



**Australian Government**

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**Department of Health**

# **PMHC-MDS Data Specification**

Version 4.0.0-draft.3

As at 30 June, 2022

# Table of Contents

1. Introduction.....	3
1.1. Contexts.....	4
1.2. New Records and Fields in Version 4.....	6
1.3. Data release and confidentiality.....	8
2. Reporting arrangements.....	8
2.1. Reporting data.....	9
2.2. Reporting timeliness.....	9
2.3. Inputs to help replicate system generated reports.....	9
2.4. Support arrangements.....	10
3. Identifier management.....	10
3.1. Managing Provider Organisation Keys.....	11
3.2. Managing Client Keys.....	11
3.3. Managing all other entity keys.....	11
4. Data model and specifications.....	12
4.1. Data model.....	13
4.2. Key concepts.....	16
4.3. Record formats.....	18
4.4. Definitions.....	128
4.5. Download Specification Files.....	261
5. Upload specification.....	261
5.1. File requirements.....	262
5.2. Files or worksheets to upload.....	262
5.3. File format.....	265
5.4. Example Upload files.....	269
5.5. Deleting records.....	269
5.6. Frequently Asked Questions.....	270
6. Data item summary.....	271
7. Using the data specification to create client forms.....	275
7.1. Not stated/missing codes.....	276
7.2. Country of Birth.....	137
7.3. Main Language Spoken at Home.....	179
8. Validation Rules.....	278
8.1. Current Validations.....	279
9. Test Data Sets.....	284
9.1. SLK Test Data Set.....	285
10. Reserved Tags.....	286
10.1. !br20 - Australian Government Mental Health Response to Bushfire.....	287
11. Data Specification Change log.....	289
11.1. ??/?/2022 - 4.0.0-draft.3.....	290
11.2. 31/5/2022 - 4.0.0-draft.2.....	290

11.3. 1/12/2021 - 4.0.0-draft.1 .....	290
11.4. 30/11/2021.....	3
11.5. 25/11/2021 - Draft Version 4.0 .....	290

# 1. Introduction

The recording of intake related activity (including activity for the Head to Health 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 three contexts where data can be submitted using the version 4 specification:

- 1. Intake teams
- 2. Treatment organisations
- 3. Combined Intake/Treatment organisations

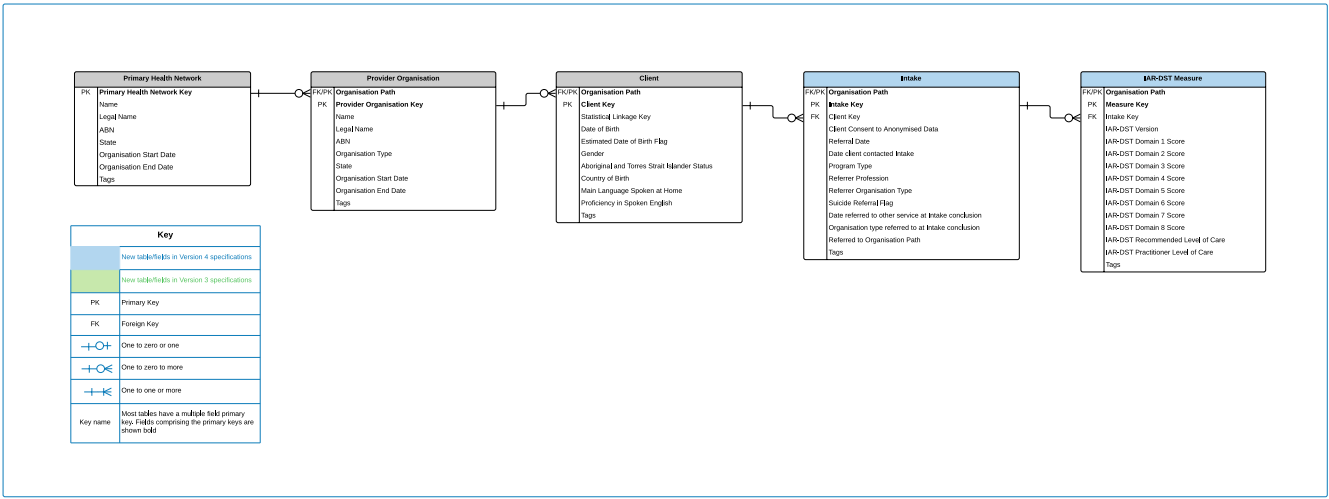
Different records in the specification are intended to be used in each of these contexts.

Within the PMHC-MDS system a single intake team and individual service providers/treatment organisations will each have their own organisation path and report data against those organisations.

### 1.1.1. Intake Context

Where an organisation is only providing intake services and not providing any treatment services, they can use the following data model to submit data to the PMHC MDS:

PMHC MDS v4.0 Intake Only Data Model Usage Scenario



Version v4.0 22/06/2022

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

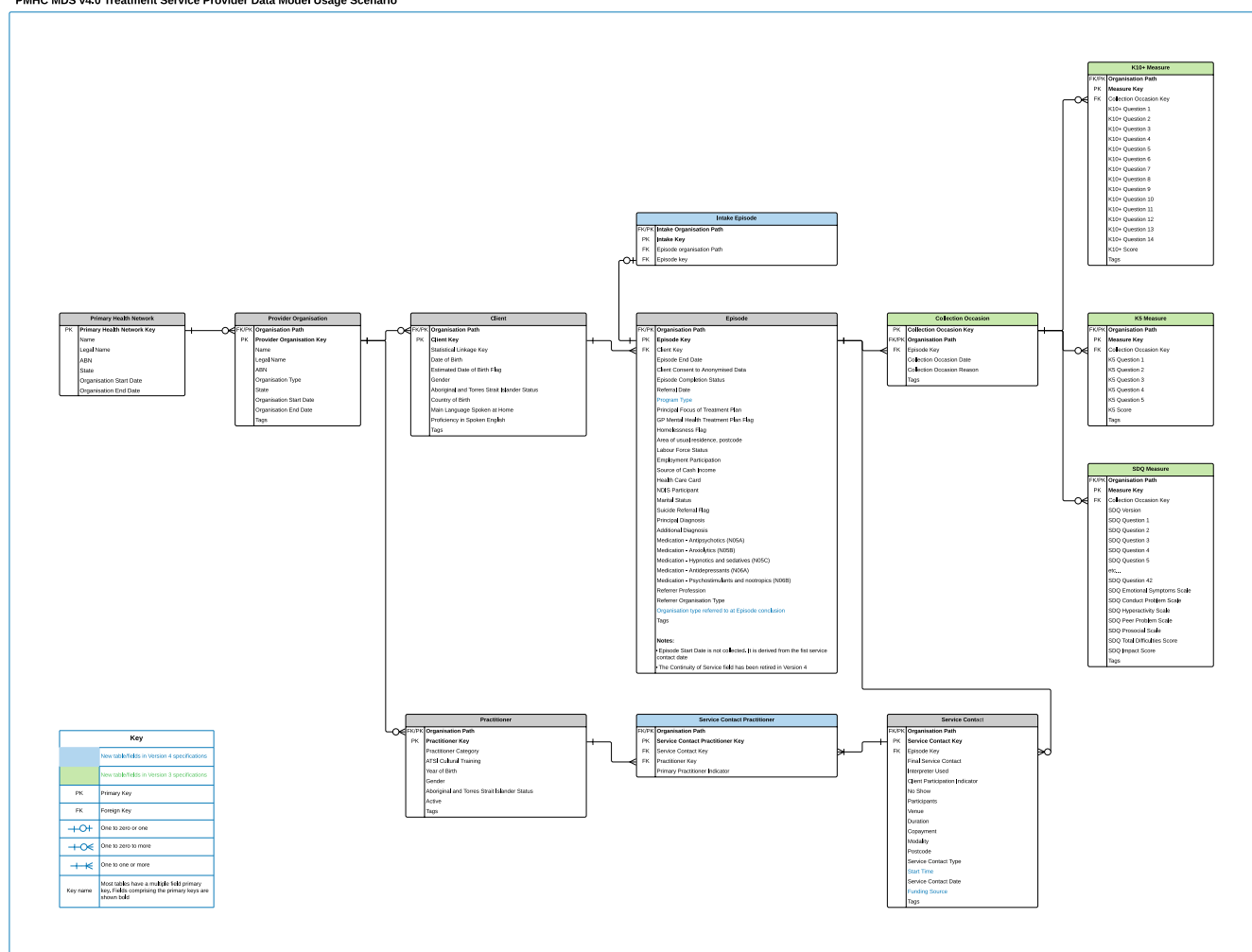
- Client
- Intake
- IAR-DST

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

### 1.1.2. Treatment Service Provider Context

Where an organisation is only providing treatment services and not providing any intake services, they can use the following data model to submit data to the PMHC MDS:

PMHC MDS v4.0 Treatment Service Provider Data Model Usage Scenario

[illegible]

