

# Profile of specialised mental health care facilities

Specialised mental health care is delivered in and by a range of specialised facilities in Australia including [public](#) and [private](#) psychiatric hospitals, [psychiatric units or wards](#) in [public acute hospitals](#), [community mental health care services](#) and [government](#) and [non-government-operated residential mental health services](#).

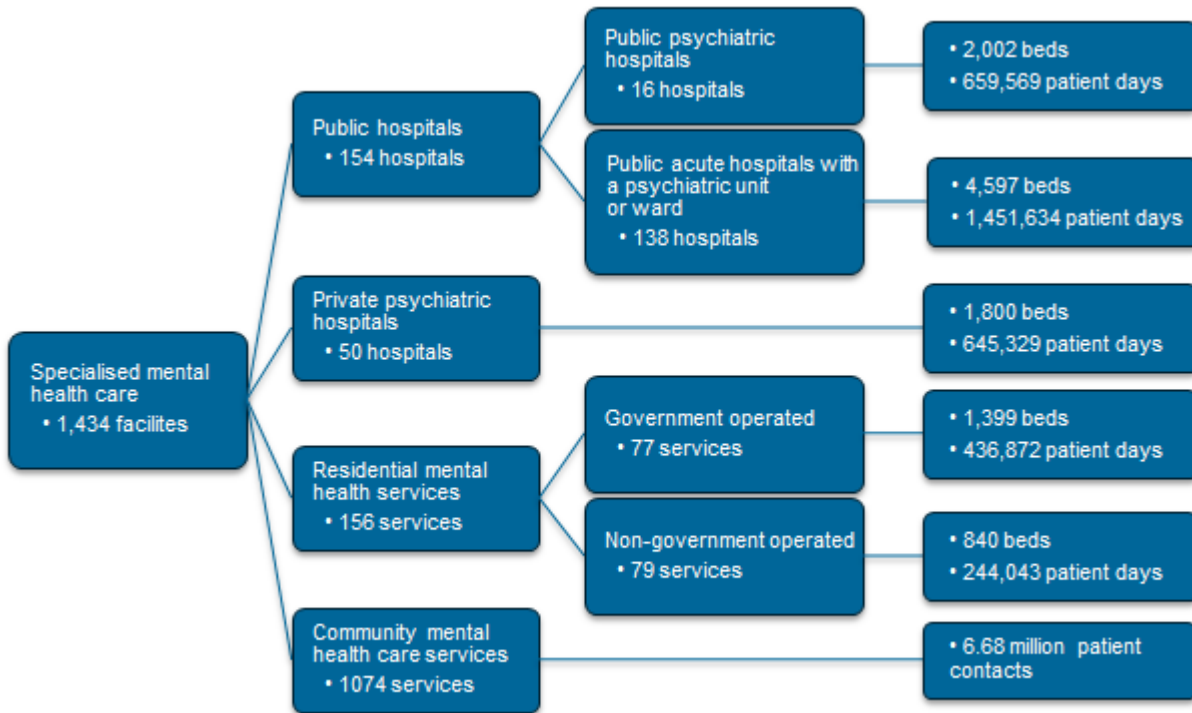
The information presented in this section is drawn primarily from the National Mental Health Establishments Database. For more detail about this and the other data used in this section see the [data source](#) section.

## Key points

- There were 1,434 facilities across Australia providing specialised mental health services during 2009–10.
- Specialised mental health services for admitted patients were provided by 154 public hospitals during 2009–10. These facilities employed nearly 14,000 full-time-equivalent staff, had 6,599 specialised mental health beds available, and provided care to admitted patients for over 2.1 million patient days. In addition, 50 private hospitals delivered specialised mental health services, providing 1,800 specialised mental health service beds.
- There were 2,239 residential mental health service beds available during 2009–10, with over one-third operated by non-government organisations.
- Public sector community mental health services employed over 40% of all staff across public sector specialised mental health services during 2009–10.
- The proportion of specialised mental health organisations employing consumer and carer consultants increased between 2005–06 (31.4% and 10.5% respectively) and 2009–10 (45.2% and 31.0% respectively).

## Overview

There were 1,434 specialised mental health care facilities providing care in 2009–10 (Figure 12.1). There has been a shift in the proportion of the various types of facilities providing specialised mental health services across Australia between 2005–06 and 2009–10, reflecting the implementation of jurisdictional policies on the provision of mental health services. The number of public hospitals providing specialised mental health services has remained stable; however, the number of non-government operated residential mental health services increased by an annual average of 8.0% between 2005–06 and 2009–10.



**Figure 12.1: Number of specialised mental health care facilities, available beds and activity in Australia, 2009–10**

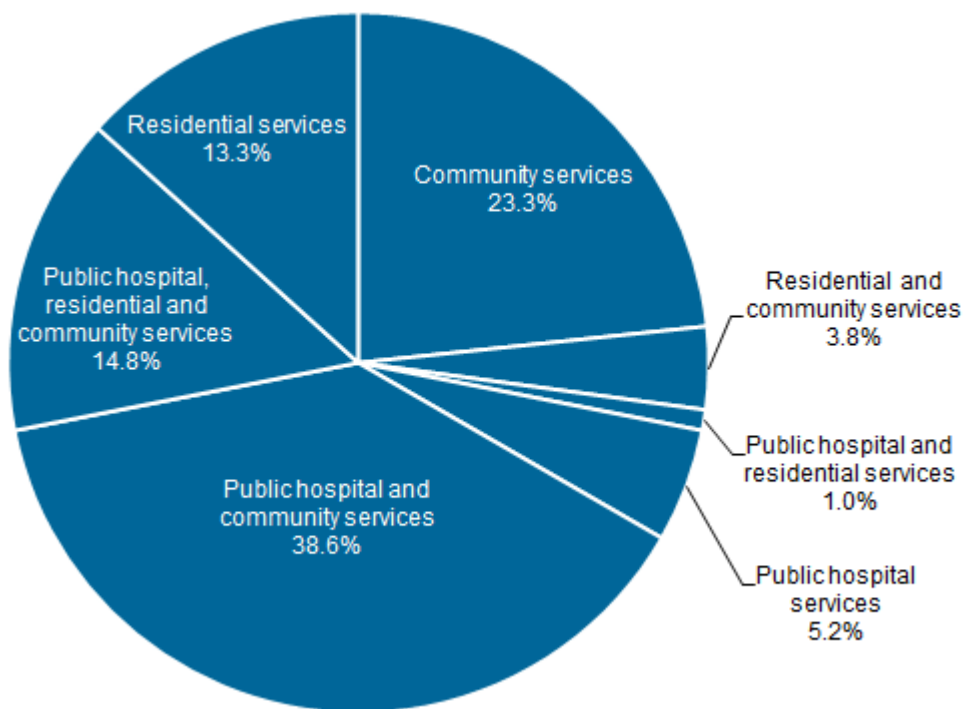
**Reference**

ABS (Australian Bureau of Statistics) 2011. Private hospitals, Australia 2009–10. Canberra: ABS. Viewed May 2012, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4390.0>

## Specialised mental health service organisations

There were 210 [specialised mental health service organisations](#) responsible for the administration of the 1,384 public sector state and territory specialised mental health facilities during 2009–10 (Figure 12.2). These organisations are equivalent to the area health services or district mental health services in most states and territories.

