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

Mental Health Data Collection

Data Dictionary

No Longer Applicable. Superseded 1 July 2026.

July 2025

Classification: Official

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No Longer Applicable.
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Abbreviations

ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
AV	Audiovisual
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
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
MHS	Mental Health Service
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No Longer Applicable.
Superseded 1 July 2026.

1. Purpose

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

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

This data dictionary is to be read in conjunction with this policy and other related documents and supporting information as listed below:

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

2. Background

The WA health system relies on mental health data that is high-quality, 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 1 July 2026.

4. Client demographics

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

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

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

No Longer Applicable.
Superseded 1 July 2026.

Aboriginal Status

Field name:	PT_ETHNICITY_CODE
Source data element(s):	[Aboriginal Status] – PSOLIS
Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
1	Aboriginal but not Torres Strait Islander origin	A person of Aboriginal descent who identifies as an Australian Aboriginal.	01/01/1600	31/12/9999
2	Torres Strait Islander but not Aboriginal origin	A person of Torres Strait Island descent who identifies as Torres Strait Islander.	01/01/1600	31/12/9999
3	Both Aboriginal and Torres Strait Islander origin	A person who identifies as both an Australian Aboriginal and Torres Strait Islander.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

There are three components to this definition: descent, self-identification and community

acceptance. All three should be satisfied for a client to be Aboriginal. However, it is not usually possible to collect proof of descent or community acceptance in health care settings. If a client identifies as Aboriginal, assign the most appropriate code (1 – 3).

The following question must be asked of all clients:

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

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

Only the most current Aboriginal status is to be recorded.

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Whole number from 0 to 130	Only the whole number for the completed years.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Activation Date and Time].

Guide for use

This data element is a derived measure using the mental health consumer's date of birth and the creation date of the mental health consumer record in PSOLIS. This date is consistently the same data as the mental health consumer's activation date.

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

Examples

	Age of Mental health consumer
A mental health consumer with a birthdate of 1 January 2005 has a record created in PSOLIS on 10 May 2021	16
A mental health consumer is recorded in PSOLIS on 25 July 2021, and he thinks he was born in 1950	71

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Age on Activation

Field name:	PT_AGE_ON_ACTIVATION
Source data element(s):	[Age on Activation] – PSOLIS
Definition:	The age of the is **recorded in PSOLIS** in (completed) years at the date of activation.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]

Permitted values

Permitted values	Definition	Start date	End date
Whole number from 0 to 130	Only the whole number for the completed years.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Activation Date and Time].

Guide for use

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Whole number from 0 to 130	Only the whole number for the completed years.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Alert Start Date].

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Whole number from 0 to 130	Only the whole number for the completed years.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Service Contact Start Date and Time].

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

Age on Incident

Field name:	PT_AGE_ON_INCIDENT
Source data element(s):	[Age on Incident] – PSOLIS
Definition:	The age of the client in (completed) years at the date of incident.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]

Permitted values

Permitted values	Definition	Start date	End date
Whole number from 0 to 130	Only the whole number for the completed years.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Incident Start Date].

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

Age on Referral

Field name:	PT_AGE_ON_REFERRAL
Source data element(s):	[Age on Referral] – PSOLIS
Definition:	The age of the client in (completed) years at the date of referral.
Requirement status:	N/A
Data type:	Numeric
Format:	N[NN]

Permitted values

Permitted values	Definition	Start date	End date
Whole number from 0 to 130	Only the whole number for the completed years.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Referral Date and Time].

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

Arrival Year

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

Permitted values

Permitted values	Definition	Start date	End date
Any valid year greater than 1900	The whole number for the year of arrival in Australia, from 1900 onwards.	01/01/1600	31/12/9999

Guide for use

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

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

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

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

No Longer Applicable.
Superseded 1 July 2026.

Examples

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

Related national definition

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

Revision history

N/A

Australian Postcode

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

Permitted values

Permitted values	Definition	Start date	End date
Valid Australian postcode	Any of the four-digit numbers used by the Australian postal service to assist with mail delivery. The postcode recorded is the one related to the client's usual residential address.	01/01/1600	31/12/9999

Guide for use

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

Australian residential addresses must include a valid postcode.

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026

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

Permitted values	Definition	Start date	End date
A code as per the Standard Australian Classification of Countries 2016 (SACC 2016)	Any of the codes produced by the Australian Bureau of statistics in the list of the Standard Australian Classification of Countries.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

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

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

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

Examples

	Country of Birth
Client's state of birth is Western Australia	1101
Client's country of birth is Australia (not otherwise specified)	1101
Client's country of birth is Japan	6201
Client born at sea but eligible for Polish citizenship	3307
Client born on Christmas Island	1199

Related national definition

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

Revision history

N/A

Client Identifier

Field name:	PT_IDENTIFIER_RAW
Source data element(s):	[Client Identifier] – PSOLIS
Definition:	The PSOLIS unique identifier for each mental health client.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNNNNNNNNN (10)

Permitted values

Permitted values	Definition	Start date	End date
Unique numeric identifier	The system generated unique 10-digit number assigned to an individual in PSOLIS. It is attached to all records in PSOLIS related to that individual.	01/01/1600	31/12/9999

Guide for use

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

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

The CMHI is system generated to prevent duplicates.

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
A code as per the Standard Australian Classification of Countries 2016 (SACC 2016)	Any of the codes produced by the Australian Bureau of statistics in the list of the Standard Australian Classification of Countries.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

Date of Birth

Field name:	PT_DATE_OF_BIRTH
Source data element(s):	[Date of Birth] – PSOLIS
Definition:	Date on which a client was born.
Requirement status:	Mandatory
Data type:	Datetime
Format:	DDMMYYYY

Permitted values

Permitted values	Definition	Start date	End date
Valid date	The day month and year of the date the client was born on.	01/01/1600	31/12/9999

Guide for use

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

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

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	No	No components of the recorded date of birth have been estimated	01/01/1600	31/12/9999
1	Yes	One or more of the date components has been estimated in the recorded date of birth.	01/01/1600	31/12/9999
Null	Null	No data recorded	01/01/1600	31/12/9999

Guide for use

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

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

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

Examples

	Date of Birth	Date of Birth Indicator
Client episode activated on 1 June 2015, estimated age 50 years	01071965	1

Related national definition

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

Revision history

N/A

No Longer Applicable: Superseded 1 July 2026

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

Permitted values	Definition	Start date	End date
Valid date	The day month and year of the date of the client's death.	01/01/1600	31/12/9999

Guide for use

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

Examples

	Date of Death
Client died on 8th February 2010	08022010

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Employment Status

Field name:	PT_EMPLOYMENT_STATUS_CODE
Source data element(s):	[Employment Status] – PSOLIS
Definition:	The self-reported employment status of a client at the time of the service event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
1	Child not at school	Refers to children not attending schooling (can refer to those attending playgroup or kindergarten). Does not refer to children not at school due to illness or disability. Refer to option 8 for children who are not attending school due to illness or disability.	01/01/1600	31/12/9999
2	Student	Refers to children attending school or individuals with study commitments equivalent to 20 hours per week or more (including children in pre-primary). If the study commitments are less than 20 hours per week and the individual does not fit into any other category, then record the Employment Status as '8 – Other'.	01/01/1600	31/12/9999
3	Employed	Refers to individuals who have full-time or part-time employment either as an employee, employer, self-employed or volunteer.	01/01/1600	31/12/9999
4	Unemployed	Refers to individuals who are unemployed regardless of whether they are actively seeking employment or receiving unemployment benefits.	01/01/1600	31/12/9999
5	Home duties	Refers to individuals whose sole role is performing home duties (i.e., they do not have any other occupation).	01/01/1600	31/12/9999
6	Retired	Refers to individuals who are retired from work but not receiving an aged pension (i.e. self-funded retiree)	01/01/1600	31/12/9999
7	Pensioner	Refers to individuals who are retired from work and receiving an aged pension or a person who is unable to work and receives another type of pension (i.e., Disability Support Pension).	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026

Code	Description	Definition	Start date	End date
8	Other	Refers to individuals with an illness or disability aged between 6 and 15 who are not attending school. Once the individual reaches 16 years of age, they should be entered as employed, unemployed or pensioner (Disability Support Pension).	01/01/1600	31/12/9999
9	Not/Stated Inadequately described	Not enough information is given for a correct assignment of employment status	01/01/1600	31/12/9999

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable:
Superseded 1 July 2026

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

Permitted values	Definition	Start date	End date
Alpha characters only	The Clients family name in a maximum of 50 alpha characters.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

Family name must be recorded as follows:

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

Examples

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

Related national definition

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

Revision history

N/A

First Given Name

Field name:	PT_NAME_FIRST
Source data element(s):	[First Given Name] – PSOLIS
Definition:	The first given name of the client.
Requirement status:	Conditional
Data type:	String
Format:	X[X(49)]

Permitted values

Permitted values	Definition	Start date	End date
Alpha characters only	The Clients first given name in a maximum of 50 alpha characters.	01/01/1600	31/12/9999

Guide for use

No Longer Applicable. Superseded 1 July 2026.

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

Interpreter Required

Field name:	PT_INTERPRETER_REQUIRED
Source data element(s):	[Interpreter Required] – PSOLIS
Definition:	Whether an interpreter service is required by or for the client.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
1	Yes	An official paid interpreter is used to assist the patient to communicate, or an official paid interpreter is used to assist the patient's family or friends to communicate on the patient's behalf.	01/01/1600	31/12/9999
2	No	Family or friends are interpreting for the patient or no formal interpreting services required.	01/01/1600	31/12/9999
9	Not stated/inadequately described	The value for this data item was reported as not being known.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

Marital Status

Field name:	PT_MARITAL_STATUS_CODE
Source data element(s):	[Marital Status] – PSOLIS
Definition:	The client's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
1	Never Married	The person has never been married.	01/01/1600	31/12/9999
2	Widowed	The client's spouse has died.	01/01/1600	31/12/9999
3	Divorced	The client's marriage has been legally dissolved	01/01/1600	31/12/9999
4	Separated	The client and their spouse no longer live together, but the marriage has not been legally dissolved	01/01/1600	31/12/9999
5	Married	The client is a part of a formally recognised union of two people in a personal relationship.	01/01/1600	31/12/9999
6	Unknown	The value for this data item was reported as not being known.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Marital status is mandatory.

Marital status is a core variable used in a wide range of social statistics. Its main purpose is to establish the living arrangements of individuals in general and is used to gauge the need for care of patients who live alone. This field must reflect the current marital status of the patient, including same sex couples.

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Person Sex at Birth

Field name:	PT_SEX_CODE
Source data element(s):	[Sex] – PSOLIS
Definition:	A person's sex is understood in relation to sex characteristics, including chromosomes, hormones and reproductive organs.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
1	Male	Persons whose sex at birth or infancy was recorded as male, or who reported their sex as male at the time of collection.	01/01/1600	31/12/9999
2	Female	Persons whose sex at birth or infancy was recorded as female, or who reported their sex as female at the time of collection.	01/01/1600	31/12/9999
3	Another term	Persons whose sex at birth or infancy was recorded as another term (not male or female), or who reported their sex as another term (not male or female) at the time of collection.	01/01/1600	31/12/9999
9	Not stated/inadequately described	Not enough information is given for a correct assignment of sex at birth.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

When comparing the concepts of sex and gender:

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

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

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

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

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

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

Examples

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

Related national definition

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

Revision history

Historical Values

Code	Description	Definition	Start date	End date
3	**Intersex or indeterminate** This has also been labelled **Other**	This code was normally used for babies for whom sex has not been determined for whatever reason. It should not generally be used on data collection forms completed by the client. It 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 male nor female.	01-08-2005	01-07-2022

No Longer Applicable.
Superseded 1 July 2026.

Preferred Language

Field name:	PT_PREFERRED_LANGUAGE_CODE
Source data element(s):	[Preferred Language] – PSOLIS
Definition:	The language a person prefers most for communication.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N[NNN]

Permitted values

Permitted values	Definition	Start date	End date
As per the Australian Standard Classification of Languages 2016 (ASCL 2016)	Any of the codes produced by the Australian Bureau of statistics in the list of the Australian Standard Classification of Languages 2016	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

Religion

Field name:	PT_RELIGION_CODE
Source data element(s):	[Religion] – PSOLIS
Definition:	The religious group to which a person belongs to or adheres to, as represented by a code.
Requirement status:	Optional
Data type:	Numeric
Format:	N[NNN]

Permitted values

Permitted values	Definition	Start date	End date
As per the Australian Standard Classification of Religious Groups 2016 (ASCRG 2016)	Any of the codes produced by the Australian Bureau of statistics in the list of the Australian Standard Classification of Religious Groups 2016	01/01/1600	31/12/9999

Guide for use

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The description of the client's usual place of residence in a maximum of 255 alphanumeric characters.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

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

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

Second Given Name

Field name:	PT_NAME_MIDDLE
Source data element(s):	[Second Given Name] – PSOLIS
Definition:	The second given name of the client.
Requirement status:	Conditional
Data type:	String
Format:	X[X(49)]

Permitted values

Permitted values	Definition	Start date	End date
Alpha characters only	The clients second given name in a maximum of 50 alpha characters.	01/01/1600	31/12/9999

Guide for use

No Longer Applicable. Superseded 1 July 2026.

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

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

Code	Description	Definition	Start date	End date
NSW	New South Wales	The usual residential address is in the state of New South Wales	01/01/1600	31/12/9999
VIC	Victoria	The usual residential address is in the state of Victoria	01/01/1600	31/12/9999
QLD	Queensland	The usual residential address is in the state of Queensland	01/01/1600	31/12/9999
SA	South Australia	The usual residential address is in the state of South Australia	01/01/1600	31/12/9999
WA	Western Australia	The usual residential address is in the state of Western Australia	01/01/1600	31/12/9999
TAS	Tasmania	The usual residential address is in the state of Tasmania	01/01/1600	31/12/9999
NT	Northern Territory	The usual residential address is in the Northern Territory	01/01/1600	31/12/9999
ACT	Australian Capital Territory	The usual residential address is in the Australian Capital Territory	01/01/1600	31/12/9999
AAT	Australian Antarctic Territory	The usual residential address is in the Australian Antarctic Territory	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid Australian suburb	The suburb name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. Description in a maximum of 255 alphanumeric characters	01/01/1600	31/12/9999

Guide for use

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	Can be alphanumeric or numeric up to a maximum of 10 characters	01/01/1600	31/12/9999

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 only 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.

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

5. Inpatient services

The following section details specific inpatient data elements captured in the MHDC for clients who are admitted for hospital level care, 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.

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day month year hour minutes and seconds of when the client was admitted to an inpatient mental health program.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

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 used to accurately document specific changes in a patient's treatment during an episode of care. This ensures that any modifications, such as a change in the type of care, are properly recorded.

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

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

The admission date must be prior to the discharge date.

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

Examples

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

admission date and time reflecting the date and time of ward transfer.	

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
25	Maintenance/ Non-Acute 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/ non-acute care often require care over an indefinite period. Maintenance/ Non-Acute care excludes care which meets the definition of mental health care.	01/01/1600	31/12/9999
26	Newborn	Initiated when the patient is born in hospital or is nine days old or less at the time of admission, and continues until the care type changes or the patient is separated: • patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders • patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated • patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type • patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type • within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day • a newborn is qualified when it meets at least one of the criteria detailed in newborn qualification status. Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.	01/01/1600	31/12/9999
27	Organ procurement	Organ procurement is the procurement of human tissue for the purpose of	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
32	Mental health	Care in which the primary clinical purpose	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
	care	or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder. Mental health care: • is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health. • is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and • may include significant psychosocial components, including family and carer support.		
33	Mental health rehabilitation	Mental health rehabilitation care type is only applicable at certain hospitals. It is used for Hospital Extended Care Service wards where long term non-acute mental health care is provided, subsequent to an acute component of care only. This care type is used to separate long stay per diem funded episodes from other Mental Health Care Type patients.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Care type is assigned by the clinician responsible for the management of the patient/client's care. This is 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 assigning a mental health or subacute care type, 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 any 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 the patient/client's care may not necessarily be located in the same facility as the patient. In these circumstances, a clinician at the patient's location may also have a role in the care of the patient; the expertise of this clinician does not affect the assignment of care type.

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

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

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

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

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

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Unique numeric identifier	A system generated unique number that is a maximum of 20 digits long that is assigned to each Legal order as a means of unique identification.	01/01/1600	31/12/9999

Guide for use

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when the patient was discharged from the inpatient mental health service.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

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 used to accurately document specific changes in a patient's treatment during an episode of care. This ensures that any modifications, such as a change in the type of care, are properly recorded.

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

The discharge date must be after the admission date.

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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:	YYYYMMDD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when the episode of mental health care within that setting is formally or statistically completed	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

Episode Start Date and Time

Field name:	EPISODE_START_DATETIME
Source data element(s):	[Episode Start Date and Time] – PSOLIS
Definition:	The date and time on which the episode of mental health care within that setting formally or statistically commences.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYYMMDD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when the episode of mental health care within that setting formally or statistically commences	01/01/1600	31/12/9999

Guide for use

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

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

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

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

No Longer Applicable.
Superseded 1 July 2026.

Examples

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

Related national definition

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

Revision history

N/A

Establishment Code

Field name:	ESTABLISHMENT_CODE
Source data element(s):	[Establishment Code] – PSOLIS
Definition:	A unique code assigned by Department of Health (WA) to hospitals and other health related locations or establishments.
Requirement status:	Conditional
Data type:	Numeric
Format:	NNN(N)

Permitted values

Permitted values	Definition	Start date	End date
Any valid code from Establishment Code List.	A unique four-digit number that is assigned by Department of Health (WA) to hospitals and other health related locations or establishments. Refer to the Establishment Code List	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

Establishment Name

Field name:	ESTABLISHMENT_HOSP
Source data element(s):	[Establishment Name] – PSOLIS
Definition:	The name of the hospital represented by the Establishment Code
Requirement status:	Conditional
Data type:	Alphanumeric
Format:	X[X(149)]

Permitted values

Permitted values	Definition	Start date	End date
Alphanumeric Combination	The name of the hospital that is required to report admitted activity information to the HMDS Refer to the Establishment Code List	01/01/1600	31/12/9999

Guide for use

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

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

Each organisation must only have one establishment.

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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:	Derived
Data type:	Numeric
Format:	N(4)

Permitted Values

Permitted Values	Definition	Start date	End date
Whole number	The number of days as a whole number that the patient was away on leave from the hospital.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Derivation logic

This data element is derived by calculating the number of days between each [Leave start Date and time] and [Leave End Date and Time] pairs in each inpatient episode of care. The number of days for each period of leave are added together to get the total number of leave days in an episode.

Guide for use

This data element is a derived measure using [Leave start Date and time] and [Leave End Date and Time].

Leave that begins and ends on the same date is 0 days of leave.

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. He goes on leave on Tuesday and returns on Thursday (2 days), goes on leave Saturday morning and returns at 7pm that day (0 days), goes on leave the following Wednesday returning 1 day later on Thursday (1 day).	3

Related national definition

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

Revision history

N/A

Leave End Date and Time

Field name:	LEAVE_END_DATETIME
Source data element(s):	[Leave End Date and Time] – PSOLIS
Definition:	The date and time the patient returned from leave during an inpatient mental health episode of care.
Requirement status:	Conditional on [Leave Start Date and Time] having a value
Data type:	Datetime
Format:	YYYYMMDD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds when the patient ended a period of leave from the inpatient mental health service.	01/01/1600	31/12/9999

Guide for use

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

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

Leave end date must be:

- after the admission date.
- after the leave start date.
- before the discharge date.

Examples

	Leave End Date and Time
An admitted patient returns from leave to an inpatient mental health ward on 3 May 2021 at 09:05:00.	2021-05-03 09:05:00

Related national definition

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

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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 on the patient taking leave.
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds when the patient commenced a period of leave from the inpatient mental health service.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

Leave start date must be:

- after the admission date.
- before the leave end date.
- before the discharge date.

Examples

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

Related national definition

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

Revision history

N/A

Length of Stay

Field name:	LENGTH_OF_STAY
Source data element(s):	[Length of Stay] – PSOLIS
Definition:	The period of time in days a person was admitted to hospital or service for an episode of care.
Requirement status:	Derived
Data type:	Numeric
Format:	N(4)

Permitted Values

Permitted Values	Definition	Start date	End date
Whole number	The number of days as a whole number that the patient was an inpatient for.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of days between the [Admission Date and Time] and the [Discharge Date and Time].

Guide for use

This data element is a derived measure that totals the number of days between two dates using the episode admission and discharge dates.

Examples

	Duration
A patient is admitted to Midland Hospital on 13/07/2022 and discharged on 20/07/2022.	7

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Planned Admission Date and Time

Field name:	PLANNED_ADMIT_DATETIME
Source data element(s):	[Planned Admission Date and Time] – PSOLIS
Definition:	The admission date and time that it had been planned for the patient to be admitted to the mental health program.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date including day, month and year for the planned admission date and time prior to the actual admission into the mental health program. The time which is captured in hour minutes and seconds is automatically recorded as 00:00:0000000.	01/01/1600	31/12/9999

Guide for use

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

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

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

No Longer Applicable: Superseded 1 July 2026.

Examples

	Planned Admission Date and Time
At the time of admission to hospital on 9 May 2021, the patient advised he had been booked to be admitted on 8 May 2021 at 10am but was unable to get transport organised.	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 discharge date and time planned at the time of admission to, or any time before discharge from, a mental health program.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date including day, month and year of the planned discharge date and time prior to the actual discharge from the mental health program. The time which is captured in hour minutes and seconds is automatically recorded as 00:00:0000000.	01/01/1600	31/12/9999

Guide for use

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

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

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

No Longer Applicable.
Superseded 1 July 2026.

Examples

	Planned Discharge Date and Time
Upon admission to a mental health unit the patient was advised she could plan for discharge on 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 inpatient under an Order Authorising Reception and Detention in an Authorised Hospital for Further Examination (Form 3D)
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when the client was received as an inpatient.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

The reception data and time is associated with the ordering of a person's reception and detention in an Authorised Hospital to enable further examination by a psychiatrist (Form 3D) under the *Mental Health Act 2014*. This order follows the examination of a person by a psychiatrist at a place other than an Authorised Hospital.

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

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

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

Examples

	Reception Date and Time
A user entered a reception date of 23 August 2021 at 9am.	2021-08-23 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

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds on which an admitted client completes an episode of care (otherwise known as 'visit').	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

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

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

Examples

	Visit End Date and Time
A client is discharged 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 on [admission date and time] having a value
Data type:	Numeric
Format:	N[N(19)]

Permitted values

Permitted values	Definition	Start date	End date
Unique numeric identifier	A system generated unique number that is a maximum of 20 digits long that is assigned to each visit	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

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 consist of one or more visits; each is assigned their own visit number.

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

Examples

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

Related national definition

N/A

Revision history

N/A

Visit Start Date and Time

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

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when an admitted client commences the inpatient episode of care (otherwise known as 'visit').	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

Examples

	Visit Start Date and Time
A client is admitted to 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 name of the ward the patient was admitted to, at the time of admission to the hospital.
Requirement status:	Conditional on [admission start date and time] having a value
Data type:	String
Format:	X[X(59)]

Permitted values

Permitted values	Definition	Start date	End date
Valid ward name descriptor	Any of the descriptors from the list of accepted ward identifiers to a maximum of 60 characters	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Ward on Discharge

Field name:	WARD_ON_DISCHARGE
Source data element(s):	[Ward on Discharge] – PSOLIS
Definition:	The ward the patient was discharged from, at the time of discharge from the hospital.
Requirement status:	Conditional on [separation date and time] having a value
Data type:	String
Format:	X[X(59)]

Permitted values

Permitted values	Definition	Start date	End date
Valid ward name descriptor	Any of the descriptors from the list of accepted ward identifiers to a maximum of 60 characters	01/01/1600	31/12/9999

Guide for use

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

6. Referrals

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

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

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when the action occurred.	01/01/1600	31/12/9999

Guide for use

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

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

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

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

No Longer Applicable.
Superseded 1 July 2026.

Examples

	Action Date and Time
The result of a NOCC assessment for a client is recorded at 10:15:00 on 11 June 2021.	2021-06-11 10:15:00
A client's details are completed in the PAS on 15 December 2020 at 12:51:21 and then a service event is recorded for the client 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 person was activated as a client of a community mental health service.
Requirement status:	Conditional on a client being activated
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when the client was activated in the community mental health service.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

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:

- must be the same date and time as when the decision occurred to admit a client to a community program and provide care to the client
- must be between the referral date and deactivation date
- may be the original date of entry to care within the ambulatory service.

Activation:

- can only occur if the referral is no older than 3 months or is within the extended deadline of a waitlist status
- requires that the related referral is closed (outcome)
- is the process of admitting a client to a community program for ongoing care or service provision
- can be within the first service contact
- can occur for one client to multiple programs if there is a referral for each program
- must occur when a clinical decision is made to provide care to a client and this decision is documented
- must occur if the 'client present' (face-to face, video, telephone) occurred for 10 reportable service contacts
  - Service contacts of an administrative nature (i.e. non-reportable service contacts) are excluded
- must be made to the appropriate program/stream
- can occur again for a client previously deactivated from the mental health service but must meet all the same requirements of a first activation.

Activation cannot:

- Be assumed because a client has had one or two service contacts
- Be assumed because a client had 10 or more service contacts unless a clinician has also confirmed that the client will be accepted to the Program (activated)
- Occur if the referral is more than three months old and has no extension caused by waitlist status.

Clients with a clinical decision NOT to activate must:

- have all referrals assigned an outcome
- record no more service events against the referral/s

Examples

	Activation Date and Time
A client is activated to a program on 3 May 2021 at 09:01:36.	2021-05-03 09:01:36

Related national definition

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

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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 who was allocated the management of the client's referral
Requirement status:	Conditional on [Referral Identifier] having a value.
Data type:	String
Format:	X[X(9)]

Permitted Values

Permitted Values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the clinician the referral was allocated to.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

Examples

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

Related national definitions

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 on [Allocated to Clinician HE Number] having a value.
Data type:	String
Format:	X[X(149)]

Permitted Values

Permitted Values	Definition	Start date	End date
Alphanumeric combination	The name of the clinician the referral was allocated to in a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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 on [Referral Identifier] having a value
Data type:	String
Format:	N[N(7)]

Permitted values

Permitted values	Definition	Start date	End date
Valid numeric team code	One of the codes applied to identify the clinical mental health teams.	01/01/1600	31/12/9999

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Referral Date and Time

Field name:	REFERRAL_DATETIME
Source data element(s):	[Referral Date and Time] – PSOLIS
Definition:	The date and time the community mental health service received the referral for the client.
Requirement status:	Conditional on [Referral Identifier] having a value
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted Values

Permitted Values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of when the community mental health service received the referral for the client.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection is conditional on the service event item not being a pre-referral action and a referral being received.

A formal referral is a process in which a client is introduced by a health practitioner to a mental health service via fax, phone call, letter or email as a person requiring mental health services or they have self-presented to the service for care.

This is the date and time the community mental health service received the referral regardless of the medium of communication.

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

All activations must have a valid referral.

Referrals are valid for three months.

A new referral is required for the client to be activated or for additional service events to be provided.

Referral date and time must be before or the same as the activation date and time.

Examples

	Referral Date and Time
A client is referred to Fremantle Mental Health Service for assessment with referral being received by email on 1st July 2021 at 5:52 pm.	2021-07-01 17:52:00

Related national definition

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

Revision history

N/A

Referral Identifier

Field name:	REFERRAL_IDENTIFIER
Source data element(s):	[Referral Identifier] – PSOLIS
Definition:	Unique identifier assigned by PSOLIS system for the referral.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(8)

Permitted Values

Permitted Values	Definition	Start date	End date
Unique numeric identifier	PSOLIS generated unique number that is assigned to each referral as a means of unique identification (it is a maximum of 8 digits long)	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection is conditional on the service event item not being a pre-referral action and a referral being received.

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

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

All activations must have a valid referral.

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

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

Examples

	Referral Identifier
A referral for a client assessment is received by Fremantle Mental Health Service on 1st July 2021.	3285475

Related national definition

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

Revision history

N/A

Referral Medium

Field name:	REFERRAL_MEDIUM_CODE
Source data element(s):	[Referral Medium] – PSOLIS
Definition:	The medium the referral was received by, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(2)
Field name:	REFERRAL_MEDIUM
Data type:	String
Format:	[X(150)]

Permitted values

Code	Description	Definition	Start date	End date
1	Email	Referral information attached or embedded within an email received by the mental health service	01/01/1600	31/12/9999
2	Fax	Referral information transmitted as a document via the phone line and received by the mental health service	01/01/1600	31/12/9999
3	Letter	Referral information on paper document received via Australia Post by the mental health service	01/01/1600	31/12/9999
4	Phone	Referral information transmitted as a document via Australia Post to the mental health service	01/01/1600	31/12/9999
5	Self-presented	The client referred self to the mental health service by any medium requesting assessment or care	01/01/1600	31/12/9999
6	Triage	A requirement for mental health service assessment was determined during the healthcare triage process	01/01/1600	31/12/9999
7	Brought in by police	The client was brought by police officers to the mental health service requiring assessment, care, or intervention	01/01/1600	31/12/9999
8	Brought in by community nurses	The client was brought by a community nurse to the mental health service requiring assessment, care, or intervention	01/01/1600	31/12/9999
9	Other	The referral was received by the mental health service by another means not listed.	01/01/1600	31/12/9999
10	Electronic	Referral information was transmitted	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
	referral	digitally to the mental health service and loaded to clinical system, PSOLIS.		

