Australian Government

Department of Health

Adult Mental Health Clinics Minimum Data Set and Dictionary

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Introduction

The recording of AMHC activity in the PMHC MDS will be implemented as an extension to the as yet unreleased core PMHC-MDS version 3 specification. This is to minimise the amount of work required to implement a AMHC-usable MDS.

The extension will comprise 5 new tables with new fields, and a small number of additions to existing fields in existing record types.

The new tables are Intake, Intake Collection Occasion, AMHC Episode, AMHC Service Contact, and IAR-DST Measure.

There are two contexts collecting AMHC data - the AMHC Intake teams and the AMHC hubs. Different records in the extension are intended to be used in both of these contexts.

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

In the Intake context the following records will need to be provided: * Client, * Intake * Intake Collection Occasion * IAR-DST Measure

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

In the hub context the extension specification works almost the same as a service reporting via the core PMHC-MDS specification using the extension fields to identify additional detail regarding referrals in from the AMHC intake teams (Intake Organisation Path and Intake Key), referrals out to additional services (Referral Out Organisation Type), and the involvement of additional practitioners involved in service contacts (AMHC - Service Contact - Practitioner Category) which allows multiple endorsements.

AMHC Intake

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

The Intake table comprises records information about the intake.

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

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

AMHC Episode

When the client is referred to a PMHC MDS reporting service (either an AMHC hub or an AMHC non-hub) a new Episode record is created like any other PMHC funded episode.

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

The AMHC Episode table comprises a composite foreign key to link it back to a standard episode record on which all the standard information is recorded plus three new fields.

1. The identifier of the intake team (Intake Organisation Path)
2. The episode identifier of the intake team (Intake Key)
3. The organisation(s) to which the organisation (intake team or hub) refers the client (Referral Out Organisation Type)

AMHC Service Contact

This new record type is pertinent only to hub activity. The AMHC Service Contact extends the existing Service Contact record with two new fields:

1. A multi choice AMHC - Service Contact - Practitioner Category, which allows the type of professionals used in multidisciplinary teams to be recorded against a contact
2. The time that the contact started (AMHC - Service Contact - Start Time)

The AMHC - Service Contact - Practitioner Category field is in addition to the standard PHMC MDS field for identifying a specific practitioner. The standard model only allows a single practitioner to be recorded against a contact. The extended process still requires identification of a single practitioner (intended to be the 'main' one) but also allows capturing the discipline(s) of other practitioners who might be involved. The discipline (practitioner type) of the main practitioner is already stored on an existing table and does not need to be added to the new practitioner categories field.

AMHC - Service Contact - Start Time is intended to enable identification of activity undertaken during extended hours.

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 AMHC intake process. A new IAR-DST Measure record, and corresponding intake collection occasion 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.

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 AMHC Service will be utilised for Commonwealth, State and Territory planning and statistical purposes. Appropriate consent and ethics approval processes will be adhered to.

Data specification

Key concepts

Below is a list of key words that are commonly used within the PMHC MDS and their definitions. If you require more information, please click on the linked text to see the relevant data elements field definition as shown under Specifications.

PMHC MDS

As AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS) the current PMHC MDS Key terms will be used. These are also available to be viewed at https://docs.pmhc-mds.com/data-specification/data-model-and-specifications.html#key-concepts.

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.

Provider Organisation

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

Practitioner

The Practitioner is the person who is delivering the service.

Client

The Client (patient) is the person who is receiving the service.

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*.

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

- **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 date.
- **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.

AMHC-Episode

AMHC-Episode is the record format for collecting AMHC episode data.

See AMHC Episode for the data elements for AMHC-Episode.

Service Contact

Service Contact data linked to an Episode will be used in AMHC.

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.

AMHC will allow the following data records to be collected at a collection occasion:

- IAR-DST Measure

See Collection Occasion data elements.

Identifier management

AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); the current PMHC MDS Identifier Management rules apply. These are available to be viewed at https://docs.pmhc-mds.com/data-specification/identifier-management.html.

Managing keys

The Collection Occasion Key and Measure Key will be created and managed by Provider Organisations.

The PMHC MDS specification requires each of these keys to be unique and stable at the Provider Organisation level. See above links for the specification requirements for these data elements:

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.

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.

Managing PMHC MDS Episode Key

Each AMHC Episode record needs to record the corresponding PMHC MDS episode key in order to link it to an existing episode within the PMHC data and facilitate adding/updating/deleting each item when uploading/entering AMHC data.

See below links for the specification requirements for these data elements:

- Episode Key

Identifying AMHC-Episode data records

To enable the PMHC MDS to add a AMHC-Episode record to a PMHC Episode, the '**!amhc**' tag must be included on the 'Tags' field of all hub episode data records. If not included, the system will automatically include it.

For users inputting data through the PMHC-MDS data entry interface adding this tag will enable the additional AMHC specific data entry elements.

For users uploading data where the tag is not included but the upload includes the additional AMHC records, the system will automatically add the tag.

Data model and specifications

Adult Mental Health Centres (AMHC) is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); the current PMHC MDS Data model and specification rules may apply. These are available to be viewed at https://docs.pmhc-mds.com/data-specification/index.html.

Data model

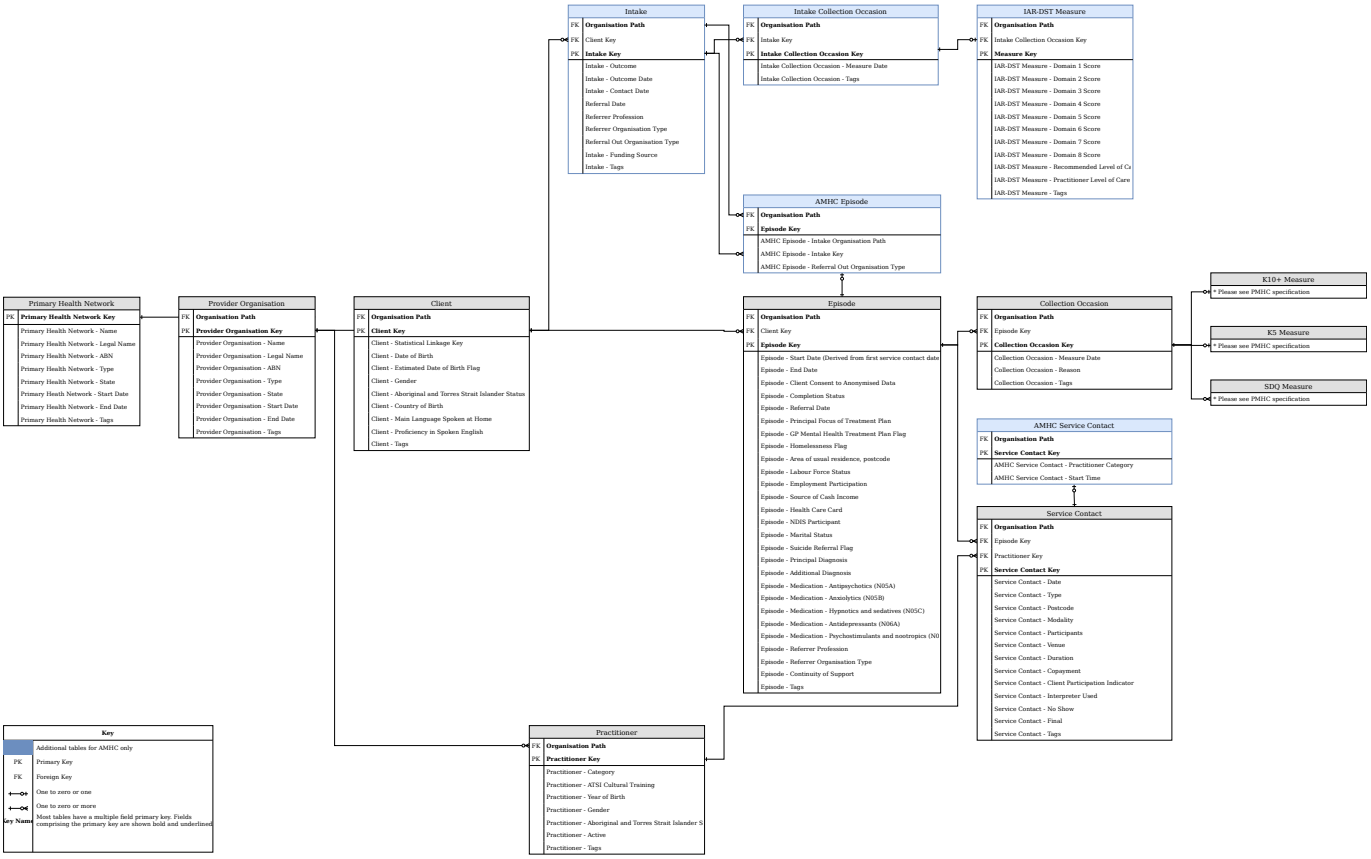

Fig. 1 AMHC data model within the PMHC MDS

Record formats

PMHC MDS record formats

As AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS), the current PMHC MDS Data model and specification record formats are available to be viewed at https://docs.pmhc-mds.com/data-specification/data-model-and-specifications.html#record-formats.

