Australian Government

Department of Health

PMHC-MDS Data Specification

Version 4.0.0-draft.0

As at 24 November, 2021

4bbf6789fa3cac2de66440ac890dbf264126be1f

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1. Introduction

The recording of intake related activity (including activity for the HeadtoHelp/HeadtoHealth and AMHC programmes) in the PMHC MDS will be implemented as a core PMHC-MDS version 4 specification.

The new version 4 specification will comprise 4 entirely new tables, and the revised collection occasion/measure tables that have been included in the the Wayback and HeadtoHelp extension specifications.

The new tables are Intake, IAR-DST, Intake Episode, Service Contact Practitioner.

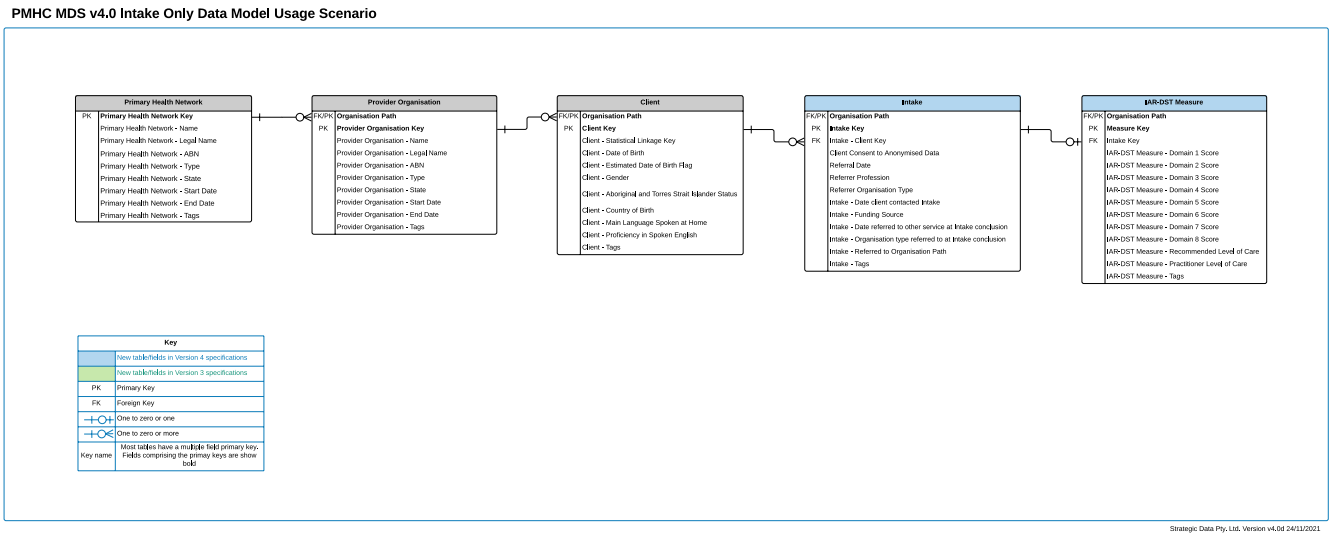
1.1. Contexts

There are four contexts where data can be submitted using the version 4 specification - Intake teams, Hubs, Combined Intake/Hubs and Service Providers where there is no intake process.

Different records in the specification are intended to be used in each of these contexts.

Within the PMHC-MDS system a single intake team and individual service providers/hubs will each have their own organisation path and report data against those organisations. It is noted that some service providers/hubs may be existing provider organisations within the PMHC-MDS. The version 4 specification is compatible with this reality.

1.1.1. Intake Context

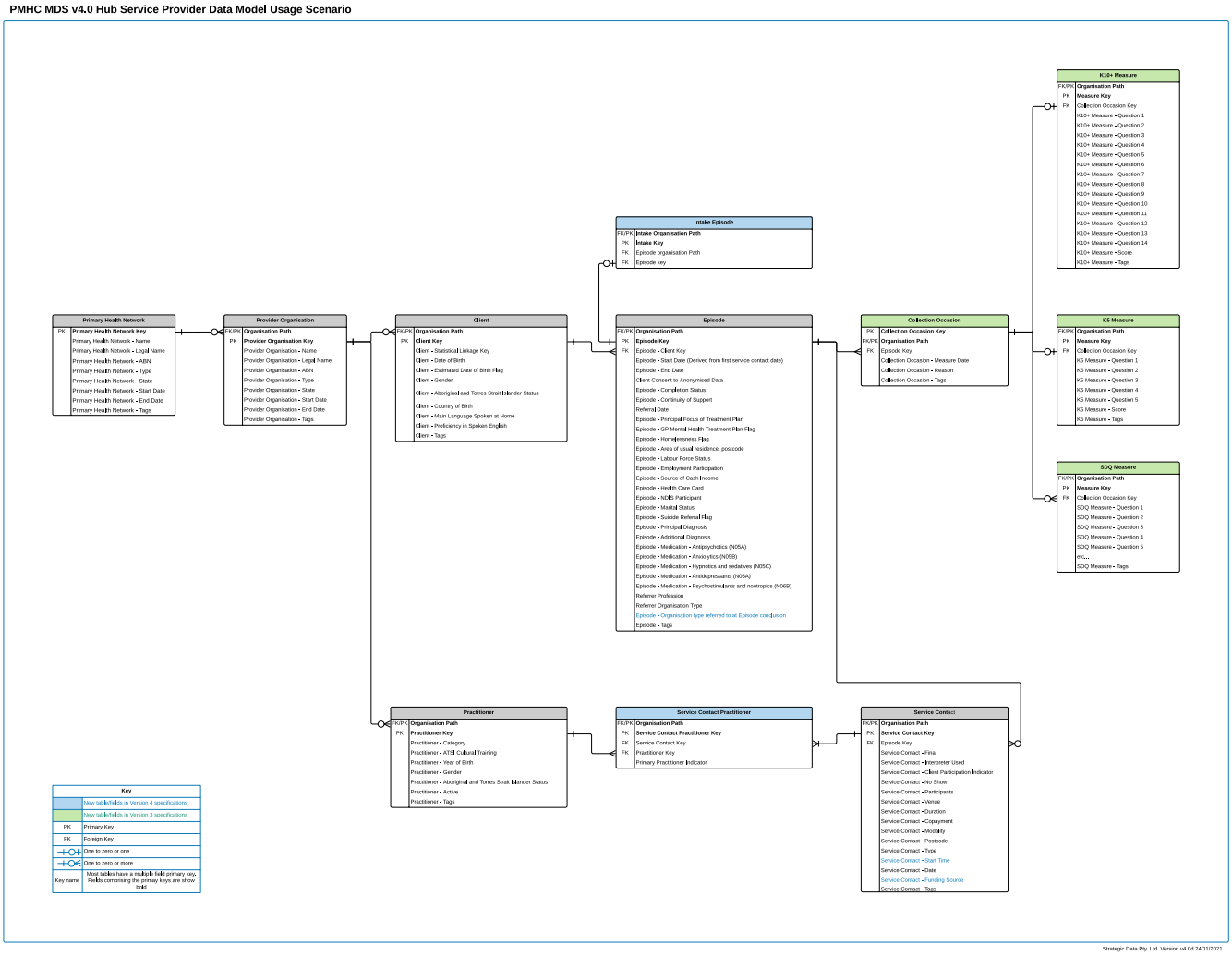


In the Intake context the following records will need to be provided:

- Client
- Intake
- IAR-DST

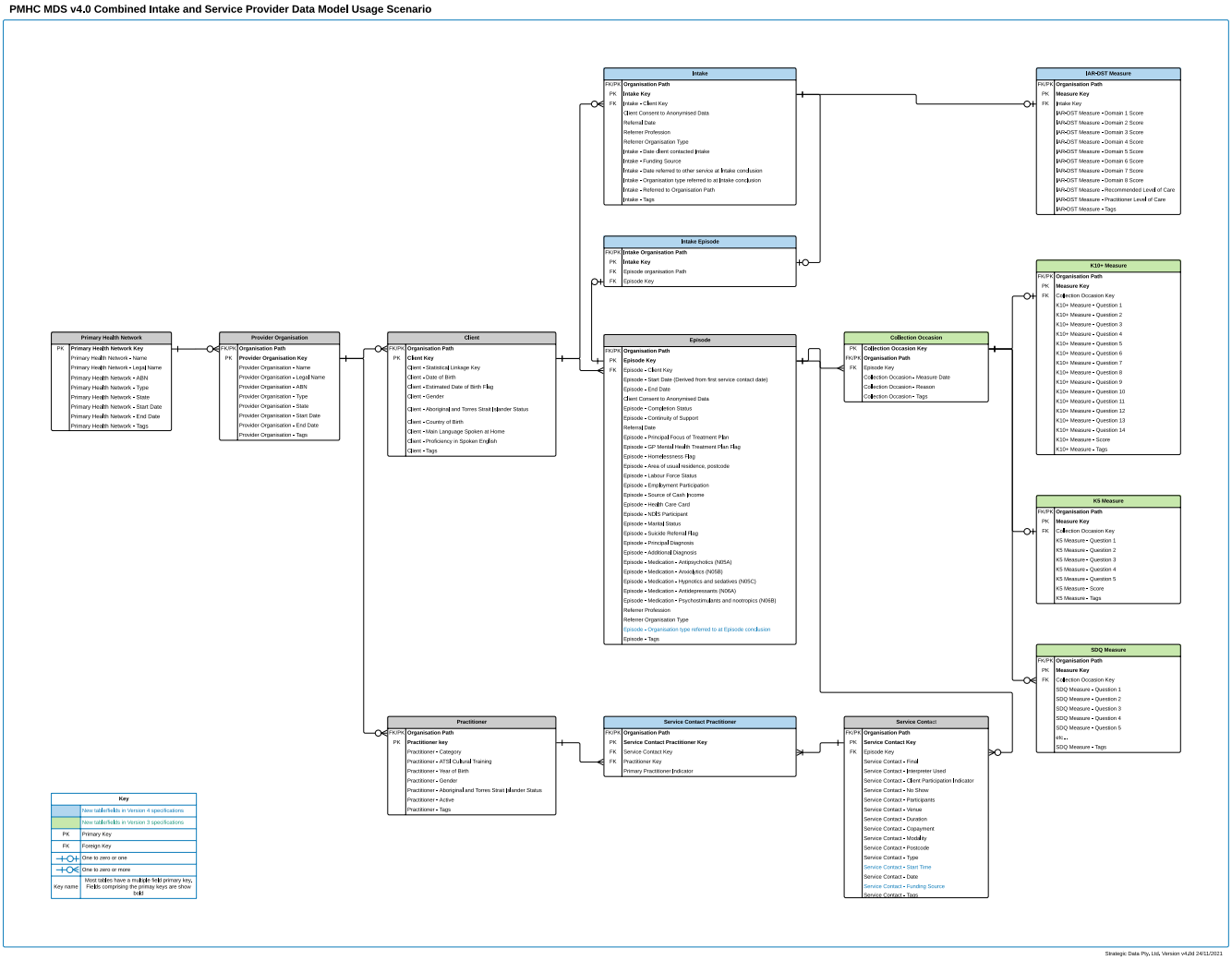
Episode and Service contact activity is not submitted in this context.

1.1.2. Hub Service Provider Context



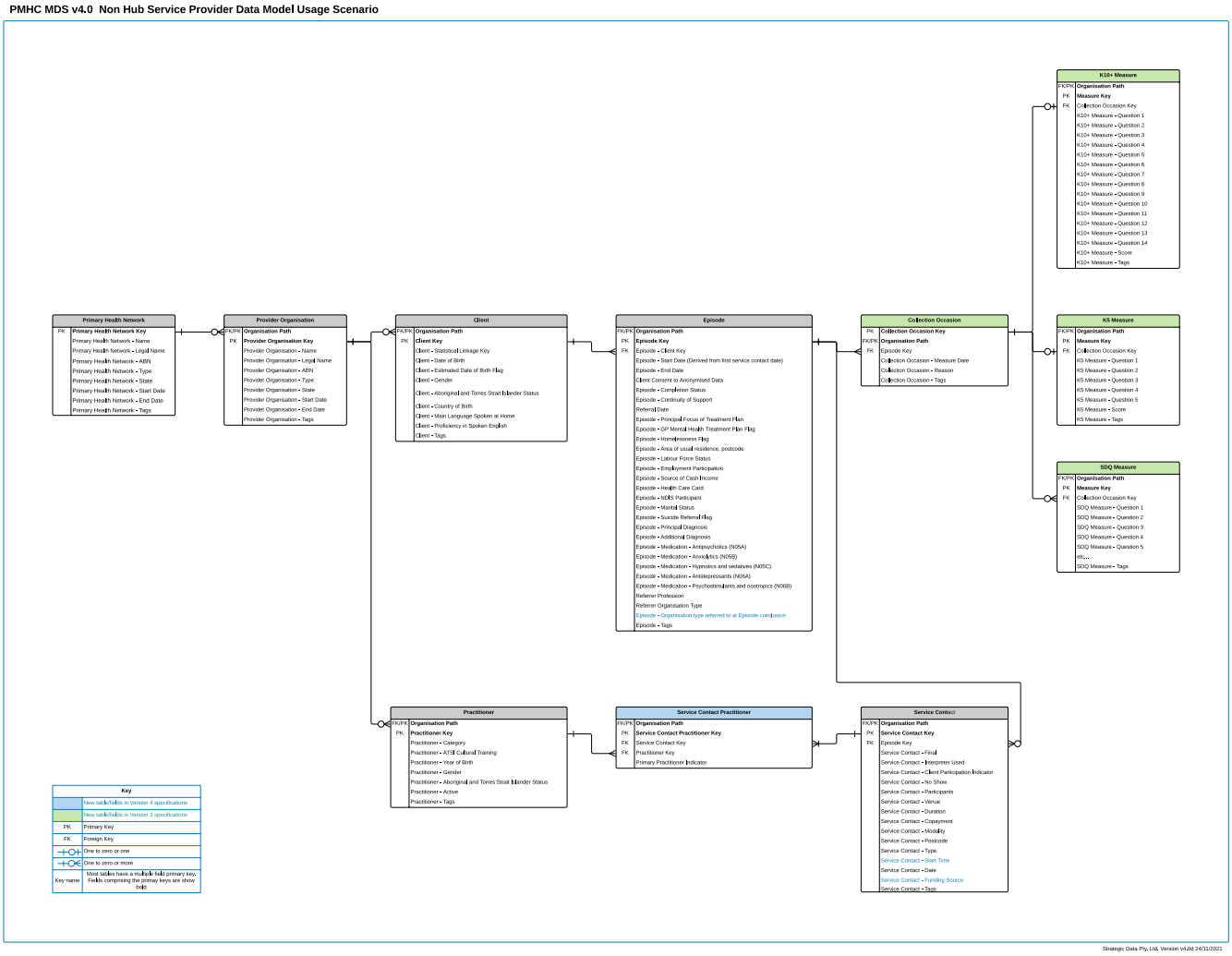
In the hub context the specification works almost the same as a service reporting via the Version 2 core PMHC-MDS specification using the new Intake Episode record to identify additional detail regarding referrals in from the intake teams (Intake Organisation Path and Intake Key), referrals out to additional services (Organisation type referred to at Episode conclusion), and the involvement of multiple practitioners in service contacts (Service Contact Practitioner) which allows multiple endorsements.

1.1.3. Combined Intake/Hub Context



In the combined context all the records described in both the Intake Context and Hub Service Provider Context can be submitted.

1.1.4. Non Hub Service Provider Context



In the non hub context (this is where there is no intake and is analogous with the current Version 2 specification), the specification works almost the same as a service reporting via the Version 2 core PMHC-MDS specification.

The Intake and Intake Episode do not need to be supplied where there is no Intake component.

Version 4 allows for the involvement of multiple practitioners in service contacts (Service Contact Practitioner) which allows multiple endorsements.

1.2. New Records and Fields in Version 4

1.2.1. Intake

The model requires a new Intake record for every intake process.

The Intake table comprises records information about the intake.

Organisation Path and Intake Key are the two fields required to link the hub intake at the intake provider organisation to the episode record at the hub organisation.

The values of these fields should be passed along by the intake organisation to the hub organisation where the hub organisation will use them to fill in Intake Organisation Path and Intake Key. This will then link the intake record at the intake organisation with the Episode record at the hub organisation.

1.2.2. IAR-DST Measure

A new record type is required to capture the domains and the recommended level of care pertinent to the IAR-DST that clients have completed for them as part of the intake process. A new IAR-DST record will be created for each intake process.

Consistent with the existing measures in the MDS, the domain scores will be captured as well as the recommended level of care. The purpose of collecting both domain scores and recommended level of care is to:

- allow verification of IAR-DST scoring processes, thereby catching scoring implementation errors early should they arise, and
- provide a resource that can be used to better understand how the IAR-DST scoring algorithm performs in real world environments supporting ongoing improvement of the tool.

1.2.3. Episode and Intake Episode

When the client is referred to a PMHC MDS reporting service (either a hub or a non-hub) a new Episode record is created.

Where the service is a hub an additional Intake Episode record is also created.

The Intake Episode table comprises a composite foreign key to link it back to an episode record on which all the episode information is recorded. This linkage is done via two fields:

1. The identifier of the intake team (Intake Organisation Path)
2. The episode identifier of the intake team (Intake Key)

The Episode record has been expanded with one new field - the organisation(s) to which the organisation refers the client (Organisation type referred to at Episode conclusion)

1.2.4. Service Contact

The Service Contact record has been expanded with two new fields:

1. The time that the contact started (Service Contact - Start Time). This is intended to enable identification of activity undertaken during extended hours.
2. The funding source for the service contact (Service Contact - Funding Source)

1.2.5. Service Contact Practitioner

A new record - Service Contact Practitioner replaces the Practitioner Key field on the Version 2 Service Contact record.

Service Contact Practitioner acknowledges the involvement of multiple practitioners in a service contact. One practitioner (and only one) must be identified as the primary practitioner.

1.3. Data release and confidentiality

All data collection and reporting requirements are required to comply with relevant Commonwealth, State and Territory Information Privacy and Health Records regulations. Clients will be informed that some de-identified portions of the information collected through the PMHC MDS Service will be utilised for Commonwealth, State and Territory planning and statistical purposes. Appropriate consent and ethics approval processes will be adhered to.

2. Reporting arrangements

2.1. Reporting data

PHNs and their service providers are able to either export data from their client systems and upload to the PMHC MDS or enter data manually via the data entry interface.

The system is able to accept data for any period in which the provider organisation is active, either in its entirety or partially. Please note the section below regarding timeliness.

Accepting data for any period allows organisations to upload corrections when erroneous data has been identified. Allowing partial uploads allows for submission of data by separate providers without the need for the PHN to aggregate all data prior to upload.

Where associated unique keys match (e.g. Patient Key or Episode Key) these records will be replaced, if the key is new, a new record will be created.

Data may be uploaded in either Excel or CSV format.

2.2. Reporting timeliness

Records must be reported to the MDS within 31 days of the activity which generated them. For example if a client was added to the system on the 12th of November 2016 their client record must be added to the MDS on or before the 13th of December 2016. Similarly, if a service contact occurred on that date, the data associated with that contact must be submitted to the MDS by 13th of December 2016 also.

The Department accesses information within the MDS for internal planning and governance purposes therefore data in the MDS needs to be current to ensure the accuracy of the data produced for the Department.

2.3. Inputs to help replicate system generated reports

Organisations frequently replicate the system reports at a local level for their own auditing purposes.

Some reports, such as the Out series reports, use extra inputs that cannot be generated locally.

These inputs are being supplied here to assist organisations who wish to replicate the system reports.

2.3.1. Outcome Measure Standard Deviations

Outcome Measure Standard Deviations will be updated in the second half of August each year.

Current version:

Download PMHC Outcome Measure Standard Deviations 2021 as XLSX.

Previous versions:

- Download PMHC Outcome Measure Standard Deviations 2020 as XLSX.

2.4. Support arrangements

Support is available to PHNs and their third party developers to assist with implementing upload facilities in existing client management systems. For those PHNs who do not upload via a client management system, documentation and support is available to manually enter data via a web data entry interface.

3. Identifier management

PMHC MDS keys are case sensitive and must have between 2-50 valid unicode characters. Keys must start with A-Za-z0-9 (POSIX :alnum:).

Where data is being exported from client systems, these keys can be auto generated, providing that a key does not change once it is assigned.

Keys must be generated by the organisation to be unique at the Provider Organisation level and must persist across time. Creation of keys in this way allows records to be merged (where duplicate keys of the same record type have been identified) without having to re-allocate keys since they can never clash.

A recommended approach for the creation of keys is to compute random UUIDs.

3.1. Managing Provider Organisation Keys

Provider Organisations will be created and managed by Primary Health Networks (PHNs) via upload or data entry. Each PHN must either create their own Provider Organisations before any data can be uploaded, or if the PHN is uploading the data, the Provider Organisation must be included in the upload.

Each Provider Organisation will need to be assigned a unique key. It is the responsibility of the PHN to assign and manage these keys.

3.2. Managing Client Keys

Client records will be created and managed by Provider Organisations via the upload and/or data entry interface. Each Client record needs to be assigned a unique key in order to facilitate adding/updating/deleting each item when uploading data. Once assigned, this key cannot change.

The Client Key will be managed by the Provider Organisation, however, the PHN may decide to play a role in coordinating assignment and management of these client keys.

Initially the Department wanted these keys to be unique across the PHN in order to ensure that there is a single key for a client within the PHN, and will continue to investigate options for the PMHC MDS implementation of a Master Client Index during Stage Two of development.

3.3. Managing all other entity keys

The following entity keys will be created and managed by Provider Organisations:

- Practitioner Key,
- Intake Key,
- Episode Key,

- Service Contact Key,
- Service Contact Practitioner Key,
- Collection Occasion Key,
- Measure Key.

The PMHC MDS specification requires each of these keys to be unique and stable at the Provider Organisation level.

Each record needs to be assigned a unique key in order to facilitate adding/updating/deleting each item when uploading/entering data. These keys will be created and managed by the Provider Organisation.

If you still have questions after reading this information, please visit the Department's responses to Questions about Unique Identifiers and 'Keys'

4. Data model and specifications

4.1. Data model

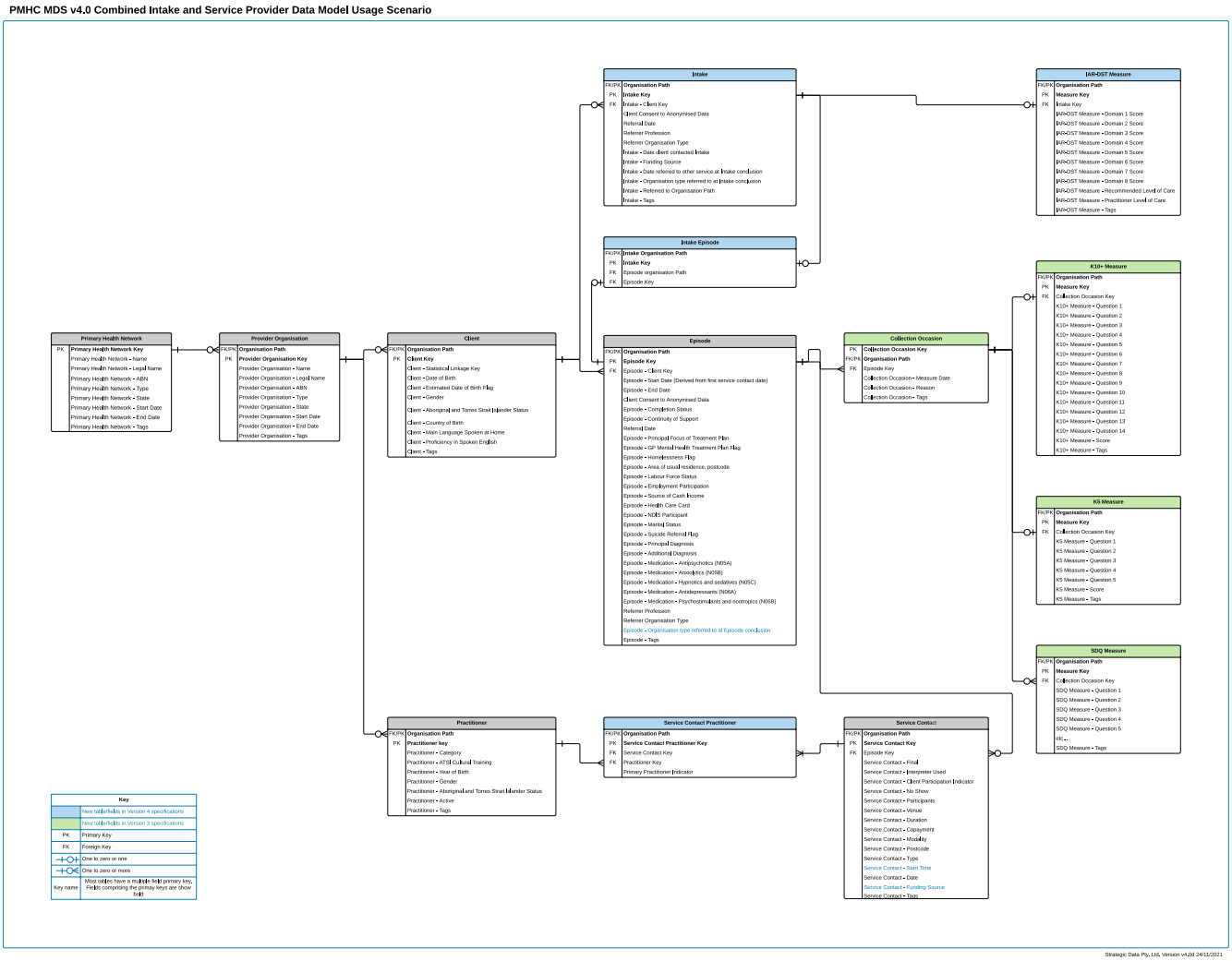


Fig. 4.1 PMHC data model

Note: PMHC Collection Occasion data model for more details about Collection Occasion records.

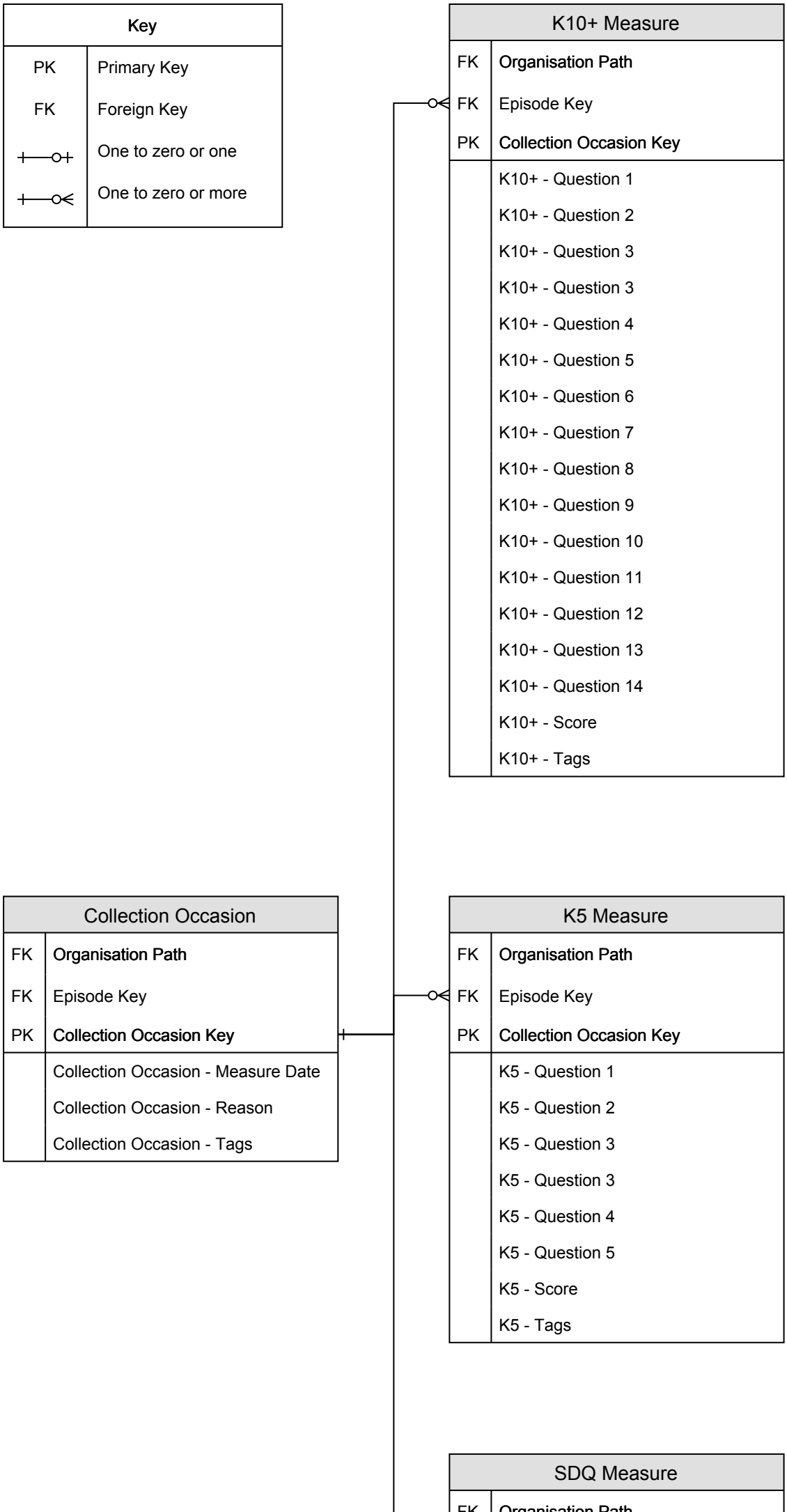

Key
PK
Primary Key
FK
Foreign Key
One to zero or one
One to zero or more
K10+ Measure
FK
Organisation Path
FK
Episode Key
PK
Collection Occasion Key
K10+ - Question 1
K10+ - Question 2
K10+ - Question 3
K10+ - Question 3
K10+ - Question 4
K10+ - Question 5
K10+ - Question 6
K10+ - Question 7
K10+ - Question 8
K10+ - Question 9
K10+ - Question 10
K10+ - Question 11
K10+ - Question 12
K10+ - Question 13
K10+ - Question 14
K10+ - Score
K10+ - Tags
Collection Occasion
FK
Organisation Path
FK
Episode Key
PK
Collection Occasion Key
Collection Occasion - Measure Date
Collection Occasion - Reason
Collection Occasion - Tags
K5 Measure
FK
Organisation Path
FK
Episode Key
PK
Collection Occasion Key
K5 - Question 1
K5 - Question 2
K5 - Question 3
K5 - Question 3
K5 - Question 4
K5 - Question 5
K5 - Score
K5 - Tags
SDQ Measure

Fig. 4.2 PMHC Collection Occasion data model

Note: See PMHC data model for more details about how Collection Occasion records fit into the overall structure.

