Mental Health Information Development

Mental Health National Outcomes and Casemix Collection

Technical specification of State and Territory reporting requirements

Version 1.60

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As with previous versions of the specifications, this document contains both original material and content taken from other sources. Special acknowledgment is made to the Centre for Mental Health, New South Wales Department of Health Department, for allowing access to and use of internal documentation developed to support the Mental Health Outcomes and Assessment Training Initiative (MH-OAT) being implemented in that State. Acknowledgment is also given to the Mental Health Branch, Victorian Department of Human Services, for use of various documentation prepared to support the Victorian Mental Health Outcomes Strategy.

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CONTENTS

1. Background

1.1. The regular assessment of outcomes has been an aim of the National Mental Health Strategy since it was first agreed by all Australian Health Ministers in 1992. Two of the 38 objectives outlined in the original 1992 National Mental Health Policy related specifically to outcomes, and stated that the Policy would:

- "institute regular reviews of outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery"; and
- "encourage the development of national outcome standards for mental health services, and systems for assessing whether services are meeting these standards".[1]

1.2. These concepts were simple but ambitious in the context of the poor status of information in mental health services in the early 1990s. Most services did not routinely collect basic clinical and service delivery data nor have systems capable of timely analysis and reporting of such data to inform clinical care. Simple and reliable instruments for measuring consumer outcomes were not available at the commencement of the Strategy, nor was a set of candidate measures evident. Perhaps more significantly, there were few precedents to follow as no other country had established routine consumer outcome measures comprehensively across their publicly funded mental health services.

1.3. In response, a research and development program was initiated early in the Strategy to identify measures of outcome that were feasible for use in routine clinical practice with adult consumers, resulting in the selection of a small set of standard measures that were put to trial.[2,3] Similar work was undertaken in relation to outcome measures for use in child and adolescent mental health services.[4]

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[1] Australian Health Ministers (1992). *National Mental Health Policy.* Australian Government Publishing Service, Canberra.

[2] Andrews G, Peters L and Teeson M (1994). *The Measurement of Consumer Outcome in Mental Health: A Report to the National Mental Health Information Strategy Committee*. Australian Government Publishing Service, Canberra.

[3] Stedman T, Yellowlees P, Mellsop G, Clarke R., and Drake S (1997). *Measuring Consumer Outcomes in Mental Health: Field Testing of Selected Measures of Consumer Outcomes in Mental Health*. Department of Health and Aged Care, Canberra.

[4] Bickman L, Nurcombe B, Townsend C, Belle M, Schut J, Karver M. (1999). *Consumer Measurement Systems for Child and Adolescent Mental Health*. Department of Health and Aged Care, Canberra.

1.4. Implementation of the selected measures in public sector mental health services commenced under the Second National Mental Health Plan (1998-2003). Recognising the complexity of the work required and its national significance, the Australian Government contributed substantial funding to assist States and Territories in implementing their plans and support a range of related quality and safety initiatives in specialist mental health care. This was made available through bilaterally negotiated 'Information Development Agreements', and later, 'Quality Through Outcomes' Agreements.

1.5. Implementation of the 'simple concept' articulated in 1992 has taken the mental health sector into a period of major industry re-development and involved all public mental health services. By June 2003, approximately 60% of Australian public mental health services had commenced the process of consumer outcome measurement and an estimated 10,000 clinicians had participated in training sessions for the collection and use of outcome information.

1.6. Six years on, in 2009, the work has advanced substantially. More than 95% of state and territory mental health services are involved in the routine collection and use of consumer outcomes data. A national body has been established (the Australian Mental Health Outcomes and Classification Network) to support the initiative through a range of industry development activity, and national data analysis and reporting of the outcomes data. More widely, national expert outcomes advisory groups have been set up to provide clinician, consumer and carer perspectives. Internationally, Australia is recognised as leading the field in the use of consumer outcome measures in mental health services.

1.7. Version 1 of the Mental Health National Outcomes and Casemix Collection (NOCC) specifications was released in August 2003, to guide States and Territories in the implementation of routine consumer outcomes measurement. Developed collaboratively between the jurisdictions, the NOCC specifications set the agreed 'ground rules' for how consumer outcomes should be collected locally and reported nationally. The document was later revised (version 1.5, released December 2003) to incorporate new measures for children and young people.

1.8. This revised version of the specifications retains the fundamentals of the previous versions but has been updated to:

- align aspects of the NOCC collection with the National Minimum Data Sets for Mental Health Care that are also collected and reported nationally by all states and territories; and
- remove inconsistencies, redundancies and errors in the earlier documentation.

2. Purpose and scope of document

2.1. The purpose of this document is to outline the reporting requirements for provision of the NOCC dataset by States and Territories to the Australian Government. The document provides details about the:

- *data content* of all items included in the Mental Health National Outcomes and Casemix Collection;
- *business rules* to be followed in the reporting of those data items (i.e. what data are required when); and
- *extract format* to be used when preparing data files for submission to the Australian Government.

2.2. The document limits its scope to the above and does not include detailed discussion of the data collection and system design issues that need to be resolved at State and Territory level to enable collection of NOCC data. Whilst common issues continue to be faced by all States and Territories, solutions to many of those issues must address local requirements and system contexts. Accordingly, it is understood that all States and Territories will continue to develop and revise their local data collection protocols.

2.3. Similarly, the document does not address issues concerning the analysis and interpretation of the outcomes and casemix data to be gathered under the reporting arrangements. There have been many developments in the reporting of NOCC since the introduction seven years ago of routine consumer outcomes data in public mental health services in Australia. Readers are referred for further information to the national website (www.amhocn.org) managed by the Australian Mental Health Outcomes and Classification Network.

2.4. The reporting requirements outlined in this document represent the agreed national minimum requirements and are not intended to limit the scope of data collections maintained by individual service agencies or States and Territories.

3. Overview of the clinical data to be collected

The agreed national requirements for outcomes and casemix data were first outlined in broad terms in the publication, *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003* (First Edition June 1999).

The specific clinical data to be collected depend on the type of *Episode of Mental Health Care* (inpatient, ambulatory, residential), the *Age Group* of the consumer, the *Episode Service Setting* and the *Reason for Collection*. Each of these concepts is discussed later in this document along with details on how they influence specific reporting requirements.

Each of the standard clinical and consumer self-rated measures is subject to its own set of collection guidelines, documented in their respective glossaries. These are not included in the current document but have been compiled separately in a resource document.[5]

This section provides an overview of each of the clinical and consumer self-rated measures and data items included in the Mental Health National Outcomes and Casemix Collection.

3.1. Clinical data specific to adults and older people

3.1.1. Health of the Nation Outcome Scales (HoNOS & HoNOS65+)

The Health of the Nation Outcome Scales (HoNOS) is 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. 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.

The 65+ variant of the HoNOS has been designed for use with adults aged older than 65 years. It consists of the same item set and is scored in the same way, however the accompanying glossary has been modified to better reflect the problems and symptoms likely to be encountered when rating older persons.

Key references

General adult version:

Wing J, Beevor A, Curtis R, Park S, Hadden S, Burns A (1998) Health of the Nation Outcome Scales (HoNOS). Research and development. *British Journal of Psychiatry*, 172, 11-18.

[5] See *Mental Health National Outcomes and Casemix Collection: Overview of clinical and consumer self-report measures and data items, Version 1.50.* Commonwealth Department of Health and Ageing, Canberra 2003.

Wing J, Curtis R, Beevor A (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432–434.

Older persons version: [6]

Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). *British Journal of Psychiatry*, 174, 424-427.

Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+): Glossary for HoNOS 65+ score sheet. *British Journal of Psychiatry*, 174, 435-438.

3.1.2. Abbreviated Life Skills Profile (LSP-16)

The original LSP was developed by a team of clinical researchers in Sydney (Rosen et al 1989, Parker et al 1991) and, prior to the introduction of the NOCC collection, was in fairly wide use in Australia as well as several other countries. It was designed to be a brief, specific and jargon free scale to assess a consumer's abilities with respect to basic life skills. It is capable of being completed by family members and community housing members as well as professional staff.

The original form of the LSP consists of 39 items. Work undertaken as part of the Australian Mental Health Classification and Service Costs (MH-CASC) study saw the 39 items reduced to 16 by the original designers in consultation with the MH-CASC research team. This reduction in item number aimed to minimise the rating burden on clinicians when the measure is used in conjunction with the HoNOS. The abbreviated 16-item instrument is the version to be reported under the Mental Health National Outcomes and Casemix Collection.

Key references

Original 39 item version of the LSP:

Rosen A, Hadzi-Pavlovic D, Parker G (1989) The Life Skills Profile: A measure assessing function and disability in schizophrenia. *Schizophrenia Bulletin*, 1989, 325-337.

Parker G, Rosen A, Emdur N, Hadzi-Pavlov D (1991) The Life Skills Profile: Psychometric properties of a measure assessing function and disability in schizophrenia. *Acta Psychiatrica Scandinavica*, 83 145-152.

Trauer T, Duckmanton RA, Chiu E (1995) The Life Skills Profile: A study of its psychometric properties. *Australian and New Zealand Journal of Psychiatry*, 29, 492-499.

Reference for LSP-16 (abbreviated 16 item version):

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials.* Canberra: Commonwealth Department of Health and Family Services.

[6] The version listed here is recommended for use in Australia. A newer version (the HoNOS 65+ Version 3, Tabulated) is published on the UK Royal College of Psychiatrists website at http://www.rcpsych.ac.uk/cru/honoscales/honos65/ but is not recommended for use at this stage due to non comparability with the general adult HoNOS.

3.1.3. Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)

Developed by Fries et al for the measurement of nursing dependency in skilled nursing facilities in the USA, the RUG-ADL measures ability with respect to 'late loss' activities – those activities that are likely to be lost last in life (eating, bed mobility, transferring and toileting). 'Early loss' activities (such as managing finances, social relationships, grooming) are included in the LSP. The RUG-ADL is widely used in Australian nursing homes and other aged care residential settings.

The RUG-ADL comprises 4 items only and is usually completed by nursing staff.

Key reference

Fries BE, Schneider DP, et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). *Medical Care*, 32, 668-685.

3.1.4. Focus of Care

Focus of Care is a data item developed in the Australian Mental Health Classification and Service Costs (MH-CASC) study that requires the clinician to make a judgement about each consumer's primary goal of care. It is a single item requiring selection of one of four options: Acute; Functional Gain; Intensive Extended; and Maintenance.

Key reference

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials.* Canberra: Commonwealth Department of Health and Family Services.

3.1.5. Consumer self-report outcome measure

While the original Information Priorities document released in 1999 proposed the national use of a specific self-report measure (the Mental Health Inventory – MHI), this was subsequently changed to allow States and Territories to introduce an 'agreed' alternative measure. This recognised that, at the time when the NOCC reporting arrangements were designed, limited Australian research had been undertaken on consumer rated measures to identify the most suitable measure for use routine use in service delivery.

Following consultations with consumers within their jurisdictions, States and Territories introduced one of the following:

- Mental Health Inventory (MHI-38);
- Behaviour and Symptoms Identification Scale (BASIS-32); or
- Kessler–10 Plus (K-10+).

Table 1 provides a summary of the consumer self rated measure currently used with adult and older consumers within each of the States and Territories.

Table 1: State and Territory selected adult consumer self rated measures

Jurisdiction	
Victoria	BASIS-32
New South Wales	K10+
Tasmania	***BASIS-32***
Australian Capital Territory	BASIS 32
Northern Territory	K10+
South Australia	K10+
Western Australia	K10+
Queensland	MHI-38

3.1.5.1. Mental Health Inventory (MHI-38)

The Mental Health Inventory (MHI-38) was designed to measure general psychological distress and well-being in the RAND Health Insurance Experiment, a study designed to estimate the effects of different health care financing arrangements on the demand for services as well as on the health status of the patients in the study.

The full form contains 38 items. Each item includes a description of a particular symptom or state of mind. The MHI can be completed either as a self-report measure or as part of an interview.

Key references

Veit CT and Ware JE (1983) The structure of psychological distress and well-being in general populations. *Journal of Consulting and Clinical Psychology*, 51 730-742.

Davies AR, Sherbourne CD, Peterson JR and Ware JE (1998) *Scoring manual: Adult health status and patient satisfaction measures used in RAND's Health Insurance Experiment*. Santa Monica. RAND Corporation.

3.1.5.2. Behaviour and Symptom Identification Scale (BASIS-32)

The Behaviour and Symptom Identification Scale (BASIS-32) was developed in the early 1990's by a team in the United States for use in outcome assessment. The BASIS-32 asks the consumer to respond to 32 questions that assess the extent to which the person has been experiencing difficulties on a range of dimensions.

Key references

Eisen SV, Dill, DL and Grob MC (1994) Reliability and validity of a brief patient-report instrument for psychiatric patient outcome evaluation. *Hospital and Community Psychiatry*, 45, 242-247.

Eisen SV, Dickey B and Sederer LI (2000) A self-report symptom and problem scale to increase inpatients' involvement in treatment. *Psychiatric Services*, 51, 349-353.

3.1.5.3. Kessler 10 Plus (K10+)

Originally developed in 1992 by Kessler & Mroczek[7] for use in the United States National Health Interview Survey, the K10 is a ten-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 additional questions to assess functioning and related factors, and it is this instrument which is being used by four States and Territories (New South Wales, Western Australia, South Australia, Northern Territory) in the NOCC. Overall, the K10+ is an extremely brief symptoms and functioning measure, validated against diagnosis, that is intended to be supplemented with additional measures of domains relevant to consumers.

Key references

Andrews et al (1998): Andrews G. Sanderson K. Beard J (1998) Burden of disease. Methods of calculating disability from mental disorder. *British Journal of Psychiatry* 1998;173:123-31.

Kessler R, Costello EJ, Merikangas KR, Ustun TB (2000) Psychiatric Epidemiology: Recent Advances and Future Directions Chapter 5 in Manderscheid R, Henderson MJ (2000) *Mental Health, United States, 2000.* Rockville MD: Substance Abuse & Mental Health Services Administration, www.mentalhealth.org/publications/allpubs/SMA01-3537/

Andrews G and Slade T (2001) Interpreting scores on the K10. *Australian and New Zealand Journal of Public Health*, 25, 494-497.

Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczec DK, Normand S, Walters EE (2002) Short screening scales to monitor population prevalence and trends in non-specific psychological distress. *Psychological Medicine*, 32(6): 959-976.

Kessler RC, Colpe LJ, Epstein JF, Groerer JC, Hiripi E, Howes MJ, Normnad S-L T, Manderscheid RW, Walters EE, Zasalvsky AM (2003) Screening for serious mental illness in the general population. *Archives of General Psychiatry 2003*: 60(2), 184-189.

Note: Additional resource material is being prepared by the Centre for Mental Health, New South Wales Health Department and will be made available to all States and Territories. See also http://www.health.nsw.gov.au/policy/cmh/mhoat

3.2. Clinical data specific to children and adolescents

3.2.1. Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) is a 15 item clinician-rated measure modelled on the HoNOS and designed specifically for use in the assessment of child and adolescent consumer outcomes in mental health services. Ratings are made by clinicians based on their assessment of the patient. In completing their ratings, the clinician makes use of a specific glossary which details the meaning of each point on the scale being rated.

[7] Kessler R, Mroczek D. *Final versions of our Non-Specific Psychological Distress Scale*. Ann Arbor MI: Survey Research Centre of the Institute for Social Research, University of Michigan, Memo dated March 10, 1994

Key references

Gowers S, Harrington R, Whitton A, Lelliott P, Beevor A, Wing J, Jezzard R (1999a) Brief scale for measuring the outcomes of emotional and behavioural disorders in children: Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry*, 174, 413-416.

Gowers S, Harrington R, Whitton A, Beevor A, Lelliott P, Jezzard R, Wing J (1999b) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433.

3.2.2. Children's Global Assessment Scale (CGAS)

The CGAS was developed by Schaffer and colleagues at the Department of Psychiatry, Columbia University to provide a global measure of severity of disturbance in children and adolescents. Similar to the HoNOSCA, it is designed to reflect the lowest level of functioning for a child or adolescent during a specified period. The measure provides a single global rating only, on a scale of 1–100.

Key reference

Schaffer D, Gould MS, Brasic J, et al (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.

3.2.3. Factors Influencing Health Status (FIHS)

The Factors Influencing Health Status (FIHS) measure is a checklist of seven 'psychosocial complications' based on the problems and issues identified in the chapter of ICD-10 regarding Factors Influencing Health Status. It is a simple checklist of the ICD factors, originally developed for use in the MH-CASC project.

Key reference

Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials.* Canberra: Commonwealth Department of Health and Family Services.

3.2.4. Parent and Consumer self report measure – the Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire designed for 4-17 year olds and developed by Goodman et al in the United Kingdom. It exists in several versions to meet the needs of researchers, clinicians and educationalists.

General documentation of the SDQ is available on the website: www.sdqinfo.com[8].

[8] Please note that the versions labelled 'English (Austral)' currently on the SDQ website are not the versions specified for use in Australia. The versions for use in Australia can be found in the document:

> *Mental Health National Outcomes and Casemix Collection: Overview of clinician rated and consumer self-report measures, Version 1.50.*

Key references

Goodman, R. (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38, 581-586

Goodman, R. Meltzer, H. & Bailey, V. (1998) The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry*, 7, 125-130. (Abstract)

Goodman, R. & Scott, S. (1999) Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? *Journal of Abnormal Child Psychology*, 27, 17-24.

Goodman, R. (1999) The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry*, 40,791-801.

Goodman, R (2001) Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40:11, November 2001.

3.3. Other clinical data common to all consumer groups

3.3.1. Principal and Additional Diagnoses

The *Principal Diagnosis* is the diagnosis established after study to be chiefly responsible for occasioning the patient or client's care in the period of care preceding the *Collection Occasion. Additional Diagnoses* identify main secondary diagnoses that affected the person's care during the period in terms of requiring therapeutic intervention, clinical evaluation, extended management, or increased care or monitoring. Up to two *Additional Diagnoses* may be recorded.

Both *Principal Diagnosis* and *Additional Diagnosis* are collected as part of the Admitted Patient Mental Health Care NMDS, and *Principal Diagnosis* (but not *Additional Diagnosis*) is included in the Community Mental Health Care NMDS. Nevertheless, both data items are incorporated in the NOCC because the NMDS definitions are not suitable for development of outcomes and casemix analysis. Specifically, the reporting under the Admitted Patient Mental Health Care NMDS is based on the total hospital episode, while the Community Mental Health Care NMDS requires the diagnosis at the point of each service contact.

Under the NOCC protocol, the diagnoses assigned to the consumer are based on the *Period of Care* preceding the *Collection Occasion,* that is, the interval between the current *Collection Occasion* and that immediately preceding it within the current *Episode of Mental Health Care*.

3.3.2. Mental Health Legal Status

This item is used to indicate whether the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the period preceding the *Collection Occasion*.

Like the diagnosis items, *Mental Health Legal Status* is also collected under the National Mental Health Minimum Data Set arrangements but also included in the

NOCC requirements due to differences in the reporting period used as the basis for recording the data item.

3.4. Purpose of the clinical data

The standard measures will be used for the purpose of measuring consumer outcomes or casemix classification, or both.

Table 2 summarises the data to be collected across the various consumer groups and the purposes of collection. In general, many of the measures will be used for both casemix development and outcome evaluation purposes.

Table 2: Data to be collected and purpose of collection

	Age Group			Purpose	
	Child & Adolescent	Adults	Older People	Outcomes Evaluation	Casemix Classification
Clinical measurement scales					
Health of the Nation Outcome Scales (HoNOS)		●		●	●
Health of the Nation Outcome Scales for Older People (HoNOS 65+)			●	●	●
Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)	●			●	●
Life Skills Profile (LSP-16)		●	●	●	●
Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL)			●		●
Children's Global Assessment Scale (CGAS)	●				●
Factors Influencing Health Status (FIHS)	●			○	●
Other clinical data					
Mental Health Legal Status	●	●	●	○	●
Principal and Additional diagnosis	●	●	●	○	●
Focus of Care (FoC)		●	●	○	●
Consumer self-report					
Kessler 10 (K10+), Behavior and Symptom Identification Scales(BASIS-32, or Mental Health Inventory (MHI-38)		●	●	●	
Strengths and Difficulties Questionnaire (SDQ, all versions)	●			●	

Note: See also Table 4 for details on when each of the above measures are to be collected.

Key to symbols

- ● Indicates the data will be used for the specified purpose of building the casemix classification or measuring outcomes.
- ○ Indicates the data is not an outcomes measure as such but is important for the interpretation of outcome data.

4. Scope of the NOCC collection

Two features define the scope of the National Outcomes and Casemix Collection reporting requirements.

- They are designed to cover *specialised mental health services* managed by, or in receipt of funds from, State or Territory health authorities.
- Within specialised mental health services, the focus of the collection is on the activities of *Mental Health Service Organisations.*

Both of these features also define the scope of long established data collections on mental health services in Australia, being central to the current NMDS – Mental Health Establishments and its predecessor, the annual National Survey of Mental Health Services that was conducted between 1994-2005.

4.1. The definition of specialised mental health services

4.1.1. Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The concept of a specialised mental health service is not dependent on the inclusion of the service within the State or Territory mental health budget.

A service is not defined as a specialised mental health service solely because its clients include people affected by a mental illness or psychiatric disability. The definition excludes specialist drug and alcohol services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.

These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc).

4.1.2. Specialised mental health services include:

- Public psychiatric hospitals and designated psychiatric units in general hospitals;[9]
- Community-based residential services[10]; and
- Ambulatory care mental health services.

4.2. The definition of a Mental Health Service Organisation

4.2.1. Within specialised mental health services, the focus of the collection is on the activities of Mental Health Service Organisations. This concept was first defined in NOCC Version 1.0, and subsequently, formally recognised under the National Health Data Dictionary (as an object class with the METeOR identifier 286449) and used to guide all national mental health data collections.

4.2.2. For the purposes of the current specifications, the definition of a Mental Health Service Organisation is identical to that given under the NHDD. That definition is summarised below.

4.2.3. A *Mental Health Service Organisation* is a separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised mental health care.

4.2.4. A Mental Health Service Organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings. For example, a Mental Health Service Organisation may consist of several hospitals or two or more community centres.

4.2.5. Where the Mental Health Service Organisation consists of multiple service units, those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and

[9] Use of the term 'designated' to refer to mental health services in this document is not intended to imply any specific status under the State or Territory mental health legislation. Instead, it refers to the service as having as its primary function the delivery of treatment or care to people affected by mental illness.

[10] Aged care residential services (eg, psychogeriatric nursing homes) in receipt of funding under the Aged Care Act and subject to Australian Government reporting requirements (ie, report to the System for the Payment of Aged Residential Care (SPARC) collection) are considered to be 'out of scope' for reporting under NOCC on the condition that they are accredited or are formally engaged in a quality improvement process aimed at achieving accreditation under Aged Care standards.

- share clinical records or, in the case where is more than one physical clinical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

4.2.6. For most States and Territories, the Mental Health Service Organisation is equivalent to the Area or District Mental Health Service. These are usually organised to provide the full range of admitted patient, residential and ambulatory services to a given catchment population. However, the term may also be used to refer to health care organisations which provide only one type of mental health service (e.g. acute admitted patient care) or which serve a specialised or state-wide function.

4.2.7. As noted in the next section, Mental Health Service Organisation is a critical concept in the NOCC reporting arrangements as it is a key field used to uniquely identify each Episode of Mental Health care for each consumer.

5. Key concepts underpinning the NOCC protocol

Under the NOCC protocols the required data is collected at key *Collection Occasions* within an *Episode of Mental Health Care* provided by a *Mental Health Service Organisation* within a specific *Episode Service Setting*. The specific clinical measures and other data elements that should or may be collected at any given Collection Occasion are determined by the *Episode Service Setting* within which the occasion occurs, the *Collection Age Group* to which the patient or client has been assigned, and whether the Collection Occasion itself is defined as an *Admission*, a *Review* or a *Discharge*.

The key concepts: *Episode of Mental Health Care*; *Episode Service Setting; Collection Occasion; Collection Age Group;* and *Mental Health Service Provider Entity* are each discussed in detail below.

5.1. Episodes of Mental Health Care

5.1.1. Concepts of episodes are used widely throughout the health system as a convenient method to describe the activities of health services and to organise data collection, reporting and analysis. In general, an episode of care is used to refer to a period of care with discrete start and end points.

5.1.2. Most work on defining episodes has been tied to acute hospital settings, where the principle is relatively simple – one episode per patient per hospital at any one time, with the episode beginning at admission and ending at discharge.

5.1.3. In the original planning for introduction of NOCC, significant problems arose when translating this concept to community-based mental health services. No concept of episode had been agreed to quantify these types of services. There are several issues that make the definition of an episode in that setting particularly difficult. First, whilst the initiation of community–based mental health care is usually accompanied by formal well–defined processes, its termination often is more difficult to define, either clinically or administratively. Second, many patients undergo care over extended periods. Finally, multiple agencies or teams working in either the same or different service settings, may be involved in providing care during a particular period, with each agency or team regarding their intervention as a discrete episode.

5.1.4. For the purposes of the NOCC specification, an *Episode of Mental Health Care* is defined as a more or less continuous period of contact

between a consumer[11] and a *Mental Health Service Organisation* that occurs within the one *Episode Service Setting*.

