TE POU

Guide to PRIMHD supplementary consumer record (SCR) requirements including social outcome indicators

To be used in conjunction with PRIMHD code set standard HISO 10023.3:2017

Version 1.5, March 2022

MINISTRY OF HEALTH
MANATŪ HAUORA

PRIMHD
Programme for the Integration of Mental Health Data

Who we are

Te Pou is the national centre of evidence-based workforce development for the New Zealand mental health, addiction and disability sectors. We're funded in most part by the Ministry of Health.

We are at the heart of delivering services that empower and inspire people working in mental health, addiction and disability services to make their clients' lives better.

We support organisations to implement policy and plan and develop their workforce with practical resources, consultation and education. We use a sound evidence base that builds better services to improve people's lives.

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Te Pou is a national centre of evidence-based workforce development for the mental health, addiction and disability sectors in New Zealand.

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Document control

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Version control

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1.0	December 2015	First published version	
1.1	January 2016	Minor adjustments	▪ removal of additional guidelines in Table 4, addition to aggregated national level reporting inclusions, Section 4.
1.2	September 2016	Revised version	▪ revised to include further definition of indicator valid values and addition of more comprehensive frequently asked questions (FAQ) to aid implementation ▪ format update.
1.3	July 2018	Revised version	▪ updated links to HISO documents ▪ removed non-relevant links ▪ amended FAQ ▪ removed PHO registration row ▪ amended advice regarding accommodation (Prisons and inpatients units) ▪ added information regarding three face to face activities or more ▪ clarified what is meant by 'supplementary' ▪ amended target population ▪ use of tāngata whai ora (plural) and tangata whai ora (singular) as an encompassing term for client, service user, consumer ▪ update brand and format.
1.4	October 2019	Revised version	▪ update to MoH email address formats.

			▪ minor amendments to text following publication of ‘He Ara Oranga’ ▪ additional references
1.5	March 2022	Revised version	▪ remove reference in section 1 Target Population to PRIMHD warnings due to the implementation of the NCAMP21 change to remove warnings for SCR records from PRIMHD. ▪ content and link checks and updates as required throughout. ▪ Update brand and format

Important

It is important that you use the current version of this document. All Health Information Standards Organisation (HISO) standards are living documents and are reviewed periodically to assess and maintain their currency. This document will be reviewed as required at each HISO review or National Collection Annual Maintenance Project (NCAMP) change process and will incorporate amendments issued since the document was first published. Detailed information about HISO standards, drafts, amendments and new projects can be found by visiting the HISO website

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Introduction

Purpose of PRIMHD

The Programme for the Integration of Mental Health Data (PRIMHD) is a Ministry of Health service user-centric database designed to capture a range of services (interventions or activities) being delivered to tāngata whai ora by contracted mental health and addiction providers. The primary objective of PRIMHD is to obtain a national picture of the mix of services being delivered to tāngata whai ora by District Health Boards (DHBs) and non-government organisations (NGOs); and how this pattern changes over time. Supplementary consumer records (SCRs) identify social and environmental indicators that can impact on the recovery of a tangata whai ora, and also allow monitoring of change over time. Supplementary in this instance means ‘in addition to’ other data, it is not optional. This information will help build a bigger picture of the situation and needs of tāngata whai ora and help services tailor their delivery more individually.

PRIMHD data is used to report on what services are being provided, who is providing the services, and what outcomes are being achieved for tāngata whai ora across New Zealand’s mental health sector. These reports enable better quality service planning and decision making by mental health and addiction (MH&A) service providers at the local, regional and national levels.

PRIMHD represents service provider activities and tāngata whai ora outcomes that are significant to the treatment journey of a tangata whai ora. While many individual provider information systems have the capacity to collect a broader and more granular range of data, PRIMHD is not intended to capture information about everything.

Purpose of this guide

The collection of social outcome indicators as part of a SCR in PRIMHD was made mandatory for all MH&A service referrals from 1 July 2016.

The purpose of this guide is to provide MH&A services with a consistent methodology for the collection and use of SCRs in PRIMHD from 1 July 2016. This guide will also inform funders and planners and the Ministry of Health’s PRIMHD national collections team. It is not a replacement for the PRIMHD technical documentation or HISO PRIMHD standards, but it is intended to support a consistent national approach. High levels of quality in SCR data reported to PRIMHD will ensure maximum utility of data in the national collection.

It is understood that DHB and NGO services may collect wellness plan and social outcome data at a much more granular level. This guide does not prohibit this granular collection; but serves to ensure that detailed local level data can be mapped consistently to meet PRIMHD requirements.

This document should be used in conjunction with the HISO PRIMHD standards and specifications, and NCAMP 16 documentation. Links are provided on the following page.

PRIMHD Standards documentation

This document should be used in conjunction with:

- HISO PRIMHD standards, data and code sets
- PRIMHD specifications

NCAMP16 documentation

See also the change notifications, supporting documents, compliance testing files, and questions and answers for the National Collections Annual Maintenance Project 2016.

Intended audience

NGO and DHB service providers (front-line staff, data analysts, administrators, DHB and regional coordinators for PRIMHD); portfolio managers, funders and planners; and the Ministry of Health PRIMHD national collections and national MH&A workforce centres. This guide is designed to support good judgement.

Out of scope

Although wellness plan and social outcome indicator data are linked to referral information, referral start and end codes as well as the referral process are out of scope for this guide.

Please see HISO PRIMHD standards, data and code sets and the Guide to PRIMHD Referral Collection and Use.

Process for ongoing review and development

The Ministry of Health (the Ministry) acknowledges that this is a first step in understanding how the social determinants of health may influence the treatment journey of a tangata whai ora. Existing options for the supplementary indicators have undergone a full HISO and business review and approval process. Future modifications will be implemented through the National Collections Annual Maintenance Project (NCAMP) after approved updates to the standards by the HISO processes.

Further details about NCAMP are available here. Questions or comments relating to NCAMP should be directed in the first instance to: ncamp@health.govt.nz

Terminology used in this guide

The term tāngata whai ora (or tangata whai ora without a macron for an individual) is used throughout this guide. It is intended to cover all terms used to describe people who access MH&A services, including service users, clients and consumers. Where the guide quotes directly from existing HISO PRIMHD standards, the terminology used in those resources has been retained.

How to use this guide

This guide uses hyperlinks to navigate to relevant sections and resources (Ctrl + mouse click). Hyperlinks are words that are underlined. If using keyboard shortcuts Ctrl+F will let you navigate through document headings and pages and allow you to search for specific words or phrases.

About social outcome data in PRIMHD

The World Health Organisation's (WHO) (2014) report on the *Social Determinants of Mental Health* highlights the growing evidence that:

> "a person's mental health and many common mental disorders are shaped by social, economic, and physical environments. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk."

The WHO report concludes that social arrangements and institutions, such as education, social care, and work have a huge impact on the opportunities that empower people to choose their own course in life. It urges policy makers worldwide to further research and act on the social determinants of mental health to make a positive difference to mental health outcomes.

In New Zealand, the inclusion of a measure of social outcome for mental health and addiction service users has been much debated since PRIMHD was established in 2008. More recently it has been the focus of Key Performance Indicator (KPI) forums; a PRIMHD Working Group work stream; and the subject of a pilot undertaken by Waitematā and Auckland NGOs[1].

The Ministry of Health requires social outcome data to be collected and reported to PRIMHD, as part of a supplementary consumer record (SCR), for all mental health and addiction service users from 1 July 2016.

The inclusion of social outcome measures in PRIMHD is intended to complement existing measures of outcome by providing information on the social contexts relevant to tāngata whai ora care. These indicators are about measuring change in relation to longer term,

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[1] *Review of the collection and use of social outcome performance indicators by mental health NGOs, Final Report*, 29 July 2015. Prepared by and available from Platform Trust on behalf of the Social Outcome Indicators Group.

rather than immediate, goals and understanding the relationship between social outcomes and overall well-being.

The four indicators are consistent with the expectations outlined in '*Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017*', and are in alignment with *He Ara Oranga;* Report of the Government Inquiry into Mental Health and Addiction findings and recommendations, which states in the executive summary:

"People said that unless New Zealand tackles the social and economic determinants of health, we will never stem the tide of mental health and addiction problems. There are clear links between poverty and poor mental health. People need safe and affordable houses, good education, jobs and income for mental wellbeing. (page 9)."

He Ara Oranga states as part of recommendation 16 "tackling social determinants that impact on multiple outcomes and that lead to inequities within society".