The most common organisation type comprised specialised mental health public hospital service(s) and community mental health care service(s) only (81 organisations or 38.6%). These organisations accounted for over half of the [beds](#) and patient days in specialised mental health public hospital services and 46.1% of all community mental health care services.



*Note:* Public hospital includes public psychiatric hospitals and public acute hospitals with a psychiatric unit or ward.

*Source:* National Mental Health Establishments Database.

**Figure 12.2: Specialised mental health organisations, by the type of services managed by the organisation, 2009–10**

## Consumer and carer involvement

Specialised mental health organisations provide the management structures for the employment of [consumer](#) and [carer consultants](#). In addition to employed consultants, specialised mental health organisations report the extent to which [consumer committee representation arrangements](#) are in place.

### Consumer and carer consultant employment

Of the 210 specialised mental health service organisations reported nationally in 2009–10, 95 (45.2%) employed consumer consultants and 65 (31.0%) employed carer consultants. Queensland had the highest proportion of mental health organisations employing consumer consultants (73.9%), while Victoria had the highest proportion of organisations employing carer consultants (54.5%). Specialised mental health organisations in the Australian Capital Territory and the Northern Territory did not employ any consumer or carer consultants during 2009–10.

The proportion of specialised mental health organisations employing consumer consultants has increased between 2005–06 and 2009–10 from 31.4% to 45.2%. The proportion of specialised mental health organisations employing carer consultants increased from 10.5% to 31.0% over the same period.

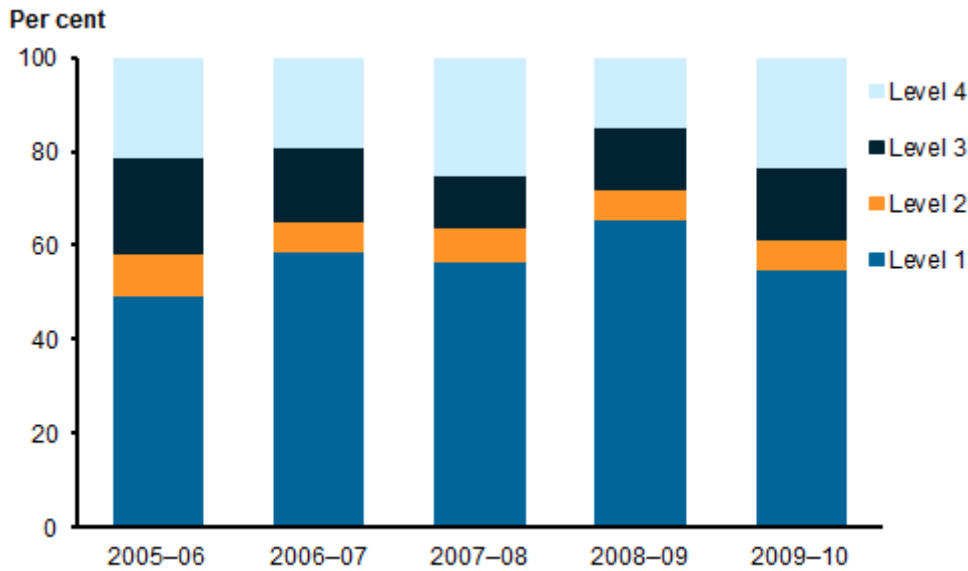
The number of consumer consultants and carer consultants employed, represented as a proportion of [direct care](#) staff, is an important indicator of organisational engagement of consumers and carers in the delivery of mental health services. The number of consumer consultants employed has remained relatively stable between 2005–06 and 2009–10, with 27.8 FTE per 10,000 direct care staff in 2009–10. Over the same period, the number of carer consultants employed has risen to from 7.2 FTE per 10,000 direct care staff to 16.0.

### Consumer committee representation arrangements

In 2009–10, 115 (54.8%) specialised mental health organisations reported that they have a formal position on their organisation's management committee or that a specific consumer advisory committee exists to provide advice on all relevant mental health services managed (level 1)—see the [data sources](#) section for full descriptions of the level. Levels 2–4 represent successively less consumer committee representation within the organisation.

All mental health service organisations in the Northern Territory and the Australian Capital Territory reported level 1 consumer participation arrangements.

The proportion of specialised mental health service organisations with level 1 consumer participation arrangements fluctuated between 2005–06 and 2009–10, with an overall increase from 49.3% during 2005–06 to 54.8% during 2009–10 (Figure 12.3).



**Key**

*Level 4* No consumer representation on any advisory committee; meetings with senior representatives encouraged.

*Level 3* Consumers participate on an advisory committee representing a wide range of interests.

*Level 2* Specific consumer advisory committee(s) exist to advise on some mental health services managed.

*Level 1* Formal consumer position(s) exist on the organisation’s management committee; or specific consumer advisory committee(s) exist to advise on all mental health services managed.

Source: National Mental Health Establishments database.

**Figure 12.3: Number of specialised mental health organisations, by level of consumer committee representation, 2005–06 to 2009–10**