5.1.5. This formal concept of an episode should not be confused with either the clinical concept of an episode of care or the more narrowly defined, inpatient-centred definition currently used in the National Health Data Dictionary.

5.1.6. Three broad episode types are identified which are based on the Episode Service Setting – Psychiatric Inpatient, Community Residential and Ambulatory.

- *Psychiatric Inpatient episodes (Overnight admitted)* – refers to the period of care provided to a consumer who is admitted for overnight care to a designated psychiatric inpatient service.
- *Community Residential episodes* – refers to the period of care provided to a consumer who is admitted for overnight care to a designated community-based residential service.
- *Ambulatory episodes* – refers to all other types of care provided to consumers of a designated mental health service.

Note that Psychiatric inpatient episodes' as defined for the purpose of the NOCC protocol are confined to the category of *overnight admitted patients* as used in the National Health Data Dictionary and specifically exclude same day admitted patients. Same day admitted patient episodes, which account for approximately one quarter of all separations from public sector psychiatric inpatient units, are defined as occasions of service within Ambulatory care episodes for NOCC purposes. This is consistent with the reporting practices that have been in place for the National Survey of Mental Health Services since 1994, and its successor, the NMDS – Mental Health Establishments.

5.1.7. Two business rules apply to episodes of mental health care:

- ***One episode at a time****:* While an individual may have multiple episodes of mental health care over the course of their illness, they may be considered as being in only one episode at any given point of time for **a particular Mental Health Service Organisation**. The practical implication is that the care provided by a Mental Health Service Organisation to an individual consumer at any point in time is subject to only one set of reporting requirements. Where a person might be considered as receiving concurrently two or

[11] For the purposes of these specifications, the terms consumer, client and patient are used interchangeably and refer to a person for whom a *Mental Health Service Organisation* accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record.

more episodes of mental health care by virtue of being treated by the organisation in more than one setting simultaneously, the following order of precedence applies: Inpatient, Community Residential, Ambulatory.[12]

- ***Change of setting = new episode***: A new episode is deemed to commence when a person's care is transferred between inpatient, community residential and ambulatory settings. A change of *Episode Service Setting* therefore marks the end of one episode and the beginning of another.

5.2. Episode Service Setting

5.2.1. The Episode Service Setting is the setting within which the *Episode of Mental Health Care* takes place, as defined by the domain specified in the following clauses.

5.2.2. **Psychiatric inpatient service**. This setting includes overnight care provided in public psychiatric hospitals and designated psychiatric units in public acute hospitals. Psychiatric hospitals are establishments devoted primarily to the 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 a Ambulatory mental health service team to a person admitted to a designated Special Care Suite or 'Rooming-In' facility within in a community general hospital for treatment of a mental or behavioural disorder is also included under this setting.

5.2.3. **Community residential mental health service**. A residential mental health service is a specialised mental health service that:

- employs mental health-trained staff on site;
- provides rehabilitation, treatment or extended care;
- to residents provided with care intended to be on an overnight basis;
- in a domestic-like environment; and
- encourages the resident to take responsibility for their daily living activities.

[12] The 'one episode at a time' rule is an important administrative device to facilitate data collection and development of business rules that clarify 'what should happen when'. It is not intended to undermine the important concept of *continuity of care* in mental health service delivery, nor to imply segregation in the service delivery roles of clinical staff working across inpatient and community-based settings.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However all these services employ on-site mental health trained staff for some part of each day.

For non-24 hour staffed services to be included in NOCC data reporting, they must employ mental health trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day. This is consistent with the scope of the NMDS – Residential Mental Health Care.

5.2.4. **Ambulatory care mental health service**. This setting includes all non–admitted, non–residential services provided by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include 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, psychogeriatric assessment services and so forth. For the purposes of the NOCC protocol, care provided by hospital–based consultation–liaison services to admitted patients in non–psychiatric and hospital emergency settings is also included under this setting.

5.3. Collection Occasion

5.3.1. A *Collection Occasion* is defined as an occasion during an *Episode of Mental Health Care* when the required dataset is to be collected in accordance with a standard protocol. The broad rule is that collection of data is required at both *episode start* and *episode end.*

5.3.2. In many cases, the beginning and end of episodes is marked by some objective event such as admission or discharge from hospital or completion of community treatment. However, because episodes may extend over prolonged periods, outcomes and casemix data need to be collected at regular review points during that care, in order to monitor progress and determine if the consumer's condition has changed during the defined period.

5.3.3. For the purposes of the specification, the maximum interval between collection occasions is based on the standard review period of three months (91 days) as required under the *National Standards for Mental Health Services.*

5.3.4. Based on the above, three *Collection Occasions* are identified within an episode when the required data are to be collected:

- ***Admission to mental health care episode***[13] – this refers to the beginning of an inpatient, ambulatory or community residential *Episode of Mental Health Care*. For the purposes of the NOCC protocol, episodes may start for a number of reasons. These include, for example, a new referral to community care, admission to an inpatient unit, transfer of care from an inpatient unit to a community team and so forth. Regardless of the reason, admission to a new episode acts as the 'trigger' for a specific set of data to be collected.
- ***Discharge from mental health care episode*** [14] – this refers to the end of an inpatient, ambulatory or community residential *Episode of Mental Health Care.* As per *Admission*, episodes may end for a number of reasons such as discharge from an inpatient unit, case closure of a consumer's community care, admission to hospital of a consumer previously under community care. Regardless of the reason, the end of an episode acts as a 'trigger' for a specific set of clinical data to be collected.
- ***3 month (91-day) Review of mental health care episode*** – this refers to the point at which the consumer has been under 13 weeks of continuous care since *Admission* to the episode, or 13 weeks has passed since the last *Review* was conducted during the current episode.

5.3.5. Specification of 3-monthly (91 day) reviews as the minimum requirement for consumers under ongoing care is not intended to restrict *Reviews* that may be conducted at shorter intervals. Such *Reviews* of a consumer's status may occur for a number of reasons including, for example:

- in response to critical clinical events or changes in the consumer's status;
- in response to a change from voluntary to involuntary status or vice versa;
- following a transfer of care between community teams or change of case manager;

[13] 'Admission' and 'Discharge' are used as abbreviated generic terms throughout this document to refer to entry to or exit from care in all treatment settings. While it is recognised that for some mental health clinicians and consumers the terms are not 'community friendly', they are used here as economical ways of describing similar events in the cycle of mental health care. Alternative terms for Admission and Discharge are 'Episode Start' and 'Episode End' or 'Entry to Episode' and 'Exit from Episode', respectively.

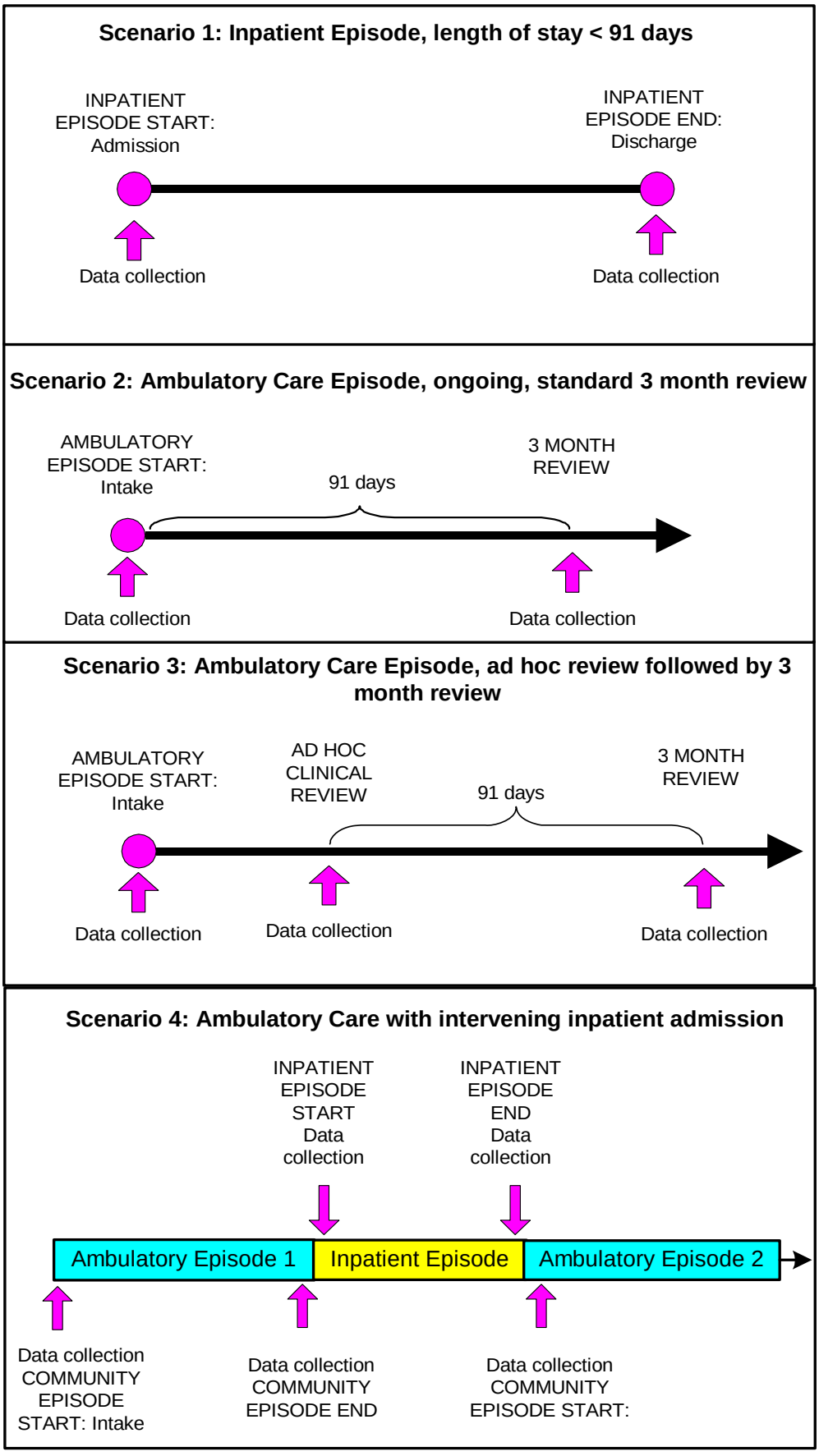
[14] 'Discharge' is not formally defined in the National Health Data Dictionary, which uses instead the term 'separation' defined as *'the process by which an episode of care for an admitted patient ceases.'* The NOCC protocol uses the term 'discharge' by preference as a generic term to cover the completion of episodes across all treatment settings.

- transfers between inpatient wards within a multi-ward hospital;
- compliance with local agency or State-level requirements such as reviews conducted at the 35 day point within inpatient units;
- consumer or carer-requested reviews; and
- other situations where a review may be indicated.

5.3.6. Where an ad hoc *Review* is conducted for any of the above reasons, it will also be deemed a *Collection Occasion* and included in the data reported. Such ad hoc *Reviews* move forward the next due *Collection Occasion* to 3 months (91 days) subsequently, or *Discharge*, whichever occurs sooner.

5.3.7. Figure 1 (page 27) summarises the data collection points under various episode scenarios.

Figure 1: Data collection requirements under four episode scenarios



5.4. Age Group

5.4.1. The specific clinical measures to be reported at a particular *Collection Occasion* depend on the broad age group to which the consumer is assigned (Child and Adolescent, Adult, or Older persons).

5.4.2. Generally, throughout mental health services, **Adults** are defined as persons between the age of 18 and 64 years inclusive, **Older Persons** are defined as persons aged 65 years and older and **Children and Adolescents** are defined as persons under the age of 18 years.

5.4.3. States and Territories will be responsible for determining whether *Age Group* (and thus the clinical measures to be used) is determined on the basis of the actual age, condition and care needs of the consumer or deemed on the basis of the type of service providing the treatment and care, or a mixture of both. Currently, all mental health services in-scope are required under the NMDS – Mental Health Establishments to be classified according to the age group of their target population (General Adult, Child and Adolescent, Older Persons, Forensic). Selection of the clinical measures to be applied by a given service can be based on this service classification.

5.4.4. Thus, in some circumstances a person may be assigned to a different *Age Group* to that in which they would assigned on the basis of their actual age, condition and care needs. For example, a person aged 60 years who was being cared for in a specialist Older Persons inpatient unit may be assigned to the Older people age group. Similarly, a 15 year old admitted to an general adult psychiatric unit may be assigned to the Adult group if the adult measures are used.

5.4.5. The alternative option of determining which clinical measures to apply on the basis of the consumer's actual age, condition and care needs has more complex workforce training implications which can only be resolved at the State and Territory level.

5.4.6. Special issues arise in relation to Forensic Psychiatry Services, which may cover all age groups and require additional measures to assessing outcomes. Future national developments in mental health outcome measures will consider options for introducing an agreed set of supplementary measures for Forensic Psychiatry services. In the meantime, each jurisdiction will continue to determine how the concept of *Age Group* will be interpreted for the Forensic Psychiatry services operating within its public sector.

5.5. Mental Health Provider Entity Hierarchy

5.5.1. A systematic approach to the identification of the *Mental Health Provider Entity* is essential for several reasons:

5.5.1.1 It allows the organisational and service provider contexts in which data are collected to be described. Understanding these service provider contexts is essential for identifying 'like with like' services and using the data for benchmarking purposes.

5.5.1.2 When used in combination with the *Patient Identifier* (see 5.6 below), it provides the means to:

- assemble data collected at one or more *Collection Occasions* for a given consumer into higher-level *Episodes of Mental Health Care* which will be the subject of analysis and reporting; and
- link the outcomes and casemix data provided through the NOCC dataset to unit record data provided by States and Territories collected under related national data sets, in particular, the NMDS – Admitted Patient Mental Health Care, NMDS – Community Mental Health Care and NMDS – Residential Mental Health Care.

5.5.2. Additionally, a systematic approach to the specification of the *Mental Health Provider Entity* is critical because it determines two aspects of the NOCC protocol:

- It provides the basis for setting the boundaries for how the 'one episode at a time' rule is applied. For example, where two ambulatory care teams within a single organisation share responsibility for the care of a consumer, under NOCC this is not considered two separate episodes because both teams (or service units) belong to a single organisation.
- It determines the level at which the consumer is identified uniquely (see section 5.6) below.

5.5.3. Complex issues are raised in designing a system to identify and classify mental health service providers. Services have diversified following the extensive structural reforms under the National Mental Health Strategy. Provider organisations typically provide an array of interlocking services through a number of discrete 'service units' or teams which include inpatient units, community-based residential

facilities, hospital and community-based outpatient services and mobile assessment and treatment services. The clinical pathways between the various units are also complex. Patients may sometimes be transferred between inpatient facilities, depending on the intensity of care they require. Clients may receive care from more than one ambulatory service within the organisation at the same time, or be transferred between ambulatory care teams for more intensive care for short periods as their needs change.

5.5.4. An additional requirement is that the manner and level at which the responsible Mental Health Provider Entity is specified must enable the meaningful linkage of NOCC data with the unit record data provided by States and Territories under the relevant related NMDS arrangements.

5.5.5. A hierarchical approach is required to deal with this complexity in which the following levels are identified:

- State.
- Region.
- Mental Health Service Organisation.
- Hospital or Service Unit Cluster
- Service Unit.

5.5.6. This 'layered' approach to the identification of mental health entities developed originally from the National Survey of Mental Health Services that ran between 1994-2005, and has been introduced as a central feature of all National Minimum Data Sets. It has proved its worth as an approach to dealing with the complexity of the mental health service system.

5.5.7. In this approach, States and Territories report data aggregated around the concept of a *Mental Health Service Organisation* and further specify data relating to the various inpatient, ambulatory care and community residential service units that operate beneath the level of the 'parent' organisation. All mental health service organisations are in turn grouped into regions.

Specification

5.5.8. Each *Collection Occasion* record reported as part of the NOCC extract should be assigned to a *Service Unit*, which is identified by a unique *Service Unit Identifier*.

5.5.9. Service Units represent the lowest level component of a hierarchically ordered set of entities, comprising five levels within the mental health service system:

- State or Territory
- Region
- Mental health service organisation
- Hospital or Service unit cluster
- Service unit

5.5.10. **State or Territory**. This level refers to the state or territory and should be reported using the *Australian state or territory identifier* data element.

5.5.11. **Region**. The region refers to an administrative concept and is the same as the region concept in the NMDS – Mental Health Establishments. States and territories may have one or more regions into which the jurisdiction is divided and to which its mental health service organisations belong. In those cases, Region should be reported using the *Region* data element. In the smaller states or in the territories there may only be one or no region applicable. In these cases the Region code would be reported as '00' and the Region details would repeat the name of the State or Territory.

5.5.12. **Mental Health Service Organisation**. As defined and described under clause 4.2 above. Identifiers used to report Mental Health Service Organisations within NOCC should be the same as those used identify organisations in the NMDS – Mental Health Establishments.

5.5.13. **Hospital or Service Unit Cluster.** A mental health service organisation may consist of one or more clusters of service units providing services in admitted patient, residential and ambulatory settings. For example, a mental health service organisation may consist of several hospitals (clusters of admitted patient service units) and/or ambulatory or residential service unit clusters (for example, a cluster of child and adolescent ambulatory service units, and a cluster of aged residential service units).

To allow service units (as defined below using agreed data elements) to be individually identified, but still also to be identified as part of a hospital (for the admitted patient service setting), or as part of another type of cluster (e.g., other cluster types for ambulatory or residential service setting), a separate reporting level called 'Hospital' for admitted patient service units and 'Service unit cluster' for ambulatory service units and residential service units is necessary.

While all admitted patient service units must be physically part of a hospital, ambulatory and residential service units will not necessarily be part of a natural cluster. However, for some ambulatory service units, the service unit may 'belong' to a hospital that contains both admitted patient and ambulatory service units. In this instance, the service unit cluster identifier for the ambulatory service unit would be the 'hospital identifier'. Other groups of ambulatory and residential service units could also be usefully identified as clusters. For example, clusters may exist of groups of residential services for aged persons, or groups of ambulatory service units in particular geographical areas.

When there is no Service unit cluster, then the Service unit cluster identifier is to be reported as '00000' and the Service unit cluster details would use the relevant organisation name.

Note that hospitals are to be reported as the equivalent of service unit clusters rather than as service units.

5.5.14. **Service Unit**. The Service Unit represents the lowest level in the Mental Health Provider Entity Hierarchy but is the most critical because it is the level at which patient care is delivered. Three 'service unit types' are identified, comprising:

- Psychiatric inpatient (admitted patient) service units
- Residential service units
- Ambulatory service units

5.5.15. **Service Unit Type** is intended to describe the most common type of care provided by the service unit. Service Unit Type should not be confused with Episode Service Setting. As described below, the latter is an attribute of the Episode of Mental Health Care, while the former is an attribute of the service provider.

5.5.16. Several guidelines apply to the way in which an organisation's mental health services are reported as service units. These are based on the minimum reporting that is required for the purposes of the National Minimum Data Sets, particularly the NMDS – Mental Health Establishments.

5.5.16.1. **Admitted patient service units**: Admitted patient service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic) and Program Type (Acute vs Other). For example, if a hospital had separate wards for Child & Adolescent and General Adult populations, these should be reported as separate service units. Similarly, if the

hospital provided separate wards for Older Persons acute and Older Person other program types, this would require separate service units to be identified (that is, defined by the program type as well as the target population). The overarching principle is that the same service unit identification policy must be applied to the admitted patient service units data reported under NOCC and the NMDS – Mental Health Establishments.

5.5.15.2. **Residential service units**: Residential service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic). Where possible, it is also desirable that residential service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS – Residential Mental Health Care.

5.5.15.3. **Ambulatory service units**: Ambulatory service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic). Where an organisation provides multiple teams serving the same target population, these may be grouped and reported as a single Service Unit, or identified as individual Service Units in their own right. Where possible, it is also desirable that residential service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS – Residential Mental Health Care.

5.5.17. When assigning a Service Unit to a Collection Occasion, the following overarching reporting rule applies**: Identify the Service Unit that is principally responsible for provision of services to the person during the current episode of care**.

5.5.18. Two implications follow from this overarching rule

5.5.18.1. The Service Unit Identifier recorded for any given Collection Occasion will not necessarily refer to the Service Unit that collected the Collection Occasion data. For example, where an ambulatory care service assists in the admission to hospital of a consumer and completes the required data items and standard measures, the Service Unit Identifier recorded for that Collection Occasion should refer to the admitted patient services unit, not the ambulatory care service unit.

5.5.18.2. The setting reported for the Service Unit (at the data element 'service unit type') will not necessarily match the Episode Service Setting within which the Episode of Care takes place as reported at the Collection Occasion level. For example, this could occur where an inpatient service is primarily responsible for providing the services to person in an ambulatory episode following discharge from hospital.

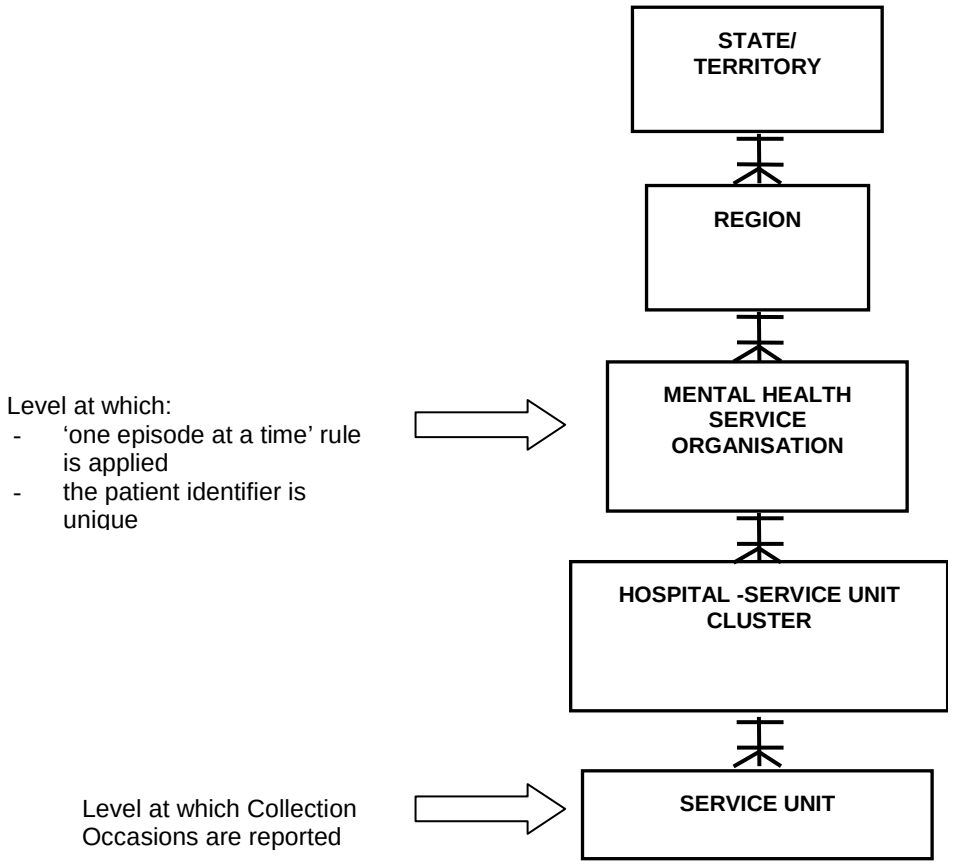
5.5.19. While the NOCC specifications need to recognise that complex interactions can do occur between service type and episode type, in the vast majority of instances the following simple situations will apply.

- Where the collection occasion occurs in the context of an inpatient episode, the Service Unit identified will be the admitted patient service unit within the hospital to which the patient is currently admitted.
- Where the collection occasion occurs in the context of a community residential episode, the Service Unit identified will be the community residential facility to which the patient is admitted.
- Where the collection occasion occurs in the context of an ambulatory episode, the Service Unit identified will generally be the single ambulatory care service that is providing the treatment and care to the person during the episode.

5.5.20. **The 'one episode at a time' business rule should be applied across the Mental Health Service Organisation not at the Service Unit level.** Thus, where multiple Service Units within the organisation are simultaneously involved in providing treatment and care to a consumer, that consumer is considered as receiving only one Episode of Mental Health Care using the order of precedence described in clause 5.1.7. A consumer may however be regarded as receiving more than one episode of care when each episode is provided by a separate Mental Health Service Organisation.

5.5.21. The hierarchical relationship between the components of the Mental Health Provider Entity Hierarchy and the levels at which key NOCC business rules are applied is summarised in Figure 2.

Figure 2: Mental Health Provider Entity Hierarchy – Elements and levels



5.6. Unique identification of consumers

5.6.1. Unique identification of the consumer is an essential requirement in clinical information systems, both for ensuring that local information collections support continuity of care, as well as for State/Territory and national-level analysis.

5.6.2. All unit record data reported by States and Territories is to be assigned to an individual consumer, identified by a numerical **Patient identifier** that is unique at the level of the *Mental Health Service Organisation* and shared by all service units operating under the organisation.

5.6.3. States and Territories vary in the extent to which service units operating as components of a *Mental Health Service Organisation* share a unique identifier for patients under care. However, where these are not in place, States and Territories are taking steps to establish such arrangements.