AMHC record formats

AMHC adds the following records on top of PMHC MDS current specifications:

- See Intake data specifications.
- See Intake Collection Occasion data specifications.
- See AMHC-Episode data specifications.
- See Collection Occasion data specifications for Collection Occasions.
- See IAR-DST Measure data specifications.
- See AMHC-Service Contact data specifications for Service Contact Data.

When uploading PMHC clients at the same time as AMHC clients, the following records will also need to be supplied. **NB. These record specifications are different to the standard PMHC specifications. The AMHC upload format separates collection occasion data into a separate Collection Occasion worksheet so that multiple measures can be collected at a single collection occasion. The AMHC upload format aligns with a future PMHC MDS Version 3.0 file format. No date has been set for the release of the PMHC MDS Version 3.0 upload file format.**

- See K10+ Measure data specifications.
- See K5 Measure data specifications.
- See SDQ Measure data specifications.
- See Service Contact data specifications.

Metadata

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

Table 1 Metadata record layout

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

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

key	value
type	AMHC
version	3

Provider Organisation

Same as standard PMHC MDS Provider Organisation.

Practitioner

Practitioners are managed by the hub organisations via upload or data entry. The practitioner record is the same as standard PMHC MDS Practitioner.

No practitioner records should be provided in the intake context.

Client

Clients are managed by the intake and hub organisations via upload or data entry. The client record is the same as standard PMHC MDS Client.

Intake

Intakes are managed by the intake organisations via upload or data entry.

No intake records should be provided in the hub context.

Table 2 Intake record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Intake Key (intake_key)	string (2,50)	yes	This is a number or code assigned to each intake. The Intake Key is unique and stable for each intake at the level of the organisation.
Client Key (client_key)	string (2,50)	yes	This is a number or code assigned to each individual referred to the commissioned organisation. The client identifier is unique and stable for each individual at the level of the PMHC top level organisation.
Intake - Outcome (outcome)	string	—	0 Intake open 1 Intake closed - client did not require service 2 Intake closed - client referred to a clinic

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Intake - Outcome Date (outcome_date)	date	—	The date the intake had an outcome
Intake - Contact Date (contact_date)	date	—	The date on which the client first contacted the intake service
Referral Date (referral_date)	date	—	The date the referrer made the referral to the intake service.
Referrer Profession (referrer_profession)	string	yes	1 General Practitioner 2 Psychiatrist 3 Obstetrician 4 Paediatrician 5 Other Medical Specialist 6 Midwife 7 Maternal Health Nurse 8 Psychologist 9 Mental Health Nurse 10 Social Worker 11 Occupational therapist 12 Aboriginal Health Worker 13 Educational professional 14 Early childhood service worker 15 Other 98 N/A - Self referral 99 Not stated

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Referrer Organisation Type (referrer_organisation_type)	string	yes	1 General Practice 2 Medical Specialist Consulting Rooms 3 Private practice 4 Public mental health service 5 Public Hospital 6 Private Hospital 7 Emergency Department 8 Community Health Centre 9 Drug and Alcohol Service 10 Community Support Organisation NFP 11 Indigenous Health Organisation 12 Child and Maternal Health 13 Nursing Service 14 Telephone helpline 15 Digital health service 16 Family Support Service 17 School 18 Tertiary Education institution 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
Referral Out Organisation Type (referral_out_organisation_type)	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 18 Tertiary Education institution 19 Housing service 20 Centrelink 21 Other 22 HeadtoHelp Hub 23 Non HeadtoHelp Hub PHN funded service 99 Not stated Multiple space separated values allowed
Intake - Funding Source (intake_funding_source)	string	yes	1 HeadtoHelp 2 AMHC

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Intake - Tags (intake_tags)	string	—	List of tags for the intake.

Intake Collection Occasion

See Collection Occasion for definition of a collection occasion.

Intake Collection occasions are managed by the intake organisations via upload or data entry.

No intake collection occasion records should be provided in the hub context.

Table 3 Intake record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Intake Collection Occasion Key (intake_collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each intake collection occasion of service activities. The Intake Collection Occasion Key is unique and stable for each intake collection occasion at the level of the organisation.
Intake Key (intake_key)	string (2,50)	yes	This is a number or code assigned to each PMHC MDS intake. The Intake Key is unique and stable for each intake at the level of the organisation. This key must link to an existing intake within the PMHC MDS.
Collection Occasion - Date (collection_occasion_date)	date	yes	The date of the collection occasion.
Intake Collection Occasion - Tags (intake_collection_occasion_tags)	string	—	List of tags for the collection occasion.

Episode

See Episode for definition of an episode.

Episodes are managed by the hub organisations via upload or data entry. The episode record is the same as standard PMHC.

No episode records should be provided in the intake context.

Table 4 Episode record layout

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Completion Status (episode_completion_status)	string	—	0 Episode open 1 Episode closed - treatment concluded 2 Episode closed administratively - client could not be contacted 3 Episode closed administratively - client declined further contact 4 Episode closed administratively - client moved out of area 5 Episode closed administratively - client referred elsewhere 6 Episode closed administratively - other reason
Referral Date (referral_date)	date	—	The date the referrer made the referral.
Episode - Principal Focus of Treatment Plan (principal_focus)	string	yes	1 Psychological therapy 2 Low intensity psychological intervention 3 Clinical care coordination 4 Complex care package 5 Child and youth-specific mental health services 6 Indigenous-specific mental health services 7 Other 8 Psychosocial Support

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - GP Mental Health Treatment Plan Flag (mental_health_treatment_plan)	string	yes	1 Yes 2 No 3 Unknown 9 Not stated/ inadequately described
Episode - Homelessness Flag (homelessness)	string	yes	1 Sleeping rough or in non-conventional accommodation 2 Short-term or emergency accommodation 3 Not homeless 9 Not stated / Missing
Episode - Area of usual residence, postcode (client_postcode) METeOR ID 429894	string	yes	The Australian postcode of the client.
Episode - Labour Force Status (labour_force_status) METeOR ID 621450	string	yes	1 Employed 2 Unemployed 3 Not in the Labour Force 9 Not stated/ inadequately described
Episode - Employment Participation (employment_participation) METeOR ID 269950	string	yes	1 Full-time 2 Part-time 3 Not applicable - not in the labour force 9 Not stated/ inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Source of Cash Income (income_source) METeOR ID 386449	string	yes	0 N/A - Client aged less than 16 years 1 Disability Support Pension 2 Other pension or benefit (not superannuation) 3 Paid employment 4 Compensation payments 5 Other (e.g. superannuation, investments etc.) 6 Nil income 7 Not known 9 Not stated/ inadequately described
Episode - Health Care Card (health_care_card) METeOR ID 605149	string	yes	1 Yes 2 No 3 Not Known 9 Not stated
Episode - NDIS Participant (ndis_participant)	string	yes	1 Yes 2 No 9 Not stated/ inadequately described
Episode - Marital Status (marital_status) METeOR ID 291045	string	yes	1 Never married 2 Widowed 3 Divorced 4 Separated 5 Married (registered and de facto) 6 Not stated/ inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Suicide Referral Flag (suicide_referral_flag)	string	yes	1 Yes 2 No 9 Unknown

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

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

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			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
Episode - Medication - Antipsychotics (N05A) (medication_antipsychotics)	string	yes	**1** Yes **2** No **9** Unknown
Episode - Medication - Anxiolytics (N05B) (medication_anxiolytics)	string	yes	**1** Yes **2** No **9** Unknown

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Episode - Medication - Hypnotics and sedatives (N05C) (medication_hypnotics)	string	yes	1 Yes 2 No 9 Unknown
Episode - Medication - Antidepressants (N06A) (medication_antidepressants)	string	yes	1 Yes 2 No 9 Unknown
Episode - Medication - Psychostimulants and nootropics (N06B) (medication_psychostimulants)	string	yes	1 Yes 2 No 9 Unknown
Referrer Profession (referrer_profession)	string	yes	1 General Practitioner 2 Psychiatrist 3 Obstetrician 4 Paediatrician 5 Other Medical Specialist 6 Midwife 7 Maternal Health Nurse 8 Psychologist 9 Mental Health Nurse 10 Social Worker 11 Occupational therapist 12 Aboriginal Health Worker 13 Educational professional 14 Early childhood service worker 15 Other 98 N/A - Self referral 99 Not stated

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Referrer Organisation Type (referrer_organisation_type)	string	yes	1 General Practice 2 Medical Specialist Consulting Rooms 3 Private practice 4 Public mental health service 5 Public Hospital 6 Private Hospital 7 Emergency Department 8 Community Health Centre 9 Drug and Alcohol Service 10 Community Support Organisation NFP 11 Indigenous Health Organisation 12 Child and Maternal Health 13 Nursing Service 14 Telephone helpline 15 Digital health service 16 Family Support Service 17 School 18 Tertiary Education institution 19 Housing service 20 Centrelink 21 Other 98 N/A - Self referral 99 Not stated
Episode - Continuity of Support (continuity_of_support)	string	yes	1 Yes 2 No 9 Not stated/ inadequately described
Episode - Tags (episode_tags)	string	—	List of tags for the episode.

