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

Mental Health Data Collection
Research Data Dictionary

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Abbreviations

AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
AV	Audiovisual
BSRS	BedState Reporting System
CTO	Community Treatment Order
HMDC	Hospital Morbidity Data Collection
HMDS	Hospital Morbidity Data System
ISPD	Information and System Performance Directorate
LAMHIS	Local Administration Mental Health Information System
MHDC	Mental Health Data Collection
MHIS	Mental Health Information System
MHPoC	Mental Health Phase of Care
MIND	Mental Health Information Data Collection
NOCC	National Outcomes and Casemix Collection
PSOLIS	Psychiatric Services On-line Information System
QA	Quality assurance
SSCD	State-wide Standardised Clinical Documentation
UMRN	Unit Medical Record Number
WA	Western Australia

1. Purpose

The purpose of the *Mental Health Data Collection Research Data Dictionary* is to detail the data elements captured in the Mental Health Data Collection (MHDC) which are available for research use.

2. Background

The MHDC is comprised of the Mental Health Information System and the Mental Health Information Data Collection:

Mental Health Information System (MHIS)

MHIS is the former state-wide mental health data collection. Dating from 1966, it is one of the oldest health related data collections in WA and relied on the manual entry of data from predominantly paper-based notifications and forms.

MHIS also included data from the Local Administration Mental Health Information System (LAMHIS) collected in the mid-1990s to early 2003/04.

In 2014 a review of MHIS was undertaken which led to its replacement and a shift in focus from a patient-centric system to an event-based data collection with embedded data quality assurance processes.

Mental Health Information Data Collection (MIND)

MIND replaced the MHIS from December 2017.

The primary purpose of MIND is to collect record-level information from the Psychiatric Services Online Information System (PSOLIS) for patients who access public specialised mental health services, including public patients admitted in private hospitals.

The data collected in MIND is extracted from PSOLIS on a regular basis and provides the minimum data required to support and meet mental health reporting requirements deriving from legislation, national agreements and the policy obligations of the WA health system.

The initial development of MIND includes:

- referrals to community mental health (data from 1 January 2005).
- community mental health service events and community activations and de-activations (data from 1 January 2005).
- National Outcome and Casemix Collection (NOCC) (data from 1 January 2005).
- Mental Health Act 2014 Legal Forms, excluding seclusion forms 11A-11G (data from 1 July 2016).
- mental health inpatient admissions (data from 1 January 2005).

Future development work will see the capture of additional data from PSOLIS in MIND, including more data relating to:

- community mental health residential services; and
- State-wide Standardised Clinical Documentation (SSCD).

The current scope of MIND is activity collected in PSOLIS by specialised mental health services. Data relating to this activity are based on service contacts.

The following data sources contribute data to this collection:

- Psychiatric Services Online Information System (PSOLIS)
- Hospital Morbidity Data System (HMDS)
- BedState Reporting System (BSRS)

3. Data definitions

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

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

Aboriginal Status

Field name:	pt_ethnicity_code
Source Data Element(s):	[Aboriginal Status] – PSOLIS
Definition:	The client's Aboriginal status.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Aboriginal but not Torres Strait Islander origin 2 – Torres Strait Islander but not Aboriginal origin 3 – Both Aboriginal and Torres Strait Islander origin 4 – Neither Aboriginal nor Torres Strait Islander origin 9 – Not stated/inadequately described

Guide for use

Collection of this data element is mandatory.

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

Permitted value definitions

1 – Aboriginal but not Torres Strait Islander origin

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

2 – Torres Strait Islander but not Aboriginal origin

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

3 – Both Aboriginal and Torres Strait Islander origin

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

4 – Neither Aboriginal nor Torres Strait Islander origin

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

9 – Not stated/inadequately described

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

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

The following question must be asked of all clients:

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

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

Only the most current Aboriginal status is to be recorded.