5.6.4. The unique **Patient identifier** reported in the NOCC extract submitted to the Australian Government should be in encrypted form and meet two fundamental requirements:

- It should be identical to the identifier used in supplying unit record data in respect of the individual consumer in the corresponding NMDS dataset. Thus:
    - For consumers reported in the NOCC data set as currently experiencing an ambulatory care episode, the patient identifier used should be identical to that used to supply data in respect of the consumer to the NMDS – Community Mental Health Care.
    - For consumers reported in the NOCC data set as currently experiencing a residential care episode, the patient identifier used should be identical to that used to supply data in respect of the consumer to the NMDS – Residential Mental Health Care.
    - For consumers reported in the NOCC data set as currently experiencing a psychiatric inpatient episode, the patient identifier used should be identical to that used to supply data in respect of the consumer to the NMDS – Admitted Patient Mental Health Care.
- The encrypted identifier used to supply data to NOCC in respect a consumer should be stable over time – that is, it should allow the consumer's data to be linked across reporting years.

6. Unit of reporting

6.1. Basic unit of reporting – the *Collection Occasion*

6.1.1. For the purposes of NOCC reporting requirements, the unit of reporting is the *Collection Occasion*. A specified data set is to be reported for three defined collection occasions (*Admission, Review, Discharge*).

6.1.2. It is important to distinguish the *unit of reporting* from the *unit of analysis.* The units of reporting serve as the building blocks to assemble higher level 'units of care' which will be the subject of analysis. For this there needs to be both:

- a capacity to link discrete collection occasion events, using as a primary key the data elements Mental Health Service Organisation, *Patient Identifier and Episode of Mental Health Care Identifier;* and
- a conceptual framework to guide the bundling of those events into coherent units for analysis.

6.2. Reporting context — *Episode of Mental Health Care Identifier*

6.2.1. The Episode of Mental Health Care Identifier links together Collection Occasions which arise from the same Episode of Mental Health Care. As such, a single Admission occasion, any number of Review occasions, and a single Discharge occasion collected in respect of a given Episode of Mental Health Care should share the same value on this identifier.

6.2.2. For each uniquely identified patient or client the Episode of Mental Health Care Identifier must uniquely identify each episode. That is, the union of Patient Identifier with Episode of Mental Health Care Identifier must itself be unique within the broader scope of the Mental Health Service Organisation, however the Episode of Mental Health Care Identifier on its own need not be unique within that broader scope. This will ensure that Episodes of Mental Health Care are uniquely identified within the scope at which they themselves are defined.

6.2.3. As with Patient Identifiers, the Episode of Mental Health Care Identifier used to refer to supply NOCC data should be stable over time – that is, it should allow Collection Occasion components of the

episode to be linked even when those components are spread across multiple reporting years.

6.3. Reporting context — *Reason for Collection*

6.3.1. Application of the reporting protocol requires that the defined *Collection Occasions* be mapped to a range of key events (i.e.. admission to hospital, registration by community services, clinical review, transfer, discharge etc) which may occur within the context of an *Episode of Mental Health Care*.

6.3.2. Understanding the nature of the events triggering admission, discharge or review is necessary for subsequent informed analysis. For example, it will be desirable to separately analyse the differential outcomes of new consumers admitted to ambulatory care from those who commence an ambulatory episode following discharge from hospital.

6.3.3. In addition, to promote consistency in the development of guidelines for the regular review and closure of cases under ongoing Ambulatory care use of a concept of '**active care**' has been found necessary. For this purpose, States and Territories have been moving to progressively implement the following business rule, or some variation that closely approximates the rule:

A person is defined as being under '**active care**' at any point in time when:

- they have not been discharged from care; AND
- some services (either direct to or on behalf of the consumer) have been provided over the previous 3 months; AND
- plans have been made to provide further services to the person within the next 3 months.

Thus, where no future services are planned in the next 3 months, the person is not considered to be under '**active care**'.

6.3.4. These considerations are captured within the data element *Reason for Collection.* The domain of the *Reason for Collection* item is shown in Table 3 below.[15]

Individual States and Territories have the option of specifying the domain in greater detail and are encouraged to do. For example, New

[15] It is noted that the *Reasons for Collection* item has some conceptual similarities to the National Health Data Dictionary data elements Mode of Admission, Mode of Separation and Reason for Cessation of Treatment. However, the items have different domains and purposes. The *Reasons for Collection* domain incorporates two concepts: 'Why is the information being collected now?' And 'where is the patient coming from/going to' in terms of the next step in their sequence of care.

South Wales uses a list of 39 hierarchically ordered *Reasons for Collection*, which accommodate a range of local service issues and State requirements that go beyond the national requirements. However, where the domain is further specified, States and Territories should ensure a capacity to map to the national definitions. These represent the mandatory national conditions for collection of data at *Admission*, *Review* and *Discharge*.

Table 3: Domain and data definitions for *Reason for Collection*

Collection Occasion	Reason for Collection	Definition
Admission to mental health care episode	**01.** New referral	Admission to a new inpatient, community residential or ambulatory episode of care of a consumer not currently under the active care of the *Mental Health Service Organisation*.
	02. 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 Organisation*
	03. Admission – Other	Admission to a new inpatient, community residential or ambulatory episode of care for any reason other than defined above
Review of mental health care episode	**04.** 3-month review	Standard review conducted at 3 months (91 days) following admission to the current episode of care or 91 days subsequent to the preceding Review
	05. Review – Other	Standard review conducted for reasons other than the above.
Discharge from mental health care episode	**06.** No further care	Discharge from an inpatient, community residential or ambulatory episode of care of a consumer for whom no further care is planned to be provided by the *Mental Health Service Organisation*.
	07. 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 Organisation*.
	08. Death	Completion of an episode of care following the death of the consumer.
	09. Discharge - Other	Discharge from an inpatient, community residential or ambulatory setting for any reason other than defined above.

6.4. Collection Occasion Date

6.4.1. The *Collection Occasion Date* is the reference date for all data collected at any given *Collection Occasion*.

6.4.2. For data collected at the **beginning** of an *Episode of Mental Health Care* the *Collection Occasion Date* is referred to as the *Admission Date*. For data collected at **end** of an *Episode of Mental Health Care*, the *Collection Occasion Date* is referred to as *Discharge Date.* For data collected at *Review* during an ongoing *Episode of Mental Health Care*, the *Collection Occasion Date* is referred to as the *Review Date*.

6.4.3. 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, the various measures may be completed by clinicians and consumers over several days. For example, at *Review* during ambulatory care, the client's case manager might complete the HoNOS and LSP during the clinical case review on the scheduled date, but in order to include their client's responses to the consumer 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*.[16] The actual collection dates of the individual data items and standard measures may be collected locally but is not required in the national reporting extract.

6.4.4. A special requirement applies in the case of inpatient episodes to facilitate record matching with corresponding records collected under the NMDS – Admitted Patient Mental Health Care. For *Admission* to inpatient episodes, the *Collection Occasion Date* should be the date of admission as recorded in the NMDS data set. For *Discharge* from inpatient episodes, the *Collection Occasion Date* should be the date of separation as recorded in the NMDS data set.[17]

[16] The implication is that each data item and standardised measure needs to 'belong' to a specific *Collection Occasion* and assumes the date properties of the *Collection Occasion*. Technical solutions are needed within local information systems to group all relevant data items and standardised measures collected as part of the NOCC dataset and attach them to a specific, dated *Collection Occasion.*

[17] This requirement is workable for the vast majority of inpatient episodes but may not be appropriate for those episodes that include extended periods of leave. See Section 7.3 for proposed approach for dealing with such cases.

7. Collection protocol

This section describes the protocol to be used to guide the collection of outcomes and casemix data. It focuses on what data is to be collected and when it is to be collected.

The NOCC protocol defines the minimum requirements and should not be interpreted as confining participating States and Territories to those requirements. Additionally, local services may elect to collect additional measures or to increase the frequency of ratings.

Implementing the protocol within service delivery agencies requires consideration of how the required data collection will be integrated within agency-level clinical processes and broader information requirements. Local systems vary with different business processes, data collection forms and so forth that reflect differences in service delivery structures. Resolving these issues is beyond the scope of the current document but will need to be addressed by all States and Territories.

7.1. Data requirements at each Collection Occasion

7.1.1. Design of the protocol needs to accommodate both the outcomes and casemix development objectives of the agreed information development strategy. These are not identical. Simply put, casemix requirements need key data to be collected only once during each episode to allow the episode to be adequately described and classified. From the casemix perspective, the only issue is to ensure that the information is collected at the most appropriate point within the overall episode of care. For example, assessment on the HoNOS at *Admission* would suffice for casemix purposes because it is the best measure of the level of severity of the condition presented by the consumer to the treatment system.

7.1.2. In comparison, measurement of consumer outcomes by definition presumes a comparison over time and requires data to be collected on at least two occasions in order to allow assessment of change in the consumer's health status. Thus, taking the same example of the HoNOS, a minimal requirement would be to collect the HoNOS at Admission and Discharge.

7.1.3. The national protocol takes all these issues into account and requires that:

- clinical measures that are to be used for outcomes evaluation and casemix purposes be collected at the *Admission, Review* and *Discharge Collection Occasions* within episodes to allow change in the consumer's clinical status to be assessed; and

- items required only for casemix purposes be collected at points which are consistent with the MH-CASC classification to allow the classification to be further developed. In general, the decision about whether to collect these at episode start or episode end is based on using the *Collection Occasion* that best describes the consumer during the overall episode of care.

7.1.4. Table 4 brings together these considerations and provides summary details of the various measures to be reported at the three *Collection Occasions* during each episode of mental health care.

Table 4: Data to be reported at each *Collection Occasion* within each *Episode Service Setting*, for consumers in each *Age Group*[1]

Episode Service Setting	INPATIENT			COMMUNITY RESIDENTIAL			AMBULATORY		
Collection Occasion	A	R	D	A	R	D	A	R	D
Children and Adolescents									
HoNOSCA [2]	●	●	●	●	●	●	●	●	●
CGAS	●	●	✘	●	●	✘	●	●	✘
FIHS	✘	●	●	✘	●	●	✘	●	●
Parent / Consumer self report (SDQ) [3, 4]	●	●	●	●	●	●	●	●	●
Principal and Additional Diagnoses	✘	●	●	✘	●	●	✘	●	●
Mental Health Legal Status	✘	●	●	✘	●	●	✘	●	●
Adults									
HoNOS [2]	●	●	●	●	●	●	●	●	●
LSP-16 [5]	✘	✘	✘	●	●	●	✘	●	●
Consumer self-report (MHI, BASIS32, K10+) [4, 6]	✘	✘	✘	●	●	●	●	●	●
Principal and Additional Diagnoses	✘	●	●	✘	●	●	✘	●	●
Focus of Care [7]	✘	✘	✘	✘	✘	✘	✘	●	●
Mental Health Legal Status	✘	●	●	✘	●	●	✘	●	●
Older persons									
HoNOS 65+ [2]	●	●	●	●	●	●	●	●	●
LSP-16 [2]	✘	✘	✘	●	●	●	✘	●	●
RUG-ADL	●	●	✘	●	●	✘	✘	✘	✘
Consumer self-report (MHI, BASIS32, K10+ [4, 6])	✘	✘	✘	●	●	●	●	●	●
Principal and Additional Diagnoses	✘	●	●	✘	●	●	✘	●	●
Focus of Care [7]	✘	✘	✘	✘	✘	✘	✘	●	●
Mental Health Legal Status	✘	●	●	✘	●	●	✘	●	●

Abbreviations and Symbols

A Admission to Mental Health Care
R Review of Mental Health Care
D Discharge from Mental Health Care

● Reporting of data on this occasion is mandatory
✘ No reporting requirements apply

Notes to Table 4

(1) This table identifies the national reporting requirements and is not intended to restrict a State or Territory from the collection of additional data at specific collection occasions (e.g., collection of consumer self report measure at admission to inpatient care). Where data are collected that are in excess of the national requirements, and reported as part of the jurisdiction's NOCC submission, they will be accepted and incorporated as part of the national 'data repository'. The only exception is where 'excess' data are collected that are illogical or not meaningful. For example: Collection of Principal Diagnosis and Focus of Care at Admission is not meaningful because both of the these elements are defined as indicating judgements that are made, in retrospect, after a period of care within an episode.

(2) Discharge ratings for the HoNOS, HoNOS65+ and HoNOSCA are not required for inpatient episodes less than 3 days duration.

(3) 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.

(4) The classification of consumer self-report measures as mandatory is intended only to indicate the expectation that consumers will be invited to complete self-report measures at the specified *Collection Occasions*, not that such measures will always be appropriate. Special considerations applying to the collection of self-report measures are described in section 7.4.

(5) The LSP-16 is not included as a measure for use in inpatient settings as, in its current form, it requires ratings to be based on the consumer's functioning over the previous three months. This is difficult for the majority of inpatient episodes which are relatively brief.

(6) Introduction of adult consumer self-report measures in inpatient episodes is not included as a national requirement but will be continue to be reviewed following experience in use of the measures in other settings. Individual States and Territories or service agencies may however choose to trial these measures in inpatient settings.

(7) Restriction of the Focus of Care only to ambulatory care episodes for adults and older persons is based on experience in the MH-CASC study which found it be of limited value in inpatient and community residential settings and with child/adolescent patients.

7.2. Rating periods for the clinical and consumer self-report measures and data items

Completion of each of the clinical measures and data items is based on a period of observation that is specific to each scale or item, and may vary according to the *Collection Occasion*. Table 5 identifies the usual rating periods and their exceptions for all clinical data.

Table 5: Rating periods for each of the clinical and consumer self-report measures and data items

Standardised measure or Data item	Usual rating period	Exceptions
HoNOS / HoNOS 65+	Previous 2 weeks	At discharge from Inpatient psychiatric care, based on previous 3 days including day of discharge.
LSP	Previous 3 months	No exceptions
RUG-ADL	Current status	No exceptions
K10 / K10+	For K10+LM, based on previous 4 weeks. For K10L3D, based on previous 3 days.[18]	No exceptions
BASIS-32	Previous 2 weeks	No exceptions
MHI-38	Previous 4 weeks	No exceptions
HoNOSCA	Previous 2 weeks	At discharge from Inpatient psychiatric care, based on previous 3 days including day of discharge.
CGAS	Previous 2 weeks	No exceptions
FIHS	The period of care bound by the current *Collection occasion* and the preceding *Collection Occasion*.	No exceptions
SDQ	At admission to a service, the previous six months At review and discharge, the previous one month	No exceptions
Focus of Care	The period of care bound by the current *Collection occasion* and the preceding *Collection Occasion*.	no exceptions
Principal and Additional Diagnoses	The period of care bound by the current *Collection occasion* and the preceding *Collection occasion*.	no exceptions
Mental Health Legal Status	The period of care bound by the current *Collection Occasion* and the preceding *Collection Occasion*.	no exceptions

[18] The K10L3D is a variation of the K10 designed for use in inpatient settings where the episode is of less than 3 days duration. Use of adult consumer self-report measures within inpatient settings is not required under current NOCC specifications but is being used by some jurisdictions.

7.3. Special issues in interpreting the protocol at service delivery level

7.3.1. The standard protocol is designed to fit most clinical situations without there being an expectation that the fit will be perfect. Based on experience to date, it is expected that implementation of the protocol for the majority of cases should be relatively straightforward once information systems are in place and clinician training in use of the instruments has been completed.

7.3.2. However, there is a range of special issues that will need to be resolved within each jurisdiction where application of the standard protocol is more complex. Most of these concern clarifying the interface between episodes in complex sequences of care and interpreting the two business rules which act as triggers to data collection (one episode at a time, change of setting = new episode).

7.3.3. It is beyond the scope of the current document to provide detailed guidelines on all potential complexities arising in the translation of the standard protocol to the many service delivery environments in which mental health services operate in Australia. However, a summary of the approach recommended to the main issues is provided in Table 6 as a basis for further discussion within States and Territories and development of workforce training programs.

Table 6: Recommended approach to special issues in interpreting the protocol at service delivery level

Scenario	Common Questions	National minimum requirement
1. Movement between inpatient and community settings	Do ratings need to be recorded for the end of the community episode as well as the beginning of the inpatient episode when a consumer is transferred from ambulatory care to hospital?	Yes, because one episode has ended and another commenced. How this is achieved depends on the service structures established within the organisation. It does not necessarily imply that separate ratings are made by two independent clinicians. Potential to integrate the data requirements within a single rating should be explored.
2. Transfer between two wards of the psychiatric unit	Is the transfer of a patient from one psychiatric ward to another within the same hospital campus a new episode and thus requiring new data collection?	No, because there has not been a change of treatment setting. However, there may be good clinical reasons to reassess the patient when transfer occurs eg, when the transfer is from an acute to a rehabilitation ward, or from a general acute unit to a forensic ward within the hospital. Decisions about whether such additional ratings are required need to be resolved at the local level. Where they do occur, they should be reported and Reason for Collection coded as 'Review – Other'.
3. Transfer between psychiatric units from one hospital campus to	Should a new inpatient episode be commenced when a consumer is transferred from one hospital to another within the same mental health care organisation?	Yes. Even though this is not technically a change in treatment setting, States and Territories have agreed that an inpatient episode should be recorded in these circumstances, with the associated data collection requirements.

Scenario	Common Questions	National minimum requirement
another		
4. Transfer of care between community teams	Does a new cycle of data collection begin when case management is transferred from one ambulatory care team to another within the same organisation?	No, within the national episode model the consumer is regarded as remaining within the same episode of care. However, as in the example (2) above, there may be good clinical reasons to reassess the patient when between-team transfer occurs. For example, transfer from crisis team to continuing care team. Decisions about whether such additional ratings are required need to be resolved at the local level.
5. Multiple team involvement in case management	Is each team expected to complete ratings on the consumer?	No, the consumer is regarded as receiving only one episode of care at a time. Decisions about which team (or clinician) is responsible for completing the required ratings need to be at the local level. In general, this is expected to be the service unit that is principally responsible for providing treatment and care during the current Episode of Mental Health Care.
6. 'Intended' same day admissions:	Is each day of care a new inpatient episode, requiring a full set of ratings?	No. Definitions developed under the *National Survey of Mental Health Services* since 1994, and now replicated in NMDS – Mental Health Establishments, regard 'intended same day admissions' as a component of ambulatory care services.
7. Discharge from hospital on indefinite leave	Does an inpatient episode continue when a patient is placed on extended leave but remains, legally, an inpatient?	This is a common but complex issue in mental health services. As a general rule, it is recommended that, for the purposes of the NOCC dataset, the inpatient episode be deemed to have ended when the patient is sent on leave and where there is no intention that he/she return for an overnight stay *within the next 7 day period*.
8. Return to hospital from indefinite leave	Does a new inpatient episode begin when a patient returns to hospital after a period of extended leave?	This is the converse of the above. It is recommended that where an inpatient episode is deemed to have ended as a result of indefinite leave, and the patient returns unexpectedly, a new inpatient episode should be commenced.
9. Brief inpatient episodes	Are discharge ratings required for very brief inpatient episodes?	In general yes, but there are exceptions: • For inpatient episodes in all Age Groups where the episode is of less than 3 days duration: the HoNOS/HoNOS65+/HoNOSCA is not required. • For <u>all</u> Child and Adolescent episodes of less than 21 days duration, the discharge SDQ is not required. In both instances above, the exclusion is because the period that would be rated at discharge would overlap with the admission ratings Apart from the above exceptions, all other aspects of the collection protocol are required at discharge from inpatient episodes.
10. Rapid readmission to hospital	If a patient is discharged from an inpatient unit and is readmitted within a very short period, is this a new inpatient episode or a continuation of the previous one?	Where the readmission was unplanned, there are strong clinical grounds for recording a new episode and reassessing the patient. However, this issue remains controversial. Further advice will be sought from the various national mental health outcome expert groups.

Scenario	Common Questions	National minimum requirement
11. 'Assessment only' cases seen by community teams	Is outcomes and casemix data required on every person seen by community teams, regardless of whether they are accepted for treatment?	This is an issue that needs to be resolved by each State and Territory. It is recognised that many people are seen only briefly by community teams and referred elsewhere following assessment. Similarly, community teams may provide services on a consultation and shared care basis to many people, some of whom they do not assess directly. Collection of the full set of outcomes and casemix data in such instances may be impractical. A nationally agreed process for registering this important aspect of mental health team work is yet to be developed (see Appendix 4). In the meantime, States and Territories should develop local guidelines and business rules for clinicians regarding the handling of 'assessment only' cases. In general, there is consensus that use of the standard clinical measures at the assessment point represents good practice for all cases. Where further care is not provided beyond the assessment, or where the care episode is of very brief duration, collection of discharge data may not be meaningful.
12. Consumers seen regularly but at intervals of greater than 3 months	How should the 3 monthly (91 day) review 'rule' be applied in these cases? Does it mean that they will need to be seen more regularly?	No, definitely not, the collection protocol is intended to support good practice rather than dictate how services should be delivered. Where the needs of a consumer require that they be seen regularly but at greater than 3 monthly intervals, then reviews using the standard instruments should be conducted on the next appointment that occurs after 3 months have elapsed since the last collection occasion.
13. Admission to general medical (non mental health) ward	Is a new episode of mental health inpatient care commenced when the person is admitted to a (non mental health) medical ward for the primary purpose of mental health care?	No. This is a continuation of the ambulatory episode. It is recommended however that a review of the consumer be conducted at this stage.
14. Consultation Liaison teams	What is expected of C-L teams in terms of collection of the NOCC data?	It does not make sense to establish a single rule to apply to C-L teams. Mental health teams referred to under the descriptive label 'Consultation Liaison' deliver services in varied ways and across all treatment settings. In some instances the consumer may be seen briefly, or not at all. Such services share similar characteristics to the 'assessment only' scenario described above. In others, the consumer may be seen for a series of consultations in much the same way as in many 'standard' mental health services, indicating that the full sequence of NOCC data is appropriate. Further work will continue to develop the episode model underpinning NOCC to better differentiate the work of C-L teams. In the meantime, each jurisdiction is expected to resolve how C-L services should approach the NOCC collection. This will usually require resolution at the local level based on an understanding of how each service operates rather

Scenario	Common Questions	National minimum requirement
		than instituting a blanket rule. It is worth noting that the RANZCP Consultation – Liaison Psychiatry Section prepared a report in November 2002 that recommended the adoption of the NOCC measures within C-L psychiatry.[19]

7.4. Special considerations applying to the collection of consumer self-report and parent measures

7.4.1. In general, all consumers should be asked to complete self–report measures at the *Collection Occasions* indicated in Table 4. However, due to the nature and severity of their mental health or other problems, it is likely that some consumers 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. Suggested criteria for defining the reasons why the collection of self–report measures would be contraindicated are outlined below.

7.4.2. In all cases, clinical judgement as to the appropriateness of inviting the consumer to complete the measures should be the determining factor at any given *Collection Occasion*. Where collection of consumer self–report measures is contraindicated, the reasons should be recorded.

7.4.3. Similar considerations also apply in relation to the parent version of the SDQ.

General exclusions

7.4.4. 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 or language issues make the measures inappropriate.[20]

[19] Royal Australian and New Zealand College of Psychiatry Consultation Liaison Section. Report of Outcome Data Measurement National Working Group, November 29 2002.

[20] Substantial development work is required in the future to address cultural issues in the use and interpretation of self-report outcome measures. See Appendix 3.

Temporary contraindications

7.4.5. Under certain conditions, a consumer (or in the case of the SDQ a 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 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 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 consumers or parents in crisis are too distressed to complete the measure.

7.4.6. It is suggested that in these circumstances consumers and parents need not be invited to complete the measures. At all other times, an attempt should be made to obtain their responses.

7.4.7. 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 consumer (or parent) 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.

Special issues related to the Strengths and Difficulties Questionnaire versions

7.4.8. The SDQ has six versions currently specified for NOCC reporting:[21]

- Parent-report for children aged 04-10 on admission to a mental health care episode;
- Parent-report for children aged 04-10 on follow up contact (review and discharge);

[21] An additional four versions are available for use by Teachers but these are not included in the national protocol. Details of these versions however are provided in the document *Mental Health National Outcomes and Casemix Collection: Overview of clinician rated and self-report measures, Version 1.50.* Department of Health and Ageing, Canberra, 2003.

- Parent-report for children and adolescents aged 11-17 on admission to a mental health care episode;
- Parent Report Measure for Youth aged 11-17 on follow up contact (review and discharge);
- Youth self report measure (11-17) on admission to a mental health care episode; and
- Youth self report measure (11-17) on follow up contact (review and discharge).

7.4.9. 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 consumers and parents, the following guide is suggested:

Transfer of care between an inpatient, community residential or ambulatory setting of a consumer 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.

7.4.10. The 'admission' versions are to be used on admission of a consumer who is a new referral – that is, they are not currently under the active care of the Mental Health Service Organisation.

7.1 7.5. Future development of the protocol

7.1.1 The original version of the National Outcomes and Casemix Collection was prepared from the research and development undertaken in the first decade of the National Mental Health Strategy and the experiences by jurisdictions in introducing standard outcome measurement into routine clinical practice.

7.1.2 Much has been learnt over the past six years through trial and application of the NOCC data. The changes introduced in the current version of the NOCC specifications go some way to addressing the

range of complex technical issues entailed in the introduction of routine consumer outcome measurement in to day to day clinical practice.

