



How can community managed mental health providers adopt the new Australian Mental Health Care Classification?

A Preliminary Needs Assessment

DECEMBER 2015

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Glossary

ABF	Activity Based Funding
ABF MHC DSS	Activity Based Funding Mental Health Care Data Set Specification
AMHCC	Australian Mental Health Care Classification
AMHOCN	Australian Mental Health Outcomes and Classification Network
APQ 6	Activity and Participation Questionnaire
BASIS-32	Behaviour and Symptom Identification Scale
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CGAS	Children's Global Assessment Scale
CMHA	Community Mental Health Australia
CMO	Community managed organisation: a private, not-for-profit organisation that may be managed by a board of representatives and/or elected community members.
Consumer	Referring to a person with a lived experience of mental illness and/or recovery who has used/or uses treatment, rehabilitation and/or support services.
Carer	A person with lived experience of caring for someone with a mental health problem. This can be a family member or friend – paid or unpaid.
DASS	Depression and Anxiety Stress Scales
DSS	Data Set Specification
FIHS	Factors Influencing Health Status Scale
GAF	Global Assessment of Functioning Scale
HoNOS	Health of the Nation Outcome Scales
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents
HoNOS 65+	Health of the Nation Outcome Scales 65+
IHPA	Independent Hospital Pricing Authority
K-10	Kessler 10 Scale
LSP-16	Life Skills Profile 16 Scale
METeOR	Metadata Online Registry
MHCC	Mental Health Coordinating Council



MHIC	Mental Health Intervention Classification
MH NGOE DSS	Mental Health Non-Government Organisation Establishments Data Set Specification
MH NGOE NMDS	Mental Health Government Organisation Establishments (NGO) National Minimum Data Set
NGO	Non-government organisation
NOCC	National Outcomes and Casemix Collection
NMDS	National Minimum Data Set
ORS	Outcome Rating Scale
PSI	Psychological Screening Inventory
RAS	Recovery Self Assessment Scale
RUG-ADL	Resource Utilisation Groups – Activities of Daily Living Scale
SF 12	Short-Form Health Survey
SIQ	Suicidal Ideation Questionnaire
SRS	Session Rating Scale
WHO-QoL	World Health Organisation Quality of Life Scale

Caveat

This needs assessment was prepared by Mental Health Australia with financial support from the Independent Hospital Pricing Authority (IHPA). The findings and recommendations herein are Mental Health Australia's own, and do not necessarily reflect IHPA's current position on the issues raised.



Executive Summary

This needs assessment is part of program of work undertaken by Mental Health Australia to assist the Independent Hospital Pricing Authority (IHPA) to engage the mental health sector in the development of the new Australian Mental Health Care Classification (AMHCC). It was produced to inform IHPA's work to ensure that the services provided through the community managed mental health sector are appropriately reflected in the evolving development of the AMHCC.

With the assistance of Mental Health Australia, IHPA sought to gain an understanding of the capacity of mental health community managed organisations (CMOs) to collect the data necessary to adopt the draft AMHCC Version 1.0. This needs assessment includes:

1. A review of the data capacity building work completed to date within the sector
2. The results of a national online survey of community managed mental health organisations carried out by Mental Health Australia, to assess their readiness to collect the specific data elements proposed for the draft AMHCC Version 1.0.

To design the draft Version 1.0 of the AMHCC, IHPA drew on established data collection frameworks from the public mental health sector, as these have historically produced the majority of data currently available on mental health services in Australia. These data collection systems have benefited from considerable investment from, and reflect the language and service delivery models prevalent in, acute-care hospital settings.

It is IHPA's intention that, in time, the AMHCC will cover all mental health care services requiring collection of data across all settings including admitted, non-admitted, public community mental health care and community managed organisations.

The review of data capacity building work in this report provides information on:

- what data is currently being collected by CMOs at both Commonwealth and jurisdictional levels
- which jurisdictions and peak bodies have invested in advancing the capacity of CMOs to collect data, by developing state-level data sets
- the agreed and recommended list of tools and measures for use by the community managed mental health sector
- the capacity of the community managed mental health sector to collect routine data about their services into the future.



The national survey of CMOs reveals that the outcome measures proposed in the draft AMHCC Version 1.0 are not the measures currently used by the majority of organisations in the community managed mental health sector. Further, the proposed measures in the draft AMHCC Version 1.0 do not reflect the services provided by CMOs and will not provide meaningful data linking the services CMOs are funded to deliver with the costs of service delivery.

Despite these findings, Mental Health Australia's investigations suggest that, with adequate funding for data collection systems, CMOs could collect appropriate outcome measures and data at the level required to contribute to the AMHCC. Feedback received through the consultation process showed that CMOs would welcome an opportunity to increase their data collection capacity by collecting measures that meaningfully describe their service models and provide evidence regarding the quality and cost-effectiveness of these services.

The development of the AMHCC presents both challenges and opportunities for mental health CMOs. Further developments in how mental health care services are counted and costed at the national level may lead to new or alternative funding arrangements which promote increased investment by governments in data infrastructure outside the public mental health system. This would help close the significant gap in our understanding of the contribution made by the CMOs to improving mental health outcomes. Without such investment, future versions of the AMHCC may not be able to include data items that accurately reflect the nature of CMO service delivery.

Mental Health Australia looks forward to continuing to engage with IHPA to maximise the utility of the AMHCC and ensure that it will assist policy-makers to better integrate services and funding sources, support continuity across treatment settings and promote mental health outcomes regardless of service setting.

Recommendations and next steps

The goal of extending the AMHCC to mental health care services provided in a community based setting is ambitious, challenging and complex. To develop a classification that would accurately represent services provided by CMOs, Mental Health Australia recommends that IHPA:

- considers the inclusiveness and explanatory power of the 'mental health care type' definition, particularly with respect to that definition's representativeness across the range of mental health services and models of care delivered by CMOs
- explores options to ensure that future iterations of the AMHCC are applicable to CMOs and truly representative of their service models, including the various options available to jurisdictions as outlined below.

Mental Health Australia's investigations for this project suggest there are various actions that government can pursue to support IHPA's work on the AMHCC. If the AMHCC is to reflect the full range of mental health service settings – not just services that are delivered in or are associated with public hospitals – then the CMO sector must have the capacity to collect nationally consistent patient-level data that can be linked meaningfully to costs and outcomes. Nevertheless, we recognise that investment in data capacity and data infrastructure across the CMO sector is the responsibility of jurisdictions, not IHPA. Realising this ambition would require commitment from across government over a substantial period.



Mental Health Australia notes that the Mental Health Non Government Organisation (NGO) Establishment Data Set Specification is establishment level rather than patient level and would not provide the level of detail or receive the level of support required to make it a National Minimum Data Set (NMDS).

Mental Health Australia also recommends that the Australian Government considers supporting the following avenues of work:

- Creation of an NGO/CMO client level NMDS, based on a taxonomy that reflects the services provided by CMOs.
- Development of an NGO/CMO national outcomes data collection. This could run in parallel to the public sector National Outcomes and Casemix Collection, and include both provider assessment measures and consumer experience of care outcome measures that appropriately reflect services provided in the community managed mental health sector.

Beyond the health portfolio, Mental Health Australia notes the implications for data development associated with the National Disability Insurance Scheme (NDIS), which will result in substantial changes to the way CMOs collect client-level data. We anticipate significant benefits in IHPA and the National Disability Insurance Agency (NDIA) working in partnership to develop systems for classifying and counting community mental health services, to avoid dual systems that will be either incompatible or very difficult to reverse engineer.

Mental Health Australia also sees considerable merit in IHPA, NDIA and the community-managed sector working together to ensure further classification development work can apply to the broadest range of services, funding sources and organisational profiles, both within and beyond state-run mental health services. This would involve different parts of government working in partnership with the non-government sector to build an integrated data collection system based on the principle of 'create once – use often'.



1. Introduction

The AMHCC, a proposed, nationally agreed process for counting and costing mental health care services, is a significant policy reform for the mental health sector. Its successful implementation will support more transparent and equitable funding arrangements and increase provision of the much needed data on mental health care services.

Mental Health Australia, as the peak, national non-government organisation representing and promoting the interests of Australia's mental health sector, is conducting a 12 month program of work to assist IHPA in engaging the sector in the development of the AMHCC Version 1.0 and the supporting Activity Based Funding Mental Health Care Data Set Specification (ABF MHC DSS).

