



**Australian Government**

**Department of Health**

# **PRIMARY MENTAL HEALTH CARE MINIMUM DATA SET**

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Overview of purpose, design, scope and  
key decision issues

**16 SEPTEMBER 2016**

For details on the PMHC MDS go to: <https://www.pmhc-mds.com/>

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### Version History

Date	Details
17 June 2016	Version prepared for initial consultation with PHN PMHC MDS Reference Group
8 July 2016	Version released for PHN consultation
16 September	Version prepared to accompany release of V1.0 of PMHC MDS specifications

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## 1. PURPOSE

This paper outlines the approach taken to the design of the Primary Mental Health Care Minimum Data Set (PMHC MDS) and associated reporting arrangements to be implemented across all Primary Health Networks (PHNs). The PMHC MDS arrangements will provide the basis for monitoring and evaluation of primary mental health care services commissioned through the PHNs flexible funding pool. They will do this by:

- defining the common data to be collected in relation to all mental health services commissioned by PHNs;
- setting standards for how the various data items are defined; and
- specifying the requirements for national reporting.

The PMHC MDS data reported through PHNs will form the basis for production of key performance indicators used to monitor services delivered across the 31 PHN regions covered by PHNs. Summary details of these indicators are included in the current paper and have been more fully documented in a separate paper.<sup>1</sup>

This paper provides an outline of what the PMHC dataset and reporting arrangements will entail. The final section of the paper describes critical decision points in the design of the collection on which feedback will be sought from PHNs via the PMHC MDS Reference Group.

## 2. BACKGROUND

### 2.1 Primary mental health care reforms

Funding has been provided to Primary Health Networks (PHNs) through a Primary Mental Health Care Funding Pool to support commissioning of mental health and suicide prevention services in six key service delivery areas:

- low intensity psychological interventions for people with, or at risk of, mild mental illness;
- psychological therapies delivered by mental health professionals to underserved groups;
- early intervention services for children and young people with, or at risk of mental illness;
- services for people with severe and complex mental illness who are being managed in a primary care setting;
- enhanced Aboriginal and Torres Strait Islander mental health services; and

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<sup>1</sup> *Performance indicators for Primary Health Network-led mental health reform: Draft specifications for reporting by Primary Health Networks. Mental Health Reform Task Force, Department of Health*

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- a regional approach to suicide prevention activities with a focus on improved follow-up for people who have attempted suicide or are at high risk of suicide.

The PMHC MDS is designed to capture service delivery across all six areas.

### 2.2 Key performance indicators

A set of 11 key service delivery performance indicators (KPIs) has been specified for monitoring overall delivery of services commissioned by PHNs, covering four performance domains – access, efficiency, appropriateness and effectiveness (Figure 1).

**Figure 1: Service delivery performance indicators and associated performance domains**

PERFORMANCE INDICATOR	Number of performance indicators	PERFORMANCE DOMAIN			
		Access	Efficiency	Appropriateness	Effectiveness
Proportion of regional population receiving PHN commissioned mental health services: <ul style="list-style-type: none"> <li>• Low intensity psychological interventions</li> <li>• Psychological therapies delivered by mental health professionals</li> <li>• Clinical care coordination for people with severe and complex mental illness</li> </ul>	3	▲			
Average cost of PHN commissioned mental health services: <ul style="list-style-type: none"> <li>• Low intensity psychological interventions</li> <li>• Psychological therapies delivered by mental health professionals</li> <li>• Clinical care coordination for people with severe and complex mental illness</li> </ul>	3		▲		
Proportion of regional youth population receiving PHN commissioned youth-specific mental health services	1	◆		▲	
Proportion of PHN commissioned mental health services delivered to the regional Indigenous people where the services were culturally appropriate	1	◆		▲	
Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they are at risk of suicide followed up within 7 days of referral	1	◆		▲	
Clinical outcomes for regional population receiving PHN commissioned mental health services: <ul style="list-style-type: none"> <li>• Low intensity psychological interventions</li> <li>• Psychological therapies delivered by mental health professionals</li> </ul>	2				▲

▲ Primary domain      ◆ Secondary domain

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The performance indicators have been specified on the premise that a comprehensive primary mental health care dataset is developed and reported by all PHN commissioned services.

### 2.3 Minimum data set specified as requirement of funding schedules

Funding schedules developed to provide mental health funding to PHNs stipulate the reciprocal obligations of the Department and PHN organisations in the development and reporting of the new PMHC MDS. The schedules require:

- the Department to develop specifications for the PMHC MDS and establish arrangements for reporting of data by PHNs by December 2016, using as a foundation the previous data collection and reporting arrangements established for the ATAPS and MHSRRA programs;
- the Department to undertake this work in consultation with PHNs to ensure that all mandatory data are both relevant to monitoring achievement of key objectives and feasible for reporting; and
- PHNs to ensure all mandatory data are reported to the PMHC MDS, achieving full compliance with reporting by 30 June 2017.

## 3. OVERVIEW OF THE PMHC MINIMUM DATA SET

### 3.1 Design principles

#### 3.1.1 *Minimum data set to meet a range of purposes*

The PMHC MDS is designed to meet a number of regional and national purposes. At the regional level, the collection is aimed at supporting the role of PHNs by:

- providing the basis for monitoring service delivery by commissioned organisations across the key performance domains and informing judgements about outcomes and value for money;
- supporting ongoing regional needs analysis and planning by identifying service coverage and potential gaps;
- providing meaningful data for benchmarking both within across regions to support targeted regional service quality improvement initiatives;
- establishing a base collection for local program evaluations that can be augmented by additional purpose-specific data; and
- informing communication with regional stakeholder and the broader community based on information that is comparable to other regions.

The PMHC MDS does not confine PHNs to the data specified. Rather, it sets the minimum and common ground for what data are to be collected and reported for services

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commissioned by PHNs. It is anticipated that many PHNs will seek to collect an enhanced set of data to meet local needs, however this data will not be submitted to the MDS.