7.1.3 Nevertheless, the protocol continues to represent an attempt to achieve a compromise between the desirable and the achievable. A range of issues remain controversial and specific areas require further development. These will be progressively addressed as further version of the specification are released.

7.1.4 Much of the input to future development will continue to come from day-to-experience in using the measures and the protocol governing their collection. Experience from the technical side of system development will also inform future revisions, along with analysis of the national data and formal research studies of the measurement instruments themselves. Input from the various National Mental Health Outcomes Expert groups will also be critical.

8. NOCC data extract and file layout specification

This section identifies the layout and format of NOCC data files to be prepared and submitted by States and Territories to the Australian Government Department of Health and Ageing.

8.1. Overview of data model for NOCC extract

8.1.1. The basic design of the extract consists of a set of data records for each Collection Occasion: the record of the Collection Occasion itself, together with the relevant associated records standardised measures and associated data items collected in respect of that Collection Occasion. Depending on the Episode Service Setting, Age Group and Collection Occasion, zero or one each of HoNOS, LSP, RUG-ADL, HoNOSCA, CGAS, FIHS, consumer self-rated measure and other individual data items (Diagnosis - Principal and Additional, Focus of Care, Mental health legal status) may be recorded.

8.1.2. In addition, each *Collection Occasion* 'belongs' to an *Episode of Mental Health Care*, which in turn 'belongs' to *Person* (the consumer)), who in turn is linked to a *Service Unit* (the principal or responsible provider of services), which is linked to a *Hospital or Service Cluster*, which is linked to a *Mental Health Service Organisation*, which is linked to a *Region* within the *State/Territory*.

8.1.3. The structure of data to be reported is represented in the data model shown in Figure 3. Several features of the model should be noted.

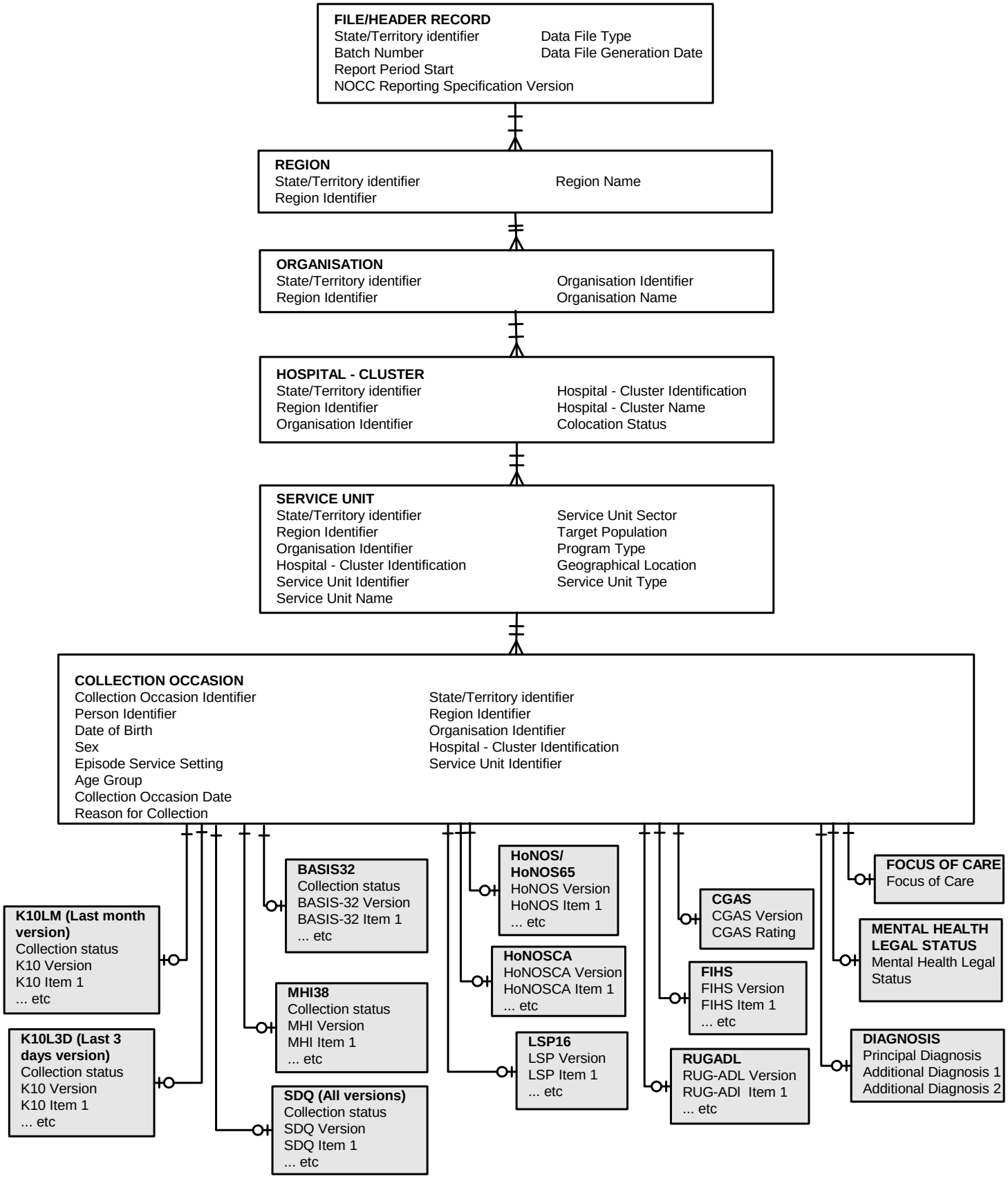
8.1.3.1 Details of the Service Units reporting NOCC data are incorporated as part of the data extract, allowing linkage to related datasets provided by States and Territories (in particular, the NMDS – Mental Health Establishments).

8.1.3.2 Neither the concept of an *Episode of Mental Health Care* nor the concept of a *Period of Care* are represented as entities in the model. Information regarding either entity may be derived for statistical purposes from sequential instances of *Collection Occasions*.

8.1.3.3 Similarly, the concept of Person is not represented as and entity but is implicit, embedded within the Collection Occasion Details record. Information regarding persons who are the subject of the NOCC data can derived directly from information contained in Collection Occasion records.

8.1.3.4 The model separates the record for each individual standardised measure from the *Collection Occasion*, even though the measures have a one-to-one relationship with it. This enables additional measures to be more easily added as the need arises. It also makes the process of accommodating the different consumer self-report instruments that will be used by States and Territories less complex for all parties.

Figure 3: Data model underlying the NOCC data extract



8.2. File type and naming convention

8.2.1. Data submitted to the Australian Government should be formatted as a Fixed Format data file, with each record in the file being terminated with Carriage Return (CR) and Line Feed (LF) characters.

8.2.2. The data file will have the naming convention of NOCC*SSSYYYYNNNNN*.DAT where:

- NOCC denotes "National Outcomes and Casemix Collection".
- SSS is the abbreviation for the State or Territory name; using the following convention –

  for New South Wales use 'NSW',

  for Victoria use 'VIC',

  for Queensland use 'QLD',

  for Western Australia use 'WAU',

  for South Australia use 'SAU',

  for Tasmania use 'TAS',

  for the Australian Capital Territory use 'ACT',

  and for the Northern Territory use 'NTE';
- YYYY indicates the reporting year covered in the file, using the convention where financial years are abbreviated by referring to the last calendar year of the pair (e.g., the 2006–2007 financial year is identified as 2007); and
- NNNNN represents an incremental batch number (leading zeros present).

Note that successive quarterly files and any resubmitted files must have a batch number greater than all preceding files for that year..

For example, suppose that the Australian Capital Territory submitted quarterly data files in respect of the 2007–2008 financial year, then submitted a final submission for that year. Their first NOCC data file would be named "NOCCACT2008000001.DAT", whilst the second would be named "NOCCACT200800002.DAT", and so on. If no resubmissions were made the final submission for that year would be named "NOCCACT200800004.DAT". If that file then had to be resubmitted for some reason, then it would be named "NOCCACT200600005.DAT". Their first submission for the 2008–2009 financial year would then be named "NOCCACT200900001.DAT".

8.3. Reporting period and delivery date

8.3.1. Files are to be prepared on an annual basis and sent to the Department of Health and Ageing by **{date to be confirmed}** each year, or closest working day).

8.3.2. Each annual file will include data for the immediately preceding financial year, e.g., December 2008 file should include data for the 2007-08 financial year.

8.4. File structure

8.4.1. The extract format consists of a set of hierarchically ordered *Data Records*, of which there are 19 types:

- Region details records
- Organisation details records
- Hospital or Service Cluster details records
- Service Unit details records
- Collection Occasion details records
- Diagnosis records
- Focus of Care records
- Legal Status records
- HoNOS or HoNOS65+ measure records
- LSP–16 measure records
- RUG–ADL measure records
- HoNOSCA measure records
- CGAS measure records
- FIHS measure records
- MHI–38 (consumer self–rated) measure records
- BASIS–32 (consumer self–rated) measure records
- K10+ Last Month records
- K10+ Last 3 Days records
- SDQ (all versions of both consumer and parent–rated) measure records

8.4.2. In each extract file for any given period, the *Data records* must be preceded by a single *File Header Record* having the structure outlined below in section 8.6.

8.4.3. All records presented in the extract file must be grouped in the following order: Header Record, Region details records, Organisation details records, Hospital – Cluster details records, Service unit details records, Collection Occasion details records, Diagnosis details records, Focus of Care details records, Mental Health Legal Status details

records, HoNOS or HoNOS65+ measure records, LSP–16 measure records, RUG–ADL measure records, HoNOSCA measure records, CGAS measure records, FIHS measure records, MHI–38 measure records, BASIS–32 measure records, K10+ Last 3 Days measure records, K10+ Last Month measure records, and SDQ measure records.

8.4.4. The content and order of fields in a record must be the same as the order they are specified in the Record Layouts specified in the tables presented in Appendix A. Field values should be formatted as specified in the Record Layouts.

8.4.5. The first field in each record must be *Record Type.* Valid values are shown below.

Table 7: Valid values for *Record Type*

Record Type	***Description***
HR	File Header Record
REG	Region details
ORG	Organisation details
HOSPCLUS	Hospital – Cluster details
SERV	Service Unit details
COD	Collection Occasion Details
DIAG	Diagnosis
FOC	Focus of Care
MHLS	Mental Health Legal Status
HONOS	HoNOS or HoNOS65+
LSP16	LSP–16
RUGADL	RUG–ADL
HONOSCA	HoNOSCA
CGAS	CGAS
FIHS	FIHS
MHI38	MHI (Consumer Self–Rated Measure)
BASIS32	BASIS-32 (Consumer Self–Rated Measure)
K10L3D	K10+ (Last 3 Days Version)

Record Type	*Description*
K10LM	K10+ (Last Month Version)
SDQ	SDQ (all versions)

8.5. Data integrity

8.5.1. Values in Date [**Date**] fields must be recorded in compliance with the standard format used across the National Health Data Dictionary, specifically; dates must be of fixed 8 column width in the format DDMMYYYY, with leading zeros used when necessary to pad out a value. For instance, 13th March 2007 would appear as 13032007.

8.5.2. Values in Numeric [**Num**] fields must be zero-filled and right-justified. These should consist only of the numerals 0-9 and the decimal (".") point if applicable.

Note: Fields defined as 'Numeric' are those that have numeric properties – that is, the values, for example, can be added or subtracted in a manner that is valid. Where a field uses numeric characters that do not have these properties (e.g. the use of numbers for *Patient Identifier*), the field is defined as 'Character'.

8.5.3. Values in Character [**Char**] fields must be left justified and space-filled. These should consist of any of the printable ASCII character set (i.e. excluding control codes such as newline, bell and linefeed).

8.6. File header record

8.6.1. The first record of the extract file must be a File Header Record (Record type = 'HR'), and it must be the only such record in the file.

8.6.2. The File Header Record is a quality control mechanism, which uniquely identifies each file that is sent to the Australian Government. (i.e.. who sent the file, what date the file was sent, how many records are in the file, etc). The information contained in the header fields will be checked against the actual details of the file to ensure that the file received has not been corrupted.

8.6.3. The layout of the File Header Record is shown in Table 8 below.

Table 8: Record Layout for *File Header Record* within the data extract

Data Element	Type [Length]	Start	Notes
Record type	Char [8]	1	Value = HR
State/Territory identifier	Char [1]	9	Domain = 1 New South Wales; 2 Victoria; 3 Queensland; 4 South Australia; 5 Western Australia; 6 Tasmania; 7 Northern Territory; 8 Australian Capital Territory.
Batch Number	Char [9]	10	
Report period start date	Date [8]	19	
Report period end date	Date [8]	27	
Data file generation date	Date [8]	35	
Data file type	Char [4]	47	Value = NOCC
NOCC reporting specification version	Char [5]	46	Value = 01.60
Record length =	51		

8.7. Detailed record layouts

8.7.1. Detailed specifications on the extract format for all NOCC records are provided in Appendix A.

8.8. Data dictionary

8.8.1. Detailed definitions and data element domains or all components of the NOCC dataset are provided in Appendix B.

8.9. Data submission and validation requirements

8.9.1. Submission requirements and an overview of the requirements for data validation are provided in Appendix C.

Appendix A — Record Layouts

Record Layout Table of Contents

Record Layout for HR: File Header Record

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "HR"

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
State/Territory Identifier (State)	Char[1]	9	286919	1 – New South Wales 2 – Victoria 3 – Queensland 4 – South Australia 5 – Western Australia 6 – Tasmania 7 – Northern Territory 8 – Australian Capital Territory
Batch Number (BatchNo)	Char[9]	10	—	YYYYNNNNN
Report Period Start Date (RepStart)	Date[8]	19	—	Any valid date. Identification of this date is mandatory.
Report Period End Date (RepEnd)	Date[8]	27	—	Any valid date. Identification of this date is mandatory.
Data File Generation Date (GenDt)	Date[8]	35	—	Any valid date expressed as DDMMYYYY. Identification of this date is mandatory in the NOCC extract file.
Data File Type (FileType)	Char[4]	43	—	Value: "NOCC" representing National Outcomes and Casemix Collection
NOCC Reporting Specification Version (SpecVer)	Char[5]	47	—	Value: "01.60" representing Version 1.6 (current version)
Total record length: **51**				

Record Layout for REG: Region Details

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "REG"

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
State/Territory Identifier (State)	Char[1]	9	286919	1 – New South Wales 2 – Victoria 3 – Queensland 4 – South Australia 5 – Western Australia 6 – Tasmania 7 – Northern Territory 8 – Australian Capital Territory
Region Identifier (RegId)	Char[2]	10	269940	AA: (values as specified by individual jurisdiction)
Region Name (RegName)	Char[60]	12	—	
*Total record length:***71**				

Record Layout for ORG: Organisation Details

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "ORG"
State/Territory Identifier (State)	Char[1]	9	286919	1 – New South Wales 2 – Victoria 3 – Queensland 4 – South Australia 5 – Western Australia 6 – Tasmania 7 – Northern Territory 8 – Australian Capital Territory
Region Identifier (RegId)	Char[2]	10	269940	AA: (values as specified by individual jurisdiction)
Organisation Identifier (OrgId)	Char[4]	12	—	NNNN: Mental health service organisation identifier. Identifiers used in this collection should map to the identifiers used in data for the NMDS for Mental Health Establishments.

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Organisation Name (OrgName)	Char[100]	16	—	
Total record length: **115**				

Record Layout for HOSPCLUS: Hospital - Cluster Details

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "HOSPCLUS"
State/Territory Identifier (State)	Char[1]	9	286919	1 – New South Wales 2 – Victoria 3 – Queensland 4 – South Australia 5 – Western Australia 6 – Tasmania 7 – Northern Territory 8 – Australian Capital Territory
Region Identifier (RegId)	Char[2]	10	269940	AA: (values as specified by individual jurisdiction)
Organisation Identifier (OrgId)	Char[4]	12	—	NNNN: Mental health service organisation identifier. Identifiers used in this collection should map to the identifiers used in data for the NMDS for Mental Health Establishments.
Hospital - Cluster Identifier (HospClusId)	Char[5]	16	—	For admitted patient service units, the Hospital-Cluster identifier should be identical to that used to identify the hospital to which the service unit 'belongs'. For ambulatory and residential services units, where there is no Service unit cluster, the Hospital - Cluster identifier is to be reported as '00000' and the Hospital - Cluster Name would use the relevant organisation name.
Hospital - Cluster Name (HospClusName)	Char[100]	21	—	For admitted patient service units, the Hospital-Cluster identifier should be identical to that used to identify the hospital to which the service unit 'belongs'. For ambulatory and residential services units, where there is no Service unit cluster, the Hospital - Cluster identifier is to be reported as '00000' and the Hospital - Cluster Name would use the relevant organisation name.

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Co-Location Status (CoLocStatus)	Char[1]	121	286995	1 – Co-located 2 – Not co-located 8 – Not applicable
Total record length: **121**				

Record Layout for SERV: Service Unit Details

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "SERV"
State/Territory Identifier (State)	Char[1]	9	286919	1 – New South Wales 2 – Victoria 3 – Queensland 4 – South Australia 5 – Western Australia 6 – Tasmania 7 – Northern Territory 8 – Australian Capital Territory
Region Identifier (RegId)	Char[2]	10	269940	AA: (values as specified by individual jurisdiction)
Organisation Identifier (OrgId)	Char[4]	12	—	NNNN: Mental health service organisation identifier. Identifiers used in this collection should map to the identifiers used in data for the NMDS for Mental Health Establishments.
Hospital - Cluster Identifier (HospClusId)	Char[5]	16	—	For admitted patient service units, the Hospital-Cluster identifier should be identical to that used to identify the hospital to which the service unit 'belongs'. For ambulatory and residential services units, where there is no Service unit cluster, the Hospital - Cluster identifier is to be reported as '00000' and the Hospital - Cluster Name would use the relevant organisation name.
Service Unit Identifier (SUId)	Char[6]	21	—	NNNNNN: Unique Service Unit Identifier
Service Unit Name (SUName)	Char[100]	27	—	

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Service Unit Sector (Sector)	Char[1]	127	—	1 – Public 2 – Private
Target Population (TargetPop)	Char[1]	128	288957	1 – Child and adolescent 2 – Older person 3 – Forensic 4 – General 9 – Not available
Program Type (ProgType)	Char[1]	129	288889	1 – Acute care 2 – Other 8 – Not applicable (Non-admitted service units only) 9 – Not available
Geographical Location of Establishment (EstSLA)	Char[5]	130	—	Geographical location code (ASGC 20xx). NNNNN
Service Unit Type (SUType)	Char[1]	135	—	1 – Admitted patient service unit 2 – Residential care service unit 3 – Ambulatory care service unit
Total record length: **135**				

Record Layout for COD: Collection Occasion Details

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "COD"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
Person Identifier (PID)	Char[20]	39	—	Any valid identifier as defined by the *Mental Health Service Organisation.*
Date of Birth (DoB)	Date[8]	59	—	Any valid date expressed as DDMMYYYY

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Sex (Sex)	Char[1]	67	—	1 – Male 2 – Female 3 – Indeterminate 9 – Not stated / Missing
Episode Service Setting (Setting)	Char[1]	68	—	1 – Psychiatric inpatient service 2 – Community residential mental health service 3 – Ambulatory mental health service
Age Group (AgeGrp)	Char[1]	69	—	1 – Child or adolescent (0-17) 2 – Adult (18-64) 3 – Older person (65+) In some circumstances a person may be legitimately assigned to a different *Age Group* to that in which they would assigned on the basis of their actual age. For example, a person aged 60 years who was being cared for in an inpatient psychogeriatric unit may be assigned to the Older person's *Age Group* .
Collection Occasion Date (ColDt)	Date[8]	70	—	Any valid date expressed as DDMMYYYY
Reason for Collection (ColRsn)	Char[2]	78	—	01 – New referral 02 – Admitted from other treatment setting 03 – Admission - Other 04 – 3-month (91 day) review 05 – Review - Other 06 – No further care 07 – Discharge to change of treatment setting 08 – Death 09 – Discharge - Other
State/Territory Identifier (State)	Char[1]	80	286919	1 – New South Wales 2 – Victoria 3 – Queensland 4 – South Australia 5 – Western Australia 6 – Tasmania 7 – Northern Territory 8 – Australian Capital Territory
Region Identifier (RegId)	Char[2]	81	269940	AA: (values as specified by individual jurisdiction)

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Organisation Identifier (OrgId)	Char[4]	83	—	NNNN: Mental health service organisation identifier. Identifiers used in this collection should map to the identifiers used in data for the NMDS for Mental Health Establishments.
Hospital - Cluster Identifier (HospClusId)	Char[5]	87	—	For admitted patient service units, the Hospital-Cluster identifier should be identical to that used to identify the hospital to which the service unit 'belongs'. For ambulatory and residential services units, where there is no Service unit cluster, the Hospital - Cluster identifier is to be reported as '00000' and the Hospital - Cluster Name would use the relevant organisation name.
Service Unit Identifier (SUId)	Char[6]	92	—	NNNNNN: Unique Service Unit Identifier
Episode Identifier (EpiId)	Char[36]	98	—	As constructed by the organisation which generates the file. If no Episode link is available, the field should be filled with spaces.
Total record length: **133**				

Record Layout for HONOS: HoNOS or HoNOS65+

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "HONOS"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
HoNOS Version (HnosVer)	Char[2]	39	—	A1 – General adult version as described in Wing J, Curtis R, Beevor A (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432-434 and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003 G1 – HoNOS 65+ as described in Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). *British Journal of Psychiatry*, 174, 424-427 and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003. G2 – HoNOS 65+ Version 3 (Tabulated) as presented on the UK Royal College of Psychiatrists website http://www.rcpsych.ac.uk/cru/honoscales/honos65/ (Note - this version is not currently recommended for use in Australia)
HoNOS Item 01 (Hnos01)	Number[1]	41	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 02 (Hnos02)	Number[1]	42	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 03 (Hnos03)	Number[1]	43	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
HoNOS Item 04 (Hnos04)	Number[1]	44	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 05 (Hnos05)	Number[1]	45	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 06 (Hnos06)	Number[1]	46	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 07 (Hnos07)	Number[1]	47	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 08 (Hnos08)	Number[1]	48	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
HoNOS Item 08a (Hnos08a)	Char[1]	49	—	A – Phobias - including fear of leaving home, crowds, public places, travelling, social phobias and specific phobias B – Anxiety and panics C – Obsessional and compulsive problems D – Reactions to severely stressful events and traumas E – Dissociative ('conversion') problems F – Somatisation - Persisting physical complaints in spite of full investigation and reassurance that no disease is present G – Problems with appetite, over- or under-eating H – Sleep problems I – Sexual problems J – Problems not specified elsewhere :an expansive or elated mood, for example. X – Not applicable (Item 8 rated 0, 7, or 8) Z – Not stated / Missing
HoNOS Item 09 (Hnos09)	Number[1]	50	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 10 (Hnos10)	Number[1]	51	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOS Item 11 (Hnos11)	Number[1]	52	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
HoNOS Item 12 (Hnos12)	Number[1]	53	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
Total record length: **53**				

Record Layout for LSP16: LSP-16

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "LSP16"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
LSP-16 Version (LspVer)	Char[2]	39	—	Value: "01" representing The string '01' referring to the version of the LSP-16 as described in the item definition.
LSP-16 Item 01 (Lsp01)	Number[1]	41	—	0 – No difficulty with conversation 1 – Slight difficulty with conversation 2 – Moderate difficulty with conversation 3 – Extreme difficulty with conversation 7 – Unable to rate (insufficient information) 9 – Not stated / Missing The order of coding of domain for each LSP-16 item shows increasing levels of disability with increasing scores. No disability is coded as 0 whilst the most severe level of disability is coded as 3. This scoring is consistent with the scoring used by the other clinician- rated measures. However, the original 39 item version of the LSP employed the reverse of this convention, with high levels of disability being coded 0.
LSP-16 Item 02 (Lsp02)	Number[1]	42	—	0 – Does not withdraw at all 1 – Withdraws slightly 2 – Withdraws moderately 3 – Withdraws totally or near totally 7 – Unable to rate (insufficient information) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
LSP-16 Item 03 (Lsp03)	Number[1]	43	—	0 – Considerable warmth 1 – Moderate warmth 2 – Slight warmth 3 – No warmth at all 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 04 (Lsp04)	Number[1]	44	—	0 – Well groomed 1 – Moderately well groomed 2 – Poorly groomed 3 – Extremely poorly groomed 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 05 (Lsp05)	Number[1]	45	—	0 – Maintains cleanliness of clothes 1 – Moderate cleanliness of clothes 2 – Poor cleanliness of clothes 3 – Very poor cleanliness of clothes 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 06 (Lsp06)	Number[1]	46	—	0 – No neglect 1 – Slight neglect of physical problems 2 – Moderate neglect of physical problems 3 – Extreme neglect of physical problems 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 07 (Lsp07)	Number[1]	47	—	0 – Not at all 1 – Rarely 2 – Occasionally 3 – Often 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 08 (Lsp08)	Number[1]	48	—	0 – Friendships made or kept well 1 – Friendships made or kept with slight difficulty 2 – Friendships made or kept with considerable difficulty 3 – No friendships made or none kept 7 – Unable to rate (insufficient information) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
LSP-16 Item 09 (Lsp09)	Number[1]	49	—	0 – No problem 1 – Slight problem 2 – Moderate problem 3 – Extreme problem 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 10 (Lsp10)	Number[1]	50	—	0 – Reliable with medication 1 – Slightly unreliable 2 – Moderately unreliable 3 – Extremely unreliable 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 11 (Lsp11)	Number[1]	51	—	0 – Always 1 – Usually 2 – Rarely 3 – Never 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 12 (Lsp12)	Number[1]	52	—	0 – Always 1 – Usually 2 – Rarely 3 – Never 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 13 (Lsp13)	Number[1]	53	—	0 – No obvious problem 1 – Slight problems 2 – Moderate problems 3 – Extreme problems 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 14 (Lsp14)	Number[1]	54	—	0 – Not at all 1 – Rarely 2 – Occasionally 3 – Often 7 – Unable to rate (insufficient information) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
LSP-16 Item 15 (Lsp15)	Number[1]	55	—	0 – Not at all 1 – Rarely 2 – Occasionally 3 – Often 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
LSP-16 Item 16 (Lsp16)	Number[1]	56	—	0 – Capable of full-time work 1 – Capable of part-time work 2 – Capable of sheltered work 3 – Totally incapable of work 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
Total record length: **56**				

Record Layout for RUGADL: RUG-ADL

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "RUGADL"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
RUGADL Version (RugAdlVer)	Char[2]	39	—	Value: "01" representing The string '01' referring to the version of the measure as described in the item definition.
RUGADL Item 01 (RugAdl1)	Number[1]	41	—	1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than 2 - person physical assistance 5 – 2 - person physical assistance 7 – Unable to rate (insufficient information) 9 – Not stated / Missing Notice that a rating of 2 is not included in the domain of valid ratings.