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/602543

Revision history

N/A

Age on Contact

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

Guide for use

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

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

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/303794

Revision history

N/A

Associate Present Indicator

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

Guide for use

Collection of this data element is mandatory.

An associate can be a person or organisation.

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Australian Postcode

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

Guide for use

Collection of this data element is mandatory.

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

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/index.phtml/itemId/611398

Revision history

N/A

Australian State or Country of Birth

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

Guide for use

Collection of this data element is mandatory.

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

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

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

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

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

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

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/659454

Revision history

N/A

Client Present Indicator

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

Guide for use

Collection of this data element is mandatory.

Permitted value definitions

0 – Not present

This code is to be used for service events between a specialised mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

1 – Present

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

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

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

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

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

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/677806

Revision history

N/A

Date of Birth

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

Guide for use

Collection of this data element is mandatory.

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/287007

Revision history

N/A

Deactivation Outcome

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

Guide for use

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Employment Status

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

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 16-year-old child, not attending school and not employed	8 – Unemployed

Related national definition

N/A

Revision history

N/A

Episode End Date and Time

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

Guide for use

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

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

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

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

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/722725

Revision history

N/A

Episode Start Date and Time

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

Guide for use

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

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

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

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

Examples

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

Related national definition

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

Revision history

N/A

Legal Status

Field name:	mh_legal_status
Source Data Element(s):	[Mental Health Legal Status] – HMDS
Definition:	Whether a patient is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Involuntary 2 – Voluntary

Guide for use

Collection of this data element is required if the patient is a mental health patient.

Permitted value definitions

1 – Involuntary

Patients not willing or unable to provide consent for treatment, and who can be admitted or treated as an involuntary patient under the *Mental Health Act 2014.*

2 – Voluntary

Patient who require and give consent for mental assessment and/or treatment.

Legal status must be reported if a patient is treated as a mental health patient under relevant legislation.

The legal status must be retained including if a patient is admitted to another facility during an episode. For example; a patient is admitted at Graylands and is placed on leave to attend a day procedure at Sir Charles Gairdner Hospital. Both sites should list the patient with a mental health legal status.

When reporting a legal status, psychiatric days may or may not be reported and/or a care type of mental health may or may not be reported.

Examples

	Legal Status
A patient was admitted to Fremantle Hospital on an involuntary basis for five days of treatment for acute schizophrenia. After the fifth day, he then agreed to remain in hospital as a voluntary patient for extensive treatment. Reported to HMDS as involuntary.	1 – Involuntary

A patient is admitted voluntarily to Abbotsford Private Hospital for treatment of severe depression.	2 – Voluntary

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/722675

Revision history

N/A

Marital Status

Field name:	pt_marital_status_code
Source Data Element(s):	[Marital Status] – PSOLIS
Definition:	The client's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – Never Married 2 – Widowed 3 – Divorced 4 – Separated 5 – Married 6 – Unknown

Guide for use

Collection of this data element is mandatory.

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

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

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/291045

Revision history

N/A

Principal Diagnosis

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

Guide for use

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

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

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

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

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

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

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

Principal diagnosis 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/index.phtml/itemId/699609

Revision history

N/A

Program

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

Guide for use

Collection of this data element is mandatory.

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

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

Service Contact Duration

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

Guide for use

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

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/494345

Revision history

N/A

Service Contact End Date and Time

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

Guide for use

Collection of this data element is mandatory.

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/index.phtml/itemId/268983

Revision history

N/A

Service Contact Medium

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

Guide for use

Collection of this data element is mandatory.

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Service Contact Session Type

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

Guide for use

Collection of this data element is mandatory.

Examples

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

Related national definition

N/A

Revision history

N/A

Service Contact Start Date and Time

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

Guide for use

Collection of this data element is mandatory.

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/index.phtml/itemId/268983

Revision history

N/A

Service Event Category

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

Guide for use

Collection of this data element is mandatory.

This field is automatically determined 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 event.

