



# Draft PMHC-MDS Data Specification

Version 4.1.0-Draft

## **Warning**

This is a draft version of the proposed PMHC MDS 4.1 specification. The PMHC MDS does not currently support this specification. It is being published for information and feedback purposes only.

As at 17 September, 2024

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# 1. Introduction

Version 4.0 introduces the recording of intake related activity (including activity for the Head to Health and AMHC programmes) in the PMHC MDS as part of the core specification.

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

The new tables are [Intake](#), [IAR-DST](#), [Intake Episode](#), [Service Contact Practitioner](#).

## 1.1. Contexts

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

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

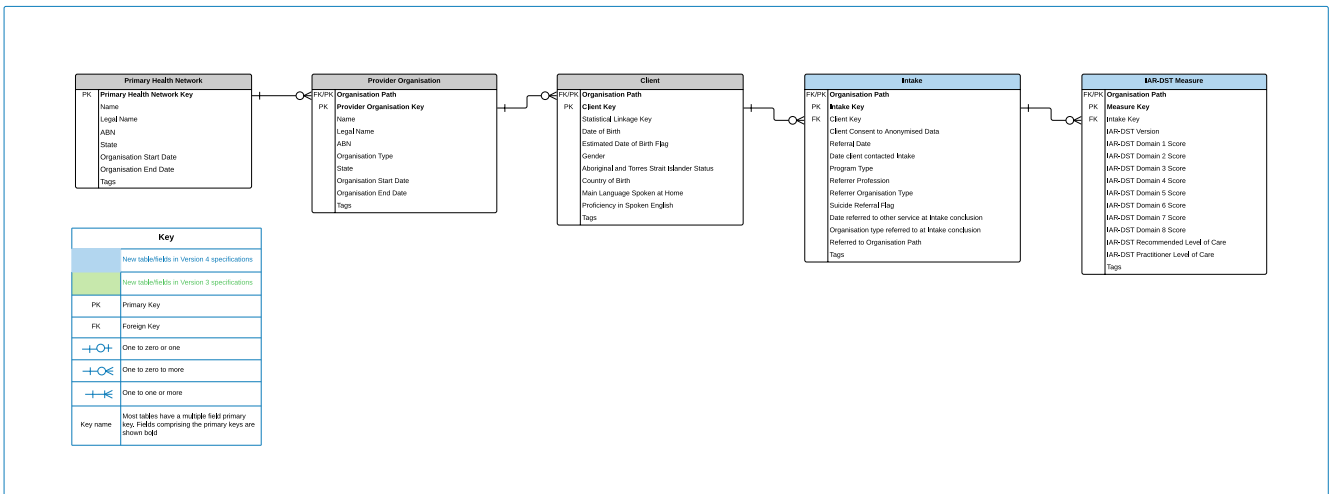
Different records in the specification are intended to be used in each of these contexts.

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

### 1.1.1. Intake Context

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

PMHC MDS v4.0 Intake Only Data Model Usage Scenario



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

- Client
- Intake
- IAR-DST

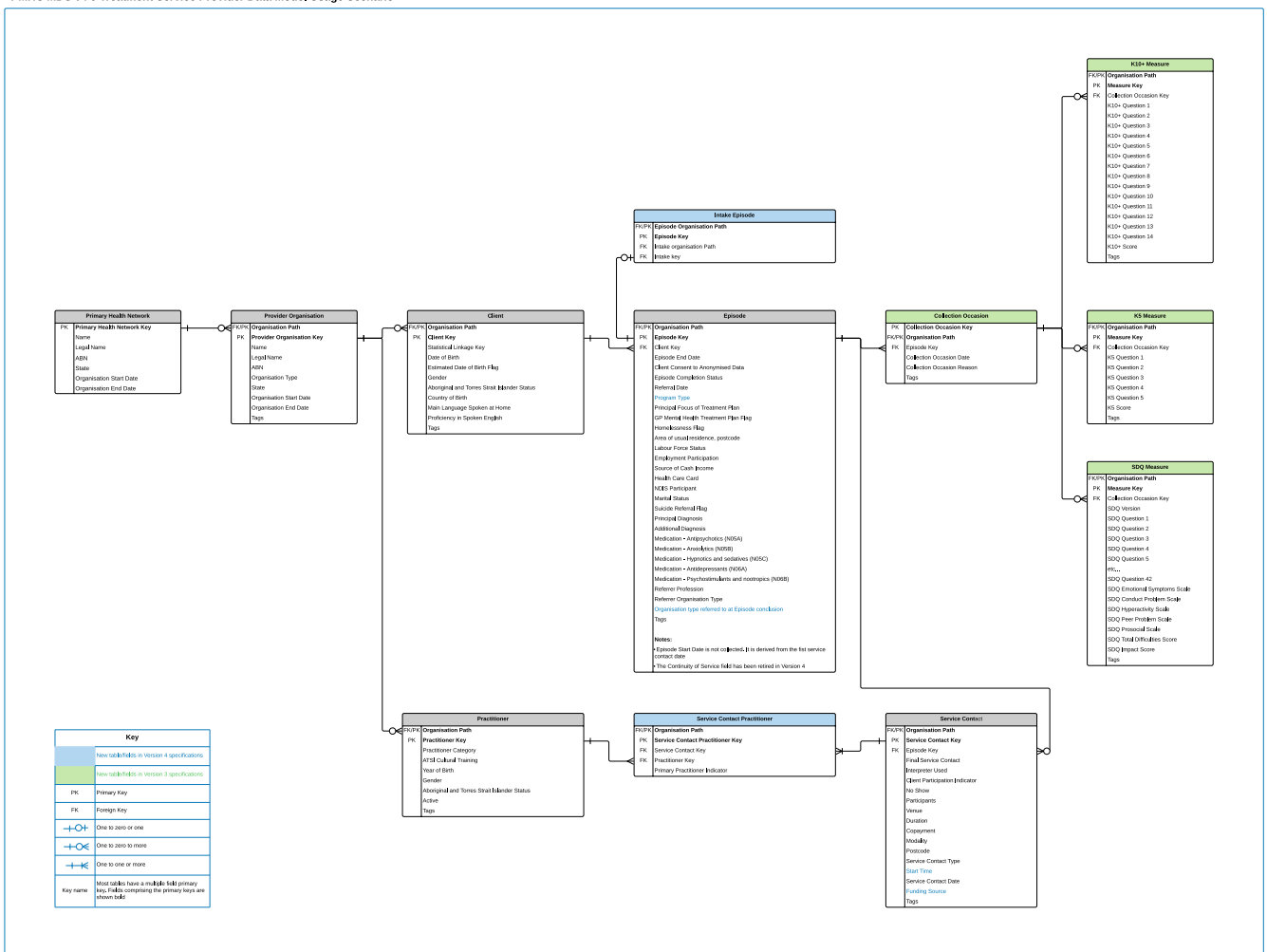
Episode and Service contact activity is not submitted in this context.

The collection of Intake and IAR data may not be required for all programs. Please see [Intake](#).

### 1.1.2. Treatment Service Provider Context

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

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



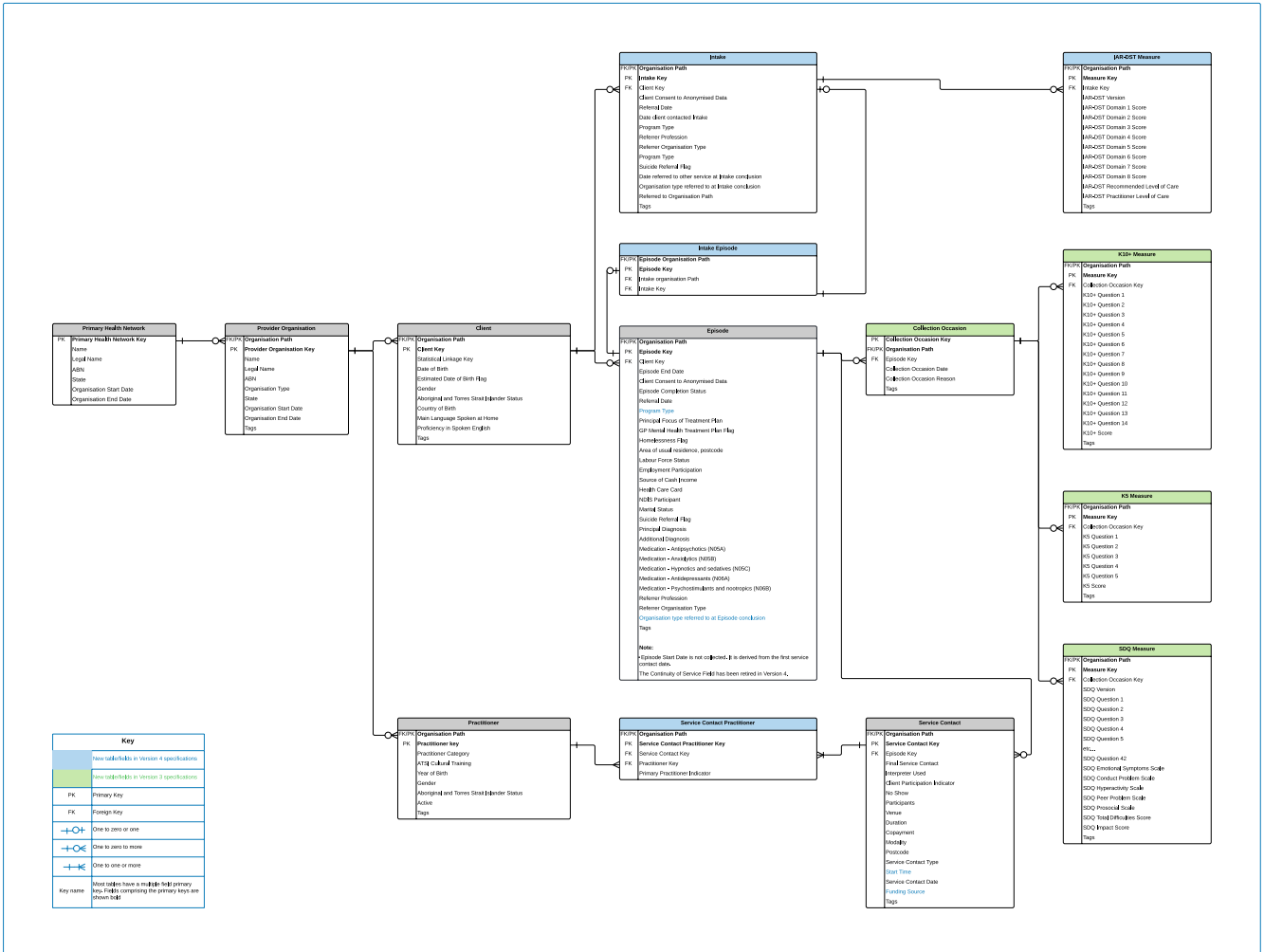
In the treatment context the specification works almost the same as a service reporting via the Version 2 core PMHC-MDS specification using the new [Intake Episode](#) record to identify additional detail regarding referrals in from the intake teams ([Intake Organisation Path](#) and [Intake Key](#)),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

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

### 1.1.3. Combined Intake/Treatment Context

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

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



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

## 1.2. New Records and Fields in Version 4

### 1.2.1. Intake

The model now records a new **Intake** record where an episode has undertaken an Intake process. The collection of Intake and IAR data may not be required for all programs. Please see **Intake**.

The **Intake** table records information about the intake.

[Organisation Path](#) and [Intake Key](#) are the two fields required to link the Intake record at the intake provider organisation to the Episode record at the treatment organisation.

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

### 1.2.2. IAR-DST Measure

The model now captures the domains and the recommended level of care pertinent to the IAR-DST that clients have completed for them as part of the intake process. A new [IAR-DST](#) record will be created for each intake process.

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

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

The collection of Intake and IAR data may not be required for all programs. Please see [Intake](#).

### 1.2.3. Episode and Intake Episode

When the client is referred to a PMHC MDS reporting treatment service, a new [Episode](#) record is created.

Where the client has been referred via an intake process, an additional [Intake Episode](#) record is also created.

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

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

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

The collection of Intake and IAR data may not be required for all programs. Please see [Intake](#).

## 1.2.4. Entering/Uploading Intake and Episode data

When entering or uploading Intake and Episode data, the PMHC MDS does not validate that an Intake record exists when an Intake Episode record is uploaded. They can be uploaded independently of each other. There is a planned suite of reports that will allow organisations to identify Intake and Episode records that are not linked.

## 1.2.5. Service Contact

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

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

## 1.2.6. Service Contact Practitioner

A new record - [Service Contact Practitioner](#) replaces the Practitioner Key field on the Version 2 Service Contact record.

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

## 1.3. Data release and confidentiality

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



## 2. Changes from Version 4.0

Version 4.1 introduces the recording of sites within a Provider Organisation.

A [Sites](#) has been added to the Provider Organisation record where the sites of a Provider Organisation can be defined.

A [Service Contact Site](#) field has been added to the Service Contact record to record at which site the service contact took place.

### 2.1. Steps required to upgrade to Version 4.1 uploads

1. Upgrade your Client Management System to export files in the new Version 4.1 format which adds a 'sites' column to the Provider Organisation worksheet and a 'service\_contact\_site' column to the Service Contact worksheet.

### 2.2. Changes from Version 2

Please refer to [Changes and Upgrading from Version 2](#).

## **3. Reporting arrangements**

### **3.1. Reporting data**

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

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

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

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

Data may be uploaded in either Excel or CSV format.

### **3.2. Reporting timeliness**

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

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

### **3.3. Inputs to help replicate system generated reports**

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

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

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

#### **3.3.1. Outcome Measure Standard Deviations**

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

Current version:

[Download PMHC Outcome Measure Standard Deviations 2024 as XLSX.](#)

Previous versions:

- [Download PMHC Outcome Measure Standard Deviations 2023 as XLSX.](#)
- [Download PMHC Outcome Measure Standard Deviations 2022 as XLSX.](#)
- [Download PMHC Outcome Measure Standard Deviations 2021 as XLSX.](#)
- [Download PMHC Outcome Measure Standard Deviations 2020 as XLSX.](#)

### **3.4. Support arrangements**

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

## 4. Identifier management

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

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

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

A recommended approach for the creation of keys is to compute [random UUIDs](#).

### 4.1. Managing Provider Organisation Keys

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

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

### 4.2. Managing Client Keys

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

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

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

### 4.3. Managing all other entity keys

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

- [Practitioner Key](#),
- [Intake Key](#),

- [Episode Key](#),
- [Service Contact Key](#),
- [Service Contact Practitioner Key](#),
- [Collection Occasion Key](#),
- [Measure Key](#).

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

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

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

# 5. Data model and specifications

## 5.1. Data model

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

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

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

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

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

PMHC MDS v4.1 Combined Intake and Service Provider Data Model Usage Scenario

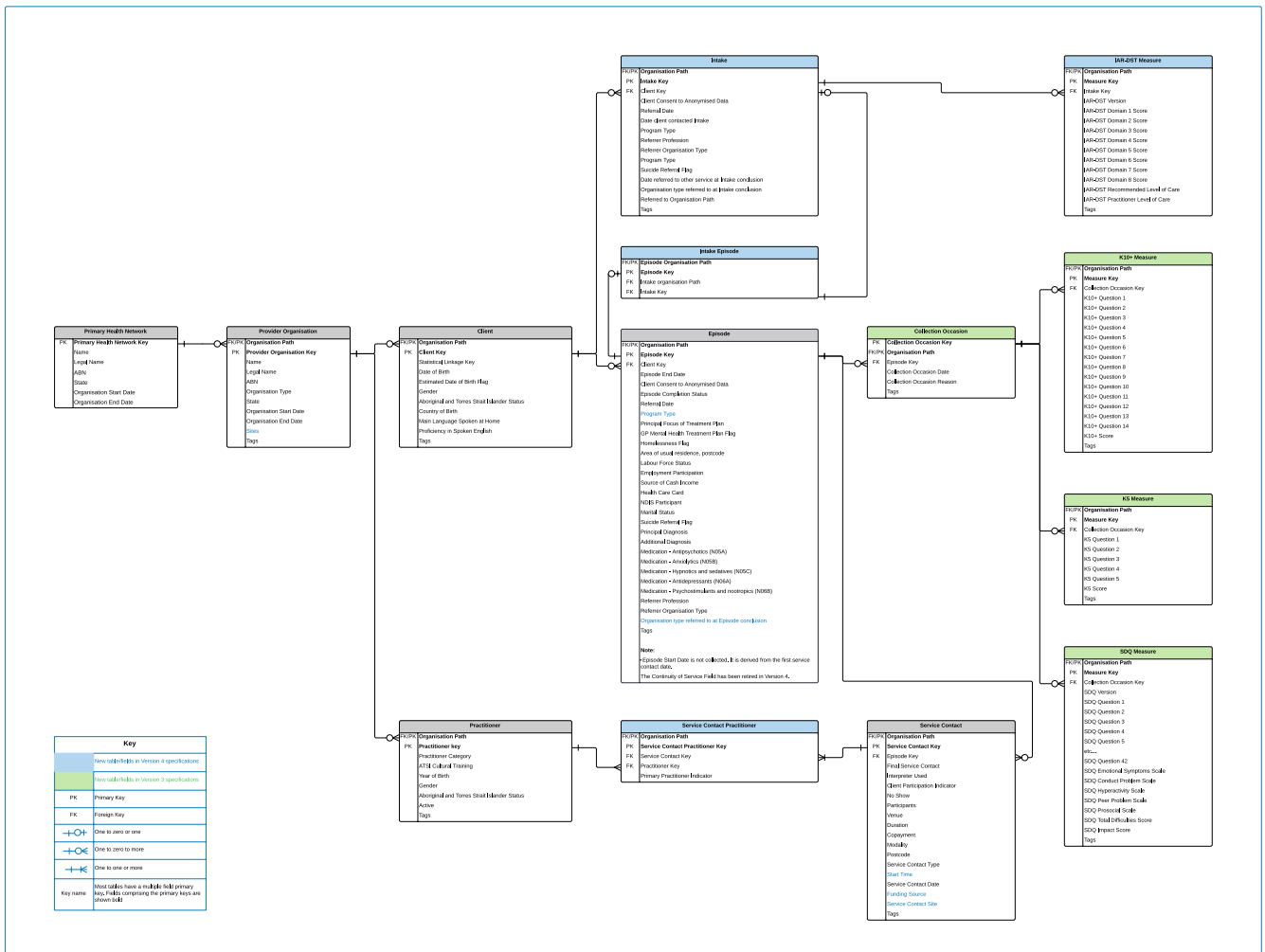
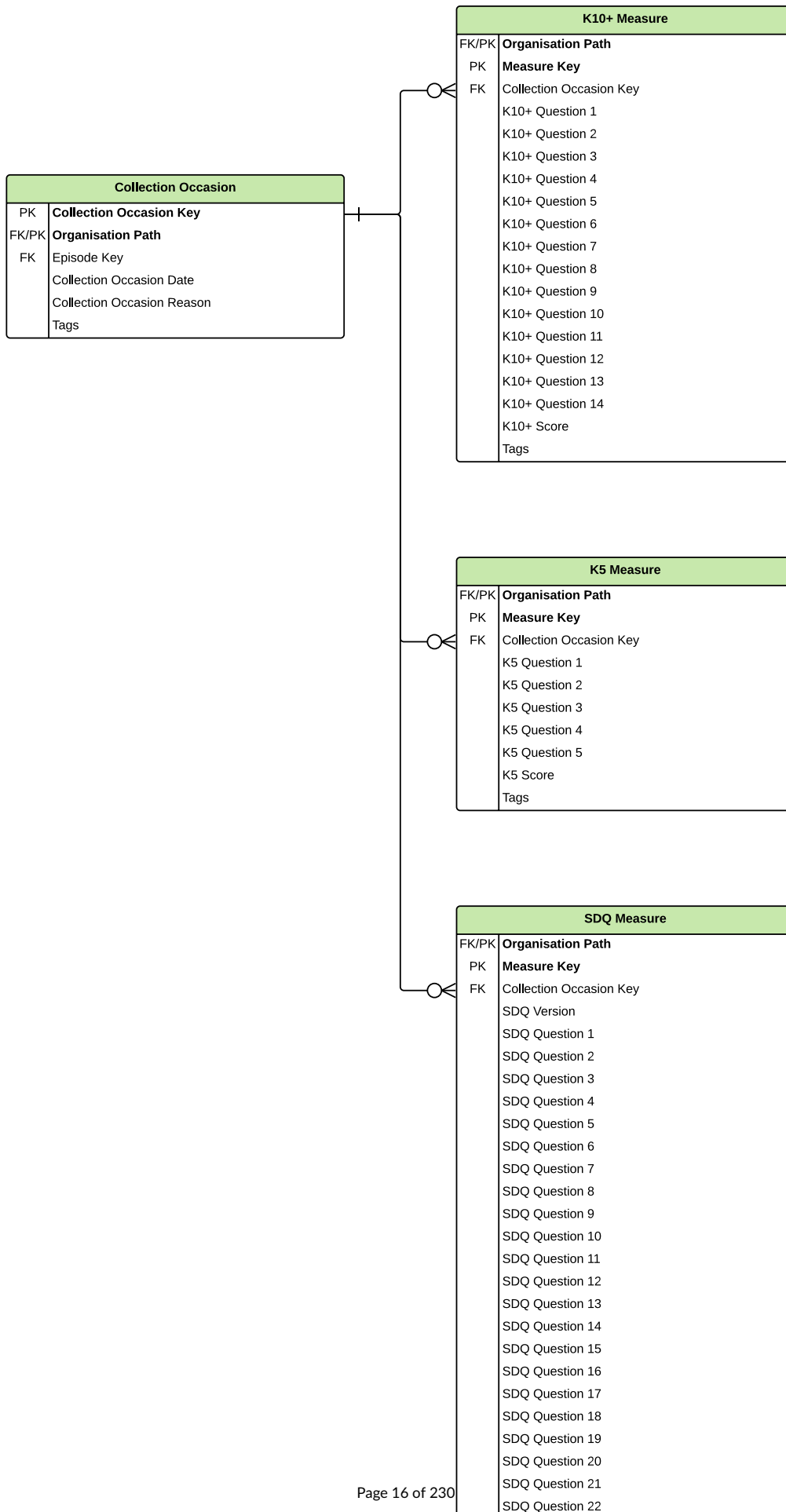


Fig. 5.1 PMHC MDS Version 4.1 combined data model

## Note

- The above data model diagram is in the SVG format and can be enlarged or zoomed by opening in a new tab or window or by downloading it.

# PMHC MDS v4.0 Collection Occasion Data Model





### Note

See [PMHC MDS Version 4.1 combined data model](#) for more details about how Collection Occasion records fit into the overall structure.

## 5.2. Key concepts

### 5.2.1. Primary Health Network

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

### 5.2.2. Provider Organisation

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

See [Provider Organisation](#) for the data elements for a provider organisation.

### 5.2.3. Site

Some Provider Organisations provide services to clients at multiple locations. In the PMHC MDS a site is a particular location at which a Provider Organisation provides a service to a client.

### 5.2.4. Practitioner

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

See [Practitioner](#) for the data elements for a practitioner.

### 5.2.5. Client

The Client is the person who is receiving the service.

See [Client](#) for the data elements for a client.