It is intended that the AMHCC will cover all mental health care services, requiring collection of data from all settings including admitted, non-admitted, public community mental health care and community managed/non-government organisations. The purpose of this paper is to assess the community mental health sector's ability to respond to IHPA's data collection requirements for AMHCC Version 1.0 and future iterations.

To evaluate the community managed mental health sector's data collection capability, this paper details data capacity building work that has taken place in the sector to date and identifies tools and measures currently used by organisations to collect data about their clients. In addition Mental Health Australia, in partnership with Community Mental Health Australia (CMHA), conducted a preliminary needs survey, to further understand the community managed mental health sector's readiness to adopt and respond to the draft AMHCC Version 1.0 and the supporting ABF MHC DSS. The results of the survey are reported in this paper.

The findings and recommendations in this paper are based on what is known about the AMHCC at the time of writing and precede the release of the draft AMHCC for public consultation between 10 November and 18 December 2015. Survey respondents were consulted on the information that was publically available at the time. This information was sourced from IHPA's first consultation paper¹, presentations given by IHPA to the mental health sector in May 2015 and through direct meetings with IHPA to agree on the survey content.

¹ Independent Hospital Pricing Authority (2015), Development of the Australian Mental Health Care Classification; Public Consultation Paper 1. Sydney, Australia.



2. Data collection in community managed mental health organisations

Mental health services in Australia are provided by Commonwealth and state/territory governments, private hospitals, private practitioners, and non-government/community managed organisations. These providers deliver services across a number of settings, covering acute hospital care, residential bed-based care, outpatient services, private clinical consultations, and services addressing the social determinants of mental health such as employment, housing and peer support.

Mental health CMOs provide services that are both unique in service type and complementary to clinical treatment, such as psychosocial rehabilitation, helpline and counselling services, subacute step-up/step down services, accommodation support, self-help and peer support, employment, education and family and carer support. These services are recovery-oriented and, when delivered according to contemporary best practice, promote cultural change to counter stigma and discrimination and increase social inclusion. The range of services and settings within the community managed mental health sector may best be understood with the description provided by the National Standards for Mental Health Services: Implementation Guidelines for Non-government Community Services².

“There is diversity between different sectors of the mental health service system and diversity within each of those sectors. The range of services delivered by the non-government community mental health sector also varies from state to state. Services range from intensive personal recovery support to day activity programs and have diverse target groups—for example, a geographic community, people with a particular service need such as accommodation, or people who share a common characteristic such as being carers or being from an Aboriginal and Torres Strait Islander background. The organisational complexity of the service providers also varies enormously. Some are large national organisations, some are multi service and multi-site agencies within states and others are very small organisations with few paid staff and a heavy reliance on the contribution of dedicated volunteers”.

In recent decades there has been a policy shift by both Commonwealth and state/ territory governments to an increasing focus on services delivered through community managed

² Commonwealth Department of Health (2010) *National Mental Health Strategy, National Standards for Mental Health Services: Implementation Guidelines for Non-government Community Services*. Canberra, Australia, p.4.



organisations. Nationally, with the exception of NSW, every Australian jurisdiction recorded an increase in spending directed towards community managed organisations between 2007 and 2011.³ This is generally regarded by the broader mental health sector as a positive development reflecting the intent of national health policy articulated in the 4th National Mental Health Plan.⁴

It is anticipated provision of mental health services by CMOs will increase in future and become more integrated with public mental health care services. This is supported by a recommendation in the recent report by the National Mental Health Commission that “as capacity and competence is built, NGOs should look at developing greater capacity to move into broader provision of clinical support services, in addition to the current suite of non-clinical services”.⁵

With increased focus comes the need to provide evidence for the effectiveness of these services and to demonstrate the value of redirecting health budgets away from high cost acute public services, to community based models of care that provide lower cost more person centred integrated psychosocial support. New and different funding models will require increased accountability reporting and a greater reliance on the ability to collect routine client and outcome data. The most recent of the nation’s mental health plans, by the NSW Mental Health Commission notes the changing landscape for community managed organisations:

“The CMO sector faces a period of seismic change in NSW and across Australia with governments looking increasingly towards service delivery options that are open to tender and involve community-managed and private-sector operators. In NSW many CMOs are preparing for a shift from a grants-based, government-funding scheme to competitive tendering arrangements being established through NSW Health’s Grants Management Improvement Program. Many are also adjusting to the new individualised packaging and brokering system under the National Disability Insurance Scheme. The survival and growth of the sector will depend on its capacity to adopt business models that fit with the new contestable and customer driven environment and on the continued professionalisation and accreditation of its workforce”.⁶

Existing Data Capacity Building work within the Community Managed Mental Health Sector

Most mental health CMOs receive funding from state and territory governments in the form of a grant - a sum of money for service delivery accompanied with generalised reporting provisions. Reporting requirements are as diverse as the sources of funding, varying across jurisdictions and between levels of government, with organisations reporting separately to funding bodies on different aspects of their work. Grant funding in blocks can be advantageous and can allow for innovation with different ways of allocating funds to achieve an agreed goal. However it is often difficult to compare the results of such spending and this funding model can present major and systematic barriers to the establishment and

³ Commonwealth Department of Health and Ageing (2013). *National Mental Health Report 2013: Tracking progress of mental health reform in Australia 1993-2011*, Canberra, Australia.

⁴ Commonwealth of Australia (2009) *Fourth National Mental Health Plan – An Agenda for collaborative government action in mental health 2009-2014*, Canberra, Australia.

⁵ National Mental Health Commission, (2014) *The National Review of Mental Health Programs and Services: Fact Sheet 7 What this means for NGO’s*, Sydney.

⁶ New South Wales Mental Health Commission. (2014). *Living Well: A Strategic Plan for Mental Health in NSW*. Sydney, p. 103.



implementation of consistent costing and outcome measurement tools.

In contrast, there has been considerable investment by all levels of government in the design of uniform information collection tools and supporting infrastructure in the public health system. The introduction of ABF in the NHRA 2011 accelerated expenditure and built on existing jurisdictional casemix systems for funding hospitals. Casemix funding requires the use of classifications that bundle patient care episodes into clinically coherent and resource homogeneous groups to describe what services are currently being provided.

In comparing the two funding streams, block funding pays for the intention to treat patients and ABF for the actual number of 'activities' and work performed. Not all services fit the casemix/ABF model well and challenges for the design of a classification to fund mental health care services include the unpredictable nature of mental health problems, the diversity of services and the wide range of factors in addition to diagnosis influencing the costs of care.

In acknowledging funding models often drive the need for reporting of data and establishment of supporting technological infrastructure, it is understandable mental health care services outside the public system have not benefited from the same level of data collection development. However the community managed mental health sector recognises that without effective data collection and evidence of the impact of their services, the gains made in quality processes, outcome monitoring and workforce development will not be evident.

Work to date on building the data collection capacity of the community managed mental health sector has been minimal in comparison to the significant investment in information collection and management within the public system.

Summarised below is work that has directly contributed to, investigated or addressed data collection capacity within the community mental health sector.

1. National Community Managed Organisation Outcome Measurement project 2013

This project was the most extensive national body of work addressing the current status of information infrastructure in the community managed mental health sector. Several components relate directly to assessing the sector's readiness to adopt and respond to the draft AMHCC Version 1.0 and ABF. A core project objective was: ⁷

⁷Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia. (2013) *National Community Managed Organisation (CMO) Outcome Measurement project: Final Report to the Mental Health Information Strategy Standing Committee 1.1*. Sydney, NSW, p 3.



- *to describe the information infrastructure in place across the mental health community managed sector that supports the use of routine consumer outcome measurement, and the extent to which suitable information infrastructure is comprehensively available.*

Recommendations were also made on:

- *the information infrastructure development that would be required to introduce reporting of consumer outcomes as a component of future national dataset requirements covering the mental health CMO sector*
- *a short list of consumer outcome measurement instruments that offer most potential for use in Australia across the various service types, and*
- *to review the available measures of consumer outcomes that may be suitable for use in the mental health CMO sector, taking account of the range of service types delivered by the sector.*

To achieve these objectives the largest national survey to date of CMOs was undertaken resulting in 132 validated responses. This was estimated to be representative of almost half the total number of specialised mental health CMOs using outcome measurement in Australia. Of the organisations that responded to the survey, 23% indicated they operated in more than one jurisdiction, and 9% operated nationwide. The response data was complemented with interviews of major jurisdictional funders about requirements for the use of outcomes measures.⁸

The survey found while a majority of CMOs use tools based on their own written instructions, less than half formally trained staff to use the outcome tools or forms. Only slightly more than half, 54% have implemented some kind of fully computerised data collection system. Survey responses indicated only 47% of CMOs are currently capable of collecting client-level outcome data, however 77% would be capable with data system modification or expansion. A further 24% indicated they could only collect client-level outcome data if additional funding and resources were provided. The majority of organisations paid for their own data systems.⁹

A total of 62 organisations declared use of established individual outcome measurement instruments. The eight most common established tools in descending order were the K-10, Behaviour and Symptom Identification Scale (BASIS-32), Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), Depression and Anxiety Stress Scales (DASS), HoNOS, LSP-16, World Health Organisation Quality of Life (WHO-QoL) and the Mental Health Recovery STAR.

