

# Specialised mental health care facilities

Specialised mental health care is delivered in and by a range of facilities in Australia including [public](#) and [private](#) psychiatric hospitals, [psychiatric units or wards](#) in [public acute hospitals](#), [Community mental health care services](#) and [government-operated](#) and [non-government-operated Residential mental health care services](#). The information presented in this section is drawn primarily from the National Mental Health Establishments Database. More detail about these and the other data used in this section can be found in the [data source](#) section.

## Data downloads

[Excel Link](#)

[PDF link](#)

Data coverage includes the time period 1992–93 to 2017–18. This section was last updated in January 2020.

## Key points

**161 public hospitals** and **66 private hospitals** provided specialised mental health services for admitted patients during 2017–18.

**6,920** specialised mental health public hospital beds were available in 2017–18; providing 2.2 million patient days to people in hospital.

**3,146** mental health beds were available in private hospitals in 2017–18.

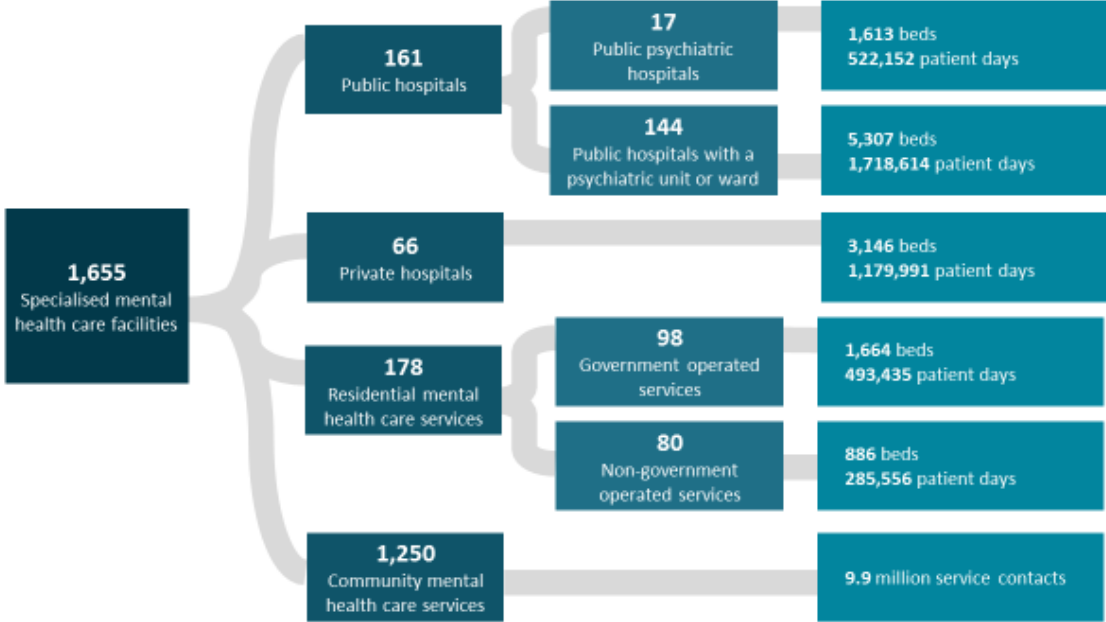
**2,550** residential mental health beds were available during 2017–18, with almost two-thirds operated by government organisations.

**12,870 full-time-equivalent staff** were employed by *Community mental health care services* in 2017–18.

## Overview

There were 1,655 specialised mental health care facilities providing care in 2017–18 (Figure FAC.1).

**Figure FAC.1: Number of specialised mental health care facilities, available beds and activity in Australia, 2017–18**



**Social and emotional wellbeing services for Aboriginal and Torres Strait Islander people**

In addition to the specialised mental health care facilities described above, Aboriginal and Torres Strait Islander people may access a range of more culturally appropriate mental health services provided by Australian and state and territory governments.

