

# PRIMARY MENTAL HEALTHCARE MINIMUM DATA SET (PMHC MDS): PROVIDER QUICK REFERENCE GUIDE

Version 1.0

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## VERSION HISORY

Version	Date	Notes / Key changes
1.0	July 2018	Template provided by Strategic Data updated to reflect Hunter, New England and Central Coast PHN requirements of Providers.

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## 1. PURPOSE

This document serves as a quick reference guide to introduce Providers to the main concepts and requirements of the Primary Mental Healthcare Minimum Data Set (PMHC MDS).

Three important points about this guide should be noted at the outset:

- 1) It aims to describe features of the PMHC MDS that are relevant to all regions and service providers.
- 2) The guide makes reference to the previous Access to Allied Psychological Services (ATAPS)/Mental Health Services in Rural and Remote Areas (MHSRRA) MDS, which is intended to specifically support data collection/entry/upload by Providers who were previously involved in the delivery of these services for PHNs (and their predecessors, Medicare Locals and/or Divisions of General Practice). Reference to the ATAPS/MHSRRA MDS is not relevant to new Providers of primary mental health care who were not involved in the delivery of the historic ATAPS/MHSRRA programs.
- 3) This guide is subject to change as the PMHC MDS develops, which means you should keep an eye out for updated versions posted on the PMHC MDS website ([www.pmhc-mds.com/resources](http://www.pmhc-mds.com/resources)). There are also more detailed information and resources available on the website.

## 2. BACKGROUND

The delivery of primary mental healthcare services in Australia is currently in transition as a result of recent Australian mental health reforms.<sup>1</sup> Commencing July 2016, funding was provided to PHNs through a flexible

funding pool to enable commissioning of a wide range of primary mental healthcare and suicide prevention services.

In order to monitor and evaluate regional service delivery against key performance indicators, all 31 PHNs are required to collect and enter/upload data into the PMHC MDS. The PMHC MDS has been developed on the basis of the previous ATAPS/MHSRRA MDS, but has been expanded to capture the broader range of mental health services that are now being commissioned by PHNs.

While principal responsibility for establishing regional arrangements for data collection and reporting rests with PHNs, the process depends on commissioned organisations and individual providers to play their role in ensuring accurate and timely capture and reporting of data. Much of the data can only be reported with the full participation of providers.

## 3. WHY COLLECT DATA?

Collection and use of data are essential in your role as a mental health service provider, for PHNs as commissioners and regional planners, and for the Department of Health as the national funder of primary mental healthcare services. Most importantly, clients ultimately benefit from service providers collecting and using data to monitor and improve the performance of the service system, thereby optimising client outcomes.

As a service provider, collecting data (e.g., client outcomes) can assist with your clinical decision-making and review of the client's treatment plan, including decisions to inform stepping up or down between different levels of treatment intensity in the stepped care model. Data collection (e.g., individual items on standardised outcome measures) can provide you with information that will help identify appropriate targets (e.g., symptoms) for intervention.

Most importantly, collecting and using data can assist you to monitor client progress and make informed decisions about the course of treatment.

PHNs require a range of data to pay service providers, monitor overall regional service provision and plan future service improvements. These are all core functions of PHNs and require that PHNs collect and analyse data on what services are delivered, by whom, to what clients, at what costs and with what outcomes. Without data, PHNs cannot undertake these functions.

Provision of information to the Department of Health is necessary for Government to undertake its role in funding, monitoring and planning future national service delivery.

The PMHC MDS is designed to support all of these purposes. However, PHNs (and service providers) may choose to collect additional data to that specified in the PMHC MDS in order to meet local needs; such additional data will not be submitted to the PMHC MDS.

## 4. WHAT DATA AM I EXPECTED TO COLLECT AND WHEN?

### 4.1 Activities in, and out of, scope

The PMHC MDS is designed to capture data on PHN-commissioned mental health services delivered to individual clients, including group-based delivery to individual clients. Initially this will include, but not be restricted to:

- psychological therapies delivered by mental health professionals (as per previous ATAPS/MHSRRA programs);
- services delivered by mental health nurses, formerly captured through the Mental Health Nurse Incentive Program (MHNIP) session claim process maintained by the Department of Human Services;
- mental health interventions delivered by a new 'low intensity' workforce;
- care coordination targeted at people with severe and complex mental illness;
- suicide prevention services delivered to individuals; and
- services delivered to Aboriginal and Torres Strait Islander people.

