The practical implication is that the care provided by a Mental Health Service Organisation to an individual consumer at any point in time is subject to only one set of reporting

\textsuperscript{11}For the purposes of these specifications, the terms consumer, client and patient are used interchangeably and refer to a person for whom a \textit{Mental Health Service Organisation} accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record.
requirements. Where a person might be considered as receiving concurrently two or more episodes of mental health care by virtue of being treated by the organisation in more than one setting simultaneously, the following order of precedence applies: Inpatient, Community Residential, Ambulatory.\(^\text{12}\)

- **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 *Episode Service Setting* therefore marks the end of one episode and the beginning of another.

### 5.2. Episode Service Setting

5.2.1. The Episode Service Setting is the setting within which the *Episode of Mental Health Care* takes place, as defined by the domain specified in the following clauses.

5.2.2. **Psychiatric inpatient service**. This setting includes overnight care provided in 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 an Ambulatory mental health service team to a person admitted to a designated Special Care Suite or ‘Rooming-In’ facility within a community general hospital for treatment of a mental or behavioural disorder is also included under this setting.

5.2.3. **Community residential mental health service**. A residential mental health service is a specialised mental health service that:

- employs mental health-trained staff on site;
- provides rehabilitation, treatment or extended care;
- to residents provided with care intended to be on an overnight basis;
- in a domestic-like environment; and

\(^{12}\) The ‘one episode at a time’ rule is an important 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.
• encourages the resident to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However all these services employ on-site mental health trained staff for some part of each day.

For non-24 hour staffed services to be included in NOCC data reporting, they must employ mental health trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day. This is consistent with the scope of the NMDS – Residential Mental Health Care.

5.2.4. **Ambulatory care mental health service.** This setting includes all 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 the NOCC protocol, care provided by hospital–based consultation–liaison services to admitted patients in non–psychiatric and hospital emergency settings is also included under this setting.

5.3. **Collection Occasion**

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

5.3.2. In many cases, the beginning and end of episodes is 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, outcomes and casemix data need to 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.

5.3.3. For the purposes of the specification, the maximum interval between collection occasions is based on the standard review period of three months (91 days) as required under the *National Standards for Mental Health Services*. 
5.3.4. 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 episode**\(^{13}\) – 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 acts as the ‘trigger’ for a specific set of data to be collected.

- **Discharge from mental health care episode**\(^{14}\) – 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 data to be collected.

- **3 month (91-day) Review of mental health care episode** – 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.

5.3.5. 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 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;

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\(^{13}\) ‘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’ or ‘Entry to Episode’ and ‘Exit from Episode’, 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.
• 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.

5.3.6. 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.

5.3.7. Figure 1 (following) summarises the data collection points under various episode scenarios.
Figure 1: Data collection requirements under four episode scenarios

**Scenario 1: Inpatient Episode, length of stay < 91 days**

- **INPATIENT EPISODE START:** Admission
- **INPATIENT EPISODE END:** Discharge
- Data collection

**Scenario 2: Ambulatory Care Episode, ongoing, standard 3 month review**

- **AMBULATORY EPISODE START:** Intake
- **3 MONTH REVIEW:** 91 days
- Data collection

**Scenario 3: Ambulatory Care Episode, ad hoc review followed by 3 month review**

- **AMBULATORY EPISODE START:** Intake
- **AD HOC CLINICAL REVIEW:** 91 days
- Data collection

**Scenario 4: Ambulatory Care with intervening inpatient admission**

- **INPATIENT EPISODE START:** Data collection
- **INPATIENT EPISODE END:** Data collection
- **Ambulatory Episode 1**
- **Inpatient Episode**
- **Ambulatory Episode 2**
- Data collection
- **COMMUNITY EPISODE START:** Intake
- **COMMUNITY EPISODE END:** Data collection
- **COMMUNITY EPISODE START:**
5.4. Age Group

5.4.1. 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 and Adolescent, Adult, or Older Persons).

5.4.2. Generally, throughout mental health services, Adults are defined as persons between the age of 18 and 64 years inclusive, Older Persons are defined as persons aged 65 years and older and Children and Adolescents are defined as persons under the age of 18 years.

5.4.3. 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 NMDS – Mental Health Establishments to be classified according to the age group of their target population (Child and Adolescent, Older Persons, Forensic, General, Youth). Selection of the clinical measures to be applied by a given service can be based on this service classification.

5.4.4. Thus, in some circumstances a person may be assigned to a different Age Group to that in which they would be 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 a specialist Older Persons inpatient unit may be assigned to the Older Persons age group. Similarly, a 15 year old admitted to a general adult psychiatric unit may be assigned to the Adult group if the adult measures are used.

5.4.5. 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.

5.4.6. 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 introducing an agreed set of supplementary measures for Forensic Psychiatry services. In the meantime, each jurisdiction will continue to determine how the concept of Age Group will be interpreted for the Forensic Psychiatry services operating within its public sector.
5.5. Mental Health Provider Entity Hierarchy

5.5.1. A systematic approach to the identification of the Mental Health Provider Entity is essential for several reasons:

5.5.1.1 It allows the organisational and service provider contexts in which data are collected to be described. Understanding these service provider contexts is essential for identifying ‘like with like’ services and using the data for benchmarking purposes.

5.5.1.2 When used in combination with the Patient Identifier (see 5.6 below), 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, NMDS – Community Mental Health Care and NMDS – Residential Mental Health Care.