For example, the Australian Government funds health organisations to provide social and emotional wellbeing/mental health/counselling (SEWB) services for Aboriginal and Torres Strait Islander people (AIHW 2019). SEWB services provide a range of support services including counselling, casework, family tracing and reunion support and other wellbeing activities for individuals, families and communities.

In 2017–18, 534 social and emotional wellbeing staff were located at 337 sites across Australia, providing approximately 217,000 client contacts (AIHW 2019). For more information on the organisation profile, staffing and types of services provided by SEWB services, see the *Aboriginal and Torres Strait Islander health organisations: Online Services Report (2017–18)*.

## Specialised mental health service organisations

There were 170 [specialised mental health service organisations](#) responsible for the administration of the 1,589 state and territory specialised mental health facilities (excluding private hospitals) during 2017–18.

Of organisations that provided two types of services within an organisational structure, the most common pairing was specialised mental health public hospital services and *Community mental health care services* (68 organisations or 40.0%). These organisations accounted for over half of the [beds](#) and [patient days](#) (54.4% and 53.6% respectively) provided by specialised mental health public hospital services and over two-fifths (43.7%) of all community mental health care service contacts.

Furthermore, the majority of organisations provided specialised *Community mental health care services* (135 of 170, or 79.4%). A smaller majority provided specialised mental health public hospital services (117 of 170, or 68.8%), and a minority provided *Residential mental health services* (75 of 170 or 44.1%).

## Consumer and carer involvement

Specialised mental health organisations employ [mental health consumer workers](#) and [mental health carer workers](#) for the expertise developed from their lived experience of mental illness and caring for people with mental illness. The definition used to describe this component of the workforce changed for the 2010–11 collection to better capture a variety of contemporary roles. Caution is therefore required when interpreting time series data for this workforce. More information can be found in the [key concepts](#). In addition to reporting the number of employed workers, specialised mental health organisations also report the extent to which [consumer committee representation arrangements](#) are in place.

## Mental health consumer and carer worker employment

Of the 170 specialised mental health service organisations reported nationally in 2017–18, 77 (45.3%) employed mental health consumer workers and 46 (27.1%) employed mental health carer workers. Queensland had the highest proportion of mental health organisations employing consumer workers (14 of 20) and South Australia had the highest proportion employing carer workers (12 of 21).

Nationally, the rate of mental health consumer workers employed increased from 26.8 FTE per 10,000 mental health care provider FTE staff in 2013–14 to 64.3 FTE in 2017–18; an annual average increase of 24.4%. Over the same period, the rate of mental health carer workers employed increased from 14.2 FTE per 10,000 mental health FTE staff in 2013–14 to 24.0 in 2017–18; an annual average increase of 14.1%.

