Government of **Western Australia**
Department of **Health**

Mental Health Data Collection
Data Dictionary

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Links to:	Information Management Policy Framework https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management

Contents

Abbreviations

ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
ASSIST	Alcohol, Smoking and Substance Involvement Screening Tool
AV	Audiovisual
bHCG	Beta-Human Chorionic Gonadotropin
BSL	Blood Sugar Level
BSRS	BedState Reporting System
CEO	Chief Executive Officer
CGAS	Children's Global Assessment Scale
CLMIAA	*Criminal Law Mentally Impaired Accused Act 1996*
CMHI	Central Mental Health Identifier
CRP	C-reactive Protein
CT	Computed tomography
CTO	Community Treatment Order
CXR	Chest X-Ray
FBC	Full Blood Count
FIHS	Factors Influencing Health Status
HbA1c	Haemoglobin A1c
HE	Health Employee
HIAT	Health Information Audit Team
HMDC	Hospital Morbidity Data Collection
HMDS	Hospital Morbidity Data System
HoNOS	Health of the Nation Outcome Scales
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents
ISPD	Information and System Performance Directorate
K10 / K10-L3D / K10+LM	Kessler Psychological Distress Scale
LFT	Liver Function Test
LSP	Life Skills Profile
MCS	Microscopy, Culture and Sensitivity
MHA	Mental Health Assessment
MHDC	Mental Health Data Collection
MHPoC	Mental Health Phase of Care

MIND	Mental Health Information Data Collection
MRI	Magnetic Resonance Imaging
NOCC	National Outcomes and Casemix Collection
NT	Northern Territory
PSOLIS	Psychiatric Services On-line Information System
QA	Quality Assurance
RUG-ADL	Resource Utilisation Groups – Activities of Daily Living
SDQ	Strengths and Difficulties Questionnaire
SSCD	State-wide Standardised Clinical Documentation
TFT	Thyroid Function Test
UEC	Urea Electrolytes and Creatinine
UMRN	Unit Medical Record Number
WA	Western Australia

1. Purpose

The purpose of the *Mental Health Data Collection Data Dictionary* is to detail the data elements captured in the Mental Health Data Collection (MHDC).

The *Mental Health Data Collection Data Dictionary* is a Related Document under *MP 0164/21 Patient Activity Data Policy*.

This data dictionary is to be read in conjunction with this policy and other Related Documents and Supporting Information as follows:

- *Community Mental Health Patient Activity Data Business Rules*
- *Mental Health Data Collection Data Specifications*
- *Patient Activity Data Policy Information Compendium*.

2. Background

The use of mental health data by the Department of Health is dependent on high quality data that is valid, accurate and consistent.

3. Recording of data

Data that is submitted to the MHDC must be recorded in accordance with the data definitions outlined in the following sections:

- Section 4: Client demographics
- Section 5: Inpatient services
- Section 6: Referrals
- Section 7: Alerts
- Section 8: Incidents
- Section 9: Community mental health and service contacts
- Section 10: NOCC and AMHCC clinical measures
- Section 11: Legal orders
- Section 12: Triage
- Section 13: Risk assessment and management plan
- Section 14: Child and adolescent risk assessment and management plan

4. Client demographics

The following section provides specific information about the client demographics data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections.

Where relevant, related national definitions have been referenced. The Department of Health Western Australia acknowledges the assistance of the Australian Institute of Health and Welfare (AIHW) for services provided in relation to METeOR, Australia's repository for national metadata standards for the health, community services, early childhood, homelessness and housing assistance sectors, which is owned by the AIHW.

Aboriginal Status

Field name:	pt_ethnicity_code
Source Data Element(s):	[Aboriginal Status] – PSOLIS
Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	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 nor Torres Strait Islander origin 9 – Not stated/inadequately described

Guide for use

Within WA, the term Aboriginal is generally used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal peoples are the original inhabitants of WA.

Aboriginal status is critical to health data collections throughout Australia. Historically there have been significant data quality issues with the collection of aboriginality resulting in unreliable measures of activity.

Permitted value definitions

1 – Aboriginal but not Torres Strait Islander origin

A person of Aboriginal descent who identifies as an Australian Aboriginal.

2 – Torres Strait Islander but not Aboriginal origin

A person of Torres Strait Island descent who identifies as Torres Strait Islander.

3 – Both Aboriginal and Torres Strait Islander origin

A person who identifies as both an Australian Aboriginal and Torres Strait Islander.

4 – Neither Aboriginal nor Torres Strait Islander origin

A person who does not identify as either an Australian Aboriginal, Torres Strait Islander, or both. Generally, a person who identifies under this category is considered non-indigenous. Persons of other ethnicities such as Caucasian, Afro-American, Polynesian, Asian or Indian must be recorded with a code of 4.

9 – Not stated/inadequately described

This is only to be recorded where the answer cannot be determined without clarification from the respondent; or the answer was declined; or the question was not able to be asked because the client was unable to communicate or a person who knows the client was not available.

There are three components to this definition: descent, self-identification and community acceptance. All three should be satisfied for a client to be Aboriginal. However, it is not usually possible to collect proof of descent or community acceptance in health care settings. If a client identifies as Aboriginal, assign the most appropriate code (1-3).

The following question must be asked of all clients:

"Are you (or your family member) of Aboriginal or Torres Strait Islander origin?"

In circumstances where it is impossible to ask the client directly, such as in the case of death or lack of consciousness, the question should be asked of a close relative or friend if available to do so.

Only the most current Aboriginal status is to be recorded.

Examples

	Aboriginal Status
A client native to another country (not Australia) has a service contact with the community mental health service. The client is neither an Aboriginal nor Torres Strait Islander.	4 (Neither Aboriginal nor Torres Strait Islander origin)
An Aboriginal client was transferred from Kununurra and gave his place of birth as Torres Strait. (Note: It is important to clarify whether the client wants both heritages recorded).	3 (Both Aboriginal and Torres Strait Islander origin)
If the above client does not wish to have both heritages recorded, assign the heritage as provided (Aboriginal but not Torres Strait Islander).	1 (Aboriginal but not Torres Strait Islander origin)

Related national definition

https://meteor.aihw.gov.au/content/602543

Revision history

N/A

Age of Client

Field name:	pt_age
Source Data Element(s):	[Age of Client] – PSOLIS
Definition:	The age of the client in (completed) years.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]
Permitted values:	Whole number from 0 to 130

Guide for use

This data element is a derived measure using the client's date of birth and the creation date of the client record in PSOLIS.

Age is a core data element in a wide range of social, health and demographic statistics. It is used in the analyses of service use by age group and can be used as an assistance eligibility criterion.

Examples

	Age of Client
A client with a birthdate of 1 January 2005 is activated on 10 May 2021	16
A client activated on 25 July 2021 thinks he was born in 1950	71

Related national definition

https://meteor.aihw.gov.au/content/303794

Revision history

N/A

Age on Activation

Field name:	pt_age_on_activation
Source Data Element(s):	[Age on Activation] – PSOLIS
Definition:	The age of the client in (completed) years at the date of activation.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]
Permitted values:	Whole number from 0 to 130

Guide for use

This data element is a derived measure using the client's date of birth and the date of activation.

Age is a core data element in a wide range of social, health and demographic statistics. It is used in the analyses of service use by age group and can be used as an assistance eligibility criterion.

Examples

	Age on Activation
A client with a birthdate of 1 January 2005 is activated on 10 May 2021	16
A client activated on 25 July 2021 thinks he was born in 1950	71

Related national definition

https://meteor.aihw.gov.au/content/303794

Revision history

N/A

Age on Alert

Field name:	pt_age_on_alert
Source Data Element(s):	[Age on Alert] – PSOLIS
Definition:	The age of the client in (completed) years at the date of alert.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]
Permitted values:	Whole number from 0 to 130

Guide for use

This data element is a derived measure using the client's date of birth and the date the alert was created.

Age is a core data element in a wide range of social, health and demographic statistics. It is used in the analyses of service use by age group and can be used as an assistance eligibility criterion.

Examples

	Age on Alert
A client with a birthdate of 1 May 2001 has an alert created on 10 June 2021	20
An alert is created on 12 August 2021 for a client thought to be born in 1960	61

Related national definition

https://meteor.aihw.gov.au/content/303794

Revision history

N/A

Age on Contact

Field name:	pt_age_on_contact
Source Data Element(s):	[Age on Contact] – PSOLIS
Definition:	The age of the client in (completed) years at the date of contact.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]
Permitted values:	Whole number from 0 to 130

Guide for use

This data element is a derived measure using the client's date of birth and the date of contact.

Age is a core data element in a wide range of social, health and demographic statistics. It is used in the analyses of service use by age group and can be used as an assistance eligibility criterion.

Examples

	Age on Contact
A client with a birthdate of 1 January 2005 is contacted on 10 May 2021	16
A client contacted on 25 July 2021 thinks he was born in 1950	71

Related national definition

https://meteor.aihw.gov.au/content/303794

Revision history

N/A

Age on Incident

Field name:	pt_age_on_incident
Source Data Element(s):	[Age on Incident] – PSOLIS
Definition:	The age of the client in (completed) years at the date of incident.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]
Permitted values:	Whole number from 0 to 130

Guide for use

This data element is a derived measure using the client's date of birth and the date of the incident.

Age is a core data element in a wide range of social, health and demographic statistics. It is used in the analyses of service use by age group and can be used as an assistance eligibility criterion.

Examples

	Age on Incident
A client born on 1 May 2003 has an incident created on 10 June 2021	18
A client with an incident created on 25 July 2021 thinks he was born in 1950	71

Related national definition

https://meteor.aihw.gov.au/content/303794

Revision history

N/A

Age on Referral

Field name:	pt_age_on_referral
Source Data Element(s):	[Age on Referral] – PSOLIS
Definition:	The age of the client in (completed) years at the date of referral.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]
Permitted values:	Whole number from 0 to 130

Guide for use

This data element is a derived measure using the client's date of birth and the date of referral.

Age is a core data element in a wide range of social, health and demographic statistics. It is used in the analyses of service use by age group and can be used as an assistance eligibility criterion.

Examples

	Age on Referral
A client with a birthdate of 1 January 2005 is referred on 10 May 2021	16
A client referred on 25 July 2021 thinks he was born in 1950	71

Related national definition

https://meteor.aihw.gov.au/content/303794

Revision history

N/A

Arrival Year

Field name:	pt_arrival_year
Source Data Element(s):	[Arrival Year] – PSOLIS
Definition:	The year a client (born outside of Australia) first arrived in Australia, from another country, with the intention of staying in Australia for one year or more.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY
Permitted values:	Valid year greater than 1900

Guide for use

Collection of this data element is conditional – if a client was born outside of Australia then arrival year is a mandatory data element.

The arrival year is the actual year of arrival in Australia.

For most clients this will be the year of their only arrival in Australia.

Some clients may have multiple arrivals in Australia. In such cases the year of first arrival only must be used.

Examples

	Arrival Year
A client born in Argentina arrived in Australia in 2007	2007
A client born in England arrived in Australia in 1998 then again in 2002	1998

Related national definition

https://meteor.aihw.gov.au/content/269929

Revision history

N/A

Australian Postcode

Field name:	pt_residential_postcode
Source Data Element(s):	[Australian Postcode] – PSOLIS
Definition:	The Australian numeric descriptor for a postal delivery area for an address. The postcode relates to the patient's area of usual residence.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNNN
Permitted values:	Valid Australian postcode

Guide for use

Australian postcode may be used in the analysis of data on a geographical basis.

Australian residential addresses must include a valid postcode.

Where 'no fixed address' has been entered in line one of the address and the suburb has been entered as 'unknown' then postcode 6999 representing WA must be used.

Examples

	Australian Postcode
A client's address is 188 Fourth Avenue, Mount Lawley, WA 6050	6050
A client has no fixed address	6999

Related national definition

https://meteor.aihw.gov.au/content/611398

Revision history

N/A

Australian State or Country of Birth

Field name:	pt_country_of_birth_code
Source Data Element(s):	[Australian State or Country of Birth] – PSOLIS
Definition:	The Australian state or country in which a person was born, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNNN
Permitted values:	As per the Standard Australian Classification of Countries 2016 (SACC 2016)

Guide for use

This code list is aligned with Standard Australian Classification of Countries, 2016, with additional codes to allow the collection of the Australian state of birth.

If the client is born overseas indicate country of birth, e.g. Italy, Peru, England, or Wales.

If the client is born in an Australian Territory other than the Australian Capital Territory (ACT) or Northern Territory (NT) (e.g. Christmas Island, Cocos (Keeling) Islands), enter code (1199) Australian External Territories, nec.

If the client is born on a ship or aircraft, indicate country of citizenship.

The code Not Stated (0003) should only be used where this information is not available.

'Australia' should only be used when the Australian state of birth is not known for a person born in Australia.

Examples

Client born:	Country of Birth
In Western Australia	1101
In Australia (not otherwise specified)	1101
In Tokyo	6201
At sea but eligible for Polish citizenship	3307
On Christmas Island	1199

Related national definition

https://meteor.aihw.gov.au/content/659454

Revision history

N/A

Client Identifier

Field name:	pt_identifier_raw
Source Data Element(s):	[Client Identifier] – PSOLIS
Definition:	The PSOLIS unique identifier for each mental health client.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNNNNNNNNN
Permitted values:	Unique numeric identifier

Guide for use

This data element is the unique number assigned to each client created in PSOLIS.

The number is identified in PSOLIS as the central mental health identifier (CMHI).

The CMHI is system generated to prevent duplicates.

Examples

	CMHI
A new client's details are entered in PSOLIS	1068052503

Related national definition

https://meteor.aihw.gov.au/content/290046

Revision history

N/A

Country of Residence

Field name:	pt_country_of_residence_code
Source Data Element(s):	[Country of Residence] – PSOLIS
Definition:	The country in which a person usually resides, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNNN
Permitted values:	As per the Standard Australian Classification of Countries 2016 (SACC 2016)

Guide for use

This data element is aligned with Standard Australian Classification of Countries, 2016.

If the client usually resides overseas indicate country of residence, e.g. Italy, France, England, Scotland, or Wales.

Examples

Client usually resides:	Country of Residence
In Western Australia	1101
In Australia (not otherwise specified)	1101
In Spain	3108
In Victoria	1101
On Christmas Island	1199

Related national definition

https://meteor.aihw.gov.au/content/666397

Revision history

N/A

Date of Birth

Field name:	pt_date_of_birth
Source Data Element(s):	[Date of Birth] – PSOLIS
Definition:	Date on which a client was born.
Requirement status:	Mandatory
Data type:	Datetime
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Date of Birth is used to derive the age of a person for use in demographic analysis. It also assists in the unique identification of individuals if other identifying information is missing or in question and may be required for the derivation of other metadata items.

It is important to be as accurate as possible when completing the date of birth.

It is recognised that some clients do not know their exact date of birth.

If the date of birth is not known or cannot be obtained, provision must be made to collect or estimate age.

Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years.

A date of birth indicator data element must also be reported in conjunction with all estimated dates of birth.

Examples

	Date of Birth
Client born on 12th June 1980	12061980
Client activated on 15th November 2020 and estimated age is 75 years	01071945
Client activated on 24th September 2018 and estimated age is 30 years	01071988

Related national definition

https://meteor.aihw.gov.au/content/287007

Revision history

N/A

Date of Birth Indicator

Field name:	pt_date_of_birth_indicator
Source Data Element(s):	[Date of Birth Indicator] – PSOLIS
Definition:	An indicator of whether any component of a client's date of birth was estimated.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes Null

Guide for use

Collection of this data element is conditional – if any part of a client's date of birth represents an estimate rather than the actual or known date then date of birth indicator is a mandatory data element.

The date of birth indicator is reported in conjunction with the date of birth data element.

The 'Estimate' check box must be selected if the date of birth or age is estimated.

Examples

Client episode activated on 1 June 2015:	Date of Birth	Date of Birth Indicator
Estimated age 50 years	01071965	1 (estimate = yes)

Related national definition

https://meteor.aihw.gov.au/content/329314

Revision history

N/A

Date of Death

Field name:	pt_date_of_death
Source Data Element(s):	[Date of Death] – PSOLIS
Definition:	Client's date of death.
Requirement status:	Conditional
Data type:	Datetime
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

Collection of this data element is conditional – if the client has died then date of death is a mandatory data element.

Examples

Client died on:	Date of Death
8th February 2010	08022010

Related national definition

https://meteor.aihw.gov.au/content/646025

Revision history

N/A

Employment Status

Field name:	pt_employment_status_code
Source Data Element(s):	[Employment Status] – PSOLIS
Definition:	The self-reported employment status of a client at the time of the service event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Child not at school 2 – Student 3 – Employed 4 – Unemployed 5 – Home duties 6 – Retired 7 – Pensioner 8 – Other

Guide for use

Employment status is a key factor explaining health differentials in the Australian population. The identification of groups of concern requires the recording of indicators of socioeconomic status, with the highest priority indicator being employment status.

Examples

	Employment Status
A 14-year-old, attending school	2 – Student
A 16-year-old child, not attending school and not employed	4 – Unemployed

Related national definition

N/A

Revision history

N/A

Family Name

Field name:	pt_name_surname
Source Data Element(s):	[Family Name] – PSOLIS
Definition:	The part of a name a client usually has in common with other members of their family, as distinguished from their given names.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(49)]
Permitted values:	Alpha characters only

Guide for use

Family name is a 50-character alphabetical field in which dots, dashes, apostrophes and hyphens are allowed.

Family name must be recorded as follows:

- Alias or assumed names must not be included if the legal family name is known.
- The use of parentheses ( ) for alias names in the family name must not be recorded.
- Where the family name is unknown or there is no family name, ‘Unknown’ must be recorded in the family name field and the other name fields left blank.
- Numeric values are not permitted.

Examples

	Family Name
A client’s full name is John-Paul D’Arcy O’Rourke	O’Rourke
A client seeking a referral refuses to provide his name/s.	Unknown

Related national definition

https://meteor.aihw.gov.au/content/613331

Revision history

N/A

First Given Name

Field name:	pt_name_first
Source Data Element(s):	[First Given Name] – PSOLIS
Definition:	The first given name of the client.
Requirement status:	Conditional
Data type:	String
Format:	X[X(49)]
Permitted values:	Alpha characters only

Guide for use

Collection of this data element is conditional – if the client has a first or given name then this data element is mandatory.

First given name is a 50-character alphabetical field in which dots, dashes, apostrophes and hyphens are allowed.

The first given name, if the client has one, must be recorded as follows:

- Alias or assumed names must not be included if the legal first given name is known.
- The use of parentheses ( ) for alias names in the first given name are not to be recorded.
- Numeric values are not permitted.

Examples

	First Given Name
A client's full name is John-Paul D'Arcy O'Rourke	John-Paul

Related national definition

https://meteor.aihw.gov.au/content/613342

Revision history

N/A

Interpreter Required

Field name:	pt_interpreter_required
Source Data Element(s):	[Interpreter Required] – PSOLIS
Definition:	Whether an interpreter service is required by or for the client.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Yes 2 – No 9 – Not stated/inadequately described

Guide for use

Includes verbal language, non-verbal language and languages other than English.

Code 1 (Yes) where interpreter services are required.

Code 2 (No) where interpreter services are not required.

Persons requiring interpreter services for any form of sign language or other forms of non-verbal communication must be coded as 'Yes', interpreter service required.

Examples

	Interpreter Required
A Spanish-speaking client has difficulty understanding English	1 – Yes
A client has occasional hearing difficulties	1 – Yes

Related national definition

https://meteor.aihw.gov.au/content/639616

Revision history

N/A

Marital Status

Field name:	pt_marital_status_code
Source Data Element(s):	[Marital Status] – PSOLIS
Definition:	The client'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.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Never Married 2 – Widowed 3 – Divorced 4 – Separated 5 – Married 6 – Unknown

Guide for use

The category '2 – Married' applies to registered unions and de facto relationships, including same sex couples.

Where a client's marital status has not been specified and the client is a minor (16 years of age or less), assign '3 – Never married' as a default.

Examples

	Marital Status
A client was in a de facto relationship which has now ended	5 – Separated
A 16-year-old client has had a boyfriend for two years	3 – Never married

Related national definition

https://meteor.aihw.gov.au/content/766507

Revision history

N/A

Preferred Language

Field name:	pt_preferred_language_code
Source Data Element(s):	[Preferred Language] – PSOLIS
Definition:	The language most preferred by the person for communication.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N[NNN]
Permitted values:	As per the Australian Standard Classification of Languages 2016 (ASCL 2016)

Guide for use

A client's preferred language may be a language other than English even where the person can speak fluent English.

This data element is aligned with the Australian Standard Classification of Languages, 2016.

The client's preferred language code must be selected from this classification.

Examples

	Preferred Language Code
A client's preferred language is Nyungar	8935
A client's preferred language is Russian	3402
A client's preferred language is Auslan	9701

Related national definition

https://meteor.aihw.gov.au/content/659407

Revision history

N/A

Religion

Field name:	pt_religion_code
Source Data Element(s):	[Religion] – PSOLIS
Definition:	The religious group to which a person belongs or adheres, as represented by a code.
Requirement status:	Optional
Data type:	Numeric
Format:	N[NNN]
Permitted values:	As per the Australian Standard Classification of Religious Groups 2016 (ASCRG 2016)

Guide for use

It is essential that where this question is asked, it be clearly marked as optional.

This data element is aligned with the Australian Standard Classification of Religious Groups, 2016.

The client's religion, where stated, must be a code selected from this classification.

Examples

	Preferred Language Code
A client's religion is Lutheran	2171
A client adheres to an Australian Aboriginal traditional religion	6011
A client has no religion	7101

Related national definition

https://meteor.aihw.gov.au/content/493242

Revision history

N/A

Residential Address

Field name:	pt_residential_address
Source Data Element(s):	[Residential Address] – PSOLIS
Definition:	The house number, street name and street type of the client's place of usual residence.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(254)]
Permitted values:	Alphanumeric combination

Guide for use

Every effort must be made to collect the client's actual residential address.

Under activity based funding the client's physical address may play an important role in funding calculations.

The address must be the physical location where the client resides.

A residential address is a house number, street name and street type and must be on the first of two address lines. Suburb must be recorded on another line.

Non-residential addresses for accounts or billing purposes (e.g. PO Boxes) are not acceptable as residential addresses.

Enter only a client's physical location where they reside as the address.

If a client resides in a nursing home, hostel, or community residential facility, the name of the facility must be included as part of the address information.

Where appropriate 'no fixed address' must be entered in line one of the address and the suburb must be entered as 'unknown' with postcode 6999 representing WA.

Examples

Client address is:	Address Line 1	Address Line 2
Flat 3, 188 Fourth Avenue, Mount Lawley, WA	Flat 3	188 Fourth Avenue
Rose Village, 1144 Ord Street, Bicton, WA	Rose Village	1144 Ord Street

Related national definition

https://meteor.aihw.gov.au/content/611149

Revision history

N/A

Second Given Name

Field name:	pt_name_middle
Source Data Element(s):	[Second Given Name] – PSOLIS
Definition:	The second given name of the client.
Requirement status:	Conditional
Data type:	String
Format:	X[X(49)]
Permitted values:	Alpha characters only

Guide for use

Collection of this data element is conditional – if the client has a second given name then this data element is mandatory.

Second given name is a 50-character alphabetical field in which dots, dashes, apostrophes and hyphens are allowed.

The second given name, if the client has one, must be recorded as follows:

- Alias or assumed names must not be included if the legal second given name is known.
- The use of parentheses ( ) for alias names in the second given name are not to be recorded.
- Numeric values are not permitted.

Examples

	Second Given Name
A client's full name is John-Paul D'Arcy O'Rourke	D'Arcy

Related national definition

https://meteor.aihw.gov.au/content/613331

Revision history

N/A

Sex

Field name:	pt_sex_code
Source Data Element(s):	[Sex] – PSOLIS
Definition:	A person's sex. Sex is understood in relation to sex characteristics, such as chromosomes, hormones and reproductive organs.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Male 2 – Female 3 – Another term 9 – Not stated/inadequately described

Guide for use

Sex is often used interchangeably with gender, however they are distinct concepts and it is important to differentiate between them.

When comparing the concepts of sex and gender:

- Sex is understood in relation to sex characteristics.
- Gender is about social and cultural differences in identity, expression and experience.

While they are related concepts, caution should be exercised when comparing counts for sex with those for gender.

Sex is important clinical information and must be collected for all patients. Current practice is to collect sex at the time of presentation to hospital/health service.

To ensure accuracy and consistency of data collection, gender diverse patients must still report their sex. Until an additional gender field becomes available, health service providers may give consideration to their own local processes to recognise a patient's gender where it may not correlate with their recorded sex.

The use of code 3 'Another term' replaces 'Other' and 'Intersex or indeterminate' in previous versions of this code list. This option recognises that there are a range of different terms used.

The interviewer may ask whether clients not present at the interview are male or female.

Examples

	Sex
A female client is activated into a mental health service	2 (Female)
A client who has undergone a sex change from male to female	2 (Female)
A client undergoing sex reassignment from male to female and reassignment is not yet complete	1 (Male)

Related national definition

https://meteor.aihw.gov.au/content/741686

Revision history

N/A

State or Territory

Field name:	pt_residential_state
Source Data Element(s):	[State or Territory] – PSOLIS
Definition:	The state or territory of usual residence of the client, as represented by a code.
Requirement status:	Mandatory
Data type:	String
Format:	AA[A]
Permitted values:	NSW – New South Wales VIC – Victoria QLD – Queensland SA – South Australia WA – Western Australia TAS – Tasmania NT – Northern Territory ACT – Australian Capital Territory AAT – Australian Antarctic Territory

Guide for use

These Australian state/territory codes are used for addressing purposes only.

The codes are listed in the order commonly used for statistical reporting by the ABS and used in the National Standard for Australian state/territory identifier.

Examples

	State or Territory
A client's address is 188 Fourth Avenue, Mount Lawley, WA 6050	WA
A client is visiting WA but lives permanently in Hobart, Tasmania	TAS

Related national definition

https://meteor.aihw.gov.au/content/722751

Revision history

N/A

Suburb

Field name:	pt_residential_suburb
Source Data Element(s):	[Suburb] – PSOLIS
Definition:	The name of the locality/suburb of the address, as represented by text.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(254)]
Permitted values:	Valid Australian suburb

Guide for use

The suburb name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.

This data element may be used to describe the location of a person's physical address. It can be a component of a street or postal address.

Examples

	Suburb
A client's address is 188 Fourth Avenue, Mount Lawley, WA 6050	Mount Lawley

Related national definition

https://meteor.aihw.gov.au/content/429889

Revision history

N/A

Unit Medical Record Number (UMRN)

Field name:	pt_identifier
Source Data Element(s):	[UMRN] – PSOLIS
Definition:	A unique medical record number, also referred to as Unit Medical Record Number.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – if a referral is created or a client activated then the UMRN is a mandatory data element. Collection of the UMRN is optional for initial contacts.

Alternate names for the UMRN include Unique Medical Record Number (UMRN) or Unit Record Number (URN).

The same UMRN is retained by the program for the mental health client for all service contacts within a particular program.

UMRN can be alphanumeric or numeric up to a maximum of 10 characters.

The year number must not form any part of the UMRN.

Examples

	UMRN
A client is activated and assigned a UMRN of L2309999	L2309999

Related national definition

https://meteor.aihw.gov.au/content/290046

Revision history

N/A

5. Inpatient services

The following section provides specific information about the inpatient services data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Admission Date and Time

Field name:	admission_datetime
Source Data Element(s):	[Admission Date and Time] – PSOLIS
Definition:	The date and time the patient was admitted to an inpatient mental health program.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – admission date and time must be recorded if the patient is admitted to an inpatient setting.

In the admitted and community residential settings this is the actual or statistical date of admission to the mental health service.

A formal admission is the commencement of the patient's treatment within a hospital.

The formal admission may commence in a general ward or commence as a direct admission to a mental health ward (program).

A statistical admission is a process that occurs within an episode of care to capture commencement of particular change to the patient's treatment, i.e. change of care type.

Admission to an inpatient setting does not require that the client be deactivated from a community program.

The admission date visible in PSOLIS reflects the date and time the client was admitted to the mental health ward and must reflect the information entered in webPAS.

The admission date must be prior to the discharge date.

The admission date for ward transfers between mental health programs must reflect the date and time the ward transfer occurred.

Examples

	Admission Date and Time
A patient is admitted into a mental health ward on 3 May 2021 at 09:05:00.	2021-05-03 09:05:00
A patient's care type changed from acute to mental health on 1 March 2020 at 11.20am.	2020-03-01 11:20:00
A patient is ward transferred in webPAS from MH program 1 to MH program 2 on 15 November 2021 at 3.30pm. The admission to MH program 2 is manually created in PSOLIS with the admission date and time reflecting the date and time of ward transfer.	2021-11-15 15:30:00

Related national definition

https://meteor.aihw.gov.au/content/730809

Revision history

N/A

Care Type

Field name:	care_type_code
Source Data Element(s):	[Care Type] – PSOLIS
Definition:	The clinical intent and purpose of the treatment being delivered.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NN
Permitted values:	21 – Acute care 22 – Rehabilitation care 23 – Palliative care 24 – Psychogeriatric care 25 – Maintenance care 26 – Newborn 27 – Organ procurement 28 – Boarder 29 – Geriatric evaluation and management 32 – Mental health care 33 – Mental health rehabilitation

Guide for use

Permitted value definitions

21 – Acute care

Care in which the primary clinical purpose or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

Acute care excludes care which meets the definition of mental health care.

22 – Rehabilitation care

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is always:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

Rehabilitation care excludes care which meets the definition of mental health care.

23 – Palliative care

Care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- delivered under the management of or informed by a clinician with specialised expertise in palliative care, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

Palliative care excludes care which meets the definition of mental health care.

24 – Psychogeriatric care

Care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related organic brain impairment or a physical condition.

Psychogeriatric care is always:

- delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Psychogeriatric care is not applicable if the primary focus of care is acute symptom control.

Psychogeriatric care excludes care which meets the definition of mental health care.

25 – Maintenance care

Care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.

Maintenance care excludes care which meets the definition of mental health care.

26 – Newborn care

Initiated when the patient is born in hospital or is nine days old or less at the time of admission, and continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated

- patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type
- patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

27 – Organ procurement

Organ procurement is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

28 – Boarder

A boarder is a person who is receiving food and/or accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and/or care.

Boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

29 – Geriatric evaluation and management

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric evaluation and management is always:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management, and
- evidenced by an individualised multidisciplinary management plan, documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Geriatric evaluation and management excludes care which meets the definition of mental health care.

32 – Mental health care

Care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient’s mental disorder. Mental health care:

- is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;
- is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and
- may include significant psychosocial components, including family and carer support.

33 – Mental health rehabilitation

Mental health rehabilitation care type is only applicable at certain hospitals. It is used for Hospital Extended Care Service wards only, where long term non-acute mental health care is provided,

subsequent to an acute component of care. This care type is used to separate long stay per diem funded episodes from other Mental Health Care Type patients.

Care type is assigned by the clinician responsible for the management of the care, based on clinical judgements as to the primary clinical purpose of the care to be provided and, for mental health and subacute care types, the specialised expertise of the clinician who will be responsible for management of the care.

At the time of mental health or subacute care type assignment, a multidisciplinary management plan may not be in place but the intention to prepare one should be known to the clinician assigning the care type.

Only one type of care can be assigned at a time. When a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal must be assigned.

Where the primary clinical purpose or treatment goal of the patient changes, the care type is assigned by the clinician taking over responsibility for the management of the patient. In some circumstances the patient may continue to be managed by the same clinician.

The care type change must be clearly documented in the patient's medical record.

The clinician responsible for the management of care may not necessarily be located in the same facility as the patient. In these circumstances, a clinician at the patient's location may also have a role in the care of the patient; the expertise of this clinician does not affect the assignment of care type.

The care type must not be retrospectively changed unless it is for the correction of a data recording error or the reason for change is clearly documented in the patient's medical record and it has been approved by the hospital's director of clinical services.

While psychogeriatric care is a subspecialty of mental health, it is an established component of subacute care. Therefore, if a patient meets the definition of psychogeriatric care, then the psychogeriatric care type must be allocated.

Admissions to mental health inpatient programs are determined by classifying the care type as mental health care.

Ambulatory service contacts and episodes of care recorded in PSOLIS are deemed mental health care as the activity by default meets the mental health care type definition.

For the subacute or mental health care types, it is unlikely that more than one change in care type will take place within a 24-hour period. Changes involving subacute or mental health care types are unlikely to occur on the date of formal separation.

Patients who receive intervention(s) (e.g. dialysis, chemotherapy or radiotherapy) during a subacute or non-acute episode of care do not change care type. Instead, procedure codes for the acute same-day intervention(s) and an additional diagnosis (if relevant) must be added to the record of the subacute or non-acute episode of care.

Palliative care episodes can include grief and bereavement support for the family and carers of the patient where it is documented in the patient's medical record.

Each care type must have a unique account/admission number.

Episodes with more than one care type must have an episode of care link number. This enables episodes of care within a hospital stay to be rolled up into one admission.

Examples

	Care Type
A patient is admitted to a mental health ward with a mental health care type.	32
A patient with Alzheimer's disease is statistically admitted under a psychogeriatric team for behaviour modification.	24

Related national definition

https://meteor.aihw.gov.au/content/711010

Revision history

N/A

Contact Program Identifier

Field name:	contact_program_identifier
Source Data Element(s):	[Contact Program Identifier] – PSOLIS
Definition:	Unique identifier for the client's current contact program
Requirement status:	Conditional
Data type:	Numeric
Format:	N(20)
Permitted values:	Unique numeric identifier

Guide for use

Collection of this data element is conditional – contact program identifier is mandatory if the patient is admitted into a PSOLIS program and stream.

This is a system-generated identifier that is not visible to front-end users of PSOLIS.

If a client has been admitted into multiple programs within a stream, the client will have multiple contact program IDs within the stream.

Examples

An adult stream client is active in one inpatient and two outpatient programs	Contact Program Identifier
Inpatient program 1	222172
Outpatient program 1	374844
Outpatient program 2	214803

Related national definition

N/A

Revision history

N/A

Discharge Date and Time

Field name:	discharge_datetime
Source Data Element(s):	[Discharge Date and Time] – PSOLIS
Definition:	The date and time the patient was discharged from the inpatient mental health service.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – discharge date and time must be recorded if the patient is admitted to an inpatient setting.

In the admitted and community residential settings this is the actual or statistical date of discharge from the mental health service.

A formal discharge is the conclusion of the patient's treatment within a hospital.

A statistical discharge is a process that occurs within an episode of care to capture a particular change to the patient's treatment, i.e. change of care type.

The discharge date visible in PSOLIS reflects the date and time the client was discharged from the mental health ward and must reflect the information entered in webPAS.

The discharge date must be after the admission date.

The discharge date for ward transfers between mental health programs must reflect the date and time the ward transfer occurred.

Examples

	Discharge Date and Time
A patient is discharged from a MH ward on 6 March 2021 at 09:05:00.	2021-03-06 09:05:00
A patient's care type changed from MH to acute on 1 May 2020 at 11.20am.	2020-05-01 11:20:00
A patient is ward transferred in webPAS from MH program 1 to MH program 2 on 15 November 2021 at 3.30pm. The discharge from MH program 1 is manually created in PSOLIS with the discharge date and time reflecting the date and time of ward transfer, plus one minute.	2021-11-15 15:31:00

Related national definition

https://meteor.aihw.gov.au/content/722725

Revision history

N/A

Episode End Date and Time

Field name:	episode_end_datetime
Source Data Element(s):	[Episode End Date and Time] – PSOLIS
Definition:	The date and time on which the episode of mental health care within that setting is formally or statistically completed.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – episode end date and time must be recorded if the client is discharged or deactivated.

This is the end date for the stream episode. It may or may not be equivalent to the original date of discharge/deactivation from the mental health care program.

The episode will remain open while the client is active in any program within the stream.

If the client is deactivated from one program but is active in another program of the same stream the episode end date must be the date of deactivation/discharge from the remaining program.

Examples

	Episode End Date and Time
A client is reviewed and it is determined that they need no further care in the service and can be deactivated from the program. The client is deactivated from the program on 01/10/2020 at 2pm.	01102020 14:00:00

Related national definition

https://meteor.aihw.gov.au/content/722725

Revision history

N/A

Episode Start Date and Time

Field name:	episode_start_datetime
Source Data Element(s):	[Episode Start Date and Time] – PSOLIS
Definition:	The date and time on which the episode of mental health care within that setting formally or statistically commences.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – episode start date and time must be recorded if the client is admitted or activated.

The treatment and/or care provided to a patient during an episode of care can occur in three different settings: admitted, ambulatory or residential.

This is the start date for the stream episode of care. It is equivalent to the date of the first admission/activation into a program and the commencement of the mental health care episode within that service.

The episode start date is assigned to all NOCC measures collected within the same episode of care.

Examples

	Episode Start Date and Time
A mental health client is activated into a MH Youth Outpatient program on 20/07/2020 at 2pm and attends a review where three NOCC assessments are collected: HoNOS, K10+ and LSP-16.	20072020 14:00:00
The client attends a review on 15/09/2020 where the same three NOCC assessments are performed.	20072020 14:00:00
The client is admitted to the metal health service's inpatient unit on 1/10/2020 when an admission NOCC is collected.	20072020 14:00:00

Related national definition

https://meteor.aihw.gov.au/content/723143

Revision history

N/A

Establishment Code

Field name:	establishment_code
Source Data Element(s):	[Establishment Code] – PSOLIS
Definition:	A unique four-digit number that is assigned by Department of Health (WA) to hospitals and other health related locations or establishments.
Requirement status:	Conditional
Data type:	Numeric
Format:	NNNN
Permitted values:	Refer to the Establishment Code List

Guide for use

Collection of this data element is conditional – establishment code must be recorded if the patient is admitted to an inpatient setting.

An establishment refers to an authorised/accredited physical location where patients can receive health care and stay overnight. This includes acute hospitals, residential aged care and nursing homes, rehabilitation and residential mental health facilities.

