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

Mental Health Data Collection
Data Dictionary

July 2021

No Longer Applicable.
Superseded on 1 July 2022.

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Contents

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Abbreviations

ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
AV	Audiovisual
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
CTO	Community Treatment Order
FIHS	Factors Influencing Health Status
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
LSP	Life Skills Profile
MHDC	Mental Health Data Collection
MHPoC	Mental Health Phase of Care
MIND	Mental Health Information Data Collection
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
UMRN	Unit Medical Record Number
WA	Western Australia

No Longer Applicable.
Superseded on 1 July 2022.

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 the *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

No Longer Applicable. Superseded on 1 July 2022.

4. Data definitions – 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.

Aboriginal Status

Field name:	pt_ethnicity_code
Source Data Element(s):	[Aboriginal Status] – PSOLIS
Definition:	The client's Aboriginal status.
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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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.

QA / validations

Exception Code	Exception Comment
PN016	Client record is missing Aboriginal Status. Please review and enter the missing value.
PN026	Client's Aboriginal Status is recorded as Not Stated. Please review and enter the correct Aboriginal Status.

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/index.phtml/itemId/602543

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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/index.phtml/itemId/303794

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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/index.phtml/itemId/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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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/index.phtml/itemId/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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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/index.phtml/itemId/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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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/index.phtml/itemId/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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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/index.phtml/itemId/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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/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:	String
Format:	NNNN
Permitted values:	Valid Australian postcode

Guide for use

Collection of this data element is mandatory.

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

Rules

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.

QA / validations

Exception Code	Exception Comment
PN035	Postcode is not recognised. Please review client residential postcode.
PN039	The client's address is blank. Please review and update.

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/index.phtml/itemId/611398

Revision history

N/A

No Longer Applicable - Superseded on 1 July 2022.

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)

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

The country of birth code embodies an important concept in the study of disease patterns between different ethnic population groups in Australia.

It also allows health care authorities to monitor the health status of migrants and assists in the provision of health services for diverse population groups.

Rules

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

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 the 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.

QA / validations

N/A

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/index.phtml/itemId/659454

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

Rules

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.

QA / validations

N/A

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/290046

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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)

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

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

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

QA / validations

N/A

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/index.phtml/itemId/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

Collection of this data element is mandatory.

Rules

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.

QA / validations

Exception Code	Exception Comment
PN006	Client's date of birth or estimated date of birth are missing. Please review.
PN031	The client's date of birth is greater than the commencement of the episode of care.

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/index.phtml/itemId/287007

No Longer Applicable. Superseded on 1 July 2022.

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/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.

Rules

N/A

QA / validations

Exception Code	Exception Comment
	Date of death must be equal to or greater than date of birth for the same client.

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/646025

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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:	Datetime
Format:	DDMMYYYY
Permitted values:	1 – Child not at school 2 – Employed 3 – Home duties 4 – Other 5 – Pensioner 6 – Retired 7 – Student 8 – Unemployed

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

Examples

	Employment Status
A 14-year-old, attending school	7 – Student
A 16-year-old child, not attending school and not employed	8 – Unemployed

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

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.

QA / validations

Exception Code	Exception Comment
PN018	Client record is missing family name. Please review and enter the missing value.
PN025	Client's family name is recorded as Not Stated. Please review and enter the correct surname.

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/index.phtml/itemId/286953

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/286953

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/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 – Divorced 2 – Married 3 – Never married 4 – Not stated/inadequately described 5 – Separated 6 – Widowed

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/291045

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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)

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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

Rules

This data element is aligned with the Australian Standard Classification of Languages, 2016 (see https://www.abs.gov.au/ausstats/abs@.nsf/mf/1267.0).

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

QA / validations

N/A

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/index.phtml/itemId/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.

Rules

This data element is aligned with the Australian Standard Classification of Religious Groups, 2016 (see https://www.abs.gov.au/ausstats/abs@.nsf/mf/1266.0).

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

QA / validations

N/A

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/index.phtml/itemId/493242

Revision history

N/A

No Longer Applicable
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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 or 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.