Guide for use

Collection is conditional on the service event item not being a pre-referral action.

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

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

All activations must have a valid referral.

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

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

Examples

	Referral Medium
A mental health client enters Broome Hospital seeking treatment for depression.	5 – Self presented
Bunbury Mental Health Service receives an email with a referral attached for a client of a GP.	1 – Email

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Referral Outcome

Field name:	REFERRAL_OUTCOME_CODE
Source data element(s):	[Referral Outcome] – PSOLIS
Definition:	The outcome of a referral, as represented by a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Field name:	REFERRAL_OUTCOME
Data type:	String
Format:	X(150)

Permitted values

Code	Description	Definition	Start date	End date
1	Admitted to service	This indicates that the referral was used to directly activate the client to a mental health program.	01/01/1600	31/12/9999
2	Referred to other service	Once this outcome is selected, PSOLIS will ask one to enter details of the other service.	01/01/1600	31/12/9999
3	No further action	Clinical decision has been made that no further assistance is required.	01/01/1600	31/12/9999
4	No further action, already Active	This outcome is predominantly used to outcome multiple referrals to the same program.	01/01/1600	31/12/9999
5	Did not engage/attend appointment	Client was not willing to engage with the service	01/01/1600	31/12/9999
6	Information only	The record is for information purposes only	01/01/1600	31/12/9999
7	Admitted via PAS	This indicates that client has been admitted to an Inpatient setting, via the primary administrative system PAS, and that referral and admission information has been fed across to PSOLIS.	01/01/1600	31/12/9999
8	Client declined	MH services has been refused by the client	01/01/1600	31/12/9999
Null	Not specified	Not specified	01/01/1600	31/12/9999

No Longer Applicable - Superseded 1 July 2026

Guide for use

Collection of this data element is conditional on referral being received and the service event not being 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'.

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 in a service stream, or if the client has a current Referral for a service stream where the status is 'Pending' or 'In progress' the referral outcome must immediately be assigned as 'No further action, already Active.'

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable:
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Any of the valid codes as per Appendix C – Triage Presenting Complaint and Referral Presenting Problem Codes	The 2-digit codes as per Appendix C – Triage Presenting Complaint and Referral Presenting Problem Codes.	01/01/1600	31/12/9999

Guide for use

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

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

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

All activations must have a valid referral.

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

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

No Longer Applicable. Superseded 1 July 2026.

Examples

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

Related national definition

N/A

Revision history

N/A

Referral Purpose

Field name:	REFERRAL_PURPOSE_CODE
Source data element(s):	[Referral Purpose] – PSOLIS
Definition:	The underlying reason for the referral.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Field name:	REFERRAL_PURPOSE
Data type:	String
Format:	X(150)

Permitted values

Code	Description	Definition	Start date	End date
1	Seeking assistance/referral	The reason for the referral is to seek assistance from mental healthcare specialists or for the clients care to be taken over by mental health care specialists	01/01/1600	31/12/9999
2	Information	The referral is seeking information from mental health care specialists such as an assessment as to whether further mental health care is required	01/01/1600	31/12/9999
3	Assessment	The referral is seeking an assessment of the client from mental health care specialists	01/01/1600	31/12/9999
4	GP Phone Advice	The referral is a General Practitioner seeking further advice form mental health care specialists	01/01/1600	31/12/9999
5	GP Liaison	The referral is from a GP liaison.	01/01/1600	31/12/9999
Null	Not specified	The reason for the referral is not specified	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026

Guide for use

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

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

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

All activations must have a valid referral.

Referrals are valid for three months whereupon a new referral is required for the client to be

activated or for additional service event items to be entered.

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	A detailed reason for the referral in a maximum of 500 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

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

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

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

All activations must have a valid referral.

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the person program or organisation making the referral in a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

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

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

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

All activations must have a valid referral.

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

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

No Longer Applicable. Superseded 1 July 2026.

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)
Description field name:	REFERRAL_SOURCE_TYPE
Description data type:	String
Description format:	[X(150)]

Permitted values

No Longer Applicable: Superseded 1 July 2026:

Code	Description	Definition	Start date	End date
2	Breach release order	A referral due to a failure to comply with the conditions in a court order	01/01/1600	31/12/9999
3	Condition of bail	A client must receive mental health care as a term set in their bail conditions	01/01/1600	31/12/9999
4	Court	A court orders a client to attend mental health care	01/01/1600	31/12/9999
5	Family/friend	A family member or friend directs the client to receive care	01/01/1600	31/12/9999
8	Internal program	An internal program that the client is a part of refers them for new or further treatment	01/01/1600	31/12/9999
9	Medical practitioner	A person registered to practise as a Medical Practitioner under the Health Practitioner Regulation National Law	01/01/1600	31/12/9999
12	Other establishment	The referral is set by another establishment not otherwise listed	01/01/1600	31/12/9999
13	Other organisation	The referral is set by another organisation not otherwise listed	01/01/1600	31/12/9999
16	Police	The police refer the client for mental health care	01/01/1600	31/12/9999
17	Correctional facility	A correctional facility where the client is being held refer the client for mental health care	01/01/1600	31/12/9999
22	Self	The client themselves seek mental health care	01/01/1600	31/12/9999
23	Unknown	The source is not identified	01/01/1600	31/12/9999
24	Refuge	A refuge where the client is seeking shelter refer them for mental health care	01/01/1600	31/12/9999

Code	Description	Definition	Start date	End date
25	School	A school the client attends refers the client for mental health care	01/01/1600	31/12/9999
26	Other professional	A professional other than a medical practitioner refers the client for mental health care	01/01/1600	31/12/9999
27	External program	A program external to mental health programs refers the client for mental health care	01/01/1600	31/12/9999
28	Nursing home/hostel	A nursing home or hostel where the client is residing refers the client for mental health care	01/01/1600	31/12/9999
29	Hospital	A hospital refers the client to receive mental health care	01/01/1600	31/12/9999
30	Mental health program	Another mental health care program refers the client to a different program	01/01/1600	31/12/9999
31	Restructure	A restructure in programs resulting in clients being referred to new programs	01/01/1600	31/12/9999
32	Police officer	A police officer brings a client in for mental health care	01/01/1600	31/12/9999
99	PAS	An automatic refer from Patient Administration System following admission to particular wards	01/01/1600	31/12/9999
Null	Not specified	No data is recorded	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026.

Guide for use

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

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

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

All activations must have a valid referral.

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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
Description field name:	REFERRAL_STATUS
Description data type:	String
Description format:	[X(150)]

Permitted values

Code	Description	Definition	Start date	End date
1	Pending	When a referral is first recorded in PSOLIS the status automatically defaults to pending	01/01/1600	31/12/9999
2	In progress	Referrals that are being progressed	01/01/1600	31/12/9999
3	Waitlist	Used for clients who are waiting for a vacant place in a program	01/01/1600	31/12/9999
4	Completed	When the outcome of the referral has been determined	01/01/1600	31/12/9999
5	Sent	The referral has been sent to its intended recipient	01/01/1600	31/12/9999
Null	Not specified	No information recorded	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026.

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.

All activations must have a valid referral.

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

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

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

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

Referrals must not be left pending, in progress or waitlisted indefinitely. Action must be taken

to ensure that current referrals with a status of ‘Pending’ or ‘In progress’ or ‘Waitlist’ are reviewed regularly, and an appropriate outcome assigned within three months.

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the person program or organisation the client has been referred to receive mental health care in a maximum of 130 alphanumeric characters	01/01/1600	31/12/9999

Guide for use

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

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

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

All activations must have a valid referral.

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

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

No Longer Applicable.
Superseded 1 July 2026.

Examples

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

Related national definition

N/A

Revision history

N/A

Referred On Type

Field name:	REFERRED_ON_TYPE_CODE
Source data element(s):	[Referred On Type] – PSOLIS
Definition:	The type of person, program or organisation the mental health client has been referred to.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(2)
Description field name:	REFERRED_ON_TYPE
Description data type:	String
Description format:	[X(150)]

Permitted values

Code	Description	Definition	Start date	End date
1	Hospital (non-psychiatric)	A hospital that provides care other than psychiatric care	01/01/1600	31/12/9999
8	Internal program	Referred to a different mental health program that is run by the same establishment/ organisation	01/01/1600	31/12/9999
9	Medical practitioner	A person registered to practise as a Medical Practitioner under the Health Practitioner Regulation National Law	01/01/1600	31/12/9999
10	Community and outpatient MHS	A mental health service that is run in the community or outpatient setting	01/01/1600	31/12/9999
12	Other establishment	The referral is set by another establishment not otherwise listed	01/01/1600	31/12/9999
13	Other organisation	The referral is set by another organisation not otherwise listed	01/01/1600	31/12/9999
19	Hospital (psychiatric)	A hospital that provides psychiatric care	01/01/1600	31/12/9999
26	Other professional	A professional other than a medical practitioner	01/01/1600	31/12/9999
27	External program	Referred to a different mental health program that is not run by the same establishment/ organisation	01/01/1600	31/12/9999
29	Hospital	A hospital that provides care that includes psychiatric care but is not only psychiatric care	01/01/1600	31/12/9999
31	Restructure	A restructure in programs requiring clients	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		to be referred to new programs		
Null	Not specified	No Information recorded	01/01/1600	31/12/9999

Guide for use

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

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

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

All activations must have a valid referral.

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

7. Alerts

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

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

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	A description about the cause and nature of the alert in a maximum of 500 alphanumeric characters.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

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 for clients that are Active or have a referral, or during triage.

Examples

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

Related national definition

N/A

Revision history

N/A

Alert Duration

Field name:	ALERT_DURATION_DAYS
Source data element(s):	[Alert Duration] – PSOLIS
Definition:	The duration of the alert in days.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)

Permitted values

Permitted values	Definition	Start date	End date
Whole number	The number of days as a whole number that the alert is Active for.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of days between the [Alert Start Date] and the [Alert Expiry Date].

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the person creating the alert.	01/01/1600	31/12/9999

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 for clients that are Active or have a referral, or during triage.

Examples

	Alert Entered By
A user creates an alert	HE999990

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the person who ends the alert.	01/01/1600	31/12/9999

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 for clients that are Active or have a referral, or during triage.

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

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date	The full date including day, month and year of when an alert ends. The time which is captured in hour minutes and seconds is automatically recorded as 00:00:0000000.	01/01/1600	31/12/9999

Guide for use

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

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

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

Alerts can be entered for clients that are Active or have a referral, or during triage.

Alert expiry date must be after the alert start date.

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

No Longer Applicable.
Superseded 1 July 2026.

Examples

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

Related national definition

N/A

Revision history

N/A

Alert Identifier

Field name:	ALERT_IDENTIFIER
Source data element(s):	[Alert Identifier] – PSOLIS
Definition:	A unique identifier for each alert.
Requirement status:	Conditional
Data type:	String
Format:	N(6)

Permitted values

Permitted values	Definition	Start date	End date
Unique numeric identifier	A system generated unique number that is a maximum of 6 digits long that is assigned to each alert as a means of unique identification	01/01/1600	31/12/9999

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 for clients that are Active or have a referral, or during triage.

This data element is system generated to prevent duplicates.

Examples

	Alert Identifier
A new alert is created in PSOLIS.	106805

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	A description of the alert in a maximum of 50 alphanumeric characters.	01/01/1600	31/12/9999

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 for clients that are Active or have a referral, or during triage.

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

No Longer Applicable.
Superseded 1 July 2026.

Examples

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

Related national definition

N/A

Revision history

N/A

Alert Reviewed By

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

Permitted values

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the person who reviewed the alert.	01/01/1600	31/12/9999

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 for clients that are Active or have a referral, or during triage.

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

Examples

	Alert Reviewed By
A user reviews an alert	HE888880

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date	The full date including day, month and year of when an alert is reviewed. The time which is captured in hour minutes and seconds is automatically recorded as 00:00:0000000	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

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 for clients that are Active or have a referral, or during triage.

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

Alert reviewed date cannot be:

- prior to the alert start date.
- the same as the alert start date.
- cannot be after the current date (i.e. a future date).

Examples

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

Related national definition

N/A

Revision history

N/A

Alert Start Date

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

Permitted values

Permitted values	Definition	Start date	End date
Valid date	The full date including day, month and year of when an alert is initiated. The time which is captured in hour minutes and seconds is automatically recorded as 00:00:0000000.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

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 for clients that are Active or have a referral, or during triage.

Alert start date must be before the alert expiry date.

Examples

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

Related national definition

N/A

Revision history

N/A

Alert Type

Field name:	ALERT_TYPE_CODE
Source data element(s):	[Alert Type] – PSOLIS
Definition:	Identifies the category of the alert.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Description field name:	ALERT_TYPE
Description data type:	Numeric
Description format:	N

Permitted values

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
1	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.	01/01/1600	31/12/9999
2	Forensic	Any criminal conviction, CLMIDA issue, condition of bail or parole.	01/01/1600	31/12/9999
3	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.	01/01/1600	31/12/9999
4	Microbiological	Any infectious diseases or antibiotic resistance, e.g., to penicillin.	01/01/1600	31/12/9999
5	Other	Any other alert. May not necessarily be related directly to the client but is a risk to mental health staff.	01/01/1600	31/12/9999
6	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.	01/01/1600	31/12/9999

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 for clients that are Active or have a referral, or during triage.

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 1 July 2026.

8. Incidents

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

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

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	No	Incident does not appear as an alert on PSOLIS	01/01/1600	31/12/9999
1	Yes	Incident does appear as an alert on PSOLIS	01/01/1600	31/12/9999

Derivation logic

This field is derived using the following sequential logic:

[Alert Details] is present = 1

Include all records where [Alert Details] is present

[Alert Details] is not present = 0

Include all records where [Alert Details] is not present

Guide for use

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

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

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

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

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

Examples

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

Related national definition

N/A

No Longer Applicable. Superseded 1 July 2026.

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Incident Duration

Field name:	INCIDENT_DURATION
Source data element(s):	[Incident Duration] – PSOLIS
Definition:	The duration of the incident in days.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)

Permitted values

Permitted values	Definition	Start date	End date
Whole number	The number of days as a whole number to a maximum of 3 digits totalling the duration of the incident.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of days between the [Incident Start Date] and the [Incident End Date].

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds when the client incident concludes.	01/01/1600	31/12/9999

Guide for use

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

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Any of the valid codes as per Appendix E – Incident Locations	The up to 4 digit codes as per Appendix E – Incident Locations	01/01/1600	31/12/9999

Guide for use

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

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

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

Incidents can only be created for clients that are Active or have a Referral.

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	Additional information detailing the incident in a maximum of 500 alphanumeric characters.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

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

Incidents can only be created for clients that are Active or have a Referral.

Examples

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

Related national definition

N/A

Revision history

N/A

Incident Recurrence Risk

Field name:	INCIDENT_RECURRENCE_TYPE_CODE
Source data element(s):	[Incident Recurrence Risk] – PSOLIS
Definition:	The likelihood of a recurrence of the incident.
Requirement status:	Optional
Data type:	Numeric
Format:	N
Description field name:	INCIDENT_RECURRENCE_TYPE
Description data type:	String
Description format:	[X(150)]

Permitted values

Code	Description	Definition	Start date	End date
6	1 Rare	The event does not occur very often, and it has a very low probability of occurring again. Odds of 1 in 100,000 or more.	01/01/1600	31/12/9999
7	2 Unlikely	The event does not occur often and has a low chance of occurring again odds of 1 in 10,000 or more	01/01/1600	31/12/9999
8	3 Possible	The event can happen, but it is not certain or probable. Odds of 1 in 1,000 or more	01/01/1600	31/12/9999
9	4 Likely	The event happens often and has a high probability of occurring again odds of 1 in 100 or more	01/01/1600	31/12/9999
10	5 Very likely	The event happens very often and has a very high probably of occurring again odds of 1 in 10 or more	01/01/1600	31/12/9999
Null	Not Specified	No information reported	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Historical Values

Code	Description	Definition	Start date	End date
1	Remote Possibility of Recurrence	The event does not occur very often, and it has a very low probability of occurring again.	01/01/1600	03/01/2011
2	Unlikely to Reoccur	The event does not occur often and has a low chance of occurring again	01/01/1600	29/10/2010
3	Will Possibly Reoccur	The event can happen, but it is not certain or probable.	01/01/1600	21/02/2011

Code	Description	Definition	Start date	End date
4	Likely to Reoccur	The event happens often and has a high probability of occurring again	01/01/1600	19/02/2011
5	Almost Certain to Reoccur	The event happens very often and has a very high probably of occurring again	01/01/1600	19/02/2011

Guide for use

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable:
Superseded 1 July 2026.

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
Description field name:	INCIDENT_SEVERITY
Description data type:	String
Description format:	[X(150)]

No Longer Applicable: Superseded 1 July 2026

Permitted values

Code	Description	Definition	Start date	End date
4	1 Insignificant	• Increased level of care (minimal) • No increase in length of stay • Not disabling	01/01/1600	31/12/9999
1	2 Minor	• Increased level of care (minimal) • Increased length of stay (up to 72 hours) • Recovery without complication of permanent disability	01/01/1600	31/12/9999
2	3 Moderate	• Increased level of care (moderate) • Extended length of stay (72 hours to one week) • Recovery with significant complication or significant permanent disability	01/01/1600	31/12/9999
5	4 Major	• Increased level of care (significant) • Extended length of stay (greater than one week) • Significant complication and/or significant permanent disability	01/01/1600	31/12/9999
7	5 Catastrophic	• Death, permanent total disability • All sentinel events	01/01/1600	31/12/9999

Historical Values

Code	Description	Definition	Start date	End date
6	5- Extreme	• Death, permanent total disability	01/01/1600	22/02/2011

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.

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day month year hour minutes and seconds of when an incidence commenced.	01/01/1600	31/12/9999

Guide for use

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

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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
Description field name:	INCIDENT_TYPE
Description data type:	String
Description format:	[X(150)]

Permitted values

Code	Description	Definition	Start date	End date
1	Absconding	To leave without permission or notification	01/01/1600	31/12/9999
2	Assault of another person	A physical attack on another person	01/01/1600	31/12/9999
3	Assault of patient	A physical attack on another patient	01/01/1600	31/12/9999
4	Assault of staff	A physical attack on a member of staff	01/01/1600	31/12/9999
5	Attempted suicide	An attempt to cease one's life	01/01/1600	31/12/9999
6	Damage to property	Harm inflicted upon property as a result of the client's negligence or wilful destruction	01/01/1600	31/12/9999
7	Forensic – attempted escape	An attempt to leave the confinement of the forensic unit without consent or legal authority to do so.	01/01/1600	31/12/9999
8	Forensic – hostage	Taking a person against their will and removing that person's ability to leave in the forensic unit	01/01/1600	31/12/9999
9	Forensic – riot	Inciting or being a part of a violent disturbance of the peace in the forensic unit	01/01/1600	31/12/9999
10	Illegal activity	Performing an activity that contravenes laws	01/01/1600	31/12/9999
11	Medication incident	An event around medication that results in the order written by a medical practitioner not being followed.	01/01/1600	31/12/9999
12	Other	Any other incident not otherwise mentioned.	01/01/1600	31/12/9999
13	Patient injured	The client receives an injury	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026

Code	Description	Definition	Start date	End date
14	Seclusion	The client is removed from all interaction with others for a period of time	01/01/1600	31/12/9999
15	Self-harm	The client inflicts harm or injury to themselves	01/01/1600	31/12/9999
16	Serious medical incident	The client experiences a significate medical event that requires timely intervention.	01/01/1600	31/12/9999
17	Sexual assault	The client was subjected to unwanted behaviour of sexual nature that they did not consent to	01/01/1600	31/12/9999
18	Substance abuse	The client has overused a substance often at a dangerous level for a period of time and this use has caused social problems	01/01/1600	31/12/9999
19	Verbal abuse – others	The client has used words to assault, dominate, ridicule, manipulate, and/or degrade another person.	01/01/1600	31/12/9999
20	Verbal abuse – patients	The client has used words to assault, dominate, ridicule, manipulate, and/or degrade another patient.	01/01/1600	31/12/9999
21	Verbal abuse – staff	The client has used words to assault, dominate, ridicule, manipulate, and/or degrade a member of staff.	01/01/1600	31/12/9999
22	Seclusion with restraint	The client is removed from all interaction with others for a period of time with the use of restraints on them.	01/01/1600	31/12/9999
23	Restraint	The restriction of liberty or freedom of movement	01/01/1600	31/12/9999
24	Fall	The client moved from a higher to a lower level without control	01/01/1600	31/12/9999
25	Apprehension of baby	The removal of the baby or child from the client with custody and guardianship of that baby/child being transferred to another for an extended period of time	01/01/1600	31/12/9999
26	Removal of baby	A baby or child is removed from the clients care not at the clients request and or indirect opposition to the client's expressed wishes.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
Y	Yes	The incident has been blocked and is not visible to other PSOLIS users	01/01/1600	31/12/9999
N	No	The incident is open and can be viewed by other PSOLIS users- it is not blocked.	01/01/1600	31/12/9999

Derivation logic

This field is derived using the following sequential logic

[Record Blocked Flag] check box is selected = Y

Include all records where [Record Blocked Flag] check box is selected

[[Record Blocked Flag] check box is not selected = N

Include all records where [Record Blocked Flag] check box is not selected

Guide for use

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

9. Community mental health and service contacts

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

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

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number or 'webPAS'	The Health Employee number assigned to the person who performed the last recoded action.	01/01/1600	31/12/9999

Guide for use

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

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
As per ICD Schedule in use at time of activation, currently ICD-10-AM	A condition either coexisting with the principal diagnosis or arising during the episode of care, as represented by a code from the International Classification of Disease in use at the time.	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026

Guide for use

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

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

There are two additional diagnosis fields.

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	Not present	The client was present alone	01/01/1600	31/12/9999
1	Present	The client was not alone an associate was present	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Derivation logic

This field is derived using the following sequential logic:

[Associate Present Indicator] check box is selected = 1

Include all records where [Associated Present Indicator] check box is selected

[Associate Present Indicator] check box is not selected = 0

Include all records where [Associated Present Indicator] check box is not selected

Guide for use

An associate can be a person or organisation.

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

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

Examples

	Associate Present Indicator
A client attends a review alone.	0
A client attends a review accompanied by his sister.	1
A parent attends a review without the mental health client (their child who is receiving the MH care) being present	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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the case manager to whom the mental health client is allocated.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

This data element represents the HE number of that clinician.

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

Examples

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

Related national definition

N/A

Revision history

N/A

Client Present Indicator

Field name:	CLIENT_PRESENT_INDICATOR
Source data element(s):	[Client Present Indicator] – PSOLIS
Definition:	A flag indicating whether the client was present at the service event.
Requirement status:	Mandatory
Data type:	String
Format:	X

Permitted values

Code	Description	Definition	Start date	End date
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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999

Derivation logic

This field is derived using the following sequential logic

[Client Present Indicator] check box is selected = 1

Include all records where [Client Present Indicator] check box is selected

[Client Present Indicator] check box is not selected = 0

Include all records where [Client Present Indicator] check box is not selected

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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 attendee's tab in PSOLIS and the client present box on the items tab must be unchecked.

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

Examples

	Client Present Indicator
A mental health client attends a face-to-face appointment with a clinician for an assessment.	1
The treating team undertakes a clinical review just with other members of the team for a client who has been Active in the service for three months.	0
A clinician records a clinical record keeping service event item for a client.	0
A family meeting is provided with both the client and the client's carer present during the service event.	1

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month day hour minute and second format of when the client was deactivated from the community mental health service.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

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

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

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

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

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

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

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

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

The deactivation date must be later than the activation date.

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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)]
Description field name:	DEACTIVATION_OUTCOME
Description data type:	String
Description format:	[X(150)]

Permitted values

Code	Description	Definition	Start date	End date
1	Discharge/transfer to hospital	The client was discharged from current hospital or was transferred to another hospital	01/01/1600	31/12/9999
2	Discharge to home	The client was discharged home	01/01/1600	31/12/9999
3	Program transfer	The client was transferred to another program	01/01/1600	31/12/9999
15	Restructure	There was a restructure of programs resulting in the client being deactivated from the current program	01/01/1600	31/12/9999
16	Police MH	Client is discharged to	01/01/1600	31/12/9999
101	Treatment has been completed	No further treatment is required so client is deactivated	01/01/1600	31/12/9999
102	Client has moved to another area	Client has moved to another area and will be referred to a service closer to the new location	01/01/1600	31/12/9999
103	Referred to other service	The client was referred to another service for treatment	01/01/1600	31/12/9999
104	Other	Client is deactivated due to other reason not listed	01/01/1600	31/12/9999
105	Client stopped coming/did not attend	The client ceased attending appointments prior to discharge	01/01/1600	31/12/9999
106	Deceased	The client has died	01/01/1600	31/12/9999
107	One off assessment	A one-off assessment was conducted and no further care is required	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
Null	Null	No information recorded.	01/01/1600	31/12/9999

Guide for use

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

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

Examples

	Deactivation Outcome
The community mental health treating team decides a client no longer requires treatment and is deactivated from the program.	101
The client has moved interstate.	102
The client is deceased.	106
The client is still Active in the service.	
The client no longer requires service by the community mental health program and is referred to another community mental health service.	103
The community mental health program has been realigned to a different mental health organisation and the decision is made to deactivate clients in order to reactivate the client into the new mental health organisation.	15

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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
Field name:	DEACTIVATION_STATUS
Data type:	String
Format:	[X(150)

Permitted values

Code	Description	Definition	Start date	End date
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).	01/01/1600	31/12/9999
2	Discharged outright	This code is to be used when the client is deactivated or transferred from one service to the next.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
4	Discharge conditional	This code is to be used when the client is discharged with conditions attached.	01/01/1600	31/12/9999
5	S46 Transfer to authorised hospital	This code is to be used when the client is transferred to another authorised hospital.	01/01/1600	31/12/9999
6	Restructure	This code has been used for administrative purposes.	01/01/1600	31/12/9999
NULL	NULL	No information recorded.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

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.

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 1 July 2026.

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

Code	Description	Definition	Start date	End date
Y	Yes	A specific act or service provided to a patient that provides care or treatment and meets the specifications for reporting and can be counted as an occasion of service.	01/01/1600	31/12/9999
N	No	The service event item does not meet the specifications for reporting and cannot be counted as an occasion of service. A specific act or service provided to a patient but does not meet the specifications for reporting and cannot be counted as an occasion of service.	01/01/1600	31/12/9999
C	Conditional	A specific act or service provided to a patient that provides care or treatment and may meet the specifications for reporting if either the client or associate is identified as being present.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Derivation logic

This field is derived using the following sequential logic

Include all records where [Associated Present Indicator] = 1

[Admitted Voluntary Indicator] = 1 [Occasion of Service Code]=C

Include all records where [Client Present Indicator] =1

[Client Present Indicator] = 1[Occasion of Service Code]=C

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.

Occasions of service are based on the service event items. Service event items are the actual service activity/intervention delivered, such as counselling, assessment or travel.

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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)
Field name:	ESTABLISHMENT_MH_ORGANISATION
Data type:	String
Format:	[X(150)]

Permitted values

Permitted values	Definition	Start date	End date
Any of the valid codes as per Appendix F – Mental Health Organisation Codes	The max 4-digit codes as per Appendix F – Mental Health Organisation Codes	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

Planned Deactivation Date and Time

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

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The full date including day month and year of the planned deactivation date and time prior to the actual deactivation from the community mental health service. The time which is captured in hour minutes and seconds is automatically recorded as 00:00:0000000.	01/01/1600	31/12/9999

Guide for use

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026

Principal Diagnosis

Field name:	DIAGNOSIS_ADMISSION_PRINCIPAL
Source data element(s):	[Principal Diagnosis] – PSOLIS
Definition:	The diagnosis established to be chiefly responsible for an occasion of service or episode of care following clinical assessment.
Requirement status:	Conditional
Data type:	String
Format:	[ANN.NNNN]

Permitted values

Permitted values	Definition	Start date	End date
As per ICD Schedule in use at time of activation, currently ICD-10-AM	The diagnosis established after study to be chiefly responsible for occasioning an episode of care or an attendance at the health care establishment as represented by a code.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

Principal diagnosis must be:

- recorded at the time of admission or activation of the client.
- a valid code from the current edition of the International Statistical Classification of Diseases and Related Health Problems*, 10th revision, Australian modification (ICD-10-AM).*

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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)
Field name:	ESTABLISHMENT_MH_PROGRAM
Data type:	String
Format:	[X(150)

Permitted values

Permitted values	Definition	Start date	End date
Any of the valid codes as per Appendix G – Mental Health Program Codes	The 4-digit codes as per Appendix G – Mental Health Program Codes	01/01/1600	31/12/9999

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

PSOLIS Triage Outcome

Field name:	PSOLIS_TRIAGE_OUTCOME_CODE
Source data element(s):	[Triage Outcome] – PSOLIS
Definition:	Numeric identifier indicating the outcome of a triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Guide for Use

Refer to data element Triage Outcome for further information.