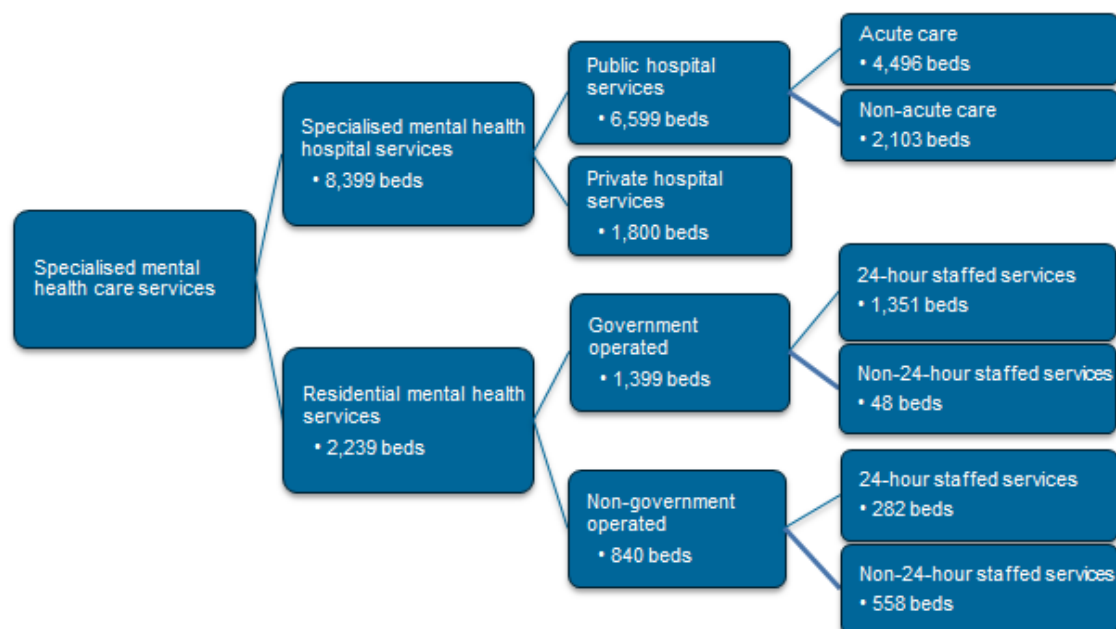
## National Standards for Mental Health Services

Services provided by specialised mental health organisations are measured against the [National standards for mental health services](#). There are eight levels available to describe the degree to which a [specialised mental health service unit](#) meets the National standards for mental health services. See the [data source](#) section for the full description of all eight levels. For reporting purposes, the data presented are restricted to two levels.

The national standards were applicable to 1,449 specialised mental health service units during 2009–10. Of these, 1,219 (84.1%) were externally reviewed and met the standards (level 1). An additional 142 service units (9.8%) were judged to have met some, but not all, of the standards (level 2). The Australian Capital Territory and the Northern Territory were the only jurisdictions to report all service units meeting level 1 standards implementation. Tasmania (12.0%) reported the smallest proportion of service units achieving level 1 or 2 standards implementation.

## Number of specialised mental health beds

There were 10,638 specialised mental health beds available nationally during 2009–10, with 6,599 beds provided by public hospital services, 1,800 beds provided by private hospitals, and an additional 2,239 beds provided by residential mental health services (Figure 12.4).



**Figure 12.4: Specialised mental health beds, 2009–10**

### Public sector specialised mental health hospital beds

There were 6,599 public sector specialised mental health hospital beds available in 2009–10 in Australia. About two-thirds of these beds (69.7% or 4,597 beds) were in specialised psychiatric units or wards within public acute hospitals, while the remaining 2,002 beds were in public psychiatric hospitals.

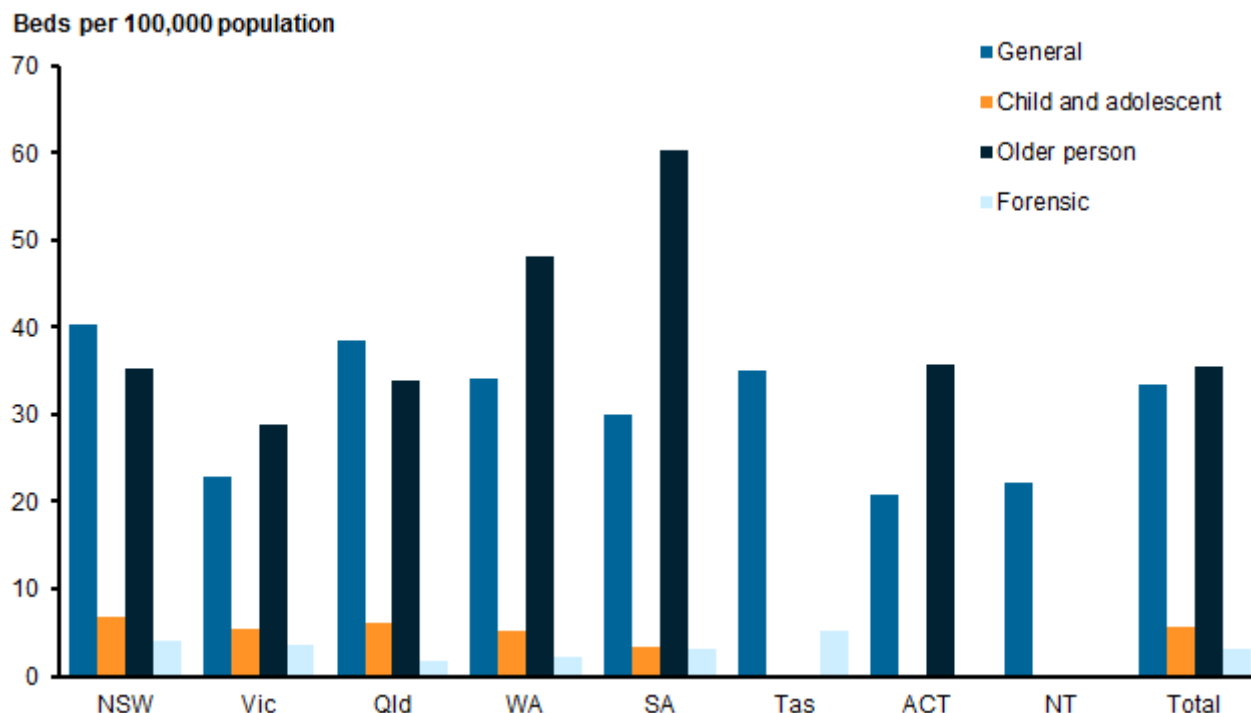
New South Wales (35.2) had the highest number of beds per 100,000 population in 2009–10, while the Northern Territory had the lowest (14.9), compared to the national average of 29.8 beds per 100,000 population.

Public sector specialised mental health hospital beds can be described using [target population](#) categories, [program type](#) categories or a combination of both.

#### Target population

The majority of public sector specialised mental health hospital beds were within *General* services (4,727 or 71.6%) during 2009–10. A further 16.0% of specialised mental health hospital beds were within *Older person* services, 8.2% were in *Forensic* services and 4.3% were in *Child and adolescent* services.

New South Wales had the highest number of hospital beds per 100,000 population for both *General* services (40.3) and *Child and adolescent* services (6.7) compared to the national averages of 33.5 and 5.5 per 100,000 population respectively (Figure 12.5). South Australia (60.3) had the highest number of *Older person* hospital beds per 100,000 population (national average 35.6) and Tasmania (5.2) had the most hospital beds per 100,000 population within *Forensic* services (national average 3.2).



Source: National Mental Health Establishments Database.

**Figure 12.5: Public sector specialised mental health hospital beds per 100,000 population, by target population, states and territories, 2009–10**

### Program type

Around two-thirds (4,496 beds or 68.1%) of all public sector specialised mental health hospital beds across Australia were in *Acute* services during 2009–10.