At the national level, the collection will:

- provide the basis for monitoring the implementation of Government primary mental health care reforms;
- be used as a foundation for accountability arrangements with PHNs and inform regular review and updating of annual activity work plans;
- serve as the core data for use in national evaluations of mental health reforms; and
- support ongoing national planning and policy development for primary mental health care.

### **3.1.2** *Scope – activities included and excluded*

The new arrangements are 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 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 and report on a broader range of services than the current ATAPS/MHSRRA minimum data set, covering the full spectrum of individual client-centred services expected to be developed 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’. PHNs commissioning activities of this type will have flexibility to establish local data reporting arrangements that suit requirements.

First stage development will focus on the above areas and not include existing youth-specific services (headspace, Early Psychosis Youth Services) that currently collect and report a standardised dataset to headspace National Office. Pending the future of these arrangements, and access to data by PHNs, the PMHC minimum data set can be expanded

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at a future stage to allow incorporation of headspace and Early Psychosis Youth Services should this be required.

### **3.1.3** *Built on existing ATAPS foundation*

The PMHC MDS does not represent a ground up development but rather is built on the foundation established by the current ATAPS/MHSRRA minimum data set. Established in 2003 to cover the then new ATAPS primary mental health program, this system has been used successfully by Divisions of General Practice, and later, Medicare Locals to collect and report unit record data to the Department. In 2015-16, the system was broadened to cover the MHSRRA program. In July 2015 PHNs took over responsibility for the ATAPS and MHSRRA programs and with it collection of the minimum dataset. Currently, all PHNs have access to the system and are reporting data to the Department.

This ATAPS/MHSRRA data collection comprises socio-demographic and clinical information collected by the general practitioner or referrer and service-level information collected by the mental health professional at each session, which is entered or uploaded from local systems into a web-based portal.

### **3.1.4** *Flexibility to incorporate emerging requirements*

Changes to the PMHC MDS are expected to be made following the establishment phase, and in response to expansion by PHNs and their experience of the data collection. The design of the data model is aimed to be sufficiently comprehensive to allow future modifications.

Changes to requirements will be undertaken in consultation with PHNs.

## **3.2 The data to be collected**

The content of the PMHC data is designed to answer the complex multi-part 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 covers 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). Figure 2 summarises the type of data to be collected.

**Figure 2: Summary of information to be collected**

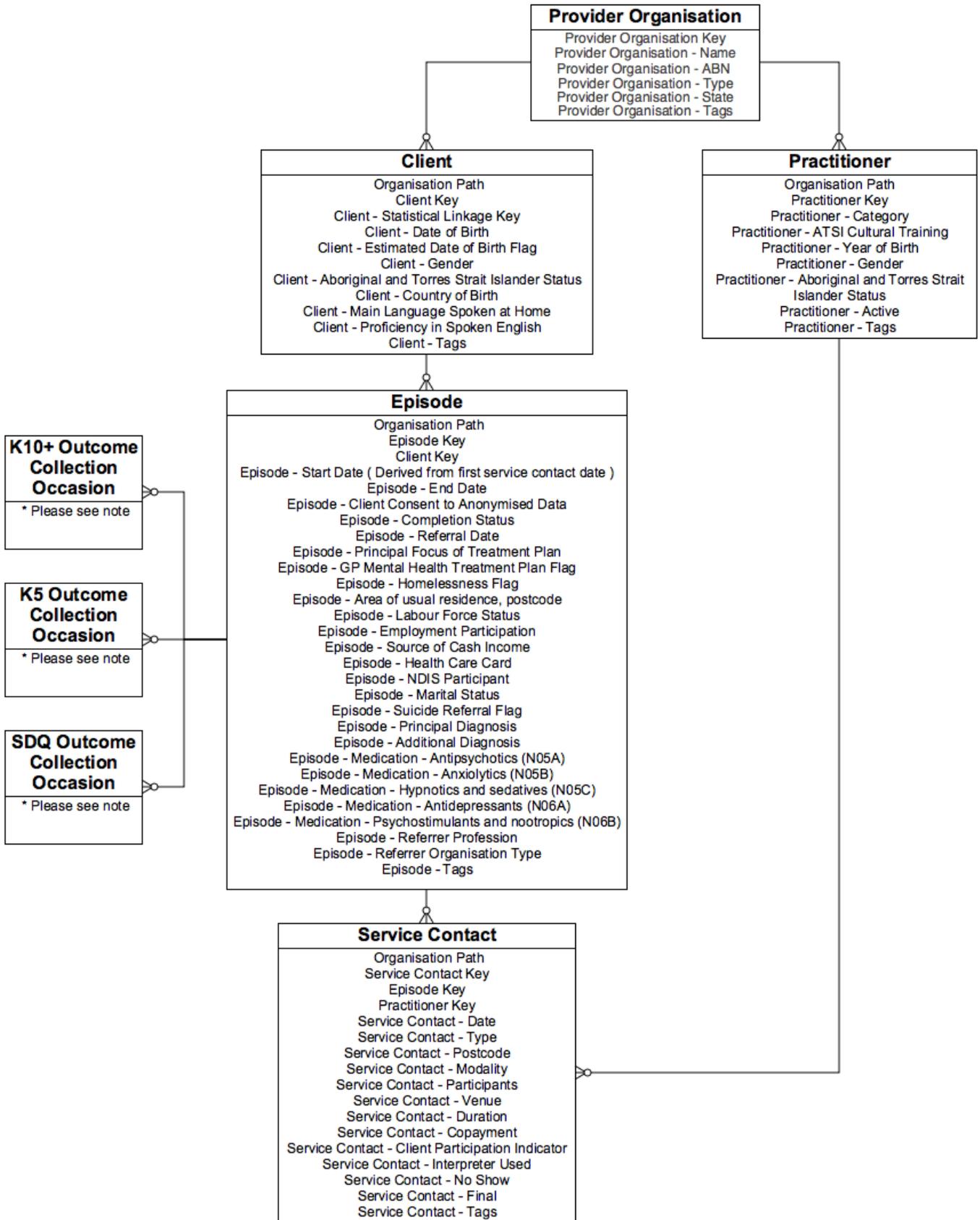
Question	What data will inform this question?
Who receives ...	Demographic and clinical characteristics of service consumers, collected at episode level by service providers
What services ...	Range of data collected by service provider for each individual service event (e.g., date and type of service, duration)
From whom ...	Service provider and organisation details characteristics Details of organisation and mental health workforce delivering services, reported by provider
At what cost ...	Cost data to be derived from annual financial statements maintained by PHN, supplemented by out of pocket costs to consumer collected and reported by providers for each service event
With what effect	Client outcome data, maintained by provider using standard instruments

Summary details of the items to be collected are provided at Attachment A. Full details of all items including definitions, data domains and formats are available on-line at <https://www.pmhc-mds.com/> .