AMHC Episode

AMHC Episodes are managed by the hub provider organisations via upload or data entry.

Where available, the Intake Organisation Path and Intake Key provide a link back to the intake record at the intake organisation.

Table 5 AMHC Episode record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Episode Key (episode_key)	string (2,50)	yes	This is a number or code assigned to each 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.
Intake Organisation Path (intake_organisation_path)	string	—	A sequence of colon separated Organisation Keys that fully specifies the Intake Organisation that referred the client to the hub service. In conjuctionion with the intake key, this allows linkage from the hub episode back to the intake.
Intake Key (intake_key)	string (2,50)	—	This is a number or code assigned to the intake organisation. The Intake Key is unique and stable for each intake at the level of the intake organisation. In conjuctionion with the intake organisation path, this allows linkage from the hub episode back to the intake.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Referral Out Organisation Type (referral_out_organisation_type)	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 18 Tertiary Education institution 19 Housing service 20 Centrelink 21 Other 22 HeadtoHelp Hub 23 Non HeadtoHelp Hub PHN funded service 99 Not stated Multiple space separated values allowed

Service Contact

See Service Contact for definition of a service contact.

Service contacts are managed by the hub organisations via upload or data entry.

No service contacts should be provided in the intake context.

Table 6 Service Contact record layout

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

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

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Service Contact - Duration (service_contact_duration)	string	yes	0 No contact took place 1 1-15 mins 2 16-30 mins 3 31-45 mins 4 46-60 mins 5 61-75 mins 6 76-90 mins 7 91-105 mins 8 106-120 mins 9 over 120 mins
Service Contact - Copayment (service_contact_copayment)	number	yes	0 - 999999.99
Service Contact - Client Participation Indicator (service_contact_participation_indicator) METeOR ID 494341	string	yes	1 Yes 2 No
Service Contact - Interpreter Used (service_contact_interpreter)	string	yes	1 Yes 2 No 9 Not stated
Service Contact - No Show (service_contact_no_show)	string	yes	1 Yes 2 No
Service Contact - Final (service_contact_final)	string	yes	1 No further services are planned for the client in the current episode 2 Further services are planned for the client in the current episode 3 Not known at this stage
Service Contact - Tags (service_contact_tags)	string	—	List of tags for the service contact.

AMHC Service Contact

See Service Contact for definition of a service contact.

AMHC Service Contacts are managed by the hub organisations via upload or data entry.

No AMHC Service Contacts should be provided in the intake context.

Table 7 AMHC Service Contact record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Service Contact Key (service_contact_key)	string (2,50)	yes	This is a number or code assigned to each service contact. The Service Contact Key is unique and stable for each service contact at the level of the organisation.
AMHC - Service Contact - Start Time (service_contact_start_time)	time	yes	The start time of each mental health service contact between a health service provider and patient/client.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
AMHC - Service Contact - Practitioner Category (service_contact_practitioner_category)	string	yes	0 None 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 Multiple space separated values allowed

Collection Occasion

See Collection Occasion for definition of a collection occasion.

Collection occasions are managed by the hub organisations via upload or data entry.

Table 8 Collection Occasions 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.
Collection Occasion Key (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.
Episode Key (episode_key)	string (2,50)	yes	This is a number or code assigned to each PMHC MDS episode. The Episode Key is unique and stable for each episode at the level of the organisation. This key must link to an existing episode within the PMHC MDS.
Collection Occasion - Date (collection_occasion_date)	date	yes	The date of the collection occasion.
Collection Occasion - Reason (reason_for_collection)	string	yes	1 Episode start 2 Review 3 Episode end
Collection Occasion - Tags (collection_occasion_tags)	string	—	List of tags for the collection occasion.

IAR-DST Measure

IAR-DST measures are managed by the intake organisations via upload or data entry.

No IAR-DST measures should be provided in the hub context. The IAR-DST will be available from the linked intake record.

IAR-DST records must include all of the domain scores and the resulting recommended level of care. Records will be rejected where supplied scores and recommended level of care disagree.

Table 9 IAR-DST record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
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 Collection Occasion Key (intake_collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each intake collection occasion of service activity. The Intake Collection Occasion Key is unique and stable for each intake collection occasion at the level of the organisation.
IAR-DST - Domain 1 - Symptom Severity and Distress (Primary Domain) (iar_dst_domain_1)	string	yes	0 No problem in this domain 1 Mild or sub diagnostic 2 Moderate 3 Severe 4 Very severe
IAR-DST - Domain 2 - Risk of Harm (Primary Domain) (iar_dst_domain_2)	string	yes	0 No identified risk in this domain 1 Low risk of harm 2 Moderate risk of harm 3 High risk of harm 4 Very high risk of harm

Data Element (Field Name)	Type (min,max)	Required	Format / Values
IAR-DST - Domain 3 - Functioning (Primary Domain) (iar_dst_domain_3)	string	yes	0 No problems in this domain 1 Mild impact 2 Moderate impact 3 Severe impact 4 Very severe to extreme impact
IAR-DST - Domain 4 - Impact of Co-existing Conditions (Primary Domain) (iar_dst_domain_4)	string	yes	0 No problem in this domain 1 Minor impact 2 Moderate impact 3 Severe impact 4 Very severe impact
IAR-DST - Domain 5 - Treatment and Recovery History (Contextual Domain) (iar_dst_domain_5)	string	yes	0 No prior treatment history 1 Full recovery with previous treatment 2 Moderate recovery with previous treatment 3 Minor recovery with previous treatment 4 Negligible recovery with previous treatment
IAR-DST - Domain 6 - Social and Environmental Stressors (Contextual Domain) (iar_dst_domain_6)	string	yes	0 No problem in this domain 1 Mildly stressful environment 2 Moderately stressful environment 3 Highly stressful environment 4 Extremely stressful environment

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	**1** Level 1 - Self Management **1+** Level 1 or above - Review assessment on Contextual Domains to determine most appropriate placement **2** Level 2 - Low Intensity Services **2+** Level 2 or above - Review assessment on Contextual Domains to determine most appropriate placement **3** Level 3 - Moderate Intensity Services **3+** Level 3 or above - Review assessment on Contextual Domains to determine most appropriate placement **4** Level 4 - High Intensity Services **4+** Level 4 or above - Review assessment on Contextual Domains to determine most appropriate placement **5** Level 5 - Acute and Specialist Community Mental Health Services

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

K10+ Measure

Please note: The format for reporting the K10+ with AMHC data is different than for standard PMHC MDS as explained at AMHC Base Version.

K10+ measures are managed by the hub organisation via upload or data entry.

No K10+ measures should be provided in the intake context.

Table 10 K10+ record layout

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

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

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

K5 Measure

Please note: The format for reporting the K5 with AMHC data is different than for standard PMHC MDS as explained at AMHC Base Version.

K5 measures are managed by the hub organisation via upload or data entry.

No K5 measures should be provided in the intake context.

Table 11 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
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

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

SDQ Measure

Please note: The format for reporting the SDQ with AMHC data is different than for standard PMHC MDS as explained at AMHC Base Version.

SDQ measures are managed by the hub organisation via upload or data entry.

No SDQ measures should be provided in the intake context.

Table 12 SDQ record layout

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

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.
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.
SDQ Collection Occasion - Version (sdq_version)	string	yes	**PC101** Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1 **PC201** Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1 **PY101** Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1 **PY201** Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1 **YR101** Self report Version, 11-17 years, Baseline version, Australian Version 1 **YR201** Self report Version, 11-17 years, Follow Up version, Australian Version 1
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

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

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

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

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

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

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

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

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

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

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

AMHC definitions

Definitions

AMHC - Service Contact - Practitioner Category

The types or categories of the practitioners, as represented by a set of codes.

Field name

service_contact_practitioner_category

Data type

string

Required

yes

Domain

0 None

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

Multiple space separated values allowed

Notes

Practitioner Category is a multi choice field which allows the type of professionals used in multidisciplinary teams to be recorded against a contact.

The Practitioner Category field is in addition to the standard PHMC MDS field for identifying a specific practitioner. The standard model only allows a single practitioner to be recorded against a contact. The extended process still requires identification of a single practitioner (intended to be the 'main' one) but also allows capturing the discipline(s) of other practitioners who might be involved. The discipline (practitioner type) of the main practitioner is already stored on an existing table and does not need to be added to the new practitioner categories field.