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
RUGADL Item 02 (RugAdl2)	Number[1]	42	—	1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than 2 - person physical assistance 5 – 2 - person physical assistance 7 – Unable to rate (insufficient information) 9 – Not stated / Missing Notice that a rating of 2 is not included in the domain of valid ratings.
RUGADL Item 03 (RugAdl3)	Number[1]	43	—	1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than 2 - person physical assistance 5 – 2 - person physical assistance 7 – Unable to rate (insufficient information) 9 – Not stated / Missing Notice that a rating of 2 is not included in the domain of valid ratings.
RUGADL Item 04 (RugAdl4)	Number[1]	44	—	1 – Independent or supervision only 2 – Limited assistance 3 – Extensive assistance / Total dependence / Tube fed 7 – Unable to rate (insufficient information) 9 – Not stated / Missing Ratings of 4 and 5 are not included in the domain of valid ratings.
Total record length: **44**				

Record Layout for HONOSCA: HoNOSCA

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "HONOSCA"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
HoNOSCA Version (HnosCVer)	Char[2]	39	—	Value: "01" representing The string '01' representing the sole version allowed as per the definition.

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
HoNOSCA Item 01 (HnosC01)	Number[1]	41	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 02 (HnosC02)	Number[1]	42	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 03 (HnosC03)	Number[1]	43	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 04 (HnosC04)	Number[1]	44	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 05 (HnosC05)	Number[1]	45	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
HoNOSCA Item 06 (HnosC06)	Number[1]	46	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 07 (HnosC07)	Number[1]	47	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 08 (HnosC08)	Number[1]	48	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 09 (HnosC09)	Number[1]	49	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 10 (HnosC10)	Number[1]	50	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
HoNOSCA Item 11 (HnosC11)	Number[1]	51	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 12 (HnosC12)	Number[1]	52	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 13 (HnosC13)	Number[1]	53	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 14 (HnosC14)	Number[1]	54	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
HoNOSCA Item 15 (HnosC15)	Number[1]	55	—	0 – No problem within the period rated 1 – Minor problem requiring no formal action 2 – Mild problem. Should be recorded in a care plan or other case record 3 – Problem of moderate severity 4 – Severe to very severe problem 7 – Not stated / Missing 9 – Unable to rate because not known or not applicable to the consumer
Total record length: **55**				

Record Layout for CGAS: CGAS

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "CGAS"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
CGAS Version (CgasVer)	Char[2]	39	—	Value: "01" representing The string '01' representing the sole version allowed as per the definition.
CGAS Rating (Cgas)	Number[3]	41	—	001-010 – Needs constant supervision 011-020 – Needs considerable supervision 021-030 – Unable to function in almost all areas 031-040 – Major impairment of functioning in several areas and unable to function in one of these areas 041-050 – Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area 051-060 – Variable functioning with sporadic difficulties or symptoms in several but not all social areas 061-070 – Some difficulty in a single area but generally functioning pretty well 071-080 – No more than slight impairments in functioning 081-090 – Good functioning in all areas 091-100 – Superior functioning 997 – Unable to rate 999 – Not stated / Missing
Total record length: **43**				

Record Layout for FIHS: FIHS

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "FIHS"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
FIHS Version (FihsVer)	Char[2]	39	—	Value: "01" representing The string '01' representing the sole version allowed as per the definition.
FIHS Item 01 (Fihs1)	Number[1]	41	—	1 – Yes, the person had one or more of these factors influencing their health status 2 – No, none of these factors were present 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
FIHS Item 02 (Fihs2)	Number[1]	42	—	1 – Yes, the person had one or more of these factors influencing their health status 2 – No, none of these factors were present 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
FIHS Item 03 (Fihs3)	Number[1]	43	—	1 – Yes, the person had one or more of these factors influencing their health status 2 – No, none of these factors were present 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
FIHS Item 04 (Fihs4)	Number[1]	44	—	1 – Yes, the person had one or more of these factors influencing their health status 2 – No, none of these factors were present 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
FIHS Item 05 (Fihs5)	Number[1]	45	—	1 – Yes, the person had one or more of these factors influencing their health status 2 – No, none of these factors were present 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
FIHS Item 06 (Fihs6)	Number[1]	46	—	1 – Yes, the person had one or more of these factors influencing their health status 2 – No, none of these factors were present 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
FIHS Item 07 (Fihs7)	Number[1]	47	—	1 – Yes, the person had one or more of these factors influencing their health status 2 – No, none of these factors were present 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
Total record length: **47**				

Record Layout for MHI38: MHI38 (Standard 38 item version)

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "MHI38"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
MHI38 Version (MHIVer)	Char[2]	39	—	Value: "01" representing The string '01' referring to the version of the MHI38 as described in the item definition.
Collection Status (ColSt)	Char[1]	41	—	1 – Complete or Partially complete 2 – Not completed due to temporary contraindication 3 – Not completed due to general exclusion 4 – Not completed due to refusal by patient or client 7 – Not completed for reasons not elsewhere classified 9 – Not stated / Missing
MHI38 Item 01 (MHI01)	Number[1]	42	—	1 – Extremely happy, could not have been more satisfied or pleased 2 – Very happy most of the time 3 – Generally satisfied, pleased 4 – Sometimes fairly satisfied, sometimes fairly unhappy 5 – Generally dissatisfied, unhappy 6 – Very dissatisfied, unhappy most of the time 9 – Not stated / Missing
MHI38 Item 02 (MHI02)	Number[1]	43	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 03 (MHI03)	Number[1]	44	—	1 – Always 2 – Very often 3 – Fairly often 4 – Sometimes 5 – Almost never 6 – None of the time 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
MHI38 Item 04 (MHI04)	Number[1]	45	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 05 (MHI05)	Number[1]	46	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 06 (MHI06)	Number[1]	47	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 07 (MHI07)	Number[1]	48	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 08 (MHI08)	Number[1]	49	—	1 – No, not at all 2 – Maybe a little 3 – Yes, but not enough to be concerned or worried about 4 – Yes, and I have been a little concerned 5 – Yes, and I am quite concerned 6 – Yes, and I am very concerned about it 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
MHI38 Item 09 (MHI09)	Number[1]	50	—	1 – Yes, to the point that I did not care about anything for days at a time 2 – Yes, very depressed almost every day 3 – Yes, quite depressed several times 4 – Yes, a little depressed now and then 5 – No, never felt depressed at all 9 – Not stated / Missing
MHI38 Item 10 (MHI10)	Number[1]	51	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 11 (MHI11)	Number[1]	52	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 12 (MHI12)	Number[1]	53	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 13 (MHI13)	Number[1]	54	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
MHI38 Item 14 (MHI14)	Number[1]	55	—	1 – Yes, very definitely 2 – Yes, for the most part 3 – Yes, I guess so 4 – No, not too well 5 – No, and I am somewhat disturbed 6 – No, and I am very disturbed 9 – Not stated / Missing
MHI38 Item 15 (MHI15)	Number[1]	56	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 16 (MHI16)	Number[1]	57	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 17 (MHI17)	Number[1]	58	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 18 (MHI18)	Number[1]	59	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
MHI38 Item 19 (MHI19)	Number[1]	60	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 20 (MHI20)	Number[1]	61	—	1 – Always 2 – Very often 3 – Fairly often 4 – Sometimes 5 – Almost never 6 – Never 9 – Not stated / Missing
MHI38 Item 21 (MHI21)	Number[1]	62	—	1 – Always 2 – Very often 3 – Fairly often 4 – Sometimes 5 – Almost never 6 – Never 9 – Not stated / Missing
MHI38 Item 22 (MHI22)	Number[1]	63	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 23 (MHI23)	Number[1]	64	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
MHI38 Item 24 (MHI24)	Number[1]	65	—	1 – Always 2 – Very often 3 – Fairly often 4 – Sometimes 5 – Almost never 6 – Never 9 – Not stated / Missing
MHI38 Item 25 (MHI25)	Number[1]	66	—	1 – Extremely so, to the point where I could not take care of things 2 – Very much bothered 3 – Bothered quite a bit by nerves 4 – Bothered some, enough to notice 5 – Bothered just a little by nerves 6 – Not bothered at all by this 9 – Not stated / Missing
MHI38 Item 26 (MHI26)	Number[1]	67	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 27 (MHI27)	Number[1]	68	—	1 – Always 2 – Very often 3 – Fairly often 4 – Sometimes 5 – Almost never 6 – Never 9 – Not stated / Missing
MHI38 Item 28 (MHI28)	Number[1]	69	—	1 – Yes, very often 2 – Yes, fairly often 3 – Yes, a couple of times 4 – Yes, at one time 5 – No, never 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
MHI38 Item 29 (MHI29)	Number[1]	70	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 30 (MHI30)	Number[1]	71	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 31 (MHI31)	Number[1]	72	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 32 (MHI32)	Number[1]	73	—	1 – Always 2 – Very often 3 – Fairly often 4 – Sometimes 5 – Almost never 6 – Never 9 – Not stated / Missing
MHI38 Item 33 (MHI33)	Number[1]	74	—	1 – Yes, extremely to the point of being sick or almost sick 2 – Yes, very much so 3 – Yes, quite a bit 4 – Yes, some, enough to bother me 5 – Yes, a little bit 6 – No, not at all 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
MHI38 Item 34 (MHI34)	Number[1]	75	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 35 (MHI35)	Number[1]	76	—	1 – Always 2 – Very often 3 – Fairly often 4 – Sometimes 5 – Almost never 6 – Never 9 – Not stated / Missing
MHI38 Item 36 (MHI36)	Number[1]	77	—	1 – All of the time 2 – Most of the time 3 – A good bit of the time 4 – Some of the time 5 – A little of the time 6 – None of the time 9 – Not stated / Missing
MHI38 Item 37 (MHI37)	Number[1]	78	—	1 – Always, every day 2 – Almost every day 3 – Most days 4 – Some days, but usually not 5 – Hardly ever 6 – Never wake up feeling rested 9 – Not stated / Missing
MHI38 Item 38 (MHI38)	Number[1]	79	—	1 – Yes, almost more than I could stand or bear 2 – Yes, quite a bit of pressure 3 – Yes, some more than usual 4 – Yes, some, but about normal 5 – Yes, a little bit 6 – No, not at all 9 – Not stated / Missing
Total record length: **79**				

Record Layout for BASIS32: BASIS32 (Standard 32 item version)

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "BASIS32"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
BASIS32 Version (BASISVer)	Char[2]	39	—	Value: "01" representing The string '01' representing the sole version allowed as per the definition.
Collection Status (ColSt)	Char[1]	41	—	1 – Complete or Partially complete 2 – Not completed due to temporary contraindication 3 – Not completed due to general exclusion 4 – Not completed due to refusal by patient or client 7 – Not completed for reasons not elsewhere classified 9 – Not stated / Missing
BASIS32 Item 01 (BASIS01)	Number[1]	42	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 02 (BASIS02)	Number[1]	43	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 03 (BASIS03)	Number[1]	44	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
BASIS32 Item 04 (BASIS04)	Number[1]	45	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 05 (BASIS05)	Number[1]	46	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 06 (BASIS06)	Number[1]	47	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 07 (BASIS07)	Number[1]	48	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 08 (BASIS08)	Number[1]	49	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 09 (BASIS09)	Number[1]	50	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
BASIS32 Item 10 (BASIS10)	Number[1]	51	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 11 (BASIS11)	Number[1]	52	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 12 (BASIS12)	Number[1]	53	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 13 (BASIS13)	Number[1]	54	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 14 (BASIS14)	Number[1]	55	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 15 (BASIS15)	Number[1]	56	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
BASIS32 Item 16 (BASIS16)	Number[1]	57	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 17 (BASIS17)	Number[1]	58	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 18 (BASIS18)	Number[1]	59	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 19 (BASIS19)	Number[1]	60	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 20 (BASIS20)	Number[1]	61	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 21 (BASIS21)	Number[1]	62	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
BASIS32 Item 22 (BASIS22)	Number[1]	63	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 23 (BASIS23)	Number[1]	64	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 24 (BASIS24)	Number[1]	65	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 25 (BASIS25)	Number[1]	66	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 26 (BASIS26)	Number[1]	67	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 27 (BASIS27)	Number[1]	68	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
BASIS32 Item 28 (BASIS28)	Number[1]	69	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 29 (BASIS29)	Number[1]	70	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 30 (BASIS30)	Number[1]	71	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 31 (BASIS31)	Number[1]	72	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
BASIS32 Item 32 (BASIS32)	Number[1]	73	—	0 – No difficulty 1 – A little difficulty 2 – Moderate difficulty 3 – Quite a bit of difficulty 4 – Extreme difficulty 9 – Not stated / Missing
Total record length: **73**				

Record Layout for K10LM: K10+LM (Last Month version)

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "K10LM"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
K10+LM Version (K10LMVer)	Char[2]	39	—	Value: "M1" representing The string 'M1' representing the sole version allowed as per the definition.
Collection Status (ColSt)	Char[1]	41	—	1 – Complete or Partially complete 2 – Not completed due to temporary contraindication 3 – Not completed due to general exclusion 4 – Not completed due to refusal by patient or client 7 – Not completed for reasons not elsewhere classified 9 – Not stated / Missing
K10+LM Item 01 (K10LM01)	Number[1]	42	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 02 (K10LM02)	Number[1]	43	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 03 (K10LM03)	Number[1]	44	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
K10+LM Item 04 (K10LM04)	Number[1]	45	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 05 (K10LM05)	Number[1]	46	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 06 (K10LM06)	Number[1]	47	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 07 (K10LM07)	Number[1]	48	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 08 (K10LM08)	Number[1]	49	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
K10+LM Item 09 (K10LM09)	Number[1]	50	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 10 (K10LM10)	Number[1]	51	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10+LM Item 11 (K10LM11)	Number[2]	52	—	00-28 – 0-28 days 99 – Not stated / Missing
K10+LM Item 12 (K10LM12)	Number[2]	54	—	00-28 – 0-28 days 99 – Not stated / Missing
K10+LM Item 13 (K10LM13)	Number[2]	56	—	00-89 – 0-89 consultations 99 – Not stated / Missing
K10+LM Item 14 (K10LM14)	Number[1]	58	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
Total record length: **58**				

Record Layout for K10L3D: K10L3D (Last 3 days version)

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "K10L3D"

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
K10L3D Version (K10L3DVer)	Char[2]	39	—	Value: "31" representing The string '31' representing the sole version allowed as per the definition.
Collection Status (ColSt)	Char[1]	41	—	1 – Complete or Partially complete 2 – Not completed due to temporary contraindication 3 – Not completed due to general exclusion 4 – Not completed due to refusal by patient or client 7 – Not completed for reasons not elsewhere classified 9 – Not stated / Missing
K10L3D Item 01 (K10L3D01)	Number[1]	42	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10L3D Item 02 (K10L3D02)	Number[1]	43	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10L3D Item 03 (K10L3D03)	Number[1]	44	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
K10L3D Item 04 (K10L3D04)	Number[1]	45	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10L3D Item 05 (K10L3D05)	Number[1]	46	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10L3D Item 06 (K10L3D06)	Number[1]	47	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10L3D Item 07 (K10L3D07)	Number[1]	48	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10L3D Item 08 (K10L3D08)	Number[1]	49	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
K10L3D Item 09 (K10L3D09)	Number[1]	50	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
K10L3D Item 10 (K10L3D10)	Number[1]	51	—	1 – None of the time 2 – A little of the time 3 – Some of the time 4 – Most of the time 5 – All of the time 6 – Don't know 9 – Not stated / Missing
Total record length: **51**				

Record Layout for SDQ: SDQ, all versions

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "SDQ"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
SDQ Version (SDQVer)	Char[5]	39	—	PC101 – Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1 PC201 – Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1 PY101 – Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1 PY201 – Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1 YR101 – Self report Version, 11-17 years, Baseline version, Australian Version 1 YR201 – Self report Version, 11-17 years, Follow Up version, Australian Version 1
Collection Status (ColSt)	Char[1]	44	—	1 – Complete or Partially complete 2 – Not completed due to temporary contraindication 3 – Not completed due to general exclusion 4 – Not completed due to refusal by patient or client 7 – Not completed for reasons not elsewhere classified 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 01 (SDQ01)	Number[1]	45	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 02 (SDQ02)	Number[1]	46	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 03 (SDQ03)	Number[1]	47	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 04 (SDQ04)	Number[1]	48	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 05 (SDQ05)	Number[1]	49	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 06 (SDQ06)	Number[1]	50	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 07 (SDQ07)	Number[1]	51	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 08 (SDQ08)	Number[1]	52	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 09 (SDQ09)	Number[1]	53	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 10 (SDQ10)	Number[1]	54	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 11 (SDQ11)	Number[1]	55	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 12 (SDQ12)	Number[1]	56	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 13 (SDQ13)	Number[1]	57	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 14 (SDQ14)	Number[1]	58	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 15 (SDQ15)	Number[1]	59	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 16 (SDQ16)	Number[1]	60	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 17 (SDQ17)	Number[1]	61	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 18 (SDQ18)	Number[1]	62	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 19 (SDQ19)	Number[1]	63	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 20 (SDQ20)	Number[1]	64	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 21 (SDQ21)	Number[1]	65	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 22 (SDQ22)	Number[1]	66	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 23 (SDQ23)	Number[1]	67	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 24 (SDQ24)	Number[1]	68	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 25 (SDQ25)	Number[1]	69	—	0 – Not True 1 – Somewhat True 2 – Certainly True 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 26 (SDQ26)	Number[1]	70	—	0 – No 1 – Yes - minor difficulties 2 – Yes - definite difficulties 3 – Yes - severe difficulties 7 – Unable to rate (insufficient information) 9 – Not stated / Missing
SDQ Item 27 (SDQ27)	Number[1]	71	—	0 – Less than a month 1 – 1-5 months 2 – 6-12 months 3 – Over a year 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 28 (SDQ28)	Number[1]	72	—	0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing
SDQ Item 29 (SDQ29)	Number[1]	73	—	0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing
SDQ Item 30 (SDQ30)	Number[1]	74	—	0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing
SDQ Item 31 (SDQ31)	Number[1]	75	—	0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 32 (SDQ32)	Number[1]	76	—	0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing
SDQ Item 33 (SDQ33)	Number[1]	77	—	0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing
SDQ Item 34 (SDQ34)	Number[1]	78	—	0 – Much worse 1 – A bit worse 2 – About the same 3 – A bit better 4 – Much better 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing
SDQ Item 35 (SDQ35)	Number[1]	79	—	0 – Not at all 1 – A little 2 – A medium amount 3 – A great deal 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 36 (SDQ36)	Number[1]	80	—	0 – No 1 – A little 2 – A lot 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0) 9 – Not stated / Missing
SDQ Item 37 (SDQ37)	Number[1]	81	—	0 – No 1 – A little 2 – A lot 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected) 9 – Not stated / Missing
SDQ Item 38 (SDQ38)	Number[1]	82	—	0 – No 1 – A little 2 – A lot 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected) 9 – Not stated / Missing
SDQ Item 39 (SDQ39)	Number[1]	83	—	0 – No 1 – A little 2 – A lot 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected) 9 – Not stated / Missing
SDQ Item 40 (SDQ40)	Number[1]	84	—	0 – No 1 – A little 2 – A lot 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected) 9 – Not stated / Missing
SDQ Item 41 (SDQ41)	Number[1]	85	—	0 – No 1 – A little 2 – A lot 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected) 9 – Not stated / Missing

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
SDQ Item 42 (SDQ42)	Number[1]	86	—	0 – No 1 – A little 2 – A lot 7 – Unable to rate (insufficient information) 8 – Not applicable (collection not required - item not included in the version collected) 9 – Not stated / Missing
Total record length: **86**				

Record Layout for DIAG: Diagnosis

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "DIAG"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
Principal Diagnosis (Dx1)	Char[8]	39	—	ICD-10-AM (current version) Formatted as ANNNNNN
Additional Diagnosis 1 (Dx2)	Char[8]	47	—	ICD-10-AM (current version) Formatted as ANNNNNN
Additional Diagnosis 2 (Dx3)	Char[8]	55	—	ICD-10-AM (current version) Formatted as ANNNNNN
Total record length: **62**				

Record Layout for FOC: Focus of Care

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "FOC"

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
Focus of Care (FoC)	Char[1]	39	—	1 – Acute 2 – Functional Gain 3 – Intensive Extended 4 – Maintenance 9 – Not stated / Missing
Total record length: **39**				

Record Layout for MHLS: Mental Health Legal Status

Data Element Alias (Field Name)	Type [Length]	Start	METeOR Identifier	Notes / Values
Record Type (RecType)	Char[8]	1	—	Value: "MHLS"
Collection Occasion Identifier (ColId)	Char[30]	9	—	A unique identifier for the collection occasion as constructed by the organisation which generates the file.
Mental Health Legal Status (LegalSt)	Char[1]	39	—	1 – Person was an involuntary patient for all or part of the period of care 2 – Person was not an involuntary patient at any time during the period of care 9 – Not stated / Missing
Total record length: **39**				

Appendix B — Defined Data Elements and Concepts

Definition Table of Contents

Active Care {concept}

Definition: A person is defined as being under 'active community care' at any point in time when:

- they have not been discharged from care AND
- some services (either direct to or on behalf of the consumer) have been provided over the previous 3 months AND
- plans have been made to provide further services to the person within the next 3 months.

Thus, where no future services are planned in the next 3 months, the person is not considered to be under 'active care'

Field Name: abs_ActiveCare

Additional Diagnosis 1

Definition: An additional diagnosis is a condition or complaint either coexisting with the Principal Diagnosis or arising during the *Episode of Mental Health Care*. For the purposes of NOCC, the item is used to identify up to two secondary or underlying conditions that affected the person'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.

Domain: ICD-10-AM (current version)

Formatted as ANNNNNN

Comments: The National Centre for Classification and Coding in Health has developed simplified ICD-10-AM Mental Health Subset for use in community-based mental health service settings. Services may use this subset as the basis for coding.

Note that the *Principal* and *Additional Diagnoses* should not be confused with the patient or client's current clinical diagnoses or with the reasons for contact with respect to any given Service contact. Also note that definition given here is conceptually consistent but not identical with that given in the NHDD. The NHDD definition refers to the preceding Episode of care. In episodes of acute inpatient care, the Episode of care and the Period of care will almost always refer to the same interval. In extended episodes of care, the reference interval is different.

Field Name: Dx2

Additional Diagnosis 2

Definition: An additional diagnosis is a condition or complaint either coexisting with the Principal Diagnosis or arising during the *Episode of Mental Health Care*. For the purposes of NOCC, the item is used to identify up to two secondary or underlying conditions that affected the person'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.

Domain: ICD-10-AM (current version)

Formatted as ANNNNNN

Comments: The National Centre for Classification and Coding in Health has developed simplified ICD-10-AM Mental Health Subset for use in community-based mental health service settings. Services may use this subset as the basis for coding.

Note that the *Principal* and *Additional Diagnoses* should not be confused with the patient or client's current clinical diagnoses or with the reasons for contact with respect to any given Service contact. Also note that definition given here is conceptually consistent but not identical with that given in the NHDD. The NHDD definition refers to the preceding Episode of care. In episodes of acute inpatient care, the Episode of care and the Period of care will almost always refer to the same interval. In extended episodes of care, the reference interval is different.

Field Name: Dx3

Admission Date

Definition: The date on which the *Episode of Mental Health Care* is deemed to have commenced within the specified *Mental Health Service Setting*. In inpatient and community residential settings this is the actual or statistical date of admission. In ambulatory settings this is the date on which the *Episode of Mental Health Care* within that setting was initiated, as defined under the standard NOCC protocol. It may or may not be equivalent to the original date of 'entry to care' within the ambulatory service.