The intent is to ensure that the PMHC MDS has capacity to collect data and report on a broader range of services than the previous ATAPS/MHSRRA MDS, covering the full spectrum of individual client-centred services expected to be delivered through PHN commissioning processes.

The scope of coverage does not extend to services targeted at communities, such as the community capacity building activities previously funded under projects sourced from National Suicide Prevention Program funding. Collection and reporting of activities of this type requires a different approach to 'counting' and identification of the 'client'. A national MDS covering suicide

prevention activities of this type has been in place for several years and is currently being considered for the future. PHNs commissioning activities of this type will have flexibility to establish local data reporting arrangements that suit their requirements.

First stage development of the PMHC MDS does not include existing youth-specific services (*headspace*, Early Psychosis Youth Services) that currently, and will continue to, collect and report a standardised dataset to *headspace* National Office. Pending the future of these arrangements, and access to data by PHNs, the PMHC MDS may be expanded at a future stage to allow incorporation of *headspace* and Early Psychosis Youth Services should this be required.

#### 4.2 Overview of data types and when these should be collected

Data captured in the PMHC MDS is designed to answer the important question: “*Who receives what services, delivered by whom, at what cost, and with what effect?*” Collection of data to answer each element of this question is equally important to PHNs in their commissioning role as it is to Government in monitoring the implementation of mental health policy reforms.

The data broadly cover the same content as captured in the ATAPS/MHSRRA system, covering person-level (demographics, clinical), and service event-level, information (e.g., session details such as duration, place of delivery etc.). Table 1 summarises the type of data to be collected and indicates when the data should be collected.

Full details of all items including definitions, data domains and formats are available on-line at <https://docs.pmhc-mds.com/data-specification/index.html>.

**Table 1: Summary of data types and when they need to be collected**

Question	What data will inform this question?	When should I collect these data?
<b>Who receives</b>	Demographic and clinical characteristics of clients, collected at episode level by service providers.	Some person-level data will have already been collected by the referring professional (if the client was not self-referred) and/or regional intake systems. You may wish to confirm (and override) already-collected data and collect any missing person-level data at the commencement of treatment.
<b>What services</b>	Range of data collected by service provider for each individual service event (e.g., date and type of service, duration).	You should collect service-level data at each service contact. See section 6 of this guide for more information.
<b>From whom</b>	Service provider and organisation characteristics.	The service provider organisation (or PHN) that has employed or contracted your services is responsible for collecting these data, which will include obtaining data from you at the commencement of your involvement in order to describe and understand their local mental health workforce.
<b>At what cost</b>	Cost data to be derived from annual financial statements maintained by PHN, supplemented by out-of-pocket costs to clients.	You should collect data on out-of-pocket costs to clients at each service contact.
<b>With what effect</b>	Client outcome data using standard instruments.	At minimum, you should collect client outcome data at the commencement and conclusion of each treatment episode. Outcome data can also be collected throughout the course of the treatment episode to review clients, as frequently as clinically indicated. See section 8 of this guide for more information.

## 5. HOW SHOULD I COLLECT AND REPORT DATA?

HNECC requires Providers to either enter data manually into the PMHC MDS via the web interface <https://pmhc-mds.net> or upload data via an Excel spreadsheet or CSV files extracted from their client management systems.

If you have been contracted by a Provider organisation, that organisation will advise you about how to collect data, for example you may be required to collect data manually (paper forms) or directly enter it electronically (via client information management systems or pre-defined template spreadsheets). Electronic systems will allow the data you enter to be uploaded to the PMHC MDS, alternatively, you may be required to enter data directly into the PMHC MDS via the web interface.

### 5.2 How often should I report data?

The value of the PMHC MDS relies on timely reporting. The national requirement is for Providers to report data to the PMHC MDS within 31 days of the activity that generated the data. HNECC further requires that all Providers have their data entered upon submission of the corresponding Quarterly Report.

## 6. HOW IS AN EPISODE OF CARE DEFINED?

A central feature of the PMHC MDS design is that the unit of service delivery is the episode of care. Episodes, in turn, comprise a series of one or more service contacts (see Section 7 of this guide).