#### 5.2.5.1. Active Client

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

## 5.2.6. Intake

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

The collection of Intake and IAR data may not be required for all programs. Please see [Intake](#).

### 5.2.6.1. Concluded Intake

Concluded intakes are intakes where [Organisation type referred to at Intake conclusion](#) is **not** blank.

## 5.2.7. Intake Episode

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

## 5.2.8. Episode

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

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

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

While an individual may have multiple *Episodes of Care* over the course of their illness, they may be considered as being in only one episode at any given point of time for **any particular PHN-commissioned provider organisation**. The implication is that the care provided by the organisation to an individual client at any point in time is subject to only one set of reporting requirements.

- **Episodes commence at the point of first contact.** The episode start date will be derived from the first service contact regardless of no show state as long as there is a service contact that isn't a no show. Therefore, if there is no attended service contact the episode is uncommenced.

Some examples:

- If a service contact occurs on the 1/1/2018 that is recorded as a no show then the episode is uncommenced.

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

- **Discharge from care concludes the episode**

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

See [Episode](#) for the data elements for a episode.

### **5.2.8.1. Open Episode**

Open episodes are those with [Episode Completion Status](#) recorded as open (Response item 0).

### **5.2.8.2. Closed Episode**

Closed episodes are those with [Episode Completion Status](#) recorded using one of the 'Episode closed' responses (Response items 1-6).

### **5.2.8.3. Active Episode**

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

## **5.2.9. Service Contact**

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

Definition based on METeOR: [493304](#) with modification.

### **5.2.9.1. Attended Service Contact**

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

See [Service Contact](#) for the data elements for a service contact.

### 5.2.10. Service Contact Practitioner

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

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

See [Service Contact Practitioner](#) for the data elements for a service contact practitioner.

### 5.2.11. Collection Occasion

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

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

See [Collection Occasion](#) for the data elements for a collection occasion.

## 5.3. Record formats

### 5.3.1. Metadata

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

*Table 5.1 Metadata record layout*

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Key</a> (key)	string	yes	A metadata key name.
<a href="#">Value</a> (value)	string	yes	The metadata value.

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

key	value
type	PMHC
version	4.0

## 5.3.2. Provider Organisation

See [Provider Organisation](#) for the definition of a provider organisation.

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

Table 5.2 Provider Organisation record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Organisation Key</a> (organisation_key)	string (2,50)	yes	A sequence of characters which uniquely identifies the provider organisation to the Primary Health Network. Assigned by the Primary Health Network.
<a href="#">Name</a> (organisation_name)	string (2,100)	yes	The name of the provider organisation.
<a href="#">Legal Name</a> (organisation_legal_name)	string	—	The legal name of the provider organisation.
<a href="#">ABN</a> (organisation_abn)	string (11)	yes	The Australian Business Number of the provider organisation.
<a href="#">Organisation Type</a> (organisation_type)	string	yes	<ul style="list-style-type: none"> <li>1:Private Allied Health Professional Practice</li> <li>2:Private Psychiatry Practice</li> <li>3:General Medical Practice</li> <li>4:Private Hospital</li> <li>5:Headspace Centre</li> <li>6:Early Youth Psychosis Centre</li> <li>7:Community-managed Community Support Organisation</li> <li>8:Aboriginal Health/Medical Service</li> <li>9:State/Territory Health Service Organisation</li> <li>10:Drug and/or Alcohol Service</li> <li>11:Primary Health Network</li> <li>12:Medicare Local</li> <li>13:Division of General Practice</li> <li>98:Other</li> <li>99:Missing</li> </ul>
<a href="#">State</a> (organisation_state) METEOR: <a href="#">613718</a>	string	yes	<ul style="list-style-type: none"> <li>1:New South Wales</li> <li>2:Victoria</li> <li>3:Queensland</li> <li>4:South Australia</li> <li>5:Western Australia</li> <li>6:Tasmania</li> <li>7:Northern Territory</li> <li>8:Australian Capital Territory</li> <li>9:Other Territories</li> </ul>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Start Date</a> (organisation_start_date)	date	yes	The date on which a provider organisation started delivering services.
<a href="#">Organisation End Date</a> (organisation_end_date)	date	yes	The date on which a provider organisation stopped delivering services.
<a href="#">Sites</a> (sites)	string	–	Multiple comma separated values allowed
<a href="#">Organisation Tags</a> (organisation_tags)	string	–	List of tags for the provider organisation.

### 5.3.3. Practitioner

See [Practitioner](#) for the definition of a practitioner.

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

*Table 5.3 Practitioner record layout*

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Practitioner Key</a> (practitioner_key)	string (2,50)	yes	A unique identifier for a practitioner within the responsible provider organisation. Assigned by either the PHN or Provider Organisation depending on local procedures.
<a href="#">Practitioner Category</a> (practitioner_category)	string	yes	<ul style="list-style-type: none"> <li>1: Clinical Psychologist</li> <li>2: General Psychologist</li> <li>3: Social Worker</li> <li>4: Occupational Therapist</li> <li>5: Mental Health Nurse</li> <li>6: Aboriginal and Torres Strait Islander Health/ Mental Health Worker</li> <li>7: Low Intensity Mental Health Worker</li> <li>8: General Practitioner</li> <li>9: Psychiatrist</li> <li>10: Other Medical</li> <li>11: Other</li> <li>12: Psychosocial Support Worker</li> <li>13: Peer Support Worker</li> <li>99: Not stated</li> </ul>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">ATSI Cultural Training</a> (atsi_cultural_training)	string	yes	1:Yes 2:No 3:Not required 9:Missing / Not recorded
<a href="#">Year of Birth</a> (practitioner_year_of_birth)	gYear	yes	gYear
<a href="#">Practitioner Gender</a> (practitioner_gender) ABS	string	yes	0:Not stated/Inadequately described 1:Male 2:Female 3:Other
<a href="#">Practitioner Aboriginal and Torres Strait Islander Status</a> (practitioner_atsi_status) METEOR: 291036	string	yes	1:Aboriginal but not Torres Strait Islander origin 2:Torres Strait Islander but not Aboriginal origin 3:Both Aboriginal and Torres Strait Islander origin 4:Neither Aboriginal or Torres Strait Islander origin 9:Not stated/inadequately described
<a href="#">Active</a> (practitioner_active)	string	yes	0:Inactive 1:Active
<a href="#">Practitioner Tags</a> (practitioner_tags)	string	—	List of tags for the practitioner.

### 5.3.4. Client

See [Client](#) for definition of a client.

Clients are managed by the provider organisations via either the PMHC MDS administrative interface or upload.

Table 5.4 Client 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="#">Client Key</a> (client_key)	string (2,50)	yes	This is a number or code assigned to each individual client referred to the commissioned organisation. The client identifier must be unique and stable for each individual within the Provider Organisation. Assigned by either the PHN or Provider Organisation depending on local procedures.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Statistical Linkage Key (slk)</a> METEOR: 349510	string (14,40)	yes	A key that enables two or more records belonging to the same individual to be brought together.
<a href="#">Date of Birth (date_of_birth)</a> METEOR: 287007	date	yes	The date on which an individual was born.
<a href="#">Estimated Date of Birth Flag (est_date_of_birth)</a>	string	yes	<ul style="list-style-type: none"> <li>1:Date of birth is accurate</li> <li>2:Date of birth is an estimate</li> <li>8:Date of birth is a 'dummy' date (ie, 09099999)</li> <li>9:Accuracy of stated date of birth is not known</li> </ul>
<a href="#">Client Gender (client_gender)</a> ABS	string	yes	<ul style="list-style-type: none"> <li>0:Not stated/Inadequately described</li> <li>1:Male</li> <li>2:Female</li> <li>3:Other</li> </ul>
<a href="#">Aboriginal and Torres Strait Islander Status (client_atssi_status)</a> METEOR: 291036	string	yes	<ul style="list-style-type: none"> <li>1:Aboriginal but not Torres Strait Islander origin</li> <li>2:Torres Strait Islander but not Aboriginal origin</li> <li>3:Both Aboriginal and Torres Strait Islander origin</li> <li>4:Neither Aboriginal or Torres Strait Islander origin</li> <li>9:Not stated/inadequately described</li> </ul>



Data Element (Field Name)	Type (min,max)	Required	Format / Values
<p>Country of Birth (country_of_birth) METEOR: 459973 ABS</p>	string (4)	yes	<p>1101:Australia 1102:Norfolk Island 1199:Australian External Territories, nec 1201:New Zealand 1301:New Caledonia 1302:Papua New Guinea 1303:Solomon Islands 1304:Vanuatu 1401:Guam 1402:Kiribati 1403:Marshall Islands 1404:Micronesia, Federated States of 1405:Nauru 1406:Northern Mariana Islands 1407:Palau 1501:Cook Islands 1502:Fiji 1503:French Polynesia 1504:Niue 1505:Samoa 1506:Samoa, American 1507:Tokelau 1508:Tonga 1511:Tuvalu 1512:Wallis and Futuna 1513:Pitcairn Islands 1599:Polynesia (excludes Hawaii), nec 1601:Adelie Land (France) 1602:Argentinian Antarctic Territory 1603:Australian Antarctic Territory 1604:British Antarctic Territory 1605:Chilean Antarctic Territory 1606:Queen Maud Land (Norway) 1607:Ross Dependency (New Zealand) 2102:England 2103:Isle of Man 2104:Northern Ireland 2105:Scotland 2106:Wales 2107:Guernsey 2108:Jersey 2201:Ireland 2301:Austria 2302:Belgium 2303:France 2304:Germany 2305:Liechtenstein 2306:Luxembourg 2307:Monaco 2308:Netherlands 2311:Switzerland 2401:Denmark</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>2402:Faroe Islands  2403:Finland  2404:Greenland  2405:Iceland  2406:Norway  2407:Sweden  2408:Aland Islands  3101:Andorra  3102:Gibraltar  3103:Holy See  3104:Italy  3105:Malta  3106:Portugal  3107:San Marino  3108:Spain  3201:Albania  3202:Bosnia and Herzegovina  3203:Bulgaria  3204:Croatia  3205:Cyprus  3206:The former Yugoslav Republic of  Macedonia  3207:Greece  3208:Moldova  3211:Romania  3212:Slovenia  3214:Montenegro  3215:Serbia  3216:Kosovo  3301:Belarus  3302:Czech Republic  3303:Estonia  3304:Hungary  3305:Latvia  3306:Lithuania  3307:Poland  3308:Russian Federation  3311:Slovakia  3312:Ukraine  4101:Algeria  4102:Egypt  4103:Libya  4104:Morocco  4105:Sudan  4106:Tunisia  4107:Western Sahara  4108:Spanish North Africa  4111:South Sudan  4201:Bahrain  4202:Gaza Strip and West Bank  4203:Iran  4204:Iraq</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>4205:Israel  4206:Jordan  4207:Kuwait  4208:Lebanon  4211:Oman  4212:Qatar  4213:Saudi Arabia  4214:Syria  4215:Turkey  4216:United Arab Emirates  4217:Yemen  5101:Myanmar  5102:Cambodia  5103:Laos  5104:Thailand  5105:Vietnam  5201:Brunei Darussalam  5202:Indonesia  5203:Malaysia  5204:Philippines  5205:Singapore  5206:Timor-Leste  6101:China (excludes SARs and Taiwan)  6102:Hong Kong (SAR of China)  6103:Macau (SAR of China)  6104:Mongolia  6105:Taiwan  6201:Japan  6202:Korea, Democratic People's Republic of (North)  6203:Korea, Republic of (South)  7101:Bangladesh  7102:Bhutan  7103:India  7104:Maldives  7105:Nepal  7106:Pakistan  7107:Sri Lanka  7201:Afghanistan  7202:Armenia  7203:Azerbaijan  7204:Georgia  7205:Kazakhstan  7206:Kyrgyzstan  7207:Tajikistan  7208:Turkmenistan  7211:Uzbekistan  8101:Bermuda  8102:Canada  8103:St Pierre and Miquelon  8104:United States of America  8201:Argentina</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8202:Bolivia 8203:Brazil 8204:Chile 8205:Colombia 8206:Ecuador 8207:Falkland Islands 8208:French Guiana 8211:Guyana 8212:Paraguay 8213:Peru 8214:Suriname 8215:Uruguay 8216:Venezuela 8299:South America, nec 8301:Belize 8302:Costa Rica 8303:El Salvador 8304:Guatemala 8305:Honduras 8306:Mexico 8307:Nicaragua 8308:Panama 8401:Anguilla 8402:Antigua and Barbuda 8403:Aruba 8404:Bahamas 8405:Barbados 8406:Cayman Islands 8407:Cuba 8408:Dominica 8411:Dominican Republic 8412:Grenada 8413:Guadeloupe 8414:Haiti 8415:Jamaica 8416:Martinique 8417:Montserrat 8421:Puerto Rico 8422:St Kitts and Nevis 8423:St Lucia 8424:St Vincent and the Grenadines 8425:Trinidad and Tobago 8426:Turks and Caicos Islands 8427:Virgin Islands, British 8428:Virgin Islands, United States 8431:St Barthelemy 8432:St Martin (French part) 8433:Bonaire, Sint Eustatius and Saba 8434:Curacao 8435:Sint Maarten (Dutch part) 9101:Benin 9102:Burkina Faso

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9103:Cameroon 9104:Cabo Verde 9105:Central African Republic 9106:Chad 9107:Congo, Republic of 9108:Congo, Democratic Republic of 9111:Cote d'Ivoire 9112:Equatorial Guinea 9113:Gabon 9114:Gambia 9115:Ghana 9116:Guinea 9117:Guinea-Bissau 9118:Liberia 9121:Mali 9122:Mauritania 9123:Niger 9124:Nigeria 9125:Sao Tome and Principe 9126:Senegal 9127:Sierra Leone 9128:Togo 9201:Angola 9202:Botswana 9203:Burundi 9204:Comoros 9205:Djibouti 9206:Eritrea 9207:Ethiopia 9208:Kenya 9211:Lesotho 9212:Madagascar 9213:Malawi 9214:Mauritius 9215:Mayotte 9216:Mozambique 9217:Namibia 9218:Reunion 9221:Rwanda 9222:St Helena 9223:Seychelles 9224:Somalia 9225:South Africa 9226:Swaziland 9227:Tanzania 9228:Uganda 9231:Zambia 9232:Zimbabwe 9299:Southern and East Africa, nec 9999:Unknown

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<p>Main Language Spoken at Home (main_lang_at_home) METEOR: 460125 ABS</p>	string (4)	yes	<p>1101:Gaelic (Scotland) 1102:Irish 1103:Welsh 1199:Celtic, nec 1201:English 1301:German 1302:Letzeburgish 1303:Yiddish 1401:Dutch 1402:Frisian 1403:Afrikaans 1501:Danish 1502:Icelandic 1503:Norwegian 1504:Swedish 1599:Scandinavian, nec 1601:Estonian 1602:Finnish 1699:Finnish and Related Languages, nec 2101:French 2201:Greek 2301:Catalan 2302:Portuguese 2303:Spanish 2399:Iberian Romance, nec 2401:Italian 2501:Maltese 2901:Basque 2902:Latin 2999:Other Southern European Languages, nec 3101:Latvian 3102:Lithuanian 3301:Hungarian 3401:Belorussian 3402:Russian 3403:Ukrainian 3501:Bosnian 3502:Bulgarian 3503:Croatian 3504:Macedonian 3505:Serbian 3506:Slovene 3507:Serbo-Croatian/Yugoslavian, so described 3601:Czech 3602:Polish 3603:Slovak 3604:Czechoslovakian, so described 3901:Albanian 3903:Aromunian (Macedo-Romanian) 3904:Romanian 3905:Romany 3999:Other Eastern European Languages, nec</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			4101:Kurdish 4102:Pashto 4104:Balochi 4105:Dari 4106:Persian (excluding Dari) 4107:Hazaraghi 4199:Iranic, nec 4202:Arabic 4204:Hebrew 4206:Assyrian Neo-Aramaic 4207:Chaldean Neo-Aramaic 4208:Mandaean (Mandaic) 4299:Middle Eastern Semitic Languages, nec 4301:Turkish 4302:Azeri 4303:Tatar 4304:Turkmen 4305:Uygur 4306:Uzbek 4399:Turkic, nec 4901:Armenian 4902:Georgian 4999:Other Southwest and Central Asian Languages, nec 5101:Kannada 5102:Malayalam 5103:Tamil 5104:Telugu 5105:Tulu 5199:Dravidian, nec 5201:Bengali 5202:Gujarati 5203:Hindi 5204:Konkani 5205:Marathi 5206:Nepali 5207:Punjabi 5208:Sindhi 5211:Sinhalese 5212:Urdu 5213:Assamese 5214:Dhivehi 5215:Kashmiri 5216:Oriya 5217:Fijian Hindustani 5299:Indo-Aryan, nec 5999:Other Southern Asian Languages 6101:Burmese 6102:Chin Haka 6103:Karen 6104:Rohingya 6105:Zomi

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			6199:Burmese and Related Languages, nec 6201:Hmong 6299:Hmong-Mien, nec 6301:Khmer 6302:Vietnamese 6303:Mon 6399:Mon-Khmer, nec 6401:Lao 6402:Thai 6499:Tai, nec 6501:Bisaya 6502:Cebuano 6503:Ilokano 6504:Indonesian 6505:Malay 6507:Tetum 6508:Timorese 6511:Tagalog 6512:Filipino 6513:Acehnese 6514:Balinese 6515:Bikol 6516:Iban 6517:Ilonggo (Hiligaynon) 6518:Javanese 6521:Pampangan 6599:Southeast Asian Austronesian Languages, nec 6999:Other Southeast Asian Languages 7101:Cantonese 7102:Hakka 7104:Mandarin 7106:Wu 7107:Min Nan 7199:Chinese, nec 7201:Japanese 7301:Korean 7901:Tibetan 7902:Mongolian 7999:Other Eastern Asian Languages, nec 8101:Anindilyakwa 8111:Maung 8113:Ngan'gikurunggurr 8114:Nunggubuyu 8115:Rembarrnga 8117:Tiwi 8121:Alawa 8122:Dalabon 8123:Gudanji 8127:Iwaidja 8128:Jaminjung 8131:Jawoyn



Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8132:Jingulu
			8133:Kunbarlang
			8136:Larrakiya
			8137:Malak Malak
			8138:Mangarrayi
			8141:Maringarr
			8142:Marra
			8143:Marrithiyel
			8144:Matngala
			8146:Murrinh Patha
			8147:Na-kara
			8148:Ndjebbana (Gunavidji)
			8151:Ngalakgan
			8152:Ngaliwurru
			8153:Nungali
			8154:Wambaya
			8155:Wardaman
			8156:Amurdak
			8157:Garrwa
			8158:Kuwema
			8161:Marramaninyshi
			8162:Ngandi
			8163:Waanyi
			8164:Wagiman
			8165:Yanyuwa
			8166:Marridan (Maridan)
			8171:Gundjeihmi
			8172:Kune
			8173:Kuninjku
			8174:Kunwinjku
			8175:Mayali
			8179:Kunwinjkuan, nec
			8181:Burarra
			8182:Gun-nartpa
			8183:Gurr-goni
			8189:Burarran, nec
			8199:Arnhem Land and Daly River Region Languages, nec
			8211:Galpu
			8212:Golumala
			8213:Wangurri
			8219:Dhangu, nec
			8221:Dhalwangu
			8222:Djarrwark
			8229:Dhay'yi, nec
			8231:Djambarrpuyngu
			8232:Djapu
			8233:Daatiwuy
			8234:Marrangu
			8235:Liyagalawumirr
			8236:Liyagawumirr
			8239:Dhuwal, nec

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8242:Gumatj
			8243:Gupapuyngu
			8244:Guyamirrili
			8246:Manggalili
			8247:Wubulkarra
			8249:Dhuwala, nec
			8251:Wurlaki
			8259:Djinang, nec
			8261:Ganalbingu
			8262:Djinba
			8263:Manyjalpingu
			8269:Djinba, nec
			8271:Ritharrngu
			8272:Wagilak
			8279:Yakuy, nec
			8281:Nhangu
			8282:Yan-nhangu
			8289:Nhangu, nec
			8291:Dhuwaya
			8292:Djangu
			8293:Madarrpa
			8294:Warramiri
			8295:Rirratjingu
			8299:Other Yolngu Matha, nec
			8301:Kuku Yalanji
			8302:Guugu Yimidhirr
			8303:Kuuku-Ya'u
			8304:Wik Mungkan
			8305:Djabugay
			8306:Dyirbal
			8307:Girramay
			8308:Koko-Bera
			8311:Kuuk Thayorre
			8312:Lamalama
			8313:Yidiny
			8314:Wik Ngathan
			8315:Alngith
			8316:Kugu Muminh
			8317:Morrobalama
			8318:Thaynakwith
			8321:Yupangathi
			8322:Tjungundji
			8399:Cape York Peninsula Languages, nec
			8401:Kalaw Kawaw Ya/Kalaw Lagaw Ya
			8402:Meriam Mir
			8403:Yumplatok (Torres Strait Creole)
			8504:Bilinarra
			8505:Gurindji
			8506:Gurindji Kriol
			8507:Jaru
			8508:Light Warlpiri
			8511:Malngin

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>8512:Mudburra</p> <p>8514:Ngardi</p> <p>8515:Ngarinyman</p> <p>8516:Walmajarri</p> <p>8517:Wanyjirra</p> <p>8518:Warlmanpa</p> <p>8521:Warlpiri</p> <p>8522:Warumungu</p> <p>8599:Northern Desert Fringe Area Languages, nec</p> <p>8603:Alyawarr</p> <p>8606:Kaytetye</p> <p>8607:Antekerrepenh</p> <p>8611:Central Anmatyerr</p> <p>8612:Eastern Anmatyerr</p> <p>8619:Anmatyerr, nec</p> <p>8621:Eastern Arrente</p> <p>8622:Western Arrarnta</p> <p>8629:Arrente, nec</p> <p>8699:Arandic, nec</p> <p>8703:Antikarinya</p> <p>8704:Kartujarra</p> <p>8705:Kukatha</p> <p>8706:Kukatja</p> <p>8707:Luritja</p> <p>8708:Manyjilyjarra</p> <p>8711:Martu Wangka</p> <p>8712:Ngaanyatjarra</p> <p>8713:Pintupi</p> <p>8714: Pitjantjatjara</p> <p>8715:Wangkajunga</p> <p>8716:Wangkatha</p> <p>8717:Warnman</p> <p>8718:Yankunytjatjara</p> <p>8721:Yulparija</p> <p>8722:Tjupany</p> <p>8799:Western Desert Languages, nec</p> <p>8801:Bardi</p> <p>8802:Bunuba</p> <p>8803:Gooniyandi</p> <p>8804:Miriwoong</p> <p>8805:Ngarinyin</p> <p>8806:Nyikina</p> <p>8807:Worla</p> <p>8808:Worrorra</p> <p>8811:Wunambal</p> <p>8812:Yawuru</p> <p>8813:Gambera</p> <p>8814:Jawi</p> <p>8815:Kija</p> <p>8899:Kimberley Area Languages, nec</p> <p>8901:Adnymathanha</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			8902:Arabana
			8903:Bandjalang
			8904:Banyjima
			8905:Batjala
			8906:Bidjara
			8907:Dhanggatti
			8908:Diyari
			8911:Gamilaraay
			8913:Garuwali
			8914:Githabul
			8915:Gumbaynggir
			8916:Kanai
			8917:Karajarri
			8918:Kariyarra
			8921:Kurna
			8922:Kayardild
			8924:Kriol
			8925:Lardil
			8926:Mangala
			8927:Muruwari
			8928:Narungga
			8931:Ngarluma
			8932:Ngarrindjeri
			8933:Nyamal
			8934:Nyangumarta
			8935:Nyungar
			8936:Paakantyi
			8937:Palyku/Niyiyaparli
			8938:Wajarri
			8941:Wiradjuri
			8943:Yindjibarndi
			8944:Yinhawangka
			8945:Yorta Yorta
			8946:Baanbay
			8947:Badimaya
			8948:Barababaraba
			8951:Dadi Dadi
			8952:Dharawal
			8953:Djabwurrung
			8954:Gudjal
			8955:Keerray-Woorroong
			8956:Ladji Ladji
			8957:Mirning
			8958:Ngatjumaya
			8961:Waluwarra
			8962:Wangkangurru
			8963:Wargamay
			8964:Wergaia
			8965:Yugambah
			8998:Aboriginal English, so described
			8999:Other Australian Indigenous Languages, nec