For the purposes of reporting and other business requirements, virtual hospitals, same-day clinics, surgeries, nursing posts, detention centres or prisons may also be assigned an establishment code.

Establishment codes are assigned by the Department of Health and a list of valid establishments is provided in the Establishment Code List .

Examples

	Establishment
A patient is admitted to Albany Hospital.	0201
A patient is admitted to St John of God Health Care Murdoch.	0640

Related national definition

https://meteor.aihw.gov.au/content/269975

Revision history

N/A

Establishment Name

Field name:	establishment_hosp
Source Data Element(s):	[Establishment Name] – PSOLIS
Definition:	The name of the hospital that is required to report admitted activity information to the HMDS
Requirement status:	Conditional
Data type:	Alphanumeric
Format:	X[X(149)]
Permitted values:	Refer to the Establishment Code List

Guide for use

Collection of this data element is conditional – establishment name must be recorded if the patient is admitted to an inpatient setting.

Please refer to the Establishment Code List for a list of the valid hospital and health services.

Each organisation must only have one establishment.

Examples

	Establishment Name
A patient is admitted to establishment code 201.	Albany Hospital
A patient is admitted to establishment code 640.	St John of God Health Care Murdoch

Related national definition

https://meteor.aihw.gov.au/content/269975

Revision history

N/A

Leave Days

Field name:	leave_days
Source Data Element(s):	[Leave Days] – PSOLIS
Definition:	Sum of the length of leave for all periods within the hospital stay
Requirement status:	N/A
Data type:	Numeric
Format:	N(4)
Permitted values:	Whole number

Guide for use

This data element is a derived measure using the start and end dates of periods of the client's leave during an admitted episode.

Examples

	Leave Days
A patient is admitted to Midland Hospital for five days and takes no leave.	0
A patient is admitted to Albany Hospital for three weeks and takes two days of leave on one occasion and one day of leave on another occasion.	3

Related national definition

https://meteor.aihw.gov.au/content/270251

Revision history

N/A

Leave End Date and Time

Field name:	leave_end_datetime
Source Data Element(s):	[Leave End Date and Time] – PSOLIS
Definition:	The date and time the patient ended a period of leave from the inpatient mental health service.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – leave end date and time must be recorded if the patient takes leave while admitted to an inpatient setting.

The leave end date visible in PSOLIS reflects the date and time the client ended a period of leave from the mental health ward and must reflect the information entered in webPAS.

Leave end date must be after the admission date.

Leave end date must be after the leave start date.

Leave end date must be before the discharge date.

Examples

	Leave End Date and Time
A patient ends a period of leave from a mental health ward on 3 May 2021 at 09:05:00.	2021-05-03 09:05:00

Related national definition

https://meteor.aihw.gov.au/content/722725

Revision history

N/A

Leave Start Date and Time

Field name:	leave_start_datetime
Source Data Element(s):	[Leave Start Date and Time] – PSOLIS
Definition:	The date and time the patient commenced a period of leave from the inpatient mental health service.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – leave start date and time must be recorded if the patient takes leave while admitted to an inpatient setting.

The leave start date visible in PSOLIS reflects the date and time the client started a period of leave from the mental health ward and must reflect the information entered in webPAS.

Leave start date must be after the admission date.

Leave start date must be before the leave end date.

Leave start date must be before the discharge date.

Examples

	Leave Start Date and Time
A patient starts a period of leave from a mental health ward on 1 May 2021 at 2:30pm.	2021-05-01 14:30:00

Related national definition

https://meteor.aihw.gov.au/content/722725

Revision history

N/A

Length of Stay

Field name:	length_of_stay
Source Data Element(s):	[Length of Stay] – PSOLIS
Definition:	The duration of the inpatient episode in days.
Requirement status:	N/A
Data type:	Numeric
Format:	N(4)
Permitted values:	Whole number

Guide for use

This data element is a derived measure using the episode admission and discharge dates.

Examples

	Incident Duration
A patient is admitted to Midland Hospital on 13/07/2022 and discharged on 20/07/2022.	8

Related national definition

N/A

Revision history

N/A

Planned Admission Date and Time

Field name:	planned_admit_datetime
Source Data Element(s):	[Planned Admission Date and Time] – PSOLIS
Definition:	The planned admission date and time prior to the actual admission into the mental health program.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

The planned admission date and time reflects information when a pre-admission date is specified in webPAS.

The planned admission date and time can also be entered during manual creation of the admission in PSOLIS.

The planned admission date must be prior to actual admission date and time.

Examples

	Planned Admission Date and Time
A user entered a planned admission date of 8 May 2021 at 10am.	2021-05-08 10:00:00

Related national definition

N/A

Revision history

N/A

Planned Discharge Date and Time

Field name:	planned_discharge_datetime
Source Data Element(s):	[Planned Discharge Date and Time] – PSOLIS
Definition:	The planned discharge date and time prior to the actual discharge from the mental health program.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

The planned discharge date and time can be recorded in webPAS at the time of admission.

For manually created admissions, the user can enter this information into PSOLIS.

The planned discharge date and time must be after the admission date and time.

Examples

	Planned Discharge Date and Time
A user entered a planned discharge date of 16 May 2021 at 9am.	2021-05-16 09:00:00

Related national definition

N/A

Revision history

N/A

Reception Date and Time

Field name:	reception_datetime
Source Data Element(s):	[Reception Date and Time] – PSOLIS
Definition:	The date and time the client was received as an impatient.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

The reception date and time can be recorded in webPAS at the time of admission.

For manually created admissions, the user can enter this information into PSOLIS.

The reception date and time must be before the discharge date and time.

Examples

	Reception Date and Time
A user entered a reception date of 23 August 2021 at 9am.	2021-08-2**3** 09:00:00

Related national definition

N/A

Revision history

N/A

Visit End Date and Time

Field name:	visit_disch_datetime
Source Data Element(s):	[Visit End Date and Time] – PSOLIS
Definition:	The date and time on which an admitted client completes an episode of care (otherwise known as ‘visit’).
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – visit end date and time must be recorded if the patient is admitted to an inpatient setting.

Where there is only one visit in the overall webPAS case (formal admission) the visit end date and time will reflect the same information as the discharge date and time.

Where a statistical discharge is performed in webPAS, the visit end date and time will reflect the date and time of the change applied.

Examples

	Visit End Date and Time
A user discharges a client from a mental health ward on 3 May 2021 at 9am.	2021-05-03 09:00:00
A client is statistically discharged in webPAS on 1 March 2020 at 11.20am.	2020-03-01 11:20:00

Related national definition

N/A

Revision history

N/A

Visit Number

Field name:	visit_number
Source Data Element(s):	[Visit Number] – PSOLIS
Definition:	A numeric business identifier for each visit (also known as account number in other collections).
Requirement status:	Conditional
Data type:	Numeric
Format:	N[N(19)]
Permitted values:	Unique numeric identifier

Guide for use

Collection of this data element is conditional – visit number must be recorded if the patient is admitted to an inpatient setting.

A webPAS case (formal admission) can contain one or more visits; each is assigned their own visit number.

In webPAS clients are statistically discharged and admitted in order to change a client's care type. This creates a new webPAS visit within the overall webPAS case. These visits display as separate rows on the primary admission in PSOLIS.

Examples

	Visit Number
A client is admitted into a mental health ward.	224020

Related national definition

N/A

Revision history

N/A

Visit Start Date and Time

Field name:	visit_adm_datetime
Source Data Element(s):	[Visit Start Date and Time] – PSOLIS
Definition:	The date and time on which an admitted client commences the inpatient episode of care (otherwise known as ‘visit’).
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – visit start date and time must be recorded if the patient is admitted to an inpatient setting.

Where there is only one visit in the overall webPAS case (formal admission) the visit start date and time will reflect the same information as the admission date and time.

Statistical admissions result in a new visit number. The visit start date and time will reflect the date and time of the change applied (i.e. commencement of a new care type).

Examples

	Visit Start Date and Time
A user admits a client into a mental health ward on 3 May 2021 at 9am.	2021-05-03 09:00:00
A client is statistically admitted in webPAS on 1 March 2020 at 11.20am.	2020-03-01 11:20:00

Related national definition

N/A

Revision history

N/A

Ward on Admission

Field name:	ward_on_admission
Source Data Element(s):	[Ward on Admission] – PSOLIS
Definition:	The ward the patient was admitted to, at the time of admission to the hospital.
Requirement status:	Conditional
Data type:	String
Format:	X[X(59)]
Permitted values:	Valid ward name descriptor

Guide for use

Collection of this data element is conditional – ward on admission must be recorded if the patient is admitted to an inpatient setting.

Ward details must be entered at time of completing the admission in webPAS.

Examples

	Ward on Admission
A client is admitted into an inpatient mental health ward ‘W42’	W42

Related national definition

N/A

Revision history

N/A

Ward on Discharge

Field name:	ward_on_discharge
Source Data Element(s):	[Ward on Discharge] – PSOLIS
Definition:	The ward the patient was discharged from, at the time of discharge from the hospital.
Requirement status:	Conditional
Data type:	String
Format:	X[X(59)]
Permitted values:	Ward name descriptors

Guide for use

Collection of this data element is conditional – ward on discharge must be recorded if the patient is admitted to an inpatient setting.

Ward details must be entered at time of completing the discharge in webPAS.

Examples

	Ward on Admission
A client is discharged from an inpatient mental health ward ‘W26’	W26

Related national definition

N/A

Revision history

N/A

6. Referrals

The following section provides specific information about the referrals data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Action Date and Time

Field name:	record_modified_datetime
Source Data Element(s):	[Action Date and Time] – PSOLIS
Definition:	Date and time the action occurred.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Action date and time is system generated and records the date and time of changes to the client record that have been committed to the system.

The action date and time collected in the MHDC is the latest action date and time from any of the tables that the extract sources from the system.

If changes are made in webPAS and no other changes are made to the client record in PSOLIS, the action date and time records when the change was made in webPAS.

If, after a change in webPAS, a change also occurs in PSOLIS, the action date and time recorded is when the change was made in PSOLIS.

Examples

	Action Date and Time
A user records a NOCC assessment for a client at 10:15:00 on 11 June 2021.	2021-06-11 10:15:00
A user finishes entering a client's details in the PAS on 15 December 2020 at 12:51:21 and then at enters a service event in PSOLIS at 13:00:00.	2020-12-15 13:00:00

Related national definition

N/A

Revision history

N/A

Activation Date and Time

Field name:	activation_datetime
Source Data Element(s):	[Activation Date and Time] – PSOLIS
Definition:	The date and time the client was activated in the community mental health service.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – activation date and time must be recorded if the client is activated.

In the community setting the activation date and time is the date on which the episode of mental health care within the community mental health program commenced. It may or may not be equivalent to the original date of entry to care within the ambulatory service.

Activation is the process of admitting a client to a community program for ongoing care or service provision.

Clients can be activated to the mental health service with the first service contact; however, one or two service contacts do not mean that the client has to be activated.

When the ‘client present’ box has been selected ten times for reportable service contacts, PSOLIS will enforce activation into the service.

The activation date recorded in PSOLIS must be the date the decision to admit and provide care to the client occurred.

The activation date must be after or the same as the referral date and prior to the deactivation date.

The client must be activated when a clinical decision has been made to provide care to a client and this decision must be reflected in PSOLIS.

Once a client, who is currently inactive, has had more than ten reportable service contacts with the client present (face-to face, video, telephone), then the clinician must decide whether to provide care to the client and proceed accordingly.

If a decision to provide care is made the client must be activated.

If a decision has been made not to provide care to the client all related referrals must be assigned an outcome and no more service events may be entered against those referrals.

Service contacts of an administrative nature (i.e. non-reportable service contacts) are excluded from the ten service contacts.

Activation can only be done if a referral exists in PSOLIS. Once a client is activated, PSOLIS will automatically close (outcome) the related referral.

A client cannot be activated against a referral that is more than three months old. PSOLIS will return an error message to the user if this is attempted and the activation will not proceed. A new referral must be created for the activation to proceed. The exception is when the referral has a waitlist status as these referrals will be valid for longer than three months.

Activation must be made to the appropriate program/stream.

Clients can be activated to multiple programs but must only have one referral per program.

If a client who has been deactivated from the mental health service has subsequent interaction with the service then the criteria for re-activation must be the same as if there was no prior activation.

Examples

	Activation Date and Time
A user activates a client into a program on 3 May 2021 at 09:01:36.	2021-05-03 09:01:36

Related national definition

https://meteor.aihw.gov.au/content/730809

Revision history

N/A

Allocated to Clinician HE Number

Field name:	allocated_to_clinician_henumber
Source Data Element(s):	[Allocated to Clinician HE Number] – PSOLIS
Definition:	The health employee (HE) number of the clinician the referral was allocated to.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – allocated to clinician HE number must be recorded if a referral has been created.

Examples

	Allocated to Clinician HE Number
A referral is created and allocated to clinician HE888880.	HE888880

Related national definition

N/A

Revision history

N/A

Allocated to Clinician Name

Field name:	allocated_to_clinician_name
Source Data Element(s):	[Allocated to Clinician Name] – PSOLIS
Definition:	The name of the clinician the referral was allocated to.
Requirement status:	Conditional
Data type:	String
Format:	X[X(149)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – allocated to clinician name must be recorded if a referral has been created.

Examples

	Allocated to Clinician Name
A referral is created and allocated to clinician Joe Citizen.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Allocated to Team

Field name:	allocated_to_team
Source Data Element(s):	[Allocated to Team] – PSOLIS
Definition:	The numerical identifier of the clinical team the referral was allocated to.
Requirement status:	Conditional
Data type:	String
Format:	N[N(7)]
Permitted values:	Valid numeric team code

Guide for use

Collection of this data element is conditional – allocated to team must be recorded if a referral has been created.

Examples

	Allocated to Clinician Team
A referral is created and allocated to team 26107.	26107

Related national definition

N/A

Revision history

N/A

Referral Date and Time

Field name:	referral_datetime
Source Data Element(s):	[Referral Date and Time] – PSOLIS
Definition:	The date and time the mental health client was referred to the community mental health service.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event item is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element is the date and time the relevant mental health service receives the referral regardless of the medium of communication.

This data element represents the active referral date and time of the mental health client at the time of the service event item. Each subsequent service event item recorded for the client will retain this referral date and time while the referral remains current.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Referral date and time can be the same as the activation date but must not be after the activation date.

Examples

	Referral Date and Time
A client is referred to Fremantle Mental Health Service on 1st July 2021 for an assessment. A service event item is recorded for this assessment.	2021-07-01 00:00:00.000

Related national definition

https://meteor.aihw.gov.au/content/663262

Revision history

N/A

Referral Identifier

Field name:	referral_identifier
Source Data Element(s):	[Referral Identifier] – PSOLIS
Definition:	Unique identifier for each referral.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event item is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element represents the active referral identifier of the mental health client at the time of a service event item. Each subsequent service event item recorded for the client will retain this referral identifier while the referral remains current.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referral Identifier
A client is referred to Fremantle Mental Health Service on 1st July 2021 for an assessment. A service event item is recorded for this assessment.	3285475

Related national definition

https://meteor.aihw.gov.au/content/493164

Revision history

N/A

Referral Medium

Field name:	referral_medium_code
Source Data Element(s):	[Referral Medium] – PSOLIS
Definition:	The medium the referral was received by, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(2)
Permitted values:	1 – Email 2 – Fax 3 – Letter 4 – Phone 5 – Self presented 6 – Triage 7 – Brought by police 8 – Brought in by community nurses 9 – Other 10 – Electronic referral

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event item is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element represents the communication medium of a mental health client's referral.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referral Medium
A mental health client enters Broome Hospital seeking treatment for depression.	5 – Self presented
A patient is referred to Bunbury Mental Health Service via email.	1 – Email

Related national definition

N/A

Revision history

N/A

Referral Outcome

Field name:	referral_outcome_code
Source Data Element(s):	[Referral Outcome] – PSOLIS
Definition:	Identifies the outcome of a referral.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Admitted to service 2 – Referred to other service 3 – No further action 4 – No further action, already active 5 – Did not engage/attend appointment 6 – Information only 7 – Admitted via PAS 8 – Client declined Null – Not specified

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element represents the outcome of a mental health client's referral.

1. **Admitted to service** - this indicates that the referral was used to directly activate the client to one of the programs in PSOLIS. This outcome automatically applies itself to the referral that was used to activate the client.
2. **Referred to Other Service** - once this outcome is selected PSOLIS will ask to enter details of the other service.
3. **No further action** - clinical decision has been made that no further assistance is required.
4. **No further action, already active** - this outcome is predominantly used to outcome multiple referrals to the same program.
5. **Did not engage/attend appointment** - client was not willing to engage with the service.
6. **Information Only**

7. **Admitted via PAS** - this indicates that the client has been admitted to an Inpatient setting via the primary administrative system PAS and that referral and admission information has flown across to PSOLIS.

8. **Client declined** - MH services has been refused by the client.

Once a referral outcome is entered, the referral status will automatically change to 'completed'.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Multiple referrals can be recorded in PSOLIS, but if the client is currently active at a service stream, or if the client has a current referral at a service stream with a status of 'pending' or 'in progress' the referral outcome must immediately be assigned as 'no further action, already active.'

If it is not appropriate for the mental health service to provide a service to a client, then any decision to refer the client on, or not to provide further care to the client, must be reflected in an appropriate referral outcome as outlined above.

Examples

	Referral Outcome
A mental health client enters Broome Hospital seeking treatment for depression.	4 – No further action, already active
A patient is referred to Bunbury Mental Health Service via email.	1 – Admitted to service

Related national definition

N/A

Revision history

N/A

Referral Presenting Problem

Field name:	presenting_problem_code
Source Data Element(s):	[Referral Presenting Problem] – PSOLIS
Definition:	The problem the client is presenting to a mental health service for, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(2)
Permitted values:	1 – Relationship/family problem 2 – Social interpersonal (other than family problem) 3 – Problems coping with daily roles and activities 4 – School problems 5 – Physical problems 6 – Existing mental illness - exacerbation 7 – Existing mental illness - contact/information only 8 – Existing mental illness - alteration in medication/treatment regime 9 – Depressed mood 10 – Grief/loss issues 11 – Anxious 12 – Elevated mood and/or disinhibited behaviour 13 – Psychotic symptoms 14 – Disturbed thoughts, delusions etc. 15 – Perceptual disturbances 16 – Problematic behaviour 17 – Dementia related behaviours 18 – Risk of harm to self 19 – Risk of harm to others 20 – Alcohol/drugs 21 – Aggressive/threatening behaviour 22 – Legal problems 23 – Eating disorder 24 – Sexual assault 25 – Sexual abuse

	26 – Assault victim 27 – Homelessness 28 – Accommodation problems 29 – Information only 30 – Other 31 – Mood disturbance 32 – Adverse drug reaction 33 – Medication 34 – Depot injection 35 – Deliberate self harm 36 – Suicidal ideation 41 – Cultural issues

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element represents the problem the mental health client's is presenting with.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referral Presenting Problem
A mental health client enters Broome Hospital seeking treatment for depression.	9 – Depressed mood

Related national definition

N/A

Revision history

N/A

Referral Purpose

Field name:	referral_purpose_code
Source Data Element(s):	[Referral Purpose] – PSOLIS
Definition:	The underlying reason for the referral.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Seeking assistance/referral 2 – Information Null – Not specified

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element represents the reason underlying the mental health client's referral.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referral Purpose
A client enters Broome Hospital seeking treatment for depression.	1 – Seeking assistance/referral

Related national definition

N/A

Revision history

N/A

Referral Reason

Field name:	referral_reason
Source Data Element(s):	[Referral Reason] – PSOLIS
Definition:	Information detailing the reason for the referral.
Requirement status:	Conditional
Data type:	String
Format:	[X(500)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element provides information detailing the reason for the mental health client's referral.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referral Reason
A client is referred to Albany Mental Health Service.	Reports feeling suicidal.
An admitted patient suffering from anxiety is referred to the Fremantle Mental Health Service.	Initial mental health assessment.

Related national definition

N/A

Revision history

N/A

Referral Source Name

Field name:	referral_source_name
Source Data Element(s):	[Referral Source Name] – PSOLIS
Definition:	Person, program or organisation making the referral.
Requirement status:	Conditional
Data type:	String
Format:	[X(150)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element details the name of the person, program or organisation who made the mental health client's referral.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referral Source Name
A client is referred to Albany Mental Health Service	Tom from Albany After Hours GP
A client is referred to the State Forensic Mental Health Service	Hakea Prison

Related national definition

N/A

Revision history

N/A

Referral Source Type

Field name:	referral_source_type_code
Source Data Element(s):	[Referral Source Type] – PSOLIS
Definition:	The type of person or agency responsible for the referral of a mental health client.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(2)
Permitted values:	2 – Breach release order 3 – Condition of bail 4 – Court 5 – Family/friend 8 – Internal program 9 – Medical practitioner 12 – Other establishment 13 – Other organisation 16 – Police 17 – Correctional facility 22 – Self 23 – Unknown 24 – Refuge 25 – School 26 – Other professional 27 – External program 28 – Nursing home/hostel 29 – Hospital 30 – Mental health program 31 – Restructure 32 – Police officer 99 – PAS Null – not specified

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element details the type of source the mental health client's referral was issued from.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referral Source Type
Tom from Albany After Hours GP refers a client to Albany Mental Health Service	9 – Medical practitioner
Hakea Prison refers a client to the State Forensic Mental Health Service	17 – Correctional facility

Related national definition

https://meteor.aihw.gov.au/content/297450

Revision history

N/A

Referral Status

Field name:	referral_status_code
Source Data Element(s):	[Referral Status] – PSOLIS
Definition:	The stage that a referral reaches in processing, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Pending 2 – In progress 3 – Waitlist 4 – Completed 5 – Sent Null – Not specified

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element details the processing stage of the mental health client's referral.

Permitted value definitions

Pending

When a referral is first recorded in PSOLIS the status automatically defaults to pending.

In Progress

Referrals that are being progressed.

Waitlist

Used for clients who are waiting for a vacant place in a program.

Completed

When the outcome of the referral has been determined.

Sent

The referral has been sent to its intended recipient.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

To complete a referral, an outcome must be entered onto the referral details.

If a client cannot be admitted to a program because there are currently no vacancies, their referral status must be changed to ‘Waitlist’.

Referrals must not be left pending, in progress or waitlisted indefinitely. Action must be taken to ensure that current referrals with a status of ‘Pending’ or ‘In progress’ or ‘Waitlist’ are reviewed regularly, and an appropriate outcome assigned within three months.

Examples

	Referral Status
Tom from Albany After Hours GP refers a client to Albany Mental Health Service	2 – In progress
Hakea Prison refers a client is to the State Forensic Mental Health Service	1 – Pending

Related national definition

N/A

Revision history

N/A

Referred On Name

Field name:	referred_on_name
Source Data Element(s):	[Referred On Name] – PSOLIS
Definition:	The name of the person, program or organisation the mental health client has been referred to.
Requirement status:	Conditional
Data type:	String
Format:	[X(130)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element details the name of the person, program or organisation the mental health client has been referred to.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referred On Name
Hakea Prison refers a client to the Graylands Hospital	Graylands Hospital

Related national definition

N/A

Revision history

N/A

Referred On Type

Field name:	referred_on_type_code
Source Data Element(s):	[Referred On Type] – PSOLIS
Definition:	The type of person, program or organisation the mental health client has been referred to.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(2)
Permitted values:	1 – Hospital (non psychiatric) 8 – Internal program 9 – Medical practitioner 10 – Community and outpatient MHS 12 – Other establishment 13 – Other organisation 19 – Hospital (psychiatric) 26 – Other professional 27 – External program 29 – Hospital 31 – Restructure Null – Not specified

Guide for use

Collection of this data element is conditional – it is mandatory unless the service event is a pre-referral action.

A formal referral is a process in which a client has had a fax, phone call, letter or email provided to the mental health service on their behalf requesting service or they have self-presented to the mental health service.

This data element details the type of person, program or organisation the mental health client has been referred to.

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be activated or for additional service event items to be entered.

Referrals must be recorded in PSOLIS, regardless of the communication medium.

Examples

	Referred On Type
Broome Mental Health Service refers a client to Phil, a local GP.	9
Graylands Hospital refers a client to Fiona Stanley Hospital.	1

Related national definition

N/A

Revision history

N/A

7. Alerts

The following section provides specific information about the alerts data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Alert Details

Field name:	alert_details
Source Data Element(s):	[Alert Details] – PSOLIS
Definition:	Information about the cause and nature of the alert.
Requirement status:	Optional
Data type:	String
Format:	X[X(499)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is optional – it is free text field where users can enter more information related to an alert.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Examples

	Alert Details
A user creates an alert with a 'Physical Aggression' message	Can become aggressive when visiting in home; known to throw furniture

Related national definition

N/A

Revision history

N/A

Alert Duration

Field name:	alert_duration_days
Source Data Element(s):	[Alert Duration] – PSOLIS
Definition:	The duration of the alert in days.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)
Permitted values:	Whole number

Guide for use

This data element is a derived measure using the start and end dates of an alert created in relation to a client.

Examples

	Alert Duration
An alert is created on 13/07/2022 for a patient admitted to Midland Hospital and removed for the patient on 20/07/2022.	8

Related national definition

N/A

Revision history

N/A

Alert Entered By

Field name:	alert_entered_by
Source Data Element(s):	[Alert Entered By] – PSOLIS
Definition:	The health employee (HE) number of the person creating the alert.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – it must be recorded if an alert has been created.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Examples

	Alert Entered By
A user creates an alert.	HE999990

Related national definition

N/A

Revision history

N/A

Alert Expired By

Field name:	alert_expired_by
Source Data Element(s):	[Alert Expired By] – PSOLIS
Definition:	The health employee (HE) number of the person who ends the alert.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – it must be recorded if an alert has been ended.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

This data element must be completed if the alert is no longer relevant.

Examples

	Alert Expired By
A user ends an alert.	HE888880

Related national definition

N/A

Revision history

N/A

Alert Expiry Date

Field name:	alert_end_datetime
Source Data Element(s):	[Alert Expiry Date] – PSOLIS
Definition:	The end date of the alert.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD
Permitted values:	Valid date

Guide for use

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Alert expiry date must be after the alert start date.

This data element must be completed if the alert is no longer relevant.

Examples

	Alert Expiry Date
A user creates an alert with an end date of 3 May 2022.	2022-05-03

Related national definition

N/A

Revision history

N/A

Alert Identifier

Field name:	alert_identifier
Source Data Element(s):	[Alert Identifier] – PSOLIS
Definition:	A unique identifier for each alert.
Requirement status:	Conditional
Data type:	String
Format:	N(6)
Permitted values:	Unique numeric identifier

Guide for use

Collection of this data element is conditional – alert identifier must be recorded if an alert has been created.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

This data element is system generated to prevent duplicates.

Examples

	Alert Identifier
A new alert is created in PSOLIS.	106805

Related national definition

N/A

Revision history

N/A

Alert Message

Field name:	alert_message
Source Data Element(s):	[Alert Message] – PSOLIS
Definition:	Information that defines the alert.
Requirement status:	Conditional
Data type:	String
Format:	X[X(49)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – alert message must be recorded if an alert has been created.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Alert message is a free text field where the user must enter information that briefly defines the immediate risk.

Examples

	Alert Message
A user creates an alert for a physically aggressive client	Physical Aggression

Related national definition

N/A

Revision history

N/A

Alert Reviewed By

Field name:	alert_reviewed_by
Source Data Element(s):	[Alert Reviewed By] – PSOLIS
Definition:	The health employee (HE) number of the person who reviews the alert.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – alert reviewed by must be recorded if an alert has been reviewed.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Client alerts must be reviewed on a regular basis by the clinical team.

Examples

	Alert Reviewed By
A user reviews an alert.	HE888880

Related national definition

N/A

Revision history

N/A

Alert Reviewed Date

Field name:	alert_reviewed_datetime
Source Data Element(s):	[Alert Reviewed Date] – PSOLIS
Definition:	The date the alert was reviewed by the case manager or multidisciplinary team.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD
Permitted values:	Valid date

Guide for use

Collection of this data element is conditional – alert reviewed date must be recorded if an alert has been reviewed.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Client alerts must be reviewed on a regular basis by the clinical team.

Alert reviewed date cannot be prior to the alert start date.

Alert reviewed date cannot be the same as the alert start date.

Alert reviewed date cannot be after the current date (i.e. a future date).

Examples

	Alert Reviewed Date
A user creates an alert on 5 April 2021 and reviews the alert on 3 May 2021.	2021-05-03

Related national definition

N/A

Revision history

N/A

Alert Start Date

Field name:	alert_start_date
Source Data Element(s):	[Alert Start Date] – PSOLIS
Definition:	The date the alert was initiated.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD
Permitted values:	Valid date

Guide for use

Collection of this data element is conditional – alert start date must be recorded if an alert has been created.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Alert start date must be before the alert expiry date.

Examples

	Alert Start Date
A user creates an alert on 3 May 2021.	2021-05-03

Related national definition

N/A

Revision history

N/A

Alert Type

Field name:	alert_type_code
Source Data Element(s):	[Alert Type] – PSOLIS
Definition:	Identifies the category of the alert.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Behavioural 2 – Forensic 3 – Medical 4 – Microbiological 5 – Other 6 – Social

Guide for use

Collection of this data element is conditional – it must be recorded if an alert has been created.

Alerts provide immediate information regarding risk factors that increase the vulnerability of the client, staff, relatives or other clients to physical, environmental, social or psychological harm.

The presence of alerts provides an immediate source of important information for staff that must be taken into consideration when treating the client.

Access to alerts information is not restricted to the user's permission and stream access. This information is available to read on a State-wide level.

Alerts can be entered against clients that are active or have a referral, or during triage.

Permitted value definitions

Behavioural

Assaultive behaviour including verbal aggression, self-harm, substance/alcohol misuse, possession/access to/misuse of weapons, medication adherence/compliance, absconding or resistance to admission to hospital (requires enticement), and non-compliance to treatment.

Forensic

Any criminal conviction, CLMIDA issue, condition of bail or parole.

Medical

Any physical medical condition or disability, allergies (drug, food organic, topical drugs, dressings), or treatment resistant conditions, i.e., resistance to anti-psychotic drugs.

Microbiological

Any infectious diseases or antibiotic resistance, e.g., to penicillin.

Social

Family history of threatening staff, sexual assault, domestic violence, child abuse/neglect, patient/client requests (e.g., boyfriend not to visit), hostile living conditions (e.g., lives in a house with drug users) etc.

Other

Any other alert. May not necessarily be related directly to the client but is a risk to mental health staff.

Examples

	Alert Type
A user creates an alert for a physically aggressive client.	Behavioural

Related national definition

N/A

Revision history

N/A

8. Incidents

The following section provides specific information about the incidents data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Incident Alert

Field name:	incident_is_alert
Source Data Element(s):	[Incident Alert] – PSOLIS
Definition:	Flag to indicate if the incident appears as an alert on PSOLIS.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Collection of this data element is conditional – incident alert must be recorded if a client alert is created.

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

This data element is used to determine whether an incident alert will appear on the client overview bar in PSOLIS.

Incidents can only be created for clients that are active or have a referral.

Examples

	Incident Alert
A client assaults a staff member during a therapy session and the user recording the incident event also creates a Behavioural Alert in PSOLIS. The incident alert flag appears against the client.	1

Related national definition

N/A

Revision history

N/A

Incident Duration

Field name:	incident_duration
Source Data Element(s):	[Incident Duration] – PSOLIS
Definition:	The duration of the incident in days.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)
Permitted values:	Whole number

Guide for use

This data element is a derived measure using the start and end dates of an incident created in relation to a client.

Examples

	Incident Duration
An incident is created on 13/07/2022 for a patient admitted to Midland Hospital and is ended on 20/07/2022.	8

Related national definition

N/A

Revision history

N/A

Incident End Date

Field name:	incident_end_datetime
Source Data Element(s):	[Incident End Date] – PSOLIS
Definition:	The date and time when the client incident concludes.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Incidents can only be created for clients that are active or have a referral.

Incident end date and time must be after the incident start date and time.

Examples

	Incident End Date
A client assaults a member of staff during a therapy session at 2.25pm on 21st November 2020 and leaves the building several minutes later.	2020-11-21 14:30:00

Related national definition

N/A

Revision history

N/A

Incident Location

Field name:	incident_location_code
Source Data Element(s):	[Incident Location] – PSOLIS
Definition:	The location the incident occurred, represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(4)
Permitted values:	Valid location code

Guide for use

Collection of this data element is conditional – incident location must be recorded if a client incident is created.

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Incidents can only be created for clients that are active or have a referral.

Examples

	Incident Location
A client becomes verbally aggressive in the foyer of Fitzroy House.	374
A patient assaults a staff member in G ward at Albany Hospital.	4

Related national definition

N/A

Revision history

N/A

Incident Notes

Field name:	incident_notes
Source Data Element(s):	[Incident Notes] – PSOLIS
Definition:	Additional information detailing the incident.
Requirement status:	Optional
Data type:	String
Format:	[X(500)]
Permitted values:	Alphanumeric combination

Guide for use

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Incidents can only be created for clients that are active or have a referral.

Examples

	Incident Notes
A client becomes verbally aggressive in the foyer of Fitzroy House.	Threatened to assault staff.
A patient assaults a staff member in G ward at Albany Hospital.	Refused medication and punched staff member.

Related national definition

N/A

Revision history

N/A

Incident Recurrence Risk

Field name:	incident_recurrence_type_code
Source Data Element(s):	[Incident Recurrence Risk] – PSOLIS
Definition:	The likelihood of a recurrence of the incident.
Requirement status:	Optional
Data type:	Numeric
Format:	N
Permitted values:	6 – 1 Rare 7 – 2 Unlikely 8 – 3 Possible 9 – 4 Likely 10 – 5 Very likely

Guide for use

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Incidents can only be created for clients that are active or have a referral.

Examples

	Incident Recurrence Risk
A client assaults a staff member in the foyer of Fitzroy House and before absconding threatens to return the following day with a knife.	5

Related national definition

N/A

Revision history

N/A

Incident Severity

Field name:	incident_severity_code
Source Data Element(s):	[Incident Severity] – PSOLIS
Definition:	The severity of the incident, represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	4 – 1 Insignificant 1 – 2 Minor 2 – 3 Moderate 5 – 4 Major 7 – 5 Catastrophic

Guide for use

Collection of this data element is conditional – incident severity must be recorded if a client incident is created.

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Permitted value definitions

1 – Insignificant

- Increased level of care (minimal)
- No increase in length of stay
- Not disabling

2 – Minor

- Increased level of care (minimal)
- Increased length of stay (up to 72 hours)
- Recovery without complication of permanent disability

3 – Moderate

- Increased level of care (moderate)
- Extended length of stay (72 hours to one week)
- Recovery with significant complication or significant permanent disability

4 – Major

- Increased level of care (significant)
- Extended length of stay (greater than one week)

- Significant complication and/or significant permanent disability

9 – Catastrophic

- Death, permanent total disability
- All sentinel events

Incidents can only be created for clients that are active or have a referral.

Examples

	Incident Severity
A client raises hands in a threatening manner towards staff	1
A patient is restrained and secluded following an unprovoked attack on a staff member.	4

Related national definition

N/A

Revision history

N/A

Incident Start Date

Field name:	incident_start_datetime
Source Data Element(s):	[Incident Start Date] – PSOLIS
Definition:	The date and time the incident started.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – incident start date must be recorded if a client incident is created.

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Incidents can only be created for clients that are active or have a referral.

Examples

	Incident Start Date
A client assaults a member of staff during a therapy session at 2.25pm on 21st November 2020.	2020-11-21 14:25:00

Related national definition

N/A

Revision history

N/A

Incident Type

Field name:	incident_type_code
Source Data Element(s):	[Incident Type] – PSOLIS
Definition:	The category the incident that has taken place belongs to.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Absconding 2 – Assault of other person 3 – Assault of patient 4 – Assault of staff 5 – Attempted suicide 6 – Damage to property 7 – Forensic – attempted escape 8 – Forensic – hostage 9 – Forensic – riot 10 – Illegal activity 11 – Medication incident 12 – Other 13 – Patient injured 14 – Seclusion 15 – Self harm 16 – Serious medical incident 17 – Sexual assault 18 – Substance abuse 19 – Verbal abuse – others 20 – Verbal abuse – patients 21 – Verbal abuse – staff 22 – Seclusion with restraint 23 – Restraint 24 – Fall 25 – Apprehension of baby 26 – Removal of baby

Guide for use

Collection of this data element is conditional – incident type must be recorded if a client incident is created.

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Incidents can only be created for clients that are active or have a referral.

Examples

	Incident Type
A client raises hands in a threatening manner towards staff	12
A patient is restrained and secluded following an unprovoked attack on a staff member.	4

Related national definition

N/A

Revision history

N/A

Record Blocked Flag

Field name:	record_blocked_flag
Source Data Element(s):	[Record Blocked Flag] – PSOLIS
Definition:	Flag to indicate if the incident has been blocked.
Requirement status:	Optional
Data type:	String
Format:	X
Permitted values:	Y – Yes Null – No

Guide for use

An incident details an event or circumstances associated with a client that could have, or did, cause harm, suffering, loss or damage.

PSOLIS users with clinical and administrative roles can access, create and edit client incidents within the stream they have access to.

Incidents can only be created for clients that are active or have a referral.

Examples

	Record Blocked Flag
A PSOLIS user wishes to block the details of an incident from appearing to other users.	Y

Related national definition

N/A

Revision history

N/A

9. Community mental health and service contacts

The following section provides specific information about the community mental health and service contacts data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Actioned By

Field name:	record_modified_by
Source Data Element(s):	[Actioned By] – ePalCIS, PSOLIS, QoCR, webPAS
Definition:	The user who performed the last recorded action
Requirement status:	Mandatory
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number or ‘webPAS’

Guide for use

Actioned by is system generated and records the health employee (HE) number from the log-in credentials of the current user making changes to client records.

This data element is used to provide an audit trail of actions performed.