No Longer Applicable.
Superseded 1 July 2026.

PSOLIS Triage Severity

Field name:	PSOLIS_TRIAGE_SEVERITY_CODE
Source data element(s):	[Triage Urgency] – PSOLIS
Definition:	Numeric identifier indicating the urgency of the triage service event and recommended wait time for an assessment service event item.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)

Guide for Use

Refer to data element Triage Severity for further information.

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
H	Historical	Any record other than the most recent record	01/01/1600	31/12/9999
L	Latest	The most recent record in the clients record	01/01/1600	31/12/9999

Guide for use

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

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

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

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

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

Historical records are kept for data quality and assurance processes.

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026

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

Code	Description	Definition	Start date	End date
0	No	The service event item does not meet the specifications for reporting and does not need to be counted	01/01/1600	31/12/9999
1	Yes	The service event item does meet the specifications for reporting and will be counted	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

Service Contact Duration

Field name:	SERVICE_CONTACT_DURATION
Source data element(s):	[Service Contact Duration] – MIND
Definition:	Duration of the service contact in minutes.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)

Permitted values

Permitted values	Definition	Start date	End date
A whole number	Only the whole number for the total number of minutes of the combined reportable service event items that make up the service contact.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Derivation logic

This data element is derived by calculating the number of minutes between the [Service Contact Start Date and Time].and the [Service Contact End Date and Time].

Guide for use

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

Examples

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

Related national definition

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

Revision history

N/A

Service Contact End Date and Time

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

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month day hour minute and second format of when the service contact concluded.	01/01/1600	31/12/9999

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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)
Field name:	SERVICE_CONTACT_MEDIUM
Data type:	String
Format:	[X(150)]

Permitted values

Code	Description	Definition	Start date	End date
5	Face to face	The contact between the mental health practitioner and the client occurs when they are physically in the same room	01/01/1600	31/12/9999
6	By phone	The contact between the mental health practitioner and the client occurs over a telephone call	01/01/1600	31/12/9999
7	By video link	The contact between the mental health practitioner and the client occurs over a video link up.	01/01/1600	31/12/9999
8	Not applicable	Assigning a medium is not applicable	01/01/1600	31/12/9999
9	Email	The contact between the mental health practitioner and the client occurs in emails	01/01/1600	31/12/9999
10	Other electronic	The contact between the mental health practitioner and the client occurs over another electronic medium not listed	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026:

Historical Values

Code	Description	Definition	Start date	End date
1	Face to face	The contact between the mental health practitioner and the client occurs when they are physically in the same room	01/01/1600	22/05/2007
2	By phone	The contact between the mental health practitioner and the client occurs over a telephone call	01/01/1600	22/05/2007
3	By video link	The contact between the mental health practitioner and the client occurs over a video link up	01/01/1600	22/05/2007

Code	Description	Definition	Start date	End date
4	Not applicable	Assigning a medium is not applicable	01/01/1600	22/05/2007

Guide for use

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	Not reportable	The service event item does not meet the specifications to be reported and does not make up part of a service contact	01/01/1600	31/12/9999
1	Reportable	The service event item meets the specifications to be reported and makes up part of a service contact	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Service Contact Session Type

Field name:	SERVICE_CONTACT_SESSION_TYPE_CODE
Source data element(s):	[Service Contact Session Type] – MIND
Definition:	Flag to identify whether a service contact was an individual or group session.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
0	Individual	The session type that the contact occurred in was between only one client and the mental health practitioners	01/01/1600	31/12/9999
1	Group	The session type that the contact occurred in was between more than one client and the mental health practitioners	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

Service Contact Start Date and Time

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

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year, month, day, hour, minute and second format of when the service contact commenced.	01/01/1600	31/12/9999

Guide for use

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

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

Examples

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

Related national definition

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

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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
Field name:	SERVICE_EVENT_CATEGORY
Data type:	String
Format:	[X(150)

Permitted values

Code	Description	Definition	Start date	End date
1	Triage	For recorded triage events using the Triage Module.	01/01/1600	31/12/9999
2	Pre-admission	When the service event commenced, the client was not Active in the community mental health program providing the service event.	01/01/1600	31/12/9999
3	Active	At the commencement of the service event, the client was Active in the community mental health program.	01/01/1600	31/12/9999
4	Post discharge	The service event was provided after the client was deactivated from the community mental health program.	01/01/1600	31/12/9999
5	Staff only	Service events that do not include mental health clients.	01/01/1600	31/12/9999
6	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.	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026.

Guide for use

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

A service event can have one or many items.

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

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

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

Examples

	Service Event Category
A triage service event is recorded for a client when they telephone a mental health clinic for information only, and no further action is required.	1 – Triage
A client is referred to a community mental health program and attends a service for an initial assessment.	2 – Preadmission
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 1 July 2026.

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

Permitted values	Definition	Start date	End date
Unique numeric identifier	System generated unique number that is a maximum of 8 digits long that is assigned to each service event record as a means of unique identification	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

A service event can have one or many items.

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

Examples

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

Related national definition

N/A

Revision history

N/A

Service Event Item

Field name:	SERVICE_EVENT_ITEM_CODE
Source data element(s):	[Service Event Item] – PSOLIS
Definition:	A code that represents the service event item(s) delivered to the mental health client at the service event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNN

Permitted values

Permitted values	Definition	Start date	End date
Any of the valid codes as per Appendix A – Service Event Item Codes	The 3-digit codes as per Appendix A – Service Event Item Codes	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

A service event can have one or many items.

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

Examples

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

Related national definition

N/A

Revision history

N/A

Service Event Item End Date and Time

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

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month, day, hour, minute and second format of when the service event item ended.	01/01/1600	31/12/9999

Guide for use

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

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

A service event can have one or many items.

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Unique numeric identifier	System generated unique number that is a maximum of 8 digits long that is assigned to each service event item recorded as a means of unique identification	01/01/1600	31/12/9999

Guide for use

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

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

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

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

A service event can have one or many items.

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

Examples

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

No Longer Applicable.
Superseded 1 July 2026.

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 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month day hour minute and second format of when the service event item commenced.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

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

A service event can have one or many items.

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Staff Full Name

Field name:	STAFF_FULL_NAME
Source data element(s):	[Staff Full Name] – PSOLIS
Definition:	The name of the staff member with PSOLIS access.
Requirement status:	Mandatory
Data type:	String
Format:	X[X(149)]

Permitted values

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the Staff member with PSOLIS access to a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the clinician with PSOLIS access.	01/01/1600	31/12/9999

Guide for use

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Staff User ID

Field name:	STAFF_USERID
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

Permitted values	Definition	Start date	End date
Unique numeric identifier	System generated unique number that is a maximum of 8 digits long that is assigned to each PSOLIS user as a means of unique identification	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

Examples

	Staff User ID
Staff member Joe Citizen, HE888880, logs in to PSOLIS.	10423362

Related national definition

N/A

Revision history

N/A

Stream

Field name:	establishment_mh_stream
Source Data Element(s):	[Stream] – PSOLIS
Definition:	The specialised mental health program providing care to the client.
Requirement status:	Conditional
Data type:	String
Format:	X(150)
Permitted values:	As per Appendix B – Stream codes

Guide for use

Collection of this data element is conditional – stream must be collected if the client is activated.

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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
Field name:	ESTABLISHMENT_MH_STREAM
Data type:	String
Format:	[X(150)]

Permitted values

Permitted values	Definition	Start date	End date
Any of the valid codes as per Appendix B – Stream Codes	The 3-digit codes as per Appendix B – Stream Codes	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – stream code must be collected if the client is activated.

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

Examples

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

Related national definition

N/A

Revision history

N/A

No Longer Applicable: Superseded 1 July 2026

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
Field name:	ESTABLISHMENT_MH_STREAM_TYPE
Data type:	String
Format:	[X9150)

Permitted values

Code	Description	Definition	Start date	End date
1	Child and adolescent	Contains programs for people aged 0 – 17 years	01/01/1600	31/12/9999
2	Adult	Contains programs for people aged 18 – 64 years	01/01/1600	31/12/9999
3	Elderly	Contains programs for people aged 65 years and over	01/01/1600	31/12/9999
4	PET (Psychiatric Emergency Team)	Contains programs for people experiencing an acute psychiatric emergency	01/01/1600	31/12/9999
5	SARC (Sexual Assault Resource Centre)	Contains programs for people requiring assistance from the SARC	01/01/1600	31/12/9999
6	Youthlink	Contains programs for people considered to be youth, this can include people in teenage years through to young adults.	01/01/1600	31/12/9999

No Longer Applicable:
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – stream type must be collected if the client is activated.

This data element represents the stream type of the specialised mental health programs providing care to the mental health client.

Mental health services are defined by the broad age groups of clients they service. These groupings are Child & Adolescent (ages 0 – 17), Adult/General (ages 18 – 64), and Older Adult (ages 65 and over).

The services provided are not defined or restricted by the actual age of a client. For example, a client who is 60 years of age may be serviced by the Older Adult stream type.

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

Examples

	Stream Type
A client is activated into a community outpatient program applicable to adults.	2 – Adult

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Triage Outcome

Field name:	TRIAGE_OUTCOME_CODE
Source data element(s):	[Triage Outcome] – webPSOLIS
Definition:	Numeric identifier indicating the outcome of a triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Description field name:	TRIAGE_OUTCOME
Description data type:	String
Description format:	[X(150)

Permitted values

Code	Description	Definition	Start date	End date
1	To be admitted to service	Following completion of the triage the consumer is to be admitted to the service	01/01/1600	31/12/9999
2	Referred on	Following completion of the triage the consumer is to be referred to another MHS	01/01/1600	31/12/9999
3	No further action	Following completion of triage no further action is required	01/01/1600	31/12/9999
4	Information only	The contact was made with the service for information only	01/01/1600	31/12/9999
5	Placed to waitlist	Following completion of triage the consumer is placed on waitlist for further intervention	01/01/1600	31/12/9999
6	Community visit initiated	Following completion of triage a community visit is initiated for the consumer	01/01/1600	31/12/9999
8	Referred to clinical intake	Following completion of the triage the consumer is referred to clinical intake	01/01/1600	31/12/9999
9	Unable to complete	The triage was not able to be completed	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Derivation logic

This field is derived using the following sequential logic

[Triage outcome] = [PSOLIS triage outcome]

Include all unassigned records where [PSOLIS triage outcome code] is not NULL

[Triage outcome] = [WebPSOLIS triage outcome]

Include all unassigned records where [WebPSOLIS triage outcome code] is not NULL

Guide for use

Triage outcome indicates if there is a need for additional clinical intervention, and whether a Referral to community or inpatient mental health services will be progressed.

Examples

	Triage Outcome
A consumer presents to a clinic with a triage presenting problem of experiencing disturbed thoughts. It is determined the consumer should be referred to community mental health services for further assessment within two days.	8 – Referred to clinical intake
A consumer presents to an emergency department with a triage presenting problem of intentional self-harm. It is determined the consumer should be immediately admitted to hospital.	1 – To be admitted to service
A consumer telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services.	3 – No further action

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Triage Presenting Complaint

Field name:	TRIAGE_PRESENTING_COMPLAINT
Source data element(s):	[Triage Presenting Complaint] – webPSOLIS
Definition:	Describes the consumer's presenting problem at triage.
Requirement status:	Mandatory
Data type:	String
Format:	[X(150)

Permitted values

Permitted values	Definition	Start date	End date
Any of the valid descriptor names as per Appendix C – Triage Presenting Complaint and Referral Presenting Problem Codes	The valid descriptor names as per Appendix C – Triage Presenting Complaint and Referral Presenting Problem Codes	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

This data element is used to indicate the consumer's principal presenting problem at triage, for example: risk of harm to self, depressed mood and existing mental illness. Provides the basis from which the triage severity identifier is determined.

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

Examples

	Triage Presenting Problem
A consumer presents to a clinic with a problem of experiencing disturbed thoughts. It is determined the client should be referred to community mental health services for further assessment within two days.	Disturbed thoughts, delusions etc. (14)
A consumer presents to an ED with a problem of intentional self-harm. It is determined that the client should immediately be admitted to hospital.	Deliberate self-harm (35)

Related national definition

N/A

Revision history

N/A

Triage Presenting Complaint Code

Field name:	TRIAGE_PRESENTING_COMPLAINT_CODE
Source data element(s):	[Triage Presenting Complaint Code] – webPSOLIS
Definition:	Numeric identifier indicating the consumer's presenting problem at triage.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(4)

Permitted values

Permitted values	Definition	Start date	End date
Any of the valid codes as per Appendix C – Triage Presenting Complaint and Referral Presenting Problem Codes	The 4-digit codes as per Appendix C – Triage Presenting Complaint and Referral Presenting Problem Codes.	01/01/1600	31/12/9999

Guide for use

This data element is used to indicate the consumer's principal presenting problem at triage, for example: risk of harm to self, depressed mood and existing mental illness. Provides the basis from which the triage severity identifier is determined.

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

Examples

	Triage Presenting Problem
A consumer 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

No Longer Applicable. Superseded 1 July 2026.

Triage severity

Field name:	TRIAGE_SEVERITY_CODE
Source data element(s):	[Triage Urgency] – webPSOLIS and [Triage Urgency]-PSOLIS
Definition:	Numeric identifier indicating the urgency of the triage service event and recommended wait time for an assessment service event item.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Description field name:	TRIAGE_SEVERITY
Description data type:	String
Description format:	[X(150)

Permitted values

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
9	A. Immediate	Extreme urgency; immediate response requiring police/ambulance or other service (e.g., overdose, siege, imminent violence).	01/01/1600	31/12/9999
10	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).	01/01/1600	31/12/9999
11	C. Within 12 hours	Medium urgency; see within 12 hours (e.g., distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).	01/01/1600	31/12/9999
12	D. Within 48 hours	Low urgency; see within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).	01/01/1600	31/12/9999
13	E. Within 2 weeks	Non-urgent; see within 2 weeks.	01/01/1600	31/12/9999
14	F. Requires further triage contact/follow up	Further contact or follow up required.	01/01/1600	31/12/9999
15	G. No further action	Requires no further action.	01/01/1600	31/12/9999

Historical Values

Code	Description	Definition	Start date	End date
1	Emergency	Extreme urgency; immediate response requiring police/ambulance or other service (e.g., overdose, siege, imminent violence).	01/01/1600	29/09/2021
2	Urgent	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).	01/01/1600	29/09/2021
3	Routine	Low urgency: see within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).	01/01/1600	29/09/2021
4	Level 1 - Immediate	Extreme urgency; immediate response requiring police/ambulance or other service (e.g., overdose, siege, imminent violence)	01/01/1600	29/09/2021
5	Level 2 – Rapid (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)	01/01/1600	29/09/2021
6	Level 3 – Prompt (Within 8 Hours)	Medium urgency; see within 12 hours (e.g., distressed, suicidal ideation of moderate to severe nature, disturbed behaviour)	01/01/1600	29/09/2021
7	Level 4 – Timely (Within 2 Days)	Low urgency; see within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).	01/01/1600	29/09/2021
8	Level 5 – Standard (Within 1 Week)	Non-urgent; see within 1 week.	01/01/1600	29/09/2021
9	Immediate	Extreme urgency; immediate response requiring police/ambulance or other service (e.g., overdose, siege, imminent violence).	01/01/1600	29/09/2021
10	Within 2 Hours	High urgency; see within 2 hours	01/01/1600	29/09/2021

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		or present to Psychiatric Emergency Service or emergency department in general hospital (e.g., acute suicidality, threatening violence, acute severe non-recurrent stress).		
11	Within 12 Hours	Medium urgency; see within 12 hours (e.g., distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).	01/01/1600	29/09/2021
12	Within 48 Hours	Low urgency; see within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).	01/01/1600	29/09/2021
13	Within 2 Weeks	Non-urgent; see within 2 weeks.	01/01/1600	29/09/2021
14	Requires Further Triage Contact/ Follow Up	Further contact or follow up required.	01/01/1600	29/09/2021
15	No Further Action	Requires no further action.	01/01/1600	29/09/2021

No Longer Applicable.
Superseded 1 July 2026.

Derivation logic

This field is derived using the following sequential logic

[Triage severity] = [PSOLIS triage severity]

Include all unassigned records where [PSOLIS triage severity] is not NULL

[Triage severity] = [WebPSOLIS triage severity]

Include all unassigned records where [WebPSOLIS triage severity] is not NULL

Guide for use

Mental health consumers are triaged into one of seven categories on the selected triage scale.

The category assigned is dependent on the triaging clinician's response to this question: *This patient should wait for medical care no longer than...?*

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

If the triage severity category assigned to the consumer changes, the most urgent category is recorded.

Examples

	Triage Severity
A consumer presents to a clinic with a problem of experiencing disturbed thoughts. It is determined the consumer should be referred to community mental health services for further assessment within two days.	12 – D. Within 48 hours
A consumer presents to an emergency department with a triage presenting problem of intentional self-harm. It is	9 – A. Immediate

determined that the consumer should be immediately admitted to hospital.	
A consumer telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services.	15 – G. No further action
A consumer telephones a clinic, and the triage presenting problem concerns family problems. It is determined that a community visit should be undertaken within 12 hours.	11 – C. Within 12 hours

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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)
Field name:	VENUE
Data type:	String
Format:	[X(150)

Permitted values

Code	Description	Definition	Start date	End date
1	Clinic	A department where outpatients receive psychiatric care or advice	01/01/1600	31/12/9999
2	Community centre	A public building where members of a neighbourhood or community can meet	01/01/1600	31/12/9999
3	Court	A building where legal proceedings are held	01/01/1600	31/12/9999
4	Education facility	A building or place used for education	01/01/1600	31/12/9999
5	Emergency department	A specialist multidisciplinary unit specifically designed and staffed to provide 24-hour emergency care.	01/01/1600	31/12/9999
6	Entertainment venue	A publicly or privately owned place that holds live entertainment events where the entertainment events are presented for a price of admission.	01/01/1600	31/12/9999
7	General hospital	A non-specialised hospital treating patients with all types of medical conditions	01/01/1600	31/12/9999
8	GP surgery	A location where a general practitioner regularly sees patients.	01/01/1600	31/12/9999
9	Group home	A home where a small number of unrelated people live together while they are in need of care, support or supervision	01/01/1600	31/12/9999
10	Home/private dwelling	A residential address where people reside	01/01/1600	31/12/9999
11	Hostel	An establishment that provides inexpensive lodging for a specific group of people	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
12	Inhouse school	At a school within the hospital	01/01/1600	31/12/9999
13	Lock up	A place where police can incarcerate people for a limited period of time prior to legal proceedings taking place.	01/01/1600	31/12/9999
14	Nursing home	A private institution providing residential accommodation with healthcare, especially for elderly people	01/01/1600	31/12/9999
15	Police station	A building which serves to accommodate police officers and other members of police staff	01/01/1600	31/12/9999
16	Prison	A building in which people are legally held as a punishment for a crime they have committed or while awaiting trial:	01/01/1600	31/12/9999
17	Psychiatric hospital	An establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.	01/01/1600	31/12/9999
18	Public space	A social space that is generally open and accessible to members of the public	01/01/1600	31/12/9999
19	Rehab centre	Location that provides specialised services to assist people to recover and improve their lives following illness or injury	01/01/1600	31/12/9999
20	Other government organisation	Another government organisation not listed	01/01/1600	31/12/9999
21	General hospital outpatient clinic	A department in a hospital where outpatients receive care or advice	01/01/1600	31/12/9999
22	Neonatal intensive care unit	A department in a hospital specifically designed and staffed to provide care.to newborn babies	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

This identifier is used to represent the venue where the service event item took place, such as psychiatric hospital, nursing home or clinic.

This data element is useful for determining additional activity characteristics such as client liaison activity within hospitals.

Examples

	Venue
A clinician records a service event item for travel time taken to a home visit.	10 – Home/private dwelling
A mental health client attends an assessment in a mental health clinic.	1 - Clinic

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

WEBPSOLIS Triage Outcome

Field name:	WEBPSOLIS_TRIAGE_OUTCOME_CODE
Source data element(s):	[Triage Outcome] – WEBPSOLIS
Definition:	Numeric identifier indicating the outcome of a triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Guide for Use

Refer to data element Triage Outcome for further information.

No Longer Applicable.
Superseded 1 July 2026.

WEBPSOLIS Triage Severity

Field name:	WEBPSOLIS_TRIAGE_SEVERITY_CODE
Source data element(s):	[Triage Urgency] – WEBPSOLIS
Definition:	Numeric identifier indicating the urgency of the triage service event and recommended wait time for an assessment service event item.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)

Guide for Use

Refer to data element Triage Severity for further information.

No Longer Applicable.
Superseded 1 July 2026.

10. NOCC and AMHCC clinical measures

The following section provides specific information about the National Outcomes and Casemix Collection (NOCC) and Australian Mental Health Care Classification (AMHCC) clinical measures data elements captured in the MHDC, including definitions, permitted values, guide for use, rules and operational examples.

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

No Longer Applicable.
Superseded 1 July 2026.

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]
Field name:	ASSESSMENT_SCALE
Data type:	String
Format:	[X(150)

Permitted values

Code	Description	Definition	Start date	End date
1	HoNOSCA	Health of the Nation Outcome Scale Child Adolescent 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.	01/01/1600	31/12/9999
2	CGAS	Childrens Global Assessment Scale 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.	01/01/1600	31/12/9999
3	FIHS	Factors Influencing Health Status 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	01/01/1600	31/12/9999
4	HoNOS	Health of the Nation Outcome Scale 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	01/01/1600	31/12/9999
5	LSP–16	Life Skills Profile Score (LSP-16)	01/01/1600	31/12/9999

No Longer Applicable: Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		Level of difficulty with activities in a life area		
6	MHI	Mental Health Inventory A 38-item measure of psychological distress and well-being	01/01/1600	31/12/9999
7	HoNOS 65+	Health of the Nation Outcome Scales 65+ (HoNOS 65+) 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.	01/01/1600	31/12/9999
8	RUG–ADL	Resource Utilisation Groups–Activities of Daily Living (RUG-ADL) Score An assessment of patient motor function	01/01/1600	31/12/9999
9	KESSLER 10+	Kessler (K10+) The level of psychological distress experienced by a person in the four weeks prior to interview, containing 4 extra questions to the standard (K10) as represented by a code	01/01/1600	31/12/9999
10	KESSLER 10	Kessler (K10) The level of psychological distress experienced by a person in the four weeks prior to interview, as represented by a code	01/01/1600	31/12/9999
11	SDQ PC1	Strengths and Difficulties Questionnaire SDQ Parent Report Baseline 4–10 years	01/01/1600	31/12/9999
12	SDQ PC2	Strengths and Difficulties Questionnaire SDQ Parent Follow-up 4–10 years	01/01/1600	31/12/9999
13	SDQ PY1	Strengths and Difficulties Questionnaire SDQ Parent Report Baseline 11–17 years	01/01/1600	31/12/9999
14	SDQ PY2	Strengths and Difficulties Questionnaire SDQ Parent Follow-up 11–17 years	01/01/1600	31/12/9999
15	SDQ YR1	Strengths and Difficulties Questionnaire SDQ Self-report Baseline 11–17 years	01/01/1600	31/12/9999
16	SDQ YR2	Strengths and Difficulties Questionnaire SDQ Self-report Follow Up 11–17 years	01/01/1600	31/12/9999
17	SDQ TC1	Strengths and Difficulties Questionnaire SDQ Teacher Report Measure for children aged 4–10 on initial contact with service	01/01/1600	31/12/9999
19	SDQ TY1	Strengths and Difficulties Questionnaire SDQ Teacher report measure for youth	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		aged 11–17 on initial contact with service		
20	SDQ TY2	Strengths and Difficulties Questionnaire SDQ Teacher report measure for youth aged 11–17 on follow up contact with service	01/01/1600	31/12/9999
21	NOCC CLEARANCE	An action to complete NOCC assessment requirements	01/01/1600	31/12/9999

Historical

Code	Description	Definition	Start date	End date
18	SDQ TC2	Strengths and Difficulties Questionnaire SDQ Teacher Report Measure for Children and Adolescents aged 04-10 on follow up	01/01/1600	02/2022

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Assessment scale is the numerical code that represents the NOCC outcome measure used to assess the client's current health status at the collection occasion.

The NOCC protocol determines which instrument or measure is required, based on the setting, collection reason and stream (age group) of the mental health service program.

For more details on NOCC assessment scales refer to the Australian Mental Health Outcomes and Classification Network (AMHOCN) website.

Examples

	Assessment Scale
A client is activated and undergoes an HoNOS 65+ assessment	7 – HoNOS 65+
A client is activated and undergoes a CGAS assessment	2 – CGAS

Related national definition

N/A

Revision history

N/A

Assessment Scale Version

Field name:	ASSESSMENT_SCALE_VERSION
Source data element(s):	[Assessment Scale Version] – PSOLIS
Definition:	The version of the NOCC instrument which has been used with the client, as represented by a code.
Requirement status:	Mandatory
Data type:	String
Format:	XX[XXX]

Permitted values

Code	Description	Definition	Start date	End date
01 – CGAS	CGAS	As described in Schaffer et al (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.	01/01/1600	31/12/9999
01 – FIHS	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.	01/01/1600	31/12/9999
A1 – HoNOS	HoNOS	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.	01/01/1600	31/12/9999
01 – HoNOSCA	HoNOSCA	As described in Gowers et al (1999) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433.	01/01/1600	31/12/9999
G1 – HoNOS 65+	HoNOS 65+	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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
01 – LSP–	LSP–16	As described in Buckingham et al	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
16		(1998) *Developing a Casemix Classification for Mental Health Services Volume 2: Resource Materials,* Canberra: Commonwealth Department of Health and Family Services.		
01 – RUG–ADL	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.	01/01/1600	31/12/9999
PC101	SDQ Parent Report Baseline 4-10 years	Parent Report Measure 4-10 yrs., Baseline version, Australian Version 1	01/01/1600	31/12/9999
PC201	SDQ Parent Follow-up 4-10 years	Parent Report Measure 4-10 yrs., Follow Up version, Australian Version 1	01/01/1600	31/12/9999
PY101	SDQ Parent Report Baseline 11-17 years	Parent Report Measure 11-17 yrs., Baseline version, Australian Version 1	01/01/1600	31/12/9999
PY201	SDQ Parent Follow-up 11-17 years	Parent Report Measure 11-17 yrs., Follow Up version, Australian Version 1	01/01/1600	31/12/9999
YR101	SDQ Self-report Baseline 11-17 years	Self-report Version, 11-17 yrs., Baseline version, Australian Version 1	01/01/1600	31/12/9999
YR201	SDQ Self-report Follow Up 11-17 years	Self-report Version, 11-17 yrs., Follow Up version, Australian Version 1	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

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

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 1 July 2026.

Children's Global Assessment Scale (CGAS)

Field name:	CGAS_SCORE
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

Code/Score	Description/Definition	Start date	End date
091 to 100:	Superior functioning	01/01/1600	31/12/9999
081 to 090:	Good functioning in all areas	01/01/1600	31/12/9999
071 to 080:	No more than slight impairments in functioning	01/01/1600	31/12/9999
061 to 070:	Some difficulty in a single area but generally functioning pretty well	01/01/1600	31/12/9999
051 to 060:	Variable functioning with sporadic difficulties or symptoms in several but not all social areas	01/01/1600	31/12/9999
041 to 050:	Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area	01/01/1600	31/12/9999
031 to 040:	Major impairment of functioning in several areas and unable to function in one of these areas	01/01/1600	31/12/9999
021 to 030:	Unable to function in almost all areas	01/01/1600	31/12/9999
011 to 020:	Needs considerable supervision	01/01/1600	31/12/9999
001 to 010:	Needs constant supervision	01/01/1600	31/12/9999
997:	Unable to rate	01/01/1600	31/12/9999
998:	Not Applicable	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – CGAS is only required for the child and adolescent stream type when the collection occasion is admission or review.

A valid CGAS measure must have one valid score recorded (Score: 1 - 100).

Clinicians assign a score, with 1 representing the most functionally impaired child, and 100 the highest functioning.

AMHOCN provides a guide to CGAS score ranges which indicates the type of service a client would usually receive services from:

- 01 to 29 – specialist inpatient services or equivalent level of dependency

- 30 to 69 – specialist mental health services; ambulatory mental health care
- 70 to 100 – primary health care services; general practitioner; school counsellors

For more details on rating clients, refer to the CGAS section on the AMHOCN website.