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9101:American Languages 9201:Acholi 9203:Akan 9205:Mauritian Creole 9206:Oromo 9207:Shona 9208:Somali 9211:Swahili 9212:Yoruba 9213:Zulu 9214:Amharic 9215:Bemba 9216:Dinka 9217:Ewe 9218:Ga 9221:Harari 9222:Hausa 9223:Igbo 9224:Kikuyu 9225:Krio 9226:Luganda 9227:Luo 9228:Ndebele 9231:Nuer 9232:Nyanja (Chichewa) 9233:Shilluk 9234:Tigre 9235:Tigrinya 9236:Tswana 9237:Xhosa 9238:Seychelles Creole 9241:Anuak 9242:Bari 9243:Bassa 9244:Dan (Gio-Dan) 9245:Fulfulde 9246:Kinyarwanda (Rwanda) 9247:Kirundi (Rundi) 9248:Kpelle 9251:Krahn 9252:Liberian (Liberian English) 9253:Loma (Lorma) 9254:Lumun (Kuku Lumun) 9255:Madi 9256:Mandinka 9257:Mann 9258:Moro (Nuba Moro) 9261:Themne 9262:Lingala 9299:African Languages, nec 9301:Fijian 9302:Gilbertese

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			9303:Maori (Cook Island) 9304:Maori (New Zealand) 9306:Nauruan 9307:Niue 9308:Samoa 9311:Tongan 9312:Rotuman 9313:Tokelauan 9314:Tuvaluan 9315:Yapese 9399:Pacific Austronesian Languages, nec 9402:Bislama 9403:Hawaiian English 9404:Norfolk-Pitcairn 9405:Solomon Islands Pijin 9499:Oceanian Pidgins and Creoles, nec 9502:Kiwai 9503:Motu (HiriMotu) 9504:Tok Pisin (Neomelanesian) 9599:Papua New Guinea Languages, nec 9601:Invented Languages 9701:Auslan 9702:Key Word Sign Australia 9799:Sign Languages, nec 9999:Unknown
<a href="#">Proficiency in Spoken English (prof_english)</a> METEOR: 270203	string	yes	0:Not applicable (persons under 5 years of age or who speak only English) 1:Very well 2:Well 3:Not well 4:Not at all 9:Not stated/inadequately described
<a href="#">Client Tags (client_tags)</a>	string	–	List of tags for the client.

### 5.3.5. Intake

See [Intake](#) for definition of an intake.

The collection of Intake and IAR data is a requirement for Head to Health programs. This includes the Head to Health Phone Service, centres, satellites and Pop-Up clinics. PHNs may choose to collect Intake and IAR data for other non-Head to Health programs using the PMHC-MDS v4 specification, however reporting of this data remains optional subject to further guidance from the department.

Intakes are managed by the provider organisations via either the PMHC MDS administrative interface or upload.

Table 5.5 Intake record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Intake Key (intake_key)	string (2,50)	yes	This is a number or code assigned to each intake. The Intake Key is unique and stable for each intake at the level of the organisation.
Client Key (client_key)	string (2,50)	yes	This is a number or code assigned to each individual client referred to the intake organisation. The client identifier must be unique and stable for each individual within the intake organisation. Assigned by either the PHN or intake organisation depending on local procedures.
Client Consent to Anonymised Data (client_consent)	string	yes	1:Yes 2:No
Referral Date (referral_date)	date	yes	The date the referrer made the referral.
Program Type (program_type)	string	yes	1:Flexible Funding Pool 2:Head to Health 3:AMHC 4:Psychosocial 5:Bushfire Recovery 2020 7:Supporting Recovery

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



Data Element (Field Name)	Type (min,max)	Required	Format / Values
Referrer Organisation Type (referrer_organisation_type)	string	yes	1:General Practice 2:Medical Specialist Consulting Rooms 3:Private practice 4:Public mental health service 5:Public Hospital 6:Private Hospital 7:Emergency Department 8:Community Health Centre 9:Drug and Alcohol Service 10:Community Support Organisation NFP 11:Indigenous Health Organisation 12:Child and Maternal Health 13:Nursing Service 14:Telephone helpline 15:Digital health service 16:Family Support Service 17:School 18:Tertiary Education institution 19:Housing service 20:Centrelink 21:Other 98:N/A - Self referral 99:Not stated
Date client contacted Intake (date_client_contacted_intake)	date	yes	The date on which the client first contacted the intake service
Suicide Referral Flag (suicide_referral_flag)	string	yes	1:Yes 2:No 9:Unknown
Date referred to other service at Intake conclusion (date_referred_to_other_service_at_intake_conclusion)	date	—	The date the client was referred to another organisation at Intake conclusion.

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<p><a href="#">Organisation type referred to at Intake conclusion</a> (organisation_type_referred_to_at_intake_conclusion)</p>	string	—	<p>1:GP/Medical Practitioner  2:Hospital  3:Psychiatric/mental health service or facility  4:Alcohol and other drug treatment service  5:Other community/ health care service  6:Correctional service  7:Police diversion  8:Court diversion  9:Legal service  10:Child protection agency  11:Community support groups/ agencies  12:Centrelink or employment service  13:Housing and homelessness service  14:Telephone &amp; online services/ referral agency e.g. direct line  15:Disability support service  16:Aged care facility/service  17:Immigration department or asylum seeker/ refugee support service  18:School/other education or training institution  19:Community based Drug and Alcohol Service  20:Youth service (non-AOD)  21:Indigenous service (non-AOD)</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>22:Extended care/ rehabilitation facility</p> <p>23:Palliative care service</p> <p>24:Police (not diversion)</p> <p>25:Public dental provider - community dental agency</p> <p>26:Dental Hospital</p> <p>27:Private Dental Provider</p> <p>28:Early childhood service</p> <p>29:Maternal and Child Health Service</p> <p>30:Community nursing service</p> <p>31:Emergency relief</p> <p>32:Family support service (excl family violence)</p> <p>33:Family violence service</p> <p>34:Gambling support service</p> <p>35:Maternity services</p> <p>36:Peer support/ self-help group</p> <p>37:Private allied health provider</p> <p>38:Sexual Assault service</p> <p>39:Financial counsellor</p> <p>40:Sexual health service</p> <p>41:Medical specialist</p> <p>42:AMHC</p> <p>43:Other PHN funded service</p> <p>44:HeadtoHelp / HeadtoHealth</p> <p>97:No Referral</p> <p>98:Other</p> <p>99:Not stated/ Inadequately described</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			Multiple space separated values allowed
<a href="#">Referred to Organisation Path</a> (referred_to_organisation_path)	string	—	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation to which the intake referred the client.
<a href="#">Intake Tags</a> (intake_tags)	string	—	List of tags for the intake.

### 5.3.6. Intake Episode

See [Intake Episode](#) for definition of an intake episode.

Intake Episodes are managed by the provider organisations via either the PMHC MDS administrative interface or upload.

*Table 5.6 Intake Episode record layout*

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

### 5.3.7. Episode

See [Episode](#) for definition of an episode.

Episodes are managed by the provider organisations via either the PMHC MDS administrative interface or upload.

Table 5.7 Episode record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Episode Key (episode_key)	string (2,50)	yes	This is a number or code assigned to each episode. The Episode Key is unique and stable for each episode at the level of the Provider Organisation.
Client Key (client_key)	string (2,50)	yes	This is a number or code assigned to each individual client referred to the commissioned organisation. The client identifier is unique and stable for each individual within the Provider Organisation.
Episode End Date (episode_end_date) METEOR: 730859	date	—	The date on which an <i>Episode of Care</i> is formally or administratively ended
Client Consent to Anonymised Data (client_consent)	string	yes	1:Yes 2:No

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<p><a href="#">Episode Completion Status</a> (episode_completion_status)</p>	string	—	<p>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</p>
<p><a href="#">Referral Date</a> (referral_date)</p>	date	yes	The date the referrer made the referral.
<p><a href="#">Program Type</a> (program_type)</p>	string	yes	<p>1:Flexible Funding Pool  2:Head to Health  3:AMHC  4:Psychosocial  5:Bushfire Recovery 2020  7:Supporting Recovery</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Principal Focus of Treatment Plan (principal_focus)	string	yes	1: Psychological therapy 2: Low intensity psychological intervention 3: Clinical care coordination 4: Complex care package 5: Child and youth-specific mental health services 6: Indigenous-specific mental health services 7: Other
GP Mental Health Treatment Plan Flag (mental_health_treatment_plan)	string	yes	1: Yes 2: No 3: Unknown 9: Not stated / inadequately described
Homelessness Flag (homelessness)	string	yes	1: Sleeping rough or in non-conventional accommodation 2: Short-term or emergency accommodation 3: Not homeless 9: Not stated / Missing
Area of usual residence, postcode (client_postcode) METEOR: 429894	string	yes	The Australian postcode of the client.
Labour Force Status (labour_force_status) METEOR: 621450	string	yes	1: Employed 2: Unemployed 3: Not in the Labour Force 9: Not stated / inadequately described

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Employment Participation</a> (employment_participation) METEOR: 269950	string	yes	1:Full-time 2:Part-time 3:Not applicable - not in the labour force 9:Not stated/ inadequately described
<a href="#">Source of Cash Income</a> (income_source) METEOR: 386449	string	yes	0:N/A - Client aged less than 16 years 1:Disability Support Pension 2:Other pension or benefit (not superannuation) 3:Paid employment 4:Compensation payments 5:Other (e.g. superannuation, investments etc.) 6:Nil income 7:Not known 9:Not stated/ inadequately described
<a href="#">Health Care Card</a> (health_care_card) METEOR: 605149	string	yes	1:Yes 2:No 3:Not Known 9:Not stated
<a href="#">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
<p><a href="#">Marital Status</a> (marital_status) METEOR: 291045</p>	string	yes	<p>1:Never married 2:Widowed 3:Divorced 4:Separated 5:Married (registered and de facto) 6:Not stated/ inadequately described</p>
<p><a href="#">Suicide Referral Flag</a> (suicide_referral_flag)</p>	string	yes	<p>1:Yes 2:No 9:Unknown</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Principal Diagnosis (principal_diagnosis)	string	yes	<p>100:Anxiety disorders (ATAPS)</p> <p>101:Panic disorder</p> <p>102:Agoraphobia</p> <p>103:Social phobia</p> <p>104:Generalised anxiety disorder</p> <p>105:Obsessive-compulsive disorder</p> <p>106:Post-traumatic stress disorder</p> <p>107:Acute stress disorder</p> <p>108:Other anxiety disorder</p> <p>200:Affective (Mood) disorders (ATAPS)</p> <p>201:Major depressive disorder</p> <p>202:Dysthymia</p> <p>203:Depressive disorder NOS</p> <p>204:Bipolar disorder</p> <p>205:Cyclothymic disorder</p> <p>206:Other affective disorder</p> <p>300:Substance use disorders (ATAPS)</p> <p>301:Alcohol harmful use</p> <p>302:Alcohol dependence</p> <p>303:Other drug harmful use</p> <p>304:Other drug dependence</p> <p>305:Other substance use disorder</p> <p>400:Psychotic disorders (ATAPS)</p> <p>401:Schizophrenia</p> <p>402:Schizoaffective disorder</p> <p>403:Brief psychotic disorder</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>404:Other psychotic disorder</p> <p>501:Separation anxiety disorder</p> <p>502:Attention deficit hyperactivity disorder (ADHD)</p> <p>503:Conduct disorder</p> <p>504:Oppositional defiant disorder</p> <p>505:Pervasive developmental disorder</p> <p>506:Other disorder of childhood and adolescence</p> <p>601:Adjustment disorder</p> <p>602:Eating disorder</p> <p>603:Somatoform disorder</p> <p>604:Personality disorder</p> <p>605:Other mental disorder</p> <p>901:Anxiety symptoms</p> <p>902:Depressive symptoms</p> <p>903:Mixed anxiety and depressive symptoms</p> <p>904:Stress related</p> <p>905:Other</p> <p>999:Missing</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Additional Diagnosis (additional_diagnosis)	string	yes	<b>000:</b> No additional diagnosis <b>100:</b> Anxiety disorders (ATAPS) <b>101:</b> Panic disorder <b>102:</b> Agoraphobia <b>103:</b> Social phobia <b>104:</b> Generalised anxiety disorder <b>105:</b> Obsessive-compulsive disorder <b>106:</b> Post-traumatic stress disorder <b>107:</b> Acute stress disorder <b>108:</b> Other anxiety disorder <b>200:</b> Affective (Mood) disorders (ATAPS) <b>201:</b> Major depressive disorder <b>202:</b> Dysthymia <b>203:</b> Depressive disorder NOS <b>204:</b> Bipolar disorder <b>205:</b> Cyclothymic disorder <b>206:</b> Other affective disorder <b>300:</b> Substance use disorders (ATAPS) <b>301:</b> Alcohol harmful use <b>302:</b> Alcohol dependence <b>303:</b> Other drug harmful use <b>304:</b> Other drug dependence <b>305:</b> Other substance use disorder <b>400:</b> Psychotic disorders (ATAPS) <b>401:</b> Schizophrenia <b>402:</b> Schizoaffective disorder

Data Element (Field Name)	Type (min,max)	Required	Format / Values
			<p>403: Brief psychotic disorder</p> <p>404: Other psychotic disorder</p> <p>501: Separation anxiety disorder</p> <p>502: Attention deficit hyperactivity disorder (ADHD)</p> <p>503: Conduct disorder</p> <p>504: Oppositional defiant disorder</p> <p>505: Pervasive developmental disorder</p> <p>506: Other disorder of childhood and adolescence</p> <p>601: Adjustment disorder</p> <p>602: Eating disorder</p> <p>603: Somatoform disorder</p> <p>604: Personality disorder</p> <p>605: Other mental disorder</p> <p>901: Anxiety symptoms</p> <p>902: Depressive symptoms</p> <p>903: Mixed anxiety and depressive symptoms</p> <p>904: Stress related</p> <p>905: Other</p> <p>999: Missing</p>
<p>Medication - Antipsychotics (N05A) (medication_antipsychotics)</p>	<p>string</p>	<p>yes</p>	<p>1: Yes</p> <p>2: No</p> <p>9: Unknown</p>
<p>Medication - Anxiolytics (N05B) (medication_anxiolytics)</p>	<p>string</p>	<p>yes</p>	<p>1: Yes</p> <p>2: No</p> <p>9: Unknown</p>

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<p>Referrer Organisation Type (referrer_organisation_type)</p>	string	yes	<p>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</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation type referred to at Episode conclusion</a> (organisation_type_referred_to_at_episode_conclusion)	string	—	0:None/Not applicable 1:General Practice 2:Medical Specialist Consulting Rooms 3:Private practice 4:Public mental health service 5:Public Hospital 6:Private Hospital 7:Emergency Department 8:Community Health Centre 9:Drug and Alcohol Service 10:Community Support Organisation NFP 11:Indigenous Health Organisation 12:Child and Maternal Health 13:Nursing Service 14:Telephone helpline 15:Digital health service 16:Family Support Service 17:School 18:Tertiary Education institution 19:Housing service 20:Centrelink 21:Other 22:HeadtoHelp / HeadtoHealth Hub 23:Other PHN funded service 24:AMHC 99:Not stated  Multiple space separated values allowed
<a href="#">Episode Tags</a> (episode_tags)	string	—	List of tags for the episode.



### 5.3.8. Service Contact

See [Service Contact](#) for definition of a service contact.

Service contacts are managed by the provider organisations via either the PMHC MDS administrative interface or upload.

Table 5.8 Service contact record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Service Contact Key</a> (service_contact_key)	string (2,50)	yes	This is a number or code assigned to each service contact. The Service Contact Key is unique and stable for each service contact at the level of the Provider Organisation.
<a href="#">Episode Key</a> (episode_key)	string (2,50)	yes	This is a number or code assigned to each episode. The Episode Key is unique and stable for each episode at the level of the organisation.
<a href="#">Service Contact Date</a> (service_contact_date) METEOR: 494356	date	yes	The date of each mental health service contact between a health service provider and patient/client.
<a href="#">Service Contact Type</a> (service_contact_type)	string	yes	<ul style="list-style-type: none"> <li>0:No contact took place</li> <li>1:Assessment</li> <li>2:Structured psychological intervention</li> <li>3:Other psychological intervention</li> <li>4:Clinical care coordination/liaison</li> <li>5:Clinical nursing services</li> <li>6:Child or youth specific assistance NEC</li> <li>7:Suicide prevention specific assistance NEC</li> <li>8:Cultural specific assistance NEC</li> <li>9:Psychosocial support</li> <li>98:ATAPS</li> </ul>
<a href="#">Postcode</a> (service_contact_postcode) METEOR: 429894	string	yes	The Australian postcode where the service contact took place.
<a href="#">Modality</a> (service_contact_modality)	string	yes	<ul style="list-style-type: none"> <li>0:No contact took place</li> <li>1:Face to Face</li> <li>2:Telephone</li> <li>3:Video</li> <li>4:Internet-based</li> </ul>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Participants</a> (service_contact_participants)	string	yes	<b>1:</b> Individual client <b>2:</b> Client group <b>3:</b> Family / Client Support Network <b>4:</b> Other health professional or service provider <b>5:</b> Other <b>9:</b> Not stated
<a href="#">Venue</a> (service_contact_venue)	string	yes	<b>1:</b> Client's Home <b>2:</b> Service provider's office <b>3:</b> GP Practice <b>4:</b> Other medical practice <b>5:</b> Headspace Centre <b>6:</b> Other primary care setting <b>7:</b> Public or private hospital <b>8:</b> Residential aged care facility <b>9:</b> School or other educational centre <b>10:</b> Client's Workplace <b>11:</b> Other <b>12:</b> Aged care centre - non-residential <b>98:</b> Not applicable (Service Contact Modality is not face to face) <b>99:</b> Not stated
<a href="#">Duration</a> (service_contact_duration)	string	yes	<b>0:</b> No contact took place <b>1:</b> 1-15 mins <b>2:</b> 16-30 mins <b>3:</b> 31-45 mins <b>4:</b> 46-60 mins <b>5:</b> 61-75 mins <b>6:</b> 76-90 mins <b>7:</b> 91-105 mins <b>8:</b> 106-120 mins <b>9:</b> over 120 mins
<a href="#">Copayment</a> (service_contact_copayment)	number	yes	0 - 999999.99
<a href="#">Client Participation Indicator</a> (service_contact_participation_indicator) METEOR: 494341	string	yes	<b>1:</b> Yes <b>2:</b> No
<a href="#">Interpreter Used</a> (service_contact_interpreter)	string	yes	<b>1:</b> Yes <b>2:</b> No <b>9:</b> Not stated

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Funding Source</a> (funding_source)	string	yes	<p><b>0:</b>Flexible funding pool - Not Otherwise Stated</p> <p><b>11:</b>Flexible funding pool - Low intensity</p> <p><b>12:</b>Flexible funding pool - Youth Severe</p> <p><b>13:</b>Flexible funding pool - Child and Youth</p> <p><b>14:</b>Flexible funding pool - Psychological therapies for hard to reach</p> <p><b>15:</b>Flexible funding pool - Services for People with Severe Mental Illness</p> <p><b>16:</b>Flexible funding pool - Suicide Prevention - Indigenous</p> <p><b>17:</b>Flexible funding pool - Suicide Prevention - General</p> <p><b>18:</b>Indigenous Mental Health</p> <p><b>19:</b>Commonwealth Psychosocial Support</p> <p><b>20:</b>Psychological Treatment in Residential Aged Care Facilities</p> <p><b>21:</b>Emergency Response - Bushfire Recovery 2020</p> <p><b>22:</b>Emergency Response - Flood 2022</p> <p><b>23:</b>Head to Health program</p> <p><b>24:</b>Head to Health Kids Hubs</p> <p><b>25:</b>Norfolk Island</p> <p><b>26:</b>National Suicide Prevention Trial</p> <p><b>27:</b>Way Back Support Service</p> <p><b>73:</b>Other Government Funding - Commonwealth: Other Commonwealth</p> <p><b>97:</b>Other funding source - no Commonwealth Funding</p> <p><b>98:</b>Unknown/Not stated</p>
<a href="#">Service Contact Site</a> (service_contact_site)	string (2,50)	—	The site at which an Organisation provides services to clients.
<a href="#">Service Contact Tags</a> (service_contact_tags)	string	—	List of tags for the service contact.

### 5.3.9. Service Contact Practitioner

See [Service Contact Practitioner](#) for definition of a service contact practitioner.

Service contacts practitioners are managed by the provider organisations via either the PMHC MDS administrative interface or upload.

*Table 5.9 Service contact practitioner record layout*

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<a href="#">Service Contact Practitioner Key</a> (service_contact_practitioner_key)	string (2,50)	yes	This is a number or code assigned to each service contact practitioner. The Service Contact Practitioner Key is unique and stable for each service contact practitioner at the level of the Provider Organisation.
<a href="#">Service Contact Key</a> (service_contact_key)	string (2,50)	yes	This is a number or code assigned to each service contact. The Service Contact Key is unique and stable for each service contact at the level of the Provider Organisation.
<a href="#">Practitioner Key</a> (practitioner_key)	string (2,50)	yes	A unique identifier for a practitioner within the provider organisation.
<a href="#">Primary Practitioner Indicator</a> (primary_practitioner_indicator)	string	yes	1:Yes 2:No

### 5.3.10. Collection Occasion

See [Collection Occasion](#) for definition of a collection occasion.

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

Collection occasions are managed by the provider organisations via either the PMHC MDS administrative interface or upload.

*Table 5.10 Collection Occasion record layout*

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

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

## 5.3.11. Measures

### 5.3.11.1. Measures at Intake

#### 5.3.11.1.1. IAR-DST

The collection of Intake and IAR DST data may not be required for all programs. Please see [Intake](#).

Where an Intake is recorded, an associated [IAR-DST](#) should also be recorded. However, this is not enforced by the PMHC MDS as Intake data could be collected separately from IAR DST data.