The indicators are as follows:

- Accommodation status
- Employment status
- Education and training status
- Wellness (relapse prevention or transition) plan.

This data will provide the Ministry of Health, DHB and NGO services with a measure to determine if services have achieved expected results for an individual, or group of, tāngata whai ora, because of services provided. Results specified in *Rising to the Challenge* include priority actions that focus on enhancing social inclusion opportunities and promoting wellness planning. SCR indicators will also specifically help monitor progress to increased employment and education opportunities for people with low prevalence conditions.

The vision is for the collected data to be aggregated to a service provider, local, regional or national level to measure changes in tāngata whai ora social outcomes from year to year. This will help us understand the extent to which MH&A services are contributing towards the change.

1. Supplementary Consumer Record (SCR) requirements

The HISO PRIMHD standards include information on a range of social outcome indicators and the presence of a wellness (relapse prevention or transition) plan. All four indicators are linked to one SCR collection date with a unique identifier for each SCR reported.

A summary of the social outcome indicators included in the SCR can be found in Table 1.

Table 1: Summary of the PRIMHD SCR social outcome indicators

Accommodation status	Indicates whether a service user's accommodation is funded in part or whole by Mental Health services, whether their accommodation is funded independent of Mental Health services or whether a service user is homeless.
Employment status	Indicates whether a service user is in paid employment for greater than or equal to 30 hours per week (full time); more than one hour per week but less than 30 hours per week (part time); or less than one hour per week (not in paid employment).
Education and training status	Indicates whether a service user is participating in education or training that is NZQA recognised.
Wellness (relapse prevention or transition) plan	Indicates whether a plan is in place for the service user, with any service related to this episode of care.

Note: Additional social outcome measure categories may be added to the SCR by future NCAMP projects. Systems developed to collect this data must be able to scale to accommodate a growing number of measures and/or valid values.

Target population

Social outcome indicator and wellness plan data, as part of the SCR, should be collected:

- by all DHB and NGO MH&A services for all tāngata whai ora. There are no minimum or maximum age thresholds. However, it is important to note that the employment status and education or training indicators are focussed on people aged 15 to 64 years, with scope for those 65 and over who may be in paid employment or volunteering.

Note: SCR records are not required where the services provided are support for family, whānau, or support for children of parents with mental illness and addictions supporting parents, healthy children (also known as COPMIA).

- There are also exceptions to reporting for telehealth, consult liaison and respite services.
- Brief services (two face to face activities or less) are excluded. This means SCR's should only be collected when there are three or more activities. This is in line with DHB performance measures.
- For a tangata whai ora accessing services from a range of different teams or organisations at the same time there is no limit on the number of supplementary consumer records for each referral.

How will data be collected?

Social outcome indicator and wellness plan data will be collected and recorded against MH&A service referrals. This allows maximum data utility, robust business rules, data validation and data quality checks. One tangata whai ora episode within a MH&A service may span multiple referrals. For this reason, each referral will require a unique SCR for the collection of social outcome indicator and wellness plan data.

While this may require more data collections to be made, the social context for the care provided within a given referral is captured alongside the service activity, diagnostic information and clinical outcome measures such as the Health of the Nation Outcome Scores (HoNOS) measures or Alcohol and Drug Outcome Measure (ADOM). This allows for a more complete picture of a treatment journey for a tangata whai ora.

How will the data be used?

Existing outcome collections, such as HoNOS and ADOM, provide snapshots of health and psychosocial status at regular intervals throughout an episode of care for tāngata whai ora. Change is commonly gauged by comparing a treatment start collection with a review or a discharge collection. As such, it is important to have a reference point at the start and end of an episode of care, and ideally during an episode of care to capture any changes. It is the same for these supplementary measures.

PRIMHD will retain a history of all supplementary consumer records submitted. Analysis of change from referral start to referral end, or during a referral where collections are submitted more frequently, will allow services to better understand the outcomes for tāngata whai ora at regular intervals during an episode of care, as well as providing opportunities to understand the wider social context in which care is being provided.

Section 4 provides further information about the potential use of social outcome data.

2. Guidelines for collection of the PRIMHD SCR

This guide standardises the collection of data in the SCR, ensuring SCR information complies with PRIMHD requirements and can be compared nationally, across services and tāngata whai ora.

Frequency of collection

MH&A service providers must submit SCR records in accordance with the business rules in Table 2. All SCR data and collection dates[2] will be captured in PRIMHD for reporting, regardless of how many there are. SCR data submitted to PRIMHD will be monitored by the Ministry of Health's data management team.

Table 2: Business rules for the frequency of SCR collection

SCR data collection is mandatory: • for all MH&A referrals with a start date on or after 1 July 2016 (see exceptions above) • at the start and end of each MH&A service referral • annually for those tāngata whai ora whose episode of care is longer than 12 months. MH&A services may optionally submit retrospective SCR data for referrals with a start date prior to 1 July 2016.

It is **recommended** that MH&A services additionally collect SCR data in the following circumstances:

- If one of the indicators' value changes during a mental health episode. This is particularly important for the wellness (relapse prevention or transition) plan indicator as the one SCR date will force the assumption that a 'wellness plan' review, and a review of the other indicators, has occurred on that date.
- At three monthly intervals for tāngata whai ora in ongoing care to ensure information is up-to-date. This aligns with the collection protocol for the nationally mandated outcome measures (HoNOS and ADOM).

The Ministry's expectation is that information for all SCR indicators will be reviewed with tāngata whai ora at every given opportunity, to determine what has or has not changed for the individual at a local level. This will ensure an up-to-date view of how the needs of tāngata whai ora are changing at a national level.

Collection at referral or treatment start

The first mandatory collection of SCR data occurs at point of entry or treatment start. For inpatient or residential services this is the date of admission. For community services this is the date of the first face-to-face activity.

[2] Note that, where more than one SCR is collected on the same date, only the most recent update should be submitted to PRIMHD. This is because 'date' and not 'time' is captured on the SCR.

Note: In community services, it is acknowledged that there will be variation between organisations and across services in terms of referral and entry protocols and procedures. All SCR collections at referral start must comply with the following business rules:

- SCR data collection at point of entry/treatment start is expected and required within 91 days of the first face-to-face activity, on referrals with 3 or more face to face activities.
- No SCR is required if the referral ended because the tangata whai ora died, was lost to follow-up, did not attend following the referral, was involuntarily discharged; or the referral was declined either because of inability to provide services or because other services were more appropriate. (PRIMHD Code Set Section *2.3.1.3 Referral End Codes* DD, DG, DM, DZ, ID, RI, or RO).

Collection during an episode of care

Complete the SCR **optionally** at the following times after the initial collection:

- If a change in the value of an indicator occurs. For example, from 'not in paid employment' to 'part-time employment'.
- At 12 weeks or 3 months from the first collection in accordance with best clinical practice. This provides the first opportunity to determine to what extent the goals of the tangata whai ora have been met. Complete reviews on an ongoing basis at 3 monthly intervals thereafter.

Where an episode of care for a tangata whai ora lasts longer than one year, it is mandatory to collect SCR data annually.