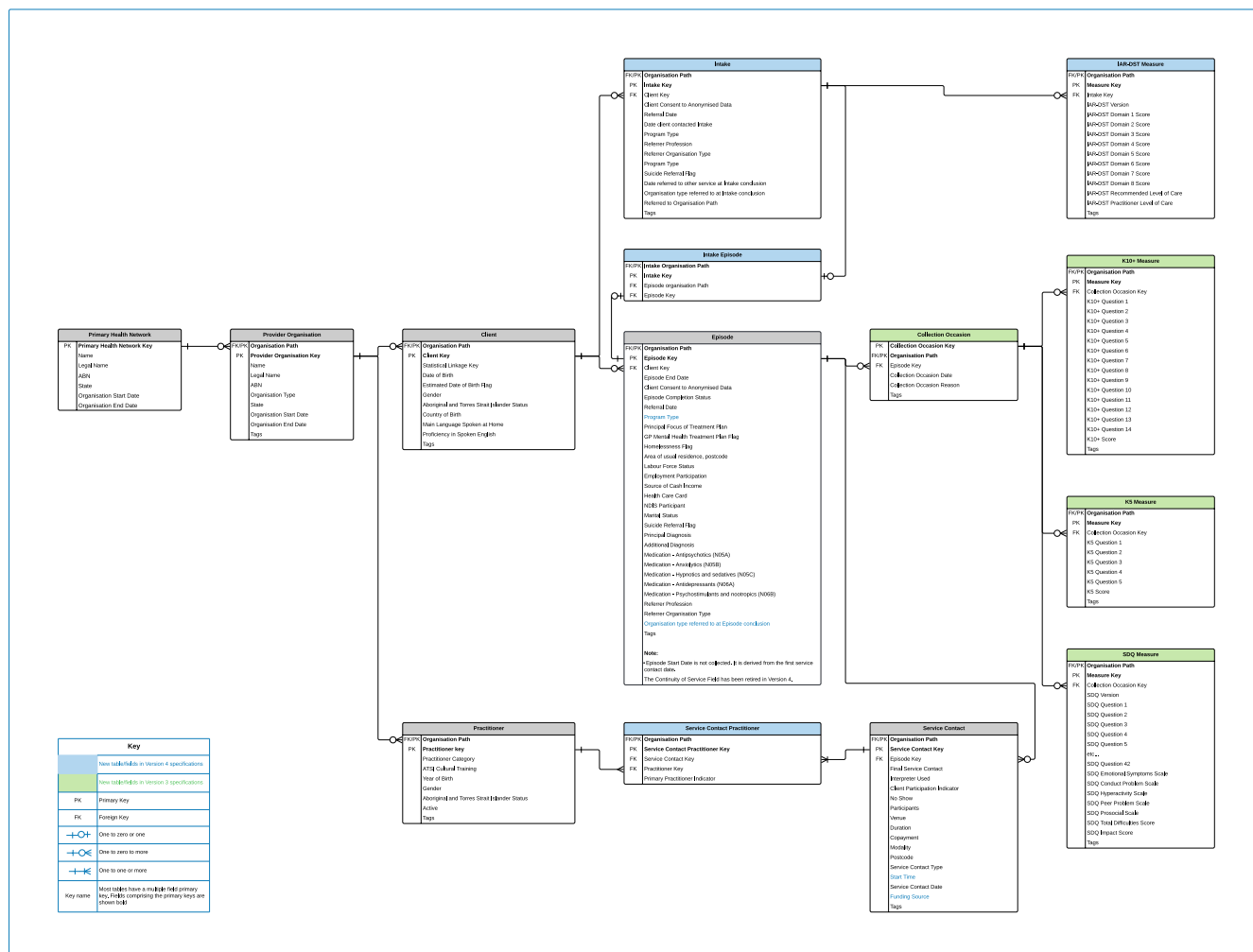
In the treatment context the specification works almost the same as a service reporting via the Version 2 core PMHC-MDS specification using the new [Intake Episode](#) record to identify additional detail regarding referrals in from the intake teams ([Intake Organisation Path](#) and [Intake Key](#)), 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.

Intake and IAR-DST activity is not submitted in this context.

### 1.1.3. Combined Intake/Treatment Context

Where an organisation is providing both intake services and treatment services, they can use the full data model to submit data to the PMHC MDS:

PMHC MDS v4.0 Combined Intake and Service Provider Data Model Usage Scenario



In the combined context all the records described in both the [Intake Context](#) and [Treatment Service Provider Context](#) can be submitted.

## 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 Intake record at the intake provider organisation to the Episode record at the treatment organisation.

The values of these fields should be passed along by the intake organisation to the treatment organisation where the treatment 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 treatment 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 treatment service, a new [Episode](#) record is created.

Where the client has been referred via an intake process, 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 ([Start Time](#)). This is intended to enable identification of activity undertaken during extended hours.
2. The funding source for the 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

There are three contexts where data can be submitted using the version 4 specification:

1. Intake teams
2. Treatment organisations
3. Combined Intake/Treatment organisations

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

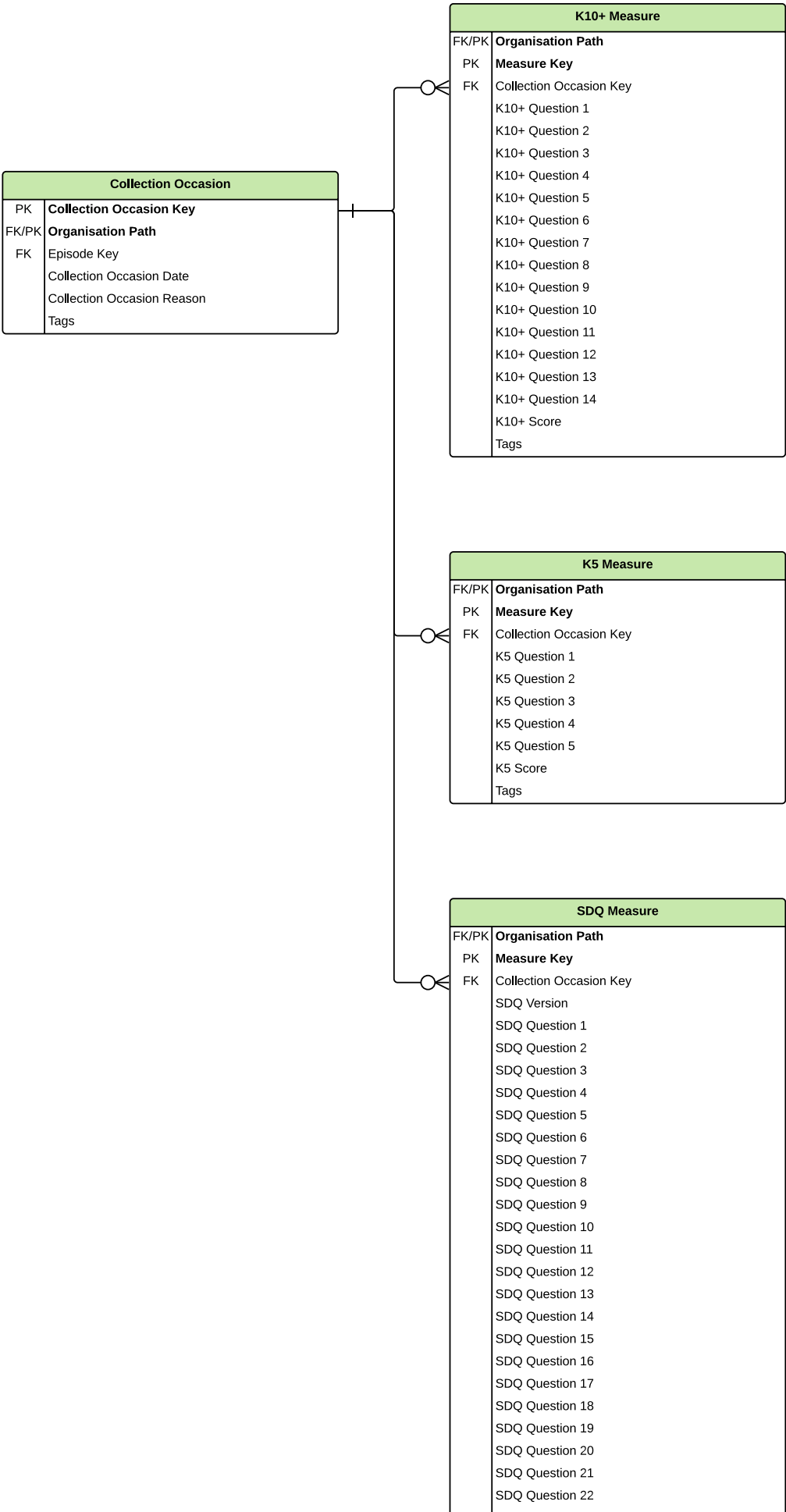
Within the PMHC-MDS system a single intake team and individual service providers/treatment organisations will each have their own organisation path and report data against those organisations.

Below is the combined Intake/Treatment data model. If an Intake only or Treatment only organisation is submitting data, a sub set of this data model may be submitted. Please refer to [Contexts](#) for data models of the different contexts that may be submitted.



Final Version: 2022/03/22

PMHC MDS v4.0 Collection Occasion Data Model



## ***Fig. 4.2 PMHC MDS Version 4.0 Collection Occasion data model***

**Note:** See [PMHC MDS Version 4.0 combined 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
<a href="#">Key</a> (key)	string	yes	A metadata key name.
<a href="#">Value</a> (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
<a href="#">Organisation Path</a> (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
<a href="#">Organisation Key</a> (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.
<a href="#">Name</a> (organisation_name)	string (2,100)	yes	The name of the provider organisation.
<a href="#">Legal Name</a> (organisation_legal_name)	string	—	The legal name of the provider organisation.
<a href="#">ABN</a> (organisation_abn)	string (11)	yes	The Australian Business Number of the provider organisation.

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">State</a> (organisation_state)  METeOR: <a href="#">613718</a>	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
<a href="#">Organisation Start Date</a> (organisation_start_date)	date	yes	The date on which a provider organisation started delivering services.
<a href="#">Organisation End Date</a> (organisation_end_date)	date	yes	The date on which a provider organisation stopped delivering services.
<a href="#">Organisation Tags</a> (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
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Practitioner Key</a> (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
ATSI Cultural Training (atsi_cultural_training)	string	yes	1 Yes 2 No 3 Not required 9 Missing / Not recorded
Year of Birth (practitioner_year_of_birth)	gYear	yes	gYear



Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Practitioner Gender</a> (practitioner_gender)  <a href="#">ABS</a>	string	yes	0 Not stated/ Inadequately described  1 Male  2 Female  3 Other
<a href="#">Practitioner Aboriginal and Torres Strait Islander Status</a> (practitioner_atssi_status)  METeOR: <a href="#">291036</a>	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
<a href="#">Active</a> (practitioner_active)	string	yes	0 Inactive  1 Active
<a href="#">Practitioner Tags</a> (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.
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.
Date of Birth (date_of_birth)  METeOR: 287007	date	yes	The date on which an individual was born.
Estimated Date of Birth Flag (est_date_of_birth)	string	yes	<ol style="list-style-type: none"> <li>1 Date of birth is accurate</li> <li>2 Date of birth is an estimate</li> <li>8 Date of birth is a 'dummy' date (ie, 09099999)</li> <li>9 Accuracy of stated date of birth is not known</li> </ol>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Client Gender</a> (client_gender)  <a href="#">ABS</a>	string	yes	0 Not stated/ Inadequately described  1 Male  2 Female  3 Other
<a href="#">Practitioner Aboriginal and Torres Strait Islander Status</a> (practitioner_atssi_status)  METeOR: <a href="#">291036</a>	string	yes	Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin, as represented by a code.