4.2. Key concepts

4.2.1. Primary Health Network

Primary Health Networks (PHNs) have been established by the Australian Government with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

4.2.2. Provider Organisation

The Provider Organisation is the business entity that the PHN has commissioned to provide the service.

See Provider Organisation for the data elements for a provider organisation.

4.2.3. Practitioner

The Practitioner is the person who is delivering the service. Multiple practitioners can deliver a service.

See Practitioner for the data elements for a practitioner.

4.2.4. Client

The Client is the person who is receiving the service.

See Client for the data elements for a client.

4.2.4.1. Active Client

An **active client** is a client who has had one or more Service Contacts in a reference reporting period.

4.2.5. Intake

For the purpose of the PMHC MDS, an *Intake* is defined as a point of contact between a client and a PHN-commissioned organisation where the client is assessed to determine the appropriate level of care and referred to a service provider to provide clinical care. An Intake may include the collection of an IAR-DST measure.

4.2.6. Intake Episode

The Intake Episode record links an Intake record and an Episode record. It must be provided by the organisation that delivers the episode, not the intake.

4.2.7. Episode

For the purposes of the PMHC MDS, an *Episode of Care* is defined as a more or less continuous period of contact between a client and a PHN-commissioned provider organisation/clinician that starts at the point of first contact, and concludes at discharge. Episodes comprise a series of one or more Service Contacts. This structure allows for a logical data collection protocol that specifies what data are collected when, and by whom. Different sets of PMHC MDS items are collected at various points in the client's engagement with the provider organisation. Some items are only collected once at the episode level, while others are collected at each *Service Contact*.

Four business rules apply to how the *Episode of Care* concept is implemented across PHN-commissioned services:

- **One Intake may be associated with each episode.** An episode is not required to be associated with an Intake.
- **One episode at a time for each client, defined at the level of the provider organisation.**

  While an individual may have multiple *Episodes of Care* over the course of their illness, they may be considered as being in only one episode at any given point of time for **any particular PHN-commissioned provider organisation**. The implication is that the care provided by the organisation to an individual client at any point in time is subject to only one set of reporting requirements.
- **Episodes commence at the point of first contact.** The episode start date will be derived from the first service contact regardless of no show state as long as there is a service contact that isn't a no show. Therefore, if there is no attended service contact the episode is uncommenced.

  Some examples:

  - If a service contact occurs on the 1/1/2018 that is recorded as a no show then the episode is uncommenced.
  - If a service contact occurs on the 1/1/2018 that is recorded as a no show and another service contact occurs on the 2/1/2018 that is attended then the episode start date is derived as 1/1/2018.
- **Discharge from care concludes the episode**

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

See Episode for the data elements for a episode.

4.2.7.1. Active Episode

An **active episode** is an episode with one or more Attended Service Contacts recorded in a reference reporting period.

4.2.8. Service Contact

- Service contacts are defined as the provision of a service by one or more PHN commissioned mental health service provider(s) for a client where the nature of the service would normally warrant a dated entry in the clinical record of the client.

- A service contact must involve at least two persons, one of whom must be a mental health service provider.
- Service contacts can be either with the client or with a third party, such as a carer or family member, and/or other professional or mental health worker, or other service provider.
- Service contacts are not restricted to face-to-face communication but can include telephone, internet, video link or other forms of direct communication.
- Service provision is only regarded as a service contact if it is relevant to the clinical condition of the client. This means that it does not include services of an administrative nature (e.g. telephone contact to schedule an appointment).

  Definition based on METeOR: 493304 with modification.

4.2.8.1. Attended Service Contact

An attended service contact is one that is not marked as 'No show'.

See Service Contact for the data elements for a service contact.

4.2.9. Service Contact Practitioner

Service Contacts can have more than one practitioner. Practitioners are linked to Service Contacts through Service Contact Practitioner.

One (and only one) practitioner must be specified as the Primary Practitioner for each Service Contact.

See Service Contact Practitioner for the data elements for a service contact practitioner.

4.2.10. Collection Occasion

A Collection Occasion is defined as an occasion during an Episode of Care when specific Service Activities are required to be collected. At a minimum, collection is required at both Episode Start and Episode End, but may be more frequent if clinically indicated and agreed by the client.

Measures will be the Kessler Psychological Distress Scale K10+ (in the case of Aboriginal and Torres Strait Islander clients, the K5) as well as the Strengths & Difficulties Questionnaires.

See Collection Occasion for the data elements for a collection occasion.

4.3. Record formats

4.3.1. Metadata

The Metadata table must be included in file uploads in order to identify the type and version of the uploaded data.

Table 4.1 Metadata record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Key (key)	string	yes	A metadata key name.
Value (value)	string	yes	The metadata value.

For this version of the specification the required content is shown in the following table:

key	value
type	PMHC
version	4.0

4.3.2. Provider Organisation

See Provider Organisation for the definition of a provider organisation.

Provider Organisation data is for administrative use within the PMHC MDS system. It is managed by the PHN's via the PMHC MDS administrative interface, it cannot be uploaded.

Table 4.2 Provider Organisation record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Key (organisation_key)	string (2,50)	yes	A sequence of characters which uniquely identifies the provider organisation to the Primary Health Network. Assigned by the Primary Health Network.
Provider Organisation - Name (organisation_name)	string (2,100)	yes	The name of the provider organisation.
Provider Organisation - Legal Name (organisation_legal_name)	string	—	The legal name of the provider organisation.
Provider Organisation - ABN (organisation_abn)	string (11)	yes	The Australian Business Number of the provider organisation.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Provider Organisation - Type (organisation_type)	string	yes	1 Private Allied Health Professional Practice 2 Private Psychiatry Practice 3 General Medical Practice 4 Private Hospital 5 Headspace Centre 6 Early Youth Psychosis Centre 7 Community-managed Community Support Organisation 8 Aboriginal Health/Medical Service 9 State/Territory Health Service Organisation 10 Drug and/or Alcohol Service 11 Primary Health Network 12 Medicare Local 13 Division of General Practice 98 Other 99 Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Provider Organisation - State (organisation_state) METeOR: 613718	string	yes	1 New South Wales 2 Victoria 3 Queensland 4 South Australia 5 Western Australia 6 Tasmania 7 Northern Territory 8 Australian Capital Territory 9 Other Territories
Provider Organisation - Start Date (organisation_start_date)	date	yes	The date on which a provider organisation started delivering services.
Provider Organisation - End Date (organisation_end_date)	date	yes	The date on which a provider organisation stopped delivering services.
Provider Organisation - Tags (organisation_tags)	string	—	List of tags for the provider organisation.

4.3.3. Practitioner

See Practitioner for the definition of a practitioner.

Practitioner data is intended to provide workforce planning data for use regionally by the PHN and nationally by the Department. It is managed by the provider organisations via either the PMHC MDS administrative interface or upload.

Table 4.3 Practitioner record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Practitioner Key (practitioner_key)	string (2,50)	yes	A unique identifier for a practitioner within the responsible provider organisation. Assigned by either the PHN or Provider Organisation depending on local procedures.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Practitioner - Category (practitioner_category)	string	yes	1 Clinical Psychologist 2 General Psychologist 3 Social Worker 4 Occupational Therapist 5 Mental Health Nurse 6 Aboriginal and Torres Strait Islander Health/ Mental Health Worker 7 Low Intensity Mental Health Worker 8 General Practitioner 9 Psychiatrist 10 Other Medical 11 Other 12 Psychosocial Support Worker 13 Peer Support Worker 99 Not stated
Practitioner - ATSI Cultural Training (atsi_cultural_training)	string	yes	1 Yes 2 No 3 Not required 9 Missing / Not recorded
Practitioner - Year of Birth (practitioner_year_of_birth)	gYear	yes	gYear

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Practitioner - Gender (practitioner_gender) ABS	string	yes	0 Not stated/ Inadequately described 1 Male 2 Female 3 Other
Practitioner - Aboriginal and Torres Strait Islander Status (practitioner_atsi_status) METeOR: 291036	string	yes	1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Neither Aboriginal or Torres Strait Islander origin 9 Not stated/ inadequately described
Practitioner - Active (practitioner_active)	string	yes	0 Inactive 1 Active
Practitioner - Tags (practitioner_tags)	string	—	List of tags for the practitioner.

4.3.4. Client

See Client for definition of a client.

Clients are managed by the provider organisations via upload.

Table 4.4 Client record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Client Key (client_key)	string (2,50)	yes	This is a number or code assigned to each individual client referred to the commissioned organisation. The client identifier must be unique and stable for each individual within the Provider Organisation. Assigned by either the PHN or Provider Organisation depending on local procedures.
Client - Statistical Linkage Key (slk) METeOR: 349510	string (14,40)	yes	A key that enables two or more records belonging to the same individual to be brought together.
Client - Date of Birth (date_of_birth) METeOR: 287007	date	yes	The date on which an individual was born.
Client - Estimated Date of Birth Flag (est_date_of_birth)	string	yes	1 Date of birth is accurate 2 Date of birth is an estimate 8 Date of birth is a 'dummy' date (ie, 09099999) 9 Accuracy of stated date of birth is not known

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Client - Gender (client_gender) ABS	string	yes	0 Not stated/ Inadequately described 1 Male 2 Female 3 Other
Client - Aboriginal and Torres Strait Islander Status (client_atsi_status) METeOR: 291036	string	yes	1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Neither Aboriginal or Torres Strait Islander origin 9 Not stated/ inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Client - Country of Birth (country_of_birth) METeOR: 459973 ABS	string (4)	yes	**1101** Australia **1102** Norfolk Island **1199** Australian External Territories, nec **1201** New Zealand **1301** New Caledonia **1302** Papua New Guinea **1303** Solomon Islands **1304** Vanuatu **1401** Guam **1402** Kiribati **1403** Marshall Islands **1404** Micronesia, Federated States of **1405** Nauru **1406** Northern Mariana Islands **1407** Palau **1501** Cook Islands **1502** Fiji **1503** French Polynesia **1504** Niue **1505** Samoa **1506** Samoa, American **1507** Tokelau **1508** Tonga **1511** Tuvalu **1512** Wallis and Futuna **1513** Pitcairn Islands

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			1599 Polynesia (excludes Hawaii), nec **1601** Adelie Land (France) **1602** Argentinian Antarctic Territory **1603** Australian Antarctic Territory **1604** British Antarctic Territory **1605** Chilean Antarctic Territory **1606** Queen Maud Land (Norway) **1607** Ross Dependency (New Zealand) **2102** England **2103** Isle of Man **2104** Northern Ireland **2105** Scotland **2106** Wales **2107** Guernsey **2108** Jersey **2201** Ireland **2301** Austria **2302** Belgium **2303** France **2304** Germany **2305** Liechtenstein **2306** Luxembourg **2307** Monaco

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			2308 Netherlands **2311** Switzerland **2401** Denmark **2402** Faroe Islands **2403** Finland **2404** Greenland **2405** Iceland **2406** Norway **2407** Sweden **2408** Aland Islands **3101** Andorra **3102** Gibraltar **3103** Holy See **3104** Italy **3105** Malta **3106** Portugal **3107** San Marino **3108** Spain **3201** Albania **3202** Bosnia and Herzegovina **3203** Bulgaria **3204** Croatia **3205** Cyprus **3206** The former Yugoslav Republic of Macedonia **3207** Greece **3208** Moldova **3211** Romania **3212** Slovenia

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			3214 Montenegro **3215** Serbia **3216** Kosovo **3301** Belarus **3302** Czech Republic **3303** Estonia **3304** Hungary **3305** Latvia **3306** Lithuania **3307** Poland **3308** Russian Federation **3311** Slovakia **3312** Ukraine **4101** Algeria **4102** Egypt **4103** Libya **4104** Morocco **4105** Sudan **4106** Tunisia **4107** Western Sahara **4108** Spanish North Africa **4111** South Sudan **4201** Bahrain **4202** Gaza Strip and West Bank **4203** Iran **4204** Iraq **4205** Israel **4206** Jordan

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			4207 Kuwait **4208** Lebanon **4211** Oman **4212** Qatar **4213** Saudi Arabia **4214** Syria **4215** Turkey **4216** United Arab Emirates **4217** Yemen **5101** Myanmar **5102** Cambodia **5103** Laos **5104** Thailand **5105** Vietnam **5201** Brunei Darussalam **5202** Indonesia **5203** Malaysia **5204** Philippines **5205** Singapore **5206** Timor-Leste **6101** China (excludes SARs and Taiwan) **6102** Hong Kong (SAR of China) **6103** Macau (SAR of China) **6104** Mongolia **6105** Taiwan **6201** Japan

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			6202 Korea, Democratic People's Republic of (North) **6203** Korea, Republic of (South) **7101** Bangladesh **7102** Bhutan **7103** India **7104** Maldives **7105** Nepal **7106** Pakistan **7107** Sri Lanka **7201** Afghanistan **7202** Armenia **7203** Azerbaijan **7204** Georgia **7205** Kazakhstan **7206** Kyrgyzstan **7207** Tajikistan **7208** Turkmenistan **7211** Uzbekistan **8101** Bermuda **8102** Canada **8103** St Pierre and Miquelon **8104** United States of America **8201** Argentina **8202** Bolivia **8203** Brazil **8204** Chile

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8205 Colombia **8206** Ecuador **8207** Falkland Islands **8208** French Guiana **8211** Guyana **8212** Paraguay **8213** Peru **8214** Suriname **8215** Uruguay **8216** Venezuela **8299** South America, nec **8301** Belize **8302** Costa Rica **8303** El Salvador **8304** Guatemala **8305** Honduras **8306** Mexico **8307** Nicaragua **8308** Panama **8401** Anguilla **8402** Antigua and Barbuda **8403** Aruba **8404** Bahamas **8405** Barbados **8406** Cayman Islands **8407** Cuba **8408** Dominica **8411** Dominican Republic

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8412 Grenada **8413** Guadeloupe **8414** Haiti **8415** Jamaica **8416** Martinique **8417** Montserrat **8421** Puerto Rico **8422** St Kitts and Nevis **8423** St Lucia **8424** St Vincent and the Grenadines **8425** Trinidad and Tobago **8426** Turks and Caicos Islands **8427** Virgin Islands, British **8428** Virgin Islands, United States **8431** St Barthelemy **8432** St Martin (French part) **8433** Bonaire, Sint Eustatius and Saba **8434** Curacao **8435** Sint Maarten (Dutch part) **9101** Benin **9102** Burkina Faso **9103** Cameroon **9104** Cabo Verde **9105** Central African Republic

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9106 Chad **9107** Congo, Republic of **9108** Congo, Democratic Republic of **9111** Cote d'Ivoire **9112** Equatorial Guinea **9113** Gabon **9114** Gambia **9115** Ghana **9116** Guinea **9117** Guinea-Bissau **9118** Liberia **9121** Mali **9122** Mauritania **9123** Niger **9124** Nigeria **9125** Sao Tome and Principe **9126** Senegal **9127** Sierra Leone **9128** Togo **9201** Angola **9202** Botswana **9203** Burundi **9204** Comoros **9205** Djibouti **9206** Eritrea **9207** Ethiopia **9208** Kenya **9211** Lesotho

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9212 Madagascar **9213** Malawi **9214** Mauritius **9215** Mayotte **9216** Mozambique **9217** Namibia **9218** Reunion **9221** Rwanda **9222** St Helena **9223** Seychelles **9224** Somalia **9225** South Africa **9226** Swaziland **9227** Tanzania **9228** Uganda **9231** Zambia **9232** Zimbabwe **9299** Southern and East Africa, nec **9999** Unknown

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Client - Main Language Spoken at Home (main_lang_at_home) METeOR: 460125 ABS	string (4)	yes	**1101** Gaelic (Scotland) **1102** Irish **1103** Welsh **1199** Celtic, nec **1201** English **1301** German **1302** Letzeburgish **1303** Yiddish **1401** Dutch **1402** Frisian **1403** Afrikaans **1501** Danish **1502** Icelandic **1503** Norwegian **1504** Swedish **1599** Scandinavian, nec **1601** Estonian **1602** Finnish **1699** Finnish and Related Languages, nec **2101** French **2201** Greek **2301** Catalan **2302** Portuguese **2303** Spanish **2399** Iberian Romance, nec **2401** Italian **2501** Maltese **2901** Basque

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			2902 Latin **2999** Other Southern European Languages, nec **3101** Latvian **3102** Lithuanian **3301** Hungarian **3401** Belorussian **3402** Russian **3403** Ukrainian **3501** Bosnian **3502** Bulgarian **3503** Croatian **3504** Macedonian **3505** Serbian **3506** Slovene **3507** Serbo-Croatian/ Yugoslavian, so described **3601** Czech **3602** Polish **3603** Slovak **3604** Czechoslovakian, so described **3901** Albanian **3903** Aromunian (Macedo-Romanian) **3904** Romanian **3905** Romany **3999** Other Eastern European Languages, nec **4101** Kurdish

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			4102 Pashto **4104** Balochi **4105** Dari **4106** Persian (excluding Dari) **4107** Hazaraghi **4199** Iranic, nec **4202** Arabic **4204** Hebrew **4206** Assyrian Neo-Aramaic **4207** Chaldean Neo-Aramaic **4208** Mandaean (Mandaic) **4299** Middle Eastern Semitic Languages, nec **4301** Turkish **4302** Azeri **4303** Tatar **4304** Turkmen **4305** Uygur **4306** Uzbek **4399** Turkic, nec **4901** Armenian **4902** Georgian **4999** Other Southwest and Central Asian Languages, nec **5101** Kannada **5102** Malayalam **5103** Tamil

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			5104 Telugu **5105** Tulu **5199** Dravidian, nec **5201** Bengali **5202** Gujarati **5203** Hindi **5204** Konkani **5205** Marathi **5206** Nepali **5207** Punjabi **5208** Sindhi **5211** Sinhalese **5212** Urdu **5213** Assamese **5214** Dhivehi **5215** Kashmiri **5216** Oriya **5217** Fijian Hindustani **5299** Indo-Aryan, nec **5999** Other Southern Asian Languages **6101** Burmese **6102** Chin Haka **6103** Karen **6104** Rohingya **6105** Zomi **6199** Burmese and Related Languages, nec **6201** Hmong **6299** Hmong-Mien, nec

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			6301 Khmer **6302** Vietnamese **6303** Mon **6399** Mon-Khmer, nec **6401** Lao **6402** Thai **6499** Tai, nec **6501** Bisaya **6502** Cebuano **6503** Ilokano **6504** Indonesian **6505** Malay **6507** Tetum **6508** Timorese **6511** Tagalog **6512** Filipino **6513** Acehnese **6514** Balinese **6515** Bikol **6516** Iban **6517** Ilonggo (Hiligaynon) **6518** Javanese **6521** Pampangan **6599** Southeast Asian Austronesian Languages, nec **6999** Other Southeast Asian Languages **7101** Cantonese **7102** Hakka **7104** Mandarin

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			7106 Wu **7107** Min Nan **7199** Chinese, nec **7201** Japanese **7301** Korean **7901** Tibetan **7902** Mongolian **7999** Other Eastern Asian Languages, nec **8101** Anindilyakwa **8111** Maung **8113** Ngan'gikurunggurr **8114** Nunggubuyu **8115** Rembarrnga **8117** Tiwi **8121** Alawa **8122** Dalabon **8123** Gudanji **8127** Iwaidja **8128** Jaminjung **8131** Jawoyn **8132** Jingulu **8133** Kunbarlang **8136** Larrakiya **8137** Malak Malak **8138** Mangarrayi **8141** Maringarr **8142** Marra **8143** Marrithiyel

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8144 Matngala **8146** Murrinh Patha **8147** Na-kara **8148** Ndjebbana (Gunavidji) **8151** Ngalakgan **8152** Ngaliwurru **8153** Nungali **8154** Wambaya **8155** Wardaman **8156** Amurdak **8157** Garrwa **8158** Kuwema **8161** Marramaninyshi **8162** Ngandi **8163** Waanyi **8164** Wagiman **8165** Yanyuwa **8166** Marridan (Maridan) **8171** Gundjeihmi **8172** Kune **8173** Kuninjku **8174** Kunwinjku **8175** Mayali **8179** Kunwinjkuan, nec **8181** Burarra **8182** Gun-nartpa **8183** Gurr-goni **8189** Burarran, nec

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8199 Arnhem Land and Daly River Region Languages, nec **8211** Galpu **8212** Golumala **8213** Wangurri **8219** Dhangu, nec **8221** Dhalwangu **8222** Djarrwark **8229** Dhay'yi, nec **8231** Djambarrpuyngu **8232** Djapu **8233** Daatiwuy **8234** Marrangu **8235** Liyagalawumirr **8236** Liyagawumirr **8239** Dhuwal, nec **8242** Gumatj **8243** Gupapuyngu **8244** Guyamirrililil **8246** Manggalili **8247** Wubulkarra **8249** Dhuwala, nec **8251** Wurlaki **8259** Djinang, nec **8261** Ganalbingu **8262** Djinba **8263** Manyjalpingu **8269** Djinba, nec **8271** Ritharrngu **8272** Wagilak

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8279 Yakuy, nec **8281** Nhangu **8282** Yan-nhangu **8289** Nhangu, nec **8291** Dhuwaya **8292** Djangu **8293** Madarrpa **8294** Warramiri **8295** Rirratjingu **8299** Other Yolngu Matha, nec **8301** Kuku Yalanji **8302** Guugu Yimidhirr **8303** Kuuku-Ya'u **8304** Wik Mungkan **8305** Djabugay **8306** Dyirbal **8307** Girramay **8308** Koko-Bera **8311** Kuuk Thayorre **8312** Lamalama **8313** Yidiny **8314** Wik Ngathan **8315** Alngith **8316** Kugu Muminh **8317** Morrobalama **8318** Thaynakwith **8321** Yupangathi **8322** Tjungundji

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8399 Cape York Peninsula Languages, nec **8401** Kalaw Kawaw Ya/Kalaw Lagaw Ya **8402** Meriam Mir **8403** Yumplatok (Torres Strait Creole) **8504** Bilinarra **8505** Gurindji **8506** Gurindji Kriol **8507** Jaru **8508** Light Warlpiri **8511** Malngin **8512** Mudburra **8514** Ngardi **8515** Ngarinyman **8516** Walmajarri **8517** Wanyjirra **8518** Warlmanpa **8521** Warlpiri **8522** Warumungu **8599** Northern Desert Fringe Area Languages, nec **8603** Alyawarr **8606** Kaytetye **8607** Antekerrepenh **8611** Central Anmatyerr **8612** Eastern Anmatyerr

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8619 Anmatyerr, nec **8621** Eastern Arrernte **8622** Western Arrarnta **8629** Arrernte, nec **8699** Arandic, nec **8703** Antikarinya **8704** Kartujarra **8705** Kukatha **8706** Kukatja **8707** Luritja **8708** Manyjilyjarra **8711** Martu Wangka **8712** Ngaanyatjarra **8713** Pintupi **8714** Pitjantjatjara **8715** Wangkajunga **8716** Wangkatha **8717** Warnman **8718** Yankunytjatjara **8721** Yulparija **8722** Tjupany **8799** Western Desert Languages, nec **8801** Bardi **8802** Bunuba **8803** Gooniyandi **8804** Miriwoong **8805** Ngarinyin **8806** Nyikina **8807** Worla

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8808 Worrorra **8811** Wunambal **8812** Yawuru **8813** Gambera **8814** Jawi **8815** Kija **8899** Kimberley Area Languages, nec **8901** Adnymathanha **8902** Arabana **8903** Bandjalang **8904** Banyjima **8905** Batjala **8906** Bidjara **8907** Dhanggatti **8908** Diyari **8911** Gamilaraay **8913** Garuwali **8914** Githabul **8915** Gumbaynggir **8916** Kanai **8917** Karajarri **8918** Kariyarra **8921** Kaurna **8922** Kayardild **8924** Kriol **8925** Lardil **8926** Mangala **8927** Muruwari **8928** Narungga

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8931 Ngarluma **8932** Ngarrindjeri **8933** Nyamal **8934** Nyangumarta **8935** Nyungar **8936** Paakantyi **8937** Palyku/Nyiyaparli **8938** Wajarri **8941** Wiradjuri **8943** Yindjibarndi **8944** Yinhawangka **8945** Yorta Yorta **8946** Baanbay **8947** Badimaya **8948** Barababaraba **8951** Dadi Dadi **8952** Dharawal **8953** Djabwurrung **8954** Gudjal **8955** Keerray-Woorroong **8956** Ladji Ladji **8957** Mirning **8958** Ngatjumaya **8961** Waluwarra **8962** Wangkangurru **8963** Wargamay **8964** Wergaia **8965** Yugambeh

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8998 Aboriginal English, so described **8999** Other Australian Indigenous Languages, nec **9101** American Languages **9201** Acholi **9203** Akan **9205** Mauritian Creole **9206** Oromo **9207** Shona **9208** Somali **9211** Swahili **9212** Yoruba **9213** Zulu **9214** Amharic **9215** Bemba **9216** Dinka **9217** Ewe **9218** Ga **9221** Harari **9222** Hausa **9223** Igbo **9224** Kikuyu **9225** Krio **9226** Luganda **9227** Luo **9228** Ndebele **9231** Nuer **9232** Nyanja (Chichewa)

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9233 Shilluk **9234** Tigre **9235** Tigrinya **9236** Tswana **9237** Xhosa **9238** Seychelles Creole **9241** Anuak **9242** Bari **9243** Bassa **9244** Dan (Gio-Dan) **9245** Fulfulde **9246** Kinyarwanda (Rwanda) **9247** Kirundi (Rundi) **9248** Kpelle **9251** Krahn **9252** Liberian (Liberian English) **9253** Loma (Lorma) **9254** Lumun (Kuku Lumun) **9255** Madi **9256** Mandinka **9257** Mann **9258** Moro (Nuba Moro) **9261** Themne **9262** Lingala **9299** African Languages, nec **9301** Fijian **9302** Gilbertese

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9303 Maori (Cook Island) **9304** Maori (New Zealand) **9306** Nauruan **9307** Niue **9308** Samoan **9311** Tongan **9312** Rotuman **9313** Tokelauan **9314** Tuvaluan **9315** Yapese **9399** Pacific Austronesian Languages, nec **9402** Bislama **9403** Hawaiian English **9404** Norf'k-Pitcairn **9405** Solomon Islands Pijin **9499** Oceanian Pidgins and Creoles, nec **9502** Kiwai **9503** Motu (HiriMotu) **9504** Tok Pisin (Neomelanesian) **9599** Papua New Guinea Languages, nec **9601** Invented Languages **9701** Auslan **9702** Key Word Sign Australia

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9799 Sign Languages, nec 9999 Unknown
Client - Proficiency in Spoken English (prof_english) METeOR: 270203	string	yes	0 Not applicable (persons under 5 years of age or who speak only English) 1 Very well 2 Well 3 Not well 4 Not at all 9 Not stated/ inadequately described
Client - Tags (client_tags)	string	—	List of tags for the client.

4.3.5. Intake

See Intake for definition of an intake.

Intakes are managed by the provider organisations via upload.

Table 4.5 Intake record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Intake Key (intake_key)	string (2,50)	yes	This is a number or code assigned to each intake. The Intake Key is unique and stable for each intake at the level of the organisation.
Client Key (client_key)	string (2,50)	yes	This is a number or code assigned to each individual client referred to the intake organisation. The client identifier must be unique and stable for each individual within the intake organisation. Assigned by either the PHN or intake organisation depending on local procedures.
Client Consent to Anonymised Data (client_consent)	string	yes	An indication that the client has consented to their anonymised data being provided to the Department of Health for statistical purposes in planning and improving mental health services.
Referral Date (referral_date)	date	yes	The date the referrer made the referral.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Referrer Profession (referrer_profession)	string	yes	1 General Practitioner 2 Psychiatrist 3 Obstetrician 4 Paediatrician 5 Other Medical Specialist 6 Midwife 7 Maternal Health Nurse 8 Psychologist 9 Mental Health Nurse 10 Social Worker 11 Occupational therapist 12 Aboriginal Health Worker 13 Educational professional 14 Early childhood service worker 15 Other 98 N/A - Self referral 99 Not stated

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Referrer Organisation Type (referrer_organisation_type)	string	yes	1 General Practice 2 Medical Specialist Consulting Rooms 3 Private practice 4 Public mental health service 5 Public Hospital 6 Private Hospital 7 Emergency Department 8 Community Health Centre 9 Drug and Alcohol Service 10 Community Support Organisation NFP 11 Indigenous Health Organisation 12 Child and Maternal Health 13 Nursing Service 14 Telephone helpline 15 Digital health service 16 Family Support Service

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			17 School 18 Tertiary Education institution 19 Housing service 20 Centrelink 21 Other 98 N/A - Self referral 99 Not stated
Intake - Date client contacted Intake (date_client_contacted_intake)	date	yes	The date on which the client first contacted the intake service
Intake - Funding Source (intake_funding_source)	string	yes	1 HeadtoHelp 2 AMHC 3 Other / Flexible Funding Pool
Intake - Date referred to other service at Intake conclusion (date_referred_to_other_service_at_intake_conclusion)	date	—	The date the client was referred to another organisation at Intake conclusion.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation type referred to at Intake conclusion (organisation_type_referred_to_at_intake_conclusion)	string	yes	1 GP/Medical Practitioner 2 Hospital 3 Psychiatric/ mental health service or facility 4 Alcohol and other drug treatment service 5 Other community/ health care service 6 Correctional service 7 Police diversion 8 Court diversion 9 Legal service 10 Child protection agency 11 Community support groups/ agencies 12 Centrelink or employment service 13 Housing and homelessness service 14 Telephone & online services/ referral agency e.g. direct line

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			15 Disability support service 16 Aged care facility/service 17 Immigration department or asylum seeker/ refugee support service 18 School/other education or training institution 19 Community based Drug and Alcohol Service 20 Youth service (non-AOD) 21 Indigenous service (non-AOD) 22 Extended care/ rehabilitation facility 23 Palliative care service 24 Police (not diversion) 25 Public dental provider - community dental agency 26 Dental Hospital 27 Private Dental Provider

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			28 Early childhood service 29 Maternal and Child Health Service 30 Community nursing service 31 Emergency relief 32 Family support service (excl family violence) 33 Family violence service 34 Gambling support service 35 Maternity services 36 Peer support/ self-help group 37 Private allied health provider 38 Sexual Assault service 39 Financial counsellor 40 Sexual health service 41 Medical specialist 42 AMHC 43 Other PHN funded service

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			44 HeadtoHelp / HeathtoHealth 97 No Referral 98 Other 99 Not stated/ Inadequately described Multiple space separated values allowed
Referred to Organisation Path (referred_to_organisation_path)	string	—	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation to which the intake referred the client.
Intake - Tags (intake_tags)	string	—	List of tags for the intake.