5.5.2. Additionally, a systematic approach to the specification of the Mental Health Provider Entity is critical because it determines two aspects of the NOCC protocol:

- It provides the basis for setting the boundaries for how the ‘one episode at a time’ rule is applied. For example, where two ambulatory care teams within a single organisation share responsibility for the care of a consumer, under NOCC this is not considered two separate episodes because both teams (and service units) belong to a single organisation.

- It determines the level at which the consumer is identified uniquely (see section 5.6) below.

5.5.3. 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 receive care from more than one ambulatory service within the organisation at the same time, or be transferred between ambulatory care teams for more intensive care for short periods as their needs change.

5.5.4. An additional requirement is that the manner and level at which the responsible Mental Health Provider Entity is specified must enable the meaningful linkage of NOCC data with the unit record data provided by States and Territories under the relevant related NMDS arrangements.

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

- State
- Region
- Mental Health Service Organisation
- Hospital or Service Unit Cluster
- Service Unit

5.5.6. This ‘layered’ approach to the identification of mental health entities developed originally from the National Survey of Mental Health Services that ran between 1994 and 2005, and has been introduced as a central feature of all National Minimum Data Sets. It has proved its worth as an approach to dealing with the complexity of the mental health service system.

5.5.7. In this approach, States and Territories report 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 in turn grouped into regions.

**Specification**

5.5.8. Each Collection Occasion record reported as part of the NOCC extract should be assigned to a Service Unit, which is identified by a unique Service Unit Identifier.

5.5.9. Service Units represent the lowest level component of a hierarchically ordered set of entities, comprising five levels within the mental health service system:
• State or Territory
• Region
• Mental health service organisation
• Hospital or Service unit cluster
• Service unit

5.5.10. **State or Territory.** This level refers to the state or territory and should be reported using the *Australian state or territory identifier* data element.

5.5.11. **Region.** The region refers to an administrative concept and is the same as the region concept in the NMDS – Mental Health Establishments. States and Territories may have one or more regions into which the jurisdiction is divided and to which its mental health service organisations belong. In those cases, Region should be reported using the *Region* data element. In the smaller states or in the territories there may only be one or no region applicable. In these cases the Region code would be reported as ‘00’ and the Region details would repeat the name of the State or Territory.

5.5.12. **Mental Health Service Organisation.** As defined and described under clause 4.2 above. Identifiers used to report Mental Health Service Organisations within NOCC should be the same as those used identify organisations in the NMDS – Mental Health Establishments.

5.5.13. **Hospital or Service Unit Cluster.** A mental health service organisation may consist of one or more clusters of service units providing services in admitted patient, residential and ambulatory settings. For example, a mental health service organisation may consist of several hospitals (clusters of admitted patient service units) and/or ambulatory or residential service unit clusters (for example, a cluster of child and adolescent ambulatory service units, and a cluster of aged residential service units).

To allow service units (as defined below using agreed data elements) to be individually identified, but still also to be identified as part of a hospital (for the admitted patient service setting), or as part of another type of cluster (e.g., other cluster types for ambulatory or residential service setting), a separate reporting level called ‘Hospital’ for admitted patient service units and ‘Service unit cluster’ for ambulatory service units and residential service units is necessary.

While all admitted patient service units must be physically part of a hospital, ambulatory and residential service units will not necessarily be part of a natural cluster. However, for some ambulatory service units, the service unit
may ‘belong’ to a hospital that contains both admitted patient and ambulatory service units. In this instance, the service unit cluster identifier for the ambulatory service unit would be the ‘hospital identifier’. Other groups of ambulatory and residential service units could also be usefully identified as clusters. For example, clusters may exist of groups of residential services for aged persons, or groups of ambulatory service units in particular geographical areas.

When there is no Service unit cluster, then the Service unit cluster identifier is to be reported as ‘00000’ and the Service unit cluster details would use the relevant organisation name.

Note that hospitals are to be reported as the equivalent of service unit clusters rather than as service units.

5.5.14. **Service Unit.** The Service Unit represents the lowest level in the Mental Health Provider Entity Hierarchy but is the most critical because it is the level at which patient care is delivered. Three ‘service unit types’ are identified, comprising:

- Psychiatric inpatient (admitted patient) service units
- Residential service units
- Ambulatory service units

5.5.15. **Service Unit Type** is intended to describe the most common type of care provided by the service unit. Service Unit Type should not be confused with Episode Service Setting. As described below, the latter is an attribute of the Episode of Mental Health Care, while the former is an attribute of the service provider.

5.5.16. Several guidelines apply to the way in which an organisation’s mental health services are reported as service units. These are based on the minimum reporting that is required for the purposes of the National Minimum Data Sets, particularly the NMDS – Mental Health Establishments.

5.5.16.1. **Admitted patient service units:** Admitted patient service units should be differentiated by Target Population (Child and Adolescent, Older Persons, Forensic, General, Youth) and Program Type (Acute vs Other). For example, if a hospital had separate wards for Child & Adolescent and General Adult populations, these should be reported as separate service units. Similarly, if the hospital provided separate wards for Older Persons acute and Older Person other program types, this would require separate
service units to be identified (that is, defined by the program type as well as the target population). The overarching principle is that the same service unit identification policy must be applied to the admitted patient service units data reported under NOCC and the NMDS – Mental Health Establishments.

