

Community mental health care NMDS 2013–14: National Community Mental Health Care Database, 2015; Quality Statement

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Identifying and definitional attributes

Metadata item type:	Data Quality Statement
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Data quality

Data quality statement summary:

- The National Community Mental Health Care Database (NCMHCD) contains data on service contacts provided by public sector specialised community mental health services in Australia.
- There is some variation in the types of service contacts included in jurisdictional data. For example, some jurisdictions may include written correspondence as service contacts while others do not.
- The Indigenous status data should be interpreted with caution due to the varying quality of Indigenous identification across jurisdictions reporting to the database. While all jurisdictions consider the quality of Indigenous status data to be acceptable, most acknowledge that further improvement is required. Indigenous status missing for 9.2% of contacts in the 2013–14 NCMHCD. Data are reported by the jurisdiction that delivered the service and therefore include people receiving services in one jurisdiction who reside in another. These cross-border flows are particularly relevant when interpreting ACT data.
- There is variation across jurisdictions in the coverage of services providing contact data and the estimated service contact data coverage.
- The quality of principal diagnosis data may be affected by the variability in collection and coding practices across jurisdictions.

Description

The National Community Mental Health Care Database (NCMHCD) contains data on community (also sometimes termed 'ambulatory') mental health service contacts provided by government-funded community mental health care services as specified by the Community mental health care (CMHC) National Minimum Data Set (NMDS) (see [link](#)). The NCMHCD includes data for each year from 2000–01 to 2013–14.

The NCMHCD includes information relating to each individual service contact provided by an in-scope mental health service. Examples of data elements included in the collection are demographic characteristics of patients, such as age and sex, clinical information, such as principal diagnosis and mental health legal status, and service provision information, such as contact duration and session type.

The CMHC NMDS is associated with the Mental Health Establishments (MHE) NMDS, which is used to collect data about the services that provide service contacts.

Institutional environment: The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the [Australian Institute of Health and Welfare Act 1987](#) to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent corporate Commonwealth Entity established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national data sets based on data from each jurisdiction, to analyse these data sets and disseminate information and statistics.

The [Australian Institute of Health and Welfare Act 1987](#), in conjunction with compliance to the [Privacy Act 1988](#), (Cth) ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au.

Community mental health services may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. States and territories use these data for service planning, monitoring and internal and public reporting. In addition, state and territory health authorities supply data for the NCMHCD under the terms of the National Health Information Agreement (see [link](#)), as specified by the CMHC NMDS (see 'Interpretability' section below).

Expenditure and resource information for community mental health services reporting to the NCMHCD are reported through the associated National Mental Health Establishments Database, as specified by the MHE NMDS (see [link](#)).

Timeliness: Data for the NCMHCD were first collected in 2000–01.

States and territories are required to supply data annually in accordance with the CMHC NMDS specifications. The reference period for this data set is 2013–14, that is, service contacts provided between 1 July 2013 and 30 June 2014. Data for the 2013–14 reference period were supplied to the AIHW at the end of December 2014.

The AIHW publishes data from the NCMHCD in [Mental health services in Australia](#) annually.

Accessibility: The AIHW produces the annual series *Mental health services in Australia*, primarily as an online publication at <http://mhsa.aihw.gov.au/home/>. This includes pdf documents of all sections in the publication, as well as data workbooks and an interactive data portal. In addition, a companion hard copy 'In brief' summary document is produced and is available from the Digital and Media Communications Unit of the AIHW.

Interpretability:

Metadata information for the CMHC NMDS is published in the AIHW's online metadata repository—METeOR.

METeOR can be accessed on the AIHW website:

<http://meteor.aihw.gov.au>

Data published annually in *Mental health services in Australia* include additional important caveat information to ensure appropriate interpretation of the analyses presented by the AIHW. Readers are advised to take note of footnotes and caveats specific to individual data tables that influence interpretability of specific data.

Relevance:

The purpose of the NCMHCD is to collect information on all ambulatory mental health service contacts provided by community mental health care services, as specified by the CMHC NMDS. The scope for this collection is all government-funded and operated community mental health care services in Australia.

A mental health service contact, for the purposes of this collection, is defined as the provision of a clinically significant service by a specialised mental health service provider for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any one patient can have one or more service contacts over the reporting period (that is, 2013–14). Service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. Service contacts can also be either with the patient or with a third party, such as a carer or family member, or other professional or mental health workers or other service providers.