For the purposes of the PMHC MDS, an episode of care is defined as a more or less continuous period of contact between a PHN-commissioned service provider organisation and a client that starts at the point of first contact and concludes at discharge.

While an individual may have multiple episodes of mental healthcare over the course of their treatment, they are considered as being in only one episode at any given point of time for any particular PHN-commissioned provider organisation. The practical implication is that the care provided by the organisation to an individual client at any point in time is subject to only one set of reporting requirements.

Discharge may occur clinically (i.e., when treatment is complete) or administratively (statistically) in instances where treatment is not complete either because contact has been lost with the client or due to other barriers. A new episode is deemed to commence if the person re-presents to the organisation irrespective of the lapsed timeframe.

### 6.1 Classifying different types of episodes of care

For all accepted referrals, you will need to group each episode of care into one of six high-level categories based on the type of care to be provided (referred to as 'principal focus of treatment plan') that align with the PHN service delivery priorities for mental health that have been set by government.

In practical terms, this requirement means that you will need to make a judgement about the main focus of the services to be delivered to the client for the current episode of care. This judgement will usually be made following initial assessment and is modifiable at a later stage. The 'principal focus of treatment plan' categories and main features of each category are described in Table 2, including guidance as to how HNECC commissioned mental health services should be categorised in the PMHC MDS.

Table 2: Principal focus of treatment plan categories

Category	Main feature(s) of treatment plan	HNECC Guidance
<b>Psychological therapy</b>	Primarily involves the delivery of psychological therapy by one or more mental health professionals. This category most closely matches the type of services delivered under the previous ATAPS (and MHSRRA) program. 'Mental health professionals' refers to service providers who meet the requirements for registration, credentialing or recognition as a qualified mental health professional (i.e., psychiatrists, registered psychologists, clinical psychologists, mental health nurses, occupational therapists, social workers, Aboriginal and Torres Strait Islander health workers).	Services delivered under Primary Mental Health fall in this category.
<b>Low intensity psychological intervention</b>	Primarily involves the delivery of time-limited, structured psychological interventions that aim to provide a less costly intervention alternative to 'standard' psychological therapy. Low intensity interventions are characterised by utilising nil or minimal qualified mental health professional time per client and are targeted at people with, or at risk of, mild mental illness.	Specific Low Intensity Services will fall in this category.
<b>Clinical care coordination</b>	Primarily involves the delivery of a range of services aimed at coordinating and better integrating care for the individual across multiple providers in order to improve clinical outcomes. Consultation and liaison may occur with primary healthcare providers, acute health, emergency services, rehabilitation and support services, family, friends, other support people and carers and/or other agencies that have some level of responsibility for the client's treatment and/or well-being. If endorsed as the response option for 'principal focus of treatment', clinical care coordination and liaison activities are expected to account for a <b>significant proportion</b> of service contacts delivered throughout the episode.	Services delivered under MHNIP fall in this category.
<b>Complex care package</b>	Primarily involves the delivery of an individually tailored 'package' of services for a client with a severe and complex mental illness who is being managed principally within a primary care setting. The client receives an individually tailored 'package' of services that bundles a range of services that extend beyond 'standard' service delivery and which is funded through innovative, non-standard funding models. <b>Note: Only three selected PHN Lead Sites with responsibilities for trialling work in this area are expected to deliver complex care packages. A wider rollout may be undertaken in the future.</b>	HNECC is not a lead site for this trial work. This category is not to be used.
<b>Child and youth-specific mental health services</b>	Primarily involves the delivery of a range of services for children (0-11 years) or youth (aged 12-24 years) who present with, or are at risk of developing, a mental illness. The treatment episode provides services that are designed specifically for children and young people, includes a broader range of both clinical and non-clinical services and may include a significant component of clinical care coordination and liaison. Child and youth-specific mental health episodes have substantial flexibility in types of services actually delivered.	Services designed specifically for children / youth i.e. Youth Complex Mental Health Service fall in this category.
<b>Indigenous-specific mental health services</b>	Primarily involves the delivery of mental health services that are specifically designed to be culturally appropriate for Aboriginal and Torres Strait Islander peoples.	Services delivered under Indigenous Mental Health Services fall in this category.
<b>Other</b>	Primarily involves services that cannot be described by the above categories.	HNECC commissioned mental health services captured in the PMHC-MDS fall in one of the above categories.