⁸ Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia. (2013) *National Community Managed Organisation (CMO) Outcome Measurement project: Final Report to the Mental Health Information Strategy Standing Committee 1.1*. Sydney, NSW, p.7.

⁹ *Ibid.*, p.11.



Established tools in use by community managed organisations¹⁰

Tool Name	No. Orgs
K10	22
BASIS-32	16
CANSAS	15
DASS	13
HoNOS	13
LSP-16	13
WHO-QoL	12
Recovery STAR	12
RAS	6
GAF	5
Personal Wellbeing Index	5
Homeless STAR	5
Recovery Interview	4
Mental Health Recovery Measure	3
ORS & SRS	2
APQ6	2
SF12	2
SIQ	2
Recovery Enhancing Environment Measure	2
PSI	2

Government funders reported few programs funded by jurisdictions are currently mandating the use of outcome measurement tools, however it was noted many jurisdictions are making future plans to implement outcome measurement as a component of program evaluations. Two jurisdictions with firm policy developments are Western Australia (WA) and Victoria (Vic). Both jurisdictions are working with consumers, carers and organisations to consider the use of standardised outcome measurement tools, and have indicated the national project helped inform this work.

Jurisdictions noted implementing measures in the community managed sector had considerable challenges:

- not all grant funding is managed centrally which increases the complexity for mandating tools
- there is a huge array of service models and types amongst community managed organisations making it difficult to determine what mandated tools might look like for such a wide and varied sector
- some states have not yet made the transition to outcome measurement, with outputs still the main activity being collected, and
- funding is needed to assist with the complicated and resource intensive nature of implementation.

¹⁰ Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia. (2013) *National Community Managed Organisation (CMO) Outcome Measurement project: Final Report to the Mental Health Information Strategy Standing Committee 1.1*. Sydney, NSW, p.10.



Attachment A to this paper is a summary of activities and future plans by government funders for the use of outcome measurement tools in the community managed sector.¹¹

Following the initial study, 31 measures were rated as suitable for use in the community managed sector. This was further refined to a recommended set of outcomes measures judged as representing the best balance between ease of use, reasonable psychometric properties, appropriateness for the community managed sector and opportunity for comparability across services. An important feature of the measures selected is that they are all completed by the consumer or carer as relevant. The measures are listed below;¹²

Recovery	Recovery Assessment Scale (RAS)† or Stages of Recovery Instrument (STORI)†
Thoughts and Feelings	Kessler-10 (K-10)† or CarerQoL (CarerQoL-7D+VAS)† or Strengths and Difficulties Questionnaire (SDQ) (used in Child and Adolescent services)†
Daily Living and Maintaining Relationships	Work and Social Adjustment Scale (WSAS)†
Social Inclusion	Living in the Community Questionnaire (LCQ)†#
Quality of Life	World Health Organisation Quality of Life –Brief, Australian Version (WHOQoL- BREF)†
Experience of Service	Your Experiences Survey (YES)† or Carers Experience of Service Provision†#
Multi Dimensional	Camberwell Assessment of Need – Short Appraisal Scale (CANSAS) †*

† Consumer and carer rates, † * Consumer, carer and worked rated components
†# Measure in development

¹¹ Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia. (2013) *National Community Managed Organisation (CMO) Outcome Measurement project: Final Report to the Mental Health Information Strategy Standing Committee 1.1*. Sydney, NSW, pp.14-15.

¹² Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia (2015). *Implementing Routine Outcome Measurements in Community Managed Organisations*. AMHOCN, Sydney, NSW. p.7.



2. Individual jurisdictional work and contributions by large community managed organisations

The NSW Community Managed Mental Health Sector Data Management Strategy Report. Mental Health Coordinating Council (MHCC). 2010

Western Australian Mental Health Non-Government Organisations Information Development Technical Report; NGO Information Development Project. Government of Western Australia Mental Health Commission. 2012

Within the jurisdictions of New South Wales (NSW) and (WA) separate pieces of work have been undertaken to address the lack of data capacity building initiatives for the community mental health sector.

In 2010 the Mental Health Coordinating Council (MHCC) NSW completed phase one of a data management strategy to develop a comprehensive minimum data set for NSW mental health community managed organisations.¹³

Relevant outcomes of the project included development of comprehensive data set and proposed minimum data set for community managed organisations working in mental health in NSW. The data sets were supported by the production of a mental health community managed organisation minimum data set (CMO MDS) data dictionary and identification of specific data management systems to enable organisations to make effective and efficient use of information.

This project had a detailed program structure consisting of sector reference groups established to advise on the data management strategy, design of the minimum data set and data dictionary. The results of the MHCC Mapping Sector Report also informed the project which found most community managed organisations collect many types of client data including client personal information (85%), referral source (82%), type of assistance provided (81%), mental health diagnosis (75%), client circumstances (73%), progress monitoring (70%), consumer functional status (63%), exit details (60%), amount of time assistance provided (59%), and other data (49%). Eighteen percent (18%) of this data was collected by a fully computerised data collection, 60% by a mixture of manual and computerised data collection and 13% by manual data collection.¹⁴

A comprehensive data set was developed based on seven program types to capture the data collection and funding requirements of NSW mental health CMOs:

- Helpline and Counselling Services
- Self-Help and Peer Support
- Accommodation Support and Outreach
- Employment and Education
- Family Support and Carer Programs
- Information, Advocacy and Promotion
- Leisure and Recreation

¹³ Mental Health Coordinating Council. (2010). *The NSW Community Managed Mental Health Sector Data Management Strategy Report: Phase One*, NSW Australia.

¹⁴ Mental Health Coordinating Council. (2010). *The NSW Community Managed Mental Health Sector Mapping Report*, NSW Australia.



From the comprehensive data set a minimum data set was produced. The data sets are consumer-focused, recognise the role of carers, have rationales for inclusion of data elements and are compatible with national data dictionaries

In developing the data set CMOs were asked to identify which outcome tools were used within their organisations. Organisations that provided only mental health services predominantly used DASS, K-10, HoNOS and Global Assessment of Functioning (GAF). While those that delivered some mental health services as part of their overall service offering principally used the DASS, K-10, CANSAS and HoNOS.

There were challenges identified with CMOs collecting the data set including that the organisations often reported having little or no IT infrastructure for data collection. However the project established a set of criteria against which organisations can assess the applicability of data systems to their specific requirements including links to human resource and occupational health and safety processes. This report provides the most extensive and considered advice available to CMOs on how to maintain quality data systems, especially in relation to using available resources in the most effective way, including the time required for the system choice to deliver identifiable benefits, to staffing and outsourcing options.

The rollout of Data Development Strategy – Phase Two of the project is yet to be realised. However a recent paper by the MHCC,¹⁵ proposes continuing work on establishing a minimum data set for NSW as part of the NSW Government's Partnerships for Health (P4H) reform process.

Building on the work of MHCC in NSW the WA Mental Health Commission (the Commission) recognised there is no standardised collection of mental health CMO/NGOs data at either a state or national level. The Commission contracted Deloitte Consulting to assist in developing a state level data collection to support the MH NGOE DSS. A minimum data set was developed to collect client level data within WA.

Phase 1 of the project determined what information NGOs are currently collecting, how this information is stored, options for developing a new information system and a draft of the data items to be collected under a proposed new system. Phase 2 delivered a preferred option for implementation of a state level client information system (CIS) and defined the data items to be collected within METeOR metadata protocols. This was followed by developing a data model for reporting client and establishment information at state level, with consideration to how each will inform collections at a higher national level. Phase 3 included detailed design and implementation of the client level collection, requiring appropriate information systems and software to securely store and manage the information collected.