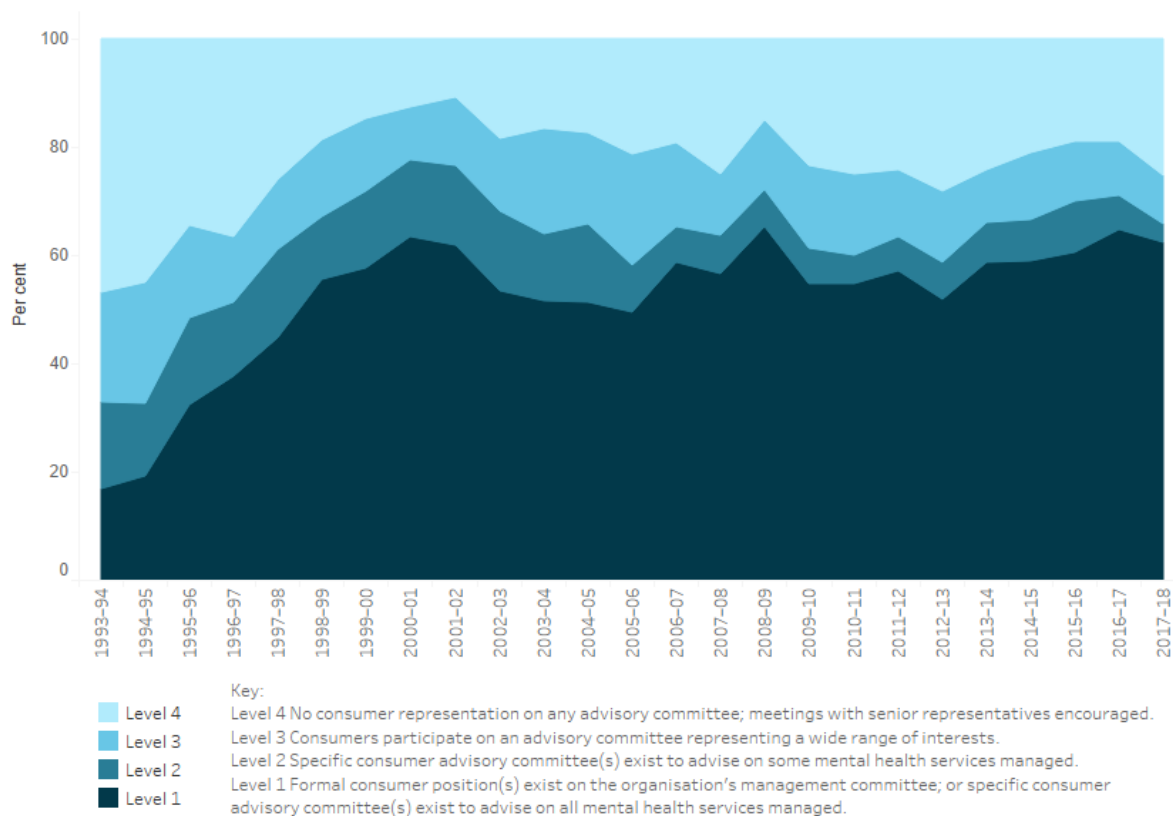
Caution is required when interpreting these data since consumer worker and carer worker FTE is relatively small, and therefore small changes in these FTE may have a relatively large percentage impact on the rates of change.

## **Consumer committee representation arrangements**

In 2017–18, 106 (62.4%) specialised mental health organisations reported that they had 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 in the classification of consumer participation arrangements—the [data source](#) section provides full descriptions of each level). Levels 2–4 represent less consumer committee representation within the organisation.

The proportion of specialised mental health service organisations with Level 1 consumer committee representation arrangements increased from 58.6% in 2013–14 to 62.4% in 2017–18 (Figure FAC.2); and is substantially higher than the 16.8% in 1993–94, the first year of reported data. Conversely, the proportion of specialised mental health service organisations with Level 4 consumer committee representation (no consumer representation on any advisory committee) has substantially decreased from 46.7% in 1993–94 to 25.3% in 2017–18. This transformation to a higher proportion of representation essentially occurred in the years immediately following 1993–94, with 1998–99 being the first year in which over half of organisations were classified as Level 1. Between 1998–99 and 2017–18 the proportion classified as Level 1 has fluctuated in a range between 49.3% to 65.4%.

Figure FAC.2: Specialised mental health organisations, by level of consumer committee representation, 1993-94 to 2017-18



Source: National Mental Health Establishments database; Table FAC.8.

www.aihw.gov.au/mhsa

## National standards for mental health services

Services provided by specialised mental health organisations are measured against the [National Standards for Mental Health Services](#) (the National Standards). There are 8 levels available to describe the degree to which a [specialised mental health service unit](#) meets the National Standards, from Level 1 (a service unit has met all national standards) through to Level 8 (national standards do not apply). Reporting levels for National Standards can be found in the [data source](#) section, which provides full descriptions of all 8 levels and how they are grouped into 4 levels for reporting purposes.