## 6.2 What about episodes of care focusing on suicide prevention?

The 'principal focus of treatment plan' response options do not specifically address the key service delivery area of 'suicide prevention'. To include 'suicide prevention' as a 'principal focus of treatment plan' would create categories that are not mutually exclusive (i.e. suicide prevention could be a focus within any of the listed 'principal focus' categories). Therefore, instead of using the 'principal focus' categories, you will be able to identify individuals who have a recent history of suicide attempt, or suicide risk as a factor noted in the referral, at the outset of the episode by using a 'suicide referral flag' in the PMHC MDS (<https://docs.pmhc-mds.com/data-specification/data-model-and-specifications.html#episode-suicide-referral-flag>).

## 6.3 Do I need to record the client's diagnosis for each episode of care?

Yes. Collection of the 'principal' (and 'additional') diagnosis of clients receiving services is essential to understand the types of mental health problems and disorders managed through PHN-commissioned services. You need to report diagnosis ('principal' and 'additional') at the overall episode level. If a diagnosis has been provided by the referrer, you should confirm or override the diagnosis based on your own assessment. If you are not clinically trained to diagnose mental disorders, your supervising clinical practitioner should determine the diagnosis ('principal' and 'additional').

The previous ATAPS/MHSRRA specification for diagnosis reporting represented a 'mixed bag'. It was set as a small number of categories to record high-level codes (based on the International Classification of Diseases (ICD)-10, Primary Care Version)<sup>2</sup> for anxiety and depressive disorders but amended

over the years to incorporate the various requirements of special funding devoted to high needs (or 'Tier 2') services as they were added.

The PMHC MDS provides a 'pick list' of diagnosis coding options developed to balance comprehensiveness and brevity. They comprise a mix of the most prevalent mental disorders in the Australian adult, child and adolescent population, supplemented by less prevalent conditions that may be experienced by clients of PHN-commissioned mental health services.

The diagnosis options are based on an abbreviated set of clinical terms and groupings specified in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV-TR)<sup>3</sup>.<sup>a</sup> These summarise the approximate 300 unique mental health disorder codes in the full DSM-IV to a set of 9 major (high-level) categories, and 37 individual codes. The diagnosis code list available in the PMHC MDS includes the following:

### Anxiety disorders

- 101 Panic disorder
- 102 Agoraphobia
- 103 Social phobia
- 104 Generalised anxiety disorder
- 105 Obsessive-compulsive disorder
- 106 Post-traumatic stress disorder
- 107 Acute stress disorder
- 108 Other anxiety disorder

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<sup>a</sup> The DSM-IV is the diagnostic classification currently used by the majority of Australian mental health clinicians. It is unlikely that most clinicians providing services through PHN commissioning arrangements have had training in, and moved across to, the new DSM-V system. Pending uptake of DSM-V, there is scope to change to the new classification in future versions of the PMHC MDS.

**Affective (Mood) disorders**

- 201 Major depressive disorder
- 202 Dysthymia
- 203 Depressive disorder NOS
- 204 Bipolar disorder
- 205 Cyclothymic disorder
- 206 Other affective disorder

**Substance use disorders**

- 301 Alcohol harmful use
- 302 Alcohol dependence
- 303 Other drug harmful use
- 304 Other drug dependence
- 305 Other substance use disorder

**Psychotic disorder**

- 401 Schizophrenia
- 402 Schizoaffective disorder
- 403 Brief psychotic disorder
- 404 Other psychotic disorder

**Disorders with onset usually occurring in childhood and adolescence not listed elsewhere**

- 501 Separation anxiety disorder
- 502 Attention deficit hyperactivity disorder (ADHD)
- 503 Conduct disorder
- 504 Oppositional defiant disorder
- 505 Pervasive developmental disorder
- 506 Other disorder of childhood and adolescence

**Other mental disorder**

- 601 Adjustment disorder
- 602 Eating disorder
- 603 Somatoform disorder
- 604 Personality disorder
- 605 Other mental disorder

**No formal mental disorder but sub-syndromal problem**

- 901 Anxiety symptoms
- 902 Depressive symptoms
- 903 Mixed anxiety and depressive symptoms
- 904 Stress related
- 905 Other

The diagnostic options accommodate PHN-led reforms, which require extending service delivery to 'low intensity' clients who do not currently meet formal diagnostic criteria, but are at risk of developing a mental illness and present with significant mental health problems that are 'sub-syndromal'.