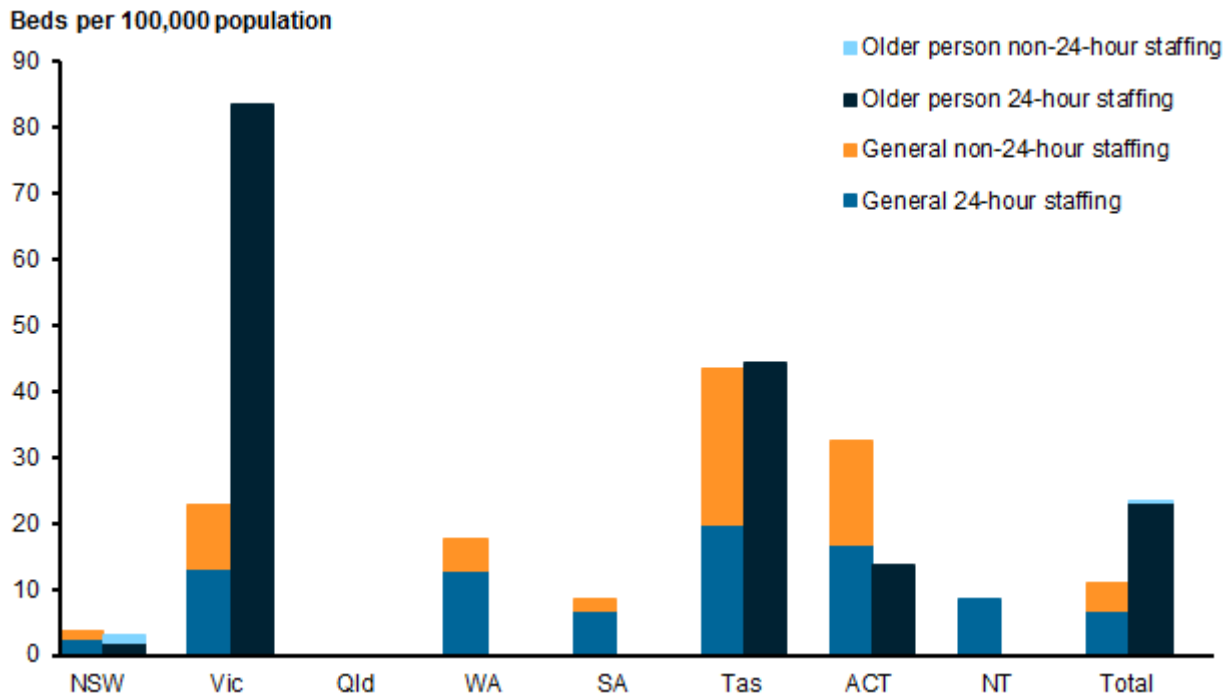
### Residential mental health service beds

There were 2,239 residential mental health service beds available nationally in 2009–10. These can be further characterised by the level of staffing provided, target population and the service operator (government or non-government).

Around three-quarters (1,633 or 72.9%) of residential beds were operated with mental health trained staff working in active shifts for 24 hours a day. Approximately two-thirds of residential mental health specialised beds were in *General* services (1,542 or 68.9%). Around two-thirds (1,399 or 62.5%) of residential mental health service beds were available in government-operated services.

Nationally there were 10.1 residential mental health beds per 100,000 population. Of those jurisdictions reporting residential mental health beds, Tasmania (33.4) had the highest number of available beds per 100,000 population, while New South Wales (2.7) had the lowest. Note that Queensland does not report any residential mental health care services.

Victoria (83.6) had the highest rate of residential mental health beds providing 24 hour care for *Older persons* per 100,000 population. New South Wales was the only jurisdiction to provide non-24-hour care within *Older person* services. Tasmania provided the highest number of residential beds per 100,000 population for *General services* with 24 hour care (19.7) and without 24-hour care (23.6).



Source: National Mental Health Establishments Database

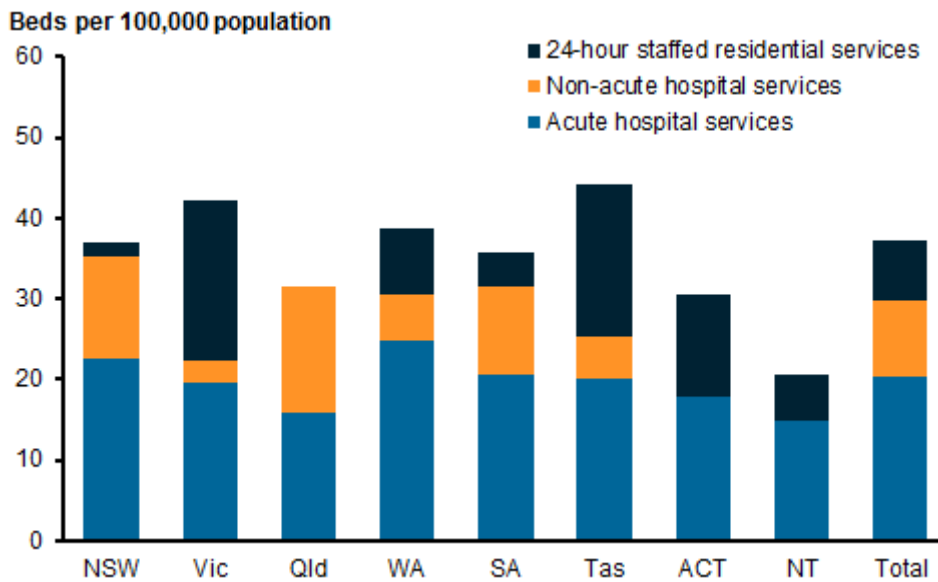
**Figure 12.6: Residential mental health service beds per 100,000 population, by target population and hours staffed, states and territories 2009–10**

### 24-hour staffed public sector care

Mental health services with staff employed in active shifts for 24 hours a day are provided through either public sector specialised mental health hospital services (inpatient care) or 24-hour staffed residential mental health services. Comparisons between states and territories can be undertaken if these different types of 24-hour care data are combined.

Tasmania had the greatest number of these 24-hour care beds available per 100,000 (44.3) while the Northern Territory had the least (20.6) compared to the national average of 37.2 beds per 100,000 population in 2009–10 (Figure 12.7).





Source: National Mental Health Establishments Database.