If changes are made in webPAS and no other changes are made to the client record in PSOLIS, the ‘actioned by’ recorded is ‘webPAS’.

If, after a change in webPAS, a change also occurs in PSOLIS, the ‘actioned by’ recorded is the HE number of the staff member making the change.

Examples

	Actioned By
A user with HE number HE999990 records an activation diagnosis in PSOLIS	HE999990
A user with HE number HE888880 updates an address in webPAS	webPAS
A user with HE number HE777770 finishes entering a client’s details in webPAS and then enters a service event in PSOLIS	HE777770

Related national definition

N/A

Revision history

N/A

Additional Diagnosis

Field name:	diagnosis_assessment_additional_N
Source Data Element(s):	[Additional Diagnosis] – PSOLIS
Definition:	A condition either coexisting with the principal diagnosis or arising during the episode of care, as represented by a code.
Requirement status:	Conditional
Data type:	String
Format:	[ANN.NNNN]
Permitted values:	As per ICD-10-AM

Guide for use

Collection of this data element is conditional – additional diagnosis must be recorded where applicable to the treatment of the client.

Additional diagnosis codes give information on the conditions that are significant in terms of treatment required during the episode of care.

There are two additional diagnosis fields.

The additional diagnosis code must be a valid code from the current edition of the *International statistical classification of diseases and related health problems, 10th revision, Australian modification* (ICD-10-AM).

These fields are used to identify up to two secondary or underlying conditions that affected the client's care during the period of care preceding the collection occasion, in terms of requiring therapeutic intervention, clinical evaluation, extended length of episode, or increased care or monitoring and includes co-morbid conditions and complications.

These fields are derived from and must be substantiated by clinical documentation.

Examples

	Principal Diagnosis	Additional Diagnosis 1	Additional Diagnosis 2
A client has been assessed as having a mental and behavioural disorder due to use of sedatives or hypnotics (F13.9) secondary to a principal diagnosis of adjustment disorder (F43.2).	F43.2	F13.9	

Related national definition

https://meteor.aihw.gov.au/content/746667

Revision history

N/A

Associate Present Indicator

Field name:	associate_present_indicator
Source Data Element(s):	[Associate Present Indicator] – PSOLIS
Definition:	A flag indicating whether an associate of the client was present at the service event.
Requirement status:	Mandatory
Data type:	String
Format:	X
Permitted values:	0 – Not present 1 – Present

Guide for use

An associate can be a person or organisation.

An associate is anyone who is related or connected to the client and involved in their care. This can include family members, carer, GP, emergency contact, agencies etc.

An associate must not be government mental health staff or organisations.

Examples

	Associate Present Indicator
A client attends a review alone.	0
A client attends a review accompanied by his sister.	1

Related national definition

N/A

Revision history

N/A

Case Manager

Field name:	case_manager
Source Data Element(s):	[Case Manager] – PSOLIS
Definition:	The health employee (HE) number of the case manager to whom the mental health client is allocated.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – case manager must be recorded if a client has been activated.

Each mental health client must have a clinical case manager assigned to them.

This data element represents the HE number of that clinician.

The case manager will receive all reminders that relate to the client's care including reviews and management plans.

Examples

	Case Manager
Upon activation into a community program, a client is allocated to a case manager with a HE number of HE099999.	HE099999
A client has been assessed by the community assessment team, is not yet activated into the service and does not have a case manager at the time of the service event.	.

Related national definition

N/A

Revision history

N/A

Client Present Indicator

Field name:	client_present_indicator
Source Data Element(s):	[Client Present Indicator] – PSOLIS
Definition:	A flag indicating whether the client was present at the service event.
Requirement status:	Mandatory
Data type:	String
Format:	X
Permitted values:	0 – Not present 1 – Present

Guide for use

Permitted value definitions

0 – Not present

This code is to be used for service events between a specialised 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.

1 – Present

This code is to be used for service events between a specialised 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.

This data element is used to indicate whether the mental health client was present during a service event.

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

If the client is not present at the service event but the event relates to the client their name must be added in the attendees tab in PSOLIS and the client present box on the items tab must be unchecked.

Client present indicator is a critical field for determining whether a service event item with a conditional occasion of service flag is reportable or not, as well as an inclusion for community mental health follow-up within seven days of discharge from an acute mental health service.

Examples

	Client Present Indicator
A mental health client attends a face to face appointment with a clinician for an assessment.	1

The treating team undertakes a clinical review just with other members of the team for a client who has been active in the service for three months.	0
A clinician records a clinical record keeping service event item for a client.	0
A family meeting is provided with both the client and the client's carer present during the service event.	1

Related national definition

https://meteor.aihw.gov.au/content/737291

Revision history

N/A

Deactivation Date and Time

Field name:	deactivation_datetime
Source Data Element(s):	[Deactivation Date and Time] – PSOLIS
Definition:	The date and time the client was deactivated from the community mental health service.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – deactivation date and time must be recorded if the client is deactivated.

In the community mental health setting a deactivation is the process by which a client exits a mental health service when they have made progress in their recovery and no further treatment or review is planned.

Clients can be deactivated from one program while remaining active in other programs at the same mental health service organisation.

Admission to an inpatient setting within the same service stream does not require that the client be deactivated from community programs.

The deactivation of a client is a clinical decision. A client can only remain active if there is a clinical reason.

The decision and reason for deactivation can be determined at a clinical appointment or team meeting. Therefore, this is the date that must be entered as the deactivation date in PSOLIS regardless of when data entry is carried out.

If a client who has been deactivated from the mental health service has subsequent interaction with the service, then the criteria for re-activation must be the same as if there was no prior activation.

If a client re-presents after being deactivated with a problem, then the referral/activation cycle recommences, and a new community mental health episode of care begins.

All clients who have not had a clinical contact with a health professional for three months must be reviewed. This process may include follow up with the client if required. If following the review, no further action is planned then the client must be deactivated.

Any decision not to deactivate a client, who has had no clinical contact with a health professional for three months, must be based on clinical reasons only and documented in the medical record.

If a client advises that they are moving permanently out of the community mental health service area then the mental health service must complete a deactivation.

The deactivation date must be later than the activation date.

Examples

	Deactivation Date and Time
A client moves town and is referred to another service. The treating team makes the decision to deactivate the client from the program on 3 May 2021 at 2.30pm.	2021-05-03 14:30:00

Related national definition

https://meteor.aihw.gov.au/content/730859

Revision history

N/A

Deactivation Outcome

Field name:	deactivation_outcome_code
Source Data Element(s):	[Deactivation Outcome] – PSOLIS
Definition:	The reason a client has been deactivated from a community mental health service, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N[N(2)]
Permitted values:	1 – Discharge/transfer to hospital 2 – Discharge to home 3 – Program transfer 15 – Restructure 16 – Police MH 101 – Treatment has been completed 102 – Client has moved to another area 103 – Referred to other service 104 – Other 105 – Client stopped coming/did not attend 106 – Deceased 107 – One off assessment Null

Guide for use

Collection of this data element is conditional – deactivation outcome must be recorded if the client is deactivated.

This data element is used to detail the reason for the mental health client's deactivation from a community mental health service.

Examples

	Deactivation Outcome
The community mental health treating team decides a client no longer requires treatment and is deactivated from the program.	101
The client has moved interstate.	102
The client is deceased.	106
The client is still active in the service.	

The client no longer requires service by the community mental health program and is referred to another community mental health service.	103
The community mental health program has been realigned to a different mental health organisation and the decision is made to deactivate clients in order to reactivate the client into the new mental health organisation.	15

Related national definition

N/A

Revision history

N/A

Deactivation Status

Field name:	deactivation_status_code
Source Data Element(s):	[Deactivation Status] – PSOLIS
Definition:	Numeric identifier indicating the status of the client when they are deactivated from a community mental health service.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Community treatment order 2 – Discharged outright 3 – Received not admitted 4 – Discharge conditional 5 – S46 Transfer to authorised hospital 6 – Restructure Null

Guide for use

Collection of this data element is conditional – deactivation status must be recorded if the client is deactivated.

This data element is used to detail the standing of the mental health client on deactivation from a community mental health service.

Permitted value definitions

1 – Community treatment order

This code is to be used when the client is discharged from an inpatient setting to a community setting on a 5A community treatment order (CTO).

2 – Discharged outright

This code is to be used when the client is deactivated or transferred from one service to the next.

3 – Received not admitted

This code is to be used when the client has been received to the service for mental health assessment, but the clinical decision has been made not to admit the client to the service.

4 – Discharge conditional

This code is to be used when the client is discharged with conditions attached.

5 – S46 Transfer to authorised hospital

This code is to be used when the client is transferred to another authorised hospital.

6 – Restructure This code has been used for administrative purposes.

Examples

	Deactivation Status
A mental health client is deactivated from a program because their community treatment order has finished.	1

Related national definition

N/A

Revision history

N/A

Occasion of Service

Field name:	occasion_of_service_code
Source Data Element(s):	[Occasion of Service] – PSOLIS
Definition:	A flag that indicates whether the service event item is an occasion of service.
Requirement status:	Mandatory
Data type:	String
Format:	X
Permitted values:	Y – Yes N – No C – Conditional

Guide for use

Collection of this data element is mandatory.

This flag is used to indicate whether a service event is a mandatory and reportable occasion of service.

For a service event item to be assigned a value of 'conditional', a mental health client or an associate must be identified as being present for the service event item to be reportable.

Examples

	Occasion of Service
A client attends a face-to-face service contact session, where the type of service event item is 'Aboriginal Cultural Input'. This type of service event item is considered to be an occasion of service if the client is present.	C
A case manager records a service event item of 'Clinical Record Keeping' for a client. This type of service event item is not considered an occasion of service.	N
A client attends a service contact session by phone, where the type of service event item is 'Client Assistance'. This type of service event item is considered to be an occasion of service.	Y

Related national definition

https://meteor.aihw.gov.au/content/727358

Revision history

N/A

Organisation

Field name:	establishment_mh_organisation_code
Source Data Element(s):	[Organisation] – PSOLIS
Definition:	The mental health service organisation identifier.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(4)
Permitted values:	Valid establishment code

Guide for use

Organisation is used to identify the mental health service organisation that reports service activity. These organisation codes are different to the codes used for the Mental Health Establishments National Minimum Dataset.

Examples

	Organisation
A client is activated into the Albany Youth community mental health program, which is overseen by Albany Mental Health Services.	226

Related national definition

N/A

Revision history

N/A

Planned Deactivation Date and Time

Field name:	planned_deactivation_datetime
Source Data Element(s):	[Planned Deactivation Date and Time] – PSOLIS
Definition:	The planned deactivation date and time prior to the actual deactivation from the community mental health service.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

The planned deactivation date and time can be recorded in webPAS at the time of activation.

For manually created activations, the user can enter this information into PSOLIS.

The planned deactivation date must be after the activation date and time.

Examples

	Planned Deactivation Date and Time
A user entered a planned deactivation of 9am on 1 May 2023.	2023-05-01 09:00:00

Related national definition

N/A

Revision history

N/A

Principal Diagnosis

Field name:	diagnosis_admission_principal
Source Data Element(s):	[Principal Diagnosis] – PSOLIS
Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of care or an attendance at the health care establishment.
Requirement status:	Conditional
Data type:	String
Format:	[ANN.NNNN]
Permitted values:	As per ICD-10-AM

Guide for use

Collection of this data element is conditional – principal diagnosis must be recorded if a client is admitted or activated.

Principal diagnosis codes give information on the conditions that are significant in terms of treatment required during the episode of care.

Principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Principal diagnosis must be recorded at the time of admission or activation of the client.

Principal diagnosis must be a valid code from the current edition of the *International statistical classification of diseases and related health problems, 10th revision, Australian modification* (ICD-10-AM).

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, cannot be used as a principal diagnosis.

Diagnosis codes which are morphology codes cannot be used as a principal diagnosis.

This data element is derived from and must be substantiated by clinical documentation.

Examples

	Principal Diagnosis
A client has been activated and assessed as having a mental and behavioural disorder due to use of sedatives or hypnotics (F13.9) secondary to a principal diagnosis of adjustment disorder (F43.2).	F43.2

Related national definition

https://meteor.aihw.gov.au/content/746665

Revision history

N/A

Program

Field name:	establishment_mh_program_code
Source Data Element(s):	[Program] – PSOLIS
Definition:	A unique identifier for the program with which the mental health client has a service contact.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(4)
Permitted values:	Valid program identifier

Guide for use

This is a system generated identifier used to identify the mental health service program across specialised mental health inpatient, community and residential settings.

Examples

	Program
A client is activated into the Albany Youth community mental health program, which is overseen by Albany Mental Health Services.	4153

Related national definition

N/A

Revision history

N/A

Record Status

Field name:	record_status
Source Data Element(s):	[Record Status] – PSOLIS
Definition:	Identifies whether the record is an historical record or the latest record.
Requirement status:	N/A
Data type:	String
Format:	X
Permitted values:	H – Historical L – Latest

Guide for use

This is a system generated identifier used to identify whether the record is an historical record or the latest record.

Record status is set during the extract of data from PSOLIS.

When a record is initially reported in the extract it is assigned status ‘L’.

If an update to this record is reported in a subsequent extract, this update is assigned status ‘L’ and the status of the earlier record changes to ‘H’.

If data is being extracted for reporting the latest record should always be used.

Historical records are kept for data quality and assurance processes.

Examples

	Record Status
A service event item is reported for the first time.	L
The service event item is subsequently reported again as an update. The status of the original instance of the record changes.	H
The latest update record	L

Related national definition

N/A

Revision history

N/A

Service Contact Count

Field name:	service_contact_count
Source Data Element(s):	[Service Contact Count] – MIND
Definition:	Flag using the count of reportable service event items to determine if a service contact is reportable.
Requirement status:	N/A
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

This is a system generated identifier used to aggregate service event items to the service contact level.

Examples

	Service Contact Count
(i) A 15-minute handover with no client present.	1
(ii) Travel of 10 minutes to the client's accommodation.	0
(iii) A 30-minute clinical assessment of the client.	1
(iv) Return travel of 10 minutes.	0
(v) Clinical record keeping of 15 minutes.	0

Related national definition

N/A

Revision history

N/A

Service Contact Duration

Field name:	service_contact_duration
Source Data Element(s):	[Service Contact Duration] – MIND
Definition:	Duration of the service contact in minutes.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)
Permitted values:	Whole number

Guide for use

This is a derived data element containing the total number of minutes of the combined reportable service event items that make up the service contact.

Examples

	Service Contact Duration
(i) A 15-minute handover with no client present.	15
(ii) Travel of 10 minutes to the client's accommodation.	0
(iii) A 30-minute clinical assessment of the client.	30
(iv) Return travel of 10 minutes.	0
(v) Clinical record keeping of 15 minutes.	0
Total service contact duration in minutes (note: service event items (ii), (iv) and (v) are non-reportable and do not contribute to the service contact	*45*

Related national definition

https://meteor.aihw.gov.au/content/737218

Revision history

N/A

Service Contact End Date and Time

Field name:	service_contact_end_datetime
Source Data Element(s):	[Service Contact End Date and Time] – MIND
Definition:	The date and time the service contact concluded.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

This data element is the end date and time for a particular service contact.

Service contact end date and time is used to calculate the duration of the service contact.

Examples

	Service Contact End Date and Time
A clinician records a 30-minute appointment for a client's clinical record keeping, ending 01/08/2021 at 9.30am.	2021-08-01 09:30:00.000

Related national definition

https://meteor.aihw.gov.au/content/744335

Revision history

N/A

Service Contact Medium

Field name:	service_contact_medium_code
Source Data Element(s):	[Service Contact Medium] – MIND
Definition:	The medium used to communicate with the mental health client for a service event item.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Permitted values:	5 – Face to face 6 – By phone 7 – By videolink 8 – Not applicable 9 – Email 10 – Other electronic

Guide for use

This is data element details the communication medium through which the service event item takes place.

Code ‘8 – Not applicable’ must be recorded against a service event item when the mental health client is not present

Examples

	Service Contact Medium
A 15-minute telephone handover with no client present.	6 – By phone
A 30-minute clinical assessment of the client.	5 – Face to face

Related national definition

N/A

Revision history

N/A

Service Contact Reportable Indicator

Field name:	service_contact_reportable_indicator
Source Data Element(s):	[Service Contact Reportable Indicator] – MIND
Definition:	Flag to identify whether a service event item is reportable and makes up part of a service contact.
Requirement status:	N/A
Data type:	Numeric
Format:	N
Permitted values:	0 – Not reportable 1 – Reportable

Guide for use

This is a system generated indicator used to identify service event items which are reportable and contribute to the service contact being considered reportable.

When the sum of the service contact reportable indicator is zero then the service contact is 0 – Not reportable.

When the sum of the service contact reportable indicator is greater than zero then the service contact is 1 – Reportable.

Examples

	Service Contact Reportable Indicator
(i) A 15-minute handover with no client present.	1
(ii) Travel of 10 minutes to the client's accommodation.	0
(iii) A 30-minute clinical assessment of the client.	1
(iv) Return travel of 10 minutes.	0
(v) Clinical record keeping of 15 minutes.	0

Related national definition

N/A

Revision history

N/A

Service Contact Session Type

Field name:	service_contact_session_type_code
Source Data Element(s):	[Service Contact Session Type] – MIND
Definition:	Flag to identify whether a service contact was an individual or group session.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Individual 1 – Group

Guide for use

This data element is used to indicate whether a service contact was associated with an individual or group session.

Examples

	Service Contact Session Type
A client participates in a group therapy session.	1 - Group
A client undergoes a clinical assessment while accompanied by a support worker.	0 – Individual

Related national definition

N/A

Revision history

N/A

Service Contact Start Date and Time

Field name:	service_contact_start_datetime
Source Data Element(s):	[Service Contact Start Date and Time] – MIND
Definition:	The date and time the service contact commenced.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

This data element is the start date and time for a particular service contact.

Service contact start date and time is used to calculate the duration of the service contact.

Examples

	Service Contact Start Date and Time
A clinician records a 30-minute appointment for a client's clinical record keeping, commencing 01/08/2021 at 9am.	2021-08-01 09:00:00.000

Related national definition

https://meteor.aihw.gov.au/content/268983

Revision history

N/A

Service Event Category

Field name:	service_event_category_code
Source Data Element(s):	[Service Event Category] – PSOLIS
Definition:	The status of the client in the community mental health program when the service event occurred.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Triage 2 – Pre-admission 3 – Active 4 – Post discharge 5 – Staff only 6 – Pre-referral

Guide for use

This field is automatically determined in the system when a service event is recorded based on the status of the client within the community program at the start date and time of the service event.

Permitted value definitions

Triage

For recorded triage events using the Triage Module.

Pre-admission

When the service event commenced, the client was not active in the community mental health program providing the service event.

Active

At the commencement of the service event, the client was active in the community mental health program.

Post discharge

The service event was provided after the client was deactivated from the community mental health program.

Staff only

Service events that do not include mental health clients.

Pre-referral

The client did not have an open referral to the community mental health program and was considered unlikely to have a continuing service into the future.

A service event can have one or many items.

For a single service event these items must be continuous and relate to the same client or event.

The service event category of ‘Pre-referral’ must be used to collect all activity outside the context of a referral, admission or activation.

By default, ‘Pre-referral’ is assigned where the client has neither an open referral in the stream nor an open activation.

Examples

	Service Event Category
A triage service event is recorded for a client when they telephone a mental health clinic for information only, and no further action is required.	1 – Triage
A client is referred to a community mental health program and attends a service for an initial assessment.	2 – Pre admission
A client is activated into a community mental health program and attends a service contact for an assessment.	3 – Active
A client contacts a community mental health program to obtain information on the service	6 – Pre-referral

Related national definition

N/A

Revision history

N/A

Service Event Identifier

Field name:	service_event_identifier
Source Data Element(s):	[Service Event Identifier] – PSOLIS
Definition:	The unique identifier for each service event recorded.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

This data element is the unique, system generated number assigned to each service event created in PSOLIS.

A service event can have one or many items.

For a single service event these items must be continuous and relate to the same client or event.

Examples

	Service Event Identifier
A mental health client attends a face to face appointment on 01/08/2021, comprising three service event items, over a continuous period:	
(i) An assessment, starting at 9am and finishing at 10am.	13280527
(ii) A consultation, starting at 10am and finishing at 11am.	13280527
(iii) Client assistance, starting at 11am and finishing at 11.15am.	13280527

Related national definition

N/A

Revision history

N/A

Service Event Item

Field name:	service_event_item_code
Source Data Element(s):	[Service Event Item] – PSOLIS
Definition:	A code that represents the service event item(s) delivered to the mental health client at the service event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNN
Permitted values:	As per Appendix A – Service event item codes

Guide for use

This data element is the code used to represent the actual service delivered to the client at each service event item, such as assessment, therapy, client assistance, clinical review, etc.

A service event can have one or many items.

For a single service event these items must be continuous and relate to the same client or event.

Examples

	Service Event Item
A mental health client attends a face to face appointment on 01/08/2021, comprising three service event items, over a continuous period:	
(i) A clinical review, starting at 9am and finishing at 10am.	61 – Clinical reviews
(ii) A consultation, starting at 10am and finishing at 11am.	72 – Liaison/consultation
(iii) Client assistance, starting at 11am and finishing at 11.15am.	56 – Client assistance

Related national definition

N/A

Revision history

N/A

Service Event Item End Date and Time

Field name:	service_event_item_end_datetime
Source Data Element(s):	[Service Event Item End Date and Time] – PSOLIS
Definition:	The date and time the service event item ended.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

This data element is the end time for a particular service event item.

Service event item end date and time is used to calculate the duration of the service event item and/or service contact as applicable.

A service event can have one or many items.

For a single service event these items must be continuous and relate to the same client or event.

When a single service event consists of multiple continuous service event items the end and start times must be back to back to ensure accurate service contact reporting.

Examples

	Service Event Item End Date and Time
A clinician records a 30-minute appointment for a client's clinical record keeping, commencing 01/08/2021 at 9am.	2021-08-01 09:30:00.000

Related national definition

N/A

Revision history

N/A

Service Event Item Identifier

Field name:	service_event_item_identifier
Source Data Element(s):	[Service Event Item Identifier] – PSOLIS
Definition:	The unique identifier for each service event item recorded.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

This data element is the unique, system generated number assigned to each service event item created in PSOLIS.

A service event item is the lowest level that service event data is collected.

A single service event item consists of the item in question, such as assessment, depot injection, or clinical review.

The service event item identifier is particularly useful to identify all clients within the same group session as all clients listed as attending a group session will have one record each with matching service event item identifier, start and end times, health professionals, etc.

A service event can have one or many items.

For a single service event these items must be continuous and relate to the same client or event.

Examples

	Service Event Item Identifier
A mental health client attends a face to face appointment on 01/08/2021, comprising three service event items, over a continuous period:	
(i) A clinical review, starting at 9am and finishing at 10am.	17959962
(ii) A consultation, starting at 10am and finishing at 11am.	17959963
(iii) Client assistance, starting at 11am and finishing at 11.15am.	17959964

	Service Event Item Identifier
Three clients are activated into a community rehabilitation program and a group session is recorded, with a service event item of ‘Clinical reviews’. One service contact per client is recorded against this service event item, and all will share the same service event item identifier:	
Client – 10000001 Session type – Group	11785471
Client – 10000002 Session type – Group	11785471
Client – 10000003 Session type – Group	11785471

Related national definition

N/A

Revision history

N/A

Service Event Item Start Date and Time

Field name:	service_event_item_start_datetime
Source Data Element(s):	[Service Event Item Start Date and Time] – PSOLIS
Definition:	The date and time the service event item commenced.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

This data element is the start time for a particular service event item.

Service event item start date and time is used to calculate the duration of the service event item and/or service contact as applicable.

A service event can have one or many items.

For a single service event these items must be continuous and relate to the same client or event.

When a single service event consists of multiple continuous service event items the end and start times must be back to back to ensure accurate service contact reporting.

Examples

	Service Event Item Start Date and Time
A clinician records a 30-minute appointment for a client's clinical record keeping, commencing 01/08/2021 at 9am.	2021-08-01 09:00:00.000

Related national definition

N/A

Revision history

N/A

Staff Full Name

Field name:	staff_full_name
Source Data Element(s):	[Staff Full Name] – PSOLIS
Definition:	The name of the staff member with PSOLIS access.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(149)]
Permitted values:	Alphanumeric combination

Guide for use

This data element is the full name of the staff member with access to PSOLIS.

Examples

	Staff Full Name
A staff member is provided with read only access to PSOLIS.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Staff HE Number

Field name:	staff_he_number
Source Data Element(s):	[Staff HE Number] – PSOLIS
Definition:	The health employee (HE) number of the staff member with PSOLIS access.
Requirement status:	Mandatory
Data type:	String
Format:	X([X(9)]
Permitted values:	Valid HE number

Guide for use

This data element is the Health Employee (HE) number for a specific member of staff who has access to PSOLIS.

Examples

	Staff HE Number
A staff member is provided with read only access to PSOLIS.	HE888880

Related national definition

N/A

Revision history

N/A

Staff User ID

Field name:	staff_user_id
Source Data Element(s):	[Staff User ID] – PSOLIS
Definition:	The unique identifier for each PSOLIS user.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

This data element is the unique, constant, system generated identifier assigned to each PSOLIS user.

Examples

	Staff User ID
Staff member Joe Citizen, HE888880, logs in to PSOLIS.	10423362

Related national definition

N/A

Revision history

N/A

Stream

Field name:	establishment_mh_stream
Source Data Element(s):	[Stream] – PSOLIS
Definition:	The specialised mental health program providing care to the client.
Requirement status:	Conditional
Data type:	String
Format:	X(150)
Permitted values:	As per Appendix B – Stream codes

Guide for use

Collection of this data element is conditional – stream must be collected if the client is activated.

The stream reported must be a valid stream as per the list detailed in Appendix B of this document.

Examples

	Stream
A client is activated into the Alma Street Adult Outpatients program.	Fremantle Adult

Related national definition

N/A

Revision history

N/A

Stream Code

Field name:	establishment_mh_stream_code
Source Data Element(s):	[Stream Code] – PSOLIS
Definition:	Numeric identifier for the specialised mental health program providing care to the client.
Requirement status:	Conditional
Data type:	Numeric
Format:	NNN
Permitted values:	As per Appendix B – Stream codes

Guide for use

Collection of this data element is conditional – stream code must be collected if the client is activated.

The stream code reported must be a valid code as per the list detailed in Appendix B of this document.

Examples

	Stream Code
A client is activated into the Alma Street Adult Outpatients program.	5

Related national definition

N/A

Revision history

N/A

Stream Type

Field name:	establishment_mh_stream_type_code
Source Data Element(s):	[Stream Type] – PSOLIS
Definition:	Identifier of the stream type for the specialised mental health programs providing care to the client.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Child and adolescent 2 – Adult 3 – Elderly 4 – PET (Psychiatric Emergency Team) 5 – SARC (Sexual Assault Resource Centre) 6 – Youthlink

Guide for use

Collection of this data element is conditional – stream type must be collected if the client is activated.

This data element represents the stream type of the specialised mental health programs providing care to the mental health client.

Mental health services are defined by the broad age groups of clients they service. These groupings are Child & Adolescent (ages 0-17), Adult/General (ages 18-64), and Older Adult (ages 65 and over).

The services provided are not defined or restricted by the actual age of a client. For example, a client who is 60 years of age may be serviced by the Older Adult stream type.

The MHDC does not collect SARC data and records for this stream type must not be present.

Examples

	Stream Type
A client is activated into a community outpatient program applicable to adults.	2 - Adult

Related national definition

N/A

Revision history

N/A

Venue

Field name:	venue_code
Source Data Element(s):	[Venue] – PSOLIS
Definition:	Numeric identifier for the type of venue where the service event item took place.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Permitted values:	1 – Clinic 2 – Community centre 3 – Court 4 – Education facility 5 – Emergency department 6 – Entertainment venue 7 – General hospital 8 – GP surgery 9 – Group home 10 – Home/private dwelling 11 – Hostel 12 – Inhouse school 13 – Lock up 14 – Nursing home 15 – Police station 16 – Prison 17 – Psychiatric hospital 18 – Public space 19 – Rehab centre 20 – Other government organisation 21 – General hospital outpatient clinic 22 – Neonatal intensive care unit

Guide for use

This identifier is used to represent the venue where the service event item took place, such as psychiatric hospital, nursing home or clinic.

This data element is useful for determining additional activity characteristics such as client liaison activity within hospitals.

Examples

	Venue
A clinician records a service event item for travel time taken to a home visit.	10 – Home/private dwelling
A mental health client attends an assessment in a mental health clinic.	1 - Clinic

Related national definition

N/A

Revision history

N/A

10. NOCC and AMHCC clinical measures

The following section provides specific information about the National Outcomes and Casemix Collection (NOCC) and Australian Mental Health Care Classification (AMHCC) clinical measures data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Assessment Scale

Field name:	assessment_scale_code
Source Data Element(s):	[Assessment Scale] – PSOLIS
Definition:	The specific assessment outcome measure included in the NOCC, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N[N]
Permitted values:	1 – HoNOSCA 2 – CGAS 3 – FIHS 4 – HoNOS 5 – LSP–16 6 – MHI 7 – HoNOS 65+ 8 – RUG–ADL 9 – KESSLER 10+ 10 – KESSLER 10 11 – SDQ PC1 12 – SDQ PC2 13 – SDQ PY1 14 – SDQ PY2 15 – SDQ YR1 16 – SDQ YR2 17 – SDQ TC1 19 – SDQ TY1 20 – SDQ TY2 21 – NOCC CLEARANCE

Guide for use

Assessment scale is the numerical code that represents the NOCC outcome measure used to assess the client's current health status at the collection occasion.

The NOCC protocol determines which instrument or measure is required, based on the setting, collection reason and stream (age group) of the mental health service program.

For more details on NOCC assessment scales refer to the Australian Mental Health

Outcomes and Classification Network (AMHOCN) website.

Examples

	Assessment Scale
A client is activated and undergoes an HoNOS 65+ assessment	7 – HoNOS 65+
A client is activated and undergoes a CGAS assessment	2 – CGAS

Related national definition

N/A

Revision history

N/A

Assessment Scale Version

Field name:	assessment_scale_version
Source Data Element(s):	[Assessment Scale Version] – PSOLIS
Definition:	The version of the NOCC instrument which has been used with the client, as represented by a code.
Requirement status:	Mandatory
Data type:	String
Format:	XX[XXX]
Permitted values:	01 – CGAS 01 – FIHS A1 – HoNOS 01 – HoNOSCA G1 – HoNOS 65+ M1 – KESSLER 10+ 01 – LSP–16 01 – RUG–ADL PC101 – SDQ Parent Report Baseline 4-10 years PC201 – SDQ Parent Follow-up 4-10 years PY101 – SDQ Parent Report Baseline 11-17 years PY201 – SDQ Parent Follow-up 11-17 years YR101 – SDQ Self-report Baseline 11-17 years YR201 – SDQ Self-report Follow Up 11-17 years

Guide for use

Assessment scale version specifies the version of the instrument being used to assess the health status of the client.

The versions of the instruments to be used for each assessment are detailed below.

Permitted value definitions

01 – CGAS

As described in Schaffer et al (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.

01 – FIHS

As described in Buckingham et al (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*, Canberra: Commonwealth Department of Health and Family Services.

A1 – HoNOS General adult version

As described in Wing et al (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432-434.

01 – HoNOSCA version

As described in Gowers et al (1999) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433.

G1 – HoNOS 65+ version

As described in Burns et al (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). *British Journal of Psychiatry*, 174, 424-427.

M1 – Kessler 10+

As specified by the Department of Health and Ageing and reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinician rated and consumer self-report measures,* Department of Health and Ageing, Canberra, 2003.

01 – LSP-16

As described in Buckingham et al (1998) *Developing a Casemix Classification for Mental Health Services Volume 2: Resource Materials,* Canberra: Commonwealth Department of Health and Family Services.

01 – RUG-ADL

As described in Fries et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). *Medical Care*, 32, 668-685.

SDQ VERSIONS

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 yrs., Baseline version, Australian Version 1

YR201 – Self report Version, 11-17 yrs., Follow Up version, Australian Version 1

Details of the above assessments has also been reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items,* Commonwealth Department of Health and Ageing, Canberra, 2003.

Examples

	Assessment Scale Version
A client is activated and undergoes an HoNOS 65+ assessment	G1
A client is activated and undergoes a CGAS assessment	01

Related national definition

N/A

Revision history

N/A

Children's Global Assessment Scale (CGAS)

Field name:	cgas
Source Data Element(s):	[CGAS] – PSOLIS
Definition:	An assessment to reflect the lowest level of functioning for a child or adolescent during a specified rating period, as represented by a single global rating only on a scale of 1-100.
Requirement status:	Conditional
Data type:	String
Format:	NNN
Permitted values:	091 to 100: Superior functioning 081 to 090: Good functioning in all areas 071 to 080: No more than slight impairments in functioning 061 to 070: Some difficulty in a single area but generally functioning pretty well 051 to 060: Variable functioning with sporadic difficulties or symptoms in several but not all social areas 041 to 050: Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area 031 to 040: Major impairment of functioning in several areas and unable to function in one of these areas 021 to 030: Unable to function in almost all areas 011 to 020: Needs considerable supervision 001 to 010: Needs constant supervision 997: Unable to rate 998: Not Applicable

Guide for use

Collection of this data element is conditional – CGAS is only required for the child and adolescent stream type when the collection occasion is admission or review.

A valid CGAS measure must have one valid score recorded (Score: 1 - 100).

Clinicians assign a score, with 1 representing the most functionally impaired child, and 100 the highest functioning.

AMHOCN provides a guide to CGAS score ranges which indicates the type of service a

client would usually receive services from:

- 01 to 29 – specialist inpatient services or equivalent level of dependency
- 30 to 69 – specialist mental health services; ambulatory mental health care
- 70 to 100 – primary health care services; general practitioner; school counsellors

For more details on rating clients, refer to the CGAS section on the AMHOCN website.

Examples

	CGAS
A 12-year-old is admitted as an ambulatory mental health client.	Collected
A 15-year-old ambulatory mental health client is reviewed.	Collected

Related national definition

N/A

Revision history

N/A

Collection Occasion

Field name:	collection_occasion_code
Source Data Element(s):	[Collection Occasion] – PSOLIS
Definition:	This identifies the occasion when the NOCC assessment is collected within a specified setting at an admission, review or discharge.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N[N]
Permitted values:	1 – Referral 2 – Activation 3 – Admission (inpatient only) 4 – Review (inpatient only) 5 – Deactivation 6 – Discharge (inpatient only) 7 – Review 8 – Referral (inpatient only) 9 – Reverse deactivation 10 – Reverse discharge (inpatient only)

Guide for use

Collection occasion relates to a range of key events that may occur within the context of an episode of mental health care and indicates whether the occasion where the client has a NOCC collected is related to an admission to, review or discharge from an inpatient, community residential or ambulatory care setting.

Three collection occasions within an episode of mental health care are identified: admission, review and discharge.

Collection occasion is system driven (i.e. not selected by the user within PSOLIS) and is derived from the collection reason. In the community mental health setting these are:

Collection Occasion	Collection Reason
Activation	• New referral • Transfer from other treatment setting of the same MH service • Activation – other
Review	• 3-month review • Review – MHPoC change • Review – other

Deactivation	• Discharge – other • Death • Transfer to other treatment setting of the same MH service • No further care • Planned deactivation

The exception is when the collection reason selected is ‘planned deactivation’. The selection of this reason allows for completion of the NOCC prior to the assessment episode ending. This is considered a review (collection occasion) until the client is deactivated (within seven days of the NOCC collection).

Once deactivation is performed the collection occasion will be converted to discharge. If the deactivation does not occur within seven days of collection the collection occasion will remain as review.

Examples

	Collection Occasion
A client is activated into a MH youth outpatient program, and a NOCC assessment is collected	2 - Activation

Related national definition

N/A

Revision history

N/A

Collection Occasion Date

Field name:	assessment_collection_date
Source Data Element(s):	[Collection Occasion Date] – PSOLIS
Definition:	The reference date for all data collected at any given collection occasion, defined as the date on which the collection occasion (activation, review, deactivation) occurred.
Requirement status:	Mandatory
Data type:	Datetime
Format:	DDMMYYYY
Permitted values:	Valid date

Guide for use

The collection occasion date should be distinguished from the actual date of completion of individual measures that are required at the specific occasion.

In practice, various measures may be completed by clinicians and clients over several days. For example, a clinician might complete a HoNOS and LSP during a review on the scheduled date, but to include client responses to the self-report measure they would most likely have asked the client to complete the measure at their last contact with them.

For national reporting and statistical purposes, a single date is required which ties all the standardised measures and other data items together in a single collection occasion.

Examples

	Collection Occasion Date
A client is activated into a MH program and attends a review on 01/08/2020 where three assessments are collected: HoNOS, Kessler 10+ and LSP-16. All three of these measures share the same assessment collection date.	01082020

Related national definition

N/A

Revision history

N/A

Collection Occasion Identifier

Field name:	nocc_collection_occasion_identifier
Source Data Element(s):	[Collection Occasion Identifier] – PSOLIS
Definition:	A unique identifier for each assessment collection occasion in a NOCC episode.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

This is a system generated identifier for every individual NOCC collection occasion.

The ID is used to identify and group all the individual NOCC assessment measures collected at the same occasion (activation, review or deactivation).

Examples

	Collection Occasion Identifier
A client is activated into a MH youth outpatient program and attends a review on 01/08/2020 where three NOCC assessments are collected: HoNOS, Kessler 10+ and LSP-16. All three of these measures share the same assessment collection date.	20008581

Related national definition

N/A

Revision history

N/A

Collection Occasion Reason

Field name:	collection_occasion_reason_code
Source data element(s):	[Collection Occasion Reason] – PSOLIS
Definition:	The reason for the collection of the standardised measures and individual data items on the identified collection occasion.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NN
Permitted values:	03,11 – Admission – other 04,16 – 3-month review 05,17 – Review – other 06,12 – No further care 08,14 – Death 09,15 – Discharge – other 18,19 – New referral 20 – Reverse deactivation 21 – Reverse discharge 22 – Planned deactivation 23 – Planned discharge 24 – Non-NOCC collection 29,30 – Review – MHPoC change 31,32 – Transfer from other treatment setting 33,34 – Transfer to other treatment setting

Guide for use

Collection of this data element is mandatory.

