



**Australian Government**

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**Department of Health**

# **Adult Mental Health Clinics Minimum Data Set and Dictionary**

Version 3.0.0

As at 14 May, 2021

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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 ([AMHC Episode - Intake Organisation Path](#) and [AMHC Episode - Intake Episode Key](#)), referrals out to additional services ([AMHC Episode - 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 dfn-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 dfn-intake-organisation-key and dfn-intake-episode-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 ([AMHC Episode - Intake Organisation Path](#))
2. The episode identifier of the intake team ([AMHC Episode - Intake Episode Key](#))
3. The organisation(s) to which the organisation (intake team or hub) refers the client ([AMHC Episode - 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

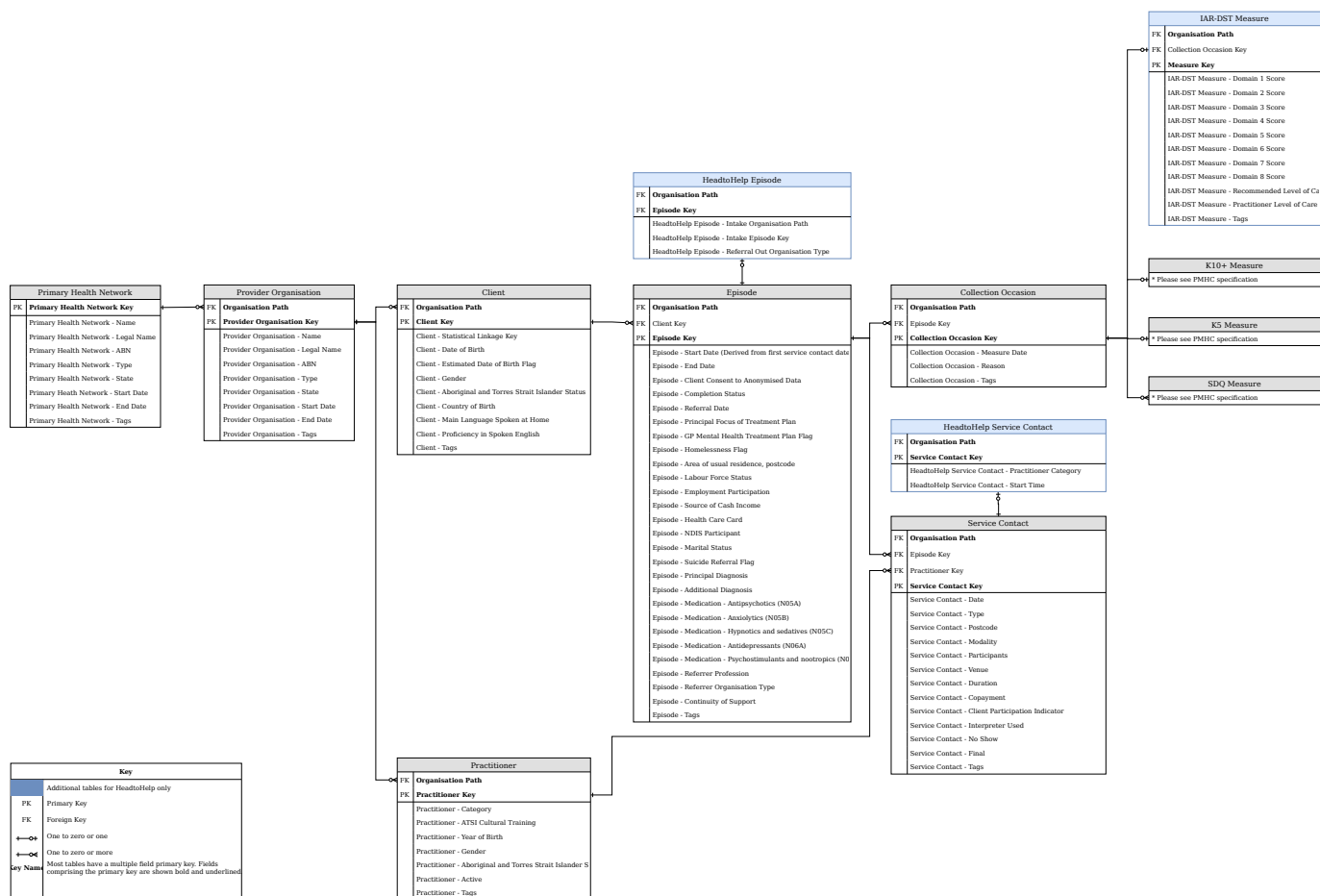


Fig. 1 AMHC data model within the PMHC MDS

### 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
<a href="#">Key</a> (key)	string	yes	A metadata key name.
<a href="#">Value</a> (value)	string	yes	The metadata value.

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

key	value
type	AMHC
version	3

## Provider Organisation

Same as standard [PMHC MDS Provider Organisation](#).

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## 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.

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## 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](#).

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## Intake

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

No intake records should be provided in the hub context.

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## 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.