### **3.3 Data model**

The basic model follows the structural concepts that have been successfully applied for ATAPS/MHSRRA. These concepts have broad applicability and are not tied exclusively to the types of services delivered through ATAPS and MHSRAA. The data model is summarised in Figure 3.

Figure 3: The data model and data to be collected at each level

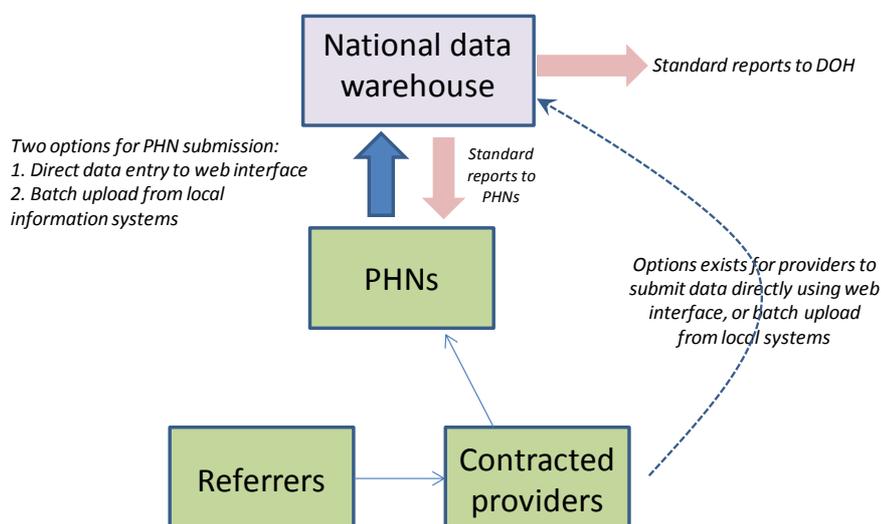


### 3.4 Comparison to current ATAPS system

In addition to continuation of much of the data content captured in the current ATAPS/MHSRRA arrangements, the PMHC MDS retains many of the previous design features. These include the basic data flow (Figure 4) and following features:

- data managed via a national data warehouse
- data submitted by service providers through a secure web-based portal, or to PHNs to collate/aggregate and submit through the web-based portal, with option to batch upload from local systems or direct data entry via web interface for providers without suitable systems
- standard reports to be designed to meet PHN and departmental requirements
- capacity for PHNs to download data for further detailed analytics
- automated receipting and validation of data.

**Figure 4: Data flows in existing arrangements that will be maintained**



Changes to the existing arrangements have focused on, but limited to:

- addition of new data items, or amendments to existing items, necessary to accommodate the broader range of primary mental health care services being commissioned by PHNs;
- an enhanced approach to defining episodes;
- introduction of a process for allocation of region-wide unique client identifiers;
- improvements to the type of data captured on the mental health workforce delivering PHN-commissioned mental health services;
- alignment of data items with national standards that have emerged since 2003; and
- retirement of previous data items that have not demonstrated their worth, to reduce data collection burden to the maximum extent possible.

### 3.5 What the new arrangements mean for PHNs and commissioned service providers

The PMHC MDS sets the requirements for data collection and reporting that are expected by all PHNs. PHNs therefore need to ensure that the requirements are met by all contracted providers of individual client mental health services.

Decisions about how the data are collected and reported across the region will be at the discretion of each PHN.

### 3.6 Timelines

The PMHC MDS is progressing in stages, commencing with development of data specifications and followed by progressive upgrading of the existing web-based data submission and reporting arrangements. The process entails a set of short-term, interim arrangements for reporting of data covering new services that will run alongside the existing ATAPS/MHSRRA system.

The timetable for rollout of the new arrangement is outlined below.

11 July 2016	<p>Release of first draft of data specifications developed following feedback from PHN MDS Reference Group.</p> <p>These were released to foreshadow to all PHNs the indicative content of mandatory data to be reported and invite comment prior to finalisation.</p>
21 September) 2016	<p>Full minimum data set specifications released for use by PHNs in developing local systems and setting reporting requirements of commissioned providers.</p>
By end Oct 2016	<p><i>STAGE 1 of new data submission arrangements</i></p> <p>Interim web-based data submission process released for reporting by PHNs on all aspects of client service delivery including those not currently captured in the ATAPS/MHSRRA system.</p> <p>The interim process incorporates all new data items and excludes those 'retired' from the former ATAPS/MHSRRA minimum data set.</p> <p>Stage 1 requires PHNs and their service providers to <b>either</b>:</p> <ul style="list-style-type: none"><li>• export data from their client systems and upload to the MDS; or</li><li>• manually create spreadsheets that can then be uploaded.</li></ul> <p>It also includes a user management interface to allow PHNs to manage their service providers and a core set of reports relating to departmental reporting. However, the interim data submission process has significantly less functionality than the ATAPS system, including web-based data entry and editing.</p> <p>The ATAPS/MHSRRA system will be maintained and run alongside these interim arrangements for PHNs that are reliant on this system for data capture or chose to maintain parallel systems. However, new data</p>

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items being introduced to the PMHC MDS are **not** included.

The ATAPS/MHSRRA system will be maintained until a new integrated data entry interface is available in stage two.

By final quarter  
2016-17

### *STAGE 2 – integrated data submission arrangement*

This stage will bring together all reporting into a single data submission process. It will include a re-designed data entry user interface that allows online editing of the data in the MDS, a master patient index to allow service providers to manage client identifiers across PHNs and other reporting functionality.