#### Note

Versions 4.0.0 through 4.0.2 of the PMHC MDS specification only described version 1 of the IAR DST. This version was to be used only for adults. As of PMHC-MDS specification v4.0.3 you may supply either v1 or v2 IAR-DST versions. Version 2 adds child, adolescent, and older adult adaptations. The PMHC-MDS implementation of this change is backward compatible with the existing v1 format as the only difference is the extension of the [IAR-DST - Version](#) domain with v2 specific values.

For more information regarding IAR-DST v2 see the [official IAR-DST v2 specification documentation](#).

#### Note

##### Technical implementation guidance

The version data element now contains both the version ( `1` or `2` ) and, in the case of version 2, a sub-version indicating the age-group specific form of the IAR-DST used. i.e. `child` , `adolescent` , `adult` , and `older` . For example a rating generated using the child form must have the version set to `2.child` .

This approach has been taken for backwards compatibility with v1 to minimise the changes required by data providers to extract and supply v2 data to the PMHC-MDS for reporting.

Carefully consider how these two related but separate data items are stored within local systems. Analysis and reporting of future IAR-DST data may be simplified if they are recorded separately in local systems and only combined for use during data supply.

Table 5.11 IAR-DST record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">Organisation Path</a> (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
<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="#">Intake Key</a> (intake_key)	string (2,50)	yes	This is a number or code assigned to each intake. The Intake Key is unique and stable for each intake at the level of the organisation.
<a href="#">IAR-DST - Version</a> (iar_dst_version)	string	yes	<p><b>1:</b>IAR-DST version 1.05</p> <p><b>2.child:</b>IAR-DST Children (5-11 years) version 2.00</p> <p><b>2.adolescent:</b>IAR-DST Adolescent (12-17 years) version 2.00</p> <p><b>2.adult:</b>IAR-DST Adult (18-64 years) version 2.00</p> <p><b>2.older-adult:</b>IAR-DST Older Adult (65 years and over) version 2.00</p>
<a href="#">IAR-DST - Domain 1</a> (iar_dst_domain_1)	string	yes	<p><b>0:</b>Refer to the relevant IAR-DST specification linked above</p> <p><b>1:</b>Refer to the relevant IAR-DST specification linked above</p> <p><b>2:</b>Refer to the relevant IAR-DST specification linked above</p> <p><b>3:</b>Refer to the relevant IAR-DST specification linked above</p> <p><b>4:</b>Refer to the relevant IAR-DST specification linked above</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<a href="#">IAR-DST - Domain 2</a> (iar_dst_domain_2)	string	yes	<p><b>0:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>1:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>2:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>3:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>4:</b> Refer to the relevant IAR-DST specification linked above</p>
<a href="#">IAR-DST - Domain 3</a> (iar_dst_domain_3)	string	yes	<p><b>0:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>1:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>2:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>3:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>4:</b> Refer to the relevant IAR-DST specification linked above</p>
<a href="#">IAR-DST - Domain 4</a> (iar_dst_domain_4)	string	yes	<p><b>0:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>1:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>2:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>3:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>4:</b> Refer to the relevant IAR-DST specification linked above</p>
<a href="#">IAR-DST - Domain 5</a> (iar_dst_domain_5)	string	yes	<p><b>0:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>1:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>2:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>3:</b> Refer to the relevant IAR-DST specification linked above</p> <p><b>4:</b> Refer to the relevant IAR-DST specification linked above</p>



Data Element (Field Name)	Type (min,max)	Required	Format / Values
<p>IAR-DST - Domain 6 (iar_dst_domain_6)</p>	string	yes	<p><b>0:</b> Refer to the relevant IAR-DST specification linked above  <b>1:</b> Refer to the relevant IAR-DST specification linked above  <b>2:</b> Refer to the relevant IAR-DST specification linked above  <b>3:</b> Refer to the relevant IAR-DST specification linked above  <b>4:</b> Refer to the relevant IAR-DST specification linked above</p>
<p>IAR-DST - Domain 7 (iar_dst_domain_7)</p>	string	yes	<p><b>0:</b> Refer to the relevant IAR-DST specification linked above  <b>1:</b> Refer to the relevant IAR-DST specification linked above  <b>2:</b> Refer to the relevant IAR-DST specification linked above  <b>3:</b> Refer to the relevant IAR-DST specification linked above  <b>4:</b> Refer to the relevant IAR-DST specification linked above</p>
<p>IAR-DST - Domain 8 (iar_dst_domain_8)</p>	string	yes	<p><b>0:</b> Refer to the relevant IAR-DST specification linked above  <b>1:</b> Refer to the relevant IAR-DST specification linked above  <b>2:</b> Refer to the relevant IAR-DST specification linked above  <b>3:</b> Refer to the relevant IAR-DST specification linked above  <b>4:</b> Refer to the relevant IAR-DST specification linked above</p>

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

### 5.3.11.2. Measures during an Episode

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

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

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

### 5.3.11.2.1. K10+

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

Table 5.12 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.
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	<ul style="list-style-type: none"> <li>1:None of the time</li> <li>2:A little of the time</li> <li>3:Some of the time</li> <li>4:Most of the time</li> <li>5:All of the time</li> <li>9:Not stated / Missing</li> </ul>
K10+ - Question 2 (k10p_item2)	string	yes	<ul style="list-style-type: none"> <li>1:None of the time</li> <li>2:A little of the time</li> <li>3:Some of the time</li> <li>4:Most of the time</li> <li>5:All of the time</li> <li>9:Not stated / Missing</li> </ul>
K10+ - Question 3 (k10p_item3)	string	yes	<ul style="list-style-type: none"> <li>1:None of the time</li> <li>2:A little of the time</li> <li>3:Some of the time</li> <li>4:Most of the time</li> <li>5:All of the time</li> <li>9:Not stated / Missing</li> </ul>
K10+ - Question 4 (k10p_item4)	string	yes	<ul style="list-style-type: none"> <li>1:None of the time</li> <li>2:A little of the time</li> <li>3:Some of the time</li> <li>4:Most of the time</li> <li>5:All of the time</li> <li>9:Not stated / Missing</li> </ul>

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
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

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

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

#### 5.3.11.2.2. K5

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

Table 5.13 K5 record layout

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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
K5 - Question 2 (k5_item2)	string	yes	1:None of the time 2:A little of the time 3:Some of the time 4:Most of the time 5:All of the time 9:Not stated / Missing
K5 - Question 3 (k5_item3)	string	yes	1:None of the time 2:A little of the time 3:Some of the time 4:Most of the time 5:All of the time 9:Not stated / Missing
K5 - Question 4 (k5_item4)	string	yes	1:None of the time 2:A little of the time 3:Some of the time 4:Most of the time 5:All of the time 9:Not stated / Missing
K5 - Question 5 (k5_item5)	string	yes	1:None of the time 2:A little of the time 3:Some of the time 4:Most of the time 5:All of the time 9:Not stated / Missing
K5 - Score (k5_score)	integer	yes	5 - 25, 99 = Not stated / Missing
K5 - Tags (k5_tags)	string	–	List of tags for the measure.

### 5.3.11.2.3. SDQ

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

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

The versions specified for PMHC MDS reporting are:

- PC1 - SDQ Parent Report: 4-10 years (Baseline version);
- PC2 - SDQ Parent Report: 4-10 years (Follow up version);
- PY1 - SDQ Parent Report: 11-17 years (Baseline version);
- PY2 - SDQ Parent Report: 11-17 years (Follow up version);
- YR1 - SDQ Youth Report: 11-17 years (Baseline version); and
- YR2 - SDQ Youth Report: 11-17 years (Follow up version).

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

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

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

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

### 5.3.11.2.3.1. SDQ items and Scale Summary scores

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

		Not True	Some-what True	Certainly True	Summary Score
Standard Values for Data Entry		0	1	2	
Data element	SDQ Item number and description	Item Score			
<i>Emotional Symptoms Scale</i>					0-10
Item 03	Often complains of headaches ...	0	1	2	
Item 08	Many worries or often seems worried	0	1	2	
Item 13	Often unhappy, depressed or tearful	0	1	2	
Item 16	Nervous or clingy in new situations ...	0	1	2	
Item 24	Many fears, easily scared	0	1	2	
<i>Conduct Problem Scale</i>					0-10
Item 05	Often loses temper ...	0	1	2	
Item 07	Generally well behaved ...	2	1	0	
Item 12	Often fights with other children ...	0	1	2	
Item 18	Often lies or cheats	0	1	2	
Item 22	Steals from home, school ...	0	1	2	
<i>Hyperactivity Scale</i>					0-10
Item 02	Restless, overactive ...	0	1	2	
Item 10	Constantly fidgeting ...	0	1	2	
Item 15	Easily distracted ...	0	1	2	
Item 21	Thinks things out before acting	2	1	0	
Item 25	Good attention span ...	2	1	0	
<i>Peer Problem Scale</i>					0-10
Item 06	Rather solitary, prefers to play alone	0	1	2	
Item 11	Has at least one good friend	2	1	0	
Item 14	Generally liked by other children	2	1	0	



		Not True	Some-what True	Certainly True	Summary Score
Standard Values for Data Entry		0	1	2	
Data element	SDQ Item number and description	Item Score			
Item 19	Picked on or bullied ...	0	1	2	
Item 23	Gets along better with adults ...	0	1	2	
<i>Prosocial Scale</i>					0-10
Item 01	Considerate of other people's feelings	0	1	2	
Item 04	Shares readily with other children ...	0	1	2	
Item 09	Helpful if someone is hurt ...	0	1	2	
Item 17	Kind to younger children	0	1	2	
Item 20	Often volunteers to help others ...	0	1	2	
<i>SDQ Total Difficulties Score = Sum of Scales below</i>					0-40
	<i>Emotional Symptoms Scale</i>	0-10			
	<i>Conduct Problem Scale</i>	0-10			
	<i>Hyperactivity Scale</i>	0-10			
	<i>Peer Problem Scale</i>	0-10			

- NB. Bold items indicate reverse scoring

### 5.3.11.2.3.2. Scoring the SDQ

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

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

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

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

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

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

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

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

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

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

Table 5.14 SDQ record layout

Data Element (Field Name)	Type (min,max)	Required	Format / Values
Organisation Path (organisation_path)	string	yes	A sequence of colon separated Organisation Keys that fully specifies the Provider Organisation providing a service to the client.
Measure Key (measure_key)	string (2,50)	yes	This is a number or code assigned to each instance of a measure. The Measure Key is unique and stable for each instance of a measure at the level of the organisation.
Collection Occasion Key (collection_occasion_key)	string (2,50)	yes	This is a number or code assigned to each collection occasion of service activity. The Collection Occasion Key is unique and stable for each collection occasion at the level of the organisation.
SDQ Collection Occasion - Version (sdq_version)	string	yes	<b>PC101:</b> Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1 <b>PC201:</b> Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1 <b>PY101:</b> Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1 <b>PY201:</b> Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1 <b>YR101:</b> Self report Version, 11-17 years, Baseline version, Australian Version 1 <b>YR201:</b> Self report Version, 11-17 years, Follow Up version, Australian Version 1

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 1 (sdq_item1)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 2 (sdq_item2)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 3 (sdq_item3)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 4 (sdq_item4)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 5 (sdq_item5)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 6 (sdq_item6)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 7 (sdq_item7)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 8 (sdq_item8)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 9 (sdq_item9)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 10 (sdq_item10)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 11 (sdq_item11)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 12 (sdq_item12)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 13 (sdq_item13)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 14 (sdq_item14)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 15 (sdq_item15)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 16 (sdq_item16)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 17 (sdq_item17)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 18 (sdq_item18)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 19 (sdq_item19)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 20 (sdq_item20)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing
SDQ - Question 21 (sdq_item21)	string	yes	0:Not True 1:Somewhat True 2:Certainly True 7:Unable to rate (insufficient information) 9:Not stated / Missing

Data Element (Field Name)	Type (min,max)	Required	Format / Values
<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
<a href="#">SDQ - Question 27</a> (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

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 28 (sdq_item28)	string	yes	<p>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</p>
SDQ - Question 29 (sdq_item29)	string	yes	<p>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</p>
SDQ - Question 30 (sdq_item30)	string	yes	<p>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</p>
SDQ - Question 31 (sdq_item31)	string	yes	<p>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</p>

Data Element (Field Name)	Type (min,max)	Required	Format / Values
SDQ - Question 32 (sdq_item32)	string	yes	<p>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</p>
SDQ - Question 33 (sdq_item33)	string	yes	<p>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</p>
SDQ - Question 34 (sdq_item34)	string	yes	<p>0:Much worse  1:A bit worse  2&gt;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</p>
SDQ - Question 35 (sdq_item35)	string	yes	<p>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</p>



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

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

## 5.4. Definitions

### 5.4.1. ABN

The Australian Business Number of the provider organisation.

**Field name:**organisation\_abn

**Data type:**string (11)

**Required:**yes

**Notes:**The Australian Business Registry maintains ABN search and technical docs. The PMHC MDS does not check the if ABN is registered, only that it satisfies the algorithm documented at <https://abr.business.gov.au/Help/AbnFormat>

---

### 5.4.2. Aboriginal and Torres Strait Islander Status

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

**Field name:**client\_atssi\_status

**Data type:**string

**Required:**yes

**Domain:** 1:Aboriginal but not Torres Strait Islander origin

2:Torres Strait Islander but not Aboriginal origin

3:Both Aboriginal and Torres Strait Islander origin

4:Neither Aboriginal or Torres Strait Islander origin

9:Not stated/inadequately described

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

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

**METEOR:**[291036](#)

---

### 5.4.3. Active

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

**Field name:**practitioner\_active

**Data type:**string

**Required:**yes

**Domain:** 0:Inactive

1:Active

---

#### 5.4.4. Additional Diagnosis

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

**Field name:**additional\_diagnosis

**Data type:**string

**Required:**yes

**Domain:** 000:No additional diagnosis

100:Anxiety disorders (ATAPS)

101:Panic disorder

102:Agoraphobia

103:Social phobia

104:Generalised anxiety disorder

105:Obsessive-compulsive disorder

106:Post-traumatic stress disorder

107:Acute stress disorder

108:Other anxiety disorder

200:Affective (Mood) disorders (ATAPS)

201:Major depressive disorder

202:Dysthymia

203:Depressive disorder NOS

204:Bipolar disorder

205:Cyclothymic disorder

206:Other affective disorder

300:Substance use disorders (ATAPS)

301:Alcohol harmful use

302:Alcohol dependence

303:Other drug harmful use

304:Other drug dependence

305:Other substance use disorder

400:Psychotic disorders (ATAPS)

401:Schizophrenia

402:Schizoaffective disorder

403:Brief psychotic disorder

404:Other psychotic disorder

501:Separation anxiety disorder

502:Attention deficit hyperactivity disorder (ADHD)

503:Conduct disorder

504:Oppositional defiant disorder

505:Pervasive developmental disorder

506:Other disorder of childhood and adolescence

601:Adjustment disorder  
602:Eating disorder  
603:Somatoform disorder  
604:Personality disorder  
605:Other mental disorder  
901:Anxiety symptoms  
902:Depressive symptoms  
903:Mixed anxiety and depressive symptoms  
904:Stress related  
905:Other  
999:Missing

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

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

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

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

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

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

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

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

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

---

#### **5.4.5. Area of usual residence, postcode**

The Australian postcode of the client.

**Field name:**client\_postcode

**Data type:**string

**Required:**yes

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

The full list of Australian Postcodes can be found at [Australia Post](#).

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

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

**METEOR:**[429894](#)

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### 5.4.6. ATSI Cultural Training

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

**Field name:**atsi\_cultural\_training

**Data type:**string

**Required:**yes

**Domain:** 1:Yes

2:No

3:Not required

9:Missing / Not recorded

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

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

**1 - Yes**The practitioner has:

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

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

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

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

---

### 5.4.7. Client Consent to Anonymised Data

An indication that the client has consented to their anonymised data being provided to the Department of Health and Aged Care 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 and Aged Care 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 and Aged Care.

**2 - No**The client has not consented to their anonymised data being provided to the Department of Health and Aged Care 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 and Aged Care.

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.

#### Note

From June 2024 onward consent collection notices were updated to include that anonymised client data may be shared with relevant state and territory departments/agencies in addition to the Department of Health and Aged Care, if the client consents.

---

### 5.4.8. Client Gender

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

**Field name:**client\_gender

**Data type:**string

**Required:**yes

**Domain:** 0:Not stated/Inadequately described

1:Male

2:Female

3:Other

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

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

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

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

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

---

### 5.4.9. Client Key

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

**Field name:**client\_key

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

**Required:**yes

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

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

See [Managing Client Keys](#)

---

### 5.4.10. Client Participation Indicator

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

**Field name:**service\_contact\_participation\_indicator



**Data type:**string

**Required:**yes

**Domain:** 1:Yes

2:No

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

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

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

*Note:* Where a client intended to participate in a service contact but failed to attend, [Client Participation Indicator](#) should be recorded as '1: Yes' and [No Show](#) should be recorded as '1: Yes'.

**METEOR:**[494341](#)

---

### 5.4.11. Client Tags

List of tags for the client.

**Field name:**client\_tags

**Data type:**string

**Required:**no

**Notes:**A comma separated list of tags.

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

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

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

---

### 5.4.12. Collection Occasion Date

The date of the collection occasion.

**Field name:**collection\_occasion\_date

**Data type:**date

**Required:**yes

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

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

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

---

### 5.4.13. Collection Occasion Key

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

**Field name:**collection\_occasion\_key

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

**Required:**yes

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

---

### 5.4.14. Collection Occasion Reason

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

**Field name:**reason\_for\_collection

**Data type:**string

**Required:**yes

**Domain:** 1:Episode start

2:Review

3:Episode end

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

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

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

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

---

### 5.4.15. 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`.

---

### 5.4.16. 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.

---

## 5.4.17. Country of Birth

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

**Field name:**country\_of\_birth

**Data type:**string (4)

**Required:**yes

**Domain:** 1101:Australia

1102:Norfolk Island

1199:Australian External Territories, nec

1201:New Zealand

1301:New Caledonia

1302:Papua New Guinea

1303:Solomon Islands

1304:Vanuatu

1401:Guam

1402:Kiribati

1403:Marshall Islands

1404:Micronesia, Federated States of

1405:Nauru

1406:Northern Mariana Islands

1407:Palau

1501:Cook Islands

1502:Fiji

1503:French Polynesia

1504:Niue

1505:Samoa

1506:Samoa, American

1507:Tokelau

1508:Tonga

1511:Tuvalu

1512:Wallis and Futuna

1513:Pitcairn Islands

1599:Polynesia (excludes Hawaii), nec

1601:Adelie Land (France)

1602:Argentinian Antarctic Territory

1603:Australian Antarctic Territory

1604:British Antarctic Territory

1605:Chilean Antarctic Territory

1606:Queen Maud Land (Norway)

1607:Ross Dependency (New Zealand)

2102:England

2103: Isle of Man  
2104: Northern Ireland  
2105: Scotland  
2106: Wales  
2107: Guernsey  
2108: Jersey  
2201: Ireland  
2301: Austria  
2302: Belgium  
2303: France  
2304: Germany  
2305: Liechtenstein  
2306: Luxembourg  
2307: Monaco  
2308: Netherlands  
2311: Switzerland  
2401: Denmark  
2402: Faroe Islands  
2403: Finland  
2404: Greenland  
2405: Iceland  
2406: Norway  
2407: Sweden  
2408: Aland Islands  
3101: Andorra  
3102: Gibraltar  
3103: Holy See  
3104: Italy  
3105: Malta  
3106: Portugal  
3107: San Marino  
3108: Spain  
3201: Albania  
3202: Bosnia and Herzegovina  
3203: Bulgaria  
3204: Croatia  
3205: Cyprus  
3206: The former Yugoslav Republic of Macedonia  
3207: Greece  
3208: Moldova  
3211: Romania  
3212: Slovenia

3214:Montenegro  
3215:Serbia  
3216:Kosovo  
3301:Belarus  
3302:Czech Republic  
3303:Estonia  
3304:Hungary  
3305:Latvia  
3306:Lithuania  
3307:Poland  
3308:Russian Federation  
3311:Slovakia  
3312:Ukraine  
4101:Algeria  
4102:Egypt  
4103:Libya  
4104:Morocco  
4105:Sudan  
4106:Tunisia  
4107:Western Sahara  
4108:Spanish North Africa  
4111:South Sudan  
4201:Bahrain  
4202:Gaza Strip and West Bank  
4203:Iran  
4204:Iraq  
4205:Israel  
4206:Jordan  
4207:Kuwait  
4208:Lebanon  
4211:Oman  
4212:Qatar  
4213:Saudi Arabia  
4214:Syria  
4215:Turkey  
4216:United Arab Emirates  
4217:Yemen  
5101:Myanmar  
5102:Cambodia  
5103:Laos  
5104:Thailand  
5105:Vietnam

5201:Brunei Darussalam  
5202:Indonesia  
5203:Malaysia  
5204:Philippines  
5205:Singapore  
5206:Timor-Leste  
6101:China (excludes SARs and Taiwan)  
6102:Hong Kong (SAR of China)  
6103:Macau (SAR of China)  
6104:Mongolia  
6105:Taiwan  
6201:Japan  
6202:Korea, Democratic People's Republic of (North)  
6203:Korea, Republic of (South)  
7101:Bangladesh  
7102:Bhutan  
7103:India  
7104:Maldives  
7105:Nepal  
7106:Pakistan  
7107:Sri Lanka  
7201:Afghanistan  
7202:Armenia  
7203:Azerbaijan  
7204:Georgia  
7205:Kazakhstan  
7206:Kyrgyzstan  
7207:Tajikistan  
7208:Turkmenistan  
7211:Uzbekistan  
8101:Bermuda  
8102:Canada  
8103:St Pierre and Miquelon  
8104:United States of America  
8201:Argentina  
8202:Bolivia  
8203:Brazil  
8204:Chile  
8205:Colombia  
8206:Ecuador  
8207:Falkland Islands  
8208:French Guiana

8211:Guyana  
8212:Paraguay  
8213:Peru  
8214:Suriname  
8215:Uruguay  
8216:Venezuela  
8299:South America, nec  
8301:Belize  
8302:Costa Rica  
8303:El Salvador  
8304:Guatemala  
8305:Honduras  
8306:Mexico  
8307:Nicaragua  
8308:Panama  
8401:Anguilla  
8402:Antigua and Barbuda  
8403:Aruba  
8404:Bahamas  
8405:Barbados  
8406:Cayman Islands  
8407:Cuba  
8408:Dominica  
8411:Dominican Republic  
8412:Grenada  
8413:Guadeloupe  
8414:Haiti  
8415:Jamaica  
8416:Martinique  
8417:Montserrat  
8421:Puerto Rico  
8422:St Kitts and Nevis  
8423:St Lucia  
8424:St Vincent and the Grenadines  
8425:Trinidad and Tobago  
8426:Turks and Caicos Islands  
8427:Virgin Islands, British  
8428:Virgin Islands, United States  
8431:St Barthelemy  
8432:St Martin (French part)  
8433:Bonaire, Sint Eustatius and Saba  
8434:Curacao



8435:Sint Maarten (Dutch part)  
9101:Benin  
9102:Burkina Faso  
9103:Cameroon  
9104:Cabo Verde  
9105:Central African Republic  
9106:Chad  
9107:Congo, Republic of  
9108:Congo, Democratic Republic of  
9111:Cote d'Ivoire  
9112:Equatorial Guinea  
9113:Gabon  
9114:Gambia  
9115:Ghana  
9116:Guinea  
9117:Guinea-Bissau  
9118:Liberia  
9121:Mali  
9122:Mauritania  
9123:Niger  
9124:Nigeria  
9125:Sao Tome and Principe  
9126:Senegal  
9127:Sierra Leone  
9128:Togo  
9201:Angola  
9202:Botswana  
9203:Burundi  
9204:Comoros  
9205:Djibouti  
9206:Eritrea  
9207:Ethiopia  
9208:Kenya  
9211:Lesotho  
9212:Madagascar  
9213:Malawi  
9214:Mauritius  
9215:Mayotte  
9216:Mozambique  
9217:Namibia  
9218:Reunion  
9221:Rwanda

9222:St Helena  
9223:Seychelles  
9224:Somalia  
9225:South Africa  
9226:Swaziland  
9227:Tanzania  
9228:Uganda  
9231:Zambia  
9232:Zimbabwe  
9299:Southern and East Africa, nec  
9999:Unknown

**Notes:** [Standard Australian Classification of Countries \(SACC\), 2016 4-digit code \(ABS Catalogue No. 1269.0\)](#)

SACC 2016 is a four-digit, three-level hierarchical structure specifying major group, minor group and country. 9999 is used when the information is not known or the client has refused to provide the information.