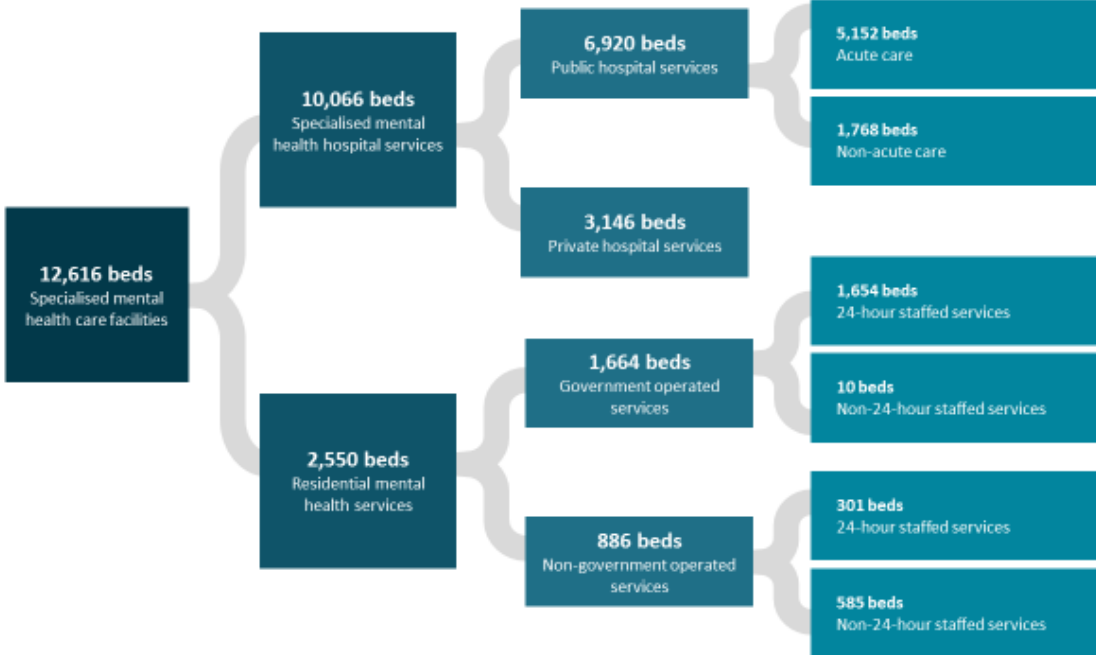
To accurately reflect the proportion of mental health services meeting the various National Standards levels, the expenditure reported for each service unit is used to calculate the proportion of services meeting the four reporting levels. In this way, the relative size of a service unit is accounted for when calculating the proportion of services meeting the National Standards levels. It is important to note that the accreditation process is cyclical in nature and therefore state and territory results may vary greatly from year to year.

Using this approach, 85.1% of all service units which were reviewed by an external accreditation agency, such as the Australian Council on Healthcare Standards (ACHS) or the Quality Improvement Council (QIC), met the National Standards (Level 1) in 2017–18. The jurisdictions reporting the highest proportion of service units meeting Level 1 were Queensland (99.8%), South Australia (99.4%), Western Australia (96.1%), and New South Wales (90.1%). The Northern Territory reported that all service units were assessed under service accreditation standards that do not include certification for the National Standards for Mental Health Services, therefore it has reported that 100% of service units meet Level 4.

## Specialised mental health beds and patient days

During 2017–18, there were 12,616 specialised mental health beds available nationally, with 6,920 beds provided by public hospital services, 3,146 by private hospitals, and 2,550 by *Residential mental health care services* (Figure FAC.3).

**Figure FAC.3: Distribution of specialised mental health beds in Australia, 2017–18**



## Public sector specialised mental health hospital beds

In 2017–18, there were 6,920 public sector specialised mental health hospital beds available in Australia. About three quarters of these (76.7% or 5,307 beds) were in

specialised psychiatric units or wards within public acute hospitals, with the remainder in public psychiatric hospitals (1,613 beds).

New South Wales (34.8) had the highest number of beds per 100,000 population in 2017–18, while the Northern Territory had the lowest (17.4), compared to the national rate of 27.9 beds per 100,000 population.