AMHC - Service Contact - Start Time

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

Field name

service_contact_start_time

Data type

time

Required

yes

Notes

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

Client Key

This is a number or code assigned to each individual referred to the commissioned organisation. The client identifier is unique and stable for each individual at the level of the PMHC top level organisation.

Field name

client_key

Data type

string (2,50)

Required

yes

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 and 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.

Collection Occasion - Reason

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

Field name

reason_for_collection

Data type

string

Required

yes

Domain

1 Episode start

2 Review

3 Episode end

Notes

Intake Context

In the intake context, only response *1 - Episode start* may be used.

1 - Episode start

Refers to a service activity 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.

Hub Context

In the hub context, all responses may be used.

1 - Episode start

Refers to a service activity 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 a service activity undertaken during the course of an Episode of Care that post-dates Episode Start and pre-dates Episode End. A service activity 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 service activities collected at the end of an Episode of Care.

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`.

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 are case sensitive and must be valid unicode characters.

Episode - Additional Diagnosis

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

Field name

additional_diagnosis

Data type

string

Required

yes

Domain

000 No additional diagnosis

100 Anxiety disorders (ATAPS)

101 Panic disorder

102 Agoraphobia

103 Social phobia

104 Generalised anxiety disorder

105 Obsessive-compulsive disorder

106 Post-traumatic stress disorder

107 Acute stress disorder

108 Other anxiety disorder

200 Affective (Mood) disorders (ATAPS)

201 Major depressive disorder

202 Dysthymia

203 Depressive disorder NOS

204 Bipolar disorder

205 Cyclothymic disorder

206 Other affective disorder

300 Substance use disorders (ATAPS)

301 Alcohol harmful use

302 Alcohol dependence

303 Other drug harmful use

304 Other drug dependence

305 Other substance use disorder

400 Psychotic disorders (ATAPS)

401 Schizophrenia

402 Schizoaffective disorder

403 Brief psychotic disorder

404 Other psychotic disorder

501 Separation anxiety disorder

502 Attention deficit hyperactivity disorder (ADHD)

503 Conduct disorder

504 Oppositional defiant disorder

505 Pervasive developmental disorder

506 Other disorder of childhood and adolescence

601 Adjustment disorder

602 Eating disorder

603 Somatoform disorder

604 Personality disorder

605 Other mental disorder

901 Anxiety symptoms

902 Depressive symptoms

903 Mixed anxiety and depressive symptoms

904 Stress related

905 Other

999 Missing

Notes

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

- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures
- Increased clinical care and/or monitoring

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

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

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

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

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

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

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

Episode - Area of usual residence, postcode

The Australian postcode of the client.

Field name

client_postcode

Data type

string

Required

yes

Notes

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

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

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

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

Source

METeOR ID 429894

Episode - 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

Domain

1 Yes

2 No

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.

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

Intake Context

1 - Episode closed - treatment concluded

The client has been discharged not requiring service.

5 - Episode closed administratively - client referred elsewhere

Client was referred to a clinic.

Hub Context

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.

Both Contexts

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.

Episode - Continuity of Support

Is the client a Continuity of Support Client?

Field name

continuity_of_support

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Not stated/inadequately described

Notes

Introduced 1 July 2019

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

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

1 - Yes

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

2 - No

9 - Not stated/inadequately described

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

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

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

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

Episode - Employment Participation

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

Field name

employment_participation

Data type

string

Required

yes

Domain

1 Full-time

2 Part-time

3 Not applicable - not in the labour force

9 Not stated/inadequately described

Notes

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

1 - Full-time

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

2 - Part-time

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

9 - Not stated / inadequately described

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

Source

METeOR ID 269950

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

Intake Context

In the AMHC intake context, the Episode End Date must be recorded as the date when the referral is sent to the clinic.

Both Intake and Hub Contexts

- 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.

Source

METeOR ID 614094

Episode - GP Mental Health Treatment Plan Flag

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

Field name

mental_health_treatment_plan

Data type

string

Required

yes

Domain

1 Yes

2 No

3 Unknown

9 Not stated/inadequately described

Episode - Health Care Card

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

Field name

health_care_card

Data type

string

Required

yes

Domain

1 Yes

2 No

3 Not Known

9 Not stated

Notes

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

Source

METeOR ID 605149

Episode - Homelessness Flag

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

Field name

homelessness

Data type

string

Required

yes

Domain

1 Sleeping rough or in non-conventional accommodation

2 Short-term or emergency accommodation

3 Not homeless

9 Not stated / Missing

Notes

1 - Sleeping rough or in non-conventional accommodation

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

2 - Short-term or emergency accommodation

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

3 - Not homeless

Includes sleeping in own accommodation/rental accommodation or living with friends or relatives on a stable, long term basis

9 - Not stated / Missing

Not stated / Missing

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

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

Episode Key

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.

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.

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

Episode - Labour Force Status

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

Field name

labour_force_status

Data type

string

Required

yes

Domain

1 Employed

2 Unemployed

3 Not in the Labour Force

9 Not stated/inadequately described

Notes

1 - Employed

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

- Worked for one hour or more for pay, profit, commission or payment in kind, in a job or business or son a farm (employees and owner managers of incorporated or unincorporated enterprises).
- Worked for one hour or more without pay in a family business or on a farm (contributing family workers).
- Were employees who had a job but were not at work and were:
  - away from work for less than four weeks up to the end of the reference week; or
  - away from work for more than four weeks up to the end of the reference week and
  - received pay for some or all of the four week period to the end of the reference week; or
  - away from work as a standard work or shift arrangement; or
  - on strike or locked out; or
  - on workers' compensation and expected to return to their job.
- Were owner managers who had a job, business or farm, but were not at work.

2 - Unemployed

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

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

Actively looked for work includes:

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

3 - Not in the labour force

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

Source

METeOR ID 621450

Episode - Marital Status

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

Field name

marital_status

Data type

string

Required

yes

Domain

1 Never married

2 Widowed

3 Divorced

4 Separated

5 Married (registered and de facto)

6 Not stated/inadequately described

Notes

Refers to the current marital status of a person.

2 - Widowed

This code usually refers to registered marriages but when self-reported may also refer to de facto marriages.

4 - Separated

This code refers to registered marriages but when self-reported may also refer to de facto marriages.

5 - Married (registered and de facto)

Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex.

6 - Not stated/inadequately described

This code is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source

METeOR ID 291045

Episode - Medication - Antidepressants (N06A)

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

Field name

medication_antidepressants

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Unknown

Notes

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

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

Episode - Medication - Antipsychotics (N05A)

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

Field name

medication_antipsychotics

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Unknown

Notes

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

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

Episode - Medication - Anxiolytics (N05B)

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

Field name

medication_anxiolytics

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Unknown

Notes

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

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

Episode - Medication - Hypnotics and sedatives (N05C)

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

Field name

medication_hypnotics

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Unknown

Notes

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

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

Episode - Medication - Psychostimulants and nootropics (N06B)

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

Field name

medication_psychostimulants

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Unknown

Notes

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

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

Episode - NDIS Participant

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

Field name

ndis_participant

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Not stated/inadequately described

Episode - Principal Diagnosis

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

Field name

principal_diagnosis

Data type

string

Required

yes

Domain

100 Anxiety disorders (ATAPS)

101 Panic disorder

102 Agoraphobia

103 Social phobia

104 Generalised anxiety disorder

105 Obsessive-compulsive disorder

106 Post-traumatic stress disorder

107 Acute stress disorder

108 Other anxiety disorder

200 Affective (Mood) disorders (ATAPS)

201 Major depressive disorder

202 Dysthymia

203 Depressive disorder NOS

204 Bipolar disorder

205 Cyclothymic disorder

206 Other affective disorder

300 Substance use disorders (ATAPS)

301 Alcohol harmful use

302 Alcohol dependence

303 Other drug harmful use

304 Other drug dependence

305 Other substance use disorder

400 Psychotic disorders (ATAPS)

401 Schizophrenia

402 Schizoaffective disorder

403 Brief psychotic disorder

404 Other psychotic disorder

501 Separation anxiety disorder

502 Attention deficit hyperactivity disorder (ADHD)

503 Conduct disorder

504 Oppositional defiant disorder

505 Pervasive developmental disorder

506 Other disorder of childhood and adolescence

601 Adjustment disorder

602 Eating disorder

603 Somatoform disorder

604 Personality disorder

605 Other mental disorder

901 Anxiety symptoms

902 Depressive symptoms

903 Mixed anxiety and depressive symptoms

904 Stress related

905 Other

999 Missing

Notes

Diagnoses are grouped into 7 major categories:

- 1xx - Anxiety disorders
- 2xx - Affective (Mood) disorders
- 3xx - Substance use disorders
- 4xx - Psychotic disorder
- 5xx - Disorders with onset usually occurring in childhood and adolescence not listed elsewhere
- 6xx - Other mental disorder
- 9xx - No formal mental disorder but subsyndromal problem

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

The coding options developed for the PMHC MDS have been selected to balance comprehensiveness and brevity. They comprise a mix of the most prevalent mental disorders in the Australian adult, child and adolescent population, supplemented by less prevalent conditions that may be experienced by clients of PHN-commissioned mental health services. The diagnosis options are based on an abbreviated set of clinical terms and groupings specified in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV-TR). These code list summarises the approximate 300 unique mental health disorder codes in the full DSM-IV to a set to 9 major categories, and 37 individual codes. Diagnoses are grouped under higher level categories, based on the DSM-IV. Code numbers have been assigned specifically for the PMHC MDS to create a logical ordering but are capable of being mapped to both DSM-IV and ICD-10 codes.