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

**METEOR:** [459973](#)

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

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#### 5.4.18. Date client contacted Intake

The date on which the client first contacted the intake service

**Field name:** date\_client\_contacted\_intake

**Data type:** date

**Required:** yes

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

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

#### 5.4.19. Date of Birth

The date on which an individual was born.

**Field name:** date\_of\_birth

**Data type:**date

**Required:**yes

**Notes:**The date of birth must not be before January 1st 1900.

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

**METEOR:**[287007](#)

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#### 5.4.20. Date referred to other service at Intake conclusion

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

**Field name:**date\_referred\_to\_other\_service\_at\_intake\_conclusion

**Data type:**date

**Required:**no

**Notes:**The referral out date must not be before 1st January 2020.

- The referral out end date must not be in the future.
- 

#### 5.4.21. 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.

---

## 5.4.22. Employment Participation

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

**Field name:** employment\_participation

**Data type:** string

**Required:** yes

**Domain:** 1:Full-time

2:Part-time

3:Not applicable - not in the labour force

9:Not stated/inadequately described

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

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

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

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

**METEOR:** [269950](#)

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### 5.4.23. Episode Completion Status

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

**Field name:**episode\_completion\_status

**Data type:**string

**Required:**no

**Domain:** 0:Episode open

1:Episode closed - treatment concluded

2:Episode closed administratively - client could not be contacted

3:Episode closed administratively - client declined further contact

4:Episode closed administratively - client moved out of area

5:Episode closed administratively - client referred elsewhere

6:Episode closed administratively - other reason

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

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

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

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

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

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

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

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

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

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

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

---

## 5.4.24. Episode End Date

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

**Field name:** episode\_end\_date

**Data type:** date

**Required:** no

**Notes:** The episode end date must not be before 1st January 2016.

- The episode end date must not be in the future.

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

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

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

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

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

---

### 5.4.25. Episode Key

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

**Field name:**episode\_key

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

**Required:**yes

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

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

A recommended approach for the creation of Episode Keys is to compute [random UUIDs](#).

---

### 5.4.26. Episode Organisation Path

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

**Field name:**episode\_organisation\_path

**Data type:**string

**Required:**yes

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

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

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

---

### 5.4.27. Episode Tags

List of tags for the episode.

**Field name:**episode\_tags

**Data type:**string

**Required:**no

**Notes:**A comma separated list of tags.

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

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

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

---

### 5.4.28. Estimated Date of Birth Flag

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

**Field name:**est\_date\_of\_birth

**Data type:**string

**Required:**yes

**Domain:** 1:Date of birth is accurate

2:Date of birth is an estimate

8:Date of birth is a 'dummy' date (ie, 09099999)

9:Accuracy of stated date of birth is not known

---

### 5.4.29. Final Service Contact

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

**Field name:**service\_contact\_final

**Data type:**string

**Required:**yes

**Domain:** 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.

---

### 5.4.30. Funding Source

The source of PHN Mental Health funds that are wholly or primarily funding the Service Contact.

**Field name:** funding\_source

**Data type:** string

**Required:** yes

**Domain:** 0:Flexible funding pool - Not Otherwise Stated

- 11:Flexible funding pool - Low intensity
- 12:Flexible funding pool - Youth Severe
- 13:Flexible funding pool - Child and Youth
- 14:Flexible funding pool - Psychological therapies for hard to reach
- 15:Flexible funding pool - Services for People with Severe Mental Illness
- 16:Flexible funding pool - Suicide Prevention - Indigenous
- 17:Flexible funding pool - Suicide Prevention - General
- 18:Indigenous Mental Health
- 19:Commonwealth Psychosocial Support
- 20:Psychological Treatment in Residential Aged Care Facilities
- 21:Emergency Response - Bushfire Recovery 2020
- 22:Emergency Response - Flood 2022
- 23:Head to Health program
- 24:Head to Health Kids Hubs
- 25:Norfolk Island
- 26:National Suicide Prevention Trial
- 27:Way Back Support Service
- 73:Other Government Funding - Commonwealth: Other Commonwealth
- 97:Other funding source - no Commonwealth Funding
- 98:Unknown/Not stated

**Notes:** Organisations must record this information for all new Service Contacts under the Version 4 specification.

**0 - Flexible funding pool - Not Otherwise Stated** This response is only to be used for existing data entered under a Version 2 or HeadtoHelp Version 3 specification.

**23 - Head to Health program** This includes Head to Health Adult Centres and Satellites, and pop-up clinics.

**25 - Norfolk Island** This category only applies to services commissioned through the Central and Eastern Sydney PHN.

**27 - Way Back Support Service**This category must only to be used in conjunction with the Wayback Extension.

**97 - Other funding source - no Commonwealth Funding**This category can only to be used where a service is wholly funded by a non-PHN funding source such as State/Territory jurisdictional funds.

Where a service is co-funded by both PHN funds and State/Territory jurisdictional funds, the appropriate Funding Source category for PHN funding used to pay for the service should be selected unless otherwise advised by relevant guidance from the Department. Tags and/or other reporting measures can be used to differentiate co-funded arrangements.

---

### 5.4.31. 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

---

### 5.4.32. Health Care Card

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

**Field name:**health\_care\_card

**Data type:**string

**Required:**yes

**Domain:** 1:Yes

2:No

3:Not Known

9:Not stated

**Notes:**Details on the Australian Government Health Care Card are available at:

<https://www.humanservices.gov.au/customer/services/centrelink/health-care-card>

**METEOR:**605149

---

### 5.4.33. 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

---

### 5.4.34. IAR-DST - Domain 1

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,

- [Version 2](#)

**Field name:**jar\_dst\_domain\_1

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

1:Refer to the relevant IAR-DST specification linked above

2:Refer to the relevant IAR-DST specification linked above

3:Refer to the relevant IAR-DST specification linked above

4:Refer to the relevant IAR-DST specification linked above

---

### 5.4.35. IAR-DST - Domain 2

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,
- [Version 2](#)

**Field name:**jar\_dst\_domain\_2

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

1:Refer to the relevant IAR-DST specification linked above

2:Refer to the relevant IAR-DST specification linked above

3:Refer to the relevant IAR-DST specification linked above

4:Refer to the relevant IAR-DST specification linked above

---

### 5.4.36. IAR-DST - Domain 3

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,
- [Version 2](#)

**Field name:**jar\_dst\_domain\_3

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

- 1:Refer to the relevant IAR-DST specification linked above
  - 2:Refer to the relevant IAR-DST specification linked above
  - 3:Refer to the relevant IAR-DST specification linked above
  - 4:Refer to the relevant IAR-DST specification linked above
- 

#### 5.4.37. IAR-DST - Domain 4

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,
- [Version 2](#)

**Field name:**jar\_dst\_domain\_4

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

- 1:Refer to the relevant IAR-DST specification linked above
  - 2:Refer to the relevant IAR-DST specification linked above
  - 3:Refer to the relevant IAR-DST specification linked above
  - 4:Refer to the relevant IAR-DST specification linked above
- 

#### 5.4.38. IAR-DST - Domain 5

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,
- [Version 2](#)

**Field name:**jar\_dst\_domain\_5

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

- 1:Refer to the relevant IAR-DST specification linked above
  - 2:Refer to the relevant IAR-DST specification linked above
  - 3:Refer to the relevant IAR-DST specification linked above
  - 4:Refer to the relevant IAR-DST specification linked above
-

### 5.4.39. IAR-DST - Domain 6

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,
- [Version 2](#)

**Field name:**iar\_dst\_domain\_6

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

1:Refer to the relevant IAR-DST specification linked above

2:Refer to the relevant IAR-DST specification linked above

3:Refer to the relevant IAR-DST specification linked above

4:Refer to the relevant IAR-DST specification linked above

---

### 5.4.40. IAR-DST - Domain 7

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,
- [Version 2](#)

**Field name:**iar\_dst\_domain\_7

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

1:Refer to the relevant IAR-DST specification linked above

2:Refer to the relevant IAR-DST specification linked above

3:Refer to the relevant IAR-DST specification linked above

4:Refer to the relevant IAR-DST specification linked above

---

### 5.4.41. IAR-DST - Domain 8

For details about values of this field, please **refer to the relevant IAR-DST specification** for the version of the IAR-DST that you are using:

- [Version 1](#) or,

- [Version 2](#)

**Field name:**jar\_dst\_domain\_8

**Data type:**string

**Required:**yes

**Domain:** 0:Refer to the relevant IAR-DST specification linked above

1:Refer to the relevant IAR-DST specification linked above

2:Refer to the relevant IAR-DST specification linked above

3:Refer to the relevant IAR-DST specification linked above

4:Refer to the relevant IAR-DST specification linked above

---

#### 5.4.42. IAR-DST - Practitioner Level of Care

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

**Field name:**jar\_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 the Levels of Care section in the documentation for the version of the IAR-DST that you are using.

[Version 1](#) or [Version 2](#)

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.

---

#### 5.4.43. 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:**jar\_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 the Levels of Care section in the documentation for the version of the IAR-DST that you are using.

[Version 1](#) or [Version 2](#)

---

#### 5.4.44. 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`.

---

#### 5.4.45. IAR-DST - Version

The version of the IAR-DST collected.

**Field name:**iar\_dst\_version

**Data type:**string

**Required:**yes

**Domain:** 1:IAR-DST version 1.05

2.child:IAR-DST Children (5-11 years) version 2.00



2.adolescent: IAR-DST Adolescent (12-17 years) version 2.00

2.adult: IAR-DST Adult (18-64 years) version 2.00

2.older-adult: IAR-DST Older Adult (65 years and over) version 2.00

---

#### 5.4.46. Intake Key

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

**Field name:** intake\_key

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

**Required:** yes

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

A recommended approach for the creation of Intake Keys is to compute [random UUIDs](#).

---

#### 5.4.47. Intake Organisation Path

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

**Field name:** intake\_organisation\_path

**Data type:** string

**Required:** yes

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

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

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

---

#### 5.4.48. Intake Tags

List of tags for the intake.

**Field name:**intake\_tags

**Data type:**string

**Required:**no

**Notes:**A comma separated list of tags.

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

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

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

---

### 5.4.49. 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.

---

### 5.4.50. Key

A metadata key name.

**Field name:**key

**Data type:**string

**Required:**yes

**Notes:**Current allowed metadata keys are *type* and *version*.

Please refer to [Metadata file](#) for an example of the metadata file/worksheet that must be used with this specification.

---

### 5.4.51. 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'

---

### 5.4.52. 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'

---

### 5.4.53. 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'

---

#### 5.4.54. 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'

---

#### 5.4.55. 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'

---

### 5.4.56. 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'

---

### 5.4.57. 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`.

---

### 5.4.58. 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'

---

### 5.4.59. 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'

---

### 5.4.60. 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'

---

#### 5.4.61. 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'

---

#### 5.4.62. 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'

---

#### 5.4.63. 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'

---

#### 5.4.64. 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'

---

#### 5.4.65. 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'

---

### 5.4.66. 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'

---

### 5.4.67. 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'

---

### 5.4.68. 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.

---

### 5.4.69. 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.

---

### 5.4.70. 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.

---

### 5.4.71. 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.

---

### 5.4.72. 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

When items 01 through 10 has one item "not stated/missing" (value 9), the Total Score is pro-rated using the following formula:

$$\text{Total score} = \text{round}(\text{sum of valid item scores} / 9 * 10)$$

When items 01 through 10 has more than one item "not stated/missing" (value 9), the Total Score is set as invalid. Where this is the case, the "not stated/missing" (value 99) should be used.

For more information on scoring the K10+, please refer to page 58 of AMHOCN's Overview of clinician-rated and consumer self-report measures at [https://www.amhocn.org/sites/default/files/publication\\_files/nocc\\_clinician\\_and\\_self-report\\_measures\\_overview\\_v2.1\\_20210913\\_1.pdf](https://www.amhocn.org/sites/default/files/publication_files/nocc_clinician_and_self-report_measures_overview_v2.1_20210913_1.pdf)

When upload report individual item scores and use a Total Score '99 - Not stated / Missing', the PMHC MDS will calculate the total score.

---

### 5.4.73. 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`.

---

### 5.4.74. Labour Force Status

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

**Field name:**labour\_force\_status

**Data type:**string

**Required:**yes

**Domain:** 1:Employed

2:Unemployed

3:Not in the Labour Force

9:Not stated/inadequately described

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

- Worked for one hour or more for pay, profit, commission or payment in kind, in a job or business or son a farm (employees and owner managers of incorporated or unincorporated enterprises).

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

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

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

Actively looked for work includes:

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

**3 - Not in the labour force** Persons not in the labour force are those aged 15 years and over who were not in the categories employed or unemployed, as defined, during the reference week.

They include people who undertook unpaid household duties or other voluntary work only, were retired, voluntarily inactive and those permanently unable to work.

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

METEOR:621450

## 5.4.75. Legal Name

The legal name of the provider organisation.

**Field name:**organisation\_legal\_name

Data type:string

Required:no

---

#### 5.4.76. Main Language Spoken at Home

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

Field name:main\_lang\_at\_home

Data type:string (4)

Required:yes

Domain: 1101:Gaelic (Scotland)

1102:Irish

1103:Welsh

1199:Celtic, nec

1201:English

1301:German

1302:Letzeburgish

1303:Yiddish

1401:Dutch

1402:Frisian

1403:Afrikaans

1501:Danish

1502:Icelandic

1503:Norwegian

1504:Swedish

1599:Scandinavian, nec

1601:Estonian

1602:Finnish

1699:Finnish and Related Languages, nec

2101:French

2201:Greek

2301:Catalan

2302:Portuguese

2303:Spanish

2399:Iberian Romance, nec

2401:Italian

2501:Maltese

2901:Basque

2902:Latin

2999:Other Southern European Languages, nec

3101:Latvian

3102:Lithuanian

3301:Hungarian

3401:Belorussian

3402:Russian

3403:Ukrainian

3501:Bosnian

3502:Bulgarian

3503:Croatian

3504:Macedonian

3505:Serbian

3506:Slovene

3507:Serbo-Croatian/Yugoslavian, so described

3601:Czech

3602:Polish

3603:Slovak

3604:Czechoslovakian, so described

3901:Albanian

3903:Aromunian (Macedo-Romanian)

3904:Romanian

3905:Romany

3999:Other Eastern European Languages, nec

4101:Kurdish

4102:Pashto

4104:Balochi

4105:Dari

4106:Persian (excluding Dari)

4107:Hazaraghi

4199:Iranic, nec

4202:Arabic

4204:Hebrew

4206:Assyrian Neo-Aramaic

4207:Chaldean Neo-Aramaic

4208:Mandaean (Mandaic)

4299:Middle Eastern Semitic Languages, nec

4301:Turkish

4302:Azeri

4303:Tatar

4304:Turkmen

4305:Uygur

4306:Uzbek

4399:Turkic, nec  
4901:Armenian  
4902:Georgian  
4999:Other Southwest and Central Asian Languages, nec  
5101:Kannada  
5102:Malayalam  
5103:Tamil  
5104:Telugu  
5105:Tulu  
5199:Dravidian, nec  
5201:Bengali  
5202:Gujarati  
5203:Hindi  
5204:Konkani  
5205:Marathi  
5206:Nepali  
5207:Punjabi  
5208:Sindhi  
5211:Sinhalese  
5212:Urdu  
5213:Assamese  
5214:Dhivehi  
5215:Kashmiri  
5216:Oriya  
5217:Fijian Hindustani  
5299:Indo-Aryan, nec  
5999:Other Southern Asian Languages  
6101:Burmese  
6102:Chin Haka  
6103:Karen  
6104:Rohingya  
6105:Zomi  
6199:Burmese and Related Languages, nec  
6201:Hmong  
6299:Hmong-Mien, nec  
6301:Khmer  
6302:Vietnamese  
6303:Mon  
6399:Mon-Khmer, nec  
6401:Lao  
6402:Thai  
6499:Tai, nec



6501:Bisaya  
6502:Cebuano  
6503:Ilokano  
6504:Indonesian  
6505:Malay  
6507:Tetum  
6508:Timorese  
6511:Tagalog  
6512:Filipino  
6513:Acehnese  
6514:Balinese  
6515:Bikol  
6516:Iban  
6517:Ilonggo (Hiligaynon)  
6518:Javanese  
6521:Pampangan  
6599:Southeast Asian Austronesian Languages, nec  
6999:Other Southeast Asian Languages  
7101:Cantonese  
7102:Hakka  
7104:Mandarin  
7106:Wu  
7107:Min Nan  
7199:Chinese, nec  
7201:Japanese  
7301:Korean  
7901:Tibetan  
7902:Mongolian  
7999:Other Eastern Asian Languages, nec  
8101:Anindilyakwa  
8111:Maung  
8113:Ngan'gikurunggurr  
8114:Nunggubuyu  
8115:Rembarrnga  
8117:Tiwi  
8121:Alawa  
8122:Dalabon  
8123:Gudanji  
8127:Iwaidja  
8128:Jaminjung  
8131:Jawoyn  
8132:Jingulu

8133:Kunbarlang  
8136:Larrakiya  
8137:Malak Malak  
8138:Mangarrayi  
8141:Maringarr  
8142:Marra  
8143:Marrithiyel  
8144:Matngala  
8146:Murrinh Patha  
8147:Na-kara  
8148:Ndjebbana (Gunavidji)  
8151:Ngalakgan  
8152:Ngaliwurru  
8153:Nungali  
8154:Wambaya  
8155:Wardaman  
8156:Amurdak  
8157:Garrwa  
8158:Kuwema  
8161:Marramaninyshi  
8162:Ngandi  
8163:Waanyi  
8164:Wagiman  
8165:Yanyuwa  
8166:Marridan (Maridan)  
8171:Gundjeihmi  
8172:Kune  
8173:Kuninjku  
8174:Kunwinjku  
8175:Mayali  
8179:Kunwinjkuan, nec  
8181:Burarra  
8182:Gun-nartpa  
8183:Gurr-goni  
8189:Burarran, nec  
8199:Arnhem Land and Daly River Region Languages, nec  
8211:Galpu  
8212:Golumala  
8213:Wangurri  
8219:Dhangu, nec  
8221:Dhalwangu  
8222:Djarrwark

8229:Dhay'yi, nec  
8231:Djambarrpuyngu  
8232:Djapu  
8233:Daatiwuy  
8234:Marrangu  
8235:Liyagalawumirr  
8236:Liyagawumirr  
8239:Dhuwal, nec  
8242:Gumatj  
8243:Gupapuyngu  
8244:Guyamirrilili  
8246:Manggalili  
8247:Wubulkarra  
8249:Dhuwala, nec  
8251:Wurlaki  
8259:Djinang, nec  
8261:Ganalbingu  
8262:Djinba  
8263:Manyjalpingu  
8269:Djinba, nec  
8271:Ritharrngu  
8272:Wagilak  
8279:Yakuy, nec  
8281:Nhangu  
8282:Yan-nhangu  
8289:Nhangu, nec  
8291:Dhuwaya  
8292:Djangu  
8293:Madarrpa  
8294:Warramiri  
8295:Rirratjingu  
8299:Other Yolngu Matha, nec  
8301:Kuku Yalanji  
8302:Guugu Yimidhirr  
8303:Kuuku-Ya'u  
8304:Wik Mungkan  
8305:Djabugay  
8306:Dyirbal  
8307:Girramay  
8308:Koko-Bera  
8311:Kuuk Thayorre  
8312:Lamalama

8313:Yidiny  
8314:Wik Ngathan  
8315:Alngith  
8316:Kugu Muminh  
8317:Morrobalama  
8318:Thaynakwith  
8321:Yupangathi  
8322:Tjungundji  
8399:Cape York Peninsula Languages, nec  
8401:Kalaw Kawaw Ya/Kalaw Lagaw Ya  
8402:Meriam Mir  
8403:Yumplatok (Torres Strait Creole)  
8504:Bilinarra  
8505:Gurindji  
8506:Gurindji Kriol  
8507:Jarú  
8508:Light Warlpiri  
8511:Malngin  
8512:Mudburra  
8514:Ngardi  
8515:Ngarinyman  
8516:Walmajarri  
8517:Wanyjirra  
8518:Warlmanpa  
8521:Warlpiri  
8522:Warumungu  
8599:Northern Desert Fringe Area Languages, nec  
8603:Alyawarr  
8606:Kaytetye  
8607:Antekerrepenh  
8611:Central Anmatyerr  
8612:Eastern Anmatyerr  
8619:Anmatyerr, nec  
8621:Eastern Arrernte  
8622:Western Arrarnta  
8629:Arrernte, nec  
8699:Arandic, nec  
8703:Antikarinya  
8704:Kartujarra  
8705:Kukatha  
8706:Kukatja  
8707:Luritja

8708:Manyjilyjarra  
8711:Martu Wangka  
8712:Ngaanyatjarra  
8713:Pintupi  
8714:Pitjantjatjara  
8715:Wangkajunga  
8716:Wangkatha  
8717:Warnman  
8718:Yankunytjatjara  
8721:Yulparija  
8722:Tjupany  
8799:Western Desert Languages, nec  
8801:Bardi  
8802:Bunuba  
8803:Gooniyandi  
8804:Miriwoong  
8805:Ngarinyin  
8806:Nyikina  
8807:Worla  
8808:Worrorra  
8811:Wunambal  
8812:Yawuru  
8813:Gambera  
8814:Jawi  
8815:Kija  
8899:Kimberley Area Languages, nec  
8901:Adnymathanha  
8902:Arabana  
8903:Bandjalang  
8904:Banyjima  
8905:Batjala  
8906:Bidjara  
8907:Dhanggatti  
8908:Diyari  
8911:Gamilaraay  
8913:Garuwali  
8914:Githabul  
8915:Gumbaynggir  
8916:Kanai  
8917:Karajarri  
8918:Kariyarra  
8921:Kurna

8922:Kayardild  
8924:Kriol  
8925:Lardil  
8926:Mangala  
8927:Muruwari  
8928:Narungga  
8931:Ngarluma  
8932:Ngarrindjeri  
8933:Nyamal  
8934:Nyangumarta  
8935:Nyungar  
8936:Paakantyi  
8937:Palyku/Nyiyaparli  
8938:Wajarri  
8941:Wiradjuri  
8943:Yindjibarndi  
8944:Yinhawangka  
8945:Yorta Yorta  
8946:Baanbay  
8947:Badimaya  
8948:Barababaraba  
8951:Dadi Dadi  
8952:Dharawal  
8953:Djabwurrung  
8954:Gudjal  
8955:Keeray-Woorroong  
8956:Ladji Ladji  
8957:Mirning  
8958:Ngatjumaya  
8961:Waluwarra  
8962:Wangkangurru  
8963:Wargamay  
8964:Wergaia  
8965:Yugambah  
8998:Aboriginal English, so described  
8999:Other Australian Indigenous Languages, nec  
9101:American Languages  
9201:Acholi  
9203:Akan  
9205:Mauritian Creole  
9206:Oromo  
9207:Shona

9208:Somali  
9211:Swahili  
9212:Yoruba  
9213:Zulu  
9214:Amharic  
9215:Bemba  
9216:Dinka  
9217:Ewe  
9218:Ga  
9221:Harari  
9222:Hausa  
9223:Igbo  
9224:Kikuyu  
9225:Krio  
9226:Luganda  
9227:Luo  
9228:Ndebele  
9231:Nuer  
9232:Nyanja (Chichewa)  
9233:Shilluk  
9234:Tigre  
9235:Tigrinya  
9236:Tswana  
9237:Xhosa  
9238:Seychelles Creole  
9241:Anuak  
9242:Bari  
9243:Bassa  
9244:Dan (Gio-Dan)  
9245:Fulfulde  
9246:Kinyarwanda (Rwanda)  
9247:Kirundi (Rundi)  
9248:Kpelle  
9251:Krahn  
9252:Liberian (Liberian English)  
9253:Loma (Lorma)  
9254:Lumun (Kuku Lumun)  
9255:Madi  
9256:Mandinka  
9257:Mann  
9258:Moro (Nuba Moro)  
9261:Themne

9262:Lingala  
9299:African Languages, nec  
9301:Fijian  
9302:Gilbertese  
9303:Maori (Cook Island)  
9304:Maori (New Zealand)  
9306:Nauruan  
9307:Niue  
9308:Samoaan  
9311:Tongan  
9312:Rotuman  
9313:Tokelauan  
9314:Tuvaluan  
9315:Yapese  
9399:Pacific Austronesian Languages, nec  
9402:Bislama  
9403:Hawaiian English  
9404:Norf'k-Pitcairn  
9405:Solomon Islands Pijin  
9499:Oceanian Pidgins and Creoles, nec  
9502:Kiwai  
9503:Motu (HiriMotu)  
9504:Tok Pisin (Neomelanesian)  
9599:Papua New Guinea Languages, nec  
9601:Invented Languages  
9701:Auslan  
9702:Key Word Sign Australia  
9799:Sign Languages, nec  
9999:Unknown

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

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

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

**METEOR:**460125

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



## 5.4.77. Marital Status

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

**Field name:**marital\_status

**Data type:**string

**Required:**yes

**Domain:** 1:Never married

2:Widowed

3:Divorced

4:Separated

5:Married (registered and de facto)

6:Not stated/inadequately described

**Notes:**Refers to the current marital status of a person.

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

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

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

**6 - Not stated/inadequately described**This code is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

**METEOR:**[291045](#)

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## 5.4.78. 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.