Examples

	CGAS
A 12-year-old is admitted as an ambulatory mental health client.	Collected
A 15-year-old ambulatory mental health client is reviewed.	Collected

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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]
Field name:	COLLECTION_OCCASION
Data type:	String
Format:	[X(150)

Permitted values

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
1	Referral	A request for a client to receive a review or treatment from a mental health professional	01/01/1600	31/12/9999
2	Activation	• New Referral • Transfer from other treatment setting of the same MH service • Activation – other	01/01/1600	31/12/9999
3	Admission (inpatient only)	The client is activated in PSOLIS following an inpatient admission for mental health care	01/01/1600	31/12/9999
4	Review (inpatient only)	A patient currently admitted to a hospital • 3-month review • Review – MHPoC change • Review – other	01/01/1600	31/12/9999
5	Deactivation	• Discharge – other • Death • Transfer to other treatment setting of the same MH service • No further care • Planned deactivation	01/01/1600	31/12/9999
6	Discharge (inpatient only)	The client is deactivated in PSOLIS following competition of an inpatient admission for	01/01/1600	31/12/9999

Code	Description	Definition	Start date	End date
		mental health care		
7	Review	• 3-month review • Review – MHPoC change • Review – other	01/01/1600	31/12/9999
8	Referral (inpatient only)	A request for a patient currently admitted in a hospital to receive a review or treatment from a mental health professional.	01/01/1600	31/12/9999
9	Reverse deactivation	The patient is reactivated in PSOLIS following a recent deactivation of the same condition	01/01/1600	31/12/9999
10	Reverse discharge (inpatient only)	The patient is reactivated in PSOLIS following a recent inpatient discharge for the same condition	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Collection occasion relates to a range of key events that may occur within the context of an episode of mental health care and indicates whether the occasion where the client has a NOCC collected is related to an admission to, review or discharge from an inpatient, community residential or ambulatory care setting.

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

Collection occasion is system driven (i.e. not selected by the user within PSOLIS) and is derived from the collection reason. In the community mental health setting these are:

The exception is when the collection reason selected is 'planned deactivation'. The selection of this reason allows for completion of the NOCC prior to the assessment episode ending. This is considered a review (collection occasion) until the client is deactivated (within seven days of the NOCC collection).

Once deactivation is performed the collection occasion will be converted to discharge. If the deactivation does not occur within seven days of collection the collection occasion will remain as review.

Examples

	Collection Occasion
A client is activated into a MH youth outpatient program, and a NOCC assessment is collected	2 - Activation

Related national definition

N/A

Revision history

N/A

Collection Occasion Date

Field name:	ASSESSMENT_COLLECTION_DATE
Source data element(s):	[Collection Occasion Date] – PSOLIS
Definition:	The reference date for all data collected at any given collection occasion, defined as the date on which the collection occasion (activation, review, deactivation) occurred.
Requirement status:	Mandatory
Data type:	Datetime
Format:	DDMMYYYY

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month day hour minute and second format for 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.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

The collection occasion date should be distinguished from the actual date of completion of individual measures that are required at the specific occasion.

In practice, various measures may be completed by clinicians and clients over several days. For example, a clinician might complete a HoNOS and LSP during a review on the scheduled date, but to include client responses to the self-report measure they would most likely have asked the client to complete the measure at their last contact with them.

For national reporting and statistical purposes, a single date is required which ties all the standardised measures and other data items together in a single collection occasion.

Examples

	Collection Occasion Date
A client is activated into a MH program and attends a review on 01/08/2020 where three assessments are collected: HoNOS, Kessler 10+ and LSP-16. All three of these measures share the same assessment collection date.	01082020

Related national definition

N/A

Revision history

N/A

Collection Occasion Identifier

Field name:	NOCC_COLLECTION_OCCASION_IDENTIFIER
Source data element(s):	[Collection Occasion Identifier] – PSOLIS
Definition:	A unique identifier for each assessment collection occasion in a NOCC episode.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(8)

Permitted values

Permitted values	Definition	Start date	End date
Unique numeric identifier	System generated unique number that is a maximum of 8 digits long that is assigned to each assessment collection occasion in a NOCC episode.as a means of unique identification	01/01/1600	31/12/9999

Guide for use

This is a system generated identifier for every individual NOCC collection occasion.

The ID is used to identify and group all the individual NOCC assessment measures collected at the same occasion (activation, review or deactivation).

Examples

	Collection Occasion Identifier
A client is activated into a MH youth outpatient program and attends a review on 01/08/2020 where three NOCC assessments are collected: HoNOS, Kessler 10+ and LSP-16. All three of these measures share the same assessment collection date.	20008581

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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
Field name:	COLLECTION_OCCASION_REASON
Data type:	Numeric
Format:	NN

Permitted values

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
1	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.	01/01/1600	31/12/9999
2	ADMITTED 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.	01/01/1600	31/12/9999
3	ADMISSION OTHER	Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.	01/01/1600	31/12/9999
4	3 MONTH REVIEW	Standard review conducted at 91 days following admission to the current episode of mental health care or 91 days subsequent to the preceding review.	01/01/1600	31/12/9999
5	REVIEW – OTHER	Standard review conducted for reasons other than the above.	01/01/1600	31/12/9999
6	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.	01/01/1600	31/12/9999
7	DISCHARGE TO CHANGE OF	Transfer of care between an inpatient, community residential or	01/01/1600	31/12/9999

Code	Description	Definition	Start date	End date
	TREATMENT SETTING	ambulatory setting of a consumer currently under the care of the mental health service.		
8	DEATH	Completion of an episode of mental health care following the death of the client.	01/01/1600	31/12/9999
9	DISCHARGE – OTHER	Discharge from an inpatient, community residential or ambulatory episode of mental health care for any reason other than defined above.	01/01/1600	31/12/9999
10	ADMITTED 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.	01/01/1600	31/12/9999
11	ADMISSION OTHER	Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.	01/01/1600	31/12/9999
12	NO FURTHER CARE	Discharge from an inpatient, community residential or ambulatory episode of care of a consumer for whom no further care is planned by the mental health service.	01/01/1600	31/12/9999
13	DISCHARGE 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.	01/01/1600	31/12/9999
14	DEATH	Completion of an episode of mental health care following the death of the client.	01/01/1600	31/12/9999
15	DISCHARGE – OTHER	Discharge from an inpatient, community residential or ambulatory episode of mental health care for any reason other than defined above.	01/01/1600	31/12/9999
16	3 MONTH REVIEW	Standard review conducted at 91 days following admission to the current episode of mental health care or 91 days subsequent to the preceding review.	01/01/1600	31/12/9999
17	REVIEW – OTHER	Standard review conducted for reasons other than the above.	01/01/1600	31/12/9999
18	NEW REFERRAL	Admission to a new inpatient, community residential or	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		ambulatory episode of mental health care of a consumer not currently under the Active care of the mental health service.		
19	NEW REFERRAL	Admission to a new inpatient, community residential or ambulatory episode of mental health care of a consumer not currently under the Active care of the mental health service.	01/01/1600	31/12/9999
20	REVERSE DEACTIVATION	Reversal of a client deactivation.	01/01/1600	31/12/9999
21	REVERSE DISCHARGE	Reversal of a client discharge.	01/01/1600	31/12/9999
22	PLANNED DEACTIVATION	The planned deactivation of a client.	01/01/1600	31/12/9999
23	PLANNED DISCHARGE	The planned discharge of a client.	01/01/1600	31/12/9999
29	REVIEW – MHPoC CHANGE	Review due to change in the mental health phase of care.	01/01/1600	31/12/9999
30	REVIEW – MHPoC CHANGE	Review due to change in the mental health phase of care.	01/01/1600	31/12/9999
31	TRANSFER FROM OTHER TREATMENT SETTING OF THE SAME MENTAL HEALTH SERVICE ORGANISATION	Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the Active care of the mental health service.	01/01/1600	31/12/9999
32	TRANSFER FROM OTHER TREATMENT SETTING OF THE SAME MENTAL HEALTH SERVICE ORGANISATION	Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the Active care of the mental health service.	01/01/1600	31/12/9999
33	TRANSFER TO OTHER TREATMENT SETTING OF THE SAME MENTAL HEALTH SERVICE ORGANISATION	Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the care of the mental health service.	01/01/1600	31/12/9999
34	TRANSFER TO OTHER TREATMENT SETTING OF THE SAME MENTAL HEALTH SERVICE ORGANISATION	Transfer of care between an inpatient, community residential or ambulatory setting of a consumer currently under the care of the mental health service.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

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.

Examples

	Collection Occasion Reason
A client is referred and activated into a MH youth outpatient program and a NOCC assessment is collected.	18 – New referral
A client is deactivated from an outpatient program with no further treatment planned and a NOCC assessment is collected.	06 – No further care

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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]
Field name:	COLLECTION_STATUS_RAW
Data type:	Numeric
Format:	N[N]

Permitted values

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
1	Complete	The Outcome Measure is completed with all items having a valid value reported.	01/01/1600	31/12/9999
2	Not completed due to temporary contraindication	The Outcome Measure cannot be completed due to: the consumer's current clinical state is of sufficient severity to make it unlikely that their responses to a self–report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that the responses give a reasonable indication of the consumer's feelings and thoughts about their current emotional and behavioural problems and wellbeing; where an invitation to complete the measures is likely to cause distress or requires a level of concentration and effort the consumer feels unable to give; or where consumers or parents in crisis are too distressed to complete the measure.	01/01/1600	31/12/9999
4	Not completed due to general exclusion	The Outcome Measure cannot be completed due to: The person's cognitive functioning permanently or ongoing insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability; or There is a Language and/or literacy	01/01/1600	31/12/9999

Code	Description	Definition	Start date	End date
		issues that makes the measures inappropriate.		
5	Not completed due to refusal by the client	The Outcome Measure cannot be completed due to: The person/parent refuses to complete the measure. The measure was not returned.	01/01/1600	31/12/9999
7	Not completed for reasons not elsewhere classified	The Outcome Measure cannot be completed due to: The patient is deceased, The patient was discharged whilst being on leave (leave is 3 days or more) and did not return prior to Discharge. Note: The input of client data is based on decisions made by the Multidisciplinary Team, which informs the consumer management plan at each stage of the consumer episode of care, Therefore if it has been identified a staff member does not have the knowledge / skills to formulate a reasonable management plan and record this information via the mandatory requirements for documentation (e.g. Unable to assess) , it would need to be addressed via their education/manger.	01/01/1600	31/12/9999
8	Not completed due to protocol exclusion	The Outcome Measure is not required to be completed due to AMHOCN protocols such as: Discharge rating for HONOS, HONOSCA or HONOS 65+ are not required for inpatient episodes of 3 days or less, Discharge rating for CGAS not required, Admission rating for FIHS not required, Discharge rating for RUG-ADL in inpatient and community residential setting not required, Discharge rating for ambulatory episodes where the number of days between admission and discharge is 14 days or less duration. Discharge rating for SQD not required for episodes of less than 21 days	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		duration. Admission SDQ is generated where the Follow UP SDQ is more appropriate.		
10	Partially complete	The Psychiatric Services Online Information System (PSOLIS) has allocated this Collection Status due to: Not all values have been reported with valid values.	01/01/1600	31/12/9999
11	Not completed due to cultural inappropriateness	The outcome measure cannot be completed due to: Cultural issues make answering this measure inappropriate Interpreter availability or issues does not allow the measure to be completed, Literacy understanding due to cultural background.	01/01/1600	31/12/9999
12	Previous outcome measure is clinically relevant & accepted	The most recent Assessment and outcome is still clinically relevant and is utilised to meet requirements	01/01/1600	31/12/9999
13	Completed within last 7 days at different stream	The assessment was completed in another stream which meets the assessment requirements.	01/01/1600	31/12/9999
14	Offered to client, awaiting response	The Outcome Measure has been offered to the client and the clinician is awaiting a response. This Outcome Status should not be reported after 72hours. Outcome Measures must be followed up with consumers, and an appropriate Outcome Status be reported (e.g., 5 – Not completed due to refusal by client)	01/01/1600	31/12/9999
15	Follow-up SDQ version used	The completion status of a particular NOCC assessment measure entered, including the reason that the assessment measure was not completed (collected).	01/01/1600	31/12/9999
16	Dismissed – automatic cleanup	The assessment was not completed, and the requirement was removed in a system cleanup	01/01/1600	31/12/9999
17	Dismissed – manual program exclusion	The assessment was not completed, and the requirement was removed in a manual program exclusion	01/01/1600	31/12/9999
18	Dismissed –	The assessment was not completed,	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
	manual user request	and the requirement was removed in a manual user request		
19	Dismissed – service split / amalgamation	The assessment was not completed, and the requirement was removed in service split or amalgamation.	01/01/1600	31/12/9999
20	Dismissed - restructure	The assessment was not completed, and the requirement was removed in program restructure.	01/01/1600	31/12/9999

Guide for use

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

Examples

	Collection Status
A NOCC assessment is offered to a client but after 3 days there has been no response received from the client.	14 – Offered to client, awaiting response

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Unique numeric identifier	System generated unique number that is a maximum of 8 digits long that is assigned to each NOCC episode of care as a means of unique identification	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

This is a system generated identifier for each NOCC episode (the complete period of treatment from admission/activation to discharge/deactivation).

This identifier is assigned to all NOCC assessment measures collected within a single episode of care.

Examples

	Episode Identifier
A client is activated into a MH youth outpatient program and attends a review on 01/08/2020, where three NOCC assessments are collected: HoNOS, Kessler 10+ and LSP 16. The client then attends a review on 01/11/2020 where the same three NOCC assessments are collected. All six of these assessment measures share the same NOCC episode identifier.	12830

Related national definition

N/A

Revision history

N/A

Episode Service Setting

Field name:	ESTABLISHMENT_SETTING
Source data element(s):	[Episode Service Setting] – PSOLIS
Definition:	A category identifier to indicate whether the mental health episode of care took place in an inpatient, ambulatory or community residential setting.
Requirement status:	Mandatory
Data type:	String
Format:	A

Permitted values

Code	Description	Definition	Start date	End date
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.	01/01/1600	31/12/9999
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	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Code	Description	Definition	Start date	End date
		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.)	01/01/1600	31/12/9999

Guide for use

Episode service setting indicates whether the mental health care episode took place in the inpatient, ambulatory or community residential setting.

This data element helps determine which assessments will be required to be completed at each of the collection occasions within a NOCC episode, for a given age group (stream type) of mental health consumers.

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 1 July 2026.

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

Code	Description	Definition	Start date	End date
1	Yes	This code is used to indicate the presence of the selected factor, as listed in the FIHS chapter in ICD-10-AM.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
7	Unable to rate	The question is unable to be answered	01/01/1600	31/12/9999
8	Not Applicable	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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

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.

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.

No Longer Applicable. Superseded 1 July 2026.

Examples

	FIHS measure
A 15-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected
A 9-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 13-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/730840

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Health of the Nation Outcome Scales (HoNOS)

Field name:	ITEM1 – ITEM12, ITEM8A
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

Code	Description	Start date	End date
0	No problems within the period stated	01/01/1600	31/12/9999
1	Minor problem requiring no action	01/01/1600	31/12/9999
2	Mild problem but definitely present	01/01/1600	31/12/9999
3	Moderately severe problem	01/01/1600	31/12/9999
4	Severe to very severe problem	01/01/1600	31/12/9999
7	Not stated/missing	01/01/1600	31/12/9999
9	Not known or not applicable	01/01/1600	31/12/9999

Refer to Mental Health National Outcomes and Casemix Collection – Overview of clinician-rated and consumer self-report measures for each question's requirements.

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – HoNOS is only required for the adult stream type when the collection occasion is admission, review or discharge.

The HoNOS is a 12-item clinician rated measure for use in the assessment of consumer outcomes in mental health services. The focus of the HoNOS is on health status and severity of symptoms. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

HoNOS is answered on an item-specific 4-point scale with higher scores indicating more problems. Each scale is assigned a value between 0 and 4. The 12 scales are as follows:

- Behavioural disturbance
- Non-accidental self-injury
- Problem drinking or drug use
- Cognitive problems
- Problems related to physical illness or disability
- Problems associated with hallucinations and delusions
- Problems associated with depressive symptoms

- Other mental and behavioural problems
- Problems with social or supportive relationships
- Problems with activities of daily living
- Overall problems with living conditions
- Problems with work and leisure activities and the quality of the daytime environment.

The sum of the individual scores of each of the scales represents the total HoNOS score. The total HoNOS score ranges from 0 to 48 and represents the overall severity of an individual's psychiatric symptoms.

For more details on rating clients (adults 65 years of age or younger) on each scale/item, refer to the AMHOCN website.

For community mental health care, HoNOS is only required for persons aged 18 to 64 years when the collection occasion is admission, review or discharge.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

No Longer Applicable.
Superseded 1 July 2026.

Examples

	HoNOS
A 42-year-old ambulatory mental health client is reviewed.	Collected
A 58-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 46-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected
A 51-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/717795

Revision history

N/A

Health of the Nation Outcome Scales 65+ (HoNOS 65+)

Field name:	ITEM1 – ITEM12 ITEM 8A
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

Code	Description	Start date	End date
0	No problems within the period rated	01/01/1600	31/12/9999
1	Minor problem requiring no action	01/01/1600	31/12/9999
2	Mild problem but definitely present	01/01/1600	31/12/9999
3	Moderately severe problem	01/01/1600	31/12/9999
4	Severe to very severe problem	01/01/1600	31/12/9999
7	Not stated/missing	01/01/1600	31/12/9999
9	Not known or not applicable	01/01/1600	31/12/9999

Refer to Mental Health National Outcomes and Casemix Collection – Overview of clinician-rated and consumer self-report measures for each question's requirements.

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – HoNOS 65+ is only required for the older adult stream type when the collection occasion is admission, review or discharge.

The HoNOS 65+ is a 12-item clinician-rated measure for use in the assessment of consumer outcomes in mental health services. The focus of the HoNOS 65+ is on health status and severity of symptoms. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

HoNOS 65+ is an item-specific 4-point scale with higher scores indicating more problems. Each scale is assigned a value between 0 and 4. The 12 scales are as follows:

- behavioural disturbance
- non-accidental self-injury
- problem drinking or drug use
- cognitive problems
- problems related to physical illness or disability
- problems associated with hallucinations and delusions
- problems associated with depressive symptoms

- other mental and behavioural problems
- problems with social or supportive relationships
- problems with activities of daily living
- overall problems with living conditions
- problems with work and leisure activities and the quality of the daytime environment.

The sum of the individual scores of each of the scales represents the total HoNOS 65+ score. The total HoNOS 65+ score ranges from 0 to 48 and represents the overall severity of an individual's psychiatric symptoms.

For more details on rating clients (adults 65 years of age and older) on each scale/item, refer to the AMHOCN website.

For community mental health care, HoNOS 65+ is only required for persons aged 65 years and older when the collection occasion is admission, review or discharge.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

No Longer Applicable.
Superseded 1 July 2026.

Examples

	HoNOS 65+
A 65-year-old ambulatory mental health client is reviewed.	Collected
An 82-year-old ambulatory mental health client is discharged from ambulatory care to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 78-year-old ambulatory mental health client is discharged from ambulatory care to the care of their GP, after a 23-day ambulatory episode of care.	Collected
A 91-year-old ambulatory mental health client is discharged from ambulatory care to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/730844

Revision history

N/A

HoNOS for Children and Adolescents (HoNOSCA)

Field name:	ITEM1 – ITEM15
Source data element(s):	[HoNOSCA] – PSOLIS
Definition:	A variant of the HoNOS designed for use with children and adolescents. It is a 15-item clinician-rated measure designed specifically for use in the assessment of child and adolescent consumer outcomes in mental health services.
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Start date	End date
0	No problems within the period rated	01/01/1600	31/12/9999
1	Minor problem requiring no action	01/01/1600	31/12/9999
2	Mild problem but definitely present	01/01/1600	31/12/9999
3	Moderately severe problem	01/01/1600	31/12/9999
4	Severe to very severe problem	01/01/1600	31/12/9999
7	Not stated/missing	01/01/1600	31/12/9999
9	Not known or not applicable	01/01/1600	31/12/9999

Refer to Mental Health National Outcomes and Casemix Collection – Overview of clinician-rated and consumer self-report measures for each question's requirements

No Longer Applicable - Superseded 1 July 2026

Guide for use

Collection of this data element is conditional – HoNOSCA is only required for the child and adolescent stream type when the collection occasion is admission, review or discharge.

The HoNOSCA is a 15-item clinician-rated measure for use in the assessment of consumer outcomes in mental health services. The focus of the HoNOSCA is on health status and severity of symptoms. Ratings are made by clinicians based on their assessment of the consumer. In completing their ratings, the clinician makes use of a glossary which details the meaning of each point on the scale being rated.

HoNOSCA is answered on an item-specific 4-point scale with higher scores indicating more problems. Each scale is assigned a value between 0 and 4. The 15 scales are:

- Disruptive, antisocial or aggressive behaviour
- Overactivity attention and concentration
- Non-accidental self-injury
- Alcohol, substance/solvent misuse
- Scholastic or language skills
- Physical illness or disability problems
- Hallucinations and delusions

- Non-organic somatic symptoms
- Emotional and related symptoms
- Peer relationships
- Self-care and independence
- Family life and relationships
- Poor school attendance
- Lack of knowledge – nature of difficulties
- Lack of information – services/management.

The sum of the individual scores of each of the scales from 1 to 15 represents the total HoNOSCA score. The total HoNOSCA score represents the overall severity of an individual's psychiatric symptoms.

For more details on rating clients (17 years of age and younger) on each scale/item, refer to the AMHOCN website.

For community mental health care, HoNOSCA is only required for persons aged 17 years and younger when the collection occasion is admission, review or discharge.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

No Longer Applicable. Superseded 1 July 2026.

Examples

	HoNOSCA
A 12-year-old ambulatory mental health client is reviewed.	Collected
A 9-year-old ambulatory mental health client is discharged from ambulatory care, to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 12-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after a 23-day ambulatory episode of care.	Collected
A 14-year-old ambulatory mental health client is discharged from ambulatory care, to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/717784

Revision history

N/A

Kessler (K10+) Score

Field name:	ITEM1 – ITEM10
Source data element(s):	[Kessler (K10+) Score] – PSOLIS
Definition:	The level of psychological distress experienced by a person in the four weeks prior to interview, as represented by a code
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Start date	End date
1	None of the time	01/01/1600	31/12/9999
2	A little of the time	01/01/1600	31/12/9999
3	Some of the time	01/01/1600	31/12/9999
4	Most of the time	01/01/1600	31/12/9999
5	All of the time	01/01/1600	31/12/9999
6	Don't know	01/01/1600	31/12/9999

Refer to Mental Health National Outcomes and Casemix Collection – Overview of clinician-rated and consumer self-report measures for each question's requirements

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional - K10+ is only required for the adult and older adult stream types when the collection occasion is admission, review or discharge.

The K10 is a 10-item self-report questionnaire designed to yield a global measure of non-specific psychological distress based on questions about the level of nervousness, agitation, psychological fatigue and depression in the relevant rating period.

The K10+ contains four additional questions to assess functioning and related factors, but these items do not get used in the overall score.

The 10 categories of questions are as follows:

- Feeling tired
- Feeling nervous
- Nervousness that nothing could calm it down
- Feeling hopeless
- Feeling restless or fidgety
- Restlessness that you could not sit still
- Feeling depressed
- Feeling that everything was an effort
- Feeling sad and nothing cheered you up

- Feeling worthless

For more details on rating clients on each scale/item, refer to the AMHOCN website.

For community mental health care, K10+ is only required for adults and older adults when the collection occasion is admission, review or discharge.

The standard rating period in Australia for the K10+ is the last four weeks. The score range is from 10 to 50, with lower scores indicating lower levels of distress.

The measure covers the previous two weeks.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

Special considerations

The classification of client self-report measures as mandatory is intended only to indicate the expectation that clients will be invited to complete self-report measures at the specified collection occasions, not that such measures will always be appropriate.

Due to the nature and severity of their mental health or other problems, it is likely that some clients should never be asked to complete self–report measures, others may not be able to complete the self–report measures at the scheduled occasion, whilst still others may sometimes find completion of the self–report measures to be difficult or stressful.

In all cases, clinical judgement as to the appropriateness of inviting the client to complete the measures must be the determining factor at any given collection occasion. Where collection of client self–report measures is contraindicated, the reasons must be recorded.

Some persons may not be able to complete the measures at any time and should not be asked to do so. A definitive list of circumstances in which a general exclusion applies is beyond the scope of this document but broadly it would include situations where:

- the person's cognitive functioning is insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability.
- cultural, language and/or literacy issues make the measures inappropriate.

Under certain conditions, a client may not be able to complete the measure at a specific collection occasion. Circumstances where it may be appropriate to refrain from inviting the person to complete the measure include:

- where the client's current clinical state is of sufficient severity to make it unlikely that their responses to a self–report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that they were a reasonable indication of the person's feelings and thoughts about their current emotional and behavioural problems and wellbeing.
- where an invitation to complete the measures is likely to be experienced as distressing or require a level of concentration and effort the person feels unable to give; or

No Longer Applicable. Superseded 1 July 2026.

- where clients in crisis are too distressed to complete the measure.

In these circumstances clients need not be invited to complete the measures. At all other times, an attempt must be made to obtain their responses.

In many cases, the severity of the person's clinical state and the degree of family distress experienced will diminish with appropriate treatment and care. It is suggested that, if within a period of up to seven days following the collection occasion in an ambulatory care setting the client is likely to be able to complete the measure then their responses should be sought at that time. Otherwise, no further attempt to administer the measure at that collection occasion should be made.

Examples

	K10+
A 33-year-old ambulatory mental health client is being reviewed. The clinical judgement at this time is that a request to complete the K10+ will cause the client distress.	Not collected
A 26-year-old ambulatory mental health client is being reviewed. The clinical judgement at this time is that a request to complete the K10+ is appropriate.	Collected
An 82-year-old ambulatory mental health client is discharged from ambulatory care to an inpatient facility of the organisation, after a 23-day ambulatory episode of care.	Not collected
A 74-year-old ambulatory mental health client is discharged from ambulatory care to the care of their GP, after a 23-day ambulatory episode of care.	Collected

Related national definition

https://meteor.aihw.gov.au/content/634094

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Start date	End date
0	Score of 0	01/01/1600	31/12/9999
1	Score of 1	01/01/1600	31/12/9999
2	Score of 2	01/01/1600	31/12/9999
3	Score of 3	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999
9	Not stated/missing	01/01/1600	31/12/9999

Refer to Mental Health National Outcomes and Casemix Collection – Overview of clinician-rated and consumer self-report measures for each question's requirements

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – LSP-16 is only required for adults and older adults when the collection occasion is admission, review or discharge.

LSP-16 contains 16 items which provide a measure of function and disability in people with mental illness. It focuses on general functioning, i.e., how a person functions in terms of social relationships, ability to do day-to-day tasks etc. Each item is scored on a scale of 0 to 3. Lower scores indicate a higher level of functioning. The 16 items are:

1. Does this person generally have any difficulty with initiating and responding to conversation?
2. Does this person generally withdraw from social contact?
3. Does this person generally show warmth to others?
4. Is this person generally well groomed (e.g., neatly dressed, hair combed)?
5. Does this person wear clean clothes generally, or ensure they are cleaned if dirty?
6. Does this person generally neglect her or his physical health?
7. Is this person violent to others?
8. Does this person generally make and/or keep up friendships?
9. Does this person generally maintain an adequate diet?
10. Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?

11. Is this person willing to take psychiatric medication when prescribed by a doctor?
12. Does this person co-operate with health services (e.g., doctors and/or other health workers)?
13. Does this person generally have problems (e.g., friction, avoidance) living with others in the household?
14. Does this person behave offensively (includes sexual behaviour)?
15. Does this person behave irresponsibly?
16. What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?

For more details on rating clients on each scale/item, refer to the AMHOCN website.

For community mental health care, LSP-16 is only required for the adult and older adult stream types when the collection occasion is admission, review or discharge.

The standard rating period in Australia for the LSP-16 is the previous three months.

Exceptions to collection requirements

If an ambulatory episode is closed because the consumer is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and consumer measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the consumer's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

For the exceptions above, details are still required to be recorded for principal and additional diagnoses and mental health legal status relevant to the episode of care.

No Longer Applicable:
Superseded 1 July 2026.

Examples

	LSP-16
A 26-year-old ambulatory mental health client is being reviewed.	Collected
An 85-year-old ambulatory mental health client is discharged from ambulatory care to an inpatient facility of the organisation, after a 2-month ambulatory episode of care.	Not collected
A 62-year-old ambulatory mental health client is discharged from ambulatory care to the care of their GP, after a 2-month ambulatory episode of care.	Collected
A 50-year-old ambulatory mental health client is discharged from ambulatory care to the care of their GP, after an 8-day ambulatory episode of care.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/654401

Revision history

N/A

Phase End Date and Time

Field name:	PHASE_END_DATETIME
Source data element(s):	[Phase End Date and Time] – PSOLIS
Definition:	The date and time on which the client completes a phase of mental health care.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month day hour minute and second format of when the client completes a phase of mental health care	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – phase end date and time must be recorded if a phase of mental health care has been recorded.

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

Examples

	Phase End Date and Time
A client is reviewed and it is determined that a change in the mental health care phase is warranted. The client's phase is changed on 01/10/2023 at 2pm.	2023-10-01 14:00:00

Related national definition

https://meteor.aihw.gov.au/content/575248

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
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).	01/01/1600	31/12/9999
9	Not reported	No information is reported.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

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.

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).

No Longer Applicable: Superseded 1 July 2026.

Examples

	Phase of Care
A client is activated into a youth outpatient program for assessment purposes.	5 – Assessment only
A client undergoing treatment to improve social functioning attends a review.	2 – Functional gain

Related national definition

https://meteor.aihw.gov.au/content/682464

Revision history

N/A

Phase Start Date and Time

Field name:	PHASE_START_DATETIME
Source data element(s):	[Phase Start Date and Time] – PSOLIS
Definition:	The date and time on which a mental health care phase commences.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month day hour minute and second format of when the mental health care phase commences	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – phase start date and time must be recorded if a phase of mental health care has been recorded.