QA / validations

Exception Code	Exception Comment
PN039	The client's address is blank. Please review and update.

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/index.phtml/itemId/611149

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

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

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/286953

Revision history

N/A

Sex

Field name:	pt_sex_code
Source Data Element(s):	[Sex] – PSOLIS
Definition:	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Male 2 – Female 3 – Intersex or indeterminate 9 – Not stated/inadequately described

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Operationally, sex is the distinction between male and female, as reported by a client or as determined by an interviewer.

Rules

When collecting data on sex by personal interview, asking the sex of the client is usually unnecessary and may be inappropriate, or even offensive.

It is usually a simple matter to infer the sex of the client through observation, or from other cues such as the relationship of the person(s) accompanying the client, or first name.

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

A client's sex may change during their lifetime through procedures known alternatively as sex change, gender reassignment, transgender reassignment or sexual reassignment.

Throughout this process, which may be over a considerable period of time, the client's sex could be recorded as either male or female.

<u>Code 3 – Intersex or indeterminate</u>

- Is normally used for babies for whom sex has not been determined for whatever reason.
- Should not generally be used on data collection forms completed by the client.

  Must only be used if the client or respondent volunteers that the client is intersex or where it otherwise becomes clear during the collection process that the individual is neither make nor female.

QA / validations

Exception Code	Exception Comment
PN024	Client record is missing Sex. Please review and enter the missing value.

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/index.phtml/itemId/287316

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / Validations

Exception Code	Exception Comment
PN039	The client's address is blank. Please review and update.

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/index.phtml/itemId/430134

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

Exception Code	Exception Comment
PN089	The client's address is blank. Please review and update.

Examples

	Suburb
A client's address is 168 Fourth Avenue, Mount Lawley, WA 6050	Mount Lawley

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/429889

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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

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

QA / validations

N/A

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/290046

Revision history

N/A

5. Data definitions – 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.

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

Exception Code	Exception Comment
IP003	Client's admission is missing and Admission Date and Time. Please review and enter the missing value.
IP004	Client's admission has a discharge date but is missing an Admission Date and Time. Please review and enter the missing value.

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/index.phtml/itemId/730809

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

Guide for use

Collection of this data element is mandatory.

Rules

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.

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

- 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.

No Longer Applicable - Superseded on 1 July 2022.

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.

QA / validations

All data quality performed on this data element is incorporated in the HMDC data quality process.

No Longer Applicable - Superseded on 1 July 2022

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/index.phtml/itemId/584408

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA validations

N/A

Examples

	Discharge Date and Time
A patient is discharged from 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 mental health to acute 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 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/index.phtml/itemId/680891

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

Establishment Code

Field name:	establishment_code
Source Data Element(s):	[Establishment Code] – PSOLIS
Definition:	A unique four-digit number that is assigned globally by HMDS to each establishment that is required to report admitted activity information to the HMDS
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.

Please refer to the Establishment Code List for a list of the valid hospital and health services and for detailed information on how establishment codes are allocated.

Rules

Each organisation must only have one establishment code assigned.

QA / validations

All data quality performed on this data element is incorporated in the HMDC data quality process.

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/index.phtml/itemId/269975

Revision history

N/A

No Longer Applicable: Superseded on 1 July 2022.

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.

Rules

Each organisation must only have one establishment.

QA / validations

All data quality performed on this data element is incorporated in the HMDC data quality process.

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/index.phtml/itemId/269975

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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:	NNNN
Permitted values:	Whole numbers

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.

Rules

N/A

QA / validations

All data quality performed on this data element is incorporated in the HMDC data quality process.

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/index.phtml/itemId/270251

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

Exception Code	Exception Comment
IP007	The leave end date is visible but the leave start date is missing. Please review.

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/index.phtml/itemId/680891

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

Exception Code	Exception Comment
P007	The leave end date is visible but the leave start date is missing. Please review.

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/index.phtml/itemId/680891

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is optional.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is optional.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is optional.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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.

Rules

N/A

QA / validations

Exception Code	Exception Comment
IP009	Client leave information is missing associated visit number. Please review.