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## 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 2 Episode record layout*

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Episode Key</a> (episode_key)	string (2,50)	yes	This is a number or code assigned to each episode. The Episode Key is unique and stable for each episode at the level of the organisation.
<a href="#">Client Key</a> (client_key)	string (2,50)	yes	This is a number or code assigned to each individual referred to the commissioned organisation. The client identifier is unique and stable for each individual at the level of the PMHC top level organisation.
<a href="#">Episode - End Date</a> (episode_end_date)  <a href="#">METeOR ID 614094</a>	date	—	The date on which an <i>Episode of Care</i> is formally or administratively ended
<a href="#">Episode - Client Consent to Anonymised Data</a> (client_consent)	string	yes	1 Yes 2 No
<a href="#">Episode - Completion Status</a> (episode_completion_status)	string	—	0 Episode open 1 Episode closed - treatment concluded 2 Episode closed administratively - client could not be contacted 3 Episode closed administratively - client declined further contact 4 Episode closed administratively - client moved out of area 5 Episode closed administratively - client referred elsewhere 6 Episode closed administratively - other reason
<a href="#">Episode - Referral Date</a> (referral_date)	date	—	The date the referrer made the referral.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Episode - Principal Focus of Treatment Plan</a> (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
<a href="#">Episode - GP Mental Health Treatment Plan Flag</a> (mental_health_treatment_plan)	string	yes	1 Yes 2 No 3 Unknown 9 Not stated/ inadequately described
<a href="#">Episode - Homelessness Flag</a> (homelessness)	string	yes	1 Sleeping rough or in non-conventional accommodation 2 Short-term or emergency accommodation 3 Not homeless 9 Not stated / Missing
<a href="#">Episode - Area of usual residence, postcode</a> (client_postcode)  METeOR ID 429894	string	yes	The Australian postcode of the client.
<a href="#">Episode - Labour Force Status</a> (labour_force_status)  METeOR ID 621450	string	yes	1 Employed 2 Unemployed 3 Not in the Labour Force 9 Not stated/ inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Episode - Employment Participation</a> (employment_participation)  <a href="#">METeOR ID 269950</a>	string	yes	1 Full-time 2 Part-time 3 Not applicable - not in the labour force 9 Not stated/ inadequately described
<a href="#">Episode - Source of Cash Income</a> (income_source)  <a href="#">METeOR ID 386449</a>	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
<a href="#">Episode - Health Care Card</a> (health_care_card)  <a href="#">METeOR ID 605149</a>	string	yes	1 Yes 2 No 3 Not Known 9 Not stated
<a href="#">Episode - NDIS Participant</a> (ndis_participant)	string	yes	1 Yes 2 No 9 Not stated/ inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Episode - Marital Status</a> (marital_status)  <a href="#">METeOR ID 291045</a>	string	yes	1 Never married 2 Widowed 3 Divorced 4 Separated 5 Married (registered and de facto) 6 Not stated/ inadequately described
<a href="#">Episode - Suicide Referral Flag</a> (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
Episode - 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
<a href="#">Episode - Referrer Organisation Type</a> (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
<a href="#">Episode - Continuity of Support</a> (continuity_of_support)	string	yes	1 Yes 2 No 9 Not stated/ inadequately described
<a href="#">Episode - Tags</a> (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 [AMHC Episode - Intake Organisation Path](#) and [AMHC Episode - Intake Episode Key](#) provide a link back to the intake record at the intake organisation.

Table 3 AMHC Episode record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Episode Key</a> (episode_key)	string (2,50)	yes	This is a number or code assigned to each PMHC MDS episode. The Episode Key is unique and stable for each episode at the level of the organisation. This key must link to an existing episode within the PMHC MDS.
<a href="#">AMHC Episode - Intake Organisation Path</a> (intake_organisation_path)	string	—	<p>A sequence of colon separated Organisation Keys that fully specifies the Intake Organisation that referred the client to the hub service. In conjunction with the intake episode key, this allows linkage from the hub episode back to the intake episode.</p> <p>This will be blank in the context of the intake organisation.</p>
<a href="#">AMHC Episode - Intake Episode Key</a> (intake_episode_key)	string (2,50)	—	<p>This is a number or code assigned to the intake episode organisation. The Episode Key is unique and stable for each episode at the level of the intake organisation. In conjunction with the intake organisation path, this allows linkage from the hub episode back to the intake episode.</p> <p>This will be blank in the context of the intake organisation.</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
AMHC Episode - 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 4 Service Contact record layout*

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

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



Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Service Contact - Participants</a> (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
<a href="#">Service Contact - Venue</a> (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 5 AMHC Service Contact record layout*

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">AMHC - Service Contact - Practitioner Category</a> (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 6 Collection Occasions record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Collection Occasion Key</a> (collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each collection occasion of service activities. The Collection Occasion Key is unique and stable for each collection occasion at the level of the organisation.
<a href="#">Episode Key</a> (episode_key)	string (2,50)	yes	This is a number or code assigned to each PMHC MDS episode. The Episode Key is unique and stable for each episode at the level of the organisation. This key must link to an existing episode within the PMHC MDS.
<a href="#">Collection Occasion - Date</a> (collection_occasion_date)	date	yes	The date of the collection occasion.
<a href="#">Collection Occasion - Reason</a> (reason_for_collection)	string	yes	<ol style="list-style-type: none"> <li>1 Episode start</li> <li>2 Review</li> <li>3 Episode end</li> </ol>
<a href="#">Collection Occasion - Tags</a> (collection_occasion_tags)	string	—	List of tags for the collection occasion.