This is the start date for the phase. It may or may not be equivalent to the original date of admission/activation to the mental health care program.

Examples

	Phase Start Date and Time
A mental health client is activated into a MH Youth Outpatient program on 20/07/2023 at 2pm for assessment purposes.	2023-07-20 14:00:00

Related national definition

https://meteor.aihw.gov.au/content/575253

Revision history

N/A

Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) Score

Field name:	ITEM1 – ITEM4
Source data element(s):	[RUG-ADL Score] – PSOLIS
Definition:	An assessment of patient motor function
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Start date	End date
Scoring scale for bed mobility, toileting and transfers:			
1	Independent or supervision only	01/01/1600	31/12/9999
3	Limited physical assistance	01/01/1600	31/12/9999
4	Other than two persons physical assist	01/01/1600	31/12/9999
5	Two or more persons physical assist	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999
Scoring scale for eating:			
1	1 – Independent or supervision only	01/01/1600	31/12/9999
2	2 – Limited assistance	01/01/1600	31/12/9999
3	3 – Extensive assistance/total dependence/tube fed	01/01/1600	31/12/9999
7	7 – Unable to rate	01/01/1600	31/12/9999
8	8 – Not applicable	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) is only required for the older adult stream type in the inpatient or community residential settings when the collection occasion is admission or review.

RUG-ADL is a clinical assessment tool that measures the level of functional dependence of a patient for four activities of daily living. The values assigned provide an indication of what a person actually does, not what they are capable of doing.

RUG-ADL measures the motor function of a patient for four activities of daily living:

- Bed mobility
- Toileting
- Transfers
- Eating

RUG-ADL measures ability with respect to ‘late loss’ activities – ‘early loss’ activities (e.g., managing finances, social relationships, grooming) are included in the LSP.

As a general rule, the higher the total RUG-ADL score the more dependent and potentially clinically complex the patient is.

For more details on scoring and interpreting the RUG-ADL, refer to the AMHOCN website.

Permitted values	Definition
Scoring scale for 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.
Scoring scale for 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.
Scoring scale for 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.

No Longer Applicable.
Superseded 1 July 2026.

Permitted values	Definition
4 – Other than two persons physical assist	Requires the use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.
5 – Two or more persons physical assist	Requires two or more assistants to perform any transfer of the day/night
Scoring scale for 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.

No Longer Applicable.
Superseded 1 July 2026.

Examples

	RUG-ADL
A 46-year-old mental health patient is reviewed.	Not collected
A 67-year-old patient is admitted as an ambulatory mental health patient.	Not collected
An 85-year-old is admitted as a mental health inpatient.	Collected
A 72-year-old community residential patient is reviewed.	Collected
A 76-year-old mental health inpatient is discharged.	Not collected

Related national definition

https://meteor.aihw.gov.au/content/495909

Revision history

N/A

Strengths and Difficulties Questionnaire (SDQ) Score

Field name:	ITEM1 – ITEM42
Source data element(s):	[SDQ Score] – PSOLIS
Definition:	A behavioural screening questionnaire designed for 4 to 17-year-olds.
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Start date	End date
Item 1 – Item 25			
0	Not true	01/01/1600	31/12/9999
1	Somewhat true	01/01/1600	31/12/9999
2	Certainly true	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999
Item 26			
0	No	01/01/1600	31/12/9999
1	Yes – minor difficulties	01/01/1600	31/12/9999
2	Yes – definite difficulties	01/01/1600	31/12/9999
3	Yes – severe difficulties	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999
Item 27			
0	Less than a month	01/01/1600	31/12/9999
1	1 – 5 months	01/01/1600	31/12/9999
2	6 – 12 months	01/01/1600	31/12/9999
3	Over a year	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999
Item 28 – Item 33, Item 35			
0	Not at all	01/01/1600	31/12/9999
1	A little	01/01/1600	31/12/9999

No Longer Applicable:
Superseded 1 July 2026.

Code	Description	Start date	End date
3	A great deal	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999
Item 34			
0	Much worse	01/01/1600	31/12/9999
1	A bit worse	01/01/1600	31/12/9999
2	About the same	01/01/1600	31/12/9999
4	Much better	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999
Item 36 – Item 42			
0	No	01/01/1600	31/12/9999
1	A little	01/01/1600	31/12/9999
2	A lot	01/01/1600	31/12/9999
7	Unable to rate	01/01/1600	31/12/9999
8	Not applicable	01/01/1600	31/12/9999

Refer to SDQ Information for researchers and professional about the Strengths & Difficulties Questionnaires for each question's requirements.

No Longer Applicable: Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional - Strengths and Difficulties Questionnaire (SDQ) is only required for the child and adolescent stream type when the collection occasion is admission, review or discharge.

There are six versions of the SDQ (parent report and youth self-report) currently specified for NOCC reporting with an additional four versions (teacher report) that may be of use at the clinical level.

Baseline versions are used at admission, while follow-up versions are used at review and discharge.

The versions specified for NOCC reporting are:

- PC101 – Parent Report Measure 4-10 yrs., Baseline version
- PC201 – Parent Report Measure 4-10 yrs., Follow Up version
- PY101 – Parent Report Measure 11-17 yrs., Baseline version
- PY201 – Parent Report Measure 11-17 yrs., Follow Up version
- YR101 – Youth Self-report Measure 11-17 yrs., Baseline version
- YR201 – Youth Self-report Measure 11-17 yrs., Follow Up version

For more details on scoring and interpreting the SDQ, refer to the AMHOCN website.

There are three issues to be aware of in the collection of the SDQ. The first is the exceptions

to collection requirements, the second is when the admission or follow up versions must be collected, and the third is special considerations which apply to self-report measures.

Exceptions to collection requirements

If an ambulatory episode is closed because the client is being transferred to a bed-based treatment service setting of that organisation (i.e., psychiatric inpatient or community residential service), this measure is not collected at discharge from that ambulatory episode. (Where possible, the clinician and client measure ratings for the admission NOCC in the inpatient unit or the community residential care setting are reported as the client's discharge ratings from the ambulatory episode).

If an ambulatory episode is brief (those where the number of days between admission to and discharge from the episode of care is 14 days or less duration), then this measure is not collected at discharge from that ambulatory episode.

In the above situations, details are still required, however, regarding principal and additional diagnoses and mental health legal status relevant to the ambulatory episode of care.

Discharge ratings for the SDQ are not required for any episode of less than 21 days duration because the rating period used at discharge (previous month) would overlap significantly with the period rated at admission.

Which version of the SDQ (admission or follow-up) is to be collected

Generally, the admission versions are administered on admission and rated over the standard rating period of six months and the follow up versions are administered on review and discharge and rated over a one-month period. However, for Referral from another setting, to prevent duplication and undue burden on clients and parents, the following guide is suggested:

No Longer Applicable.
Superseded 1 July 2026.

Transfer of care between an inpatient, community residential or ambulatory setting of a client currently under the Active care of the mental health service organisation.	**Admission SDQ** - if follow-up SDQ required at the end of referring treatment settings episode is neither completed nor provided by referring setting.
	Follow-up SDQ - if follow-up SDQ is required at end of referring treatment settings episode has in fact been completed and provided by the referring setting.
Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above.	**Admission SDQ** - if follow-up SDQ required at the end of referring treatment settings episode is neither completed nor provided by referring setting.
	Follow-up SDQ - if follow-up SDQ required at end of referring treatment settings episode has not been completed or is not provided by the referring setting.

Special considerations which apply to self-report measures

The classification of client self-report measures as mandatory is intended only to indicate the expectation that clients will be invited to complete self-report measures at the specified collection occasions, not that such measures will always be appropriate.

Due to the nature and severity of their mental health or other problems, it is likely that some clients should never be asked to complete self–report measures, others may not be able to complete the self–report measures at the scheduled occasion, whilst still others may sometimes find completion of the self–report measures to be difficult or stressful.

In all cases, clinical judgement as to the appropriateness of inviting the client to complete the measures must be the determining factor at any given collection occasion. Where collection of client self–report measures is contraindicated, the reasons must be recorded. Similar considerations also apply in relation to the parent version of the SDQ.

Some persons may not be able to complete the measures at any time and should not be asked to do so. A definitive list of circumstances in which a general exclusion applies is beyond the scope of this document but broadly it would include situations where:

- the person's cognitive functioning is insufficient to enable understanding of the task as a result of an organic mental disorder or an intellectual disability.
- cultural, language and/or literacy issues make the measures inappropriate.

Under certain conditions, a client or parent may not be able to complete the measure at a specific collection occasion.

Circumstances where it may be appropriate to refrain from inviting the person to complete the measure include:

- where the client's current clinical state is of sufficient severity to make it unlikely that their responses to a self–report questionnaire could be obtained, or that if their responses were obtained it would be unlikely that they were a reasonable indication of person's feelings and thoughts about their current emotional and behavioural problems and wellbeing.
- where an invitation to complete the measures is likely to be experienced as distressing or require a level of concentration and effort the person feels unable to give; or
- where clients or parents in crisis are too distressed to complete the measure.

It is suggested that in these circumstances clients and parents need not be invited to complete the measures. At all other times, an attempt must be made to obtain their responses.

In many cases, the severity of the person's clinical state and the degree of family distress experienced will diminish with appropriate treatment and care. It is suggested that, if within a period of up to seven days following the collection occasion in an ambulatory care setting, the client is likely to be able to complete the measure then their responses should be sought at that time. Otherwise, no further attempt to administer the measure at that collection occasion should be made.

No Longer Applicable.
Superseded 1 July 2026.

For a total difficulties score to be calculated, a valid SDQ measure must have 3/5 item scores recorded for each of the following 4 subscales, Emotional Problems Subscale 1, Conduct Problems Subscale 2, Hyperactivity Subscale 3 and Peer Problems Subscale 4 (scores: 0, 1, 2).

Emotional Problems	Subscale 1	(item03, item08, item13, item16, item24)
Conduct Problems	Subscale 2	(item05, item07, item12, item18, item22)
Hyperactivity	Subscale 3	(item02, item10, item15, item21, item25)
Peer Problems	Subscale 4	(item06, item11, item14, item19, item23)
Prosocial	Subscale 5	(item01, item04, item09, item17, item20)

Prosocial Subscale 5 scores are recorded as a part of the Strengths and Difficulties Questionnaire, but they are not included in the calculation of the total difficulties score.

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

Examples

	SDQ
A client aged 9 is discharged from ambulatory care to the care of their GP, after a 35-day ambulatory episode of care.	Collected
A client aged 12 is being reviewed. The clinical judgement at this time is that a request to complete the SDQ will cause the client or their parents' distress.	Not collected
A client aged 17 is being reviewed. The clinical judgement is that a request to complete the SDQ is appropriate.	Collected
A client aged 14 is discharged from ambulatory care to an inpatient facility of the organisation after a 35-day ambulatory episode of care.	Not collected

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

11. Legal orders

The following section provides specific information about the legal orders data elements captured in the MHDC under the *Mental Health Act 2014* (the Act), including definitions, permitted values, guide for use, rules and operational examples.

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

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	No	A client is not admitted voluntarily	01/01/1600	31/12/9999
1	Yes	A client is admitted voluntarily	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – admitted voluntary indicator must be collected for Legal Order 3E if the client is admitted as a voluntary patient.

This data element is an indicator for Legal Order 3E. Order that a Person Cannot Continue to be Detained.

The voluntary inpatient checkbox available within PSOLIS must be selected if a Legal Order 3E is created and the patient is being admitted as a voluntary patient.

Examples

	Admitted Voluntary Indicator
The checkbox 'Is the person being admitted as a voluntary inpatient' was selected on creation of the Legal Order 3E.	1
The checkbox 'Is the person being admitted as a voluntary inpatient' was not selected on creation of the Legal Order 3E.	0

Related national definition

N/A

Revision history

N/A

Ancestor Identifier

Field name:	ANCESTOR_IDENTIFIER
Source data element(s):	[Ancestor Identifier] – PSOLIS
Definition:	The identifier that references the legal order that commenced the legal episode (ancestor of the order).
Requirement status:	Conditional
Data type:	Numeric
Format:	[N(20)]

Permitted values

Permitted values	Definition	Start date	End date
Whole number	The system generated number up to a maximum of 20 digits that identifies the ancestor of the order.	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – ancestor identifier must be collected for all legal orders in a legal episode except for the first legal order.

This data element is system generated and references the ancestor of the order.

The first legal order in the episode will always show a value of null in this field, given that it is the order that is starting the client's legal episode.

Examples

	Ancestor Identifier
A client was transitioned from a 1A: Referral for Examination by Psychiatrist to a 6A: Involuntary Treatment Order. In this scenario, the 1A would be the ancestor ID provided to the transitioned order (i.e., 6A: ITO).	6166

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The date and time in year month day hour minute and second format of when the assessment was conducted prior to the legal order form being made.	01/01/1600	31/12/9999

Guide for use

Assessment date and time records the date and time the client was assessed prior to the legal order form 1A: Referral for Examination by Psychiatrist being made.

Examples

	Action Date and Time
The clinician enters 20 July 2021 at 8am as the date and time the client was assessed.	2021-07-20 08:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the staff member who authorised the legal order change. Starting with HE then the individualised number.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is mandatory to record the HE identifier of the person who approved a change to certain legal orders.

In PSOLIS, the 'Authorised by' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if the 'authorised by name' is entered by free text.

Collection of this data element must take place when a change has occurred on legal orders 1A to 7D, 9A & 9B, 12B & 12C, and pseudo-orders.

Examples

	Authorised By
The 'Authorised By' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

Authorised By Name

Field name:	AUTHORISED_BY_NAME
Source data element(s):	[Authorised By Name] – PSOLIS
Definition:	The name of the staff member who authorised the legal order change.
Requirement status:	Conditional
Data type:	String
Format:	X(150)

Permitted values

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the staff member who authorised the legal order change to a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – it is mandatory to record the name of the person who approved a change to certain legal orders.

In PSOLIS, the 'Authorised by' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

Collection of this data element must take place when a change has occurred on legal orders 1A to 7D, 9A & 9B, 12B & 12C, and pseudo-orders.

Examples

	Authorised By Name
The 'Authorised By Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	Not applicable/relevant	This filed is not relevant to this client.	01/01/1600	31/12/9999
1	Not completed by AV	The psychiatric examination of a client was not conducted by audio video conference.	01/01/1600	31/12/9999
2	Completed by AV, not subsequent face-to-face	The psychiatric examination of a client was conducted by audio video conference without a prior face to face examination.	01/01/1600	31/12/9999
3	Completed by AV, and subsequent face-to-face	The psychiatric examination of a client was conducted by audio video conference following a prior face to face examination.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

A psychiatric assessment/examination can be conducted via audio-visual (AV) communication.

Under the Act, AV communication means using videoconferencing to provide "real-time, synchronous video and audio transmission between locations to bring people together."

In non-metropolitan areas an assessment for Referral or examination by a psychiatrist under the Act (s.48 and s.79c) can be conducted via AV communication.

A checkbox is available within the order screen in PSOLIS to confirm if the client has had a psychiatric examination via AV.

Examples

	AV Exam
A client examination under the Act was conducted via videoconference; there was no subsequent face-to-face examination.	2

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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. Criminal Law Mentally Impaired Accused Act (CLMIAA)
Requirement status:	Mandatory
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
0	No known CLMIAA status	CLMIAA status is unknown.	01/01/1600	31/12/9999
1	Subject of CLMIAA custody order	Client is subject to a CLMIAA custody order	01/01/1600	31/12/9999
2	Subject of CLMIAA hospital order	Client is subject to a CLMIAA hospital order	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

CLMIAA status is recorded to identify whether the client is subject to an order under the *Criminal Law Mentally Impaired Accused Act 1996* (CLMIAA).

CLMIAA Custody Order: A custody order is an order made by the court that the accused person be detained for an indefinite period. A mentally impaired accused under a custody order can be detained in one of four places:

1. An authorised hospital.
2. A declared place.
3. A detention centre; or
4. A prison.

CLMIAA Hospital Order: A hospital order is an order that the accused person be taken and detained in an authorised hospital and examined by a psychiatrist.

CLMIAA status is selected by the PSOLIS user in the CLMIAA order section.

For further information, refer to Mentally Impaired Accused.

Examples

	CLMIAA Status
A user selects the CLMIAA status 'Subject of CLMIAA Custody Order' in PSOLIS.	1

Revision history

N/A

CTO Appointment Date and Time

Field name:	CTO_APPT_DATETIME
Source data element(s):	[CTO Appointment Date and Time] – PSOLIS
Definition:	Date and time of the scheduled first appointment under the CTO. Community Treatment Order (CTO)
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The date and time of the scheduled first appointment for a client placed on a Community Treatment Order (CTO).	01/01/1600	31/12/9999

Guide for use

Community Treatment Order: Is an order under the Act for a person to receive treatment as an involuntary patient in the community.

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

Examples

	CTO Appointment Date and Time
The supervising psychiatrist enters 20 July 2021 at 8am as the date and time for the client's first appointment.	2021-07-20 08:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

Expiry Date

Field name:	EXPIRY_DATE
Source data element(s):	[Expiry Date] – PSOLIS
Definition:	Date the legal order expires.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD

Permitted values

Permitted values	Definition	Start date	End date
Valid date	The full date including the day year and month of the date the legal order is due to expire.	01/01/1600	31/12/9999

Guide for use

This data item is the date a legal order is due to expire.

Examples

	Expiry Date
A legal order is due to expire on 15 May 2021 at 10am.	2021-05-15

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Unique numeric identifier	The unique identifier for the legal episode.	01/01/1600	31/12/9999

Guide for use

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

Examples

	Legal Episode Identifier
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	159

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	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.	01/01/1600	31/12/9999

Guide for use

Legal order effective date and time must not be later than the expiry date and time of the parent Involuntary Treatment Order (ITO) Form 6A or 6B or Continuation 6C (if one exists).

Examples

	Legal Order Effective Date and Time
A Leave Order was made on 15 May 2021 at 10am.	2021-05-15 10:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the staff member who authorised the legal order. Starting with HE then the individualised number.	01/01/1600	31/12/9999

Guide for use

This field displays the HE number of the person making an electronic order (Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo orders).

The 'Order Made By' field in PSOLIS displays the logged in username and cannot be changed.

For Transcribed Paper Orders and Tribunal Orders, 'the Order Made By' field displays the logged in username with the capacity to search within PSOLIS for an alternative clinician name.

Examples

	Made By
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	HE123456

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the Staff member who authorised the legal order to a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

This field displays the name of the person making an electronic order (Forms 1A to 7D, 9A & 9B, 12B & 12C, and pseudo-orders).

The ‘Order Made By’ field in PSOLIS displays the logged in username and cannot be changed.

For Transcribed Paper Orders and Tribunal Orders, ‘the Order Made By’ field displays the logged in username with the capacity to search within PSOLIS for an alternative clinician name.

Examples

	Made By Name
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	Joe Staff

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The professional qualification of the staff member who made the legal order for a maximum of 255 alphanumeric characters.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is mandatory to record the qualification of the person who made certain legal orders.

The professional qualification of the person who made the legal order is a free text field.

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

Examples

	Made By Qualification
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	FRANZCP

Related national definition

N/A

Revision history

N/A

Made by Qualification Type

Field name:	MADE_BY_QUALIFICATION_TYPE_CODE
Source data element(s):	[Made By Qualification Type] – PSOLIS
Definition:	Numeric identifier of the qualification role of the person making the legal order.
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
1	Medical Practitioner	A person registered to practise as a Medical Practitioner under the Health Practitioner Regulation National Law.	01/01/1600	31/12/9999
2	Authorised mental health practitioner	Authorised mental health practitioners (1) The Chief Psychiatrist may, by order published in the Gazette, designate a mental health practitioner as an authorised mental health practitioner if satisfied that the practitioner has the qualifications, training and experience appropriate for performing the functions of an authorised mental health practitioner under this Act.	01/01/1600	31/12/9999
3	Psychiatrist	A qualified medical doctor who has obtained additional qualifications to practise in the specialty of psychiatry and is registered by the Medical Board of Australia	01/01/1600	31/12/9999
4	Mental health practitioner	A mental health practitioner is a person who, as one of the following, has at least 3 years' experience in the management of people who have a mental illness (a) a psychologist. (b) a nurse whose name is entered on Division 1 of the Register of Nurses kept under the Health Practitioner Regulation National Law (Western Australia) as a registered nurse. (c) an occupational therapist. (d) a social worker	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is mandatory to record the qualification role of the person who made certain legal orders.

The qualification role of the person making the order is selected from the 'Qualification Role' drop down list in the PSOLIS 'Legal Order' screen.

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

Examples

	Made By Qualification Type
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	3

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the staff member who determined that the referral was no longer required. Starting with HE then the individualised number.	01/01/1600	31/12/9999

Guide for use

This field displays the HE number of the person who determined that the referral was not required and is completed in PSOLIS via Pseudo Order – Referral not Required.

In PSOLIS, the 'Determined by' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if the 'no referral determined by name' is entered by free text.

Examples

	No Referral Determined By
The 'Determined by' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the staff member who determined that the referral was no longer required to a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

This field displays the name of the person who determined that the referral was not required and is completed in PSOLIS via Pseudo Order – Referral not Required.

In PSOLIS, the 'Determined by Name' field has:

a. Free text capability to cater for situations when the authorising person is not listed in PSOLIS.

b. The ability to search for, and select, a PSOLIS user.

Examples

	No Referral Determined By Name
The 'Determined by Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Order Changed By

Field name:	ORDER_CHANGED_BY
Source data element(s):	[Order Changed By] – PSOLIS
Definition:	The health employee (HE) number of the staff member who made changes to an existing legal order.
Requirement status:	Conditional
Data type:	String
Format:	X[(X9)]

Permitted values

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the staff member who made changes to an existing legal order. Starting with HE then the individualised number.	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – it is only mandatory where a change has been made to an existing legal order.

The 'Order Changed By' person may or may not be the same as the person who authorised the change to the legal order.

In PSOLIS, the 'Order Changed By' field defaults to the logged in user and is not editable.

Examples

	Order Changed By
Joe Staff makes changes in PSOLIS to a client's existing legal order and saves the record.	HE123456

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
1	Transcription error	An error in the data entry when the transcription of the written legal order is recorded in PSOLIS is detected and corrected.	01/01/1600	31/12/9999
2	Content error	Incorrect information was detected on the original form as was corrected.	01/01/1600	31/12/9999
3	Process error	An error in the legal order process was detected and corrected.	01/01/1600	31/12/9999
4	Additional information added	New information is added to the order that was not present on the original	01/01/1600	31/12/9999
5	Change in location	The location of the client has been changed and the legal order needs to be changed to reflect this	01/01/1600	31/12/9999
6	Change in circumstance	There has been a change in circumstance since the original legal order was written and it has been updated to reflect the change.	01/01/1600	31/12/9999
7	MHT alteration	Legal order is updated to reflect changes in eb MHT.	01/01/1600	31/12/9999
8	OCP alteration	Legal order has been updated due to OCP requirements	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is only mandatory where a change has been made to certain existing legal orders.

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

Examples

	Order Changed Reason
Joe Staff updates a client's existing legal order in PSOLIS.	4 – Additional information added

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

Order Duration

Field name:	ORDER_DURATION
Source data element(s):	[Order Duration] – PSOLIS
Definition:	The duration of the legal order in days.
Requirement status:	N/A
Data type:	Numeric
Format:	N(3)

Permitted values

Permitted values	Definition	Start date	End date
Whole number	The number of days as a whole number that the legal order is Active for.	01/01/1600	31/12/9999

Guide for use

This data element is a derived measure using the start and end dates of a legal order.

Examples

	Order Duration
A legal order is created on 13/07/2022 for a patient admitted to Graylands Hospital and is ended on 20/07/2022.	8

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	Legal order end date and time is the documented date and time a legal order is due to expire	01/01/1600	31/12/9999

Guide for use

Order end date and time is the documented date and time a legal order is due to expire.

Examples

	Order End Date and Time
A legal order is due to expire on 15 May 2021 at 10am.	2021-05-15 10:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Unique numeric identifier	A system generated unique number that is a maximum of 20 digits long that is assigned to each Legal order as a means of unique identification	01/01/1600	31/12/9999

Derivation logic

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

Guide for use

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

Examples

	Legal Record Identifier
Details of a new client under legal order form 1A: Referral for Examination by Psychiatrist are entered into PSOLIS.	2061

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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)
Field name:	ORDER_NAME
Data type:	String
Format:	X(130)

Permitted values

Permitted values	Definition	Start date	End date
As per Appendix D – Legal orders	Any of the names or two-digit codes assigned to the legal orders listed in Appendix D	01/01/1600	31/12/9999

Guide for use

This data element identifies the name of the legal order form using the legal order form's assigned number reference, as per its documented title.

Examples

	Order Name Code
A PSOLIS user selects a legal order Form 4A – Transport Order.	16

Related national definition

N/A

Revision history

N/A

No Longer Applicable: Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds a legal order commences	01/01/1600	31/12/9999

Guide for use

This date element is completed with the start date and time the legal order commences.

The PSOLIS field defaults to created date and time but is editable and therefore can be 'backdated'.

There are specific rules related to this data element which are detailed in the individual legal orders.

Order start date and time must not be in the future relative to the current date and time.

Examples

	Order Start Date and Time
A legal order commenced on 15 May 2021 at 10am.	2021-05-15 10:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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:	Conditional to a 5F form being present Mandatory if form is present.
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds that a Form 5F comes into enforcement ordering a client to attend a location.	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – it is only mandatory where a Form 5F: Order to Attend has been made following a client being in breach of their community treatment order (CTO).

The date and time the client is ordered to attend a place is recorded in this PSOLIS field.

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

Examples

	Order to Attend Date and Time
The supervising psychiatrist creates a 5F order and enters the date and time of attendance as 21 June 2021 at 11am.	2021-06-21 11:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
E	Electronically made order	An electronically completed form where there is no paper version.	01/01/1600	31/12/9999
P	Paper transcribed order	A form completed on paper that is transcribed into PSOLIS.	01/01/1600	31/12/9999
C	Court/tribunal	An order made by a Court or Tribunal.	01/01/1600	31/12/9999
M	Migrated from legal status lite	The preexisting	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

This data element refers to the code used to represent how a legal order was created.

Examples

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

Related national definition

N/A

Revision history

N/A

Parent Identifier

Field name:	PARENT_IDENTIFIER
Source data element(s):	[Parent Identifier] – PSOLIS
Definition:	Numeric code uniquely assigned to the current legal order which identifies the preceding legal order within a legal episode.
Requirement status:	Mandatory
Data type:	Numeric
Format:	[N(20)]

Permitted values

Permitted values	Definition	Start date	End date
Whole number	System generated unique number that is a maximum of 20 digits long that is assigned to each Legal order as a means of unique identification	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Derivation logic

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

Guide for use

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

Examples

	Parent Identifier
The supervising psychiatrist creates a 5F order with an order identifier of 2351.	159

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

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds of the expiry date of the client's previous legal order.	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – it is only mandatory where an earlier legal order for the mental health client exists.

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

Examples

	Previous Expiry Date and Time
The supervising psychiatrist creates a 6C Continuation of Inpatient Treatment Order and enters the date and time of expiry of the previous legal order as 21 June 2021 at 11am.	2021-06-21 11:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the staff member who took receival of the mental health client.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client at the recorded place of examination.

This field displays the HE number of the person who took receival of the client.

In PSOLIS, the 'Received Patient By' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if 'received patient by name' is entered by free text.

Examples

	Received Patient By
The 'Received Patient By' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

Received Patient By Name

Field name:	RECEIVED_PATIENT_BY_NAME
Source data element(s):	[Received Patient By Name] – PSOLIS
Definition:	The name of the staff member who took receival of the mental health client.
Requirement status:	Conditional
Data type:	String
Format:	X(150)

Permitted values

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the staff member who took receival of the mental health client. to a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client at the recorded place of examination.

This field displays the name of the person who took receival of the client.

In PSOLIS, the 'Received Patient By Name' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

Examples

	Received Patient By Name
The 'Received Patient By Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

Received Patient Date and Time

Field name:	RECEIVED_PATIENT_DATETIME
Source data element(s):	[Received Patient Date and Time] – PSOLIS
Definition:	The date and time the client was received at the place of examination.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS

Permitted values

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day month year hour minutes and seconds of the expiry date of the client's previous legal order.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been received at the recorded place of examination.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client.

This data element records the date and time the client was actually physically received at the place of examination.

Received patient date and time must not be:

- in the future relative to the current date and time.
- prior to the legal order effective date and time.
- later than the order expiry date and time.

Examples

	Received Patient Date and Time
A mental health client is received at the recorded place of examination on 21 June 2021 at 11am.	2021-06-21 11:00:00

Related national definition

N/A

Revision history

N/A

Received Patient Indicator

Field name:	RECEIVED_PATIENT_INDICATOR
Source data element(s):	[Received Patient Indicator] – PSOLIS
Definition:	Indicates whether the client has been received at the recorded place of examination.
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
0	Not received	The client has not been received at the recorded place of examination	01/01/1600	31/12/9999
1	Received	The Client has been received at the recorded place of examination	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026

Guide for use

Collection of this data element is conditional – it is only mandatory for specific legal orders where a client has been received at the recorded place of examination.