¹⁵ Mental Health Coordinating Council (2015). *Community Managed Mental Health Sector Considerations for the Partnerships for Health Reform Process*. NSW, Australia



The table below shows the alignment between the MHCC and WA Non-Government Organisations Data Set Specification (WA NGO DSS) (blue items).¹⁶

1. Client: Gender	18. Additional Comorbidity Factor
2. Client: Date of Birth	19. Activity and Participation in Life Area
3. Residential Postcode	20. Level of Difficulty with Activities in Life Areas
4. Aboriginal Status	21. Individual Assessment Date
5. Torres Strait Islander Status	22. Service Start Date
6. Country of Birth	23. Service End Date
7. Main Language other than English spoken at Home	24. Hours of Service per Contact - Direct
8. Referral Receipt Date	25. Hours of Service per Contact - Indirect
9. Referral Source	26. Service / Other Agency Use on Entry
10. Accommodation Type	27. Outcome Measures
11. Living Arrangement	28. Program Name Type
12. Children under 16 years living in Household	29. Funding Source/s
13. Children under 16 years not living in Household	30. Program Suburb
14. Primary Carer nominated	31. Program Postcode
15. Principal Documented Diagnosis	32. Service Type
16. Additional Mental Health Diagnosis	33. Workforce FTE
17. Additional Other Diagnosis	34. Age Range - Workforce

The following tables provide a snapshot of what consumer level data was being collected within this jurisdiction at project inception.¹⁷

¹⁶ Government of Western Australia Mental Health Commission. (2011) *Western Australian Mental Health Non-Government Organisations Information Development Technical Report; NGO Information Development Project*, p. 7

¹⁷ Government of Western Australia Mental Health Commission. (2011) *Western Australian Mental Health Non-Government Organisations Information Development Technical Report; NGO Information Development Project*, pp. 8–9.



Data item collection regarding Services Client and Carer Characteristics

Overview	<p>Most NGOs collect data about clients' personal details, the referral source, services provided and mental health diagnosis. However, there is less data consistency when collecting client functional assessments, progress monitoring or amount of time assistance is provided.</p> <ul style="list-style-type: none"> Most NGOs collect most Consumer and Carer characteristics information and are relatively consistent in the collection On average 92% of the Client characteristics information is being collected across the NGOs, consistently (73 %) or sometimes (19%) Certain data items, such as gender and address vary in definition Few organisations do not collect identity information 																																															
Results	<table border="1"> <thead> <tr> <th>Item</th> <th>Collected</th> <th>Sometimes</th> <th>Not collected</th> </tr> </thead> <tbody> <tr> <td>Name</td> <td>83%</td> <td>6%</td> <td>11%</td> </tr> <tr> <td>Address</td> <td>81%</td> <td>8%</td> <td>11%</td> </tr> <tr> <td>Gender</td> <td>87%</td> <td>4%</td> <td>9%</td> </tr> <tr> <td>Date of Birth / Age group</td> <td>83%</td> <td>6%</td> <td>11%</td> </tr> <tr> <td>Aboriginality</td> <td>63%</td> <td>12%</td> <td>25%</td> </tr> <tr> <td>Preferred language</td> <td>58%</td> <td>12%</td> <td>30%</td> </tr> <tr> <td>Living arrangements</td> <td>63%</td> <td>8%</td> <td>29%</td> </tr> <tr> <td>Income source</td> <td>60%</td> <td>10%</td> <td>30%</td> </tr> <tr> <td>Principal diagnosis</td> <td>75%</td> <td>12%</td> <td>13%</td> </tr> <tr> <td>Source of referral</td> <td>83%</td> <td>6%</td> <td>11%</td> </tr> </tbody> </table> <p>Colour coding indicates status of the collection; green positive; red negative</p>	Item	Collected	Sometimes	Not collected	Name	83%	6%	11%	Address	81%	8%	11%	Gender	87%	4%	9%	Date of Birth / Age group	83%	6%	11%	Aboriginality	63%	12%	25%	Preferred language	58%	12%	30%	Living arrangements	63%	8%	29%	Income source	60%	10%	30%	Principal diagnosis	75%	12%	13%	Source of referral	83%	6%	11%			
Item	Collected	Sometimes	Not collected																																													
Name	83%	6%	11%																																													
Address	81%	8%	11%																																													
Gender	87%	4%	9%																																													
Date of Birth / Age group	83%	6%	11%																																													
Aboriginality	63%	12%	25%																																													
Preferred language	58%	12%	30%																																													
Living arrangements	63%	8%	29%																																													
Income source	60%	10%	30%																																													
Principal diagnosis	75%	12%	13%																																													
Source of referral	83%	6%	11%																																													
Most commonly collected data items	<p>The following were characteristics were identified as being most commonly collected:</p> <ul style="list-style-type: none"> Gender; with 91%, Name, address and date of birth; with ca. 90 %, and Source of referral; with 89% of NGOs consistently or sometimes collecting items 																																															
Least commonly collected data items	<p>The following characteristics were identified as being least commonly collected:</p> <ul style="list-style-type: none"> Preferred language; with 69%, Preferred language; with 70%, Income source; with 70%, and Living arrangements; with 71% of NGOs consistently or sometimes collecting this data item. 																																															

Data item collection regarding Services Provided

Overview	<p>Most NGOs collect data about clients' personal details, the referral source, services provided and mental health diagnosis. However, there is less consistency collecting data such as client functional assessments, progress monitoring or amount of time assistance is provided.</p> <ul style="list-style-type: none"> A majority of the data items identified in the survey instrument regarding services provided is being collected and stored On average 81% of the service information is being collected across the NGOs 																																											
Results	<table border="1"> <thead> <tr> <th>Item</th> <th>Collected</th> <th>Sometimes</th> <th>Not Collected</th> </tr> </thead> <tbody> <tr> <td>Types of Services provided to the Consumer</td> <td>77%</td> <td>4%</td> <td>19%</td> </tr> <tr> <td>Date of entry into Service</td> <td>87%</td> <td>3%</td> <td>10%</td> </tr> <tr> <td>Date of exit from Service</td> <td>83%</td> <td>2%</td> <td>15%</td> </tr> <tr> <td>Date and Duration of Service Event Items</td> <td>83%</td> <td>7%</td> <td>10%</td> </tr> <tr> <td>Consumer level of independence / recovery</td> <td>60%</td> <td>17 %</td> <td>23%</td> </tr> <tr> <td>Consumer progress monitoring e.g. reviews of Consumer needs</td> <td>79%</td> <td>6%</td> <td>15%</td> </tr> <tr> <td>Recovery / Management Plan</td> <td>67%</td> <td>10%</td> <td>23%</td> </tr> <tr> <td>Reason for exiting Service</td> <td>54%</td> <td>25%</td> <td>21%</td> </tr> <tr> <td>Client waitlist</td> <td>48%</td> <td>23 %</td> <td>29%</td> </tr> </tbody> </table> <p>Colour coding indicates status of the collection; green positive; red negative</p>	Item	Collected	Sometimes	Not Collected	Types of Services provided to the Consumer	77%	4%	19%	Date of entry into Service	87%	3%	10%	Date of exit from Service	83%	2%	15%	Date and Duration of Service Event Items	83%	7%	10%	Consumer level of independence / recovery	60%	17 %	23%	Consumer progress monitoring e.g. reviews of Consumer needs	79%	6%	15%	Recovery / Management Plan	67%	10%	23%	Reason for exiting Service	54%	25%	21%	Client waitlist	48%	23 %	29%			
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Least commonly collected data items	<p>The following characteristics were identified as being least commonly collected:</p> <ul style="list-style-type: none"> Client waitlist, with 71%, Consumer level of independence / recovery, with 77%, and Recovery / Management Plans, with 77% of NGOs collecting, or sometimes collecting this data item 																																											



The project also provided a breakdown of outcome measures used by the sector in WA, with 51% collecting information regularly, 9% sometimes collecting information and 39% not collecting information. The range of outcome measures used by the organisations surveyed is listed below;¹⁸

- K-10 (used by at least 8 NGOs)
- DASS (used by at least 2 NGOs)
- HoNOS (used by at least 2 NGOs)
- EPDS (Edinburgh Post Natal Depression Scale)
- Mental Health Recovery Measure (MHRM)
- Cognitive Assessment System (CAS)
- Monthly Clinical Analyses
- Client Support Plans
- Beck Depression Inventory
- Beck Anxiety Inventory
- Suicide Risk Assessment

The key outcome of the project has been the completion of the Western Australian Non-Government Organisation Establishment State Data Collection (WA NGOE SDC) for the 2013-14 financial year.¹⁹

The system to collect the data is the Non-Government Organisation Establishments Online Reporting System (NGOE reporting system), which went live 1 July 2014 for reporting against the 2013-14 financial year. An evaluation process was conducted and found that 92% of organisations were satisfied with the system, however only 20% felt the system did not require further improvement.²⁰

Contributions by individual community managed organisations/NGO's

In addition to the jurisdictional projects reported in this paper, some larger CMOs data collection capacity and establish quality outcome measures. These sizable and complex organisations operating across jurisdictions have the opportunity to draw on broader experience and more established data infrastructure systems. An example is the work by Mind Australia which commissioned a discussion paper to explore key issues in outcome measurement for the community based mental health services sector.²¹ The paper reviews various types of outcome measures, the issues surrounding their use and identifies challenges for advancing outcome measurement in recovery oriented services. The research in the paper is substantial and details advantages and disadvantages of outcome measurement tools currently in use, in particular the CANSAS, BASIS-32, WHOQoL and the

¹⁸ Government of Western Australia Mental Health Commission. (2011) *Western Australian Mental Health Non-Government Organisations Information Development Technical Report; NGO Information Development Project*. p. 10.