## 7. WHAT INFORMATION DO I NEED TO REPORT AT EACH SERVICE CONTACT?

### 7.1 What is a service contact?

Service contacts represent the basic unit for counting and describing activities in the PMHC MDS. Under previous ATAPS/MHSRRA arrangements, the concept was referred to as a 'session' and involved a direct interaction between a service provider and the client, whether it was face to face or through another medium (telephone, internet). However, in order to capture the full extent of new mental health services delivered to people principally managed in the primary healthcare setting, the PMHC MDS provides for a wider definition of service contact, but which is client-related, clinically relevant activity.

Therefore, a 'service contact' is defined as an interaction between you (the service provider) and either the client or a third party (e.g., carer, family member, other professional/service provider) which is:

- relevant to the clinical condition of the client (i.e., non-administrative in nature);
- involves direct communication irrespective of whether occurring face to face, by telephone, internet, video link etc.; and
- would normally warrant a dated entry in the clinical record of the client.

An implication of this approach is that the data collection requires a 'flag' against each recorded service contact to indicate whether the client participated, and if not, who was the recipient of the contact (<https://docs.pmhc-mds.com/data-specification/data-model-and-specifications.html#service-contact-participants>).

### 7.2 Classifying types of services delivered at each service contact

In addition to basic details about each service contact (e.g., date, duration, location, client out of pocket costs etc.), you will need to collect information about the type of services delivered in order to enable a description of the mix of services provided (within and across episodes of care).

The previous ATAPS/MHSRRA data collection categorised types of services according to the specific psychological interventions delivered, but this is too narrow for the broader range of services to be offered under the new primary mental healthcare arrangements.

Therefore, the approach adopted for the PMHC MDS will require you to report on the **main service** delivered (based on the activity that accounted for **most** of your time) at each service contact from the list shown in Table 3.

Classifying an episode of care into a 'principal focus of treatment plan' category does not restrict what is recorded at each service contact. For example, an episode with a 'principal focus' of 'clinical care coordination' may include contacts of any type.

Table 3: Service type categories

Category	Definitions
<b>Assessment</b>	Determination of a person's mental health status and need for mental health services, made by suitably trained mental health professional, based on collection and evaluation of data obtained through interview and observation, of the person's history and presenting problem(s). Assessment may include consultation with person's family and concludes with formation of problems/issues, documentation of preliminary diagnosis, and treatment plan.
<b>Structured psychological intervention</b>	Psychological interventions which include structured interaction between you and client using recognised, psychological method (e.g., cognitive behavioural techniques, relaxation strategies, skills training, interpersonal therapy, family therapy, or psycho-education counselling). Structured psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health. Can be delivered to either an individual client or group of clients, typically in an office or community setting. May be delivered by trained mental health professionals or other individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional.
<b>Other psychological intervention</b>	Psychological interventions that do not meet criteria for structured psychological intervention.
<b>Clinical care coordination/ liaison</b>	Activities focused on working in partnership and liaison with other healthcare and service providers and other individuals to coordinate and integrate service delivery to the client with the aim of improving their clinical outcomes. Consultation and liaison may occur with primary healthcare providers, acute health, emergency services, rehabilitation and support services, family, friends, other support people and carers and other agencies that have some level of responsibility for the client's treatment and/or wellbeing.
<b>Clinical nursing services</b>	Services delivered by mental health nurses that cannot be described elsewhere. Typically, these aim to provide clinical support to clients to effectively manage their symptoms and avoid unnecessary hospitalisation. Clinical nursing services include: <ul style="list-style-type: none"> <li>• monitoring a client's mental state;</li> <li>• liaising closely with family and carers as appropriate;</li> <li>• administering and monitoring compliance with medication;</li> <li>• providing information on physical healthcare that assists in addressing the physical health inequities of people with mental illness; and</li> <li>• improving links to other health professionals/clinical service providers.</li> </ul>
<b>Child or youth specific assistance - not elsewhere classified (NEC)</b>	Services delivered to, or on behalf of, a child or young person that cannot be described elsewhere (e.g., working with a child's teacher to provide advice on assisting the child in their educational environment; working with a young person's employer to assist the young person in their work environment).
<b>Suicide prevention specific assistance - NEC</b>	Services delivered to, or on behalf of, a client who presents with risk of suicide that cannot be described elsewhere (e.g., working with the person's employers to advise on changes in the workplace; working with a young person's teacher to assist the child in their school environment; or working with relevant community-based groups to assist the client to participate in their activities). <b>Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that the majority of Service Contacts delivered to clients who have a risk of suicide can be assigned to other categories.</b>
<b>Cultural specific assistance - NEC</b>	Culturally appropriate services delivered to, or on behalf of, an Aboriginal or Torres Strait Islander client that cannot be described elsewhere (e.g., working with the client's community support network including family and carers, men's and women's groups, traditional healers, interpreters and social and emotional wellbeing counsellors).

