

PRIMHD Code Set

HISO 10023.3

Version 2.0

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Document reordered for NGO Required Data Elements

To be used in conjunction with:

HISO 10023.1 – Integrated Mental Health Data Process Standard
and HISO 10023.2 – PRIMHD Data Set

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Related Documents

NZS/AS

AS/NZS 7799.2 Information security management. Part 2: Specification for information security management systems. (This standard was redesignated from AS/NZS 4444.2:2000.)

ISO

ISO/IEC 17799 Information Technology – Code of practice for information security management. (This standard supersedes AS/NZS 4444.1:1999.)

ISO/IEC 11179 ISO Standard 11179-3 Information technology – specification and standardization of data elements. Part 3: Basic attributes of data elements, 1994.

Other standards

HL7 V2.4 Health Level Seven Standard Version 2.4. Ann Arbor: Health Level Seven Inc., 2001.

HISO Ministry of Health. Ethnicity Data Protocols for the Health and Disability Sector. Wellington: Ministry of Health, 2004.

HISO 10005 Health Practitioner Index Data Set.

HISO 10006 Health Practitioner Index Common Code Set.

HISO Referrals and Discharges Data Set

HISO Referrals and Discharges Common Code Set.

Other publications

NZSCC99 Statistics New Zealand Country Code List.

HNBC HealthNet/BC Provider Data Standards, Version 1.0.

NHDD National Health Data Committee. National Health Data Dictionary, Version 12.0. Canberra: Australian Institute of Health and Welfare, 2003.

New Zealand legislation

Alcoholism and Drug Addiction Act 1966

Criminal Procedure (Mentally Impaired Persons) Act 2003

Health Act 1956

Health Practitioners Competence Assurance Act, 2003

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Mental Health (Compulsory Assessment and Treatment) Act 1992

Parole Act 2002

1 INTRODUCTION

This chapter of the standard provides an introductory summary about HISO standards for the PRIMHD code set and what contributes to the development and makeup of the HISO standards for PRIMHD, including why standards are required for PRIMHD.

1.1 Overview of the code set standard for PRIMHD

This document defines the common set of codes to be used for each data element of the Integrated Mental Health Collection (PRIMHD) data set that requires coding.

The adoption of a common code set for the health sector will reduce the need for complex interface programmes to translate or manipulate data being exchanged. It will also contribute towards creating a common understanding of data, thus allowing better analysis and interpretation.

Most codes fall into one of two categories:

generic codes: these are codes or values that are used throughout the health sector, such as codes for 'Title' (Mr, Mrs, etc; or organisation name, etc). These need to be used consistently.

speciality specific codes: these are specific to mental health (for example, DSM IV). However, the speciality specific codes need to be incorporated into common systems, such as PRIMHD, to ensure that they can be accurately represented to users.

Within this document the code sets are presented as follows:

code: the value that is used for data storage and data entry.

- (a) description of the code: a textual description of the code that would be displayed on reports and for viewing on-screen.
- (b) 'Valid From' and 'Valid To' fields indicate the time period a code is valid for. This information enables old codes to be retired and new codes to be created, whilst retaining the ability to validate incoming data.
- (c) definition: a textual explanation of the code. This is for information only and can be used for training and user documentation. A definition may not be included where the description is obvious.

For example:

Data element	Code	Description	Code 'Valid From'	Code 'Valid To'	Definition
Sex	F	Female	01-01-1900 ¹		
Sex	U	Unknown	01-01-1900		Not stated or inadequately described.
Outcome Tool	A1	HoNOS	01-03-2002		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. <i>British Journal of Psychiatry</i> 174:432-434.

¹ The 'Valid From' dates have been populated, where known, with the dates that the codes were created. Where the codes were created in the former MHINC or MH-SMART systems, the 'Valid From' dates have been set to a default of 01-01-1900 to allow for migration of data from these systems into the new collection. The 'Valid To' dates have been populated with the date 30-06-2011 to reflect the requirement to review that standard within a three year period. At the point of review, the decision will then be made to retire or extend the validity of the current codes.

1.2 The purpose of the PRIMHD

The purpose of PRIMHD is to provide:

Secure Information Access and Reporting to underpin Decision Support and Policy Development through Consistent use of Benchmarking, Standards and Key Performance Indicators.

Facts about the Value of mental health services, supporting Workforce Development activities, Cultural Relevance and transforming mental health data into Knowledge to support our vision;

“IMPROVED HEALTH OUTCOMES FOR ALL HEALTH CONSUMERS”

1.3 The requirement for standards

The PRIMHD will provide an integrated collection of activity and outcome information for consumers within the mental health service.

The MHINC/MH-SMART feasibility project examined the issues that surrounded the integration of two quite different data collections. The sector recognised the value of the MHINC data collection and it was also felt that, with the introduction of MH-SMART, there was an opportunity to address some of the underlying actual and perceived issues with MHINC. The sector recognised the difficulties that would be created and the associated costs of having two distinct national collections. Therefore, it was recommended that a single national collection be established, hence the creation of the PRIMHD project.

Most mental health services within New Zealand are structured in a manner that has been developed to suit the local environment and the same is true for the information systems present within these organisations. There exists a plethora of differing systems throughout the country, recording and reporting on consumer admissions, discharges and activity. Even when the same system is in use in two organisations, it has often been implemented in quite different ways. The introduction of MH-SMART has introduced some system standards in the collection of information around outcome measurement.

As the PRIMHD system will be a new collection, it is appropriate that it is established based on solid standards that have been developed and endorsed by representatives from the sector.

As part of the MH-SMART implementation, organisations will need to modify the content and the structure of the files that are reported through to the national collection housed by NZHIS. Organisations should benefit substantially from the existence of a data standard for core information prior to commencing this work.

1.4 Collection of data

Initially, data will be collected from District Health Boards (DHBs). This will be expanded out to the NGO sector as the NGO sector develops capability. The PRIMHD ‘Online Web-based Form Solution’ will assist the NGO sector in their ability to capture and report information electronically.

2 PRIMHD RECORD CODE SETS

This chapter of the standard describes each of the code sets for each of the record types that are detailed in Chapter 2, PRIMHD RECORD TYPES, in HISO 10023.2 – PRIMHD Data Set.

2.1 Team (TR) Record Code Sets

2.1.1 Team Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Team' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Team Code	2.1.1.1	(i) Team Service Type	2.1.1.4
(b) File Version	2.5.1.1	(j) Team Target Population	2.1.1.5
(c) Team Type	2.1.1.2	(k) Agency Code	2.1.1.6
(d) Team Setting	2.1.1.3	(l) Organisation Type	2.1.1.7

2.1.1.1 Team Code

A 'Team Code' uniquely identifies a mental health services team. This team can be defined as a person or functionally discrete grouping of people based in a particular location providing mental health care to a consumer group in either an inpatient or community setting. The 'Team Codes' change as mental health services teams are established and disestablished. The 'Team Code' is uniquely linked to 'Organisation Identifier' and/or 'Health Agency' code. Currently, this code table is managed by NZHIS via an external MS Access database and an updated extract is published to the NZHIS web site at the web address, below:

<http://www.nzhis.govt.nz/moh.nsf/pagesns/470>

2.1.1.2 Team Type

A code that categorises the primary function of the healthcare team. See table below:

Code	Description	Code Valid From	Code Valid To	Note
01	Inpatient Team	01-01-1900	30-06-2011	Inpatient teams provide services in a medical environment such as a hospital to eligible persons who are in need of a period of close observation, intensive investigation or intervention. Note: <ul style="list-style-type: none"> Inpatient teams aimed at a specific client group or purpose eg A&D, CAFS, Kaupapa Maori should be mapped to the specific team below.
02	Community Team	01-01-1900	30-06-2011	Community teams provide non residential assessment and treatment services including outpatient services. Note: <ul style="list-style-type: none"> Community teams aimed at a specific client group or purpose eg A&D, CAFS, Kaupapa Maori should be mapped to the specific team below.

Code	Description	Code Valid From	Code Valid To	Note
03	Alcohol and Drug Team	01-01-1900	30-06-2011	<p>Alcohol and drug teams provide assessment and treatment services to people with alcohol and other drug problems. Includes inpatient, residential or community based alcohol and drug teams.</p> <p>Note:</p> <ul style="list-style-type: none"> • Alcohol and drug kaupapa Maori teams should be mapped to 10. • Children and youth, alcohol and drug teams should be mapped to 21.
04	Child, Adolescent and Family Team	01-01-1900	30-06-2011	<p>Child, adolescent and family teams provide assessment and treatment services to people aged 0–19 years inclusive. Includes inpatient, residential or community based child, adolescent and family teams.</p> <p>Note:</p> <ul style="list-style-type: none"> • Children and youth, alcohol and drug teams should be mapped to 21. • Kaupapa Maori Tamariki and Rangatahi (child and youth) mental health teams should be mapped to 22.
05	Forensic Team	01-01-1900	30-06-2011	<p>Forensic teams provide assessment and treatment services to alleged offenders charged with criminal offences, who have or are thought to have a psychiatric illness. Also includes individuals who are unable to be managed safely with general mental health services due to a high level of serious and persistent danger to others. Includes inpatient, residential or community based forensic teams.</p>
06	Kaupapa Maori Team	01-01-1900	30-06-2011	<p>Kaupapa Maori teams provide assessment and treatment services to people within a Maori kaupapa. Includes inpatient, residential or community based teams within a Maori kaupapa (including child, adolescent and family, youth specialty and psychogeriatric services).</p> <p>Note:</p> <ul style="list-style-type: none"> • Alcohol and drug kaupapa Maori teams should be mapped to 10. • Kaupapa Maori Tamariki and Rangatahi (child and youth) mental health teams should be mapped to 22. • Kaupapa Maori dual diagnosis mental health and alcohol and drug teams should be mapped to 23.
07	Pacific Island Team	01-01-1900	30-06-2011	<p>Pacific Island teams provide assessment and treatment services under a Pacific model. Includes inpatient, residential or community based teams working under a Pacific model (including alcohol and drug, child, adolescent and family, youth specialty and psychogeriatric services).</p>