The expected implementation timetable for PHNs, including decisions to be made regionally is:

From 1 July  
2016

Have in place data collection arrangements to cover services that fall in scope of previous ATAPS/MHSRRA programs and the new range of services being commissioned.

Based on regional requirements, decide whether to:

- maintain the existing ATAPS/MHSRRA data collection and submission arrangements in parallel with interim arrangements for new services, or
- to move across to a single approach to collection that will use the interim data submission process from 1 November 2016

From 1 Nov  
2016

Commence processes required for reporting/uploading of new service activity using interim reporting system.

Maintain existing ATAPS/MHSRRA reporting in parallel if the PHN decided to maintain this arrangement pending integrated Stage 2 developments.

By final quarter  
2016-17

Begin adoption of Stage 2 integrated PMHC data collection and submission arrangements.

30 June 2017

Full compliance with integrated reporting.

### 3.7 Consultation process

The Department is committed to engaging with PHNs in undertaking the development work and established a Reference Group to oversee the redesign of the MDS. Expressions of interest were called in April and met with significant interest. A total of 16 of the 31 PHNs nominated for Reference Group membership. An initial meeting of the group was held on 21 June 2016.

The Department appreciates that PHNs need to be aware of the specific data items they would need to report on to ensure that the commissioned services are collecting and

reporting on such data items. To this end it made available to all PHNs all materials prepared for the Reference Group consideration and requested comments to be submitted by those PHNs who are not Reference Group members. Comments and suggestions submitted by PHNs have been used to develop the final version of the specifications.

## 4. KEY DESIGN ISSUES

Like all minimum data sets, design of the PMHC MDS has entailed a number of critical decisions about what to collect, when to collect and how to collect the required data. This section of the paper describes the key decision issues considered by the Department and how these were resolved.

### 4.1 Defining episodes

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. This structure allows for determining a logical data collection protocol that specifies what data are collected when, and by whom. Different sets of PMHC MDS items are collected at various points in the client's engagement with the provider organisation. Some items are only collected once at the episode level, while others are re-collected at each service contact.

Concepts of episodes are used widely throughout the health system as a 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. 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.

There are several issues that make the definition of an episode in primary care settings particularly difficult. First, whilst the initiation of primary 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 clients may undergo treatment over extended periods. Finally, multiple organisations or practitioners within organisations may be involved in providing care during a particular period, with each provider agency or practitioner regarding their intervention as a discrete episode.

#### *Approach taken in PMHC MDS*

- For the purposes of the PMHC MDS, an episode of care is **defined as a more or less continuous period of contact between a client and a PHN-commissioned provider organisation that starts at the point of first contact, and concludes at discharge.**
- Three business rules apply to episodes of mental health care:

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### 1. One episode at a time for each client, defined at the level of the provider organisation

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 **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.

### 2. Episodes commence at the point of first contact

### 3. Discharge from care concludes the episode

Discharge may occur clinically or administratively in instances where contact has been lost with the client. A new episode is deemed to commence if the person re-presents to the organisation.

## 4.2 Identifying and classifying commissioned episodes of care to enable monitoring of policy implementation

Monitoring of service delivery needs to have capacity to group episodes of care into high level categories that align with policy priorities for primary mental health care reform – these have been the basis for the KPIs set for PHNs. Of particular importance are the six key service delivery areas required of PHNs identified in funding schedules described in brief as:

- low intensity psychological interventions
- psychological therapies delivered by mental health professionals
- early intervention services for children and young people
- services for people with severe and complex mental illness
- enhanced Aboriginal and Torres Strait Islander mental health services; and
- regional approach to suicide prevention activities focused on improved follow-up for people who have attempted suicide or are at high risk of suicide

Government requires a reliable mechanism to monitor service delivery across these areas just as PHNs require a means to monitor regional service delivery.

A nuanced solution to this issue has been adopted in the proposed PMHC MDS. This is based on the following considerations:

- *Principal category to be reported by the service provider*
  - While all key service areas could be ‘carved out’ post-facto from activity data by specific data analysis rules (e.g., only classify an episode as low intensity if the majority of services are delivered ‘low intensity’ workers), there is an over-riding requirement to ensure the data collection and reporting system

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allows PHNs to monitor service delivery against its commissioning targets in an ongoing manner.

- This should be based on data reported by providers rather than complex manipulations of data after the fact. The implication is that episodes of care delivered need to include a specific marker, reported by the service provider, of the main category of services to be provided and for these to be aligned where practical to the key areas of service delivery.
- *Categories need to be meaningful and mutually exclusive*
  - Robust definitions are required that allow the provider to make a judgement about complex facts. Service categories need to be as mutually exclusive as possible to minimise provider confusion about how to assign episodes.
- *Monitoring delivery across all six key service areas will require a mix of methods*
  - The six priority areas comprise a mix of concepts – ranging from a focus on specific sub-populations (e.g., children) to specific types of services (e.g., low intensity). A single approach to capturing all of these is not considered feasible.

### *Approach taken in PMHC MDS*

- Service providers are required to report on the ‘Principal focus of treatment plan’ for all accepted referrals.
- This requires a judgement to be made about the main focus of the services to be delivered to the client for the current episode of care, made following initial assessment and modifiable at a later stage.
- Operationally, the concept of ‘principal focus’ will be defined as **the range of activities that best describes the overall services intended to be delivered to the client across the course of the episode**. For most clients, this will equate to the activities that account for most time spent by the service provider.
- Principal focus of treatment plan is necessarily a judgement made by the provider at the outset of service delivery but consistent with good practice, would be made on the basis of a treatment plan developed in collaboration with the client. It may be modified throughout the course of treatment if the initial assessment proved incorrect.
- It is chosen from a defined list of categories, with the provider required to select the category that best fits the treatment plan designed for the client

Expanded definitions for the ‘principal focus of treatment plan’ concept have been developed. The categories and main features of each category are described below.