Collection at referral end or discharge

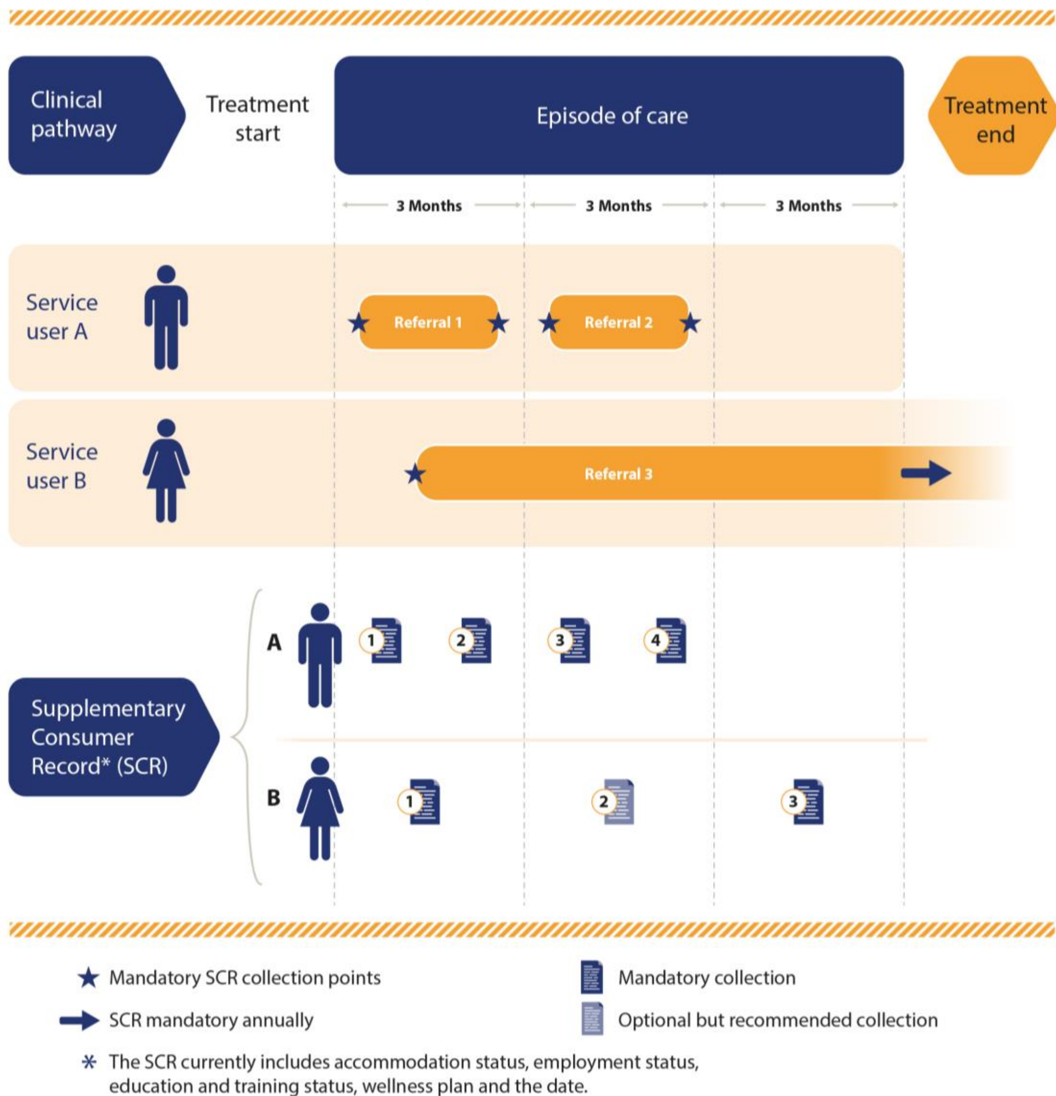
The final mandatory collection should occur at the end of an episode of care when the tangata whai ora is discharged from the team or service and the referral ends. This may be at a planned treatment end (eg inpatient or residential or community services) or when a tangata whai ora is discharged to another service or back to GP. All SCR collections at referral end must comply with the following business rules:

- SCR data collection at the time of discharge is mandatory and should be completed within 91 days before the referral end date.
- No SCR is required if the referral ended because the service user died; was lost to follow-up; did not attend following the referral; was involuntarily discharged; or the referral was declined either because of inability to provide services or because other services were more appropriate. (PRIMHD Code Set Section *2.3.1.3 Referral End Codes* DD, DG, DM, DZ, ID, RI, or RO).

Data collection points

Figure 1 shows example collection points for two tāngata whai ora. Tangata whai ora A has two referrals with collections of SCR data at point of entry or treatment start, and at point of discharge or treatment end for both referrals. Tangata whai ora B has SCR collections at treatment start and within 3 months of treatment start. Tangata whai ora B's episode has not ended in the period. If it extends beyond 12 months an annual SCR record will be required.

Figure 1: PRIMHD supplementary consumer record collection guide



<table>
<tr><th colspan="2">Key to figure 1</th><th colspan="4">Service user A</th><th colspan="3">Service user B</th></tr>
<tr><td rowspan="7">SCR Data</td><td rowspan="2">Category</td><th colspan="2">Referral 1</th><th colspan="2">Referral 2</th><th colspan="3">Referral 3</th></tr>
<tr><td>Referral Start SCR 1</td><td>Referral End SCR 2</td><td>Referral Start SCR 3</td><td>Referral End SCR 4</td><td>Referral Start SCR 1</td><td>3-month review SCR 2</td><td>12-month review SCR 3</td></tr>
<tr><td>Accommodation status</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td><td rowspan="5">O*</td><td>M</td></tr>
<tr><td>Employment status</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td></tr>
<tr><td>Education and training Status</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td></tr>
<tr><td>Wellness plan</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td></tr>
<tr><td>Date</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td><td>M</td></tr>
</table>

M = mandatory. *The 3-month review SCR is optional but recommended. If submitted, all four of the SCR fields must be populated along with the collection date.

3. SCR categories

This section provides guidance on each of the four social outcome indicators included in the SCR plus the collection date. It includes:

- the PRIMHD Code Set definition for each of the categories
- the question relating to the indicator and, where applicable, rationale and business rules for the indicator
- definitions for each of the valid values, where required
- links to external resources, where additional information may be useful.

SCR collection date

One date is to be submitted for each SCR record that covers all items within the SCR record.

The rationale behind collecting all SCR data with one collection date is twofold. Firstly, it is expected that the service provider will check all four of the SCR indicators at the point of collection to see what has or has not changed for the tangata whai ora. Secondly, it provides a way to report more effectively if the one collection date encompasses all the indicators.

Multiple SCR collections may be made between referral start and referral end dates.

Note: As time is not collected along with the date, only one SCR can be submitted per day.

Employment status

PRIMHD Code Set 10023.3 definition

A code to identify the hours of work the tangata whai ora/consumer was involved in.

PRIMHD SCR question

What is the service user's employment status?

Supporting rationale

This question will identify if the tangata whai ora is engaged in full time employment, part time employment or not in paid employment. It serves as a raw indicator of household income and a way of identifying whether a service user is maintaining work throughout the episode of care.

Note: that this will not provide information on the quality of employment; job security; nor provide an indication of the level of income for hours worked. Employment status is based on the week prior to face-to-face activity.

Table 3: Employment status valid options

Code	Description	Note	Additional guidelines
1	In Paid employment >=30 hrs a week	Full time	Aligns with the definition of 'full time' employment as per NZ Labour Market Statistics[3].
2	In Paid employment for 1 to less than 30 hrs a week	Part time	Aligns with the definition of 'part time' employment as per the NZ Labour Market Statistics.
3	Not in Paid Employment (less than 1 hour per week)	Includes those who are unemployed and those not in the labour force.	'Not in the labour force' concerns anyone in the working-age population who is neither employed nor unemployed. This residual category includes: ▪ retired people ▪ people with personal or family responsibilities (eg as unpaid housework or childcare) ▪ people attending educational institutions ▪ people permanently unable to work due to physical or mental handicaps ▪ people who were temporarily unavailable for work in the survey reference week ▪ people who were not actively seeking work. (Statistics NZ, Labour Market Statistics) Also includes people too young to work and people carrying out voluntary work.

[3] For more definitions on New Zealand Labour Market Statistics see: https://www.stats.govt.nz/topics/labour-market

Statistics New Zealand census employment-related definitions:

Employment relates to everyone in the working-age population who, during the reference week:

- worked for one hour or more for pay or profit in the context of an employee/employer relationship or self-employment
- worked without pay for one hour or more in work that contributed directly to the operation of a farm, business, or profession practice owned or operated by a relative (before April 1990 this was defined as 15 hours or more)
- had a job but was not at work due to illness or injury, personal or family responsibilities, bad weather or mechanical breakdown, direct involvement in industrial dispute, leave, or holiday.

Unemployment relates to everyone in the working-age population who, during their reference week, were without a paid job, were available for work, and:

- had actively sought work in the past four weeks ending with the reference week
- had a new job to start within four weeks.

Not in the labour force concerns anyone in the working-age population who is neither employed nor unemployed (as defined above). This residual category includes:

- retired people
- people with personal or family responsibilities (eg as unpaid housework or childcare)
- people attending educational institutions
- people permanently unable to work due to physical or mental handicaps
- people who were temporarily unavailable for work in the survey reference week
- people who were not actively seeking work.

Accommodation status

PRIMHD Code Set 10023.3 definition

A code to identify the accommodation status of the tangata whai ora/consumer.

PRIMHD SCR question

What is the service user's accommodation status?

Note: Accommodation should be the service user's usual accommodation, where they live long term.