### 5.4.79. 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.whooc.no/atc\\_ddd\\_index/?code=N06A](http://www.whooc.no/atc_ddd_index/?code=N06A)

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### 5.4.80. 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.whooc.no/atc\\_ddd\\_index/?code=N05A](http://www.whooc.no/atc_ddd_index/?code=N05A)

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### 5.4.81. 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)

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### 5.4.82. 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)

---

### 5.4.83. 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.whooc.no/atc\\_ddd\\_index/?code=N06B](http://www.whooc.no/atc_ddd_index/?code=N06B)

---

### 5.4.84. Modality

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

**Field name:** service\_contact\_modality

**Data type:** string

**Required:** yes

**Domain:** 0:No contact took place

1:Face to Face

2:Telephone

3:Video

4:Internet-based

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

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

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

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

**3 - Video** Includes any video based communication.

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

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

---

#### **5.4.85. Name**

The name of the provider organisation.

**Field name:**organisation\_name

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

**Required:**yes

---

#### **5.4.86. 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

---

#### **5.4.87. 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.

---

### 5.4.88. Organisation End Date

The date on which a provider organisation stopped delivering services.

**Field name:**organisation\_end\_date

**Data type:**date

**Required:**yes

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

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

For validation rules please refer to [Organisation](#).

---

### 5.4.89. Organisation Key

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

**Field name:**organisation\_key

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

**Required:**yes

**Notes:**Organisation Keys must be generated by the PHN to be unique and must persist across time. See [Managing Provider Organisation Keys](#)

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

---

### 5.4.90. 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

---

### 5.4.91. Organisation Start Date

The date on which a provider organisation started delivering services.

**Field name:**organisation\_start\_date

**Data type:**date

**Required:**yes

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

For validation rules please refer to [Organisation](#).

---

### 5.4.92. Organisation Tags

List of tags for the provider organisation.

**Field name:**organisation\_tags

**Data type:**string

**Required:**no

**Notes:**A comma separated list of tags.

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

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

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

## 5.4.93. Organisation Type

The category that best describes the provider organisation.

**Field name:**organisation\_type

**Data type:**string

**Required:**yes

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

- Notes:**1 - **Private Allied Health Professional Practice**The provider organisation is a group of single- or multi-discipline allied health practitioners operating as private service providers. This includes both group and solo practitioner entities.
- 2 - **Private Psychiatry practice**The provider organisation is a Private Psychiatry practice. This includes both group and solo practitioner entities.
- 3 - **General Medical Practice**The provider organisation is a General Medical Practice. This includes both group and solo practitioner entities.
- 4 - **Private Hospital**The provider organisation is a private hospital. This includes for-profit and not-for-profit hospitals.
- 5 - **Headspace Centre**The provider organisation is a Headspace centre, delivering services funded by the PHN.

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



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

Note: See Note above re Headspace.

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

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

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

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

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

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

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

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

---

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

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

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

**Data type:**string

**Required:**no

**Domain:** 0:None/Not applicable

1:General Practice

2:Medical Specialist Consulting Rooms

3:Private practice

4:Public mental health service

5:Public Hospital

6:Private Hospital

- 7:Emergency Department
- 8:Community Health Centre
- 9:Drug and Alcohol Service
- 10:Community Support Organisation NFP
- 11:Indigenous Health Organisation
- 12:Child and Maternal Health
- 13:Nursing Service
- 14:Telephone helpline
- 15:Digital health service
- 16:Family Support Service
- 17:School
- 18:Tertiary Education institution
- 19:Housing service
- 20:Centrelink
- 21:Other
- 22:HeadtoHelp / HeadtoHealth Hub
- 23:Other PHN funded service
- 24:AMHC
- 99:Not stated

Multiple space separated values allowed

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

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

#### 5.4.95. Organisation type referred to at Intake conclusion

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

**Field name:**organisation\_type\_referred\_to\_at\_intake\_conclusion

**Data type:**string

**Required:**no

**Domain:** 1:GP/Medical Practitioner

- 2:Hospital
- 3:Psychiatric/mental health service or facility
- 4:Alcohol and other drug treatment service
- 5:Other community/health care service
- 6:Correctional service
- 7:Police diversion

- 8: Court diversion
- 9: Legal service
- 10: Child protection agency
- 11: Community support groups/agencies
- 12: Centrelink or employment service
- 13: Housing and homelessness service
- 14: Telephone & online services/referral agency e.g. direct line
- 15: Disability support service
- 16: Aged care facility/service
- 17: Immigration department or asylum seeker/refugee support service
- 18: School/other education or training institution
- 19: Community based Drug and Alcohol Service
- 20: Youth service (non-AOD)
- 21: Indigenous service (non-AOD)
- 22: Extended care/rehabilitation facility
- 23: Palliative care service
- 24: Police (not diversion)
- 25: Public dental provider - community dental agency
- 26: Dental Hospital
- 27: Private Dental Provider
- 28: Early childhood service
- 29: Maternal and Child Health Service
- 30: Community nursing service
- 31: Emergency relief
- 32: Family support service (excl family violence)
- 33: Family violence service
- 34: Gambling support service
- 35: Maternity services
- 36: Peer support/self-help group
- 37: Private allied health provider
- 38: Sexual Assault service
- 39: Financial counsellor
- 40: Sexual health service
- 41: Medical specialist
- 42: AMHC
- 43: Other PHN funded service
- 44: HeadtoHelp / HeadtoHealth
- 97: No Referral
- 98: Other
- 99: Not stated/Inadequately described

Multiple space separated values allowed

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

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

The intent is that each referral out only has one organisation type and that multiple organisation types implies multiple referrals. Where an organisation could belong to multiple types, the type that best suits the reason for the referral should be selected.

---

## 5.4.96. 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/s), without the participation of the client or family support network.

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

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

## 5.4.97. Postcode

The Australian postcode where the service contact took place.

**Field name:**service\_contact\_postcode

**Data type:**string

**Required:**yes

**Notes:**A valid Australian postcode or 9999 if the postcode is unknown. The full list of Australian Postcodes can be found at [Australia Post](#).

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

**METEOR:**[429894](#)

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## 5.4.98. Practitioner Aboriginal and Torres Strait Islander Status

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

**Field name:**practitioner\_atSI\_status

**Data type:**string

**Required:**yes

**Domain:** 1:Aboriginal but not Torres Strait Islander origin

2:Torres Strait Islander but not Aboriginal origin

3:Both Aboriginal and Torres Strait Islander origin

4:Neither Aboriginal or Torres Strait Islander origin

9:Not stated/inadequately described

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

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

**METEOR:**[291036](#)

---

## 5.4.99. Practitioner Category

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

**Field name:**practitioner\_category

**Data type:**string

**Required:**yes

**Domain:** 1:Clinical Psychologist

2:General Psychologist

3:Social Worker

4:Occupational Therapist

5:Mental Health Nurse

6:Aboriginal and Torres Strait Islander Health/Mental Health Worker

7:Low Intensity Mental Health Worker

8:General Practitioner

9:Psychiatrist

10:Other Medical

11:Other

12:Psychosocial Support Worker

13:Peer Support Worker

99:Not stated

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

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

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

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

#### **Changes in effect from 1 January 2019**

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

## 5.4.100. Practitioner Gender

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

**Field name:**practitioner\_gender

**Data type:**string

**Required:**yes

**Domain:** 0:Not stated/Inadequately described

1:Male

2:Female

3:Other

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

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

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

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

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## 5.4.101. Practitioner Key

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

**Field name:**practitioner\_key

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

**Required:**yes

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

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

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

A recommended approach for the creation of keys is to compute [random UUIDs](#).

---

### 5.4.102. Practitioner Tags

List of tags for the practitioner.

**Field name:**practitioner\_tags

**Data type:**string

**Required:**no

**Notes:**A comma separated list of tags.

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

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

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

---

### 5.4.103. Primary Practitioner Indicator

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

**Field name:**primary\_practitioner\_indicator

**Data type:**string

**Required:**yes

**Domain:** 1:Yes

2:No

---

### 5.4.104. Principal Diagnosis

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

**Field name:**principal\_diagnosis

**Data type:**string

**Required:**yes

**Domain:** 100:Anxiety disorders (ATAPS)

101:Panic disorder

102:Agoraphobia

103:Social phobia

104:Generalised anxiety disorder

105:Obsessive-compulsive disorder

106:Post-traumatic stress disorder



107:Acute stress disorder  
108:Other anxiety disorder  
200:Affective (Mood) disorders (ATAPS)  
201:Major depressive disorder  
202:Dysthymia  
203:Depressive disorder NOS  
204:Bipolar disorder  
205:Cyclothymic disorder  
206:Other affective disorder  
300:Substance use disorders (ATAPS)  
301:Alcohol harmful use  
302:Alcohol dependence  
303:Other drug harmful use  
304:Other drug dependence  
305:Other substance use disorder  
400:Psychotic disorders (ATAPS)  
401:Schizophrenia  
402:Schizoaffective disorder  
403:Brief psychotic disorder  
404:Other psychotic disorder  
501:Separation anxiety disorder  
502:Attention deficit hyperactivity disorder (ADHD)  
503:Conduct disorder  
504:Oppositional defiant disorder  
505:Pervasive developmental disorder  
506:Other disorder of childhood and adolescence  
601:Adjustment disorder  
602:Eating disorder  
603:Somatoform disorder  
604:Personality disorder  
605:Other mental disorder  
901:Anxiety symptoms  
902:Depressive symptoms  
903:Mixed anxiety and depressive symptoms  
904:Stress related  
905:Other  
999:Missing

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

- 000 - No additional diagnosis (Additional Diagnosis only)
- 1xx - Anxiety disorders

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

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

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

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

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

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

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

- 100: Anxiety disorders (ATAPS)
- 200: Affective (Mood) disorders (ATAPS)

- 300: Substance use disorders (ATAPS)
- 400: Psychotic disorders (ATAPS)

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

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

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

### 5.4.105. 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

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

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

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

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

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

- Psychiatrists
- Registered Psychologists
- Clinical Psychologists
- Mental Health Nurses;
- Occupational Therapists;
- Social Workers
- Aboriginal and Torres Strait Islander health workers.

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

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

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

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

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

**5 - Child and youth-specific mental health services**The treatment plan for the client is primarily based around the delivery of a range of services for children (0-11 years) or youth (aged 12-24 years) who present with a mental illness, or are at risk of mental illness. These episodes are characterised by services that are designed specifically for children and young people, include a broader range of both clinical and non-clinical services and may include a significant component of clinical care coordination and liaison. Child and youth-specific mental health episodes have substantial flexibility in types of services actually delivered.

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

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

---

### 5.4.106. Proficiency in Spoken English

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

**Field name:**prof\_english

**Data type:**string

**Required:**yes

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

1:Very well

2:Well

3:Not well

4:Not at all

9:Not stated/inadequately described

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

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

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---

### 5.4.107. Program Type

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

**Field name:**program\_type

**Data type:**string

**Required:**yes

**Domain:** 1:Flexible Funding Pool

2:Head to Health

3:AMHC

4:Psychosocial

5:Bushfire Recovery 2020

7:Supporting Recovery

**Notes:****1 - Flexible Funding Pool** Organisations can use this field for episodes being delivered through all other Programs commissioned through Primary Mental Health Care Schedule that are not otherwise described by another category. This may include but is not limited to general Stepped Care, Mental Health in Residential Aged Care Facilities, and Indigenous Mental Health.

**2 - Head to Health** Organisations can use this field for episodes delivered through the Head to Health Program. This includes Head to Health Adult Centres and Satellites and pop-up clinics.

NSW and Victorian pop-up clinics data have been identified using the Head to Help Version 3 extension and !covid19 tag. Any historical or new records that are identified this way will be mapped to this Program Type field under the Version 4 specification. The !covid19 tag will remain as a reserved tag for the original purpose of indicating that an episode has occurred as result of the COVID-19 pandemic once Head to Help Version 3 extension reaches it's end of life date.

**3 - AMHC** Organisations can use this field for episodes delivered through the Head to Health Program by organisations that were already delivering the Adult Mental Health Centre (AMHC) trial sites.

This change only applies to the following PHNs implementing AMHCs from December 2021:

- West Victoria PHN
- Northern Territory PHN
- ACT PHN
- North Perth PHN
- Nepean Blue Mountains PHN

- North Queensland PHN
- Tasmania PHN

AMHC data has been identified using the !amhc tag. Any historical records created on or before 30 June 2022 that use this tag will be mapped to this Program Type under the Version 4 specification. The !amhc tag will be removed from future use once PMHC MDS Version 2 specification reaches its end of life date.

From July 1 2022 the AMHC trial sites were consolidated under the Head to Health program. For data collection purposes, organisations delivering Head to Health services that were already delivering AMHC trial sites can use either the AMHC or Head to Health program type for records created on or after 1 July 2022.

#### **4 - Psychosocial** Organisations can use this field for episodes delivered through the National Psychosocial Support Services Program.

Psychosocial data has been identified using the Principal Focus of Treatment Plan (PFOT) “Psychosocial” category. Any historical or new records that utilise the Psychosocial PFOT will be mapped to this Program Type field under the Version 4 specification. The Psychosocial PFOT category will no longer be available under the Version 4 specification and further guidance will be provided by the Department to support the management of this change in data collection requirements.

Any records that have the Psychosocial PFOT but also have a !covid19, !amhc, or !br20 tag will be mapped to the respective Program Type associated with those tags rather than the Psychosocial Program Type.

#### **5 - Bushfire Recovery 2020** Organisations in fire affected communities can use this field for episodes delivered through the Australian Government Mental Health Response to Bushfire Trauma.

This data has been identified using the !br20 tag. Any historical or new records using this tag will be mapped to this Program Type field under the Version 4 specification. The !br20 tag will be removed from future use once the Bushfire Program is concluded.

#### **7 - Supporting Recovery** Valid as of May 2024. Organisations can use this field for supports being provided under the Supporting Recovery pilot. The Supporting Recovery pilot provides case management services and trauma-informed mental health services to victim-survivors of family, domestic and sexual violence. As at April 2024, only the following PHNs are able to provide services under this pilot:

- Gippsland PHN
- Hunter New England and Central Coast PHN
- Southwestern Sydney PHN
- Brisbane South PHN
- Northern Territory PHN, and
- Country Western Australia PHN.

## 5.4.108. Referral Date

The date the referrer made the referral.

**Field name:**referral\_date

**Data type:**date

**Required:**yes

**Notes:**The referral date is the date the client was originally referred to an MDS reporting service. Typically the referral is made by an external (non-MDS) provider - such as a general practitioner, but it may be another MDS reporting service or the client themselves.

Where there is a linked intake and treatment both the Intake and Episode records must use the same date - ie. the date the client was originally referred. The referral date is NOT the date that an intake service refers a client to a treatment organisation.

For clients who self refer, the referral date should be the date the client first contacted the intake service or provider organisation. For the intake of a client who self referred, the referral date will be the same as the [Date client contacted Intake](#).

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

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

Referral date was optional in specifications prior to Version 4. In Version 4 referral date has been made mandatory. In order to export and re-upload episode data that was uploaded or entered prior to Version 4 the value '09099999' will be used in data exports and allowed for existing episode data without a referral date. See [Episode](#) for rules on how this value may be used.

---

## 5.4.109. Referred to Organisation Path

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

**Field name:**referred\_to\_organisation\_path

**Data type:**string

**Required:**no

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

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



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

### 5.4.110. 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 specialised residential mental health care services).

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

Where there is a linked intake and treatment, both the Intake and Episode records must use the same referrer organisation type - ie the intake service is NOT the referrer.

---

### 5.4.111. 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'.

Where there is a linked intake and treatment, both the Intake and Episode records must use the same referrer profession - ie the intake service is not the referrer.

---

#### 5.4.112. 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>

---

#### 5.4.113. 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'.

---

#### 5.4.114. 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'.

---

#### 5.4.115. 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'.

---

#### **5.4.116. 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'.

---

#### **5.4.117. 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'.

---

#### **5.4.118. 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'.

---

#### **5.4.119. 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'.

---

### 5.4.120. 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'.

---

### 5.4.121. 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'.

---

#### **5.4.122. 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'.

---

#### **5.4.123. 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'.

---

#### 5.4.124. 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'.

---

#### 5.4.125. 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'.

---

#### 5.4.126. 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'.

---

#### 5.4.127. 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'.

---

#### **5.4.128. 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'.

---

#### **5.4.129. 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'.

---

### 5.4.130. 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'.

---

### 5.4.131. 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'.

---

### 5.4.132. 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'.

---

### 5.4.133. 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'.

---

### 5.4.134. SDQ - Question 16

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

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

**Field name:**sdq\_item16

**Data type:**string

**Required:**yes

**Domain:** 0:Not True

1:Somewhat True

2:Certainly True

7:Unable to rate (insufficient information)

9:Not stated / Missing

**Notes:**Required Versions: All

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

---

#### **5.4.135. 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'.

---

#### **5.4.136. 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'.

---

### 5.4.137. 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'.

---

### 5.4.138. 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'.

---

#### 5.4.139. 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'.

---

#### 5.4.140. 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'.

---

#### 5.4.141. 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'.

---

#### 5.4.142. 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'.

---

#### 5.4.143. 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'.

---

#### 5.4.144. 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'.

---



#### 5.4.145. 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'.

---

#### 5.4.146. 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'.

---

### 5.4.147. 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'.

---

### 5.4.148. 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'.

---

### 5.4.149. 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'.

---

### 5.4.150. 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'.

---

### 5.4.151. 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'.

---

### 5.4.152. 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'.

---

### 5.4.153. 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'.

---

### 5.4.154. 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'.

---

### 5.4.155. 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'.

---

### 5.4.156. 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'.

---

### 5.4.157. 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'.

---

### 5.4.158. 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'.

---

#### 5.4.159. 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'.

---

#### 5.4.160. 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'.

---

### 5.4.161. 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`.

---

### 5.4.162. 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'.

---

### 5.4.163. Service Contact Date

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

**Field name:**service\_contact\_date

**Data type:**date

**Required:**yes

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

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

**METEOR:**[494356](#)

---

#### 5.4.164. Service Contact Key

This is a number or code assigned to each service contact. The Service Contact Key is unique and stable for each service contact at the level of the Provider Organisation.

**Field name:**service\_contact\_key

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

**Required:**yes

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

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

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

A recommended approach for the creation of keys is to compute [random UUIDs](#).

---

#### 5.4.165. Service Contact Practitioner Key

This is a number or code assigned to each service contact practitioner. The Service Contact Practitioner Key is unique and stable for each service contact practitioner at the level of the Provider Organisation.

**Field name:**service\_contact\_practitioner\_key

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

**Required:**yes

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

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

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

A recommended approach for the creation of keys is to compute [random UUIDs](#).

---

#### 5.4.166. Service Contact Site

The site at which an Organisation provides services to clients.

**Field name:**service\_contact\_site

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

**Required:**no

**Notes:**Site names are case sensitive and must have between 2-50 valid unicode characters excluding commas (;). Keys must start with A-Za-z0-9 (POSIX :alnum:).

Leave blank if the organisation only has one site.

The site name must match a site name that is defined in [Sites](#) for the Provider Organisation providing the Service Contact.

---

#### 5.4.167. 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`.

---

## 5.4.168. Service Contact Type

The main type of service provided in the service contact, as represented by the service type that accounted for most provider time.

**Field name:**service\_contact\_type

**Data type:**string

**Required:**yes

**Domain:** 0:No contact took place

1:Assessment

2:Structured psychological intervention

3:Other psychological intervention

4:Clinical care coordination/liaison

5:Clinical nursing services

6:Child or youth specific assistance NEC

7:Suicide prevention specific assistance NEC

8:Cultural specific assistance NEC

9:Psychosocial support

98:ATAPS

**Notes:**Describes the main type of service delivered in the contact, selected from a defined list of categories. Where more than service type was provided select that which accounted for most provider time. Service providers are required to report on Service Type for all Service Contacts.