4.3.6. Intake Episode

See Intake Episode for definition of an intake episode.

Intake Episodes are managed by the provider organisations via upload.

Table 4.6 Intake Episode record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Intake Organisation Path (intake_organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing the intake to the client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Intake Key (intake_key)	string (2,50)	yes	This is a number or code assigned to each intake. The Intake Key is unique and stable for each intake at the level of the organisation.
Episode Organisation Path (episode_organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing the clinical service to the client.
Episode Key (episode_key)	string (2,50)	yes	This is a number or code assigned to each PMHC MDS episode. The Episode Key is unique and stable for each episode at the level of the organisation. This key must link to an existing episode within the PMHC MDS.

4.3.7. Episode

See Episode for definition of an episode.

Episodes are managed by the provider organisations via upload.

Table 4.7 Episode record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Episode Key (episode_key)	string (2,50)	yes	This is a number or code assigned to each episode. The Episode Key is unique and stable for each episode at the level of the Provider Organisation.
Client Key (client_key)	string (2,50)	yes	This is a number or code assigned to each individual client referred to the commissioned organisation. The client identifier is unique and stable for each individual within the Provider Organisation.
Episode - End Date (episode_end_date) METeOR: 614094	date	—	The date on which an *Episode of Care* is formally or administratively ended
Client Consent to Anonymised Data (client_consent)	string	yes	**1** Yes **2** No

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Completion Status (episode_completion_status)	string	—	0 Episode open 1 Episode closed - treatment concluded 2 Episode closed administratively - client could not be contacted 3 Episode closed administratively - client declined further contact 4 Episode closed administratively - client moved out of area 5 Episode closed administratively - client referred elsewhere 6 Episode closed administratively - other reason
Episode - Continuity of Support (continuity_of_support)	string	yes	1 Yes 2 No 9 Not stated/ inadequately described
Referral Date (referral_date)	date	—	The date the referrer made the referral.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Principal Focus of Treatment Plan (principal_focus)	string	yes	1 Psychological therapy 2 Low intensity psychological intervention 3 Clinical care coordination 4 Complex care package 5 Child and youth-specific mental health services 6 Indigenous-specific mental health services 7 Other 8 Psychosocial Support
Episode - GP Mental Health Treatment Plan Flag (mental_health_treatment_plan)	string	yes	1 Yes 2 No 3 Unknown 9 Not stated/ inadequately described
Episode - Homelessness Flag (homelessness)	string	yes	1 Sleeping rough or in non-conventional accommodation 2 Short-term or emergency accommodation 3 Not homeless 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Area of usual residence, postcode (client_postcode) METeOR: 429894	string	yes	The Australian postcode of the client.
Episode - Labour Force Status (labour_force_status) METeOR: 621450	string	yes	1 Employed 2 Unemployed 3 Not in the Labour Force 9 Not stated/ inadequately described
Episode - Employment Participation (employment_participation) METeOR: 269950	string	yes	1 Full-time 2 Part-time 3 Not applicable - not in the labour force 9 Not stated/ inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Source of Cash Income (income_source) METeOR: 386449	string	yes	0 N/A - Client aged less than 16 years 1 Disability Support Pension 2 Other pension or benefit (not superannuation) 3 Paid employment 4 Compensation payments 5 Other (e.g. superannuation, investments etc.) 6 Nil income 7 Not known 9 Not stated/ inadequately described
Episode - Health Care Card (health_care_card) METeOR: 605149	string	yes	1 Yes 2 No 3 Not Known 9 Not stated
Episode - NDIS Participant (ndis_participant)	string	yes	1 Yes 2 No 9 Not stated/ inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Marital Status (marital_status) METeOR: 291045	string	yes	1 Never married 2 Widowed 3 Divorced 4 Separated 5 Married (registered and de facto) 6 Not stated/ inadequately described
Episode - Suicide Referral Flag (suicide_referral_flag)	string	yes	1 Yes 2 No 9 Unknown

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Principal Diagnosis (principal_diagnosis)	string	yes	**100** Anxiety disorders (ATAPS) **101** Panic disorder **102** Agoraphobia **103** Social phobia **104** Generalised anxiety disorder **105** Obsessive-compulsive disorder **106** Post-traumatic stress disorder **107** Acute stress disorder **108** Other anxiety disorder **200** Affective (Mood) disorders (ATAPS) **201** Major depressive disorder **202** Dysthymia **203** Depressive disorder NOS **204** Bipolar disorder **205** Cyclothymic disorder **206** Other affective disorder **300** Substance use disorders (ATAPS) **301** Alcohol harmful use

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			302 Alcohol dependence **303** Other drug harmful use **304** Other drug dependence **305** Other substance use disorder **400** Psychotic disorders (ATAPS) **401** Schizophrenia **402** Schizoaffective disorder **403** Brief psychotic disorder **404** Other psychotic disorder **501** Separation anxiety disorder **502** Attention deficit hyperactivity disorder (ADHD) **503** Conduct disorder **504** Oppositional defiant disorder **505** Pervasive developmental disorder **506** Other disorder of childhood and adolescence **601** Adjustment disorder

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			602 Eating disorder **603** Somatoform disorder **604** Personality disorder **605** Other mental disorder **901** Anxiety symptoms **902** Depressive symptoms **903** Mixed anxiety and depressive symptoms **904** Stress related **905** Other **999** Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Additional Diagnosis (additional_diagnosis)	string	yes	**000** No additional diagnosis **100** Anxiety disorders (ATAPS) **101** Panic disorder **102** Agoraphobia **103** Social phobia **104** Generalised anxiety disorder **105** Obsessive-compulsive disorder **106** Post-traumatic stress disorder **107** Acute stress disorder **108** Other anxiety disorder **200** Affective (Mood) disorders (ATAPS) **201** Major depressive disorder **202** Dysthymia **203** Depressive disorder NOS **204** Bipolar disorder **205** Cyclothymic disorder **206** Other affective disorder **300** Substance use disorders (ATAPS)

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			301 Alcohol harmful use **302** Alcohol dependence **303** Other drug harmful use **304** Other drug dependence **305** Other substance use disorder **400** Psychotic disorders (ATAPS) **401** Schizophrenia **402** Schizoaffective disorder **403** Brief psychotic disorder **404** Other psychotic disorder **501** Separation anxiety disorder **502** Attention deficit hyperactivity disorder (ADHD) **503** Conduct disorder **504** Oppositional defiant disorder **505** Pervasive developmental disorder **506** Other disorder of childhood and adolescence

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			601 Adjustment disorder 602 Eating disorder 603 Somatoform disorder 604 Personality disorder 605 Other mental disorder 901 Anxiety symptoms 902 Depressive symptoms 903 Mixed anxiety and depressive symptoms 904 Stress related 905 Other 999 Missing
Episode - Medication - Antipsychotics (N05A) (medication_antipsychotics)	string	yes	1 Yes 2 No 9 Unknown
Episode - Medication - Anxiolytics (N05B) (medication_anxiolytics)	string	yes	1 Yes 2 No 9 Unknown
Episode - Medication - Hypnotics and sedatives (N05C) (medication_hypnotics)	string	yes	1 Yes 2 No 9 Unknown

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Medication - Antidepressants (N06A) (medication_antidepressants)	string	yes	1 Yes 2 No 9 Unknown
Episode - Medication - Psychostimulants and nootropics (N06B) (medication_psychostimulants)	string	yes	1 Yes 2 No 9 Unknown
Referrer Profession (referrer_profession)	string	yes	Profession of the provider who referred the client.
Referrer Organisation Type (referrer_organisation_type)	string	yes	Type of organisation in which the referring professional is based.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation type referred to at Episode conclusion (organisation_type_referred_to_at_episode_conclusion)	string	yes	0 None/Not applicable 1 General Practice 2 Medical Specialist Consulting Rooms 3 Private practice 4 Public mental health service 5 Public Hospital 6 Private Hospital 7 Emergency Department 8 Community Health Centre 9 Drug and Alcohol Service 10 Community Support Organisation NFP 11 Indigenous Health Organisation 12 Child and Maternal Health 13 Nursing Service 14 Telephone helpline 15 Digital health service 16 Family Support Service 17 School

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			18 Tertiary Education institution 19 Housing service 20 Centrelink 21 Other 22 HeadtoHelp / HeadtoHealth Hub 23 Other PHN funded service 24 AMHC 99 Not stated Multiple space separated values allowed
Episode - Tags (episode_tags)	string	—	List of tags for the episode.

4.3.8. Service Contact

See Service Contact for definition of a service contact.

Service contacts are managed by the provider organisations via upload.

Table 4.8 Service contact record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact Key (service_contact_key)	string (2,50)	yes	This is a number or code assigned to each service contact. The Service Contact Key is unique and stable for each service contact at the level of the Provider Organisation.
Episode Key (episode_key)	string (2,50)	yes	This is a number or code assigned to each episode. The Episode Key is unique and stable for each episode at the level of the organisation.
Practitioner Key (practitioner_key)	string (2,50)	yes	A unique identifier for a practitioner within the provider organisation.
Service Contact - Date (service_contact_date) METeOR: 494356	date	yes	The date of each mental health service contact between a health service provider and patient/client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact - Type (service_contact_type)	string	yes	**0** No contact took place **1** Assessment **2** Structured psychological intervention **3** Other psychological intervention **4** Clinical care coordination/ liaison **5** Clinical nursing services **6** Child or youth specific assistance NEC **7** Suicide prevention specific assistance NEC **8** Cultural specific assistance NEC **9** Psychosocial support **98** ATAPS
Service Contact - Postcode (service_contact_postcode) METeOR: 429894	string	yes	The Australian postcode where the service contact took place.
Service Contact - Modality (service_contact_modality)	string	yes	**0** No contact took place **1** Face to Face **2** Telephone **3** Video **4** Internet-based

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact - Participants (service_contact_participants)	string	yes	1 Individual client 2 Client group 3 Family / Client Support Network 4 Other health professional or service provider 5 Other 9 Not stated

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact - Venue (service_contact_venue)	string	yes	1 Client's Home 2 Service provider's office 3 GP Practice 4 Other medical practice 5 Headspace Centre 6 Other primary care setting 7 Public or private hospital 8 Residential aged care facility 9 School or other educational centre 10 Client's Workplace 11 Other 12 Aged care centre - non-residential 98 Not applicable (Service Contact Modality is not face to face) 99 Not stated

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact - Duration (service_contact_duration)	string	yes	0 No contact took place 1 1-15 mins 2 16-30 mins 3 31-45 mins 4 46-60 mins 5 61-75 mins 6 76-90 mins 7 91-105 mins 8 106-120 mins 9 over 120 mins
Service Contact - Copayment (service_contact_copayment)	number	yes	0 - 999999.99
Service Contact - Client Participation Indicator (service_contact_participation_indicator) METeOR: 494341	string	yes	1 Yes 2 No
Service Contact - Interpreter Used (service_contact_interpreter)	string	yes	1 Yes 2 No 9 Not stated
Service Contact - No Show (service_contact_no_show)	string	yes	1 Yes 2 No

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact - Final (service_contact_final)	string	yes	1 No further services are planned for the client in the current episode 2 Further services are planned for the client in the current episode 3 Not known at this stage
Service Contact - Start Time (service_contact_start_time)	time	yes	The start time of each mental health service contact between a health service provider and patient/client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact - Funding Source (funding_source)	string	yes	7 PHN flexible funding NOS 8 Low intensity 9 Child and youth specific services NOS 10 Youth enhanced services 11 Psychological therapies 12 Care coordination for severe and complex 13 Suicide prevention NOS 14 Suicide prevention - Indigenous 15 Suicide Prevention - General 16 Indigenous MH 17 Psychosocial NOS 18 Psychosocial NPS 19 Psychosocial COS 20 Other Commonwealth flexible funding NOS 21 Drought measure 22 Psychological treatment services for

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			people with mental illness living in RACFs **23** Co-funded – Commonwealth and state **24** Co-funded – Commonwealth and other Quarantined **25** Quarantined funding NOS **26** PFAS response (retired) **27** Natural Disaster Response **28** HeadtoHelp **29** AMHC **30** Eating disorders trial **31** Norfolk Island **32** Other funding source – no Commonwealth Funding **33** COVID Response NOS **34** COVID Response Head To Help **35** COVID Response Head To Health **98** Unknown/Not stated **99** Missing
Service Contact - Tags (service_contact_tags)	string	—	List of tags for the service contact.

4.3.9. Service Contact Practitioner

See Service Contact Practitioner for definition of a service contact practitioner.

Service contacts practitioners are managed by the provider organisations via upload.

Table 4.9 Service contact practitioner record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Service Contact Practitioner Key (service_contact_practitioner_key)	string (2,50)	yes	This is a number or code assigned to each service contact practitioner. The Service Contact Practitioner Key is unique and stable for each service contact practitioner at the level of the Provider Organisation.
Service Contact Key (service_contact_key)	string (2,50)	yes	This is a number or code assigned to each service contact. The Service Contact Key is unique and stable for each service contact at the level of the Provider Organisation.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Practitioner Key (practitioner_key)	string (2,50)	yes	A unique identifier for a practitioner within the provider organisation.
Primary Practitioner Indicator (primary_practitioner_indicator)	string	yes	1 Yes 2 No

4.3.10. Collection Occasion

See Collection Occasion for definition of a collection occasion.

Individual item scores will eventually be required, however, it is noted that in the short term there are issues with collecting individual item scores. Therefore, as a transitional phase, reporting overall scores/subscales will be allowed.

Collection occasions are managed by the provider organisations via upload.

4.3.11. Measures

4.3.11.1. Measures at Intake

PMHC MDS requires the use of the IAR-DST IAR-DST at intake.

4.3.11.1.1. IAR-DST

Table 4.10 IAR-DST record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Measure Key (measure_key)	string (2,50)	yes	This is a number or code assigned to each instance of a measure. The Measure Key is unique and stable for each instance of a measure at the level of the organisation.
Intake Key (intake_key)	string (2,50)	yes	This is a number or code assigned to each intake. The Intake Key is unique and stable for each intake at the level of the organisation.
IAR-DST - Domain 1 - Symptom Severity and Distress (Primary Domain) (iar_dst_domain_1)	string	yes	0 No problem in this domain 1 Mild or sub diagnostic 2 Moderate 3 Severe 4 Very severe
IAR-DST - Domain 2 - Risk of Harm (Primary Domain) (iar_dst_domain_2)	string	yes	0 No identified risk in this domain 1 Low risk of harm 2 Moderate risk of harm 3 High risk of harm 4 Very high risk of harm

Data Element (Field Name)	Type (min,max)	Required	Format / Values
IAR-DST - Domain 3 - Functioning (Primary Domain) (iar_dst_domain_3)	string	yes	0 No problems in this domain 1 Mild impact 2 Moderate impact 3 Severe impact 4 Very severe to extreme impact
IAR-DST - Domain 4 - Impact of Co-existing Conditions (Primary Domain) (iar_dst_domain_4)	string	yes	0 No problem in this domain 1 Minor impact 2 Moderate impact 3 Severe impact 4 Very severe impact
IAR-DST - Domain 5 - Treatment and Recovery History (Contextual Domain) (iar_dst_domain_5)	string	yes	0 No prior treatment history 1 Full recovery with previous treatment 2 Moderate recovery with previous treatment 3 Minor recovery with previous treatment 4 Negligible recovery with previous treatment

Data Element (Field Name)	Type (min,max)	Required	Format / Values
IAR-DST - Domain 6 - Social and Environmental Stressors (Contextual Domain) (iar_dst_domain_6)	string	yes	0 No problem in this domain 1 Mildly stressful environment 2 Moderately stressful environment 3 Highly stressful environment 4 Extremely stressful environment
IAR-DST - Domain 7 - Family and Other Supports (Contextual Domain) (iar_dst_domain_7)	string	yes	0 Highly supported 1 Well supported 2 Limited supports 3 Minimal supports 4 No supports
IAR-DST - Domain 8 - Engagement and Motivation (Contextual Domain) (iar_dst_domain_8)	string	yes	0 Optimal 1 Positive 2 Limited 3 Minimal 4 Disengaged

Data Element (Field Name)	Type (min,max)	Required	Format / Values
IAR-DST - Recommended Level of Care (iar_dst_recommended_level_of_care)	string	yes	1 Level 1 - Self Management 1+ Level 1 or above - Review assessment on Contextual Domains to determine most appropriate placement 2 Level 2 - Low Intensity Services 2+ Level 2 or above - Review assessment on Contextual Domains to determine most appropriate placement 3 Level 3 - Moderate Intensity Services 3+ Level 3 or above - Review assessment on Contextual Domains to determine most appropriate placement 4 Level 4 - High Intensity Services

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			4+ Level 4 or above - Review assessment on Contextual Domains to determine most appropriate placement 5 Level 5 - Acute and Specialist Community Mental Health Services
IAR-DST - Practitioner Level of Care (iar_dst_practitioner_level_of_care)	string	yes	1 Level 1 - Self Management 2 Level 2 - Low Intensity Services 3 Level 3 - Moderate Intensity Services 4 Level 4 - High Intensity Services 5 Level 5 - Acute and Specialist Community Mental Health Services 9 Not stated
IAR-DST - Tags (iar_dst_tags)	string	—	List of tags for the measure.

4.3.11.2. Measures during an Episode

PMHC MDS requires the use of one of the following three required measures, as follows:

- **For adults (18+ years)** - Kessler Psychological Distress Scale (K10+) is the prescribed measure, with the option to use the K5 for Aboriginal and Torres Strait Islander people if that is considered more appropriate.
- **For children and young people (up to and including 17 years)** - the Strengths & Difficulties Questionnaires (SDQ) is the prescribed tool. The specified versions include the parent-report for 4-10 years and 11-17 years; and the self-report for 11-17 years.

Please note: For adolescents, clinician-discretion is allowed, and that the K10+ or K5 may be used, even though the person is under 18 years

4.3.11.2.1. K10+

As noted above, reporting individual item scores will eventually be required. In the short term, respondents can either report all 14 item scores or report the K10 total score as well as item scores for the 4 extra items in the K10+.

Table 4.11 K10+ record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Measure Key (measure_key)	string (2,50)	yes	This is a number or code assigned to each instance of a measure. The Measure Key is unique and stable for each instance of a measure at the level of the organisation.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Collection Occasion Key (collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each collection occasion of service activity. The Collection Occasion Key is unique and stable for each collection occasion at the level of the organisation.
K10+ - Question 1 (k10p_item1)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Question 2 (k10p_item2)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Question 3 (k10p_item3)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
K10+ - Question 4 (k10p_item4)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Question 5 (k10p_item5)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Question 6 (k10p_item6)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
K10+ - Question 7 (k10p_item7)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Question 8 (k10p_item8)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Question 9 (k10p_item9)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
K10+ - Question 10 (k10p_item10)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Question 11 (k10p_item11)	integer	yes	0 - 28, 99 = Not stated / Missing
K10+ - Question 12 (k10p_item12)	integer	yes	0 - 28, 99 = Not stated / Missing
K10+ - Question 13 (k10p_item13)	integer	yes	0 - 89, 99 = Not stated / Missing
K10+ - Question 14 (k10p_item14)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K10+ - Score (k10p_score)	integer	yes	10 - 50, 99 = Not stated / Missing
K10+ - Tags (k10p_tags)	string	—	List of tags for the measure.

When the client's responses to Q1-10 are all recorded as 1 'None of the time', they are not required to answer questions 11-14. Where a question has not been answered please select a response of 'Not stated / missing'.

4.3.11.2.2. K5

As noted above, reporting individual item scores will eventually be required. In the short term, respondents can either report all 5 item scores or report the K5 total score.

Table 4.12 K5 record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Measure Key (measure_key)	string (2,50)	yes	This is a number or code assigned to each instance of a measure. The Measure Key is unique and stable for each instance of a measure at the level of the organisation.
Collection Occasion Key (collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each collection occasion of service activity. The Collection Occasion Key is unique and stable for each collection occasion at the level of the organisation.
K5 - Question 1 (k5_item1)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
K5 - Question 2 (k5_item2)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K5 - Question 3 (k5_item3)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K5 - Question 4 (k5_item4)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
K5 - Question 5 (k5_item5)	string	yes	1 None of the time 2 A little of the time 3 Some of the time 4 Most of the time 5 All of the time 9 Not stated / Missing
K5 - Score (k5_score)	integer	yes	5 - 25, 99 = Not stated / Missing
K5 - Tags (k5_tags)	string	—	List of tags for the measure.

4.3.11.2.3. SDQ

Extensive support materials are available on the SDQ developers' website, including copies of the various versions of the instrument, background information and scoring instructions. See http://www.sdqinfo.com. There are six versions (parent-report and youth-self report) currently specified format PMHC MDS reporting.

The "1" versions are administered on admission and are rated on the basis of the proceeding 6 months. The "2" follow up versions are administered on review and discharge and are rated on the basis of the previous 1 month period.

The versions specified for PMHC MDS reporting are:

- PC1 - Parent Report Measure for Children aged 4-10, Baseline version;
- PC2 - Parent Report Measure for Children and Adolescents aged 4-10, Follow up version;
- PY1 - Parent Report Measure for Youth aged 11-17, Baseline version;
- PY2 - Parent Report Measure for Youth aged 11-17, Follow up version;
- YR1 - Youth self report measure (11-17), Baseline version; and
- YR2 - Youth self report measure (11-17), Follow up version.

We acknowledge that there is also a parent-report for 2-4 years; and teacher versions for all the years (2-4; 4-10 and 11-17) but that these are not to be reported the PMHC-MDS.

Please note that the item numbering in the SDQ versions is deliberately non sequential because it covers all items in all versions, both to indicate item equivalence across versions and to assist data entry, especially of translated versions. The table below indicates the items that are included in each version, the rating periods used and the broad content covered by each item.

	Informant	**Parent**				**Young Person**	
	Age range	**4-10**		**11-17**		**11 - 17**	
	Application	**Baseline**	**Followup**	**Baseline**	**Followup**	**Baseline**	**Followup**
	Rating period	**6 months**	**1 month**	**6 months**	**1 month**	**6 months**	**1 month**
Items	**Item Content**	**Version**					
		PC1	**PC2**	**PY1**	**PY2**	**YR1**	**YR2**
1-25	Symptoms	✓	✓	✓	✓	✓	✓
26	Overall	✓	✓	✓	✓	✓	✓
27	Duration	✓	X	✓	X	✓	
28-33	Impact	✓	✓	✓	✓	✓	✓
34-35	Follow up progress	X	✓	X	✓	X	✓
36-38	Cross-Informant information	✓	X	✓	X	X	X
39-42	Cross-Informant information	X	X	X	X	✓	X

As noted above, reporting individual item scores will eventually be required. In the short term, respondents can either report all 42 item scores or report the SDQ subscale scores.

4.3.11.2.3.1. SDQ items and Scale Summary scores

The first 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales before working out the Total Difficulties score. For data entry, the responses to items should always be entered the same way (see below), but they are not all scored the same way. Somewhat True is always scored as 1, but the scoring of Not True and Certainly True varies with each item (see Table 5). For each of the 5 scales the score can range from 0-10 if all 5 items were completed. Scale scores can be prorated if at least 3 items were completed.

		Not True	Some-what True	Certainly True	
Standard Values for Data Entry		**0**	**1**	**2**	**Summa**
Data element	**SDQ Item number and description**		**Item Score**		
Emotional Symptoms Scale					0-10
Item 03	Often complains of headaches …	0	1	2	
Item 08	Many worries or often seems worried	0	1	2	
Item 13	Often unhappy, depressed or tearful	0	1	2	
Item 16	Nervous or clingy in new situations …	0	1	2	
Item 24	Many fears, easily scared	0	1	2	
Conduct Problem Scale					0-10
Item 05	Often loses temper …	0	1	2	
Item 07	**Generally well behaved …**	**2**	**1**	**0**	
Item 12	Often fights with other children …	0	1	2	
Item 18	Often lies or cheats	0	1	2	
Item 22	Steals from home, school …	0	1	2	
Hyperactivity Scale					0-10
Item 02	Restless, overactive …	0	1	2	
Item 10	Constantly fidgeting …	0	1	2	
Item 15	Easily distracted …	0	1	2	
Item 21	**Thinks things out before acting**	**2**	**1**	**0**	

		Not True	Some-what True	Certainly True	
Standard Values for Data Entry		**0**	**1**	**2**	**Summa**
Data element	**SDQ Item number and description**	**Item Score**			
Item 25	**Good attention span …**	**2**	**1**	**0**	
Peer Problem Scale					0-10
Item 06	Rather solitary, prefers to play alone	0	1	2	
Item 11	**Has at least one good friend**	**2**	**1**	**0**	
Item 14	**Generally liked by other children**	**2**	**1**	**0**	
Item 19	Picked on or bullied …	0	1	2	
Item 23	Gets along better with adults …	0	1	2	
Prosocial Scale					0-10
Item 01	Considerate of other people's feelings	0	1	2	
Item 04	Shares readily with other children …	0	1	2	
Item 09	Helpful if someone is hurt …	0	1	2	
Item 17	Kind to younger children	0	1	2	
Item 20	Often volunteers to help others …	0	1	2	
SDQ Total Difficulties Score = Sum of Scales below					0-40
	Emotional Symptoms Scale	0-10			
	Conduct Problem Scale	0-10			
	Hyperactivity Scale	0-10			
	Peer Problem Scale	0-10			

- *NB. Bold items indicate reverse scoring*

4.3.11.2.3.2. Scoring the SDQ

The standard values for coding individual Item responses are 0 (Not True), 1 (Somewhat True), 2 (Certainly True) and 9 (Missing data).

For completed items (response coded 0,1,2) the Item scores are usually the same as the standard values. Them exceptions are item 07, 11, 14, 21 and 25. These items are “reverse-scored”, that is, the standard value is mapped to Item scores as follows: 0->2, 1->1, 2->0.

Summary scores are only calculated if at least three of the five items have been completed (that is, coded 0, 1 or 2). Otherwise the summary score is set to missing. For the Summary scores, the missing value used should be 99.

The Summary scores are computed using the equation shown below, with the result being rounded to the nearest whole number. In the first 25 SDQ questions, each summary scale is composed of five items.

Summary score = (sum of item scores/number of valid completed items) x number of items

The simplest way to calculate the total difficulties score is to add up the following summary scores with the result being rounded to the nearest whole number.

Total score = Emotional Scale + Conduct Scale + Hyperactivity Scale + Peer Problem Scale

However, some of the summary scores may be missing. The rule is if more than one summary score is missing the Total Score is set to missing, value 99.

Items 28-32 are not completed if respondents have answered “No” to Item 26, which asks for an overall opinion about difficulties being present. In this case, all Item responses for Items 27 through 33 should be coded “8” for “not applicable”, and the impact score should be coded to zero. Item 27 is not included in the Impact Score since it assesses the chronicity of the difficulties- the length of time they have been present. Item 33 is not included in the Impact Score, since it assess the burden on others rather than on the child/youth.

The coded Item Responses for the remaining Items 28 through 32 have to be mapped to their Item Scores before adding up. This mapping is the same for all, namely: 0->0, 1->0, 2->1, 3->2.