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Category	Principal focus of treatment plan
<ul style="list-style-type: none"><li>• Psychological therapy</li></ul>	<p>The treatment plan for the client is primarily based around the delivery of psychological therapy by one or more mental health professionals. This category most closely matches the range of services delivered under the previous ATAPS program.</p> <p>The concept of ‘mental health professionals’ has a specific meaning defined in the guidance documentation prepared to support PHNs in implementation of reforms.<sup>2</sup> It refers to service providers who meet the requirements for registration, credentialing or recognition as a qualified mental health professional and includes:</p> <ul style="list-style-type: none"><li>• Psychiatrists</li><li>• Registered Psychologists</li><li>• Clinical Psychologists</li><li>• Mental Health Nurses;</li><li>• Occupational Therapists;</li><li>• Social Workers</li><li>• Aboriginal and Torres Strait Islander health workers.</li></ul>
<ul style="list-style-type: none"><li>• Low intensity psychological intervention</li></ul>	<p>The treatment plan for the client is primarily based around delivery of time-limited, structured psychological interventions that are aimed at providing a less costly intervention alternative to ‘standard’ psychological therapy. The essence of low intensity interventions is that they utilise nil or relatively little qualified mental health professional time per client<sup>3</sup> and are targeted at people with, or at risk of, mild mental illness.</p> <p>Low intensity episodes can be delivered through a range of mechanisms including use of individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional; delivery of services principally through group-based programs; and delivery of brief or low cost forms of treatment by mental health professionals.</p>
<ul style="list-style-type: none"><li>• Clinical care coordination</li></ul>	<p>The treatment plan for the client is primarily based around delivery of a range of services where the overarching aim is to coordinate and better integrate care for the individual across multiple providers with the aim of improving clinical outcomes. Consultation and liaison may occur with primary health care</p>

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<sup>2</sup> Department of Health, PHN primary mental health care flexible funding pool implementation guidance: Psychological therapies provided by mental health professionals to underserved groups. August 2016. [http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental\\_Tools](http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools)

<sup>3</sup> Based on Bennet-Levy J, Richards D, Farrand P et al. *Oxford Guide to Low Intensity CBT Interventions*. Oxford University Press, 2010. [www.oup.com.au/titles/academic/psychology/9780199590117](http://www.oup.com.au/titles/academic/psychology/9780199590117)

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providers, acute health, emergency services, rehabilitation and support services or other agencies that have some level of responsibility for the client's clinical outcomes. These clinical care coordination and liaison activities are expected to account for a significant proportion of service contacts delivered throughout these episodes.

- **Complex care package**

The treatment plan for the client is primarily based around the delivery of an individually tailored 'package' of services for a client with severe and complex mental illness who is being managed principally within a primary care setting. The overarching requirement is that the client receives an individually tailored 'package' of services that bundles a range of services that extends beyond 'standard' service delivery and which is funded through innovative, non-standard funding models.

*Note: As outlined in the relevant guidance documentation, only the three selected PHN Lead Sites with responsibilities for trialling work in this area are expected to deliver complex care packages.<sup>4</sup> A wider roll-out may be undertaken in the future pending results of the trial.*
- **Child and youth-specific mental health services**

The treatment plan for the client is primarily based around the delivery of a range of services for children (0-11 years) or youth (aged 12-24 years) who present with a mental illness, or are at risk of mental illness. These episodes are characterised by services that are designed specifically for children and young people, include 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.
- **Indigenous-specific services**

The treatment plan for the client is primarily based around delivery of mental health services that are specifically designed to provide culturally appropriate services for Aboriginal and Torres Strait Islander peoples.
- **Other**

The treatment plan for the client is primarily based around services that cannot be described by other categories.

The categories do not specifically address one of the six key service delivery areas required of PHNs (Suicide prevention activities focused on improved follow-up for people who have

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<sup>4</sup> Department of Health, PHN primary mental health care flexible funding pool implementation guidance: Primary mental health care services for people with severe mental illness, August 2016.  
[http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental\\_Tools](http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools)

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attempted suicide or are at high risk of suicide) because to do so would create ambiguity in data reporting and compromise the mutual exclusivity requirement.

A different approach is required to identify people referred for episodes where suicide risk was an issue. This is described below.

### 4.3 How suicide prevention activity will be managed in the collection

Initial consideration was given to including suicide prevention as a separate 'principal focus' episode type. This was not considered a workable option because it would confuse the mutually exclusive boundaries that need to be created. Services delivered to individuals who have recently attempted suicide or are at risk of such may be a feature of all of the other 'principal focus' categories.

A specific marker of suicide prevention-oriented services to individuals is essential however, given that PHN KPIs include one that is focused on timely follow up of people referred following a recent suicide attempt or because they are at risk of suicide.

#### *Approach taken in PMHC MDS*

- The PMHC MDS includes a new 'suicide referral flag' in the dataset, recorded by the service provider at the outset of the episode. This item is defined to identify those individuals where a recent history of suicide attempt, or suicide risk, was a factor noted in the referral.

### 4.4 Determining what activities are in scope for reporting as service contacts

Service contacts represent the basic unit for counting and describing activities in the PMHC MDS. An effective, reliable approach to defining and counting service contacts is essential for PHNs to monitor service volumes, unit costs and overall service coverage of the regional population. Reliance on a measure of service contact (or 'occasion of service') to monitor service delivery is consistent with all equivalent data collections in the health field, including those covering state and territory community mental health services, community health centres and 'non-admitted' services delivered through public hospitals.

Under previous ATAPS/MHSRRA arrangements, the concept was referred to as a 'session'. However, with some exceptions, sessions could only be recorded **when there was a direct interaction between a service provider and the client**, whether it was face to face or through another medium (telephone, internet). This approach excluded a range of client-related activities that were undertaken **on behalf of the client**, such as interaction with significant others, care coordination activities entailing engagement with other agencies and so forth.