¹⁹ Government of Western Australia. Australian Non-Government Organisation Establishment State Data Collection 2013/14.

²⁰ Government of Western Australia Mental Health Commission. (2014). Evaluation of the Mental Health Non-Government Organisation Establishment Reporting System; End of Financial Year Reporting 2013-14.

²¹ University of Melbourne and Mind Australia (2012) L. Brophy & K. Moeller-Saxone, *Using Outcome Measure in Mind Australia; Discussion Paper*. Melbourne.



Recovery Star. It was concluded that challenges lie in the choice and use of appropriate tools that are meaningful to consumers and carers, and in ensuring that staff are committed to embedding outcome measures into day to day practice. Once established the measures will only be effective if resources are allocated to engaging consumers and carers, staff supervision and IT support.

3. Federal government programs contributing to data collection

Partners in Recovery (PIR)

Personal Helpers and Mentors (PHaMs)

The Commonwealth Government requires community mental health organisations to collect data under two national programs.

The Partners in Recovery (PIR) program aims to support people with severe and persistent mental illness and complex needs, by enabling multiple sectors, services and supports to work in a more collaborative, coordinated and integrated way. PIR provides funding to approximately 24,000 consumers nationally. Those CMOs providing services with PIR funding are required to submit data on individual needs assessments using the CANSAS. Details of the full data set collected can be found in the PIR Client Minimum Data Set.²²

The Personal Helpers and Mentors (PHaMs) program aims to provide increased opportunities for recovery for people whose lives are severely affected by mental illness. A person does not need to have a formal clinical diagnosis of a severe mental illness to access the service, and providers use a functional assessment tool specifically developed by the Department of Social Services in collaboration with the AIHW. Data is submitted through an online reporting tool which includes demographic, organisational and de-identified client data.

4. National Disability Insurance Scheme (NDIS)

The implementation of the NDIS will be the largest and most significant change to the way community managed organisations will be required to collect data. Measures to be used to define outcomes for participants are yet to be developed by the National Disability Insurance Agency (NDIA), however the World Health Organisation Disability Assessment Schedule 2.0 (WHODAS 2.0) is being used as a generic assessment instrument for entry to the scheme. CMOs will be required to substantially upgrade and change their data management systems to both claim payment for services provided and report against participant outcomes over time.

²² Commonwealth Department of Health (2014) Partners in Recovery: Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative; PIR Client Minimum Data Set, Version 1.3. Canberra Australia.



3. Preliminary needs assessment

To assist IHPA in understanding the community mental health sector's capacity to collect data under the draft AMHCC Version 1.0 and ABF MHC DSS, Mental Health Australia partnered with CMHA to conduct a national online survey supported by with a series of workshops to explain the importance of IHPA's work and the details and concepts within the survey.

Consultation methodology

CMHA invited mental health CMOs in each state and territory to attend a series of workshops held in July and August 2015. Invitations targeted staff with knowledge of their organisation's business practices and service delivery programs and/or the organisation's IT infrastructure.

Workshops were held in all states and territories with the exception of the Northern Territory. The Northern Territory's absence was due to the unavailability of local staff to host the workshop. Fifty one organisations attended the workshops nationally, with greater representation in the larger states.

Workshops were hosted by the jurisdictional peak bodies and conducted by Mental Health Australia and consultant Mr Tully Rosen, who was engaged to design the online survey. The workshops were designed to communicate to the community managed mental health sector the relevance of IHPA's work, as many organisations were not aware that the classification was being built to extend beyond the hospital and public setting. These workshops were also required prior to survey distribution to explain the survey content to participants, as the draft AMHCC Version 1.0 has been designed using terminology and outcome measures traditionally used in hospital and public mental health services, but not necessarily in community managed organisations. Explaining the intent of each item in the survey increased not only the accuracy of the response, but also ensured questions were not deemed irrelevant by respondents and left unanswered. The workshops provided an opportunity to gather feedback on survey design and amend questions for ease of completion prior to finalisation.

General feedback was also collected at the workshops, providing IHPA with broader information on the suitability of the design of the classification for predicting the cost of community mental health care services.



The survey was circulated to participants following the workshops. Open invitations to complete the survey were also distributed through various Mental Health Australia and state/territory peak body communications channels.

The survey responses were collated and analysed by consultant Tully Rosen to form the survey report at [Attachment B](#).

Results

Thirty-one (31) survey responses were received, comprising of 18 responses from workshop participants and 13 responses from the open invitations. Responses were received from all states and territories, with representation from a full range of organisational sizes. Figure 3 of the survey report shows the percentage of funding organisations reported receiving from varying funding sources. The number of survey responses received was considered positive considering the technical nature of the content, and that many CMOs are not aware of the relevance of IHPA's work.

A full range of community mental health program types are delivered by the organisations that responded to the survey. These services are represented in Figure 4 of the report and reflect the agreed taxonomy of the MH NGOE DSS. There were two additional program types identified outside the taxonomy; dual-disability and crisis intervention services.

The survey was designed to determine at what level (e.g. organisational or client level), CMOs can collect data, what outcome measures are more commonly used and whether organisations were intending to upgrade or change their IT infrastructure in response to changes in the policy or funding landscape.

In responding to the survey organisations were first asked to categorise their services with the aim of understanding how these services could fit under the three ABF MHC DSS clusters of admitted, ambulatory and residential. The categories, shown in Figure 5 of the survey report, were devised to mirror the ABF MHC DSS by using the language and descriptive terms employed by the community managed mental health sector. Most organisations fitted under the category of community based/drop-in, 84%, followed by residential/supported accommodation at 58% and only 13% under the hospital/admitted. 29% reported in the 'other' category, however many of those responses could be reclassified as 'community based' services. It was noted some organisations picked 'other' as they believed the cluster definitions were too medical to be inclusive of their services. Examples of service type provided under 'other' are listed under Figure 6 in the survey report.

Following the categorisation of services question respondents were then asked to report if it was possible to collect specific data items; 'episode of care', contact occasion intervention/service provided and 'phase of care'. In addition to respondents identifying what items could be collected at contact occasion in each cluster, they were also asked to submit details of the types of 'intervention'/service or practice methodology being provided. The list of results is at [Appendix A](#) to the survey report. Respondents were also asked if collecting these items would require an upgrade or modification to their existing collection system.



Client level data

Community cluster

Twenty-six (26) out of 31 organisations identified as providing services under the community cluster. Eighty-four percent (84%) of these organisations were able to collect organisational level data and 92% basic details of the client.²³

Seventy-three percent (73%) reported they are capable of collecting the 'episode of care' item, 15% capable with some upgrade to their systems, 8% with major upgrades and 4% not currently capable. As can be seen in Table 1 below most organisations are currently not capable of collecting legal status without system modification, as many reported that clients being treated on an involuntary or voluntary basis does not fit within their service model. While others reported that it would be inappropriate to ask the client this type of question and if a client's status did change they were often not informed by the administering clinical team or funder. Table 1 below from the Survey Report, shows respondents' capacity to collect each of the data items within an 'episode of care'.