Permitted value definitions

Triage

For recorded triage events using the Triage Module.

Pre-admission

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

Active

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

Post discharge

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

Staff only

Service events that do not include mental health clients.

Pre-referral

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

A service event can have one or many items.

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Sex

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

Guide for use

Collection of this data element is mandatory.

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

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

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

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

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

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

Code 3 – Intersex or indeterminate

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

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

Examples

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

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/287316

Revision history

N/A

Stream Type

Field name:	establishment_mh_stream_type_code
Source Data Element(s):	[Stream Type] – PSOLIS
Definition:	Identifier of the stream type for the specialised mental health programs providing care to the client.
Requirement status:	Conditional
Data type:	Numeric
Format:	N
Permitted values:	1 – Child and adolescent 2 – Adult 3 – Elderly 4 – PET (Psychiatric Emergency Team) 5 – SARC (Sexual Assault Resource Centre) 6 – Youthlink

Guide for use

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

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

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

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

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

Examples

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

Related national definition

N/A

Revision history

N/A

Suburb

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

Guide for use

Collection of this data element is mandatory.

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

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

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/index.phtml/itemId/429889

Revision history

N/A

Triage Outcome

Field name:	triage_outcome_code
Source Data Element(s):	[Triage Outcome] – PSOLIS
Definition:	Identifies the outcome of a triage event.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N
Permitted values:	1 – To be admitted to service 2 – Referred on 3 – No further action 4 – Information only 5 – Placed to waitlist 6 – Community visit initiated 8 – Referred to clinical intake 9 – Unable to complete

Guide for use

Collection of this data element is mandatory.

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

Related national definition

N/A

Revision history

N/A

Triage Presenting Problem

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

Guide for use

Collection of this data element is mandatory.

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

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

Examples

	Triage Presenting Problem
A client presents to a clinic with a problem of experiencing disturbed thoughts. It is determined the client should be referred to community mental health services for further assessment within two days.	14 – Disturbed thoughts, delusions etc.
A client presents to an ED with a problem of intentional self-harm. It is determined that the client should immediately be admitted to hospital.	35 – Deliberate self-harm
A client telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services.	22 – Legal problems

Related national definition

N/A

Revision history

N/A

Triage Severity

Field name:	triage_severity_code
Source Data Element(s):	[Triage Severity] – PSOLIS
Definition:	Numeric identifier indicating the severity of the triage service event and recommended wait time for an assessment service event item.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Permitted values:	9 – A. Immediate 10 – B. Within 2 hours 11 – C. Within 12 hours 12 – D. Within 48 hours 13 – E. Within 2 weeks 14 – F. Requires further triage contact/follow up 15 – G. No further action

Guide for use

Collection of this data element is mandatory.

Since November 2015 mental health clients are triaged into one of seven categories on the selected triage scale.

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

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

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

Permitted value definitions

A. Immediate

Extreme urgency; immediate response requiring police/ambulance or other service (e.g. overdose, siege, imminent violence).

B. Within 2 hours

High urgency; see within 2 hours or present to Psychiatric Emergency Service or emergency department in general hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress).

C. Within 12 hours

Medium urgency; see within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).

D. Within 48 hours

Low urgency; see within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).

E. Within 2 weeks

Non-urgent; see within 2 weeks.

F. Requires further triage contact/follow up

Further contact or follow up required.

G. No further action

Requires no further action.