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9799 Sign Languages, nec 9999 Unknown
<a href="#">Proficiency in Spoken English</a> (prof_english)  METeOR: <a href="#">270203</a>	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
<a href="#">Client Tags</a> (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
<a href="#">Organisation Path</a> (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
<a href="#">Intake Key</a> (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.
<a href="#">Client Key</a> (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.
<a href="#">Client Consent to Anonymised Data</a> (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.
<a href="#">Referral Date</a> (referral_date)	date	yes	The date the referrer made the referral.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Program Type (program_type)	string	yes	<div><div>1</div>Flexible Funding Pool</div> <div><div>2</div>Head to Health</div> <div><div>3</div>AMHC</div> <div><div>4</div>Psychosocial Support</div> <div><div>5</div>Bushfire 20</div>



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	<ol style="list-style-type: none"> <li>1 General Practice</li> <li>2 Medical Specialist Consulting Rooms</li> <li>3 Private practice</li> <li>4 Public mental health service</li> <li>5 Public Hospital</li> <li>6 Private Hospital</li> <li>7 Emergency Department</li> <li>8 Community Health Centre</li> <li>9 Drug and Alcohol Service</li> <li>10 Community Support Organisation NFP</li> <li>11 Indigenous Health Organisation</li> <li>12 Child and Maternal Health</li> <li>13 Nursing Service</li> <li>14 Telephone helpline</li> <li>15 Digital health service</li> <li>16 Family Support Service</li> </ol>

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
<a href="#">Date client contacted Intake</a> (date_client_contacted_intake)	date	yes	The date on which the client first contacted the intake service
<a href="#">Suicide Referral Flag</a> (suicide_referral_flag)	string	yes	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 intake or entry to the episode, as represented by a code.
<a href="#">Date referred to other service at Intake conclusion</a> (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
<p>Organisation type referred to at Intake conclusion (organisation_type_referred_to_at_intake_conclusion)</p>	string	yes	<ol style="list-style-type: none"> <li>1 GP/Medical Practitioner</li> <li>2 Hospital</li> <li>3 Psychiatric/ mental health service or facility</li> <li>4 Alcohol and other drug treatment service</li> <li>5 Other community/ health care service</li> <li>6 Correctional service</li> <li>7 Police diversion</li> <li>8 Court diversion</li> <li>9 Legal service</li> <li>10 Child protection agency</li> <li>11 Community support groups/ agencies</li> <li>12 Centrelink or employment service</li> <li>13 Housing and homelessness service</li> <li>14 Telephone &amp; online services/ referral agency e.g. direct line</li> </ol>

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>27 Private Dental Provider</p> <p>28 Early childhood service</p> <p>29 Maternal and Child Health Service</p> <p>30 Community nursing service</p> <p>31 Emergency relief</p> <p>32 Family support service (excl family violence)</p> <p>33 Family violence service</p> <p>34 Gambling support service</p> <p>35 Maternity services</p> <p>36 Peer support/ self-help group</p> <p>37 Private allied health provider</p> <p>38 Sexual Assault service</p> <p>39 Financial counsellor</p> <p>40 Sexual health service</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			41 Medical specialist 42 AMHC 43 Other PHN funded service 44 HeadtoHelp / HeadtoHealth 97 No Referral 98 Other 99 Not stated/ Inadequately described  Multiple space separated values allowed
<a href="#">Referred to Organisation Path</a> (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.
<a href="#">Intake Tags</a> (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
<a href="#">Episode Organisation Path</a> (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.
<a href="#">Episode Key</a> (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.
<a href="#">Intake Organisation Path</a> (intake_organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing the intake to the client.
<a href="#">Intake Key</a> (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.

### 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
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Episode Key</a> (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.
<a href="#">Client Key</a> (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.
<a href="#">Episode End Date</a> (episode_end_date)  METeOR: <a href="#">614094</a>	date	—	The date on which an <i>Episode of Care</i> is formally or administratively ended
<a href="#">Client Consent to Anonymised Data</a> (client_consent)	string	yes	1 Yes 2 No

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Episode Completion Status</a> (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
<a href="#">Referral Date</a> (referral_date)	date	yes	The date the referrer made the referral.
<a href="#">Program Type</a> (program_type)	string	yes	1 Flexible Funding Pool 2 Head to Health 3 AMHC 4 Psychosocial Support 5 Bushfire 20

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Principal Focus of Treatment Plan (principal_focus)	string	yes	<ul style="list-style-type: none"> <li>1 Psychological therapy</li> <li>2 Low intensity psychological intervention</li> <li>3 Clinical care coordination</li> <li>4 Complex care package</li> <li>5 Child and youth-specific mental health services</li> <li>6 Indigenous-specific mental health services</li> <li>7 Other</li> <li>8 Psychosocial Support</li> </ul>
GP Mental Health Treatment Plan Flag (mental_health_treatment_plan)	string	yes	<ul style="list-style-type: none"> <li>1 Yes</li> <li>2 No</li> <li>3 Unknown</li> <li>9 Not stated/ inadequately described</li> </ul>
Homelessness Flag (homelessness)	string	yes	<ul style="list-style-type: none"> <li>1 Sleeping rough or in non-conventional accommodation</li> <li>2 Short-term or emergency accommodation</li> <li>3 Not homeless</li> <li>9 Not stated / Missing</li> </ul>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Area of usual residence, postcode</a> (client_postcode)  METeOR: <a href="#">429894</a>	string	yes	The Australian postcode of the client.
<a href="#">Labour Force Status</a> (labour_force_status)  METeOR: <a href="#">621450</a>	string	yes	1    Employed 2    Unemployed 3    Not in the Labour Force 9    Not stated/ inadequately described
<a href="#">Employment Participation</a> (employment_participation)  METeOR: <a href="#">269950</a>	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
<p><a href="#">Source of Cash Income</a> (income_source)</p> <p>METeOR: <a href="#">386449</a></p>	string	yes	<p>0 N/A - Client aged less than 16 years</p> <p>1 Disability Support Pension</p> <p>2 Other pension or benefit (not superannuation)</p> <p>3 Paid employment</p> <p>4 Compensation payments</p> <p>5 Other (e.g. superannuation, investments etc.)</p> <p>6 Nil income</p> <p>7 Not known</p> <p>9 Not stated/ inadequately described</p>
<p><a href="#">Health Care Card</a> (health_care_card)</p> <p>METeOR: <a href="#">605149</a></p>	string	yes	<p>1 Yes</p> <p>2 No</p> <p>3 Not Known</p> <p>9 Not stated</p>
<p><a href="#">NDIS Participant</a> (ndis_participant)</p>	string	yes	<p>1 Yes</p> <p>2 No</p> <p>9 Not stated/ inadequately described</p>

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

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

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
<a href="#">Additional Diagnosis</a> (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
<a href="#">Medication - Antipsychotics (N05A)</a> (medication_antipsychotics)	string	yes	1 Yes 2 No 9 Unknown
<a href="#">Medication - Anxiolytics (N05B)</a> (medication_anxiolytics)	string	yes	1 Yes 2 No 9 Unknown
<a href="#">Medication - Hypnotics and sedatives (N05C)</a> (medication_hypnotics)	string	yes	1 Yes 2 No 9 Unknown

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Medication - Antidepressants (N06A)</a> (medication_antidepressants)	string	yes	1 Yes 2 No 9 Unknown
<a href="#">Medication - Psychostimulants and nootropics (N06B)</a> (medication_psychostimulants)	string	yes	1 Yes 2 No 9 Unknown
<a href="#">Referrer Profession</a> (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	<ol style="list-style-type: none"> <li>1 General Practice</li> <li>2 Medical Specialist Consulting Rooms</li> <li>3 Private practice</li> <li>4 Public mental health service</li> <li>5 Public Hospital</li> <li>6 Private Hospital</li> <li>7 Emergency Department</li> <li>8 Community Health Centre</li> <li>9 Drug and Alcohol Service</li> <li>10 Community Support Organisation NFP</li> <li>11 Indigenous Health Organisation</li> <li>12 Child and Maternal Health</li> <li>13 Nursing Service</li> <li>14 Telephone helpline</li> <li>15 Digital health service</li> <li>16 Family Support Service</li> <li>17 School</li> <li>18 Tertiary Education institution</li> </ol>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			19 Housing service 20 Centrelink 21 Other 98 N/A - Self referral 99 Not stated

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation type referred to at Episode conclusion</a> (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
<a href="#">Episode Tags</a> (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
<a href="#">Organisation Path</a> (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
<a href="#">Service Contact Key</a> (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.
<a href="#">Episode Key</a> (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.
<a href="#">Service Contact Date</a> (service_contact_date)  METeOR: <a href="#">494356</a>	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
<a href="#">Service Contact Type</a> (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
<a href="#">Postcode</a> (service_contact_postcode)  METeOR: <a href="#">429894</a>	string	yes	The Australian postcode where the service contact took place.
<a href="#">Modality</a> (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
Participants (service_contact_participants)	string	yes	<div>1 Individual client</div> <div>2 Client group</div> <div>3 Family / Client Support Network</div> <div>4 Other health professional or service provider</div> <div>5 Other</div> <div>9 Not stated</div>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
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
<a href="#">Duration</a> (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
<a href="#">Copayment</a> (service_contact_copayment)	number	yes	0 - 999999.99
<a href="#">Client Participation Indicator</a> (service_contact_participation_indicator)  METeOR: <a href="#">494341</a>	string	yes	1 Yes 2 No
<a href="#">Interpreter Used</a> (service_contact_interpreter)	string	yes	1 Yes 2 No 9 Not stated
<a href="#">No Show</a> (service_contact_no_show)	string	yes	1 Yes 2 No