A receival section is included in the legal form screen of those orders in PSOLIS to enable the recording of the receival of the client.

This checkbox data element records whether the client was actually received at the place of examination.

Examples

	Received Patient Indicator
A client is not received at the recorded place of examination and the 'Received Patient Indicator' checkbox remains unchecked.	0

Related national definition

N/A

Revision history

N/A

Referred From Place

Field name:	REFERRED_FROM_PLACE_CODE
Source data element(s):	[Referred From Place] – PSOLIS
Definition:	The name of the place the client is transferred from, expressed as a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(4)

Permitted values

Permitted values	Definition	Start date	End date
Valid location code	Any of the codes of up to 4 digits that are assigned to the list of locations in PSOLIS.	01/01/1600	31/12/9999

Guide for use

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

This data element identifies the service or program from which the client was transferred. This is selected from a drop-down value on the PSOLIS Legal Order screen.

Examples

	Referred From Place
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	16

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	Non-metropolitan	Client is referred from a location not in the metropolitan area	01/01/1600	31/12/9999
1	Metropolitan	Client is referred from a location within the metropolitan area.	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Activation Date and Time].

Guide for use

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

Examples

	Referred From Place Metro Indicator
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	0

Related national definition

N/A

Revision history

N/A

Referred From Place Type

Field name:	REFERRED_FROM_PLACE_TYPE_CODE
Source data element(s):	[Referred From Place Type] – PSOLIS
Definition:	The type of place the client was transferred from.
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Definition	Start date	End date
1	Authorised	A location authorised under section 542 of the Act, that provides the location with the power to detain and provide care to those subject to a mental health legal order	01/01/1600	31/12/9999
2	General hospital	A building gazetted as hospital that does not have the powers of an authorised location	01/01/1600	31/12/9999
3	Other PSOLIS place	Another mental health care provider listed in PSOLIS	01/01/1600	31/12/9999
4	Other metro place	Another location in the metropolitan area	01/01/1600	31/12/9999
5	Other non-metro place	Another location in a non-metropolitan area	01/01/1600	31/12/9999
Null	Not specified	The area is not clearly specified	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

Examples

	Referred From Place Type
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	2

Related national definition

N/A

Revision history

N/A

Referred To Place

Field name:	REFERRED_TO_PLACE_CODE
Source data element(s):	[Referred To Place] – PSOLIS
Definition:	The name of the place the client is transferred to, expressed as a code.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(4)

Permitted values

Permitted values	Definition	Start date	End date
Valid location code	Any of the codes of up to 4 digits that are assigned to the list of locations in PSOLIS.	01/01/1600	31/12/9999

Guide for use

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

This data element identifies the service or program to which the client was transferred. This is selected from a drop-down value on the PSOLIS Legal Order screen.

Examples

	Referred To Place
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	3

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	Non-metropolitan	Client is referred to a location not in the metropolitan area	01/01/1600	31/12/9999
1	Metropolitan	Client is referred to a location within the metropolitan area.	01/01/1600	31/12/9999

Derivation logic

This data element is derived by calculating the number of years between the [Date of Birth] and the [Activation Date and Time].

Guide for use

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

Examples

	Referred From Place Metro Indicator
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	0

Related national definition

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
1	Authorised	A location authorised undersection 542 of the Act that provides the location with the power to detain and provide care to those subject to a mental health legal order	01/01/1600	31/12/9999
2	General hospital	A building gazetted as hospital that does not have the powers of an authorised location	01/01/1600	31/12/9999
3	Other PSOLIS place	Another mental health care provider listed in PSOLIS	01/01/1600	31/12/9999
4	Other metro place	Another location in the metropolitan area	01/01/1600	31/12/9999
5	Other non-metro place	Another location in a non-metropolitan area	01/01/1600	31/12/9999
Null	Not specified	The area is not clearly specified	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

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

Examples

	Referred From Place Type
A client is transferred from Albany Acute Psychiatric Unit to Graylands Hospital.	2

Related national definition

N/A

Revision history

N/A

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

Code	Description	Definition	Start date	End date
0	No	The Practitioner recorded as revoking the Form 1A is not the same practitioner who made the order	01/01/1600	31/12/9999
1	Yes	The Practitioner recorded as revoking the Form 1A is the same practitioner who made the order	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

This data element is collected via a checkbox in PSOLIS, and its values represent whether the same medical practitioner made and revoked the Form 1A Referral.

Examples

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

Related national definition

N/A

Revision history

N/A

Supervising Psychiatrist

Field name:	SUPERVISOR
Source data element(s):	[Supervising Psychiatrist] – PSOLIS
Definition:	The health employee (HE) number of the supervising psychiatrist.
Requirement status:	Mandatory
Data type:	String
Format:	X[(X9)]

Permitted values

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the clients supervising psychiatrist.	01/01/1600	31/12/9999

Guide for use

This field displays the HE number of the supervising psychiatrist.

In PSOLIS, the 'Supervising Psychiatrist.' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if 'supervising psychiatrist name' is entered by free text.

Examples

	Supervising Psychiatrist
The 'Supervising Psychiatrist' person was selected from within the PSOLIS user search facility	HE123456

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the staff member who authorised the legal order to a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

This field displays the name of the supervising psychiatrist.

In PSOLIS, the 'Supervising Psychiatrist Name' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

Examples

	Supervising Psychiatrist Name
The 'Supervising Psychiatrist Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Valid date and time	The full date and time including day, month, year, hour, minutes and seconds a transcribed legal order ends.	01/01/1600	31/12/9999

Guide for use

Collection of this data element is conditional – it is only mandatory when there is an order expiry, and the record type is transcribed order.

The transcribed order end date and time is the date and time of expiry of any legal form entered in PSOLIS by transcription.

Examples

	Transcribed Order End Date and Time
A transcribed order has an expiry date and time of 15 December 2021 at 5pm.	2021-12-15 17:00:00

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
0	Null	Client was not transported by a police office or a transport officer.	01/01/1600	31/12/9999
1	Police officer	Client was transported by Police officers	01/01/1600	31/12/9999
2	Transport officer	Client was transported by medical transport officers	01/01/1600	31/12/9999
3	Police officer and/or transport officer	Client was transported by medical transport officers and Police officers	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

This data element is used to identify whether a client was transported by a police officer or transport officer, or both – it is expressed as a numeric code.

Examples

	Transport By
A client is transported from Albany Acute Psychiatric Unit to Graylands Hospital by a transport officer.	2

Related national definition

N/A

Revision history

N/A

Transport Police Reason

Field name:	TRANSPORT_POLICE_REASON
Source data element(s):	[Transport Police Reason] – PSOLIS
Definition:	Numeric code identifying the reason for police officer transportation.
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Start date	End date
1	I am satisfied that there is a significant risk of serious harm to the person being transported or to another person.	01/01/1600	31/12/9999
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.	01/01/1600	31/12/9999
Null	Not specified	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026.

Guide for use

Collection of this data element is conditional – it is only mandatory if a transport order has been created and 'transport by police' has been selected.

Examples

	Transport Police Reason
A clinician believes the client needs to be transported by the police.	1

Related national definition

N/A

Revision history

N/A

Transport Reason Satisfy

Field name:	TRANSPORT_REASON_SATISFY_CODE
Source data element(s):	[Transport Reason Satisfy] – PSOLIS
Definition:	Numeric code identifying the reason for making the transport order.
Requirement status:	Conditional
Data type:	Numeric
Format:	N

Permitted values

Code	Description	Start date	End date
1	Referred person needs to be taken to the place for examination by psychiatrist	01/01/1600	31/12/9999
2	Person needs to be taken to general hospital to be detained under inpatient treatment order	01/01/1600	31/12/9999
3	Person needs to be taken to authorised hospital for further examination by psychiatrist	01/01/1600	31/12/9999
4	Involuntary inpatient in general hospital needs to be taken to authorised hospital following a transfer order	01/01/1600	31/12/9999
5	Involuntary inpatient on leave of absence to obtain medical or surgical treatment at a general hospital to be taken to the general hospital	01/01/1600	31/12/9999
6	Involuntary inpatient on leave of absence that expires or is cancelled needs to be taken to hospital	01/01/1600	31/12/9999
7	Involuntary community patient not complying with order to attend needs to be taken to specified place	01/01/1600	31/12/9999
8	Involuntary community patient needs to be taken to hospital as involuntary inpatient	01/01/1600	31/12/9999
9	Involuntary inpatient in authorised hospital needs to be taken to another authorised hospital following a transfer order	01/01/1600	31/12/9999
Null	Null – Not specified	01/01/1600	31/12/9999

No Longer Applicable.
Superseded 1 July 2026

Guide for use

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

Examples

	Transport Reason Satisfy
The reason 'Person needs to be taken to authorised hospital for further examination by psychiatrist' is selected in PSOLIS.	3

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Code	Description	Start date	End date
1	Automatically revoked because a referral has been revoked.	01/01/1600	31/12/9999
2	I am satisfied that the transport order is no longer needed.	01/01/1600	31/12/9999
Null	Not specified	01/01/1600	31/12/9999

Guide for use

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

Examples

	Transport Revoke Reason
A clinician believes the client no longer needs to be transported.	2

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026

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

Permitted values	Definition	Start date	End date
Valid HE number	The Health Employee number assigned to the clients supervising psychiatrist.	01/01/1600	31/12/9999

Guide for use

This field displays the HE number of the treating practitioner.

In PSOLIS, the 'Treating Practitioner' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

This field will remain blank if 'treating practitioner name' is entered by free text.

Examples

	Supervising Psychiatrist
The 'Treating Practitioner' person was selected from within the PSOLIS user search facility.	HE123456

Related national definition

N/A

Revision history

N/A

No Longer Applicable.
Superseded 1 July 2026.

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

Permitted values	Definition	Start date	End date
Alphanumeric combination	The name of the Staff member who is the client's treating practitioner to a maximum of 150 alphanumeric characters.	01/01/1600	31/12/9999

Guide for use

This field displays the name of the treating practitioner.

In PSOLIS, the 'Treating Practitioner Name' field has:

a. Free text capability to cater for situations when the person is not listed in PSOLIS.
b. The ability to search for, and select, a PSOLIS user.

Examples

	Supervising Psychiatrist Name
The 'Treating Practitioner Name' person was not found via the PSOLIS user search facility, so was manually entered into the field.	Joe Citizen

Related national definition

N/A

Revision history

N/A

No Longer Applicable. Superseded 1 July 2026.

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

Code	Description	Definition	Start date	End date
1	Medical practitioner	A person registered to practise as a Medical Practitioner under the Health Practitioner Regulation National Law.	01/01/1600	31/12/9999
4	Mental health practitioner	A mental health practitioner is a person who, as one of the following, has at least 3 years' experience in the management of people who have a mental illness (a) a psychologist. (b) a nurse whose name is entered on Division 1 of the Register of Nurses kept under the Health Practitioner Regulation National Law (Western Australia) as a registered nurse; (c) an occupational therapist; (d) a social worker	01/01/1600	31/12/9999
Null	Not specified	The treating practitioner's qualification has not been specified	01/01/1600	31/12/9999

No Longer Applicable. Superseded 1 July 2026.

Guide for use

The data item is a numeric code which represents the treating practitioner's qualification type.

Examples

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

Related national definition

N/A

Revision history

N/A

Appendix A – Service Event Item Codes

(Note: TBD = To be determined)

Code	Name	Start Date	End Date	Clinical	Service Contact
TBD	NDIS ASSESSMENT	TBD		1	Y
TBD	NDIS REPORT WRITING	TBD		1	N
TBD	NDIS LIAISON – OTHER	TBD		1	Y
1	ASSESSMENT	1/01/2002	8/12/2003	1	Y
2	ASSESSMENTS OUTCOME MEASURES	1/01/2002	8/12/2003	1	Y
3	CASE CONFERENCES	1/01/2002	8/12/2003	1	C
4	CLIENT ADVOCACY	1/01/2002	8/12/2003	1	Y
5	CLIENT ASSISTANCE	1/01/2002	8/12/2003	1	Y
6	CLIENT EDUCATION	1/01/2002	8/12/2003	1	Y
7	CLIENT ESCORT	1/01/2002	8/12/2003	1	Y
8	CLINICAL RECORD KEEPING	1/01/2002	8/12/2003	1	N
9	CLINICAL REVIEWS	1/01/2002	8/12/2003	1	N
10	CLINICAL SUPERVISION	1/01/2002	8/12/2003	1	N
11	LIAISON - CONSULTATION	1/01/2002	8/12/2003	1	Y
12	COUNSELLING	1/01/2002	8/12/2003	1	Y
13	CRISIS INTERVENTION	1/01/2002	8/12/2003	1	Y
14	CRITICAL INCIDENT STRESS DEBRIEFING (CISD)	1/01/2002	8/12/2003	1	Y
15	DIETETICS	1/01/2002	7/04/2003	1	C
16	DRUG & ALCOHOL REHAB/DETOX	1/01/2002	8/12/2003	1	Y
17	FAMILY MEETINGS	1/01/2002	8/12/2003	1	Y
18	FAMILY SUPPORT	1/01/2002	8/12/2003	1	Y
19	LIAISON - GP	1/01/2002	8/12/2003	1	Y
20	GROUP PREPARATION	1/01/2002	8/12/2003	0	N
21	HEALTH PROMOTION	1/01/2002	8/12/2003	0	N
22	DEPOT INJECTION	1/01/2002	8/12/2003	1	Y
23	INTAKE MEETING	1/01/2002	8/12/2003	1	N
24	LEGAL	1/01/2002	27/03/2003	1	C
25	LIAISON - OTHER	1/01/2002	8/12/2003	1	C
26	MEDICATION REVIEW	1/01/2002	8/12/2003	1	Y
27	MEETINGS	1/01/2002	8/12/2003	0	N
28	MENTAL STATE ASSESSMENT	1/01/2002	7/04/2003	1	Y
29	PHYSIOTHERAPY	1/01/2002	8/12/2003	1	Y
30	LIAISON - POLICE	1/01/2002	8/12/2003	1	C
31	PROFESSIONAL DEVELOPMENT	1/01/2002	8/12/2003	1	N
32	PSYCHIATRIC ASSESSMENT	1/01/2002	7/04/2003	1	Y
33	PSYCHOLOGY APS	1/01/2002	27/03/2003	1	Y
34	QUALITY ASSURANCE	1/01/2002	7/04/2003	0	N
35	REPORT WRITING	1/01/2002	8/12/2003	0	N
36	RESEARCH ACTIVITIES	1/01/2002	8/12/2003	0	N
37	RESUSCITATION	1/01/2002	8/12/2003	0	Y
38	RISK ASSESSMENT	1/01/2002	8/12/2003	0	Y
39	SERVICE MANAGEMENT	1/01/2002	8/12/2003	0	N
40	SOCIAL WORK (SCGH)	1/01/2002	27/03/2003	0	Y
41	STUDENT EDUCATION	1/01/2002	8/12/2003	0	N
42	RISK ASSESSMENT - SUICIDE	1/01/2002	8/12/2003	0	Y

No Longer Applicable - Superseded 1 July 2026

Code	Name	Start Date	End Date	Clinical	Service Contact
43	THERAPY	1/01/2002	8/12/2003	0	Y
44	TRAVEL	1/01/2002	8/12/2003	0	N
45	WELFARE	1/01/2002	27/03/2003	0	C
46	CONSULTATION INITIAL	1/01/2002	27/03/2003	1	Y
47	WARD ROUND	1/01/2002	8/12/2003	1	N
48	CONSULTATION SUBSEQUENT	1/01/2002	27/03/2003	1	Y
49	STAFF DEVELOPMENT	1/01/2002	8/12/2003	1	C
50	ASSESSMENT	8/12/2003	30/06/2018	1	Y
51	ASSESSMENTS OUTCOME MEASURES	8/12/2003	30/06/2018	1	Y
52	CARER INTERVENTIONS - ADMITTED CLIENT	8/12/2003	30/06/2018	1	Y
53	CARER INTERVENTIONS - NON-ADMITTED CLIENT	8/12/2003	30/06/2018	1	N
54	CASE CONFERENCES	8/12/2003	30/06/2018	1	Y
55	CLIENT ADVOCACY	8/12/2003	30/06/2018	1	Y
56	CLIENT ASSISTANCE	8/12/2003	30/06/2018	1	Y
57	CLIENT DID NOT ATTEND	8/12/2003		0	N
58	CLIENT EDUCATION & SKILLS TRAINING	8/12/2003	30/06/2018	1	Y
59	CLIENT ESCORT	8/12/2003		1	Y
60	CLINICAL RECORD KEEPING	8/12/2003	30/06/2018	1	N
61	CLINICAL REVIEWS	8/12/2003	30/06/2018	1	Y
62	CLINICAL SUPERVISION	8/12/2003	30/06/2018	1	N
63	COUNSELLING	8/12/2003	30/06/2018	1	Y
64	CRISIS INTERVENTION	8/12/2003	30/06/2018	1	Y
65	CRITICAL INCIDENT STRESS DEBRIEFING (CISD)	8/12/2003	30/06/2018	1	Y
66	DEPOT INJECTION	8/12/2003	30/06/2018	1	Y
67	DRUG & ALCOHOL REHAB/DETOX	8/12/2003		1	Y
68	FAMILY MEETINGS	8/12/2003	30/06/2018	1	Y
69	FAMILY SUPPORT	8/12/2003		1	Y
70	HEALTH PROMOTION/PREVENTION	8/12/2003	30/06/2018	0	N
71	INTAKE MEETING	8/12/2003	30/06/2018	1	N
72	LIAISON - CONSULTATION	8/12/2003	30/06/2018	1	Y
73	LIAISON - GP (CLIENT SPECIFIC)	8/12/2003	30/06/2018	1	Y
74	LIAISON - GP (NON-CLIENT SPECIFIC)	8/12/2003	30/06/2018	1	N
75	LIAISON - OTHER	8/12/2003	30/06/2018	1	Y
76	LIAISON - POLICE	8/12/2003	30/06/2018	1	Y
77	MEDICATION, ADMINISTERING	8/12/2003	30/06/2018	1	Y
78	MEDICATION REVIEW	8/12/2003	30/06/2018	1	Y
79	MEETINGS	8/12/2003	30/06/2018	0	N
80	PHYSIOTHERAPY	8/12/2003	30/06/2018	1	Y
81	PROFESSIONAL DEVELOPMENT	8/12/2003	30/06/2018	1	N
82	REPORT WRITING	8/12/2003	30/06/2018	1	N
83	RESEARCH ACTIVITIES	8/12/2003	30/06/2018	0	N
84	RESUSCITATION	8/12/2003	30/06/2018	1	Y
85	SERVICE MANAGEMENT	8/12/2003	30/06/2018	0	N
86	SESSION PREPARATION	8/12/2003	30/06/2018	0	N
87	STAFF DEVELOPMENT	8/12/2003	30/06/2018	0	N
88	STUDENT EDUCATION	8/12/2003	30/06/2018	0	N

No Longer Applicable.
Superseded 1 July 2026.

Code	Name	Start Date	End Date	Clinical	Service Contact
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
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

No Longer Applicable. Superseded 1 July 2026.

Code	Name	Start Date	End Date	Clinical	Service Contact
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 1 July 2026.

Appendix B – Stream Codes

Code	Name	Start Date	Stream Type	Organisation ID
1	ALBANY CAMHS	1/01/2002	1	226
2	ALBANY ADULT	1/01/2002	2	226
3	ALBANY ELDERLY	1/01/2002	3	226
4	FREMANTLE CAMHS	1/01/2002	1	103
5	FREMANTLE ADULT	1/01/2002	2	103
6	FREMANTLE ELDERLY	1/01/2002	3	103
7	JHC MHS ADULT	1/06/2014	2	143
8	ARMADALE CAMHS	1/01/2002	1	101
9	ARMADALE ADULT	1/01/2002	2	101
10	ARMADALE OLDER ADULT	1/01/2002	3	101
11	BROOME CAMHS	1/01/2002	1	214
12	BROOME ADULT	1/01/2002	2	214
13	BROOME ELDERLY	1/01/2002	3	214
14	CARNARVON CAMHS	1/01/2002	1	229
15	CARNARVON ADULT	1/01/2002	2	229
16	CARNARVON OLDER ADULT	1/01/2002	3	229
17	DERBY CAMHS	1/01/2002	1	215
18	DERBY ADULT	1/01/2002	2	215
19	DERBY ELDERLY	1/01/2002	3	215
26	INNER CITY CAMHS	1/01/2002	1	106
27	SUBIACO ADULT	1/01/2002	2	106
28	INNER CITY ELDERLY	1/01/2002	3	106
30	KARRATHA CAMHS	1/01/2002	1	218
31	KARRATHA ADULT	1/01/2002	2	218
32	KARRATHA ELDERLY	1/01/2002	3	218
33	KATANNING CAMHS	1/01/2002	1	228
34	KATANNING ADULT	1/01/2002	2	228
35	KATANNING ELDERLY	1/01/2002	3	228
40	KUNUNURRA CAMHS	1/01/2002	1	216
41	KUNUNURRA ADULT	1/01/2002	2	216
42	KUNUNURRA ELDERLY	1/01/2002	3	216
44	BENTLEY CAMHS	1/01/2002	1	102
45	BENTLEY ADULT	1/01/2002	2	100
46	BENTLEY OLDER ADULT	1/01/2002	3	100
47	NARROGIN CAMHS	1/01/2002	1	227
48	NARROGIN ADULT	1/01/2002	2	227
49	NARROGIN ELDERLY	1/01/2002	3	227
50	CAHS-CAMHS	1/12/2012	1	139
51	YOUTH MH SERVICES ADULT	1/12/2012	2	140
52	YOUTH MH SERVICES CAMHS	1/12/2012	1	140
53	NM INDIVIDUALISED COMMUNITY LIVING STRATEGY ADULT	1/03/2012	2	141
54	FSH CAMHS	1/07/2014	1	142
55	FSH ADULT	1/07/2014	2	142
56	FSH OLDER ADULT	1/07/2014	3	142

No Longer Applicable.
Superseded 1 July 2026.

Code	Name	Start Date	Stream Type	Organisation ID
57	PCH CAMHS INPATIENT	8/06/2018	1	139
62	HEDLAND CAMHS	1/01/2002	1	217
63	HEDLAND ADULT	1/01/2002	2	217
64	HEDLAND ELDERLY	1/01/2002	3	217
66	GRAYLANDS ELDERLY	1/01/2002	3	104
67	BUNBURY CAMHS	1/01/2002	1	223
68	BUNBURY ADULT	1/01/2002	2	223
69	BUNBURY ELDERLY	1/01/2002	3	223
76	WARREN BLACKWOOD CAMHS	1/01/2002	1	224
77	WARREN BLACKWOOD ADULT	1/01/2002	2	224
78	WARREN BLACKWOOD ELDERLY	1/01/2002	3	224
82	SWAN CAMHS	1/01/2002	1	110
83	MIDLAND ADULT COMMUNITY	1/01/2002	2	100
84	MIDLAND OLDER ADULT COMMUNITY	1/01/2002	3	100
85	NEWMAN CAMHS	1/01/2002	1	219
86	NEWMAN ADULT	1/01/2002	2	219
87	NEWMAN AND TOM PRICE ELDERLY	1/01/2002	3	219
88	KALGOORLIE BOULDER CAMHS	1/01/2002	1	207
89	KALGOORLIE BOULDER ADULT	1/01/2002	2	207
90	KALGOORLIE BOULDER ELDERLY	1/01/2002	3	207
92	MEEKATHARRA CAMHS	1/01/2002	1	222
93	MEEKATHARRA ADULT	1/01/2002	2	222
94	MEEKATHARRA OLDER ADULT	1/01/2002	3	222
95	GRAYLANDS ADULT	1/01/2002	2	104
96	PMH/KEMH CAMHS	1/01/2002	1	107
97	ROCKINGHAM AND KWINANA SENIORS	1/01/2002	3	111
101	FORENSIC SERVICES ADULT	1/01/2002	2	116
103	KEMH ADULT	1/01/2002	2	136
106	EXMOUTH CAMHS	1/01/2002	1	229
107	EXMOUTH ADULT	1/01/2002	2	229
108	EXMOUTH OLDER ADULT	1/01/2002	3	229
112	SCGH MENTAL HEALTH SERVICE ADULT	1/01/2002	2	108
113	NORTH METRO OSBORNE CAMHS	1/01/2002	1	112
114	NORTH METRO STIRLING ADULT	1/01/2002	2	112
115	NORTH METRO OSBORNE ELDERLY	1/01/2002	3	112
116	NORTH METRO JOONDALUP/CLARKSON CAMHS	1/01/2002	1	113
117	NORTH METRO WANNEROO ADULT	1/01/2002	2	113
118	NORTH METRO WANNEROO OLDER ADULT	1/01/2002	3	113
119	NORTH METRO SUBIACO CAMHS	1/01/2002	1	105
120	NORTH METRO SUBIACO ADULT	1/01/2002	2	105
121	NORTH METRO SUBIACO ELDERLY	1/01/2002	3	105
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

No Longer Applicable:
Superseded 1 July 2026.

Code	Name	Start Date	Stream Type	Organisation ID
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
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

No Longer Applicable.
Superseded 1 July 2026.

Code	Name	Start Date	Stream Type	Organisation ID
178	SOUTH CATT ELDERLY	1/07/2006	3	126
179	MHERL ADULT	12/09/2006	2	100
180	HAWTHORN HOUSE ADULT	16/10/2006	2	129
181	NORTH METRO CLINICAL ACCOMMODATION SUPPORT SERVICE	1/11/2007	2	130
182	CLIENT RECORD SEARCH STREAM	12/02/2008	2	46708
183	NMHS HOSPITAL IN THE HOME	1/11/2007	2	131
184	NORTH METRO MIRRABOOKA ADULT	1/07/2008	2	132
185	RPH ADULT	1/07/2008	2	100
186	RPH OLDER ADULT	1/07/2008	3	100
187	WUNGEN KARTUP ABORIGINAL MENTAL HEALTH SERVICE ADULT	1/04/2010	2	100
189	WUNGEN KARTUP ABORIGINAL MENTAL HEALTH SERVICE OLDER ADULT	1/04/2010	3	100
190	SMAHS - MH ADULT	1/05/2010	2	135
191	SMAHS - MH CAMHS	1/05/2010	1	135
192	SMAHS - MH ELDERLY	1/05/2010	3	135
193	SOUTHWEST MHS ADULT	1/07/2010	2	231
194	SOUTHWEST MHS CAMHS	1/07/2010	1	231
195	SOUTHWEST 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
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

No Longer Applicable.
Superseded 1 July 2026.

Code	Name	Start Date	Stream Type	Organisation ID
250	KARRATHA YOUTH	1/01/2017	2	218
251	HEDLAND YOUTH	1/01/2017	2	217
252	SOUTHWEST MHS YOUTH	1/01/2017	2	231
253	KEMH CAMHS	1/03/2017	1	136
254	NEWMAN YOUTH	1/01/2017	2	219
255	BENTLEY YOUTH	29/01/2018	2	100
256	BUSSELTON YOUTH	1/04/2018	2	212
257	SPEAK UP ADULT	27/08/2013	2	136
258	MIA REVIEW BOARD	1/04/2016	2	237
259	OFFICE OF THE CHIEF PSYCHIATRIST	1/04/2016	2	238
260	MENTAL HEALTH ADVOCACY SERVICE	1/04/2016	2	239
261	MENTAL HEALTH TRIBUNAL	1/04/2016	2	240
262	WHEATBELT YOUTH	1/10/2018	2	205
263	BROOME YOUTH	1/11/2019	2	214
264	BUNBURY YOUTH	1/11/2019	2	223
265	CARNARVON YOUTH	1/11/2019	2	229
266	DERBY YOUTH	1/11/2019	2	215
267	ESPERANCE YOUTH	1/11/2019	2	206
268	EXMOUTH YOUTH	1/11/2019	2	229
269	FITZROY CROSSING YOUTH	1/11/2019	2	232
270	GERALDTON YOUTH	1/11/2019	2	204
271	HALLS CREEK YOUTH	1/11/2019	2	234
272	KALGOORLIE BOULDER YOUTH	1/11/2019	2	207
273	KUNUNURRA YOUTH	1/11/2019	2	216
274	MARGARET RIVER YOUTH	1/11/2019	2	212
275	MEEKATHARRA YOUTH	1/11/2019	2	222
276	WARREN BLACKWOOD YOUTH	1/11/2019	2	224
277	DEPARTMENT OF HEALTH	16/12/2019	2	241
278	WACHS MH ETS ADULT	1/07/2020	2	242
279	NMHS ACTIVE RECOVERY TEAM	6/04/2021	2	243
280	WACHS MH ETS CAMHS	01/09/2022		242
281	EMHS CRISIS RESOLUTION HOSPITAL IN THE HOME (CRHITH) ARMADALE	30/01/2023		101
282	NM EATING DISORDERS SPECIALIST SERVICE	01/07/2022		236
283	EMHS CRISIS RESOLUTION HOSPITAL IN THE HOME (CRHITH) CITY	30/01/2023		101
284	DEPARTMENT OF JUSTICE	16/08/2022		244
285	SJOG MT LAWLEY ELDERLY	01/12/2021		30
286	MENTAL HEALTH CO-RESPONSE	01/10/2022		100
287	RPBG TRANSITIONAL CARE UNIT	28/07/2023		100
288	JHC MHS CAMHS	28/08/2023	1	143
289	JHC MHS OLDER ADULT	28/08/2023	1	143
290	HEADSPACE	14/07/2023	2	246
291	RPH YOUTH	01/01/2023		
292	EMHS CRISIS RESOLUTION HOSPITAL IN THE HOME (CRHiTH) MIDLAND	01/07/2023		101
293	RPH OLDER ADULT	01/01/2023		100

No Longer Applicable.
Superseded 1 July 2026.