## 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 7 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.
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.
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	<p>1 Level 1 - Self Management</p> <p>1+ Level 1 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>2 Level 2 - Low Intensity Services</p> <p>2+ Level 2 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>3 Level 3 - Moderate Intensity Services</p> <p>3+ Level 3 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>4 Level 4 - High Intensity Services</p> <p>4+ Level 4 or above - Review assessment on Contextual Domains to determine most appropriate placement</p> <p>5 Level 5 - Acute and Specialist Community Mental Health Services</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
IAR-DST - Practitioner Level of Care (iar_dst_practitioner_level_of_care)	string	yes	<ol style="list-style-type: none"> <li>1 Level 1 - Self Management</li> <li>2 Level 2 - Low Intensity Services</li> <li>3 Level 3 - Moderate Intensity Services</li> <li>4 Level 4 - High Intensity Services</li> <li>5 Level 5 - Acute and Specialist Community Mental Health Services</li> <li>9 Not stated</li> </ol>
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 8 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 9 K5 record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Measure Key</a> (measure_key)	string (2,50)	yes	This is a number or code assigned to each instance of a measure. The Measure Key is unique and stable for each instance of a measure at the level of the organisation.
<a href="#">Collection Occasion Key</a> (collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each collection occasion of service activity. The Collection Occasion Key is unique and stable for each collection occasion at the level of the organisation.
<a href="#">K5 - Question 1</a> (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
<a href="#">K5 - Question 2</a> (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
<a href="#">K5 - Question 3</a> (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
<a href="#">K5 - Question 4</a> (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
<a href="#">K5 - Question 5</a> (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
<a href="#">K5 - Score</a> (k5_score)	integer	yes	5 - 25, 99 = Not stated / Missing
<a href="#">K5 - Tags</a> (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 10 SDQ record layout*

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

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	<p><b>PC101</b>Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1</p> <p><b>PC201</b>Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1</p> <p><b>PY101</b>Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1</p> <p><b>PY201</b>Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1</p> <p><b>YR101</b>Self report Version, 11-17 years, Baseline version, Australian Version 1</p> <p><b>YR201</b>Self report Version, 11-17 years, Follow Up version, Australian Version 1</p>
SDQ - Question 1 (sdq_item1)	string	yes	<p><b>0</b> Not True</p> <p><b>1</b> Somewhat True</p> <p><b>2</b> Certainly True</p> <p><b>7</b> Unable to rate (insufficient information)</p> <p><b>9</b> Not stated / Missing</p>



Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">SDQ - Question 2</a> (sdq_item2)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 3</a> (sdq_item3)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 4</a> (sdq_item4)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 5</a> (sdq_item5)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 6</a> (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
<a href="#">SDQ - Question 7</a> (sdq_item7)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 8</a> (sdq_item8)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 9</a> (sdq_item9)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 10</a> (sdq_item10)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 11</a> (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
<a href="#">SDQ - Question 12</a> (sdq_item12)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 13</a> (sdq_item13)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 14</a> (sdq_item14)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 15</a> (sdq_item15)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 16</a> (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
<a href="#">SDQ - Question 17</a> (sdq_item17)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 18</a> (sdq_item18)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 19</a> (sdq_item19)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 20</a> (sdq_item20)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 21</a> (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
<a href="#">SDQ - Question 22</a> (sdq_item22)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 23</a> (sdq_item23)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 24</a> (sdq_item24)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 25</a> (sdq_item25)	string	yes	0 Not True 1 Somewhat True 2 Certainly True 7 Unable to rate (insufficient information) 9 Not stated / Missing
<a href="#">SDQ - Question 26</a> (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 Episode - Intake Episode Key

This is a number or code assigned to the intake episode organisation. The Episode Key is unique and stable for each episode at the level of the intake organisation. In conjunction with the intake organisation path, this allows linkage from the hub episode back to the intake episode.

This will be blank in the context of the intake organisation.

#### Field name

intake\_episode\_key

**Data type**

string (2,50)

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

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](#).

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**AMHC Episode - 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 conjunction with the intake episode key, this allows linkage from the hub episode back to the intake episode.

This will be blank in the context of the intake organisation.

**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.

---

**AMHC Episode - 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.

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## 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.