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Final Service Contact (service_contact_final)	string	yes	<ol style="list-style-type: none"> <li>1 No further services are planned for the client in the current episode</li> <li>2 Further services are planned for the client in the current episode</li> <li>3 Not known at this stage</li> </ol>
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
<a href="#">Funding Source</a> (funding_source)	string	yes	<b>100</b> PHN flexible funding NOS <b>110</b> Low intensity <b>120</b> Child and youth specific services NOS <b>121</b> Youth enhanced services <b>130</b> Psychological therapies <b>140</b> Care coordination for severe and complex <b>150</b> Suicide prevention NOS <b>151</b> Suicide prevention - Indigenous <b>152</b> Suicide Prevention - General <b>160</b> Indigenous MH <b>200</b> Psychosocial NOS <b>210</b> Psychosocial NPS <b>220</b> Psychosocial COS <b>300</b> Other Commonwealth flexible funding NOS <b>310</b> Drought measure <b>320</b> Psychological treatment services for



Data Element (Field Name)	Type (min,max)	Required	Format / Values
			people with mental illness living in RACFs  <b>400</b> Co-funded – Commonwealth and state  <b>500</b> Co-funded – Commonwealth and other Quarantined  <b>800</b> Quarantined funding NOS  <b>810</b> PFAS response (retired)  <b>820</b> Natural Disaster Response  <b>830</b> COVID Response NOS  <b>831</b> COVID Response Head To Help  <b>832</b> COVID Response Head To Health  <b>840</b> AMHC  <b>850</b> Eating disorders trial  <b>860</b> Norfolk Island  <b>900</b> Other funding source – no Commonwealth Funding  <b>999</b> Unknown/Not stated
<a href="#">Service Contact Tags</a> (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
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Service Contact Practitioner Key</a> (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.
<a href="#">Service Contact Key</a> (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.
<a href="#">Practitioner Key</a> (practitioner_key)	string (2,50)	yes	A unique identifier for a practitioner within the provider organisation.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Primary Practitioner Indicator</a> (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.

*Table 4.10 Collection Occasion record layout*

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Collection Occasion Key</a> (collection_occasion_key)	string (2,50)	yes	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.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Episode Key</a> (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.
<a href="#">Collection Occasion Date</a> (collection_occasion_date)	date	yes	The date of the collection occasion.
<a href="#">Collection Occasion Reason</a> (reason_for_collection)	string	yes	<ol style="list-style-type: none"> <li>1 Episode start</li> <li>2 Review</li> <li>3 Episode end</li> </ol>
<a href="#">Collection Occasion Tags</a> (collection_occasion_tags)	string	—	List of tags for the collection occasion.

#### 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 4.11 IAR-DST record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (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 - Version (iar_dst_version)	string	yes	1 DST specified by National PHN Guidance Initial Assessment and Referral for Mental Healthcare version 1.05
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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
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
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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
IAR-DST - Domain 5 - Treatment and Recovery History (Contextual Domain) (iar_dst_domain_5)	string	yes	<p>0 No prior treatment history</p> <p>1 Full recovery with previous treatment</p> <p>2 Moderate recovery with previous treatment</p> <p>3 Minor recovery with previous treatment</p> <p>4 Negligible recovery with previous treatment</p>
IAR-DST - Domain 6 - Social and Environmental Stressors (Contextual Domain) (iar_dst_domain_6)	string	yes	<p>0 No problem in this domain</p> <p>1 Mildly stressful environment</p> <p>2 Moderately stressful environment</p> <p>3 Highly stressful environment</p> <p>4 Extremely stressful environment</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
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	<p>1 Level 1 - Self Management</p> <p>1+ Level 1 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>2 Level 2 - Low Intensity Services</p> <p>2+ Level 2 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>3 Level 3 - Moderate Intensity Services</p> <p>3+ Level 3 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>4 Level 4 - High Intensity Services</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>4+ Level 4 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>5 Level 5 - Acute and Specialist Community Mental Health Services</p>
IAR-DST - Practitioner Level of Care (iar_dst_practitioner_level_of_care)	string	yes	<p>1 Level 1 - Self Management</p> <p>2 Level 2 - Low Intensity Services</p> <p>3 Level 3 - Moderate Intensity Services</p> <p>4 Level 4 - High Intensity Services</p> <p>5 Level 5 - Acute and Specialist Community Mental Health Services</p> <p>9 Not stated</p>
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 4.12 K10+ record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Measure Key</a> (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
<a href="#">Collection Occasion Key</a> (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.
<a href="#">K10+ - Question 1</a> (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
<a href="#">K10+ - Question 2</a> (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
<a href="#">K10+ - Question 3</a> (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 4.13 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 - SDQ Parent Report: 4-10 years (Baseline version);
- PC2 - SDQ Parent Report: 4-10 years (Follow up version);
- PY1 - SDQ Parent Report: 11-17 years (Baseline version);
- PY2 - SDQ Parent Report: 11-17 years (Follow up version);
- YR1 - SDQ Youth Report: 11-17 years (Baseline version); and
- YR2 - SDQ Youth Report: 11-17 years (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
Version							
Items	Item Content						
		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	
<i>Peer Problem Scale</i>					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	
<i>Prosocial Scale</i>					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	
<i>SDQ Total Difficulties Score = Sum of Scales below</i>					0-40
	<i>Emotional Symptoms Scale</i>	0-10			
	<i>Conduct Problem Scale</i>	0-10			
	<i>Hyperactivity Scale</i>	0-10			
	<i>Peer Problem Scale</i>	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. There are exceptions for items 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 assesses 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 4.14 SDQ record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Measure Key</a> (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.
<a href="#">Collection Occasion Key</a> (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	<p><b>PC101</b>Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1</p> <p><b>PC201</b>Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1</p> <p><b>PY101</b>Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1</p> <p><b>PY201</b>Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1</p> <p><b>YR101</b>Self report Version, 11-17 years, Baseline version, Australian Version 1</p> <p><b>YR201</b>Self report Version, 11-17 years, Follow Up version, Australian Version 1</p>



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	<p>0 Less than a month</p> <p>1 1-5 months</p> <p>2 6-12 months</p> <p>3 Over a year</p> <p>7 Unable to rate (insufficient information)</p> <p>8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)</p> <p>9 Not stated / Missing</p>
SDQ - Question 28 (sdq_item28)	string	yes	<p>0 Not at all</p> <p>1 A little</p> <p>2 A medium amount</p> <p>3 A great deal</p> <p>7 Unable to rate (insufficient information)</p> <p>8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)</p> <p>9 Not stated / Missing</p>



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	<p>0 Not at all</p> <p>1 A little</p> <p>2 A medium amount</p> <p>3 A great deal</p> <p>7 Unable to rate (insufficient information)</p> <p>8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)</p> <p>9 Not stated / Missing</p>
SDQ - Question 34 (sdq_item34)	string	yes	<p>0 Much worse</p> <p>1 A bit worse</p> <p>2 About the same</p> <p>3 A bit better</p> <p>4 Much better</p> <p>7 Unable to rate (insufficient information)</p> <p>8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)</p> <p>9 Not stated / Missing</p>

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	<p>0 No</p> <p>1 A little</p> <p>2 A lot</p> <p>7 Unable to rate (insufficient information)</p> <p>8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)</p> <p>9 Not stated / Missing</p>
SDQ - Question 38 (sdq_item38)	string	yes	<p>0 No</p> <p>1 A little</p> <p>2 A lot</p> <p>7 Unable to rate (insufficient information)</p> <p>8 Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)</p> <p>9 Not stated / Missing</p>

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
<a href="#">SDQ - Hyperactivity Scale</a> (sdq_hyperactivity)	integer	yes	0 - 10, 99 = Not stated / Missing
<a href="#">SDQ - Peer Problem Scale</a> (sdq_peer_problem)	integer	yes	0 - 10, 99 = Not stated / Missing
<a href="#">SDQ - Prosocial Scale</a> (sdq_prosocial)	integer	yes	0 - 10, 99 = Not stated / Missing
<a href="#">SDQ - Total Difficulties Score</a> (sdq_total)	integer	yes	0 - 40, 99 = Not stated / Missing
<a href="#">SDQ - Impact Score</a> (sdq_impact)	integer	yes	0 - 10, 99 = Not stated / Missing
<a href="#">SDQ - Tags</a> (sdq_tags)	string	—	List of tags for the measure.

## 4.4. Definitions

### 4.4.1. ABN

The Australian Business Number of the provider organisation.

**Field name**organisation\_abn

**Data type**string (11)

**Required**yes

### 4.4.2. 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**0Inactive

1 Active



### 4.4.3. 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**000No additional diagnosis

100Anxiety disorders (ATAPS)

101Panic disorder

102Agoraphobia

103Social phobia

104Generalised anxiety disorder

105Obsessive-compulsive disorder

106Post-traumatic stress disorder

107Acute stress disorder

108Other anxiety disorder

200Affective (Mood) disorders (ATAPS)

201Major depressive disorder

202Dysthymia

203Depressive disorder NOS

204Bipolar disorder

205Cyclothymic disorder

206Other affective disorder

300Substance use disorders (ATAPS)

301Alcohol harmful use

302Alcohol dependence

303Other drug harmful use

304Other 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.

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#### 4.4.4. 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](#)

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#### 4.4.5. 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**1Yes

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.

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#### 4.4.6. 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.

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#### 4.4.7. Client Gender

The term 'gender' refers to the way in which a person identifies their masculine or feminine characteristics. A person's 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**0Not 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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#### 4.4.8. 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](#)

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#### 4.4.9. 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, [Client Participation Indicator](#) should be recorded as '1: Yes' and [No Show](#) should be recorded as '1: Yes'.

METeOR[494341](#)

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#### 4.4.10. 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`.