Code	Description	Code Valid From	Code Valid To	Note
08	Residential Team	01-01-1900	30-06-2011	Accommodation, rehabilitation and support provided in a community residence to eligible persons with psychiatric disabilities.
09	Community Skills Enhancement Team	01-01-1900	30-06-2011	Community skills enhancement teams provide non residential, activity-based services to assist people with psychiatric disabilities improve their life skills, overcome social isolation and return to optimal functioning.
10	Alcohol and Drug Kaupapa Maori Team	01-01-1900	30-06-2011	Alcohol and drug kaupapa Maori teams provide assessment and treatment services within a Maori kaupapa to people with alcohol and other drug problems. Includes inpatient, residential or community based alcohol and drug kaupapa Maori teams. Note: <ul style="list-style-type: none"> Alcohol and drug kaupapa Maori teams should be mapped to 10. Kaupapa Maori dual diagnosis mental health and alcohol and drug teams should be mapped to 23.
11	Alcohol and Drug Dual Diagnosis Team	01-01-1900	30-06-2011	Alcohol and drug dual diagnosis teams provide assessment and treatment services to people with coexisting problems of mental illness and alcohol and drug use. Includes inpatient, residential or community based alcohol and drug dual diagnosis teams. Note: <ul style="list-style-type: none"> Kaupapa Maori dual diagnosis mental health and alcohol and drug teams should be mapped to 23.
12	Intellectual Disability Dual Diagnosis Team	01-01-1900	30-06-2011	Intellectual disability dual diagnosis teams provide assessment and treatment services to people with coexisting problems of mental illness and intellectual disability. Includes inpatient, residential or community based intellectual disability dual diagnosis teams.
13	Psychogeriatric Team	01-01-1900	30-06-2011	Psychogeriatric teams provide assessment and treatment services to people aged 65 and older with some flexibility based on the nature of the presenting problems. Includes inpatient, residential or community based psychogeriatric teams.
14	Youth Specialty Team	01-01-1900	30-06-2011	Youth specialty teams provide assessment and treatment services to people aged 15–19 years inclusive. Includes inpatient, residential or community based youth specialty teams.

Code	Description	Code Valid From	Code Valid To	Note
15	Maternal Mental Health Team	01-01-1900	30-06-2011	Maternal mental health teams provide assessment and treatment services to pregnant women, women in the post partum period and their infants. Includes inpatient, residential or community based maternal mental health teams.
16	Eating Disorder Team	01-01-1900	30-06-2011	Eating disorder teams provide assessment and treatment services to people with eating disorders. Includes inpatient, residential or community based eating disorder teams.
17	Needs Assessment and Service Coordination Team	01-01-1900	30-06-2011	Needs assessment and service coordination teams provide comprehensive assessment of needs and facilitation of ongoing provision of services and support to people with psychiatric disabilities. The assessment process meets the Standards for Needs Assessment for People with disabilities (MOH). These teams are usually community based.
18	Specialist Psychotherapy Team	01-01-1900	30-06-2011	Specialist psychotherapy teams provide assessment and psychotherapy treatment to people with severe psychological disorders. These teams are usually community or outpatient based.
19	Services for Profoundly Deaf Team	01-01-1900	30-06-2011	Services for profoundly deaf teams provide assessment, therapy and referral services for profoundly deaf people who require specialist mental health services. These teams are usually community based.
20	Refugee Team	01-01-1900	30-06-2011	Refugee teams provide specialist assessment, treatment and liaison services that meet the particular mental health needs of refugees. These teams are usually community based.
21	Children and youth, alcohol and drug services	01-01-1900	30-06-2011	Children and youth, alcohol and drug teams provide assessment and treatment services to people aged 0–19 years inclusive with alcohol and other drug problems. Includes inpatient, residential or community based teams.
22	Kaupapa Maori Tamariki and Rangatahi (child and youth) mental health services	01-01-1900	30-06-2011	Kaupapa Maori Tamariki and Rangatahi mental health teams provide assessment and treatment services within a Maori kaupapa to people aged 0–19 years inclusive. Includes inpatient, residential or community based teams.
23	Kaupapa Maori dual diagnosis mental health and alcohol and drug services	01-01-1900	30-06-2011	Kaupapa Maori dual diagnosis mental health and alcohol and drug teams provide assessment and treatment services within a Maori kaupapa to people with coexisting problems of mental illness and alcohol and drug use. Includes inpatient, residential or community based teams.

Code	Description	Code Valid From	Code Valid To	Note
99	Other	01-01-1900	01-07-2008	Any teams not specifically covered above. Note: <ul style="list-style-type: none"> Retired 1 July 2008. Listed in this table for Historical reference purposes only.

2.1.1.3 Team Setting

A code that categorises the activity setting of the healthcare team. See table below:

Code	Description	Code Valid From	Code Valid To	Note
C	Community	01-07-2008	30-06-2011	
G	General Hospital	01-07-2008	30-06-2011	
I	Inpatient	01-07-2008	30-06-2011	
J	Court	01-07-2008	30-06-2011	
M	Mixed	01-07-2008	30-06-2011	
P	Prison	01-07-2008	30-06-2011	
R	Community Residential	01-07-2008	30-06-2011	

2.1.1.4 Team Service Type

A code that categorises whether the team is a designated cultural service healthcare team. See table below:

Code	Description	Code Valid From	Code Valid To	Note
KM	Kaupapa Māori Service	01-07-2008	30-06-2011	
NC	Mainstream Service	01-07-2008	30-06-2011	
OC	Other Cultural Service	01-07-2008	30-06-2011	
PI	Pacific Peoples Service	01-07-2008	30-06-2011	
AC	Asian Cultural Service	01-07-2008	30-06-2011	
CD	Consumer-driven Service	01-07-2008	30-06-2011	
PD	Profoundly Deaf Service	01-07-2008	30-06-2011	
RE	Refugee Service	01-07-2008	30-06-2011	

2.1.1.5 Team Target Population

A code that categorises the age group or target population group that the healthcare team provides service to. See table below:

Code	Description	Code Valid From	Code Valid To	Note
1	Older People Population	01-07-2008	30-06-2011	Formerly known as Psychogeriatric.
2	General Adult Population	01-07-2008	30-06-2011	
3	Youth Specific Population	01-07-2008	30-06-2011	
4	Child and Youth Population	01-07-2008	30-06-2011	
5	Child Specific Population	01-07-2008	30-06-2011	
6	Mixed Population	01-07-2008	30-06-2011	

2.1.1.6 Agency Code

This code set uniquely identifies an Agency. An agency is the historical or legacy systems terminology for an organisation, institution or group of institutions that contracts directly with the principal health services purchaser to deliver healthcare services to the community.

In PRIMHD, The agency code will be used as a secondary reference identifier only. The agency code will be mapped to its replacement HPI Organisation Identifier to populate the PRIMHD Organisation Identifier data elements, where the team/provider's systems are not able to use HPI Organisation Identifiers. Currently, this code table is managed by Information Directorate, Sector Services Group, Data Management Services, Data Quality- National Systems Team via an external MS Access database and an updated extract is published to the MoH web site at the web address, below:

<http://www.nzhis.govt.nz/moh.nsf/pagesns/423>

2.1.1.7 Organisation Type

A code that enables differentiation between different organisational entities.

Code	Description	Code Valid From	Code Valid To	Note
001	District Health Board (DHB)	01-07-2005	30-06-2011	DHBs provide (or fund the provision of) health and disability services to 21 districts throughout New Zealand.
002	Community Trust	01-07-2005	30-06-2011	Community Trusts are Non-profit Organisations that provide Health and Disability Services, and do not include Charitable Trusts.
003	Government Organisations	01-07-2005	30-06-2011	This includes both National and Local Government Bodies but excludes DHBs.

Code	Description	Code Valid From	Code Valid To	Note
004	Charitable Trust or Incorporated Society	01-07-2005	30-06-2011	A Trust is a group of people (called Trustees) who agree to hold money or assets and carry out activities for the benefit of certain other people (called beneficiaries), or in the case of a Charitable Trust, for the benefit of the community, and does not include Community Trusts.
005	Non-Governmental Organisations	01-07-2005	30-06-2011	Organisations that receive government funding to provide a set service. All non-governmental organisations that are not charitable trusts.
006	Responsible Authority	01-07-2005	30-06-2011	Responsible Authorities are Listed in the Health Practitioner Competency Assurance Act, 2003.
007	Research Institutions	01-07-2005	30-06-2011	Research institutions not involved in education.
008	Education Institutions	01-07-2005	30-06-2011	Education institutions – these may include those involved in research, e.g. Universities.
009	Primary Health Organisation	01-07-2005	30-06-2011	PHOs are the local provider organisations through which DHBs implement the Primary Health Care Strategy.
010	Independent Practitioner Associations	01-07-2005	30-06-2011	An association for independent practitioners that is not a PHO.
011	Private Hospital	01-07-2005	30-06-2011	A hospital that is not a public facility.
012	Pharmacy	01-07-2005	30-06-2011	An organisation that includes the business of dispensing pharmaceuticals.
013	General Practice	01-07-2005	30-06-2011	Where one or more medical practitioners are practising.
014	Community Based Clinical Services	01-07-2005	30-06-2011	Where a service is provided in an office environment including specialists, physiotherapists, dentists, laboratories, radiology clinics, etc.
000	Other	01-07-2005	30-06-2011	

2.2 Healthcare User (HC) Record Code Sets

2.2.1 Healthcare User Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Healthcare User' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Sex	2.2.1.1	(b) Ethnicity	2.2.1.2

2.2.1.1 Sex

A classification of the SEX of an individual, as supplied by the organisation. The coded data for the following code set is listed below for reference purposes only. The PRIMHD data is sourced from either the Legal Status or Referral Discharge records in PRIMHD and then transposed during the PRIMHD load processing into the Healthcare User Record.