Examples

	Triage Severity
A client presents to a clinic with a problem of experiencing disturbed thoughts. It is determined the client should be referred to community mental health services for further assessment within two days.	12 – D. Within 48 hours
A client presents to an emergency department with a triage presenting problem of intentional self-harm. It is determined that the client should be immediately admitted to hospital.	9 – A. Immediate
A client telephones a mental health help line, and the triage presenting problem is assessed as a legal problem. It is determined that no further action is required by mental health services.	15 – G. No further action
A client telephones a clinic, and the triage presenting problem concerns family problems. It is determined that a community visit should be undertaken within 12 hours.	11 – C. Within 12 hours

Related national definition

N/A

Revision history

N/A

Venue

Field name:	venue_code
Source Data Element(s):	[Venue] – PSOLIS
Definition:	Numeric identifier for the type of venue where the service event item took place.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(2)
Permitted values:	1 – Clinic 2 – Community centre 3 – Court 4 – Education facility 5 – Emergency department 6 – Entertainment venue 7 – General hospital 8 – GP surgery 9 – Group home 10 – Home/private dwelling 11 – Hostel 12 – Inhouse school 13 – Lock up 14 – Nursing home 15 – Police station 16 – Prison 17 – Psychiatric hospital 18 – Public space 19 – Rehab centre 20 – Other government organisation 21 – General hospital outpatient clinic 22 – Neonatal intensive care unit

Guide for use

Collection of this data element is mandatory.

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

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

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

Appendix A – Triage problem codes

Code	Name	Start Date
1	RELATIONSHIP/FAMILY PROBLEM	1/01/2002
2	SOCIAL INTERPERSONAL (OTHER THAN FAMILY PROBLEM)	1/01/2002
3	PROBLEMS COPING WITH DAILY ROLES AND ACTIVITIES	1/01/2002
4	SCHOOL PROBLEMS	1/01/2002
5	PHYSICAL PROBLEMS	1/01/2002
6	EXISTING MENTAL ILLNESS - EXACERBATION	1/01/2002
7	EXISTING MENTAL ILLNESS - CONTACT/INFORMATION ONLY	1/01/2002
8	EXISTING MENTAL ILLNESS - ALTERATION IN MEDICATION/TREATMENT REGIME	1/01/2002
9	DEPRESSED MOOD	1/01/2002
10	GRIEF/LOSS ISSUES	1/01/2002
11	ANXIOUS	1/01/2002
12	ELEVATED MOOD AND/OR DISINHIBITED BEHAVIOUR	1/01/2002
13	PSYCHOTIC SYMPTOMS	1/01/2002
14	DISTURBED THOUGHTS, DELUSIONS ETC	1/01/2002
15	PERCEPTUAL DISTURBANCES	1/01/2002
16	PROBLEMATIC BEHAVIOUR	1/01/2002
17	DEMENTIA RELATED BEHAVIOURS	1/01/2002
18	RISK OF HARM TO SELF	1/01/2002
19	RISK OF HARM TO OTHERS	1/01/2002
20	ALCOHOL/DRUGS	1/01/2002
21	AGGRESSIVE/THREATENING BEHAVIOUR	1/01/2002
22	LEGAL PROBLEMS	1/01/2002
23	EATING DISORDER	1/01/2002
24	SEXUAL ASSAULT	1/01/2002
25	SEXUAL ABUSE	1/01/2002
26	ASSAULT VICTIM	1/01/2002
27	HOMELESSNESS	1/01/2002
28	ACCOMMODATION PROBLEMS	1/01/2002
29	INFORMATION ONLY	1/01/2002
30	OTHER	1/01/2002
31	MOOD DISTURBANCE	9/06/2009
32	ADVERSE DRUG REACTION	9/06/2009
33	MEDICATION	9/06/2009
34	DEPOT INJECTION	9/06/2009
35	DELIBERATE SELF HARM	8/09/2009
36	SUICIDAL IDEATION	8/09/2009
37	RISK OF HARM FROM OTHERS	30/10/2012
38	SEXUAL ASSAULT/ABUSE - PAST	30/10/2012
39	SEXUAL ASSAULT - RECENT	30/10/2012
40	FAMILY AND DOMESTIC VIOLENCE	30/10/2012
41	CULTURAL ISSUES	8/05/2014

Appendix B – Summary of revisions

Version	Date Released	Author	Amendment
2.0	1 July 2021	David Oats	Document updated.

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