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A modified approach is embedded in the PMHC MDS that is based on the following considerations:

- Multiple studies have demonstrated that a significant component of the work of treatment clinicians who work with people with mental illness entails engaging with individuals other than the client. Typically, these include other health or social service providers, family members or other significant others in the client's support network.
- The increased flexibility given to PHNs in commissioning services to meet individual client needs requires that a broader range of services than the constricted ATAPS 'session' concept.
- States and territories have grappled with the issue and resolved many years ago to allow service delivered on behalf of clients – where the client was not present – to be recorded and counted as service contacts in the community mental health information collections, endorsed also in the national data. These make up about 30% of total contacts recorded.
- The primary care reform emphasis in improved care coordination for people with severe mental illness who are being principally managed by primary health care services necessitates a wider definition of contact to allow the full extent of service provision to this target group to be gauged.
- Any broadening of what can be reported as a Service Contact needs to confine the scope to client related, clinically relevant activity. This is necessary to prevent the PMHC MDS being designed as an all-encompassing 'time and motion' record of all activities engaged in by mental health service providers.

### *Approach taken in PMHC MDS*

- Service contacts are defined using an approach based on that established for state and territory mental health community mental health services, with appropriate modifications. The essence of the definition is below:
  - Service contacts are defined as the provision of a service by a PHN commissioned mental health service provider for a client where the nature of the service would normally warrant a dated entry in the clinical record of the client.
  - A service contact must involve at least two persons, one of whom must be a mental health service provider.
  - Service contacts can be either with the client or with a third party, such as a carer or family member, and/or other professional or mental health worker, or other service provider.

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- Service contacts are not restricted to face-to-face communication but can include telephone, internet, video link or other forms of direct communication.
- Service provision is only regarded as a service contact if it is relevant to the clinical condition of the client. This means that it does not include services of an administrative nature (e.g. telephone contact to schedule an appointment).

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. Two items have been added to the collection to capture these aspects - see the data items:

- Mental health service contact - client participation indicator
- Service participants

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

In addition to basic details about each service contact (e.g., date, duration, location etc), the MDS also should include capture of information about the type of services delivered. This is necessary to understand the mix of services provided within and across episodes of care. The key requirements are to design a list of service types that is:

- policy relevant;
- meaningful to both consumers, practitioners and PHNs; and
- minimalist but comprehensive

Meeting all these requirements is a challenge. Information system developers in the health field have variously approached the task. A common approach is to develop a list of interventions from which the provider is required to select one or more options that describes what was delivered at each treatment encounter. Typically, the lists are extensive, aimed at comprehensively covering all options, and overwhelm service providers with choice. Data quality is often poor as a result.

The previous ATAPS data collection collects information about types of services delivered based around specific psychological interventions but this is too narrow for the broader range of services to be offered under the new primary mental health care arrangements. Data quality has also been problematic as the code list offered to clinicians lacks definitional specificity and is over inclusive.

#### *Approach taken in PMHC MDS*

- The approach adopted for the PMHC MDS includes an item titled 'Service contact – Type' that requires service providers to report on the main service delivered at each service contact. This is selected from a small list of options, and based on the

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activity that accounted for most provider time. The categories for selection of main service type are:

- 1 Assessment
  - 2 Structured psychological intervention
  - 3 Other psychological intervention
  - 4 Clinical care coordination/liaison
  - 5 Clinical nursing services
  - 6 Child or youth specific assistance NEC<sup>5</sup>
  - 7 Suicide prevention specific assistance NEC
  - 8 Cultural specific assistance NEC
- Definitions are provided at Attachment B.
  - Service Contact – Type differs from the data item ‘Principal focus of treatment plan’ because it requires information about each service contact. ‘Principal focus of treatment plan’ requires a judgement about the overall episode of care, made at the point of developing the clients treatment plan (but can be modified later). 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.

### 4.6 Diagnosis coding

Collection of the principal diagnosis of clients receiving services is essential to understand the types of mental health problems and disorders managed through PHN-commissioned services. Diagnosis is to be reported at overall episode level, with diagnosis (Principal and Additional) assigned by the treating or supervising clinical practitioner.

The key issue to be resolved concerned the level of diagnosis coding that should be set as the minimum and what classification system is to be used. The previous ATAPS specification for diagnosis reporting represented a ‘mixed bag’. It was set as a small number of categories to record high level codes for anxiety and depressive disorders but amended over the years to incorporate the various requirements of special Tier 2 funding levels as they were added. Where diagnosis was recorded, anxiety-related and depressive conditions together accounted for around 80%. Diagnoses entered as un-coded free text account for 19%. Most importantly, diagnosis was not recorded for just under a third (28%) of all clients, likely due to a number of problems including poor compliance with requirements and inadequacies of the coding options provided to clinicians.

Multiple options are available for use in the PMHC MDS. These include:

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<sup>5</sup> NEC refers to ‘not elsewhere classified’ – that is, the activity cannot be described by the available categories.

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- Incorporation of the full ICD-10 AM coding list for mental disorders. This would entail allowing many hundreds of diagnostic codes most of which are very rarely seen in primary mental health care, if at all.
- Base the coding around the high level mental disorder chapters of the ICD-10. This approach has the advantage of simplicity but is poorly targeted to report on the most common disorders seen in primary mental health care. For example, around 80% of clients treated would fall within two categories. (F30-F39 and F40-48). A more fine-grained approach is required that allows better clinical profiling of clients but does not cause 'diagnosis clutter'.
- Base the coding on the full set of codes developed for the ICPC-2 primary care system to describe psychological problems, as used for example in the reporting of BEACH studies of General Practitioner activities. While intuitively appealing, this approach more reflects an extensive list of presenting problems than formal diagnostic codes. It is also regarded as unhelpful by many mental health clinicians.
- Develop a customised list of diagnosis codes that are based on the most prevalent conditions included in Australian National Surveys of Mental Health and Wellbeing conducted across adult and child and adolescent populations over the past two decades (see Figure 5 and Figure 6). Although based on DSM-IV clinical diagnoses and descriptions rather than ICD-10, these more closely align with diagnostic approaches used by Australian mental health clinicians.
- An additional consideration concerns the need to design the approach to diagnosis reporting to reflect that PHN-led reforms require extending service delivery to 'low intensity' clients who are at risk of developing a mental illness. Many in this group are anticipated to present with significant mental health problems that are subsyndromal and do not currently meet formal diagnostic criteria.