Comments: Note that this data element is derived from the *Collection Occasion Date* and is not specifically required under NOCC reporting arrangements.

Admission date is defined under AIHW KB item 000008 as the 'Date on which an admitted patient commences an episode of care.'

Field Name: AdmnDt

Admission to Mental Health Care Episode {concept}

Definition: Refers to the beginning of an inpatient, ambulatory or community residential *Episode of Mental Health Care* . For the purposes of the NOCC protocol, episodes may start for a number of reasons. These include, for example, a new referral to community care, admission to an inpatient unit, transfer of care from an inpatient unit to a community team and so forth. Regardless of the reason, admission to a new episode should act as the 'trigger' for a specific set of data to be collected.

Comments: *Admission* is defined under AIHW KB item 000007 as the 'the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.'

Field Name: abs_Admission

Age Group

Definition: The *Age Group* to which the patient or client has been assigned for the purposes of the data collection protocol. Generally, throughout mental health services, **Adults** are defined as persons between the age of 18 and 64 years inclusive, **Older persons** are defined as persons aged 65 years and older and **Children and adolescents** are defined as persons under the age of 18 years. States and Territories will be responsible for determining whether *Age Group* (and thus the clinical measures to be used) is determined on the basis of the actual age, condition and care needs of the consumer or deemed on the basis of the type of service providing the treatment and care, or a mixture of both.

Domain:
1 – Child or adolescent (0-17)
2 – Adult (18-64)
3 – Older person (65+)

In some circumstances a person may be legitimately assigned to a different *Age Group* to that in which they would assigned on the basis of their actual age. For example, a person aged 60 years who was being cared for in an inpatient psychogeriatric unit may be assigned to the Older person's *Age Group* .

Field Name: AgeGrp

BASIS32 Item 01

Definition: In the past two weeks, how much difficulty have you been having in the area of managing day-to-day life (eg, getting places on time, handling money, making everyday decisions)?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS01

BASIS32 Item 02

Definition: In the past two weeks, how much difficulty have you been having in the area of household responsibilities (eg, shopping, cooking, laundry, cleaning, other chores)?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS02

BASIS32 Item 03

Definition: In the past two weeks, how much difficulty have you been having in the area of work (eg, completing tasks, performance level, finding/keeping a job)?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS03

BASIS32 Item 04

Definition: In the past two weeks, how much difficulty have you been having in the area of school (eg, academic performance, completing assignments, attendance)?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS04

BASIS32 Item 05

Definition: In the past two weeks, how much difficulty have you been having in the area of leisure time or recreational activities?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS05

BASIS32 Item 06

Definition: In the past two weeks, how much difficulty have you been having in the area of adjusting to major life stresses (eg, separation, divorce, moving, new job, new school, a death)?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS06

BASIS32 Item 07

Definition: In the past two weeks, how much difficulty have you been having in the area of relationships with family members?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS07

BASIS32 Item 08

Definition: In the past two weeks, how much difficulty have you been having in the area of getting along with people outside of the family?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS08

BASIS32 Item 09

Definition: In the past two weeks, how much difficulty have you been having in the area of isolation or feelings of loneliness?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS09

BASIS32 Item 10

Definition: In the past two weeks, how much difficulty have you been having in the area of being able to feel close to others?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS10

BASIS32 Item 11

Definition: In the past two weeks, how much difficulty have you been having in the area of being realistic about yourself or others?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS11

BASIS32 Item 12

Definition: In the past two weeks, how much difficulty have you been having in the area of recognizing and expressing emotions appropriately?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS12

BASIS32 Item 13

Definition: In the past two weeks, how much difficulty have you been having in the area of developing independence, autonomy?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS13

BASIS32 Item 14

Definition: In the past two weeks, how much difficulty have you been having in the area of goals or direction in life?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS14

BASIS32 Item 15

Definition: In the past two weeks, how much difficulty have you been having in the area of lack of self-confidence, feeling bad about yourself?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS15

BASIS32 Item 16

Definition: In the past two weeks, how much difficulty have you been having in the area of apathy, lack of interest in things?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS16

BASIS32 Item 17

Definition: In the past two weeks, how much difficulty have you been having in the area of depression, hopelessness?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS17

BASIS32 Item 18

Definition: In the past two weeks, how much difficulty have you been having in the area of suicidal feelings or behaviour?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS18

BASIS32 Item 19

Definition: In the past two weeks, how much difficulty have you been having in the area of physical symptoms (eg, headaches, aches and pains, sleep disturbance, stomach aches, dizziness)?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS19

BASIS32 Item 20

Definition: In the past two weeks, how much difficulty have you been having in the area of fear, anxiety, or panic?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS20

BASIS32 Item 21

Definition: In the past two weeks, how much difficulty have you been having in the area of confusion, concentration, memory?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS21

BASIS32 Item 22

Definition: In the past two weeks, how much difficulty have you been having in the area of disturbing or unreal thoughts or beliefs?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS22

BASIS32 Item 23

Definition: In the past two weeks, how much difficulty have you been having in the area of hearing voices, seeing things?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS23

BASIS32 Item 24

Definition: In the past two weeks, how much difficulty have you been having in the area of manic, bizarre behaviour?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS24

BASIS32 Item 25

Definition: In the past two weeks, how much difficulty have you been having in the area of mood swings, unstable moods?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS25

BASIS32 Item 26

Definition: In the past two weeks, how much difficulty have you been having in the area of uncontrollable, compulsive behaviour (eg, eating disorder, hand-washing, hurting yourself)?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS26

BASIS32 Item 27

Definition: In the past two weeks, how much difficulty have you been having in the area of sexual activity or preoccupation?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS27

BASIS32 Item 28

Definition: In the past two weeks, how much difficulty have you been having in the area of drinking alcoholic beverages?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS28

BASIS32 Item 29

Definition: In the past two weeks, how much difficulty have you been having in the area of taking illegal drugs, misusing drugs?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS29

BASIS32 Item 30

Definition: In the past two weeks, how much difficulty have you been having in the area of controlling temper, outbursts of anger, violence?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS30

BASIS32 Item 31

Definition: In the past two weeks, how much difficulty have you been having in the area of impulsive, illegal, or reckless behaviour?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS31

BASIS32 Item 32

Definition: In the past two weeks, how much difficulty have you been having in the area of feeling satisfaction with your life?

Domain:
0 – No difficulty
1 – A little difficulty
2 – Moderate difficulty
3 – Quite a bit of difficulty
4 – Extreme difficulty
9 – Not stated / Missing

Field Name: BASIS32

BASIS32 Version

Definition: The version of the BASIS 32 as described in Eisen SV, Dickey B and Sederer LI (2000) A self-report symptom and problem rating scale to increase inpatients' involvement in treatment. *Psychiatric Services*, 51, 349-353 and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003.

Domain: Value: "01" representing The string '01' representing the sole version allowed as per the definition.

Field Name: BASISVer

Batch Number

Definition: Represents the YYYYNNNNN component of the extract file name.

Domain: YYYYNNNNN

Field Name: BatchNo

CGAS Rating

Definition: Rating on the Children's Global Assessment Scale.

Domain:

001-010 – Needs constant supervision
011-020 – Needs considerable supervision
021-030 – Unable to function in almost all areas
031-040 – Major impairment of functioning in several areas and unable to function in one of these areas
041-050 – Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area
051-060 – Variable functioning with sporadic difficulties or symptoms in several but not all social areas
061-070 – Some difficulty in a single area but generally functioning pretty well
071-080 – No more than slight impairments in functioning
081-090 – Good functioning in all areas
091-100 – Superior functioning
997 – Unable to rate
999 – Not stated / Missing

Field Name: Cgas

CGAS Version

Definition: The version of the CGAS completed as described in Schaffer D, Gould MS, Brasic J, et al (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231 and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items*, Version 1.50. Department of Health and Ageing, Canberra, 2003.

Domain: Value: "01" representing The string '01' representing the sole version allowed as per the definition.

Field Name: CgasVer

Collection Occasion Date

Definition: The reference date for all data collected at any given *Collection Occasion,* defined as the date on which the *Collection Occasion (Admission, Review, Discharge)* occurred.

Domain: Any valid date expressed as DDMMYYYY

Comments: 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, the various measures may be completed by clinicians and consumers over several days. For example, at *Review* during ambulatory care, the client's case manager might complete the HoNOS and LSP during the clinical case review on the scheduled date, but in order to include their client's responses to the consumer 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* . The actual collection dates of the individual data items and standard measures may be collected locally but is not required in the national reporting extract.

Field Name: ColDt

Collection Occasion Identifier

Definition: A unique identifier of a *Collection Occasion* that links data items from the Collection Occasion record to data items in each of the following records:

HoNOS/HoNOS65, LSP16, RUGADL, HoNOSCA, FIHS, CGAS, BASIS32, MHI38, K10LM, K10L3D, SDQ, DIAG, FOC and MHLS.

Domain: A unique identifier for the collection occasion as constructed by the organisation which generates the file.

Field Name: ColId

Collection Occasion {concept}

Definition: A *Collection Occasion* is defined as an occasion during an *Episode of Mental Health Care* when the required dataset is to be collected in accordance with a standard protocol.

Three *Collection Occasions* within an *Episode of Mental Health Care* are identified: *Admission* , *Review*, and *Discharge*.

Field Name: abs_CollectionOccasion

Collection Status

Definition: The status of the data recorded and, if missing data is recorded, the reason for the non-completion of the measure.

Domain:
1 – Complete or Partially complete
2 – Not completed due to temporary contraindication
3 – Not completed due to general exclusion
4 – Not completed due to refusal by patient or client
7 – Not completed for reasons not elsewhere classified
9 – Not stated / Missing

Comments: Used within BASIS32, MHI38, K10LM, K10L3D and SDQ.

Field Name: ColSt

Co-Location Status

Definition: Whether a mental health service is co-located with an acute care hospital, as represented by a code.

Domain:
1 – Co-located
2 – Not co-located
8 – Not applicable

Comments: Code 8 should only be used only where Service Unit Type = 2 (Residential care service unit) or 3 (Ambulatory care service unit).

Field Name: CoLocStatus

METeOR ID: 286995

Data File Generation Date

Definition: The date on which the current file was created.

Domain: Any valid date expressed as DDMMYYYY. Identification of this date is mandatory in the NOCC extract file.

Field Name: GenDt

Data File Type

Definition: A constant value inserted in the file header record to indicate that the file contains NOCC data.
Domain: Value: "NOCC" representing National Outcomes and Casemix Collection
Field Name: FileType

Date of Birth

Definition: The consumer's date of birth.
Domain: Any valid date expressed as DDMMYYYY
Field Name: DoB

Diagnosis {concept}

Definition: A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient.

NOCC includes provision for recording one Principal Diagnosis and up to two Additional Diagnoses.
Field Name: abs_Diagnosis

Discharge Date

Definition: The date on which the *Episode of Mental Health Care* is deemed to have ended within the specified *Mental Health Service Setting* . In inpatient and community residential settings this is the actual or statistical date of separation. In ambulatory settings this is the date on which the *Episode of Mental Health Care* within that setting ceased, as defined under the standard NOCC protocol. It may or may not be equivalent to the actual date of case closure by the ambulatory service
Comments: Note that this data element is derived from the *Collection Occasion Date*

Separation date is defined under AIHW KB item 000043 as the 'Date on which an admitted patient completes an episode of care.'
Field Name: DschDt

Discharge from Mental Health Care {concept}

Definition: Refers to the end of an inpatient, ambulatory or community residential *Episode of Mental Health Care*. As per *Admission*, for the purposes of the NOCC protocol episodes may end for a number of reasons such as discharge from an inpatient unit, case closure of a consumer's community care, admission to hospital of a consumer previously under community care. Regardless of the reason, the end of an episode acts as a 'trigger' for a specific set of clinical data to be collected
Comments: *Separation* is a related concept defined under AIHW KB item 000148 as the 'the process by which an episode of care for an admitted patient ceases'. A separation may be formal or statistical.
Field Name: abs_Discharge

Episode Identifier

Definition: A unique identifier of an *Episode of Care* within an Organisation that links Collection Occasions belonging to a single Episode.

Domain: As constructed by the organisation which generates the file. If no Episode link is available, the field should be filled with spaces.

Field Name: EpiId

Episode of Mental Health Care Type {concept}

Definition: The type of *Episode of Mental Health Care*. Three broad episode types are identified which are based on the *Mental Health Service Setting recorded at the Collection Occasion* - Inpatient, Community Residential and Ambulatory.

- *Psychiatric Inpatient episode (Overnight admitted)*- refers to the period of care provided to a consumer who is admitted for overnight care to a designated psychiatric inpatient service.
- *Community Residential episode* - refers to the period of care provided to a consumer who is admitted for overnight care to a designated 24-hour community-based residential service.
- *Ambulatory episode* - refers to all other types of care provided to consumers of a designated mental health service.

Field Name: abs_EpisodeType

Episode of Mental Health Care {concept}

Definition: An *Episode of Mental Health Care* is defined as a more or less continuous period of contact between a consumer and a *Mental Health Service Organisation* that occurs within the one *Episode Service Setting.* The episode begins when the person is admitted into care within the given setting and ends when he is discharged from care within that setting. An episode also ends if the person is transferred into care in a different service setting. By definition, a person may only be the subject of one such *Episode of Mental Health Care* at any given time while under the care of a given *Mental Health Service Organisation.* Note that this formal concept of an episode should not be confused with the clinical concept of an episode of care

Comments: *Episode of Care* is defined under AIHW KB item 000445 as the 'The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.'

Field Name: abs_Episode

Episode Service Setting

Definition: The setting within which the *Episode of Mental Health Care* takes place, as defined by the specified domain.

Domain:
1 – Psychiatric inpatient service
2 – Community residential mental health service
3 – Ambulatory mental health service

Comments:

Psychiatric inpatient service

Refers to overnight care provided in public psychiatric hospitals and designated psychiatric units in public acute hospitals. Psychiatric hospitals are establishments devoted primarily to the 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 in a community general hospital for treatment of a mental or behavioural disorder is also included under this setting.

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.

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 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, psychogeriatric assessment services and so forth. For the purposes of NOCC specification, care provided by hospital-based consultation-liaison services to admitted patients in non-psychiatric and hospital emergency settings is also included under this setting.

Notes:

1. This item will be used to derive the type of *Episode of Mental Health Care* provided to the consumer.
2. A single *Service Unit* may provide care in all three settings. For example, a psychiatric hospital may provide group programs tailored for people living in the community who attend on a regular basis, or run a community nursing outreach service that visits people in the homes. It is essential that these programs be differentiated when reporting the *Mental Health Service Setting* that is providing the episode of care, even though all programs may share the same *Service Unit Identifier.* For example, in the above scenario, where a consumer who is not currently an overnight admitted patient attends the hospital-based group program, the *Episode Service Setting* should be recorded as Ambulatory mental health service, **not** Psychiatric inpatient service.
3. Episode Service Setting should not be confused with *Service Unit Type*, which classifies service units into inpatient, residential or ambulatory service types. The former is an attribute of the Episode of Mental Health Care, the latter is an attribute of the Service Unit.
4. Where a person might be considered as receiving concurrently two or more episodes of mental health care by virtue of being treated in more than one setting simultaneously the following order of precedence applies: Inpatient, Community Residential, Ambulatory

Field Name: Setting

FIHS Item 01

Definition: Maltreatment syndromes.

Domain:
1 – Yes, the person had one or more of these factors influencing their health status
2 – No, none of these factors were present
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Comments: Includes: Neglect or abandonment; Physical abuse; Sexual abuse; Psychological abuse.

Field Name: Fihs1

FIHS Item 02

Definition: Problems related to negative life events in childhood.

Domain:
1 – Yes, the person had one or more of these factors influencing their health status
2 – No, none of these factors were present
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Comments: Includes: Loss of love relationship in childhood; Removal from home in childhood; Altered pattern of family relationships in childhood; Problems related to alleged sexual abuse of child by person within primary support group; Problems related to alleged sexual abuse of child by person outside primary support group; Problems related to alleged physical abuse of child; Personal frightening experience in childhood; Other negative life events in childhood.

Field Name: Fihs2

FIHS Item 03

Definition: Problems related to upbringing.

Domain:
1 – Yes, the person had one or more of these factors influencing their health status
2 – No, none of these factors were present
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Comments: Includes: Inadequate parental supervision and control; Parental overprotection; Institutional upbringing; Hostility towards and scapegoating of child; Emotional neglect of child; Other problems related to neglect in upbringing; Inappropriate parental pressure and other abnormal qualities of upbringing; Other specified problems related to upbringing.

Field Name: Fihs3

FIHS Item 04

Definition: Problems related to primary support group, including family circumstances.

Domain:
1 – Yes, the person had one or more of these factors influencing their health status
2 – No, none of these factors were present
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Comments: Includes: Problems in relationship with spouse or partner; Problems in relationship with parents and in-laws; Inadequate family support; Absence of family member; Disappearance or death of family member; Disruption of family by separation and divorce; Dependant relative needing care at home; Other stressful life events affecting family and household; Other problems related to primary support group.

Field Name: Fihs4

FIHS Item 05

Definition: Problems related to social environment.

Domain:
1 – Yes, the person had one or more of these factors influencing their health status
2 – No, none of these factors were present
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Comments: Includes: Problems of adjustment to lifecycle transitions; Atypical parenting situation; Living alone; Acculturation difficulty; Social exclusion and rejection; Target of perceived adverse discrimination and rejection.

Field Name: Fihs5

FIHS Item 06

Definition: Problems related to certain psychosocial circumstances.

Domain:
1 – Yes, the person had one or more of these factors influencing their health status
2 – No, none of these factors were present
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Comments: Includes: Problems related to unwanted pregnancy; Problems related to multiparity; Seeking or accepting physical, nutritional or chemical interventions known to be hazardous or harmful; Seeking or accepting behavioural or psychological interventions known to be hazardous or harmful; Discord with counsellors.

Field Name: Fihs6

FIHS Item 07

Definition: Problems related to other psychosocial circumstances.

Domain:
1 – Yes, the person had one or more of these factors influencing their health status
2 – No, none of these factors were present
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Comments: Includes: Conviction in civil and criminal proceedings without imprisonment; Imprisonment or other incarceration; Problems related to release from prison; Problems related to other legal circumstances; Victim of crime or terrorism; Exposure to disaster, war or other hostilities.

Field Name: Fihs7

FIHS Version

Definition: The version of the FIHS completed as described in Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services. Volume 2: Resource Materials*, Canberra: Commonwealth Department of Health and Family Services and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003.

Domain: Value: "01" representing The string '01' representing the sole version allowed as per the definition.

Field Name: FihsVer

Focus of Care

Definition: The focus of care identifies the primary goal of care provided during the period of care preceding the *Collection Occasion*.

Domain:
1 – Acute
2 – Functional Gain
3 – Intensive Extended
4 – Maintenance
9 – Not stated / Missing

Comments: **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.

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.

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.

Maintenance

The primary goal is to maintain the level of functioning, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently.

Field Name: FoC

Geographical Location of Establishment

Definition: Geographical location of the establishment, as represented by a code. For establishments with more than one geographical location, the location is defined as that of the main administrative centre.

Domain: Geographical location code (ASGC 20xx). NNNNN

Comments: For the purposes of the NOCC dataset, SLA data are reported at Service Unit level. ASGC versions are amended annually by the Australian Bureau of Statistics.The version used for reporting the NOCC data should be the most recent ASGC as available at the beginning of the data reporting year. (FOR COMMENT)

Field Name: EstSLA

HoNOSCA Item 01

Definition: Disruptive, antisocial, or aggressive behaviour.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC01

HoNOSCA Item 02

Definition: Problems with overactivity, attention or concentration.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC02

HoNOSCA Item 03

Definition: Non-accidental self-injury.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC03

HoNOSCA Item 04

Definition: Alcohol, substance or solvent misuse.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC04

HoNOSCA Item 05

Definition: Problems with scholastic or language skills.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC05

HoNOSCA Item 06

Definition: Physical illness or disability problems.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC06

HoNOSCA Item 07

Definition: Problems associated with hallucinations, delusions, or abnormal perceptions.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC07

HoNOSCA Item 08

Definition: Problems with non-organic somatic symptoms.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC08

HoNOSCA Item 09

Definition: Problems with emotional and related symptoms.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC09

HoNOSCA Item 10

Definition: Problems with peer relationships.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC10

HoNOSCA Item 11

Definition: Problems with self-care and independence.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC11

HoNOSCA Item 12

Definition: Problems with family life and relationships.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC12

HoNOSCA Item 13

Definition: Poor school attendance.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: HnosC13

HoNOSCA Item 14

Definition: Problems with lack of knowledge or understanding about the nature of the child or adolescent's difficulties.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Comments: Items 14 and 15 are excluded from the calculation of the Total Score because they describe the patient or client's parent's knowledge about the person's problems and the services available rather than aspects of the child or adolescent's problems.

Field Name: HnosC14

HoNOSCA Item 15

Definition: Problems with lack of information about services or management of the child or adolescent's difficulties.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Comments: Items 14 and 15 are excluded from the calculation of the Total Score because they describe the patient or client's parent's knowledge about the person's problems and the services available rather than aspects of the child or adolescent's problems.

Field Name: HnosC15

HoNOSCA Version

Definition: Version as described in Gowers S, Harrington R, Whitton A, Beevor A, Lelliott P, Jezzard R, Wing J (1999b) Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, 174, 428-433 and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003.

Domain: Value: "01" representing The string '01' representing the sole version allowed as per the definition.

Field Name: HnosCVer

HoNOS Item 01

Definition: Overactive, aggressive, disruptive or agitated behaviour.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos01

HoNOS Item 02

Definition: Non-accidental self-injury.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos02

HoNOS Item 03

Definition: Problem drinking or drug-taking.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos03

HoNOS Item 04

Definition: Cognitive problems.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos04

HoNOS Item 05

Definition: Physical illness or disability problems.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos05

HoNOS Item 06

Definition: Problems associated with hallucinations and delusions.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos06

HoNOS Item 07

Definition: Problems with depressed mood.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos07

HoNOS Item 08

Definition: Other mental and behavioural problems.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos08

HoNOS Item 08a

Definition: The type or kind of problem rated in Item 8.

Domain:
- A – Phobias - including fear of leaving home, crowds, public places, travelling, social phobias and specific phobias
- B – Anxiety and panics
- C – Obsessional and compulsive problems
- D – Reactions to severely stressful events and traumas
- E – Dissociative ('conversion') problems
- F – Somatisation - Persisting physical complaints in spite of full investigation and reassurance that no disease is present
- G – Problems with appetite, over- or under-eating
- H – Sleep problems
- I – Sexual problems
- J – Problems not specified elsewhere :an expansive or elated mood, for example.
- X – Not applicable (Item 8 rated 0, 7, or 8)
- Z – Not stated / Missing

Field Name: Hnos08a

HoNOS Item 09

Definition: Problems with relationships.

Domain:
- 0 – No problem within the period rated
- 1 – Minor problem requiring no formal action
- 2 – Mild problem. Should be recorded in a care plan or other case record
- 3 – Problem of moderate severity
- 4 – Severe to very severe problem
- 7 – Not stated / Missing
- 9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos09

HoNOS Item 10

Definition: Problems with activities of daily living.

Domain:
- 0 – No problem within the period rated
- 1 – Minor problem requiring no formal action
- 2 – Mild problem. Should be recorded in a care plan or other case record
- 3 – Problem of moderate severity
- 4 – Severe to very severe problem
- 7 – Not stated / Missing
- 9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos10

HoNOS Item 11

Definition: Problems with living conditions.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos11

HoNOS Item 12

Definition: Problems with occupation and activities.

Domain:
0 – No problem within the period rated
1 – Minor problem requiring no formal action
2 – Mild problem. Should be recorded in a care plan or other case record
3 – Problem of moderate severity
4 – Severe to very severe problem
7 – Not stated / Missing
9 – Unable to rate because not known or not applicable to the consumer

Field Name: Hnos12

HoNOS Version

Definition: The version of the HoNOS or HoNOS65+ completed.

Domain:
A1 – General adult version as described in Wing J, Curtis R, Beevor A (1999) Health of the Nation Outcome Scales (HoNOS): Glossary for HoNOS score sheet. *British Journal of Psychiatry*, 174, 432-434 and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003

G1 – HoNOS 65+ as described in Burns A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J, Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). *British Journal of Psychiatry*, 174, 424-427 and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003.

G2 – HoNOS 65+ Version 3 (Tabulated) as presented on the UK Royal College of Psychiatrists website http://www.rcpsych.ac.uk/cru/honoscales/honos65/

(Note - this version is not currently recommended for use in Australia)

Field Name: HnosVer

Hospital - Cluster Identifier

Definition: An identifier to indicate that a service unit is one of a cluster of service units, defined through administrative or clinical governance arrangements.

Domain: For admitted patient service units, the Hospital-Cluster identifier should be identical to that used to identify the hospital to which the service unit 'belongs'. For ambulatory and residential services units, where there is no Service unit cluster, the Hospital - Cluster identifier is to be reported as '00000' and the Hospital - Cluster Name would use the relevant organisation name.