---

#### 4.4.11. 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.

---

#### 4.4.12. 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 name**collection\_occasion\_key

**Data type**string (2,50)

**Required**yes

**Notes**Collection Occasion Keys must be generated by the organisation to be unique at the Provider Organisation level and must persist across time. See [Identifier Management](#)

---

#### 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**1Episode 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 name** collection\_occasion\_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`.

---

#### 4.4.15. 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.

---

#### 4.4.16. 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**1101Australia

1102Norfolk Island

1199Australian External Territories, nec

1201New Zealand

1301New Caledonia

1302Papua New Guinea

1303Solomon Islands

1304Vanuatu

1401Guam

1402Kiribati

1403Marshall Islands

1404Micronesia, Federated States of

1405Nauru

1406Northern Mariana Islands

1407Palau

1501Cook Islands

1502Fiji

1503French Polynesia

1504Niue

1505Samoa

1506Samoa, American

1507Tokelau

1508Tonga

1511Tuvalu

1512Wallis and Futuna

1513Pitcairn Islands

1599Polynesia (excludes Hawaii), nec

1601Adelie Land (France)

1602Argentinian Antarctic Territory

1603Australian Antarctic Territory

1604British Antarctic Territory

1605Chilean Antarctic Territory

1606Queen Maud Land (Norway)

1607Ross Dependency (New Zealand)

2102England

2103Isle of Man

2104Northern Ireland

2105Scotland

2106Wales

2107Guernsey

2108Jersey

2201Ireland

2301Austria

2302Belgium

2303France

2304Germany

2305Liechtenstein

2306Luxembourg

2307Monaco

2308Netherlands

2311Switzerland

2401Denmark

2402Faroe Islands

2403Finland

2404Greenland

2405Iceland

2406Norway

2407Sweden

2408Aland Islands

3101Andorra

3102Gibraltar

3103Holy See

3104Italy

3105Malta

3106Portugal

3107San Marino

3108Spain

3201Albania

3202Bosnia and Herzegovina

3203Bulgaria

3204Croatia

3205Cyprus

3206The former Yugoslav Republic of Macedonia

3207Greece

3208Moldova

3211Romania

3212Slovenia

3214Montenegro

3215Serbia

3216Kosovo

3301Belarus

3302Czech Republic

3303Estonia

3304Hungary

3305Latvia

3306Lithuania

3307Poland

3308Russian Federation

3311Slovakia

3312Ukraine

4101Algeria

4102Egypt

4103Libya

4104Morocco

4105Sudan

4106Tunisia

4107Western Sahara

4108Spanish North Africa

4111South Sudan

4201Bahrain

4202Gaza Strip and West Bank

4203Iran

4204Iraq

4205Israel

4206Jordan

4207Kuwait

4208Lebanon

4211Oman

4212Qatar

4213Saudi Arabia

4214Syria

4215Turkey

4216United Arab Emirates

4217Yemen

5101Myanmar

5102Cambodia

5103Laos

5104Thailand

5105Vietnam

5201Brunei Darussalam

5202Indonesia

5203Malaysia

5204Philippines

5205Singapore

5206Timor-Leste

6101China (excludes SARs and Taiwan)

6102Hong Kong (SAR of China)

6103Macau (SAR of China)

6104Mongolia

6105Taiwan

6201Japan

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

6203Korea, Republic of (South)

7101Bangladesh

**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

8212Paraguay

8213Peru

8214Suriname

8215Uruguay

8216Venezuela

8299South America, nec

8301Belize

8302Costa Rica

8303El Salvador

8304Guatemala

8305Honduras

8306Mexico

8307Nicaragua

8308Panama

8401Anguilla

8402Antigua and Barbuda

8403Aruba

8404Bahamas

8405Barbados

8406Cayman Islands

8407Cuba

8408Dominica

8411Dominican Republic

8412Grenada

8413Guadeloupe

8414Haiti

8415Jamaica

8416Martinique



8417Montserrat

8421Puerto Rico

8422St Kitts and Nevis

8423St Lucia

8424St Vincent and the Grenadines

8425Trinidad and Tobago

8426Turks and Caicos Islands

8427Virgin Islands, British

8428Virgin Islands, United States

8431St Barthelemy

8432St Martin (French part)

8433Bonaire, Sint Eustatius and Saba

8434Curacao

8435Sint Maarten (Dutch part)

9101Benin

9102Burkina Faso

9103Cameroon

9104Cabo Verde

9105Central African Republic

9106Chad

9107Congo, Republic of

9108Congo, Democratic Republic of

9111Cote d'Ivoire

9112Equatorial Guinea

9113Gabon

9114Gambia

9115Ghana

9116Guinea

9117Guinea-Bissau

9118Liberia

9121Mali

9122Mauritania

9123Niger

9124Nigeria

9125Sao Tome and Principe

9126Senegal

9127Sierra Leone

9128Togo

9201Angola

9202Botswana

9203Burundi

9204Comoros

9205Djibouti

9206Eritrea

9207Ethiopia

9208Kenya

9211Lesotho

9212Madagascar

9213Malawi

9214Mauritius

9215Mayotte

9216Mozambique

9217Namibia

9218Reunion

9221Rwanda

9222St Helena

9223Seychelles

9224Somalia

9225South Africa

9226Swaziland

9227Tanzania

9228Uganda

9231Zambia

9232Zimbabwe

9299Southern and East Africa, nec

9999Unknown

**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.

**METeOR** [459973](#)

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

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#### 4.4.17. 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.
-

#### 4.4.18. 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'

**METeOR** [287007](#)

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#### 4.4.19. 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.
- 

#### 4.4.20. Duration

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

**Field name**service\_contact\_duration

**Data type**string

**Required**yes

**Domain**0No 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.

---

#### 4.4.21. 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**1Full-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](#)

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#### 4.4.22. 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.

---

#### 4.4.23. 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<sup>614094</sup>

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#### 4.4.24. 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](#).

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### 4.4.25. 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	Organisation
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:PO101

### 4.4.26. 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.

#### 4.4.27. 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**1Date 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
- 

#### 4.4.28. Final Service Contact

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**1No 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.

---

#### 4.4.29. Funding Source

The source of funding for a service contact

**Field name** funding\_source

**Data type** string

**Required** yes

**Domain** 100PHN flexible funding NOS

110Low intensity

120Child and youth specific services NOS

121Youth enhanced services

130Psychological therapies

140Care coordination for severe and complex

150Suicide prevention NOS

151Suicide prevention - Indigenous

152Suicide Prevention - General

160Indigenous MH

200Psychosocial NOS

210Psychosocial NPS

220Psychosocial COS

300Other Commonwealth flexible funding NOS

310Drought measure

320Psychological treatment services for people with mental illness living in RACFs

400Co-funded – Commonwealth and state

500Co-funded – Commonwealth and other Quarantined

800Quarantined funding NOS

810PFAS response (retired)

820Natural Disaster Response

830COVID Response NOS

831 COVID Response Head To Help

832 COVID Response Head To Health

840 AMHC

850 Eating disorders trial

860 Norfolk Island

900 Other funding source – no Commonwealth Funding

999 Unknown/Not stated

**Notes** The response codes published in this draft are not finalised. They may be changed before the final specification is published.

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#### 4.4.30. 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

---

#### 4.4.31. 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

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#### 4.4.32. 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

---

#### 4.4.33. 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**0No 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 \(Primary Domain\)](#)

---

#### 4.4.34. 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**0No 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 \(Primary Domain\)](#)

---

#### 4.4.35. 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 \(Primary Domain\)](#)

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#### 4.4.36. 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**0No 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 \(Primary Domain\)](#)

---

#### **4.4.37. 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**0No 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 \(Contextual Domain\)](#)

---

#### **4.4.38. 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**0No 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 \(Contextual Domain\)](#)

---

#### **4.4.39. 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**0Highly 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 \(Contextual Domain\)](#)

---

#### **4.4.40. 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**0Optimal

- 1 Positive
- 2 Limited
- 3 Minimal
- 4 Disengaged

**Notes**Please refer to [IAR-DST Domain 8 - Engagement and Motivation \(Contextual Domain\)](#)

---

#### 4.4.41. 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**1Level 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.

---

#### 4.4.42. 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**1Level 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](#)

---

#### 4.4.43. 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`.

---

#### 4.4.44. IAR-DST - Version

The version of the IAR-DST collected.

**Field name** `iar_dst_version`

**Data type** `string`

**Required** `yes`

**Domain** `1` DST specified by National PHN Guidance Initial Assessment and Referral for Mental Healthcare version 1.05

---

#### 4.4.45. 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](#).

---

#### 4.4.46. 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	Organisation
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:PO

---

#### 4.4.47. 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`.

---

#### 4.4.48. Interpreter Used

Whether an interpreter service was used during the Service Contact

**Field name**service\_contact\_interpreter

**Data type**string

**Required**yes

**Domain**1Yes

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.

---

#### 4.4.49. Key

A metadata key name.

**Field name**key

**Data type**string

**Required**yes

---

#### 4.4.50. 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**1None 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'

---

#### 4.4.51. 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**1None 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'

---

#### 4.4.52. 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**1None 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'

---

#### 4.4.53. 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**1None 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'

---

#### 4.4.54. 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**1None 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'

---

#### 4.4.55. 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'

---

#### 4.4.56. 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`.

---

#### 4.4.57. 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**1None 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'

---

#### 4.4.58. 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**1None 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. 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**1None 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. K10+ - Question 4

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

**Field name**k10p\_item4

**Data type**string

**Required**yes

**Domain**1None 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. 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**1None 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. 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**1None 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. 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'

---

#### 4.4.64. 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'

---

#### 4.4.65. 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'

---

#### 4.4.66. 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'

---

#### 4.4.67. 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.

---

#### 4.4.68. 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.

---

#### 4.4.69. 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.

---

#### 4.4.70. 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.

---

#### 4.4.71. 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 completed 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'.

---

#### 4.4.72. K10+ - Tags

List of tags for the measure.

**Field name**<sub>k10p\_tags</sub>

**Data type**<sub>string</sub>

**Required**<sub>no</sub>

**Notes**<sub>A comma separated list of tags.</sub>

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.