## 8. WHAT OUTCOMES DATA ARE REQUIRED AND WHEN SHOULD THESE BE COLLECTED?

Ongoing monitoring of client progress using standardised measures is critical to informing treatment decisions and ongoing dialogue between you and your clients. The previous ATAPS/MHSRRA allowed an extensive list of outcome measures options from which the service provider made a selection at his/her discretion, but these had relatively poor uptake. A small number of outcome measures has been carefully selected and set as mandatory for all episodes of care recorded in the PMHC MDS. These mandatory outcome measures have been selected for their psychometric properties, brevity, wide use, and their availability in the public domain. Importantly, the selected mandatory outcome measures enable better comparisons within the new primary mental healthcare service delivery model (i.e., pre- and post-treatment for a given client in terms of movement towards recovery, and between clients). In addition, these outcome measures will enable comparisons external to PHN-commissioned primary mental healthcare services, such as with Australian general and clinical populations.

Table 4 shows which outcomes measures are mandatory according to the client population group.

Multiple versions of the Strengths and Difficulties Questionnaire (SDQ)<sup>4</sup> are available and vary according to when the measure is used (baseline vs follow-up), age (4-10 year, 11-17 years) and who provides the information (parent vs child self-report). The versions specified for PMHC MDS reporting are:

- PC1 - Parent Report Measure for Children aged 4-10, Baseline version;
- PC2 - Parent Report Measure for Children aged 4-10, Follow-up version;

- PY1 - Parent Report Measure for Youth aged 11-17, Baseline version;
- PY2 - Parent Report Measure for Youth aged 11-17, Follow-up version;
- YR1 - Youth Self Report Measure (11-17), Baseline version; and
- YR2 - Youth Self Report Measure (11-17), Follow-up version.

For the mandatory measures, the concept of 'collection occasion' is defined as an occasion during an episode of care when you need to collect the required outcome measure data. At a minimum, you are expected to collect outcome data at both the commencement and conclusion of each episode of care. You may do so more frequently if clinically indicated and agreed by the client; these collection occasions can now be captured in the PMHC MDS, which differs from the ATAPS/MHSRRA collection that did not allow outcome measures to be recorded beyond episode start and end.

Individual item scores may be reported for all scales and will eventually be required once the system has been implemented. In the short term, acknowledging that reporting individual item scores may not be possible for all providers, reporting overall scores/subscales is allowed. Therefore:

- For the K10+, you can either report all 14 item scores, or report the K10 total score as well as item scores for the 4 extra items in the K10+.
- For the K5, you can either report all 5 item scores, or report the K5 total score.
- For the SDQ, you can either report all 42 item scores, the SDQ subscale scores or the total difficulties score.

Details of mandatory outcome measures are available on the PMHC MDS website (<https://www.pmhc-mds.com/resources/>).

You may choose to use additional outcome measures to meet local (service provider organisation or PHN) requirements, but these are not necessary for entering into the PMHC MDS. If you choose to use additional outcome measures, it is your responsibility to make sure that they are freely available in the public domain and do not require a copyright license.