Table 4.13 SDQ record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Measure Key (measure_key)	string (2,50)	yes	This is a number or code assigned to each instance of a measure. The Measure Key is unique and stable for each instance of a measure at the level of the organisation.
Collection Occasion Key (collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each collection occasion of service activity. The Collection Occasion Key is unique and stable for each collection occasion at the level of the organisation.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ Collection Occasion - Version (sdq_version)	string	yes	**PC101** Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1 **PC201** Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1 **PY101** Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1 **PY201** Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1 **YR101** Self report Version, 11-17 years, Baseline version, Australian Version 1 **YR201** Self report Version, 11-17 years, Follow Up version, Australian Version 1

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 1 (sdq_item1)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 2 (sdq_item2)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 3 (sdq_item3)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 4 (sdq_item4)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 5 (sdq_item5)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 6 (sdq_item6)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 7 (sdq_item7)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 8 (sdq_item8)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 9 (sdq_item9)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 10 (sdq_item10)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 11 (sdq_item11)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 12 (sdq_item12)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 13 (sdq_item13)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 14 (sdq_item14)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 15 (sdq_item15)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 16 (sdq_item16)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 17 (sdq_item17)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 18 (sdq_item18)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 19 (sdq_item19)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 20 (sdq_item20)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 21 (sdq_item21)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 22 (sdq_item22)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 23 (sdq_item23)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
SDQ - Question 24 (sdq_item24)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 25 (sdq_item25)	string	yes	**0** Not True **1** Somewhat True **2** Certainly True **7** Unable to rate (insufficient information) **9** Not stated / Missing
SDQ - Question 26 (sdq_item26)	string	yes	**0** No **1** Yes - minor difficulties **2** Yes - definite difficulties **3** Yes - severe difficulties **7** Unable to rate (insufficient information) **9** Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 27 (sdq_item27)	string	yes	**0** Less than a month **1** 1-5 months **2** 6-12 months **3** Over a year **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing
SDQ - Question 28 (sdq_item28)	string	yes	**0** Not at all **1** A little **2** A medium amount **3** A great deal **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 29 (sdq_item29)	string	yes	0 Not at all 1 A little 2 A medium amount 3 A great deal 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing
SDQ - Question 30 (sdq_item30)	string	yes	0 Not at all 1 A little 2 A medium amount 3 A great deal 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 31 (sdq_item31)	string	yes	**0** Not at all **1** A little **2** A medium amount **3** A great deal **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing
SDQ - Question 32 (sdq_item32)	string	yes	**0** Not at all **1** A little **2** A medium amount **3** A great deal **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 33 (sdq_item33)	string	yes	0 Not at all 1 A little 2 A medium amount 3 A great deal 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing
SDQ - Question 34 (sdq_item34)	string	yes	0 Much worse 1 A bit worse 2 About the same 3 A bit better 4 Much better 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 35 (sdq_item35)	string	yes	0 Not at all 1 A little 2 A medium amount 3 A great deal 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing
SDQ - Question 36 (sdq_item36)	string	yes	0 No 1 A little 2 A lot 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 37 (sdq_item37)	string	yes	**0** No **1** A little **2** A lot **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing
SDQ - Question 38 (sdq_item38)	string	yes	**0** No **1** A little **2** A lot **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 39 (sdq_item39)	string	yes	0 No 1 A little 2 A lot 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing
SDQ - Question 40 (sdq_item40)	string	yes	0 No 1 A little 2 A lot 7 Unable to rate (insufficient information) 8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 41 (sdq_item41)	string	yes	**0** No **1** A little **2** A lot **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing
SDQ - Question 42 (sdq_item42)	string	yes	**0** No **1** A little **2** A lot **7** Unable to rate (insufficient information) **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) **9** Not stated / Missing
SDQ - Emotional Symptoms Scale (sdq_emotional_symptoms)	integer	yes	0 - 10, 99 = Not stated / Missing
SDQ - Conduct Problem Scale (sdq_conduct_problem)	integer	yes	0 - 10, 99 = Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Hyperactivity Scale (sdq_hyperactivity)	integer	yes	0 - 10, 99 = Not stated / Missing
SDQ - Peer Problem Scale (sdq_peer_problem)	integer	yes	0 - 10, 99 = Not stated / Missing
SDQ - Prosocial Scale (sdq_prosocial)	integer	yes	0 - 10, 99 = Not stated / Missing
SDQ - Total Difficulties Score (sdq_total)	integer	yes	0 - 40, 99 = Not stated / Missing
SDQ - Impact Score (sdq_impact)	integer	yes	0 - 10, 99 = Not stated / Missing
SDQ - Tags (sdq_tags)	string	—	List of tags for the measure.

4.4. Definitions

4.4.1. Client - Aboriginal and Torres Strait Islander Status

Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin, as represented by a code.

Field name client_atsi_status

Data type string

Required yes

Domain

1 Aboriginal but not Torres Strait Islander origin

2 Torres Strait Islander but not Aboriginal origin

3 Both Aboriginal and Torres Strait Islander origin

4 Neither Aboriginal or Torres Strait Islander origin

9 Not stated/inadequately described

Notes **Code 9 is not to be available as a valid answer to the questions but is** intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

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4.4.2. Client Consent to Anonymised Data

An indication that the client has consented to their anonymised data being provided to the Department of Health for statistical purposes in planning and improving mental health services.

Field name client_consent

Data type string

Required yes

Notes **1 - Yes** The client has consented to their anonymised data being provided to the Department of Health for statistical purposes in planning and improving mental health services. The client's data will be included in reports and extracts accessible by the Department of Health.

2 - No The client has not consented to their anonymised data being provided to the Department of Health for statistical purposes in planning and improving mental health services. The client's data will be excluded from reports and extracts accessible by the Department of Health.

All data can be uploaded, regardless of consent flag.

All data will be available to PHNs to extract for their own internal data evaluation purposes.

4.4.3. Client - Country of Birth

The country in which the client was born, as represented by a code.

Field name country_of_birth

Data type string (4)

Required yes

Domain

1101	Australia
1102	Norfolk Island
1199	Australian External Territories, nec
1201	New Zealand
1301	New Caledonia
1302	Papua New Guinea

1303 Solomon Islands

1304 Vanuatu

1401 Guam

1402 Kiribati

1403 Marshall Islands

1404 Micronesia, Federated States of

1405 Nauru

1406 Northern Mariana Islands

1407 Palau

1501 Cook Islands

1502 Fiji

1503 French Polynesia

1504 Niue

1505 Samoa

1506 Samoa, American

1507 Tokelau

1508 Tonga

1511 Tuvalu

1512 Wallis and Futuna

1513 Pitcairn Islands

1599 Polynesia (excludes Hawaii), nec

1601 Adelie Land (France)

1602 Argentinian Antarctic Territory

1603 Australian Antarctic Territory

1604 British Antarctic Territory

1605 Chilean Antarctic Territory

1606 Queen Maud Land (Norway)

1607 Ross Dependency (New Zealand)

2102 England

2103 Isle of Man

2104 Northern Ireland

2105 Scotland

2106 Wales

2107 Guernsey

2108 Jersey

2201 Ireland

2301 Austria

2302 Belgium

2303 France

2304 Germany

2305 Liechtenstein

2306 Luxembourg

2307 Monaco

2308 Netherlands

2311 Switzerland

2401 Denmark

2402 Faroe Islands

2403 Finland

2404 Greenland

2405 Iceland

2406 Norway

2407 Sweden

2408 Aland Islands

3101 Andorra

3102 Gibraltar

3103 Holy See

3104 Italy

3105 Malta

3106 Portugal

3107 San Marino

3108 Spain

3201 Albania

3202 Bosnia and Herzegovina

3203 Bulgaria

3204 Croatia

3205 Cyprus

3206 The former Yugoslav Republic of Macedonia

3207 Greece

3208 Moldova

3211 Romania

3212 Slovenia

3214 Montenegro

3215 Serbia

3216 Kosovo

3301 Belarus

3302 Czech Republic

3303 Estonia

3304 Hungary

3305 Latvia

3306 Lithuania

3307 Poland

3308 Russian Federation

3311 Slovakia

3312 Ukraine

4101 Algeria

4102 Egypt

4103 Libya

4104 Morocco

4105 Sudan

4106 Tunisia

4107 Western Sahara

4108 Spanish North Africa

4111 South Sudan

4201 Bahrain

4202 Gaza Strip and West Bank

4203 Iran

4204 Iraq

4205 Israel

4206 Jordan

4207 Kuwait

4208 Lebanon

4211 Oman

4212 Qatar

4213 Saudi Arabia

4214 Syria

4215 Turkey

4216 United Arab Emirates

4217 Yemen

5101 Myanmar

5102 Cambodia

5103 Laos

5104 Thailand

5105 Vietnam

5201 Brunei Darussalam

5202 Indonesia

5203 Malaysia

5204 Philippines

5205 Singapore

5206 Timor-Leste

6101 China (excludes SARs and Taiwan)

6102 Hong Kong (SAR of China)

6103 Macau (SAR of China)

6104 Mongolia

6105 Taiwan

6201 Japan

6202 Korea, Democratic People's Republic of (North)

6203 Korea, Republic of (South)

7101 Bangladesh

7102 Bhutan

7103 India

7104 Maldives

7105 Nepal

7106 Pakistan

7107 Sri Lanka

7201 Afghanistan

7202 Armenia

7203 Azerbaijan

7204 Georgia

7205 Kazakhstan

7206 Kyrgyzstan

7207 Tajikistan

7208 Turkmenistan

7211 Uzbekistan

8101 Bermuda

8102 Canada

8103 St Pierre and Miquelon

8104 United States of America

8201 Argentina

8202 Bolivia

8203 Brazil

8204 Chile

8205 Colombia

8206 Ecuador

8207 Falkland Islands

8208 French Guiana

8211 Guyana

8212 Paraguay

8213 Peru

8214 Suriname

8215 Uruguay

8216 Venezuela

8299 South America, nec

8301 Belize

8302 Costa Rica

8303 El Salvador

8304 Guatemala

8305 Honduras

8306 Mexico

8307 Nicaragua

8308 Panama

8401 Anguilla

8402 Antigua and Barbuda

8403 Aruba

8404 Bahamas

8405 Barbados

8406 Cayman Islands

8407 Cuba

8408 Dominica

8411 Dominican Republic

8412 Grenada

8413 Guadeloupe

8414 Haiti

8415 Jamaica

8416 Martinique

8417 Montserrat

8421 Puerto Rico

8422 St Kitts and Nevis

8423 St Lucia

8424 St Vincent and the Grenadines

8425 Trinidad and Tobago

8426 Turks and Caicos Islands

8427 Virgin Islands, British

8428 Virgin Islands, United States

8431 St Barthelemy

8432 St Martin (French part)

8433 Bonaire, Sint Eustatius and Saba

8434 Curacao

8435 Sint Maarten (Dutch part)

9101 Benin

9102 Burkina Faso

9103 Cameroon

9104 Cabo Verde

9105 Central African Republic

9106 Chad

9107 Congo, Republic of

9108 Congo, Democratic Republic of

9111 Cote d'Ivoire

9112 Equatorial Guinea

9113 Gabon

9114 Gambia

9115 Ghana

9116 Guinea

9117 Guinea-Bissau

9118 Liberia

9121 Mali

9122 Mauritania

9123 Niger

9124 Nigeria

9125 Sao Tome and Principe

9126 Senegal

9127 Sierra Leone

9128 Togo

9201 Angola

9202 Botswana

9203 Burundi

9204 Comoros

9205 Djibouti

9206 Eritrea

9207 Ethiopia

9208 Kenya

9211 Lesotho

9212 Madagascar

9213 Malawi

9214 Mauritius

9215 Mayotte

9216 Mozambique

9217 Namibia

9218 Reunion

9221 Rwanda

9222 St Helena

9223 Seychelles

9224 Somalia

9225 South Africa

9226 Swaziland

9227 Tanzania

9228 Uganda

9231 Zambia

9232 Zimbabwe

9299 Southern and East Africa, nec

9999 Unknown

Notes Standard Australian Classification of Countries (SACC), 2016 4-digit code (ABS Catalogue No. 1269.0) SACC 2016 is a four-digit, three-level hierarchical structure specifying major group, minor group and country. 9999 is used when the information is not known or the client has refused to provide the information.

Organisations are encouraged to produce customised lists of the most common languages in use by their local populations from the above resource. Please refer to Country of Birth for help on designing forms.

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ABS http://www.abs.gov.au/ausstats/abs@.nsf/mf/1269.0

4.4.4. Client - Date of Birth

The date on which an individual was born.

Field name date_of_birth

Data type date

Required yes

Notes

- The date of birth must not be before January 1st 1900.
- The date of birth must not be in the future.
- If the date of birth is unknown, the following approaches should be used:
  - If the age of the person is known, the age should be used to derive the year of birth
  - If the age of the person is unknown, an estimated age of the person should be used to estimate a year of birth
  - An actual or estimated year of birth should then be converted into an estimated date of birth using the following convention: 0101Estimated year of birth.
  - If the date of birth is totally unknown, use 09099999.
  - If you have estimated the year of birth make sure you record this in the 'Estimated date of birth flag'

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4.4.5. Client - Estimated Date of Birth Flag

The date of birth estimate flag records whether or not the client's date of birth has been estimated.

Field name est_date_of_birth

Data type string

Required yes

Domain **1** Date of birth is accurate

2 Date of birth is an estimate

8 Date of birth is a ‘dummy’ date (ie, 09099999)

9 Accuracy of stated date of birth is not known

4.4.6. Client - Gender

The term ‘gender’ refers to the way in which a person identifies their masculine or feminine characteristics. A persons gender relates to their deeply held internal and individual sense of gender and is not always exclusively male or female. It may or may not correspond to their sex assigned at birth.

Field name client_gender

Data type string

Required yes

Domain **0** Not stated/Inadequately described

1 Male

2 Female

3 Other

Notes **1 - M - Male** Adults who identify themselves as men, and children who identify themselves as boys.

2 - F - Female Adults who identify themselves as women, and children who identify themselves as girls.

3 - X- Other Adults and children who identify as non-binary, gender diverse, or with descriptors other than man/boy or woman/girl.

ABS http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/1200.0.55.012Main%20Features12016?opendocument&tabname=Summary&prodno=1200.0.55.012&issue=2016&num

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4.4.7. Client Key

This is a number or code assigned to each individual client referred to the commissioned organisation. The client identifier must be unique and stable for each individual within the Provider Organisation. Assigned by either the PHN or Provider Organisation depending on local procedures.

Field name client_key

Data type string (2,50)

Required yes

Notes Client keys must be unique within each Provider Organisation. The Client Key will be managed by the Provider Organisation, however, the PHN may decide to play a role in coordinating assignment and management of these client keys. Clients should not be assigned multiple keys within the same Provider Organisation.

Client keys are case sensitive and must be valid unicode characters.

See Managing Client Keys

4.4.8. Client - Main Language Spoken at Home

The language reported by a client as the main language other than English spoken by that client in his/her home (or most recent private residential setting occupied by the client) to communicate with other residents of the home or setting and regular visitors, as represented by a code.

Field name main_lang_at_home

Data type string (4)

Required yes

Domain

1101 Gaelic (Scotland)

1102 Irish

1103 Welsh

1199 Celtic, nec

1201 English

1301 German

1302 Letzeburgish

1303 Yiddish

1401 Dutch

1402 Frisian

1403 Afrikaans

1501 Danish

1502 Icelandic

1503 Norwegian

1504 Swedish

1599 Scandinavian, nec

1601 Estonian

1602 Finnish

1699 Finnish and Related Languages, nec

2101 French

2201 Greek

2301 Catalan

2302 Portuguese

2303 Spanish

2399 Iberian Romance, nec

2401 Italian

2501 Maltese

2901 Basque

2902 Latin

2999 Other Southern European Languages, nec

3101 Latvian

3102 Lithuanian

3301 Hungarian

3401 Belorussian

3402 Russian

3403 Ukrainian

3501 Bosnian

3502 Bulgarian

3503 Croatian

3504 Macedonian

3505 Serbian

3506 Slovene

3507 Serbo-Croatian/Yugoslavian, so described

3601 Czech

3602 Polish

3603 Slovak

3604 Czechoslovakian, so described

3901 Albanian

3903 Aromunian (Macedo-Romanian)

3904 Romanian

3905 Romany

3999 Other Eastern European Languages, nec

4101 Kurdish

4102 Pashto

4104 Balochi

4105 Dari

4106 Persian (excluding Dari)

4107 Hazaraghi

4199 Iranic, nec

4202 Arabic

4204 Hebrew

4206 Assyrian Neo-Aramaic

4207 Chaldean Neo-Aramaic

4208 Mandaean (Mandaic)

4299 Middle Eastern Semitic Languages, nec

4301 Turkish

4302 Azeri

4303 Tatar

4304 Turkmen

4305 Uygur

4306 Uzbek

4399 Turkic, nec

4901 Armenian

4902 Georgian

4999 Other Southwest and Central Asian Languages, nec

5101 Kannada

5102 Malayalam

5103 Tamil

5104 Telugu

5105 Tulu

5199 Dravidian, nec

5201 Bengali

5202 Gujarati

5203 Hindi

5204 Konkani

5205 Marathi

5206 Nepali

5207 Punjabi

5208 Sindhi

5211 Sinhalese

5212 Urdu

5213 Assamese

5214 Dhivehi

5215 Kashmiri

5216 Oriya

5217 Fijian Hindustani

5299 Indo-Aryan, nec

5999 Other Southern Asian Languages

6101 Burmese

6102 Chin Haka

6103 Karen

6104 Rohingya

6105 Zomi

6199 Burmese and Related Languages, nec

6201 Hmong

6299 Hmong-Mien, nec

6301 Khmer

6302 Vietnamese

6303 Mon

6399 Mon-Khmer, nec

6401 Lao

6402 Thai

6499 Tai, nec

6501 Bisaya

6502 Cebuano

6503 Ilokano

6504 Indonesian

6505 Malay

6507 Tetum

6508 Timorese

6511 Tagalog

6512 Filipino

6513 Acehnese

6514 Balinese

6515 Bikol

6516 Iban

6517 Ilonggo (Hiligaynon)

6518 Javanese

6521 Pampangan

6599 Southeast Asian Austronesian Languages, nec

6999 Other Southeast Asian Languages

7101 Cantonese

7102 Hakka

7104 Mandarin

7106 Wu

7107 Min Nan

7199 Chinese, nec

7201 Japanese

7301 Korean

7901 Tibetan

7902 Mongolian

7999 Other Eastern Asian Languages, nec

8101 Anindilyakwa

8111 Maung

8113 Ngan’gikurunggurr

8114 Nunggubuyu

8115 Rembarrnga

8117 Tiwi

8121 Alawa

8122 Dalabon

8123 Gudanji

8127 Iwaidja

8128 Jaminjung

8131 Jawoyn

8132 Jingulu

8133 Kunbarlang

8136 Larrakiya

8137 Malak Malak

8138 Mangarrayi

8141 Maringarr

8142 Marra

8143 Marrithiyel

8144 Matngala

8146 Murrinh Patha

8147 Na-kara

8148 Ndjebbana (Gunavidji)

8151 Ngalakgan

8152 Ngaliwurru

8153 Nungali

8154 Wambaya

8155 Wardaman

8156 Amurdak

8157 Garrwa

8158 Kuwema

8161 Marramaninyshi

8162 Ngandi

8163 Waanyi

8164 Wagiman

8165 Yanyuwa

8166 Marridan (Maridan)

8171 Gundjeihmi

8172 Kune

8173 Kuninjku

8174 Kunwinjku

8175 Mayali

8179 Kunwinjkuan, nec

8181 Burarra

8182 Gun-nartpa

8183 Gurr-goni

8189 Burarran, nec

8199 Arnhem Land and Daly River Region Languages, nec

8211 Galpu

8212 Golumala

8213 Wangurri

8219 Dhangu, nec

8221 Dhalwangu

8222 Djarrwark

8229 Dhay'yi, nec

8231 Djambarrpuyngu

8232 Djapu

8233 Daatiwuy

8234 Marrangu

8235 Liyagalawumirr

8236 Liyagawumirr

8239 Dhuwal, nec

8242 Gumatj

8243 Gupapuyngu

8244 Guyamirrililil

8246 Manggalili

8247 Wubulkarra

8249 Dhuwala, nec

8251 Wurlaki

8259 Djinang, nec

8261 Ganalbingu

8262 Djinba

8263 Manyjalpingu

8269 Djinba, nec

8271 Ritharrngu

8272 Wagilak

8279 Yakuy, nec

8281 Nhangu

8282 Yan-nhangu

8289 Nhangu, nec

8291 Dhuwaya

8292 Djangu

8293 Madarrpa

8294 Warramiri

8295 Rirratjingu

8299 Other Yolngu Matha, nec

8301 Kuku Yalanji

8302 Guugu Yimidhirr

8303 Kuuku-Ya'u

8304 Wik Mungkan

8305 Djabugay

8306 Dyirbal

8307 Girramay

8308 Koko-Bera

8311 Kuuk Thayorre

8312 Lamalama

8313 Yidiny

8314 Wik Ngathan

8315 Alngith

8316 Kugu Muminh

8317 Morrobalama

8318 Thaynakwith

8321 Yupangathi

8322 Tjungundji

8399 Cape York Peninsula Languages, nec

8401 Kalaw Kawaw Ya/Kalaw Lagaw Ya

8402 Meriam Mir

8403 Yumplatok (Torres Strait Creole)

8504 Bilinarra

8505 Gurindji

8506 Gurindji Kriol

8507 Jaru

8508 Light Warlpiri

8511 Malngin

8512 Mudburra

8514 Ngardi

8515 Ngarinyman

8516 Walmajarri

8517 Wanyjirra

8518 Warlmanpa

8521 Warlpiri

8522 Warumungu

8599 Northern Desert Fringe Area Languages, nec

8603 Alyawarr

8606 Kaytetye

8607 Antekerrepenh

8611 Central Anmatyerr

8612 Eastern Anmatyerr

8619 Anmatyerr, nec

8621 Eastern Arrernte

8622 Western Arrarnta

8629 Arrernte, nec

8699 Arandic, nec

8703 Antikarinya

8704 Kartujarra

8705 Kukatha

8706 Kukatja

8707 Luritja

8708 Manyjilyjarra

8711 Martu Wangka

8712 Ngaanyatjarra

8713 Pintupi

8714 Pitjantjatjara

8715 Wangkajunga

8716 Wangkatha

8717 Warnman

8718 Yankunytjatjara

8721 Yulparija

8722 Tjupany

8799 Western Desert Languages, nec

8801 Bardi

8802 Bunuba

8803 Gooniyandi

8804 Miriwoong

8805 Ngarinyin

8806 Nyikina

8807 Worla

8808 Worrorra

8811 Wunambal

8812 Yawuru

8813 Gambera

8814 Jawi

8815 Kija

8899 Kimberley Area Languages, nec

8901 Adnymathanha

8902 Arabana

8903 Bandjalang

8904 Banyjima

8905 Batjala

8906 Bidjara

8907 Dhanggatti

8908 Diyari

8911 Gamilaraay

8913 Garuwali

8914 Githabul

8915 Gumbaynggir

8916 Kanai

8917 Karajarri

8918 Kariyarra

8921 Kaurna

8922 Kayardild

8924 Kriol

8925 Lardil

8926 Mangala

8927 Muruwari

8928 Narungga

8931 Ngarluma

8932 Ngarrindjeri

8933 Nyamal

8934 Nyangumarta

8935 Nyungar

8936 Paakantyi

8937 Palyku/Nyiyaparli

8938 Wajarri

8941 Wiradjuri

8943 Yindjibarndi

8944 Yinhawangka

8945 Yorta Yorta

8946 Baanbay

8947 Badimaya

8948 Barababaraba

8951 Dadi Dadi

8952 Dharawal

8953 Djabwurrung

8954 Gudjal

8955 Keerray-Woorroong

8956 Ladji Ladji

8957 Mirning

8958 Ngatjumaya

8961 Waluwarra

8962 Wangkangurru

8963 Wargamay

8964 Wergaia

8965 Yugambeh

8998 Aboriginal English, so described

8999 Other Australian Indigenous Languages, nec

9101 American Languages

9201 Acholi

9203 Akan

9205 Mauritian Creole

9206 Oromo

9207 Shona

9208 Somali

9211 Swahili

9212 Yoruba

9213 Zulu

9214 Amharic

9215 Bemba

9216 Dinka

9217 Ewe

9218 Ga

9221 Harari

9222 Hausa

9223 Igbo

9224 Kikuyu

9225 Krio

9226 Luganda

9227 Luo

9228 Ndebele

9231 Nuer

9232 Nyanja (Chichewa)

9233 Shilluk

9234 Tigre

9235 Tigrinya

9236 Tswana

9237 Xhosa

9238 Seychelles Creole

9241 Anuak

9242 Bari

9243 Bassa

9244 Dan (Gio-Dan)

9245 Fulfulde

9246 Kinyarwanda (Rwanda)

9247 Kirundi (Rundi)

9248 Kpelle

9251 Krahn

9252 Liberian (Liberian English)

9253 Loma (Lorma)

9254 Lumun (Kuku Lumun)

9255 Madi

9256 Mandinka

9257 Mann

9258 Moro (Nuba Moro)

9261 Themne

9262 Lingala

9299 African Languages, nec

9301 Fijian

9302 Gilbertese

9303 Maori (Cook Island)

9304 Maori (New Zealand)

9306 Nauruan

9307 Niue

9308 Samoan

9311 Tongan

9312 Rotuman

9313 Tokelauan

9314 Tuvaluan

9315 Yapese

9399 Pacific Austronesian Languages, nec

9402 Bislama

9403 Hawaiian English

9404 Norf'k-Pitcairn

9405 Solomon Islands Pijin

9499 Oceanian Pidgins and Creoles, nec

9502 Kiwai

9503 Motu (HiriMotu)

9504 Tok Pisin (Neomelanesian)

9599 Papua New Guinea Languages, nec

9601 Invented Languages

9701 Auslan

9702 Key Word Sign Australia

9799 Sign Languages, nec

9999 Unknown

Notes Australian Standard Classification of Languages (ASCL), 2016 4-digit code (ABS Catalogue No. 1267.0) or 9999 if info is not known or client refuses to supply.

The ABS recommends the following question in order to collect this data: Which language does the client mainly speak at home? (If more than one language, indicate the one that is spoken most often.)

Organisations are encouraged to produce customised lists of the most common countries based on their local populations from the above resource. Please refer to Main Language Spoken at Home for help on designing forms.

METeOR 460125

ABS http://www.abs.gov.au/ausstats/abs@.nsf/mf/1267.0

4.4.9. Client - Proficiency in Spoken English

The self-assessed level of ability to speak English, asked of people whose first language is a language other than English or who speak a language other than English at home.

Field name prof_english

Data type string

Required yes

Domain

0 Not applicable (persons under 5 years of age or who speak only English)

1 Very well

2 Well

3 Not well

4 Not at all

9 Not stated/inadequately described

Notes **0 - Not applicable (persons under 5 years of age or who speak only English)** Not applicable, is to be used for people under 5 years of age and people who speak only English.

9 - Not stated/inadequately described Not stated/inadequately described, is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

METeOR 270203

4.4.10. Client - Statistical Linkage Key

A key that enables two or more records belonging to the same individual to be brought together.

Field name slk

Data type string (14,40)

Required yes

Notes System generated non-identifiable alphanumeric code derived from information held by the PMHC organisation.

Supported formats: 14 character SLK

- a Crockford encoded sha1 hash of a 14 character SLK. This must be 32 characters in length.
- a hex encoded sha1 hash of a 14 character SLK. This must be 40 characters in length.

SLK values are stored in sha1_hex format.

METeOR 349510

4.4.11. Client - Tags

List of tags for the client.

Field name client_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.12. Collection Occasion - Date

The date of the collection occasion.

Field name collection_occasion_date

Data type date

Required yes

Notes For Date fields, data must be recorded in compliance with the standard format used across the National Health Data Dictionary; specifically, dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2008 would appear as 13032008.

If the date the activity was performed is unknown, 09099999 should be used.

- For an intake collection occasion, the collection date must not be before 1st January 2020, otherwise, the collection date must not be before 1st January 2016.
- The collection date must not be in the future.

4.4.13. Collection Occasion - Reason

The reason for the collection of the service activities on the identified Collection Occasion.

Field name reason_for_collection

Data type string

Required yes

Domain

1	Episode start
2	Review
3	Episode end

Notes **1 - Episode start** Refers to an outcome measure undertaken at the beginning of an Episode of Care. For the purposes of the PMHC MDS protocol, episodes may start at the point of first Service Contact with a new client who has not been seen previously by the organisation, or a first contact for a new Episode of Care for a client who has received services from the organisation in a previous Episode of Care that has been completed.

2 - **Review**Refers to an outcome measure undertaken during the course of an Episode of Care that post-dates Episode Start and pre-dates Episode End. An outcome measure may be undertaken at Review for a number of reasons including:

- in response to critical clinical events or changes in the client's mental health status;
- following a client-requested review; or
- other situations where a review may be indicated.

3 - **Episode end**Refers to the outcome measures collected at the end of an Episode of Care.

4.4.14. Collection Occasion - Tags

List of tags for the collection occasion.

Field namecollection_occasion_tags

Data typestring

Requiredno

NotesA comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.15. Collection Occasion Key

This is a number or code assigned to each collection occasion of service activities. The Collection Occasion Key is unique and stable for each collection occasion at the level of the organisation.

Field namecollection_occasion_key

Data typestring (2,50)

Requiredyes

NotesCollection Occasion Keys must be generated by the organisation to be unique at the Provider Organisation level and must persist across time. See Identifier Management

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4.4.16. Episode - Additional Diagnosis

The main additional condition or complaint co-existing with the Principal Diagnosis or arising during the episode of care.

Field name additional_diagnosis

Data type string

Required yes

Domain

000 No additional diagnosis

100 Anxiety disorders (ATAPS)

101 Panic disorder

102 Agoraphobia

103 Social phobia

104 Generalised anxiety disorder

105 Obsessive-compulsive disorder

106 Post-traumatic stress disorder

107 Acute stress disorder

108 Other anxiety disorder

200 Affective (Mood) disorders (ATAPS)

201 Major depressive disorder

202 Dysthymia

203 Depressive disorder NOS

204 Bipolar disorder

205 Cyclothymic disorder

206 Other affective disorder

300 Substance use disorders (ATAPS)

301 Alcohol harmful use

302 Alcohol dependence

303 Other drug harmful use

304 Other drug dependence

305 Other substance use disorder

400 Psychotic disorders (ATAPS)

401 Schizophrenia

402 Schizoaffective disorder

403 Brief psychotic disorder

404 Other psychotic disorder

501 Separation anxiety disorder

502 Attention deficit hyperactivity disorder (ADHD)

503 Conduct disorder

504 Oppositional defiant disorder

505 Pervasive developmental disorder

506 Other disorder of childhood and adolescence

601 Adjustment disorder

602 Eating disorder

603 Somatoform disorder

604 Personality disorder

605 Other mental disorder

901 Anxiety symptoms

902 Depressive symptoms

903 Mixed anxiety and depressive symptoms

904 Stress related

905 Other

999 Missing

Notes Additional Diagnosis gives information on conditions that are significant in terms of treatment required and resources used during the episode of care. Additional diagnoses should be interpreted as conditions that affect client management in terms of requiring any of the following:

- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures

- Increased clinical care and/or monitoring

Where the client one or more comorbid mental health conditions in addition to the condition coded as the Principal Diagnosis, record the main condition as the Additional Diagnosis.