Collection occasion reason further describes the collection occasion and relates to a range of key events that may occur within an episode of mental health care.

Permitted value definitions

18,19 – New referral

Admission to a new inpatient, community residential or ambulatory episode of mental health care of a consumer not currently under the active care of the mental health service.

31,32 – Transfer from other treatment setting

Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the active care of the mental health service.

03,11 – Admission - other

Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.

04,16 – 3-month review

Standard review conducted at 91 days following admission to the current episode of mental health care or 91 days subsequent to the preceding review.

05,17 – Review - other

Standard review conducted for reasons other than the above.

06,12 – No further care

Discharge from an inpatient, community residential or ambulatory episode of care of a consumer for whom no further care is planned by the mental health service.

33,34 – Transfer to change of treatment setting

Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the care of the mental health service.

08,14 – Death

Completion of an episode of mental health care following the death of the client.

09,15 – Discharge - other

Discharge from an inpatient, community residential or ambulatory episode of mental health care for any reason other than defined above.

20 – Reverse deactivation

Reversal of a client deactivation.

21 – Reverse discharge

Reversal of a client discharge.

22 – Planned deactivation

The planned deactivation of a client.

23 – Planned discharge

The planned discharge of a client.

24 – Non-NOCC collection

Collection of measures occasion is for non-NOCC collection reasons.

29,30 – Review – MHPoC change

Review due to change in the mental health phase of care.

Examples

	Collection Occasion Reason
A client is referred and activated into a MH youth outpatient program and a NOCC assessment is collected.	18 – New referral
A client is deactivated from an outpatient program with no further treatment planned and a NOCC assessment is collected.	06 – No further care

Related national definition

N/A

Revision history

N/A

Collection Status

Field name:	collection_status_raw_code
Source Data Element(s):	[Collection Status] – PSOLIS
Definition:	The completion status of a particular NOCC assessment measure entered, including the reason that the assessment measure was not completed (collected).
Requirement status:	Mandatory
Data type:	Numeric
Format:	N[N]
Permitted values:	1 – Complete 2 – Not completed due to temporary contraindication 4 – Not completed due to general exclusion 5 – Not completed due to refusal by the client 7 – Not completed for reasons not elsewhere classified 8 – Not completed due to protocol exclusion 10 – Partially complete 11 – Not completed due to cultural inappropriateness 14 – Offered to client, awaiting response 16 – Dismissed – automatic cleanup 17 – Dismissed – manual program exclusion 18 – Dismissed – manual user request 19 – Dismissed – service split / amalgamation 20 – Dismissed - restructure

Guide for use

Collection status describes the outcome of an assessment measure in terms of completion.

Examples

	Collection Status
The Outcome Measure is completed with all items having a valid value reported.	1 – Complete

The Outcome Measure cannot be completed due to: - the consumer's current clinical state is of sufficient severity to make it unlikely that their responses to a self–report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that the responses give a reasonable indication of the consumer's feelings and thoughts about their current emotional and behavioural problems and wellbeing; - where an invitation to complete the measures is likely to cause distress or requires a level of concentration and effort the consumer feels unable to give; or - where consumers or parents in crisis are too distressed to complete the measure.	2 - Not completed due to temporary contraindication
The Outcome Measure cannot be completed due to: - The person's cognitive functioning permanently or ongoing insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability; or - There is a Language and/or literacy issues that makes the measures inappropriate.	4 – Not completed due to general exclusion
The Outcome Measure cannot be completed due to: - The person/parent refuses to complete the measure. - The measure was not returned.	5 – Not completed due to refusal by the client
The Outcome Measure cannot be completed due to: - The patient is deceased, - The patient was discharged whilst being on leave (leave is 3 days or more) and did not return prior to Discharge. Note: The input of client data is based on decisions made by the Multidisciplinary Team, which informs the consumer management plan at east stage of the consumer episode of care, *Therefore if it has been identified a staff member does not have the knowledge / skills to formulate a reasonable management plan and record this information via the mandatory requirements for documentation* (e.g. Unable to assess) *, it would need to be addressed via their education/manger.*	7 – Not completed for reasons not elsewhere classified
The Outcome Measure is not required to be completed due to AMHOCN protocols such as: - Discharge rating for HONOS, HONOSCA or HONOS 65+ are not required for inpatient episodes of 3 days or less, - Discharge rating for CGAS not required, - Admission rating for FIHS not required, - Discharge rating for RUG-ADL in inpatient and community residential setting not required, - Discharge rating for ambulatory episodes where the number of days between admission and discharge is 14 days or less duration. - Discharge rating for SQD not required for episodes of less than 21 days duration. - Admission SDQ is generated where the Follow UP SDQ is more appropriate.	8 – Not completed due to protocol exclusion
The Psychiatric Services Online Information System (PSOLIS) has allocated this Collection Status due to: - Not all values have been reported with valid values.	10 – Partially Complete
The outcome measure cannot be completed due to: - Cultural issues make answering this measure inappropriate - Interpreter availability or issues does not allow the measure to be completed, - Literacy understanding due to cultural background.	11 - Not completed due to cultural inappropriateness
The Outcome Measure has been offered to the client and the clinician is awaiting a response. This Outcome Status should not be reported after 72hours.	14 – Offered to client, awaiting response.

Outcome Measures must be followed up with consumers, and an appropriate Outcome Status be reported (e.g., 5 – Not completed due to refusal by client)	

Related national definition

N/A

Revision history

N/A

Episode Identifier

Field name:	nocc_episode_identifier
Source Data Element(s):	[Episode Identifier] – PSOLIS
Definition:	Unique identifier for each NOCC episode of care.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

This is a system generated identifier for each NOCC episode (the complete period of treatment from admission/activation to discharge/deactivation).

This identifier is assigned to all NOCC assessment measures collected within a single episode of care.

Examples

	Episode Identifier
A client is activated into a MH youth outpatient program and attends a review on 01/08/2020, where three NOCC assessments are collected: HoNOS, Kessler 10+ and LSP-16. The client then attends a review on 01/11/2020 where the same three NOCC assessments are collected. All six of these assessment measures share the same NOCC episode identifier.	12830

Related national definition

N/A

Revision history

N/A

Episode Service Setting

Field name:	establishment_setting
Source Data Element(s):	[Episode Service Setting] – PSOLIS
Definition:	A category identifier to indicate whether the mental health episode of care took place in an inpatient, ambulatory or community residential setting.
Requirement status:	Mandatory
Data type:	String
Format:	A
Permitted values:	I – Psychiatric inpatient service O – Ambulatory mental health service R – Community residential mental health service

Guide for use

Episode service setting indicates whether the mental health care episode took place in the inpatient, ambulatory or community residential setting.

This data element helps determine which assessments will be required to be completed at each of the collection occasions within a NOCC episode, for a given age group (stream type) of mental health consumers.

Permitted value definitions

I – Psychiatric inpatient service

Refers to overnight care provided in public psychiatric hospitals and designated psychiatric units in public acute hospitals. Psychiatric hospitals are specialist mental health establishments that provide treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Designated psychiatric units in a public acute hospital are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. For the purposes of NOCC specification, care provided by an ambulatory mental health service team to a person admitted to a designated special care suite or 'rooming-in' facility within a community general hospital for treatment of a mental or behavioural disorder is also included under this setting.

O – Ambulatory mental health service

Refers to non-admitted, non-residential services provided by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include, for example, community-based crisis assessment and treatment teams, day programs, psychiatric outpatient clinics provided by either hospital or community-based services, child and adolescent outpatient and community teams, social and living skills programs and psychogeriatric assessment services For the purposes of NOCC specification, care provided by hospital-based consultation-liaison services to admitted patients in non-psychiatric and emergency settings is also included under this setting.

R – Community residential mental health service

Refers to overnight care provided in residential units staffed on a 24-hour basis by health professionals with specialist mental health qualifications or training and established in a community setting which provides specialised treatment, rehabilitation or care for people affected by a mental illness or

psychiatric disability. Psychogeriatric hostels and psychogeriatric nursing homes are included in this category. (Note: Community residential (Hampton Road) is currently recorded as an ambulatory program, so there are no ‘R’ values recorded in the data.)

Examples

	Episode Service Setting
A client is activated into community care.	O

Related national definition

N/A

Revision history

N/A

Factors Influencing Health Status (FIHS)

Field name:	item1 – item7
Source Data Element(s):	[FIHS] – PSOLIS
Definition:	An indicator of the presence of one or more factors impacting on the relationship between social interaction/environment with behaviour and thoughts which have a negative effect on an individual's psychological health and requires additional clinical input, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Yes 2 – No 7 – Unable to rate 8 – Not Applicable 9 – Not stated/inadequately described

Guide for use

Collection of this data element is conditional – this measure is only required for the child and adolescent stream type when the collection occasion is review or discharge.

The FIHS code set is derived from the FIHS chapter (Chapter 21) in ICD-10-AM and contains seven categories:

- maltreatment syndromes
- problems related to negative life events in childhood
- problems related to upbringing
- problems related to primary support group, including family circumstances
- problems related to social environment
- problems related to certain psychosocial circumstances
- problems related to other psychosocial circumstances.

The FIHS is a simple checklist used to indicate whether one or more psychosocial factors are present during an episode of care.

The purpose of the FIHS is to identify the degree to which the child or adolescent has complicating psychosocial factors that require additional clinical input during the episode of care.

These factors are important in understanding variations in outcomes and are based on advice by clinicians that children or adolescents seen by specialist mental health services

may present in the context of a range of circumstances which influence the client's health status but are not in themselves a current illness or injury. For example, the child may be severely affected by a history of sexual abuse but is being primarily being treated for depression.

Permitted value definitions

1 – Yes

This code is used to indicate the presence of the selected factor, as listed in the FIHS chapter in ICD-10-AM.

2 – No

This code is used to indicate that the selected factor was not present, as listed in the FIHS chapter in ICD-10-AM.

8 – Unknown

This code is used to indicate that it was not possible to determine the presence of the selected factor, as listed in the FIHS chapter in ICD-10-AM.

9 – Not stated/inadequately described

This code is used to indicate that the presence of the selected factor, as listed in the FIHS chapter in ICD-10-AM, was not stated or was missing or where a response contained insufficient information to be coded to 1, 2 or 8.

FIHS is only required for children and adolescents when the collection occasion is review or discharge.

The measure covers the period of care bound by both the current and preceding collection occasions.

There are two exceptions to these collection requirements.

If an ambulatory episode is closed because the client is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. Where possible, the clinician and client measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the client's discharge ratings from the ambulatory episode.

If an ambulatory episode is brief (where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

In both situations details are still required, however, regarding principal and additional diagnoses and mental health legal status relevant to the ambulatory episode of care.

In accordance with the NOCC protocol, a valid FIHS measure must have 6 valid scores recorded (scores: 1 or 2). Valid scores must be recorded for each: FIHS1, FIHS2, FIHS3, FIHS4, FIHS5, FIHS6, and FIHS7.

Examples

	FIHS measure
A 15-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected

A 9-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 13-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/730840

Revision history

N/A

Health of the Nation Outcome Scales (HoNOS)

Field name:	item1 – item12
Source Data Element(s):	[HoNOS] – PSOLIS
Definition:	A 12-item clinician-rated measure designed by the Royal College of Psychiatrists specifically for use in the assessment of consumer outcomes in mental health services.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No problems within the period stated 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem 7 – Not stated/missing 9 – Not known or not applicable

Guide for use

Collection of this data element is conditional – HoNOS is only required for the adult stream type when the collection occasion is admission, review or discharge.

The HoNOS is a 12-item clinician-rated measure for use in the assessment of consumer outcomes in mental health services. The focus of the HoNOS is on health status and severity of symptoms. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

HoNOS is answered on an item-specific 4-point scale with higher scores indicating more problems. Each scale is assigned a value between 0 and 4. The 12 scales are as follows:

- Behavioural disturbance
- Non-accidental self injury
- Problem drinking or drug use
- Cognitive problems
- Problems related to physical illness or disability
- Problems associated with hallucinations and delusions
- Problems associated with depressive symptoms
- Other mental and behavioural problems

- Problems with social or supportive relationships
- Problems with activities of daily living
- Overall problems with living conditions
- Problems with work and leisure activities and the quality of the daytime environment.

The sum of the individual scores of each of the scales represents the total HoNOS score. The total HoNOS score ranges from 0 to 48 and represents the overall severity of an individual's psychiatric symptoms.

For more details on rating clients (adults 65 years of age or younger) on each scale/item, refer to the AMHOCN website.

For community mental health care, HoNOS is only required for persons aged 18 to 64 years when the collection occasion is admission, review or discharge.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

Examples

	HoNOS
A 42-year-old ambulatory mental health client is reviewed.	Collected
A 58-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 46-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected
A 51-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/717795

Revision history

N/A

Health of the Nation Outcome Scales 65+ (HoNOS 65+)

Field name:	item1 – item12
Source Data Element(s):	[HoNOS 65+] – PSOLIS
Definition:	A variant of the HoNOS designed for use with adults aged 65 years and older. It is a 12-item clinician-rated measure designed specifically for use in the assessment of older adult consumer outcomes.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No problems within the period rated 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem 7 – Not stated/missing 9 – Not known or not applicable

Guide for use

Collection of this data element is conditional – HoNOS 65+ is only required for the older adult stream type when the collection occasion is admission, review or discharge.

The HoNOS 65+ is a 12-item clinician-rated measure for use in the assessment of consumer outcomes in mental health services. The focus of the HoNOS 65+ is on health status and severity of symptoms. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

HoNOS 65+ is an item-specific 4-point scale with higher scores indicating more problems. Each scale is assigned a value between 0 and 4. The 12 scales are as follows:

- behavioural disturbance
- non-accidental self injury
- problem drinking or drug use
- cognitive problems
- problems related to physical illness or disability
- problems associated with hallucinations and delusions
- problems associated with depressive symptoms
- other mental and behavioural problems

- problems with social or supportive relationships
- problems with activities of daily living
- overall problems with living conditions
- problems with work and leisure activities and the quality of the daytime environment.

The sum of the individual scores of each of the scales represents the total HoNOS 65+ score. The total HoNOS 65+ score ranges from 0 to 48 and represents the overall severity of an individual's psychiatric symptoms.

For more details on rating clients (adults 65 years of age and older) on each scale/item, refer to the AMHOCN website.

For community mental health care, HoNOS 65+ is only required for persons aged 65 years and older when the collection occasion is admission, review or discharge.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

Examples

	HoNOS 65+
A 65-year-old ambulatory mental health client is reviewed.	Collected
An 82-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 78-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected
A 91-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/730844

Revision history

N/A

HoNOS for Children and Adolescents (HoNOSCA)

Field name:	item1 – item15
Source Data Element(s):	[HoNOSCA] – PSOLIS
Definition:	A variant of the HoNOS designed for use with children and adolescents. It is a 15-item clinician-rated measure designed specifically for use in the assessment of child and adolescent consumer outcomes in mental health services.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No problems within the period rated 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem 7 – Not stated/missing 9 – Not known or not applicable

Guide for use

Collection of this data element is conditional – HoNOSCA is only required for the child and adolescent stream type when the collection occasion is admission, review or discharge.

The HoNOSCA is a 15-item clinician-rated measure for use in the assessment of consumer outcomes in mental health services. The focus of the HoNOSCA is on health status and severity of symptoms. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

HoNOSCA is answered on an item-specific 4-point scale with higher scores indicating more problems. Each scale is assigned a value between 0 and 4. The 15 scales are:

- Disruptive, antisocial or aggressive behaviour
- Overactivity attention and concentration
- Non-accidental self injury
- Alcohol, substance/solvent misuse
- Scholastic or language skills
- Physical illness or disability problems
- Hallucinations and delusions
- Non-organic somatic symptoms

- Emotional and related symptoms
- Peer relationships
- Self care and independence
- Family life and relationships
- Poor school attendance
- Lack of knowledge - nature of difficulties
- Lack of information - services/management.

The sum of the individual scores of each of the scales from 1 to 15 represents the total HoNOSCA score. The total HoNOSCA score represents the overall severity of an individual's psychiatric symptoms.

For more details on rating clients (17 years of age and younger) on each scale/item, refer to the AMHOCN website.

For community mental health care, HoNOSCA is only required for persons aged 17 years and younger when the collection occasion is admission, review or discharge.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

Examples

	HoNOSCA
A 12-year-old ambulatory mental health client is reviewed.	Collected
A 9-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 12-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected
A 14-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/717784

Revision history

N/A

Kessler (K10+) Score

Field name:	item1 – item10
Source Data Element(s):	[Kessler (K10+) Score] – PSOLIS
Definition:	The level of psychological distress experienced by a person in the four weeks prior to interview, as represented by a code
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	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 6 – Don't know

Guide for use

Collection of this data element is conditional – K10+ is only required for the adult and older adult stream types when the collection occasion is admission, review or discharge.

The K10 is a 10-item self-report questionnaire designed to yield a global measure of non-specific psychological distress based on questions about the level of nervousness, agitation, psychological fatigue and depression in the relevant rating period.

The K10+ contains four additional questions to assess functioning and related factors, but these items do not get used in the overall score.

The 10 categories of questions are as follows:

- Feeling tired
- Feeling nervous
- Nervousness that nothing could calm it down
- Feeling hopeless
- Feeling restless or fidgety
- Restlessness that you could not sit still
- Feeling depressed
- Feeling that everything was an effort
- Feeling sad and nothing cheered you up
- Feeling worthless

For more details on rating clients on each scale/item, refer to the AMHOCN website.

For community mental health care, K10+ is only required for adults and older adults when the collection occasion is admission, review or discharge.

The standard rating period in Australia for the K10+ is the last four weeks. The score range is from 10 to 50, with lower scores indicating lower levels of distress.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

Special considerations

The classification of client self-report measures as mandatory is intended only to indicate the expectation that clients will be invited to complete self-report measures at the specified collection occasions, not that such measures will always be appropriate.

Due to the nature and severity of their mental health or other problems, it is likely that some clients should never be asked to complete self–report measures, others may not be able to complete the self–report measures at the scheduled occasion, whilst still others may sometimes find completion of the self–report measures to be difficult or stressful.

In all cases, clinical judgement as to the appropriateness of inviting the client to complete the measures must be the determining factor at any given collection occasion. Where collection of client self–report measures is contraindicated, the reasons must be recorded.

Some persons may not be able to complete the measures at any time and should not be asked to do so. A definitive list of circumstances in which a general exclusion applies is beyond the scope of this document but broadly it would include situations where:

- the person's cognitive functioning is insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability;
- cultural, language and/or literacy issues make the measures inappropriate.

Under certain conditions, a client may not be able to complete the measure at a specific collection occasion. Circumstances where it may be appropriate to refrain from inviting the person to complete the measure include:

- where the client's current clinical state is of sufficient severity to make it unlikely that their responses to a self–report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that they were a reasonable indication of the person's feelings and thoughts about their current emotional and behavioural problems and wellbeing;
- where an invitation to complete the measures is likely to be experienced as

distressing or require a level of concentration and effort the person feels unable to give; or

- where clients in crisis are too distressed to complete the measure.

In these circumstances clients need not be invited to complete the measures. At all other times, an attempt must be made to obtain their responses.

In many cases, the severity of the person's clinical state and the degree of family distress experienced will diminish with appropriate treatment and care. It is suggested that, if within a period of up to seven days following the collection occasion in an ambulatory care setting the client is likely to be able to complete the measure then their responses should be sought at that time. Otherwise, no further attempt to administer the measure at that collection occasion should be made.

Examples

	K10+
A 33-year-old ambulatory mental health client is being reviewed. The clinical judgement at this time is that a request to complete the K10+ will cause the client distress.	Not collected
A 26-year-old ambulatory mental health client is being reviewed. The clinical judgement at this time is that a request to complete the K10+ is appropriate.	Collected
An 82-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 74-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected

Related national definition

https://meteor.aihw.gov.au/content/634094

Revision history

N/A

Life Skills Profile Score (LSP-16)

Field name:	item1 – item16
Source Data Element(s):	[LSP-16 Score] – PSOLIS
Definition:	Level of difficulty with activities in a life area
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – Score of 0 1 – Score of 1 2 – Score of 2 3 – Score of 3 7 – Unable to rate 8 – Not applicable 9 – Not stated/missing

Guide for use

Collection of this data element is conditional – LSP-16 is only required for adults and older adults when the collection occasion is admission, review or discharge.

LSP-16 contains 16 items which provide a measure of function and disability in people with mental illness. It focuses on general functioning, i.e., how a person functions in terms of social relationships, ability to do day-to-day tasks etc. Each item is scored on a scale of 0 to 3. Lower scores indicate a higher level of functioning. The 16 items are:

1. Does this person generally have any difficulty with initiating and responding to conversation?
2. Does this person generally withdraw from social contact?
3. Does this person generally show warmth to others?
4. Is this person generally well groomed (e.g., neatly dressed, hair combed)?
5. Does this person wear clean clothes generally, or ensure they are cleaned if dirty?
6. Does this person generally neglect her or his physical health?
7. Is this person violent to others?
8. Does this person generally make and/or keep up friendships?
9. Does this person generally maintain an adequate diet?
10. Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?
11. Is this person willing to take psychiatric medication when prescribed by a doctor?
12. Does this person co-operate with health services (e.g., doctors and/or other health workers)?
13. Does this person generally have problems (e.g., friction, avoidance) living with others in the household?
14. Does this person behave offensively (includes sexual behaviour)?
15. Does this person behave irresponsibly?

16. What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?

For more details on rating clients on each scale/item, refer to the AMHOCN website.

For community mental health care, LSP-16 is only required for the adult and older adult stream types when the collection occasion is admission, review or discharge.

The standard rating period in Australia for the LSP-16 is the previous three months.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

Examples

	LSP-16
A 26-year-old ambulatory mental health client is being reviewed.	Collected
An 85-year-old ambulatory mental health client is discharged from ambulatory care to an inpatient facility of the organisation, after a 2-month ambulatory episode of care.	Not collected
A 62-year-old ambulatory mental health client is discharged from ambulatory care to the care of their GP, after a 2-month ambulatory episode of care.	Collected
A 50-year-old ambulatory mental health client is discharged from ambulatory care to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/654401

Revision history

N/A

Phase End Date and Time

Field name:	phase_end_datetime
Source Data Element(s):	[Phase End Date and Time] – PSOLIS
Definition:	The date and time on which the client completes a phase of mental health care.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – phase end date and time must be recorded if a phase of mental health care has been recorded.

This is the end date for the phase. It may or may not be equivalent to the original date of discharge/deactivation from the mental health care program.

Examples

	Phase End Date and Time
A client is reviewed and it is determined that a change in the mental health care phase is warranted. The client's phase is changed on 01/10/2023 at 2pm.	2023-10-01 14:00:00

Related national definition

https://meteor.aihw.gov.au/content/575248

Revision history

N/A

Phase of Care

Field name:	phase_of_care
Source Data Element(s):	[Phase of Care] – PSOLIS
Definition:	Identifies the intended primary goal of care for the period of treatment recorded at the time of NOCC collection.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Acute 2 – Functional gain 3 – Intensive extended 4 – Consolidating gain 5 – Assessment only 9 – Not reported

Guide for use

Collection of this data element is conditional – phase of care is only required for the child and adolescent, adult and older adult stream types in the ambulatory setting when the collection occasion is admission or review.

Phase of care is a prospective description of the primary goal of care in the client's mental health treatment plan at the point in time when the data is being reported and refers to the next stage of the client's care.

While it is recognised that there may be aspects of each mental health phase of care represented in the client's mental health plan, the phase of care is intended to identify the main goal or aim that will underpin the next period of care.

Note: this data element was introduced in December 2017, replacing Focus of Care.

Permitted value definitions

1 – Acute

The primary goal is the short-term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder.

2 – Functional gain

The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder.

3 – Intensive extended

The primary goal is prevention or minimisation of further deterioration, and reduction of risk of harm in a patient who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period.

4 – Consolidating gain

The primary goal is to maintain the level of functioning, or improve functioning during a period of recover, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently.

5 – Assessment only

The primary goal is to obtain information, including collateral information where possible, to determine the intervention/treatment needs and to arrange for this to occur (includes brief history, risk assessment, referral to treating team or other service).

Collection of the phase of care will be required on activation into an ambulatory service and collection will be stream based. Phase of care may be reviewed at any point during the activation and will similarly be mandatory on review collection occasions.

Phase of care is collected as part of the AMHCC requirements and recorded in the client record in PSOLIS.

When an AMHCC instrument collection is triggered by the start of a new phase of care all NOCC instruments required for that setting and age group are also to be collected.

PSOLIS will indicate and enforce the mandatory outcome measures instruments for the NOCC collection depending on:

- assessment episode (inpatient or outpatient)
- stream type (adult, CAMHS or elderly)
- collection occasion type (admission/activation, review or discharge/deactivation).

Examples

	Phase of Care
A client is activated into a youth outpatient program for assessment purposes.	5 – Assessment only
A client undergoing treatment to improve social functioning attends a review.	2 – Functional gain

Related national definition

https://meteor.aihw.gov.au/content/682464

Revision history

N/A

Phase Start Date and Time

Field name:	phase_start_datetime
Source Data Element(s):	[Phase Start Date and Time] – PSOLIS
Definition:	The date and time on which a mental health care phase commences.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – phase start date and time must be recorded if a phase of mental health care has been recorded.

This is the start date for the phase. It may or may not be equivalent to the original date of admission/activation to the mental health care program.

Examples

	Phase Start Date and Time
A mental health client is activated into a MH Youth Outpatient program on 20/07/2023 at 2pm for assessment purposes.	2023-07-20 14:00:00

Related national definition

https://meteor.aihw.gov.au/content/575253

Revision history

N/A

Resource Utilisation Groups–Activities of Daily Living (RUG-ADL) Score

Field name:	item1 – item4
Source Data Element(s):	[RUG-ADL Score] – PSOLIS
Definition:	An assessment of patient motor function
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	*Scoring scale for bed mobility, toileting and transfers:* 1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than two persons physical assist 5 – Two or more persons physical assist 7 – Unable to rate 8 – Not applicable *Scoring scale for eating:* 1 – Independent or supervision only 2 – Limited assistance 3 – Extensive assistance/total dependence/tube fed 7 – Unable to rate 8 – Not applicable

Guide for use

Collection of this data element is conditional – Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) is only required for the older adult stream type in the inpatient or community residential settings when the collection occasion is admission or review.

RUG-ADL is a clinical assessment tool that measures the level of functional dependence of a patient for four activities of daily living. The values assigned provide an indication of what a person actually does, not what they are capable of doing.

RUG-ADL measures the motor function of a patient for four activities of daily living:

- Bed mobility
- Toileting
- Transfers
- Eating

RUG-ADL measures ability with respect to ‘late loss’ activities – ‘early loss’ activities (e.g.,

managing finances, social relationships, grooming) are included in the LSP.

As a general rule, the higher the total RUG-ADL score the more dependent and potentially clinically complex the patient is.

For more details on scoring and interpreting the RUG-ADL, refer to the AMHOCN website.

Permitted value definitions

Bed Mobility

Ability to move in bed after the transfer into bed has been completed.

1 – Independent or supervision only

Able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.

3 – Limited physical assistance

Able to readjust position in bed, and perform own pressure area relief, with the assistance of one person.

4 – Other than two persons physical assist

Requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief. Still requires the assistance of one person for task.

5 – Two or more persons physical assist

Requires two or more assistants to readjust patient's position in bed, and perform pressure area relief.

Toileting

Includes mobilising to the toilet, adjustment of clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If level of assistance differs between voiding and bowel movement, record the lower performance.

1 – Independent or supervision only

Able to mobilise to toilet, adjusts clothing, cleans self, has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.

3 – Limited physical assistance

Requires hands-on assistance of one person for one or more of the tasks**.**

4 – Other than two persons physical assist

Requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/suppository. Requires assistance of one person for management of the device

5 – Two or more persons physical assist

Requires two or more assistants to perform any step of the task.

Transfers

Includes the transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night.

1 – Independent or supervision only

Able to perform all transfers independently or with prompting of carer. No hands-on assistance required. May be independent with the use of a device.

3 – Limited physical assistance

Requires hands-on assistance of one person to perform any transfer of the day/night.

4 – Other than two persons physical assist

Requires the use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.

5 – Two or more persons physical assist

Requires two or more assistants to perform any transfer of the day/night.

Eating

Includes the tasks of cutting food, bringing food to mouth and chewing and swallowing food. Does not include preparation of the meal.

1 – Independent or supervision only

Able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. No hands-on assistance required. If individual relies on parenteral or gastrostomy feeding that he/she administers him/herself then score 1.

2 – Limited assistance

Requires hands on assistance of one person to set up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).

3 – Extensive assistance/total dependence/tube fed

Needs to be fed meal by assistant, or does not eat or drink full meals by mouth but relies on parenteral/gastrostomy feeding and does not administer feeds by him/herself.

A score of 2 is not valid for bed mobility, toileting and transfer items.

The total RUG-ADL score (the sum of the individual scale items) must be a value between 4 and 18.

A person with a total RUG-ADL score of 4 is considered independent. A person with a total RUG-ADL score of 18 requires the full assistance of two people.

Examples

	RUG-ADL
A 46-year-old mental health patient is reviewed.	Not collected
A 67-year-old patient is admitted as an ambulatory mental health patient.	Not collected
An 85-year-old is admitted as a mental health inpatient.	Collected
A 72-year-old community residential patient is reviewed.	Collected
A 76-year-old mental health inpatient is discharged.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/495909

Revision history

N/A

Strengths and Difficulties Questionnaire (SDQ) Score

Field name:	item1 – item42
Source Data Element(s):	[SDQ Score] – PSOLIS
Definition:	A behavioural screening questionnaire designed for 4 to 17-year-olds.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	*Item1 – item25* 0 – Not true 1 – Somewhat true 2 – Certainly true 7 – Unable to rate 8 – Not applicable *Item26* 0 – No 1 – Yes - minor difficulties 2 – Yes - definite difficulties 3 – Yes - severe difficulties 7 – Unable to rate 8 – Not applicable *Item27* 0 – Less than a month 1 – 1-5 months 2 – 6-12 months 3 – Over a year 7 – Unable to rate 8 – Not applicable *Item28 – item33, item35* 0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate

	8 – Not applicable *Item34* 0 – Much worse 1 – A bit worse 2 – About the same 3 – A bit better 4 – Much better 7 – Unable to rate 8 – Not applicable *Item36 – item42* 0 – No 1 – A little 2 – A lot 7 – Unable to rate 8 – Not applicable

Guide for use

Collection of this data element is conditional – Strengths and Difficulties Questionnaire (SDQ) is only required for the child and adolescent stream type when the collection occasion is admission, review or discharge.

There are six versions of the SDQ (parent report and youth self-report) currently specified for NOCC reporting with an additional four versions (teacher report) that may be of use at the clinical level.

Baseline versions are used at admission, while follow-up versions are used at review and discharge.

The versions specified for NOCC reporting are:

- PC101 – Parent Report Measure 4-10 yrs, Baseline version
- PC201 – Parent Report Measure 4-10 yrs, Follow Up version
- PY101 – Parent Report Measure 11-17 yrs, Baseline version
- PY201 – Parent Report Measure 11-17 yrs, Follow Up version
- YR101 – Youth Self-report Measure 11-17 yrs, Baseline version
- YR201 – Youth Self-report Measure 11-17 yrs, Follow Up version

For more details on scoring and interpreting the SDQ, refer to the AMHOCN website.

There are three issues to be aware of in the collection of the SDQ. The first is the exceptions to collection requirements, the second is when the admission or follow up versions must be collected, and the third is special considerations which apply to self-report measures.

Exceptions to collection requirements

If an ambulatory episode is closed because the client is being transferred to a bed-based

treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and client measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the client's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

In the above situations, details are still required, however, regarding principal and additional diagnoses and mental health legal status relevant to the ambulatory episode of care.

Discharge ratings for the SDQ are not required for any episode of less than 21 days duration because the rating period used at discharge (previous month) would overlap significantly with the period rated at admission.

Which version of the SDQ (admission or follow-up) is to be collected

Generally, the admission versions are administered on admission and rated over the standard rating period of six months and the follow up versions are administered on review and discharge and rated over a one-month period. However, for referral from another setting, to prevent duplication and undue burden on clients and parents, the following guide is suggested:

Transfer of care between an inpatient, community residential or ambulatory setting of a client currently under the active care of the mental health service organisation.	**Admission SDQ** - if follow-up SDQ required at the end of referring treatment settings episode is neither completed nor provided by referring setting.
	Follow-up SDQ - if follow-up SDQ is required at end of referring treatment settings episode has in fact been completed and provided by the referring setting.
Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.	**Admission SDQ** - if follow-up SDQ required at the end of referring treatment settings episode is neither completed nor provided by referring setting.
	Follow-up SDQ - if follow-up SDQ required at end of referring treatment settings episode has not been completed or is not provided by the referring setting.

Special considerations which apply to self-report measures

The classification of client self-report measures as mandatory is intended only to indicate the expectation that clients will be invited to complete self-report measures at the specified collection occasions, not that such measures will always be appropriate.

Due to the nature and severity of their mental health or other problems, it is likely that some clients should never be asked to complete self–report measures, others may not be able to complete the self–report measures at the scheduled occasion, whilst still others may sometimes find completion of the self–report measures to be difficult or stressful.

In all cases, clinical judgement as to the appropriateness of inviting the client to complete the measures must be the determining factor at any given collection occasion. Where collection of client self–report measures is contraindicated, the reasons must be recorded. Similar considerations also apply in relation to the parent version of the SDQ.

Some persons may not be able to complete the measures at any time and should not be asked to do so. A definitive list of circumstances in which a general exclusion applies is beyond the scope of this document but broadly it would include situations where:

- the person's cognitive functioning is insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability.
- cultural, language and/or literacy issues make the measures inappropriate.

Under certain conditions, a client or parent may not be able to complete the measure at a specific collection occasion.

Circumstances where it may be appropriate to refrain from inviting the person to complete the measure include:

- where the client's current clinical state is of sufficient severity to make it unlikely that their responses to a self–report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that they were a reasonable indication of person's feelings and thoughts about their current emotional and behavioural problems and wellbeing.
- where an invitation to complete the measures is likely to be experienced as distressing or require a level of concentration and effort the person feels unable to give; or
- where clients or parents in crisis are too distressed to complete the measure.

It is suggested that in these circumstances clients and parents need not be invited to complete the measures. At all other times, an attempt must be made to obtain their responses.

In many cases, the severity of the person's clinical state and the degree of family distress experienced will diminish with appropriate treatment and care. It is suggested that, if within a period of up to seven days following the collection occasion in an ambulatory care setting, the client is likely to be able to complete the measure then their responses should be sought at that time. Otherwise, no further attempt to administer the measure at that collection occasion should be made.

For a total difficulties score to be calculated, a valid SDQ measure must have 3/5 item scores recorded for each of the following 4 subscales, Emotional Problems Subscale 1, Conduct Problems Subscale 2, Hyperactivity Subscale 3 and Peer Problems Subscale 4 (scores: 0, 1, 2).

Emotional Problems	Subscale 1	(item03, item08, item13, item16, item24)
Conduct Problems	Subscale 2	(item05, item07, item12, item18, item22)
Hyperactivity	Subscale 3	(item02, item10, item15, item21, item25)
Peer Problems	Subscale 4	(item06, item11, item14, item19, item23)
Prosocial	Subscale 5	(item01, item04, item09, item17, item20)

Prosocial Subscale 5 scores, are recorded as a part of the Strengths and Difficulties Questionnaire but they are not included in the calculation of the total difficulties score.

Prosocial Subscale 5 (item01, item04, item09, item17, item20)

Examples

	SDQ
A client aged 9 is discharged from ambulatory care to the care of their GP, after a 35-day ambulatory episode of care.	Collected
A client aged 12 is being reviewed. The clinical judgement at this time is that a request to complete the SDQ will cause the client or their parents' distress.	Not collected
A client aged 17 is being reviewed. The clinical judgement is that a request to complete the SDQ is appropriate.	Collected
A client aged 14 is discharged from ambulatory care to an inpatient facility of the organisation after a 35-day ambulatory episode of care.	Not collected

Related national definition

N/A

Revision history

N/A

11. Legal orders

The following section provides specific information about the legal orders data elements captured in the MHDC under the *Mental Health Act 2014* (the Act), including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Admitted Voluntary Indicator

Field name:	admitted_voluntary_indicator
Source Data Element(s):	[Admitted Voluntary Indicator] – PSOLIS
Definition:	Flag indicating if the detained person is currently an admitted voluntary patient.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Collection of this data element is conditional – admitted voluntary indicator must be collected for Legal Order 3E if the client is admitted as a voluntary patient.

This data element is an indicator for Legal Order 3E: Order that a Person Cannot Continue to be Detained.

The voluntary inpatient checkbox available within PSOLIS must be selected if a Legal Order 3E is created and the patient is being admitted as a voluntary patient.

Examples

	Admitted Voluntary Indicator
The checkbox 'Is the person being admitted as a voluntary inpatient' was selected on creation of the Legal Order 3E.	1
The checkbox 'Is the person being admitted as a voluntary inpatient' was not selected on creation of the Legal Order 3E.	0

Related national definition

N/A

Revision history

N/A

Ancestor Identifier

Field name:	ancestor_identifier
Source Data Element(s):	[Ancestor Identifier] – PSOLIS
Definition:	The identifier that references the legal order that commenced the legal episode (ancestor of the order).
Requirement status:	Conditional
Data type:	Numeric
Format:	[N(20)]
Permitted values:	Whole number

Guide for use

Collection of this data element is conditional – ancestor identifier must be collected for all legal orders in a legal episode except for the first legal order.

This data element is system generated and references the ancestor of the order.

The first legal order in the episode will always show a value of null in this field, given that it is the order that is starting the client's legal episode.