Appendix C – Triage Presenting Complaint and Referral Presenting 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
42	PERINATAL LOSS	29/09/2021

No Longer Applicable.
Superseded 1 July 2026.

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 REVOCATIONS 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
39	9A RECORD OF EMERGENCY PSYCHIATRIC TREATMENT
40	9B REPORT ON URGENT NON-PSYCHIATRIC TREATMENT
41	12B REFUSAL OF REQUEST TO ACCESS DOCUMENT

No Longer Applicable. Superseded 1 July 2026.

Code	Name
42	12C RESTRICTION OF FREEDOM OF COMMUNICATION
43	ABSENT WITHOUT LEAVE
44	CLMIAA DISCHARGE
45	CLMIAA ORDER
46	DETAINED ON LEAVE
47	DETENTION EXPIRED
48	DISCHARGED FROM HOSPITAL
49	FURTHER OPINION
50	FURTHER OPINION DID NOT OCCUR
51	INVOLUNTARY ORDER EXPIRED
52	RECORD OF DEATH
53	REFERRAL EXPIRED
54	REFERRAL NOT REQUIRED
55	REQUEST FOR FURTHER OPINION
56	RETURN FROM LEAVE
57	RETURNED TO CARE
58	TRANSFER CANCELLATION
59	TRIBUNAL / COURT TERMS
60	TRIBUNAL / COURT TERMS LIFTED
61	VOLUNTARY ADMISSION

No Longer Applicable.
Superseded 1 July 2026.

Appendix E – Incident Locations

Code	Incident Location	Code	Incident Location
1	PUBLIC OPEN SPACE	170	HOSTEL
2	OUTPATIENT CLINIC	177	PUBLIC SPACE
3	CLIENT'S HOME	198	PUBLIC SPACE
4	ALBANY HOSPITAL - G WARD	202	OTHER
5	ALBANY HOSPITAL	205	OTHER
8	COMMUNITY SETTING	207	WARD 4.1
26	EUDORIA STREET CENTRE	208	WARD 4.2
27	LESCHEN UNIT - HDU	209	WARD 5.1
28	LESCHEN UNIT - OPEN	210	TRIAGE
29	LESCHEN UNIT - KARRI	211	EMERGENCY DEPARTMENT
31	EMERGENCY DEPARTMENT	212	OUTPATIENT CLINIC
33	OTHER	216	HAMPTON ROAD SERVICE
34	CLINIC	217	HOME
35	LESHCEN UNIT - BANKSIA	219	GENERAL WARDS FREMANTLE HOSPITAL
39	OTHER	221	COMMUNITY
40	WARD 6	222	OTHER
41	WARD 7	231	WARD 4.1
42	WARD 8	232	WARD 4.3
43	WARD 9	240	COMMUNITY
44	ECT SUITE	242	OTHER
45	THERAPY UNIT	243	OTHER
46	OUTPATIENT CLINIC	244	OTHER
47	TRIAGE	252	ART ROOM
48	KIOSK/QUAD	273	PINCH- DAY ROOM
52	HOME	274	PINCH - BEDROOM
53	HOSTEL	275	PINCH - DINING ROOM
54	COMMUNITY, OTHER	276	PINCH - SMOKING ROOM
55	OTHER	277	PINCH - PASSAGE WAY
57	WARD 5	278	PINCH - TREATMENT ROOM
59	TRANSITION UNIT	279	CASSON - DAY ROOM
63	HOME	280	CASSON - BEDROOM
68	WARD 10: A, B OR C	281	CASSON - DINING ROOM
69	DAY HOSPITAL	283	CASSON - PASSAGE WAY
70	OUTPATIENTS	284	CASSON - TREATMENT ROOM
72	HOME	285	CASSON - ECT SUITE
73	HOSTEL	286	CASSON - NURSE'S STATION
75	OTHER	287	DORRINGTON - DAY ROOM
76	HOSPITAL	288	DORRINGTON - BEDROOM
78	INPATIENT WARD	289	DORRINGTON - DINING ROOM
79	CLINIC	290	DORRINGTON - SMOKING ROOM
80	HOME	291	DORRINGTON - PASSAGE WAY
81	POLICE STATION	292	DORRINGTON - TREATMENT ROOM
85	HOSPITAL	293	DORRINGTON - OT AREA
89	HOME	294	DORRINGTON -NURSE'S STATION
103	OTHER	296	HUTCHISON - DAY ROOM
106	OTHER	297	HUTCHISON - BEDROOM
139	CLINIC	298	HUTCHISON - DINING ROOM
140	COMMUNITY HEALTH SERVICE	299	HUTCHISON - VERANDA
143	EMERGENCY DEPARTMENT	300	HUTCHISON - SMOKING ROOM
145	GENERAL HOSPITAL	301	HUTCHISON - PASSAGE ROOM
146	GP SURGERY	302	HUTCHISON - TREATMENT ROOM
148	HOME/PRIVATE DWELLING	304	HUTCHISON - NURSE'S STATION
156	PUBLIC SPACE	309	HUTCHISON - BATHROOM
169	HOME/PRIVATE DWELLING	311	MEDICAL COMORBIDITY - BEDROOM

No Longer Applicable.
Superseded 1 July 2026.

Code	Incident Location	Code	Incident Location
312	MEDICAL COMORBIDITY - DINING ROOM	388	MOORE HOUSE - CASHIER AND PROPERTY OFFICE
315	MEDICAL COMORBIDITY - TREATMENT ROOM	391	ASHBURTON HOUSE - ENTRANCE
319	MONTGOMERY - DAY ROOM	393	ASHBURTON HOUSE - MEETING ROOM
320	MONTGOMERY - BEDROOM	394	ASHBURTON HOUSE - DOCTOR'S OFFICE
321	MONTGOMERY - BATHROOM	395	ASHBURTON HOUSE - OT AREA
322	MONTGOMERY - DINING ROOM	396	PRIMARY REHAB UNIT - OFFICE
323	MONTGOMERY - DINNING ROOM	397	PRIMARY REHAB UNIT - RECREATION AREA
324	MONTGOMERY - SMOKING ROOM	398	PRIMARY REHAB UNIT - CARPENTRY AREA
325	MONTGOMERY - PASSAGE WAY	401	50 MURRAY STREET
326	MONTGOMERY - TREATMENT ROOM	402	70 MURRAY STREET (OUTPATIENT CLINIC)
327	MONTGOMERY - OT AREA	403	74 MURRAY STREET (OFFICES ONLY)
328	MONTGOMERY - NURSE'S STATION	405	CLIENT'S HOME
330	MONTGOMERY - VISITOR'S ROOM	406	HOSTEL
331	MURCHISON - DAY ROOM EAST	407	COMMUNITY CENTRE
332	MURCHISON - DAY ROOM WEST	422	OTHER
333	MURCHISON - BEDROOM	423	OTHER
334	MURCHISON - DINING ROOM	425	HOSPITAL
335	MURCHISON - VERANDA	426	ACCIDENT AND EMERGENCY
336	MURCHISON - SMOKING AREA	432	REMOTE COMMUNITY
337	MURCHISON - PASSAGE WAY	457	COMMUNITY SETTING
338	MURCHISON - TREATMENT ROOM	458	KATANNING HOSPITAL
339	MURCHISON - OT AREA	539	OTHER
340	MURCHISON - NURSE'S STATION	543	OTHER
341	MURCHISON - DOCTOR'S ROOM	550	NARROGIN REGIONAL HOSPITAL
342	MURCHISON - TEAM RECEPTION	554	CLIENT'S HOME
344	MURCHSION - BATHROOM	557	COMMUNITY SETTING
345	PLAISTOWE - DAY ROOM	622	HOSPITAL
346	PLAISTOWE - BEDROOM	623	ACCIDENT AND EMERGENCY
348	PLAISTOWE - VERANDA	624	INPATIENT WARD
350	PLAISTOWE - PASSAGE WAY	625	CLINIC
352	PLAISTOWE - OT AREA	626	HOME
353	PLAISTOWE - NURSE'S STATION	627	POLICE STATION
359	PLAISTOWE - ROTUNDA	628	PRISON
360	SMITH - DAY ROOM	629	REMOTE COMMUNITY
361	SMITH - BEDROOM	635	HOME
362	SMITH - BATHROOM	638	REMOTE COMMUNITY
363	SMITH - DINING ROOM	649	OTHER
364	SMITH - SMOKING AREA	652	OTHER
365	SMITH - PASSAGE WAY	658	OUTPATIENT CLINIC
366	SMITH - TREATMENT ROOM	659	INTERVIEW ROOMS
367	SMITH - OT AREA	660	CLIENT'S HOME
368	SMITH - NURSE'S STATION	661	HOSTEL
369	SMITH - DOCTOR'S ROOM	662	COMMUNITY CENTRE
370	SMITH - VISITOR'S ROOM	666	WING 1
371	TRIAGE - NURSE'S STATION	667	WING 2
372	TRIAGE - DOCTOR'S ROOM	668	WING 3
373	TRIAGE - RECEPTION	669	DAY THERAPY
374	FITZROY HOUSE - FOYER	675	HOSTEL
375	FITZROY HOUSE - RECEPTION	686	CLARKSON CAMHS CENTRE
382	FITZROY HOUSE - ADMIN OFFICE	692	SWAN CAMHS CENTRE
387	FORTESQUE HOUSE - KIOSK	693	HOME

No Longer Applicable.
Superseded 1 July 2026.

Code	Incident Location	Code	Incident Location
695	COMMUNITY/PUBLIC SPACE	914	OTHER
696	GENERAL HOSPITAL (WARD)	916	50 MURRAY STREET
697	EMERGENCY DEPARTMENT	917	70 MURRAY STREET (OUTPATIENT CLINIC)
698	GP SURGERY	918	74 MURRAY STREET (OFFICES ONLY)
699	OUTPATIENT CLINIC	919	58 PALMERSTON STREET
702	LIVING SKILLS	920	CLIENT'S HOME
705	WORKPLACE	921	HOSTEL
712	HOME	922	COMMUNITY CENTRE
746	PATIENT'S HOME	923	CLINIC
747	KEMH HOSPITAL WARD	924	TREATMENT ROOM
752	SPECIAL CARE NURSERY (SCN)	927	CLIENT'S HOME
754	SCHOOLROOM	928	CLINIC CAR PARK
764	CLIENT'S HOME	932	CLIENT'S HOME
769	WARD 7TEEN	935	GYM
778	KITCHEN	936	COURTYARD
780	HOSPITAL GROUNDS	937	CARPARK
783	EMERGENCY DEPARTMENT	938	CLINIC
788	HOSPITAL	939	TREATMENT ROOM
789	ACCIDENT AND EMERGENCY	940	INTERVIEW ROOM
791	CLINIC	941	WAITING ROOM
792	HOME	942	CLIENT'S HOME
795	REMOTE COMMUNITY	944	PUBLIC SPACE
800	CLINIC	946	CLINIC
801	HOME	948	INTERVIEW ROOM
815	CLINIC	950	CLIENT'S HOME
816	PARK IDTU BUILDING	952	PUBLIC SPACE
818	RKDH EMERGENCY DEPARTMENT	955	TREATMENT ROOM
821	HOME	956	INTERVIEW ROOM
829	PUBLIC SPACE	960	PUBLIC SPACE
833	GENERAL HOSPITAL	962	CLINIC
834	PSYCHIATRIC HOSPITAL	963	TREATMENT ROOM
837	OTHER	965	WAITING ROOM
846	CLINIC	966	CLIENT'S HOME
849	SHOPS	968	PUBLIC SPACE
858	OTHER	980	CLINIC
859	COMMUNITY OUTPATIENTS	987	EMERGENCY DEPARTMENT
860	DAY THERAPY UNIT	988	ED WAITING ROOM
861	SELBY A	989	OBSERVATION WARD
862	SELBY B	992	OBSERVATION WARD
863	MED C (MEDICAL CO-MORBIDITY)	993	ELLIS - BEDROOM
864	WARD D20	994	ELLIS - DAY ROOM
866	OUTPATIENT CLINIC AREA	995	ELLIS - DINING ROOM
867	INTERVIEW ROOMS	996	ELLIS - DOCTORS ROOM
868	CLIENT'S HOME	997	ELLIS - PASSAGE WAY
870	COMMUNITY CENTRE	998	ELLIS - NURSES STATION
885	OTHER	999	DORRINGTON - SECLUSION ROOM
889	OTHER	1000	PINCH - SECLUSION ROOM
890	OTHER	1001	SMITH - SECLUSION ROOM
891	OTHER	1002	MONTGOMERY - SECLUSION ROOM
893	OTHER	1003	ELLIS - SECLUSION ROOM
894	OTHER	1004	MURCHISON - SECLUSION ROOM
895	OTHER	1005	SECURE WARD
896	OTHER	1006	OTHER
897	OTHER	1007	HOME
911	COMMUNITY	1008	CLIENT'S HOME

No Longer Applicable.
Superseded 1 July 2026.

Code	Incident Location
1009	HOSPITAL
1011	INPATIENT WARD
1012	EMERGENCY DEPARTMENT
1013	PUBLIC SPACE
1015	PUBLIC OPEN SPACE
1023	INPATIENT WARD
1030	OTHER
1033	HOSPITAL
1035	INPATIENT WARD
1036	EMERGENCY DEPARTMENT
1037	PUBLIC SPACE
1039	PUBLIC OPEN SPACE
1040	CARPARK
1090	OTHER
1091	HOME
1092	CLIENT'S HOME
1093	HOSPITAL
1095	INPATIENT WARD
1096	EMERGENCY DEPARTMENT
1097	PUBLIC SPACE
1099	PUBLIC OPEN SPACE
1100	CARPARK
1104	CLINIC
1105	COMMUNITY CENTRE
1108	GENERAL HOSPITAL (WARD)
1112	HOME (OF CLIENT/PATIENT)
1113	HOME (OTHER)
1114	HOSPITAL
1116	INPATIENT WARD
1120	OTHER
1121	OUTPATIENT CLINIC
1125	PUBLIC OPEN SPACE
1128	SCHOOL/SCHOOL ROOM
1136	CLINIC
1144	HOME (OF CLIENT/PATIENT)
1152	OTHER
1561	HOME (OTHER)
1562	HOSPITAL
1566	NON-GOVERNMENT AGENCY
1568	OTHER
1573	PUBLIC OPEN SPACE
1584	CLINIC
1624	HOME (OF CLIENT/PATIENT)
1632	OTHER
1784	HOME (OF CLIENT/PATIENT)
2020	PRISON
2078	OUTPATIENT CLINIC
2098	MBU BEDROOM
2099	MBU CORRIDOR
2105	OTHER
2106	HOME
2108	HOSPITAL
2110	INPATIENT WARD
2111	EMERGENCY DEPARTMENT
2165	OTHER
2166	HOME
2167	CLIENT'S HOME
2169	OUTPATIENT CLINIC
2173	GOVT VEHICLE
2174	PUBLIC OPEN SPACE
2175	CARPARK
2182	INPATIENT WARD
2189	OTHER
2193	OUTPATIENT CLINIC
2204	HOSPITAL
2214	HOME
2237	WARD MBU
2238	WARD MHA
2239	WARD MHB
2240	WARD MHEC
2241	WARD MHEO
2242	WARD MHAC
2243	WARD MHAO
2256	MURCHISON - COURTYARD
2259	CLIENT'S HOME
2281	WARD 11
2282	AMBULANCE BAY
2283	COURTYARD
2284	CARPARK
2285	OTHER
2286	OTHER
2289	HOSPITAL
2291	INPATIENT WARD
2304	EMERGENCY DEPARTMENT
2493	HOSPITAL
2551	HOME
2627	INPATIENT WARD
2673	HOSPITAL

No Longer Applicable. Superseded 1 July 2026.

Appendix F – Mental Health Organisation Codes

Code	Name
100	ROYAL PERTH BENTLEY GROUP
101	ARMADALE HEALTH SERVICE
102	BENTLEY HEALTH SERVICE
103	FREMANTLE MENTAL HEALTH SERVICE
104	GRAYLANDS SPECIAL HEALTH CARE SERVICES
105	NORTH METRO - SUBIACO
106	CITY MHS
107	PRINCESS MARGARET HOSPITAL - KING EDWARD MEMORIAL HOSPITAL
108	SIR CHARLES GAIRDNER HOSPITAL
109	CITY LOWER WEST OLDER ADULT
110	MIDLAND COMMUNITY MENTAL HEALTH CENTRE
111	ROCKINGHAM KWINANA MENTAL HEALTH SERVICE
112	NORTH METRO STIRLING
113	NORTH METRO JOONDALUP
115	PSYCHIATRIC EMERGENCY TEAM
116	STATE FORENSIC MHS
117	YOUTHLINK - INNER CITY MENTAL HEALTH SERVICES
118	GHS JOINT SERVICES DEVELOPMENT UNIT (JSDU)
119	GHS CENTRE FOR CLINICAL INTERVENTION (CCI)
120	GHS CREATIVE EXPRESSION CENTRE FOR ARTS THERAPY
121	GHS NEUROSCIENCES
122	PEEL
123	NORTH METROPOLITAN
124	MULTI SYSTEMIC THERAPY (MST)
125	YOUTH REACH SOUTH
126	SOUTH CATT
127	NORTH COMMUNITY EMERGENCY RESPONSE TEAM (CERT)
129	HAWTHORN HOUSE
130	NORTH METRO HOSTEL LIAISON SERVICE
131	NMAHS, HOSPITAL IN THE HOME
132	NORTH METRO MIRRABOOKA ADULT
135	SMAHS - MH
136	WOMEN AND NEWBORN HEALTH SERVICE
137	NORTH METROPOLITAN THERAPY SERVICES
139	CAHS-CAMHS
140	YOUTH MH SERVICES
142	FIONA STANLEY
143	JOONDALUP HEALTH CAMPUS
204	GERALDTON
205	WHEATBELT MHS WEST
206	ESPERANCE
207	KALGOORLIE BOULDER
212	VASSE LEEUWIN
214	BROOME
215	DERBY
216	KUNUNURRA

No Longer Applicable.
Superseded 1 July 2026.

Code	Name
217	PORT HEDLAND
218	KARRATHA
219	NEWMAN - TOM PRICE
222	MEEKATHARRA
223	BUNBURY MENTAL HEALTH
224	WARREN BLACKWOOD
226	ALBANY MENTAL HEALTH SERVICES
227	NARROGIN
228	KATANNING MENTAL HEALTH SERVICE
229	CARNARVON / EXMOUTH
230	WHEATBELT MHS EAST
231	SOUTHWEST MHS
232	FITZROY CROSSING
233	STATEWIDE DEPARTMENT NEUROPHYSIOLOGY
234	HALLS CREEK
235	ST JOHN OF GOD MIDLAND PUBLIC AND PRIVATE HOSPITALS
236	STATEWIDE SPECIALISED MENTAL HEALTH SERVICE
241	DEPARTMENT OF HEALTH
242	WACHS MH TELEHEALTH
243	NMHS ACTIVE RECOVERY TEAM

No Longer Applicable.
Superseded 1 July 2026.

Appendix G – Mental Health Program Codes

Code	Program Name	Code	Program Name
3	ACCOMMODATION SUPPORT AVRO	44	CARNARVON ADULT COMMUNITY MH
4	ALBANY ADULT CTT	45	CARNARVON CAMHS
5	ALBANY CAMHS	46	CARNARVON OLDER ADULT
6	ALBANY ELDERLY SERVICES	47	GERALDTON ADULT COMMUNITY MH
7	ALBANY HOME WITHDRAWAL	48	GERALDTON CAMHS
8	ALBANY ACUTE PSYCHIATRIC UNIT	49	GERALDTON OLDER ADULT
9	ALBANY SESSIONAL CLINIC	50	CENTRAL WHEATBELT COMMUNITY MH
10	ALMA SENIORS DAY THERAPY	51	OLD FAMILIES AT WORK INPATIENT
11	FREMANTLE OLDER ADULT OUTPATIENT	52	WANNEROO CTT - BUTLER
12	FREMANTLE ATT TRIAGE	53	OLD CLARKSON CAMHS
13	FREMANTLE ADULT OUTPATIENT	54	COASTAL & WHEATBELT FAMILY INTERVENTION
14	FREMANTLE ADULT INPATIENT UNIT	55	COASTAL & WHEATBELT MH CAMHS
15	ANDREW RELPH PROGRAM	56	COASTAL & WHEATBELT MH SENIORS
16	ARMADALE ADULT ACUTE MH UNIT	57	COMMUNITY FORENSIC MH ADULT
17	HORIZONS	58	CECAT COMMUNITY ADULT
18	ARMADALE MHS FOR OLDER PEOPLE AUTHORISED	59	OLD FAMILIES AT WORK OUTPATIENT
19	ARMADALE MHS FOR OLDER PEOPLE COMMUNITY	60	CSRP
20	ARMADALE MHS FOR OLDER PEOPLE DAY THERAPY	61	DENHAM COMMUNITY MH
21	ALMA STREET GROUP PROGRAM	62	DERBY CAMHS
22	AVON COMMUNITY MENTAL HEALTH	63	DERBY COMMUNITY ADULT MH
23	AVRO CLINIC	66	EAST WHEATBELT ADULT
24	BENTLEY OLDER ADULT INPATIENT	68	ESPERANCE CAMHS
25	OLD BENTLEY FAMILY CLINIC	69	ESPERANCE COMMUNITY MH
26	BENTLEY OLDER ADULT DAY THERAPY SERVICE	71	ESPERANCE SENIORS
27	BENTLEY OLDER ADULT COMMUNITY SERVICE	72	ESPERANCE YOUTH
29	OLD BENTLEY TRANSITIONAL UNIT OUTPATIENTS	73	EXMOUTH CAMHS
30	OLD BENTLEY ADOLESCENT INPATIENTS UNIT	74	EXMOUTH ADULT COMMUNITY MH
31	BENTLEY ADOLESCENT OUTPATIENTS' UNIT	75	EXMOUTH OLDER ADULT
32	BHIP - BRIEF HOME INTERVENTION PROGRAM BENTLEY	76	FAMILY EARLY INTERVENTION PROGRAM (FEIP)
33	BORONIA INPATIENT UNIT	77	OLD FAMILY PATHWAYS PROGRAM
34	BORONIA EXIT FOLLOW UP	78	FORENSIC COURT LIAISON
35	BORONIA NURSING HOME/HOSTEL SERVICE	79	PRISON CONSULTATION LIAISON
36	MIDLAND OLDER ADULT COMMUNITY MENTAL HEALTH SERVICE	80	FREMANTLE COMMUNITY LIAISON
37	BROOME CAMHS	81	FREMANTLE ASSERTIVE COMMUNITY TREATMENT TEAM
38	BROOME COMMUNITY MH	82	FREMANTLE LIVING SKILLS
40	BUNBURY ACUTE PSYCHIATRIC RESIDENTIAL UNIT	86	GRAYLANDS HOSPITAL
41	BUNBURY REHABILITATION PROGRAM	87	HAMPTON ROAD SERVICE (MILPARA)
42	BUNBURY COMMUNITY MENTAL HEALTH	88	OLD SUBIACO RECOVERY NETWORK CENTRE
43	BUNBURY APU ACUTE THERAPY PROGRAM	89	HARVEY YARLOOP COMMUNITY MH

No Longer Applicable. Superseded 1 July 2026.

Code	Program Name	Code	Program Name
90	OLD HILLARYS CAMHS	137	MIRRABOOKA CLINIC(EXPIRED)
91	MIDLAND CTT FOREST	138	MORLEY ADULT MENTAL HEALTH
92	HOSTEL LIAISON TEAM	139	NARROGIN ADULTS’ COMMUNITY MH
93	INNER CITY AFFECTIVE DISORDERS CLINIC	140	NARROGIN CAMHS
94	SUBIACO CTT - GREEN	141	NARROGIN ELDERLY SERVICES
95	RPH CONSULTATION AND LIAISON	142	NEUROSCIENCES ADULT
96	RPH ADULT 7 DAY FOLLOW-UP	143	NEWMAN ADULT COMMUNITY MH
97	INNER CITY DRUG AND ALCOHOL ADVISORY SERVICE	144	NORTH METRO (HSTLS)
98	INNER CITY ED LIAISON	145	SUBIACO RECOVERY NETWORK CENTRE
99	INNER CITY ENHANCE	146	ONSLOW COMMUNITY MH
100	INNER CITY LIFE SKILLS	147	OSBORNE LODGE CARERS SUPPORT PROGRAM
101	INNER CITY MH SERVICE FOR OLDER ADULTS	149	STIRLING CTT - OSBORNE DUKE
102	JARRAH ROAD CENTRE	150	OSBORNE OLDER ADULT MH INPATIENT UNIT
103	JOINT SERVICES DEVELOPMENT UNIT ADULT	151	OSBORNE PARK LODGE DAY HOSPITAL
104	WANNEROO CTT - EAST	152	OSBORNE COMMUNITY OLDER ADULT MH
105	KALGOORLIE HOSPITAL PSYCH UNIT	153	ROCKINGHAM KWINANA CARER SUPPORT PROGRAM
106	KALGOORLIE DETOX AND METHADONE CLINIC	154	PARK INTENSIVE SUPPORT PROGRAM
108	KALGOORLIE YOUTH	155	ROCKINGHAM KWINANA SENIORS MHS
109	KALGOORLIE/ BOULDER ELDERLY SERVICES	156	ROCKINGHAM KWINANA CONNECT & RECOVERY MODULES (CARM)
110	KALGOORLIE/BOULDER CAMHS	157	PATRICIA STREET CENTRE
111	KALGOORLIE BOULDER COMMUNITY MH ADULT	158	PEEL COMMUNITY MENTAL HEALTH (ADULT)
112	KALGOORLIE/BOULDER OUTREACH	159	OLD PEEL CAMHS
113	OLD KALAMUNDA CAMHS	161	PMH 4H TRANSITION
114	KARRATHA CAMHS	162	OLD PMH CONSULTATION LIAISON
115	KARRATHA ADULT COMMUNITY MH	163	PMH DAY HOSPITAL
116	KATANNING ADULT CTT	164	OLD PMH EATING DISORDER CLINIC
117	KATANNING CAMHS	165	PMH PSYCHIATRIC OUTPATIENT CLINIC
118	KATANNING ELDERLY SERVICES	166	OLD PMH WARD 4H DAY PROGRAM
119	OLD ARMADALE CAMHS	167	OLD PMH WARD 4H INPATIENTS
120	KEMH CONSULTATION LIAISON	168	HEDLAND CAMHS
121	KEMH PSYCHOLOGICAL MEDICINE	169	HEDLAND ADULT COMMUNITY MH
124	WANNEROO OLDER ADULT MENTAL HEALTH SERVICE	170	PRIMARY REHAB. UNIT
125	KUNUNURRA ADULT COMMUNITY MH	172	OLD ROCKINGHAM KWINANA CAMHS
126	KUNUNURRA CAMHS	173	ROCKINGHAM KWINANA CMNTY PSY SERVICE (ADULT)
127	ROCKINGHAM SRT	174	SCARBOROUGH/OSBORNE REHAB
128	ARMADALE ATT	175	SELBY OLDER ADULT MH INPATIENT UNIT
129	MEEKATHARRA ADULT COMMUNITY MH	176	SHENTON CHILD & ADOLESCENT CENTRE
130	MEEKATHARRA CAMHS	177	SELBY COMMUNITY OLDER ADULT MH
131	MEEKATHARRA OLDER ADULT	178	CLW THERAPY SERVICES
132	MIDLAND CTT RIVER	179	SHEOAK REHABILITATION UNIT
133	BENTLEY ACUTE ADULT INPATIENT	180	OLD FREMANTLE CAMHS
135	EARLY INTERVENTION IN PSYCHOSIS	181	BUNBURY CAMHS
136	BENTLEY CTT	182	SOUTH GUILDFORD CENTRE

No Longer Applicable.
Superseded 1 July 2026.