Options for recording Principal Diagnosis include the broad category 'No formal mental disorder but subsyndromal problem' (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.

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.

Episode - Principal Focus of Treatment Plan

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

Field name

principal_focus

Data type

string

Required

yes

Domain

1 Psychological therapy

2 Low intensity psychological intervention

3 Clinical care coordination

4 Complex care package

5 Child and youth-specific mental health services

6 Indigenous-specific mental health services

7 Other

8 Psychosocial Support

Notes

Describes the main focus of the services to be delivered to the client for the current Episode of Care.

7 - Other

Only this response should be used for either AMHC Hub episodes

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Episode - Source of Cash Income

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

Field name

income_source

Data type

string

Required

yes

Domain

0 N/A - Client aged less than 16 years

1 Disability Support Pension

2 Other pension or benefit (not superannuation)

3 Paid employment

4 Compensation payments

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

6 Nil income

7 Not known

9 Not stated/inadequately described

Notes

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

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

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

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

Source

METeOR ID 386449

Episode - Suicide Referral Flag

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

Field name

suicide_referral_flag

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Unknown

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`.

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

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

Field name

iar_dst_domain_1

Data type

string

Required

yes

Domain

- **0** No problem in this domain
- **1** Mild or sub diagnostic
- **2** Moderate
- **3** Severe
- **4** Very severe

Notes

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

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

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

Field name

iar_dst_domain_2

Data type

string

Required

yes

Domain

- **0** No identified risk in this domain
- **1** Low risk of harm
- **2** Moderate risk of harm
- **3** High risk of harm
- **4** Very high risk of harm

Notes

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

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)

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

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

Field name

iar_dst_domain_4

Data type

string

Required

yes

Domain

- **0** No problem in this domain
- **1** Minor impact
- **2** Moderate impact
- **3** Severe impact
- **4** Very severe impact

Notes

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

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

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

Field name

iar_dst_domain_5

Data type

string

Required

yes

Domain

- **0** No prior treatment history
- **1** Full recovery with previous treatment
- **2** Moderate recovery with previous treatment
- **3** Minor recovery with previous treatment

4 Negligible recovery with previous treatment

Notes

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

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

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

Field name

iar_dst_domain_6

Data type

string

Required

yes

Domain

0 No problem in this domain

1 Mildly stressful environment

2 Moderately stressful environment

3 Highly stressful environment

4 Extremely stressful environment

Notes

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

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

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

Field name

iar_dst_domain_7

Data type

string

Required

yes

Domain

- **0** Highly supported
- **1** Well supported
- **2** Limited supports
- **3** Minimal supports
- **4** No supports

Notes

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

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

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

Field name

iar_dst_domain_8

Data type

string

Required

yes

Domain

- **0** Optimal
- **1** Positive
- **2** Limited
- **3** Minimal
- **4** Disengaged

Notes

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

IAR-DST - Practitioner Level of Care

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

Field name

iar_dst_practitioner_level_of_care

Data type

string

Required

yes

Domain

1 Level 1 - Self Management

2 Level 2 - Low Intensity Services

3 Level 3 - Moderate Intensity Services

4 Level 4 - High Intensity Services

5 Level 5 - Acute and Specialist Community Mental Health Services

9 Not stated

Notes

Please refer to IAR-DST Levels of Care

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

IAR-DST - Recommended Level of Care

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

Field name

iar_dst_recommended_level_of_care

Data type

string

Required

yes

Domain

1 Level 1 - Self Management

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

2 Level 2 - Low Intensity Services

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

3 Level 3 - Moderate Intensity Services

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

4 Level 4 - High Intensity Services

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

5 Level 5 - Acute and Specialist Community Mental Health Services

Notes

Please refer to IAR-DST Levels of Care

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`.

Intake Collection Occasion - Tags

List of tags for the collection occasion.

Field name

intake_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`.

Intake Collection Occasion Key

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

Field name

intake_collection_occasion_key

Data type

string (2,50)

Required

yes

Notes

Intake Collection Occasion keys are case sensitive and must be valid unicode characters.

Intake - Contact Date

The date on which the client first contacted the intake service

Field name

contact_date

Data type

date

Required

no

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.

Intake - Funding Source

The source of funding for the intake

Field name

intake_funding_source

Data type

string

Required

yes

Domain

1 HeadtoHelp

2 AMHC

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.

Intake Organisation Path

A sequence of colon separated Organisation Keys that fully specifies the Intake Organisation that referred the client to the hub service. In conjuctionion with the intake key, this allows linkage from the hub episode back to the intake.

Field name

intake_organisation_path

Data type

string

Required

no

Notes

This field should only be completed for an episode at the hub provider organisation. It should be left blank for an episode at an intake organisation.

This field is a combination of the Organisation Key of the Intake Organisation's Primary Health Network(PHN) and the Intake Organisation's Organisation Key separated by a colon.

This information must be included with the other referral information provided to the Hub by the Intake organisation.

Intake - Outcome

An indication of the completion status of an *Intake*.

Field name

outcome

Data type

string

Required

no

Domain

0 Intake open

1 Intake closed - client did not require service

2 Intake closed - client referred to a clinic

Notes

1 - Intake closed - client did not require service

The client has been discharged not requiring service.

2 - Intake closed - client referred to a clinic

Client was referred to either an AMHC hub clinic, an AMHC non hub clinic or non PMHC MDS funded clinic.

Intake Outcome interacts *Outcome Date*.

Outcome Date

Where a closed outcome was recorded the Outcome Date should be recorded as the date of the intake was closed.

Intake - Outcome Date

The date the intake had an outcome

Field name

outcome_date

Data type

date

Required

no

Notes

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

Outcome Date interacts with *Outcome*.

Outcome

This field should be recorded as one of the intake closed options when an *Outcome Date* is recorded.

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`.

Key

A metadata key name.

Field name

key

Data type

string

Required

yes

K5 - Question 1

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

Field name

k5_item1

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K5 - Question 2

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

Field name

k5_item2

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K5 - Question 3

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

Field name

k5_item3

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K5 - Question 4

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

Field name

k5_item4

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K5 - Question 5

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

Field name

k5_item5

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

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'

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`.

K10+ - Question 1

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

Field name

k10p_item1

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K10+ - Question 2

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

Field name

k10p_item2

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K10+ - Question 3

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

Field name

k10p_item3

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K10+ - Question 4

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

Field name

k10p_item4

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K10+ - Question 5

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

Field name

k10p_item5

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

K10+ - Question 6

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

Field name

k10p_item6

Data type

string

Required

yes

Domain

1 None of the time

2 A little of the time

3 Some of the time

4 Most of the time

5 All of the time

9 Not stated / Missing

Notes

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

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’

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’

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’

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’

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.

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.

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.

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.

K10+ - Score

The overall K10 score.

Field name

k10p_score

Data type

integer

Required

yes

Domain

10 - 50, 99 = Not stated / Missing

Notes

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

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

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

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

K10+ - Tags

List of tags for the measure.

Field name

k10p_tags

Data type

string

Required

no

Notes

A comma separated list of tags.

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

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

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

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.

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 Path
PHN999	Test PHN	Primary Health Network	None	PHN999
PO101	Test Provider Organisation	Private Allied Health Professional Practice	PHN999	PHN999:PO101

Practitioner Key

A unique identifier for a practitioner within the provider organisation.

Field name

practitioner_key

Data type

string (2,50)

Required

yes

Referral Date

The date the referrer made the referral to the intake service.

Field name

referral_date

Data type

date

Required

no

Notes

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

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

Referral Out Organisation Type

Type of organisation to which the client is being referred.

Field name

referral_out_organisation_type

Data type

string

Required

yes

Domain

0 None/Not applicable

1 General Practice

2 Medical Specialist Consulting Rooms

3 Private practice

4 Public mental health service

5 Public Hospital

6 Private Hospital

7 Emergency Department

8 Community Health Centre

9 Drug and Alcohol Service

10 Community Support Organisation NFP

11 Indigenous Health Organisation

12 Child and Maternal Health

13 Nursing Service

14 Telephone helpline

15 Digital health service

16 Family Support Service

17 School

18 Tertiary Education institution

19 Housing service

20 Centrelink

21 Other

22 HeadtoHelp Hub

23 Non HeadtoHelp Hub PHN funded service

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.