- 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

000No additional diagnosis

100Anxiety disorders (ATAPS)

101Panic disorder

102Agoraphobia

103Social phobia

104Generalised anxiety disorder

105Obsessive-compulsive disorder

106Post-traumatic stress disorder

107Acute stress disorder

108Other anxiety disorder

200Affective (Mood) disorders (ATAPS)

201Major depressive disorder

202Dysthymia

203Depressive disorder NOS

204Bipolar disorder

205Cyclothymic disorder

206Other affective disorder

300Substance use disorders (ATAPS)

301Alcohol harmful use

302Alcohol dependence

303Other drug harmful use

304Other drug dependence

305Other substance use disorder

400Psychotic disorders (ATAPS)

401Schizophrenia

402Schizoaffective disorder

403Brief psychotic disorder

404Other psychotic disorder

501Separation anxiety disorder

502Attention deficit hyperactivity disorder (ADHD)

503Conduct disorder

504Oppositional defiant disorder

505Pervasive developmental disorder

506Other disorder of childhood and adolescence

601Adjustment disorder

602Eating disorder

603Somatoform disorder

604Personality disorder

605Other mental disorder

901Anxiety symptoms

902Depressive symptoms

903Mixed anxiety and depressive symptoms

904Stress related

905Other

999Missing

## 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](#)



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## 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](#)

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## 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](#)

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## 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](#)

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## 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](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](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](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](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](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**

100Anxiety disorders (ATAPS)

101Panic disorder

102Agoraphobia

103Social phobia

104Generalised anxiety disorder

105Obsessive-compulsive disorder

106Post-traumatic stress disorder

107Acute stress disorder

108Other anxiety disorder

200Affective (Mood) disorders (ATAPS)

201Major depressive disorder

202Dysthymia

203Depressive disorder NOS

204Bipolar disorder

205Cyclothymic disorder

206Other affective disorder

300Substance use disorders (ATAPS)

301Alcohol harmful use

302Alcohol dependence

303Other drug harmful use

304Other drug dependence

305Other substance use disorder

400Psychotic disorders (ATAPS)

401Schizophrenia

402Schizoaffective disorder

403Brief 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

---

### Episode - Referral Date

The date the referrer made the referral.

#### 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.

---

### Episode - 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.

---

## Episode - 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'.

---

**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



---

## 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.  would all be legitimate.

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

.

---

## 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.

---

### 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 completed K10 with more than one missing item is regarded as invalid.

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

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

---

**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

---

## 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>

---

## 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 {clingly} 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.

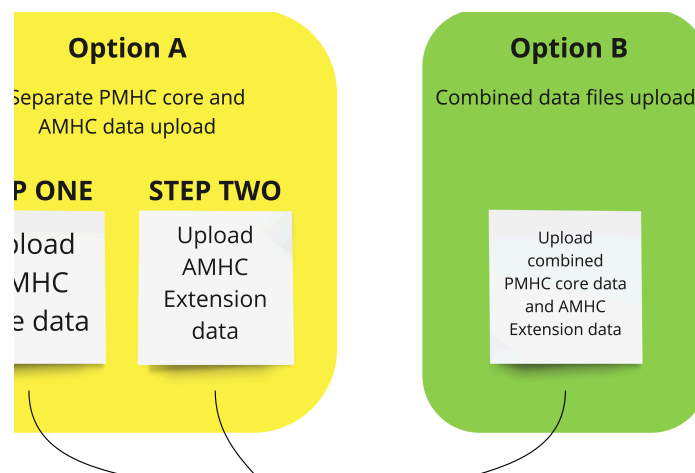
The AMHC upload format aligns with a future PMHC MDS Version 3.0 file format. No date has been set for the release of the PMHC MDS Version 3.0 upload file format.

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 11 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

File Type	CSV filename	Excel worksheet name	Required
<a href="#">IAR-DST Measures</a>	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 12 Summary of Hub files to upload*

File Type	CSV filename	Excel worksheet name	Required
<a href="#">Metadata</a>	metadata.csv	Metadata	Required
<a href="#">Organisations</a>	organisations.csv	Organisations	Optional and only available to PHN users if the user has the Organisation Management role
<a href="#">Clients</a>	clients.csv	Clients	Optional
<a href="#">Episodes</a>	episodes.csv	Episodes	Optional
<a href="#">AMHC Episodes</a>	amhc-episodes.csv	AMHC Episodes	Required
<a href="#">Collection Occasions</a>	collection-occasions.csv	Collection Occasions	Required
<a href="#">K10+ Measures</a>	k10p.csv	K10+	Required
<a href="#">K5 Measures</a>	k5.csv	K5	Required
<a href="#">SDQ Measures</a>	sdq.csv	SDQ	Required
<a href="#">Service Contacts</a>	service-contacts.csv	Service Contacts	
<a href="#">AMHC Service Contacts</a>	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 for 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.](#)

### **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. AMHC - Episode

1. [Episode Key](#) must be an existing PMHC episode within the PMHC MDS.
2. [!covid19](#) tag should be included in the [Episode - Tags](#) field of the corresponding PMHC episode, otherwise the system will automatically include it.
3. If a [AMHC Episode - Intake Organisation Path](#) is specified, that organisation must be an existing organisation within the PMHC MDS.
4. If a [AMHC Episode - Intake Episode Key](#) is specified, a [AMHC Episode - Intake Organisation Path](#) must also be specified.
5. [AMHC Episode - 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.

#### 2. 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

### 3. 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+](#)).

### 4. 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](#)).

### 5. 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](#))

### 6. IAR-DST

1. [Collection Occasion Key](#) must be an existing 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.