Table 1. Community sector cluster's capacity to collect each data item within an 'episode of care' (n=26)

	Capable	With modification	Not capable	N/A
Mental health legal status	24%	44%	20%	12%
Principal diagnosis	80%	8%	0%	12%
Additional diagnosis	64%	20%	4%	12%
Episode start date and end date	72%	12%	12%	4%
Reason for end of episode	64%	24%	8%	4%
Referral source	92%	8%	0%	0%
Referral destination	72%	16%	8%	4%

Just over half of the organisations under the community cluster 57% are currently capable of collecting client level data items on contact occasion. Twenty seven percent (27%) may be capable with some upgrades to their systems, 8% with major upgrades and a further 8% not capable. Both in the workshops and through written feedback in the survey, respondents noted the term 'intervention' was problematic, as it was a clinical expression and not a term used in community managed models of service delivery. Table 2 below from the Survey Report shows what items can be collected on contact occasion for this cluster.

Table 2. Community sector cluster's capacity to collect client level data items on contact occasion (n=26)

	Capable	With modification	Not capable	N/A
Date of contact	92%	8%	0%	0%
Contact duration	83%	17%	0%	0%
Mode of contact	79%	21%	0%	0%
Location	67%	29%	4%	0%
Direct or indirect	75%	25%	0%	0%
Individual or group session	71%	29%	0%	0%
Intervention/service type provided	63%	29%	8%	0%

²³ NGO providers may collect data because (a) their funder(s) require(s) them to collect that data, (b) their funder(s) require(s) them to collect that data and report it to the funder or in another way, and/or (c) the organisation finds the data useful for whatever reason, such as practice improvement, regardless of funder requirements. The ability to collect data is therefore distinct from the reporting of data.



Fifty-two percent (52%) of community cluster respondents were able to collect the ‘phase of care’ (track, date and report on the different stages of the clients service usage) data items without any change to their data infrastructure system. Respondents were asked to give examples of possible categorisations of ‘phase of care’, the community cluster suggested examples such as; movement between program levels of support, mutually agreed milestones, achievement of care plan goals and score on recovery outcome tools.

Of the eighteen (18) organisations that identified as providing services under the residential (non-admitted) cluster 94% were able to collect data at both organisation and a basic client level.

Eighty-three percent (83%) of organisations providing residential services are currently capable of collecting the ‘episode of care’ item with a further 17% capable with a system upgrade. No respondents in this cluster reported being incapable of collecting the data.

Again legal status was problematic, although not as difficult to collect as for the community cluster. The percentage of capability for residential services to collect data was greater across all ‘episode of care’ items in comparison to the community cluster. This result may be attributed to less variance in the service types provided in residential care and to the greater homogeneity of the service setting. The use of the term ‘intervention’ was also described by this group as being inappropriate and inaccurate to describe services delivered in community residential care. Table 3 below from the Survey Report, shows respondents’ capacity to collect each of the data items within an ‘episode of care’.

Table 3. Residential sector cluster’s capacity to collect each data item within an ‘episode of care’ (n=18)

	Capable	With modification	Not capable	N/A
Mental health legal status	39%	33%	17%	11%
Principal diagnosis	89%	6%	0%	6%
Additional diagnosis	78%	17%	0%	6%
Episode start date and end date	94%	6%	0%	0%
Reason for end of episode	72%	22%	0%	6%
Referral source	94%	6%	0%	0%
Referral destination	67%	22%	6%	6%
Number of leave days during episode	50%	11%	22%	17%

Seventy-two percent (72%) of organisations under the residential cluster are currently capable of collecting the client level data items on contact occasion. A further 22% may be capable with some upgrades to their systems and 6% with major upgrades. No respondents in this cluster reported being incapable of collecting the data. Table 4 below from the Survey Report shows what items can be collected on contact occasion for this cluster.

Table 4. Residential sector cluster’s capacity to collect client level data items on contact occasion (n=18)

	Capable	With modification	Not capable	N/A
Date of contact	89%	11%	0%	0%
Contact duration	78%	11%	11%	0%
Mode of contact	78%	22%	0%	0%
Direct or indirect	72%	28%	0%	0%
Individual or group session	78%	22%	0%	0%
Intervention/service type provided	67%	22%	11%	0%



The ability of respondents in the residential cluster to collect the 'phase of care' (track, date and report on the different stages of the clients service usage) data items without any change to their data infrastructure system was 50%, a very similar figure to the community cluster. Respondents also gave examples of possible categorisations of 'phase of care' adding to the community cluster suggestions with the example of service levels negotiated with local health district.

Hospital/admitted cluster

Four (4) out of 31 respondents reported they provided hospital based/admitted mental health services. Seventy-five (75%) of this cluster was able to collect organisational level data and 100% able to collect basic client level data.

One hundred percent (100%) of organisations providing hospital based/admitted services are currently capable of collecting the 'episode of care' data items. No respondents in this cluster reported being incapable of collecting the data. One respondent was capable of collecting all three data items; legal status, principal diagnosis and additional diagnoses, but noted these measures were not relevant to the services they are contracted to provide. Within this cluster that was most easily able to collect the data items, the capacity to collect legal status was at 50%. Table 5 below from the Survey Report, shows respondents' capacity to collect each of the data items within an 'episode of care'.

Table 5. Hospital/admitted sector cluster's capacity to collect each data item within an 'episode of care' (n=4)

	Capable	With modification	Not capable	N/A
Mental health legal status	50%	25%	0%	25%
Principal diagnosis	75%	0%	0%	25%
Additional diagnosis	75%	0%	0%	25%
Episode start date and end date	100%	0%	0%	0%
Reason for end of episode	100%	0%	0%	0%
Referral source	100%	0%	0%	0%
Referral destination	75%	25%	0%	0%
Number of leave days during episode	50%	50%	0%	0%
Psychiatric care type (e.g. acute, rehab, psychogeriatric, etc.)	75%	25%	0%	0%

Seventy-five percent (75%) of organisations providing hospital-based mental health services are currently capable of collecting contact occasion level data items and 25% are capable with some system modifications. Table 6 below from the Survey Report shows what items can be collected on contact occasion for this cluster.



Table 6. Hospital/admitted sector cluster's capacity to collect client level data items on contact occasion (n=4)

	Capable	With modification	Not capable	N/A
Date of contact	75%	25%	0%	0%
Contact duration	75%	0%	25%	0%
Mode of contact	75%	0%	0%	25%
Location	50%	50%	0%	0%
Direct or indirect	75%	0%	0%	25%
Individual or group session	75%	25%	0%	0%
Intervention provided	100%	0%	0%	0%

The issues noted by other clusters regarding the use of the term 'intervention' was not as problematic for this cluster, as interventions were recorded by community managed organisations as per hospital protocol when providing admitted services.

Seventy-five percent (75%) of organisations providing hospital-based mental health services are able to track, date and report on a change of client phase. Examples provided for possible categorisations of phase were in alignment with the other clusters.

Other/ not catered for cluster

Nine (9) out of 31 organisations identified as providing 'other' services e.g. non-admitted, non-residential. Of those organisations 78% were able to collect data at both an organisation level and a basic client level. The remaining 22% will require system upgrades to collect organisation level data. Eleven percent (11%) are currently unable to collect 'basic client level data'.

Seventy-eight percent (78%) of organisations providing 'other' services are currently capable of collecting the 'episode of care' level data items. The other 22% are not capable of collecting the item. Some explained that asking consumers for information under many of the items, including those items they are capable of collecting, would be counter to their practice models. Mental health legal status appears to be the least problematic for this group.

Table 7 below from the Survey Report, shows respondents' capacity to collect each of the data items within an 'episode of care'.

Table 7. Other sector cluster's capacity to collect each data item within an 'episode of care' (n=9)

	Capable	With modification	Not capable	N/A
Mental health legal status	57%	14%	29%	0%
Principal diagnosis	86%	0%	0%	14%
Additional diagnosis	71%	14%	0%	14%
Episode start date and end date	100%	0%	0%	0%
Reason for end of episode	86%	0%	14%	0%
Referral source	100%	0%	0%	0%
Referral destination	71%	14%	14%	0%
Number of leave days during episode	29%	0%	14%	57%

Seventy-eight percent (78%) of the organisations under the residential cluster are currently capable of collecting client level data items on contact occasion. A further 22% may be



capable with some, or major, upgrades to their systems. The concept of ‘intervention’ was again problematic, therefore organisations reported on the ‘service’ provided.

Table 8 below from the Survey Report shows what items can be collected on contact occasion for this cluster.

Table 8. Other sector cluster’s capacity to collect client level data items on contact occasion (n=9)

	Capable	With modification	Not capable	N/A
Date of contact	100%	0%	0%	0%
Contact duration	100%	0%	0%	0%
Mode of contact	100%	0%	0%	0%
Location	100%	0%	0%	0%
Direct or indirect	88%	0%	0%	13%
Individual or group session	75%	0%	0%	25%
Intervention provided	88%	13%	0%	0%

Seventy-one percent (71%) of organisations providing ‘other’ mental health services are able to track, date and report on a change of client phase. Examples of possible categorisations of phase remained similar to the other clusters.