Supporting rationale

There is a growing body of evidence to support the view that lack of access to safe and secure housing exacerbates mental health illnesses of those housed in such accommodation. Accommodation status is based on the week prior to face to face activity.

The intent of collecting accommodation status data is to measure the change over time in the numbers of service users living independently, those in supported accommodation, or

who are homeless. This will assist in understanding how mental health services are influencing tāngata whai ora lifestyles, and to what extent.

Table 4: Accommodation status valid options

Code	Description	Note	Additional guidelines
1	Independent	Living in owner-occupied dwellings, or living with owner-occupier. Renting: private sector renting with or without accommodation supplement; social housing.	Includes living in own home or family home, renting, boarding. Includes MSD funded social housing services.
2	Supported	Accommodation financially supported either partly or fully by the funder. Living in institutions. Living in residential rehabilitation facilities.	Includes residential recovery and rehabilition beds, including AOD. Includes rest homes, irrespective of funding source. People in prison should be considered as in supported accomodation.
3	Homeless	Living without shelter. Living in temporary accommodation. Uninhabitable housing.	Homelessness is defined as a living situation where people with no other options to acquire safe and secure housing are: without shelter, in temporary accommodation, sharing accommodation with a household, or living in uninhabitable housing.(from Statistics NZ)

Supported accommodation guidelines

Consistent with the Adult KPI Project, 'the funder' is defined as the mental health funder.

For the purposes of the SCR, 'supported accommodation' includes:

- residential recovery and rehabilitation beds funded partly or fully by mental health
- tāngata whai ora in prisons or long-term DHB run forensic inpatient units where there is no other 'usual accommodation'
- rest homes – irrespective of funding source(s) (including privately run dementia units).

It excludes:

- social housing funded through MSD
- DHB run acute inpatient units – use service user's usual accommodation

Tip: If you cannot determine whether the supported accommodation provided is funded through mental health, health or MSD, record as 'supported accommodation' and update as necessary when the information is available.

Statistics New Zealand definition of homeless (2014)

Definition and requirements

Homelessness is defined as a living situation where people with no other options to acquire safe and secure housing are: without shelter, in temporary accommodation, sharing accommodation with a household, or living in uninhabitable housing.

Note: The constraint in providing for full coverage across all living situations of the homeless is the difficulty in locating them (Edgar & Meert, 2006). The likelihood is that people without shelter, people staying long-term in motor camps and boarding houses, people sharing accommodation, and people residing in dilapidated dwellings may only be measured when the individuals are in contact with a provider, agency, or researcher.

The homeless living situations for each of the conceptual categories of the definition are outlined below.

Without shelter

Living situations that provide no shelter, or makeshift shelter, are considered as ‘without shelter’. These include situations such as living on the street and inhabiting improvised dwellings (eg living in a shack or a car).

Temporary accommodation

Living situations are considered ‘temporary accommodation’ when they provide shelter overnight, or when 24-hour accommodation is provided in a non-private dwelling that is not intended to be lived in long-term. This includes hostels for the homeless, transitional supported accommodation for the homeless, and women's refuges. Also included are people staying long-term in motor camps and boarding houses, as these are not intended for long-term accommodation.

Sharing accommodation

Living situations that provide temporary accommodation for people through sharing someone else's private dwelling is considered ‘sharing accommodation’. The usual residents of the dwelling are not considered homeless.

Uninhabitable housing

Living situations where people reside in a dilapidated dwelling are considered ‘uninhabitable housing’.

The Stats NZ New Zealand definition of homelessness: 2015 update provides the classification categories to operationalise these definitions.

Statistics New Zealand recommend that

“Ideally, a number of variables should be collected together with homelessness information, such as: age, sex, ethnicity, geographic location (except for women's refuges for safety reasons), family composition, related and unrelated groups, and iwi/hapū where required” (p.6).

Apart from ‘family composition’ and ‘related and unrelated groups’, all other recommended indicators are collected as part of the tangata whai ora NHI and are accessible in PRIMHD.

Education and training status

PRIMHD Code Set 10023.3 Definition

A code that identifies the education and training status of the tangata whai ora/consumer.

PRIMHD SCR question

Is the service user in education or training?

Supporting rationale

Education improves people's abilities to meet their basic needs, widens the range of career options open to them, and allows them more control over the direction their lives take. Education and training status is based on the week prior to face to face activity. In New Zealand, formal education is compulsory for those aged 6 to 16 years. Early childhood education and tertiary study are optional (NZQA).

Discussion about the best definition of 'education and training' resulted in the suggestion that this be restricted to **NZQA registered, recognised or accredited education organisations only**. This is to mitigate the risk of people recording attendance at various day activity centres as 'training'.

There is general support for the education and training indicator to be answered with a 'yes' or 'no'. More detailed information may be collected at a local level and mapped to the 'yes' or 'no' values.

Table 5: Education and training valid options

Code	Description	Note	Additional notes
1	Yes	The tangata whai ora is participating in education or training provided by an education organisation which is accredited, registered or recognised by NZQA. This includes: ▪ Schools ▪ polytechnics, institutes of technology ▪ private or government training establishments ▪ Māori providers ▪ Wānanga ▪ Universities ▪ industry training organisations and standard-setting bodies.	Default for all services users aged six to16 years of age. This does not include day activity centres.
2	No	Includes attendance at day activity centres and programmes provided that are not education organisations recognised by NZQA.	

What is an education or training organisation?

An education organisation can be any educational organisation supplying education and/or training and/or assessment services to learners. A wide range of programmes and qualifications are offered in New Zealand.

All education organisations can be *accredited* to assess for national qualifications. Before applying for accreditation, private and government training establishments must be *registered* with the New Zealand Qualifications Authority (NZQA).

Accreditation

Is a process where a tertiary education organisation (TEO) seeks permission to use or deliver an NZQA-approved programme that has already been developed, including one developed by another TEO.

Registration

Is a process where an organisation seeks to be recognised by NZQA as a private training establishment (PTE). An organisation needs to be registered as a PTE before applying for any NZQA approvals or accreditations. For more information see www.nzqa.govt.nz/providers-partners/about-education-organisations/

Education organisations

The NZQA website allows users to search for up-to-date information on recognised education organisations by region and can be found at www.nzqa.govt.nz/providers/index.do

Table 6: Types of education organisations in New Zealand[4]

Organisation type	Description
School	There are primary, intermediate and secondary schools in New Zealand. The New Zealand Qualifications Authority deals largely with schools at the secondary level (years 11-13).
Polytechnic/institute of technology	Delivers technical, vocational and professional education. They also promote research, particularly applied and technological research, which aids development.
Private training establishment	A private organisation providing education/training (i.e. they are not state-owned). Many companies and government training establishments register their staff training operations as training establishments.
Government training establishment	A state-owned organisation providing education or training (for example, NZ Police Training Services, New Zealand Army).
Māori provider	Over 100 registered providers identify themselves as Māori providers. These educational institutions deliver Māori subjects, conduct their courses in a Māori environment, or focus specifically on the needs of Māori learners.
Wānanga	A teaching and research institution that maintains, advances and disseminates knowledge, develops intellectual independence, and assists the application of knowledge regarding āhuatanga Māori (Māori tradition) according to tikanga Māori (Māori custom).

4 Retrieved from www.nzqa.govt.nz/providers-partners/about-education-organisations/

University	Is characterised by a wide diversity of teaching and research, especially at a higher level, that maintains, advances, disseminates, and assists the application of knowledge and develops intellectual independence.
Industry training organisation	A body recognised under the Industry Training Act 1992 as having responsibility for setting standards and arranging the delivery of industry training for the sector it represents. Commonly known as an ITO. Industry training organisations (ITOs) are not education providers but can become accredited to register assessors within specified fields of the framework.
Standard setting bodies	A collective term that covers industry training organisations and advisory groups. These organisations are recognised by NZQA as nationally representative of experts in a field, for the purposes of establishing standards for national qualifications.

Wellness (relapse prevention or transition) plan

PRIMHD Code Set 10023.3 Definition

A code to identify if a Wellness (Relapse Prevention or Transition) plan has been used.

PRIMHD SCR question

Is a wellness (relapse prevention or transition) plan in place?

Supporting rationale

The existence of a wellness (relapse prevention or transition) plan is a key feature of effective service delivery. Personal assessment and treatment plans aim to ensure there is a mutually agreed plan for the episode of care, including the milestones for its accomplishment, that is reviewed regularly. Relapse prevention or aftercare plans for tāngata whai ora leaving a service educate them in how to recognise when things might be going wrong and ensure crisis services are alert and responsive to the specific needs of registered tāngata whai ora (Te Pou, KPP, 2008). While the wellness plan indicator is collected against referrals, the purpose is less about having a plan against a referral and more about a plan completed during treatment and prior to discharge.