The following responses have been added to allow mapping of ATAPS data to PMHC format.

- 100: Anxiety disorders (ATAPS)
- 200: Affective (Mood) disorders (ATAPS)
- 300: Substance use disorders (ATAPS)
- 400: Psychotic disorders (ATAPS)

Note: These four codes should only be used for Episodes that are migrated from ATAPS MDS sources that cannot be described by any other Diagnosis. It is expected that the majority of Episodes delivered to clients from 1st July, 2017 can be assigned to other diagnoses.

These responses will only be allowed on episodes where the original ATAPS referral date was before 1 July 2017

These responses will only be allowed on episodes with the !ATAPS flag.

For further notes on the recording of diagnosis codes see Principal Diagnosis.

4.4.17. Episode - Area of usual residence, postcode

The Australian postcode of the client.

Field name client_postcode

Data type string

Required yes

Notes A valid Australian postcode or 9999 if the postcode is unknown or the client has not provided sufficient information to confirm their current residential address.

The full list of Australian Postcodes can be found at Australia Post.

When collecting the postcode of a person's usual place of residence, the ABS recommends that 'usual' be defined as: 'the place where the person has or intends to live for 6 months or more, or the place that the person regards as their main residence, or where the person has no other residence, the place they currently reside.'

Postcodes are deemed valid if they are in the range 0200-0299, 0800-9999.

METeOR 429894

4.4.18. Episode - Completion Status

An indication of the completion status of an *Episode of Care*.

Field name episode_completion_status

Data type string

Required no

Domain

0 Episode open

1 Episode closed - treatment concluded

2 Episode closed administratively - client could not be contacted

3 Episode closed administratively - client declined further contact

4 Episode closed administratively - client moved out of area

5 Episode closed administratively - client referred elsewhere

6 Episode closed administratively - other reason

Notes

In order to use code 1 (Episode closed - treatment concluded) the client must have at least one service contact. All other codes may be applicable even when the client has no service contacts.

0 or Blank - Episode open The client still requires treatment and further service contacts are required.

1 - Episode closed - treatment concluded No further service contacts are planned as the client no longer requires treatment.

2 - Episode closed administratively - client could not be contacted Further service contacts were planned but the client could no longer be contacted.

3 - Episode closed administratively - client declined further contact Further service contacts were planned but the client declined further treatment.

4 - Episode closed administratively - client moved out of area Further service contacts were planned but the client moved out of the area without a referral elsewhere. Where a client was referred somewhere else *Episode Completion Status* should be recorded as code 5 (Episode closed administratively - client referred elsewhere).

5 - Episode closed administratively - client referred elsewhere Where a client still requires treatment, but a different service has been deemed appropriate or a client has moved out of the area so has moved to a different provider.

6 - Episode closed administratively - other reason Where a client is no longer being given treatment but the reason for conclusion is not covered above.

Episode Completion Status interacts with two other data items in the PMHC MDS - *Service Contact - Final*, and *Episode End Date*.

Service Contact - Final Collection of data for *Service Contacts* includes a *Service Contact - Final* item that requires the service provider to indicate whether further Service Contacts are planned. Where this item is recorded as 'no further services planned', the *Episode Completion Status* should be recorded as code 1 (Episode closed - treatment concluded) code 3 (Episode closed administratively - client declined further contact), code 4 (Episode closed administratively - client moved out of area), or code 5 (Episode closed administratively - client referred elsewhere). Selection of coding option should be that which best describes the circumstances of the episode ending.

Episode End Date Where a Final Service Contact is recorded *Episode End Date* should be recorded as the date of the final Service Contact.

4.4.19. Episode - Continuity of Support

Is the client a Continuity of Support Client?

Field name continuity_of_support

Data type string

Required yes

Domain

1 Yes

2 No

9 Not stated/inadequately described

Notes *Introduced 1 July 2019*

Similar challenges to Psychosocial Support are faced with the Continuity of Support initiative. The important issues here are:

- The proposed changes to be made for the Psychosocial Support measure should accommodate most requirements for Continuity of Support clients.
- The one important difference is that CoS clients are a highly specific cohort – those currently in Commonwealth funded PIR, PHaMS and D2DL measures found to be ineligible for the NDIS. These clients should be readily identified.
- CoS clients need to have a marker in the PMHC MDS data that allows the cohort to be identified for separate reporting.

1 - Yes The person was a client of the Personal Helpers and Mentors (PHaMs), Partners In recovery (PIR) and/or Day to Day Living (D2DL) programs and has been found to be ineligible for the National Disability Insurance Scheme (NDIS).

2 - No

9 - Not stated/inadequately described

It is expected that most **new clients** recorded as CoS clients will have their episodes classified as Psychosocial Support.

For existing clients who have an active (not closed) episode of care who become CoS clients after 1 July 2019, there is no need to close the current episode. PHNs may however wish to change the Principal Focus of Treatment Plan to Psychosocial Support if this better reflects the overall episode goals. Alternatively, PHNs may choose to close the existing episode and commence a new episode. This decision can be made locally.

Services delivered under the new CoS arrangements should be coded as Psychosocial Support in the Service Contact Type field. This is not intended to restrict CoS clients to only Psychosocial Support services. Contact Types delivered to CoS clients can vary across the full range (e.g., they could receive psychological therapy-type service contacts). However, where services are delivered under the CoS arrangements it is essential that they be coded as Psychosocial Support contacts to enable monitoring and reporting of the new CoS measure.

As the new measure does not commence until 1 July 2019, all clients in active episodes prior to that date should be coded as 'No'. This will be implemented by Strategic Data in the PMHC MDS as a system-wide change for all existing clients in active episodes as at 30 June 2019. Changes made to those existing clients from 1 July 2019 can then be made locally.

4.4.20. Episode - Employment Participation

Whether a person in paid employment is employed full-time or part-time, as represented by a code.

Field name employment_participation

Data type string

Required yes

Domain

1 Full-time

2 Part-time

3 Not applicable - not in the labour force

9 Not stated/inadequately described

Notes Applies only to people whose labour force status is employed. (See metadata item Labour Force Status, for a definition of 'employed'). Paid employment includes persons who performed some work for wages or salary, in cash or in kind, and persons temporarily absent from a paid employment job but who retained a formal attachment to that job.

1 - Full-time Employed persons are working full-time if they: (a) usually work 35 hours or more in a week (in all paid jobs) or (b) although usually working less than 35 hours a week, actually worked 35 hours or more during the reference period.

2 - Part-time Employed persons are working part-time if they usually work less than 35 hours a week (in all paid jobs) and either did so during the reference period, or were not at work in the reference period.

9 - Not stated / inadequately described Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

METeOR 269950

4.4.21. Episode - End Date

The date on which an *Episode of Care* is formally or administratively ended

Field name episode_end_date

Data type date

Required no

Notes

- The episode end date must not be before 1st January 2016.
- The episode end date must not be in the future.

An *Episode of Care* may be ended in one of two ways:

- clinically, consequent upon conclusion of treatment for the client and discharge from care; or
- administratively (statistically), where contact with the client has been lost by the organisation prior to completion of treatment or other factors prevented treatment being completed.

Episode End Date interacts with two other data items in the PMHC MDS - *Service Contact - Final*, and *Episode Completion Status*.

Service Contact - Final Collection of data for *Service Contacts* includes a *Service Contact - Final* item that requires the service provider to indicate whether further *Service Contacts* are planned. Where this item is recorded as 'no further services planned', the date of the final *Service Contact* should be recorded as the *Episode End Date*.

Episode Completion Status This field should be recorded as 'Episode closed treatment concluded' when a *Service Contact - Final* is recorded. The *Episode Completion Status* field can also be manually recorded to allow for administrative closure of episodes (e.g., contact has been lost with a client over a prolonged period - see *Episode Completion Status* for additional guidance). Where an episode is closed administratively, the *Episode End Date* should be recorded as the date on which the organisation made the decision to close episode.

METeOR 614094

4.4.22. Episode - GP Mental Health Treatment Plan Flag

An indication of whether a client has a GP mental health treatment plan. A GP should be involved in a referral where appropriate however a mental health treatment plan is not mandatory.

Field name mental_health_treatment_plan

Data type string

Required yes

Domain

1 Yes

2 No

3 Unknown

9 Not stated/inadequately described

4.4.23. Episode - Health Care Card

An indication of whether the person is a current holder of a Health Care Card that entitles them to arrange of concessions for Government funded health services.

Field name health_care_card

Data type string

Required yes

Domain

1 Yes

2 No

3 Not Known

9 Not stated

Notes Details on the Australian Government Health Care Card are available at: https://www.humanservices.gov.au/customer/services/centrelink/health-care-card

METeOR 605149

4.4.24. Episode - Homelessness Flag

An indication of whether the client has been homeless in the 4 weeks prior to the current service episode.

Field name homelessness

Data type string

Required yes

Domain

1 Sleeping rough or in non-conventional accommodation

2 Short-term or emergency accommodation

3 Not homeless

9 Not stated / Missing

Notes

1 - Sleeping rough or in non-conventional accommodation Includes sleeping on the streets, in a park, in cars or railway carriages, under bridges or other similar 'rough' accommodation

2 - Short-term or emergency accommodation Includes sleeping in short-term accommodation, emergency accommodation, due to a lack of other options. This may include refuges; crisis shelters; couch surfing; living temporarily with friends and relatives; insecure accommodation on a short term basis; emergency accommodation arranged in hotels, motels etc by a specialist homelessness agency.

3 - Not homeless Includes sleeping in own accommodation/rental accommodation or living with friends or relatives on a stable, long term basis

9 - Not stated / Missing Not stated / Missing

Select the code that best fits the client's sleeping arrangements over the preceding 4 weeks. Where multiple options apply (e.g., client has experienced more than one of the sleeping arrangements over the previous 4 weeks) the following coding hierarchy should be followed:

- If code 1 applied at any time over the 4 week period, code 1
- If code 2 but not code 1 applied at any time over the 4 week period, code 2
- Otherwise Code 3 applies

4.4.25. Episode Key

This is a number or code assigned to each PMHC MDS episode. The Episode Key is unique and stable for each episode at the level of the organisation. This key must link to an existing episode within the PMHC MDS.

Field name episode_key

Data type string (2,50)

Required yes

Notes Episode Keys must be generated by the organisation to be unique at the Provider Organisation level and must persist across time. Creation of episode keys in this way allows clients to be merged (where duplicate Client Keys have been identified) without having to re-allocate episode identifiers since they can never clash. See Managing Episode Keys

Episode Keys are case sensitive and must be valid unicode characters.

A recommended approach for the creation of Episode Keys is to compute random UUIDs.

4.4.26. Episode - Labour Force Status

The self-reported status the person currently has in being either in the labour force (employed/unemployed) or not in the labour force, as represented by a code.

Field name labour_force_status

Data type string

Required yes

Domain

1 Employed

2 Unemployed

3 Not in the Labour Force

9 Not stated/inadequately described

Notes **1 - Employed** Employed persons are those aged 15 years and over who met one of the following criteria during the reference week:

- Worked for one hour or more for pay, profit, commission or payment in kind, in a job or business or son a farm (employees and owner managers of incorporated or unincorporated enterprises).
- Worked for one hour or more without pay in a family business or on a farm (contributing family workers).
- Were employees who had a job but were not at work and were:

    - away from work for less than four weeks up to the end of the reference week; or
    - away from work for more than four weeks up to the end of the reference week and
    - received pay for some or all of the four week period to the end of the reference week; or
    - away from work as a standard work or shift arrangement; or
    - on strike or locked out; or
    - on workers' compensation and expected to return to their job.
- Were owner managers who had a job, business or farm, but were not at work.

2 - Unemployed Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:

- had actively looked for full time or part time work at any time in the four weeks up to the end of the reference week and were available for work in the reference week; or
- were waiting to start a new job within four weeks from the end of the reference week and could have started in the reference week if the job had been available then.

Actively looked for work includes:

- written, telephoned or applied to an employer for work;
- had an interview with an employer for work;
- answered an advertisement for a job;
- checked or registered with a Job Services Australia provider or any other employment agency;
- taken steps to purchase or start your own business;
- advertised or tendered for work; and
- contacted friends or relatives in order to obtain work.

3 - Not in the labour force Persons not in the labour force are those aged 15 years and over who were not in the categories employed or unemployed, as defined, during the reference week.
They include people who undertook unpaid household duties or other voluntary work only, were retired, voluntarily inactive and those permanently unable to work.

9 - Not stated/inadequately described Includes children under 15 (0-14 years)

METeOR621450

4.4.27. Episode - Marital Status

A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.

Field name marital_status

Data type string

Required yes

Domain

1 Never married

2 Widowed

3 Divorced

4 Separated

5 Married (registered and de facto)

6 Not stated/inadequately described

Notes Refers to the current marital status of a person.

- **2 - Widowed** This code usually refers to registered marriages but when self-reported may also refer to de facto marriages.
- **4 - Separated** This code refers to registered marriages but when self-reported may also refer to de facto marriages.
- **5 - Married (registered and de facto)** Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex.
- **6 - Not stated/inadequately described** This code is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

METeOR 291045

4.4.28. Episode - Medication - Antidepressants (N06A)

Whether the client is taking prescribed antidepressants for a mental health condition as assessed at intake assessment, as represented by a code.

Field name medication_antidepressants

Data type string

Required yes

Domain

1 Yes

2 No

9 Unknown

Notes The N06A class of drugs a therapeutic subgroup of the Anatomical Therapeutic Chemical Classification System, a system of alphanumeric codes developed by the World Health Organisation (WHO) for the classification of drugs and other medical products. It covers drugs designed for the depressive disorders.

Details of drugs included in the category can be found here: http://www.whocc.no/atc_ddd_index/?code=N06A

4.4.29. Episode - Medication - Antipsychotics (N05A)

Whether the client is taking prescribed antipsychotics for a mental health condition as assessed at intake assessment, as represented by a code.

Field name medication_antipsychotics

Data type string

Required yes

Domain

1 Yes

2 No

9 Unknown

Notes The N05A class of drugs a therapeutic subgroup of the Anatomical Therapeutic Chemical Classification System, a system of alphanumeric codes developed by the World Health Organisation (WHO) for the classification of drugs and other medical products. It covers drugs designed for the treatment of psychotic disorders.

Details of drugs included in the category can be found here: http://www.whocc.no/atc_ddd_index/?code=N05A

4.4.30. Episode - Medication - Anxiolytics (N05B)

Whether the client is taking prescribed anxiolytics for a mental health condition as assessed at intake assessment, as represented by a code.

Field name medication_anxiolytics

Data type string

Required yes

Domain 1 Yes

2 No

9 Unknown

Notes The N05B class of drugs a therapeutic subgroup of the Anatomical Therapeutic Chemical Classification System, a system of alphanumeric codes developed by the World Health Organisation (WHO) for the classification of drugs and other medical products. It covers drugs designed for the treatment of disorders associated with anxiety and tension.

Details of drugs included in the category can be found here: http://www.whocc.no/atc_ddd_index/?code=N05B

4.4.31. Episode - Medication - Hypnotics and sedatives (N05C)

Whether the client is taking prescribed hypnotics and sedatives for a mental health condition as assessed at intake assessment, as represented by a code.

Field name medication_hypnotics

Data type string

Required yes

Domain 1 Yes

2 No

9 Unknown

Notes The N05C class of drugs a therapeutic subgroup of the Anatomical Therapeutic Chemical Classification System, a system of alphanumeric codes developed by the World Health Organisation (WHO) for the classification of drugs and other medical products. It covers drugs designed to have mainly sedative or hypnotic actions. Hypnotic drugs are used to induce sleep and treat severe insomnia. Sedative drugs are prescribed to reduce excitability or anxiety.

Details of drugs included in the category can be found here: http://www.whocc.no/atc_ddd_index/?code=N05C

4.4.32. Episode - Medication - Psychostimulants and nootropics (N06B)

Whether the client is taking prescribed psychostimulants and nootropics for a mental health condition as assessed at intake assessment, as represented by a code.

Field name medication_psychostimulants

Data type string

Required yes

Domain

1 Yes

2 No

9 Unknown

Notes The N06B class of drugs a therapeutic subgroup of the Anatomical Therapeutic Chemical Classification System, a system of alphanumeric codes developed by the World Health Organisation (WHO) for the classification of drugs and other medical products. It covers drugs designed to attention-deficit hyperactivity disorder (ADHD) and to improve impaired cognitive abilities.

Details of drugs included in the category can be found here: http://www.whocc.no/atc_ddd_index/?code=N06B

4.4.33. Episode - NDIS Participant

Is the client a participant in the National Disability Insurance Scheme?, as represented by a code.

Field name ndis_participant

Data type string

Required yes

Domain

1 Yes

2 No

9 Not stated/inadequately described

4.4.34. Episode Organisation Path

A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing the clinical service to the client.

Field name episode_organisation_path

Data type string

Required yes

Notes A combination of the Primary Health Network's (PHN's) Organisation Key and the Provider Organisation's Organisation Key separated by a colon.

Here is an example organisation structure showing the Organisation Path for each organisation:

Organisation Key	Organisation Name	Organisation Type	Commissioning Organisation	Organisatio
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:P

4.4.35. Episode - Principal Diagnosis

The Principal Diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the client's care during the current Episode of Care.

Field name principal_diagnosis

Data type string

Required yes

Domain
100 Anxiety disorders (ATAPS)
101 Panic disorder
102 Agoraphobia
103 Social phobia
104 Generalised anxiety disorder
105 Obsessive-compulsive disorder
106 Post-traumatic stress disorder
107 Acute stress disorder

108 Other anxiety disorder

200 Affective (Mood) disorders (ATAPS)

201 Major depressive disorder

202 Dysthymia

203 Depressive disorder NOS

204 Bipolar disorder

205 Cyclothymic disorder

206 Other affective disorder

300 Substance use disorders (ATAPS)

301 Alcohol harmful use

302 Alcohol dependence

303 Other drug harmful use

304 Other drug dependence

305 Other substance use disorder

400 Psychotic disorders (ATAPS)

401 Schizophrenia

402 Schizoaffective disorder

403 Brief psychotic disorder

404 Other psychotic disorder

501 Separation anxiety disorder

502 Attention deficit hyperactivity disorder (ADHD)

503 Conduct disorder

504 Oppositional defiant disorder

505 Pervasive developmental disorder

506 Other disorder of childhood and adolescence

601 Adjustment disorder

602 Eating disorder

603 Somatoform disorder

604 Personality disorder

605 Other mental disorder

901 Anxiety symptoms

902 Depressive symptoms

903 Mixed anxiety and depressive symptoms

904 Stress related

905 Other

999 Missing

Notes Diagnoses are grouped into 8 major categories (9 for Additional Diagnosis):

- 000 - No additional diagnosis (Additional Diagnosis only)
- 1xx - Anxiety disorders
- 2xx - Affective (Mood) disorders
- 3xx - Substance use disorders
- 4xx - Psychotic disorders
- 5xx - Disorders with onset usually occurring in childhood and adolescence not listed elsewhere
- 6xx - Other mental disorders
- 9xx except 999 - No formal mental disorder but subsyndromal problems
- 999 - Missing or Unknown

The Principal Diagnosis should be determined by the treating or supervising clinical practitioner who is responsible for providing, or overseeing, services delivered to the client during their current episode of care. Each episode of care must have a Principal Diagnosis recorded and may have an Additional Diagnoses. In some instances the client's Principal Diagnosis may not be clear at initial contact and require a period of contact before a reliable diagnosis can be made. If a client has more than one diagnosis, the Principal Diagnosis should reflect the main presenting problem. Any secondary diagnosis should be recorded under the Additional Diagnosis field.

The coding options developed for the PMHC MDS have been selected to balance comprehensiveness and brevity. They comprise a mix of the most prevalent mental disorders in the Australian adult, child and adolescent population, supplemented by less prevalent conditions that may be experienced by clients of PHN-commissioned mental health services. The diagnosis options are based on an abbreviated set of clinical terms and groupings specified in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV-TR). These code list summarises the approximate 300 unique mental health disorder codes in the full DSM-IV

to a set to 9 major categories, and 37 individual codes. Diagnoses are grouped under higher level categories, based on the DSM-IV. Code numbers have been assigned specifically for the PMHC MDS to create a logical ordering but are capable of being mapped to both DSM-IV and ICD-10 codes.

Options for recording Principal Diagnosis include the broad category 'No formal mental disorder but subsyndromal problems' (codes commencing with 9). These codes should be used for clients who present with problems that do not meet threshold criteria for a formal diagnosis - for example, people experiencing subsyndromal symptoms who may be at risk of progressing to a more severe symptom level.

Each category has a final entry for capturing other conditions that don't meet the more specific entries in the category. This includes the 'No formal mental disorder but subsyndromal problems' category. Code 905 ('Other symptoms') can be used to capture situations where a formal mental disorder has not be diagnosed, but the symptoms do not fall under the more specific 9XX series entries. The 905 code should not be used where there is a formal but unlisted mental disorder. In such a situation code 605 ('Other mental disorder') should be used.

Reference: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Copyright 2000 American Psychiatric Association.

The following responses have been added to allow mapping of ATAPS data to PMHC format.

- 100: Anxiety disorders (ATAPS)
- 200: Affective (Mood) disorders (ATAPS)
- 300: Substance use disorders (ATAPS)
- 400: Psychotic disorders (ATAPS)

Note: These four codes should only be used for Episodes that are migrated from ATAPS MDS sources that cannot be described by any other Diagnosis. It is expected that the majority of Episodes delivered to clients from 1st July, 2017 can be assigned to other diagnoses.

These responses will only be allowed on episodes where the original ATAPS referral date was before 1 July 2017

These responses will only be allowed on episodes with the !ATAPS flag.

4.4.36. Episode - Principal Focus of Treatment Plan

The range of activities that best describes the overall services intended to be delivered to the client throughout the course of the episode. For most clients, this will equate to the activities that account for most time spent by the service provider.

Field name principal_focus

Data type string

Required yes

Domain

1 Psychological therapy

2 Low intensity psychological intervention

3 Clinical care coordination

4 Complex care package

5 Child and youth-specific mental health services

6 Indigenous-specific mental health services

7 Other

8 Psychosocial Support

Notes

Describes the main focus of the services to be delivered to the client for the current Episode of Care, selected from a defined list of categories.

Service providers are required to report on the 'Principal Focus of Treatment Plan' for all accepted referrals. This requires a judgement to be made about the main focus of the services to be delivered to the client for the current Episode of Care, made following initial assessment and modifiable at a later stage. It is chosen from a defined list of categories, with the provider required to select the category that best fits the treatment plan designed for the client.

Principal Focus of Treatment Plan is necessarily a judgement made by the provider at the outset of service delivery but consistent with good practice, should be made on the basis of a treatment plan developed in collaboration with the client. It should not be confused with Service Type which is collected at each Service Contact.

1 - Psychological therapy The treatment plan for the client is primarily based around the delivery of psychological therapy by one or more mental health professionals. This category most closely matches the type of services delivered under the previous ATAPS program where up to 12 individual treatment sessions, and 18 in exceptional circumstances, could be provided. These sessions could be supplemented by up to 10 group-based sessions.

The concept of 'mental health professionals' has a specific meaning defined in the various guidance documentation prepared to support PHNs in implementation of reforms. It refers to service providers who meet the requirements for registration, credentialing or recognition as a qualified mental health professional and includes:

- Psychiatrists
- Registered Psychologists
- Clinical Psychologists
- Mental Health Nurses;
- Occupational Therapists;

- Social Workers
- Aboriginal and Torres Strait Islander health workers.

2 - Low intensity psychological intervention The treatment plan for the client is primarily based around delivery of time-limited, structured psychological interventions that are aimed at providing a less costly intervention alternative to 'standard' psychological therapy. The essence of low intensity interventions is that they utilise nil or relatively little qualified mental health professional time and are targeted at people with, or at risk of, mild mental illness. Low intensity episodes can be delivered through a range of mechanisms including:

- use of individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional;
- delivery of services principally through group-based programs; and
- delivery of brief or low cost forms of treatment by mental health professionals.

3 - Clinical care coordination The treatment plan for the client is primarily based around delivery of a range of services where the overarching aim is to coordinate and better integrate care for the individual across multiple providers with the aim of improving clinical outcomes. Consultation and liaison may occur with primary health care providers, acute health, emergency services, rehabilitation and support services or other agencies that have some level of responsibility for the client's clinical outcomes. These clinical care coordination and liaison activities are expected to account for a significant proportion of service contacts delivered throughout these episodes.

Activities focused on working in partnership and liaison with other health care and service providers and other individuals to coordinate and integrate service delivery to the client with the aim of improving their clinical outcomes. Consultation and liaison may occur with primary health care providers, acute health, emergency services, rehabilitation and support services, family, friends, other support people and carers and other agencies that have some level of responsibility for the client's treatment and/or well-being.

4 - Complex Care Package The treatment plan for the client is primarily based around the delivery of an individually tailored 'package' of services for a client with severe and complex mental illness who is being managed principally within a primary care setting. The overarching requirement is that the client receives an individually tailored 'package' of services that bundles a range of services that extends beyond 'standard' service delivery and which is funded through innovative, non-standard funding models. Note: As outlined in the relevant guidance documentation, only three selected PHN Lead Sites with responsibilities for trialling work in this area are expected to deliver complex care packages. A wider roll-out may be undertaken in the future pending results of the trial.

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

a broader range of both clinical and non-clinical services and may include a significant component of clinical care coordination and liaison. Child and youth-specific mental health episodes have substantial flexibility in types of services actually delivered.

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

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

8 - Psychosocial support Episodes of care should be classified as Psychosocial Support (code 8) where the treatment plan for the client is primarily based around the delivery of psychosocial support services. Psychosocial support services are defined for PMHC MDS purposes as services that focus on building capacity and stability in one or more of the following areas:

- social skills and friendships, family connections;
- managing daily living needs;
- financial management and budgeting;
- finding and maintaining a home;
- vocational skills and goals, including volunteering;
- educational and training goals;
- maintaining physical wellbeing, including exercise;
- building broader life skills including confidence and resilience.

These services are usually delivered by a range of non-clinical providers including peer support workers with lived experience of mental illness

Services delivered to clients receiving episodes of care classified as Psychosocial Support may receive the full range of services as described in the Service Contact Type data item, for example, assessment, care coordination and so forth. However, in general, where the Principal Focus of Treatment Plan is coded as Psychosocial Support there should be an expectation that the majority of services provided will be of a psychosocial support nature. Further details on the relationship between the episode of care concept and service contacts is available at https://docs.pmhc-mds.com/faqs/concepts-processes/data-definitions.html#episode-one-at-a-time

PHNs may wish to advise specific commissioned organisations solely funded from their Psychosocial Support Schedule that all episodes of care should be coded as Psychosocial Support, or leave it to the discretion of service providers.

Clients who are recorded as NDIS recipients would not usually be recorded as receiving a Psychosocial Support episode of care. The National Psychosocial Support guidance material states explicitly that these services are designed for individuals who have significant psychosocial disability but do not meet NDIS eligibility criteria.

Episodes of care delivered to individuals who are recorded as Continuity of Support clients (see below) may be reported as Psychosocial Support.

4.4.37. Episode - Source of Cash Income

The source from which a person derives the greatest proportion of his/her income, as represented by a code.

Field name income_source

Data type string

Required yes

Domain

0 N/A - Client aged less than 16 years

1 Disability Support Pension

2 Other pension or benefit (not superannuation)

3 Paid employment

4 Compensation payments

5 Other (e.g. superannuation, investments etc.)

6 Nil income

7 Not known

9 Not stated/inadequately described

Notes This data standard is not applicable to person's aged less than 16 years.

This item refers to the source by which a person derives most (equal to or greater than 50%) of his/her income. If the person has multiple sources of income and none are equal to or greater than 50%, the one which contributes the largest percentage should be counted.

This item refers to a person's own main source of income, not that of a partner or of other household members. If it is difficult to determine a 'main source of income' over the reporting period (i.e. it may vary over time) please report the main source of income during the reference week.

Code 7 'Not known' should only be recorded when it has not been possible for the service user or their carer/family/advocate to provide the information (i.e. they have been asked but do not know).

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4.4.38. Episode - Suicide Referral Flag

Identifies those individuals where a recent history of suicide attempt, or suicide risk, was a factor noted in the referral that underpinned the person's needs for assistance at entry to the episode, as represented by a code.

Field name suicide_referral_flag

Data type string

Required yes

Domain 1 Yes

2 No

9 Unknown

4.4.39. Episode - Tags

List of tags for the episode.

Field name episode_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.40. IAR-DST - Domain 1 - Symptom Severity and Distress (Primary Domain)

An initial assessment should examine severity of symptoms, distress and previous history of mental illness. Severity of current symptoms and associated levels of distress are important factors in assigning a level of care and making a referral decision. Assessing changes in symptom severity and distress also forms an important part of outcome monitoring.

Field name iar_dst_domain_1

Data type string

Required yes

Domain 0 No problem in this domain

1. Mild or sub diagnostic
2. Moderate
3. Severe
4. Very severe

Notes Please refer to IAR-DST Domain 1 - Symptom Severity and Distress (Primary Domain)

4.4.41. IAR-DST - Domain 2 - Risk of Harm (Primary Domain)

An initial assessment should include an evaluation of risk to determine a person's potential for harm to self or others. Results from this assessment are of fundamental importance in deciding the appropriate level of care required.

Field name iar_dst_domain_2

Data type string

Required yes

Domain 0 No identified risk in this domain

1. Low risk of harm
2. Moderate risk of harm
3. High risk of harm
4. Very high risk of harm

Notes Please refer to IAR-DST Domain 2 - Risk of Harm (Primary Domain)

4.4.42. IAR-DST - Domain 3 - Functioning (Primary Domain)

An initial assessment should consider functional impairment caused by or exacerbated by the mental health condition. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining mental health intervention intensity within a stepped care continuum.