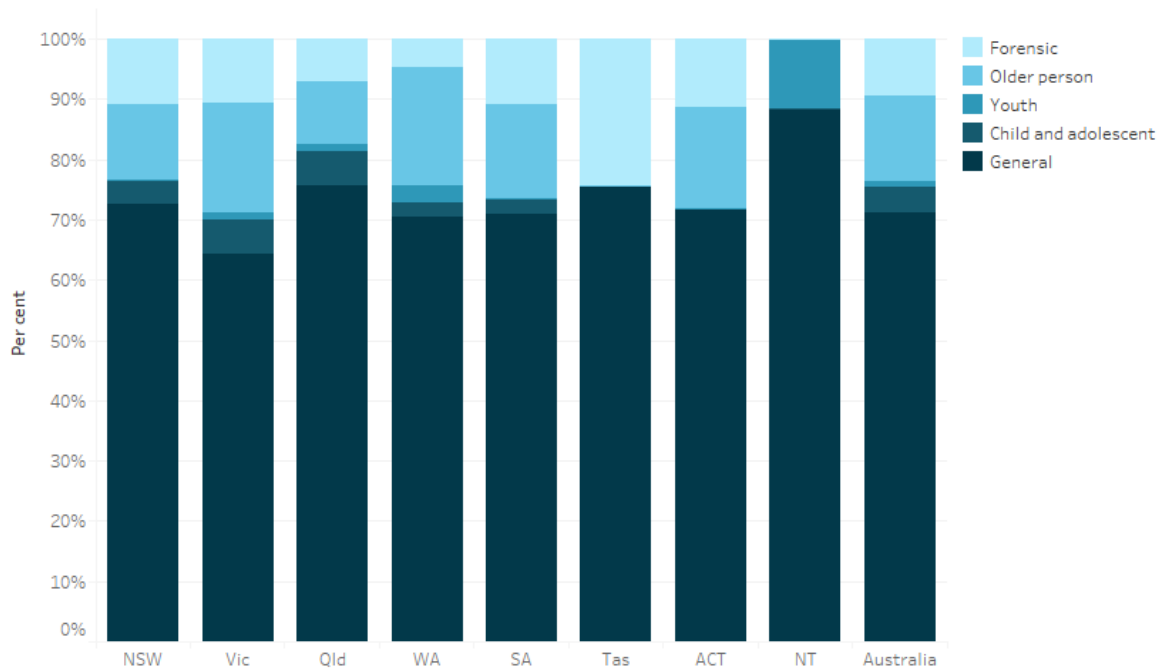
Public sector specialised mental health hospital beds can also be described by the [target population](#) or [program type](#) category of the specialised mental health service unit, or a combination of both.

## Target population

During 2017–18, the majority of public sector specialised mental health hospital beds (4,932 or 71.3%) were in *General* services, 976 beds (14.1%) were in *Older person* services, 658 (9.5%) were in *Forensic* services and 295 (4.3%) were in *Child and adolescent* services. A small number of beds were located in *Youth* services (59 beds or 0.9%); a service category that was introduced in 2011–12.

The proportion of specialised mental health hospital beds for each target population category varied among the states and territories, reflecting the different service profile adopted in each state/territory. The majority of beds were in services classified as *General*, accounting for at least 64.3% of beds in each state/territory (Figure FAC.4).

Figure FAC.4: Proportion of public sector specialised mental health hospital beds, by target population, states and territories, 2017–18



Source: National Mental Health Establishments database; Table FAC.14.

New South Wales had the highest number of hospital beds per 100,000 population for both *General* services (40.9) and *Child and adolescent* services (6.3) compared to the national rates of 32.0 and 5.3 per 100,000 population respectively. Western Australia (41.3) had the highest number of *Older person* hospital beds per 100,000 population (national average 25.3) and Tasmania (5.6) had the most *Forensic* hospital beds per 100,000 population (national average 3.4). The Northern Territory reported the highest number of *Youth* beds per 100,000 population (17.1) compared to the national rate of 2.0 per 100,000 population.

## Program type

Almost three-quarters (5,152 beds or 74.5%) of all public sector specialised mental health hospital beds across Australia were in Acute services during 2017–18 (Figure FAC.3).