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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).

Rules

N/A

QA / validations

Exception Code	Exception Comment
IP005	The admission is missing the visit start date. Please review.
IP006	The visit start date is greater than the visit discharge date. Please review this record.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

6. Data definitions – 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.

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/730809

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

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

Rules

N/A

QA / validations

N/A

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/572270

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable
Superseded on 1 July 2022.

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.

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

Rules

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.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

	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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/297450

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Triage Identifier

Field name:	triage_identifier
Source Data Element(s):	[Triage Identifier] – PSOLIS
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

Collection of this data element is mandatory.

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

Rules

N/A

QA / validations

N/A

Examples

	Triage Identifier
A client 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

No Longer Applicable. Superseded on 1 July 2022.

Triage Outcome

Field name:	triage_outcome_code
Source Data Element(s):	[Triage Outcome] – PSOLIS
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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

The outcome of the triage event indicates if there is a need for additional clinical intervention, and whether a referral to community or inpatient mental health services will be progressed.

Rules

N/A

DA / validations

N/A

Examples

	Triage Outcome
A client presents to a clinic with a triage presenting problem of experiencing disturbed thoughts. It is determined that the client should be referred to community mental health services for further assessment within two days.	8 – Referred to clinical intake
A client presents to an emergency department with a triage presenting problem of intentional self-harm. It is determined that the client should be immediately admitted to hospital.	1 – To be admitted to service

A client 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

No Longer Applicable.
Superseded on 1 July 2022.

Triage Presenting Problem

Field name:	triage_presenting_complaint_code
Source Data Element(s):	[Triage Presenting Problem] – PSOLIS
Definition:	Indicates the client's presenting problem at triage.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(4)
Permitted values:	As per Appendix C – Triage problem codes

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

This data element is used to indicate the client'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.

Rules

The triage presenting problem reported must be a valid code as per the list detailed in Appendix C of this document.

QA / validations

N/A

Examples

	Triage Presenting Problem
A client 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 client 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 client 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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

Examples

	Triage Referral Indicator
A client presents to a clinic with a triage presenting problem of experiencing disturbed thoughts. It is determined the client 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 client 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 Service Event Identifier

Field name:	triage_service_event_identifier
Source Data Element(s):	[Triage Service Event Identifier] – PSOLIS
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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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

Rules

N/A

QA / validations

N/A

Examples

	Triage Service Event Identifier
A client 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 Severity

Field name:	triage_severity_code
Source Data Element(s):	[Triage Severity] – PSOLIS
Definition:	Numeric identifier indicating the severity 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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Since November 2015 mental health clients 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...?*

Rules

Triage severity must be assigned by an appropriately qualified triage worker.

If the triage severity category assigned to the client 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.

QA / validations

N/A

Examples

	Triage Severity
A client 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.	12 – D. Within 48 hours
A client presents to an emergency department with a triage presenting problem of intentional self-harm. It is determined that the client should be immediately admitted to hospital.	9 – A. Immediate
A client 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 client 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

No Longer Applicable. Superseded on 1 July 2022.

7. Data definitions – 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.

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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

QA / validations

N/A

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

Collection of this data element is optional.

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.

Rules

Alert expiry date must be after the alert start date.

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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.

Rules

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

QA / validations

N/A

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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).

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

Alert start date must be before the alert expiry date.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

8. Data definitions – 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.

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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

QA / validations

N/A

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 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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is optional.

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.

Rules

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.

QA / validations

N/A

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

Collection of this data element is optional.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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:	1 – Rare 2 – Unlikely 3 – Possible 4 – Likely 5 – Very likely

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is optional.

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 streams they have access to.

Rules

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

QA / validations

N/A

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:	1 – Insignificant 2 – Minor 3 – Moderate 4 – Major 5 – Catastrophic

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable: Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

Collection of this data element is optional.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

9. Data definitions – 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.

No Longer Applicable.
Superseded on 1 July 2022.

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’

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

Additional diagnosis data elements are derived from and must be substantiated by clinical documentation.