Field name iar_dst_domain_3

Data type string

Required yes

Domain 0 No problems in this domain

1. Mild impact
2. Moderate impact
3. Severe impact
4. Very severe to extreme impact

Notes Please refer to IAR-DST Domain 3 - Functioning (Primary Domain)

4.4.43. IAR-DST - Domain 4 - Impact of Co-existing Conditions (Primary Domain)

Increasingly, individuals are experiencing and managing multi-morbidity (coexistence of multiple conditions including chronic disease). An initial assessment should specifically examine the presence of other concurrent health conditions that contribute to (or have the potential to contribute to) increased severity of mental health problems and/or compromises the person's ability to participate in the recommended treatment.

Field name iar_dst_domain_4

Data type string

Required yes

Domain 0 No problem in this domain

1. Minor impact
2. Moderate impact
3. Severe impact
4. Very severe impact

Notes Please refer to IAR-DST Domain 4 - Impact of Co-existing Conditions (Primary Domain)

4.4.44. IAR-DST - Domain 5 - Treatment and Recovery History (Contextual Domain)

This initial assessment domain should explore the individual's relevant treatment history and their response to previous treatment. Response to previous treatment is a reasonable predictor of future treatment need and is particularly important when determining appropriateness of lower intensity services.

Field name iar_dst_domain_5

Data type string

Required yes

Domain

0 No prior treatment history

1 Full recovery with previous treatment

2 Moderate recovery with previous treatment

3 Minor recovery with previous treatment

4 Negligible recovery with previous treatment

Notes Please refer to IAR-DST Domain 5 - Treatment and Recovery History (Contextual Domain)

4.4.45. IAR-DST - Domain 6 - Social and Environmental Stressors (Contextual Domain)

This initial assessment domain should consider how the person's environment might contribute to the onset or maintenance of a mental health condition. Significant situational or social complexities can lead to increased condition severity and/or compromise ability to participate in the recommended treatment. Unresolved situational or social complexities can limit the likely benefit of treatment. Furthermore, understanding the complexities experienced by the individual (with carer/support person perspectives if available), may alter the type of service offered, or indicate that additional service referrals may be required (e.g., a referral to an emergency housing provider).

Field name iar_dst_domain_6

Data type string

Required yes

Domain

0 No problem in this domain

1 Mildly stressful environment

2 Moderately stressful environment

3 Highly stressful environment

4 Extremely stressful environment

Notes Please refer to IAR-DST Domain 6 - Social and Environmental Stressors (Contextual Domain)

4.4.46. IAR-DST - Domain 7 - Family and Other Supports (Contextual Domain)

This initial assessment domain should consider whether informal supports are present and their potential to contribute to recovery. A lack of supports might contribute to the onset or maintenance of the mental health condition and/or compromise ability to participate in the recommended treatment.

Field name iar_dst_domain_7

Data type string

Required yes

Domain

0 Highly supported

1 Well supported

2 Limited supports

3 Minimal supports

4 No supports

Notes Please refer to IAR-DST Domain 7 - Family and Other Supports (Contextual Domain)

4.4.47. IAR-DST - Domain 8 - Engagement and Motivation (Contextual Domain)

This initial assessment domain should explore the person's understanding of the mental health condition and their willingness to engage in or accept treatment.

Field name iar_dst_domain_8

Data type string

Required yes

Domain

0 Optimal

1 Positive

2 Limited

3 Minimal

4 Disengaged

Notes Please refer to IAR-DST Domain 8 - Engagement and Motivation (Contextual Domain)

4.4.48. IAR-DST - Practitioner Level of Care

The individualised level of care assessed by the practitioner for the referral

Field name iar_dst_practitioner_level_of_care

Data type string

Required yes

Domain

1 Level 1 - Self Management

2 Level 2 - Low Intensity Services

3 Level 3 - Moderate Intensity Services

4 Level 4 - High Intensity Services

5 Level 5 - Acute and Specialist Community Mental Health Services

9 Not stated

Notes Please refer to IAR-DST Levels of Care

This field was added on 25/2/2021. IAR-DST data entered into the PMHC-MDS before 25/2/2021 will have the Practitioner Level of Care set to 9: Missing. All data entered after 25/2/2021 must use responses 1-5.

4.4.49. IAR-DST - Recommended Level of Care

The information gathered through the initial assessment is used to assign a recommended level of care and inform a referral decision. The levels of care are not intended to replace individualised assessment and care - rather to provide information to guide decision making.

Field name iar_dst_recommended_level_of_care

Data type string

Required yes

Domain

1 Level 1 - Self Management

1+ Level 1 or above - Review assessment on Contextual Domains to determine most appropriate placement

2 Level 2 - Low Intensity Services

2+ Level 2 or above - Review assessment on Contextual Domains to determine most appropriate placement

3 Level 3 - Moderate Intensity Services

3+ Level 3 or above - Review assessment on Contextual Domains to determine most appropriate placement

4 Level 4 - High Intensity Services

4+ Level 4 or above - Review assessment on Contextual Domains to determine most appropriate placement

5 Level 5 - Acute and Specialist Community Mental Health Services

Notes Please refer to IAR-DST Levels of Care

4.4.50. IAR-DST - Tags

List of tags for the measure.

Field name iar_dst_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.51. Intake - Date client contacted Intake

The date on which the client first contacted the intake service

Field name date_client_contacted_intake

Data type date

Required yes

Notes For Date fields, data must be recorded in compliance with the standard format used across the National Health Data Dictionary; specifically, dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2008 would appear as 13032008.

- The contact date must not be before 1st January 2020.
- The contact date must not be in the future.

4.4.52. Intake - Date referred to other service at Intake conclusion

The date the client was referred to another organisation at Intake conclusion.

Field name date_referred_to_other_service_at_intake_conclusion

Data type date

Required no

Notes

- The referral out date must not be before 1st January 2020.
- The referral out end date must not be in the future.

4.4.53. Intake - Funding Source

The source of funding for the intake

Field name intake_funding_source

Data type string

Required yes

Domain

1 HeadtoHelp

2 AMHC

3 Other / Flexible Funding Pool

4.4.54. Intake Key

This is a number or code assigned to each intake. The Intake Key is unique and stable for each intake at the level of the organisation.

Field name intake_key

Data type string (2,50)

Required yes

Notes Intake Keys must be generated by the organisation to be unique at the provider organisation level and must persist across time. Creation of intake keys in this way allows clients to be merged (where duplicate Client Keys have been identified) without having to re-allocate intake identifiers since they can never clash.

A recommended approach for the creation of Intake Keys is to compute random UUIDs.

4.4.55. Intake Organisation Path

A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing the intake to the client.

Field name intake_organisation_path

Data type string

Required yes

Notes A combination of the Primary Health Network's (PHN's) Organisation Key and the Provider Organisation's Organisation Key separated by a colon.

Here is an example organisation structure showing the Organisation Path for each organisation:

Organisation Key	Organisation Name	Organisation Type	Commissioning Organisation	Organisatio
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:P

4.4.56. Intake - Tags

List of tags for the intake.

Field name intake_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.57. Key

A metadata key name.

Field name key

Data type string

Required yes

4.4.58. K5 - Question 1

In the last 4 weeks, about how often did you feel nervous?

Field name k5_item1

Data type string

Required yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes When reporting total score use '9 - Not stated / Missing'

4.4.59. K5 - Question 2

In the last 4 weeks, about how often did you feel without hope?

Field name k5_item2

Data type string

Required yes

Domain

1 None of the time

2 A little of the time

- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.60. K5 - Question 3

In the last 4 weeks, about how often did you feel restless or jumpy?

Field name k5_item3

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.61. K5 - Question 4

In the last 4 weeks, about how often did you feel everything was an effort?

Field name k5_item4

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time

- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.62. K5 - Question 5

In the last 4 weeks, about how often did you feel so sad that nothing could cheer you up?

Field name k5_item5

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.63. K5 - Score

The overall K5 score.

Field name k5_score

Data type integer

Required yes

Domain 5 - 25, 99 = Not stated / Missing

Notes The K5 Total score is based on the sum of K5 item 1 through 5 (range: 5-25).

The Total score is computed as the sum of the item scores. If any item has not been completed (that is, has not been coded 1, 2, 3, 4, 5), it is excluded from the calculation and not counted as a valid item. If any item is missing, the Total Score is set as missing.

For the Total score, the missing value used should be 99.

When reporting individual item scores use '99 - Not stated / Missing'

4.4.64. K5 - Tags

List of tags for the measure.

Field name k5_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.65. K10+ - Question 1

In the past 4 weeks, about how often did you feel tired out for no good reason?

Field name k10p_item1

Data type string

Required yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.66. K10+ - Question 2

In the past 4 weeks, about how often did you feel nervous?

Field name k10p_item2

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.67. K10+ - Question 3

In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?

Field name k10p_item3

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time

- **9** Not stated / Missing

Notes When reporting total score use '9 - Not stated / Missing'

4.4.68. K10+ - Question 4

In the past 4 weeks, how often did you feel hopeless?

Field name k10p_item4

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use '9 - Not stated / Missing'

4.4.69. K10+ - Question 5

In the past 4 weeks, how often did you feel restless or fidgety?

Field name k10p_item5

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time

- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.70. K10+ - Question 6

In the past 4 weeks, how often did you feel so restless you could not sit still?

Field name k10p_item6

Data type string

Required yes

Domain

- **1** None of the time
- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.71. K10+ - Question 7

In the past 4 weeks, how often did you feel depressed?

Field name k10p_item7

Data type string

Required yes

Domain

- **1** None of the time
- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time

- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.72. K10+ - Question 8

In the past 4 weeks, how often did you feel that everything was an effort?

Field name k10p_item8

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time
- **9** Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.73. K10+ - Question 9

In the past 4 weeks, how often did you feel so sad that nothing could cheer you up?

Field name k10p_item9

Data type string

Required yes

Domain **1** None of the time

- **2** A little of the time
- **3** Some of the time
- **4** Most of the time
- **5** All of the time

9 Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.74. K10+ - Question 10

In the past 4 weeks, how often did you feel worthless?

Field name k10p_item10

Data type string

Required yes

Domain **1** None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes When reporting total score use ‘9 - Not stated / Missing’

4.4.75. K10+ - Question 11

In the past four weeks, how many days were you totally unable to work, study or manage your day to day activities because of these feelings?

Field name k10p_item11

Data type integer

Required yes

Domain 0 - 28, 99 = Not stated / Missing

Notes When the client’s responses to Q1-10 are all recorded as 1 ‘None of the time’, they are not required to answer questions 11-14. Where this question has not been answered a response of ‘99 - Not stated / Missing’ should be selected.

4.4.76. K10+ - Question 12

Aside from those days, in the past four weeks, how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of these feelings?

Field name k10p_item12

Data type integer

Required yes

Domain 0 - 28, 99 = Not stated / Missing

Notes When the client's responses to Q1-10 are all recorded as 1 'None of the time', they are not required to answer questions 11-14. Where this question has not been answered a response of '99 - Not stated / Missing' should be selected.

4.4.77. K10+ - Question 13

In the past four weeks, how many times have you seen a doctor or any other health professional about these feelings?

Field name k10p_item13

Data type integer

Required yes

Domain 0 - 89, 99 = Not stated / Missing

Notes When the client's responses to Q1-10 are all recorded as 1 'None of the time', they are not required to answer questions 11-14. Where this question has not been answered a response of '99 - Not stated / Missing' should be selected.

4.4.78. K10+ - Question 14

In the past four weeks, how often have physical health problems been the main cause of these feelings?

Field name k10p_item14

Data type string

Required yes

Domain **1** None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes When the client's responses to Q1-10 are all recorded as 1 'None of the time', they are not required to answer questions 11-14. Where this question has not been answered a response of '99 - Not stated / Missing' should be selected.

4.4.79. K10+ - Score

The overall K10 score.

Field name k10p_score

Data type integer

Required yes

Domain 10 - 50, 99 = Not stated / Missing

Notes The K10 Total score is based on the sum of K10 item 01 through 10 (range: 10-50). Items 11 through 14 are excluded from the total because they are separate measures of disability associated with the problems referred to in the preceding ten items.

The Total score is computed as the sum of the scores for items 1 to 10. If any item has not been completed (that is, has not been coded 1, 2, 3, 4, 5), it is excluded from the total with the proviso that a competed K10 with more than one missing item is regarded as invalid.

If more than one item of items 1 to 10 are missing, the Total Score is set as missing. Where this is the case, the missing value used should be 99.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.80. K10+ - Tags

List of tags for the measure.

Field name k10p_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.81. Measure Key

This is a number or code assigned to each instance of a measure. The Measure Key is unique and stable for each instance of a measure at the level of the organisation.

Field name measure_key

Data type string (2,50)

Required yes

Notes Measure keys are case sensitive and must be valid unicode characters.

4.4.82. Organisation Key

A sequence of characters which uniquely identifies the provider organisation to the Primary Health Network. Assigned by the Primary Health Network.

Field name organisation_key

Data type string (2,50)

Required yes

Notes Organisation Keys must be generated by the PHN to be unique and must persist across time. See Managing Provider Organisation Keys

Organisation keys are case sensitive and must be valid unicode characters.

4.4.83. Organisation Path

A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.

Field name organisation_path

Data type string

Required yes

Notes A combination of the Primary Health Network's (PHN's) Organisation Key and the Provider Organisation's Organisation Key separated by a colon.

Here is an example organisation structure showing the Organisation Path for each organisation:

Organisation Key	Organisation Name	Organisation Type	Commissioning Organisation	Organisatio
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:P

4.4.84. Organisation type referred to at Episode conclusion

Type of organisation to which the the client was referred at the Episode conclusion.

Field name organisation_type_referred_to_at_episode_conclusion

Data type string

Required yes

Domain

0 None/Not applicable

1 General Practice

2 Medical Specialist Consulting Rooms

3 Private practice

4 Public mental health service

5 Public Hospital

6 Private Hospital

7 Emergency Department

8 Community Health Centre

9 Drug and Alcohol Service

10 Community Support Organisation NFP

11 Indigenous Health Organisation

12 Child and Maternal Health

13 Nursing Service

14 Telephone helpline

15 Digital health service

16 Family Support Service

17 School

18 Tertiary Education institution

19 Housing service

20 Centrelink

21 Other

22 HeadtoHelp / HeadtoHealth Hub

23 Other PHN funded service

24 AMHC

99 Not stated

Multiple space separated values allowed

Notes Medical Specialist Consulting Rooms includes private medical practitioner rooms in public or private hospital or other settings.

Public mental health service refers to a state- or territory-funded specialised mental health services (i.e., specialised mental health care delivered in public acute and psychiatric hospital settings, community mental health care services, and s specialised residential mental health care services).

Not applicable should only be selected in instances of Self referral.

4.4.85. Organisation type referred to at Intake conclusion

Type of organisation to which the the client was referred at the Intake conclusion.

Field name organisation_type_referred_to_at_intake_conclusion

Data type string

Required yes

Domain

1 GP/Medical Practitioner

2 Hospital

3 Psychiatric/mental health service or facility

4 Alcohol and other drug treatment service

5 Other community/health care service

6 Correctional service

7 Police diversion

8 Court diversion

9 Legal service

10 Child protection agency

11 Community support groups/agencies

12 Centrelink or employment service

13 Housing and homelessness service

14 Telephone & online services/referral agency e.g. direct line

15 Disability support service

16 Aged care facility/service

17 Immigration department or asylum seeker/refugee support service

18 School/other education or training institution

19 Community based Drug and Alcohol Service

20 Youth service (non-AOD)

21 Indigenous service (non-AOD)

22 Extended care/rehabilitation facility

23 Palliative care service

24 Police (not diversion)

25 Public dental provider - community dental agency

26 Dental Hospital

27 Private Dental Provider

28 Early childhood service

29 Maternal and Child Health Service

30 Community nursing service

31 Emergency relief

32 Family support service (excl family violence)

33 Family violence service

34 Gambling support service

35 Maternity services

36 Peer support/self-help group

37 Private allied health provider

38 Sexual Assault service

39 Financial counsellor

40 Sexual health service

41 Medical specialist

42 AMHC

43 Other PHN funded service

44 HeadtoHelp / HeathtoHealth

97 No Referral

98 Other

99 Not stated/Inadequately described

Multiple space separated values allowed

Notes Medical Specialist Consulting Rooms includes private medical practitioner rooms in public or private hospital or other settings.

Public mental health service refers to a state- or territory-funded specialised mental health services (i.e., specialised mental health care delivered in public acute and psychiatric hospital settings, community mental health care services, and s specialised residential mental health care services).

Not applicable should only be selected in instances of Self referral.

4.4.86. Practitioner - Aboriginal and Torres Strait Islander Status

Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin, as represented by a code.

Field name practitioner_atsi_status

Data type string

Required yes

Domain

1 Aboriginal but not Torres Strait Islander origin

2 Torres Strait Islander but not Aboriginal origin

3 Both Aboriginal and Torres Strait Islander origin

4 Neither Aboriginal or Torres Strait Islander origin

9 Not stated/inadequately described

Notes **Code 9 is not to be available as a valid answer to the questions but is** intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

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4.4.87. Practitioner - Active

A flag to represent whether a practitioner is actively delivering services. This is a system field that is aimed at helping organisations manage practitioner codes.

Field name practitioner_active

Data type string

Required yes

Domain

0 Inactive

1 Active

4.4.88. Practitioner - ATSI Cultural Training

Indicates whether a practitioner has completed a recognised training programme in the delivery of culturally safe services to Aboriginal and Torres Strait Islander peoples.

Field name atsi_cultural_training

Data type string

Required yes

Domain

1 Yes

2 No

3 Not required

9 Missing / Not recorded

Notes This item is reported by the practitioner and applies to service providers who are either:

- not of Aboriginal or Torres Strait Islander status; or
- are not employed by an Aboriginal Community Controlled Health Service.

1 - Yes The practitioner has:

- undertaken specific training in the delivery of culturally appropriate mental health /health services for Aboriginal and Torres Strait Islander peoples. As a guide, recognised training programs include those endorsed by the Australian Indigenous Psychologists' Association (AIPA) or similar organisation; or
- undertaken local cultural awareness training in the community in which they are practising, as delivered or endorsed by the elders of that community or the local Aboriginal Community Controlled Health Service.

2 - No The practitioner has not met the requirements stated above.

3 - Not required This option is reserved only for practitioners who are of Aboriginal and Torres Strait Islander descent, or employed by an Aboriginal Community Controlled Health Service.

4 - Missing/Not recorded This is a system code for missing data and not a valid response option for practitioners.

4.4.89. Practitioner - Category

The type or category of the practitioner, as represented by a code.

Field name practitioner_category

Data type string

Required yes

Domain

1 Clinical Psychologist

2 General Psychologist

3 Social Worker

4 Occupational Therapist

5 Mental Health Nurse

6 Aboriginal and Torres Strait Islander Health/Mental Health Worker

7 Low Intensity Mental Health Worker

8 General Practitioner

9 Psychiatrist

10 Other Medical

11 Other

12 Psychosocial Support Worker

13 Peer Support Worker

99 Not stated

Notes Practitioner category refers to the labour classification of the service provider delivering the Service Contact. Practitioners should be assigned to the code that best describes their role for which they are engaged to deliver services to clients. Practitioners are registered in the PMHC MDS by Provider Organisations, with each practitioner assigned a code that is unique within the organisation.

In most cases, Practitioner Category will be determined by the training and qualifications of the practitioner. However, in some instances, a practitioner may be employed in a capacity that does not necessarily reflect their formal qualifications. For example, a person with a social work qualification may be employed primarily as a peer support worker on the basis of their lived experience of a mental illness. In such instances, the practitioner should be classified as a peer support worker.

12 - Psychosocial Support Worker Refers to practitioners who are principally employed to provide psychosocial support services to clients where the practitioner has specific training in the area (e.g., Cert 4 qualification) and cannot be better described by another category.

13 - Peer Support Worker Refers to practitioners who are principally employed to provide support to clients on the basis of the practitioner's lived experience of mental illness.

Changes in effect from 1 January 2019

- Two new codes have been added to the existing Practitioner Category data item, to allow for Psychosocial Support Workers (new code 12) and Peer Support Workers (new code 13) who are typically employed in psychosocial support programs.

4.4.90. Practitioner - Gender

The term 'gender' refers to the way in which a person identifies their masculine or feminine characteristics. A persons gender relates to their deeply held internal and individual sense of gender and is not always exclusively male or female. It may or may not correspond to their sex assigned at birth.

Field name practitioner_gender

Data type string

Required yes

Domain

0 Not stated/Inadequately described

1 Male

2 Female

3 Other

ABS http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/1200.0.55.012Main%20Features12016?opendocument&tabname=Summary&prodno=1200.0.55.012&issue=2016&num

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4.4.91. Practitioner Key

A unique identifier for a practitioner within the responsible provider organisation. Assigned by either the PHN or Provider Organisation depending on local procedures.

Field name practitioner_key

Data type string (2,50)

Required yes

Notes PMHC MDS keys are case sensitive and must have between 2-50 valid unicode characters. Keys must start with A-Za-z0-9 (POSIX :alnum:).

Where data is being exported from client systems, these keys can be auto generated, providing that a key does not change once it is assigned.

Keys must be generated by the organisation to be unique at the Provider Organisation level and must persist across time. Creation of keys in this way allows records to be merged (where duplicate keys of the same record type have been identified) without having to re-allocate keys since they can never clash.

A recommended approach for the creation of keys is to compute random UUIDs.

4.4.92. Practitioner - Tags

List of tags for the practitioner.

Field name practitioner_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.93. Practitioner - Year of Birth

The year the practitioner was born.

Field name practitioner_year_of_birth

Data type gYear

Required yes

Domain gYear

Notes

- The year of birth must not be in the future.
- The year of birth must be after 1900.
- If the year of birth is unknown, the following approaches should be used:
  - If the age of the practitioner is known, the age should be used to derive the year of birth
  - If the age of the practitioner is unknown, an estimated age of the practitioner should be used to estimate a year of birth

- If the date of birth is totally unknown, use 9999.

4.4.94. Primary Practitioner Indicator

An indicator of whether the practitioner was the primary practitioner responsible for the service contact.

Field name primary_practitioner_indicator

Data type string

Required yes

Domain

1 Yes

2 No

4.4.95. Provider Organisation - ABN

The Australian Business Number of the provider organisation.

Field name organisation_abn

Data type string (11)

Required yes

4.4.96. Provider Organisation - End Date

The date on which a provider organisation stopped delivering services.

Field name organisation_end_date

Data type date

Required yes

Notes For Date fields, data must be recorded in compliance with the standard format used across the National Health Data Dictionary; specifically, dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2008 would appear as 13032008.

- If the organisation end date is unknown, use 09099999.

For validation rules please refer to Organisation.

4.4.97. Provider Organisation - Legal Name

The legal name of the provider organisation.

Field name organisation_legal_name

Data type string

Required no

4.4.98. Provider Organisation - Name

The name of the provider organisation.

Field name organisation_name

Data type string (2,100)

Required yes

4.4.99. Provider Organisation - Start Date

The date on which a provider organisation started delivering services.

Field name organisation_start_date

Data type date

Required yes

Notes For Date fields, data must be recorded in compliance with the standard format used across the National Health Data Dictionary; specifically, dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2008 would appear as 13032008.

For validation rules please refer to Organisation.

4.4.100. Provider Organisation - State

The state that the provider organisation operates in.

Field name organisation_state

Data type string

Required yes

Domain

1 New South Wales

2 Victoria

3 Queensland

4 South Australia

5 Western Australia

6 Tasmania

7 Northern Territory

8 Australian Capital Territory

9 Other Territories

Notes

- Name is taken from Australian Statistical Geography Standard (ASGS) July 2011.
- Code is from Meteor with the addition of code for Other Territories.

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4.4.101. Provider Organisation - Tags

List of tags for the provider organisation.

Field name organisation_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.102. Provider Organisation - Type

The category that best describes the provider organisation.

Field name organisation_type

Data type string

Required yes

Domain

1	Private Allied Health Professional Practice
2	Private Psychiatry Practice
3	General Medical Practice
4	Private Hospital
5	Headspace Centre
6	Early Youth Psychosis Centre
7	Community-managed Community Support Organisation
8	Aboriginal Health/Medical Service
9	State/Territory Health Service Organisation
10	Drug and/or Alcohol Service
11	Primary Health Network
12	Medicare Local
13	Division of General Practice
98	Other
99	Missing

Notes

1 - Private Allied Health Professional Practice The provider organisation is a group of single- or multi-discipline allied health practitioners operating as private service providers. This includes both group and solo practitioner entities.

2 - Private Psychiatry practice The provider organisation is a Private Psychiatry practice. This includes both group and solo practitioner entities.

3 - General Medical Practice The provider organisation is a General Medical Practice. This includes both group and solo practitioner entities.

4 - Private Hospital The provider organisation is a private hospital. This includes for-profit and not-for-profit hospitals.

5 - Headspace Centre The provider organisation is a Headspace centre, delivering services funded by the PHN.

Note: Headspace and Early Psychosis Youth Centres currently collect and report a standardised dataset to headspace National Office. Pending the future of these arrangements, reporting of the PMHC minimum data set is not required by those organisations previously funded through headspace National Office that transitioned to PHNs. Where new or additional services are commissioned by PHNs and delivered through existing Headspace or Early Psychosis Youth Centres, local decisions will be required as to whether these services can be captured through headspace National Office sustem or are better reported through the PMHC MDS.

6 - Early Youth Psychosis Centre The provider organisation is a Early Youth Psychosis Centre, delivering services funded by the PHN.

Note: See Note above re Headspace.

7 - Community-managed Community Support Organisation The provider organisation is a community-managed (non-government) organisation that primarily delivers disability-related or social support services.

8 - Aboriginal Health/Medical Service The provider organisation is an Aboriginal or Torres Strait Islander-controlled health service organisation.

9 - State/Territory Health Service Organisation The provider organisation is a health service entity principally funded by a state or territory government. This includes all services delivered through Local Hospital Networks (variously named across jurisdictions).

10 - Drug and/or Alcohol Service Organisation The provider organisation is an organisation that provides specialised drug and alcohol treatment services. The organisation may be operating in the government or non-government sector, and where the latter, may be for-profit or not-for-profit.

11 - Primary Heath Network The PHN is the provider organisation and employs the service delivery practitioners. This may occur during the transition period as the PHN moves to a full commissioning role, or in cases of market failure where there is no option to commission external providers.

12 - Medicare Local The provider organisation is a former Medicare Local entity.

13 - Division of General Practice The provider organisation is a former Division of General Practice entity.

98 - Other The provider organisation cannot be described by any of the available options.

4.4.103. Referral Date

The date the referrer made the referral.

Field name referral_date

Data type date

Required yes

Notes For Date fields, data must be recorded in compliance with the standard format used across the National Health Data Dictionary; specifically, dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2008 would appear as 13032008.

- The referral date must not be before 1st January 2014.
- The referral date must not be in the future.

4.4.104. Referred to Organisation Path

A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation to which the intake referred the client.

Field name referred_to_organisation_path

Data type string

Required no

Notes A combination of the referred to Primary Health Network's (PHN's) Organisation Key and the referred to Provider Organisation's Organisation Key separated by a colon.

Here is an example organisation structure showing the Organisation Path for each organisation:

Organisation Key	Organisation Name	Organisation Type	Commissioning Organisation	Organisatio
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:P

4.4.105. Referrer Organisation Type

Type of organisation in which the referring professional is based.

Field name referrer_organisation_type

Data type string

Required yes

Domain

1 General Practice

2 Medical Specialist Consulting Rooms

3 Private practice

4 Public mental health service

5 Public Hospital

6 Private Hospital

7 Emergency Department

8 Community Health Centre

9 Drug and Alcohol Service

10 Community Support Organisation NFP

11 Indigenous Health Organisation

12 Child and Maternal Health

13 Nursing Service

14 Telephone helpline

15 Digital health service

16 Family Support Service

17 School

18 Tertiary Education institution

19 Housing service

20 Centrelink

21 Other

98 N/A - Self referral

99 Not stated

Notes Medical Specialist Consulting Rooms includes private medical practitioner rooms in public or private hospital or other settings.

Public mental health service refers to a state- or territory-funded specialised mental health services (i.e., specialised mental health care delivered in public acute and psychiatric hospital settings, community mental health care services, and s specialised residential mental health care services).

Not applicable should only be selected in instances of Self referral.

4.4.106. Referrer Profession

Profession of the provider who referred the client.

Field name referrer_profession

Data type string

Required yes

Domain

1 General Practitioner

2 Psychiatrist

3 Obstetrician

4 Paediatrician

5 Other Medical Specialist

6 Midwife

7 Maternal Health Nurse

8 Psychologist

9 Mental Health Nurse

10 Social Worker

11 Occupational therapist

12 Aboriginal Health Worker

13 Educational professional

14 Early childhood service worker

15 Other

98 N/A - Self referral

99 Not stated

Notes New arrangements for some services delivered in primary mental health care allows clients to refer themselves for treatment. Therefore, ‘Self’ is a response option included within ‘Referrer profession’.

4.4.107. SDQ Collection Occasion - Version

The version of the SDQ collected.

Field name sdq_version

Data type string

Required yes

Domain **PC101** Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1

PC201 Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1

PY101 Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1

PY201 Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1

YR101 Self report Version, 11-17 years, Baseline version, Australian Version 1

YR201 Self report Version, 11-17 years, Follow Up version, Australian Version 1

Notes Domain values align with those collected in the NOCC dataset as defined at https://webval.validator.com.au/spec/NOCC/current/SDQ/SDQVer

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4.4.108. SDQ - Conduct Problem Scale

Field name sdq_conduct_problem

Data type integer

Required yes

Domain 0 - 10, 99 = Not stated / Missing

Notes See SDQ items and Scale Summary scores for instructions on scoring the Conduct Problem Scale.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.109. SDQ - Emotional Symptoms Scale

Field name sdq_emotional_symptoms

Data type integer

Required yes

Domain 0 - 10, 99 = Not stated / Missing

Notes See SDQ items and Scale Summary scores for instructions on scoring the Emotional Symptoms Scale.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.110. SDQ - Hyperactivity Scale

Field name sdq_hyperactivity

Data type integer

Required yes

Domain 0 - 10, 99 = Not stated / Missing

Notes See SDQ items and Scale Summary scores for instructions on scoring the Hyperactivity Scale.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.111. SDQ - Impact Score

Field name sdq_impact

Data type integer

Required yes

Domain 0 - 10, 99 = Not stated / Missing

Notes See SDQ items and Scale Summary scores for instructions on scoring the Impact Score.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.112. SDQ - Peer Problem Scale

Field name sdq_peer_problem

Data type integer

Required yes

Domain 0 - 10, 99 = Not stated / Missing

Notes See SDQ items and Scale Summary scores for instructions on scoring the Peer Problem Scale.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.113. SDQ - Prosocial Scale

Field name sdq_prosocial

Data type integer

Required yes

Domain 0 - 10, 99 = Not stated / Missing

Notes See SDQ items and Scale Summary scores for instructions on scoring the Prosocial Scale.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.114. SDQ - Question 1

Parent Report: Considerate of other people's feelings.