### 7. 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

# Resources

The following resources have been provided to explain the purpose of the PMHC MDS, to describe all AMHC data collection and file formats required to submit AMHC data.

## AMHC resources

The following resources have been provided to explain the purpose of the PMHC MDS, to describe all AMHC data collection and file formats required to submit AMHC data.

### 1. Key concepts

[Key concepts](#) is a list of key words that are commonly used within the PMHC MDS and their definitions.

### 2. Specifications

The [Data model and specifications](#) website defines what data items are collected for AMHC, what file formats are accepted for upload and associated reporting requirements.

### 3. Primary Mental Health Care Minimum Data Set

AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); the PMHC MDS information is available to be viewed at <https://pmhc-mds.com>.

# User guide

The Online User Guide outlines step by step instructions for a user to be able to perform their role of adding AMHC data within the PMHC MDS.

The user guide is regularly updated to reflect each release communication.

## Access & passwords

AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); current PMHC MDS Data online User Guide is available to be viewed for the following information.

### Access

Each individual staff member should be set up with their own unique login access. User accounts can be created by a user at your provider organisation, or PHN, who has the User Management role. If unsure who this is, please contact [support@pmhc-mds.com](mailto:support@pmhc-mds.com) to find out who has this access.

Information on 'Accepting an invitation to become a PMHC MDS User', 'Logging In', and 'Logging Out', and 'Updating your details', is available at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/home.html>.

### Passwords

Password information, including 'Passwords Requirements', 'Password Expiry Notifications', and 'Forgotten or Expired Password', is available at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/home.html>.

### MDS roles available for AMHC users

Access to the PMHC MDS is based around roles. What tabs a user sees once they are logged in will depend upon what roles they have been assigned. Roles that currently exist within the PMHC MDS, is available at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/users.html#users-roles>.

The AMHC extension is available for the following roles:

Role	Feature tab	Tasks allowed
Upload	Upload	A user with the <i>Upload</i> role can upload PMHC & AMHC data to the associated organisation.
Data Entry	Data Entry	A user with the <i>Data Entry</i> role can enter PMHC & AMHC data to the associated organisation. See <a href="#">Identifying AMHC-Episode data records</a>
Aggregate Reporting	Reports	A user with the <i>Aggregate Reporting</i> role can run standard PMHC reports and filter these reports by AMHC data for the associated organisation.
Reporting	Reports	A user with the <i>Reporting</i> role can run standard PMHC reports and filter these reports by AMHC data for the associated organisation.
	Data Extract	A user with the <i>Reporting</i> role can download the PMHC and AMHC data from the associated organisation.

## Data entry

The AMHC Support Service Minimum Data Set is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); current PMHC MDS Data online User Guide for Data Entry is available to be viewed at <https://docs.pmhc-mds.com/user-documentation/data-entry.html>.

## PMHC client data

For more detail on how to search, find, view, add, edit or delete Client PMHC data in the PMHC MDS, please visit the PMHC User Guide at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/data-entry.html#client-data>.

## PMHC episodes

For more detail on how to find, view, add, edit or delete Client PMHC Episode data in the PMHC MDS, please visit the PMHC User Guide at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/data-entry.html#episodes>.

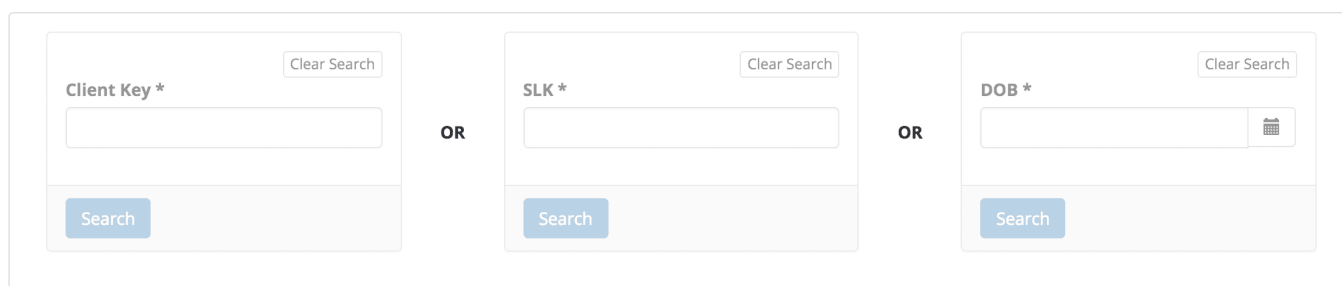
## AMHC episodes

You can view a client's episodes through Viewing a Client's details available on the Data Entry tab, by following these steps:

### Viewing a client's PMHC episode

You can view a client's AMHC episodes through viewing a client's details available on the Data Entry tab, by following these steps:

1. Search for the client using one of the three search fields.



The image displays three separate search input boxes arranged horizontally, separated by the word "OR". Each box contains a label, a search input field, a "Clear Search" button, and a "Search" button. The first box is labeled "Client Key \*" and has a "Search" button. The second box is labeled "SLK \*" and has a "Search" button. The third box is labeled "DOB \*" and has a "Search" button and a calendar icon.