*Note: NEC is used for 'Not Elsewhere Classified'. For these records, only use these service types if they cannot be classified by any of the other service options.*

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

**1 - Assessment**Determination of a person's mental health status and need for mental health services, made by a suitably trained mental health professional, based on the collection and evaluation of data obtained through interview and observation, of a person's history and presenting problem(s). Assessment may include consultation with the person's family and concludes with formation of problems/issues, documentation of a preliminary diagnosis, and a treatment plan.

**2 - Structured psychological intervention**Those interventions which include a structured interaction between a client and a service provider using a recognised, psychological method, for example, cognitive behavioural techniques, family therapy or psycho education counselling. These are recognised, structured or published techniques for the treatment of mental ill-health. Structured psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health. Structured psychological therapies can be delivered on either an individual or group basis, typically in an office or community setting. They may be

delivered by trained mental health professionals or other individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional. Structured Psychological Therapies include but are not limited to:

- Psycho-education (including motivational interviewing)
- Cognitive-behavioural therapies
- Relaxation strategies
- Skills training
- Interpersonal therapy

**3 - Other psychological intervention** Psychological interventions that do not meet criteria for structured psychological intervention.

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

**5 - Clinical nursing services** Services delivered by mental health nurses that cannot be described elsewhere.

Typically, these aim to provide clinical support to clients to effectively manage their symptoms and avoid unnecessary hospitalisation. Clinical nursing services include:

- monitoring a client's mental state;
- liaising closely with family and carers as appropriate;
- administering and monitoring compliance with medication;
- providing information on physical health care, as required and, where appropriate, assist in addressing the physical health inequities of people with mental illness; and
- improving links to other health professionals/clinical service providers.

**6 - Child or youth-specific assistance NECS** Services delivered to, or on behalf, of a child or young person that cannot be described elsewhere. These can include, for example, working with a child's teacher to provide advice on assisting the child in their educational environment; working with a young person's employer to assist the young person to their work environment.

*Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that the majority of Service Contacts delivered to children and young people can be assigned to other categories.*

**7 - Suicide prevention specific assistance NECS** Services delivered to, or on behalf, of a client who presents with risk of suicide that cannot be described elsewhere. These can include, for example, working with the person's employers to advise on changes in the workplace; working with a young person's teacher to assist the child in their school environment; or working with relevant community-based groups to assist the client to participate in their activities.

*Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that the majority of Service Contacts delivered to client's who have a risk of suicide can be assigned to other categories.*

**8 - Cultural specific assistance NECC**Culturally appropriate services delivered to, or on behalf, of an Aboriginal or Torres Strait Islander client that cannot be described elsewhere. These can include, for example, working with the client's community support network including family and carers, men's and women's groups, traditional healers, interpreters and social and emotional wellbeing counsellors.

*Note: This code should only be used for Service Contacts that cannot be described by any other Service Type. It is expected that the majority of Service Contacts (see domains below) delivered to Aboriginal or Torres Strait Islander clients can be assigned to other categories.*

**9 - Psychosocial support**Service providers are required to report on Service Contact Type for every contact with a client. This requires a judgement about the main service delivered at each contact, selected from a small list of options, and based on the activity that accounted for most provider time. Service Contact Type complements Principal Focus of Treatment Plan by capturing information to understand the mix of services provided within an individual episode of care.

Service Contact Type should be coded as Psychosocial Support (code 9) where the main services delivered during the contact involved the delivery of psychosocial support services. Psychosocial support services are defined for PMHC MDS purposes as services that focus on building capacity and stability in one or more of the following areas:

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

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

Service Contacts recorded as psychosocial support may be delivered in all episodes of care, regardless of episode type. However, it is expected that they will be mainly associated with episodes where the Principal Focus of Treatment Plan is classified as Psychosocial Support.

**98 - ATAPSS**Services delivered as part of ATAPS funded referrals that are recorded and/or migrated into the PMHC MDS.

*Note: This code should only be used for Service Contacts that are migrated from ATAPS MDS sources that cannot be described by any other Service Type. It is expected that the majority of Service Contacts delivered to clients from 1st July, 2017 can be assigned to other categories.*

This response will not be allowed on service contacts delivered after 30 June 2018. (All ATAPS referrals should have concluded by that date).

This response will only be allowed on service contacts with the !ATAPS flag.

---

#### 5.4.169. Sites

The sites at which an Organisation provides services to clients.

**Field name:** sites

**Data type:** string

**Required:** no

**Domain:** Multiple comma separated values allowed

**Notes:** Site names are case sensitive and each site name must have between 2-50 valid unicode characters excluding commas (,). Names must start with A-Za-z0-9 (POSIX :alnum:).

May be left blank if the organisation only has one site.

Multiple site fields can be defined by comma separating each site name. For example:

"Orange County, Deep Creek, Northern Side of the River"

In order to ensure consistency of data, site names cannot be deleted via upload, only data entry. An example of how uploads will process the sites field is, if "Orange County, Deep Creek" is uploaded first and then "Orange County, Northern Side of the River" is uploaded second, they would be merged and the PMHC MDS would store "Orange County, Deep Creek, Northern Side of the River".

Please refer to [Organisation](#) for validations relating to this field.

---

#### 5.4.170. 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).

**METEOR:**[386449](#)

---

### 5.4.171. 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.

The end-of-day flag "24:00" may be used as a missing time value for any existing Service Contacts that have previously been added to the MDS without a start time. See [Service Contact](#) for rules on how the end-of-day value may be used.

---

### 5.4.172. State

The state that the provider organisation operates in.

**Field name:**organisation\_state

**Data type:**string



**Required:**yes

**Domain:** 1:New South Wales

2:Victoria

3:Queensland

4:South Australia

5:Western Australia

6:Tasmania

7:Northern Territory

8:Australian Capital Territory

9:Other Territories

**Notes:**Name is taken from Australian [Statistical Geography Standard \(ASGS\) July 2011](#).

- Code is from Meteor with the addition of code for Other Territories.

**METEOR:**[613718](#)

---

### 5.4.173. Statistical Linkage Key

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

**Field name:**slk

**Data type:**string (14,40)

**Required:**yes

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

**Supported formats:**14 character [SLK](#)

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

SLK values are stored in sha1\_hex format.

**METEOR:**[349510](#)

---

### 5.4.174. Suicide Referral Flag

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

**Field name:**suicide\_referral\_flag

**Data type:**string

**Required:**yes

**Domain:** 1:Yes

2:No

9:Unknown

**Notes:**Where there is a linked intake and treatment, both the Intake and Episode records must use the same suicide referral flag.

---

### 5.4.175. Value

The metadata value.

**Field name:**value

**Data type:**string

**Required:**yes

**Notes:**Please refer to [Metadata file](#) for an example of the metadata file/worksheet that must be used with this specification.

---

### 5.4.176. Venue

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

**Field name:**service\_contact\_venue

**Data type:**string

**Required:**yes

**Domain:** 1:Client's Home

2:Service provider's office

3:GP Practice

4:Other medical practice

5:Headspace Centre

6:Other primary care setting

7:Public or private hospital

8:Residential aged care facility

9:School or other educational centre

10:Client's Workplace

11:Other

12:Aged care centre - non-residential

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

99:Not stated

**Notes:**Note that this data item concerns only where the service contact took place. It is not about where the client lives. Thus, if a resident of an aged care residential facility is seen at another venue (e.g., at a GP Clinic), then the Service Contact Venue should be recorded as 'GP Practice' (code 3) to accurately reflect where the contact took place.

Values other than '98 - Not applicable' only to be specified when Service Contact Modality is 'Face to Face'.

**6 - Other primary care setting**This code is suitable for primary care settings such as community health centres.

**8 - Residential aged care facility**Use this code when the client is seen at an aged care residential facility.

**12 - Aged care centre - non-residential**Use this code when the client is seen at a non-residential aged care centre (e.g., community day program centre for older people).

**98 - Not applicable (Service Contact Modality is not face to face)**This code must only to be used where the Service Contact Modality is not face to face

All other data items would be recorded as per the guidelines that apply to those items – there are no special requirements specific to delivery of services to residents of aged care facilities. For example, any of the episode of care types recorded under the Principal Focus of Treatment Plan may apply; similarly, service contacts delivered to aged care residents may be any of the options available in Service Contact Type field.

---

## 5.4.177. Year of Birth

The year the practitioner was born.

**Field name:**practitioner\_year\_of\_birth

**Data type:**gYear

**Required:**yes

**Domain:**gYear

**Notes:**The year of birth must not be in the future.

- The year of birth must be after 1900.
- If the year of birth is unknown, the following approaches should be used:
  - If the age of the practitioner is known, the age should be used to derive the year of birth
  - If the age of the practitioner is unknown, an estimated age of the practitioner should be used to estimate a year of birth
  - If the date of birth is totally unknown, use 9999.

---

## 5.5. Download Specification Files

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

- [Specification zip](#)

These files conform to the CSV on the Web (CSVW) standard that is defined at <https://csvw.org/>.

They are used:

- to generate the [Record formats](#) and [Definitions](#) sections of the data specification documentation
- in the first pass of upload validations

## 6. Upload specification

Files can be uploaded to the PMHC MDS manually via the web interface at <https://pmhc-mds.net/> or by using the API which is available at <https://api.pmhc-mds.net/>.

### 6.1. File requirements

Uploads will be rejected by our incoming data scanning system if they do not meet the following requirements:

- Must be either an [Excel Workbook \(.xlsx\)](#),
- OR a [zip \(.zip\) file containing CSV files](#),
- AND must be [less than 512MB](#)

#### 6.1.1. Excel Workbook (XLSX)

Excel files must be in XLSX format. Excel 2007 (v12.0) and above support this file format.

One XLSX file must be uploaded containing multiple worksheets - one worksheet for each format described [below](#).

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

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

#### 6.1.2. Zip file containing Comma Separated Values (CSV)

The CSV files must conform to [RFC 4180](#).

In addition, CSV files must be created using UTF-8 character encoding.

CSV files must have the file extension .csv

Multiple CSV files must be uploaded - one CSV file for each format described [below](#).

The CSV files must be compressed into a single file by zipping before upload. The filename of the zip file doesn't matter as long as it has the file extension .zip

#### 6.1.3. File size

Files must be less than 512MB. The file size restriction prevents our systems from becoming unstable if extremely large files are uploaded. We will monitor if this limit causes issues for anyone and adjust it if necessary.

## 6.2. Files or worksheets to upload

Version 4 allows for different files/worksheets to be uploaded depending on whether the organisation is an Intake team, Treatment Service Provider or a combined Intake/Treatment Service Provider. Please refer to [Contexts](#) for further information about these contexts.

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

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

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

*Table 6.1 Summary of files to upload in Intake context*

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

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

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

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

*Table 6.2 Summary of files to upload in Treatment Service Provider context*

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

File Type	CSV filename	Excel worksheet name	Required
Service Contacts	service-contacts.csv	Service Contacts	Required
Service Contact Practitioners	service-contact-practitioners.csv	Service Contact Practitioners	Required
Collection Occasions	collection-occasions.csv	Collection Occasions	Required
K10+ Measures	k10p.csv	K10+	Required
K5 Measures	k5.csv	K5	Required
SDQ Measures	sdq.csv	SDQ	Required
Practitioners	practitioners.csv	Practitioners	Required for first upload and when practitioner information changes. Optional otherwise
Organisations	organisations.csv	Organisations	Optional, may only be included if the user has Organisation Management Role
Metadata	metadata.csv	Metadata	Required

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

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

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

*Table 6.3 Summary of files to upload in Combined Intake/Treatment Service Provider context*

File Type	CSV filename	Excel worksheet name	Required
Clients	clients.csv	Clients	Required
Intakes	intakes.csv	Intakes	Required
IAR-DST Measures	iar-dst.csv	IAR-DST	Required
Intake Episodes	intake-episodes.csv	Intake Episodes	Required
Episodes	episodes.csv	Episodes	Required
Service Contacts	service-contacts.csv	Service Contacts	Required
Service Contact Practitioners	service-contact-practitioners.csv	Service Contact Practitioners	Required
Collection Occasions	collection-occasions.csv	Collection Occasions	Required

File Type	CSV filename	Excel worksheet name	Required
<a href="#">K10+ Measures</a>	k10p.csv	K10+	Required
<a href="#">K5 Measures</a>	k5.csv	K5	Required
<a href="#">SDQ Measures</a>	sdq.csv	SDQ	Required
<a href="#">Practitioners</a>	practitioners.csv	Practitioners	Required for first upload and when practitioner information changes. Optional otherwise
<a href="#">Organisations</a>	organisations.csv	Organisations	Optional, may only be included if the user has Organisation Management Role
<a href="#">Metadata</a>	metadata.csv	Metadata	Required

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

### 6.3. File format

Requirements for file formats:

- The first row must contain the column headings as defined for each file type.
- Data elements for each file/worksheet are defined at [Record formats](#).
- Each item is a column in the file/worksheet. The 'Field Name' as defined in [Record formats](#) must be used for the column headings. The columns must be kept in the same order.
- The second and subsequent rows must contain the data.
- All files must be internally consistent. An example of what this means is that for every row in the episode file/worksheet, there must be a corresponding client in the client file/worksheet.
- For data elements that allow multiple values, each value should be separated by a space; for example: 1 3 6.
- All version 4.0 data uploads must include a Metadata file/worksheet. See [Metadata file](#).

#### 6.3.1. Metadata file

All version 4.0 data uploads must include a Metadata file/worksheet. - In the first row, the first cell must contain 'key' and the second cell must contain 'value' - In the second row, the first cell must contain 'type' and the second cell must contain 'PMHC' - In the third row, the first cell must contain 'version' and the second cell must contain '4.0'

i.e.:

key	value
type	PMHC
version	4.0



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

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

### **6.3.2. Organisation file format**

This file is for PHN use only. The organisation file/worksheet is optional. It can be included to upload Provider Organisations in bulk or if there is a change in Provider Organisation details. There is no harm in including it in every upload.

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

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

### **6.3.3. Client format**

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

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

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

### **6.3.4. Intake format**

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

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

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

### **6.3.5. IAR-DST format**

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

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

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

### **6.3.6. Intake Episode format**

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

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

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

### **6.3.7. Episode file format**

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

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

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

### **6.3.8. Service Contact file format**

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

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

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

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

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

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

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

### **6.3.10. Collection Occasion file format**

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

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

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

### **6.3.11. K10+ file format**

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

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

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

### **6.3.12. K5 file format**

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

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

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

### **6.3.13. SDQ file format**

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

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

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

### **6.3.14. Practitioner file format**

The practitioner file/worksheet is required for the first upload and if there is a change in practitioners. It is optional otherwise. There is no harm in including it in every upload.

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

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

## 6.4. Example Upload files

Each of the example files assumes the following organisation structure:

Organisation Key	Organisation Name	Organisation Type	Parent Organisation
PHN999	Test PHN	Primary Health Network	None
PHN999:IntakeTreatment01	Example Combined Intake/ Treatment Organisation	Private Allied Health Professional Practice	PHN999
PHN999:Treatment01	Example Treatment Organisation	Private Allied Health Professional Practice	PHN999
PHN999:Intake01	Example Intake Organisation	Other	PHN999

*Table 6.4 Summary of example upload files*

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

## 6.5. Deleting records

All records except for Organisation records can be deleted via upload. Please email [support@pmhc-mds.com](mailto:support@pmhc-mds.com) if you need to delete an organisation.

- An extra optional "delete" column can be added to each of the supported upload files/worksheets.
- If included, this column must be the third column in each file, after the organisation path and the record's entity key.
- To delete a record, include its organisation path and its entity key, leave all other fields blank and put "delete" in the "delete" column. Please note that case is important. "DELETE" will not be accepted.
- Marking a record as deleted will require all child records of that record also to be marked for deletion. For example, marking a client as deleted will require all episodes, service contacts and collection occasions of that client to be marked for deletion.
- While deletions can be included in the same upload as insertions/updates, we recommend that you include all deletions in a separate upload that is uploaded before the insertions/updates.

Example files showing how to delete via upload:

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

## 6.6. Frequently Asked Questions

Please also refer to [Uploading data](#) for answers to frequently asked questions about uploading data.

## 7. Data item summary

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	Episode
Key	Organisation Path	Organisation Path	Organisation Path	Organisation Path	Episode Organisation Path	Organisation Path
Value	Organisation Key	Practitioner Key	Client Key	Intake Key	Episode Key	Episode Key
	Name	Practitioner Category	Statistical Linkage Key	Client Key	Intake Organisation Path	Client Key
	Legal Name	ATSI Cultural Training	Date of Birth	Client Consent to Anonymised Data	Intake Key	Episode End Date
	ABN	Year of Birth	Estimated Date of Birth Flag	Referral Date		Client Consent to Anonymised Data
	Organisation Type	Practitioner Gender	Client Gender	Program Type		Episode Completion Status
	State	Practitioner Aboriginal and Torres Strait Islander Status	Aboriginal and Torres Strait Islander Status	Referrer Profession		Referral Date
	Organisation Start Date	Active	Country of Birth	Referrer Organisation Type		Program Type
	Organisation End Date	Practitioner Tags	Main Language Spoken at Home	Date client contacted Intake		Principal Focus of Treatment Plan
	Sites		Proficiency in Spoken English	Suicide Referral Flag		GP Mental Health Treatment Plan Flag
	Organisation Tags		Client Tags	Date referred to other service at Intake conclusion		Homelessness Flag
				Organisation type referred to at Intake conclusion		Area of usual residence, postcode
				Referred to Organisation Path		Labour Force Status

Metadata	Provider Organisation	Practitioner	Client	Intake	Intake Episode	Episode
				Intake Tags		Employment Participation
						Source of Ca Income
						Health Care
						NDIS Particip
						Marital Statu
						Suicide Refer Flag
						Principal Diagnosis
						Additional Diagnosis
						Medication - Antipsychoti (N05A)
						Medication - Anxiolytics (N05B)
						Medication - Hypnotics and sedatives (N05C)
						Medication - Antidepressa (N06A)
						Medication - Psychostimu and nootropi (N06B)
						Referrer Profession
						Referrer Organisation Type
						Organisation type referred at Episode conclusion
						Episode Tags





<b>Metadata</b>	<b>Provider Organisation</b>	<b>Practitioner</b>	<b>Client</b>	<b>Intake</b>	<b>Intake Episode</b>	<b>Episode</b>

## 8. Using the data specification to create client forms

Some consideration needs to be taken when designing forms based on this data specification.

### 8.1. Not stated/missing codes

Not stated/missing codes (normally code 9, 99, 999 or 9999) are not to be available as a valid answers to questions but is intended for use:

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

### 8.2. Country of Birth

[Country of Birth](#) has a large permitted domain. It is not feasible to provide all allowed responses on a form. The Australian Bureau of Statistics recommends two standard question modules for Country of Birth:

- [Detailed question module](#)
- [Short question module](#)

#### 8.2.1. Detailed question module

The detailed question module is the recommended module for Country of Birth. An example is:

```
Q. In which country [were you][was the person] born?

Australia      q
England        q
New Zealand    q
India           q
Italy           q
Vietnam        q
Philippines    q
South Africa   q
Scotland       q
Malaysia        q
Other - Please specify.....
```

Form designers do not need to use the countries shown in this example. They should choose countries relevant to the population for their region. The "Other" response can then be mapped to a [Country of Birth](#) during data entry.

## 8.2.2. Short question module

The short question module can be used where there are space constraints. An example is:

Q. In which country [were you][was the person] born?

Australia      q  
Other - please specify.....

The "Other" response can then be mapped to a country code during data entry. This form has higher overheads as each response will need to be matched to a [Country of Birth](#) during data entry.

## 8.3. Main Language Spoken at Home

[Main Language Spoken at Home](#) has a large permitted domain. It is not feasible to provide all allowed responses on a form. The Australian Bureau of Statistics recommends two standard question modules for Main Language Spoken at Home:

- [Detailed question module](#)
- [Short question module](#)

### 8.3.1. Detailed question module

The detailed question module is the recommended module for Main Language Spoken at Home. An example is:

Q. [Do you][Does the person] speak a language other than English at home?  
(If more than one language, indicate the one that is spoken most often.)

No, English      q  
Yes, Mandarin      q  
Yes, Italian      q  
Yes, Arabic      q  
Yes, Cantonese      q  
Yes, Greek      q  
Yes, Vietnamese      q  
Yes, Spanish      q  
Yes, Hindi      q  
Yes, Tagalog      q  
Yes, Other - Please Specify.....

For self enumerated questionnaires, respondents should be instructed to mark one box only.

Form designers do not need to use the languages shown in this example. They should choose languages relevant to the population for their region. The "Other" response can then be mapped to a [Main Language Spoken at Home](#) during data entry.

### 8.3.2. Short question module

The short question module can be used where there are space constraints. An example is:

Q. [Do you] [Does the person] speak a language other than English at home?

No, English only      q

Yes, Other - please specify.....

The "Other" response can then be mapped to a country code during data entry. This form has higher overheads as each response will need to be matched to a [Main Language Spoken at Home](#) during data entry.

## 9. Validation Rules

This document defines validation rules between items and record types. The domain of individual items is defined in [Record formats](#).

### 9.1. Current Validations

#### 9.1.1. Keys

The following rules apply to the key fields in all records:

1. All key fields are case sensitive
2. All key fields must be valid unicode characters

#### 9.1.2. Practitioner

1. Refer to [Keys](#) for Practitioner Key validations
2. [ATSI Cultural Training](#) must only be set to '3 - Not required' where [Practitioner Aboriginal and Torres Strait Islander Status](#) is one of
  - '1: Aboriginal but not Torres Strait Islander origin'
  - '2: Torres Strait Islander but not Aboriginal origin'
  - '3: Both Aboriginal and Torres Strait Islander origin'

or

The organisation to which the practitioner belongs has [Organisation Type](#) set to '8: Aboriginal Health/Medical Service'

3. [Year of Birth](#) must not be before 1 January 1900 and must not be in the future

#### 9.1.3. Client

1. Refer to [Keys](#) for Client Key validations
2. [Date of Birth](#) must not be before 1 January 1900 and must not be in the future

## 9.1.4. Intake

1. Refer to [Keys](#) for Intake Key validations
2. The [Date referred to other service at Intake conclusion](#) must not be before the [Date client contacted Intake](#)
3. [Referrer Organisation Type](#) must be set to '98: N/A - Self referral' if and only if [Referrer Profession](#) is also '98: N/A - Self referral'
4. A maximum of one intake that is NOT [concluded](#) shall be allowed per client
5. The [Referral Date](#)
  - must not be before 1 January 2020
  - and must not be after [Organisation End Date](#)
  - and must not be in the future
6. The [Date client contacted Intake](#)
  - must not be before 1 January 2020
  - and must not be before [Provider Organisation - Start Date](#)
  - and must not be after [Provider Organisation - End Date](#)
  - and must not be in the future
7. The [Date referred to other service at Intake conclusion](#)
  - must not be before 1 January 2020
  - and must not be before [Provider Organisation - Start Date](#)
  - and must not be after [Provider Organisation - End Date](#)
  - and must not be in the future
8. If a [Referred to Organisation Path](#) is specified, that organisation must be an existing organisation within the PMHC MDS
9. [Organisation type referred to at Intake conclusion](#) will be validated as follows:
  1. If [Organisation type referred to at Intake conclusion](#) is one of 97: *No Referral* or 99: *Not stated/Inadequately described*, then no other responses can be selected
  2. If [Organisation type referred to at Intake conclusion](#) is blank or 97: *No Referral*, then:
    - [Date referred to other service at Intake conclusion](#) must be blank
    - [Referred to Organisation Path](#) must be blank
  3. If [Organisation type referred to at Intake conclusion](#) contains 98: *Other*, then:
    - [Date referred to other service at Intake conclusion](#) must NOT be blank
  4. If [Organisation type referred to at Intake conclusion](#) is 99: *Not stated/Inadequately described*, then:
    - [Date referred to other service at Intake conclusion](#) must NOT be blank
    - [Referred to Organisation Path](#) must be blank
  5. Any other values for [Organisation type referred to at Intake conclusion](#) require both
    - [Date referred to other service at Intake conclusion](#) and
    - [Referred to Organisation Path](#)

### 9.1.5. IAR-DST

1. Refer to [Keys](#) for Measure Key validations
2. [Intake Key](#) must be an existing Intake within the PMHC MDS
3. Both all 8 domains and the level of care must be provided
4. The [IAR-DST - Recommended Level of Care](#) must be consistent with the 8 domain scores provided

### 9.1.6. Intake - Episode

1. If a [Intake Organisation Path](#) is specified, that organisation must be an existing organisation within the PMHC MDS
2. If an [Intake Key](#) is specified, a [Intake Organisation Path](#) must also be specified
3. If an [Episode Organisation Path](#) is specified, that organisation must be an existing organisation within the PMHC MDS
4. [Episode Key](#) must be an existing PMHC episode within the PMHC MDS

**Note:** Intake Episode records can be submitted independently of Intake records. The PMHC MDS does not validate that the [Intake Key](#) referenced in an Intake Episode record exists, only that the [Intake Organisation Path](#) exists.