Guidelines for plans can be found on the Ministry of Health website: www.health.govt.nz/publication/transition-planning-guidelines-infant-child-and-adolescent-mental-health-alcohol-and-other-drugs. Note: While these guidelines focus on the development of plans for young people, the same principles apply to plans for all parts of the population.

Table 7: Wellness (relapse prevention or transition) plan valid options

Code	Description	Note	Additional guidelines
1	Yes	A Wellness (relapse prevention or transition) plan has been completed/is in place.	▪ In different settings and/or services this plan may be called a relapse prevention plan, a transition plan, an action plan, a personal care plan, a continuing or aftercare plan, or a recovery plan.

			▪ It is a service user centric plan, informed by and with the service user, intended to document the agreed approach to supporting the service user's journey of wellness and recovery. ▪ It is reviewed regularly. ▪ It is fine to record 'yes' even when the wellness plan is managed or held by another organisation; the knowledge of a wellness plan being in place is sufficient.
2	No	A wellness (relapse prevention or transition) plan has not been completed for this referral.	▪ It is best practice to have a wellness plan in place as soon as possible after the first face to face activity, though it is recognised that this does not always happen. It is useful for organisations to monitor how quickly wellness plans are in place.
7	Unknown	The existence of any wellness (relapse prevention or transition) plan is unknown.	▪ Restricted to collections when the existence or status of a wellness plan is unknown either because the clinician involved has not provided the information or because the information is not readily available at the time of submitting the associated SCR data. ▪ At the time of referral end or discharge the existence of a wellness (relapse prevention or transition) plan should not be 'Unknown'.

Note: It is recognised that operational practices regarding wellness plans differ between organisations. If a wellness plan has lapsed or not been reviewed, then 'no' should be used until a new or reviewed plan is in place.

4. Use of SCR social outcome indicator data

The Ministry of Health *PRIMHD information and utility resource (2016)*, Section 3 *Use of PRIMHD data*, provides a general guideline on how information, collected in PRIMHD, can be used. It also details examples of the kinds of analysis that can inform services about the work they are doing. This resource can be accessed via the Te Pou website www.tepou.co.nz/resources/primhd-information-and-utility-resource

When using SCR data please be aware of the current state of data completeness. Tāngata whai ora may have different and/or contradictory values reported on SCR records for the same or different organisations in similar time periods, which could lead to a variety of interpretations. Work is currently being undertaken to establish best practice reporting using SCR data and development of completeness reporting. This section provides guidelines about the potential use of social outcome data collected in PRIMHD (employment, accommodation and education and training).

Aggregated national level reporting

The Ministry of Health acknowledges the inclusion of the three social outcome indicators and wellness plan indicator in PRIMHD is a first step to understanding the wider social context associated with an individual's recovery. Although local collection of more granular or detailed level social outcome indicator data will allow services to maximise the use of that data in a variety of different ways for their own services (where there is analytical capacity to do so), PRIMHD can provide the aggregated national picture using this data. Aggregated organisation or national level reporting may include:

1. Measuring changes in service user outcomes from year to year to help understand the extent to which mental health and addiction services are contributing towards the change.
2. Focus on areas where there are notable gaps in research relating to, for example, Māori and Pacific populations as well as people with a dual diagnosis of mental illness and intellectual disability, and people with co-existing substance use and mental illness problems, (Te Pou o te Whakaaro Nui, 2014).
3. The production of the not in employment, education, or training (NEET) statistic for various MH&A cohorts. This statistic is commonly used in government. The NEET rate is the total number of young people aged 15 to 24 years who are not in education, employment, or training, as a proportion of the total youth working-age population. (Statistics New Zealand, 2015b)

National population level reporting will be on an annual basis to ensure an SCR exists for every service user within the reporting timeframe, for example, the number of people that were employed at any point during the reporting time period. Point in time reports, for example, number of people employed as at 31 December, would require a separate cohort i.e. only those service users discharged in the period. This is to avoid making assumptions about the data, i.e. if someone is employed in January they will still be employed in December.

It is important to note that further investigation and research would be required to make any statements about the contribution that was being made by MH&A services towards the change in social outcomes for tāngata whai ora. The issue here is about 'attribution' and

‘contribution’ in a situation where someone’s employment and housing status is driven to a large extent by factors outside health. It is related more to the socio-political and environmental context, but MH&A providers still have a role to play in supporting the individual in these areas of their life.

Demonstrating change using social outcome data

Social outcome data will provide the Ministry and service provider organisations an increased ability to show change or effectiveness in key indicators in a quantifiable way (eg increase, improvement; decrease, deterioration). In line with the guidelines in the PRIMHD Information and utility resource, contextual information and interpretation of the results, along with caveats, where required, should be provided to give meaning to the information presented.

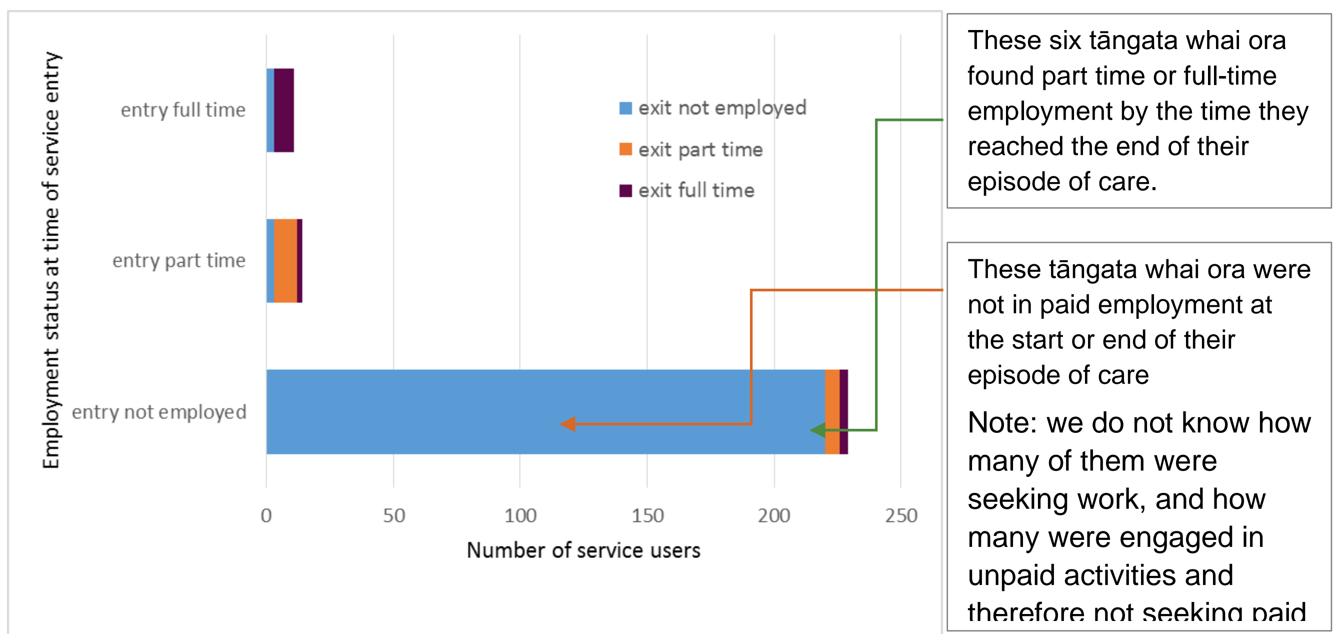
Snapshots, or point in time reports, of monthly or quarterly social outcome data must be defined separately for specific populations or cohorts, for example:

- tāngata whai ora discharged in the period
- tāngata whai ora with episodes of care greater than 3 months; and/or
- tāngata whai ora with episodes of care longer than one year in duration.

This is to ensure that all tāngata whai ora counted have a SCR collection in the period and assumptions are not made that an indicator’s status has not changed.

An example is given below of the change in employment status between referral start (entry) and referral end (exit).

Figure 2: Example, employment status at referral start (entry) and referral end (exit)



What this information shows

Figure 2 shows around 97 per cent of tāngata whai ora accessing this service were not in employment at the start of their episode of care. It also shows only a small number had

found either part-time or full-time employment by the time they reached the end of their episode of care.