Examples

	Ancestor Identifier
A client was transitioned from a 1A: Referral for Examination by Psychiatrist to a 6A: Involuntary Treatment Order. In this scenario, the 1A would be the ancestor ID provided to the transitioned order (i.e., 6A: ITO).	6166

Related national definition

N/A

Revision history

N/A

Assessment Date and Time

Field name:	assessment_datetime
Source Data Element(s):	[Assessment Date and Time] – PSOLIS
Definition:	Date and time of the client assessment.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Assessment date and time records the date and time the client was assessed prior to the legal order form 1A: Referral for Examination by Psychiatrist being made.

Examples

	Action Date and Time
The clinician enters 20 July 2021 at 8am as the date and time the client was assessed.	2021-07-20 08:00:00

Related national definition

N/A

Revision history

N/A

Authorised By

Field name:	authorised_by
Source Data Element(s):	[Authorised By] – PSOLIS
Definition:	The health employee (HE) number of the staff member who authorised the legal order change.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)}
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – it is mandatory to record the HE identifier of the person who approved a change to certain legal orders.

In PSOLIS, the 'Authorised by' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if the 'authorised by name' is entered by free text.

Collection of this data element must take place when a change has occurred on legal orders 1A to 7D, 9A & 9B, 12B & 12C, and pseudo-orders.

Examples

	Authorised By
The 'Authorised By' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

Authorised By Name

Field name:	authorised_by_name
Source Data Element(s):	[Authorised By Name] – PSOLIS
Definition:	The name of the staff member who authorised the legal order change.
Requirement status:	Conditional
Data type:	String
Format:	X(150)
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – it is mandatory to record the name of the person who approved a change to certain legal orders.

In PSOLIS, the 'Authorised by' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

Collection of this data element must take place when a change has occurred on legal orders 1A to 7D, 9A & 9B, 12B & 12C, and pseudo-orders.

Examples

	Authorised By Name
The 'Authorised By Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

AV Exam

Field name:	av_exam_code
Source Data Element(s):	[AV Exam] – PSOLIS
Definition:	Indicator detailing whether a psychiatric examination of a client was conducted by videoconference.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Not applicable/relevant 1 – Not completed by AV 2 – Completed by AV, not subsequent face-to-face 3 – Completed by AV, and subsequent face-to-face

Guide for use

A psychiatric assessment/examination can be conducted via audio-visual (AV) communication.

Under the Act, AV communication means using videoconferencing to provide “real-time, synchronous video and audio transmission between locations to bring people together.”

In non-metropolitan areas an assessment for referral or examination by a psychiatrist under the Act (s.48 and s.79c) can be conducted via AV communication.

A checkbox is available within the order screen in PSOLIS to confirm if the client has had a psychiatric examination via AV.

Examples

	AV Exam
A client examination under the Act was conducted via videoconference; there was no subsequent face-to-face examination.	2

Related national definition

N/A

Revision history

N/A

CLMIAA Status

Field name:	clmiaa_status_code
Source Data Element(s):	[CLMIAA Status] – PSOLIS
Definition:	Indicator detailing whether a client is subject to an order under CLMIAA.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No known CLMIAA status 1 – Subject of CLMIAA custody order 2 – Subject of CLMIAA hospital order

Guide for use

CLMIAA status is recorded to identify whether the client is subject to an order under the *Criminal Law Mentally Impaired Accused Act 1996* (CLMIAA).

CLMIAA status is selected by the PSOLIS user in the CLMIAA order section.

Examples

	CLMIAA Status
A user selects the CLMIAA status 'Subject of CLMIAA Custody Order' in PSOLIS.	1

Related national definition

N/A

Revision history

N/A

CTO Appointment Date and Time

Field name:	cto_appt_datetime
Source Data Element(s):	[CTO Appointment Date and Time] – PSOLIS
Definition:	Date and time of the scheduled first appointment under the CTO.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

CTO appointment date and time records the date and time of the scheduled first appointment for a client placed on a Community Treatment Order (CTO).

CTO appointment date and time must be prior to the CTO expiry date and time.

Examples

	CTO Appointment Date and Time
The supervising psychiatrist enters 20 July 2021 at 8am as the date and time for the client's first appointment.	2021-07-20 08:00:00

Related national definition

N/A

Revision history

N/A

Expiry Date

Field name:	expiry_date
Source Data Element(s):	[Expiry Date] – PSOLIS
Definition:	Date the legal order expires.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD
Permitted values:	Valid date

Guide for use

This data item is the date a legal order is due to expire.

Examples

	Expiry Date
A legal order is due to expire on 15 May 2021 at 10am.	2021-05-15

Related national definition

N/A

Revision history

N/A

Legal Episode Identifier

Field name:	episode_identifier
Source Data Element(s):	[Legal Episode Identifier] – PSOLIS
Definition:	The unique identifier for the legal episode.
Requirement status:	Mandatory
Data type:	Numeric
Format:	[N(20)]
Permitted values:	Unique numeric identifier

Guide for use

This data element is system generated and identifies the current legal episode the order is attached to.

Examples

	Legal Episode Identifier
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	159

Related national definition

N/A

Revision history

N/A

Legal Order Effective Date and Time

Field name:	effective_datetime
Source Data Element(s):	[Legal Order Effective Date and Time] – PSOLIS
Definition:	Date and time the leave order was made effective.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Legal order effective date and time records the date and time that a Leave Order (7A – Grant of Leave to an Involuntary Patient and 7B – Extension of Grant of Leave) was made.

Legal order effective date and time must not be later than the expiry date and time of the parent Involuntary Treatment Order (ITO) Form 6A or 6B or Continuation 6C (if one exists).

Examples

	Legal Order Effective Date and Time
A Leave Order was made on 15 May 2021 at 10am.	2021-05-15 10:00:00

Related national definition

N/A

Revision history

N/A

Made By

Field name:	made_by
Source Data Element(s):	[Made By] – PSOLIS
Definition:	The health employee (HE) number of the staff member making a legal order.
Requirement status:	Mandatory
Data type:	String
Format:	X[(X9)]
Permitted values:	Valid HE number

Guide for use

This field displays the HE number of the person making an electronic order (Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo orders).

The 'Order Made By' field in PSOLIS displays the logged in user name and cannot be changed.

For Transcribed Paper Orders and Tribunal Orders, 'the Order Made By' field displays the logged in user name with the capacity to search within PSOLIS for an alternative clinician name.

Examples

	Made By
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	HE123456

Related national definition

N/A

Revision history

N/A

Made By Name

Field name:	made_by_name
Source Data Element(s):	[Made By Name] – PSOLIS
Definition:	The name of the staff member who made the legal order.
Requirement status:	Mandatory
Data type:	String
Format:	X(150)
Permitted values:	Alphanumeric combination

Guide for use

This field displays the name of the person making an electronic order (Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo orders).

The 'Order Made By' field in PSOLIS displays the logged in user name and cannot be changed.

For Transcribed Paper Orders and Tribunal Orders, 'the Order Made By' field displays the logged in user name with the capacity to search within PSOLIS for an alternative clinician name.

Examples

	Made By Name
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	Joe Staff

Related national definition

N/A

Revision history

N/A

Made By Qualification

Field name:	made_by_qualification
Source Data Element(s):	[Made By Qualification] – PSOLIS
Definition:	The professional qualification of the person making the legal order.
Requirement status:	Conditional
Data type:	String
Format:	[X(255)]
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – it is mandatory to record the qualification of the person who made certain legal orders.

The professional qualification of the person who made the legal order is a free text field.

This data element must be collected for these legal orders: Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo-orders.

Examples

	Made By Qualification
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	FRANZCP

Related national definition

N/A

Revision history

N/A

Made by Qualification Type

Field name:	made_by_qualification_type_code
Source Data Element(s):	[Made By Qualification Type] – PSOLIS
Definition:	Numeric identifier of the qualification role of the person making the legal order.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Medical practitioner 2 – Authorised mental health practitioner 3 – Psychiatrist 4 – Mental health practitioner

Guide for use

Collection of this data element is conditional – it is mandatory to record the qualification role of the person who made certain legal orders.

The qualification role of the person making the order is selected from the 'Qualification Role' drop down list in the PSOLIS 'Legal Order' screen.

This data element must be collected for these legal orders: Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo-orders.

Examples

	Made By Qualification Type
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	3

Related national definition

N/A

Revision history

N/A

No Referral Determined By

Field name:	no_referral_determined_by
Source Data Element(s):	[No Referral Determined By] – PSOLIS
Definition:	The health employee (HE) number of the staff member who determined that the referral was no longer required.
Requirement status:	Mandatory
Data type:	String
Format:	X[(X9)]
Permitted values:	Valid HE number

Guide for use

This field displays the HE number of the person who determined that the referral was not required and is completed in PSOLIS via Pseudo Order – Referral not Required.

In PSOLIS, the 'Determined by' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if the 'no referral determined by name' is entered by free text.

Examples

	No Referral Determined By
The 'Determined by' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

No Referral Determined By Name

Field name:	no_referral_determined_by_name
Source Data Element(s):	[No Referral Determined By Name] – PSOLIS
Definition:	The name of the staff member who determined that the referral was no longer required.
Requirement status:	Mandatory
Data type:	String
Format:	X(150)
Permitted values:	Alphanumeric combination

Guide for use

This field displays the name of the person who determined that the referral was not required and is completed in PSOLIS via Pseudo Order – Referral not Required.

In PSOLIS, the 'Determined by Name' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

Examples

	No Referral Determined By Name
The 'Determined by Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Order Changed By

Field name:	order_changed_by
Source Data Element(s):	[Order Changed By] – PSOLIS
Definition:	The health employee (HE) number of the staff member who made changes to an existing legal order.
Requirement status:	Conditional
Data type:	String
Format:	X[(X9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – it is only mandatory where a change has been made to an existing legal order.

The ‘Order Changed By’ person may or may not be the same as the person who authorised the change to the legal order.

In PSOLIS, the ‘Order Changed By’ field defaults to the logged in user and is not editable.

Examples

	Order Changed By
Joe Staff makes changes in PSOLIS to a client’s existing legal order and saves the record.	HE123456

Related national definition

N/A

Revision history

N/A

Order Changed Reason

Field name:	order_changed_reason_code
Source Data Element(s):	[Order Changed Reason] – PSOLIS
Definition:	Reason for the change in the legal order, if the record has been updated.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Transcription error 2 – Content error 3 – Process error 4 – Additional information added 5 – Change in location 6 – Change in circumstance 7 – MHT alteration 8 – OCP alteration

Guide for use

Collection of this data element is conditional – it is only mandatory where a change has been made to certain existing legal orders.

This data element must be collected for legal orders 1A to 7D and pseudo-orders.

Examples

	Order Changed Reason
Joe Staff updates a client's existing legal order in PSOLIS.	4 – Additional information added

Related national definition

N/A

Revision history

N/A

Order Duration

Field name:	order_duration
Source Data Element(s):	[Order Duration] – PSOLIS
Definition:	The duration of the legal order in days.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)
Permitted values:	Whole number

Guide for use

This data element is a derived measure using the start and end dates of a legal order.

Examples

	Order Duration
A legal order is created on 13/07/2022 for a patient admitted to Graylands Hospital and is ended on 20/07/2022.	8

Related national definition

N/A

Revision history

N/A

Order End Date and Time

Field name:	order_end_datetime
Source Data Element(s):	[Order End Date and Time] – PSOLIS
Definition:	Date and time the legal order expires.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Order end date and time is the documented date and time a legal order is due to expire.

Examples

	Order End Date and Time
A legal order is due to expire on 15 May 2021 at 10am.	2021-05-15 10:00:00

Related national definition

N/A

Revision history

N/A

Order Identifier

Field name:	order_identifier
Source Data Element(s):	[Order Identifier] – PSOLIS
Definition:	The unique identifier for the legal order.
Requirement status:	Mandatory
Data type:	Numeric
Format:	[N(20)]
Permitted values:	Unique numeric identifier

Guide for use

This data element is system generated and identifies each legal order.

Examples

	Legal Record Identifier
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	2061

Related national definition

N/A

Revision history

N/A

Order Name

Field name:	order_name
Source Data Element(s):	[Order Name] – PSOLIS
Definition:	The full name of the legal order.
Requirement status:	Mandatory
Data type:	String
Format:	X(130)
Permitted values:	As per Appendix D – Legal orders

Guide for use

Order name is the full name of the legal order form, as per its documented title.

Examples

	Order Name
A PSOLIS user selects a legal order Form 1A.	Form 1A – Referral for Examination

Related national definition

N/A

Revision history

N/A

Order Name Code

Field name:	order_name_code
Source Data Element(s):	[Order Name Code] – PSOLIS
Definition:	The name of the legal order, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Permitted values:	As per Appendix D – Legal orders

Guide for use

This data element identifies the name of the legal order form using the legal order form's assigned number reference, as per its documented title.

Examples

	Order Name Code
A PSOLIS user selects a legal order Form 4A – Transport Order.	16

Related national definition

N/A

Revision history

N/A

Order Start Date and Time

Field name:	order_start_datetime
Source Data Element(s):	[Order Start Date and Time] – PSOLIS
Definition:	Date and time the legal order came into effect.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

This date element is completed with the start date and time the legal order commences.

The PSOLIS field defaults to created date and time but is editable and therefore can be 'backdated'.

There are specific rules related to this data element which are detailed in the individual legal orders.

Order start date and time must not be in the future relative to the current time.

Examples

	Order Start Date and Time
A legal order commenced on 15 May 2021 at 10am.	2021-05-15 10:00:00

Related national definition

N/A

Revision history

N/A

Order to Attend Date and Time

Field name:	attend_datetime
Source Data Element(s):	[Order to Attend Date and Time] – PSOLIS
Definition:	Date and time the client has been ordered to attend a place under the 5F legal order.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – it is only mandatory where a Form 5F: Order to Attend has been made following a client being in breach of their community treatment order (CTO).

The date and time the client is ordered to attend a place is recorded in this PSOLIS field.

The date and time of attendance must be after the date and time the 5F legal order was created.

Examples

	Order to Attend Date and Time
The supervising psychiatrist creates a 5F order and enters the date and time of attendance as 21 June 2021 at 11am.	2021-06-21 11:00:00

Related national definition

N/A

Revision history

N/A

Order Type

Field name:	order_type_code
Source Data Element(s):	[Order Type] – PSOLIS
Definition:	A ~~numeric~~ code identifying how the order was created.
Requirement status:	Mandatory
Data type:	String
Format:	A
Permitted values:	E – Electronically made order P – Paper transcribed order C – Court/tribunal M – Migrated from legal status lite

Guide for use

This data element refers to the code used to represent how a legal order was created.

Examples

	Order Type
The PSOLIS option order type ‘Electronically made’ is selected.	E

Related national definition

N/A

Revision history

N/A

Parent Identifier

Field name:	parent_identifier
Source Data Element(s):	[Parent Identifier] – PSOLIS
Definition:	Numeric code uniquely assigned to the current legal order which identifies the preceding legal order within a legal episode.
Requirement status:	Mandatory
Data type:	Numeric
Format:	[N(20)]
Permitted values:	Whole number

Guide for use

Parent identifier is a system generated unique number assigned to each legal order form within a legal episode.

Examples

	Parent Identifier
The supervising psychiatrist creates a 5F order with an order identifier of 2351.	1**59**

Related national definition

N/A

Revision history

N/A

Previous Expiry Date and Time

Field name:	previous_expiry_datetime
Source Data Element(s):	[Previous Expiry Date and Time] – PSOLIS
Definition:	The date and time of the expiry of a mental health client's previous legal order.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – it is only mandatory where an earlier legal order for the mental health client exists.

The previous expiry date and time must be before the effective date of the current legal order.

Examples

	Previous Expiry Date and Time
The supervising psychiatrist creates a 6C Continuation of Inpatient Treatment Order and enters the date and time of expiry of the previous legal order as 21 June 2021 at 11am.	2021-06-21 11:00:00

Related national definition

N/A

Revision history

N/A

Received Patient By

Field name:	received_patient_by
Source Data Element(s):	[Received Patient By] – PSOLIS
Definition:	The health employee (HE) number of the person who took receival of the mental health client.
Requirement status:	Conditional
Data type:	String
Format:	X[(X9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client at the recorded place of examination.

This field displays the HE number of the person who took receival of the client.

In PSOLIS, the 'Received Patient By' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if 'received patient by name' is entered by free text.

Examples

	Received Patient By
The 'Received Patient By' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

Received Patient By Name

Field name:	received_patient_by_name
Source Data Element(s):	[Received Patient By Name] – PSOLIS
Definition:	The name of the staff member who took receival of the mental health client.
Requirement status:	Conditional
Data type:	String
Format:	X(150)
Permitted values:	Alphanumeric combination

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client at the recorded place of examination.

This field displays the name of the person who took receival of the client.

In PSOLIS, the 'Received Patient By Name' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

Examples

	Received Patient By Name
The 'Received Patient By Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Received Patient Date and Time

Field name:	received_patient_datetime
Source Data Element(s):	[Received Patient Date and Time] – PSOLIS
Definition:	The date and time the client was received at the place of examination.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been received at the recorded place of examination.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client.

This data element records the date and time the client was actually physically received at the place of examination.

Received patient date and time must not be:

- in the future relative to the current time.
- prior to the legal order effective date and time.
- later than the order expiry date and time.

Examples

	Received Patient Date and Time
A mental health client is received at the recorded place of examination on 21 June 2021 at 11am.	2021-06-21 11:00:00

Related national definition

N/A

Revision history

N/A

Received Patient Indicator

Field name:	received_patient_indicator
Source Data Element(s):	[Received Patient Indicator] – PSOLIS
Definition:	Indicates whether the client has been received at the recorded place of examination.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – Not received 1 - Received

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been received at the recorded place of examination.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client.

This checkbox data element records whether the client was actually received at the place of examination.

Examples

	Received Patient Indicator
A client is not received at the recorded place of examination and the 'Received Patient Indicator' checkbox remains unchecked.	0

Related national definition

N/A

Revision history

N/A

Referred From Place

Field name:	referred_from_place_code
Source Data Element(s):	[Referred From Place] – PSOLIS
Definition:	The name of the place the client is transferred from, expressed as a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(4)
Permitted values:	Valid location code

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

This data element identifies the service or program from which the client was transferred. This is selected from a drop-down value on the PSOLIS Legal Order screen.

Examples

	Referred From Place
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	16

Related national definition

N/A

Revision history

N/A

Referred From Place Metro Indicator

Field name:	referred_from_place_metro_indicator
Source Data Element(s):	[Referred From Place Metro Indicator] – PSOLIS
Definition:	Flag identifying whether the 'referred from' place is a metropolitan or non-metropolitan area.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – Non-metropolitan 1 – Metropolitan

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Examples

	Referred From Place Metro Indicator
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	0

Related national definition

N/A

Revision history

N/A

Referred From Place Type

Field name:	referred_from_place_type_code
Source Data Element(s):	[Referred From Place Type] – PSOLIS
Definition:	The type of place the client was transferred from.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Authorised hospital 2 – General hospital 3 – Other PSOLIS place 4 – Other metro place 5 – Other non-metro place Null – Not specified

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Examples

	Referred From Place Type
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	2

Related national definition

N/A

Revision history

N/A

Referred To Place

Field name:	referred_to_place_code
Source Data Element(s):	[Referred To Place] – PSOLIS
Definition:	The name of the place the client is transferred to, expressed as a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(4)
Permitted values:	Valid location code

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

This data element identifies the service or program to which the client was transferred. This is selected from a drop-down value on the PSOLIS Legal Order screen.

Examples

	Referred To Place
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	3

Related national definition

N/A

Revision history

N/A

Referred To Place Metro Indicator

Field name:	referred_to_place_metro_indicator
Source Data Element(s):	[Referred To Place Metro Indicator] – PSOLIS
Definition:	Flag identifying whether the 'referred to' place is a metropolitan or non-metropolitan area.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – Non-metropolitan 1 – Metropolitan

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Examples

	Referred To Place Metro Indicator
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	1

Related national definition

N/A

Revision history

N/A

Referred To Place Type

Field name:	referred_to_place_type_code
Source Data Element(s):	[Referred To Place Type] – PSOLIS
Definition:	The type of place the client was transferred to.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Authorised hospital 2 – General hospital 3 – Other PSOLIS place 4 – Other metro place 5 – Other non-metro place Null – Not specified

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Examples

	Referred To Place Type
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	1

Related national definition

N/A

Revision history

N/A

Same Practitioner Indicator

Field name:	same_practitioner_indicator
Source Data Element(s):	[Same Practitioner Indicator] – PSOLIS
Definition:	Flag to indicate if the same practitioner made and revoked the Form 1A – Referral Order.
Requirement status:	Optional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

This data element is collected via a checkbox in PSOLIS, and its values represent whether the same medical practitioner made and revoked the Form 1A Referral.

Examples

	Same Practitioner Indicator
The PSOLIS ‘Same Practitioner Indicator’ checkbox remains unchecked.	0

Related national definition

N/A

Revision history

N/A

Supervising Psychiatrist

Field name:	supervisor
Source Data Element(s):	[Supervising Psychiatrist] – PSOLIS
Definition:	The health employee (HE) number of the supervising psychiatrist.
Requirement status:	Mandatory
Data type:	String
Format:	X[(X9)]
Permitted values:	Valid HE number

Guide for use

This field displays the HE number of the supervising psychiatrist.

In PSOLIS, the 'Supervising Psychiatrist.' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if 'supervising psychiatrist name' is entered by free text.

Examples

	Supervising Psychiatrist
The 'Supervising Psychiatrist' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

Supervising Psychiatrist Name

Field name:	supervisor_name
Source Data Element(s):	[Supervising Psychiatrist Name] – PSOLIS
Definition:	The name of the supervising psychiatrist.
Requirement status:	Mandatory
Data type:	String
Format:	X(150)
Permitted values:	Alphanumeric combination

Guide for use

This field displays the name of the supervising psychiatrist.

In PSOLIS, the 'Supervising Psychiatrist Name' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

Examples

	Supervising Psychiatrist Name
The 'Supervising Psychiatrist Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Transcribed Order End Date and Time

Field name:	transcribed_order_end_datetime
Source Data Element(s):	[Transcribed Order End Date and Time] – PSOLIS
Definition:	The end date and time of the transcribed legal order.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional – it is only mandatory when there is an order expiry, and the record type is transcribed order.

The transcribed order end date and time is the date and time of expiry of any legal form entered in PSOLIS by transcription.

Examples

	Transcribed Order End Date and Time
A transcribed order has an expiry date and time of 15 December 2021 at 5pm.	2021-12-15 17:00:00

Related national definition

N/A

Revision history

N/A

Transport By

Field name:	transport_by
Source Data Element(s):	[Transport By] – PSOLIS
Definition:	Numeric code identifying whether a client was transported by a police officer or transport officer or both.
Requirement status:	Optional
Data type:	Numeric
Format:	N
Permitted values:	0 – Null 1 – Police officer 2 – Transport officer 3 – Police officer and/or transport officer

Guide for use

This data element is used to identify whether a client was transported by a police officer or transport officer, or both – it is expressed as a numeric code.

Examples

	Transport By
A client is transported from Albany Acute Psychiatric Unit to Graylands Hospital by a transport officer.	2

Related national definition

N/A

Revision history

N/A

Transport Police Reason

Field name:	transport_police_reason
Source Data Element(s):	[Transport Police Reason] – PSOLIS
Definition:	Numeric code identifying the reason for police officer transportation.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – I am satisfied that there is a significant risk of serious harm to the person being transported or to another person. 2 – I am satisfied that a transport officer will not be available to carry out the order within a reasonable time, and any delay in carrying out the order beyond that time is likely to pose a significant risk of harm to the person being transported or to another person. Null – Not specified

Guide for use

Collection of this data element is conditional – it is only mandatory if a transport order has been created and ‘transport by police’ has been selected.

Examples

	Transport Police Reason
A clinician believes the client needs to be transported by the police.	1

Related national definition

N/A

Revision history

N/A

Transport Reason Satisfy

Field name:	transport_reason_satisfy_code
Source Data Element(s):	[Transport Reason Satisfy] – PSOLIS
Definition:	Numeric code identifying the reason for making the transport order.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Referred person needs to be taken to the place for examination by psychiatrist 2 – Person needs to be taken to general hospital to be detained under inpatient treatment order 3 – Person needs to be taken to authorised hospital for further examination by psychiatrist 4 – Involuntary inpatient in general hospital needs to be taken to authorised hospital following a transfer order 5 – Involuntary inpatient on leave of absence to obtain medical or surgical treatment at a general hospital to be taken to the general hospital 6 – Involuntary inpatient on leave of absence that expires or is cancelled needs to be taken to hospital 7 – Involuntary community patient not complying with order to attend needs to be taken to specified place 8 – Involuntary community patient needs to be taken to hospital as involuntary inpatient 9 – Involuntary inpatient in authorised hospital needs to be taken to another authorised hospital following a transfer order Null – Not specified

Guide for use

Collection of this data element is conditional – it is only mandatory if a transport order has been created.

Examples

	Transport Reason Satisfy
The reason 'Person needs to be taken to authorised hospital for further examination by psychiatrist' is selected in PSOLIS.	3

Related national definition

N/A

Revision history

N/A

Transport Revoke Reason

Field name:	transport_revoke_reason_code
Source Data Element(s):	[Transport Revoke Reason] – PSOLIS
Definition:	Numeric code identifying the reason for a transport order being revoked.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Automatically revoked because a referral has been revoked. 2 – I am satisfied that the transport order is no longer needed. Null – Not specified

Guide for use

Collection of this data element is conditional – it is only mandatory if a transport order has been revoked.

Examples

	Transport Revoke Reason
A clinician believes the client no longer needs to be transported.	2

Related national definition

N/A

Revision history

N/A

Treating Practitioner

Field name:	treating_practitioner
Source Data Element(s):	[Treating Practitioner] – PSOLIS
Definition:	The health employee (HE) number of the treating practitioner.
Requirement status:	Mandatory
Data type:	String
Format:	X[(X9)]
Permitted values:	Valid HE number

Guide for use

This field displays the HE number of the treating practitioner.

In PSOLIS, the 'Treating Practitioner' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if 'treating practitioner name' is entered by free text.

Examples

	Supervising Psychiatrist
The 'Treating Practitioner' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

Treating Practitioner Name

Field name:	treating_practitioner_name
Source Data Element(s):	[Treating Practitioner Name] – PSOLIS
Definition:	The name of the treating practitioner.
Requirement status:	Mandatory
Data type:	String
Format:	X(150)
Permitted values:	Alphanumeric combination

Guide for use

This field displays the name of the treating practitioner.

In PSOLIS, the 'Treating Practitioner Name' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

Examples

	Supervising Psychiatrist Name
The 'Treating Practitioner Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Treating Practitioner Qualification Type

Field name:	treating_practitioner_qualification_type_code
Source Data Element(s):	[Treating Practitioner Qualification Type] – PSOLIS
Definition:	The type of qualification of the treating practitioner, expressed as a code.
Requirement status:	Optional
Data type:	Numeric
Format:	N
Permitted values:	1 – Medical practitioner 4 – Mental health practitioner Null – Not specified

Guide for use

The data item is a numeric code which represents the treating practitioner's qualification type.

Examples

	Treating Practitioner Qualification Type
The clinician treating the client is a psychiatrist.	1

Related national definition

N/A

Revision history

N/A

12. Triage

The following section provides specific information about the triage data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Action Taken

Field name:	actionid
Source Data Element(s):	[Action Taken] – webPSOLIS
Definition:	Identifies the action/s taken during a triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Permitted values:	1 – Referred to Emergency Department 2 – Referred to Inpatient Mental Health Service 3 – Referred to Community Mental Health Service 4 – Referred to Community, Primary Care, NGO etc. 5 – Referred to Intake Meeting 6 – Department of Communities: Child Protection and Family Support notified 7 – Police notified 8 – Ambulance notified 9 – Aboriginal Liaison Officer notified 10 – Interpreter booked

Guide for use

This data item identifies the action/s taken during a triage event, expressed as a numeric code.

Examples

	Action Taken
During the triage event the police are notified, and the consumer is referred to an inpatient mental health service.	2, 7

Related national definition

N/A

Revision history

N/A

Advance Health Directive

Field name:	adhealthdirective
Source Data Element(s):	[Advance Health Directive] – webPSOLIS
Definition:	Identifies whether the consumer has an Advance Health Directive in place.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

An Advance Health Directive (AHD) is a legal document for people over the age of 18 to advise their decisions in writing about their future healthcare treatment.

An AHD can come into effect if a person is unable to make reasonable judgements about their treatment in the future.

Examples

	Advance Health Directive
During the triage event the consumer notifies the clinician that they have an AHD in place.	1

Related national definition

N/A

Revision history

N/A

AHD on Medical Record

Field name:	copymedrecord
Source Data Element(s):	[AHD on Medical Record] – webPSOLIS
Definition:	Identifies whether a copy of the consumer's Advance Health Directive is included in their medical record.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Collection of this data element is conditional. If the consumer has an Advance Health Directive (AHD) this data element must be collected.

An AHD is a legal document for people over the age of 18 to advise their decisions in writing about their future healthcare treatment.

An AHD can come into effect if a person is unable to make reasonable judgements about their treatment in the future.

Examples

	AHD on Medical Record
During the triage event the consumer notifies the clinician that they have an AHD in place but there is no copy of the AHD included in the client's medical record.	0

Related national definition

N/A

Revision history

N/A

AHD to be Provided

Field name:	copyprovided
Source Data Element(s):	[AHD to be Provided] – webPSOLIS
Definition:	Identifies whether a copy of the consumer's Advance Health Directive will be forwarded to the mental health service.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Collection of this data element is conditional. If the consumer has an Advance Health Directive (AHD) this data element must be collected.

An AHD is a legal document for people over the age of 18 to advise their decisions in writing about their future healthcare treatment.

An AHD can come into effect if a person is unable to make reasonable judgements about their treatment in the future.

Examples

	AHD to be Provided
During the triage event the consumer notifies the clinician that they have an AHD in place and will be providing it later.	1

Related national definition

N/A

Revision history

N/A

Associate Present

Field name:	associatepresent
Source Data Element(s):	[Associate Present] – webPSOLIS
Definition:	A flag indicating whether an associate of the consumer was present at the triage service event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

An associate can be a person or organisation.

An associate is anyone who is related or connected to the consumer and involved in their care. This can include family members, carer, GP, emergency contact, agencies etc.

An associate must not be government mental health staff or organisations.

Examples

	Associate Present
A consumer attends a triage service event alone.	0
A consumer attends a triage service event accompanied by his sister.	1

Related national definition

N/A

Revision history

N/A

Carer Agreeable

Field name:	isprimarycareagreeableofreferral
Source Data Element(s):	[Carer Agreeable] – webPSOLIS
Definition:	A flag indicating whether the consumer's primary carer agrees to the referral.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Collection of this data element is conditional – if the consumer has a carer this data element must be completed.

Examples

	Carer Agreeable
A consumer is referred to a triage service event and his carer agrees to the referral.	1

Related national definition

N/A

Revision history

N/A

Carer Aware

Field name:	isprimarycareawareofreferral
Source Data Element(s):	[Carer Aware] – webPSOLIS
Definition:	A flag indicating whether the consumer's primary carer is aware of the referral.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Collection of this data element is conditional – if the consumer has a carer this data element must be completed.

Examples

	Carer Aware
A consumer is referred to a triage service event alone and without the knowledge of his carer.	0

Related national definition

N/A

Revision history

N/A

Consumer Agreeable

Field name:	isclientagreeableofreferral
Source Data Element(s):	[Consumer Agreeable] – webPSOLIS
Definition:	A flag indicating whether the consumer is agreeable to the referral.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

A flag indicating whether on attendance at a triage service event, the consumer was agreeable to the referral – it is expressed as a numeric code.

Examples

	Consumer Agreeable
A consumer attends a triage service event and disagrees with the referral.	0

Related national definition

N/A

Revision history

N/A

Consumer Aware

Field name:	isclientawareofreferral
Source Data Element(s):	[Consumer Aware] – webPSOLIS
Definition:	A flag indicating whether the consumer is aware of the referral.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

A flag indicating whether on attendance at a triage service event, the consumer was aware of the referral – it is expressed as a numeric code.

Examples

	Consumer Aware
A consumer attends a triage service event and has no knowledge of the referral.	0

Related national definition

N/A

Revision history

N/A

Consumer Present

Field name:	consumerpresent
Source Data Element(s):	[Consumer Present] – webPSOLIS
Definition:	A flag indicating whether the consumer was present at the triage service event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Permitted value definitions

0 – No

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

1 – Yes

This code is to be used for triage service events between a specialised mental health service provider and the consumer in whose clinical record the service contact would normally warrant a dated entry, where the consumer is participating.

This data element is used to indicate whether the mental health consumer was present during a triage service event.

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

Examples

	Consumer Present
A mental health consumer attends a face-to-face appointment with a clinician for an assessment.	1
A clinician records a clinical record keeping service event item for a consumer.	0
A family meeting is provided with both the consumer and the consumer's carer present during the service event.	1

Related national definition

https://meteor.aihw.gov.au/content/677806

Revision history

N/A

Contact With

Field name:	contactid
Source Data Element(s):	[Contact With] – webPSOLIS
Definition:	Identifies the type of contact communication that has occurred ~~with~~ during a triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Primary carer 2 – Family member 3 – Nominated person 4 – Personal support person 5 – General practitioner 6 – Referrer 7 – Other

Guide for use

This data item identifies the type of contact communication that has occurred during a triage event – it is expressed as a numeric code.

Examples

	Contact With
During the triage event communication takes place with the consumer's mother and his general practitioner.	2, 5

Related national definition

N/A

Revision history

N/A

Designation

Field name:	designation
Source Data Element(s):	[Designation] – webPSOLIS
Definition:	The profession of the person performing the triage.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(799)]
Permitted values:	Alphanumeric combination

Guide for use

This data element indicates the designated profession of the person performing the triage assessment.

Examples

	Triaged By Designation
A consumer presents to a regional mental health service and a triage event is created.	Aboriginal Mental Health Worker

Related national definition

N/A

Revision history

N/A

Guardianship Act Status

Field name:	guardianshipactstatus
Source Data Element(s):	[Guardianship Act Status] – webPSOLIS
Definition:	Identifies the consumer's legal status under the *Guardianship and Administration Act (1990)*
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

The *Guardianship and Administration Act (1990)* recognises that people who are not capable of making reasonable judgements for themselves may need someone to make decisions for them not only to ensure their quality of life is maintained, but also to protect them from the risk of neglect, exploitation and abuse.

The Act provides that the State Administrative Tribunal (SAT} may appoint a guardian and/or administrator for a person with a decision-making disability as a substitute decision-maker.

Examples

	Guardianship Act Status
A guardian has been appointed for the consumer undergoing the triage event.	1

Related national definition

N/A

Revision history

N/A

Mental Health Act Status

Field name:	mhactstatus
Source Data Element(s):	[Mental Health Act Status] – webPSOLIS
Definition:	Identifies the consumer's legal status under the *Mental Health Act 2014*
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

The *Mental Health Act 2014* introduced new principles to support people experiencing mental illness to make and participate in treatment decisions and to have their views and preferences considered and respected.

The Act includes provisions for supported decision making and consent to medical treatment. It also supports advocacy, diversity, privacy and complaints processes.

Examples

	Mental Health Act Status
A consumer has been made an involuntary patient on a community treatment order.	1

Related national definition

N/A

Revision history

N/A

Triage End Date

Field name:	enddate
Source Data Element(s):	[Triage End Date] – webPSOLIS
Definition:	The end date of the triage service event.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

This data item is the end date the user enters when creating a triage service event.

Examples

	Triage End Date
A user creates a triage service event with an end date of 3 May 2022.	2022-05-03

Related national definition

N/A

Revision history

N/A

Triage Identifier

Field name:	id
Source Data Element(s):	[Triage Identifier] – webPSOLIS
Definition:	The unique identifier (surrogate key) for the triage event that created the referral.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

This data element is the unique, system generated number assigned to each triage event created in webPSOLIS.

Examples

	Triage Identifier
A consumer presents to a clinic with a mental health problem and the triage function is used to create a referral.	23590964

Related national definition

N/A

Revision history

N/A

Triage Outcome

Field name:	triageoutcomeid
Source Data Element(s):	[Triage Outcome] – webPSOLIS
Definition:	Identifies the outcome of a triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – To be admitted to service 2 – Referred on 3 – No further action 4 – Information only 5 – Placed to waitlist 6 – Community visit initiated 8 – Referred to clinical intake 9 – Unable to complete

Guide for use

Triage outcome indicates if there is a need for additional clinical intervention, and whether a referral to community or inpatient mental health services will be progressed.

Examples

	Triage Outcome
A consumer presents to a clinic with a triage presenting problem of experiencing disturbed thoughts. It is determined the consumer should be referred to community mental health services for further assessment within two days.	8 – Referred to clinical intake
A consumer presents to an emergency department with a triage presenting problem of intentional self-harm. It is determined the consumer should be immediately admitted to hospital.	1 – To be admitted to service
A consumer telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services.	3 – No further action

Related national definition

N/A

Revision history

N/A

Triage Presenting Problem

Field name:	problemed
Source Data Element(s):	[Triage Presenting Problem] – webPSOLIS
Definition:	Indicates the consumer's presenting problem at triage.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(4)
Permitted values:	As per Appendix C – Triage problem codes

Guide for use

This data element is used to indicate the consumer's principal presenting problem at triage, for example: risk of harm to self, depressed mood and existing mental illness. Provides the basis from which the triage severity identifier is determined.

The triage presenting problem reported must be a valid code as per the list detailed in Appendix C of this document.

Examples

	Triage Presenting Problem
A consumer presents to a clinic with a problem of experiencing disturbed thoughts. It is determined the client should be referred to community mental health services for further assessment within two days.	14 – Disturbed thoughts, delusions etc.
A consumer presents to an ED with a problem of intentional self-harm. It is determined that the client should immediately be admitted to hospital.	35 – Deliberate self-harm
A consumer telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services.	22 – Legal problems

Related national definition

N/A

Revision history

N/A

Triage Referral Indicator

Field name:	triage_referral_indicator
Source Data Element(s):	[Triage Referral Indicator] – PSOLIS
Definition:	Flag to indicate if a referral was created via the triage module
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

This data element is used to indicate whether a referral was created for the consumer using the triage module.