Code	Program Name	Code	Program Name
185	SWAN ADULT MENTAL HEALTH CENTRE	346	EAST WHEATBELT CAMHS
186	OLD SWAN CAMHS	347	EAST WHEATBELT SENIORS
187	SWAN VALLEY OUTPATIENTS	348	ESPERANCE OUTREACH CAMHS
188	SWAN VALLEY CENTRE	349	ESPERANCE OUTREACH ADULT
189	SWAN EARLY DISCHARGE SERVICE	350	ESPERANCE OUTREACH SENIORS
190	SWAN YOUTH THERAPY SERVICE	351	MIDWEST COMMUNITY MH
191	TOM PRICE ADULT COMMUNITY MH	352	SELBY/SCGH LIAISON PROGRAM
192	BUSSELTON ADULT COMMUNITY MH	353	BENTLEY ATT
193	VIVEASH REHABILITATION CENTRE	354	BROOME ELDERLY
195	CENTRE FOR CLINICAL INTERVENTIONS	355	DERBY ELDERLY
196	WARD 2K	356	KUNUNURRA ELDERLY
197	WARD D20	358	YOUTH AND ADULT COMPLEX ATTENTIONAL DISORDERS SERVICE
198	WARREN BLACKWOOD ADULT COMMUNITY MH	360	NEWMAN CAMHS
199	OLD WARWICK CAMHS	362	TOM PRICE CAMHS
200	WELLINGTON COMMUNITY MH	364	NEUROSCIENCES YOUTH
201	WHEATBELT ADULT	370	BUSSELTON CAMHS
203	OLD YOUTHLINK ADULT	371	BUSSELTON ELDERLY
204	STUBBS TCE HOSP	372	WARREN BLACKWOOD CAMHS
205	STUBBS TCE	373	WARREN BLACKWOOD ELDERLY
206	STUBBS TCE SCHOOL BASED	374	TRANSCULTURAL UNIT
207	STUBBS TERRACE DAY	375	FREMANTLE OLDER ADULT INPATIENT UNIT
208	FAMILY ADMISSION DAY	376	ICMHSOA CONSULTATION LIAISON RPH
209	PMH TRIAGE	377	FORENSIC ACUTE INPATIENTS
210	STUBBS FAMILY	378	BANKSIA FORENSIC IP UNIT
211	FAMILY PATHWAYS DAY PROGRAM	379	SCGH OUTPATIENTS
212	SCGH MITH	381	SCGH CONSULTATION LIAISON
213	FAMILY PATHWAYS DAY PROGRAM OUTPATIENT	382	FORENSIC SUB-ACUTE INPATIENTS
215	SWAN HOSTELS OUTREACH SUPPORT	383	HUTCHISON FORENSIC IP UNIT
216	SWAN EARLY INTERVENTION	384	CULLITY MOTHER BABY IP UNIT
217	MIDLAND ATT	385	MURCHISON SLOW STREAM REHAB IP UNIT
218	JARRAH RD COMMUNITY	388	FREMANTLE CONSULTATION LIAISON ADULT
225	BENTLEY ATT TRIAGE	389	FREMANTLE CONSULTATION LIAISON ELDERLY
237	NEUROPHYSIOLOGY SERVICE	391	LEMNOS HOSPITAL
239	ADOLESCENT CLINIC	401	SIR CHARLES GAIRDNER TRANSITION SUPPORT PROGRAM
252	YOUTH HOSPITAL IN THE HOME AMBULATORY	402	SIR CHARLES GAIRDNER ELDERLY CLINICAL LIAISON
253	BENTLEY OLDER ADULT 7 DAY FOLLOW UP	403	OLD YOUTHLINK CAMHS
259	MIDLAND ADULT ICLS	407	NEUROSCIENCES ELDERLY
264	WANNEROO CTT - WEST	410	ICMHSOA CONSULTATION LIAISON KIMBERLEY
314	ONSLOW YOUTH COMMUNITY MH	417	INNER CITY DISCHARGE FOLLOW UP
322	NEWMAN YOUTH COMMUNITY MH	418	BUNBURY CLINIC OUTREACH HOSPITAL
326	JHC MHOA ADULT	422	BUSSELTON BRIEF INTERVENTION TEAM
343	ALBANY SESSIONAL CLINIC	424	PEEL SENIORS MHS
344	WHEATBELT CAMHS	425	PEEL CARER SUPPORT PROGRAM
345	WHEATBELT SENIORS	426	PEEL CONNECT & RECOVERY MODULES (CARM)

No Longer Applicable.
Superseded 1 July 2026.

Code	Program Name	Code	Program Name
427	SUBIACO ICOT	546	MOTHER BABY IP UNIT KEMH
428	KALGOORLIE PSYCHIATRIC DISABILITY SUPPORT PROGRAM	547	MOTHER BABY UNIT COMMUNITY KEMH
438	NMHS-MH DBT PROGRAM	550	HAWTHORN AMBULATORY
440	PARK INTENSIVE DAY THERAPY UNIT	551	PEEL SRT
441	OLD CLARKSON CAMHS NM	554	GERALDTON HOSPITAL MH ADULT
443	OLD HILLARYS CAMHS NM	555	GERALDTON HOSPITAL MH OLDER ADULT
445	OLD CAMHS & PRIMARY SCHOOLS PROGRAM	558	CECAT INREACH
446	OLD WARWICK CAMHS NM	559	CLINICAL ACCOMMODATION SUPPORT SERVICE
448	OLD CAMHS CENTRALISED TRIAGE & ASSESSMENT TEAM	561	FREMANTLE ITS GROUP
450	OLD SHENTON CAMHS NM	562	SCGH, AMBULATORY HITH
452	OLD KALAMUNDA CAMHS NM	563	SCGH, HITH
453	OLD SWAN KALAMUNDA CAMHS NM	565	OLD PMH ACUTE COMMUNITY INTERVENTION TEAM
455	SWAN YOUTH THERAPY SERVICE NM	567	JOHN MILNE CENTRE PRE ADMISSION
456	OLD FAMILY THERAPY TEAM NM	568	JOHN MILNE CENTRE POST DISCHARGE
458	PARK MST	569	FREMANTLE EARLY EPISODE PSYCHOSIS TEAM
459	OLD MST NORTH	570	BENTLEY ADULT 7 DAY FOLLOW UP
462	SUBIACO ATT	571	DERBY YOUTH COUNSELLOR ADULT
463	CECAT COMMUNITY YOUTH-ADOLESCENT	573	DERBY YOUTH COUNSELLOR CAMHS
465	OLD YOUTH REACH SOUTH CAMHS	575	BROOME YOUTH COUNSELLOR ADULT
467	OLD YOUTH REACH SOUTH ADULT	578	BROOME YOUTH COUNSELLOR CAMHS
468	MIRRABOOKA ASSESSMENT SUPPORT TEAM(EXPIRED)	583	PEEL CAMHS EATING DISORDERS PROGRAM
469	MH HOSPITAL AT HOME	584	PEEL CAMHS FAMILY THERAPY PROGRAM
470	REFLECTIONS ART STUDIO	586	MIRRABOOKA ASSESSMENT SUPPORT TEAM
472	WHEATBELT SECOND OPINION SERVICE ADULT	587	MIRRABOOKA CLINIC
473	OLD YOUTHLINK GROUP TREATMENT PROGRAM	589	KALGOORLIE YOUTH COUNSELLOR CAMHS
474	CCI EATING DISORDERS SERVICE ADULTS	591	KALGOORLIE YOUTH COUNSELLOR ADULT
475	CCI EATING DISORDERS SERVICE CHILD & ADOLESCENT	593	ESPERANCE YOUTH COUNSELLOR CAMHS
478	JOONDALUP RECOVERY NETWORK CENTRE	595	ESPERANCE YOUTH COUNSELLOR ADULT
483	MH LIAISON ADULT GERALDTON REGIONAL HOSPITAL	596	OLD PMH EATING DISORDERS DAY PROGRAM
484	MH LIAISON OLDER ADULT GERALDTON REGIONAL HOSPITAL	597	RPH ADULT 7 DAY FOLLOW-UP
500	FREMANTLE ADULT ASSESSMENT AND TREATMENT TEAM	599	RPH DP MULTICULTURAL UNIT
526	SWAN ADULT CERT	600	RPH CONSULTATION AND LIAISON
537	BENTLEY COMMUNITY LINKS DAY THERAPY	601	RPH DP ED CL LIAISON
538	SCGH EARLY DISCHARGE SERVICE	602	RPH DP CL OPAL
540	BENTLEY FAMILIES AT WORK PRE-ADMISSION CLINIC	603	RPH WARD 2K INPATIENT
542	HAWTHORN HOUSE	604	JOHN MILNE INPATIENT
543	COMMUNITY OPTIONS REHAB PROGRAM	606	PEEL ADULT YOUTH COUNSELLOR
544	ARMADALE COMMUNITY TREATMENT TEAM	608	OLD PEEL CAMHS YOUTH COUNSELLOR

No Longer Applicable. Superseded 1 July 2026.

Code	Program Name	Code	Program Name
615	ARMADALE CONSULTATION LIAISON OAMHS	714	UPPER SOUTHWEST ADULT STEP UP STEP DOWN
617	HOST COMMUNITY OPTIONS	715	UPPER SOUTHWEST YOUTH STEP UP STEP DOWN
619	NEW BEGINNINGS PND	716	ARMADALE ADULT ICLS
620	ROCKINGHAM CONSULTATION LIAISON CAMHS	717	FH MH HTT OUTPATIENT
621	OLD COMPLEX ATTENTION AND HYPERACTIVITY DISORDERS SERVICE	718	KALGOORLIE YOUTH SEVERE
622	ROCKINGHAM CONSULTATION LIAISON ADULT	719	OSBORNE HOSPITAL IN THE HOME
623	ROCKINGHAM CONSULTATION LIAISON OLDER ADULT	721	SUBIACO CTT - PURPLE
624	CITY MEDICAL & PSYCHOLOGY	722	CAMHS CRISIS CONNECT
625	OSBORNE PERINATAL OBSTETRIC PSYCHIATRY SERVICE	775	KALGOORLIE YOUTH SEVERE ADULT
628	ARMADALE TRANSITIONAL REHABILITATION PROGRAM	777	BENTLEY JMC
629	GENDER PATHWAYS SERVICE	778	PARK MH HITH
631	CITY OLDER ADULT THERAPIES SERVICE	781	ALBANY ADULT ATT
632	MIDLAND OLDER ADULT THERAPIES SERVICE	795	MIDLAND ACTIVE RECOVERY TEAM (ART)
633	ROEBOURNE SPECIAL PROJECTS	796	SUBIACO CONNECT 2 COMMUNITY
635	PCH WARD 5A INPATIENTS	799	KALGOORLIE ADULT STEP UP STEP DOWN
637	BUSSELTON YOUTH COMMUNITY MH	801	BENTLEY ACTIVE RECOVERY TEAM (ART)
639	BENTLEY YOUTH INPATIENT UNIT	802	CITY EAST ACTIVE RECOVERY TEAM (ART)
640	BENTLEY YOUTH 7 DAY FOLLOW UP	804	ACTIVE RECOVERY TEAM
642	ARMADALE EARLY EPISODE PSYCHOSIS TEAM	805	COMMUNITY CARE UNIT
643	WHEATBELT YOUTH	806	EATING DISORDERS TRANSITION PROGRAM
646	ALBANY YOUTH STEP UP STEP DOWN	808	BENTLEY YOUTH HOMELESSNESS SERVICE
647	ALBANY ADULT STEP UP STEP DOWN	810	FSH YOUTH ED-IOP
648	ALBANY ADULT PSYCHIATRY	811	ARMADALE TRANSITION TEAM
649	ALBANY OLDER ADULT PSYCHIATRY	816	FSH MH YOUTH HITH WARD
655	KARRATHA AND ONSLOW YOUTH PLN	817	YCATT
657	ALBANY YOUTH PSYCHIATRY	819	YOUTHREACH SOUTH ADULT
662	WHEATBELT ADULT - PERINATAL-INFANT MENTAL HEALTH	821	YOUTHREACH SOUTH CAMHS
664	WHEATBELT YOUTH - PERINATAL-INFANT MENTAL HEALTH	823	HAMPTON HOUSE CLINIC
668	STIRLING CTT - OSBORNE ROYAL	824	RPH ADULT MENTAL HEALTH UNIT INPATIENT (MHU)
673	HOSPITAL IN THE HOME	825	BENTLEY ADULT COVID WARD
676	SPECIALIST DEMENTIA CARE PROGRAM	826	KEMH PERINATAL LOSS CLINIC
677	MHEC INPATIENT	827	KEMH SPECIAL CARE NURSERY (NICU)
678	EARLY ONSET DEMENTIA/NACC ELDERLY	828	KEMH GYNAECOLOGY CLINIC
702	MARGARET RIVER YOUTH COMMUNITY MH	830	TCU PREVENTION
707	FSH ADULT MH PERINATAL LIAISON OUTPATIENT	831	TCU REHABILITATION
709	THERAPEUTIC CRISIS INTERVENTION FAMILIES	833	EMHS EATING DISORDER SPECIALIST SERVICES (EMHS EDSS)
711	FH ADULT MH EXERCISE PHYSIOLOGY	840	FLEXIBLE DAY PROGRAM
712	FH MH HITH INPATIENT	844	EMHS CRISIS RESOLUTION IN THE HOME (CRHITH) ARMADALE
713	ALBANY ELDERLY DEMENTIA NAVIGATOR		

No Longer Applicable: Superseded 1 July 2026.

Code	Program Name	Code	Program Name
845	EMHS CRISIS RESOLUTION IN THE HOME (CRHITH) CITY	937	FH TRANSITIONAL CARE TEAM
849	EATING DISORDERS ADULT	938	GRAYLANDS EXTENDED CARE SERVICE
850	URSULA FRAYNE UNIT OLDER ADULT MENTAL HEALTH UNIT	939	SUBIACO - HOSTEL IN-REACH
852	EATING DISORDERS CAMHS	946	WACHS VIRTUAL ICAMHS COMMUNITY
857	CAMHS CRISIS CONNECT INTERVENTION	948	CITY EAST ICLS
860	ENHANCED GP LIAISON	2000	OLD HOMELESS YOUTH SOUTH
862	SCGH NEUROMODULATION	2020	KEMH WANDAS CLINIC
864	INTENSIVE CLINICAL MONITORING	2021	KEMH CAMI CLINIC
865	MULTIDISCIPLINARY OUTPATIENT CLINIC	2080	FREMANTLE POST TRAUMATIC STRESS CLINIC
869	GERALDTON ADULT STEP UP STEP DOWN	2101	FREMANTLE POST TRAUMATIC STRESS CLINIC ELDERLY
870	CECAT MUSIC PROGRAM	2142	OLD KOONDOOLA INTEGRATED SERVICE CENTRE
871	FREMANTLE NEUROSTIMULATION	2143	OLD PARKWOOD INTEGRATED SERVICE CENTRE
873	EATING DISORDERS OLDER ADULT	2180	WUNGEN KARTUP CAMHS INREACH
874	BENTLEY OLDER ADULT HDU	2181	WUNGEN KARTUP ADULT INREACH
875	JHC MHS YOUTH	2182	WUNGEN KARTUP ELDERLY INREACH
876	JHC PICU ADULT	2183	WUNGEN KARTUP CAMHS PROGRAM
877	JHC DAY ECT ADULT	2184	WUNGEN KARTUP ADULT PROGRAM
878	JHC DAY ECT OLDER ADULT	2185	WUNGEN KARTUP ELDERLY PROGRAM
879	JHC MHOA CAMHS	2189	SOUTH METRO CAHD
880	JHC MHS CAMHS	2191	SOUTH METRO STREET TO HOME (MCOT)
881	JHC MHS OLDER ADULT	2198	SOUTHWEST OLDER ADULT
882	JHC MHOA OLDER ADULT	2199	UPPER SOUTHWEST CAMHS
883	DETENTION EMBEDDED SERVICE CAFS	2200	UPPER SOUTHWEST BRIEF INTERVENTION TEAM
885	COMMUNITY MH CAFS	2201	UPPER SOUTHWEST ADULT COMMUNITY MH
887	BENTLEY ADULT ELECTROCONVULSIVE THERAPY (ECT)	2222	OLD PROGRAM FOR EVIDENCE BASED PSYCHOTHERAPIES
888	BENTLEY OLDER ADULT ELECTROCONVULSIVE THERAPY (ECT)	2240	KEMH ADOLESCENT CLINIC
891	ROCKINGHAM ECT	2260	OLD EASTERN CORRIDOR CHILD PROTECTION PROGRAM
893	EMHS EATING DISORDER SPECIALIST SERVICES OLDER ADULT	2262	OLD NORTH COASTAL CHILD PROTECTION PROGRAM
895	EMHS EATING DISORDER SPECIALIST SERVICES YOUTH	2300	FITZROY CAMHS
897	FREMANTLE OLDER ADULT MH HITH INPATIENTS	2304	FITZROY ADULT MH
902	WARD 9 2K	2320	CITY HOMELESSNESS TEAM
904	BENTLEY OLDER ADULT GP LIAISON	2380	PARK ADULT INPATIENT UNIT
906	EAST ACUTE CARE AND RESPONSE TEAM	2381	PARK SENIORS INPATIENT UNIT
913	KEMH NEW BEGINNINGS	2400	JOONDALUP EARLY INTERVENTION IN PSYCHOSIS
915	KEMH PREGNANCY CHOICE	2401	BENTLEY SUPPORTED ACCOMMODATION
916	WA TROPHOBLASTIC CLINIC	2440	ARMADALE GP LIAISON ADULT
917	KEMH GOLD CLINIC	2520	PEEL GP LIAISON ADULT
929	FSH COCKBURN ADULT MENTAL HEALTH INPATIENT	2522	FREMANTLE GP LIAISON ADULT
931	KATANNING ADULT ATT	2540	ROCKINGHAM GP LIAISON ADULT
933	KEMH GYNAECOLOGICAL SURVIVORSHIP CLINIC	2580	BENTLEY ATT

No Longer Applicable: Superseded 1 July 2026

Code	Program Name	Code	Program Name
2600	ARMADALE ADULT CONSULTATION LIAISON	3226	FAMILIES AT WORK INPATIENT
2620	REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION	3227	FAMILIES AT WORK OUTPATIENT
2661	ROCKINGHAM CL OUTPATIENT ADULT	3229	FREMANTLE CAMHS
2662	ROCKINGHAM CL OUTPATIENT OLDER ADULT	3231	MST NORTH
2720	FREMANTLE SUPPORTED DISCHARGE	3232	MST SOUTH
2740	HUNTINGTON'S DISEASE ELDERLY	3233	CAMHS & PRIMARY SCHOOLS PROGRAM
2741	PREDICTIVE TESTING - HD ELDERLY	3235	CLARKSON CAMHS
2742	PREDICTIVE TESTING - NON-HD ELDERLY	3237	HILLARYS CAMHS
2743	DMC ELDERLY	3239	KOONDOOLA INTEGRATED SERVICE CENTRE
2760	NEURO - KIDS	3241	PARKWOOD INTEGRATED SERVICE CENTRE
2780	HUNTINGTON'S DISEASE ADULT	3243	PROGRAM FOR EVIDENCE BASED PSYCHOTHERAPIES
2781	PREDICTIVE TESTING - HD ADULT	3245	SHENTON CAMHS
2782	PREDICTIVE TESTING - NON-HD ADULT	3247	SWAN CAMHS
2783	EARLY ONSET DEMENTIA/NACC ADULT	3249	WARWICK CAMHS
2784	DMC ADULT	3252	CHILD PROTECTION CONSULTATION LIAISON
2820	SOUTH METRO TRANSITIONAL CARE PROGRAM	3253	COMPLEX ATTENTION & HYPERACTIVITY DISORDERS SERVICE
2840	STIRLING ATT	3255	PEEL CAMHS
2841	STIRLING CTT - MIRRABOOKA EAST	3257	PEEL CAMHS YOUTH COUNSELLOR
2842	STIRLING CTT - MIRRABOOKA WEST	3259	ACUTE RESPONSE TEAM
2860	PERINATAL MENTAL HEALTH GASCOYNE ADULT	3262	FAMILY PATHWAYS PROGRAM
2880	PERINATAL MENTAL HEALTH GASCOYNE CAMHS	3263	ACUTE COMMUNITY INTERVENTION TEAM
2900	WANNEROO ATT	3264	PCH CONSULTATION LIAISON
2920	BROOME MENTAL HEALTH I/P UNIT	3266	EATING DISORDERS CLINIC
2960	BENTLEY COMMUNITY OPTIONS	3268	EATING DISORDERS DAY PROGRAM
2980	SELF MANAGEMENT SKILLS GROUP	3269	PMH WARD 4H DAY PROGRAM
3001	FREMANTLE ADULT PHYSIOTHERAPY	3270	PMH WARD 4H INPATIENTS
3002	FREMANTLE ELDERLY PHYSIOTHERAPY	3271	ROCKINGHAM KWINANA CAMHS
3020	GHS NEUROSCIENCES CAHDS (COMPLEX ATTENTION AND HYPERACTIVITY DISORDERS SERVICE)	3273	YOUTH REACH SOUTH CAMHS
3040	ALBANY RECOVERY CENTRE ADULT	3275	YOUTH REACH SOUTH ADULT
3082	MCOT	3277	HOMELESS YOUTH SOUTH
3110	HALLS CREEK CAMHS MH	3279	YOUTHLINK CAMHS
3114	HALLS CREEK ADULT MH	3281	YOUTHLINK ADULT
3118	HALLS CREEK ELDERLY MH	3300	YOUTH AXIS
3160	SAMHS GROUP	3380	MH COURT ADULT
3200	MIDLAND ICOT	3400	MH CHILDREN'S COURT LIAISION
3201	WANNEROO ICOT	3440	CITY COMMUNITY OPTIONS
3202	STIRLING ICOT	3460	EATING DISORDERS INREACH PROGRAM
3220	ARMADALE CAMHS	3540	ACIT NORTHEAST
3222	BENTLEY ADOLESCENT INPATIENTS UNIT	3560	KALGOORLIE BOULDER OUTREACH CAMHS
3223	BENTLEY FAMILY CLINIC	3561	KALGOORLIE BOULDER OUTREACH SENIORS
3225	BENTLEY TRANSITIONAL UNIT OUTPATIENTS	3595	BRIEF INTERVENTION FITZROY CROSSING ADULT

No Longer Applicable. Superseded 1 July 2026.

Code	Program Name	Code	Program Name
3596	BRIEF INTERVENTION FITZROY CROSSING CAMHS	3984	WARREN BLACKWOOD ABORIGINAL COMMUNITY MH PROGRAM
3598	BRIEF INTERVENTION BROOME CAMHS	3985	MARGARET RIVER ABORIGINAL COMMUNITY MH PROGRAM
3599	BRIEF INTERVENTION BROOME ADULT	4000	FREMANTLE ATT
3600	BRIEF INTERVENTION BROOME OLDER ADULT	4042	PATHWAYS GROUP PROGRAM
3601	BRIEF INTERVENTION DERBY CAMHS	4043	PATHWAYS DAY PROGRAM
3602	BRIEF INTERVENTION DERBY ADULT	4061	PATHWAYS ASSESSMENT AND RECOVERY PROGRAM
3605	BRIEF INTERVENTION KUNUNURRA ADULT	4103	ROCKINGHAM - ACT
3606	BRIEF INTERVENTION KUNUNURRA OLDER ADULT	4104	ROCKINGHAM - EEP
3607	BRIEF INTERVENTION HALLS CREEK CAMHS	4105	PEEL - EEP
3608	BRIEF INTERVENTION HALLS CREEK ADULT	4152	KATANNING YOUTH
3621	SCGH MH OBS WARD	4153	ALBANY YOUTH
3644	SCGH OUTPATIENTS	4161	ARMADALE COMMUNITY REHAB
3646	OSBORNE ELDERLY CONSULTATION LIAISON	4181	TRANSCULTURAL MH
3661	MITH	4201	TOUCHSTONE CAMHS
3681	GENDER DIVERSITY SERVICE	4261	SCGH MHU
3702	MIDLAND EIT	4302	ROCKINGHAM KWINANA ATT
3703	SELBY HOSPITAL IN THE HOME	4303	PEEL ATT
3752	FSH MBU OUTPATIENT	4325	MIDLAND ADULT MHU
3753	FSH ADULT DRUG AND ALCOHOL	4326	MIDLAND OLDER ADULT MHU
3755	FSH MH YOUTH OUTPATIENT	4329	MIDLAND OLDER ADULT POST DISCHARGE
3756	FSH ADULT MH LIAISON	4331	CLINICAL ACCOMMODATION SUPPORT SERVICES
3758	FSH MH YOUTH INPATIENT	4404	WAEDOCS CONSULTATION LIAISON - ADULT
3760	FSH MBU INPATIENT	4408	ONSLOW CAMHS
3761	FSH MH INPATIENT	4409	ONSLOW ADULT COMMUNITY MH
3771	FSH OLDER ADULT DRUG AND ALCOHOL	4423	FSH MH YOUTH COMMUNITY
3781	BENTLEY ADULT INDIVIDUALISED COMMUNITY LIVING STRATEGY (ICLS)	4449	ARMADALE ADULT 7 DAY FOLLOW UP
3807	MARGARET RIVER CAMHS	4452	CITY EAST ATT
3809	MARGARET RIVER ADULT	4453	CITY EAST CTT
3812	MARGARET RIVER ELDERLY	4454	CITY EAST ICOT
3862	ALMA STREET MH WELLNESS CLINIC	4456	CITY EAST COMMUNITY SERVICE OLDER ADULT
3892	EARLY INTERVENTION PROGRAM BROOME CAMHS	4480	KEMH PELVIC PAIN CLINIC
3898	EARLY INTERVENTION PROGRAM BROOME ADULT	4543	HAMPTON HOUSE MH SERVICE
3903	JHC MHS ADULT	4563	PRISON TRANSITION PROGRAM
3905	JHC MH CONSULTATION LIAISON	4581	ALBANY RECOVERY CENTRE YOUTH
3923	GERALDTON HOSPITAL PHIT CAMHS	4603	KWELENA STEP UP STEP DOWN
3924	GERALDTON HOSPITAL PHIT ADULT	4640	KARRATHA YOUTH COMMUNITY MH
3925	GERALDTON HOSPITAL PHIT OLDER ADULT	4641	HEDLAND YOUTH COMMUNITY MH
3941	YOUTH HOSPITAL IN THE HOME	4642	UPPER SOUTHWEST YOUTH COMMUNITY MH
3983	BUSSELTON ABORIGINAL COMMUNITY MH PROGRAM	4661	MESH CLINIC

No Longer Applicable.
Superseded 1 July 2026.

Code	Program Name	Code	Program Name
4683	WUNGEN KARTUP ADULT CULTURAL LIAISON PROGRAM		
4685	BENTLEY YOUTH COMMUNITY ASSESSMENT AND TREATMENT TEAM		
10012	Program Not Allocated - 83 MIDLAND ADULT COMMUNITY		

No Longer Applicable.
Superseded 1 July 2026.

Appendix H – Summary of revisions

Date Released	Author	Approval	Amendment
1 July 2021	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created.
1 July 2022	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. Removed ‘Rules’ and ‘QA / Validations’ sections from each data element. Added new Triage, RAMP and CRAMP sections and data elements. Updated ‘Guide for Use’ text under ‘Sex’ data element. Previously omitted data elements included: Length of Stay Alert Duration Incident Duration Expiry Date Order Duration Corrected errors in data elements: AV Exam Leave Days Incident Recurrence Risk Incident Severity
1 July 2023	David Oats	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. New SSCD data elements added: Mental Health Assessment (Section 15) Moved Episode Start Date and Time and Episode End Date and Time data elements from Community Mental Health and Service Contacts section to Inpatient Services section. Previously omitted data elements included: Phase Start Date Phase End Date Changed IHPA references to IHACPA and updated website links.
1 July 2024	Jenine Piper Jodie McNamara	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. Added new Care Type: Mental health rehabilitation. Clarified the definitions for referral outcomes.

No Longer Applicable.
Superseded 1 July 2026.

			Removed redundant permitted values 12, 13 & 15 from Collection Status data element. Updated permitted values in data elements in Section 10 NOCC AMHCC Clinical Measures. Updated definitions for SDQ data element Removed Mental Health Assessment section (previously section 15) as data not yet available in Collection. Updated list of PSOLIS streams with new programs and name changes. Updated 'Guide for Use' text under the following data elements: Service Contact Session Type Staff Full Name Staff HE Number Expiry Date Order End Date and Time Order Name Order Name Code Order Type Transport By Treating Practitioner Qualification Type Action Taken Consumer Agreeable Consumer Aware Contact With Designation Triage End Date Triage Start Date Triaged by HE Number
30 June 2025	Jodie McNamara & Jenine Piper	Rob Anderson, Assistant Director General, Purchasing and System Performance	Dates updated. Abbreviations table updated. Updated formatting of all data variables. Added definitions for all permitted values listed and start and end dates where known. Addition of derivation logic for derived variables. Added example to Associate Present indicator. Added variable Triage Outcome Added variable Triage Presenting Complaint and Triage Presenting Complaint Code

No Longer Applicable.
Superseded 1 July 2026.

			Added Triage Severity Correct Data Variable field name in CGAS Removed Order Name Removed Triage (previously section 12) as SSCD data not yet available in Collection. Removed Risk Assessment and Management Plan (previously section 13) as SSCD data not yet available in Collection. Removed Child and Adolescent Risk Assessment and Management Plan (previously section 14) as SSCD data not yet available in Collection. Renamed Appendix C from 'Triage problem codes' to 'Triage Presenting Complaint and Referral Presenting Problem Codes'. Terminology throughout the document has been updated in line with contemporary practice, mental health consumer preference and recent updates by IHACPA.

No Longer Applicable.
Superseded 1 July 2026.

No Longer Applicable.
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