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**Figure 5: Diagnosis range used in the 2007 National Survey of Mental Health and Wellbeing – Adults 16-85<sup>6</sup>**

	% population
<b>Anxiety disorders</b>	
Panic Disorder	2.6
Agoraphobia	2.8
Social Phobia	4.7
Generalised Anxiety Disorder	2.7
Obsessive-Compulsive Disorder	1.9
Post-Traumatic Stress Disorder	6.4
<i>Any Anxiety disorder</i>	14.4
<b>Affective disorders</b>	
Depressive Episode	4.1
Dysthymia	1.3
Bipolar Affective Disorder	1.8
<i>Any Affective disorder</i>	6.2
<b>Substance Use disorders</b>	
Alcohol Harmful Use	2.9
Alcohol Dependence	1.4
Drug Use disorders	1.4
<i>Any Substance Use disorder</i>	5.1
<b>Any 12-month mental disorder</b>	<b>20.0</b>

**Figure 6: Diagnosis range used in the 2013-14 Second Australian Child and Adolescent Survey of Mental Health and Wellbeing - 4-17 year olds<sup>7</sup>**

	% population
<b>Anxiety disorders</b>	
Social phobia	<b>2.3</b>
Separation anxiety	4.3
Generalised anxiety	2.2
Obsessive-compulsive	0.8
<i>Any anxiety disorder</i>	6.9
<b>Major depressive disorder</b>	<b>2.8</b>
<b>Attention Deficit Hyperactivity Disorder (ADHD)</b>	<b>7.4</b>
<b>Conduct disorder</b>	<b>2.1</b>
<b>Any 12-month mental disorder</b>	<b>13.9</b>

### Approach taken in PMHC MDS

- The solution adopted for the PMHC MDS uses 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). The code list summarises the approximate 300 unique mental health disorder codes in the full DSM-IV to a set to 9 major categories, and 37 individual codes. Diagnoses are grouped under higher level categories, based on the DSM-IV. Code numbers have been assigned specifically for the PMHC MDS to create

<sup>6</sup> Slade et al (2009), *The mental health of Australians2: Report on the 2007 National Survey of Mental Health and Wellbeing*. Department of Health and Ageing, Canberra.

<sup>7</sup> Lawrence et al (2015), *The mental health of children and adolescents: Report on the second Australian child and adolescent Survey of Mental Health and Wellbeing*. Department of Health, Canberra

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a logical ordering but are capable of being mapped to both DSM-IV and ICD-10 codes.

- Additional codes have been added to reflect subsyndromal conditions to accommodate reporting on clients who do not meet diagnostic criteria.
- The diagnosis list is provided at Attachment C.

### 4.7 Selecting core outcome measures

Reporting on client outcomes is a fundamental requirement and comprises two of the 11 service delivery KPIs set for PHNs. Beyond this, ongoing monitoring by service providers of client progress using standardised measures is critical to informing treatment decisions and ongoing dialogue between service providers and their clients.

There are many hundreds of standardised measures developed and available for in use in the delivery of mental health care. While some are targeted at specific conditions, or developed for use in specific treatment settings, others have been developed as broad spectrum measures for application across the full range of clients who present for assistance.

Australia's experience in introducing outcome measures into routine clinical practice is unmatched internationally. Commencing in 2003, routine use of outcome measures was introduced into state and territory specialised mental health services, progressed through a funding partnership between state and territory and the Commonwealth Governments. That year the Australian Mental Health Outcomes and Classification Network (<http://www.amhocn.org/>) was established by the Department to lead the national developments and provide support through reporting and analytic tools.

While regular use of outcome measures health services been a requirement of specific mental health funded primary care activity, including the MBS Better Access program and ATAPS, it has been subject to less developmental work. The previous ATAPS allowed an extensive list of options that was selected at the clinician's discretion but these had relatively poor compliance.

The approach to selecting outcome measures incorporated in the PMHC MDS should be based on the following considerations.

- A core (mandatory) set of standard outcome measures should be set for reporting with any additional measures used at the discretion of the provider. The principles of 'less is best', and minimisation of reporting burden are paramount.
- The core measures should be meaningful and applicable across all client groups and be capable of being used by all service providers.
- Core measures should reflect the client's perspective – that is, be based on self-report.

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- Core measures should be brief and take no more than 10 minutes to be completed by the client.
- Core measures should have sound psychometric properties and be sensitive to change in the client's condition.
- Australian population level data should be available on all core measures to enable comparison, and particularly the capacity to assess client recovery – i.e. movement into the 'normal' score range.

### *Approach taken in PMHC MDS*

- A small number of outcome measures has been set as mandatory for all episodes of care.
- For adult clients:
  - the mandatory measure is the Kessler-10 (K10+ version). This is the most widely used measure used in Australia, has comprehensive normative data and has demonstrated utility in measuring client progress (or deterioration). It also has a very high correlation with alternative measures also widely used (e.g., PHQ-9, GAD-7).
  - for Aboriginal and Torres Strait Islander clients, the K5 may be used as an alternative to the K10.
- For child and adolescent clients:
  - the mandatory measure is the Strengths and Difficulties Questionnaire (SDQ). The SDQ is used with significant utility in by all state and territory child and adolescent mental health services and also has recent population level gathered through the 2013 14 Second Australian Child and Adolescent Survey of Mental Health and Wellbeing.
  - Multiple versions of the SDQ 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 and Adolescents 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.

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- For adolescents, the clinicians may use the K10+ (or K5 for Indigenous clients) 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 headspace; the second Australian child and adolescent Survey of Mental Health and Wellbeing.
- Each PHN has the capacity to add additional outcome measures to their own regional data collection systems to meet local requirements but these are not necessary for reporting the national data PMHC minimum data set.
- For the mandatory measures, the concept of 'Collection Occasion' is defined as an occasion during an Episode of Care when the required outcome measure is to be collected. At a minimum, collection of outcome data is required at both Episode Start and Episode End, but may be more frequent if clinically indicated and agreed by the client. This differs from the ATAPS collection that did not allow outcome measures to be reported 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+, providers 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, providers can either report all 5 item scores or report the K5 total score.
  - For the SDQ, providers can either report all 42 item scores or report the SDQ subscale scores.
- Details of all outcome measures, including scoring rules, are available on the PMHC MDS website (<https://docs.pmhc-mds.com/index.html>).