---

#### 4.4.73. 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**<sub>labour\_force\_status</sub>

**Data type**<sub>string</sub>

**Required**<sub>yes</sub>

**Domain**<sub>1Employed</sub>

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 on 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)

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#### 4.4.74. Legal Name

The legal name of the provider organisation.

**Field name**organisation\_legal\_name

**Data type**string

**Required**no

---

#### 4.4.75. 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**1101Gaelic (Scotland)

1102Irish

1103Welsh

1199Celtic, nec

1201English

1301German

1302Letzeburgish

1303Yiddish

1401Dutch

1402Frisian

1403Afrikaans

1501Danish

1502Icelandic

1503Norwegian

1504Swedish

1599Scandinavian, nec

1601Estonian

1602Finnish

1699Finnish and Related Languages, nec

2101French

2201Greek

2301Catalan

2302Portuguese

2303Spanish

2399Iberian Romance, nec

2401Italian

2501Maltese

2901Basque

2902Latin

2999Other Southern European Languages, nec

3101Latvian

3102Lithuanian

3301Hungarian

3401Belorussian

3402Russian

3403Ukrainian

3501Bosnian

3502Bulgarian

3503Croatian

3504Macedonian

3505Serbian

3506Slovene

3507Serbo-Croatian/Yugoslavian, so described

3601Czech

3602Polish

3603Slovak

3604Czechoslovakian, so described

3901Albanian

3903Aromunian (Macedo-Romanian)

3904Romanian

3905Romany

3999Other Eastern European Languages, nec

4101Kurdish

4102Pashto

4104Balochi

4105Dari

4106Persian (excluding Dari)

4107Hazaraghi

4199Iranic, nec

4202Arabic

4204Hebrew

4206Assyrian Neo-Aramaic

4207Chaldean Neo-Aramaic

4208Mandaean (Mandaic)

4299Middle Eastern Semitic Languages, nec

4301Turkish

4302Azeri

4303Tatar

4304Turkmen

4305Uygur

4306Uzbek

4399Turkic, nec

4901Armenian

4902Georgian

4999Other Southwest and Central Asian Languages, nec

5101Kannada

5102Malayalam

5103Tamil

5104Telugu

5105Tulu

5199Dravidian, nec

5201Bengali

5202Gujarati

5203Hindi

5204Konkani

5205Marathi

5206Nepali

5207Punjabi

5208Sindhi

5211Sinhalese

5212Urdu

5213Assamese

5214Dhivehi

5215Kashmiri

5216Oriya

5217Fijian Hindustani

5299Indo-Aryan, nec

5999Other Southern Asian Languages

6101Burmese

6102Chin Haka

6103Karen

6104Rohingya

6105Zomi

6199Burmese and Related Languages, nec

6201Hmong

6299Hmong-Mien, nec

6301Khmer

6302Vietnamese

6303Mon

6399Mon-Khmer, nec

6401Lao

6402Thai

6499Tai, nec

6501Bisaya

6502Cebuano

6503Ilokano

6504Indonesian

6505Malay

6507Tetum

6508Timorese

6511Tagalog

6512Filipino

6513Acehnese

6514Balinese

6515Bikol

6516Iban

6517Ilonggo (Hiligaynon)

6518Javanese

6521Pampangan

6599Southeast Asian Austronesian Languages, nec

6999Other Southeast Asian Languages

7101Cantonese

7102Hakka

7104Mandarin

7106Wu

7107Min Nan

7199Chinese, nec

7201Japanese

7301Korean

7901Tibetan

7902Mongolian

7999Other Eastern Asian Languages, nec

8101Anindilyakwa

8111Maung

8113Ngan'gikurunggurr

8114Nunggubuyu

8115Rembarrnga

8117Tiwi



8121Alawa

8122Dalabon

8123Gudanji

8127Iwaidja

8128Jaminjung

8131Jawoyn

8132Jingulu

8133Kunbarlang

8136Larrakiya

8137Malak Malak

8138Mangarrayi

8141Maringarr

8142Marra

8143Marrithiyel

8144Matngala

8146Murrinh Patha

8147Na-kara

8148Ndjebbana (Gunavidji)

8151Ngalakgan

8152Ngaliwurru

8153Nungali

8154Wambaya

8155Wardaman

8156Amurdak

8157Garrwa

8158Kuwema

8161Marramaninyshi

8162Ngandi

8163Waanyi

8164Wagiman

8165Yanyuwa

8166Marridan (Maridan)

8171Gundjeihmi

8172Kune

8173Kuninjku

8174Kunwinjku

8175Mayali

8179Kunwinjkuan, nec

8181Burarra

8182Gun-nartpa

8183Gurr-goni

8189Burarran, nec

8199Arnhem Land and Daly River Region Languages, nec

8211Galpu

8212Golumala

8213Wangurri

8219Dhangu, nec

8221Dhalwangu

8222Djarrwark

8229Dhay'yi, nec

8231Djambarrpuyngu

8232Djapu

8233Daatiwuy

8234Marrangu

8235Liyagalawumirr

8236Liyagawumirr

8239Dhuwal, nec

8242Gumatj

8243Gupapuyngu

8244Guyamirrili

8246Manggalili

8247Wubulkarra

8249Dhuwala, nec

8251Wurlaki

8259Djinang, nec

8261Ganalbingu

8262Djinba

8263Manyjalpingu

8269Djinba, nec

8271Ritharrngu

8272Wagilak

8279Yakuy, nec

8281Nhangu

8282Yan-nhangu

8289Nhangu, nec

8291Dhuwaya

8292Djangu

8293Madarrpa

8294Warramiri

8295Rirratjingu

8299Other Yolngu Matha, nec

8301Kuku Yalanji

8302Guugu Yimidhirr

8303Kuuku-Ya'u

8304Wik Mungkan

8305Djabugay

8306Dyirbal

8307Girramay

8308Koko-Bera

8311Kuuk Thayorre

8312Lamalama

8313Yidiny

8314Wik Ngathan

8315AIngith

8316Kugu Muminh

8317Morrobalama

8318Thaynakwith

8321Yupangathi

8322Tjungundji

8399Cape York Peninsula Languages, nec

8401Kalaw Kawaw Ya/Kalaw Lagaw Ya

8402Meriam Mir

8403Yumplatok (Torres Strait Creole)

8504Bilinarra

8505Gurindji

8506Gurindji Kriol

8507Jaru

8508Light Warlpiri

8511Malngin

8512Mudburra

8514Ngardi

8515Ngarinyman

8516Walmajarri

8517Wanyjirra

8518Warlmanpa

8521Warlpiri

8522Warumungu

8599Northern Desert Fringe Area Languages, nec

8603Alyawarr

8606Kaytetye

8607Antekerrepenh

8611Central Anmatyerr

8612Eastern Anmatyerr

8619Anmatyerr, nec

8621Eastern Arrernte

8622Western Arrarnta

8629Arrernte, nec

8699Arandic, nec

8703Antikarinya

8704Kartujarra

8705Kukatha

8706Kukatja

8707Luritja

8708Manyjilyjarra

8711Martu Wangka

8712Ngaanyatjarra

8713Pintupi

8714Pitjantjatjara

8715Wangkajunga

8716Wangkatha

**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

8913Garuwali

8914Githabul

8915Gumbaynggir

8916Kanai

8917Karajarri

8918Kariyarra

8921Kurna

8922Kayardild

8924Kriol

8925Lardil

8926Mangala

8927Muruwari

8928Narungga

8931Ngarluma

8932Ngarrindjeri

8933Nyamal

8934Nyangumarta

8935Nyungar

8936Paakantyi

8937Palyku/Nyiyaparli

8938Wajarri

8941Wiradjuri

8943Yindjibarndi

8944Yinhawangka

8945Yorta Yorta

8946Baanbay

8947Badimaya

8948Barababaraba

8951Dadi Dadi

8952Dharawal

8953Djabwurrung

8954Gudjal

8955Keerray-Woorroong

8956Ladji Ladji

8957Mirning

8958Ngatjumaya

8961Waluwarra

8962Wangkangurru

8963Wargamay

8964Wergaia

8965Yugambeh

8998Aboriginal English, so described

8999Other Australian Indigenous Languages, nec

9101American Languages

9201Acholi

9203Akan

9205Mauritian Creole

9206Oromo

9207Shona

9208Somali

9211Swahili

9212Yoruba

9213Zulu

9214Amharic

9215Bemba

9216Dinka



9217Ewe

9218Ga

9221Harari

9222Hausa

9223Igbo

9224Kikuyu

9225Krio

9226Luganda

9227Luo

9228Ndebele

9231Nuer

9232Nyanja (Chichewa)

9233Shilluk

9234Tigre

9235Tigrinya

9236Tswana

9237Xhosa

9238Seychelles Creole

9241Anuak

9242Bari

9243Bassa

9244Dan (Gio-Dan)

9245Fulfulde

9246Kinyarwanda (Rwanda)

9247Kirundi (Rundi)

9248Kpelle

9251Krahn

9252Liberian (Liberian English)

9253Loma (Lorma)

9254Lumun (Kuku Lumun)

9255Madi

9256Mandinka

9257Mann

9258Moro (Nuba Moro)

9261Themne

9262Lingala

9299African Languages, nec

9301Fijian

9302Gilbertese

9303Maori (Cook Island)

9304Maori (New Zealand)

9306Nauruan

9307Niue

9308Samoan

9311Tongan

9312Rotuman

9313Tokelauan

9314Tuvaluan

9315Yapese

9399Pacific Austronesian Languages, nec

9402Bislama

9403Hawaiian English

9404Norf'k-Pitcairn

9405Solomon Islands Pijin

9499Oceanian Pidgins and Creoles, nec

9502Kiwai

9503 Motu (Hiri Motu)

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>

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#### 4.4.76. 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](#)

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#### 4.4.77. 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.