**Table 4: Mandatory outcome measure by client sub-population**

Sub-population	Mandatory outcome measure
Adults	<b>Kessler-Psychological Distress Scale 10<sup>5</sup></b> (K-10+ version). The K-10 is a 10-item self-report measure of non-specific psychological distress. It is the most widely used measure in Australia, has comprehensive normative data and has demonstrated utility in measuring client progress (or deterioration). It also has a very high correlation with other widely used measures (e.g., PHQ-9, GAD-7). <sup>6</sup> The K-10+ version includes an additional four items that assess functional impairment associated with psychological distress. Available at: <a href="http://www.amhocn.org/what-collected/nocc-measures">http://www.amhocn.org/what-collected/nocc-measures</a>
Aboriginal and Torres Strait Islander people	<b>Kessler-5 (K-5)<sup>7</sup></b> may be used as an alternative to the K10 for Indigenous clients. The K5 measure of psychological distress is a subset of five questions from the K10. Available at: <a href="http://www.abs.gov.au/ausstats/abs@.nsf/lookup/84330C2EDC3DB940CA2579D50015D74E?opendocument">http://www.abs.gov.au/ausstats/abs@.nsf/lookup/84330C2EDC3DB940CA2579D50015D74E?opendocument</a>
Children and adolescents (2-17 years)	<b>Strengths and Difficulties Questionnaire (SDQ)<sup>4</sup></b> . The SDQ is used with significant utility by all state and territory child and adolescent mental health services and also has recent population-level data gathered through the 2013-14 Second Australian Child and Adolescent Survey of Mental Health and Wellbeing <sup>8</sup> . Available at: <a href="http://www.amhocn.org/what-collected/nocc-measures">http://www.amhocn.org/what-collected/nocc-measures</a>
Adolescents (12+ years)	<b>K10+ (or K5 for Indigenous clients)</b> as an alternative to the SDQ if this is considered appropriate to the client's situation. The K10 has been used successfully in a number of studies of adolescents in Australia e.g., the national evaluation of <i>headspace</i> <sup>9</sup> ; the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing <sup>8</sup> .

## 9. DOES THE CLIENT HAVE TO PROVIDE CONSENT TO ALL THIS AND HOW?

In order to comply with the Commonwealth Privacy Act 1988, the Privacy Amendment (Private Sector) Act 2000 and associated Australian Privacy Principles, the client must provide consent to their data being provided to both:

- PHNs; and
- the Australian Government Department of Health, supplied by PHNs.

Note that data provided to the Department of Health will be anonymised, which means that the data will not include identifying information, such as an individual's name, address or Medicare number.

The PMHC MDS includes an item to confirm that client consent for data supply to the Department has been obtained. Any records attached to clients who do not provide consent will not be passed to the Department.

Providers are responsible for ensuring that appropriate consent processes are in place and client consent for supply of their data is obtained. Whilst in many instances the referrer will obtain the client's consent. Providers may need to obtain consent from the client in situations where, for example, the referrer has not obtained consent or the client has self-referred. The Department of Health has prepared a set of standard words that can be used, or adapted as necessary, in any locally developed consent forms. These are available on the resources section of the PMHC MDS website (<https://www.pmhc-mds.com/resources/>).

## 10. WHERE CAN I ACCESS SUPPORT IN USING THE PMHC-MDS?

The PMHC MDS is managed by Strategic Data under contract by the Department of Health. For support in using the PMHC MDS visit the support website <https://pmhc-mds.com> where there is a range of resources, including user guides, data specifications and FAQs. There is also a helpdesk function and an option to request online training. On occasion, helpdesk staff may advise that you contact your PHN to obtain local level guidance, however the majority of queries will be addressed by the Strategic Data helpdesk so it is recommended that you contact them in the first instance.

## 11. WHAT'S DIFFERENT FROM THE FORMER ATAPS/MHSRRA MDS FOR WHICH I PREVIOUSLY COLLECTED DATA?

If you were involved in delivering services via the former ATAPS/MHSRRA programs, you will notice some similarities and differences between the new PMHC MDS and the previous ATAPS/MHSRRA MDS, many of which have already been described throughout this guide.

The key similarities are that both systems capture data that describe the characteristics of clients and the services provided and both systems currently enable data to be uploaded from local systems into a web-based portal. The ATAPS/MHSRRA MDS also enables direct data entry via the web-based portal and the PMHC MDS will have this facility developed over the next few months. Like the ATAPS/MHSRRA MDS, the PMHC MDS will have the flexibility to be modified in response to emerging PHN and Department of Health requirements. Neither the ATAPS/MHSRRA, nor the PMHC MDS captures community capacity building activities, such as those undertaken as part of the National Suicide Prevention Program

The overall differences between the MDS systems are that the development of the new PMHC MDS has resulted in:

- the addition of new data items, or amendments to existing items, necessary to accommodate the broader range of primary mental healthcare services being commissioned by PHNs;
- retirement of previous data items that have not demonstrated their worth, in order to reduce data collection burden to the maximum extent possible; and
- alignment of data items (and response options) with current national data collection standards.