Referrer Organisation Type

Type of organisation in which the referring professional is based.

Field name

referrer_organisation_type

Data type

string

Required

yes

Domain

1 General Practice

2 Medical Specialist Consulting Rooms

3 Private practice

4 Public mental health service

5 Public Hospital

6 Private Hospital

7 Emergency Department

8 Community Health Centre

9 Drug and Alcohol Service

10 Community Support Organisation NFP

11 Indigenous Health Organisation

12 Child and Maternal Health

13 Nursing Service

14 Telephone helpline

15 Digital health service

16 Family Support Service

17 School

18 Tertiary Education institution

19 Housing service

20 Centrelink

21 Other

98 N/A - Self referral

99 Not stated

Notes

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

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

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

Referrer Profession

Profession of the provider who referred the client.

Field name

referrer_profession

Data type

string

Required

yes

Domain

- **1** General Practitioner
- **2** Psychiatrist
- **3** Obstetrician
- **4** Paediatrician
- **5** Other Medical Specialist
- **6** Midwife
- **7** Maternal Health Nurse
- **8** Psychologist
- **9** Mental Health Nurse
- **10** Social Worker
- **11** Occupational therapist
- **12** Aboriginal Health Worker
- **13** Educational professional
- **14** Early childhood service worker
- **15** Other
- **98** N/A - Self referral
- **99** Not stated

Notes

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

SDQ Collection Occasion - Version

The version of the SDQ collected.

Field name

sdq_version

Data type

string

Required

yes

Domain

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

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

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

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

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

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

Notes

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

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SDQ - Conduct Problem Scale

Field name

sdq_conduct_problem

Data type

integer

Required

yes

Domain

0 - 10, 99 = Not stated / Missing

Notes

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

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

SDQ - Emotional Symptoms Scale

Field name

sdq_emotional_symptoms

Data type

integer

Required

yes

Domain

0 - 10, 99 = Not stated / Missing

Notes

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

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

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'.

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'.

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'.

SDQ - Prosocial Scale

Field name

sdq_prosocial

Data type

integer

Required

yes

Domain

0 - 10, 99 = Not stated / Missing

Notes

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

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

SDQ - Question 1

Parent Report: Considerate of other people's feelings.

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

Field name

sdq_item1

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 2

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

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

Field name

sdq_item2

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 3

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

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

Field name

sdq_item3

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 4

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

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

Field name

sdq_item4

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 5

Parent Report: Often loses temper.

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

Field name

sdq_item5

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 6

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

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

Field name

sdq_item6

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 7

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

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

Field name

sdq_item7

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 8

Parent Report: Many worries or often seems worried.

Youth Self Report: I worry a lot.

Field name

sdq_item8

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 9

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

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

Field name

sdq_item9

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 10

Parent Report: Constantly fidgeting or squirming.

Youth Self Report: I am constantly fidgeting or squirming.

Field name

sdq_item10

Data type

string

Required

yes

Domain

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

Notes

Required Versions: All

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

SDQ - Question 11

Parent Report: Has at least one good friend.

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

Field name

sdq_item11

Data type

string

Required

yes

Domain

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

Notes

Required Versions: All

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

SDQ - Question 12

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

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

Field name

sdq_item12

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

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

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

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

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 15

Parent Report: Easily distracted, concentration wanders.

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

Field name

sdq_item15

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 16

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

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

Field name

sdq_item16

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 17

Parent Report: Kind to younger children.

Youth Self Report: I am kind to younger people.

Field name

sdq_item17

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 18

Parent Report: Often lies or cheats.

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

Field name

sdq_item18

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 19

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

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

Field name

sdq_item19

Data type

string

Required

yes

Domain

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

Notes

Required Versions: All

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

SDQ - Question 20

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

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

Field name

sdq_item20

Data type

string

Required

yes

Domain

- **0** Not True
- **1** Somewhat True
- **2** Certainly True
- **7** Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 21

Parent Report: Thinks things out before acting.

Youth Self Report: I think before I do things.

Field name

sdq_item21

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 22

Parent Report: Steals from home, school or elsewhere.

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

Field name

sdq_item22

Data type

string

Required

yes

Domain

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

Notes

Required Versions: All

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

SDQ - Question 23

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

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

Field name

sdq_item23

Data type

string

Required

yes

Domain

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

Notes

Required Versions: All

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

SDQ - Question 24

Parent Report: Many fears, easily scared.

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

Field name

sdq_item24

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 25

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

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

Field name

sdq_item25

Data type

string

Required

yes

Domain

0 Not True

1 Somewhat True

2 Certainly True

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 26

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

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

Field name

sdq_item26

Data type

string

Required

yes

Domain

0 No

1 Yes - minor difficulties

2 Yes - definite difficulties

3 Yes - severe difficulties

7 Unable to rate (insufficient information)

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 27

Parent Report: How long have these difficulties been present?

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

Field name

sdq_item27

Data type

string

Required

yes

Domain

- **0** Less than a month
- **1** 1-5 months
- **2** 6-12 months
- **3** Over a year
- **7** Unable to rate (insufficient information)
- **8** Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
- **9** Not stated / Missing

Notes

Required Versions: - PC101 - PY101 - YR101

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

SDQ - Question 28

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

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

Field name

sdq_item28

Data type

string

Required

yes

Domain

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

Notes

Required Versions: All

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

SDQ - Question 29

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

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

Field name

sdq_item29

Data type

string

Required

yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 30

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

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

Field name

sdq_item30

Data type

string

Required

yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 31

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

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

Field name

sdq_item31

Data type

string

Required

yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 32

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

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

Field name

sdq_item32

Data type

string

Required

yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 33

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

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

Field name

sdq_item33

Data type

string

Required

yes

Domain

0 Not at all

1 A little

2 A medium amount

3 A great deal

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions: All

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

SDQ - Question 34

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

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

Field name

sdq_item34

Data type

string

Required

yes

Domain

0 Much worse

1 A bit worse

2 About the same

3 A bit better

4 Much better

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- PC201
- PY201
- YR201

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

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'.

SDQ - Question 36

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

Field name

sdq_item36

Data type

string

Required

yes

Domain

0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- PC101
- PY101

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

SDQ - Question 37

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

Field name

sdq_item37

Data type

string

Required

yes

Domain

0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- PC101
- PY101

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

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

0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- PC101
- PY101

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

SDQ - Question 39

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

Field name

sdq_item39

Data type

string

Required

yes

Domain

0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- YR101

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

SDQ - Question 40

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

Field name

sdq_item40

Data type

string

Required

yes

Domain

0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- YR101

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

SDQ - Question 41

Does your family complain about you being awkward or troublesome?

Field name

sdq_item41

Data type

string

Required

yes

Domain

0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- YR101

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

SDQ - Question 42

Do your teachers complain about you being awkward or troublesome?

Field name

sdq_item42

Data type

string

Required

yes

Domain

0 No

1 A little

2 A lot

7 Unable to rate (insufficient information)

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

9 Not stated / Missing

Notes

Required Versions:

- YR101

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

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`.

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'.

Service Contact - Client Participation Indicator

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

Field name

service_contact_participation_indicator

Data type

string

Required

yes

Domain

1 Yes

2 No

Notes

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

1 - Yes

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

2 - No

This code is to be used for service contacts between a mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

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

Source

METeOR ID 494341

Service Contact - Copayment

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

Field name

service_contact_copayment

Data type

number

Required

yes

Domain

0 - 999999.99

Notes

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

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

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.

Source

METeOR ID 494356

Service Contact - Duration

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

Field name

service_contact_duration

Data type

string

Required

yes

Domain

0	No contact took place
1	1-15 mins
2	16-30 mins
3	31-45 mins
4	46-60 mins
5	61-75 mins
6	76-90 mins
7	91-105 mins

8 106-120 mins

9 over 120 mins

Notes

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

0 - No contact took place

Only use this code where the service contact is recorded as a no show.

Service Contact - Final

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

Field name

service_contact_final

Data type

string

Required

yes

Domain

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

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

3 Not known at this stage

Notes

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

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

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

Service Contact - Interpreter Used

Whether an interpreter service was used during the Service Contact

Field name

service_contact_interpreter

Data type

string

Required

yes

Domain

1 Yes

2 No

9 Not stated

Notes

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

1 - Yes

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

2 - No

Use this code where interpreter services were not used during the Service Contact.

9 - Not stated

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

Service Contact - Modality

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

Field name

service_contact_modality

Data type

string

Required

yes

Domain

0 No contact took place

1 Face to Face

2 Telephone

3 Video

4 Internet-based

Notes

0 - No contact took place

Only use this code where the service contact is recorded as a no show.