---

#### 4.4.78. 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

**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](http://www.whocc.no/atc_ddd_index/?code=N06A)

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#### 4.4.79. 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](http://www.whocc.no/atc_ddd_index/?code=N05A)

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#### 4.4.80. 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**1Yes

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](http://www.whocc.no/atc_ddd_index/?code=N05B)

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#### 4.4.81. 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**1Yes

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](http://www.whocc.no/atc_ddd_index/?code=N05C)

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#### 4.4.82. 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**1Yes

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](http://www.whocc.no/atc_ddd_index/?code=N06B)

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#### 4.4.83. Modality

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

**Field name**service\_contact\_modality

**Data type**string

**Required**yes

**Domain**0No contact took place

1 Face to Face

2 Telephone

3 Video

4 Internet-based

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

1 - Face to FaceIf '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.

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#### 4.4.84. Name

The name of the provider organisation.

**Field name**organisation\_name

**Data type**string (2,100)

**Required**yes

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#### 4.4.85. 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**1Yes

2 No

9 Not stated/inadequately described

---

#### 4.4.86. 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**1Yes

2 No

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

2 - NoThe intended participant(s) attended the appointment.

---

#### 4.4.87. 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](#).

---

#### 4.4.88. 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.

---

### 4.4.89. 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	Organisation
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:PO101

---

### 4.4.90. 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](#).

---

#### 4.4.91. 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`.

---

#### 4.4.92. 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 system 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 Health 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.

---

#### 4.4.93. Organisation type referred to at Episode conclusion

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

**Field name**organisation\_type\_referred\_to\_at\_episode\_conclusion

**Data type**string

**Required**yes

**Domain**0None/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.

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#### 4.4.94. 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** 1GP/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 / HeadtoHealth
- 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.

---

#### 4.4.95. 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 [Client Participation Indicator](#). Where [Participants](#) has a value of '1: Individual', [Client Participation Indicator](#) must have a value of '1: Yes'. [No Show](#) is used to record if the patient failed to attend the appointment.

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#### 4.4.96. 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](#)

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#### 4.4.97. 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.

METeOR [291036](#)

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#### 4.4.98. Practitioner Category

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

**Field name** practitioner\_category

**Data type** string

Required<sub>yes</sub>

**Domain1**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.
- 

#### 4.4.99. 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**0Not stated/Inadequately described

- 1 Male
- 2 Female
- 3 Other

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

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

3 - X- OtherAdults 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>

---

#### 4.4.100. 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](#).

---

#### 4.4.101. 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.

---

#### 4.4.102. 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**1Yes

2 No

---

#### 4.4.103. 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**100Anxiety disorders (ATAPS)

101Panic disorder

102Agoraphobia

103Social phobia

104Generalised anxiety disorder

105Obsessive-compulsive disorder

106Post-traumatic stress disorder

107Acute stress disorder

108Other anxiety disorder

200Affective (Mood) disorders (ATAPS)

201Major depressive disorder

202Dysthymia

203Depressive disorder NOS

204Bipolar disorder

205Cyclothymic disorder

206Other affective disorder

300Substance use disorders (ATAPS)

301Alcohol harmful use

302Alcohol dependence

303Other drug harmful use

304Other drug dependence

305Other 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 of 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 been 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.

---

#### 4.4.104. 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**1Psychological 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.

---

#### 4.4.105. 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.

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#### 4.4.106. Program Type

The overarching program area that an Intake or Episode record is associated with.

**Field name**program\_type

**Data type**string

**Required**yes

**Domain**1Flexible Funding Pool

2 Head to Health

3 AMHC

4 Psychosocial Support

5 Bushfire 20

**Notes**The response codes published in this draft are not finalised. They may be changed before the final specification is published.

---

#### 4.4.107. 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 for Intakes must not be before 1st January 2020.
- The referral date for Episodes must not be before 1st January 2014.
- The referral date must not be in the future.

---

#### 4.4.108. 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	Organisation
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:PO101

---

#### 4.4.109. Referrer Organisation Type

Type of organisation in which the referring professional is based.

**Field name**referrer\_organisation\_type

**Data type**string

**Required**yes

**Domain**1General 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.

---

#### 4.4.110. Referrer Profession

Profession of the provider who referred the client.

**Field name**referrer\_profession

**Data type**string

**Required**yes

**Domain**1General 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'.

---



#### 4.4.111. 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

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

---

#### 4.4.112. SDQ - Conduct Problem Scale

Field name`sdq_conduct_problem`

Data type`integer`

Required`yes`

Domain0 - 10, 99 = Not stated / Missing

NotesSee [SDQ items and Scale Summary scores](#) for instructions on scoring the Conduct Problem Scale.

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

---

#### 4.4.113. SDQ - Emotional Symptoms Scale

Field name`sdq_emotional_symptoms`

Data type`integer`

Required`yes`

Domain0 - 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'.

---

#### 4.4.114. 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'.

---

#### 4.4.115. 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'.

---

#### 4.4.116. 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'.

---

#### 4.4.117. SDQ - Prosocial Scale

**Field name**<sub>sdq\_prosocial</sub>

**Data type**<sub>integer</sub>

**Required**<sub>yes</sub>

**Domain**<sub>0 - 10, 99 = Not stated / Missing</sub>

**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'.

---

#### 4.4.118. 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**<sub>sdq\_item1</sub>

**Data type**<sub>string</sub>

**Required**<sub>yes</sub>

**Domain**<sub>0Not True</sub>

- 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 2

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

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

**Field name**<sub>sdq\_item2</sub>

**Data type**string

**Required**yes

**Domain**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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

**Domain**0Not 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 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

**Domain**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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 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**0Not 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'.

---

#### 4.4.140. 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**0Not 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'.

---

#### 4.4.141. 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**0Not 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'.

---

#### 4.4.142. 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**0Not 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'.

---

#### 4.4.143. 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**0No

- 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'.

---

#### 4.4.144. 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**0Less 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'.

---

#### 4.4.145. 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**0Not 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 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**0Not 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 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**0Not 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'.

#### 4.4.148. 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**0Not 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'.

---

#### 4.4.149. 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**0Not 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'.

---

#### 4.4.150. 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**0Not 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'.

---

#### 4.4.151. 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**0Much 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'.

---

#### 4.4.152. 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'.

---

#### 4.4.153. 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**0No

- 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'.

---

#### 4.4.154. 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**0No

- 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'.

---

#### 4.4.155. 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 name**sdq\_item38

**Data type**string

**Required**yes

**Domain**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'.

---

#### 4.4.156. 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**0No

- 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'.

---

#### 4.4.157. 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**0No

- 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'.

---

#### 4.4.158. SDQ - Question 41

Does your family complain about you being awkward or troublesome?

**Field name**sdq\_item41

**Data type**string

**Required**yes

**Domain**0No

- 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'.

---

#### 4.4.159. SDQ - Question 42

Do your teachers complain about you being awkward or troublesome?

**Field name**sdq\_item42

**Data type**string

**Required**yes

**Domain**0No

- 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)

**Notes** Required Versions:

- YR101

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

---

#### 4.4.160. 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`.

---

#### 4.4.161. 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'.

---

#### 4.4.162. 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](#)

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#### 4.4.163. 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](#).

---

#### 4.4.164. 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](#).

---

#### 4.4.165. 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`.

---

#### 4.4.166. 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 NECS** 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 NECS** 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.

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#### **4.4.167. 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** 0N/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).

METeOR<sup>386449</sup>

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#### 4.4.168. 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.

---

#### 4.4.169. 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.

METeOR<sup>613718</sup>

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#### 4.4.170. Statistical Linkage Key

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

Field name<sub>slk</sub>

Data type<sub>string (14,40)</sub>

Required<sub>yes</sub>

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

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<sup>349510</sup>

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#### 4.4.171. 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 intake or entry to the episode, as represented by a code.

Field name<sub>suicide\_referral\_flag</sub>

Data type<sub>string</sub>

Required<sub>yes</sub>

---

#### 4.4.172. Value

The metadata value.

Field name<sub>value</sub>

Data typestring

Requiredyes

---

4.4.173. Venue

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

Field nameservice\_contact\_venue

Data typestring

Requiredyes

Domain1Client'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

NotesNote 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 settingThis 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 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.

---

#### 4.4.174. 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.

---

### 4.5. 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. Excel 2007 (v12.0) and above support this file format.

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 containing 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 files/worksheets to be uploaded depending on whether the organisation is an Intake team, Treatment Service Provider or a combined Intake/Treatment Service Provider. Please refer to [Contexts](#) for further information about these contexts.

All files must be internally consistent. An example of what this means is that for every HeadtoHelp episode, service contact and measures in an upload file, there must be a corresponding episode in the episodes file/worksheet. It also means that for every row in the episodes file/worksheet, there must be a corresponding client in the clients file/worksheet.

### 5.2.1. Files/worksheets for the Intake context

When uploading Version 4 data files for the Intake context the following files/worksheets need to be uploaded to the PMHC MDS:

*Table 5.1 Summary of files to upload in Intake context*

File Type	CSV filename	Excel worksheet name	Required
<a href="#">Clients</a>	clients.csv	Clients	Required
<a href="#">Intakes</a>	intakes.csv	Intakes	Required
<a href="#">IAR-DST Measures</a>	iar-dst.csv	IAR-DST	Required
<a href="#">Organisations</a>	organisations.csv	Organisations	Optional only if the user has Organisation Management role
<a href="#">Metadata</a>	metadata.csv	Metadata	Required

Example Intake Upload files can be found at [Example Upload files](#).

### 5.2.2. Files/worksheets for the Treatment Service Provider context

When uploading Version 4 data files for the Treatment Service Provider context the following files/worksheets need to be uploaded to the PMHC MDS:

*Table 5.2 Summary of files to upload in Treatment Service Provider context*

File Type	CSV filename	Excel worksheet name	Required
<a href="#">Clients</a>	clients.csv	Clients	Required
<a href="#">Intake Episodes</a>	intake-episodes.csv	Intake Episodes	Required
<a href="#">Episodes</a>	episodes.csv	Episodes	Required
<a href="#">Service Contacts</a>	service-contacts.csv	Service Contacts	Required

File Type	CSV filename	Excel worksheet name	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

Example Treatment Upload files can be found at [Example Upload files](#).