Examples

	Triage Referral Indicator
A consumer presents to a clinic with a triage presenting problem of experiencing disturbed thoughts. It is determined the consumer should be referred to community mental health services for further assessment within two days. An entry is made via the PSOLIS triage module.	1
A consumer telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services. An entry is NOT made via the PSOLIS triage module.	0

Related national definition

N/A

Revision history

N/A

Triage Referral Purpose

Field name:	referralpurposeid
Source Data Element(s):	[Triage Referral Purpose] – webPSOLIS
Definition:	Flag to indicate the reason the triage referral was created
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Seeking assistance/referral 1 – Information 2 – Assessment 3 – GP phone advice 4 – GP liaison

Guide for use

This data element is used to identify the reason a consumer is referred to a mental health service. Noting that the permitted values for this data element include referral as a result of information received via ‘GP phone advice’ or ‘GP liaison’.

Examples

	Triage Referral Purpose
A consumer is referred to the mental health service to be assessed.	2
A triage referral is created as a result of information received over the telephone from a consumer’s GP.	3

Related national definition

N/A

Revision history

N/A

Triage Referral Reason

Field name:	referralreason
Source Data Element(s):	[Triage Referral Reason] – webPSOLIS
Definition:	The reason for the consumer's referral.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(3999)]
Permitted values:	Alphanumeric combination

Guide for use

Referral reason is a free text field which displays the reason for the consumer's referral to the mental health service as documented at triage.

Examples

	Triage Referral Reason
A consumer is referred to the mental health service after threating to take his own life.	Suicidality

Related national definition

N/A

Revision history

N/A

Triage Service Event Identifier

Field name:	serviceeventid
Source Data Element(s):	[Triage Service Event Identifier] – webPSOLIS
Definition:	The unique identifier (surrogate key) for the service event created by the triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

This data element is the unique, system generated number assigned to each triage service event created in webPSOLIS.

Examples

	Triage Service Event Identifier
A consumer presents to a clinic with a mental health problem and the triage function is used to create a service event.	13690964

Related national definition

N/A

Revision history

N/A

Triage Start Date

Field name:	startdate
Source Data Element(s):	[Triage Start Date] – webPSOLIS
Definition:	The start date of the triage service event.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

This data item is the start date the user enters when creating a triage service event.

Examples

	Triage Start Date
A user creates a triage service event with a start date of 12 June 2022.	2022-06-12

Related national definition

N/A

Revision history

N/A

Triage Urgency

Field name:	triageseverityid
Source Data Element(s):	[Triage Urgency] – webPSOLIS
Definition:	Numeric identifier indicating the urgency of the triage service event and recommended wait time for an assessment service event item.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Permitted values:	9 – A. Immediate 10 – B. Within 2 hours 11 – C. Within 12 hours 12 – D. Within 48 hours 13 – E. Within 2 weeks 14 – F. Requires further triage contact/follow up 15 – G. No further action

Guide for use

Since November 2015 mental health consumers are triaged into one of seven categories on the selected triage scale.

The category assigned is dependent on the triaging clinician's response to this question: *This patient should wait for medical care no longer than...?*

Triage urgency must be assigned by an appropriately qualified triage worker.

If the triage urgency category assigned to the consumer changes, the most urgent category is recorded.

Permitted value definitions

A. Immediate

Extreme urgency; immediate response requiring police/ambulance or other service (e.g., overdose, siege, imminent violence).

B. Within 2 hours

High urgency; see within 2 hours or present to Psychiatric Emergency Service or emergency department in general hospital (e.g., acute suicidality, threatening violence, acute severe non-recurrent stress).

C. Within 12 hours

Medium urgency; see within 12 hours (e.g., distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).

D. Within 48 hours

Low urgency; see within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).

E. Within 2 weeks

Non-urgent; see within 2 weeks.

F. Requires further triage contact/follow up

Further contact or follow up required.

G. No further action

Requires no further action.

Examples

	Triage Severity
A consumer presents to a clinic with a problem of experiencing disturbed thoughts. It is determined the consumer should be referred to community mental health services for further assessment within two days.	12 – D. Within 48 hours
A consumer presents to an emergency department with a triage presenting problem of intentional self-harm. It is determined that the consumer should be immediately admitted to hospital.	9 – A. Immediate
A consumer telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services.	15 – G. No further action
A consumer telephones a clinic, and the triage presenting problem concerns family problems. It is determined that a community visit should be undertaken within 12 hours.	11 – C. Within 12 hours

Related national definition

N/A

Revision history

N/A

Triaged By HE Number

Field name:	triagedbyuserid
Source Data Element(s):	[Triaged By HE Number] – webPSOLIS
Definition:	The health employee (HE) number of the person performing the triage event.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

This data element identifies the person who performed the consumer's triage assessment by their health employee (HE) number recorded.

Examples

	Triaged By HE Number
A user creates a triage service event.	HE999990

Related national definition

N/A

Revision history

N/A

13. Risk assessment and management plan

The following section provides specific information about the risk assessment and management plan data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Access to Available Means

Field name:	accesstoavailablemeans
Source Data Element(s):	[Access to Available Means] – webPSOLIS
Definition:	Flag to indicate if access to available means is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether access to available means is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Access to Available Means
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that access to available means is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that access to available means is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Access to Means

Field name:	accesstomeans
Source Data Element(s):	[Access to Means] – webPSOLIS
Definition:	Flag to indicate if access to means is a current suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether access to means is a current suicide risk factor for the consumer undergoing the RAMP.

Examples

	Access to Means
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that access to means is a current suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that access to means is not a current suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Afraid of Somebody

Field name:	afraidofsomebody
Source Data Element(s):	[Afraid of Somebody] – webPSOLIS
Definition:	Flag to indicate if afraid of somebody is a family and domestic violence risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether afraid of somebody is a family and domestic violence risk factor for the consumer undergoing the RAMP.

Examples

	Afraid of Somebody
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that afraid of somebody is a family and domestic violence risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that afraid of somebody is not a family and domestic violence risk factor.	0

Related national definition

N/A

Revision history

N/A

Anger, Frustration or Agitation

Field name:	angerfrustrationoragitation
Source Data Element(s):	[Anger, Frustration or Agitation] – webPSOLIS
Definition:	Flag to indicate if anger, frustration or agitation is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether anger, frustration or agitation is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Anger, Frustration or Agitation
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that anger, frustration or agitation is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that anger, frustration or agitation is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Childhood Abuse / Maladjustment

Field name:	childhoodabusemaladjustment
Source Data Element(s):	[Childhood Abuse / Maladjustment] – webPSOLIS
Definition:	Flag to indicate if childhood abuse / maladjustment is a background general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether childhood abuse / maladjustment is a background general risk factor for the consumer undergoing the RAMP.

Examples

	Childhood Abuse / Maladjustment
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that childhood abuse / maladjustment is a background general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that childhood abuse / maladjustment is not a background general risk factor.	0

Related national definition

N/A

Revision history

N/A

Command Hallucinations

Field name:	commandhallucinations
Source Data Element(s):	[Command Hallucinations] – webPSOLIS
Definition:	Flag to indicate if command hallucinations is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether command hallucinations is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Command Hallucinations
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that command hallucinations is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that command hallucinations is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Contact with Vulnerable Person/s

Field name:	contactwithvulnerablepersons
Source Data Element(s):	[Contact with Vulnerable Person/s] – webPSOLIS
Definition:	Flag to indicate if contact with vulnerable person/s is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether contact with vulnerable person/s is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Contact with Vulnerable Person/s
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that contact with vulnerable person/s is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that contact with vulnerable person/s is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Current Delusional Beliefs

Field name:	currentdelusionalbeliefs
Source Data Element(s):	[Current Delusional Beliefs] – webPSOLIS
Definition:	Flag to indicate if current delusional beliefs is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether current delusional beliefs is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Current Delusional Beliefs
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that current delusional beliefs is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that current delusional beliefs is not a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Current Intoxication / Withdrawal

Field name:	currentintoxicationwithdrawal
Source Data Element(s):	[Current Intoxication / Withdrawal] – webPSOLIS
Definition:	Flag to indicate if intoxication or withdrawal is a current general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether intoxication or withdrawal is a current general risk factor for the consumer undergoing the RAMP.

Examples

	Current Intoxication / Withdrawal
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that intoxication is a current general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither intoxication nor withdrawal is a current general risk factor.	0

Related national definition

N/A

Revision history

N/A

Current Plan / Intent

Field name:	currentplanintent
Source Data Element(s):	[Current Plan / Intent] – webPSOLIS
Definition:	Flag to indicate if current plan or intent is a current suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether current plan or intent is a current suicide risk factor for the consumer undergoing the RAMP.

Examples

	Current Plan / Intent
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that intent is a current suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither current plan nor intent is a current suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Desire / Intent to Leave Hospital

Field name:	desiretoleavehospital
Source Data Element(s):	[Desire / Intent to Leave Hospital] – webPSOLIS
Definition:	Flag to indicate if desire or intent to leave hospital is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether desire or intent to leave hospital is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Desire / Intent to Leave Hospital
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that intent to leave hospital is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither desire nor intent to leave hospital is a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Diagnosed Personality Disorder

Field name:	diagnosedpersonalitydisorder
Source Data Element(s):	[Diagnosed Personality Disorder] – webPSOLIS
Definition:	Flag to indicate if diagnosed personality disorder is a background general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether diagnosed personality disorder is a background general risk factor for the consumer undergoing the RAMP.

Examples

	Diagnosed Personality Disorder
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that diagnosed personality disorder is a background general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that diagnosed personality disorder is not a background general risk factor.	0

Related national definition

N/A

Revision history

N/A

Disinhibition / Intrusive / Impulsive Behaviour

Field name:	disinhibitionintrusiveimpulsivebehaviour
Source Data Element(s):	[Disinhibition / Intrusive / Impulsive Behaviour] – webPSOLIS
Definition:	Flag to indicate if disinhibition, intrusive or impulsive behaviour is a current general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether disinhibition, intrusive or impulsive behaviour is a current general risk factor for the consumer undergoing the RAMP.

Examples

	Disinhibition / Intrusive / Impulsive Behaviour
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that intrusive behaviour is a current general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither disinhibition, nor intrusive or impulsive behaviour, is a current general risk factor.	0

Related national definition

N/A

Revision history

N/A

Disorientation or Disorganisation

Field name:	disorientationordisorganisation
Source Data Element(s):	[Disorientation or Disorganisation] – webPSOLIS
Definition:	Flag to indicate if disorientation or disorganisation is a current general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether disorientation or disorganisation is a current general risk factor for the consumer undergoing the RAMP.

Examples

	Disorientation or Disorganisation
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that disorganisation is a current general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither disorientation nor disorganisation is a current general risk factor.	0

Related national definition

N/A

Revision history

N/A

Driving

Field name:	driving
Source Data Element(s):	[Driving] – webPSOLIS
Definition:	Flag to indicate if driving is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether driving is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Driving
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that driving is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that driving is not a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Emotional Distress / Agitation

Field name:	emotionaldistressagitation
Source Data Element(s):	[Emotional Distress / Agitation] – webPSOLIS
Definition:	Flag to indicate if emotional distress or agitation is a current general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether emotional distress or agitation is a current general risk factor for the consumer undergoing the RAMP.

Examples

	Emotional Distress / Agitation
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that agitation is a current general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither emotional distress nor agitation is a current general risk factor.	0

Related national definition

N/A

Revision history

N/A

Expressing High Levels of Distress

Field name:	expressinghighlevelsofdistress
Source Data Element(s):	[Expressing High Levels of Distress] – webPSOLIS
Definition:	Flag to indicate if expressing high levels of distress is a current suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether expressing high levels of distress is a current suicide risk factor for the consumer undergoing the RAMP.

Examples

	Expressing High Levels of Distress
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that expressing high levels of distress is a current suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that expressing high levels of distress is not a current suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Expressing Intent to Harm Others

Field name:	expressingintenttoharmothers
Source Data Element(s):	[Expressing Intent to Harm Others] – webPSOLIS
Definition:	Flag to indicate if expressing intent to harm others is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether expressing intent to harm others is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Expressing Intent to Harm Others
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that expressing intent to harm others is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that expressing intent to harm others is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Expressing Suicidal Ideas

Field name:	expressingsuicidalideas
Source Data Element(s):	[Expressing Suicidal Ideas] – webPSOLIS
Definition:	Flag to indicate if expressing suicidal ideas is a current suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether expressing suicidal ideas is a current suicide risk factor for the consumer undergoing the RAMP.

Examples

	Expressing Suicidal Ideas
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that expressing suicidal ideas is a current suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that expressing suicidal ideas is not a current suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Family and Domestic Violence

Field name:	familyanddomesticviolence
Source Data Element(s):	[Family and Domestic Violence] – webPSOLIS
Definition:	Flag to indicate if family and domestic violence is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether family and domestic violence is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Family and Domestic Violence
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that family and domestic violence is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that family and domestic violence is not a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Family History of Suicide

Field name:	familyhistoryofsuicide
Source Data Element(s):	[Family History of Suicide] – webPSOLIS
Definition:	Flag to indicate if family history of suicide is a background suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether family history of suicide is a background suicide risk factor for the consumer undergoing the RAMP.

Examples

	Family History of Suicide
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that family history of suicide is a background suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that family history of suicide is not a background suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Forensic History

Field name:	forensichistory
Source Data Element(s):	[Forensic History] – webPSOLIS
Definition:	Flag to indicate if forensic history is a background violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether forensic history is a background violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Forensic History
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that forensic history is a background violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that forensic history is not a background violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

General Risk Factors – Background Other

Field name:	generalbackgroundother
Source Data Element(s):	[General Risk Factors – Background Other] – webPSOLIS
Definition:	Other background general risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other background general risk factors for the consumer undergoing the RAMP.

Examples

	General Risk Factors – Background Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a background general risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

General Risk Factors Comments

Field name:	generalcomments
Source Data Element(s):	[General Risk Factors Comments] – webPSOLIS
Definition:	Other information relating to general risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other information relating to general risk factors for the consumer undergoing the RAMP.

Examples

	General Risk Factors Comments
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment learns that the consumer is still attending a hazardous workplace despite being unwell and unproductive.	Presenteeism occurring.

Related national definition

N/A

Revision history

N/A

General Risk Factors – Current Other

Field name:	generalcurrentother
Source Data Element(s):	[General Risk Factors – Current Other] – webPSOLIS
Definition:	Other current general risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other current general risk factors for the consumer undergoing the RAMP.

Examples

	General Risk Factors – Current Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a current general risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

History of Absconding

Field name:	historyofabsconding
Source Data Element(s):	[History of Absconding] – webPSOLIS
Definition:	Flag to indicate if history of absconding is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of absconding is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Absconding
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of absconding is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of absconding is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Exploitation

Field name:	historyofexploitation
Source Data Element(s):	[History of Exploitation] – webPSOLIS
Definition:	Flag to indicate if history of exploitation is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of exploitation is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Exploitation
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of exploitation is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of exploitation is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Falls or Other Accidents

Field name:	historyofaccidents
Source Data Element(s):	[History of Falls or Other Accidents] – webPSOLIS
Definition:	Flag to indicate if history of falls or other accidents is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of falls or other accidents is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Falls or Other Accidents
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of falls or other accidents is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of falls or other accidents is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Family and Domestic Violence

Field name:	historyoffamilyviolence
Source Data Element(s):	[History of Family and Domestic Violence] – webPSOLIS
Definition:	Flag to indicate if history of family and domestic violence is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of family and domestic violence is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Family and Domestic Violence
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of family and domestic violence is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of family and domestic violence is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Financial Vulnerability

Field name:	historyoffinancialvulnerability
Source Data Element(s):	[History of Financial Vulnerability] – webPSOLIS
Definition:	Flag to indicate if history of financial vulnerability is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of financial vulnerability is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Financial Vulnerability
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of financial vulnerability is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of financial vulnerability is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Harm to Children or Dependants

Field name:	historyofharmtochildren
Source Data Element(s):	[History of Harm to Children or Dependants] – webPSOLIS
Definition:	Flag to indicate if history of harm to children or dependants is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of harm to children or dependants is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Harm to Children or Dependants
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of harm to children or dependants is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of harm to children or dependants is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Neglect of a Serious Medical Condition

Field name:	historyofneglectseriousmedicalcondition
Source Data Element(s):	[History of Neglect of a Serious Medical Condition] – webPSOLIS
Definition:	Flag to indicate if history of neglect of a serious medical condition is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of neglect of a serious medical condition is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Neglect of a Serious Medical Condition
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of neglect of a serious medical condition is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of neglect of a serious medical condition is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of No Fixed Permanent Address

Field name:	historyofnofixedpermanentaddress
Source Data Element(s):	[History of No Fixed Permanent Address] – webPSOLIS
Definition:	Flag to indicate if history of no fixed permanent address is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of no fixed permanent address is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of No Fixed Permanent Address
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of no fixed permanent address is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of no fixed permanent address is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Non-adherence

Field name:	historyofnonadherence
Source Data Element(s):	[History of Non-adherence] – webPSOLIS
Definition:	Flag to indicate if history of non-adherence is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of non-adherence is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Non-adherence
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of non-adherence is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of non-adherence is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Physical / Sexual Victimisation

Field name:	historyofphysicalsexualvictim
Source Data Element(s):	[History of Physical / Sexual Victimisation] – webPSOLIS
Definition:	Flag to indicate if history of physical or sexual victimisation is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of physical or sexual victimisation is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Physical / Sexual Victimisation
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of physical victimisation is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither history of physical nor sexual victimisation is a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Predatory Behaviour

Field name:	historyofpredatorybehaviour
Source Data Element(s):	[History of Predatory Behaviour] – webPSOLIS
Definition:	Flag to indicate if history of predatory behaviour is a background violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of predatory behaviour is a background violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	History of Predatory Behaviour
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of predatory behaviour is a background violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of predatory behaviour is not a background violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Risk of Homelessness

Field name:	historyofriskofomelessness
Source Data Element(s):	[History of Risk of Homelessness] – webPSOLIS
Definition:	Flag to indicate if history of risk of homelessness is a background other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of risk of homelessness is a background other risk factor for the consumer undergoing the RAMP.

Examples

	History of Risk of Homelessness
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of risk of homelessness is a background other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of risk of homelessness is not a background other risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Self Harm

Field name:	historyofselfharm
Source Data Element(s):	[History of Self Harm] – webPSOLIS
Definition:	Flag to indicate if history of self harm is a background suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of self harm is a background suicide risk factor for the consumer undergoing the RAMP.

Examples

	History of Self Harm
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of self harm is a background suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that history of self harm is not a background suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Hopelessness / Despair

Field name:	hopelessnessdespair
Source Data Element(s):	[Hopelessness / Despair] – webPSOLIS
Definition:	Flag to indicate if hopelessness or despair is a current suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether hopelessness or despair is a current suicide risk factor for the consumer undergoing the RAMP.

Examples

	Hopelessness / Despair
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that hopelessness is a current suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither hopelessness nor despair is a current suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Impaired Cognition / Judgement / Self-control

Field name:	impairedcognition
Source Data Element(s):	[Impaired Cognition / Judgement / Self-control] – webPSOLIS
Definition:	Flag to indicate if impaired cognition, judgement or self-control is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether impaired cognition, judgement or self-control is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Impaired Cognition / Judgement / Self-control
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impaired judgement is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither impaired cognition, judgment nor self-control is a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Intellectual Disability / Cognitive Deficits

Field name:	intellectualdisabilitycognitivedeficits
Source Data Element(s):	[Intellectual Disability / Cognitive Deficits] – webPSOLIS
Definition:	Flag to indicate if intellectual disability / cognitive deficits is a background general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether intellectual disability / cognitive deficits is a background general risk factor for the consumer undergoing the RAMP.

Examples

	Intellectual Disability / Cognitive Deficits
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that intellectual disability / cognitive deficits is a background general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that intellectual disability / cognitive deficits is not a background general risk factor.	0

Related national definition

N/A

Revision history

N/A

Isolation / Lack of Support / Supervision

Field name:	isolationlackofsupportsupervision
Source Data Element(s):	[Isolation / Lack of Support / Supervision] – webPSOLIS
Definition:	Flag to indicate if isolation or a lack of support/supervision is a background suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether isolation or a lack of support / supervision is a background suicide risk factor for the consumer undergoing the RAMP.

Examples

	Isolation / Lack of Support/Supervision
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that lack of supervision is a background suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither isolation nor a lack of support / supervision is a background suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Major Psychiatric Illness

Field name:	majorpsychiatricillness
Source Data Element(s):	[Major Psychiatric Illness] – webPSOLIS
Definition:	Flag to indicate if major psychiatric illness is a background general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether major psychiatric illness is a background general risk factor for the consumer undergoing the RAMP.

Examples

	Major Psychiatric Illness
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that major psychiatric illness is a background general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that major psychiatric illness is not a background general risk factor.	0

Related national definition

N/A

Revision history

N/A

No Fixed Permanent Address

Field name:	nofixedpermanentaddress
Source Data Element(s):	[No Fixed Permanent Address] – webPSOLIS
Definition:	Flag to indicate if no fixed permanent address is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether no fixed permanent address is a current other risk factor for the consumer undergoing the RAMP.

Examples

	No Fixed Permanent Address
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that no fixed permanent address is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that no fixed permanent address is not a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Non-adherence to Medications / Treatment

Field name:	nonadherencetomedications
Source Data Element(s):	[Non-adherence to Medications / Treatment] – webPSOLIS
Definition:	Flag to indicate if non-adherence to medications or treatment is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether non-adherence to medications or treatment is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Non-adherence to Medications / Treatment
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that non-adherence to medications is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither non-adherence to medications nor treatment is a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Other Risk Factors – Background Other

Field name:	otherbackgroundother
Source Data Element(s):	[Other Risk Factors – Background Other] – webPSOLIS
Definition:	Other background other risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other background other risk factors for the consumer undergoing the RAMP.

Examples

	Other Risk Factors – Background Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a background other risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

Other Risk Factors – Comments

Field name:	othercomments
Source Data Element(s):	[Other Risk Factors – Comments] – webPSOLIS
Definition:	Other information relating to other risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other information relating to other risk factors for the consumer undergoing the RAMP.

Examples

	Other Risk Factors – Comments
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment learns that the consumer is still attending a hazardous workplace despite being unwell and unproductive.	Presenteeism occurring.

Related national definition

N/A

Revision history

N/A

Other Risk Factors – Current Other

Field name:	othercurrentother
Source Data Element(s):	[Other Risk Factors – Current Other] – webPSOLIS
Definition:	Other current other risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other current other risk factors for the consumer undergoing the RAMP.

Examples

	Other Risk Factors – Current Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a current other risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

Overall Assessment of Risk

Field name:	overallassessment
Source Data Element(s):	[Overall Assessment of Risk] – webPSOLIS
Definition:	The overall assessment of the consumer's level of risk.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(3999)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail the overall assessment of the consumer's level of risk.

Examples

	Overall Assessment of Risk
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer has self-harmed in the past and without treatment is likely to continue such behaviour.	High risk of self-harm.

Related national definition

N/A

Revision history

N/A

Overall Comments

Field name:	comments
Source Data Element(s):	[Overall Comments] – webPSOLIS
Definition:	Additional information relating to the overall assessment of the consumer's level of risk.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail additional information relating to the overall assessment of the consumer's level of risk.

Examples

	Overall Comments
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer has self-harmed in the past and without treatment is likely to continue such behaviour.	High risk of self-harm, but the consumer is highly engaged with services and is very receptive to treatment.

Related national definition

N/A

Revision history

N/A

Paranoid Ideation About Others

Field name:	paranoidideationaboutothers
Source Data Element(s):	[Paranoid Ideation About Others] – webPSOLIS
Definition:	Flag to indicate if paranoid ideation about others is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether paranoid ideation about others is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Paranoid Ideation About Others
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that paranoid ideation about others is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that paranoid ideation about others is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Parental / Carer Status or Access to Children

Field name:	parentalaccesstochildren
Source Data Element(s):	[Parental / Carer Status or Access to Children] – webPSOLIS
Definition:	Flag to indicate if parental/carer status or access to children is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether parental/carer status or access to children is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Parental / Carer Status or Access to Children
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that access to children is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither parental/carer status nor access to children is a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Physical Illness

Field name:	physicalillness
Source Data Element(s):	[Physical Illness] – webPSOLIS
Definition:	Flag to indicate if physical illness is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether physical illness is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Physical Illness
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that physical illness is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that physical illness is not a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Previous Dangerous / Violent Ideation

Field name:	previousdangerousviolentideation
Source Data Element(s):	[Previous Dangerous / Violent Ideation] – webPSOLIS
Definition:	Flag to indicate if previous dangerous or violent ideation is a background violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether previous dangerous or violent ideation is a background violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Previous Dangerous / Violent Ideation
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that previous violent ideation is a background violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither previous dangerous nor violent ideation is a background violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Previous Incidents of Violence

Field name:	previousincidentsofviolence
Source Data Element(s):	[Previous Incidents of Violence] – webPSOLIS
Definition:	Flag to indicate if previous incidents of violence is a background violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether previous incidents of violence is a background violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Previous Incidents of Violence
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that previous incidents of violence is a background violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that previous incidents of violence is not a background suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Previous Suicide Attempts

Field name:	previoussuicideattempts
Source Data Element(s):	[Previous Suicide Attempts] – webPSOLIS
Definition:	Flag to indicate if previous suicide attempts is a background suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether previous suicide attempts is a background suicide risk factor for the consumer undergoing the RAMP.

Examples

	Previous Suicide Attempts
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that previous suicide attempts is a background suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that previous suicide attempts is not a background suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Previous Use of Weapons

Field name:	previoususeofweapons
Source Data Element(s):	[Previous Use of Weapons] – webPSOLIS
Definition:	Flag to indicate if previous use of weapons is a background violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether previous use of weapons is a background violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Previous Use of Weapons
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that previous use of weapons is a background violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that previous use of weapons is not a background suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Protective Factors

Field name:	protectivefactors
Source Data Element(s):	[Protective Factors] – webPSOLIS
Definition:	Information relating to factors that contribute positively to the consumer's level of risk.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail information relating to factors that contribute positively to the consumer's level of risk.

Examples

	Protective Factors
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer is insightful and is willing to engage with mental health clinicians.	Insightful, engaged with services.

Related national definition

N/A

Revision history

N/A

RAMP Assessment Date

Field name:	assessmentdate
Source Data Element(s):	[RAMP Assessment Date] – webPSOLIS
Definition:	The date on which the RAMP assessment occurred.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	RAMP Assessment Date
A consumer presents to a mental health service on 2 April 2022 and a RAMP is completed.	2022-04-02

Related national definition

N/A

Revision history

N/A

RAMP Assessor HE Number

Field name:	authoruserid
Source Data Element(s):	[RAMP Assessor HE Number] – webPSOLIS
Definition:	The health employee (HE) number of the person performing the RAMP.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element identifies the person who performed the consumer's RAMP by their health employee (HE) number recorded.

Examples

	RAMP Assessor HE Number
A mental health clinician creates a RAMP.	HE999990

Related national definition

N/A

Revision history

N/A

RAMP Consulted Date

Field name:	consultdate
Source Data Element(s):	[RAMP Consulted Date] – webPSOLIS
Definition:	The date on which consultation about the RAMP assessment occurred.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional. If a consultation has occurred this data element must be recorded.

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	RAMP Consulted Date
A consumer presents to a mental health service on 2 April 2022 and a RAMP is completed. During the event the clinician performing the RAMP consults a colleague about the case.	2022-04-02

Related national definition

N/A

Revision history

N/A

RAMP Consulted With HE Number

Field name:	consultwithuserid
Source Data Element(s):	[RAMP Consulted With HE Number] – webPSOLIS
Definition:	The health employee (HE) number of the person consulted about the RAMP.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional. If a consultation has occurred this data element must be recorded.

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	RAMP Consulted With HE Number
A consumer presents to a mental health service and a RAMP is completed. During the event the clinician performing the RAMP consults a colleague about the case.	HE999990

Related national definition

N/A

Revision history

N/A

RAMP Identifier

Field name:	webrampid
Source Data Element(s):	[RAMP Identifier] – webPSOLIS
Definition:	The unique identifier (surrogate key) for the RAMP.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is the unique, system generated number assigned to each RAMP created in webPSOLIS.

Examples

	RAMP Identifier
A consumer presents to a clinic with a mental health problem and the triage function is used to create a RAMP.	23590964

Related national definition

N/A

Revision history

N/A

RAMP Next Due

Field name:	nextdue
Source Data Element(s):	[RAMP Next Due] – webPSOLIS
Definition:	The date on which the consumer's next RAMP assessment is scheduled to occur.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	RAMP Next Due
A consumer presents to a mental health service and a RAMP is completed. A further RAMP is scheduled three months hence.	2022-04-02

Related national definition

N/A

Revision history

N/A

Recent / Current Violence

Field name:	recentcurrentviolence
Source Data Element(s):	[Recent / Current Violence] – webPSOLIS
Definition:	Flag to indicate if recent or current violence is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether recent or current violence is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Recent / Current Violence
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that recent violence is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither recent nor current violence is a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Recent Significant Life Events

Field name:	recentsignificantlifeevents
Source Data Element(s):	[Recent Significant Life Events] – webPSOLIS
Definition:	Flag to indicate if recent significant life events is a current suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether recent significant life events is a current suicide risk factor for the consumer undergoing the RAMP.

Examples

	Recent Significant Life Events
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that recent significant life events is a current suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that recent significant life events is not a current suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Reduced Ability to Control Behaviour

Field name:	reducedabilitytocontrolbehaviour
Source Data Element(s):	[Reduced Ability to Control Behaviour] – webPSOLIS
Definition:	Flag to indicate if reduced ability to control behaviour is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether reduced ability to control behaviour is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Reduced Ability to Control Behaviour
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that reduced ability to control behaviour is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that reduced ability to control behaviour is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Requires Help

Field name:	requireshelp
Source Data Element(s):	[Requires Help] – webPSOLIS
Definition:	Flag to indicate if the consumer has requested help when questioned about family and domestic violence risk factors.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether help has been requested by the consumer undergoing the RAMP when questioned about family and domestic violence risk factors.

Examples

	Requires Help
A consumer presents to a mental health clinic and a RAMP is completed. The consumer requests help when questioned about family and domestic violence risk factors.	1
A consumer presents to a mental health clinic and a RAMP is completed. The consumer does not request help when questioned about family and domestic violence risk factors.	0

Related national definition

N/A

Revision history

N/A

Risk Highly Changeable

Field name:	highlychangeable
Source Data Element(s):	[Risk Highly Changeable] – webPSOLIS
Definition:	Flag to indicate if the consumer's level of risk is highly changeable.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether the consumer's level of risk is highly changeable.

Examples

	Risk Highly Changeable
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer's level of risk is highly changeable.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer's level of risk is not highly changeable.	0

Related national definition

N/A

Revision history

N/A

Risk Management Plan

Field name:	riskmanagementplan
Source Data Element(s):	[Risk Management Plan] – webPSOLIS
Definition:	The proposed plan for the management of the consumer's mental health episode.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail the proposed plan for the management of the consumer's mental health episode.

Examples

	Risk Management Plan
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer is likely to self-harm and that psychiatric admission is required to further assess and treat the underlying disorder.	Admit consumer to psychiatric ward for further assessment, treatment, etc.

Related national definition

N/A

Revision history

N/A

Risk of Homelessness

Field name:	riskofhomelessness
Source Data Element(s):	[Risk of Homelessness] – webPSOLIS
Definition:	Flag to indicate if risk of homelessness is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether risk of homelessness is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Risk of Homelessness
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that risk of homelessness is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that risk of homelessness is not a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Self-harming Behaviour

Field name:	selfharmingbehaviour
Source Data Element(s):	[Self-harming Behaviour] – webPSOLIS
Definition:	Flag to indicate if self-harming behaviour is a current suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether self-harming behaviour is a current suicide risk factor for the consumer undergoing the RAMP.

Examples

	Self-harming Behaviour
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that self-harming behaviour is a current suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that self-harming behaviour is not a current suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Self-neglect, Poor Self Care

Field name:	selfneglect
Source Data Element(s):	[Self-neglect, Poor Self Care] – webPSOLIS
Definition:	Flag to indicate if self-neglect and poor self care is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether self-neglect and poor self care is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Self-neglect, Poor Self Care
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that self-neglect and poor self care is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that self-neglect and poor self care is not a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Separated / Widowed / Divorced

Field name:	separatedwidoweddivorced
Source Data Element(s):	[Separated / Widowed / Divorced] – webPSOLIS
Definition:	Flag to indicate if separated, widowed or divorced is a background suicide risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether separated, widowed or divorced is a background suicide risk factor for the consumer undergoing the RAMP.

Examples

	Separated / Widowed / Divorced
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that divorce is a background suicide risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither separation, widowing nor divorce is a background suicide risk factor.	0

Related national definition

N/A

Revision history

N/A

Serious Medical Condition

Field name:	seriousmedicalcondition
Source Data Element(s):	[Serious Medical Condition] – webPSOLIS
Definition:	Flag to indicate if serious medical condition is a background general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether serious medical condition is a background general risk factor for the consumer undergoing the RAMP.

Examples

	Serious Medical Condition
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that serious medical condition is a background general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that serious medical condition is not a background general risk factor.	0

Related national definition

N/A

Revision history

N/A

Significant Alcohol / Drug Use History

Field name:	significantalcoholdrugusehistory
Source Data Element(s):	[Significant Alcohol / Drug Use History] – webPSOLIS
Definition:	Flag to indicate if significant alcohol / drug use history is a background general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether significant alcohol / drug use history is a background general risk factor for the consumer undergoing the RAMP.

Examples

	Significant Alcohol / Drug Use History
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that significant drug use is a background general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither significant alcohol nor drug use is a background general risk factor.	0

Related national definition

N/A

Revision history

N/A

Significant Behavioural Disorder

Field name:	significantbehaviouraldisorder
Source Data Element(s):	[Significant Behavioural Disorder] – webPSOLIS
Definition:	Flag to indicate if significant behavioural disorder is a background general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether significant behavioural disorder is a background general risk factor for the consumer undergoing the RAMP.

Examples

	Significant Behavioural Disorder
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that significant behavioural disorder is a background general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that significant behavioural disorder is not a background general risk factor.	0

Related national definition

N/A

Revision history

N/A

Significant Physical Pain

Field name:	significantphysicalpain
Source Data Element(s):	[Significant Physical Pain] – webPSOLIS
Definition:	Flag to indicate if significant physical pain is a current general risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether significant physical pain is a current general risk factor for the consumer undergoing the RAMP.

Examples

	Significant Physical Pain
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that significant physical pain is a current general risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that significant physical pain is not a current general risk factor.	0

Related national definition

N/A

Revision history

N/A

Sources of Information

Field name:	sourcesofinformation
Source Data Element(s):	[Sources of Information] – webPSOLIS
Definition:	The sources of information used for the preparation of the consumer's proposed risk management plan.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail the sources of information used for the preparation of the consumer's proposed risk management plan.

Examples

	Sources of Information
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer is likely to self-harm and that psychiatric admission is required to further assess and treat the underlying disorder.	Consumer, Consumer's carer and GP.

Related national definition

N/A

Revision history

N/A

Suicide Risk Factors – Background Other

Field name:	suicidebackgroundother
Source Data Element(s):	[Suicide Risk Factors – Background Other] – webPSOLIS
Definition:	Other background suicide risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other background suicide risk factors for the consumer undergoing the RAMP.

Examples

	Suicide Risk Factors – Background Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a background suicide risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

Suicide Risk Factors – Comments

Field name:	suicidecomments
Source Data Element(s):	[Suicide Risk Factors – Comments] – webPSOLIS
Definition:	Other information relating to suicide risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other information relating to suicide risk factors for the consumer undergoing the RAMP.

Examples

	Suicide Risk Factors – Comments
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment learns that the consumer is still attending a hazardous workplace despite being unwell and unproductive.	Presenteeism occurring.

Related national definition

N/A

Revision history

N/A

Suicide Risk Factors – Current Other

Field name:	suicidecurrentother
Source Data Element(s):	[Suicide Risk Factors – Current Other] – webPSOLIS
Definition:	Other current suicide risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other current suicide risk factors for the consumer undergoing the RAMP.

Examples

	Suicide Risk Factors – Current Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a current suicide risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

Threat to Hurt

Field name:	threattohurt
Source Data Element(s):	[Threat to Hurt] – webPSOLIS
Definition:	Flag to indicate if threat to hurt is a family and domestic violence risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether threat to hurt is a family and domestic violence risk factor for the consumer undergoing the RAMP.

Examples

	Threat to Hurt
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that threat to hurt is a family and domestic violence risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that threat to hurt is not a family and domestic violence risk factor.	0

Related national definition

N/A

Revision history

N/A

Uncertainty of Risk

Field name:	uncertaintyofrisklevel
Source Data Element(s):	[Uncertainty of Risk] – webPSOLIS
Definition:	Flag to indicate if there are factors that contribute to uncertainty regarding the consumer's level of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether there are factors that contribute to uncertainty regarding the consumer's level of risk.

Examples

	Uncertainty of Risk
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that there are factors that contribute to uncertainty regarding the consumer's level of risk.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that there are no factors that contribute to uncertainty regarding the consumer's level of risk.	0

Related national definition

N/A

Revision history

N/A

Uncertainty of Risk Comments

Field name:	uncertaintycomments
Source Data Element(s):	[Uncertainty of Risk Comments] – webPSOLIS
Definition:	Other information relating to factors that contribute to uncertainty regarding the consumer's level of risk.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other information relating to factors that contribute to uncertainty regarding the consumer's level of risk.