The proportion of acute beds differed among the target population groups. The majority of *General* beds (76.1%), *Child and adolescent* beds (90.8%), *Youth* beds (100.0%), and



*Older person* beds (78.5%) were in Acute services in 2017–18, compared with less than half of *Forensic* beds (46.4%).

## **Residential mental health service beds**

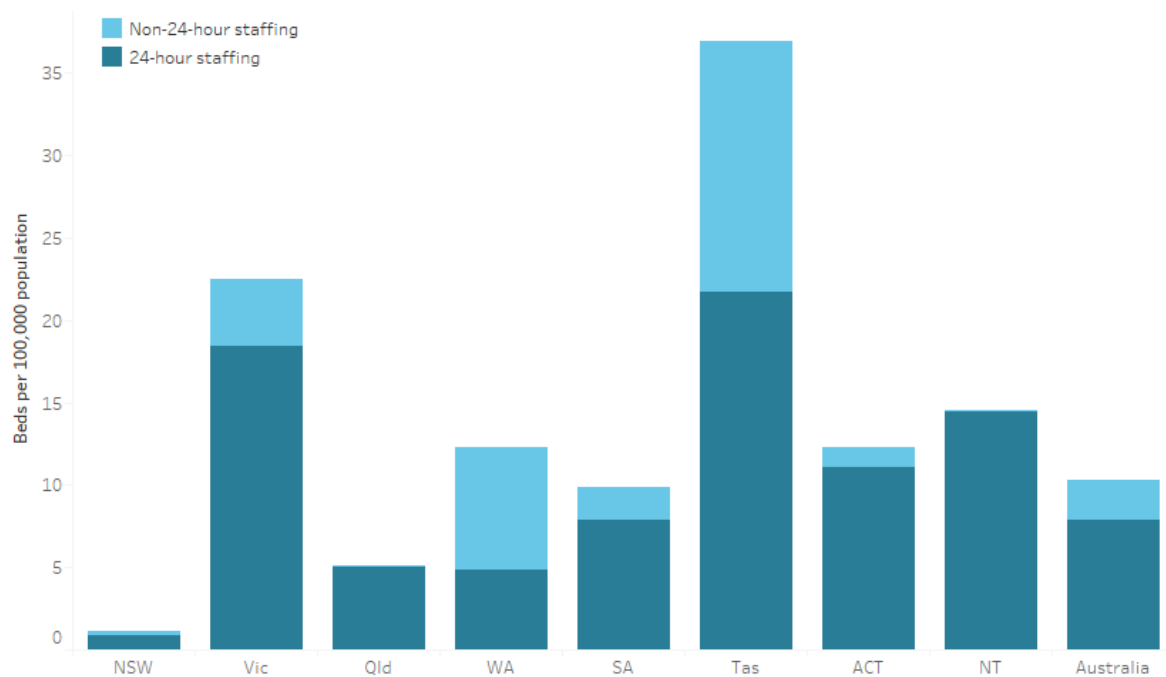
In 2017–18, there were 2,550 residential mental health service beds available nationally. These can be further characterised by the level of staffing provided, target population and the service operator (government or non-government), reflecting the service profile mix in each state or territory.

The total number of beds in government-operated services was 1,664 (65.2%). About three quarters (1,955 or 76.7%) of all residential beds were operated with mental health trained staff working in active shifts for 24 hours a day, with the majority of these beds in government operated services (1,654 beds). By contrast, non-24-hour staffed residential beds were predominately provided by the non-government sector. More than two-thirds (1,822 beds or 71.4%) of all residential beds were in *General* services with more of these beds in 24-hour staffed facilities (1,332 or 73.1%) than in non-24-hour staffed facilities (489 or 26.9%).

In the Australian Capital Territory, from 2015–16 to 2016–17 there was a decline in the reported number of non-24 hour staffed residential beds, from 45 to 5 beds. There were also 5 beds in 2017–18. These beds are still operational but as they are funded under the National Disability Insurance Scheme (NDIS), they are now out of scope for reporting to the Mental Health Establishments (MHE) NMDS. It is anticipated that as the NDIS is fully implemented across Australia, the number of non-24-hour staffed residential specialised mental health beds being reported to the MHE NMDS will decrease.