**Figure 12.7: Specialised mental health beds per 100,000 population, by 24-hour care setting, states and territories, 2009-10**

### Private hospital specialised mental health beds

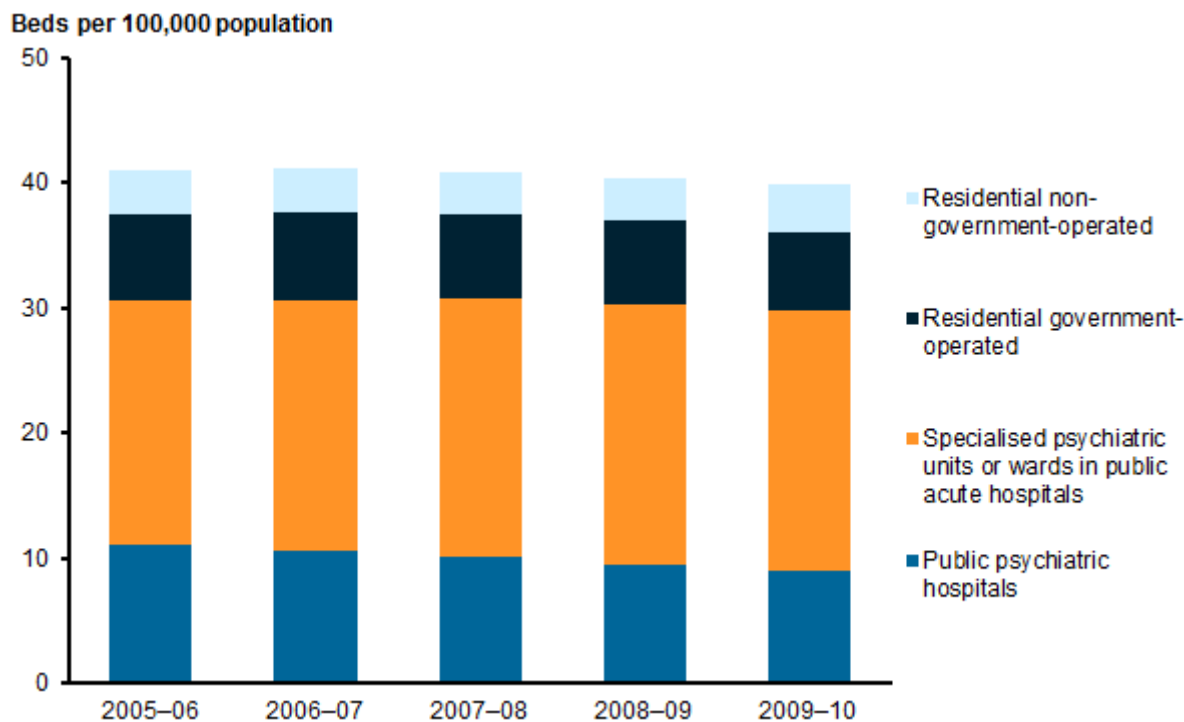
There were 1,800 available beds (8.1 per 100,000 population) in private psychiatric hospitals in 2009-10, including specialised units or wards in private hospitals.

### Supported housing places

In addition to the services described above, jurisdictions also provide [supported housing places](#) for people with a mental illness. There were 4,401 supported housing places available nationally in 2009-10 for people with a mental illness. Western Australia (33.5) had the highest number of supported housing places per 100,000 population, while Tasmania (4.6) had the least, compared to the national average of 19.9 places per 100,000 population.

## Number of available beds over time

The number of public sector specialised mental health hospital beds and residential mental health service beds increased from 8,420 beds in 2005–06 to 8,838 beds in 2009–10, with the majority of this increase due to an increase in the number of specialised mental health beds in units or wards in public acute hospitals. When population rates were considered, the number of specialised mental health beds per 100,000 population was relatively stable between 2005–06 and 2009–10 (40.9 and 39.9 beds per 100,000 population respectively; Figure 12.8).



Source: National Mental Health Establishments Database.

**Figure 12.8: Public sector specialised mental health hospital beds and residential mental health service beds per 100,000 population, 2005–06 to 2009–10**

### Public sector specialised mental health hospital beds

There was an average annual decrease of 3.0% in the number of public psychiatric hospital beds between 2005–06 and 2009–10. This was offset by an increase in the number of beds in specialised psychiatric units or wards in public acute hospitals (3.5%) over the same period. Overall, this resulted in an average annual increase (1.3%) in the number of public sector specialised mental health hospital beds between 2005–06 and 2009–10. However, the number of hospital beds per 100,000 population has decreased slightly over the same time period, with 30.5 beds per 100,000 population in 2005–06 decreasing to 29.8 beds in 2009–10.

### Private hospital specialised mental health beds

Specialised mental health hospital beds in private hospitals increased from 1,722 beds to 1,800 beds between 2005–06 and 2009–10. Private hospital specialised mental health beds per 100,000 population also fell slightly over this period, from 8.4 beds per 100,000 population in 2005–06 to 8.1 beds in 2009–10.

## **Residential mental health service beds**

The number of specialised residential mental health care beds has fluctuated over the five years to 2009–10 with an average annual increase of 1.1% since 2005–06. A decline in beds reported during 2007–08 was mostly due to the reclassification of seven services in New South Wales (105 beds) from 24-hour staffed *Older person* residential mental health services to specialised units within public acute hospitals. See the [data sources](#) section for additional information.

## **Supported housing places**

There has been an average annual increase in the number of supported housing places per 100,000 population from 18.6 in 2005–06 to 19.9 in 2009–10.

# Number of patient days

## Public sector specialised mental health hospital services

Over 2.1 million **patient days** were provided by public hospital specialised mental health services during 2009–10. Around two-thirds (68.8%) of all patient days were in specialised psychiatric units or wards in public acute hospitals. New South Wales (113.7) had the highest number of patient days per 1,000 population, while the Northern Territory (47.7) had the lowest, compared with the national rate of 95.3 (per 1,000 population).

## Residential mental health services

Residential mental health services provided 680,915 patient days during 2009–10. Almost three-quarters (72.9%) of all patient days were for residents of 24-hour staffed services. Tasmania (99.5) had the highest number of patient days per 1,000 population, while New South Wales (7.3) had the lowest, compared with the national rate of 30.7 (per 1,000 population).

## Private hospital specialised mental health services

Specialised mental health services in private hospitals provided 645,329 patient days during 2009–10, equating to 29.1 days per 1,000 population. However, in contrast to public sector services, this figure also includes same day separations.