Caveats are important in understanding what the information can and cannot tell us. In this example, it is important to note that we do not know how many of these people wanted work, were actively engaged in seeking work, and how many were engaged in unpaid activities and therefore possibly not seeking paid employment.

We also do not know whether this is an inpatient, residential or community service or whether the service has a specific employment contract component. Better access to this type of information can contribute to a service focus on employment.

This is only one example of the many ways this data could be presented. At an organisation or service level, dashboards could present this information alongside other outcome measure or key performance indicator data.

Utility of data at a local level

DHB and NGO services are encouraged to collect more detailed social outcome data providing that those subcategories can map back to the Ministry's mandatory reporting requirements (as outlined in Sections 2 and 3 of this document). More granular level social outcome data will allow MH&A services greater sensitivity to capture service user improvements occurring within one broad social indicator category.

An example of where this could be effective is *employment status*. The 'employed – part time' category captures a wide range of part time work hours, from one up to 30 hours per week. Granulation into narrower subcategories: part time one to nine hours, part time 10 to 19 hours, and part time 20 to 29 hours would have enough sensitivity to capture small movement within this broad category. For example, a person increasing work hours from eight to 28 hours per week.

The local value of exploring information about gains for people's capacity in employment could be invaluable.

The category of 'not employed' could also be subcategorised to align with Statistics New Zealand labour force definitions (2015a), for example:

- unemployed – looking for work
- retired – not in labour force
- volunteer – not in labour force
- home duties/carer – not in labour force, or
- other – not in labour force.

Having these subcategories would allow services to calculate the number and percentage of tāngata whai ora who were unemployed and looking for jobs when entering services and who subsequently entered employment during the period of service provision (see Figure 2).

Service level data analysis

Granular level data combined with existing PRIMHD data collections, will allow service providers opportunities to analyse social indicator data to inform service planning e.g. supporting tāngata whai ora to access local employment opportunities, independent housing

and training programmes. Consider the following example of Andy who is an analyst for a DHB regional mental health service:

Andy is a DHB analyst who was concerned about the impact the lack of housing was having on peoples' wellbeing. Andy worked with a few interested peers, including local NGO services, to compile a report on the needs of people recorded as being 'homeless'. The report showed these tāngata whai ora had longer inpatient stays and higher readmission rates. Andy discussed the report results with senior managers who agreed on a strategy for their service to help address some of the issues. With senior management's support Andy led a quarterly forum on housing to review progress and explore opportunities to improve the housing status of identified tāngata whai ora. Where possible, wellness plans were updated to include housing goals and referrals to external housing support services.

Combining SCR data with mandatory outcome measures

The inclusion of SCR data in the PRIMHD data collection will allow analysis of the combination of service activity data, social outcome data and information collected in the HoNOS and ADOM measures.

- HoNOS is a clinically rated measure which includes two questions related to problems with living conditions (Item 11), and occupation and activities (Item 12) for a tangata whai ora. Unlike SCR data, however, HoNOS data only applies to DHB's and some clinically focused NGO's.
- The HoNOS family includes variants for children and adolescents (HoNOSCA); users of secure mental health services (HoNOS secure); people with learning disabilities (HoNOS-LD) and for tāngata whai ora 65 years of age and older (HoNOS65+). For more information see www.tepou.co.nz/initiatives/honos-family-of-measures
- ADOM is a set of 20 questions in three sections, which is tangata whai ora rated and facilitated by a practitioner. Section 1 includes questions about type and frequency of substance use; Section 2 includes questions about lifestyle and wellbeing; Section 3 includes two questions about tangata whai ora satisfaction with their recovery goals. For more information on ADOM see www.tepou.co.nz/initiatives/alcohol-and-drug-outcome-measure

Like the social outcome data, HoNOS and ADOM are collected at specific stages in the tangata whai ora treatment, including treatment start and end. Combining social outcome data with data from these two outcome measures will provide a rich source of information that will assist service providers to better understand how social determinants of health affect outcomes for people who access MH&A services. It will assist tāngata whai ora by focussing service providers on current needs as well as informing future MH&A service planning.

Combining social outcome data categories

Meaningful activity (Employment status and training and education status)

As an indicator of meaningful activity, employment status may be analysed together with the training and education status data. The previous caveats around the interpretation of 'not in

paid employment' should also be considered when interpreting the rates for 'meaningful activity'.

This type of analysis can be split into age groups, for example, excluding those aged six to 16 who are legally required to attend school and those aged 65 and over who may be retired or working voluntarily (and are therefore considered to be 'not in paid employment').

Other combinations of social outcome data categories such as employment and accommodation may be useful for specific services or teams with contracts for, or organisation focus on, these specific areas to track improvements over time.

Using social outcome data targets as a data quality tool

Setting targets locally may be useful for focussing on specific areas of interest, for example, on reducing tāngata whai ora homelessness or the frequency of 'unknowns' recorded against the wellness plan indicator. These types of targets could assist services to focus on achieving positive changes for tāngata whai ora and, at the same time, improve data quality.

Notes for the interpretation of data

Data quality

It is important to note that the three social outcome indicators (employment status, accommodation status, education and training status) allow for valid responses only. That is, there is no room for the 'unknowns'. This may lead to erroneous data where the response is not known – to submit an entry the user must select either yes, no, or value 1, 2 or 3. A percentage margin of error must be allowed for this reason.

Employment status caveats

What the employment status response **does** tell us:

- whether a tangata whai ora is receiving any income from employment
- if they are in paid employment whether they are considered full time (In paid employment >=30 hrs per week) or part time (in paid employment between, and including, one hour to less than 30 hrs per week).

What the employment status response **does not** tell us:

- The significance of those in the 'not in paid employment' category. The category does not allow the distinction between tāngata whai ora who are participants of the labour force (eg available and seeking full time employment), or those who are not part of the labour force but engaged in unpaid activities.
- Those in the 'not in paid employment' category and engaged in unpaid activity but **not** seeking paid employment may be:
    - retired
    - unable to work due to permanent impairment
    - have family responsibilities (eg unpaid housekeeping and childcare)
    - attending training or an educational facility
    - volunteering.

The Statistics New Zealand website includes definitions and graphics to assist interpretation of employment related categories at https://www.stats.govt.nz/methods/user-guide-for-stats-nzs-employment-measures

Accommodation status caveats

What the accommodation status response **does** tell us:

- whether a tangata whai ora has permanent accommodation
- for those with permanent accommodation, whether the accommodation is independent or funded by a provider.

What the accommodation status response **does not** tell us:

- whether a tangata whai ora in independent accommodation owns, leases or rents the accommodation
- the standard of accommodation, eg adequate heating and insulation, number of people living per square metre
- the affordability of accommodation, eg whether households spend more than 30 per cent of their disposable income on housing.

Education and training status caveats

What the education and training status response **does** tell us:

- whether a tangata whai ora is currently undertaking education or training provided by an NZQA registered, recognised or accredited education or training organisation.

What the education and status response **does not** tell us:

- the level of NZQA course
- the length of NZQA course
- information about education and training prior to service provision
- information about prior and current training and education provided by an organisation without NZQA registration, recognition or accreditation.

5. Frequently asked questions

These FAQs are provided to guide implementation. If you require further advice or information not covered, please contact the Ministry of Health at primhduserinterface@health.govt.nz

Access to information

Q: Where can I find a guideline for services or developers on what is required to submit the SCR data to PRIMHD?

A: The PRIMHD sector change notice and appendix are listed under PRIMHD on the NCAMP 2016 page www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/national-collections-annual-maintenance-project/ncamp-2016/ncamp-2016-changes-national-collections

There is a notification for Supplementary Consumer Records as well as an Appendix which provides more detailed information. Additionally, the business rules for SCR records have been added to the PRIMHD file specification document available here: www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data/primhd-file-specification

These show the details of the business rules and corresponding response messages – including which are errors and which are warnings.

Indicator specific FAQs

Employment Indicator

Q: Why is voluntary work not included in the employment category as a valid value?

A: The KPI group reviewed the proposals for the inclusion of voluntary work but decided that a focus on income rather than activity would be preferable for this category at this time.

Q: Why are the paid employment values so broad, e.g. one to 30 hours or over 30 hours per week?

A: The employment values mirror those used by NZ Statistics in the Labour Force Survey. It is understood that at local level MH&A services may be collecting more detailed information around employment. Social outcome data collected in the SCR will be reviewed and may include additional values if this is deemed useful at a national level in the future. Locally, services can continue to use more detailed data to inform their service planning and map this to the PRIMHD values.