In 2017–18, there were 10.3 residential mental health beds per 100,000 population nationally. Amongst jurisdictions, Tasmania (37.0) had the highest number per 100,000 population, while New South Wales (1.1) had the lowest (Figure FAC.5). Western Australia was the only jurisdiction where non-24-hour staffed residential services provided more beds than 24-hour staffed services. 24-hour staffed services provided more beds across all other jurisdictions.

Figure FAC.5: Residential mental health service beds per 100,000 population, by hours staffed, states and territories, 2017–18



Source: National Mental Health Establishments database; Table FAC.17.

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Victoria (50.2) had the highest number of residential mental health beds per 100,000 population in *Older persons* 24-hour staffed care services. Tasmania had the highest number of residential beds per 100,000 population in *General* services for both 24-hour staffed care (23.2) and non-24-hour staffed care (25.8). New South Wales (0.6 beds per 100,000 population) was the only state or territory that reported residential mental health service beds for *Child and adolescent* services in 2017–18. Three jurisdictions reported specialised *Youth* services, with Western Australia reporting 5.5 beds per 100,000 population, Victoria 17.5, and the Australian Capital Territory 20.2.

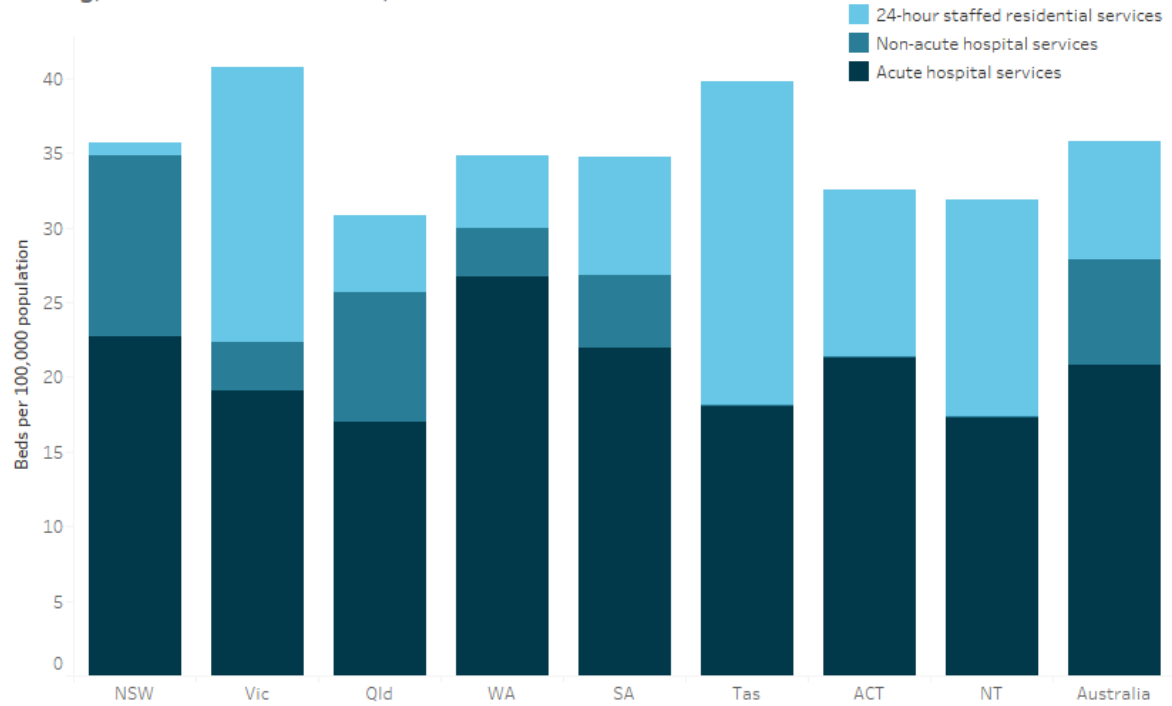
## 24-hour staffed public sector care

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 care services*. Comparisons between states and territories are possible when the data for these different types of 24-hour staffing are combined.