### 5.2.3. Files/worksheets for the Combined Intake/Treatment Service Provider context

When uploading Version 4 data files for the combined Intake/Treatment Service Provider context the following files/worksheets need to be uploaded to the PMHC MDS:

*Table 5.3 Summary of files to upload in Combined Intake/Treatment 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



File Type	CSV filename	Excel worksheet name	Required
<a href="#">Service Contact Practitioners</a>	service-contact-practitioners.csv	Service Contact Practitioners	Required
<a href="#">Collection Occasions</a>	collection-occasions.csv	Collection Occasions	Required
<a href="#">K10+ Measures</a>	k10p.csv	K10+	Required
<a href="#">K5 Measures</a>	k5.csv	K5	Required
<a href="#">SDQ Measures</a>	sdq.csv	SDQ	Required
<a href="#">Practitioners</a>	practitioners.csv	Practitioners	Required for first upload and when practitioner information changes. Optional otherwise
<a href="#">Organisations</a>	organisations.csv	Organisations	Optional only if the user has Organisation Management role
<a href="#">Metadata</a>	metadata.csv	Metadata	Required

Example Combined Upload files can be found at [Example Upload files](#).

### 5.3. File format

Requirements for file formats:

- The first row must contain the column headings as defined for each file type.
- Data elements for each file/worksheet are defined at [Record formats](#).
- Each item is a column in the file/worksheet. The 'Field Name' as defined in [Record formats](#) 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.
- 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 4.0 data uploads must include a Metadata file/worksheet. See [Metadata file](#).

#### 5.3.1. Metadata file

All version 4.0 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 '4.0'

i.e.:

key	value
type	PMHC
version	4.0

Data elements for the metadata upload file/worksheet are defined at [Metadata](#).

Example Metadata files can be found at [Example Upload files](#).

### 5.3.2. 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 files can be found in any of the example files at [Example Upload files](#).

### 5.3.3. 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 files can be found in any of the example files at [Example Upload files](#).

### 5.3.4. Intake format

The intake file/worksheet is required to be uploaded each time in the intake or combined intake/treatment service provider contexts.

Data elements for the intake upload file/worksheet are defined at [Intake](#).

Example Intake files can be found in the Intake or Combined example files at [Example Upload files](#).

### 5.3.5. IAR-DST format

The IAR-DST file/worksheet is required to be uploaded each time in the intake or combined intake/treatment service provider contexts.

Data elements for the IAR-DST upload file/worksheet are defined at [IAR-DST](#).

Example IAR-DST files can be found in the Intake or Combined example files at [Example Upload files](#).

### **5.3.6. Intake Episode format**

The intake episode file/worksheet is required to be uploaded each time in the treatment service provider or combined contexts.

Data elements for the intake episode upload file/worksheet are defined at [Intake Episode](#).

Example Intake Episode files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.7. Episode file format**

The episode file/worksheet is required to be uploaded each time in the treatment service provider or combined contexts.

Data elements for the episode upload file/worksheet are defined at [Episode](#).

Example Episode files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.8. Service Contact file format**

The service contact file/worksheet is required to be uploaded each time in the treatment service provider or combined contexts.

Data elements for the service contact upload file/worksheet are defined at [Service Contact](#).

Example Service Contact files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.9. Service Contact Practitioner file format**

The service contact practitioner file/worksheet is required to be uploaded each time in the treatment 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 files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.10. Collection Occasion file format**

The collection occasion file/worksheet is required to be uploaded each time in the treatment service provider or combined contexts.

Data elements for the collection occasion upload file/worksheet are defined at [Collection Occasion](#).

Example Collection Occasion files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.11. K10+ Collection Occasion file format**

The K10+ file/worksheet is required to be uploaded each time in the treatment service provider or combined contexts.

Data elements for the K10+ collection occasion upload file/worksheet are defined at [K10+](#).

Example K10+ files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.12. K5 Collection Occasion file format**

The K5 file/worksheet is required to be uploaded each time in the treatment service provider or combined contexts.

Data elements for the K5 collection occasion upload file/worksheet are defined at [K5](#).

Example K5 files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.13. SDQ Collection Occasion file format**

The SDQ file/worksheet is required to be uploaded each time in the treatment service provider or combined contexts.

Data elements for the SDQ collection occasion upload file/worksheet are defined at [SDQ](#).

Example SDQ files can be found in the Treatment or Combined example files at [Example Upload files](#).

### **5.3.14. 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 files can be found in the Treatment or Combined example files at [Example Upload files](#).

## 5.4. Example Upload files

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
PHN999:IntakeTreatment01	Example Combined Intake/Treatment Organisation	Private Allied Health Professional Practice	PHN999
PHN999:Treatment01	Example Treatment Organisation	Private Allied Health Professional Practice	PHN999
PHN999:Intake01	Example Intake Organisation	Other	PHN999

Table 5.4 Summary of example upload files

Context	CSV zip	XLSX
Intake	<a href="#">PMHC-4-0-intake.zip</a>	<a href="#">PMHC-4-0-intake.xlsx</a>
Treatment	<a href="#">PMHC-4-0-treatment.zip</a>	<a href="#">PMHC-4-0-treatment.xlsx</a>
Combined	<a href="#">PMHC-4-0-combined.zip</a>	<a href="#">PMHC-4-0-combined.xlsx</a>

## 5.5. Deleting records

All records except for Organisation records can be deleted via upload. Please email [support@pmhc-mds.com](mailto: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:

- [XLSX file containing all the worksheets.](#)
- [CSV zip containing all the csv files.](#)

## 5.6. 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	Episode Organisation Path	Org Pat
Value	Organisation Key	Practitioner Key	Client Key	Intake Key	Episode Key	Epis
	Name	Practitioner Category	Statistical Linkage Key	Client Key	Intake Organisation Path	Clie
	Legal Name	ATSI Cultural Training	Date of Birth	Client Consent to Anonymised Data	Intake Key	Epis Dat
	ABN	Year of Birth	Estimated Date of Birth Flag	Referral Date		Clie to A Dat
	Organisation Type	Practitioner Gender	Client Gender	Program Type		Epis Con Sta
	State	Practitioner Aboriginal and Torres Strait Islander Status	Practitioner Aboriginal and Torres Strait Islander Status	Referrer Profession		Ref
	Organisation Start Date	Active	Country of Birth	Referrer Organisation Type		Pro
	Organisation End Date	Practitioner Tags	Main Language Spoken at Home	Date client contacted Intake		Prin of T Plan

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	
	Organisation Tags		Proficiency in Spoken English	Suicide Referral Flag		GP Health Treatment Flag
			Client Tags	Date referred to other service at Intake conclusion		Homelessness Flag
				Organisation type referred to at Intake conclusion		Area of residence position
				Referred to Organisation Path		Labour Status
				Intake Tags		Employment Partner
						Social Income
						Health
						ND
						Marital
						Suicide Flag
						Primary Diagnosis
						Additional Diagnosis



Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	
						Me Ant (NO
						Me Anx (NO
						Me Hyp sed
						Me Ant (NO
						Me Psy and (NO
						Ref Pro
						Ref Org Typ
						Org typ at E con
						Epis



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

[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 [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 [Country of Birth](#) during data entry.

## 7.3. Main Language Spoken at Home

[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 [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 [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. [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 [Organisation Type](#) set to '8: Aboriginal Health/Medical Service'

#### 8.1.3. Client

1. Refer to [Keys](#) for Client Key validations
2. [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 [Date referred to other service at Intake conclusion](#) must not be before the [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 [Referral Date](#)
  - must not be before 1 January 2020
  - and must not be before [Organisation Start Date](#)
  - and must not be after [Organisation End Date](#)
  - and must not be in the future
6. The [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
7. The [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
8. 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 [Principal Diagnosis](#) and [Additional Diagnosis](#) the values:

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

must only be 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 [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 [Organisation Start Date](#)
  - and must not be after [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 [Organisation Start Date](#)
  - and must not be after [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 [Final Service Contact](#) 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 [Final Service Contact](#) is recorded as '1: No further services are planned for the client in the current episode', the date of the [Final Service Contact](#) 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', [No Show](#) must be '1: Yes'
6. If [Duration](#) is '0: No contact took place', [No Show](#) must be '1: Yes'
7. If [Modality](#) is '0: No contact took place', [No Show](#) must be '1: Yes'
8. If [Modality](#) is not '1: Face to Face', [Postcode](#) must be 9999
9. If [Modality](#) is '1: Face to Face', [Postcode](#) must not be 9999
10. If [Modality](#) is '1: Face to Face', [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 [Participants](#) is '1: Individual client' [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 [Organisation Start Date](#)
  - and must not be after [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 [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 [Date client contacted Intake](#)
  - and must not be after the earliest [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 [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 [Date client contacted Intake](#)
  - and must not be before the latest [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	Expected
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	TEE99070
No names at all			7	6	1954	3	99999070
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	Expected
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](#)

#### 10.1.5. 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](mailto:support@pmhc-mds.com).

## 11. Data Specification Change log

### 11.1. ??/?/2022 - 4.0.0-draft.3

- [Data model and specifications](#)
  - [Record formats](#)
    - Renamed 'Intake - Funding Source' to [Program Type](#) on [Intake](#)
    - Added [Program Type](#) to [Episode](#)
    - Removed Continuity of Support from [Episode](#)

### 11.2. 31/5/2022 - 4.0.0-draft.2

- [Validation Rules](#)
  - Added validation for Intake - Referral Date

### 11.3. 1/12/2021 - 4.0.0-draft.1

- [Data model and specifications](#)
  - [Record formats](#)
    - Added [Suicide Referral Flag](#) to [Intake](#)
    - [Referral Date](#) is required on [Episode](#)
    - Updated [Funding Source](#) - Response codes designed to allow heirarchy and grouping of the funding sources

### 11.4. 30/11/2021

- [Data model and specifications](#)
  - [Record formats](#)
    - Updated [Funding Source](#) - Updated response codes to start from 8 to account for 7 being used in the Wayback specification.

### 11.5. 25/11/2021 - Draft Version 4.0

- [Data model and specifications](#)
  - [Record formats](#)
    - Added [Collection Occasion](#)