Q. Should child and adolescent services be reporting the parents' employment status?

A: Reporting is for the tangata whai ora. Report 'Not in paid employment' for the child until their employment status changes, e.g. if applicable at the age of 16 or 17. See notes in Table 3.

Q: How should women on maternity leave be categorised in respect of the paid employment indicator?

A: Maternity leave is considered as employed (for the number of hours the person would usually be employed for).

Accommodation indicator

Accommodation should be the tangata whai ora usual place of residence/accommodation, where they live long-term and not on a short-term basis. Consistent with the Adult KPI Project, 'the funder' is defined as the mental health funder.

For the purposes of the SCR, 'supported accommodation' includes:

- residential recovery and rehabilitation beds funded partly or fully by mental health
- tāngata whai ora in prisons or long-term DHB run forensic inpatient units where there is no other 'usual accommodation'
- rest homes – irrespective of funding source(s) (including privately run dementia units).

It excludes:

- social housing funded through MSD
- DHB run acute inpatient units – use service user's usual accommodation

If you cannot determine whether the supported accommodation provided is funded through mental health, health or MSD, record as 'supported accommodation' and update as necessary when the information is available.

Q: Which accommodation applies when?

Question	Answer
An adult/youth is in custody	Record as supported accommodation
A defendant is bailed	Record their usual accommodation
A youth is living at home	If their family home is an independent home, ie not supported accommodation, then record 'independent'
A defendant is bailed to a hospital ward	Record their usual accommodation
A defendant is bailed to health funded Supported accommodation	If funded by mental health, record 'supported'. If not mental health funding, then use their usual place of residence

Q: For people in an acute inpatient unit, should the indicator report 'supported' accommodation or indicate their usual living circumstances?

A: Acute inpatient units are not considered 'supported accommodation'. Reporting for these people should be based on their usual living circumstances.

Q: When a person is in a DHB run or funded rehabilitation inpatient unit, which is usually for a protracted period, should this be coded as 'supported' accommodation?

A: Inpatients in a DHB run non-acute rehabilitation unit are considered to be in 'supported' accommodation.

Q: Are we reporting on the family situation and is there an assumption that parents are mental health service users?

A: Children living with family in an independent living situation are reported as ‘independent’. Similarly, if the family were in supported accommodation, the child’s accommodation would be reported as ‘supported’. There is no assumption that parents are service users.

Q: Where do children staying with other whānau members and not at home fit in? Eg children staying with their grandparents? Is this classified as temporary accommodation or sharing accommodation within a household?

A: Children living with their grandparents or other whānau members in an independent living situation are reported as ‘independent’. ‘Sharing accommodation’ comes under the definition of ‘homeless’.

Q: How is accommodation defined for dependent children living with their parents?

A: If the child is living with parents who are in supported accommodation then the accommodation status for the child should reflect that they are living in supported accommodation. If they are living in their own home, whether rented or owned, the child’s SCR accommodation status should reflect their independent living situation.

Q: The definition of a person’s personal choice to be ‘homeless’ can be problematic where there is a conflict with competence to make such decisions. In this situation, what accommodation status should be used?

A: The concept of ‘personal choice’ with regards to the issue of homelessness is a complex issue requiring robust consideration from a MH&A system perspective. ‘Homeless’ should be reported in instances where competence to have made a personal choice to be homeless is uncertain.

Education and training indicator

Q: For the Education and Training indicator, the default setting for all clients aged six to16 years is YES. Can we presume the default setting for all aged under six years will be NO?

A: For children under five, it is acceptable to default ‘No’ for Education and training status. Despite the law only requiring school attendance from six to16 years, children who are attending school from five years old should be reported as ‘Yes’. If they are not attending school report as ‘No’.

Q: As NZQA standards start in year 11 to 13 does school qualify to report as a ‘Yes’?

A: Table 5 of this guide identifies that schools are included as a valid education organisation.

Note that the Ministry of Health acknowledges that services may collect much more detailed data around the social outcome indicators than is collected for reporting nationally to PRIMHD. If it is useful for you to collect more detail around the employment, accommodation and education indicators, you can do this locally, as long as the additional values are mapped appropriately to the PRIMHD SCR values.

Compliance with business rules

Q: If the mandated supplementary records are not submitted, will this generate a referral record error (affecting our compliance percentage) or a warning?

A: Appreciating the amount of pressure the sector is presently under, the Ministry has taken on board sector comments regarding SCRs with PRIMHD.

The following overview outlines the scenarios for reporting and non-reporting of SCRs:

1. If you submit SCRs with all four elements completed the referral discharge record will be successful (subject to correct value validations). [The records required are: wellness plan, accommodation, employment and education statuses, along with supplementary consumer record ID and collection date].
2. If you submit SCRs with fewer than four elements present, then the referral discharge record will error.
3. If you do not submit any SCRs, then a warning only will be received after 91 days from the first face-to-face activity and the referral discharge record will be accepted.

Sector email from NCAMP (Ron Wood) on 28th June 2016 (excerpt).

This means there will be no impact to the compliance percentage if the records are not submitted from 1 July 2016. However, there is a plan to change from warnings to errors at some point in the future.

For more information about the business rules relating to SCRs see the PRIMHD File Specification which is available here: www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data/primhd-file-specification

Collection frequency

As per Table 2 of the Guide to PRIMHD SCR collection and use, the supplementary data elements are mandatory, at a minimum:

- for all referrals with a start date on or after 1 July 2016
- at the start and end of each referral discharge, and
- if the referral lasts longer than 12 months, at least once per year.

Additionally, if the data elements change a new record should be submitted.

Q: What is required for referrals already open on the 1 July 2016? When should SCR be collected?

A: For referrals open prior to 1 July 2016, collect SCR data at the next face to face activity with the service user. Business rules that require a SCR within 91 days from referral start do not apply to referrals open prior to 1 July 2016.

Services can submit SCR data for referrals that started prior to 1 July 2016 if they wish, as long as the collection date on the SCR record is on or after 1 July 2014.

For further details please contact primhduserinterface@health.govt.nz

Q: Where a person is using two services (i.e. two active referrals), are the social outcome measures required for each service? While this would make sense for the wellness plan (referral centric), accommodation, training and employment status (person centric) needing to be entered twice would seem overly pedantic.

A: All four social outcome indicators, accommodation, employment, education status plus the wellness plan indicator will all be collected and recorded against each MH&A service referral, irrespective of the number of referrals a tangata whai ora may have with a particular service, or number of services. This is to allow maximum data utility, validation and quality checks using PRIMHD referrals.

"One service user episode within a mental health and addiction service may span multiple referrals. For this reason, each referral will require a unique supplementary consumer record (SCR) for the collection of social outcome indicator and wellness plan data.

While this may require more data collections to be made, the social context for the care provided within a given referral is captured alongside the service activity, diagnostic information and clinical outcome measures - such as the Health of the Nation Outcome Scores (HoNOS) measures or Alcohol and Drug Outcome Measure (ADOM) - providing a more complete picture of a service user's journey."

(Guide to PRIMHD Supplementary Consumer Record Requirements, V1.1, January 2016, p.9)

Episodes of referrals less than 91 days long

Example 1: A referral starts after 1 July 2016, and has three or more face to face activity records, but the referral lasts for less than 91 days and then ends.

Two SCRs are expected for any referral that started from 1 July onwards, one at referral start and one at referral end. Where a recent SCR has been reported which reflects the current status of the tangata whai ora at the time of discharge, there is no need for an additional SCR at referral end. So in the case of referrals lasting less than 91 days, one SCR record will satisfy the requirement for both the referral start and referral end collections.

Lost to follow-up

Q: What should be recorded at referral end/discharge when a tangata whai ora does not attend (DNA) and cannot be tracked down? We cannot genuinely know their supplementary consumer record details, especially if their stay was months long.

A: If a tangata whai ora has moved, did not attend an appointment, has been 'lost to care', or died, this will be reflected in the use of the referral end code *DG = Gone No Address or Lost to follow-up*. SCR records are not required at referral end when the referral end code is DD, DG, DM, DZ, ID, RI or RO. See details of BR-P121-12 in the PRIMHD File Specification V2.3.2:

A Referral Discharge Record should contain a Supplementary Consumer Record with a Collection Date within 91 days before the Referral End Date Time for an ended referral unless the Referral End Code is DD, DG, DM, DZ, ID, RI, or RO.