5.5.16.2. **Residential service units**: Residential service units should be differentiated by Target Population (Child and Adolescent, Older Persons, Forensic, General, Youth). Where possible, it is also desirable that residential service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS – Residential Mental Health Care.

5.5.16.3. **Ambulatory service units**: Ambulatory service units should be differentiated by Target Population (Child and Adolescent, Older Persons, Forensic, General, Youth). Where an organisation provides multiple teams serving the same target population, these may be grouped and reported as a single Service Unit, or identified as individual Service Units in their own right. Where possible, it is also desirable that ambulatory service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS – Community Mental Health Care.

5.5.17. When assigning a Service Unit to a Collection Occasion, the following overarching reporting rule applies: **Identify the Service Unit that is principally responsible for provision of services to the person during the current episode of care**.

5.5.18. Two implications follow from this overarching rule.

5.5.18.1. The Service Unit Identifier recorded for any given Collection Occasion will not necessarily refer to the Service Unit that collected the Collection Occasion 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 admitted patient services unit, not the ambulatory care service unit.

5.5.18.2. The setting reported for the Service Unit (at the data element 'service unit type') will not necessarily match the Episode Service Setting within which the Episode of Care takes place as reported at the Collection Occasion level. For example, this could occur
where an inpatient service is primarily responsible for providing the services to person in an ambulatory episode following discharge from hospital.

5.5.19. While the NOCC specifications need to recognise that complex interactions can occur between service type and episode type, in the vast majority of instances the following simple situations will apply.

- Where the collection occasion occurs in the context of an inpatient episode, the Service Unit identified will be the admitted patient service unit within the hospital to which the patient is currently admitted.
- Where the collection occasion occurs in the context of a community residential episode, the Service Unit identified will be the community residential facility to which the patient is admitted.
- Where the collection occasion occurs in the context of an ambulatory episode, the Service Unit identified will generally be the single ambulatory care service that is providing the treatment and care to the person during the episode.

5.5.20. **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 clause 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.

5.5.21. The hierarchical relationship between the components of the Mental Health Provider Entity Hierarchy and the levels at which key NOCC business rules are applied is summarised in Figure 2.
5.6. Unique identification of consumers

5.6.1. 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 as for State/Territory and national-level analysis.

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

5.6.3. 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, States and Territories are taking steps to establish such arrangements.

5.6.4. The unique Patient identifier reported in the NOCC extract submitted to the Australian Government should be in encrypted form and meet two fundamental requirements:
• It should be identical to the identifier used in supplying unit record data in respect of the individual consumer in the corresponding NMDS dataset.
  
  Thus:

  • For consumers reported in the NOCC data set as currently experiencing an ambulatory care episode, the patient identifier used should be identical to that used to supply data in respect of the consumer to the NMDS – Community Mental Health Care.

  • For consumers reported in the NOCC data set as currently experiencing a residential care episode, the patient identifier used should be identical to that used to supply data in respect of the consumer to the NMDS – Residential Mental Health Care.

  • For consumers reported in the NOCC data set as currently experiencing a psychiatric inpatient episode, the patient identifier used should be identical to that used to supply data in respect of the consumer to the NMDS – Admitted Patient Mental Health Care.

  • The encrypted identifier used to supply data to NOCC in respect a consumer should be stable over time – that is, it should allow the consumer’s data to be linked across reporting years.
6. Unit of reporting

6.1. Basic unit of reporting – the Collection Occasion

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

6.1.2. It is important to distinguish the unit of reporting from the unit of analysis. The units of reporting 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 Service Organisation, Patient Identifier and Episode of Mental Health Care Identifier; and
- a conceptual framework to guide the bundling of those events into coherent units for analysis.

6.2. Reporting context — Episode of Mental Health Care Identifier

6.2.1. The Episode of Mental Health Care Identifier links together Collection Occasions which arise from the same Episode of Mental Health Care. As such, a single Admission occasion, any number of Review occasions, and a single Discharge occasion collected in respect of a given Episode of Mental Health Care should share the same value on this identifier.

6.2.2. For each uniquely identified patient or client the Episode of Mental Health Care Identifier must uniquely identify each episode. That is, the union of Patient Identifier with Episode of Mental Health Care Identifier must itself be unique within the broader scope of the Mental Health Service Organisation, however the Episode of Mental Health Care Identifier on its own need not be unique within that broader scope. This will ensure that Episodes of Mental Health Care are uniquely identified within the scope at which they themselves are defined.

6.2.3. As with Patient Identifiers, the Episode of Mental Health Care Identifier used to refer to supply NOCC data should be stable over time – that is, it should allow Collection Occasion components of the episode to be linked even when those components are spread across multiple reporting years.
6.3. Reporting context — Reason for Collection

6.3.1. 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.

6.3.2. 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.

6.3.3. In addition, to promote consistency in the development of guidelines for the regular review and closure of cases under ongoing Ambulatory care use of a concept of ‘active care’ has been found necessary. For this purpose, States and Territories have been moving to progressively implement the following business rule, or some variation that closely approximates the rule:

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
- plans have been made to provide further services to 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’.

6.3.4. These considerations are captured within the data element Reason for Collection. The domain of the Reason for Collection item is shown in Table 3 below.\(^{15}\)

Individual States and Territories have the option of specifying the domain in greater detail and are encouraged to do. 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.