Youth Self Report: I try to be nice to other people. I care about their feelings.

Field name sdq_item1

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.115. SDQ - Question 2

Parent Report: Restless, overactive, cannot stay still for long.

Youth Self Report: I am restless, I cannot stay still for long.

Field name sdq_item2

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.116. SDQ - Question 3

Parent Report: Often complains of headaches, stomach-aches or sickness.

Youth Self Report: I get a lot of headaches, stomach-aches or sickness.

Field name sdq_item3

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.117. SDQ - Question 4

Parent Report: Shares readily with other children {for example toys, treats, pencils} / young people {for example CDs, games, food}.

Youth Self Report: I usually share with others, for examples CDs, games, food.

Field name sdq_item4

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.118. SDQ - Question 5

Parent Report: Often loses temper.

Youth Self Report: I get very angry and often lose my temper.

Field name sdq_item5

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.119. SDQ - Question 6

Parent Report: {Rather solitary, prefers to play alone} / {would rather be alone than with other young people}.

Youth Self Report: I would rather be alone than with people of my age.

Field name sdq_item6

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.120. SDQ - Question 7

Parent Report: {Generally well behaved} / {Usually does what adults requests}.

Youth Self Report: I usually do as I am told.

Field name sdq_item7

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use ‘9 - Not stated / Missing’.

4.4.121. SDQ - Question 8

Parent Report: Many worries or often seems worried.

Youth Self Report: I worry a lot.

Field name sdq_item8

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use ‘9 - Not stated / Missing’.

4.4.122. SDQ - Question 9

Parent Report: Helpful if someone is hurt, upset or feeling ill.

Youth Self Report: I am helpful if someone is hurt, upset or feeling ill.

Field name sdq_item9

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.123. SDQ - Question 10

Parent Report: Constantly fidgeting or squirming.

Youth Self Report: I am constantly fidgeting or squirming.

Field name sdq_item10

Data type string

Required yes

Domain **0** Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.124. SDQ - Question 11

Parent Report: Has at least one good friend.

Youth Self Report: I have one good friend or more.

Field name sdq_item11

Data type string

Required yes

Domain **0** Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.125. SDQ - Question 12

Parent Report: Often fights with other {children} or bullies them / {young people}.

Youth Self Report: I fight a lot. I can make other people do what I want.

Field name sdq_item12

Data type string

Required yes

Domain **0** Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.126. SDQ - Question 13

Parent Report: Often unhappy, depressed or tearful.

Youth Self Report: I am often unhappy, depressed or tearful.

Field name sdq_item13

Data type string

Required yes

Domain0 Not True

- **1** Somewhat True
- **2** Certainly True
- **7** Unable to rate (insufficient information)
- **9** Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.127. SDQ - Question 14

Parent Report: Generally liked by other {children} / {young people}

Youth Self Report: Other people my age generally like me.

Field name sdq_item14

Data type string

Required yes

Domain0 Not True

- **1** Somewhat True
- **2** Certainly True
- **7** Unable to rate (insufficient information)
- **9** Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.128. SDQ - Question 15

Parent Report: Easily distracted, concentration wanders.

Youth Self Report: I am easily distracted, I find it difficult to concentrate.

Field name sdq_item15

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.129. SDQ - Question 16

Parent Report: Nervous or {clingy} in new situations, easily loses confidence {omit clingy in PY}.

Youth Self Report: I am nervous in new situations. I easily lose confidence.

Field name sdq_item16

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.130. SDQ - Question 17

Parent Report: Kind to younger children.

Youth Self Report: I am kind to younger people.

Field name sdq_item17

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.131. SDQ - Question 18

Parent Report: Often lies or cheats.

Youth Self Report: I am often accused of lying or cheating.

Field name sdq_item18

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.132. SDQ - Question 19

Parent Report: Picked on or bullied by {children} / {youth}.

Youth Self Report: Other children or young people pick on me or bully me.

Field name sdq_item19

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.133. SDQ - Question 20

Parent Report: Often volunteers to help others (parents, teachers, {other} children) / Omit 'other' in PY.

Youth Self Report: I often volunteer to help others (parents, teachers, children).

Field name sdq_item20

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use ‘9 - Not stated / Missing’.

4.4.134. SDQ - Question 21

Parent Report: Thinks things out before acting.

Youth Self Report: I think before I do things.

Field name sdq_item21

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use ‘9 - Not stated / Missing’.

4.4.135. SDQ - Question 22

Parent Report: Steals from home, school or elsewhere.

Youth Self Report: I take things that are not mine from home, school or elsewhere.

Field name sdq_item22

Data type string

Required yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.136. SDQ - Question 23

Parent Report: Gets along better with adults than with other {children} / {youth}.

Youth Self Report: I get along better with adults than with people my own age.

Field name sdq_item23

Data type string

Required yes

Domain **0** Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.137. SDQ - Question 24

Parent Report: Many fears, easily scared.

Youth Self Report: I have many fears, I am easily scared.

Field name sdq_item24

Data type string

Required yes

Domain **0** Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.138. SDQ - Question 25

Parent Report: Good attention span sees chores or homework through to the end.

Youth Self Report: I finish the work I'm doing. My attention is good.

Field name sdq_item25

Data type string

Required yes

Domain **0** Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.139. SDQ - Question 26

Parent Report: Overall, do you think that your child has difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with other people?

Youth Self Report: Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with other people?

Field name sdq_item26

Data type string

Required yes

Domain

0 No

1 Yes - minor difficulties

2 Yes - definite difficulties

3 Yes - severe difficulties

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.140. SDQ - Question 27

Parent Report: How long have these difficulties been present?

Youth Self Report: How long have these difficulties been present?

Field name sdq_item27

Data type string

Required yes

Domain

0 Less than a month

1 1-5 months

2 6-12 months

3 Over a year

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions: - PC101 - PY101 - YR101

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.141. SDQ - Question 28

Parent Report: Do the difficulties upset or distress your child?

Youth Self Report: Do the difficulties upset or distress you?

Field name sdq_item28

Data type string

Required yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.142. SDQ - Question 29

Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? HOME LIFE.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? HOME LIFE.

Field name sdq_item29

Data type string

Required yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.143. SDQ - Question 30

Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? FRIENDSHIPS.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? FRIENDSHIPS.

Field name sdq_item30

Data type string

Required yes

Domain **0** Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.144. SDQ - Question 31

Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? CLASSROOM LEARNING.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? CLASSROOM LEARNING

Field name sdq_item31

Data type string

Required yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.145. SDQ - Question 32

Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? LEISURE ACTIVITIES.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? LEISURE ACTIVITIES.

Field name sdq_item32

Data type string

Required yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.146. SDQ - Question 33

Parent Report: Do the difficulties put a burden on you or the family as a whole?

Youth Self Report: Do the difficulties make it harder for those around you (family, friends, teachers, etc)?

Field name sdq_item33

Data type string

Required yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions: All

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.147. SDQ - Question 34

Parent Report: Since coming to the services, are your child's problems:

Youth Self Report: 'Since coming to the service, are your problems:

Field name sdq_item34

Data type string

Required yes

Domain

0 Much worse

1 A bit worse

2 About the same

3 A bit better

4 Much better

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions:

- PC201
- PY201
- YR201

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.148. SDQ - Question 35

Has coming to the service been helpful in other ways eg. providing information or making the problems bearable?

Field name sdq_item35

Data type string

Required yes

Domain 0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions:

- PC201
- PY201

- YR201

When reporting subscale and total scores use ‘9 - Not stated / Missing’.

4.4.149. SDQ - Question 36

Over the last 6 months have your child’s teachers complained of fidgetiness, restlessness or overactivity?

Field name sdq_item36

Data type string

Required yes

Domain 0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions:

- PC101
- PY101

When reporting subscale and total scores use ‘9 - Not stated / Missing’.

4.4.150. SDQ - Question 37

Over the last 6 months have your child’s teachers complained of poor concentration or being easily distracted?

Field name sdq_item37

Data type string

Required yes

Domain 0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

NotesRequired Versions:

- PC101
- PY101

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.151. SDQ - Question 38

Over the last 6 months have your child's teachers complained of acting without thinking, frequently butting in, or not waiting for his or her turn?

Field namesdq_item38

Data typestring

Requiredyes

Domain0No

1 A little

2 A lot

7 Unable to rate (insufficient information)

8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

NotesRequired Versions:

- PC101
- PY101

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.152. SDQ - Question 39

Does your family complain about you having problems with overactivity or poor concentration?

Field name sdq_item39

Data type string

Required yes

Domain 0 No

- **1** A little
- **2** A lot
- **7** Unable to rate (insufficient information)
- **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
- **9** Not stated / Missing

Notes Required Versions:

- YR101

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.153. SDQ - Question 40

Do your teachers complain about you having problems with overactivity or poor concentration?

Field name sdq_item40

Data type string

Required yes

Domain 0 No

- **1** A little
- **2** A lot
- **7** Unable to rate (insufficient information)
- **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
- **9** Not stated / Missing

Notes Required Versions:

- YR101

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.154. SDQ - Question 41

Does your family complain about you being awkward or troublesome?

Field name sdq_item41

Data type string

Required yes

Domain 0 No

- **1** A little
- **2** A lot
- **7** Unable to rate (insufficient information)
- **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
- **9** Not stated / Missing

Notes Required Versions:

- YR101

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.155. SDQ - Question 42

Do your teachers complain about you being awkward or troublesome?

Field name sdq_item42

Data type string

Required yes

Domain 0 No

- **1** A little
- **2** A lot
- **7** Unable to rate (insufficient information)
- **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)

9 Not stated / Missing

Notes Required Versions:

- YR101

When reporting subscale and total scores use '9 - Not stated / Missing'.

4.4.156. SDQ - Tags

List of tags for the measure.

Field name sdq_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.157. SDQ - Total Difficulties Score

Field name sdq_total

Data type integer

Required yes

Domain 0 - 40, 99 = Not stated / Missing

Notes See SDQ items and Scale Summary scores for instructions on scoring the Total Difficulties Score.

When reporting individual item scores use '99 - Not stated / Missing'.

4.4.158. Service Contact - Client Participation Indicator

An indicator of whether the client participated, or intended to participate, in the service contact, as represented by a code.

Field name service_contact_participation_indicator

Data type string

Required yes

Domain **1** Yes

2 No

Notes Service contacts are not restricted to in-person communication but can include telephone, video link or other forms of direct communication.

1 - Yes This code is to be used for service contacts between a mental health service provider and the patient/client in whose clinical record the service contact would normally warrant a dated entry, where the patient/client is participating.

2 - No This code is to be used for service contacts between a mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

Note: Where a client intended to participate in a service contact but failed to attend, Service Contact - Client Participation Indicator should be recorded as '1: Yes' and Service Contact - No Show should be recorded as '1: Yes'.

METeOR 494341

4.4.159. Service Contact - Copayment

The co-payment is the amount paid by the client per session.

Field name service_contact_copayment

Data type number

Required yes

Domain 0 - 999999.99

Notes Up to 6 digits before the decimal point; up to 2 digits after the decimal point.

The co-payment is the amount paid by the client per service contact, not the fee paid by the project to the practitioner or the fee paid by the project to the practitioner plus the client contribution. In many cases, there will not be a co-payment charged and therefore zero should be entered. Where a co-payment is charged it should be minimal and based on an individual's capacity to pay.

4.4.160. Service Contact - Date

The date of each mental health service contact between a health service provider and patient/client.

Field name service_contact_date

Data type date

Required yes

Notes For Date fields, data must be recorded in compliance with the standard format used across the National Health Data Dictionary; specifically, dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2008 would appear as 13032008.

- The service contact date must not be before 1st January 2014.
- The service contact date must not be in the future.

METeOR 494356

4.4.161. Service Contact - Duration

The time from the start to finish of a service contact.

Field name service_contact_duration

Data type string

Required yes

Domain

0 No contact took place

1 1-15 mins

2 16-30 mins

3 31-45 mins

4 46-60 mins

5 61-75 mins

6 76-90 mins

7 91-105 mins

8 106-120 mins

9 over 120 mins

Notes For group sessions the time for client spent in the session is recorded for each client, regardless of the number of clients or third parties participating or the number of service providers providing the service. Writing up details of service contacts is not to be reported as part of the duration, except if during or contiguous with the period of client or third party participation. Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as part of the duration of the service contact.

0 - No contact took place Only use this code where the service contact is recorded as a no show.

4.4.162. Service Contact - Final

An indication of whether the Service Contact is the final for the current Episode of Care

Field name service_contact_final

Data type string

Required yes

Domain

1 No further services are planned for the client in the current episode

2 Further services are planned for the client in the current episode

3 Not known at this stage

Notes Service providers should report this item on the basis of future planned or scheduled contacts with the client. Where this item is recorded as 1 (No further services planned), the episode should be recorded as completed by:

- the date of the final Service Contact should be recorded as the Episode End Date
- the Episode Completion Status field should be recorded as 'Treatment concluded.

Note that no further Service Contacts can be recorded against an episode once it is marked as completed. Where an episode has been marked as completed prematurely, the Episode End Date can be manually corrected to allow additional activity to be recorded.

4.4.163. Service Contact - Funding Source

The source of funding for a service contact

Field name funding_source

Data type string

Required yes

Domain		
	7	PHN flexible funding NOS
	8	Low intensity
	9	Child and youth specific services NOS
	10	Youth enhanced services
	11	Psychological therapies
	12	Care coordination for severe and complex
	13	Suicide prevention NOS
	14	Suicide prevention - Indigenous
	15	Suicide Prevention - General
	16	Indigenous MH
	17	Psychosocial NOS
	18	Psychosocial NPS
	19	Psychosocial COS
	20	Other Commonwealth flexible funding NOS
	21	Drought measure
	22	Psychological treatment services for people with mental illness living in RACFs
	23	Co-funded – Commonwealth and state
	24	Co-funded – Commonwealth and other Quarantined
	25	Quarantined funding NOS
	26	PFAS response (retired)
	27	Natural Disaster Response
	28	HeadtoHelp
	29	AMHC
	30	Eating disorders trial
	31	Norfolk Island
	32	Other funding source – no Commonwealth Funding
	33	COVID Response NOS
	34	COVID Response Head To Help

35 COVID Response Head To Health

98 Unknown/Not stated

99 Missing

4.4.164. Service Contact - Interpreter Used

Whether an interpreter service was used during the Service Contact

Field name service_contact_interpreter

Data type string

Required yes

Domain **1** Yes

2 No

9 Not stated

Notes Interpreter services includes verbal language, non-verbal language and languages other than English.

1 - Yes Use this code where interpreter services were used during the Service Contact. Use of interpreter services for any form of sign language or other forms of non-verbal communication should be coded as Yes.

2 - No Use this code where interpreter services were not used during the Service Contact.

9 - Not stated Indicates that the item was not collected. This item should not appear as an option for clinicians, it is for administrative use only.

4.4.165. Service Contact - Modality

How the service contact was delivered, as represented by a code.

Field name service_contact_modality

Data type string

Required yes

Domain **0** No contact took place

1 Face to Face

2 Telephone

3 Video

4 Internet-based

Notes **0 - No contact took place** Only use this code where the service contact is recorded as a no show.

1 - Face to Face If 'Face to Face' is selected, a value other than 'Not applicable' must be selected for Service Contact Venue

- If 'Face to Face' is selected a valid Australian postcode must be entered for Service Contact Postcode. The unknown postcode is not valid.

2 - Telephone Includes any voice based communication that does not use video, regardless of the technology used to provide the voice communication. For example, this could either be over land line telephone, mobile telephone, VoIP.

3 - Video Includes any video based communication.

4 - Internet-based Any internet based communications that do not fall into the 2 - Telephone or 3 - Video categories. This includes email communication, providing the communication would normally warrant a dated entry in the clinical record of the client, involving a third party, such as a carer or family member, and/or other professional or mental health worker, or other service provider.

Note: If Service Contact Modality is not 'Face to Face' the postcode must be entered as unknown 9999.

4.4.166. Service Contact - No Show

Where an appointment was made for an intended participant(s), but the intended participant(s) failed to attend the appointment, as represented by a code.

Field name service_contact_no_show

Data type string

Required yes

Domain **1** Yes

2 No

Notes **1 - Yes** The intended participant(s) failed to attend the appointment.

2 - No The intended participant(s) attended the appointment.

4.4.167. Service Contact - Participants

An indication of who participated in the Service Contact.

Field name service_contact_participants

Data type string

Required yes

Domain

1 Individual client

2 Client group

3 Family / Client Support Network

4 Other health professional or service provider

5 Other

9 Not stated

Notes

1 - Individual Code applies for Service Contacts delivered individually to a single client without third party participants. Please refer to the Note below.

2 - Client group Code applies for Service Contacts delivered on a group basis to two or more clients.

3 - Family / Client Support Network Code applies to Service Contacts delivered to the family/social support persons of the client, with or without the participation of the client.

4 - Other health professional or service provider Code applies for Service Contacts that involve another health professional or service provider (in addition to the Practitioner), with or without the participation of the client.

5 - Other Code applies to Service Contacts delivered to other third parties (e.g., teachers, employer), with or without the participation of the client.

Note: This item interacts with Service Contact - Client Participation Indicator. Where Service Contact - Participants has a value of '1: Individual', Service Contact - Client Participation Indicator must have a value of '1: Yes'. Service Contact - No Show is used to record if the patient failed to attend the appointment.

4.4.168. Service Contact - Postcode

The Australian postcode where the service contact took place.

Field name service_contact_postcode

Data type string

Required yes

Notes A valid Australian postcode or 9999 if the postcode is unknown. The full list of Australian Postcodes can be found at Australia Post.

- If Service Contact Modality is not ‘Face to Face’ enter 9999
- If Service Contact Modality is ‘Face to Face’ a valid Australian postcode must be entered
- As of 1 November 2016, PMHC MDS currently validates that postcodes are in the range 0200-0299 or 0800-9999.

METeOR 429894

4.4.169. Service Contact - Start Time

The start time of each mental health service contact between a health service provider and patient/client.

Field name service_contact_start_time

Data type time

Required yes

Notes Notes: Indicates the time at which the Service Contact began. Time should be recorded in 24-hour time in the format HH:MM. Leading zeroes are accepted but not required. For example, 8:30 in the morning could be 8:30 or 08:30 and 3:45 in the afternoon would be 15:45.

4.4.170. Service Contact - Tags

List of tags for the service contact.

Field name service_contact_tags

Data type string

Required no

Notes A comma separated list of tags.

Organisations can use this field to tag records in order to partition them as per local requirements.

Tags can contain lower case letters (or will get lowercased), numbers, dashes, spaces, and `!`. Leading and trailing spaces will be stripped. e.g. `priority!, nurse required, pending-outcome-1` would all be legitimate.

Tags beginning with an exclamation mark (!) are reserved for future use by the Department. e.g. `!reserved, ! reserved, !department-use-only`.

4.4.171. Service Contact - Type

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

Field name service_contact_type

Data type string

Required yes

Domain

0 No contact took place

1 Assessment

2 Structured psychological intervention

3 Other psychological intervention

4 Clinical care coordination/liaison

5 Clinical nursing services

6 Child or youth specific assistance NEC

7 Suicide prevention specific assistance NEC

8 Cultural specific assistance NEC

9 Psychosocial support

98 ATAPS

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

Note: NEC is used for 'Not Elsewhere Classified'. For these records, only use these service types if they cannot be classified by any of the other service options.

0 - No contact took place Only use this code where the service contact is recorded as a no show.

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

2 - Structured psychological intervention Those interventions which include a structured interaction between a client and a service provider using a recognised, psychological method, for example, cognitive behavioural techniques, family therapy or psycho education counselling.

These are recognised, structured or published techniques for the treatment of mental ill-health. Structured psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health. Structured psychological therapies can be delivered on either an individual or group basis, typically in an office or community setting. They may be delivered by trained mental health professionals or other individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional. Structured Psychological Therapies include but are not limited to:

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

3 - Other psychological intervention Psychological interventions that do not meet criteria for structured psychological intervention.

4 - Clinical care coordination/liaison Activities focused on working in partnership and liaison with other health care and service providers and other individuals to coordinate and integrate service delivery to the client with the aim of improving their clinical outcomes. Consultation and liaison may occur with primary health care providers, acute health, emergency services, rehabilitation and support services, family, friends, other support people and carers and other agencies that have some level of responsibility for the client's treatment and/or well being.

5 - Clinical nursing services Services delivered by mental health nurses that cannot be described elsewhere. Typically, these aim to provide clinical support to clients to effectively manage their symptoms and avoid unnecessary hospitalisation. Clinical nursing services include:

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

6 - Child or youth-specific assistance NEC Services delivered to, or on behalf, of a child or young person that cannot be described elsewhere. These can include, for example, working with a child's teacher to provide advice on assisting the child in their educational environment; working with a young person's employer to assist the young person to their work environment.

Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that the majority of Service Contacts delivered to children and young people can be assigned to other categories.

7 - Suicide prevention specific assistance NEC Services delivered to, or on behalf, of a client who presents with risk of suicide that cannot be described elsewhere. These can include, for example, working with the person's employers to advise on changes in the workplace; working with a young person's teacher to assist the child in their school environment; or working with relevant community-based groups to assist the client to participate in their activities.

Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that the majority of Service Contacts delivered to client's who have a risk of suicide can be assigned to other categories.

8 - Cultural specific assistance NEC Culturally appropriate services delivered to, or on behalf, of an Aboriginal or Torres Strait Islander client that cannot be described elsewhere. These can include, for example, working with the client's community support network including family and carers, men's and women's groups, traditional healers, interpreters and social and emotional wellbeing counsellors.

Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that the majority of Service Contacts (see domains below) delivered to Aboriginal or Torres Strait Islander clients can be assigned to other categories.

9 - Psychosocial support Service providers are required to report on Service Contact Type for every contact with a client. This requires a judgement about the main service delivered at each contact, selected from a small list of options, and based on the activity that accounted for most provider time. Service Contact Type complements Principal Focus of Treatment Plan by capturing information to understand the mix of services provided within an individual episode of care.

Service Contact Type should be coded as Psychosocial Support (code 9) where the main services delivered during the contact involved the delivery of psychosocial support services. Psychosocial support services are defined for PMHC MDS purposes as services that focus on building capacity and stability in one or more of the following areas:

- social skills and friendships, family connections;
- managing daily living needs;
- financial management and budgeting;
- finding and maintaining a home;
- vocational skills and goals, including volunteering;
- educational and training goals;
- maintaining physical wellbeing, including exercise;

- building broader life skills including confidence and resilience.

These services are usually delivered by a range of non-clinical providers including peer support workers with lived experience of mental illness.

Service Contacts recorded as psychosocial support may be delivered in all episodes of care, regardless of episode type. However, it is expected that they will be mainly associated with episodes where the Principal Focus of Treatment Plan is classified as Psychosocial Support.

98 - ATAPS Services delivered as part of ATAPS funded referrals that are recorded and/or migrated into the PMHC MDS.

Note: This code should only be used for Service Contacts that are migrated from ATAPS MDS sources that cannot be described by any other Service Type. It is expected that the majority of Service Contacts delivered to clients from 1st July, 2017 can be assigned to other categories.

This response will not be allowed on service contacts delivered after 30 June 2018. (All ATAPS referrals should have concluded by that date).

This response will only be allowed on service contacts with the !ATAPS flag.

4.4.172. Service Contact - Venue

Where the service contact was delivered, as represented by a code.

Field name service_contact_venue

Data type string

Required yes

Domain

1 Client's Home

2 Service provider's office

3 GP Practice

4 Other medical practice

5 Headspace Centre

6 Other primary care setting

7 Public or private hospital

8 Residential aged care facility

9 School or other educational centre

10 Client's Workplace

11 Other

12 Aged care centre - non-residential

98 Not applicable (Service Contact Modality is not face to face)

99 Not stated

Notes Note that this data item concerns only where the service contact took place. It is not about where the client lives. Thus, if a resident of an aged care residential facility is seen at another venue (e.g., at a GP Clinic), then the Service Contact Venue should be recorded as 'GP Practice' (code 3) to accurately reflect where the contact took place.

Values other than '98 - Not applicable' only to be specified when Service Contact Modality is 'Face to Face'.

6 - Other primary care setting This code is suitable for primary care settings such as community health centres.

8 - Residential aged care facility Use this code when the client is seen at an aged care residential facility.

12 - Aged care centre - non-residential Use this code when the client is seen at a non-residential aged care centre (e.g., community day program centre for older people).

98 - Not applicable (Service Contact Modality is not face to face) This code must only to be used where the Service Contact Modality is not face to face

All other data items would be recorded as per the guidelines that apply to those items – there are no special requirements specific to delivery of services to residents of aged care facilities. For example, any of the episode of care types recorded under the Principal Focus of Treatment Plan may apply; similarly, service contacts delivered to aged care residents may be any of the options available in Service Contact Type field.

4.4.173. Service Contact Key

This is a number or code assigned to each service contact. The Service Contact Key is unique and stable for each service contact at the level of the Provider Organisation.

Field name service_contact_key

Data type string (2,50)

Required yes

Notes PMHC MDS keys are case sensitive and must have between 2-50 valid unicode characters. Keys must start with A-Za-z0-9 (POSIX :alnum:).

Where data is being exported from client systems, these keys can be auto generated, providing that a key does not change once it is assigned.

Keys must be generated by the organisation to be unique at the Provider Organisation level and must persist across time. Creation of keys in this way allows records to be merged (where duplicate keys of the same record type have been identified) without having to re-allocate keys since they can never clash.

A recommended approach for the creation of keys is to compute random UUIDs.

4.4.174. Service Contact Practitioner Key

This is a number or code assigned to each service contact practitioner. The Service Contact Practitioner Key is unique and stable for each service contact practitioner at the level of the Provider Organisation.

Field name service_contact_practitioner_key

Data type string (2,50)

Required yes

Notes PMHC MDS keys are case sensitive and must have between 2-50 valid unicode characters. Keys must start with A-Za-z0-9 (POSIX :alnum:).

Where data is being exported from client systems, these keys can be auto generated, providing that a key does not change once it is assigned.

Keys must be generated by the organisation to be unique at the Provider Organisation level and must persist across time. Creation of keys in this way allows records to be merged (where duplicate keys of the same record type have been identified) without having to re-allocate keys since they can never clash.

A recommended approach for the creation of keys is to compute random UUIDs.

4.4.175. Value

The metadata value.

Field name value

Data type string

Required yes

4.5. Download Specification Files

Available for software developers designing extracts for the PMHC MDS, please click the link below to download the PMHC MDS Specification files:

- Specification zip

5. Upload specification

5.1. File requirements

Uploads will be rejected by our incoming data scanning system if they do not meet the following requirements:

- Must be either an Excel Workbook (.xlsx),
- OR a zip (.zip) file containing CSV files,
- AND must be less than 512MB

5.1.1. Excel Workbook (XLSX)

Excel files must be in XLSX format. The following versions of Excel support this format:

- Excel 2007 (v12.0)
- Excel 2010 (v14.0)
- Excel 2013 (v15.0)
- Excel 2016 (v16.0)

One XLSX file must be uploaded containing multiple worksheets - one worksheet for each format described below.

When saving your file, please choose the filetype 'Excel Workbook (.xlsx)'.

The filename of the Excel file doesn't matter as long as it has the file extension .xlsx

5.1.2. Zip file containting Comma Separated Values (CSV)

The CSV files must conform to RFC 4180.

In addition, CSV files must be created using UTF-8 character encoding.

CSV files must have the file extension .csv

Multiple CSV files must be uploaded - one CSV file for each format described below.

The CSV files must be compressed into a single file by zipping before upload. The filename of the zip file doesn't matter as long as it has the file extension .zip

5.1.3. File size

Files must be less than 512MB. The file size restriction prevents our systems from becoming unstable if extremely large files are uploaded. We will monitor if this limit causes issues for anyone and adjust it if necessary.

5.2. Files or worksheets to upload

Version 4 allows for different following files/worksheets to be uploaded in different contexts.