Code	Description	Note
F	Female	
M	Male	
U	Unknown	Not stated, or inadequately described.

2.2.1.2 Ethnicity

A classification of the ETHNICITY of an individual, as supplied by the organisation (refer to the Ethnicity Data Protocols, Ministry of Health). (Note: NFD means Not Further Defined.) The coded data for the following code set is listed below for reference purposes only. The PRIMHD ethnicity data is sourced directly from the National Health Index (NHI) during the PRIMHD load processing when first creating the Healthcare User Record.

Code	Description	Note
10	European NFD	
11	New Zealand European	
12	Other European	
21	Māori	
30	Pacific peoples NFD	
31	Samoan	
32	Cook Island Māori	
33	Tongan	
34	Niuean	
35	Tokelauan	
36	Fijian	
37	Other Pacific peoples	
40	Asian NFD	
41	Southeast Asian	

Code	Description	Note
42	Chinese	
43	Indian	
44	Other Asian	
51	Middle Eastern	
52	Latin American/Hispanic	
53	African (or cultural group of African origin)	
61	Other ethnicity	
94	Don't know	
95	Refused to answer	
97	Response unidentifiable	
99	Not stated	

2.3 Referral Discharge (RD) Record Code Sets

2.3.1 Referral Discharge Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Referral Discharge' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) File Version	2.5.1.1	(b) Referral To	2.3.1.2
(b) Referral From	2.3.1.1	(c) Referral End Code	2.3.1.3

2.3.1.1 Referral From

The 'Referral From' identifies groups of services or people who are sources of mental health and addiction referrals.

Code	Description	Code Valid From	Code Valid To	Note
PI	Psychiatric inpatient	01-01-1900	30-06-2011	Psychiatric inpatient service.
OP	Psychiatric outpatients	01-01-1900	30-06-2011	Psychiatric outpatient service.
CM	Adult community mental health services	01-01-1900	30-06-2011	Adult community service, including mobile community teams.
AD	Alcohol and drug	01-01-1900	30-06-2011	Alcohol and drug provider or facility.
CA	Child adolescent and family mental health services	01-01-1900	30-06-2011	Child, adolescent and family service.
RE	Mental health residential	01-01-1900	30-06-2011	Mental health residential service.
SE	Mental health community skills enhancement programme	01-01-1900	30-06-2011	Mental health community skills enhancement programme.
NA	Needs assessment and co-ordination service	01-01-1900	30-06-2011	Needs assessment and co-ordination service.
KM	Kaupapa Māori Service	01-01-1900	30-06-2011	Kaupapa Māori provider or facility.
KP	Pacific peoples	01-01-1900	30-06-2011	Pacific peoples provider or facility.
NP	Hospital referral (non-psychiatric)	01-01-1900	30-06-2011	Hospital facility which is not psychiatric inpatient, paediatrics, public health or emergency services.
DH	Day hospital	01-01-1900	30-06-2011	Day hospital.
AE	Accident and emergency	01-01-1900	30-06-2011	Accident and emergency department or service.
PD	Paediatrics	01-01-1900	30-06-2011	Paediatric setting or a paediatrician.
PH	Public health	01-01-1900	30-06-2011	Child or adolescent referred from or to a non mental health community provider, e.g. public health nurse, Plunket.
GP	General practitioner	01-01-1900	30-06-2011	General practitioner or medical centre, including private after hours emergency services.
PP	Private practitioner	01-01-1900	30-06-2011	Private practitioner, e.g. psychologist, psychiatrist, medical specialist in private practice.

Code	Description	Code Valid From	Code Valid To	Note
ED	Education sector	01-01-1900	30-06-2011	Educational institution including schools, pre school, kindergarten, school guidance counsellor, special education services.
SW	Social Welfare	01-01-1900	30-06-2011	Government social welfare, e.g. CYPFA (Children, Young Persons and their Families Agency), WINZ (Work and Income New Zealand).
JU	Justice	01-01-1900	30-06-2011	Justice, Courts, corrections or youth justice.
PO	Police	01-01-1900	30-06-2011	Police.
SR	Self or relative referral	01-01-1900	30-06-2011	Self, relatives, whānau, family or significant other person, or referred to relatives, whānau, family or significant other person.
OT	Other	01-01-1900	30-06-2011	Other service or agency not specified elsewhere.
VS	Vocational Service	01-07-2008	30-06-2011	
CS	Community Support Service	01-07-2008	30-06-2011	
UN	Unknown	01-01-1900	30-06-2011	Not known.
NR	No further referral	01-01-1900	30-06-2011	

2.3.1.2 Referral To

The 'Referral To' identifies groups of services or people who are destinations of mental health and addiction referrals.

Code	Description	Code Valid From	Code Valid To	Note
PI	Psychiatric inpatient	01-01-1900	30-06-2011	Psychiatric inpatient service.
OP	Psychiatric outpatients	01-01-1900	30-06-2011	Psychiatric outpatient service.
CM	Adult community mental health services	01-01-1900	30-06-2011	Adult community service, including mobile community teams.
AD	Alcohol and drug	01-01-1900	30-06-2011	Alcohol and drug provider or facility.
CA	Child adolescent and family mental health services	01-01-1900	30-06-2011	Child, adolescent and family service.
RE	Mental health residential	01-01-1900	30-06-2011	Mental health residential service.
SE	Mental health community skills enhancement programme	01-01-1900	30-06-2011	Mental health community skills enhancement programme.
NA	Needs assessment and co-ordination service	01-01-1900	30-06-2011	Needs assessment and co-ordination service.
KM	Kaupapa Māori Service	01-01-1900	30-06-2011	Kaupapa Māori provider or facility.
KP	Pacific peoples	01-01-1900	30-06-2011	Pacific peoples provider or facility.
NP	Hospital referral (non-psychiatric)	01-01-1900	30-06-2011	Hospital facility which is not psychiatric inpatient, paediatrics, public health or emergency services.
DH	Day hospital	01-01-1900	30-06-2011	Day hospital.
AE	Accident and emergency	01-01-1900	30-06-2011	Accident and emergency department or service.

Code	Description	Code Valid From	Code Valid To	Note
PD	Paediatrics	01-01-1900	30-06-2011	Paediatric setting or a paediatrician.
PH	Public health	01-01-1900	30-06-2011	Child or adolescent referred from or to a non mental health community provider, e.g. public health nurse, Plunket.
GP	General practitioner	01-01-1900	30-06-2011	General practitioner or medical centre, including private after hours emergency services.
PP	Private practitioner	01-01-1900	30-06-2011	Private practitioner, e.g. psychologist, psychiatrist, medical specialist in private practice.
ED	Education sector	01-01-1900	30-06-2011	Educational institution including schools, pre school, kindergarten, school guidance counsellor, special education services.
SW	Social Welfare	01-01-1900	30-06-2011	Government social welfare, e.g. CYPFA (Children, Young Persons and their Families Agency), WINZ (Work and Income New Zealand).
JU	Justice	01-01-1900	30-06-2011	Justice, Courts, corrections or youth justice.
PO	Police	01-01-1900	30-06-2011	Police.
SR	Self- or relative referral	01-01-1900	30-06-2011	Self, relatives, whānau, family or significant other person, or referred to relatives, whānau, family or significant other person.
OT	Other	01-01-1900	30-06-2011	Other service or agency not specified elsewhere.
VS	Vocational Service	01-07-2008	30-06-2011	
CS	Community Support Service	01-07-2008	30-06-2011	
UN	Unknown	01-01-1900	30-06-2011	Not known.
NR	No further referral	01-01-1900	30-06-2011	

2.3.1.3 Referral End Code

Details describing the exit of a consumer from a mental health or addiction service.