\(^{15}\) 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.
<table>
<thead>
<tr>
<th>Collection Occasion</th>
<th>Reason for Collection</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission to mental health care episode</td>
<td>01. New referral</td>
<td>Admission to a new inpatient, community residential or ambulatory episode of care of a consumer not currently under the active care of the Mental Health Service Organisation.</td>
</tr>
<tr>
<td></td>
<td>02. Transfer from other treatment setting</td>
<td>Transfer of care between an inpatient, community residential and ambulatory setting of a consumer currently under the active care of the same Mental Health Service Organisation. Where a consumer’s care is “transferred from” another Mental Health Service Organisation, the Reason for Collection should be recorded as “01 - New Referral”.</td>
</tr>
<tr>
<td>03. Admission – Other</td>
<td></td>
<td>Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.</td>
</tr>
<tr>
<td>Review of mental health care episode</td>
<td>04. 3-month review</td>
<td>Standard review conducted at 3 months (91 days) following admission to the current episode of care or 91 days subsequent to the preceding Review.</td>
</tr>
<tr>
<td></td>
<td>05. Review – Other</td>
<td>Standard review conducted for reasons other than the above.</td>
</tr>
<tr>
<td>Discharge from mental health care episode</td>
<td>06. No further care</td>
<td>Discharge from an inpatient, community residential or ambulatory episode of care of a consumer for whom no further care is planned to be provided by the Mental Health Service Organisation.</td>
</tr>
<tr>
<td></td>
<td>07. Transfer to change of treatment setting</td>
<td>Transfer of care between an inpatient, community residential and ambulatory setting of a consumer currently under the care of the same Mental Health Service Organisation. Where a consumer’s care is “transferred to” another Mental Health Service Organisation, the Reason for Collection should be recorded as “06 - No Further Care”.</td>
</tr>
<tr>
<td></td>
<td>08. Death</td>
<td>Completion of an episode of care following the death of the consumer.</td>
</tr>
<tr>
<td></td>
<td>09. Discharge - Other</td>
<td>Discharge from an inpatient, community residential or ambulatory setting for any reason other than defined above.</td>
</tr>
</tbody>
</table>
6.4. **Collection Occasion Date**

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

6.4.2. 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*.

6.4.3. 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*.\(^{16}\) 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.

6.4.4. 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.\(^{17}\)

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\(^{16}\) 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 are 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*.

\(^{17}\) 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 States and Territories 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 States and Territories.

It is important to minimise the burden of collection, where possible, while preserving episodes of care as the fundamental building block of NOCC. The collection protocol as defined in this version builds on the experience of NOCC implementation since 2003. In particular, a wide range of users was consulted throughout the course of the NOCC Strategic Directions 2014-2024 project which has led to some revision of the protocol as implemented in earlier versions of the NOCC Technical Specifications.

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 agreed information development strategy. 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 presupposes 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.

7.1.3. The national protocol takes 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.

7.1.4. As noted earlier, there were several recommendations from the NOCC Strategic Directions 2014-2024 project regarding revisions to the NOCC collection protocol, particularly with respect to the data requirements at closure of mental health care episodes in ambulatory settings.

7.1.5. The NOCC data requirements at discharge from ambulatory care are dependent on the reason for collection based on two broad considerations:

(i) Whether the care of the consumer is transferred from the ambulatory service to an inpatient or residential service of the same Mental Health Service Organisation; or

(ii) Whether the duration of the ambulatory episode of mental health care was brief, as defined as an episode of care 14 days or less in duration (i.e., the number of days from admission to and discharge from the NOCC Ambulatory episode).

7.1.6. With respect to these two kinds of ambulatory discharge (i.e., transfer to bed-based care or brief episodes of care):

(i) the NOCC clinician and consumer-rated measures (i.e., the HoNOS/CA/65+, LSP-16, FIHS, the SDQ, BASIS-32/K-10/MHI-38) are not collected; and

(ii) Mental Health Legal Status and Principal and Additional Diagnoses pertaining to the ambulatory episode are to be reported.

7.1.7. Regardless of whether the NOCC ambulatory episode of mental health care is closed either as a transfer or a brief episode as described in 7.1.5, a NOCC Discharge Collection Occasion must be recorded.

7.1.8. For both consumers and providers, the transition of treatment from ambulatory to bed-based care is a critical point in the delivery of services and therefore it is important to gain an understanding of the status of consumers and the outcomes of services provided. Where ambulatory discharge results
in transfer to bed based care (i.e., an inpatient or community residential service of that Mental Health Service Organisation), wherever possible, the common clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the residential care setting should be linked to the consumers’ discharge from the ambulatory episode.

Table 4 brings together these considerations and provides summary details of the various measures to be reported at the three Collection Occasions during each episode of mental health care.
Table 4: Data to be reported at each Collection Occasion within each Episode Service Setting, for consumers in each Age Group\(^1\)

<table>
<thead>
<tr>
<th>Episode Service Setting</th>
<th>INPATIENT</th>
<th>COMMUNITY RESIDENTIAL</th>
<th>AMBULATOR</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>R</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td><strong>Children and Adolescents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HoNOSCA (^4)</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>CGAS</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>FIHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent / Consumer rated (SDQ) (^5,6)</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Principal and Additional Diagnoses</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Mental Health Legal Status</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Phase of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HoNOS (^4)</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>LSP-16</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Consumer rated (BASIS-32, K10, MHI-38(^6)(^7))</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Principal and Additional Diagnoses</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Mental Health Legal Status</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Phase of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Older persons</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HoNOS 65+ (^4)</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>LSP-16</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>RUG-ADL</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Consumer rated (BASIS-32, K10, MHI-38(^6)(^7))</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Principal and Additional Diagnoses</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Mental Health Legal Status</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Phase of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Abbreviations and Symbols**

- **A** Admission to Mental Health Care
- **R** Review of Mental Health Care
- **D** Discharge from Mental Health Care
- • Reporting of data on this occasion is mandatory
- x No reporting requirements apply
Notes to Table 4

(1) This table identifies the national reporting requirements and is not intended to restrict a State or Territory from the collection of additional data at specific collection occasions.