Client Key *	OR	SLK *	OR	DOB *
<input type="text"/>		<input type="text"/>		<input type="text"/>
<input type="button" value="Search"/>		<input type="button" value="Search"/>		<input type="button" value="Search"/>

2. Click on the Client Key in blue displayed within the table list.

Clients

Practitioners

View Clients

Add New Client

New Search

Filters

Show / Hide

Client

Filters:

Client Key : CL0

Client Key ▲▼	Organisation▼ Path	SLK ▼	Date Of Birth▼	Gender ▼	Last Known Postcode ▼	Last Contact▼ Date	Tags ▼
cl0001	PHN999:PO1	3JXPTRFFDT72...	01/01/2011	Male			
CL0001	PHN999:PO1	Z4H4TBAEASY...	17/02/1983	Female	9999	20/03/2020	tag1
CL0002	PHN999:PO1	BBR6G3CWCQ...	24/09/2007	Male	9999	17/07/2016	tag2
CL0003	PHN999:PO1	S9F9MSJSPKP...	09/09/9999	Not stated/Ina...	1103	19/06/2016	tag2 tag3
CL0004	PHN999:PO1	222J04BDNZY...	08/07/1970	Female	1104	25/06/2016	tag1
CL0005	PHN999:PO1	KD75EHJ6RTM...	17/02/1983	Other			tag2
CL0006	PHN999:PO1	MN65F3CEKY...	04/01/1958	Male	9999	24/07/2016	tag2 tag3
CL0007	PHN999:PO1	G6MMH6SXP...	09/09/9999	Not stated/Ina...	1107	10/05/2016	tag2
CL0008	PHN999:PO1	B07MMQ44YA...	28/02/1978	Female	9999	30/09/2016	tag1
CL0009	PHN999:PO1	CXN263HSPM...	19/06/2002	Other	1111	15/07/2016	tag2 tag3

⏮

⏪

1

/ 2

⏩

⏭

10

▼

items per page

1 - 10 of 19 Items

- From the Client's Summary tab, you can shortcut straight to an episode by clicking the Blue Episode Key displayed in the snapshot of the five most recent episodes.

Home / Data Entry / Clients / CL0002@PHN999:PO1 / View Summary

Client "CL0002" at PHN "Test PHN", Provider Organisation "Test Provider Organisation 1"

Summary

Details

Episodes (1)

View Summary

Client Key

CL0002

Gender

Male

Date Of Birth

24/09/2007

E03

Start Date: 15/06/2016

Referral Date: 10/06/2016

Episode Concluded: No

Last Service Contact: 17/07/2016

Number of service contacts: 2

Principal Focus of Treatment Plan: Child and youth-specific mental health services

Outcome Measure Summary

☒ Episode start

☐ Review

☒ Episode end

- Alternately, if you would like to view all episodes you can click on the Episode Tab. The heading for this tab displays in brackets the total number of episodes recorded in the PMHC MDS for this client at Provider Organisations for which you have access.



A table will display all the Client's Episodes at Provider Organisations for which you have access.

SummaryDetailsEpisodes (1)

View EpisodesAdd New Episode

FiltersShow / HideEpisode

All Episodes

Suicide Referral	Episode Key	Start Date	End Date	Completion Status	Principal Focus of Treatment Plan	Number of Service Contacts	Date of Last Service Contact	Tags
	E03	15/06/2016		Episode open	Child and youth...	2	17/07/2016	

A Drop down list is available to view:

- All Episodes
- Currently Open Episodes
- Closed Episodes

SummaryDetailsEpisodes (1)

View EpisodesAdd New Episode

FiltersShow / HideEpisode

✓ All EpisodesCurrently Open EpisodesClosed Episodes

Suicide Referral	Episode Key	Start Date	End Date	Completion Status	Principal Focus of Treatment Plan	Number of Service Contacts	Date of Last Service Contact	Tags
	E03	15/06/2016		Episode open	Child and youth...	2	17/07/2016	

To view the Client's Episode details, click the Blue Episode Key.

Client "CL0002" at PHN "Test PHN", Provider Organisation "Test Provider Organisation 1"

## ? Episode starting 15/06/2016

Details Collection Occasions (4) Service Contacts (2)

View Details Edit Details

 Delete

### Tags

**Organisation Path**

PHN999:PO1

**Episode Key**

E03

**Client Key**

CL0002

**End Date****Client Consent to Anonymised Data**

Yes

**Completion Status**

Episode open

**Continuity of Support**

No

**Referral Date**

10/06/2016

**Principal Focus of Treatment Plan**

Child and youth-specific mental health services

**GP Mental Health Treatment Plan Flag**

No

**Homelessness Flag**

Not homeless

**Area of usual residence, postcode**

2102

**Labour Force Status**

Not in the Labour Force

**Employment Participation**

Not applicable - not in the labour force

**Source of Cash Income**

N/A - Client aged less than 16 years

**Health Care Card**

Yes

**NDIS Participant**

Yes

**Marital Status**

Never married

**Suicide Referral Flag**

No

**Principal Diagnosis**

Attention deficit hyperactivity disorder (ADHD)

**Additional Diagnosis**

Missing

**Medication Antipsychotics (N05A)**

No

**Medication Anxiolytics (N05B)**

No

**Medication Hypnotics and sedatives (N05C)**

No

**Medication Antidepressants (N06A)**

No

**Medication Psychostimulants and nootropics (N06B)**

No

**Referrer Profession**

Early childhood service worker

**Referrer Organisation Type**

Child and Maternal Health

A page will display the Client's PMHC Episode details.