QA / validations

N/A

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/index.phtml/itemId/699606

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

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

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/677806

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/738859

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable - Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable - Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/722725

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/723143

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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/index.phtml/itemId/727358

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is optional.

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

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

Rules

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

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

The principal diagnosis data element is derived from and must be substantiated by clinical documentation.

QA / validations

Exception Code	Exception Comment
PD011	The NOCC principal diagnosis and the client's sex (Male) are inconsistent.
PD012	The NOCC principal diagnosis and the client's sex (Female) are inconsistent.
PD013	The NOCC principal diagnosis and the client's age (not between 15-55) are inconsistent.
PD014	The NOCC principal diagnosis and the client's age (less than 15) are inconsistent.
PD015	The NOCC principal diagnosis and the client's age (greater than 16) are inconsistent.

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/index.phtml/itemId/699609

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

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

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

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

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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/index.phtml/itemId/494345

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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

Rules

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

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

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 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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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

Rules

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.

QA / validations

N/A

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 codes

No Longer Applicable: Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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.

QA validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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.

QA / validations

N/A

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

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

This data element is the unique, constant, system generated identifier assigned to each PSOLIS user.

Rules

N/A

QA / validations

N/A

Examples

	Staff User ID
Staff member Joe Citizen, HE8888[illegible] logs in to PSOLIS.	10423362

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

The stream reported must be a valid stream as per the list detailed in Appendix B of this document.

QA / validations

N/A

Examples

	Stream
A client is activated into the Adam Street Adult Outpatients program.	Fremantle Adult

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

The stream code reported must be a valid code as per the list detailed in Appendix B of this document.

QA / validations

N/A

Examples

	Stream Code
A client is activated into the Acme Street Adult Outpatients program.	5

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

The MHDC does not collect SARC data and records for this stream type must not be present.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

10. Data definitions – 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.

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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: https://www.amhocn.org/nocc-collection/nocc-measures.

QA / validations

N/A

Examples

	Assessment Scale
A client is activated and undergoes an HoNOS 65+ assessment	1 – HoNOS 65+
A client is activated and undergoes a CGAS assessment	2 – CGAS

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Assessment scale version specifies the version of the instrument being used to assess the health status of the client.

Rules

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 (1999b) 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.

No Longer Applicable.
Superseded on 1 July 2022.

QA / Validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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 999: Not stated/missing

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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:

https://www.amhocn.org/publications/childrens-global-assessment-scale

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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)

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Collection occasion relates to a range of key events that may occur with 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.

Rules

Three collection occasions within an episode of mental health care are identified: admission, review and discharge.

The 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 as follows:

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.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

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).

QA / validations

N/A

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:	01 – New referral 02 – Transfer from other treatment setting 03 – Admission - other 04 – 3-month (91 day) review 05 – Review - other 06 – No further care 07 – Transfer to change of treatment setting 08 – Death 09 – Discharge - other

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

Permitted value definitions

01 – 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.

02 – 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 – Admission - other

Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.

04 – 3-month (91 day) 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 – Review - other

Standard review conducted for reasons other than the above.

06 – 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.

07 – 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 – Death

Completion of an episode of mental health care following the death of the client.

09 – Discharge - other

Discharge from an inpatient, community residential or ambulatory episode of mental health care for any reason other than defined above.

QA / validations

N/A

Examples

	Collection Occasion Reason
A client is referred and activated into a MH youth outpatient program and a NOCC assessment is collected.	01 – 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

No Longer Applicable. Superseded on 1 July 2022.

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 12 – Previous outcome measure is clinically relevant and accepted 13 – Completed within last 7 days at different stream 14 – Offered to client, awaiting response 15 – Follow-up SDQ version used 16 – Dismissed – automatic cleanup 17 – Dismissed – manual program exclusion 18 – Dismissed – manual user request 19 – Dismissed – service split / amalgamation 20 – Dismissed - restructure

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Collection status describes the outcome of an assessment measure in terms of completion.

Rules

N/A

QA / validations

N/A

Examples

	Collection Status
A client is referred to a MH program and a NOCC assessment is scheduled. However, the client refuses to complete the Kessler 10 (consumer rated measure).	5 – Not completed due to refusal by the client

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable - Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

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.)