Code	Description	Code Valid From	Code Valid To	Note
DD	Died	01-01-1900	30-06-2011	Maps to MHINC Code D. Consumer died while registered with team.
DG	Gone No Address or Lost to follow-up.	01-07-2008	30-06-2011	New code 2008.
DM	Consumer did not attend following the referral.	01-07-2008	30-06-2011	New code 2008.
DR	Ended routinely	01-01-1900	30-06-2011	Maps to MHINC Code C. Discharge by team - completion of treatment associated with all service codes utilised by this consumer at this team.
DS	Self discharge from hospital	01-07-2008	30-06-2011	

Code	Description	Code Valid From	Code Valid To	Note
DT	Discharge of consumer to another healthcare organisation	01-07-2008	30-06-2011	
DW	Discharge to other service within same organisation	01-07-2008	30-06-2011	
RI	Referral declined – Inability to provide services requested.	01-07-2008	30-06-2011	
RO	Referral declined – Other services more appropriate.	01-07-2008	30-06-2011	

2.4 Activity (AT) Record Code Sets

2.4.1 Activity Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating an 'Activity record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Activity Type	2.4.1.1	(b) Activity Setting	2.4.1.2

2.4.1.1 Activity Type

The 'Activity Type' classifies the type of healthcare activity provided to the Recipient. See table below:

Code	Description	Code Valid From	Code Valid To	Note
T01	Mental health crisis attendances	01-01-1900	30-06-2011	Unplanned intervention involving the consumer in assessment and/or treatment to stabilise symptoms in urgent situations which require an immediate response.
T02	Mental health intensive care inpatient occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health intensive care inpatient service. These 24-hour care and treatment services are provided to manage people with serious acute mental health disorders, whose condition presents a danger to themselves or other people. These consumers are generally the subject of a compulsory assessment or treatment order.
T03	Mental health acute inpatient occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health acute inpatient service. These 24-hour care and treatment services are provided to people experiencing severe acute symptoms, requiring intensive input for a short period of time.
T04	Mental health sub-acute inpatient occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health sub-acute inpatient service. These 24-hour care and treatment services are provided to manage unwell people, requiring less intensive input for a longer period of time.
T05	Mental health crisis respite care occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health crisis respite care service. Home-based or residential services are provided as an option for people who would otherwise require admission to acute inpatient mental health services.

Code	Description	Code Valid From	Code Valid To	Note
T06	Mental health individual treatment attendances	01-01-1900	30-06-2008	<p>Individual assessment, treatment, care planning, review and discharge services. Family/ whānau or significant others may be present.</p> <p>Note:</p> <p>A. <i>Whānau/family or couple therapy contacts should be coded as T32.</i></p> <p>B. <i>Listed here for historical reference only.</i></p> <p>C. <i>T06 is retired as from 1 July 2008. Replaced by;</i></p> <p>i. <i>T36 for Family/whānau or significant others present for assessment, treatment, care planning, review and discharge services.</i></p> <p>ii. <i>T42 for Individual assessment, treatment, care planning, review and discharge services.</i></p> <p>Note:</p> <p><i>Retired 1 July 2008. Listed in this table for Historical reference purposes only.</i></p>
T07	Mental health group programme attendances	01-01-1900	30-06-2011	Assessment, treatment, care planning, review and discharge services provided in a group setting.
T08	Mental health care co-ordination contacts	01-01-1900	30-06-2011	Significant contact between mental health professionals and other agencies/persons relating to the care of a consumer, to ensure continuity of service provision, where the mental health service is the lead agency. Consumer generally not present.
T09	Early psychosis intervention attendances	01-01-1900	30-06-2011	Assessment and treatment services provided to people experiencing a first psychotic illness, aimed at minimising the risk of chronicity.
T10	Support needs assessment attendances	01-01-1900	30-06-2011	Comprehensive assessment and review of consumer's living and support needs; the goal being return to optimal levels of functioning.
T11	Mental health maximum secure inpatient occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health maximum secure inpatient service. These 24-hour care and treatment services are provided to eligible people who require higher levels of observation and intensive treatment and/or secure care over longer periods than can be provided in medium secure units.
T12	Mental health medium secure inpatient occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health medium secure inpatient service. These 24-hour care and treatment services are provided to eligible people who are in need of more intensive assessment and/or treatment than can be provided in a less secure setting.

Code	Description	Code Valid From	Code Valid To	Note
T13	Mental health minimum secure inpatient occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health minimum secure inpatient service. These 24-hour care and treatment services are provided for eligible persons as part of recovery oriented process.
T14	Mental health forensic pre-discharge hostel occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health forensic pre-discharge hostel. These 24-hour care and treatment services are provided in a step-down facility within forensic services and usually within the hospital site.
T15	Court liaison attendances	01-01-1900	30-06-2011	Attendance at court by a staff member to provide advice, assessment and referral in respect of a consumer.
T16	Substance abuse detoxification occupied bed days (medical)	01-01-1900	30-06-2011	Time spent by a consumer in a medical substance abuse detoxification service. These 24-hour care and detoxification services are provided by or on behalf of contracted alcohol and drug providers or facilities in an inpatient setting.
T17	Substance abuse detoxification attendances (social)	01-01-1900	30-06-2011	Detoxification services provided by or on behalf of contracted alcohol and drug providers or facilities in a community setting.
T18	Methadone treatment specialist service attendances (consumers of specialist services)	01-01-1900	30-06-2011	Treatment or counselling services provided by staff from an alcohol and drug treatment provider or facility for people receiving methadone under specialist A&D service case management (excludes consumers of authorised GPs).
T19	Methadone treatment specialist service attendances (consumers of authorised GP's)	01-01-1900	30-06-2011	Treatment or counselling services provided by staff from an alcohol and drug treatment provider or facility for people receiving methadone prescribed by GPs under specialist service authority, while receiving case management from specialist A&D services.
T20	Substance abuse residential service occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a substance abuse residential service. These 24-hour care and treatment services are provided to people with particular requirements unable to be met in less structured or supported settings.
T21	Psychiatric disability rehabilitation occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a mental health psychiatric disability rehabilitation unit.
T22	Mental health day treatment programme attendances	01-01-1900	30-06-2011	Provision of non-residential assessment, treatment and recovery oriented rehabilitative programme services to non-inpatient consumers requiring specialised programmes and/or more intensive care than can be provided within outpatient services.

Code	Description	Code Valid From	Code Valid To	Note
T23	Mental health day activity programme attendances	01-01-1900	30-06-2011	Provision of non-residential therapeutic, recreational, social or other related programmes to non-inpatient consumers.
T24	Work opportunities programme attendances	01-01-1900	30-06-2011	Services provided to assist consumers to obtain, maintain or advance in employment
T25	Community mental health residential level 1 occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in level 1 community residential home. Brief/daily support provided by experienced non-clinical staff.
T26	Community mental health residential level 2 occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in level 2 community residential home. 24-hour support provided by non-clinical staff. May include sleepovers.
T27	Community mental health residential level 3 occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in level 3 community residential home. 24-hour support provided predominantly by non-clinical staff with some clinical staff available short term (day hours/sleep over).
T28	Community mental health residential level 4 occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in level 4 community residential home. 24-hour intensive support provided by a mix of clinical/non-clinical staff.
T29	Community mental health residential long-term occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in long-term community residential home. 24-hour support for consumers with complex needs over long term.
T30	Respite care occupied bed days	01-01-1900	30-06-2011	Time spent by a consumer in a respite care service or receiving home based respite care. For use by people who require a short break from their usual living situation (usually planned).
T31	Home based care contacts	01-01-1900	30-06-2008	Non-clinical support services provided to consumers with a psychiatric disability to enable them to stay in their own homes. Note: <i>Retired 1 July 2008. Listed in this table for Historical reference purposes only.</i>

Code	Description	Code Valid From	Code Valid To	Note
T32	Mental health contact with family/whānau	01-07-2002	30-06-2011	<p>Time spent in contact with family/whānau or significant other discussing family/whānau issues related to the treatment /care /management of the service user, engaging in couple or family therapy.</p> <p>Note: A. The service user is not present. B. <i>This excludes;</i> i. <i>Situations where family/whānau members accompany the service user to support them (coded T09, T36 or T43), whichever applies</i> ii. <i>Treatment to be coded T01.</i> iii. <i>Care coordination (e.g. family group conferences and strengthening families meetings), to be coded T08.</i></p>
T33	Seclusion	01-07-2008	30-06-2011	The placing of a consumer, at any time and for any duration, alone in a room or area from which they cannot freely exit.
T34	ECT	01-07-2008	30-06-2011	Electro Convulsive Therapy
T35	Did not attend	01-07-2008	30-06-2011	The consumer did not participate in the activity
T36	Mental health treatment attendances with Whānau/family present	01-07-2008	30-06-2011	<p>Assessment, treatment, care planning, review and discharge services (provided for less than 3 hours) in conjunction with either or both Family/whānau and/or significant other present.</p> <p>Note: <i>T36 replaces MHINC T06 services with whānau/family being present)</i></p>
T37	On leave	01-07-2008	30-06-2011	The absence of a consumer from the healthcare/support facility to which they were most recently admitted/entered. Leave is reported only where that consumer is absent at midnight
T38	Māori specific interventions only	01-07-2008	30-06-2011	<p>Application of Māori models of practice, traditional and contemporary, which recognise the value of culture to the healing process including whakawhānaungatanga and increased access to te ao Māori incorporating but not limited to: purakau; mau rakau; waiata; te reo; raranga; karakia; whakapapa; mirimiri and rongoa.</p> <p>This would also include services provided by tohunga, kaumatua, kuia, Māori staff and Māori cultural advisors.</p>

Code	Description	Code Valid From	Code Valid To	Note
T39	Integrated Māori and clinical interventions	01-07-2008	30-06-2011	<p>In addition to receiving mainstream clinical interventions and services, the client also received integrated Māori specific services and clinical interventions (For example, application of Māori Models of practice, traditional and contemporary, which recognise the value of culture to the healing process including, but not limited to whakawhānaungatanga and increased access to te ao Māori, incorporating but not limited to: purakau; mau rakau; waiata; te reo; raranga; karakia; whakapapa; mirimiri; and rongoa. This would also include services provided by tohunga, kaumatua, kuia, Māori staff and Māori cultural advisors.</p> <p>It would also include those clinical interventions that are supported by a western approach such as Bio-medical, etc).</p>
T40	Pacific peoples cultural activity	01-07-2008	30-06-2011	Activity involving Pacific consumers which relates to the application of traditional and contemporary Pacific peoples cultural practices, processes and models of assessment, treatment and healing with appropriate and increased access to Pacific peoples families, communities and services.
T41	Other cultural specific activity	01-07-2008	30-06-2011	Application of other cultural models of practice, traditional and contemporary, which recognise the value of culture to the healing process.
T42	Mental health individual treatment attendances: Whānau/family not present	01-07-2008	30-06-2011	<p>Individual assessment, treatment, care planning, review and discharge services. Neither Family/whānau nor significant other are present.</p> <p>Note: T42 replaces MHINC T06 individual services without whānau/family being present.</p>
T43	Community Support Contacts	01-07-2008	30-06-2011	Support services provided to consumers with a mental illness and/or addiction to support/facilitate engagement with community, including accessing and maintaining accommodation, employment and social activity.
T44	Advocacy	01-07-2008	30-06-2011	Advocacy which enhances consumer empowerment and upholds the legal rights of consumers
T45	Peer Support	01-07-2008	30-06-2011	Formal and informal support such as peer support networks and information, access to life skills programmes, community resources and services.