### Adding a client's AMHC episode data

You can edit a Client's PMHC Episode details through [Viewing a client's PMHC episode](#) available on the Data Entry tab to add a Client's AMHC Episode data, by following these steps:

1. Once [Viewing a client's PMHC episode](#).
2. From the Client's Episode table, click the Episode Key.
3. Click Edit Details tab.
4. Click on the 'Australian Government AMHC hubs (!covid19)' checkbox or type !covid19 in the 'Tags' fields and press tab

Client "CL0002" at PHN "Test PHN", Provider Organisation "Test Provider Organisation 1"

## ? Episode starting 15/06/2016

Details Collection Occasions (4) Service Contacts (2)

View Details Edit Details

**Note:** \* denotes a mandatory field**Tags ?**☐ Australian Government Mental Health Response to Bushfire (Ibr20) - [Program guidance](#)☒ Australian Government HeadtoHelp hubs (Icovid19) - [Program guidance](#)

Icovid19 x Add a tag

**Organisation Path ?**

PHN999:PO1

**Client Key ?**

CL0002

**Client Consent to Anonymised Data \*****Episode Key \* ?**

Edit Key

E03

**End Date ?**

Enter date in DD/MM/YYYY or D/M/YYYY format

**Completion Status ?**

5. Scroll to the bottom of the PMHC Episode Add the Client's AMHC Episode details. Mandatory fields are marked with an \* .  
(Specification [AMHC Episode Data Elements](#))

### HeadtoHelp Episode

**Intake Organisation Path ?****Intake Episode Key ?****Referral Out Organisation Type \* ?**

Save

6. Click the blue 'Save' button. (If you decide not to add AMHC data, you can simply navigate away from this screen)

You will receive confirmation that the Client's Episode details have been saved, and it will now be displaying.

Saved successfully



If you receive an error message, the data will need to be corrected before the record is saved and added to the PMHC MDS. See [Validation Rules - AMHC Episode](#)

### Editing a client's AMHC episode data

You can edit a Client's PMHC Episode details through [Viewing a client's PMHC episode](#) available on the Data Entry tab, by following these steps:

1. Once [Viewing a client's PMHC episode](#).
2. From the Client's Episode table, click the Episode Key.
3. Click Edit Details tab.
4. Scroll to the bottom of the PMHC Episode.

Update the Client's AMHC Episode details. Mandatory fields are marked with an \*. (Specification [AMHC Episode Data Elements](#))

### HeadtoHelp Episode

**Intake Organisation Path ?**  
PHN999:NFP01

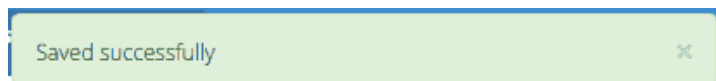
**Intake Episode Key ?**  
CL0002-E02

**Referral Out Organisation Type \* ?**  
Public mental health service x Community Support Organisation NFP x

Save

5. Click the blue 'Save' button. (If you decide not to save changes, you can simply navigate away from this screen)

You will receive confirmation that the Client's AMHC Episode details have been saved, and it will now be displaying these new details in the Episode View Details tab.



If you receive an error message, the data will need to be corrected before the record is saved and added to the PMHC MDS. See [Validation Rules - AMHC Episode](#)

## Deleting a AMHC episode

Removing the !amhc tag will delete a AMHC Episode, through [Viewing a client's PMHC episode](#) available on the Data Entry tab, by following these steps:

1. Once [Viewing a client's PMHC episode](#).
2. From the Client's Episode table, click the Episode Key.
3. Click Edit Details tab.
4. Uncheck the 'Australian Government AMHC hubs (!amhc)' checkbox or click on the cross on the !amhc tag to remove it.

[Home](#) / [Data Entry](#) / [Clients](#) / [CL0002@PHN999:PO1](#) / [Client Episodes](#) / [E03](#) / [Edit Details](#)

Client "CL0002" at PHN "Test PHN", Provider Organisation "Test Provider Organisation 1"

## ? Episode starting 15/06/2016

DetailsCollection Occasions (4)Service Contacts (2)

[View Details](#)[Edit Details](#)

**Note:** \* denotes a mandatory field

**Tags ?**  
☐ Australian Government Mental Health Response to Bushfire (!br20) - [Program guidance](#)  
☒ Australian Government HeadtoHelp hubs (!covid19) - [Program guidance](#)  
!covid19 x Add a tag