Accuracy:

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made by them in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

All states estimate that 90–100% of in-scope community mental health care services provided contact data to the collection. Overall service contact data coverage for most jurisdictions was estimated to be between 90–100%. Most states reported small collection gaps that are being addressed.

Indigenous status

Data from the NCMHCD on Indigenous status should be interpreted with caution. Jurisdictional advice is that the data quality and completeness of Indigenous identification varies. The methodology for the identification of Indigenous status varies both between jurisdictions and between services within a jurisdiction. Subsequently, the identification process may result in a different status being recorded among multiple service contacts or between service providers. Indigenous status is missing for 9.2% of contacts in the 2013–14 NCMHCD.

States and territories provided information on the quality of the Indigenous status data for 2013–14 as follows:

- New South Wales reported the quality of the Indigenous status data to be acceptable but that there are always opportunities to improve. The activity based funding model in NSW will drive improvements in data quality including Indigenous status.
- Victoria reported the quality of the Indigenous status data to be acceptable but that there continue to be areas for improvement.
- Queensland reported that the quality of Indigenous status data in 2013–14 was acceptable, with an improvement on reporting from 2012–13, and further improvement in future collections is promising.
- Western Australia reported that the quality of Indigenous status data for 2013–14 was acceptable; however, they acknowledged the importance of continuing work to improve initial data collection and validation protocols at both local and state levels. Suggested areas for improvement included education and training at the data capture point, data analysis and action in cases where the status changed between time points and routine monitoring and ad hoc auditing of data.
- South Australia reported that the quality of Indigenous status data was acceptable, and generally an improvement on the previous year's data.
- Tasmania reported the quality of Indigenous status data was acceptable and quite high for 2013–14, with an improvement on previous years due to the ceasing of industrial action.
- The Australian Capital Territory reported that the quality of Indigenous status data was acceptable.
- The Northern Territory considered the quality of the Indigenous status data to be acceptable and consistent between services. The data collection system provides multiple opportunities for the updating of Indigenous status.

Remoteness area and socioeconomic status

Numerators for remoteness area and socioeconomic status are based on the reported area of usual residence of the patient, regardless of the location or jurisdiction of the service provider. This may be relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction. Therefore, comparisons of service contact rates for jurisdictions require consideration of cross-border flows, particularly for the Australian Capital Territory.

Coherence: Metadata specified in the CMHC NMDS may change from year to year. For 2013–14, there was an update to the current classification scheme, the 8th Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification.

There are variations across jurisdictions in the scope and definition of a service contact. For example, most jurisdictions may include telephone and/or written correspondence as service contacts while the Northern Territory does not. Data on contacts with unregistered clients are not included by all jurisdictions. Unregistered client contacts refer to those mental health service contacts for which a person identifier was not recorded. Queensland and the Northern Territory do not have any unregistered clients.

Principal diagnosis

The quality of principal diagnosis data in the NCMHCD may be affected by the variability in collection and coding practices across jurisdictions. In particular, there are:

1. Differences among states and territories in the classification used as follows:
 - Queensland, Western Australia, Tasmania, the Northern Territory, Victoria and the Australian Capital Territory report that data are submitted in accordance with the ICD-10-AM 8th Edition, consistent with the NMDS
 - South Australia used a combination of ICD-10-AM 8th Edition, 4th Edition and ICD-10-AM Mental Health Manual 1st Edition
 - Western Australia noted that patients who were activated prior to and have not had a diagnosis review since the implementation may have a principal diagnosis using a code that is earlier than ICD-10-AM 8th Edition.
2. Differences according to the size of the facility (for example, large versus small) in the ability to accurately code principal diagnosis.
3. Differences in the availability of appropriately qualified clinicians to assign principal diagnoses (diagnoses are generally to be made by psychiatrists, whereas service contacts are mainly provided by non-psychiatrists).
4. Differences according to whether the principal diagnosis is applied to an individual service contact or to a period of care.

New South Wales, Victoria, Queensland, Western Australia and South Australia report the current diagnosis for each service contact rather than a principal diagnosis for a longer period of care. The remaining jurisdictions report principal diagnosis as applying to a longer period of care.

Data products

Implementation start date: 01/07/2013

Source and reference attributes

Steward: [Australian Institute of Health and Welfare](#)

Relational attributes

Related metadata references: Has been superseded by [Community mental health care NMDS 2014–15: National Community Mental Health Care Database, 2015: Quality Statement](#)
[AIHW Data Quality Statements](#), Superseded 13/10/2017