2.4.1.2 Activity Setting

The 'Activity Setting' indicates the type of physical setting or contact channel that the activity was provided in. See table below:

Code	Description	Code Valid From	Code Valid To	Note
AV	Audio Visual	01-07-2002	30-06-2011	Services provided over a television or video-conference link.
CM	Community	01-01-1900	30-06-2011	Service provided to a consumer in a non-hospital setting which is not specifically covered by any of the other definitions.
CO	Non-Māori cultural setting	01-01-1900	30-06-2008	Services provided in a cultural setting which is not Kaupapa Māori. Note: <i>Retired 1 July 2008. Listed in this table for Historical reference purposes only.</i>
CR	Community Residential	01-01-1900	30-06-2011	Services provided in mental health residential settings that are deemed to be community not domiciliary
CT	Court	01-01-1900	30-06-2011	Services provided in a Court, including when the Court is held at the healthcare agency.
DM	Domiciliary	01-01-1900	30-06-2011	Services provided to a consumer in their own home or place of residence.
DP	Day consumer setting	01-01-1900	30-06-2011	Services provided to day consumers at a day hospital on a hospital site.
ED	Emergency Department	01-01-1900	30-06-2011	Services provided in a hospital-based emergency department.
IP	Inpatient	01-01-1900	30-06-2011	Services provided in a hospital setting while the consumer is an inpatient.
MC	Māori cultural setting	01-01-1900	30-06-2011	Services provided in a setting working under kaupapa Māori.
NP	Non-psychiatric	01-01-1900	30-06-2011	Services provided in other parts of hospital.
OL	Other Location	01-07-2003	30-06-2008	Services provided in a location that is not specifically covered by any of the other definitions. Note: <i>Retired 1 July 2008. Listed in this table for Historical reference purposes only.</i>
OP	Outpatient	01-01-1900	30-06-2003	Services provided in a hospital psychiatric outpatient service. Note: <i>Retired 1 July 2008. Listed in this table for Historical reference purposes only.</i>
OS	Onsite	01-07-2003	30-06-2011	Services provided in a mental health or alcohol and drug service that is the clinicians place of work, not specifically covered by any of the other definitions.
PH	Telephone	01-07-2002	30-06-2011	Services provided where the contact with the service user is a clinically significant telephone call.
PR	Prison	01-01-1900	30-06-2011	Services provided in a Prison, including police cells.

Code	Description	Code Valid From	Code Valid To	Note
RE	Residential	01-07-2003	30-06-2011	Services provided in a community-based residential rehabilitative mental health or alcohol and drug service.
RU	Rural	01-01-1900	30-06-2011	Services provided in a community-based rural rehabilitative mental health or alcohol and drug service.
SM	SMS text messaging	01-07-2008	30-06-2011	Services provided via SMS cellular communications text messaging.
WR	Written correspondence	01-01-1900	30-06-2011	Services provided via letter, fax or email.

2.5 Legal Status (LS) Record Code Sets

2.5.1 Legal Status Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Legal Status' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) File Version	2.5.1.1	(b) Legal Status Code	2.5.1.2
(c) Sex	2.2.1.1		

2.5.1.1 File Version

A code indicating which version of the PRIMHD file specification that the data elements in the organisations extract file are compliant with.

Code	Description	Code Valid From	Code Valid To	Note
1.0	Version 1.0	01-07-2008	30-06-2009	
2.0	Version 2.0	01-07-2009	30-06-2011	

2.5.1.2 Legal Status Code

Code describing a consumer's legal status under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Criminal Procedure (Mentally Impaired Persons) Act 2003, or the Criminal Justice Act 1985.

The table below lists all the current Legal Status codes that were applicable as at the date this standard was published. For a full list of all Legal Status Codes, including those historical codes retired prior to this standard being published, please refer to the following website address.

<http://www.nzhis.govt.nz/documentation/codetables/nmdstab30.html>

Legal Status Code	Legal Status Code Description	Legislation Commencement date	Legislation Conclusion date	Used for/Comment
CA	Alcohol & Drug Addiction Act, Section 21	01-01-1900		No change. Transfer from penal institution.
CB	Alcohol & Drug Addiction Act, Section 8	01-01-1900		No change. Voluntary detention.
CC	Alcohol & Drug Addiction Act, Section 9	01-01-1900		No change. Court ordered.
CK	Mental Health Act, Section 29	01-01-1900		No change. Community order.
CL	Mental Health Act, Section 30	01-01-1900		No change. Inpatient order.
DA	IDCCR Act Section 35	01-09-2004		New code. Being transferred from penal institution or Mental Health system either for assessment or while the application of the compulsory care order is pending.
DB	IDCCR Act Section 45	01-09-2004		New Code. Compulsory care

Legal Status Code	Legal Status Code Description	Legislation Commencement date	Legislation Conclusion date	Used for/Comment
				order has been given.
DC	CP(MIP) Act Section 24(2)(b) (unfit to stand trial)	01-09-2004		New code. Detained in a secure facility as a special care recipient under the IDCCR Act.
DD	CP(MIP) Act Section 24(2)(b) (insane)	01-09-2004		New code. Detained in a secure facility as a special care recipient under the IDCCR Act.
DE	CP(MIP) Act Section 34(1)(a)(ii)	01-09-2004		New code. Convicted and sentenced to a term of imprisonment and ordered to be detained in hospital as a special care recipient under the IDCCR Act.
HA	Health Act Section 126	01-09-2004		New code. Aged, infirm, or neglected persons who are living in unsanitary conditions or without proper care and attention.
I	Voluntary Patient	01-01-1900	30-06-2008	No change to code. Description changed to Voluntary from Informal. <i>Note:</i> <i>Retired 1 July 2008. Listed in this table for Historical reference purposes only.</i>
MZ	Section 31 Mental Health Act (leave for inpatients)	01-01-1900		No change. Inpatient order but on leave in community.
PA	Parole Act Section 35	01-09-2004		New code. Directs a person to serve sentence on home detention.
RA	CP(MIP) Act Section 38(2)(a)	01-09-2004		New code. Remanded to undergo court ordered assessment on bail.
RB	CP(MIP) Act Section 38(2)(c)	01-09-2004		New code. Remanded to undergo court ordered assessment in hospital.
RC	CP(MIP) Act Section 24(2)(a) (unfit to stand trial)	01-09-2004		New code. Detained in a hospital as a special patient under the Mental Health (CAT) Act.
RD	CP(MIP) Act Section 24(2)(a) (insane)	01-09-2004		New code. Detained in a hospital as a special patient under the Mental Health (CAT) Act.
RE	CP(MIP) Act Section 44(1)	01-09-2004		New code. Detained in a hospital or secure facility pending hearing or trial.
RF	CP(MIP) Act Section 34(1)(a)(i)	01-09-2004		New code. Convicted and sentenced to a term of imprisonment and ordered to be detained in hospital as a special patient under the Mental Health (CAT) Act 1992.

Legal Status Code	Legal Status Code Description	Legislation Commencement date	Legislation Conclusion date	Used for/Comment
RG	CP(MIP) Act Section 23	01-09-2004		New code. Persons found unfit to stand trial or insane undergoing enquiry to determine the most suitable method of dealing with the person under section 24 or section 25.
RH	CP(MIP) Act Section 35	01-09-2004		New code. Court has ordered that inquiries be made to determine the most suitable method of dealing with the person before making an order under section 34
SC	Special, Mental Health Act, Sections 45 and 11	01-01-1900		No change. Special patients from penal institution.
SD	Special, Mental Health Act, Sections 45 and 13	01-01-1900		No change.
SE	Special, Mental Health Act, Section 46	01-01-1900		No change. Imprisoned but accepting voluntary treatment in secure inpatient setting.
SJ	Restricted, Mental Health Act, Section 55	01-01-1900		No change. Restricted patient.
SL	Special, Mental Health Act, Sections 45 and 30	01-01-1900		No change.
SM	Mental Health (CAT) Act Section 11	01-09-2004		New code. Entering 5 day assessment.
SN	Mental Health (CAT) Act Section 13	01-09-2004		New code. Entering 14 day assessment.
SQ	Mental Health (CAT) Act Sections 45 and 15(1)	01-09-2004		New code. Patient transferred from penal institution to hospital for the purposes of assessment or an application is pending in Court for the making of a CTO.
SR	Mental Health (CAT) Act Sections 45 and 15(2)	01-09-2004		New code. Patient transferred from penal institution to hospital for the purposes of assessment and an application is pending in Court for the making of a compulsory treatment order and the judge has extended the assessment period.
SS	Mental Health (CAT) Act Section 15(1)	01-09-2004		New code. Waiting to see judge. CTO applied for.
ST	Mental health (CAT) Act Section 14 (4)	01-Jul-2008		New code. Application to court for making of a compulsory treatment order under part 2 of the act.
TY	Community Order, MHA 29(3)(a) inpatient treatment up to 14 days	01-01-1900		No change. Patient under community order having brief inpatient episode.