**Organisation Path ?**  
PHN999:PO1

**Episode Key \* ?**  
E03 [Edit Key](#)

**Client Key ?**  
CL0002

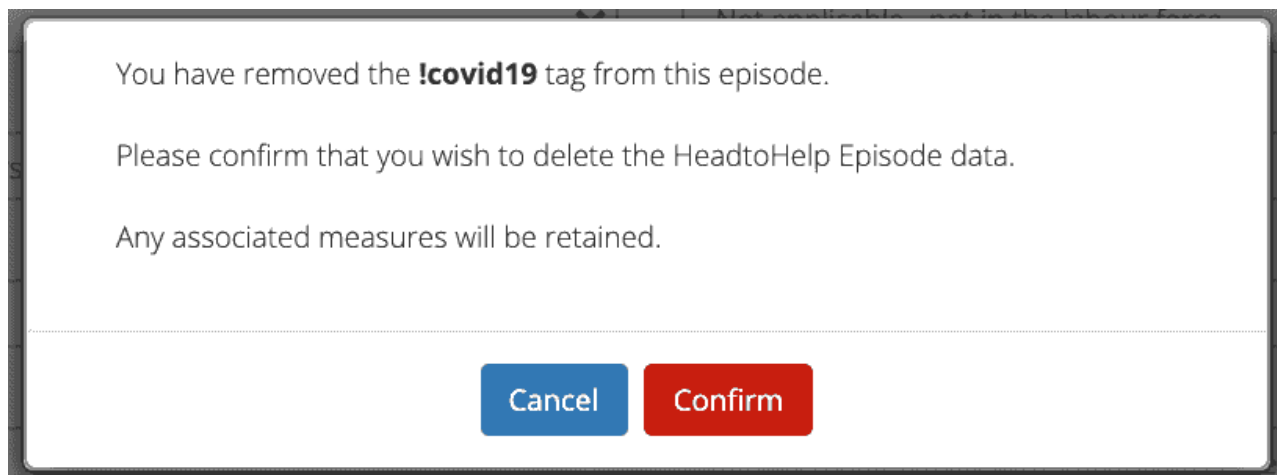
**End Date ?**  
Enter date in DD/MM/YYYY or D/M/YYYY format

**Client Consent to Anonymised Data \* ?**

**Completion Status ?**

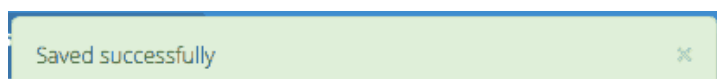
5. Click the blue 'Save' button.

Any associated measures will be retained.



**Please note: Once the episode data is deleted, you will not be able to recover this episode data.**

6. Click the red 'Confirm' button to delete the data. (If you decide not to delete the data, you can click the blue 'Cancel' button)



## Collection Occasions

For more detail on how to find, view, add, edit or delete Client PMHC Collection Occasion data in the PMHC MDS, please visit the PMHC User Guide at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/data-entry.html#outcome-collection-occasions>.

## Collection Occasion Measures

For more detail on how to find, view, add, edit or delete Client PMHC Collection Occasion Measures data in the PMHC MDS, please visit the PMHC User Guide at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/data-entry.html#collection-occasion-measures>.

## PMHC Service Contact Data

For more detail on how to search, find, view, add, edit or delete Service Contact PMHC data in the PMHC MDS, please visit the PMHC User Guide at <https://docs.pmhc-mds.com/projects/user-documentation/en/latest/data-entry.html#service-contacts>.

## AMHC Service Contact Data

AMHC adds two extra fields to the standard PMHC Service Contact:

- AMHC Service Contact - Practitioner Category and
- AMHC Service Contact - Start Time to the standard PMHC Service Contact.

**Update the Client's Service Contact details. Mandatory fields are marked**

with an \* . (Specification [Service Contact Data Elements](#) and [AMHC Service Contact Data Elements](#))

HeadtoHelp Service Contact

Practitioner Category \* ?

Start Time \* ?

12H

24H

HH

:

MM

Save

## Upload user guide

AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); current PMHC MDS Data online User Guide for Upload is available to be viewed at <https://docs.pmhc-mds.com/user-documentation/upload.html>.

## Creating upload files

To create AMHC files that fit the PMHC MDS specifications, please visit the [Upload specification](#) for the 'File Types', 'AMHC Data Types', 'File Format' requirements, along with 'Example Files'.

This information for creating upload files is available at [Upload specification](#).

## Upload users

You will only be able to see the Upload tab if you have been assigned the 'Upload' role, when logged into the PMHC MDS on <https://pmhc-mds.net>.

If you don't have access to the Upload tab and you believe you should, please contact someone in your provider organisation or provider organisation's PHN who has the 'User Management' role.

See: [MDS roles available for AMHC users](#).

## Uploading AMHC data

AMHC is an extension of the Primary Mental Health Care Minimum Data Set (PMHC MDS); the current PMHC MDS online User Guide can be followed to upload AMHC data.

Information on 'Uploading a file', 'Test Modes', 'Viewing uploads', and 'error messages', is available in the PMHC MDS online User Guide at <https://docs.pmhc-mds.com/user-documentation/upload.html>.

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

## Frequently Asked Questions change log