Outcome measures

Respondents were asked to report on the outcome measurement tools used in their organisation. Twenty-seven (27) organisations reported using outcome measurement tools. Table 9 of the survey report shows:

- the number of organisations that reported using which measure
- what percentage of respondents are using which measure
- whether the measure appears as a recommended measure in the AMHOCN guidebook.²⁴, and
- whether the measure is part of the NOCC.

The top three measures collected by the community mental health sector according the survey results are the CANSAS, which was reported as the most commonly used tool, at 63%. The Recovery Star measure is the next most frequently used measure at 37% and approximately the same number of respondents, 30%, reported using the K-10 scale which appears in both the AMHOCN guidebook and the NOCC.

Table 9 shows a list of other outcome measures used by community managed organisations, ordered from most frequently used to least frequently used.

The rates of use of the Life Skills Profile (LSP 16), HoNOS and HoNOSCA measures are important findings, as these are the measures that will be used in the draft AMHCC Version 1.0. Low rates of use were reported by organisations at 15%, 7% and 4% respectively.

²⁴ Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia (2015). *Implementing Routine Outcome Measurements in Community Managed Organisations*, AMHOCN, Sydney, NSW.



Adaptation of information and data systems to reforms

In order to assess the readiness of community managed organisations to adopt a data management system for the draft AMHCC Version 1.0 and the ABF MHC DSS survey respondents were asked if they were planning to upgrade or change their IT infrastructure and data management systems to meet the policy, funding and reporting reforms associated with either ABF, NDIS, E-Health Records or other reforms.

The results can be seen below in Table 10 of the survey report. The NDIS is clearly the biggest reform requiring community managed organisations to change and upgrade their systems. All community managed organisations surveyed have been, or will be, required to adapt to this reform. This presents a good opportunity to align any new data requirements so that these are consistent across different funding streams.

A third of organisations are updating their systems to meet the requirements of a casemix classification and associated data set collection requirements. Respondents indicated that without a clear national agreement on the implementation of the draft AMHCC Version 1.0 and ABF it would not be a priority for them.

Table 10. Intention to update data collection system in response to change of policy/funding requirements.

Reform	No. of CMOs	% of respondents
National Disability Insurance Scheme (NDIS)	27	100%
Activity based funding (ABF)/ casemix collection	9	33%
E-health records	2	7%
Queensland mental health data set	1	4%
NSW homelessness data set	1	4%

Comments from open text questions and open-ended feedback

Respondents were asked to provide general comments and answers to two open text questions:

1. What is the best way IHPA, Mental Health Australia or CMHA can help you develop your capacity to collect and report on service activity?
2. Is there anything else you would like to say about the Australian Mental Health Care Classification?

A summary of responses can be found at page 18 of the survey report with the complete set of responses at [Appendix B](#) to the survey report.

The recurring themes that emerged included:

- the need for the use of terminology, classifications, interventions and outcome measures that are relevant to community managed programs
- the use of language was highlighted as an obstacle for community managed organisations to uptake the classification effectively (e.g. 'patient', 'intervention', etc.)
- concepts of 'episode of care' and 'phase' were especially problematic for services provided at lower levels of illness severity



- the design of the classification and the associated data set appears to be incentivising hospital/inpatient mental health service provision, which is counter to most jurisdictional policies and strategies
- the draft AMHCC Version 1.0 does not seem to align with other reporting requirements of mental health community managed organisations, most obviously the NDIS. This creates two largely divergent data set requirements for many organisations, most of whom will receive funding from both sources
- the need for IT infrastructure support to enable those CMOs currently unable to collect more detailed client level information. Some suggestions were to work with major software vendors to ensure ABF DSS compatibility, funding of CMO data system upgrades, and ensuring detailed technical guidance is made available from direct funders.

General comments on the draft AMHCC Version 1.0 from the workshops were also recorded and can be found on page 19 of the survey report. Comments have been grouped under headings summarising the main topics of response.

Mental Health Care Type

Respondents reported the definition of mental health care – ‘the mental health care type’ used to define what services will be covered under the draft AMHCC Version 1.0, would exclude services provided by the majority of CMOs. It was noted the definition of ‘clinician’ used in the ‘mental health care type’ was unclear. If the traditional definition of ‘clinician’ was assumed this would be problematic for CMOs, as the service model delivered by many of these organisations does not require a clinician and that clinicians are often not willing or able to be involved in these type of services. It was explained that the clinician as the driver is not the model of service delivered by many community mental health care services, as it sets an unprecedented narrow threshold to service access. Importantly it was recorded that the accessibility criteria for many community managed services do not require a mental health plan or a formal mental health assessment, as these actions are something someone ‘does to you’ in making a decision ‘about’ what you need. This process is not in accordance with the community managed service model which practices a conversation between a consumer and staff member in deciding what might be the consumer’s needs.

The conceptual model of the draft AMHCC Version 1.0

Workshop participants explained that much of the mental health sector has advanced beyond the clinical model onto a recovery model, and that the draft AMHCC Version 1.0 appears to remain dated in describing only a discrete portion of mental health care service delivery. Participants reported the sector was committed to collecting data and could see the benefit of high quality information. However asking the community managed sector to collect the data item for the draft AMHCC Version 1.0 in its current form would characterise their services in ways that do not accurately reflect the nature or the breadth of services they are contracted to deliver. Examples of services participants could not see represented in the data set were informal, low threshold to entry services, such as telephone counselling services and drop in centres, where clients often self-reported and did not require a formal diagnosis.



The concept of 'phase of care' was difficult for workshop participants to understand. A description was given in the pre-survey workshops and guidance provided within the survey, however few survey respondents conceptualised their phases in a similar way.

'Episode of care' and 'contact occasion' also proved problematic, as respondents struggled to conceptualise how these data elements could be collected within their service models.

The use of 'interventions' as a cost predictor for community managed services

Participants wished to highlight that the use of the term 'intervention' is not an accurate way to describe services provided under their model of service delivery. The use of 'intervention' is not an appropriate way to either describe community managed mental health care services or an appropriate way to deliver that service model. It was also observed the majority of 'interventions' in the Mental Health Intervention Classification (MHIC) were only appropriate to describe services delivered in clinical public mental health care settings.

Though the course of the project the status of the MHIC in the AMHCC was not clear. However, at the time of writing it became clear that the MHIC will not be an element of the future AMHCC.

Outcome measurement tools

In response to questions regarding to the use of certain NOCC outcome measurement tools in the draft AMHCC Version 1.0 data framework, participants observed these measures were not originally designed for use in the community sector, and were not part of the suit of measures recommended for use by CMOs in the AMHOCN National Community Managed Organisation Outcome Measurement project 2013.²⁵

²⁵ Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia. (2013) *National Community Managed Organisation (CMO) Outcome Measurement project: Final Report to the Mental Health Information Strategy Standing Committee 1.1*. Sydney, NSW.



4. Conclusions and next steps

Classifying, counting and costing community mental health care services will become increasingly important as governments and funding bodies move towards new commissioning models involving individualised and/or outcomes based funding. The results of the survey conducted by Mental Health Australia in July and August 2015 have shown that CMOs are amenable to this change and already have some capacity to contribute at the level required. However to adapt to the new funding environment CMOs will be required to develop data management systems to demonstrate relevant standards of efficiency and accountability related to the services they are funded to deliver.

In the absence of effective data collection frameworks, CMOs risk being unable to capitalise on new funding opportunities. This is despite widespread recognition that the community managed sector must contribute relatively more to the mental health system of the future than hospital based services.

The draft AMHCC Version 1.0 is the first step in developing a nationally consistent way of classifying mental health care and its costs at a patient level. However, it is critical to identify the limitations of the proposed classification design for mental health care CMOs and acknowledge that this is the start of an ongoing process of classification design, with future versions requiring targeted work for inclusion of the community managed mental health sector.

Appropriate measurement tools for the community managed mental health sector

The survey results and evidence in the cited studies, clearly show the outcome measures proposed in the draft AMHCC Version 1.0 are not the measures currently used by the community mental health sector. The proportion of organisations collecting the draft AMHCC Version 1.0 outcome measures is very low, and those organisations that do, are part of a narrow cohort providing acute, inpatient-type services in partnership with public health services.