## 9.1.7. Episode

1. Refer to [Keys](#) for Episode Key validations
2. The [Episode End Date](#) must not be before the [Referral Date](#)
3. [Referrer Organisation Type](#) must be set to '98: N/A - Self referral' if and only if [Referrer Profession](#) is also '98: N/A - Self referral'
4. A maximum of one episode shall be [open](#) per client
5. [Open episodes](#) must NOT have a response to both [Episode End Date](#) and [Organisation type referred to at Episode conclusion](#)
6. [Closed episodes](#) must have a response to both [Episode End Date](#) and [Organisation type referred to at Episode conclusion](#)
7. On [Principal Diagnosis](#) and [Additional Diagnosis](#) the values:
  - '100: Anxiety disorders (ATAPS)'
  - '200: Affective (Mood) disorders (ATAPS)'
  - '300: Substance use disorders (ATAPS)'
  - '400: Psychotic disorders (ATAPS)'

must only be used where data has been migrated from ATAPS. The above responses must only be used under the following conditions:

- The [Referral Date](#) was before 1 July 2017
  - The [Episode Tags](#) field must contain the !ATAPS flag
8. The '4: Complex care package' response for [Principal Focus of Treatment Plan](#) must only be used by selected PHN Lead Sites
  9. The !ATAPS tag must only be included in the [Episode Tags](#) field where the [Referral Date](#) was before 1 July 2017
  10. The [Episode End Date](#)
    - must not be before 1 January 2016
    - and must not be before [Organisation Start Date](#)
    - and must not be after [Organisation End Date](#)
    - and must not be in the future
  11. The [Referral Date](#)
    - must not be before 1 January 2014
    - and must not be after [Organisation End Date](#)
    - and must not be in the future
  12. [Referral Date](#) value of '09099999' cannot be used on new records.
  13. Existing records already containing a [Referral Date](#) that is not '09099999' may not be updated to '09099999'.

## 9.1.8. Service Contact

1. Refer to [Keys](#) for Service Contact Key validations
2. Where [Final Service Contact](#) is recorded as '1: No further services are planned for the client in the current episode', the [Episode Completion Status](#) must be recorded using one of the 'Episode closed' responses (Response items 1-6)
3. Where [Final Service Contact](#) is recorded as '1: No further services are planned for the client in the current episode', the date of the [Final Service Contact](#) must be recorded as the Episode End Date
4. Where an [Episode End Date](#) has been recorded, a later [Service Contact Date](#) must not be added
5. If [Service Contact Type](#) is '0: No contact took place', [No Show](#) must be '1: Yes'
6. If [Duration](#) is '0: No contact took place', [No Show](#) must be '1: Yes'
7. If [Modality](#) is '0: No contact took place', [No Show](#) must be '1: Yes'
8. If [Modality](#) is not '1: Face to Face', [Postcode](#) must be 9999
9. If [Modality](#) is '1: Face to Face', [Postcode](#) must not be 9999
10. If [Modality](#) is '1: Face to Face', [Venue](#) must not be '98: Not applicable (Service Contact Modality is not face to face)'
11. On [Service Contact Type](#) the value '98: ATAPS' must only be used where data has been migrated from ATAPS. The above response must only be used under the following conditions:
  - The [Service Contact Date](#) was before 30 June 2018
  - The [Service Contact Tags](#) field must contain the !ATAPS flag
12. If [Participants](#) is '1: Individual client' [Client Participation Indicator](#) must be '1: Yes'
13. The !ATAPS tag must only be included in the [Service Contact Tags](#) field where the [Service Contact Date](#) was before 30 June 2018
14. The [Service Contact Date](#)
  - must not be before 1 January 2016
  - and must not be before [Organisation Start Date](#)
  - and must not be after [Organisation End Date](#)
  - and must not be in the future
15. [Start Time](#) value of '24:00' cannot be used on new records.
16. Existing records already containing a [Start Time](#) that is not '24:00' may not be updated to '24:00'.
17. On [Funding Source](#) the value '27: Way Back Support Service' must only be used in conjunction with the Wayback Extension.
18. Where [Program Type](#) is recorded as '7: Supporting Recovery', [Funding Source](#) must be recorded as '73: Other Government Funding - Commonwealth: Other Commonwealth'
19. Where [Funding Source](#) is recorded as '73: Other Government Funding - Commonwealth: Other Commonwealth', [Program Type](#) must be '7: Supporting Recovery'
20. The [Service Contact Site](#)
  - When a Service Contact Site is provided, it must have between 2-50 valid unicode characters excluding commas (,)
  - When a Service Contact Site is provided, it must match a site name that is defined in [Sites](#) for the Provider Organisation providing the Service Contact

### 9.1.9. Service Contact Practitioner

1. Refer to [Keys](#) for Service Contact Practitioner Key validations
2. [Service Contact Key](#) must be an existing PMHC service contact within the PMHC MDS
3. [Practitioner Key](#) must be an existing PMHC practitioner within the PMHC MDS
4. One, and only one, Service Contact Practitioner per service contact must be flagged as the Primary Practitioner

### 9.1.10. Collection Occasion

1. Refer to [Keys](#) for Collection Occasion Key validations
2. [Episode Key](#) must be an existing PMHC episode within the PMHC MDS
3. The [Collection Occasion Date](#)
  - must not be before 1 January 2016
  - and must not be before [Episode - Referral Date](#)
  - and must not be before [Provider Organisation - Start Date](#)
  - and must not be more than 7 days after [Episode - End Date](#)
  - and must not be after [Provider Organisation - End Date](#)
  - and must not be in the future

### 9.1.11. K10+

1. Refer to [Keys](#) for Measure Key validations
2. [Collection Occasion Key](#) must be an existing Collection Occasion within the PMHC MDS
3. If both item scores and a total score are specified, the item scores must add up to the total score (as per [Scoring the K10+](#))

### 9.1.12. K5

1. Refer to [Keys](#) for Measure Key validations
2. [Collection Occasion Key](#) must be an existing Collection Occasion within the PMHC MDS.
3. If both item scores and a total score are specified, the item scores must add up to the total score (as per [Scoring the K5](#)).

### 9.1.13. SDQ

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

### 9.1.14. Organisation

1. Refer to [Keys](#) for Provider Organisation Key validations
2. The [Organisation Start Date](#)
  - must not be before 1 January 2014 or before a commissioning organisation's start date
  - and must not be after the earliest [Date client contacted Intake](#)
  - and must not be after the earliest [Date referred to other service at Intake conclusion](#)
  - and must not be after the earliest [Referral Date](#)
  - and must not be after the earliest [Service Contact Date](#)
  - and must not be after the earliest [Collection Occasion Date](#)
  - and must not be in the future
3. The [Organisation End Date](#)
  - must not be before 1 January 2014 or after a commissioning organisation's end date
  - and must not be before the latest [Date client contacted Intake](#)
  - and must not be before the latest [Date referred to other service at Intake conclusion](#)
  - and must not be before the latest [Referral Date](#)
  - and must not be before the latest [Episode End Date](#)
  - and must not be before the latest [Service Contact Date](#)
  - and must not be before the latest [Collection Occasion Date](#)
  - can be in the future
4. The [ABN](#) must adhere to the format defined by the Australian Business Register at <https://abr.business.gov.au/Help/AbnFormat>
5. The [Sites](#) fields
  - is case sensitive
  - must be blank or contain one or more comma separated site names
  - must be enclosed in double quotes (") if there is more than one site listed
  - each site name must be valid as per [Service Contact](#)
  - a site cannot be deleted if it is used on at least one service contact

## 10. Test Data Sets

### 10.1. SLK Test Data Set

We are providing the following test data to allow developers to test their implementation of the SLK specification as defined at <https://docs.pmhc-mds.com/data-specification/data-model-and-specifications.html#client-statistical-linkage-key>.

#### 10.1.1. SLK Generation Test Data

Table 10.1 Summary of files to upload

Explanation	First name	Last name	Birth Day	Birth Month	Birth Year	Gender	Expected SLK
Everything there	John	Stevens	7	6	1954	1	TEEOH070619541
Everything there, padded day and month	John	Stevens	07	06	1954	2	TEEOH070619542
A short last name	John	Bo	7	6	1954	3	O22OH070619543
A short first name	Jo	Stevens	7	6	1954	9	TEEO2070619549
No last name	John		7	6	1954	1	999OH070619541
No first name		Stevens	7	6	1954	2	TEE99070619542
No names at all			7	6	1954	3	99999070619543
No gender	John	Stevens	7	6	1954	9	TEEOH070619549
Non-alpha characters in the name	Jo,hn	St' e-vens	7	6	1954	1	TEEOH070619541
No birth day	John	Stevens		6	1954	1	
No birth month	John	Stevens	7		1954	1	
No birth year	John	Stevens	7	6		1	
Non numeric inputs for dates	John	Stevens	a	b	1997`	z	
Default date of birth	John	Stevens	9	9	9999	1	TEEOH090999991

Explanation	First name	Last name	Birth Day	Birth Month	Birth Year	Gender	Expected SLK
UTF8 character in the name	John	Amélie	7	6	1954	3	MEIOH070619543

[Download SLK Generation Test Data as CSV.](#)


### 10.1.2. SLK Validation Test Data

*Table 10.2 Summary of files to upload*

Explanation	SLK	Valid/Invalid
Every component valid	TEEOH070619541	Valid
Valid with padded 2s	O22N2070619543	Valid
Valid with unknown names	99999070619543	Valid
Too short	TEEOH07061954	Invalid
Too long	99999010119993x	Invalid
Gender not valid	99999010119935	Invalid
Invalid date	99999999999999	Invalid

[Download SLK Validation Tests as CSV.](#)

## 11. Reserved Tags

This document defines the Department reserved tags used to identify specific records types in the Primary Mental Health Care Minimum Data Set (PMHC MDS). Tags beginning with an exclamation mark (  ) are reserved for future use by the Department.

Tags field definitions for each record type are available in [Record formats](#).

### 11.1. Reserved tags currently in use


The following tags can currently be used in PMHC MDS uploads and data entry:

- [!br20 - Australian Government Mental Health Response to Bushfire](#)
- [!covid19 - Episode occurred as result of COVID-19 pandemic](#)

#### 11.1.1. !br20 - Australian Government Mental Health Response to Bushfire

PHNs in fire affected communities are funded through the *Australian Government Mental Health Response to Bushfire Trauma* to deliver services including:

- Front line emergency distress and trauma counselling, with up to 10 free mental health support sessions for individuals, families and emergency services personnel
- 'Surge capacity' mental health services to individuals and families who are affected, and
- Increased demand for headspace sites in fire affected areas.

The PMHC MDS reporting changes are designed to capture this funded service activity through the reserved Episode tag .

##### 11.1.1.1. PHNs who received funding

PHNs funded through the *Australian Government Mental Health Response to Bushfire Trauma* **must** apply the bushfire response tag to all episodes where one or more service contacts is funded by the response.

For these PHNs, the service provider should apply the bushfire response tag to:

#### **11.1.1.1.1. New clients**

- Who are accessing services funded through the *Australian Government Mental Health Response to Bushfire Trauma*
- Whose access to a mental health service was prompted by exposure to bushfire (e.g. their stated reason for approaching a service is their recent exposure to bushfire), and/or
- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. based on the judgement of the service provider).

#### **11.1.1.1.2. Existing clients**

i.e. clients with an open episode.

- Who are accessing services funded through the *Australian Government Mental Health Response to Bushfire Trauma*, and/or
- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. additional or higher intensity services are required).

#### **11.1.1.2. PHNs who did not receive funding**

PHNs who did not receive funding for *Australian Government Mental Health Response to Bushfire Trauma* activities may use the PMHC MDS reporting changes to capture the service response to bushfire trauma.

For these PHNs, the service provider should apply the bushfire response tag to:

##### **11.1.1.2.1. New clients**

- Whose access to a mental health service was prompted by exposure to bushfire (e.g. their stated reason for approaching a service is their recent exposure to bushfire), and/or
- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. based on the judgement of the service provider).

##### **11.1.1.2.2. Existing clients**

i.e. clients with an open episode.

- Whose mental health service need was significantly increased by their exposure to bushfire (e.g. additional or higher intensity services are required).

#### **11.1.1.3. How to apply the tag in the PMHC MDS Data Entry interface**

The bushfire response tag is available for use on an episode record and is denoted !br20.



There are two ways to apply the tag through the PMHC MDS data entry interface:

1. Manual data entry by typing the tag `!br20` to the Episode tag field.
  - When entering data directly, episodes will need to be tagged with the string `!br20`. The data entry system already allows for the tagging of records and therefore it is possible to implement this immediately by communicating the instructions to users.
  - Please note the free text nature of the tag system increases the opportunity for errors because it is easy to mistype a tag. This should be emphasised in communications with users.
2. Tick the box labelled 'Australian Government Mental Health Response to Bushfire'.
  - This tick box automatically adds/removes the tag when ticked/unticked. This functionality will be available by 24 January 2020.

The checkbox is on the Episode add and edit screen:

- Ticking the checkbox will add the `!br20` tag to the tag field
- Typing the `!br20` tag into the tag box will also tick the checkbox
- Unticking the `!br20` checkbox will remove the `!br20` tag
- Deleting the `!br20` tag from the tag field will also untick the checkbox

#### **11.1.1.4. Considerations for applying the !br20 tag in data uploads**

Please refer to [Considerations for applying reserved tags in data uploads](#)

#### **11.1.2. !covid19 - Episode occurred as result of COVID-19 pandemic**

The !covid19 tag was originally used for indicating that an episode occurred as a result of the COVID-19 pandemic.

It's use was then changed for the purpose of implementing the Head to Help Version 3 specification as documented at [!covid19 - Australian Government HeadtoHelp hubs](#).

When migrating data during the Version 4 rollout, NSW and Victorian pop-up clinics data was identified using the Head to Help Version 3 extension and !covid19 tag. Any historical or new records that are identified this way will be mapped to this to the 2: *Head to Health Program Type* field under the Version 4 specification.

The !covid19 tag will remain as a reserved tag for the original purpose of indicating that an episode has occurred as result of the COVID-19 pandemic once the Head to Help Version 3 extension reaches it's end of life date.

## 11.2. Reserved tags no longer in use

The following tags have previously been available to be used in PMHC MDS uploads and data entry. They still remain on existing data but must not be used for new data uploaded after their retirement date. The following information is provided for historical reference only.

Tag	Retirement Date
<a href="#">!amhc - Australian Government Mental Health Centres</a>	Week of 1st August 2022

### 11.2.1. !covid19 - Australian Government HeadtoHelp hubs

The usage for the !covid19 tag is changing when the Head to Help Version 3 specification is phased out. The ongoing use for the !covid19 tag is documented at [!covid19 - Episode occurred as result of COVID-19 pandemic](#) . The following documentation is being maintained for historical purposes.

The Australian Government is providing funding to Victorian PHNs to deliver services through HeadtoHelp hubs as part of its response to the mental health impact of COVID-19.

The department is implementing a new tag in the PMHC MDS to capture activity associated with the HeadtoHelp hubs.

This change only applies to PHNs in Victoria.

The department will introduce further data collection requirements for HeadtoHelp activity in the coming weeks and is consulting with PHNs. The Department will advise Victorian PHNs of new data collection requirements in future circular/s.

#### 11.2.1.1. New 'Australian Government HeadtoHelp hubs' tag (!covid19)

The Department has introduced an 'Australian Government HeadtoHelp hubs' tag to the PMHC MDS.

All clients who either call the 1800 HeadtoHelp number or present in person at a HeadtoHelp hub and are identified as HeadtoHelp hub clients will be assessed through the 'HeadtoHelp Victorian Mental Health Hubs Intake Assessment and Referral Model of Care' as outlined in the contract. Clients will be referred to the most suitable service, which may be at a HeadtoHelp hub.

The PHN *must* apply 'Australian Government HeadtoHelp hubs' tag (!covid19) to episodes of care initiated for clients who have been referred to the hub through the IAR process and are receiving services funded through the HeadtoHelp hubs contracts.

### 11.2.1.2. How to apply the tag in the PMHC MDS Data Entry interface

The HeadtoHelp hubs tag is available for use on an episode record and is denoted `!covid19`.

There are two ways to apply the tag through the PMHC MDS data entry interface:

1. Manual data entry by typing the tag `!covid19` to the Episode tag field.
  - When entering data directly, episodes will need to be tagged with the string `!covid19`. The data entry system already allows for the tagging of records and therefore it is possible to implement this immediately by communicating the instructions to users.
  - Please note the free text nature of the tag system increases the opportunity for errors because it is easy to mistype a tag. This should be emphasised in communications with users.
2. Tick the box labelled 'Australian Government HeadtoHelp hubs (!covid19)'.
  - This tick box automatically adds/removes the tag when ticked/unticked.

The checkbox is on the Episode add and edit screen:

- Ticking the checkbox will add the `!covid19` tag to the tag field
- Typing the `!covid19` tag into the tag box will also tick the checkbox
- Unticking the `!covid19` checkbox will remove the `!covid19` tag
- Deleting the `!covid19` tag from the tag field will also untick the checkbox

### 11.2.1.3. Considerations for applying the !covid19 tag in data uploads

Please refer to [Considerations for applying reserved tags in data uploads](#)

## 11.2.2. !amhc - Australian Government Mental Health Centres

### 11.2.2.1. Scope of new interim data collection requirements

The Australian Government is providing funding to a number of PHNs who are responsible for the operation of the AMHC trial sites.

The department is implementing a new tag in the PMHC MDS to capture activity associated with AMHCs from December 2021, until the new version 4 data model is available in March 2022.

This change only applies to the following PHNs implementing AMHCs from December 2021:

- West Victoria PHN
- Northern Territory PHN
- ACT PHN

- North Perth PHN
- Nepean Blue Mountains PHN
- North Queensland PHN
- Tasmania PHN

The department will provide further advice to these PHNs regarding new version 4 data collection requirements in a future circular. PHNs implementing AMHCs will still be expected to retrospectively update AMHC data when the version 4 data model is introduced. The department will work with PHNs and Logicy to ensure that PHNs have sufficient time to make these retrospective data updates.

#### **11.2.2.2. New 'Australian Government Adult Mental Health Centre' tag (!amhc)**

The department is introducing an 'Australian Government Adult Mental Health Centre' tag to the PMHC MDS. It will be available before December 2021.

The PHN must apply 'Australian Government Adult Mental Health Centre' tag (!amhc) to episodes of care initiated for clients who have been referred to the AMHC hub through the IAR process and are receiving services funded through the AMHC hubs contracts.

A tick box will be added to the PMHC MDS interface to simplify data entry.

#### **11.2.2.3. How to apply the tag in the PMHC MDS data entry interface**

The AMHC tag is available for use on an episode record and is denoted .

There are two ways to apply the tag through the PMHC MDS data entry interface:

1. Manual data entry by typing the tag  to the Episode tag field.
  - When entering data directly, episodes will need to be tagged with the string . The data entry system already allows for the tagging of records and therefore it is possible to implement this immediately by communicating the instructions to users.
  - Please note the free text nature of the tag system increases the opportunity for errors because it is easy to mistype a tag. This should be emphasised in communications with users.
2. Tick the box labelled 'Australian Government Adult Mental Health Centre (!amhc)'.
  - This tick box automatically adds/removes the tag when ticked/unticked.

The checkbox is on the Episode add and edit screen:

- Ticking the checkbox will add the `!amhc` tag to the tag field
- Typing the `!amhc` tag into the tag box will also tick the checkbox
- Unticking the `!amhc` checkbox will remove the `!amhc` tag
- Deleting the `!amhc` tag from the tag field will also untick the checkbox

#### **11.2.2.4. Considerations for applying the !amhc tag in data uploads**

Please refer to [Considerations for applying reserved tags in data uploads](#)

### **11.3. Considerations for applying reserved tags in data uploads**

Users of local third-party or in-house developed systems will need to address varying issues depending on the capability of the system. When considering options please be aware the PMHC MDS specification does not require that data is captured in the same manner as it is supplied during upload.

For example, an ideal solution could be to add an extensible multiple choice “Tags” field to local episode data entry screens. This could initially include an “Australian Government Mental Health Response to Bushfire” option thereby providing the organisation control over the possible tags that can be captured. By ensuring that additional options were easily added in the future such a field would support future special access programs without significant changes, as well as other purposes local or as requested by the Department.

An alternative approach, requiring less development, would be to extend an existing local field at the episode level with an “Australian Government Mental Health Response to Bushfire” option. This gives the organisation control over the values that may be selected.

In both of the above examples, development work would also be required in the data extraction process used to produce PMHC MDS compliant upload files. An endorsement of “Australian Government Mental Health Response to Bushfire” via either method would be converted to the tag `!br20` on the extracted episode records where appropriate.

An alternative but not preferred option is that episode records could be uploaded and then subsequently manually tagged via the data entry interface. This would require significant manual processes and double handling but it is a use case supported by the PMHC MDS.

If you have queries about managing data upload processes please contact the PMHC MDS helpdesk at [support@pmhc-mds.com](mailto:support@pmhc-mds.com).

## 12. Data Specification Change log

### 12.1. 6/9/2024 - Draft 4.1.0

- [Data model and specifications](#)
  - [Record formats](#)
    - [Sites](#) - Added sites field to the Organisation record to allow the sites at which an organisation provides services to clients to be specified
    - [Service Contact Site](#) - Added site field to the Service Contact record to allow the site at which a Service Contact took place to be specified