(2) Discharge ratings for the clinician and consumer-rated measures (i.e., the HoNOS/CA/65+, LSP-16, FIHS, the SDQ, BASIS-32/K10/MHI-38) are not required by the ambulatory service or the consumer respectively, when the reason for the closure of the ambulatory episode is transfer to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service). Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer’s discharge ratings from the ambulatory episode. Details are required, however, regarding Principal and Additional Diagnoses and Mental Health Legal Status relevant to the ambulatory episode of care.

(3) Discharge ratings for the clinician and consumer-rated measures (i.e., the HoNOS/CA/65+, LSP-16, FIHS, the SDQ, BASIS-32/K10/MHI-38) are not required for brief ambulatory episodes. Brief ambulatory episodes are those where the number of days between admission to and discharge from the episode of care is 14 days or less duration. Details are required, however, regarding Principal and Additional Diagnoses and Mental Health Legal Status relevant to the ambulatory episode of care.

(4) Discharge ratings for the HoNOS, HoNOS65+ and HoNOSCA are not required for inpatient episodes of 3 days or less duration.

(5) Discharge ratings for the SDQ are not required for any episode of less than 21 days duration because the rating period used at discharge (previous month) would overlap significantly with the period rated at admission.

(6) The classification of consumer rated measures as mandatory is intended only to indicate the expectation that consumers will be offered to complete self-report measures at the specified Collection Occasions. There are circumstances where offering such measures will not be appropriate and special considerations applying to the collection of consumer rated measures are described in section 7.4.

(7) The K10L3D is a variation of the K10 designed for use in inpatient settings where the episode is of less than 3 days duration.
7.2. Rating periods for the clinical and consumer self-report 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. It should be noted that this Table refers only to the rating period and not to other criteria such as those relevant to the closure of Ambulatory Episodes as a result of transfer to an inpatient/residential setting or brief duration.

Table 5: Rating periods for each of the clinical and consumer self-report measures and data items

<table>
<thead>
<tr>
<th>Standardised measure or Data item</th>
<th>Usual rating period</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HoNOS / HoNOS 65+ / HoNOSCA</td>
<td>Previous 2 weeks</td>
<td>At discharge from Inpatient psychiatric care, based on previous 3 days including day of discharge.</td>
</tr>
<tr>
<td>LSP</td>
<td>Previous 3 months</td>
<td>No exceptions</td>
</tr>
<tr>
<td>RUG-ADL</td>
<td>Current status</td>
<td>No exceptions</td>
</tr>
<tr>
<td>K10 / K10+</td>
<td>For K10+LM, based on previous 4 weeks. For K10L3D, based on previous 3 days.(^{18})</td>
<td>No exceptions</td>
</tr>
<tr>
<td>BASIS-32</td>
<td>Previous 2 weeks</td>
<td>No exceptions</td>
</tr>
<tr>
<td>MHI-38</td>
<td>Previous 4 weeks</td>
<td>No exceptions</td>
</tr>
<tr>
<td>CGAS</td>
<td>Previous 2 weeks</td>
<td>No exceptions</td>
</tr>
<tr>
<td>FIHS</td>
<td>The period of care bound by the current <em>Collection occasion</em> and the preceding <em>Collection Occasion</em>.</td>
<td>No exceptions</td>
</tr>
<tr>
<td>SDQ</td>
<td>At admission to a service, the previous six months At review and discharge, the previous one month</td>
<td>No exceptions</td>
</tr>
<tr>
<td>PoC</td>
<td>There is no set rating period for PoC. PoC changes when there is a clinical decision that the primary goal of care has changed and there is a concomitant change to the mental health care plan.</td>
<td>No exceptions</td>
</tr>
<tr>
<td>Principal and Additional Diagnoses</td>
<td>The period of care bound by the current <em>Collection occasion</em> and the preceding <em>Collection occasion</em>.</td>
<td>No exceptions</td>
</tr>
<tr>
<td>Mental Health Legal Status</td>
<td>The period of care bound by the current <em>Collection Occasion</em> and the preceding <em>Collection Occasion</em>.</td>
<td>No exceptions</td>
</tr>
</tbody>
</table>

\(^{18}\) The K10L3D is a variation of the K10 designed for use in inpatient settings where the episode is of less than 3 days duration.
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 States and Territories and development of workforce training programs.