QA / validations

N/A

Examples

	Episode Service Setting
A client is activated into community care.	O

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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 8 – Unknown 9 – Not stated/inadequately described

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

No Longer Applicable. Superseded on 1 July 2022.

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/index.phtml/itemId/730840

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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 (excluding supplementary value 8 – Unknown) 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: https://www.amhocn.org/nocc-collection/nocc-measures

Rules

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.

No Longer Applicable. Superseded on 1 July 2022.

QA / validations

N/A

Examples

	HoNOS
A 42-year-old ambulatory mental health client is reviewed.	Collected
A 38-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/index.phtml/itemId/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

No Longer Applicable. Superseded on 1 July 2022.

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 (excluding supplementary value 8 Unknown) 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: https://www.amhocn.org/nocc-collection/nocc-measures

Rules

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.

No Longer Applicable. Superseded on 1 July 2022.

QA / validations

N/A

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/index.phtml/itemId/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

No Longer Applicable. Superseded on 1 July 2022.

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 as follows:

- 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 (excluding supplementary value 8 Unknown) 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: https://www.amhocn.org/nocc-collection/nocc-measures

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/717784

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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: https://www.amhocn.org/nocc-collection/nocc-measures

Rules

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;

No Longer Applicable. Superseded on 1 July 2022.

- 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.

QA / validations

N/A

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/index.phtml/itemId/634094

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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 9 – Not stated/missing

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is conditional – Life Skills Profile (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: https://www.amhocn.org/nocc-collection/nocc-measures

Rules

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.

No Longer Applicable. Superseded on 1 July 2022.

QA / validations

N/A

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/index.phtml/itemId/654401

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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).

QA / validations

Exception Code	Exception Comment
NC011	The client's episode of care is missing the mental health phase of care. Please review.

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/index.phtml/itemId/682464

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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 *Scoring scale for eating:* 1 – Independent or supervision only 2 – Limited assistance 3 – Extensive assistance/total dependence/tube fed

No Longer Applicable. Superseded on 1 July 2022.

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 setting 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: https://www.amhocn.org/nocc-collection/nocc-measures

Rules

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

No Longer Applicable. Superseded on 1 July 2022.

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.

QA / validations

N/A

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/index.phtml/itemId/495909

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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 *Item26* 0 – No 1 – Yes - minor difficulties 2 – Yes - definite difficulties 3 – Yes - severe difficulties *Item27* 0 – Less than a month 1 – 1-5 months 2 – 6-12 months 3 – Over a year *Item28 – item33, item35* 0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal *Item34* 0 – Much worse 1 – A bit worse 2 – About the same 3 – A bit better 4 – Much better

No Longer Applicable. Superseded on 1 July 2022.

	Item36 – item42 0 – No 1 – A little 2 – A lot

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

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.

Rules

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

No Longer Applicable. Superseded on 1 July 2022.

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.

No Longer Applicable. Superseded on 1 July 2022.

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.

A valid SDQ measure must have 3/5 valid scores recorded for each five subscales (scores: 0, 1, 2). Valid scores must be recorded for each:

Subscale 1 (item03, item08, item13, item16, item24)

Subscale 2 (item05, item07, item12, item18, item22)

Subscale 3 (item02, item10, item15, item21, item25)

Subscale 4 (item06, item11, item14, item19, item23)

Subscale 5 (item01, item04, item09, item17, item20)

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded on 1 July 2022.

11. Data definitions – 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.

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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 – No 1 – Yes

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

Examples

	AV Exam
A client examination under the Act was conducted via videoconference.	1

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

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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).

Rules

CTO appointment date and time must be prior to the CTO expiry date and time.

QA / validations

N/A

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

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

Collection of this data element is mandatory.

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.

Rules

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).

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

This data element is system generated and identifies the current legal episode the order is attached to.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

This data element must be collected for these legal orders: Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo orders.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

This data element must be collected for these legal orders: Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo orders.