2.6 Classification (CN) Record Code Sets

2.6.1 Classification Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Classification' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Clinical Coding System ID	2.6.1.1	(d) Issue Coding System ID	2.6.1.4
(b) Diagnosis Type	2.6.1.2	(e) Issue Type	2.6.1.5
(c) Clinical Code Value	2.6.1.3		

2.6.1.1 Clinical Coding System ID

A code identifying the clinical coding system used for diagnoses and procedures. See table below:

Code	Description	Note
01	ICD-9	
02	ICD-9-CM	
03	Read	
04	ICPC	
05	Continuum AMR codes	
06	ICD9-CMA	
07	DSM-IV	
08	SNOMED CT	For future introduction yet to be determined.
10	ICD-10-AM first edition	
11	ICD-10-AM second edition	
12	ICD-10-AM third edition	
13	ICD 10-AM sixth edition	For introduction from 1 July 2008.

2.6.1.2 Diagnosis Type

A code that groups clinical codes or indicates the priority of a 'Diagnosis'.

The table below lists only those Diagnosis Type codes that are used for Mental Health records. The full list of all Diagnosis Type Codes (aka Event Clinical Code Type Code), including those historical codes retired prior to this standard being published, please refer to the following website address.

<http://www.nzhis.govt.nz/moh.nsf/pagesns/439?Open>

Code	Description	Code Valid From	Code Valid To	Note
A	Principal diagnosis	01-01-1900	30-06-2011	
B	Other relevant diagnosis	01-01-1900	30-06-2011	
P	Mental health provisional diagnosis	01-01-1900	30-06-2011	

2.6.1.3 Clinical Code Value

A code used to classify the condition or issue. Must be a valid code in one of the specified clinical coding systems. The only coding systems currently permitted to be used in PRIMHD are listed below.

- ICD-9-CM 2nd Edition – Australian version of the International Classification of Diseases, 9th Revision, Clinical Modification.
- ICD-10-AM 1st Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition.
- ICD-10-AM 2nd Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition.
- ICD-10-AM 3rd Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition.
- ICD 10-AM 6th Edition, The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition (from 2008).
- SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms), a comprehensive clinical terminology, owned, maintained, and distributed by the international Health Terminology Development Organisation (IHTSDO) (future availability/use to be advised).
- DSM-IV – Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition.

2.6.1.4 Issue Coding System ID

A code identifying the coding system used for issues. See table below:

Code	Description	Note
IS	To be confirmed	Code set to be developed at a later date.

2.6.1.5 Issue Type

A code that groups issue codes or indicates the priority of an issue. See table below:

Code	Description	Code Valid From	Code Valid To	Note
A	Principal issue	01-07-2008	30-06-2011	
B	Other relevant issue	01-07-2008	30-06-2011	
P	Mental health provisional issue	01-07-2008	30-06-2011	

2.7 Collection Occasion (CO) Record Code Sets

2.7.1 Collection Occasion Tool Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Collection Occasion' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Reason for Collection	2.7.1.1	(c) Focus of Care	2.7.1.3
(b) Protocol Version	2.7.1.2		

2.7.1.1 Reason for Collection

The reason for the collection of the standard measures and individual data items on the identified 'Collection Occasion'. See table below:

Code	Description	Code Valid From	Code Valid To	Note
RC01	New Referral for Assessment Only	01-07-2005	30-06-2011	Admission to Mental Health Care (maximum of 2 face-to-face contacts).
RC02	New Referral	01-07-2005	30-06-2011	Admission to Mental Health Care.
RC03	Admitted from other treatment setting	01-07-2005	30-06-2011	Admission to Mental Health Care.
RC04	Admission – other	01-07-2005	30-06-2011	Admission to Mental Health Care.
RC05	3-month Review	01-07-2005	30-06-2011	Review of Mental Health Care.
RC06	Review – other	01-07-2005	30-06-2011	Review of Mental Health Care.
RC07	No further care	01-07-2005	30-06-2011	Discharge from Mental Health Care.
RC08	Discharge to change of treatment setting	01-07-2005	30-06-2011	Discharge from Mental Health Care.
RC09	Discharge – lost to care	01-07-2005	30-06-2011	Discharge from Mental Health Care.
RC10	Death	01-07-2005	30-06-2011	Discharge from Mental Health Care.
RC11	Discharge following brief episode of care	01-07-2005	30-06-2011	Discharge from Mental Health Care (<3 days in inpatient care and <14 days in community care).
RC12	Discharge - other	01-07-2005	30-06-2011	Discharge from Mental Health Care.

2.7.1.2 Protocol Version

The version of the 'Information Collection Protocol' under which the data has been collected and submitted. See table below:

Code	Description	Code Valid From	Code Valid To	Note
0100	Version 1.0	06-10-2004	01-11-2005	MH-SMART
0110	Version 1.1	01-11-2005	01-10-2006	MH-SMART
0120	Version 1.2	01-10-2006	30-06-2011	MH-SMART

2.7.1.3 Focus of Care

A code that indicates what was the 'Focus Of Care' during the preceding period. See table below:

Code	Description	Code Valid From	Code Valid To	Note
FC01	Acute	01-07-2005	30-06-2011	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.
FC02	Functional Gain	01-07-2005	30-06-2011	The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a consumer with impairment arising from a psychiatric disorder.
FC03	Intensive Extended	01-07-2005	30-06-2011	The primary goal is prevention or minimisation of further deterioration and the reduction of risk of harm in a consumer who has a stable pattern of severe symptoms, frequent relapses, and/or a severe inability to function independently, and is judged to require care over an indefinite period.
FC04	Maintenance	01-07-2005	30-06-2011	The primary goal is to maintain the level of functioning, minimise deterioration or prevent relapse where the consumer has stabilised and functions relatively independently.
FC05	Assessment Only	01-07-2005	30-06-2011	The primary goal is only to assess the consumer.
FC08	Not applicable	01-07-2005	30-06-2011	
FC09	Not stated / Missing	01-07-2005	30-06-2011	

2.8 Outcome Tool (OT) Record Code Sets

2.8.1 Outcome Tool Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Outcome Tool' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Outcome Tool Type and Version	2.8.1.1	(c) Collection Status	2.8.1.3
(b) Mode of Administration	2.8.1.2		

2.8.1.1 Outcome Tool Type and Version

A code that identifies the 'Outcome Tool' that is being used for a particular 'Episode of Care'. See table below:

Code	Description	Measure Type	Code Valid From	Code Valid To	Note
A1	HoNOS	Clinical	01-07-2005	30-06-2011	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. <i>British Journal of Psychiatry</i> 174:432-434.
G1	HoNOS65+	Clinical	01-07-2005	30-06-2011	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+). <i>British Journal of Psychiatry</i> 174:424-427.
S1	HoNOS Secure	Clinical	01-07-2005	30-06-2011	As described in HoNOS-secure version 1, December 2002. Authors: Dr Philip Sugarman and Lorraine Walker, c/o St Andrew's Hospital, Billing Road, Northampton, NN1 5DG.
L1	HoNOS LD	Clinical	01-07-2005	30-06-2011	HoNOS for people with learning disabilities as described by Ashok Roy, Helen Matthews, Paul Clifford, Vanessa Fowler and David M Martin: Health Of the Nations Outcome Scales for People with Learning Disabilities, Glossary for HoNOS-LD Score sheet. NOTE: Collected on SMA forms only (Age Group = 2 and 3) on the collection table and defaulted to the measures tables.
C1	HoNOSCA	Clinical	01-07-2005	30-06-2011	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. <i>British Journal of Psychiatry</i> 174:428-433.

2.8.1.2 Mode of Administration

The procedure or method used in the ascertainment and recording of the standard measure. See table below:

Code	Description	Code Valid From	Code Valid To	Note
MA01	Clinical rating completed following clinical assessment	01-07-2005	30-06-2011	
MA02	Clinical rating completed without clinical assessment (e.g. consumer unable to be located)	01-07-2005	30-06-2011	
MA03	Self-report completed by consumer using a paper and pencil format	01-07-2005	30-06-2011	
MA04	Self-report completed by consumer using a computer-based format	01-07-2005	30-06-2011	
MA05	Self-report read to consumer by clinician	01-07-2005	30-06-2011	
MA06	Self-report read to consumer by translator	01-07-2005	30-06-2011	
MA08	Not applicable (collection not required due to protocol exclusion or not collected for other reasons or refusal for a consumer measure)	01-07-2005	30-06-2011	
MA09	Not stated / Missing	01-07-2005	30-06-2011	

2.8.1.3 Collection Status

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

Code	Description	Code Valid From	Code Valid To	Note
CS01	Complete or partially complete	01-07-2005	30-06-2011	Clinician/Consumer
CS02	Not completed due to temporary contraindication (applies only to self-report measures)	01-07-2005	30-06-2011	Consumer
CS03	Not completed due to general exclusion (applies only to self-report measures)	01-07-2005	30-06-2011	Consumer
CS04	Not completed due to refusal by consumer (applies only to self-report measures)	01-07-2005	30-06-2011	Consumer
CS07	Not completed for reasons not elsewhere classified	01-07-2005	30-06-2011	Clinician/ Consumer
CS08	Not completed due to protocol exclusion (e.g. Collection not required at admission immediately following inpatient discharge)	01-07-2005	30-06-2011	Clinician
CS09	Not stated/Missing	01-07-2005	30-06-2011	Clinician/Consumer