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

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Common Questions</th>
<th>National minimum requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Movement between inpatient / residential, and ambulatory settings</td>
<td>Do NOCC clinical and consumer ratings need to be recorded for the end of the ambulatory episode as well as the beginning of the inpatient / residential episode when a consumer is transferred from ambulatory care to bed-based care?</td>
</tr>
<tr>
<td>2.</td>
<td>Transfer between two wards of the psychiatric unit</td>
<td>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?</td>
</tr>
<tr>
<td>Scenario</td>
<td>Common Questions</td>
<td>National minimum requirement</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3. Transfer between psychiatric units from one hospital campus to another</td>
<td>Should a new inpatient episode be commenced when a consumer is transferred from one hospital to another within the same mental health care organisation?</td>
<td>Yes. Even though this is not technically a change in treatment setting, States and Territories have agreed that an inpatient episode should be recorded in these circumstances, with the associated data collection requirements.</td>
</tr>
<tr>
<td>4. Transfer of care between community teams</td>
<td>Does a new cycle of data collection begin when case management is transferred from one ambulatory care team to another within the same organisation?</td>
<td>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. For example, transfer from crisis team to continuing care team. Decisions about whether such additional ratings are required need to be resolved at the local level.</td>
</tr>
<tr>
<td>5. Multiple team involvement in case management</td>
<td>Is each team expected to complete ratings on the consumer?</td>
<td>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. In general, this is expected to be the service unit that is principally responsible for providing treatment and care during the current Episode of Mental Health Care.</td>
</tr>
<tr>
<td>6. ‘Intended’ same day admissions</td>
<td>Is each day of care a new inpatient episode, requiring a full set of ratings?</td>
<td>No. Definitions developed under the National Survey of Mental Health Services since 1994, and now replicated in NMDS – Mental Health Establishments, regard ‘intended same day admissions’ as a component of ambulatory care services.</td>
</tr>
<tr>
<td>7. Discharge from hospital on indefinite leave</td>
<td>Does an inpatient episode continue when a patient is placed on extended leave but remains, legally, an inpatient?</td>
<td>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 is 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.</td>
</tr>
<tr>
<td>8. Return to hospital from indefinite leave</td>
<td>Does a new inpatient episode begin when a patient returns to hospital after a period of extended leave?</td>
<td>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.</td>
</tr>
<tr>
<td>9. Brief inpatient episodes</td>
<td>Are discharge ratings required for very brief</td>
<td>In general yes, but there are exceptions: • For inpatient episodes in all Age Groups where...</td>
</tr>
<tr>
<td>Scenario</td>
<td>Common Questions</td>
<td>National minimum requirement</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>inpatient episodes?</td>
<td>the episode is of 3 days or less duration: the HoNOS/HoNOS65+/HoNOSCA is not required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For all Child and Adolescent episodes of less than 21 days duration, the discharge SDQ is not required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In both instances above, the exclusion is because the period that would be rated at discharge would overlap with the admission ratings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apart from the above exceptions, all other aspects of the collection protocol are required at discharge from inpatient episodes.</td>
</tr>
<tr>
<td>10. Consumers seen regularly but at intervals of greater than 3 months</td>
<td>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?</td>
<td>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 greater 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.</td>
</tr>
<tr>
<td>11. Admission to general medical (non-mental health) ward</td>
<td>Is a new episode of mental health inpatient care commenced when the person is admitted to a (non-mental health) medical ward for the primary purpose of mental health care?</td>
<td>No. This is a continuation of the ambulatory episode. It is recommended however that a review of the consumer be conducted at this stage.</td>
</tr>
<tr>
<td>12. Consultation Liaison teams</td>
<td>What is expected of C-L teams in terms of collection of the NOCC data?</td>
<td>Consultation liaison is explicitly included as in scope for collection when there is a face-to-face assessment, with clarification that episodes extending over 14 days or less do not require discharge outcome measures to be collected.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcome measures are to be collected at admission for all face-face assessments, and are to be collected at discharge when the episode of care (defined by the elapsed days from admission to discharge) is greater than 14 days.</td>
</tr>
</tbody>
</table>
7.4. Special considerations applying to the collection of consumer self-report and parent 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.

7.4.3. Similar considerations also apply in relation to the parent version of the SDQ.

General exclusions

7.4.4. Some persons may not be able to complete the 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 person’s cognitive functioning is insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability;
- cultural, language and/or literacy issues make the measures inappropriate.\(^{19}\)

Temporary contraindications

7.4.5. Under certain conditions, a consumer (or in the case of the SDQ a parent) may not be able to complete the measure at a specific Collection Occasion. Circumstances where it may be appropriate to refrain from inviting the person to complete the 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

\(^{19}\) Substantial development work is required in the future to address cultural issues in the use and interpretation of self-report outcome measures. See Appendix 3.
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; or

- where consumers or parents in crisis are too distressed to complete the measure.

7.4.6. It is suggested that in these circumstances consumers and parents need not be invited to complete the measures. At all other times, an attempt should be made to obtain their responses.

7.4.7. In many cases, the severity of the person’s clinical state and the degree of family distress experienced will diminish with appropriate treatment and care. It is suggested that, if within a period of up to seven days following the Collection Occasion in an ambulatory care setting the consumer (or parent) is likely to be able to complete the measure then their responses should be sought at that time. Otherwise, no further attempt to administer the measure at that Collection Occasion should be made.