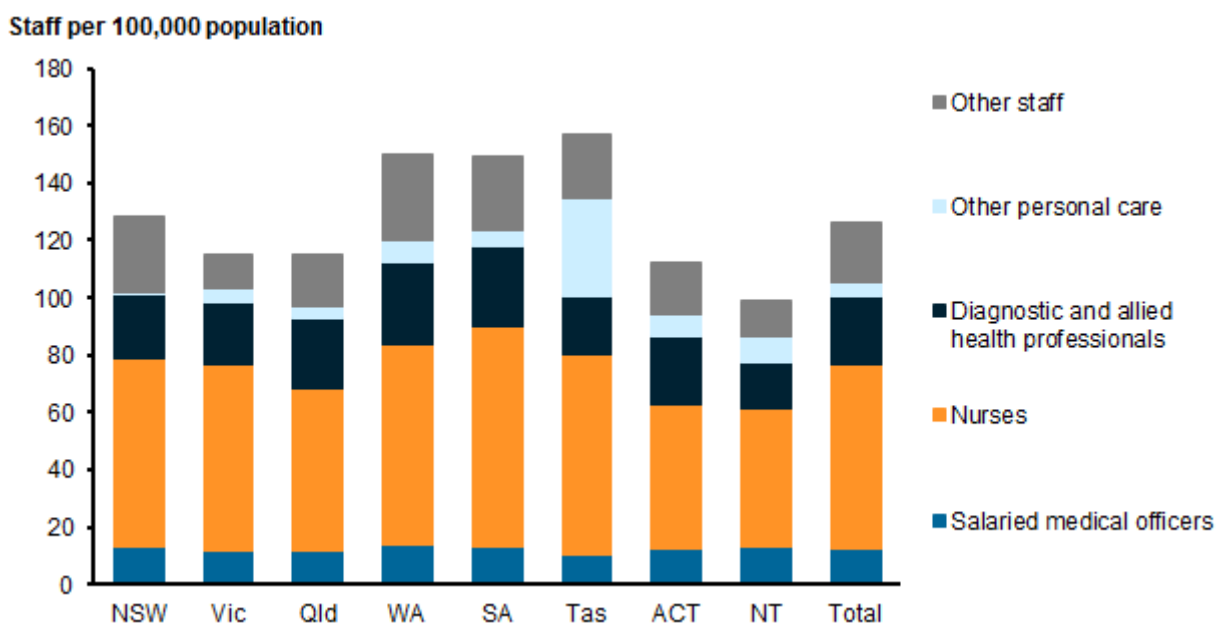
# Staffing of state and territory specialised mental health care facilities

## State and territory specialised mental health care services

State and territory specialised mental health care services include public psychiatric hospitals, psychiatric units or wards in public acute hospitals, community mental health care services and government and non-government-operated residential mental health services.

Of the 28,054 full-time-equivalent (FTE) **staff** employed in state and territory specialised mental health care facilities in 2009–10, 14,286 FTE (50.9%) were nurses with the majority being registered nurses (12,058 FTE). Diagnostic and allied health professionals (5,244 FTE or 18.7%) made up the second largest group of staff, comprising mostly social workers (1,771 FTE) and psychologists (1,725 FTE). Salaried medical officers made up 9.8% of staff, with a relatively even spread between *consultant psychiatrists and psychiatrists*, and *psychiatry registrars and trainees*.

Nationally there were 126.6 FTE staff per 100,000 population employed in specialised mental health care services in 2009–10 (Figure 12.9). Tasmania (157.1) had the highest number of FTE staff per 100,000 population employed in specialised mental health care services, while the Northern Territory (98.7) had the lowest.



Source: National Mental Health Establishments Database.

**Figure 12.9: Full-time-equivalent staff per 100,000 population by staffing category, states and territories, 2009–10**

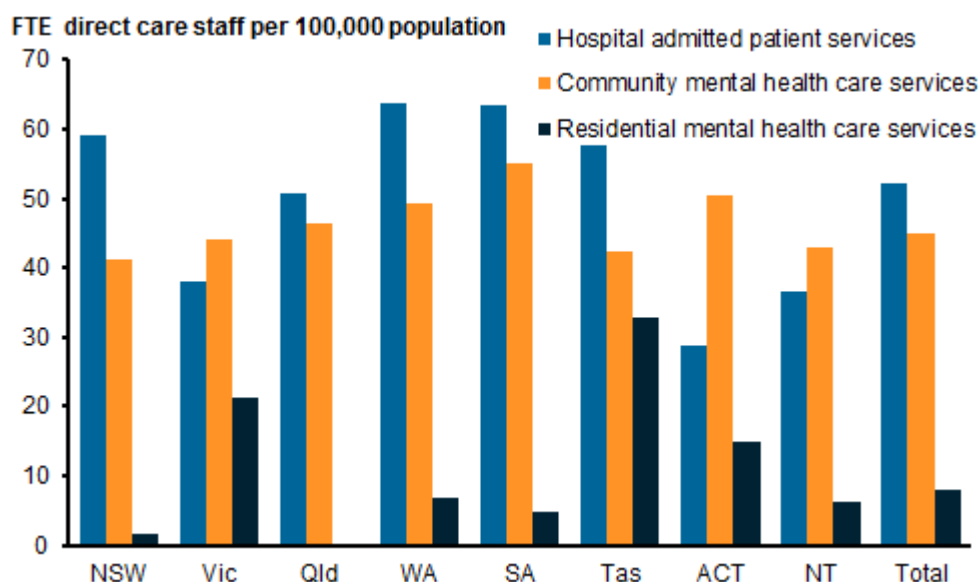
There was an average annual growth of 3.2% in the number of FTE staff in specialised mental health care services between 2005–06 and 2009–10, spread across all labour force categories. Notably, salaried medical officers increased at an average annual rate of 5.3% whilst nurses increased by 2.9% and diagnostic and allied health professionals increased by 3.3%.

## State and territory specialised mental health care service units

Staff employed by state and territory specialised mental health care services can also be described by the [service setting](#) where they are employed. Nearly 14,000 FTE staff were employed in specialised mental health admitted patient hospital services. The community mental health care service setting employed the next largest number of FTE staff (11,938 or 42.8%).

Staff involved in the [direct care](#) of a patient/client can also be described at the service setting level. Public hospital specialised mental health services employed FTE direct care staff at a rate of 52.2 per 100,000 population in 2009–10. Community mental health care services employed FTE direct care staff at a rate of 45.0 FTE per 100,000 population and residential mental health care services had a rate of 7.9 per 100,000 population.

The rate of FTE direct care staff per 100,000 population employed in the community mental health care setting increased by an annual average of 2.5% in the five years to 2009–10, compared with an increase of 1.1% in the admitted patient hospital setting and a decrease of 1.7% in the residential mental health service setting.



Source: National Mental Health Establishments Database.

**Figure 12.10: Full-time-equivalent direct care staff per 100,000 population, specialised mental health service units, by service setting, states and territories, 2009–10**

## Private hospital specialised mental health services

There were 2,462 FTE staff employed by specialised psychiatric services in private hospitals during 2009–10. There was an average annual growth of 3.2% in the number of FTE staff employed per 100,000 population in private hospital specialised mental health services from 9.8 in 2005–06 to 11.1 in 2009–10. These figures do not include Medicare-subsidised medical practitioners and other health professionals who also provide services to people admitted to private hospitals for mental health care.