Tāngata whai ora transferring between teams internally

Q: What is required when a tangata whai ora is discharged from one team and transferred to another team within the same organisation on the same day? For example, a transition from residential care to community care.

A: In this scenario the SCR details on discharge from the initial team would be repeated on admission to the subsequent team on the same day. This is because the SCR details are linked at referral level (to referrals) and not at person level (like NHI or legal status).

Reporting a full set of SCR indicators

Q: With the accommodation, education and training, employment indicators there are no options (unlike the wellness plan) to identify these as 'unknown/not stated/ missing'. Will PRIMHD accept empty fields for accommodation, education and training, employment indicators if we don't have any information? This is the only way we can communicate that there isn't any information on accommodation, education and training, employment.

A: There are no 'unknown/not stated/missing' options for Accommodation, Employment and Education and Training. PRIMHD will not accept empty fields for these. All four of the indicators need to be included and completed on each SCR record that is submitted to PRIMHD.

Family, whānau, COPMIA services

Q: There are several family/whānau teams set up to provide services to family members of mental health tāngata whai ora rather than directly to tāngata whai ora. Should SCR data be reported by these services or by services providing 'supportive activity delivered to family/whānau members of people with MH&A issues regarding the effects of these issues on the family/whānau member' (activity code T47)?

A: SCR records are not required where the services provided are support for family/whānau (T47) or support for children of parents with mental illness and addictions (COPMIA) (T49).

General FAQs

Q: What is the process for amending or including additional categories or values in the SCR?

A: Recommendations can be made to the Ministry of Health NCAMP team regarding additional values. For example, a recommendation was made that 'voluntary work' be included as another option under the broad category of 'employment'. However, in line with the obligations under the Operational Policy Framework, the Ministry of Health needs to provide the sector with nine months' notice of any changes to the national collections systems, including PRIMHD. This means that any changes, such as the inclusion of 'voluntary work', need to have gone through the HISO process and been agreed by the month of October the previous year to be implemented on 1 July the following year.

Q: Is there any standardised training being developed for implementation of the SCR, for example a PowerPoint that outlines the rationale for the measures and the minimum standard for collection?

A: No standardised training has been planned. If you require further advice or information about implementation, please contact the Ministry of Health primhduserinterface@health.govt.nz

Q: What is a wellness plan exactly, what should it contain and when should it be done?

A: In different settings and/or services this plan may be called a relapse prevention plan, a transition plan, an action plan, a personal care plan, a continuing or aftercare plan, or a recovery plan. It is a tangata whai ora centric plan, informed by and with the tangata whai ora, intended to document the agreed approach to supporting the tāngata whai ora journey of wellness and recovery. This may include whilst in treatment, transferring to other services, on discharge. There is a recognition that different plans are called different things by different services; essentially anyone coming into or leaving services should have a plan informed by their needs and designed in collaboration with the service/worker.

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Appendix 1: Glossary

The following definitions are integral to the understanding of this document.

Term	Definition
Activity	Activity is defined as an interaction (face-to-face or non-face-to-face) between tangata whai ora and/or family, whānau with a healthcare organisation that will provide or is providing a service to the tangata whai ora, or activity between a healthcare organisation and other agencies. The activity is recorded or noted in the healthcare organisations record for that tangata whai ora and/or in the personal health record of the tangata whai ora. All significant activity should be noted. Significant means, but is not limited to, interactions that advise, change or alter the support and/or care or treatment being provided for a tangata whai ora.
Addiction	A generic term used to cover the two specific cases of alcohol and drug addiction. Note that gambling or any other addiction is not part of the collection strategy operated through the PRIMHD system.
Admission or admitted	In the case of mental health and addiction, this does not mean the admission of a tangata whai ora to a facility. It is where a tangata whai ora is accepted for treatment by a service, either by way of an inpatient admission, or with outpatient services.
ADOM	Alcohol and Drug Outcome Measure (ADOM).
Tangata whai ora, tāngata whai ora	A person who accesses publicly funded healthcare. This person may be referred to elsewhere as a 'service user', 'healthcare user', 'consumer', 'client' or 'patient'. Tāngata whai ora with a macron is the plural.
Data set	Collection of data groups, used for specific purposes, eg referral data set, discharge data set.
DHB	District Health Board.
Discharge or exit	The relinquishing of care or support, in whole or in part, of a tangata whai ora by a healthcare provider or organisation. There are two common types of discharge: administrative and clinical. 'Exit' may be referred to as 'Discharge'.
Face to face activity	Exclude activity codes: T08 (care/liaison co-ordination contacts), T32 (contact with family/whānau, consumer not present), T33 (seclusion), T35 (did not attend), T37 (on leave), T47 (support for family/whānau) or T49 (support for children of parents with mental illness and addictions (COPMIA)) Exclude activity setting: PH (telephone), WR (written correspondence), SM (SMS text messaging) or OM (online media).
Health practitioner **(Practitioner)**	A person who is, or is deemed to be, registered with an authority established or continued by section 114 of the HPCA Act 2003, as a practitioner of a particular health profession.
HISO	Health Information Standards Organisation (HISO) The Health Information Standards Organisation (HISO) supports and promotes the development, understanding and use of fit-for-purpose health information standards to improve the New Zealand health system.

Term	Definition
HoNOS	Health of the Nation Outcome Scales for adults aged 18 to 65 years
HoNOS65+	Health of the Nation Outcome Scales for people aged 65 years and above.
HoNOSCA	Health of the Nation Outcome Scales for children and adolescents under 18 years.
HoNOS-secure	Health of the Nation Outcome Scales for adults who are being supported by forensic services.
HoNOS-LD	Health of the Nation Outcome Scales for adults who have a dual diagnosis, such as mental illness and intellectual disability.
KPI Project	A Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services
National Health Index (NHI)	National Health Index is a centrally managed system that is used to collect and distribute data about healthcare users or health tāngata whai ora. The NHI facilitates the timely and secure exchange of health information, ensures the accurate and unique identification of health tāngata whai ora. It offers operational support for health organisations that use that data and provides information of interest to the public. Data is supplied by authorised data sources and distributed to authorised health tāngata whai ora. The Ministry of Health is the NHI administrator and manager.
NCAMP	National Collections Annual Maintenance Project (NCAMP). In line with obligations under the Operational Policy Framework, the Ministry of Health provide notice of changes to the National Collections systems. These are effective annually from 1 July, as part of the National Collections Annual Maintenance Project (NCAMP).
NEET	Not in employment, education, or training (NEET). The NEET rate is the total number of young people aged 15 to 24 years who are not in education, employment, or training, as a proportion of the total youth working-age population.
NGO	Non-government organisation (NGO).
NZQA	New Zealand Qualifications Authority (NZQA). The role of the NZQA in the education sector is to ensure that New Zealand qualifications are regarded as credible and robust, both nationally and internationally, in order to help learners succeed in their chosen endeavours and to contribute to New Zealand society.
Organisation	An entity that provides services of interest to, or is involved in, the business of healthcare service provision. There may be a hierarchical (parent-child) relationship between organisations.
Patient	A person who accesses publicly funded healthcare, this person may also be referred to as a tangata whai ora, healthcare user, recipient, client or service user.
Person	An individual person who can assume multiple roles over time. In the HPI, 'person' is synonymous with practitioner, healthcare provider, and user.
PHO	Primary Health Organisation.

Term	Definition
PRIMHD	Programme for the Integration of Mental Health Data (PRIMHD).
Referral	Referral may take several forms, most notably: request for management of a problem or provision of a service, eg a request for an investigation, intervention or treatment; notification of a problem with the hope, expectation or imposition of its management, eg an exit summary in a setting, which imposes care or support responsibility on the tangata whai ora. The common factor in all referrals is a communication whose intent is the transfer of care or support, in part or in whole.
Referral discharge	A referral occurring in the context of discharge and comprising a referral discharge record with a referral end date and time and a referral end code.
Service provider	Any service that provides mental health and addiction services, including, but not limited to: NGOs, DHB provider arms, primary care practitioners, PHOs and other community agencies.
Team	A team consisting of a person or functionally discrete grouping of people providing mental health and addiction services within a service provider.
Wellness plan	In different settings and/or services this plan may be called a relapse prevention plan, a transition plan, an action plan, a personal care plan, a continuing or aftercare plan, or a recovery plan. It is a tangata whai ora centric plan, informed by and with them, intended to document the agreed approach to supporting their journey to wellness and recovery. It is reviewed regularly.