Those measurement tools identified in the draft AMHCC Version 1.0 were designed to be used by clinicians in public health settings. HoNOS guidelines state that the tool should only be used by a 'trained clinician' and collected by a 'health professional'. Workshop participants and survey respondents, reported that most managed mental health CMOs do not provide services requiring a clinician or clinical models of service delivery. This is evident when looking at the taxonomy of service types under the MH NGOE DSS. Few of these services listed would require a clinician or benefit from a clinician being present.



Additionally the HoNOS requires collection upon 'admission', 'discharge' and at three month intervals. Again these collection rules would not be appropriate and would be difficult to implement under many of the service types listed under the MH NGOE DSS. The LSP-16 is used by a slightly higher cohort of CMOs than the HoNOS, but uptake is still low in comparison to other preferred measures. The LSP-16 does allow for completion by the consumer and/or a CMO employee; however the employee is described as a 'health professional' which may exclude some services, such as those provided by peer workers.

Work completed to date has shown approximately 50 percent of mental health CMOs can and do collect outcome measures, and another 25 percent would be capable with upgrades to data collection systems. Extensive work by AMHOCN has provided an agreed and recommended list of outcome measures for use by CMOs. These measures were recommended as they reflect the service models provided by these organisations, are appropriate and meaningful for consumers, carers and staff, and therefore have the greatest chance of being successfully embedded in day to day practice. The two established quantitative tools that fit these criteria and appear to be most frequently used are the K-10 self-rated tool and the CANSAS. Additional measures listed in the AMHOCN guidebook showed lower rates of use in the preliminary needs survey, however this may be due to organisations and jurisdictions waiting on the very recent release of the guidebook to begin implementation of the recommended measures.

All indications suggest most CMOs can and do collect organisational and basic client data and therefore can collect the level of data required to be part of the draft AMHCC Version 1.0. Whether or not an organisation needs additional assistance with infrastructure and system upgrades to collect data will depend on its particular circumstances and the types of services that it provides.

However, identifying appropriate measures for collection by CMOs is not just a question of an ability to physically collect the data. Such measures must also meaningfully describe the outputs and outcomes of that organisation's services. Measures for use in the community managed sector must reflect the service delivery aims of moving beyond clinical management of symptoms and providing consumers and carers with flexible, recovery orientated services. If the outcome measures proposed for use in the draft AMHCC Version 1.0 do not support this model of service delivery - it is reasonable to conclude they will not be good predictors of the cost of care provided by CMOs.

The data items proposed for collection under the draft AMHCC Version 1.0 are items traditionally collected to describe clinically based services delivered by the public mental health sector. Yet the clinical model of service delivery is only part of the overall picture of mental health care in Australia, with best practice advancing beyond clinical models into recovery orientated models of care. In order to measure the costs and outcomes of services provided in community managed settings, measurement tools and data items must explicitly measure domains relating to personal recovery, take in the consumer perspective and promote dialogue between consumers and providers.

Promoting integrated care

IHPA's intent to build a classification that can be applied to all mental health care settings must be supported with language, definitions and descriptions that measure the recovery orientation of community mental health care service provision. Mental Health Australia



recognises that the draft AMHCC Version 1.0 is the starting point for classifying services in a way that is meaningful for consumers, carers, clinicians, providers, funders and system managers alike. Future iterations of the AMHCC should consider how collaboration in mental health care is needed to best serve consumers across settings.

Classification design must support and promote integrated packages of care across service settings. This would be consistent with the recommendations in the National Mental Health Commission Review. This review recommends moving away from separate payment arrangements to a focus on integrated care pathways to enable a smooth journey across the mental health system. This will result in better access to services, improved outcomes and more effective and efficient use of resources.

As noted in the Commission's review, there is a significant gap in our understanding of the contribution made by the community managed sector to improving mental health outcomes, and it is difficult to see how the draft AMHCC Version 1.0, in its current form, will contribute to addressing this gap. The development of the AMHCC is an opportunity to design a data framework that reflects a single care system, bringing together public, private and community run mental health services. To realise the AMHCC's potential, each of these sectors requires a different but complementary approach.

The practicalities and implications of applying the draft AMHCC Version 1.0 and ABF to community managed mental health services funded outside the hospital system, must be carefully considered. There is a significant risk that if community managed organisations were required to collect data items that describe clinical services and not their own models of care, their services could be redefined and inaccurately represented. Should all mental health service delivery funding (regardless of setting) be attributed through draft AMHCC Version 1.0 in its current form, there is also the possibility that incentives will be created to treat consumers in the particular settings. If those incentives are created they will not be consistent with national or jurisdictional mental health policies and will not reflect current best practice models of care. The optimal design of the AMHCC is one that integrates service settings and funding sources, promotes continuity across treatment settings and discourages the incentive to provide care in a particular environment.

Funding arrangements to promote investment

CMOs operate with multiple funding sources, often across portfolios and levels of government, and each with its own reporting requirements. This multiple-funder environment is a barrier to standardised data collection and reporting. CMOs must ensure their data collection systems are consistent with relevant funders' requirements to produce multiple reports, each with different but overlapping data sets, and absorb the resulting administrative overheads. Many CMOs would benefit greatly from an investment in developing systems, network applications and skills to enable the data they collect to be useful for comparative analysis. However, funding arrangements to date have not allowed such investments to take place. This is in comparison to public mental health systems, which see significant investment in data capacity on an ongoing basis.

Draft AMHCC Version 1.0 and the NDIS

IHPA and the NDIA are both seeking to develop an appropriate data collection system for mental health services delivered in community settings. One hundred percent of survey



respondents reported they are adapting their reporting systems to respond to the funding requirements under the NDIS. The NDIA may be considering the collection of a range of data types, including information relating to:

- clinical assessment, including severity indicators
- functional assessment, including severity indicator
- outcomes across a broad range of (non-clinical) domains, and
- important demographic and other relevant markers such as legal status and history of service use.

Many of the services to be funded by the NDIS will fall within the scope of the draft AMHCC Version 1.0, yet to date IHPA's and the NDIA's work plans have evolved largely in isolation. This is understandable, given each organisation's very different overriding objectives and legislated responsibilities. However, Mental Health Australia is concerned that separate systems to classify and count community mental health services will be developed in isolation if steps are not taken to ensure these systems are complementary.

Recommendations and next steps

The goal of extending the AMHCC to mental health care services provided in a community based setting is ambitious, challenging and complex. To develop a classification that would accurately represent services provided by CMOs, Mental Health Australia recommends that IHPA:

- considers the inclusiveness and explanatory power of the 'mental health care type' definition, particularly with respect to that definition's representativeness across the range of mental health services and models of care delivered by CMOs
- explores options to ensure that future iterations of the AMHCC are applicable to CMOs and truly representative of their service models, including the various options available to jurisdictions as outlined below.

Mental Health Australia's investigations for this project suggest there are various actions that government can pursue to support IHPA's work on the AMHCC. If the AMHCC is to reflect the full range of mental health service settings – not just services that are delivered in or are associated with public hospitals – then the CMO sector must have the capacity to collect nationally consistent patient-level data that can be linked meaningfully to costs and outcomes. Nevertheless, we recognise that investment in data capacity and data infrastructure across the CMO sector is the responsibility of jurisdictions, not IHPA. Realising this ambition would require commitment from across government over a substantial period.

Mental Health Australia recommends the following avenues of work:

- Creation of an NGO/CMO client level NMDS, based on a taxonomy that reflects the services provided by CMOs.
- Development of an NGO/CMO national outcomes data collection. This could run in parallel to the public sector National Outcomes and Casemix Collection, and include both provider assessment measures and consumer experience of care outcome measures that appropriately reflect services provided in the community managed mental health sector.



Beyond the health portfolio, Mental Health Australia notes the implications for data development associated with the National Disability Insurance Scheme (NDIS), which will result in substantial changes to the way CMOs collect client-level data. We anticipate significant benefits in IHPA and the National Disability Insurance Agency (NDIA) working in partnership to develop systems for classifying and counting community mental health services, to avoid dual systems that will be either incompatible or very difficult to reverse engineer.

Mental Health Australia also sees considerable merit in IHPA, NDIA and the community-managed sector continuing to work together to ensure further classification development work can apply to the broadest range of services, funding sources and organisational profiles, both within and beyond state-run mental health services. This would involve different parts of government working in partnership with the non-government sector to build an integrated data collection system based on the principle of 'create once – use often'.



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Mental Health Australia



Mentally healthy people,
mentally healthy communities

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