## Data source

### National Mental Health Establishments Database

Collection of data for the Mental Health Establishments (MHE) NMDS began on 1 July 2005, replacing the Community Mental Health Establishments NMDS and the National Survey of Mental Health Services. The main aim of the development of the MHE NMDS was to expand on the Community Mental Health Establishments NMDS and replicate the data previously collected by the National Survey of Mental Health Services. The National Mental Health Establishments Database is compiled as specified by the MHE NMDS.

The scope of the MHE NMDS includes all specialised mental health services managed or funded, partially or fully, by state or territory health authorities. Specialised mental health services are those with the primary function of providing 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 MHE NMDS data are reported at a number of levels: state, regional, organisational and individual mental health service unit. The data elements at each level in the NMDS collect information appropriate to that level. The state, regional and organisational levels include data elements for revenue, grants to non-government organisations and indirect expenditure. The organisational level also includes data elements for salary and non-salary expenditure, numbers of full-time-equivalent staff and consumer and carer consultant participation arrangements. The individual mental health service unit level comprises data elements that describe the function of the unit. Where applicable, these include target population, program type, number of beds, number of accrued patient days, number of separations, number of service contacts and episodes of residential care. In addition, the service unit level also includes salary and non-salary expenditure and depreciation.

#### Data validation

Data presented in this publication are the most current data for all years presented. The validation process rigorously scrutinises the data for consistency in the current collection and across historical data. The validation process applies hundreds of rules to the data to test for potential issues. Jurisdictional representatives respond to each issue before the data are accepted as the most reliable current data collection. This process may highlight issues with historical data. In such cases, historical data may be adjusted to ensure data are more consistent. Therefore, comparisons to previous *Mental health services in Australia* publications should be approached with caution.

#### Consumer committee representation arrangements

Specialised mental health organisations report the extent to which consumer participation arrangements are in place to promote the inclusion of mental health consumers in the planning, delivery and evaluation of the service. Organisations report their consumer participation arrangements at various levels, as detailed below.

##### Levels of consumer participation arrangements

Level	Description
Level 1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers. Alternatively, specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation.

Level	Description
Level 2	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation.
Level 3	Consumers participate on a broadly based advisory committee that includes a mixture of organisations and groups representing a wide range of interests.
Level 4	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required. Alternatively, no specific arrangements exist for consumer participation in planning and evaluation of services.

### National standards for mental health services review status

There are eight levels used to describe the extent to which a service unit has implemented the national standards during 2009–10, as shown in the table below.

#### National standards for mental health services review status levels

Level	Description
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the national standards.
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the national standards.
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known.
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review.
5	The service unit was engaged in self-assessment in relation to the national standards but did not have a contractual arrangement with an external accreditation agency for review.
6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future.
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the national standards.
8	The national standards are not applicable to this service unit.

Source: National Standards for Mental Health Services (DHFS 1996).

### New South Wales CADE and T-BASIS services

All New South Wales Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as specialised mental health admitted patient hospital services, termed Transitional Behavioural Assessment and Intervention Service (T-BASIS), from 1 July 2007. All data relating to these services have been reclassified from 2007–08 onwards, including number of services, number of beds, staffing and expenditure. Comparison of data over time should therefore be approached with caution.



## New South Wales HASI Program

Since 2006, New South Wales has been developing the NSW Housing Accommodation Support Initiative (HASI) Program. This model of care is a partnership program between NSW Ministry of Health, Housing NSW and the non-government organisation (NGO) sector that provides housing linked to clinical and psychosocial rehabilitation services for people with a range of levels of psychiatric disability. These services are out-of-scope as residential services according to the Mental Health Establishments NMDS, however, are reported as Supported housing places. See this link for further information about the NSW HASI program <http://www.housing.nsw.gov.au/Changes+to+Social+Housing/Partnerships/Housing+and+Mental+Health/Housing+and+Accommodation+Support+Initiative.htm>.

## Rates for target populations

Calculations of rates for target populations are based on age-specific populations as defined by the metadata and outlined below.

- General services: Includes persons aged 18–64.
- Child and adolescent services: persons aged 0–17.
- Older person: persons aged 65 and over.
- Forensic services: persons aged 18 and over.

## Reference

DHFS (Commonwealth Department of Health and Family Services) 1996. National Standards for Mental Health Services. Canberra: Commonwealth of Australia.

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## Private Health Establishments Collection

The ABS conducts a census of all private hospitals licensed by state and territory health authorities and all freestanding day hospitals facilities approved by DoHA. As part of that census, data on the staffing, finances and activity of these establishments are collected and compiled in the Private Health Establishments Collection.

The data definitions used in the Private Health Establishments Collection are largely based on definitions in the *National health data dictionary, Version 14* (HDSC 2008). The ABS defines private psychiatric hospitals as those licensed or approved by a state or territory health authority and which cater primarily for admitted patients with psychiatric, mental or behavioural disorders (ABS 2011). This is further defined as those hospitals providing 50% or more of the total patient days for psychiatric patients. This definition can be extended to include specialised units or wards in private hospitals, consistent with the approach in the public sector. Data for 2009–10 includes private psychiatric hospitals and specialised psychiatric units or wards within other private hospitals. To allow for comparisons across time, historical data has been updated to include this broadened definition. For further technical information see the Private psychiatric hospital data section of the *National mental health report 2010* (DoHA 2010).

The most recent data was collected for the 2009–10 period. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2011).

## References

ABS (Australian Bureau of Statistics) 2011. Private hospitals, Australia 2009–10. Canberra: ABS. Viewed May 2012, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4390.0>

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DOHA 2010. National mental health report 2010: summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008. Canberra: Commonwealth of Australia.

HDSC (Health Data Standards Committee) 2008. National health data dictionary. Version 14. AIHW cat. no. HWI 101. Canberra: AIHW.