**Special issues related to the Strengths and Difficulties Questionnaire versions**

7.4.8. The SDQ has six versions currently specified for NOCC reporting:20

- Parent-report for children aged 04-10 on admission to a mental health care episode;

- Parent-report for children aged 04-10 on follow up contact (review and discharge);

- Parent-report for children and adolescents aged 11-17 on admission to a mental health care episode;

- Parent Report Measure for Youth aged 11-17 on follow up contact (review and discharge);

- Youth self-report measure (11-17) on admission to a mental health care episode; and

- Youth self-report measure (11-17) on follow up contact (review and discharge).

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20 An additional four versions are available for use by Teachers but these are not included in the national protocol. Details of these versions however are provided in the document Mental Health National Outcomes and Casemix Collection: Overview of clinician rated and self-report measures, Version 1.50. Department of Health and Ageing, Canberra, 2003.
7.4.9. Generally, the ‘admission’ versions are administered on admission and rated over the standard rating period of six months and the ‘follow up’ versions are administered on review and discharge and rated over a one month period. However, for referral from another setting, to prevent duplication and undue burden on consumers and parents, the following guide is suggested:

<table>
<thead>
<tr>
<th>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.</th>
<th>Admission SDQ - if Follow Up SDQ required at the end of referring treatment settings episode is neither completed nor provided by referring setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Up SDQ - if Follow Up SDQ is required at end of referring treatment settings episode has in fact been completed and provided by the referring setting.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.</th>
<th>Admission SDQ - if Follow Up SDQ required at the end of referring treatment settings episode is neither completed nor provided by referring setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Up SDQ - if Follow Up SDQ required at end of referring treatment settings episode has not been completed or is not provided by the referring setting.</td>
<td></td>
</tr>
</tbody>
</table>

7.4.10. The ‘admission’ versions are to be used on admission of a consumer who is a new referral – that is, they are not currently under the active care of the Mental Health Service Organisation.

7.5. Future development of the protocol

The original version of the National Outcomes and Casemix Collection was prepared from the research and development undertaken in the first decade of the National Mental Health Strategy and the experiences by jurisdictions in introducing standard outcome measurement into routine clinical practice.

Recognising that the NOCC protocol has been in place for 10 years, in 2013 the MHISSC commissioned the NOCC Strategic Directions 2014-2024 project. The Final Report from that project contained 25 recommendations, several of which were implemented through earlier versions of the NOCC Technical Specifications.
The remaining recommendations require further research and development work and consultation within the mental health sector, and taking into consideration the evolving information requirements of the mental health sector.
8. **NOCC data extract and file layout specification**

This section identifies the layout and format of NOCC data files to be prepared and submitted by States and Territories to the Australian Government Department of Health.

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 record of the Collection Occasion itself, together with the relevant associated records standardised measures and associated data items collected in respect of that Collection Occasion. Depending on the Episode Service Setting, Age Group and Collection Occasion, zero or one each of HoNOS, LSP, RUG-ADL, HoNOSCA, CGAS, FIHS, consumer self-rated measure and other individual data items (Diagnosis - Principal and Additional, Phase of Care, Mental Health Legal Status) may be recorded.

8.1.2. In addition, each Collection Occasion ‘belongs’ to an Episode of Mental Health Care, which in turn ‘belongs’ to Person (the consumer), who in turn is linked to a Service Unit (the principal or responsible provider of services), which is linked to a Hospital or Service Cluster, which is linked to a Mental Health Service Organisation, which is linked to a Region within the State/Territory.

8.1.3. The structure of data to be reported is represented in the data model shown in Figure 3. Several features of the model should be noted.

8.1.3.1 Details of the Service Units reporting NOCC data are incorporated as part of the data extract, allowing linkage to related datasets provided by States and Territories (in particular, the NMDS – Mental Health Establishments).

8.1.3.2 Neither the concept of an Episode of Mental Health Care nor the concept of a Period of Care is represented as entities in the model. Information regarding either entity may be derived for statistical purposes from sequential instances of Collection Occasions.

8.1.3.3 Similarly, the concept of Person is not represented as an entity but is implicit, embedded within the Collection Occasion Details record. Information regarding persons who are the subject of the NOCC data can derived directly from information contained in Collection Occasion records.

8.1.3.4 The 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. 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.
Figure 3: Data model underlying the NOCC data extract
8.2. **File type and naming convention**

8.2.1. Data submitted to the Australian Government 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 NOCCSSSYYYYNNNNN.DAT where:

- **NOCC** denotes “National Outcomes and Casemix Collection”.
- **SSS** is the abbreviation for the State or Territory name; using the following convention –
  - for New South Wales use ‘NSW’,
  - for Victoria use ‘VIC’,
  - for Queensland use ‘QLD’,
  - for Western Australia use ‘WAU’,
  - for South Australia use ‘SAU’,
  - for Tasmania use ‘TAS’,
  - for the Australian Capital Territory use ‘ACT’,
  - and for the Northern Territory use ‘NTE’;
- **YYYY** indicates the reporting year covered in the file, using the convention where financial years are abbreviated by referring to the last calendar year of the pair (e.g., the 2006–2007 financial year is identified as 2007); and
- **NNNNN** represents an incremental batch number (leading zeros present).

Note that successive quarterly files and any resubmitted files must have a batch number greater than all preceding files for that year.