1 - Face to Face

- If ‘Face to Face’ is selected, a value other than ‘Not applicable’ must be selected for Service Contact Venue
- If ‘Face to Face’ is selected a valid Australian postcode must be entered for Service Contact Postcode. The unknown postcode is not valid.

4 - Internet-based

Includes email communication, that 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.

Service Contact - No Show

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

Field name

service_contact_no_show

Data type

string

Required

yes

Domain

1 Yes

2 No

Notes

1 - Yes

The intended participant(s) failed to attend the appointment.

2 - No

The intended participant(s) attended the appointment.

Service Contact - Participants

An indication of who participated in the Service Contact.

Field name

service_contact_participants

Data type

string

Required

yes

Domain

1 Individual client

2 Client group

3 Family / Client Support Network

4 Other health professional or service provider

5 Other

9 Not stated

Notes

1 - Individual

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

2 - Client group

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

3 - Family / Client Support Network

Code applies to Service Contacts delivered to the family/social support persons of the client, with or without the participation of the client.

4 - Other health professional or service provider

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

5 - Other

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

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

Service Contact - Postcode

The Australian postcode where the service contact took place.

Field name

service_contact_postcode

Data type

string

Required

yes

Notes

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

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

Source

METeOR ID 429894

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`.

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

Notes

Describes the main type of service delivered in the contact, selected from a defined list of categories. Service providers are required to report on Service Type for all Service Contacts.

Service Contact - Venue

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

Field name

service_contact_venue

Data type

string

Required

yes

Domain

- **1** Client's Home
- **2** Service provider's office
- **3** GP Practice
- **4** Other medical practice
- **5** Headspace Centre
- **6** Other primary care setting
- **7** Public or private hospital
- **8** Residential aged care facility

9 School or other educational centre

10 Client's Workplace

11 Other

12 Aged care centre - non-residential

98 Not applicable (Service Contact Modality is not face to face)

99 Not stated

Notes

Values other than 'Not applicable' only to be specified when Service Contact Modality is 'Face to Face'.

Note that 'Other primary care setting' is suitable for primary care settings such as community health centres.

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 organisation.

Field name

service_contact_key

Data type

string (2,50)

Required

yes

Notes

Service contact keys are case sensitive and must be valid unicode characters.

Value

The metadata value.

Field name

value

Data type

string

Required

yes

Download specification files

Available for software developers designing extracts for AMHC, please click the link below to download AMHC Specification files for the PMHC MDS:

- AMHC Specification zip

Implementation considerations

Describe how local data items can be mapped to PMHC data items.

Upload specification

File types

Files will be accepted in the following types:

- Comma Separated Values (CSV)
- Excel (XLSX)

Comma Separated Values (CSV)

Requirements for CSV files:

- 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

Excel (XLSX)

Requirements for XLSX files:

Excel files must be in XLSX format. The following versions of Excel support this format:

- Excel 2007 (v12.0)
- Excel 2010 (v14.0)
- Excel 2013 (v15.0)
- Excel 2016 (v16.0)

One XLSX file must be uploaded containing multiple worksheets - one worksheet for each format described below.

When saving your file, please choose the filetype 'Excel Workbook (.xlsx)'.

The filename of the Excel file doesn't matter as long as it has the file extension .xlsx

AMHC Base Version

The AMHC upload format is slightly different to the PMHC MDS Version 2.0 upload format.

The AMHC upload format separates collection occasion data into a separate Collection Occasions worksheet so that multiple measures can be collected at a single collection occasion.

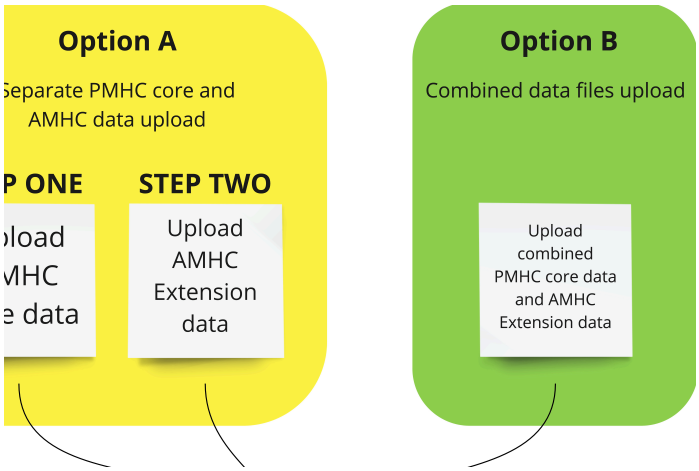
The AMHC upload format aligns with a future PMHC MDS Version 3.0 file format. No date has been set for the release of the PMHC MDS Version 3.0 upload file format.

In addition to the collection occasion/measure changes, the AMHC upload format adds additional values to support the AMHC extension.

How to upload AMHC Files

AMHC files/worksheets can be uploaded to the PMHC MDS in one of two ways:

- Option A: Separate PMHC and AMHC uploads - Option A is recommended for organisations who have not yet changed their standard upload files to include AMHC data. It allows these organisations to do their normal PMHC MDS upload and then do a second upload for AMHC data. Option A is also recommended for organisations who use Data Entry instead of upload for the PMHC MDS data, but who wish to upload AMHC data.
- Option B: One upload including PMHC and AMHC clients - Option B is recommended for organisations who have already migrated their standard PMHC MDS uploads to allow AMHC uploads at the same time. It allows both PMHC MDS and AMHC data to be uploaded together in one upload.



Option A: Separate PMHC and AMHC uploads

When uploading standard PMHC clients and AMHC clients separately, the upload for the standard PMHC clients will continue to use the PMHC MDS Version 2.0 upload format and the upload for the AMHC clients must use the format as described in this document.

Option B: One upload including PMHC and AMHC clients

For those organisations who are ready to change their standard PMHC MDS uploads, PMHC MDS and AMHC uploads can be combined together in the one upload to the PMHC MDS.

Files or worksheets to upload

The AMHC extension is used in two contexts:

1. The AMHC Intake team provide data to the PMHC MDS about clients that they have helped through the intake phone number.
2. The AMHC Hubs provide data to the PMHC MDS about clients who have been referred to them by the Intake teams.

Which files/worksheets need to be uploaded to the PMHC MDS depends on the context for which the data is being provided.

Files/worksheets for the Intake context

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

Table 13 Summary of Intake files to upload

File Type	CSV filename	Excel worksheet name	Required
Metadata	metadata.csv	Metadata	Required
Organisations	organisations.csv	Organisations	Optional and only available to PHN users if the user has the Organisation Management role
Clients	clients.csv	Clients	Optional
Intake	intakes.csv	Intakes	Required
Intake Collection Occasion	intake-collection-occasions.csv	Intake Collection Occasions	Required
IAR-DST Measures	iar-dst.csv	IAR-DST	Required

Files/worksheets for the Hub context

When uploading AMHC data files for the Hub context only the following files/worksheets need to be uploaded to the PMHC MDS:

Table 14 Summary of Hub files to upload

File Type	CSV filename	Excel worksheet name	Required
Metadata	metadata.csv	Metadata	Required
Organisations	organisations.csv	Organisations	Optional and only available to PHN users if the user has the Organisation Management role
Clients	clients.csv	Clients	Optional
Episodes	episodes.csv	Episodes	Optional
AMHC Episodes	amhc-episodes.csv	AMHC Episodes	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
Service Contacts	service-contacts.csv	Service Contacts	Required
AMHC Service Contacts	amhc-service-contacts.csv	AMHC Service Contacts	Required

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

File format

Requirements for file formats:

- The first row must contain the column headings as defined for each file type.
- Each item is a column in the file/worksheet. The 'Field Name' must be used for the column headings. The columns must be kept in the same order.
- The second and subsequent rows must contain the data.
- Data elements for each file/worksheet are defined at Record formats.
- For data elements that allow multiple values, each value should be separated by a space; for example: *1 3 6*.

All AMHC data uploads must include a Metadata file/worksheet. See Metadata file.

Each of the below example files assumes the following organisation structure:

Organisation Key	Organisation Name | Organisation Type		Parent Organisation	Organisation Path
PHN999	Example PHN	Primary Health Network	None	PHN999
Intake01	Example Intake Organisation	Other	PHN999	PHN999:Intake01
Hub01	Example Hub Organisation	State/Territory Health Service Organisation	PHN999	PHN999:Hub01

Metadata file

All AMHC data uploads in both Intake and Hub contexts 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 'AMHC' - In the third row, the first cell must contain 'version' and the second cell must contain '3.0'

i.e.:

key	value
type	AMHC
version	3.0

Data elements for the AMHC metadata upload file/worksheet are defined at Metadata.

Example AMHC metadata data:

- CSV AMHC metadata file.
- XLSX AMHC metadata worksheet.