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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 – CCP alteration

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

This data element must be collected for legal orders 1A to 7D and pseudo orders.

QA / validations

N/A

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 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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

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

Collection of this data element is mandatory.

This data element is system generated and identifies each legal order.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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'.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

The date and time of attendance must be after the date and time the 5F legal order was created.

QA / validations

N/A

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

Collection of this data element is mandatory.

Rules

N/A

QA / validations

N/A

Examples

	Order Type
The PSOLIS option order type 'Electronically made' is selected.	E

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

Parent identifier is a system generated unique number assigned to each legal form within a legal episode.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

The previous expiry date and time must be before the effective date of the current legal order.

QA / validations

N/A

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

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.

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Rules

N/A

QA / validations

N/A

Examples

	Referred From Place Metro Indicator
A client is transferred from Albany Acute Psychiatric Unit to Grayland 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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Rules

N/A

QA / validations

N/A

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Rules

N/A

QA / validations

N/A

Examples

	Referred To Place Metro Indicator
A client is transferred from Albany Acute Psychiatric Unit to Grayland 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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been transferred.

Rules

N/A

QA / validations

N/A

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

Collection of this data element is optional.

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.

Rules

N/A

QA / validations

N/A

Examples

	Same Practitioner Indicator
The PSOLIS 'Same Practitioner Indicator' checkbox remains unchecked.	0

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is optional.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable - Superseded on 1 July 2022.

Guide for use

Collection of this data element is conditional – it is only mandatory if a transport order has been created.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

Guide for use

Collection of this data element is conditional – it is only mandatory if a transport order has been revoked.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

Collection of this data element is mandatory.

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.

Rules

N/A

QA / validations

N/A

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

No Longer Applicable. Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

Guide for use

Collection of incident notes is optional.

Rules

N/A

QA / validations

N/A

Examples

	Treating Practitioner Qualification Type
The clinician treating the client is a psychiatrist.	1

Related national definition

N/A

Revision history

N/A

Appendix A – Service event item codes

Code	Name	Start Date	End Date	Clinical	Service Contact
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
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

No Longer Applicable. Superseded on 1 July 2022.

Code	Name	Start Date	End Date	Clinical	Service Contact
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
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

No Longer Applicable. Superseded on 1 July 2022.

Code	Name	Start Date	End Date	Clinical	Service Contact
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
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

No Longer Applicable.
Superseded on 1 July 2022.

Code	Name	Start Date	End Date	Clinical	Service Contact
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
169	LIAISON - GP	1/07/2018		1	Y
170	RTMS	1/07/2018		1	Y
171	HANDOVER	31/01/2019		1	Y

No Longer Applicable. Superseded on 1 July 2022.

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 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	LOWER WEST 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

No Longer Applicable - Superseded on 1 July 2022.

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	PORT HEDLAND CAMHS	1/01/2002	1	217
63	PORT HEDLAND ADULT	1/01/2002	2	217
64	PORT 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 JOONDALUP ADULT	1/01/2002	2	113
118	NORTH METRO JOONDALUP/CLARKSON ELDERLY	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

No Longer Applicable. Superseded on 1 July 2022.

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

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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	SPECIALISED ABORIGINAL MENTAL HEALTH SERVICE ADULT	1/04/2010	2	100
188	SPECIALISED ABORIGINAL MENTAL HEALTH SERVICE CAMHS	1/04/2010	1	100
189	SPECIALISED 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

No Longer Applicable - Superseded on 1 July 2022.

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	PORT 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	1/04/2016	2	212
257	SPEAK UP ADULT	27/08/2018	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

No Longer Applicable - Superseded on 1 July 2022.

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

No Longer Applicable.
Superseded on 1 July 2022.

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

No Longer Applicable. Superseded on 1 July 2022.

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 LISTED
61	VOLUNTARY ADMISSION

No Longer Applicable.
Superseded on 1 July 2022.

Appendix E – Summary of revisions

Version	Date Released	Author	Approval	Amendment
1.0	1 July 2021	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created.

No Longer Applicable.
Superseded on 1 July 2022.

No Longer Applicable.
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