For example, suppose that the Australian Capital Territory submitted quarterly data files in respect of the 2007–2008 financial year, then submitted a final submission for that year. Their first NOCC data file would be named “NOCCACT2008000001.DAT”, whilst the second would be named “NOCCACT2008000002.DAT”, and so on. If no resubmissions were made the final submission for that year would be named “NOCCACT2008000004.DAT”. If that file then had to be resubmitted for some reason, then it would be named “NOCCACT2006000005.DAT”. Their first submission for the 2008–2009 financial year would then be named “NOCCACT2009000001.DAT”.
8.3. Reporting period and delivery date

8.3.1. Files are to be prepared on an annual basis and sent to the Department of Health by **31 December** each year, or closest working day).

8.3.2. Each annual file will include data for the immediately preceding financial year, e.g., December 2013 file should include data for the 2012-13 financial year.

8.4. File structure

8.4.1. The extract format consists of a set of hierarchically ordered Data Records, of which there are 19 types:

- Region details records
- Organisation details records
- Hospital or Service Cluster details records
- Service Unit details records
- Collection Occasion details records
- Diagnosis records
- Phase of Care records
- Legal Status records
- HoNOS or HoNOS65+ measure records
- LSP–16 measure records
- RUG–ADL measure records
- HoNOSCA measure records
- CGAS measure records
- FIHS measure records
- MHI–38 (consumer self–rated) measure records
- BASIS–32 (consumer self–rated) measure records
- K10+ Last Month records
- K10+ Last 3 Days records
- SDQ (all versions of both consumer and parent–rated) measure records

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 in section 8.6.
8.4.3. All records presented in the extract file must be grouped in the following order: Header Record, Region details records, Organisation details records, Hospital – Cluster details records, Service unit details records, Collection Occasion details records, Diagnosis details records, Phase of Care details records, Mental Health Legal Status details records, HoNOS or HoNOS65+ measure records, LSP–16 measure records, RUG–ADL measure records, HoNOSCA measure records, CGAS measure records, FIHS measure records, MHI–38 measure records, BASIS–32 measure records, K10+ Last 3 Days measure records, K10+ Last Month measure records, and SDQ measure records.

8.4.4. The content and order of fields in a record must be the same as the order they are specified in the Record Layouts specified in the tables presented in Appendix A. Field values should be formatted as specified in the Record Layouts.

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

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR</td>
<td>File Header Record</td>
</tr>
<tr>
<td>REG</td>
<td>Region details</td>
</tr>
<tr>
<td>ORG</td>
<td>Organisation details</td>
</tr>
<tr>
<td>HOSPCLUS</td>
<td>Hospital – Cluster details</td>
</tr>
<tr>
<td>SERV</td>
<td>Service Unit details</td>
</tr>
<tr>
<td>COD</td>
<td>Collection Occasion Details</td>
</tr>
<tr>
<td>DIAG</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>POC</td>
<td>Phase of Care</td>
</tr>
<tr>
<td>MHLS</td>
<td>Mental Health Legal Status</td>
</tr>
<tr>
<td>HONOS</td>
<td>HoNOS or HoNOS65+</td>
</tr>
<tr>
<td>LSP16</td>
<td>LSP–16</td>
</tr>
<tr>
<td>RUGADL</td>
<td>RUG–ADL</td>
</tr>
<tr>
<td>HONOSCA</td>
<td>HoNOSCA</td>
</tr>
<tr>
<td>CGAS</td>
<td>CGAS</td>
</tr>
</tbody>
</table>
**8.5. Data integrity**

8.5.1. Values in Date [Date] fields must be recorded in compliance with the standard format used across the National Health Data Dictionary, specifically; dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2007 would appear as 13032007.

8.5.2. Values in Numeric [Num] fields must be zero-filled and right-justified. These should consist only of the numerals 0-9 and the decimal ("." ) point if applicable.

Note: Fields defined as ‘Numeric’ are those that have numeric properties – that is, the values, for example, can be added or subtracted in a manner that is valid. Where a field uses numeric characters that do not have these properties (e.g. the use of numbers for Patient Identifier), the field is defined as ‘Character’.

8.5.3. Values in Character [Char] fields must be left justified and space-filled. These should consist of any of the printable ASCII character set (i.e. excluding control codes such as newline, bell and linefeed).

**8.6. File header record**

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 Australian Government. (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 layout of the File Header Record is shown in Table 8 below.

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Type [Length]</th>
<th>Start</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record type</td>
<td>Char [8]</td>
<td>1</td>
<td>Value = HR</td>
</tr>
<tr>
<td>State/Territory identifier</td>
<td>Char [1]</td>
<td>9</td>
<td>Domain = 1 New South Wales; 2 Victoria; 3 Queensland; 4 South Australia; 5 Western Australia; 6 Tasmania; 7 Northern Territory; 8 Australian Capital Territory.</td>
</tr>
<tr>
<td>Batch Number</td>
<td>Char [9]</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Report period start date</td>
<td>Date [8]</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Report period end date</td>
<td>Date [8]</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Data file generation date</td>
<td>Date [8]</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Data file type</td>
<td>Char [4]</td>
<td>47</td>
<td>Value = NOCC</td>
</tr>
<tr>
<td>NOCC reporting specification version</td>
<td>Char [5]</td>
<td>46</td>
<td>Value = 02.00</td>
</tr>
</tbody>
</table>

Record length = 51

8.7. Detailed record layouts

8.7.1. Detailed specifications on the extract format for all NOCC records are provided in Appendix A.

8.8. Data dictionary

8.8.1. Detailed definitions and data element domains or all components of the NOCC dataset are provided in Appendix B.

8.9. Data submission and validation requirements