Organisation file format

This file is for PHN use only. The organisation file/worksheet is optional. This is similar to the standard PMHC MDS Provider Organisation file/worksheet.

Data elements for the Provider Organisation upload file/worksheet are defined at Provider Organisation data elements.

Example organisation data:

- CSV organisation file.
- XLSX organisation worksheet.

Client file format

The client file/worksheet is required to be uploaded each time.

Data elements for the client upload file/worksheet are defined at Client data elements.

Example intake client data:

- CSV Intake client file.
- XLSX Intake client worksheet.

Example hub client data:

- CSV Hub client file.
- XLSX Hub client worksheet.

Intake file format

The intake file/worksheet is required to be uploaded each time.

Data elements for the intake upload file/worksheet are defined at Intake.

Example data:

- CSV intake file.
- XLSX intake worksheet.

Intake Collection Occasion file format

The Intake Collection Occasion file/worksheet is required to be uploaded each time.

Data elements for the Intake Collection Occasion upload file/worksheet are defined at Intake Collection Occasion.

Example Intake Collection Occasion data:

- CSV Intake Collection Occasion file.
- XLSX Intake Collection Occasion worksheet.

Episode file format

The episode file/worksheet is required to be uploaded each time.

Data elements for the episode upload file/worksheet are defined at Episode data elements.

Example intake episode data:

- CSV Intake episode file.
- XLSX Intake episode worksheet.

Example hub episode data:

- CSV Hub episode file.
- XLSX Hub episode worksheet.

AMHC Episode file format

The AMHC episode file/worksheet is required to be uploaded each time.

Data elements for the AMHC Episode upload file/worksheet are defined at AMHC Episode.

Example AMHC episode data:

- CSV Hub AMHC episode file.
- XLSX Hub AMHC episode worksheet.

Collection Occasion file format

The Collection Occasion file/worksheet is required to be uploaded each time.

Data elements for the Collection Occasion upload file/worksheet are defined at Collection Occasion.

Example Hub Collection Occasion data:

- CSV Hub Collection Occasion file.
- XLSX Hub Collection Occasion worksheet.

K10+ file format

The K10+ file/worksheet is required to be uploaded each time.

Data elements for the K10+ upload file/worksheet are defined at K10+ Measure.

Example Hub K10+ data:

- CSV Hub K10+ file.
- XLSX Hub K10+ worksheet.

K5 file format

The K5 file/worksheet is required to be uploaded each time.

Data elements for the K5 upload file/worksheet are defined at K5 Measure.

Example Hub K5 data:

- CSV Hub K5 file.
- XLSX Hub K5 worksheet.

SDQ file format

The SDQ file/worksheet is required to be uploaded each time.

Data elements for the SDQ upload file/worksheet are defined at SDQ Measure.

Example Hub SDQ data:

- CSV Hub SDQ file.
- XLSX Hub SDQ worksheet.

IAR-DST file format

The IAR-DST file/worksheet is required to be uploaded each time.

Data elements for the IAR-DST upload file/worksheet are defined at IAR-DST Measure.

Example Intake IAR-DST data:

- CSV Intake IAR-DST file.
- XLSX Intake IAR-DST worksheet.

Service Contact file format

The service contact file/worksheet is required to be uploaded each time.

Data elements for the service contact upload file/worksheet are defined at Service Contact.

Example Hub service contact data:

- CSV Hub service contact file.
- XLSX Hub service contact worksheet.

AMHC Service Contact file format

The AMHC service contact file/worksheet is required to be uploaded each time.

Data elements for the AMHC Service Contact upload file/worksheet are defined at AMHC Service Contact.

Example Hub AMHC service contact data:

- CSV Hub AMHC service contact file.
- XLSX Hub AMHC service contact worksheet.

Practitioner file format

The Practitioner file/worksheet is required for the first hub upload and when practitioner information changes. It is optional otherwise. It can be left out of an Intake upload.

Data elements for the Practitioner upload file/worksheet are defined at Practitioner data elements.

Example Intake Practitioner data:

Practitioner data is not required in an Intake upload file.

Example Hub Practitioner data:

- CSV Hub practitioner file.
- XLSX Hub practitioner worksheet.

Deleting records

- Records of the following type can be deleted via upload:
    - Client
    - Intake
    - Intake Collection Occasion
    - Episode
    - AMHC Episode
    - Collection Occasion
    - K10+
    - K5
    - SDQ
    - IAR-DST
    - Service Contact
    - AMHC Service Contact
    - Practitioner
- 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 AMHC files showing how to delete via upload:

AMHC Episode data

- CSV delete metadata file.

- CSV delete client file.
- CSV delete episode file.
- CSV delete AMHC episode file.
- CSV delete collection occasion file.
- CSV delete K10+ file.
- CSV delete K5 file.
- CSV delete SDQ file.
- CSV delete IAR-DST file.
- CSV delete service contacts file.
- CSV delete AMHC service contacts file.
- CSV delete practitioners file.
- XLSX delete file.

Validation rules

AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); the current PMHC MDS Validations rules apply. These are available to be viewed at https://docs.pmhc-mds.com/data-specification/validation-rules.html.

This document defines validation rules between AMHC items and record types. The domain of individual AMHC items is defined in Record formats.

Current AMHC validations

1. Intake

1. The Intake - Outcome Date must not be before the Intake - Contact Date
2. The Intake - Outcome 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 intake shall be open per client
5. Where the Intake - Outcome has been recorded using one of the 'Intake closed' responses (Response items 1 and 2), the intake must have an Intake - Outcome Date, and/or intakes that have an Intake - Outcome Date must have an Intake - Outcome recorded using one of the 'Intake closed' responses (Response items 1 and 2)
6. The Intake - Outcome Date
    - 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 Referral Date
    - 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

2. Intake Collection Occasion

1. Intake Key must be an existing PMHC intake within the PMHC MDS.
2. The Collection Occasion - Date
    - must not be before 1 January 2020
    - and must not be before Episode - Referral Date

- and must not be before Provider Organisation - Start Date
- and must not be after Episode - End Date
- and must not be after Provider Organisation - End Date
- and must not be in the future

3. IAR-DST

1. Intake Collection Occasion Key must be an existing Intake Collection Occasion within the PMHC MDS.
2. Both all 8 domains and the level of care must be provided.
3. The level of care must be consistent with the 8 domain scores provided.

4. AMHC - Episode

1. Episode Key must be an existing PMHC episode within the PMHC MDS.
2. `!amhc` tag should be included in the Episode - Tags field of the corresponding PMHC episode, otherwise the system will automatically include it.
3. If a Intake Organisation Path is specified, that organisation must be an existing organisation within the PMHC MDS.
4. If a Intake Key is specified, a Intake Organisation Path must also be specified.
5. Referral Out Organisation Type is a multivalued field.
    - Multivalued fields can not have duplicates, For example, `1 1 1` is not allowed.
    - If `0: None/Not applicable` is provided, no other values are permitted.

5. Collection Occasion

1. Episode Key must be an existing PMHC episode within the PMHC MDS.
2. 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 after Episode - End Date
    - and must not be after Provider Organisation - End Date
    - and must not be in the future

6. K10+

1. Collection Occasion Key must be an existing Collection Occasion within the PMHC MDS.
2. 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+).

7. K5

1. Collection Occasion Key must be an existing Collection Occasion within the PMHC MDS.
2. 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. SDQ

1. Collection Occasion Key must be an existing Collection Occasion within the PMHC MDS.
2. Use the table at SDQ Data Elements to validate the items that are used in each version of the SDQ
3. If both item scores and subscales are specified, the sum of the items must agree with the subscales score (as per Scoring the SDQ)
4. If both subscales and total score are specified, the sum of the subscales must agree with the total score (as per Scoring the SDQ)

9. AMHC - Service Contact

1. AMHC - Service Contact - Practitioner Category is a multivalued field.
    - Multivalued fields can not have duplicates, For example, `1 1 1` is not allowed.
    - If `0: None/Not applicable` is provided, no other values are permitted.

Current PMHC validations

AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); the current PMHC MDS Validations rules may apply, depending on how you add your AMHC data. The current PMHC MDS validations rules are available to be viewed at https://docs.pmhc-mds.com/data-specification/validation-rules.html.

Data Specification change log

??/??/2021 - Version 3.0 - draft

- Initial draft release

Frequently Asked Questions

PMHC FAQs

As the AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS), the current PMHC MDS Frequently Asked Questions (FAQs) are available to be viewed at https://docs.pmhc-mds.com/faqs/index.html.

Getting help

PMHC MDS helpdesk

Strategic Data offers a dedicated **Helpdesk** which is available to support Primary Health Networks and Provider Organisations implementing AMHC in relation to the PMHC minimum dataset system (MDS).

All MDS enquiries should be directed to support@pmhc-mds.com.

Frequently Asked Questions change log