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## Key concepts

### Specialised mental health care facilities

Key Concept	Description
<b>Beds</b>	The number of available specialised mental health <b>beds</b> refers to the average number of beds that are immediately available for use by an admitted patient within the mental health facility over the financial year, estimated using monthly figures (METeOR identifier 270133). Data prior to 2005–06 was sourced from the National Survey of Mental Health Services, which reported the total number of beds available as at 30 June. Comparison of historical data should therefore be approached with caution.
<b>Carer</b>	A <b>carer</b> is a person whose life is affected by virtue of a family or close relationship and caring role with a mental health consumer (see METeOR identifier 288833).
<b>Community mental health care services</b>	<b>Community mental health care services</b> include hospital outpatient clinics and non-hospital community mental health care services, such as crisis or mobile assessment and treatment services, day programs, outreach services, and consultation/liaison services.
<b>Consultant</b>	Consumer and carer <b>consultants</b> are employed (or engaged through contracts) on a part-time or full-time basis to represent the interests of consumers and carers and advocate for their needs, to promote the participation of mental health carers and consumers in the planning, delivery and evaluation of the services. The consultant must have received a salary or contract fee on a regular basis to be considered as being employed by the organisation.
<b>Consumer</b>	A <b>consumer</b> is a person who is currently utilising, or has previously utilised, a mental health service. Mental health service consumers include persons receiving care for their own, or another person's mental illness or psychiatric disability (see METeOR identifier 288866).
<b>Consumer committee representation arrangements</b>	Specialised mental health organisations report the level of <b>consumer committee representation arrangements</b> . To be regarded as having a formal position on a management or advisory committee, the consumer representative needs to be a voting member (METeOR identifier 288855). This is independent to the employment of consumer and carer consultants. See <a href="#">data sources</a> section for the levels available.
<b>Direct care staff</b>	<b>Direct care staff</b> refers to following staffing categories: <i>salaried medical officers, nurses, diagnostic and allied health professionals</i> and <i>other personal care</i> .

**Government-operated residential mental health services** *Government-operated residential mental health services* are specialised residential mental health services that:

- are operated by a state or territory government
- employ mental health-trained staff on-site for a minimum of 6 hours per day and at least 50 hours per week
- provide rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment
- encourage the resident to take responsibility for their daily living activities.

**National standards for mental health services** The **National standards for mental health services** (DHFS 1996) were developed under the *First National Mental Health Plan* and are applicable to individual service units. There are eight levels available to describe a service unit's status (METeOR identifier 287800). See the [data source](#) section for the full description of all eight levels. For reporting purposes, the data are restricted to the following two levels:

- level 1: the service unit has been reviewed by an external accreditation agency and was judged to have met the standards
- level 2: the service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known.

**Non-government-operated residential mental health services** *Non-government-operated residential mental health services* are specialised residential mental health services which meet the same criteria as government-operated residential mental health services. These services, while partially or fully funded by governments, are operated by non-government agencies. Expenditure reported as non-government operated residential mental health services includes the total operating costs for the residential service, not the total operating costs of the non-government organisation as an entity. Expenditure reported as *Grants to non-government organisations* includes grants made by state and territory government departments to non-government organisations specifically for mental health-related programs and initiatives.

**Patient days** *Patient days* are days of admitted patient care provided to admitted patients in public psychiatric hospitals or specialised psychiatric units or wards in public acute hospitals and in residential mental health services. The total number of patient days is reported by specialised mental health service units. For consistency in data reporting, the following patient day data collection guidelines apply: admission and discharge on the same day equals 1 day; all days are counted during a period of admission except for the day of discharge; and leave days are excluded from the total. Note that the number of patient days reported to the National Mental Health Establishments Database is not directly comparable with the number of patient days reported to neither the National Hospital Morbidity Database (Admitted patient mental health-related care section) nor the number of residential care days reported to the National Residential Mental Health Care Database (Residential mental health care section)

**Private psychiatric hospital** A **private psychiatric hospital** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. The data are sourced from the Private Health Establishments Collection (PHEC), held by the Australian Bureau of Statistics (ABS), which identifies private psychiatric hospitals as those that are licensed/approved by a state or territory health authority and which cater primarily for admitted patients with psychiatric, mental or behavioural disorders (ABS 2011), that is, providing 50% or more of the total patient days for psychiatric patients. The data published in this section also includes psychiatric units or wards in private hospitals. See [data sources](#) for additional information.

**Program type** Public sector specialised mental health hospital services can be categorised based on **program type**, which describes the principal purpose(s) of the program rather than the classification of the individual patients. *Acute* care admitted patient programs involve short-term treatment for individuals with acute episodes of a mental disorder, characterised by recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self and/or others. *Non-acute* care refers to all other admitted patient programs, including rehabilitation and extended care services (see METeOR identifier 288889).

**Psychiatric units or wards** **Psychiatric units or wards** are specialised units or wards that are dedicated to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.

**Public acute hospital** A **public acute hospital** is an establishment that provides at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care and provides round-the-clock comprehensive qualified nursing services as well as other necessary professional services. They must be licensed by the state or territory health department or be controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average length of stay is relatively short.

**Public psychiatric hospital** A **public psychiatric hospital** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders that is controlled by a state or territory health authority and offers free diagnostic services, treatment, care and accommodation to all eligible patients.

**Service setting** Staffing of specialised mental health service units is reported as **service setting** level data for three specialist mental health service types. These settings are admitted patient services in public psychiatric hospitals and public acute hospitals with specialised psychiatric units or wards; community mental health care services; and residential mental health services, including government and non-government-operated services. The setting level data excludes some staff employed by specialised mental health service organisations, mainly those performing organisational management roles. The categories of carer consultants and consumer consultants are also excluded from service unit level staff data.

**Specialised mental health service organisation** A **specialised mental health service organisation** is a separate entity within states and territories responsible for the clinical governance, administration and financial management of services providing specialised mental health care. For most states and territories, a specialised mental health service organisation is equivalent to the area/district mental health service. These organisations may consist of one or more **specialised mental health service units**, sometimes based in different locations. Each separately identifiable unit provides either specialised mental health admitted patient hospital services, residential mental health services or community mental health care services (METeOR identifier 286449).

**Staff** **Staff** numbers reported in this section refer to the average number of full-time-equivalent (FTE) staff employed in public psychiatric hospitals, specialised psychiatric units or wards in public acute hospitals, community mental health care services and residential mental health services.

**Supported housing places** **Supported housing places** are reported by jurisdictions to describe the capacity of supported housing targeted to people affected by mental illness (METeOR identifier 288945). This is reported at the number available at 30 June and is therefore not comparable to the average available beds measures for specialised mental health hospital and residential services.

**Target population** Some specialised mental health services data are categorised using four **target population** groups (see METeOR identifier 288957):

- *Child and adolescent* services focus on those aged under 18 years.
- *Older person* programs focus on those aged 65 years and over.
- *Forensic* health services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment.
- *General* provides services to the adult population, aged 18 to 64; however, these services may also provide assistance to children, adolescents or older people.

Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However, not all states or territories report such jointly funded beds through the National Mental Health Establishments Database.

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## References

ABS (Australian Bureau of Statistics) 2011. Private hospitals, Australia 2009–10. Canberra: ABS. Viewed May 2012, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4390.0>

DHFS (Commonwealth Department of Health and Family Services) 1996. National Standards for Mental Health Services. Canberra: Commonwealth of Australia.