Examples

	Uncertainty of Risk Comments
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that the consumer is showing signs of unwillingness to engage with mental health clinicians.	Potential unwillingness to engage with mental health services.

Related national definition

N/A

Revision history

N/A

Violence / Aggression Risk Factors – Background Other

Field name:	violenceagressionbackgroundother
Source Data Element(s):	[Violence / Aggression Risk Factors – Background Other] – webPSOLIS
Definition:	Other background violence or aggression risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other background violence or aggression risk factors for the consumer undergoing the RAMP.

Examples

	Violence / Aggression Risk Factors – Background Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a background violence/aggression risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

Violence / Aggression Risk Factors – Comments

Field name:	violenceaggressioncomments
Source Data Element(s):	[Violence / Aggression Risk Factors – Comments] – webPSOLIS
Definition:	Other information relating to violence or aggression risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other information relating to violence or aggression risk factors for the consumer undergoing the RAMP.

Examples

	Violence / Aggression Risk Factors – Comments
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment learns that the consumer is still attending a hazardous workplace despite being unwell and unproductive.	Presenteeism occurring.

Related national definition

N/A

Revision history

N/A

Violence / Aggression Risk Factors – Current Other

Field name:	violenceaggressioncurrentother
Source Data Element(s):	[Violence / Aggression Risk Factors – Current Other] – webPSOLIS
Definition:	Other current violence or aggression risk factors applicable to the consumer.
Requirement status:	Optional
Data type:	String
Format:	[X(1000)]
Permitted values:	Alphanumeric combination

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail other current violence or aggression risk factors for the consumer undergoing the RAMP.

Examples

	Violence / Aggression Risk Factors – Current Other
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that impulsivity is a current violence/aggression risk factor.	Impulsivity

Related national definition

N/A

Revision history

N/A

Violence Restraining Order

Field name:	violencerestrainingorder
Source Data Element(s):	[Violence Restraining Order] – webPSOLIS
Definition:	Flag to indicate if violence restraining order is a current violence/aggression risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether violence restraining order is a current violence/aggression risk factor for the consumer undergoing the RAMP.

Examples

	Violence Restraining Order
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that violence restraining order is a current violence/aggression risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that violence restraining order is not a current violence/aggression risk factor.	0

Related national definition

N/A

Revision history

N/A

Vulnerability to Sexual Exploitation / Abuse

Field name:	vulnerabilitytosexualexploitation
Source Data Element(s):	[Vulnerability to Sexual Exploitation / Abuse] – webPSOLIS
Definition:	Flag to indicate if vulnerability to sexual exploitation or abuse is a current other risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Unknown

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether vulnerability to sexual exploitation or abuse is a current other risk factor for the consumer undergoing the RAMP.

Examples

	Vulnerability to Sexual Exploitation / Abuse
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that vulnerability to abuse is a current other risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that neither vulnerability to sexual exploitation nor abuse is a current other risk factor.	0

Related national definition

N/A

Revision history

N/A

Worried of Safety

Field name:	worriedofsafety
Source Data Element(s):	[Worried of Safety] – webPSOLIS
Definition:	Flag to indicate if worried of safety is a family and domestic violence risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether worried of safety is a family and domestic violence risk factor for the consumer undergoing the RAMP.

Examples

	Worried of Safety
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that worried of safety is a family and domestic violence risk factor.	1
A consumer presents to a mental health clinic and a RAMP is completed. The clinician performing the assessment determines that worried of safety is not a family and domestic violence risk factor.	0

Related national definition

N/A

Revision history

N/A

14. Child and adolescent risk assessment and management plan

The following section provides specific information about the child and adolescent risk assessment and management plan data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the MHDC, and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

A. Risk of Suicide

Field name:	ascore
Source Data Element(s):	[A. Risk of Suicide] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the suicide type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil suicidal ideation 1 – Fleeting suicidal ideation 2 – Ongoing suicidal ideation 3 – Ongoing ideation, plan and intent 4 – Ongoing ideation, plan, intent and a recent history of attempts

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of suicide for the consumer undergoing the CRAMP.

Examples

	A. Risk of Suicide
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing suicide ideation.	2
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing no suicide ideation.	0

Related national definition

N/A

Revision history

N/A

A. Clinical Evidence

Field name:	aevidence
Source Data Element(s):	[A. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the suicide type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the suicide type of risk.

Examples

	A. Clinical Evidence
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing suicide ideation.	GP referral notes and responses to Suicide Assessment Screener.

Related national definition

N/A

Revision history

N/A

A. PSOLIS Alert

Field name:	aalert
Source Data Element(s):	[A. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the suicide type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of suicide for the consumer undergoing the CRAMP.

Examples

	A. PSOLIS Alert
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing suicide ideation, plan and intent and an alert is raised in PSOLIS.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing no suicide ideation and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

Access to Means of Self-harm and Lethality

Field name:	accesstomeansofselfharmandlethality
Source Data Element(s):	[Access to Means of Self-harm and Lethality] – webPSOLIS
Definition:	Flag to indicate if access to means of self-harm and lethality is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether access to means of self-harm and lethality is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Access to Means of Self-harm and Lethality
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that access to means of self-harm is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that access to means of self-harm and lethality is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

B. Risk of Other Deliberate Self-harm

Field name:	bscore
Source Data Element(s):	[B. Risk of Other Deliberate Self-harm] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the other deliberate self-harm type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil ideas of self-harm 1 – Fleeting self-harm ideation 2 – Ongoing self-harm ideation 3 – Ongoing self-harm ideation, plan and intent 4 – Ongoing ideation, plan, intent and a recent history of self-harm

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of other deliberate self-harm for the consumer undergoing the CRAMP.

Examples

	B. Risk of Other Deliberate Self-harm
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing self-harm ideation.	2
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing no self-harm ideation.	0

Related national definition

N/A

Revision history

N/A

B. Clinical Evidence

Field name:	bevidence
Source Data Element(s):	[B. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the other deliberate self-harm type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the other deliberate self-harm type of risk.

Examples

	B. Clinical Evidence
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing self-harm ideation.	GP referral notes and responses to clinical questioning.

Related national definition

N/A

Revision history

N/A

B. PSOLIS Alert

Field name:	balert
Source Data Element(s):	[B. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the other deliberate self-harm type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of other deliberate self-harm for the consumer undergoing the CRAMP.

Examples

	B. PSOLIS Alert
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing self-harm ideation, plan and intent and an alert is raised in PSOLIS.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing no self-harm ideation and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

C. Risk of Self-neglect / Accidental Self-harm

Field name:	cscore
Source Data Element(s):	[C. Risk of Self-neglect / Accidental Self-harm] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the self-neglect / accidental self-harm type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil evidence of above risk 1 – Nil evidence or risk, may be at risk if untreated 2 – Recent evidence of self-neglect or accidental self-harm 3 – Ongoing evidence of self-neglect or accidental self-harm 4 – As per 3 with major impact on client's physical and mental health

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of self-neglect or accidental self-harm for the consumer undergoing the CRAMP.

Examples

	C. Risk of Self-neglect / Accidental Self-harm
A child presents to a mental health clinic and a CRAMP is completed. The clinician determines that the child shows recent evidence of self-neglect.	2
A child presents to a mental health clinic and a CRAMP is completed. The clinician determines that there is no evidence of risk to the child of self-neglect or accidental self-harm.	0

Related national definition

N/A

Revision history

N/A

C. Clinical Evidence

Field name:	cevidence
Source Data Element(s):	[C. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the self-neglect or accidental self-harm type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the self-neglect or accidental self-harm type of risk.

Examples

	C. Clinical Evidence
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is evidence that the child is experiencing self-neglect.	GP referral notes and responses to clinical questioning.

Related national definition

N/A

Revision history

N/A

C. PSOLIS Alert

Field name:	calert
Source Data Element(s):	[C. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the self-neglect or accidental self-harm type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of self-neglect or accidental self-harm for the consumer undergoing the CRAMP.

Examples

	C. PSOLIS Alert
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing self-neglect and an alert is raised in PSOLIS.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence that the child is at risk of self-neglect nor accidental self-harm and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

Consulted With Outcome

Field name:	consultoutcome
Source Data Element(s):	[Consulted With Outcome] – webPSOLIS
Definition:	The outcome of any consultation with other clinicians regarding the child or adolescent consumer's risk assessment.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail the outcome of any consultation with other clinicians regarding the consumer's risk assessment.

Examples

	Consulted With Outcome
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment consults with a colleague and it is suggested that the consumer is likely to self-harm and that psychiatric admission is required to further assess and treat the underlying disorder.	Psychiatric admission suggested.

Related national definition

N/A

Revision history

N/A

CRAMP Additional Information

Field name:	additionalinformation
Source Data Element(s):	[CRAMP Additional Information] – webPSOLIS
Definition:	Additional information regarding the child or adolescent consumer's risk assessment.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail any additional information regarding the consumer's risk assessment.

Examples

	CRAMP Additional Information
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child's identified guardian is able to provide only limited support to the child.	Only limited support able to be provided by identified guardian.

Related national definition

N/A

Revision history

N/A

CRAMP Assessment Date

Field name:	crampassessmentdate
Source Data Element(s):	[CRAMP Assessment Date] – webPSOLIS
Definition:	The date on which the CRAMP assessment occurred.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	CRAMP Assessment Date
A child presents to a mental health service on 2 April 2022 and a CRAMP is completed.	2022-04-02

Related national definition

N/A

Revision history

N/A

CRAMP Assessor HE Number

Field name:	crampauthoruserid
Source Data Element(s):	[CRAMP Assessor HE Number] – webPSOLIS
Definition:	The health employee (HE) number of the person performing the CRAMP.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	CRAMP Assessor HE Number
A mental health clinician creates a CRAMP.	HE999990

Related national definition

N/A

Revision history

N/A

CRAMP Consulted Date

Field name:	crampconsultdate
Source Data Element(s):	[CRAMP Consulted Date] – webPSOLIS
Definition:	The date on which consultation about the CRAMP assessment occurred.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional. If a consultation has occurred this data element must be recorded.

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	CRAMP Consulted Date
A child presents to a mental health service on 2 April 2022 and a CRAMP is completed. During the event the clinician performing the CRAMP consults a colleague about the case.	2022-04-02

Related national definition

N/A

Revision history

N/A

CRAMP Consulted With HE Number

Field name:	crampconsultwithuserid
Source Data Element(s):	[CRAMP Consulted With HE Number] – webPSOLIS
Definition:	The health employee (HE) number of the person consulted about the CRAMP.
Requirement status:	Conditional
Data type:	String
Format:	X[X(9)]
Permitted values:	Valid HE number

Guide for use

Collection of this data element is conditional. If a consultation has occurred this data element must be recorded.

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	CRAMP Consulted With HE Number
A child presents to a mental health service and a CRAMP is completed. During the event the clinician performing the CRAMP consults a colleague about the case.	HE999990

Related national definition

N/A

Revision history

N/A

CRAMP Identifier

Field name:	webcrampid
Source Data Element(s):	[CRAMP Identifier] – webPSOLIS
Definition:	The unique identifier (surrogate key) for the CRAMP.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)
Permitted values:	Unique numeric identifier

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is the unique, system generated number assigned to each CRAMP created in webPSOLIS.

Examples

	CRAMP Identifier
A child presents to a clinic with a mental health problem and the triage function is used to create a CRAMP.	23590964

Related national definition

N/A

Revision history

N/A

CRAMP Next Due

Field name:	crampnextdue
Source Data Element(s):	[CRAMP Next Due] – webPSOLIS
Definition:	The date on which the consumer's next CRAMP assessment is scheduled to occur.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	CRAMP Next Due
A child presents to a mental health service and a CRAMP is completed. A further CRAMP is scheduled three months hence.	2022-04-02

Related national definition

N/A

Revision history

N/A

CRAMP Sent to Referrer / GP

Field name:	copysenttoreferrer
Source Data Element(s):	[CRAMP Sent to Referrer / GP] – webPSOLIS
Definition:	Flag to indicate if a copy of the CRAMP has been sent to the referrer or GP.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Not applicable

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	CRAMP Sent to Referrer/GP
A child presents to a mental health service and a CRAMP is completed. A copy of the CRAMP is forwarded to the child's GP.	1
A child presents to a mental health service and a CRAMP is completed. A copy of the CRAMP is not forwarded to the child's GP.	0

Related national definition

N/A

Revision history

N/A

Current Intent – Suicide

Field name:	currentintentsuicide
Source Data Element(s):	[Current Intent – Suicide] – webPSOLIS
Definition:	Flag to indicate if current suicide intent is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether current suicide intent is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Current Intent – Suicide
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that current suicide intent is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that current suicide intent is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Current Medications / Conditions / Allergies

Field name:	currentmedication
Source Data Element(s):	[Current Medications / Conditions / Allergies] – webPSOLIS
Definition:	Information regarding the child or adolescent consumer's current medications, conditions or allergies.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail information regarding the consumer's current medications, conditions or allergies.

Examples

	Current Medications / Conditions / Allergies
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child's is currently allergic to peanuts.	Peanut allergy.

Related national definition

N/A

Revision history

N/A

Current Suicide Ideation

Field name:	currentsuicideideation
Source Data Element(s):	[Current Suicide Ideation] – webPSOLIS
Definition:	Flag to indicate if current suicide ideation is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether current suicide ideation is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Current Suicide Ideation
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that current suicide ideation is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that current suicide ideation is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Current Use of Drugs / Alcohol

Field name:	currentuseofdrugsalcohol
Source Data Element(s):	[Current Use of Drugs / Alcohol] – webPSOLIS
Definition:	Flag to indicate if current use of drugs or alcohol is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether current use of drugs or alcohol is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Current Use of Drugs / Alcohol
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that current use of drugs or alcohol is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that current use of drugs or alcohol is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Currently Agitated

Field name:	currentlyagitated
Source Data Element(s):	[Currently Agitated] – webPSOLIS
Definition:	Flag to indicate if currently agitated is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether currently agitated is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Currently Agitated
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that currently agitated is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that currently agitated is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Currently Psychotic

Field name:	currentlypsychotic
Source Data Element(s):	[Currently Psychotic] – webPSOLIS
Definition:	Flag to indicate if currently psychotic is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether currently psychotic is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Currently Psychotic
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that currently psychotic is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that currently psychotic is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

D. Risk of Violence / Harm to Others

Field name:	dscore
Source Data Element(s):	[D. Risk of Violence / Harm to Others] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the violence or harm to others type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil ideas of harm to others 1 – Fleeting ideation to harm others 2 – Ongoing ideation 3 – Ongoing ideation, plan and intent 4 – Ongoing ideation, plan, intent and a recent history of violence

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of violence or harm to others for the consumer undergoing the CRAMP.

Examples

	D. Risk of Violence or Harm to Others
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing harm to others ideation.	2
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing no violence or harm to others ideation.	0

Related national definition

N/A

Revision history

N/A

D. Clinical Evidence

Field name:	devidence
Source Data Element(s):	[D. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the violence or harm to others type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the violence or harm to others type of risk.

Examples

	D. Clinical Evidence
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing violence ideation.	GP referral notes and responses to clinical questioning.

Related national definition

N/A

Revision history

N/A

D. PSOLIS Alert

Field name:	dalert
Source Data Element(s):	[D. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the violence or harm to others type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of violence or harm to others for the consumer undergoing the CRAMP.

Examples

	D. PSOLIS Alert
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing harm to others ideation, plan and intent and an alert is raised in PSOLIS.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing no violence nor harm to others ideation and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

Disengagement from School / Work

Field name:	disengagementfromschoolwork
Source Data Element(s):	[Disengagement from School / Work] – webPSOLIS
Definition:	Flag to indicate if disengagement from school or work is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether disengagement from school or work is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Disengagement from School / Work
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that disengagement from school is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that disengagement from school is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Displaying Antisocial Behaviour

Field name:	displayingantisocialbehaviour
Source Data Element(s):	[Displaying Antisocial Behaviour] – webPSOLIS
Definition:	Flag to indicate if displaying antisocial behaviour is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether displaying antisocial behaviour is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Displaying Antisocial Behaviour
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that displaying antisocial behaviour is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that displaying antisocial behaviour is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

E. Risk of Vulnerability / Harm from Caregivers

Field name:	escore
Source Data Element(s):	[E. Risk of Vulnerability / Harm from Caregivers] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the vulnerability or harm from caregivers type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil evidence of above risk 1 – Nil evidence or risk, may be at risk if untreated 2 – Recent evidence of vulnerability / harm from caregivers 3 – Ongoing evidence of vulnerability / harm from caregivers 4 – As per 3 with major impact on client's physical and mental health

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of vulnerability or harm from caregivers for the consumer undergoing the CRAMP.

Examples

	E. Risk of Vulnerability / Harm from Caregivers
A child presents to a mental health clinic and a CRAMP is completed. The clinician determines there is recent evidence of vulnerability for the child.	2
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence of risk for the child from vulnerability or harm from caregivers.	0

Related national definition

N/A

Revision history

N/A

E. Clinical Evidence

Field name:	eevidence
Source Data Element(s):	[E. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the vulnerability or harm from caregivers type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the vulnerability or harm from caregivers type of risk.

Examples

	E. Clinical Evidence
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing vulnerability.	GP referral notes and responses to clinical questioning.

Related national definition

N/A

Revision history

N/A

E. Involve Protective Services

Field name:	protectiveservicesindicated
Source Data Element(s):	[E. Involve Protective Services] – webPSOLIS
Definition:	Numeric identifier indicating if protective services should be involved.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if protective services should be involved for the consumer undergoing the CRAMP.

Examples

	E. Involve Protective Services
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment decides that protective services should be involved.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment decides that it is not necessary for protective services to be involved.	0

Related national definition

N/A

Revision history

N/A

E. PSOLIS Alert

Field name:	ealert
Source Data Element(s):	[E. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the vulnerability or harm from caregivers type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of vulnerability or harm from caregivers for the consumer undergoing the CRAMP.

Examples

	E. PSOLIS Alert
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing ongoing vulnerability and an alert is raised in PSOLIS.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is experiencing no vulnerability nor harm from caregivers and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

F. Risk of Absconding / Non-compliance With Intervention

Field name:	fscore
Source Data Element(s):	[F. Risk of Absconding / Non-compliance With Intervention] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the absconding or non-compliance with intervention type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil evidence of above risk 1 – ambivalent, however willing to accept treatment 2 – nil insight, however reluctantly accepts treatment 3 – nil insight, refusing treatment 4 – nil insight, with plans and intent to abscond

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of absconding or non-compliance with intervention for the consumer undergoing the CRAMP.

Examples

	F. Risk of Absconding / Non-compliance With Intervention
A child presents to a mental health clinic and a CRAMP is completed. The clinician determines that the child is reluctantly accepting treatment.	2
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence of risk for the child from absconding or non-compliance with intervention.	0

Related national definition

N/A

Revision history

N/A

F. Clinical Evidence

Field name:	fevidence
Source Data Element(s):	[F. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the absconding or non-compliance with intervention type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the absconding or non-compliance with intervention type of risk.

Examples

	F. Clinical Evidence
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is refusing treatment.	GP referral notes and responses to clinical questioning.

Related national definition

N/A

Revision history

N/A

F. PSOLIS Alert

Field name:	falert
Source Data Element(s):	[F. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the absconding or non-compliance with treatment type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of absconding or non-compliance with intervention for the consumer undergoing the CRAMP.

Examples

	F. PSOLIS Alert
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is refusing treatment and an alert is raised in PSOLIS.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence of risk of absconding or non-compliance with treatment and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

Friend or Family Member Suicided

Field name:	friendorfamilymembersuicided
Source Data Element(s):	[Friend or Family Member Suicided] – webPSOLIS
Definition:	Flag to indicate if friend or family member suicided is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether friend or family member suicided is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Friend or Family Member Suicided
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that friend or family member suicided is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that friend or family member suicided is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

G. Risk of Impulsivity and Agitation

Field name:	gscore
Source Data Element(s):	[G. Risk of Impulsivity and Agitation] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the impulsivity and agitation type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil evidence of above risk 1 – mildly distressed, aware of symptoms and able to control impulsiveness 2 – moderately distressed, limited capacity to control impulsiveness 3 – acutely distressed, limited capacity to control impulsiveness 4 – extremely disturbed, limited capacity to control impulsiveness

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of impulsivity and agitation for the consumer undergoing the CRAMP.

Examples

	G. Risk of Impulsivity and Agitation
A child presents to a mental health clinic and a CRAMP is completed. The clinician determines that the child is moderately distressed, with limited capacity to control impulsiveness.	2
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence of risk for the child from impulsivity and agitation.	0

Related national definition

N/A

Revision history

N/A

G. Clinical Evidence

Field name:	gevidence
Source Data Element(s):	[G. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the impulsivity and agitation type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the impulsivity and agitation type of risk.

Examples

	G. Clinical Evidence
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is agitated and cannot control impulsiveness.	GP referral notes and responses to clinical questioning.

Related national definition

N/A

Revision history

N/A

G. PSOLIS Alert

Field name:	galert
Source Data Element(s):	[G. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the impulsivity and agitation type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of impulsivity and agitation for the consumer undergoing the CRAMP.

Examples

	G. PSOLIS Alert
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is acutely distressed, with limited capacity to control impulsiveness.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence of risk of impulsivity and agitation and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

H. Influence of Drugs and Alcohol

Field name:	hscore
Source Data Element(s):	[H. Influence of Drugs and Alcohol] – webPSOLIS
Definition:	Numeric identifier indicating the level of risk for the influence of drugs and alcohol type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – Nil evidence of above risk 1 – Denies recent use, has a history of use 2 – Currently intoxicated, however alert, orientated and nil behavioural disturbance 3 – Currently intoxicated, however alert, orientated and with moderate behavioural disturbance (loud / irritable) 4 – As above with extreme behavioural disturbance

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate the level of risk of influence of drugs and alcohol for the consumer undergoing the CRAMP.

Examples

	H. Influence of Drugs and Alcohol
An adolescent presents to a mental health clinic and a CRAMP is completed. The clinician determines that the adolescent is currently intoxicated with extreme behavioural disturbance.	4
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence of risk for the child from influence of drugs and alcohol.	0

Related national definition

N/A

Revision history

N/A

H. Clinical Evidence

Field name:	hevidence
Source Data Element(s):	[H. Clinical Evidence] – webPSOLIS
Definition:	Clinical evidence supporting the level of risk selected for the influence of drugs and alcohol type of risk.
Requirement status:	Mandatory
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail clinical evidence supporting the level of risk chosen for the influence of drugs and alcohol type of risk.

Examples

	H. Clinical Evidence
An adolescent presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the adolescent is currently intoxicated and has extreme behavioural disturbance.	Drug test and responses to clinical questioning.

Related national definition

N/A

Revision history

N/A

H. PSOLIS Alert

Field name:	halert
Source Data Element(s):	[H. PSOLIS Alert] – webPSOLIS
Definition:	Numeric identifier indicating if a PSOLIS alert has been raised for the influence of drugs and alcohol type of risk.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate if a PSOLIS alert has been raised for the level of risk of influence of drugs and alcohol the consumer undergoing the CRAMP.

Examples

	H. PSOLIS Alert
An adolescent presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the adolescent is currently intoxicated and has extreme behavioural disturbance.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that there is no evidence of risk of influence of drugs and alcohol and no alert is raised in PSOLIS.	0

Related national definition

N/A

Revision history

N/A

History of Family and Domestic Violence Perpetrator

Field name:	historyoffamilyanddomesticviolenceperpetrator
Source Data Element(s):	[History of Family and Domestic Violence Perpetrator] – webPSOLIS
Definition:	Flag to indicate if history of family and domestic violence perpetrator is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of family and domestic violence perpetrator is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	History of Family and Domestic Violence Perpetrator
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of family and domestic violence perpetrator is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of family and domestic violence perpetrator is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Family and Domestic Violence Victim

Field name:	historyoffamilyanddomesticviolencevictim
Source Data Element(s):	[History of Family and Domestic Violence Victim] – webPSOLIS
Definition:	Flag to indicate if history of family and domestic violence victim is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of family and domestic violence victim is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	History of Family and Domestic Violence Victim
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of family and domestic violence victim is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of family and domestic violence victim is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Violence Perpetrator

Field name:	historyofviolenceperpetrator
Source Data Element(s):	[History of Violence Perpetrator] – webPSOLIS
Definition:	Flag to indicate if history of violence perpetrator is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of violence perpetrator is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	History of Violence Perpetrator
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of violence perpetrator is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of violence perpetrator is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

History of Violence Victim

Field name:	historyofviolencevictim
Source Data Element(s):	[History of Violence Victim] – webPSOLIS
Definition:	Flag to indicate if history of violence victim is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether history of violence victim is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	History of Violence Victim
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of violence victim is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that history of violence victim is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Hopelessness

Field name:	hopelessness
Source Data Element(s):	[Hopelessness] – webPSOLIS
Definition:	Flag to indicate if hopelessness is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether hopelessness is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Hopelessness
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that hopelessness is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that hopelessness is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Ideation Harm to Others

Field name:	ideationharmtoothers
Source Data Element(s):	[Ideation Harm to Others] – webPSOLIS
Definition:	Flag to indicate if ideation harm to others is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether ideation harm to others is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Ideation Harm to Others
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that ideation harm to others is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that ideation harm to others is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Ideation Harm to Self

Field name:	ideationharmtoself
Source Data Element(s):	[Ideation Harm to Self] – webPSOLIS
Definition:	Flag to indicate if ideation harm to self is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether ideation harm to self is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Ideation Harm to Self
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that ideation harm to self is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that ideation harm to self is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Impulse / Self-control

Field name:	impulseselfcontrol
Source Data Element(s):	[Impulse / Self-control] – webPSOLIS
Definition:	Flag to indicate if impulse or self-control is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether impulse or self-control is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Impulse / Self-control
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that impulse or self-control is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that impulse or self-control is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Intent to Harm Others

Field name:	intenttoharmothers
Source Data Element(s):	[Intent to Harm Others] – webPSOLIS
Definition:	Flag to indicate if intent to harm others is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether intent to harm others is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Intent to Harm Others
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that intent to harm others is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that intent to harm others is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Intent to Self-harm

Field name:	intenttoselfharm
Source Data Element(s):	[Intent to Self-harm] – webPSOLIS
Definition:	Flag to indicate if intent to self-harm is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether intent to self-harm is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Intent to Self-harm
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that intent to self-harm is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that intent to self-harm is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Lack of Alternative Support

Field name:	lackofalternativesupport
Source Data Element(s):	[Lack of Alternative Support] – webPSOLIS
Definition:	Flag to indicate if lackofalternativesupport is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether lack of alternative support is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Lack of Alternative Support
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that lack of alternative support is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that lack of alternative support is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Lack of Insight

Field name:	lackofinsight
Source Data Element(s):	[Lack of Insight] – webPSOLIS
Definition:	Flag to indicate if lack of insight is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether lack of insight is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Lack of Insight
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that lack of insight is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that lack of insight is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Negative Attitudes to Support Services

Field name:	negativeattitudestosupportservices
Source Data Element(s):	[Negative Attitudes to Support Services] – webPSOLIS
Definition:	Flag to indicate if negative attitudes to support services is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether negative attitudes to support services is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Negative Attitudes to Support Services
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that negative attitudes to support services is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that negative attitudes to support services is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Next Appointment Date

Field name:	nextappointmentdate
Source Data Element(s):	[Next Appointment Date] – webPSOLIS
Definition:	The date on which the consumer's next appointment is scheduled to occur.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	Next Appointment Date
A child presents to a mental health service and a CRAMP is completed. A further appointment is scheduled three months hence.	2022-04-02

Related national definition

N/A

Revision history

N/A

Non-compliance or Non-engagement with Safety Planning

Field name:	noncomplianceengagementwithsafetyplanning
Source Data Element(s):	[Non-compliance or Non-engagement with Safety Planning] – webPSOLIS
Definition:	Flag to indicate if non-compliance or non-engagement with safety planning is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether non-compliance or non-engagement with safety planning is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Non-compliance or Non-engagement with Safety Planning
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that non-engagement with safety planning is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that non-compliance or non-engagement with safety planning is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Non-compliance or Non-engagement with Treatment

Field name:	noncomplianceornonengagementwithtreatment
Source Data Element(s):	[Non-compliance or Non-engagement with Treatment] – webPSOLIS
Definition:	Flag to indicate if non-compliance or non-engagement with treatment is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether non-compliance or non-engagement with treatment is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Non-compliance or Non-engagement with Treatment
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that non-engagement with treatment is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that non-compliance or non-engagement with treatment is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Other Notified

Field name:	othernotified
Source Data Element(s):	[Other Notified] – webPSOLIS
Definition:	Flag to indicate if another person/authority has been notified about the child or adolescent consumer's CRAMP.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Not applicable

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	Other Notified
A child presents to a mental health service and a CRAMP is completed. Another person or authority is notified about the CRAMP.	1
A child presents to a mental health service and a CRAMP is completed. Another person or authority is not notified about the CRAMP.	0

Related national definition

N/A

Revision history

N/A

Other Notified Date

Field name:	othernotifieddate
Source Data Element(s):	[Other Notified Date] – webPSOLIS
Definition:	The date on which another person or authority was notified about the CRAMP.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional. If another person or authority has been notified about the CRAMP this date must be recorded.

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	Other Notified Date
A child presents to a mental health service and a CRAMP is completed. On 2 April 2022 another authority is notified.	2022-04-02

Related national definition

N/A

Revision history

N/A

Past History of Suicide / Self-harm

Field name:	pasthistoryofsuicideselfharm
Source Data Element(s):	[Past History of Suicide / Self-harm] – webPSOLIS
Definition:	Flag to indicate if plans for past history of suicide or self-harm is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether past history of suicide or self-harm is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Past History of Suicide / Self-harm
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that past history of suicide/self-harm is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that past history of suicide/self-harm is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Placement / Accommodation Instability

Field name:	placementaccommodationinstability
Source Data Element(s):	[Placement / Accommodation Instability] – webPSOLIS
Definition:	Flag to indicate if placement or accommodation instability is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether placement or accommodation instability is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Placement / Accommodation Instability
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that placement or accommodation instability is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that placement or accommodation instability is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Plans for Safety Lack Feasibility

Field name:	plansforsafetylackfeasibility
Source Data Element(s):	[Plans for Safety Lack Feasibility] – webPSOLIS
Definition:	Flag to indicate if plans for safety lack feasibility is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether plans for safety lack feasibility is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Plans for Safety Lack Feasibility
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that plans for safety lack feasibility is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that plans for safety lack feasibility is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Protective Factors

Field name:	crampprotectivefactors
Source Data Element(s):	[Protective Factors] – webPSOLIS
Definition:	Information relating to factors that contribute positively to the consumer's level of risk.
Requirement status:	Optional
Data type:	String
Format:	[X(4000)]
Permitted values:	Alphanumeric combination

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to detail information relating to factors that contribute positively to the consumer's level of risk.

Examples

	Protective Factors
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that the child is insightful and is willing to engage with mental health clinicians.	Insightful, engaged with services.

Related national definition

N/A

Revision history

N/A

PSOLIS Alert

Field name:	psolisalertrecorded
Source Data Element(s):	[PSOLIS Alert] – webPSOLIS
Definition:	Flag to indicate if a PSOLIS alert for the consumer has been recorded.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Not applicable

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	PSOLIS Alert
A child presents to a mental health service and a CRAMP is completed. A PSOLIS alert is recorded.	1
A child presents to a mental health service and a CRAMP is completed. A PSOLIS alert is not recorded.	0

Related national definition

N/A

Revision history

N/A

PSOLIS Alert Date

Field name:	alertrecordeddate
Source Data Element(s):	[PSOLIS Alert Date] – webPSOLIS
Definition:	The date on which the PSOLIS alert for the consumer is recorded.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional. If a PSOLIS alert for the consumer has been entered this date must be recorded.

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	PSOLIS Alert Date
A child presents to a mental health service and a CRAMP is completed. An alert for the child is also entered into PSOLIS.	2022-04-02

Related national definition

N/A

Revision history

N/A

Psychiatric History / Current Diagnosis

Field name:	psychiatrichistorycurrentdiagnosis
Source Data Element(s):	[Psychiatric History / Current Diagnosis] – webPSOLIS
Definition:	Flag to indicate if psychiatric history or current diagnosis is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether psychiatric history or current diagnosis is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Psychiatric History / Current Diagnosis
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that psychiatric history/current diagnosis is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that psychiatric history/current diagnosis is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Recent Episodes – Harm to Others

Field name:	recentepisodesharmtoothers
Source Data Element(s):	[Recent Episodes – Harm to Others] – webPSOLIS
Definition:	Flag to indicate if recent episodes – harm to others is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether recent episodes – harm to others is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Recent Episodes – Harm to Others
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that recent episodes – harm to others is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that recent episodes – harm to others is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Recent Episodes – Self Harm

Field name:	recentepisodesselfharm
Source Data Element(s):	[Recent Episodes – Self Harm] – webPSOLIS
Definition:	Flag to indicate if recent episodes – self harm is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether recent episodes – self harm is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Recent Episodes – Self Harm
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that recent episodes – self harm is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that recent episodes – self harm is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Referrer Notified

Field name:	referrernotified
Source Data Element(s):	[Referrer Notified] – webPSOLIS
Definition:	Flag to indicate if the referrer has been notified about the child or adolescent consumer's CRAMP.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Not applicable

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	Referrer Notified
A child presents to a mental health service and a CRAMP is completed. The referrer of the child is notified about the CRAMP.	1
A child presents to a mental health service and a CRAMP is completed. The referrer of the child is not notified about the CRAMP.	0

Related national definition

N/A

Revision history

N/A

Referrer Notified Date

Field name:	referrernotifieddate
Source Data Element(s):	[Referrer Notified Date] – webPSOLIS
Definition:	The date on which the referrer was notified about the CRAMP.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional. If the referrer has been notified about the CRAMP this date must be recorded.

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	Referrer Notified Date
A child presents to a mental health service and a CRAMP is completed. On 2 April 2022 the referrer is notified.	2022-04-02

Related national definition

N/A

Revision history

N/A

Relationship Breakdown or Rejection

Field name:	relationshipbreakdownorrejection
Source Data Element(s):	[Relationship Breakdown or Rejection] – webPSOLIS
Definition:	Flag to indicate if relationship breakdown or rejection is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether relationship breakdown or rejection is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Relationship Breakdown or Rejection
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that relationship breakdown or rejection is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that relationship breakdown or rejection is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

School Notified

Field name:	schoolnotified
Source Data Element(s):	[School Notified] – webPSOLIS
Definition:	Flag to indicate if the school has been notified about the child or adolescent consumer's CRAMP.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes 2 – Not applicable

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	School Notified
A child presents to a mental health service and a CRAMP is completed. The child's school is notified about the CRAMP.	1
A child presents to a mental health service and a CRAMP is completed. The child's school is not notified about the CRAMP.	0

Related national definition

N/A

Revision history

N/A

School Notified Date

Field name:	schoolnotifieddate
Source Data Element(s):	[School Notified Date] – webPSOLIS
Definition:	The date on which the school was notified about the CRAMP.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM
Permitted values:	Valid date and time

Guide for use

Collection of this data element is conditional. If the school has been notified about the CRAMP this date must be recorded.

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

Examples

	School Notified Date
A child presents to a mental health service and a CRAMP is completed. On 2 April 2022 the child's school is notified.	2022-04-02

Related national definition

N/A

Revision history

N/A

Sexualised Behaviour

Field name:	sexualisedbehaviour
Source Data Element(s):	[Sexualised Behaviour] – webPSOLIS
Definition:	Flag to indicate if sexualised behaviour is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether sexualised behaviour is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Sexualised Behaviour
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that sexualised behaviour is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that sexualised behaviour is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Stressors that are Likely to Increase Risk

Field name:	stressorsthatarelikelytoincreaserisk
Source Data Element(s):	[Stressors that are Likely to Increase Risk] – webPSOLIS
Definition:	Flag to indicate if stressors that are likely to increase risk is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether stressors that are likely to increase risk is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Stressors that are Likely to Increase Risk
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that stressors that are likely to increase risk is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that stressors that are likely to increase risk is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Upcoming Events / Anniversary

Field name:	upcomingeventsanniversary
Source Data Element(s):	[Upcoming Events / Anniversary] – webPSOLIS
Definition:	Flag to indicate if upcoming events or anniversary is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether upcoming events or anniversary is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Upcoming Events / Anniversary
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that upcoming events/anniversary is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that upcoming events/anniversary is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Vulnerability in Terms of Personality

Field name:	vulnerabilityintermsofpersonality
Source Data Element(s):	[Vulnerability in Terms of Personality] – webPSOLIS
Definition:	Flag to indicate if vulnerability in terms of personality is a risk to self or others risk factor.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	0 – No 1 – Yes

Guide for use

Child and adolescent consumers accepted for assessment by mental health services undergo a clinical risk assessment to evaluate the possibility of harm to self or others.

This data element is used to indicate whether vulnerability in terms of personality is a risk to self or others risk factor for the consumer undergoing the CRAMP.