Field Name: HospClusId

Hospital - Cluster Name

Definition: Common name used to identify the hospital or service unit cluster.

Domain: For admitted patient service units, the Hospital-Cluster identifier should be identical to that used to identify the hospital to which the service unit 'belongs'. For ambulatory and residential services units, where there is no Service unit cluster, the Hospital - Cluster identifier is to be reported as '00000' and the Hospital - Cluster Name would use the relevant organisation name.

Field Name: HospClusName

K10+LM Item 01

Definition: In the past 4 weeks, how often did you feel tired out for no good reason?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM01

K10+LM Item 02

Definition: In the past 4 weeks, about how often did you feel nervous?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM02

K10+LM Item 03

Definition: In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM03

K10+LM Item 04

Definition: In the past 4 weeks, about how often did you feel hopeless?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM04

K10+LM Item 05

Definition: In the past 4 weeks, about how often did you feel restless or fidgety?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM05

K10+LM Item 06

Definition: In the past 4 weeks, about how often did you feel so restless you could not sit still?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM06

K10+LM Item 07

Definition: In the past 4 weeks, about how often did you feel depressed?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM07

K10+LM Item 08

Definition: In the past 4 weeks, about how often did you feel that everything was an effort?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM08

K10+LM Item 09

Definition: In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM09

K10+LM Item 10

Definition: In the past 4 weeks, about how often did you feel worthless?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM10

K10+LM Item 11

Definition: In the past four weeks, how many days were you totally unable to work, study or manage your day to day activities because of these feelings?

Domain:
00-28 – 0-28 days
99 – Not stated / Missing

Field Name: K10LM11

K10+LM Item 12

Definition: Aside from those days [coded in *K10+LM Item 11*], in the past four weeks, how many days were you able to work or study or manage your day to day activities, but had to cut down on what you did because of those feelings?

Domain:
00-28 – 0-28 days
99 – Not stated / Missing

Field Name: K10LM12

K10+LM Item 13

Definition: In the past four weeks, how many times have you seen a doctor or any other health professional about these feelings?

Domain:
00-89 – 0-89 consultations
99 – Not stated / Missing

Field Name: K10LM13

K10+LM Item 14

Definition: In the past four weeks, how often have physical health problems been the main cause of these feelings?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10LM14

K10+LM Version

Definition: The version of the K10+LM as specified by the Health Department of the jurisdiction implementing the measure and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinician rated and consumer self-report measures, Version 1.50* . Department of Health and Ageing, Canberra, 2003.

Domain: Value: "M1" representing The string 'M1' representing the sole version allowed as per the definition.

Field Name: K10LMVer

K10L3D Item 01

Definition: In the past three days, how often did you feel tired out for no good reason?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D01

K10L3D Item 02

Definition: In the past three days, about how often did you feel nervous?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D02

K10L3D Item 03

Definition: In the past three days, about how often did you feel so nervous that nothing could calm you down?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D03

K10L3D Item 04

Definition: In the past three days, about how often did you feel hopeless?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D04

K10L3D Item 05

Definition: In the past three days, about how often did you feel restless or fidgety?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D05

K10L3D Item 06

Definition: In the past three days, about how often did you feel so restless you could not sit still?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D06

K10L3D Item 07

Definition: In the past three days, about how often did you feel depressed?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D07

K10L3D Item 08

Definition: In the past three days, about how often did you feel that everything was an effort?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D08

K10L3D Item 09

Definition: In the past three days, about how often did you feel so sad that nothing could cheer you up?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D09

K10L3D Item 10

Definition: In the past three days, about how often did you feel worthless?

Domain:
1 – None of the time
2 – A little of the time
3 – Some of the time
4 – Most of the time
5 – All of the time
6 – Don't know
9 – Not stated / Missing

Field Name: K10L3D10

K10L3D Version

Definition: The version of the K10L3D completed as specified by the Health Department of the jurisdiction implementing the measure and as reproduced in: *Mental Health National Outcomes and Casemix Collection: Overview of clinician rated and consumer self-report measures, Version 1.50*. Department of Health and Ageing, Canberra, 2003.

Domain: Value: "31" representing The string '31' representing the sole version allowed as per the definition.

Field Name: K10L3DVer

LSP-16 Item 01

Definition: Does this person generally have any difficulty with initiating and responding to conversation.

Domain:
0 – No difficulty with conversation
1 – Slight difficulty with conversation
2 – Moderate difficulty with conversation
3 – Extreme difficulty with conversation
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

The order of coding of domain for each LSP-16 item shows increasing levels of disability with increasing scores. No disability is coded as 0 whilst the most severe level of disability is coded as 3. This scoring is consistent with the scoring used by the other clinician- rated measures. However, the original 39 item version of the LSP employed the reverse of this convention, with high levels of disability being coded 0.

Field Name: Lsp01

LSP-16 Item 02

Definition: Does this person generally withdraw from social contact.

Domain:
0 – Does not withdraw at all
1 – Withdraws slightly
2 – Withdraws moderately
3 – Withdraws totally or near totally
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp02

LSP-16 Item 03

Definition: Does this person generally show warmth to others.

Domain:
0 – Considerable warmth
1 – Moderate warmth
2 – Slight warmth
3 – No warmth at all
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp03

LSP-16 Item 04

Definition: Is this person generally well groomed (eg, neatly dressed, hair combed).

Domain:
0 – Well groomed
1 – Moderately well groomed
2 – Poorly groomed
3 – Extremely poorly groomed
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp04

LSP-16 Item 05

Definition: Does this person wear clean clothes generally, or ensure that they are cleaned if dirty.

Domain:
0 – Maintains cleanliness of clothes
1 – Moderate cleanliness of clothes
2 – Poor cleanliness of clothes
3 – Very poor cleanliness of clothes
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp05

LSP-16 Item 06

Definition: Does this person generally neglect their physical health.

Domain:
0 – No neglect
1 – Slight neglect of physical problems
2 – Moderate neglect of physical problems
3 – Extreme neglect of physical problems
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp06

LSP-16 Item 07

Definition: Is this person violent to others.

Domain:
0 – Not at all
1 – Rarely
2 – Occasionally
3 – Often
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp07

LSP-16 Item 08

Definition: Does this person generally make and/or keep up friendships.

Domain:
0 – Friendships made or kept well
1 – Friendships made or kept with slight difficulty
2 – Friendships made or kept with considerable difficulty
3 – No friendships made or none kept
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp08

LSP-16 Item 09

Definition: Does this person generally maintain an adequate diet.

Domain:
0 – No problem
1 – Slight problem
2 – Moderate problem
3 – Extreme problem
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp09

LSP-16 Item 10

Definition: Does this person generally look after and take their own prescribed medication (or attend for prescribed injections) on time.

Domain:
0 – Reliable with medication
1 – Slightly unreliable
2 – Moderately unreliable
3 – Extremely unreliable
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp10

LSP-16 Item 11

Definition: Is the person willing to take psychiatric medication when prescribed by a doctor.

Domain:
0 – Always
1 – Usually
2 – Rarely
3 – Never
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp11

LSP-16 Item 12

Definition: Does this person co-operate with health services (eg, doctors and/or other health workers).

Domain:
0 – Always
1 – Usually
2 – Rarely
3 – Never
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp12

LSP-16 Item 13

Definition: Does this person generally have problems (eg, friction, avoidance) living with others in the household.

Domain:
0 – No obvious problem
1 – Slight problems
2 – Moderate problems
3 – Extreme problems
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp13

LSP-16 Item 14

Definition: Does this person behave offensively (includes sexual behaviour).

Domain:
0 – Not at all
1 – Rarely
2 – Occasionally
3 – Often
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp14

LSP-16 Item 15

Definition: Does this person behave irresponsibly.

Domain:
0 – Not at all
1 – Rarely
2 – Occasionally
3 – Often
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp15

LSP-16 Item 16

Definition: What sort of work is this person capable of (even if unemployed, retired or doing unpaid domestic duties).

Domain:
0 – Capable of full-time work
1 – Capable of part-time work
2 – Capable of sheltered work
3 – Totally incapable of work
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: Lsp16

LSP-16 Version

Definition: The version of the LSP-16 as described in Buckingham W, Burgess P, Solomon S, Pirkis J, Eagar K (1998) *Developing a Casemix Classification for Mental Health Services Volume 2: Resource Materials,* Canberra: Commonwealth Department of Health and Family Services and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Commonwealth Department of Health and Ageing, Canberra, 2003.

Domain: Value: "01" representing The string '01' referring to the version of the LSP-16 as described in the item definition.

Field Name: LspVer

Mental Health Consumer {concept}

Definition: The terms consumer and patient are used interchangeably in the NOCC specification and refer to a person for whom a *Mental Health Service Organisation* accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record.

Field Name: abs_Consumer

Mental Health Legal Status

Definition: An indication that the person was treated on an involuntary basis under the relevant State or Territory mental health legislation, at some point during the *Period of Care* preceding the *Collection Occasion* .

Domain:
1 – Person was an involuntary patient for all or part of the period of care
2 – Person was not an involuntary patient at any time during the period of care
9 – Not stated / Missing

Field Name: LegalSt

Mental Health Service Organisation {concept}

Definition: The concept of a *Mental Health Service Organisation* refers to a separately constituted health care organisation that is responsible for the clinical governance, administration and financial management of the *Service Unit* in which the *Episode of Mental Health Care* is provided. A *Mental Health Service Organisation* may consist of one or more *Service Units* based in different locations and providing services in inpatient, community residential and ambulatory settings. For example, a *Mental Health Service Organisation* may consist of several hospitals or two or more community centres, each of which is a separate 'bricks and mortar' facility.

Where the *Mental Health Service Organisation* consists of multiple *Service Units* , those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and
- share medical records or, in the case where is more than one physical medical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

For most jurisdictions, the *Mental Health Service Organisation* concept is equivalent to the Area/ District Mental Health Service. These are usually organised to provide the full range of inpatient, community residential and ambulatory services to a given catchment population. However, the concept may also be used to refer to health care organisations which provide only one type of mental health service (eg, acute inpatient care) or which serve a specialised or statewide function.

Note that *Mental Health Service Organisation* is not equivalent to the concept of Health Establishment as defined in the National Health Data Dictionary. For example, multiple health care providers classified as individual Health Establishments may make up a single *Mental Health Service Organisation.*

Comments: *Mental Health Service Organisation* is a critical concept in the NOCC reporting arrangements as it is a key field used to uniquely identify each *Episode of Mental Health* care for each consumer. While an individual may receive services from multiple *Service Units* concurrently, they may only be considered as being in one episode at any given point of time. Where a patient is being treated by the organisation in two settings simultaneously the following order of precedence applies: Inpatient, Community Residential, Ambulatory.

Field Name: abs_Organization

MHI38 Item 01

Definition: How happy, satisfied, or pleased have you been with your personal life during the past month?

Domain:
1 – Extremely happy, could not have been more satisfied or pleased
2 – Very happy most of the time
3 – Generally satisfied, pleased
4 – Sometimes fairly satisfied, sometimes fairly unhappy
5 – Generally dissatisfied, unhappy
6 – Very dissatisfied, unhappy most of the time
9 – Not stated / Missing

Field Name: MHI01

MHI38 Item 02

Definition: How much of the time have you felt lonely during the past month?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI02

MHI38 Item 03

Definition: How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month?

Domain:
1 – Always
2 – Very often
3 – Fairly often
4 – Sometimes
5 – Almost never
6 – None of the time
9 – Not stated / Missing

Field Name: MHI03

MHI38 Item 04

Definition: During the past month, how much of the time have you felt that the future looks hopeful and promising?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI04

MHI38 Item 05

Definition: How much of the time, during the past month, has your daily life been full of things that were interesting to you?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI05

MHI38 Item 06

Definition: How much of the time, during the past month, did you feel relaxed and free from tension?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI06

MHI38 Item 07

Definition: During the past month, how much of the time have you generally enjoyed the things you do?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI07

MHI38 Item 08

Definition: During the past month, have you had any reason to wonder if you were losing your mind, or control over the way you act, talk, think, feel, or of your memory?

Domain:
1 – No, not at all
2 – Maybe a little
3 – Yes, but not enough to be concerned or worried about
4 – Yes, and I have been a little concerned
5 – Yes, and I am quite concerned
6 – Yes, and I am very concerned about it
9 – Not stated / Missing

Field Name: MHI08

MHI38 Item 09

Definition: Did you feel depressed during the past month?

Domain:
1 – Yes, to the point that I did not care about anything for days at a time
2 – Yes, very depressed almost every day
3 – Yes, quite depressed several times
4 – Yes, a little depressed now and then
5 – No, never felt depressed at all
9 – Not stated / Missing

Field Name: MHI09

MHI38 Item 10

Definition: During the past month, how much of the time have you felt loved and wanted?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI10

MHI38 Item 11

Definition: How much of the time, during the past month, have you been a very nervous person?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI11

MHI38 Item 12

Definition: When you have got up in the morning, this past month, about how often did you expect to have an interesting day?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI12

MHI38 Item 13

Definition: During the past month, how much of the time have you felt tense or 'high-strung'?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI13

MHI38 Item 14

Definition: During the past month, have you been in firm control of your behaviour, thoughts, emotions or feelings?

Domain:
1 – Yes, very definitely
2 – Yes, for the most part
3 – Yes, I guess so
4 – No, not too well
5 – No, and I am somewhat disturbed
6 – No, and I am very disturbed
9 – Not stated / Missing

Field Name: MHI14

MHI38 Item 15

Definition: During the past month, how often did your hands shake when you tried to do something?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI15

MHI38 Item 16

Definition: During the past month, how often did you feel that you had nothing to look forward to?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI16

MHI38 Item 17

Definition: How much of the time, during the past month, have you felt calm and peaceful?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI17

MHI38 Item 18

Definition: How much of the time, during the past month, have you felt emotionally stable?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI18

MHI38 Item 19

Definition: How much of the time, during the past month, have you felt downhearted and blue?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI19

MHI38 Item 20

Definition: How often have you felt like crying during the past month?

Domain:
1 – Always
2 – Very often
3 – Fairly often
4 – Sometimes
5 – Almost never
6 – Never
9 – Not stated / Missing

Field Name: MHI20

MHI38 Item 21

Definition: During the past month, how often have you felt that other would be better off if you were dead?

Domain:
1 – Always
2 – Very often
3 – Fairly often
4 – Sometimes
5 – Almost never
6 – Never
9 – Not stated / Missing

Field Name: MHI21

MHI38 Item 22

Definition: How much of the time, during the past month, were you able to relax without difficulty?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI22

MHI38 Item 23

Definition: How much of the time, during the past month, did you feel that your love relationships, loving and being loved, were full and complete?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI23

MHI38 Item 24

Definition: How often, during the past month, did you feel that nothing turned out for you the way you wanted it to?

Domain:
1 – Always
2 – Very often
3 – Fairly often
4 – Sometimes
5 – Almost never
6 – Never
9 – Not stated / Missing

Field Name: MHI24

MHI38 Item 25

Definition: How much have you been bothered by nervousness, or your 'nerves', during the past month?

Domain:
1 – Extremely so, to the point where I could not take care of things
2 – Very much bothered
3 – Bothered quite a bit by nerves
4 – Bothered some, enough to notice
5 – Bothered just a little by nerves
6 – Not bothered at all by this
9 – Not stated / Missing

Field Name: MHI25

MHI38 Item 26

Definition: During the past month, how much of the time has living been a wonderful adventure for you?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI26

MHI38 Item 27

Definition: How often, during the past month, have you felt so down in the dumps that nothing could cheer you up?

Domain:
1 – Always
2 – Very often
3 – Fairly often
4 – Sometimes
5 – Almost never
6 – Never
9 – Not stated / Missing

Field Name: MHI27

MHI38 Item 28

Definition: During the past month, did you think about taking your own life?

Domain:
1 – Yes, very often
2 – Yes, fairly often
3 – Yes, a couple of times
4 – Yes, at one time
5 – No, never
9 – Not stated / Missing

Field Name: MHI28

MHI38 Item 29

Definition: During the past month, how much of the time have you felt restless, fidgety, or impatient?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI29

MHI38 Item 30

Definition: During the past month, how much of the time have you been moody or brooded about things?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI30

MHI38 Item 31

Definition: How much of the time, during the past month, have you felt cheerful, lighthearted?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI31

MHI38 Item 32

Definition: During the past month, how often did you get rattled, upset or flustered?

Domain:
1 – Always
2 – Very often
3 – Fairly often
4 – Sometimes
5 – Almost never
6 – Never
9 – Not stated / Missing

Field Name: MHI32

MHI38 Item 33

Definition: During the past month, have you been anxious or worried?

Domain:
1 – Yes, extremely to the point of being sick or almost sick
2 – Yes, very much so
3 – Yes, quite a bit
4 – Yes, some, enough to bother me
5 – Yes, a little bit
6 – No, not at all
9 – Not stated / Missing

Field Name: MHI33

MHI38 Item 34

Definition: During the past month, how much of the time were you a happy person?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI34

MHI38 Item 35

Definition: How often during the past month did you find yourself trying to calm down?

Domain:
1 – Always
2 – Very often
3 – Fairly often
4 – Sometimes
5 – Almost never
6 – Never
9 – Not stated / Missing

Field Name: MHI35

MHI38 Item 36

Definition: During the past month, how much of the time have you been in low or very low spirits?

Domain:
1 – All of the time
2 – Most of the time
3 – A good bit of the time
4 – Some of the time
5 – A little of the time
6 – None of the time
9 – Not stated / Missing

Field Name: MHI36

MHI38 Item 37

Definition: How often, during the past month, have you been waking up feeling fresh and rested?

Domain:
1 – Always, every day
2 – Almost every day
3 – Most days
4 – Some days, but usually not
5 – Hardly ever
6 – Never wake up feeling rested
9 – Not stated / Missing

Field Name: MHI37

MHI38 Item 38

Definition: During the past month, have you been under or felt you were under any strain, stress or pressure?

Domain:
1 – Yes, almost more than I could stand or bear
2 – Yes, quite a bit of pressure
3 – Yes, some more than usual
4 – Yes, some, but about normal
5 – Yes, a little bit
6 – No, not at all
9 – Not stated / Missing

Field Name: MHI38

MHI38 Version

Definition: The version of the MHI38 as defined in Davies AR, Sherbourne CD, Peterson JR and Ware JE (1998) *Scoring manual: Adult health status and patient satisfaction measures used in RAND's Health Insurance Experiment,* Santa Monica: RAND Corporation, and as reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Department of Health and Ageing, Canberra, 2003.

Domain: Value: "01" representing The string '01' referring to the version of the MHI38 as described in the item definition.

Field Name: MHIVer

NOCC Reporting Specification Version

Definition: The version of the National Outcomes and Casemix Collection (NOCC) reporting specification under which the data has been collected and submitted.

Domain: Value: "01.60" representing Version 1.6 (current version)

Field Name: SpecVer

Organisation Identifier

Definition: Mental health service organisation identifier.
Domain: NNNN: Mental health service organisation identifier.

Identifiers used in this collection should map to the identifiers used in data for the NMDS for Mental Health Establishments.
Comments: Identifiers used to report Mental Health Service Organisations within NOCC should be the same as those used identify organisations in the NMDS - Mental Health Establishments.
Field Name: OrgId

Organisation Name

Definition: Common name used to identify the Organisation.
Field Name: OrgName

Period of Care {concept}

Definition: The period bound by one *Collection Occasion* and another and immediately preceding the current *Collection Occasion.*
Field Name: abs_PeriodOfCare

Person Identifier

Definition: Person identifier unique within the *Mental Health Service Organisation* .
Domain: Any valid identifier as defined by the *Mental Health Service Organisation.*
Field Name: PID

Principal Diagnosis

Definition: The Principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the patient or client's care during the *Period of Care* preceding the *Collection Occasion* .
Domain: ICD-10-AM (current version)

Formatted as ANNNNNN
Comments: The National Centre for Classification and Coding in Health has developed simplified ICD-10-AM Mental Health Subset for use in community-based mental health service settings. Services may use this subset as the basis for coding.

Note that the *Principal* and *Additional Diagnoses* should not be confused with the patient or client's current clinical diagnoses or with the reasons for contact with respect to any given Service contact. Also note that definition given here is conceptually consistent but not identical with that given in the NHDD. The NHDD definition refers to the preceding Episode of care. In episodes of acute inpatient care, the Episode of care and the Period of care will almost always refer to the same interval. In extended episodes of care, the reference interval is different.
Field Name: Dx1

Program Type

Definition: Principal type of admitted patient care program provided by a specialised mental health service, as represented by a code.

Domain:
1 – Acute care
2 – Other
8 – Not applicable (Non-admitted service units only)
9 – Not available

Comments: **Acute care**

Programs primarily providing specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder, that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with acontinuing mental disorder for whom there has been an acute exacerbation of symptoms. This category applies only to services with a mental health service setting of overnight admitted patient care or residential care.

Other

Refers to all other programs primarily providing admitted patient care.

Includes programs providing rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery.

They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Also includes programs providing extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

Field Name: ProgType

METeOR ID: 288889

Reason for Collection

Definition: The reason for the collection of the standardised measures and individual data items on the identified *Collection Occasion*.

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

Comments:

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 Organisation.*

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 Organisation*.

Admission - Other

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

3-month (91 day) review

Standard review conducted at 91 days following admission to the current *Episode of Mental Health Care* or 91 days subsequent to the preceding *Review.*

Review - Other

Standard review conducted for reasons other than the above.

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 Organisation* .

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 Organisation* .

Death

Completion of an *Episode of Mental Health Care* following the death of the consumer.

Discharge - Other

Discharge from an inpatient, community residential or ambulatory *Episode of Mental Health Care* for any reason other than defined above.

Field Name: ColRsn

Record Type

Definition: A code indicating the type of each record included in an NOCC data file.

Domain:

BASIS32	– BASIS32 (Standard 32 item version)
CGAS	– CGAS
COD	– Collection Occasion Details
DIAG	– Diagnosis
FIHS	– FIHS
FOC	– Focus of Care
HONOS	– HoNOS or HoNOS65+
HONOSCA	– HoNOSCA
HOSPCLUS	– Hospital - Cluster Details
HR	– File Header Record
K10L3D	– K10L3D (Last 3 days version)
K10LM	– K10+LM (Last Month version)
LSP16	– LSP-16
MHI38	– MHI38 (Standard 38 item version)
MHLS	– Mental Health Legal Status
ORG	– Organisation Details
REG	– Region Details
RUGADL	– RUG-ADL
SDQ	– SDQ, all versions
SERV	– Service Unit Details

Field Name: RecType

Region Identifier

Definition: A code to identify the location in which the Service Unit is located within the State/Territory.
Domain: AA: (values as specified by individual jurisdiction)
Field Name: RegId
METeOR ID: 269940

Region Name

Definition: Common name used to identify the Region.
Field Name: RegName

Report Period End Date

Definition: The date of the finish of the period to which the data included in the current file refers.
Domain: Any valid date. Identification of this date is mandatory.
Field Name: RepEnd

Report Period Start Date

Definition: The date of the start of the period to which the data included in the current file refers.
Domain: Any valid date. Identification of this date is mandatory.
Field Name: RepStart

Review of Mental Health Care {concept}

Definition: Refers to a *Collection Occasion* occurring within an *Episode of Mental Health Care.* A review may be a standard 3-month (91 day) review occurring at the point at which the consumer has been under 13 weeks of continuous care since Admission to the episode, or 13 weeks has passed since the last review was conducted during the current episode, or an ad hoc review.

Field Name: abs_Review

RUGADL Item 01

Definition: Bed Mobility - Ability to move in bed after the transfer into bed has been completed.

Domain:
1 – Independent or supervision only
3 – Limited physical assistance
4 – Other than 2 - person physical assistance
5 – 2 - person physical assistance
7 – Unable to rate (insufficient information)
9 – Not stated / Missing
Notice that a rating of 2 is not included in the domain of valid ratings.

Field Name: RugAdl1

RUGADL Item 02

Definition: 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.

Domain:
1 – Independent or supervision only
3 – Limited physical assistance
4 – Other than 2 - person physical assistance
5 – 2 - person physical assistance
7 – Unable to rate (insufficient information)
9 – Not stated / Missing
Notice that a rating of 2 is not included in the domain of valid ratings.

Field Name: RugAdl2

RUGADL Item 03

Definition: Transfer - Includes the transfer in and out of bed, bed to chair, in and out of shower or tub.

Domain:
1 – Independent or supervision only
3 – Limited physical assistance
4 – Other than 2 - person physical assistance
5 – 2 - person physical assistance
7 – Unable to rate (insufficient information)
9 – Not stated / Missing
Notice that a rating of 2 is not included in the domain of valid ratings.

Field Name: RugAdl3

RUGADL Item 04

Definition: Eating - Includes the tasks of cutting food, bringing food to the mouth and the chewing and swallowing of food. Does not include preparation of the meal.

Domain:
1 – Independent or supervision only
2 – Limited assistance
3 – Extensive assistance / Total dependence / Tube fed
7 – Unable to rate (insufficient information)
9 – Not stated / Missing
Ratings of 4 and 5 are not included in the domain of valid ratings.

Field Name: RugAdl4

RUGADL Version

Definition: The version of the RUGADL as described in Fries BE, Schneider DP, et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). *Medical Care*, 32, 668-685.

Domain: Value: "01" representing The string '01' referring to the version of the measure as described in the item definition.