2.9 Outcome Item (OI) Record Code Sets

2.9.1 Outcome Item Record coded data elements

The following table lists the data elements and the applicable code sets to be used when creating a 'Outcome Item' record. This includes those data element code sets that have been previously detailed within this standard. Data element code sets that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Outcome Tool Type and Version	2.8.1.1	(c) Outcome Item Value	2.9.1.2
(b) Outcome Item Code	2.9.1.1		

2.9.1.1 Outcome Item Code

A coded identifier that indicates the 'Outcome Measure Item' that is being measured. See table below:

Measure	Code	Description
HoNOS	01	Overactive, aggressive, disruptive or agitated behaviour.
	02	Non-accidental self-injury.
	03	Problem drinking or drug-taking.
	04	Cognitive problems.
	05	Physical illness or disability problems.
	06	Problems associated with hallucinations and delusions.
	07	Problems with depressed mood.
	08	Other mental and behavioural problems.
	08a	The type or kind of problem rated in Item 8.
	09	Problems with relationships.
	10	Problems with activities of daily living.
	11	Problems with living conditions.
	12	Problems with occupation and activities.
	S1	Behavioural problems summary score.
	S2	Impairment summary score.
	S3	Delusions/Hallucinations problems summary score.
	S4	Depression problems summary score.
S5	Social problems summary score.	
T10	Total (10 Items) 1-10.	
T12	Total (12 Items) 1-12.	
HoNOS65+	01	Behavioural disturbance (e.g. over-active, aggressive, disruptive, agitated, uncooperative or resistive behaviour).
	02	Non-accidental self-injury.
	03	Problem drinking or drug-taking.
	04	Cognitive problems.
	05	Physical illness or disability problems.
	06	Problems associated with hallucinations and delusions.
	07	Problems with depressive symptoms.
	08	Other mental and behavioural problems.
	08a	The type or kind of problem rated in Item 8.
	09	Problems with relationships.
	10	Problems with activities of daily living.
	11	Problems with living conditions.
	12	Problems with occupation and activities.
S1	Behavioural problems summary score.	

Measure	Code	Description
	S2	Impairment summary score.
	S3	Delusions/Hallucinations problems summary score.
	S4	Depression problems summary score.
	S5	Social problems summary score.
	T10	Total (10 Items) 1-10.
	T12	Total (12 Items) 1-12.
HoNOSCA	01	Problems with disruptive, antisocial or aggressive behaviour.
	02	Problems with over-activity, attention or concentration.
	03	Non-accidental self-injury.
	04	Problems with alcohol, substance or solvent misuse.
	05	Problems with scholastic or language skills.
	06	Physical illness or disability problems.
	07	Problems associated with hallucinations, delusions or abnormal perceptions.
	08	Problems with non-organic somatic symptoms.
	09	Problems with emotional and related symptoms.
	10	Problems with peer relationships.
	11	Problems with self-care and independence.
	12	Problems with family life and relationships.
	13	Poor school attendance.
	14	Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the period rated).
	15	Problems with lack of information about services or management of the child or adolescent's difficulties.
	S1	Behavioural problems summary score.
	S2	Impairment summary score.
	S3	Symptomatic problems summary score.
	S4	Social problems summary score.
	S5	Information problems summary score.
	T13	HoNOSCA Total (13 Item) score.
	T15	HoNOSCA Total (15 Item) score.
	HoNOS LD	01
02		Behavioural problems directed at self (self-injury).
03		Other mental and behavioural problems.
03a		Most prominent behaviour type.
04		Attention and concentration.
05		Memory and orientation.
06		Communication (problems with understanding).
07		Communication (problems with expression).
08		Problems associated with hallucinations and delusions.
09		Problems associated with mood changes.
10		Problems with sleeping.
11		Problems with eating and drinking.
12		Physical problems.
13		Seizures.
14		Activities of daily living at home.
15		Activities of daily living outside the home.
16		Level of self-care.
17		Problems with relationships.
18	Occupation and activities.	
T18	Total HoNOS LD (18 Item) 1-18 (excl. 3a).	

Measure	Code	Description
HoNOS Secure	SA	Potential harm to others.
	SB	Potential self-harm and self-neglect.
	SC	Need for building security.
	SD	Need for safety – staff living environment.
	SE	Need for escort on leave.
	SF	Potential harm from others.
	SG	Need for special clinical procedures.
	TS7	Total HoNOS Secure (7 Items) 1-7.

2.9.1.2 Outcome Item Value

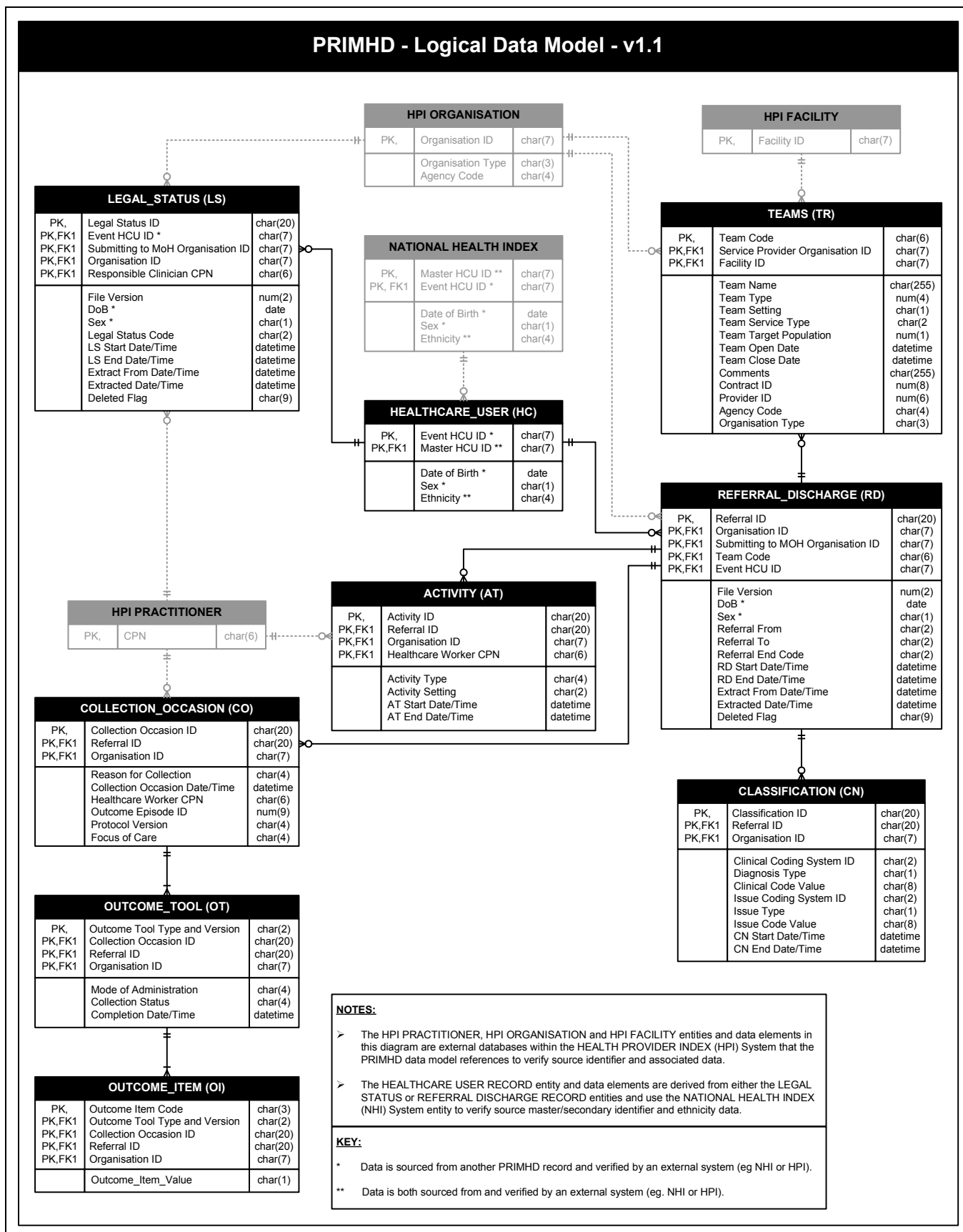
A code that indicates the consumers 'Outcome Score' for a particular Item measured as per the protocol for a particular measurement tool. See table below::