Examples

	Vulnerability in Terms of Personality
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that vulnerability in terms of personality is a risk to self or others risk factor.	1
A child presents to a mental health clinic and a CRAMP is completed. The clinician performing the assessment determines that vulnerability in terms of personality is not a risk to self or others risk factor.	0

Related national definition

N/A

Revision history

N/A

Appendix A – Service event item codes

(Note: TBD = To be determined)

Code	Name	Start Date	End Date	Clinical	Service Contact
TBD	NDIS ASSESSMENT	TBD		1	Y
TBD	NDIS REPORT WRITING	TBD		1	N
TBD	NDIS LIAISON – OTHER	TBD		1	Y
1	ASSESSMENT	1/01/2002	8/12/2003	1	Y
2	ASSESSMENTS OUTCOME MEASURES	1/01/2002	8/12/2003	1	Y
3	CASE CONFERENCES	1/01/2002	8/12/2003	1	C
4	CLIENT ADVOCACY	1/01/2002	8/12/2003	1	Y
5	CLIENT ASSISTANCE	1/01/2002	8/12/2003	1	Y
6	CLIENT EDUCATION	1/01/2002	8/12/2003	1	Y
7	CLIENT ESCORT	1/01/2002	8/12/2003	1	Y
8	CLINICAL RECORD KEEPING	1/01/2002	8/12/2003	1	N
9	CLINICAL REVIEWS	1/01/2002	8/12/2003	1	N
10	CLINICAL SUPERVISION	1/01/2002	8/12/2003	1	N
11	LIAISON - CONSULTATION	1/01/2002	8/12/2003	1	Y
12	COUNSELLING	1/01/2002	8/12/2003	1	Y
13	CRISIS INTERVENTION	1/01/2002	8/12/2003	1	Y
14	CRITICAL INCIDENT STRESS DEBRIEFING (CISD)	1/01/2002	8/12/2003	1	Y
15	DIETETICS	1/01/2002	7/04/2003	1	C
16	DRUG & ALCOHOL REHAB/DETOX	1/01/2002	8/12/2003	1	Y
17	FAMILY MEETINGS	1/01/2002	8/12/2003	1	Y
18	FAMILY SUPPORT	1/01/2002	8/12/2003	1	Y
19	LIAISON - GP	1/01/2002	8/12/2003	1	Y
20	GROUP PREPARATION	1/01/2002	8/12/2003	0	N
21	HEALTH PROMOTION	1/01/2002	8/12/2003	0	N
22	DEPOT INJECTION	1/01/2002	8/12/2003	1	Y
23	INTAKE MEETING	1/01/2002	8/12/2003	1	N
24	LEGAL	1/01/2002	27/03/2003	1	C
25	LIAISON - OTHER	1/01/2002	8/12/2003	1	C
26	MEDICATION REVIEW	1/01/2002	8/12/2003	1	Y
27	MEETINGS	1/01/2002	8/12/2003	0	N
28	MENTAL STATE ASSESSMENT	1/01/2002	7/04/2003	1	Y
29	PHYSIOTHERAPY	1/01/2002	8/12/2003	1	Y
30	LIAISON - POLICE	1/01/2002	8/12/2003	1	C
31	PROFESSIONAL DEVELOPMENT	1/01/2002	8/12/2003	1	N
32	PSYCHIATRIC ASSESSMENT	1/01/2002	7/04/2003	1	Y
33	PSYCHOLOGY APS	1/01/2002	27/03/2003	1	Y
34	QUALITY ASSURANCE	1/01/2002	7/04/2003	0	N
35	REPORT WRITING	1/01/2002	8/12/2003	0	N
36	RESEARCH ACTIVITIES	1/01/2002	8/12/2003	0	N
37	RESUSCITATION	1/01/2002	8/12/2003	0	Y
38	RISK ASSESSMENT	1/01/2002	8/12/2003	0	Y
39	SERVICE MANAGEMENT	1/01/2002	8/12/2003	0	N
40	SOCIAL WORK (SCGH)	1/01/2002	27/03/2003	0	Y

Code	Name	Start Date	End Date	Clinical	Service Contact
41	STUDENT EDUCATION	1/01/2002	8/12/2003	0	N
42	RISK ASSESSMENT - SUICIDE	1/01/2002	8/12/2003	0	Y
43	THERAPY	1/01/2002	8/12/2003	0	Y
44	TRAVEL	1/01/2002	8/12/2003	0	N
45	WELFARE	1/01/2002	27/03/2003	0	C
46	CONSULTATION INITIAL	1/01/2002	27/03/2003	1	Y
47	WARD ROUND	1/01/2002	8/12/2003	1	N
48	CONSULTATION SUBSEQUENT	1/01/2002	27/03/2003	1	Y
49	STAFF DEVELOPMENT	1/01/2002	8/12/2003	1	C
50	ASSESSMENT	8/12/2003	30/06/2018	1	Y
51	ASSESSMENTS OUTCOME MEASURES	8/12/2003	30/06/2018	1	Y
52	CARER INTERVENTIONS - ADMITTED CLIENT	8/12/2003	30/06/2018	1	Y
53	CARER INTERVENTIONS - NON ADMITTED CLIENT	8/12/2003	30/06/2018	1	N
54	CASE CONFERENCES	8/12/2003	30/06/2018	1	Y
55	CLIENT ADVOCACY	8/12/2003	30/06/2018	1	Y
56	CLIENT ASSISTANCE	8/12/2003	30/06/2018	1	Y
57	CLIENT DID NOT ATTEND	8/12/2003		0	N
58	CLIENT EDUCATION & SKILLS TRAINING	8/12/2003	30/06/2018	1	Y
59	CLIENT ESCORT	8/12/2003		1	Y
60	CLINICAL RECORD KEEPING	8/12/2003	30/06/2018	1	N
61	CLINICAL REVIEWS	8/12/2003	30/06/2018	1	Y
62	CLINICAL SUPERVISION	8/12/2003	30/06/2018	1	N
63	COUNSELLING	8/12/2003	30/06/2018	1	Y
64	CRISIS INTERVENTION	8/12/2003	30/06/2018	1	Y
65	CRITICAL INCIDENT STRESS DEBRIEFING (CISD)	8/12/2003	30/06/2018	1	Y
66	DEPOT INJECTION	8/12/2003	30/06/2018	1	Y
67	DRUG & ALCOHOL REHAB/DETOX	8/12/2003		1	Y
68	FAMILY MEETINGS	8/12/2003	30/06/2018	1	Y
69	FAMILY SUPPORT	8/12/2003		1	Y
70	HEALTH PROMOTION/PREVENTION	8/12/2003	30/06/2018	0	N
71	INTAKE MEETING	8/12/2003	30/06/2018	1	N
72	LIAISON - CONSULTATION	8/12/2003	30/06/2018	1	Y
73	LIAISON - GP (CLIENT SPECIFIC)	8/12/2003	30/06/2018	1	Y
74	LIAISON - GP (NON-CLIENT SPECIFIC)	8/12/2003	30/06/2018	1	N
75	LIAISON - OTHER	8/12/2003	30/06/2018	1	Y
76	LIAISON - POLICE	8/12/2003	30/06/2018	1	Y
77	MEDICATION, ADMINISTERING	8/12/2003	30/06/2018	1	Y
78	MEDICATION REVIEW	8/12/2003	30/06/2018	1	Y
79	MEETINGS	8/12/2003	30/06/2018	0	N
80	PHYSIOTHERAPY	8/12/2003	30/06/2018	1	Y
81	PROFESSIONAL DEVELOPMENT	8/12/2003	30/06/2018	1	N
82	REPORT WRITING	8/12/2003	30/06/2018	1	N
83	RESEARCH ACTIVITIES	8/12/2003	30/06/2018	0	N

Code	Name	Start Date	End Date	Clinical	Service Contact
84	RESUSCITATION	8/12/2003	30/06/2018	1	Y
85	SERVICE MANAGEMENT	8/12/2003	30/06/2018	0	N
86	SESSION PREPARATION	8/12/2003	30/06/2018	0	N
87	STAFF DEVELOPMENT	8/12/2003	30/06/2018	0	N
88	STUDENT EDUCATION	8/12/2003	30/06/2018	0	N
89	THERAPY	8/12/2003		1	Y
90	TRAVEL (STAFF)	8/12/2003	30/06/2018	0	N
91	WARD ROUND - INPATIENT	8/12/2003	30/06/2018	1	N
92	EXTERNAL TRAINING	23/06/2009	30/06/2018	1	N
93	SCHOOL EDUCATION	23/06/2009	30/06/2018	1	N
94	TRAINING PREPARATION	23/06/2009	30/06/2018	1	N
95	ASSESSMENTS NON-NOCC MEASURES	4/05/2010	30/06/2018	1	Y
96	NOCC CLEARANCE	29/06/2010		1	N
97	ABORIGINAL CULTURAL INPUT	13/07/2010	30/06/2018	1	C
98	ABORIGINAL TRADITIONAL MEDICINE	13/07/2010	30/06/2018	1	C
99	ABORIGINAL HEALER	13/07/2010	30/06/2018	1	C
100	ASSESSMENT BASELINE	2/08/2011	30/06/2018	1	Y
101	ASSESSMENT MID-TREATMENT	2/08/2011	30/06/2018	1	Y
102	ASSESSMENT FINAL	2/08/2011	30/06/2018	1	Y
103	RTMS-EEG	2/08/2011	30/06/2018	1	Y
104	RTMS TREATMENT	2/08/2011	30/06/2018	1	Y
105	ASSESSMENT INITIAL	13/09/2011	30/06/2018	1	Y
106	EMERGENCY CONSULTATION	1/01/2012	30/06/2018	1	Y
107	APPOINTMENT CANCELLED	1/01/2012	30/06/2018	1	N
108	EC APPOINTMENT CANCELLED	1/01/2012	30/06/2018	1	N
109	EC DID NOT ATTEND	1/01/2012	30/06/2018	1	N
110	COURT ATTENDANCE	1/01/2012	30/06/2018	1	Y
111	COURT PREPARATION	1/01/2012	30/06/2018	1	N
112	CIC REPORT	1/01/2012	30/06/2018	1	Y
113	POLICE REPORT	1/01/2012	30/06/2018	1	Y
114	SPECIMEN HANDOVER	1/01/2012	30/06/2018	1	N
115	SPECIMEN DESTRUCTION	1/01/2012	30/06/2018	1	N
116	RESULTS	1/01/2012	30/06/2018	1	Y
117	MANDATORY REPORT - CHILD PROTECTION	1/01/2012	30/06/2018	1	Y
118	NON-MANDATORY REPORT - CHILD PROTECTION	1/01/2012	30/06/2018	1	Y
119	HANDOVER (OOS)	1/01/2012	1/07/2017	1	Y
120	MEDICAL FOLLOW UP	1/01/2012		1	Y
121	CLIENT CONTACT - OTHER (OOS)	1/01/2012	1/07/2017	1	Y
122	RESTRUCTURE	1/01/2012	1/12/2012	1	N
123	POST DISCHARGE FOLLOW-UP	30/06/2017	30/06/2018	1	C
124	HANDOVER	1/07/2017	30/06/2018	1	N
125	CLIENT CONTACT - OTHER	1/07/2017	30/06/2018	1	N
126	ASSESSMENT	1/07/2018		1	Y
127	ASSESSMENTS OUTCOME MEASURES	1/07/2018		1	C

Code	Name	Start Date	End Date	Clinical	Service Contact
128	CARER INTERVENTION - REFERRED/ACTIVE CLIENT	1/07/2018		1	Y
129	CARER INTERVENTION - NON-REFERRED/NON ACTIVE CLIENT	1/07/2018		1	N
130	CASE CONFERENCES	1/07/2018		1	Y
131	CLIENT ADVOCACY	1/07/2018		1	Y
132	CLIENT ASSISTANCE	1/07/2018		1	Y
133	CLIENT EDUCATION & SKILLS TRAINING	1/07/2018		1	Y
134	CLINICAL RECORD KEEPING	1/07/2018		1	N
135	CLINICAL REVIEWS	1/07/2018		1	Y
136	CLINICAL SUPERVISION	1/07/2018		1	N
137	COUNSELLING	1/07/2018		1	Y
138	CRISIS INTERVENTION	1/07/2018		1	Y
139	DEPOT INJECTION	1/07/2018		1	Y
140	FAMILY MEETINGS	1/07/2018		1	Y
141	HEALTH EDUCATION/PREVENTION	1/07/2018		0	N
142	INTAKE MEETING	1/07/2018		1	Y
143	LIAISON - OTHER	1/07/2018		1	Y
144	LIAISON - POLICE	1/07/2018		1	Y
145	MEDICATION, ADMINISTERING	1/07/2018		1	Y
146	MEDICATION REVIEW	1/07/2018		1	Y
147	MEETINGS	1/07/2018		0	N
148	PROFESSIONAL DEVELOPMENT	1/07/2018		1	N
149	REPORT WRITING	1/07/2018		1	N
150	RESEARCH ACTIVITIES	1/07/2018		0	N
151	SERVICE MANAGEMENT	1/07/2018		0	N
152	SESSION PREPARATION	1/07/2018		0	N
153	STAFF DEVELOPMENT	1/07/2018		0	N
154	STUDENT EDUCATION	1/07/2018		0	N
155	TRAVEL (STAFF)	1/07/2018		0	N
156	EXTERNAL TRAINING	1/07/2018		1	N
157	TRAINING PREPARATION	1/07/2018		1	N
158	ASSESSMENTS NON-NOCC MEASURES	1/07/2018		1	C
159	ABORIGINAL CULTURAL INPUT	1/07/2018		1	Y
160	ABORIGINAL TRADITIONAL MEDICINE	1/07/2018		1	Y
161	ABORIGINAL TRADITIONAL HEALER	1/07/2018		1	Y
162	ASSESSMENT - INITIAL	1/07/2018		1	Y
163	POST DISCHARGE FOLLOW-UP	1/07/2018		1	C
164	HANDOVER	1/07/2018	30/01/2019	1	N
165	CLIENT CONTACT - OTHER	1/07/2018		1	N
166	APPOINTMENT CANCELLED-BY CLIENT	1/07/2018		1	N
167	APPOINTMENT CANCELLED-BY CLIENT<24HRS	1/07/2018		1	N
168	APPOINTMENT CANCELLED-BY SERVICE	1/07/2018		1	N

Code	Name	Start Date	End Date	Clinical	Service Contact
169	LIAISON - GP	1/07/2018		1	Y
170	RTMS	1/07/2018		1	Y
171	HANDOVER	31/01/2019		1	Y

Appendix B – Stream codes

Code	Name	Start Date	Stream Type	Organisation ID
1	ALBANY CAMHS	1/01/2002	1	226
2	ALBANY ADULT	1/01/2002	2	226
3	ALBANY ELDERLY	1/01/2002	3	226
4	FREMANTLE CAMHS	1/01/2002	1	103
5	FREMANTLE ADULT	1/01/2002	2	103
6	FREMANTLE ELDERLY	1/01/2002	3	103
7	JHC MHS ADULT	1/06/2014	2	143
8	ARMADALE CAMHS	1/01/2002	1	101
9	ARMADALE ADULT	1/01/2002	2	101
10	ARMADALE OLDER ADULT	1/01/2002	3	101
11	BROOME CAMHS	1/01/2002	1	214
12	BROOME ADULT	1/01/2002	2	214
13	BROOME ELDERLY	1/01/2002	3	214
14	CARNARVON CAMHS	1/01/2002	1	229
15	CARNARVON ADULT	1/01/2002	2	229
16	CARNARVON OLDER ADULT	1/01/2002	3	229
17	DERBY CAMHS	1/01/2002	1	215
18	DERBY ADULT	1/01/2002	2	215
19	DERBY ELDERLY	1/01/2002	3	215
26	INNER CITY CAMHS	1/01/2002	1	106
27	SUBIACO ADULT	1/01/2002	2	106
28	INNER CITY ELDERLY	1/01/2002	3	106
30	KARRATHA CAMHS	1/01/2002	1	218
31	KARRATHA ADULT	1/01/2002	2	218
32	KARRATHA ELDERLY	1/01/2002	3	218
33	KATANNING CAMHS	1/01/2002	1	228
34	KATANNING ADULT	1/01/2002	2	228
35	KATANNING ELDERLY	1/01/2002	3	228
40	KUNUNURRA CAMHS	1/01/2002	1	216
41	KUNUNURRA ADULT	1/01/2002	2	216
42	KUNUNURRA ELDERLY	1/01/2002	3	216
44	BENTLEY CAMHS	1/01/2002	1	102
45	BENTLEY ADULT	1/01/2002	2	100
46	BENTLEY OLDER ADULT	1/01/2002	3	100
47	NARROGIN CAMHS	1/01/2002	1	227
48	NARROGIN ADULT	1/01/2002	2	227
49	NARROGIN ELDERLY	1/01/2002	3	227
50	CAHS-CAMHS	1/12/2012	1	139
51	YOUTH MH SERVICES ADULT	1/12/2012	2	140
52	YOUTH MH SERVICES CAMHS	1/12/2012	1	140
53	NM INDIVIDUALISED COMMUNITY LIVING STRATEGY ADULT	1/03/2012	2	141
54	FSH CAMHS	1/07/2014	1	142

Code	Name	Start Date	Stream Type	Organisation ID
55	FSH ADULT	1/07/2014	2	142
56	FSH OLDER ADULT	1/07/2014	3	142
57	PCH CAMHS INPATIENT	8/06/2018	1	139
62	HEDLAND CAMHS	1/01/2002	1	217
63	HEDLAND ADULT	1/01/2002	2	217
64	HEDLAND ELDERLY	1/01/2002	3	217
66	GRAYLANDS ELDERLY	1/01/2002	3	104
67	BUNBURY CAMHS	1/01/2002	1	223
68	BUNBURY ADULT	1/01/2002	2	223
69	BUNBURY ELDERLY	1/01/2002	3	223
76	WARREN BLACKWOOD CAMHS	1/01/2002	1	224
77	WARREN BLACKWOOD ADULT	1/01/2002	2	224
78	WARREN BLACKWOOD ELDERLY	1/01/2002	3	224
82	SWAN CAMHS	1/01/2002	1	110
83	MIDLAND ADULT COMMUNITY	1/01/2002	2	100
84	MIDLAND OLDER ADULT COMMUNITY	1/01/2002	3	100
85	NEWMAN CAMHS	1/01/2002	1	219
86	NEWMAN ADULT	1/01/2002	2	219
87	NEWMAN AND TOM PRICE ELDERLY	1/01/2002	3	219
88	KALGOORLIE BOULDER CAMHS	1/01/2002	1	207
89	KALGOORLIE BOULDER ADULT	1/01/2002	2	207
90	KALGOORLIE BOULDER ELDERLY	1/01/2002	3	207
92	MEEKATHARRA CAMHS	1/01/2002	1	222
93	MEEKATHARRA ADULT	1/01/2002	2	222
94	MEEKATHARRA OLDER ADULT	1/01/2002	3	222
95	GRAYLANDS ADULT	1/01/2002	2	104
96	PMH/KEMH CAMHS	1/01/2002	1	107
97	ROCKINGHAM AND KWINANA SENIORS	1/01/2002	3	111
101	FORENSIC SERVICES ADULT	1/01/2002	2	116
103	KEMH ADULT	1/01/2002	2	136
106	EXMOUTH CAMHS	1/01/2002	1	229
107	EXMOUTH ADULT	1/01/2002	2	229
108	EXMOUTH OLDER ADULT	1/01/2002	3	229
112	SCGH MENTAL HEALTH SERVICE ADULT	1/01/2002	2	108
113	NORTH METRO OSBORNE CAMHS	1/01/2002	1	112
114	NORTH METRO STIRLING ADULT	1/01/2002	2	112
115	NORTH METRO OSBORNE ELDERLY	1/01/2002	3	112
116	NORTH METRO JOONDALUP/CLARKSON CAMHS	1/01/2002	1	113
117	NORTH METRO WANNEROO ADULT	1/01/2002	2	113
118	NORTH METRO WANNEROO OLDER ADULT	1/01/2002	3	113
119	NORTH METRO SUBIACO CAMHS	1/01/2002	1	105
120	NORTH METRO SUBIACO ADULT	1/01/2002	2	105
121	NORTH METRO SUBIACO ELDERLY	1/01/2002	3	105

Code	Name	Start Date	Stream Type	Organisation ID
124	GRAYLANDS CAMHS	1/01/2002	1	104
129	ROCKINGHAM AND KWINANA ADULT	1/01/2002	2	111
130	ROCKINGHAM AND KWINANA CAMHS	1/01/2002	1	111
131	PMH/KEMH ELDERLY	1/01/2002	3	107
132	SIR CHARLES GAIRDNER CAMHS	1/01/2002	1	108
133	SCGH MENTAL HEALTH SERVICE ELDERLY	1/01/2002	3	108
134	WHEATBELT CAMHS	1/01/2002	1	205
135	WHEATBELT ADULT	1/01/2002	2	205
136	WHEATBELT ELDERLY	1/01/2002	3	205
137	GERALDTON CAMHS	1/01/2002	1	204
138	GERALDTON ADULT	1/01/2002	2	204
139	GERALDTON OLDER ADULT	1/01/2002	3	204
140	ESPERANCE CAMHS	1/01/2002	1	206
141	ESPERANCE ADULT	1/01/2002	2	206
142	ESPERANCE ELDERLY	1/01/2002	3	206
143	BUSSELTON CAMHS	1/01/2002	1	212
144	BUSSELTON ADULT	1/01/2002	2	212
145	BUSSELTON ELDERLY	1/01/2002	3	212
146	SARC	1/01/2002	2	114
147	EAST WHEATBELT CAMHS	1/01/2002	1	230
148	EAST WHEATBELT ADULT	1/01/2002	2	230
149	EAST WHEATBELT ELDERLY	1/01/2002	3	230
150	YOUTHLINK ADULT	1/01/2002	2	117
151	PET	1/01/2002	2	115
152	FORENSIC SERVICES YOUTH	13/08/2003	1	116
153	NMHS LOWER WEST OLDER ADULT	1/01/2003	3	109
154	GHS JSDU ADULT	1/01/2002	2	118
155	GHS JSDU CAMHS	1/01/2002	1	118
156	GHS JSDU ELDERLY	1/01/2002	3	118
157	GHS CCI ADULT	1/01/2002	2	119
158	GHS CREATIVE EXPRESSION CENTRE FOR ARTS THERAPY ADULT	1/01/2002	2	120
159	GHS CREATIVE EXPRESSION CENTRE FOR ARTS THERAPY CAMHS	1/01/2002	1	120
160	GHS NEUROSCIENCES ADULT	1/01/2002	2	121
161	GHS NEUROSCIENCES CAMHS	1/01/2002	1	121
162	YOUTHLINK CAMHS	5/02/2004	1	117
163	GHS NEUROSCIENCES ELDERLY	1/01/2004	3	121
164	PEEL ADULT	1/01/2004	2	122
165	PEEL CAMHS	1/01/2004	1	122
166	PEEL SENIORS	1/01/2004	3	122
167	MENTAL HEALTH ADMIN STREAM	1/01/2002	2	199
168	NORTH METROPOLITAN CAMHS	1/07/2005	1	123
169	MULTI SYSTEMIC THERAPY CAMHS	1/08/2005	1	124
170	YOUTH REACH SOUTH CAMHS	28/11/2005	1	125

Code	Name	Start Date	Stream Type	Organisation ID
171	YOUTH REACH SOUTH ADULT	28/11/2005	2	125
172	GHS CCI CAMHS	1/05/2006	1	119
173	NORTH CERT CAMHS	1/07/2006	1	127
174	NORTH CERT ADULT	1/07/2006	2	127
175	NORTH CERT ELDERLY	1/07/2006	3	127
176	SOUTH CATT CAMHS	1/07/2006	1	126
177	SOUTH CATT ADULT	1/07/2006	2	126
178	SOUTH CATT ELDERLY	1/07/2006	3	126
179	MHERL ADULT	12/09/2006	2	100
180	HAWTHORN HOUSE ADULT	16/10/2006	2	129
181	NORTH METRO CLINICAL ACCOMMODATION SUPPORT SERVICE	1/11/2007	2	130
182	CLIENT RECORD SEARCH STREAM	12/02/2008	2	46708
183	NMHS HOSPITAL IN THE HOME	1/11/2007	2	131
184	NORTH METRO MIRRABOOKA ADULT	1/07/2008	2	132
185	RPH ADULT	1/07/2008	2	100
186	RPH OLDER ADULT	1/07/2008	3	100
187	WUNGEN KARTUP ABORIGINAL MENTAL HEALTH SERVICE ADULT	1/04/2010	2	100
189	WUNGEN KARTUP ABORIGINAL MENTAL HEALTH SERVICE OLDER ADULT	1/04/2010	3	100
190	SMAHS - MH ADULT	1/05/2010	2	135
191	SMAHS - MH CAMHS	1/05/2010	1	135
192	SMAHS - MH ELDERLY	1/05/2010	3	135
193	SOUTH WEST MHS ADULT	1/07/2010	2	231
194	SOUTH WEST MHS CAMHS	1/07/2010	1	231
195	SOUTH WEST MHS ELDERLY	1/07/2010	3	231
196	FITZROY CROSSING CAMHS	1/08/2010	1	232
197	FITZROY CROSSING ADULT	1/08/2010	2	232
198	FITZROY CROSSING ELDERLY	1/08/2010	3	232
200	NORTH METROPOLITAN ELDERLY THERAPY SERVICES	1/03/2012	3	137
201	HALLS CREEK ADULT	1/08/2012	2	234
202	HALLS CREEK ELDERLY	1/08/2012	3	234
203	HALLS CREEK CAMHS	1/08/2012	1	234
204	MOBILE CLINICAL OUTREACH TEAM (MCOT) ADULT	1/07/2012	2	100
205	MARGARET RIVER CAMHS	1/07/2014	1	212
206	MARGARET RIVER ADULT	1/07/2014	2	212
207	MARGARET RIVER ELDERLY	1/07/2014	3	212
216	RTMS ADULT	1/07/2011	2	233
236	SARC PRISON	30/10/2012	2	114
237	SARC OUTREACH	30/10/2012	2	114
238	FORENSIC CAMHS	1/03/2013	1	116
239	ALBANY YOUTH	14/04/2015	2	226

Code	Name	Start Date	Stream Type	Organisation ID
240	KATANNING YOUTH	14/04/2015	2	228
241	NARROGIN YOUTH	14/04/2015	2	227
242	SJOG MIDLAND ADULT MH	23/11/2015	2	235
243	SJOG MIDLAND OLDER ADULT MH	23/11/2015	3	235
244	WAEDOCS CAMHS	18/01/2016	1	236
245	WAEDOCS ADULT	18/01/2016	2	236
246	WAEDOCS OLDER ADULT	18/01/2016	3	236
247	CITY EAST ADULT	30/06/2016	2	100
248	CITY EAST OLDER ADULT	30/06/2016	3	100
249	FREMANTLE COMMUNITY RESIDENTIAL	30/09/2016	2	103
250	KARRATHA YOUTH	1/01/2017	2	218
251	HEDLAND YOUTH	1/01/2017	2	217
252	SOUTH WEST MHS YOUTH	1/01/2017	2	231
253	KEMH CAMHS	1/03/2017	1	136
254	NEWMAN YOUTH	1/01/2017	2	219
255	BENTLEY YOUTH	29/01/2018	2	100
256	BUSSELTON YOUTH	1/04/2018	2	212
257	SPEAK UP ADULT	27/08/2013	2	136
258	MIA REVIEW BOARD	1/04/2016	2	237
259	OFFICE OF THE CHIEF PSYCHIATRIST	1/04/2016	2	238
260	MENTAL HEALTH ADVOCACY SERVICE	1/04/2016	2	239
261	MENTAL HEALTH TRIBUNAL	1/04/2016	2	240
262	WHEATBELT YOUTH	1/10/2018	2	205
263	BROOME YOUTH	1/11/2019	2	214
264	BUNBURY YOUTH	1/11/2019	2	223
265	CARNARVON YOUTH	1/11/2019	2	229
266	DERBY YOUTH	1/11/2019	2	215
267	ESPERANCE YOUTH	1/11/2019	2	206
268	EXMOUTH YOUTH	1/11/2019	2	229
269	FITZROY CROSSING YOUTH	1/11/2019	2	232
270	GERALDTON YOUTH	1/11/2019	2	204
271	HALLS CREEK YOUTH	1/11/2019	2	234
272	KALGOORLIE BOULDER YOUTH	1/11/2019	2	207
273	KUNUNURRA YOUTH	1/11/2019	2	216
274	MARGARET RIVER YOUTH	1/11/2019	2	212
275	MEEKATHARRA YOUTH	1/11/2019	2	222
276	WARREN BLACKWOOD YOUTH	1/11/2019	2	224
277	DEPARTMENT OF HEALTH	16/12/2019	2	241
278	WACHS MH ETS ADULT	1/07/2020	2	242
279	NMHS ACTIVE RECOVERY TEAM	6/04/2021	2	243
280	WACHS MH ETS CAMHS	01/09/2022		242
281	EMHS CRISIS RESOLUTION HOSPITAL IN THE HOME (CRHITH) ARMADALE	30/01/2023		101
282	NM EATING DISORDERS SPECIALIST SERVICE	01/07/2022		236

Code	Name	Start Date	Stream Type	Organisation ID
283	EMHS CRISIS RESOLUTION HOSPITAL IN THE HOME (CRHITH) CITY	30/01/2023		101
284	DEPARTMENT OF JUSTICE	16/08/2022		244
285	SJOG MT LAWLEY ELDERLY	01/12/2021		30
286	MENTAL HEALTH CO-RESPONSE	01/10/2022		100
287	RPBG TRANSITIONAL CARE UNIT	28/07/2023		100
288	JHC MHS CAMHS	28/08/2023	1	143
289	JHC MHS OLDER ADULT	28/08/2023	1	143
290	HEADSPACE	14/07/2023	2	246
291	RPH YOUTH	01/01/2023		
292	EMHS CRISIS RESOLUTION HOSPITAL IN THE HOME (CRHiTH) MIDLAND	01/07/2023		101
293	RPH OLDER ADULT	01/01/2023		100

Appendix C – Triage problem codes

Code	Name	Start Date
1	RELATIONSHIP/FAMILY PROBLEM	1/01/2002
2	SOCIAL INTERPERSONAL (OTHER THAN FAMILY PROBLEM)	1/01/2002
3	PROBLEMS COPING WITH DAILY ROLES AND ACTIVITIES	1/01/2002
4	SCHOOL PROBLEMS	1/01/2002
5	PHYSICAL PROBLEMS	1/01/2002
6	EXISTING MENTAL ILLNESS - EXACERBATION	1/01/2002
7	EXISTING MENTAL ILLNESS - CONTACT/INFORMATION ONLY	1/01/2002
8	EXISTING MENTAL ILLNESS - ALTERATION IN MEDICATION/TREATMENT REGIME	1/01/2002
9	DEPRESSED MOOD	1/01/2002
10	GRIEF/LOSS ISSUES	1/01/2002
11	ANXIOUS	1/01/2002
12	ELEVATED MOOD AND/OR DISINHIBITED BEHAVIOUR	1/01/2002
13	PSYCHOTIC SYMPTOMS	1/01/2002
14	DISTURBED THOUGHTS, DELUSIONS ETC	1/01/2002
15	PERCEPTUAL DISTURBANCES	1/01/2002
16	PROBLEMATIC BEHAVIOUR	1/01/2002
17	DEMENTIA RELATED BEHAVIOURS	1/01/2002
18	RISK OF HARM TO SELF	1/01/2002
19	RISK OF HARM TO OTHERS	1/01/2002
20	ALCOHOL/DRUGS	1/01/2002
21	AGGRESSIVE/THREATENING BEHAVIOUR	1/01/2002
22	LEGAL PROBLEMS	1/01/2002
23	EATING DISORDER	1/01/2002
24	SEXUAL ASSAULT	1/01/2002
25	SEXUAL ABUSE	1/01/2002
26	ASSAULT VICTIM	1/01/2002
27	HOMELESSNESS	1/01/2002
28	ACCOMMODATION PROBLEMS	1/01/2002
29	INFORMATION ONLY	1/01/2002
30	OTHER	1/01/2002
31	MOOD DISTURBANCE	9/06/2009
32	ADVERSE DRUG REACTION	9/06/2009
33	MEDICATION	9/06/2009
34	DEPOT INJECTION	9/06/2009
35	DELIBERATE SELF HARM	8/09/2009
36	SUICIDAL IDEATION	8/09/2009
37	RISK OF HARM FROM OTHERS	30/10/2012
38	SEXUAL ASSAULT/ABUSE - PAST	30/10/2012
39	SEXUAL ASSAULT - RECENT	30/10/2012
40	FAMILY AND DOMESTIC VIOLENCE	30/10/2012
41	CULTURAL ISSUES	8/05/2014

Appendix D – Legal orders

Code	Name
1	1A REFERRAL FOR EXAMINATION BY PSYCHIATRIST
2	1A INFORMATION PROVIDED BY ANOTHER PERSON IN CONFIDENCE
3	1A REVOCATION OF REFERRAL FOR EXAMINATION BY PSYCHIATRIST
4	1B VARIATION OF REFERRAL
5	2 ORDER TO DETAIN VOLUNTARY INPATIENT IN AUTHORISED HOSPITAL FOR ASSESSMENT
6	2 REVOCATION OF ORDER TO DETAIN VOLUNTARY INPATIENT IN AUTHORISED HOSPITAL FOR ASSESSMENT
7	3A DETENTION ORDER
8	3B CONTINUATION OF DETENTION RECEIVED OUTSIDE METROPOLITAN AREA
9	3B CONTINUATION OF DETENTION FOR INPATIENT TREATMENT ORDER TO GENERAL HOSPITAL
10	3B CONTINUATION OF DETENTION TO BE TAKEN TO AUTHORISED HOSPITAL
11	3B CONTINUATION OF DETENTION
12	3C CONTINUATION OF DETENTION TO ENABLE A FURTHER EXAMINATION BY PSYCHIATRIST
13	3D ORDER AUTHORISING RECEPTION AND DETENTION IN AN AUTHORISED HOSPITAL FOR FURTHER EXAMINATION
14	3E ORDER THAT A PERSON CANNOT CONTINUE TO BE DETAINED
15	4A REVOCATION OF TRANSPORT ORDER
16	4A TRANSPORT ORDER
17	4B EXTENSION OF TRANSPORT ORDER
18	4C TRANSFER ORDER
19	5A COMMUNITY TREATMENT ORDER
20	5A CONFIRMATION OF COMMUNITY TREATMENT ORDER
21	5A REVOCATION OF COMMUNITY TREATMENT ORDER
22	5B CONTINUATION OF COMMUNITY TREATMENT ORDER
23	5C VARIATION OF TERMS OF COMMUNITY TREATMENT ORDER
24	5D REQUEST BY SUPERVISING PSYCHIATRIST FOR PRACTITIONER TO CONDUCT MONTHLY EXAMINATION OF A PATIENT
25	5E NOTICE OF BREACH OF CTO
26	5F ORDER TO ATTEND
27	6A INPATIENT TREATMENT ORDER IN AUTHORISED HOSPITAL
28	6A REVOCATION OF INPATIENT TREATMENT ORDER IN AUTHORISED HOSPITAL
29	6B INPATIENT TREATMENT ORDER IN GENERAL HOSPITAL: REPORT TO CHIEF PSYCHIATRIST
30	6B INPATIENT TREATMENT ORDER IN GENERAL HOSPITAL
31	6B REVOCATION OF INPATIENT TREATMENT ORDER IN GENERAL HOSPITAL
32	6C CONTINUATION OF INPATIENT TREATMENT ORDER
33	6D CONFIRMATION OF INPATIENT TREATMENT ORDER
34	7A GRANT OF LEAVE TO INVOLUNTARY INPATIENT
35	7B EXTENSION AND/OR VARIATION OF GRANT OF LEAVE
36	7C CANCELLATION OF LEAVE
37	7D APPREHENSION AND RETURN ORDER
38	7D REVOCATION OF APPREHENSION AND RETURN ORDER

Code	Name
39	9A RECORD OF EMERGENCY PSYCHIATRIC TREATMENT
40	9B REPORT ON URGENT NON-PSYCHIATRIC TREATMENT
41	12B REFUSAL OF REQUEST TO ACCESS DOCUMENT
42	12C RESTRICTION OF FREEDOM OF COMMUNICATION
43	ABSENT WITHOUT LEAVE
44	CLMIAA DISCHARGE
45	CLMIAA ORDER
46	DETAINED ON LEAVE
47	DETENTION EXPIRED
48	DISCHARGED FROM HOSPITAL
49	FURTHER OPINION
50	FURTHER OPINION DID NOT OCCUR
51	INVOLUNTARY ORDER EXPIRED
52	RECORD OF DEATH
53	REFERRAL EXPIRED
54	REFERRAL NOT REQUIRED
55	REQUEST FOR FURTHER OPINION
56	RETURN FROM LEAVE
57	RETURNED TO CARE
58	TRANSFER CANCELLATION
59	TRIBUNAL / COURT TERMS
60	TRIBUNAL / COURT TERMS LIFTED
61	VOLUNTARY ADMISSION

Appendix E – Summary of revisions

Date Released	Author	Approval	Amendment
1 July 2021	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created.
1 July 2022	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. Removed ‘Rules’ and ‘QA / Validations’ sections from each data element. Added new Triage, RAMP and CRAMP sections and data elements. Updated ‘Guide for Use’ text under ‘Sex’ data element. Previously omitted data elements included: Length of Stay Alert Duration Incident Duration Expiry Date Order Duration Corrected errors in data elements: AV Exam Leave Days Incident Recurrence Risk Incident Severity
1 July 2023	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. New SSCD data elements added: Mental Health Assessment (Section 15) Moved Episode Start Date and Time and Episode End Date and Time data elements from Community Mental Health and Service Contacts section to Inpatient Services section. Previously omitted data elements included: Phase Start Date Phase End Date Changed IHPA references to IHACPA and updated website links.

1 July 2024	Jenine Piper Jodie McNamara	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. Section 5: Added new Care Type: Mental health rehabilitation. Section 6: Clarified the definitions for referral outcomes. Section 10: - Removed redundant permitted values 12, 13 & 15 from Collection Status data element. - Updated permitted values in data elements NOCC AMHCC Clinical Measures. Updated definitions for SDQ data element Removed Mental Health Assessment section (previously section 15) as data not yet available in Collection. Appendix B: Updated list of PSOLIS streams with new programs and name changes. Updated 'Guide for Use' text under the following data elements: Service Contact Session Type Staff Full Name Staff HE Number Expiry Date Order End Date and Time Order Name Order Name Code Order Type Transport By Treating Practitioner Qualification Type Action Taken Consumer Agreeable Consumer Aware Contact With Designation Triage End Date Triage Start Date Triaged by HE Number

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