5.2.1. Intake

Table 5.1 Summary of files to upload in Intake context

File Type	CSV filename	Excel worksheet name	Required
Clients	clients.csv	Clients	Required
Intakes	intakes.csv	Intakes	Required
IAR-DST Measures	iar-dst.csv	IAR-DST	Required
Organisations	organisations.csv	Organisations	Optional only if the user has Organisation Management role
Metadata	metadata.csv	Metadata	Required

5.2.2. Hub Service Provider

Table 5.2 Summary of files to upload in Hub Service Provider context

File Type	CSV filename	Excel worksheet name	Required
Clients	clients.csv	Clients	Required
Intake Episodes	intake-episodes.csv	Intake Episodes	Required
Episodes	episodes.csv	Episodes	Required
Service Contacts	service-contacts.csv	Service Contacts	Required
Service Contact Practitioners	service-contact-practitioners.csv	Service Contact Practitioners	Required
Collection Occasions	collection-occasions.csv	Collection Occasions	Required
K10+ Measures	k10p.csv	K10+	Required
K5 Measures	k5.csv	K5	Required
SDQ Measures	sdq.csv	SDQ	Required

File Type	CSV filename	Excel worksheet name	Required
Practitioners	practitioners.csv	Practitioners	Required for first upload and when practitioner information changes. Optional otherwise
Organisations	organisations.csv	Organisations	Optional only if the user has Organisation Management role
Metadata	metadata.csv	Metadata	Required

5.2.3. Combined Intake/Hub Service Provider

Table 5.3 Summary of files to upload in Combinded Intake/Hub Service Provider context

File Type	CSV filename	Excel worksheet name	Required
Clients	clients.csv	Clients	Required
Intakes	intakes.csv	Intakes	Required
IAR-DST Measures	iar-dst.csv	IAR-DST	Required
Intake Episodes	intake-episodes.csv	Intake Episodes	Required
Episodes	episodes.csv	Episodes	Required
Service Contacts	service-contacts.csv	Service Contacts	Required
Service Contact Practitioners	service-contact-practitioners.csv	Service Contact Practitioners	Required
Collection Occasions	collection-occasions.csv	Collection Occasions	Required
K10+ Measures	k10p.csv	K10+	Required
K5 Measures	k5.csv	K5	Required
SDQ Measures	sdq.csv	SDQ	Required
Practitioners	practitioners.csv	Practitioners	Required for first upload and when practitioner information changes. Optional otherwise

File Type	CSV filename	Excel worksheet name	Required
Organisations	organisations.csv	Organisations	Optional only if the user has Organisation Management role
Metadata	metadata.csv	Metadata	Required

5.2.4. Non Hub Service Provider

Table 5.4 Summary of files to upload in Non Hub Service Provider context

File Type	CSV filename	Excel worksheet name	Required
Clients	clients.csv	Clients	Required
Episodes	episodes.csv	Episodes	Required
Service Contacts	service-contacts.csv	Service Contacts	Required
Service Contact Practitioners	service-contact-practitioners.csv	Service Contact Practitioners	Required
Collection Occasions	collection-occasions.csv	Collection Occasions	Required
K10+ Measures	k10p.csv	K10+	Required
K5 Measures	k5.csv	K5	Required
SDQ Measures	sdq.csv	SDQ	Required
Practitioners	practitioners.csv	Practitioners	Required for first upload and when practitioner information changes. Optional otherwise
Organisations	organisations.csv	Organisations	Optional only if the user has Organisation Management role
Metadata	metadata.csv	Metadata	Required

Each of the example files assumes the following organisation structure:

Organisation Key	Organisation Name	Organisation Type	Parent Organisation
PHN999	Test PHN	Primary Health Network	None
NFP01	Test Provider Organisation	Private Allied Health Professional Practice	PHN999

5.3. File format

Requirements for file formats:

- The first row must contain the column headings as defined for each file type.
- Each item is a column in the file/worksheet. The 'Field Name' must be used for the column headings. The columns must be kept in the same order.
- The second and subsequent rows must contain the data.
- Data elements for each file/worksheet are defined at Record formats.
- All files must be internally consistent. An example of what this means is that for every row in the episode file/worksheet, there must be a corresponding client in the client file/worksheet.
- All version 2.0 data uploads must include a Metadata file/worksheet. See Metadata file.

5.3.1. Metadata file

All version 2.0 data uploads must include a Metadata file/worksheet. - In the first row, the first cell must contain 'key' and the second cell must contain 'value' - In the second row, the first cell must contain 'type' and the second cell must contain 'PMHC' - In the third row, the first cell must contain 'version' and the second cell must contain '2.0'

i.e.:

key	value
type	PMHC
version	4.0

Data elements for the metadata upload file/worksheet are defined at Metadata.

Example metadata data:

- To be provided when specification finalised

5.3.2. Client format

The client file/worksheet is required to be uploaded each time.

Data elements for the client upload file/worksheet are defined at Client.

Example client data:

- To be provided when specification finalised

5.3.3. Intake format

The intake file/worksheet is required to be uploaded each time in the intake or combined intake/hub service provider contexts.

Data elements for the intake upload file/worksheet are defined at Intake.

Example intake data:

- To be provided when specification finalised

5.3.4. IAR-DST format

The IAR-DST file/worksheet is required to be uploaded each time in the intake or combined intake/hub service provider contexts.

Data elements for the IAR-DST upload file/worksheet are defined at IAR-DST.

Example IAR-DST data:

- To be provided when specification finalised

5.3.5. Intake Episode format

The intake episode file/worksheet is required to be uploaded each time in the hub service provider or combined contexts.

Data elements for the intake episode upload file/worksheet are defined at Intake Episode.

Example intake episode data:

- To be provided when specification finalised

5.3.6. Episode file format

The episode file/worksheet is required to be uploaded each time in the hub/non hub service provider or combined contexts.

Data elements for the episode upload file/worksheet are defined at Episode.

Example episode data:

- To be provided when specification finalised

5.3.7. Service Contact file format

The service contact file/worksheet is required to be uploaded each time in the hub/non hub service provider or combined contexts.

Data elements for the service contact upload file/worksheet are defined at Service Contact.

Example service contact data:

- To be provided when specification finalised

5.3.8. Service Contact Practitioner file format

The service contact practitioner file/worksheet is required to be uploaded each time in the hub/non hub service provider or combined contexts.

Data elements for the service contact practitioner upload file/worksheet are defined at Service Contact Practitioner.

Example service contact practitioner data:

- To be provided when specification finalised

5.3.9. Collection Occasion file format

The collection occasion file/worksheet is required to be uploaded each time in the hub/non hub service provider or combined contexts.

Data elements for the collection occasion upload file/worksheet are defined at Collection Occasion.

Example collection occasion data:

- To be provided when specification finalised

5.3.10. K10+ Collection Occasion file format

The K10+ file/worksheet is required to be uploaded each time in the hub/non hub service provider or combined contexts.

Data elements for the K10+ collection occasion upload file/worksheet are defined at K10+.

Example K10+ data:

- To be provided when specification finalised

5.3.11. K5 Collection Occasion file format

The K5 file/worksheet is required to be uploaded each time in the hub/non hub service provider or combined contexts.

Data elements for the K5 collection occasion upload file/worksheet are defined at K5.

Example K5 data:

- To be provided when specification finalised

5.3.12. SDQ Collection Occasion file format

The SDQ file/worksheet is required to be uploaded each time in the hub/non hub service provider or combined contexts.

Data elements for the SDQ collection occasion upload file/worksheet are defined at SDQ.

Example SDQ data:

- To be provided when specification finalised

5.3.13. Practitioner file format

The practitioner file/worksheet is required for the first upload and if there is a change in practitioners. It is optional otherwise. There is no harm in including it in every upload.

Data elements for the practitioner upload file/worksheet are defined at Practitioner.

Example practitioner data:

- To be provided when specification finalised

5.3.14. Organisation file format

This file is for PHN use only. The organisation file/worksheet is optional. It can be included to upload Provider Organisations in bulk or if there is a change in Provider Organisation details. There is no harm in including it in every upload.

Data elements for the Provider Organisation upload file/worksheet are defined at Provider Organisation.

Example organisation data:

- To be provided when specification finalised

5.3.15. Deleting records

- Records of the following type can be deleted via upload:
  - Client
  - Episode
  - Service Contact
  - K10+
  - K5
  - SDQ
  - Practitioner

  Organisation records *cannot* be deleted via upload. Please email support@pmhc-mds.com if you need to delete an organisation.
- An extra optional “delete” column can be added to each of the supported upload files/worksheets.
- If included, this column must be the third column in each file, after the organisation path and the record’s entity key.
- To delete a record, include its organisation path and its entity key, leave all other fields blank and put “delete” in the “delete” column. Please note that case is important. “DELETE” will not be accepted.
- Marking a record as deleted will require all child records of that record also to be marked for deletion. For example, marking a client as deleted will require all episodes, service contacts and collection occasions of that client to be marked for deletion.
- While deletions can be included in the same upload as insertions/updates, we recommend that you include all deletions in a separate upload that is uploaded before the insertions/updates.

Example files showing how to delete via upload:

- To be provided when specification finalised

5.4. Frequently Asked Questions

Please also refer to Uploading data for answers to frequently asked questions about uploading data.

6. Data item summary

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	
Key	Organisation Path	Organisation Path	Organisation Path	Organisation Path	Intake Organisation Path	Org Pat
Value	Organisation Key	Practitioner Key	Client Key	Intake Key	Intake Key	Epi
	Provider Organisation - Name	Practitioner - Category	Client - Statistical Linkage Key	Client Key	Episode Organisation Path	Clie
	Provider Organisation - Legal Name	Practitioner - ATSI Cultural Training	Client - Date of Birth	Client Consent to Anonymised Data	Episode Key	Epi Dat
	Provider Organisation - ABN	Practitioner - Year of Birth	Client - Estimated Date of Birth Flag	Referral Date		Clie to A Dat
	Provider Organisation - Type	Practitioner - Gender	Client - Gender	Referrer Profession		Epi Cor Sta
	Provider Organisation - State	Practitioner - Aboriginal and Torres Strait Islander Status	Client - Aboriginal and Torres Strait Islander Status	Referrer Organisation Type		Epi Cor Sup
	Provider Organisation - Start Date	Practitioner - Active	Client - Country of Birth	Intake - Date client contacted Intake		Ref

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	
	Provider Organisation - End Date	Practitioner - Tags	Client - Main Language Spoken at Home	Intake - Funding Source		Epis Prir of T Plar
	Provider Organisation - Tags		Client - Proficiency in Spoken English	Intake - Date referred to other service at Intake conclusion		Epis Me Trea Flag
			Client - Tags	Organisation type referred to at Intake conclusion		Epis Hor Flag
				Referred to Organisation Path		Epis usu pos
				Intake - Tags		Epis For
						Epis Emp Par
						Epis of C
						Epis Car
						Epis Par
						Epis Stat
						Epis Ref

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	
						Epis Prir Dia
						Epis Add Dia
						Epis Me Ant (NC
						Epis Me Anx (NC
						Epis Me Hyp sed
						Epis Me Ant (NC
						Epis Me Psy and (NC
						Ref Pro
						Ref Org Typ
						Org typ at E con
						Epis

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	

7. Using the data specification to create client forms

Some consideration needs to be taken when designing forms based on this data specification.

7.1. Not stated/missing codes

Not stated/missing codes (normally code 9, 99, 999 or 9999) are not to be available as a valid answers to questions but is intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

7.2. Country of Birth

Client - Country of Birth has a large permitted domain. It is not feasible to provide all allowed responses on a form. The Australian Bureau of Statistics recommends two standard question modules for Country of Birth:

- Detailed question module
- Short question module

7.2.1. Detailed question module

The detailed question module is the recommended module for Country of Birth. An example is:

```
Q. In which country [were you][was the person] born?

  Australia     q
  England       q
  New Zealand   q
  India         q
  Italy         q
  Vietnam       q
  Philippines   q
  South Africa  q
  Scotland      q
  Malaysia      q
  Other - Please specify.............
```

Form designers do not need to use the countries shown in this example. They should choose countries relevant to the population for their region. The “Other” response can then be mapped to a Client - Country of Birth during data entry.

7.2.2. Short question module

The short question module can be used where there are space constraints. An example is:

```
Q. In which country [were you][was the person] born?

  Australia    q
  Other - please specify.............
```

The “Other” response can then be mapped to a country code during data entry. This form has higher overheads as each response will need to be matched to a Client - Country of Birth during data entry.

7.3. Main Language Spoken at Home

Client - Main Language Spoken at Home has a large permitted domain. It is not feasible to provide all allowed responses on a form. The Australian Bureau of Statistics recommends two standard question modules for Main Language Spoken at Home:

- Detailed question module
- Short question module

7.3.1. Detailed question module

The detailed question module is the recommended module for Main Language Spoken at Home. An example is:

```
Q. [Do you][Does the person] speak a language other than English at home?
   (If more than one language, indicate the one that is spoken most often.)

  No, English       q
  Yes,  Mandarin    q
  Yes,  Italian     q
  Yes,  Arabic      q
  Yes,  Cantonese   q
  Yes,  Greek       q
  Yes,  Vietnamese  q
  Yes,  Spanish     q
  Yes,  Hindi       q
  Yes,  Tagalog     q
  Yes,  Other - Please Specify.............
```

For self enumerated questionnaires, respondents should be instructed to mark one box only.

Form designers do not need to use the languages shown in this example. They should choose languages relevant to the population for their region. The “Other” response can then be mapped to a Client - Main Language Spoken at Home during data entry.

7.3.2. Short question module

The short question module can be used where there are space constraints. An example is:

```
Q. [Do you] [Does the person] speak a language other than English at home?

  No, English only    q
  Yes,  Other - please specify.............
```

The “Other” response can then be mapped to a country code during data entry. This form has higher overheads as each response will need to be matched to a Client - Main Language Spoken at Home during data entry.

8. Validation Rules

This document defines validation rules between items and record types. The domain of individual items is defined in Record formats.

8.1. Current Validations

8.1.1. Keys

The following rules apply to the key fields in all records:

1. All key fields are case sensitive
2. All key fields must be valid unicode characters

8.1.2. Practitioner

1. Refer to Keys for Practitioner Key validations
2. Practitioner - ATSI Cultural Training must only be set to '3 - Not required' where Practitioner - Aboriginal and Torres Strait Islander Status is one of

   - '1: Aboriginal but not Torres Strait Islander origin'
   - '2: Torres Strait Islander but not Aboriginal origin'
   - '3: Both Aboriginal and Torres Strait Islander origin'

   or

   The organisation to which the practitioner belongs has Provider Organisation - Type set to '8: Aboriginal Health/Medical Service'

8.1.3. Client

1. Refer to Keys for Client Key validations
2. Client - Date of Birth must not be before 1 January 1900 and must not be in the future

8.1.4. Intake

1. Refer to Keys for Intake Key validations
2. The Intake - Date referred to other service at Intake conclusion must not be before the Intake - Date client contacted Intake
3. Referrer Organisation Type must be set to '98: N/A - Self referral' if and only if Referrer Profession is also '98: N/A - Self referral'
4. A maximum of one intake shall be open per client
5. The Intake - Date client contacted Intake
    - must not be before 1 January 2020
    - and must not be before Provider Organisation - Start Date
    - and must not be after Provider Organisation - End Date
    - and must not be in the future
6. The Intake - Date referred to other service at Intake conclusion
    - must not be before 1 January 2020
    - and must not be before Provider Organisation - Start Date
    - and must not be after Provider Organisation - End Date
    - and must not be in the future
7. If a Referred to Organisation Path is specified, that organisation must be an existing organisation within the PMHC MDS

8.1.5. IAR-DST

1. Refer to Keys for Measure Key validations
2. Intake Key must be an existing Intake within the PMHC MDS
3. Both all 8 domains and the level of care must be provided
4. The level of care must be consistent with the 8 domain scores provided

8.1.6. Intake - Episode

1. If a Intake Organisation Path is specified, that organisation must be an existing organisation within the PMHC MDS
2. If an Intake Key is specified, a Intake Organisation Path must also be specified
3. If an Episode Organisation Path is specified, that organisation must be an existing organisation within the PMHC MDS
4. Episode Key must be an existing PMHC episode within the PMHC MDS

8.1.7. Episode

1. Refer to Keys for Episode Key validations
2. The Episode - End Date must not be before the Referral Date
3. Referrer Organisation Type must be set to '98: N/A - Self referral' if and only if Referrer Profession is also '98: N/A - Self referral'
4. A maximum of one episode shall be open per client
5. Where the Episode - Completion Status has been recorded using one of the 'Episode closed' responses (Response items 1-6), the episode must have an Episode - End Date, and/or episodes that have an Episode - End Date must have an Episode - Completion Status recorded using one of the 'Episode closed' responses (Response items 1-6)
6. On Episode - Principal Diagnosis and Episode - Additional Diagnosis the values:

   - '100: Anxiety disorders (ATAPS)'
   - '200: Affective (Mood) disorders (ATAPS)'
   - '300: Substance use disorders (ATAPS)'
   - '400: Psychotic disorders (ATAPS)'

   must only used where data has been migrated from ATAPS. The above responses must only be used under the following conditions:

   - The Referral Date was before 1 July 2017
   - The Episode - Tags field must contain the `!ATAPS` flag
7. The '4: Complex care package' response for Episode - Principal Focus of Treatment Plan must only be used by selected PHN Lead Sites
8. The `!ATAPS` tag must only be included in the Episode - Tags field where the Referral Date was before 1 July 2017
9. The Episode - End Date

   - must not be before 1 January 2016
   - and must not be before Provider Organisation - Start Date
   - and must not be after Provider Organisation - End Date
   - and must not be in the future
10. The Referral Date

    - must not be before 1 January 2014
    - and must not be before Provider Organisation - Start Date
    - and must not be after Provider Organisation - End Date
    - and must not be in the future

8.1.8. Service Contact

1. Refer to Keys for Service Contact Key validations
2. Where Service Contact - Final is recorded as '1: No further services are planned for the client in the current episode', the Episode - Completion Status must be recorded using one of the 'Episode closed' responses (Response items 1-6)
3. Where Service Contact - Final is recorded as '1: No further services are planned for the client in the current episode', the date of the Service Contact - Final must be recorded as the Episode End Date
4. Where an Episode - End Date has been recorded, a later Service Contact - Date must not be added
5. If Service Contact - Type is '0: No contact took place', Service Contact - No Show must be '1: Yes'
6. If Service Contact - Duration is '0: No contact took place', Service Contact - No Show must be '1: Yes'
7. If Service Contact - Modality is '0: No contact took place', Service Contact - No Show must be '1: Yes'
8. If Service Contact - Modality is not '1: Face to Face', Service Contact - Postcode must be 9999
9. If Service Contact - Modality is '1: Face to Face', Service Contact - Postcode must not be 9999
10. If Service Contact - Modality is '1: Face to Face', Service Contact - Venue must not be '98: Not applicable (Service Contact Modality is not face to face)'
11. On Service Contact - Type the value '98: ATAPS' must only be used where data has been migrated from ATAPS. The above response must only be used under the following conditions:

    - The Service Contact - Date was before 30 June 2018
    - The Service Contact - Tags field must contain the `!ATAPS` flag
12. If Service Contact - Participants is '1: Individual client' Service Contact - Client Participation Indicator must be '1: Yes'
13. The `!ATAPS` tag must only be included in the Service Contact - Tags field where the Service Contact - Date was before 30 June 2018
14. The Service Contact - Date

    - must not be before 1 January 2016
    - and must not be before Provider Organisation - Start Date
    - and must not be after Provider Organisation - End Date
    - and must not be in the future

8.1.9. Service Contact Practitioner

1. Refer to Keys for Service Contact Practitioner Key validations
2. Service Contact Key must be an existing PMHC service contact within the PMHC MDS
3. Practitioner Key must be an existing PMHC practitioner within the PMHC MDS
4. One, and only one, Service Contact Practitioner per service contact must be flagged as the Primary Practitioner

8.1.10. Collection Occasion

1. Refer to Keys for Collection Occasion Key validations
2. Episode Key must be an existing PMHC episode within the PMHC MDS
3. The Collection Occasion - Date

    - must not be before 1 January 2016
    - and must not be before Episode - Referral Date
    - and must not be before Provider Organisation - Start Date
    - and must not be more than 7 days after Episode - End Date
    - and must not be after Provider Organisation - End Date
    - and must not be in the future

8.1.11. K10+

1. Refer to Keys for Measure Key validations
2. Collection Occasion Key must be an existing Collection Occasion within the PMHC MDS
3. If both item scores and a total score are specified, the item scores must add up to the total score (as per Scoring the K10+)

8.1.12. K5

1. Refer to Keys for Measure Key validations
2. Collection Occasion Key must be an existing Collection Occasion within the PMHC MDS.
3. If both item scores and a total score are specified, the item scores must add up to the total score (as per Scoring the K5).

8.1.13. SDQ

1. Refer to Keys for Measure Key validations
2. Collection Occasion Key must be an existing Collection Occasion within the PMHC MDS.
3. Use the table at SDQ Data Elements to validate the items that are used in each version of the SDQ
4. If both item scores and subscales are specified, the sum of the items must agree with the subscales score (as per Scoring the SDQ)
5. If both subscales and total score are specified, the sum of the subscales must agree with the total score (as per Scoring the SDQ)

8.1.14. Organisation

1. Refer to Keys for Provider Organisation Key validations
2. The Provider Organisation - Start Date
    - must not be before 1 January 2014 or before a commissioning organisation's start date
    - and must not be after the earliest Intake - Date client contacted Intake
    - and must not be after the earliest Intake - Date referred to other service at Intake conclusion
    - and must not be after the earliest Referral Date
    - and must not be after the earliest Service Contact - Date
    - and must not be after the earliest Collection Occasion - Date
    - and must not be in the future
3. The Provider Organisation - End Date
    - must not be before 1 January 2014 or after a commissioning organisation's end date
    - and must not be before the latest Intake - Date client contacted Intake
    - and must not be before the latest Intake - Date referred to other service at Intake conclusion
    - and must not be before the latest Referral Date
    - and must not be before the latest Episode - End Date
    - and must not be before the latest Service Contact - Date
    - and must not be before the latest Collection Occasion - Date
    - can be in the future

9. Test Data Sets

9.1. SLK Test Data Set

We are providing the following test data to allow developers to test their implementation of the SLK specification as defined at https://docs.pmhc-mds.com/data-specification/data-model-and-specifications.html#client-statistical-linkage-key.

9.1.1. SLK Generation Test Data

Table 9.1 Summary of files to upload

Explanation	First name	Last name	Birth Day	Birth Month	Birth Year	Gender	Expecte
Everything there	John	Stevens	7	6	1954	1	TEEOH070
Everything there, padded day and month	John	Stevens	07	06	1954	2	TEEOH070
A short last name	John	Bo	7	6	1954	3	O22OH070
A short first name	Jo	Stevens	7	6	1954	9	TEEO2070
No last name	John		7	6	1954	1	999OH070
No first name		Stevens	7	6	1954	2	TEE990706
No names at all			7	6	1954	3	999990706
No gender	John	Stevens	7	6	1954	9	TEEOH070
Non-alpha characters in the name	Jo,hn	St’ e-vens	7	6	1954	1	TEEOH070
No birth day	John	Stevens		6	1954	1	
No birth month	John	Stevens	7		1954	1	
No birth year	John	Stevens	7	6		1	

Explanation	First name	Last name	Birth Day	Birth Month	Birth Year	Gender	Expecte
Non numeric inputs for dates	John	Stevens	a	b	1997`	z	
Default date of birth	John	Stevens	9	9	9999	1	TEEOH090
UTF8 character in the name	John	Amélie	7	6	1954	3	MEIOH070

Download SLK Generation Test Data as CSV.

9.1.2. SLK Validation Test Data

Table 9.2 Summary of files to upload

Explanation	SLK	Valid/Invalid
Every component valid	TEEOH070619541	Valid
Valid with padded 2s	O22N2070619543	Valid
Valid with unknown names	99999070619543	Valid
Too short	TEEOH07061954	Invalid
Too long	99999010119993x	Invalid
Gender not valid	99999010119935	Invalid
Invalid date	99999999999999	Invalid

Download SLK Validation Tests as CSV.

10. Reserved Tags

This document defines the Department reserved tags used to identify specific records types in the Primary Mental Health Care Minimum Data Set (PMHC MDS). Tags beginning with an exclamation mark (`!`) are reserved for future use by the Department.

Tags field definitions for each record type are available in Record formats.

10.1. !br20 - Australian Government Mental Health Response to Bushfire

PHNs in fire affected communities are funded through the *Australian Government Mental Health Response to Bushfire Trauma* to deliver services including:

- Front line emergency distress and trauma counselling, with up to 10 free mental health support sessions for individuals, families and emergency services personnel
- 'Surge capacity' mental health services to individuals and families who are affected, and
- Increased demand for headspace sites in fire affected areas.

The PMHC MDS reporting changes are designed to capture this funded service activity through the reserved Episode tag `!br20`.

10.1.1. PHNs who received funding

PHNs funded through the *Australian Government Mental Health Response to Bushfire Trauma* **must** apply the bushfire response tag to all episodes where one or more service contacts is funded by the response.

For these PHNs, the service provider should apply the bushfire response tag to:

10.1.1.1. New clients

- Who are accessing services funded through the *Australian Government Mental Health Response to Bushfire Trauma*
- Whose access to a mental health service was prompted by exposure to bushfire (e.g. their stated reason for approaching a service is their recent exposure to bushfire), and/or
- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. based on the judgement of the service provider).

10.1.1.2. Existing clients

i.e. clients with an open episode.

- Who are accessing services funded through the *Australian Government Mental Health Response to Bushfire Trauma*, and/or
- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. additional or higher intensity services are required).

10.1.2. PHNs who did not receive funding

PHNs who did not receive funding for *Australian Government Mental Health Response to Bushfire Trauma* activities may use the PMHC MDS reporting changes to capture the service response to bushfire trauma.

For these PHNs, the service provider should apply the bushfire response tag to:

10.1.2.1. New clients

- Whose access to a mental health service was prompted by exposure to bushfire (e.g. their stated reason for approaching a service is their recent exposure to bushfire), and/or
- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. based on the judgement of the service provider).

10.1.2.2. Existing clients

i.e. clients with an open episode.

- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. additional or higher intensity services are required).

10.1.3. How to apply the tag in the PMHC MDS Data Entry interface

The bushfire response tag is available for use on an episode record and is denoted `!br20`.

There are two ways to apply the tag through the PMHC MDS data entry interface:

1. Manual data entry by typing the tag `!br20` to the Episode tag field.
    - When entering data directly, episodes will need to be tagged with the string `!br20`. The data entry system already allows for the tagging of records and therefore it is possible to implement this immediately by communicating the instructions to users.
    - Please note the free text nature of the tag system increases the opportunity for errors because it is easy to mistype a tag. This should be emphasised in communications with users.

2. Tick the box labelled 'Australian Government Mental Health Response to Bushfire'.
    - This tick box automatically adds/removes the tag when ticked/unticked. This functionality will be available by 24 January 2020.

The checkbox is on the Episode add and edit screen:

- Ticking the checkbox will add the `!br20` tag to the tag field
- Typing the `!br20` tag into the tag box will also tick the checkbox
- Unticking the `!br20` checkbox will remove the `!br20` tag
- Deleting the `!br20` tag from the tag field will also untick the checkbox

10.1.4. Considerations for applying the !br20 tag in data uploads

Please refer to Considerations for applying reserved tags in data uploads

10.2. !covid19 - Australian Government HeadtoHelp hubs

The Australian Government is providing funding to Victorian PHNs to deliver services through HeadtoHelp hubs as part of its response to the mental health impact of COVID-19.

The department is implementing a new tag in the PMHC MDS to capture activity associated with the HeadtoHelp hubs.

This change only applies to PHNs in Victoria.

The department will introduce further data collection requirements for HeadtoHelp activity in the coming weeks and is consulting with PHNs. The Department will advise Victorian PHNs of new data collection requirements in future circular/s.

10.2.1. New 'Australian Government HeadtoHelp hubs' tag (!covid19)

The Department has introduced an 'Australian Government HeadtoHelp hubs' tag to the PMHC MDS.

All clients who either call the 1800 HeadtoHelp number or present in person at a HeadtoHelp hub and are identified as HeadtoHelp hub clients will be assessed through the 'HeadtoHelp Victorian Mental Health Hubs Intake Assessment and Referral Model of Care' as outlined in the contract. Clients will be referred to the most suitable service, which may be at a HeadtoHelp hub.

The PHN *must* apply 'Australian Government HeadtoHelp hubs' tag (!covid19) to episodes of care initiated for clients who have been referred to the hub through the IAR process and are receiving services funded through the HeadtoHelp hubs contracts.

10.2.2. How to apply the tag in the PMHC MDS Data Entry interface

The HeadtoHelp hubs tag is available for use on an episode record and is denoted `!covid19`.

There are two ways to apply the tag through the PMHC MDS data entry interface:

1. Manual data entry by typing the tag `!covid19` to the Episode tag field.

    - When entering data directly, episodes will need to be tagged with the string `!covid19`. The data entry system already allows for the tagging of records and therefore it is possible to implement this immediately by communicating the instructions to users.
    - Please note the free text nature of the tag system increases the opportunity for errors because it is easy to mistype a tag. This should be emphasised in communications with users.

2. Tick the box labelled 'Australian Government HeadtoHelp hubs (!covid19)'.

    - This tick box automatically adds/removes the tag when ticked/unticked.

The checkbox is on the Episode add and edit screen:

- Ticking the checkbox will add the `!covid19` tag to the tag field
- Typing the `!covid19` tag into the tag box will also tick the checkbox
- Unticking the `!covid19` checkbox will remove the `!covid19` tag
- Deleting the `!covid19` tag from the tag field will also untick the checkbox

10.2.3. Considerations for applying the !covid19 tag in data uploads

Please refer to Considerations for applying reserved tags in data uploads

10.2.4. Considerations for applying reserved tags in data uploads

Users of local third-party or in-house developed systems will need to address varying issues depending on the capability of the system. When considering options please be aware the PMHC MDS specification does not require that data is captured in the same manner as it is supplied during upload.

For example, an ideal solution could be to add an extensible multiple choice "Tags" field to local episode data entry screens. This could initially include an "Australian Government Mental Health Response to Bushfire" option thereby providing the organisation control over the possible tags that can be captured. By ensuring that additional options were easily added in the future such a field would support future special access programs without significant changes, as well as other purposes local or as requested by the Department.

An alternative approach, requiring less development, would be to extend an existing local field at the episode level with an "Australian Government Mental Health Response to Bushfire" option. This gives the organisation control over the values that may be selected.

In both of the above examples, development work would also be required in the data extraction process used to produce PMHC MDS compliant upload files. An endorsement of "Australian Government Mental Health Response to Bushfire" via either method would be converted to the tag !br20 on the extracted episode records where appropriate.

An alternative but not preferred option is that episode records could be uploaded and then subsequently manually tagged via the data entry interface. This would require significant manual processes and double handling but it is a use case supported by the PMHC MDS.

If you have queries about managing data upload processes please contact the PMHC MDS helpdesk at support@pmhc-mds.com.

11. Data Specification Change log

11.1. ??/??/2021 - Draft Version 4.0

- Data model and specifications
    - Record formats
        - Added Collection Occasion