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### ATTACHMENT A: PRIMARY MENTAL HEALTH CARE MINIMUM DATA SET – DATA ELEMENTS SUMMARY

#### Provider Organisation

- Provider Organisation Key
- Provider Organisation Name
- Provider Organisation Code
- Provider Organisation ABN
- Provider Organisation Type
- Provider Organisation State

#### Practitioner

- Organisation Path
- Practitioner Key
- Practitioner Category
- ATSI Cultural Training Flag
- Practitioner Year of Birth
- Gender
- Aboriginal and Torres Strait Islander Status
- Practitioner Active

#### Client

- Organisation Path
- Client Key
- Statistical Linkage Key
- Date of Birth
- Estimated Date of Birth Flag
- Gender
- Aboriginal and Torres Strait Islander Status
- Country of Birth
- Main Language Other Than English Spoken at Home
- Proficiency in Spoken English

#### Episode

- Organisation Path
- Episode Key
- Client Key
- Client Consent to Anonymised Data
- Episode Start Date
- Episode End Date

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- Episode Completion Status
- Episode Referral Date
- Referrer Profession
- Referrer Organisation Type
- Suicide Referral Flag
- GP Mental Health Treatment Plan Flag
- Principal Focus of Treatment Plan
- Homelessness flag
- Area of Usual Residence, Postcode
- Labour Force Status
- Employment Participation
- Source of Cash Income
- Health Care Card
- NDIS Participant
- Marital Status
- Principal Diagnosis
- Additional Diagnosis
- Medication - Antipsychotics (N05A)
- Medication - Anxiolytics (N05B)
- Medication - Hypnotics and sedatives (N05C)
- Medication - Antidepressants (N06A)
- Medication - Psychostimulants and nootropics (N06B)

### **Service Contact**

- Organisation Path
- Service Contact Key
- Client Key
- Episode Key
- Practitioner Key
- Service Contact Date
- Service Contact Type
- Service Contact Postcode
- Service Contact Modality
- Service Contact Participants
- Service Contact Venue
- Service Contact Duration
- Service Contact Copayment
- Service Contact Client Participation Indicator
- Service Contact Interpreted Used
- Service Contact Final

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- Service Contact No Show

### **Outcome Collection Occasion (summary list - separate fields for K10+, K5, SDQ)**

- Organisation Path
- Collection Occasion Key
- Episode Key
- Collection Occasion Measure Name
- Collection Occasion Measure Date
- Collection Occasion Reason
- Collection Occasion Item Scores (individual items or totals and subscale scores)

## ATTACHMENT B: DRAFT DEFINITIONS FOR SERVICE TYPE

### Service Type

The main type of service provided in the service contact, as represented by the service type that accounted for most provider time.

- 1 Assessment
- 2 Structured psychological intervention
- 3 Other psychological intervention
- 4 Clinical care coordination/liaison
- 5 Clinical nursing services
- 6 Child or youth specific assistance NEC
- 7 Suicide prevention specific assistance NEC
- 8 Cultural specific assistance NEC

#### Notes:

Describes the main type of service delivered in the contact, selected from a defined list of categories. Where more than service type was provided select that which accounted for most provider time. Service providers are required to report on Service Type for all Service Contacts.

#### **1 Assessment**

Determination of a person's mental health status and need for mental health services, made by a suitably trained mental health professional, based on the collection and evaluation of data obtained through interview and observation, of a person's history and presenting problem(s). Assessment may include consultation with the person's family and concludes with formation of problems/issues, documentation of a preliminary diagnosis, and a treatment plan.

#### **2 Structured psychological intervention**

Those interventions which include a structured interaction between a client and a service provider using a recognised, psychological method, for example, cognitive behavioural techniques, family therapy or psycho education counselling. These are recognised, structured or published techniques for the treatment of mental ill-health. Structured psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health. Structured psychological therapies can be delivered on either an individual or group basis, typically in an office or community setting. They 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.

Structured Psychological Therapies include but are not limited to:

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- Psycho-education (including motivational interviewing)
- Cognitive-behavioural therapies
- Relaxation strategies
- Skills training
- Interpersonal therapy

### **3 Other psychological intervention**

Psychological interventions that do meet criteria for structured psychological intervention.

### **4 Clinical care coordination/liaison**

Activities focused on working in partnership and liaison with other health care 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 health care 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.

### **5 Clinical nursing services**

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:

- monitoring a client's mental state;
- liaising closely with family and carers as appropriate;
- administering and monitoring compliance with medication;
- providing information on physical health care, as required and, where appropriate, assist in addressing the physical health inequities of people with mental illness; and
- improving links to other health professionals/clinical service providers.

### **6 Child or youth-specific assistance NEC**

Services delivered to, or on behalf, of a child or young person that cannot be described elsewhere. These can include, for example, 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 to their work environment.

*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 children and young people can be assigned to other categories.*

### **7 Suicide prevention specific assistance NEC**

Services delivered to, or on behalf, of a client who presents with risk of suicide that cannot be described elsewhere. These can include, for example, working with the person's employers to advise on changes in the workplace; working with a young person's teacher to

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assist the child in their school environment; or working with relevant community-based groups to assist the client to participate in their activities.

*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 client's who have a risk of suicide can be assigned to other categories.*

### **8 Cultural specific assistance NEC**

Culturally appropriate services delivered to, or on behalf, of an Aboriginal or Torres Strait Islander client that cannot be described elsewhere. These can include, for example, 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.

*Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that many Service Contacts delivered to Aboriginal or Torres Strait Islander clients can be assigned to other categories.*

**ATTACHMENT C: DIAGNOSIS LIST USED IN PMHC MDS**

**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

**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

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### **Other mental disorder**

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

### **No formal mental disorder but subsyndromal problem**

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