Some of the key specific differences between the ATAPS/MHSRRA MDS and the PMHC MDS are summarised in Table 5.

## 12. WHAT'S DIFFERENT FROM THE PREVIOUS DATA REPORTING FOR NURSES UNDER THE FORMER MHNIP PROGRAM?

If you were involved in delivering services via the MHNIP program, you will notice more differences than similarities in data collection and reporting requirements in the transition from the previous MHNIP to the current PMHC flexible funding pool.

The most significant change is that the unit of reporting under MHNIP was the 'session', defined as a 3½-hour block. Multiple client contacts were reported against each session, as opposed to the PMHC MDS, which requires each contact to be reported separately.

Other key differences include:

- 1) More in-depth client and service data are required to be reported for the delivery of services via PMHC flexible funding;
- 2) The PMHC MDS provides a repository for the entry or upload of the more in-depth data (and so data will no longer need to be reported to the Department of Human Services);
- 3) Unlike the MHNIP which required use of the Health of Nation Outcome Scale (HoNOS) to assess client outcomes, the outcome measures to be used for services delivered via PMHC flexible funding are the K10+, the K5 and the SDQ as outlined in Section 8 of this guide.

Table 5: Summary of key differences between ATAPS/MHSRRA and PMHC MDS

ATAPS/MHSRRA	PMHC
ATAPS/MHSRRA data only	Other mental health services (e.g., MHNIP, low intensity), and <b>may</b> incorporate youth services (e.g., headspace, Early Youth Psychosis) in future
Only PHN (and previously Medicare Local/Division of General Practice) identified at organisation level	PHNs and their commissioned organisations identified
Workforce data incorporated as program evolved	Improved workforce data; incorporated from outset
Variable processes for allocation of region-wide unique client identifiers	Introduction of a consistent process for allocation of region-wide unique client identifiers
'Referrals' as proxy for defining 'episodes' with Tier 1 and Tier 2 ('high needs') available as referral types	Enhanced approach to defining 'episodes' according to broadened 'principal focus of treatment plan' capturing the various new types of services to be delivered (e.g., psychological therapy, low intensity psychological intervention, clinical care coordination, complex care package, child and youth-specific mental health services, Indigenous-specific mental health services)
<p>Diagnosis</p> <ul style="list-style-type: none"> <li>Limited diagnostic categories based on ICD-10 Primary Care Version</li> <li>Multiple diagnoses permitted</li> </ul>	<p>Diagnosis</p> <ul style="list-style-type: none"> <li>Comprehensive (abbreviated) diagnostic categories, based on DSM-IV-TR</li> <li>Distinguishes between principal vs additional diagnoses</li> </ul>
Service contact limited to 'session' involving clients (and /or family members)	Service contacts expanded to include interactions with third parties in relation to the client, including where the client is not present
Categorisation of services according to specific type of psychological intervention delivered	Broader categorisation of service contacts to capture new service types (e.g., clinical care coordination, clinical nursing services and other services not directly involving the client)
<p>Outcome measures</p> <ul style="list-style-type: none"> <li>extensive list limiting meaningful data analysis</li> <li>pre- and post-treatment scores only</li> <li>option to record individual item, subscale or total scores</li> </ul>	<p>Outcome measures</p> <ul style="list-style-type: none"> <li>reduced to core set of mandatory measures (K-10+, K-5, SDQ)</li> <li>pre- and post-treatment scores and scores at any time during episode</li> <li>option to record individual item, subscale or total scores initially will eventually change to mandatory recording of individual item scores</li> </ul>
Client consent not recorded	Client consent recorded

### 13. REFERENCES

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### 14. OTHER RESOURCES

[www.pmhc-mds.com](http://www.pmhc-mds.com) - provides information about the PMHC MDS, including information about how to get started, resources (e.g., specifications) and ongoing communication updates