Field Name: RugAdlVer

SDQ Item 01

Definition: Parent Report: Considerate of other people's feelings.

Youth Self Report: I try to be nice to other people. I care about their feelings.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ01

SDQ Item 02

Definition: Parent Report: Restless, overactive, cannot stay still for long.

Youth Self Report: I am restless, I cannot stay still for long.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ02

SDQ Item 03

Definition: Parent Report: Often complains of headaches, stomach-aches or sickness.

Youth Self Report: I get a lot of headaches, stomach-aches or sickness.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ03

SDQ Item 04

Definition: Parent Report: Shares readily with other children {for example toys, treats, pencils} / young people {for example CDs, games, food}.

Youth Self Report: I usually share with others, for examples CDs, games, food.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ04

SDQ Item 05

Definition: Parent Report: Often loses temper.

Youth Self Report: I get very angry and often lose my temper.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ05

SDQ Item 06

Definition: Parent Report: {Rather solitary, prefers to play alone} / {would rather be alone than with other young people}.

Youth Self Report: I would rather be alone than with people of my age.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ06

SDQ Item 07

Definition: Parent Report: {Generally well behaved} / {Usually does what adults requests}.

Youth Self Report: I usually do as I am told.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ07

SDQ Item 08

Definition: Parent Report: Many worries or often seems worried.

Youth Self Report: I worry a lot.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ08

SDQ Item 09

Definition: Parent Report: Helpful if someone is hurt, upset or feeling ill.

Youth Self Report: I am helpful if someone is hurt, upset or feeling ill.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ09

SDQ Item 10

Definition: Parent Report: Constantly fidgeting or squirming.

Youth Self Report: I am constantly fidgeting or squirming.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ10

SDQ Item 11

Definition: Parent Report: Has at least one good friend.

Youth Self Report: I have one good friend or more.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ11

SDQ Item 12

Definition: Parent Report: Often fights with other {children} or bullies them / {young people}.

Youth Self Report: I fight a lot. I can make other people do what I want.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ12

SDQ Item 13

Definition: Parent Report: Often unhappy, depressed or tearful.

Youth Self Report: I am often unhappy, depressed or tearful.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ13

SDQ Item 14

Definition: Parent Report: Generally liked by other {children} / {young people}

Youth Self Report: Other people my age generally like me.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ14

SDQ Item 15

Definition: Parent Report: Easily distracted, concentration wanders.

Youth Self Report: I am easily distracted, I find it difficult to concentrate.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ15

SDQ Item 16

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

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

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ16

SDQ Item 17

Definition: Parent Report: Kind to younger children.

Youth Self Report: I am kind to younger people.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ17

SDQ Item 18

Definition: Parent Report: Often lies or cheats.

Youth Self Report: I am often accused of lying or cheating.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ18

SDQ Item 19

Definition: Parent Report: Picked on or bullied by {children} / {youth}.

Youth Self Report: Other children or young people pick on me or bully me.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ19

SDQ Item 20

Definition: Parent Report: Often volunteers to help others (parents, teachers, {other} children) / Omit 'other' in PY.

Youth Self Report: I often volunteer to help others (parents, teachers, children).

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ20

SDQ Item 21

Definition: Parent Report: Thinks things out before acting.

Youth Self Report: I think before I do things.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ21

SDQ Item 22

Definition: Parent Report: Steals from home, school or elsewhere.

Youth Self Report: I take things that are not mine from home, school or elsewhere.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ22

SDQ Item 23

Definition: Parent Report: Gets along better with adults than with other {children} / {youth}.

Youth Self Report: I get along better with adults than with people my own age.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ23

SDQ Item 24

Definition: Parent Report: Many fears, easily scared.

Youth Self Report: I have many fears, I am easily scared.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ24

SDQ Item 25

Definition: Parent Report: Good attention span sees chores or homework through to the end.

Youth Self Report: I finish the work I'm doing. My attention is good.

Domain:
0 – Not True
1 – Somewhat True
2 – Certainly True
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ25

SDQ Item 26

Definition: Parent Report: Overall, do you think that your child has difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with other people?

Youth Self Report: Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with other people?

Domain:
0 – No
1 – Yes - minor difficulties
2 – Yes - definite difficulties
3 – Yes - severe difficulties
7 – Unable to rate (insufficient information)
9 – Not stated / Missing

Field Name: SDQ26

SDQ Item 27

Definition: Parent Report: How long have these difficulties been present?

Youth Self Report: How long have these difficulties been present?

Domain:
0 – Less than a month
1 – 1-5 months
2 – 6-12 months
3 – Over a year
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ27

SDQ Item 28

Definition: Parent Report: Do the difficulties upset or distress your child?

Youth Self Report: Do the difficulties upset or distress you?

Domain:
0 – Not at all
1 – A little
2 – A medium amount
3 – A great deal
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ28

SDQ Item 29

Definition: Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? HOME LIFE.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? HOME LIFE.

Domain:
0 – Not at all
1 – A little
2 – A medium amount
3 – A great deal
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ29

SDQ Item 30

Definition: Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? FRIENDSHIPS.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? FRIENDSHIPS.

Domain:
0 – Not at all
1 – A little
2 – A medium amount
3 – A great deal
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ30

SDQ Item 31

Definition: Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? CLASSROOM LEARNING.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? CLASSROOM LEARNING

Domain:
0 – Not at all
1 – A little
2 – A medium amount
3 – A great deal
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ31

SDQ Item 32

Definition: Parent Report: Do the difficulties interfere with your child's everyday life in the following areas? LEISURE ACTIVITIES.

Youth Self Report: Do the difficulties interfere with your everyday life in the following areas? LEISURE ACTIVITIES.

Domain:
0 – Not at all
1 – A little
2 – A medium amount
3 – A great deal
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ32

SDQ Item 33

Definition: Parent Report: Do the difficulties put a burden on you or the family as a whole?

Youth Self Report: Do the difficulties make it harder for those around you (family, friends, teachers, etc)?

Domain:
0 – Not at all
1 – A little
2 – A medium amount
3 – A great deal
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ33

SDQ Item 34

Definition: Parent Report: Since coming to the services, are your child's problems:

Youth Self Report: 'Since coming to the service, are your problems:'

Domain:
0 – Much worse
1 – A bit worse
2 – About the same
3 – A bit better
4 – Much better
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ34

SDQ Item 35

Definition: Has coming to the service been helpful in other ways eg. providing information or making the problems bearable?

Domain:
0 – Not at all
1 – A little
2 – A medium amount
3 – A great deal
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected, or SDQ Item 26 = 0)
9 – Not stated / Missing

Field Name: SDQ35

SDQ Item 36

Definition: Over the last 6 months have your child's teachers complained of fidgetiness, restlessness or overactivity?

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

Field Name: SDQ36

SDQ Item 37

Definition: Over the last 6 months have your child's teachers complained of poor concentration or being easily distracted?

Domain:
0 – No
1 – A little
2 – A lot
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected)
9 – Not stated / Missing

Field Name: SDQ37

SDQ Item 38

Definition: Over the last 6 months have your child's teachers complained of acting without thinking, frequently butting in, or not waiting for his or her turn?

Domain:
0 – No
1 – A little
2 – A lot
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected)
9 – Not stated / Missing

Field Name: SDQ38

SDQ Item 39

Definition: Does your family complain about you having problems with overactivity or poor concentration?

Domain:
0 – No
1 – A little
2 – A lot
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected)
9 – Not stated / Missing

Field Name: SDQ39

SDQ Item 40

Definition: Do your teachers complain about you having problems with overactivity or poor concentration?

Domain:
0 – No
1 – A little
2 – A lot
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected)
9 – Not stated / Missing

Field Name: SDQ40

SDQ Item 41

Definition: Does your family complain about you being awkward or troublesome?

Domain:
0 – No
1 – A little
2 – A lot
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected)
9 – Not stated / Missing

Field Name: SDQ41

SDQ Item 42

Definition: Do your teachers complain about you being awkward or troublesome?

Domain:
0 – No
1 – A little
2 – A lot
7 – Unable to rate (insufficient information)
8 – Not applicable (collection not required - item not included in the version collected)
9 – Not stated / Missing

Field Name: SDQ42

SDQ Version

Definition: The version of the SDQ collected.

Domain:
PC101 – Parent Report Measure 4-10 yrs, Baseline version, Australian Version 1
PC201 – Parent Report Measure 4-10 yrs, Follow Up version, Australian Version 1
PY101 – Parent Report Measure 11-17 yrs, Baseline version, Australian Version 1
PY201 – Parent Report Measure 11-17 yrs, Follow Up version, Australian Version 1
YR101 – Self report Version, 11-17 years, Baseline version, Australian Version 1
YR201 – Self report Version, 11-17 years, Follow Up version, Australian Version 1

Comments: Version 1 of each of the above is reproduced in *Mental Health National Outcomes and Casemix Collection: Overview of clinical and self-report measures and data items, Version 1.50*. Commonwealth Department of Health and Ageing, Canberra, 2003.

Field Name: SDQVer

Service Unit Identifier

Definition: The unique identifier for the *Service Unit* of the *Mental Health Service Organisation* primarily responsible for providing the treatment and care during the *Episode of Mental Health Care.*

Domain: NNNNNN: Unique Service Unit Identifier

Comments: Several guidelines apply to the way in which an organisation's mental health services are identified as service units. These are based on the minimum reporting that is required for the purposes of the National Minimum Data Set, particularly the NMDS - Mental Health Establishments.

A *Service Unit* is defined as a discrete service provider unit within the *Mental Health Service Organisation*. Several guidelines apply to the way in which an organisation's mental health services are reported as service units. These are based on the minimum reporting that is required for the purposes of the National Minimum Data Set, particularly the NMDS - Mental Health Establishments.

Admitted patient service units: Admitted patient service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic) and Program Type (Acute vs Other). For example, if a hospital had separate wards for Child & Adolescent and General Adult populations, these should be reported as separate service units.Similarly, if the hospital provided separate wards for Older Persons acute and Older Person other program types, this would require separate service units to be identified (that is, defined by the program type as well as the target population). The overarching principle is that the same service unit identification policy must be applied to the admitted patient service units data reported under NOCC and the NMDS - Mental Health Establishments.

Residential service units: Residential service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic). Where possible, it is also desirable that residential service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS - Residential Mental Health Care.

Ambulatory service units: Ambulatory service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic). Where an organisation provides multiple teams serving the same target population, these may be grouped and reported as a single Service Unit, or identified as individual Service Units in their own right. Where possible, it is also desirable that residential service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS - Community Mental Health Care.

States should ensure that the *Service Unit identifiers* are unique across all service unit types (i.e. admitted patient, ambulatory care, residential care services). Identifiers used to supply data to NOCC in respect of a particular service unit should be stable over time - that is, unless there has been a significant change to the unit, the same identifier should be used from year to year of reporting.

The *Service Unit Identifier* is reported at each *Collection Occasion*.

Ideally, where a mental health servce provides mixed service types (eg, overnight inpatient care as well as ambulatory care), each component will be defined as a separate *Service Unit* and assigned a unique *Service Unit Identifier.*

Field Name: SUId

Service Unit Name

Definition: Common name used to identify the service unit.

Field Name: SUName

Service Unit Sector

Definition: Service unit sector

Domain:
1 – Public
2 – Private

Field Name: Sector

Service Unit Type

Definition: The service setting in which care is most typically provided by the Service Unit.

Domain:
1 – Admitted patient service unit
2 – Residential care service unit
3 – Ambulatory care service unit

Comments: This data element is intended to describe the most common type of care provided by the service unit. It does not have to correspond to the Episode Service Setting data element reported on the Collection Occasion record. For example, a service unit that primarily provides admitted patient care may be the responsible service unit for a person receiving ambulatory care. In this scenario, data collected at each Collection Occasion would report the Episode Service Setting as 'ambulatory' (because this the setting within which the Episode of Mental Health Care takes place) and the Service Unit Type as 'admitted patient service unit' (because this correctly describes the typical setting in which care is provided by this service unit).

Field Name: SUType

Service Unit {concept}

Definition: A *Service Unit* is defined as a discrete service provider unit within the *Mental Health Service Organisation*. Several guidelines apply to the way in which an organisation's mental health services are reported as service units. These are based on the minimum reporting that is required for the purposes of the National Minimum Data Set, particularly the NMDS - Mental Health Establishments.

Admitted patient service units: Admitted patient service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic) and Program Type (Acute vs Other). For example, if a hospital had separate wards for Child & Adolescent and General Adult populations, these should be reported as separate service units.Similarly, if the hospital provided separate wards for Older Persons acute and Older Person other program types, this would require separate service units to be identified (that is, defined by the program type as well as the target population). The overarching principle is that the same service unit identification policy must be applied to the admitted patient service units data reported under NOCC and the NMDS - Mental Health Establishments.

Residential service units: Residential service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic). Where possible, it is also desirable that residential service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS - Residential Mental Health Care.

Ambulatory service units: Ambulatory service units should be differentiated by Target Population (General, Older Persons, Child & Adolescent and Forensic). Where an organisation provides multiple teams serving the same target population, these may be grouped and reported as a single Service Unit, or identified as individual Service Units in their own right. Where possible, it is also desirable that residential service units identified in NOCC data correspond directly on one-to-one basis to those reported in the NMDS - Residential Mental Health Care.

Comments: Ideally, where a mental health servce provides mixed service types (eg, overnight inpatient care as well as ambulatory care), each component will be defined as a separate *Service Unit* and assigned a unique *Service Unit Identifier.*

Field Name: abs_ServiceUnit

Sex

Definition: The sex of the person.

Domain:
1 – Male
2 – Female
3 – Indeterminate
9 – Not stated / Missing

Field Name: Sex

State/Territory Identifier

Definition: An identifier indicating the State or Territory responsible for the collection and submission of the NOCC data file.

Domain:
1 – New South Wales
2 – Victoria
3 – Queensland
4 – South Australia
5 – Western Australia
6 – Tasmania
7 – Northern Territory
8 – Australian Capital Territory

Field Name: State

METeOR ID: 286919

Target Population

Definition: The population group primarily targeted by a specialised mental health service, as represented by a code.

Domain:
1 – Child and adolescent
2 – Older person
3 – Forensic
4 – General
9 – Not available

Field Name: TargetPop

METeOR ID: 288957

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Appendix C: NOCC Submission and Validation Process

Overview and timelines

Note that this process is documented online at http://amhocn.org/data-bureau/submission-and-validation-process/. It is worth checking the website for updates since it will always have the latest version of this process.

Set out below are detailed recommendations regarding the submission of data to the national database managed by AMHOCN under contract to the the Australian Government Department of Health and Ageing.

The Australian Government recommends that States and Territories provide data to the AMHOCN Data Bureau on a quarterly basis. Doing so gives AMHOCN the opportunity to provide States and Territories with more timely feedback and reports of all kinds.

However, regardless of whether a State or Territory submits interim data to AMHOCN on a quarterly basis or not, under the Agreement each State and Territory has with the Australian Government, a complete and final extract covering the full financial year is required to be submitted by 31 December following the end of that financial year.

To ease administrative burden and quicken the process, States and Territories are encouraged to submit data directly to AMHOCN. The Australian Government has advised that final extracts of NOCC data submitted to the AMHOCN Data Bureau will be deemed to be fulfilment of the funding agreement requirements in respect of the submission of NOCC data to the Australian Government.

Accordingly, a State or Territory may adopt one of two approaches when submitting data to AMHOCN:

- OPTION 1: Just a single final extract covering the Financial Year ending June 30 of the current calendar year is created and submitted to the AMHOCN Data Bureau so that it arrives before the deadline of 31 December of that current Calendar Year.

OR

- OPTION 2: As the Financial Year progresses the State or Territory submits to the AMHOCN Data Bureau a cumulative extract covering the period from the beginning of the financial year to the end of the just-completed quarter of that financial year. It is recommended that each such extract be created and submitted no earlier than ten weeks following the end of the Quarter, that providing reasonable time for all local edits relevant to the Quarter to be completed. The State or Territory also submits a single final extract for the whole financial year to the AMHOCN Data Bureau so that it arrives before the deadline of 31 December of that current calendar year.

In either case, the single final extract submitted to the AMHOCN Data Bureau is treated as the State or Territory's definitive response in meeting their agreement to provide NOCC data to the Australian Government, whereas the quarterly extracts submitted to the AMHOCN Data Bureau, including that submitted at the end of the fourth quarter, do NOT have that status.

It is assumed that States and Territories will build an automated or semi-automated process that enables NOCC data to be extracted from source systems. That process would bring together the data from all relevant source systems, apply any transformations and restructuring to the data that was needed to bring it into conformance with the NOCC specifications, and then write the data out as a single extract file in the required format.

As noted, the Australian Government advocates Option 2 above. Under this option, the AMHOCN Data Bureau would expect to receive a 1st quarter extract covering the 3 month period July–September in mid to late December, a second quarter extract covering the 6 month period July–December in late March, a third quarter extract covering the 9 month period July–March in late June, and a fourth quarter extract covering the 12 month period July–June in late September. A final definitive extract covering the full financial year would then be submitted to the AMHOCN Data Bureau so that it arrives well before the deadline of 31 December.

Data File Naming Convention

The data file must have a formal name consistent with the format of NOCCsssyyyybbbbb.DAT. Note that the filename is case sensitive. The *sss*, *yyyy*, and *bbbbb* components are defined as :-

sss Jurisdiction code (ACT, NSW, NTE, QLD, SAU, TAS, VIC, or WAU)

yyyy Year of the end of the financial year the batch is for

bbbbb Yearly incremental batch number (leading zeros present) indicating the sequence number of the submission. Note that successive quarterly files and any resubmitted files must have a batch number greater than all preceding files for that year.

For example, suppose that the ACT submitted quarterly data files to AMHOCN in respect of the 2007-08 financial year, then submitted a final submission; their first NOCC data file would be named `NOCCACT2008000001.DAT`, whilst the second would be named `NOCCACT200800002.DAT`, and so on. If no resubmissions were made the final submission for that year would be named `NOCCACT200800005.DAT`. If that file then had to be resubmitted for some reason, then it would be named `NOCCACT200800006.DAT`. Their first submission for the 2008-09 financial year would then be named `NOCCACT200900001.DAT`.

Pre-Submission Validation

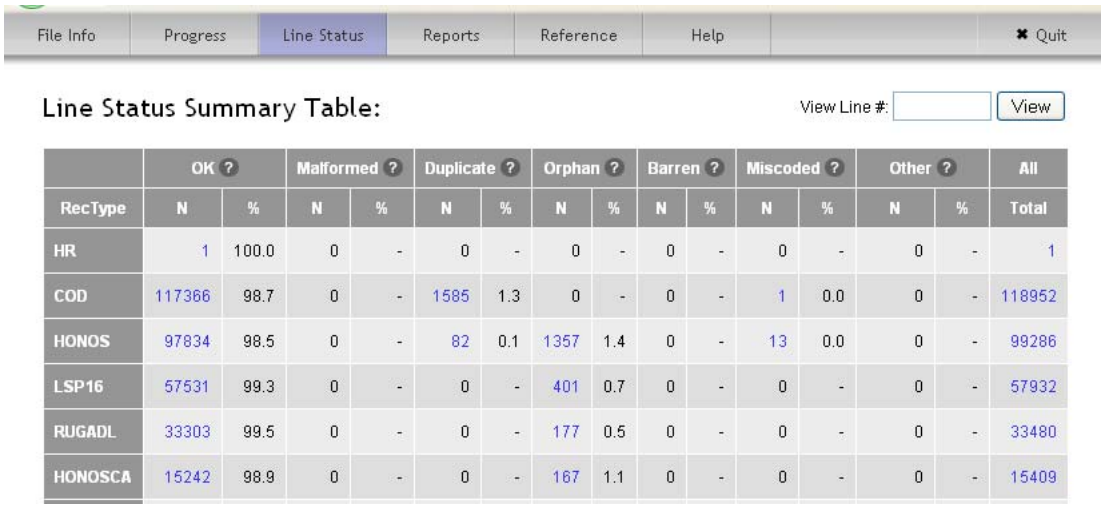
Jurisdictions are expected to have pre-validated their submissions using the Minimum Data Set (MDS) Validator. The most up to date source of information regarding the MDS Validator is the http://validator.com.au/ website. The MDS Validator can be run stand-alone or via the online validator at https://webval.validator.com.au/ .

Before submitting your file by any of the methods listed below you should inspect the reports produced by the MDS Validator; these are the same in both the stand-alone and online versions. There are two sources of information that you should review to ensure you are satisfied with the quality of your submission.

Line Status

The Line Status screen provides a high level indication of file quality and is the best place to look to ensure the basic formatting of your records and structure of the file is correct. It classifies each line in the file into a single column in the table.

Figure 1: Line Status



	OK		Malformed		Duplicate		Orphan		Barren		Miscoded		Other		All
RecType	N	%	N	%	N	%	N	%	N	%	N	%	N	%	Total
HR	1	100.0	0	-	0	-	0	-	0	-	0	-	0	-	1
COD	117366	98.7	0	-	1585	1.3	0	-	0	-	1	0.0	0	-	118952
HONOS	97834	98.5	0	-	82	0.1	1357	1.4	0	-	13	0.0	0	-	99286
LSP16	57531	99.3	0	-	0	-	401	0.7	0	-	0	-	0	-	57932
RUGADL	33303	99.5	0	-	0	-	177	0.5	0	-	0	-	0	-	33480
HONOSCA	15242	98.9	0	-	0	-	167	1.1	0	-	0	-	0	-	15409

Clicking on the links in this table provides a view of the record(s) with issues and allows for closer inspection of the problem(s).

Note that it reports in real time so it can be viewed while the validation run is in progress. Doing so can save you from validating an entire file for which it is already evident a rebuild is required.

The various issues summarised are:

OK	The record was validated without problems
Malformed	The record had at least one issue that renders it undecipherable. Examples include short lines, bad record types, or invalid key fields
Orphan	The record did not have a parent in the submitted file. This can occur if the parent record exists but has irredeemable errors
Duplicate	The record was a duplicate, there were two or more records with the same key fields
Barren	The record is expected to have child records but there are none present. This can occur if the child record exists but has irredeemable errors
Miscoded	The record had at least one incorrectly supplied non-key field. Examples include illegal characters, incorrectly formatted numbers, out of domain values, and invalid dates
Other	The record had at least one issue to be investigated. Examples include missing, zero, and inconsistent values

Reports

The Reports screen provides more detailed reports regarding the quality of data contained within the file. A number of different views on the validation run are possible and accessible via the links show in Figure 2 below.

Figure 2: Reports List

Below is an example of a report from this screen.

Figure 3: Example Reports

		Class		Total
RecType	Field	Sequence	Invalid	
COD	DoB	0	1	1
	Setting	3238	0	3238
	ColRsn	14756	0	14756
HONOS	Hnos08a	0	13	13
SDQ	SDQ39	0	272	272
Total		17994	286	18280

Reports classify issues into the classes detailed below. Unlike the “Line Status” report a single line in the submission file may be reported on multiple times. In some cases the issue is not specific to a particular file. In that instance it is assigned to the implicated record and item highest in the file hierarchy.

Invalid A field contains incorrect data, mis-formatted, or out of domain.

Missing A field contains no meaningful data. Depending on the entry involved, it may be all spaces, all zeroes, or a missing value in the domain (eg. "9").

Malformed The record had at least one issue that renders it undecipherable. Examples include short lines, bad record types, or invalid key fields

Sequence The order of Collection Occasion types is not logical. E.g. a Discharge may be followed by a Review with no preceding Admission.

MDS Validator

The Online Validator (WebVal) located at https://webval.validator.com.au/ allows you to upload your .DAT file to a secure server. Once the upload and validation process is complete (which can take some time depending on the size of your file) you will be sent an e-mail informing you of the status of your file and providing a link to the online reports. Note that you may zip your file prior to upload in order to reduce the size of the file. This zip file must not be password protected. The upload link itself is encrypted so the file does not travel across the Internet unprotected.

AMHOCN understands that data uploaded to the online validator may not be your final version ready for submission and therefore, until you make the decision to submit your file via the online validator, your upload remains in a private workspace inaccessible to anyone other than you. It is also possible to completely delete the file after validation in order to remove your data from the system.

Note that the Stand Alone Validator is no longer actively maintained and online validation is the best validation and submission method. If for some reason this is not acceptable please contact support@amhocn.org to discuss your requirements.

Submission

Having used the Online MDS Validator at https://webval.validator.com.au/ you can complete your submission from there. Validation must have completed before the option to submit a file is presented. If you have navigated away from the submission page you can return there by following these steps:

1. Select the “Files” option from the top level menu.

2. Select the year of the file you wish to submit from the second level menu labelled with years.

3. Select the desired file from the list on the left hand pane headed “Your files”

4. Providing there are no issues preventing submission you will be able to submit your file by clicking the “Submit” button on that page.

5. Upon submission the Data Bureau will be notified of your submission (you will also get a receipt e-mail) and your submission will be reviewed.

6. If the file has problems it may be rejected and you will be notified of this as you will of acceptance of the file.

Once the file is submitted you can still view the reports however the option to delete the file is no longer available via the website. Contact AMHOCN at amhocn@mhnocc.org if you have accidentally submitted a file.

If for some reason you need to submit a new file after your initial submission you may do so however instead of submitting it from the page described above you propose it as a replacement. This will notify the Data Bureau and your proposal will be reviewed.