Tool	Code	Description	Code Valid From	Code Valid To	Note
HoNOS	0	No problem within the period rated	01-07-2005	30-06-2011	
HoNOS65+	1	Sub-threshold problem	01-07-2005	30-06-2011	
	2	Mild but definitely present	01-07-2005	30-06-2011	
HoNOSCA	3	Moderately severe	01-07-2005	30-06-2011	
HoNOS LD	4	Severe to very severe	01-07-2005	30-06-2011	
	7	Unable to rate (insufficient information)	01-07-2005	30-06-2011	
HoNOS Secure	8	Not applicable (collection not required due to protocol exclusion or not collected for other reasons)	01-07-2005	30-06-2011	
	9	Not stated/missing	01-07-2005	30-06-2011	
HoNOS (Outcome item code 08a only)	A	Phobic	01-07-2005	30-06-2011	
	B	Anxiety	01-07-2005	30-06-2011	
	C	Obsessive-compulsive	01-07-2005	30-06-2011	
	D	Stress	01-07-2005	30-06-2011	
HoNOS 65+ (Outcome item code 08a only)	E	Dissociative	01-07-2005	30-06-2011	
	F	Somatoform	01-07-2005	30-06-2011	
	G	Eating	01-07-2005	30-06-2011	
HoNOS Secure (Outcome item code 08a only)	H	Sleep	01-07-2005	30-06-2011	
	I	Sexual	01-07-2005	30-06-2011	
	J	Other	01-07-2005	30-06-2011	
	X	Not Applicable	01-07-2005	30-06-2011	
	Z	Not Stated/Missing	01-07-2005	30-06-2011	
HoNOS LD (Outcome item code 03a only)	A	Behaviour destructive to property	01-07-2005	30-06-2011	
	B	Problems with personal behaviours	01-07-2005	30-06-2011	for example, spitting, smearing, eating rubbish, self-induced vomiting, continuous eating or drinking, hoarding rubbish, inappropriate sexual behaviour

Tool	Code	Description	Code Valid From	Code Valid To	Note
	C	Rocking, stereotyped and ritualistic behaviour	01-07-2005	30-06-2011	
	D	Anxiety, phobias, obsessive or compulsive behaviour	01-07-2005	30-06-2011	
	E	Others	01-07-2005	30-06-2011	
	X	Not Applicable	01-07-2005	30-06-2011	
	Z	Not Stated/Missing	01-07-2005	30-06-2011	

APPENDIX A LOGICAL DATA MODEL

The following diagram is an informative representation of the Logical Data Model for the PRIMHD Operational Data Store only. Details of the physical entity relationship diagram for the PRIMHD Datamart are in Appendix B of the PRIMHD File Specification v1.4



APPENDIX B GLOSSARY

The following definitions are integral to the understanding of this document.

Term	Definition
Admission/Admitted	In the case of mental health and addiction, this does not mean the admission of a recipient to a facility. It is where a recipient is accepted for treatment by a service, either by way of an inpatient admission, or with outpatient services.
CLIC	Client Information Collection database.
Recipient	A person who accesses publicly funded healthcare. This person may be referred to elsewhere as a 'Healthcare User', 'Client' or 'Patient'.
CPN	Common Person Number.
DAMHS	Director of Area Mental Health Services.
Data Element	An atomic piece of data, e.g. first name, last name etc.
Data Group	Group of data elements of related data, e.g. recipient identification, demographic data.
Data Set	Collection of data groups, used for specific purposes, e.g. referral data set, exit data set.
Data Source	An organisation (usually) or authorised person that supplies data about a practitioner, health worker, organisation or facility to the HPI.
DHB	District Health Board.
Exit	The relinquishing of recipient care/support in whole or in part by a healthcare provider or organisation. There are two common types of exit: (a) Administrative exit, and (b) Clinical exit. In other settings, 'Exit' may be referred to as 'Discharge'.
Exit Referral	A referral occurring in the context of exit and comprising a referral with an attached exit summary.
Exit Summary	A collection of information, reported by a provider or organisation, about events at the point of exit.
Facility	A single physical location from which health goods and/or services are provided.
Health Practitioner Index (HPI)	A centrally managed system that is used to collect and distribute practitioner, health worker, organisation and facility data. The HPI will facilitate the timely and secure exchange of health information, ensure the accurate and unique identification of practitioners, health workers, organisations and facilities and offer operational support for health organisations that use that data and provide information of interest to the public. Data is supplied by authorised data sources and distributed to authorised recipients. The Ministry of Health (as the HPI Administrator) manages the HPI.
Health Professional	A person who is, or is deemed to be, registered with an authority established or continued by section 114 of the HPCA Act 2003, as a practitioner of a particular health profession.
Health Worker	A person not registered with a responsible authority who works within the health sector.
Healthcare Provider	A person or organisation that provides recipient health care services.

Term	Definition
Healthcare User	A person who accesses publicly funded healthcare, this person may also be referred to as a 'Recipient', 'Client' or 'Patient'.
HoNOS	Health of the Nation Outcome Scales.
HoNOS - LD	Health of the Nation Outcome Scales – Learning Disabilities.
HoNOS - Secure	Health of the Nation Outcome Scales for users of secure services.
HoNOS65+	Health of the Nation Outcome Scales (for those over 65 years).
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents.
HPI Administrator	The administrative staff – employed by the MoH – who authorise and maintain data about organisations; and monitor the data quality and consistency in the HPI (this includes practitioner, health worker, organisation, and facility uniqueness).
KPI Project	A Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services
MHINC	Mental Health Information National Collection.
MH-SMART	Mental Health – Standard Measures of Assessment and Recovery
NGO	Non Government Organisation.
National Health Index (NHI)	National Health Index is a centrally managed system that is used to collect and distribute data about Healthcare Users or Recipients. The NHI will facilitate the timely and secure exchange of health information, ensure the accurate and unique identification of recipients and offer operational support for health organisations that use that data and provide information of interest to the public. Data is supplied by authorised data sources and distributed to authorised recipients. The Ministry of Health (as the NHI Administrator) manages the NHI.
NZHS	New Zealand Health Information Service.
Organisation	An entity that provides services of interest to, or is involved in, the business of healthcare service provision. There may be a hierarchical (parent-child) relationship between organisations.
Patient	A person who accesses publicly funded healthcare, this person may also be referred to as a healthcare user, recipient, or client.
Person	An individual person who can assume multiple roles over time. In the HPI, 'person' is synonymous with practitioner, health worker, and user.
PHO	Primary Healthcare Organisation.
Practising Certificate	A practising certificate issued by the relevant authority (Responsible Authority) under section 26(3) or section 29(4), or deemed to have been issued under section 191(2), of the Health Practitioners Competence Assurance Act 2003. This may be issued annually or for a shorter interim period.
Practitioner	A person who is, or is deemed to be, or has been registered with, a Responsible Authority as a practitioner of a particular health profession under the HPCA Act 2003.
PRIMHD	Project for the Integration of Mental Health Data
Privacy	The right of an individual to control access to and distribution of, information about themselves.
Referral	Referral may take several forms, most notably: <ul style="list-style-type: none"> (a) request for management of a problem or provision of a service, e.g. a request for an investigation, intervention or treatment. (b) notification of a problem with the hope, expectation or imposition of its management, e.g. an exit summary in a setting, which

Term	Definition
	<p>imposes care/support responsibility on the recipient.</p> <p>The common factor in all referrals is a communication whose intent is the transfer of care/support, in part or in whole.</p>
Referred To Healthcare Provider	The healthcare team/provider to which a recipient has been referred for advice or treatment by a referring healthcare provider. The 'Referred To Healthcare Provider' may be an individual or facility.
Referring Healthcare Provider	The healthcare team/provider that is referring the recipient for advice or treatment. The referring team/provider generally has primary care responsibilities for the recipient. Typically, the referring team/provider will be a General Practitioner, but may be a referred to healthcare team/provider (see Referring Specialist).
Referring Specialist	A 'Referred To Healthcare Provider' who is referring a recipient for advice or treatment, but not back into the care/support of the 'Referring Healthcare Provider'.
Relationship	The HPI will be able to record one or more relationships between practitioner, health worker, organisation and facility records.
Service Provider	Any service that provides mental health and addiction services, including, but not limited to: NGOs; DHB Provider Arms; PCP; PHOs; other community agencies.
Specialist	See 'Referred To Healthcare Provider' and 'Referring Healthcare Provider', above. In the context of referrals, clinical status reports and exit summaries, a specialist is an individual, not a facility.
Team	A team consisting of a person or functionally discrete grouping of people providing mental health and addiction services within a service provider.

APPENDIX C BIBLIOGRAPHY

Details of established data definitions or guidelines for data elements that have been cited in this standard are:

AS/NZS 7799.2:2000 Information security management, Part 2: Specification for information security management systems: This standard forms the basis for an assessment of the information security information management systems (ISMS) of a whole, or part, of an organisation. It may be used as a basis for formal certification. This standard was formerly known as AS 4444.2:2000. AS/NZS 7799 should be read in conjunction with AS/NZS ISO/IEC 17799.

AS/NZS ISO/IEC 17799:2001 Information technology - Code of practice for information security management: Provides recommendations for information security management for use by those who are responsible for initiating, implementing or maintaining security in their organisation. It is helpful in developing organisational security standards and effective security management practice.

New Zealand Privacy Commissioner Web Site <www.privacy.org.nz>: Details current Commonwealth privacy legislation, regulations, codes, principles, and other privacy information/links relevant for New Zealand, for both the public and private sectors.

Health Level Seven (HL7): Is an international health data messaging standard published by Health Level Seven Inc. (Ann Arbor, USA). The standard provides guidance for data exchange formats and unification of software interfaces for administrative and clinical data. AS 4700 provides an implementation standard for Australia for this international HL7 Standard. See also Section 4 'Messaging' and www.hl7.org

Statistics New Zealand Country Code List (NZSCC99): Lists all countries with a four digit identification number.

NZHS Mental Health Information National Collection Data Dictionary (version 3.8) July 2006: Provides the business and data element rules for the current MHINC system.

MHRD New Zealand Mental Health Standards and Measures of Assessment and Recovery (MH-SMART) Initiative – Information Collection Protocol v1.1: Provides business rules, protocols, that were developed as part of the MH-SMART project.

HDZ 10011/PPC Referrals, Status and Discharge Business Process Standard (Pre Public Comment Draft): Provides guidance on business processes relating to a Recipients passage through the health sector.