Victoria had the highest number of 24-hour staffed public sector beds per 100,000 population (40.7) in 2017–18, followed closely by Tasmania (39.8), while Queensland

(30.7) and the Northern Territory (31.9) had the lowest, compared with the national average of 35.8 (Figure FAC.6). Across the majority of jurisdictions, the highest number of beds per 100,000 were provided by acute hospital services, except for Tasmania where 24-hour staffed residential services had the highest number of beds per 100,000 population.

Figure FAC.6: Specialised mental health beds per 100,000 population, by 24-hour care setting, states and territories, 2017-18



Source: National Mental Health Establishments database; Table FAC.23. [www.aihw.gov.au/mhsa](http://www.aihw.gov.au/mhsa)

### Private hospital specialised mental health beds

There were 3,146 available beds (12.7 per 100,000 population) in private psychiatric hospitals in 2017-18, including specialised units or wards in private hospitals.

### Available beds over time

The number of public sector specialised mental health hospital and residential mental health service beds increased from 9,218 beds in 2013-14 to 9,470 beds in 2017-18. The combined number of hospital and residential specialised mental health beds per 100,000 population remained relatively stable across the 2013-14 to 2017-18 period, with 39.5 beds per 100,000 population being reported in 2013-14 and 38.2 in 2017-18.

## Public sector specialised mental health hospital beds

There was a decrease in the number of public sector psychiatric hospital beds reported from 1,761 beds in 2013–14 to 1,613 beds in 2017–18. By contrast, there was an increase in the number of beds in specialised psychiatric units or wards in public acute hospitals over the same period (from 5,030 beds in 2013–14 to 5,307 beds in 2017–18). Time series comparisons should be approached with caution. In 2017–18 Queensland reported specialised residential mental health service beds to the Mental Health Establishments collection for the first time due to the reclassification of some public sector mental health hospital beds.

## Residential mental health service beds

The number of specialised residential mental health service beds increased from 2,281 in 2016–17 to 2,550 in 2017–18. This increase was almost entirely due Queensland recommencing reporting of residential mental health service beds in 2017–18, accounting for 253 of the additional beds. Reported residential beds per 100,000 population nationally have remained broadly stable for about 2 decades, being about 10 since 1999–00.

## Supported housing places

In addition to the services described above, jurisdictions also provide [supported housing places](#) for people with a mental illness. There were 4,577 supported housing places available in 2017–18 for people with a mental illness. Western Australia (54.4) had the highest number of supported housing places per 100,000 population, compared with the national average of 18.5 places. However, caution should be exercised when comparing rates across jurisdictions as not all jurisdictional mental health housing support schemes are in-scope for the Mental Health Establishment NMDs. The [data source](#) section provides further information.

## Patient days

### Public sector specialised mental health hospital services

Around 2.2 million [patient days](#) were provided by public hospital specialised mental health services during 2017–18. Over three-quarters (76.7%) of all patient days were in specialised psychiatric units or wards in public acute hospitals, mirroring the number of beds for this service type. New South Wales (111.0) had the highest number of patient days per 1,000 population, while the Tasmania (56.0) had the lowest, compared with the national rate of 90.4.

## Residential mental health care services

During 2017–18, *Residential mental health care services* provided nearly 779,000 patient days. About three-quarters (75.4%) of all patient days were for residents of 24-hour staffed services. Tasmania (159.9) had the highest number of patient days per 1,000 population in *General services*, while New South Wales (4.3) had the lowest; compared with the national rate of 35.9.

## Private hospital specialised mental health services

During 2017–18, private specialised mental health hospital services provided about 1.2 million patient days, equating to 47.6 days per 1,000 population. However, in contrast with public sector services, this figure also includes same-day separations.

## Staffing of state and territory specialised mental health care facilities

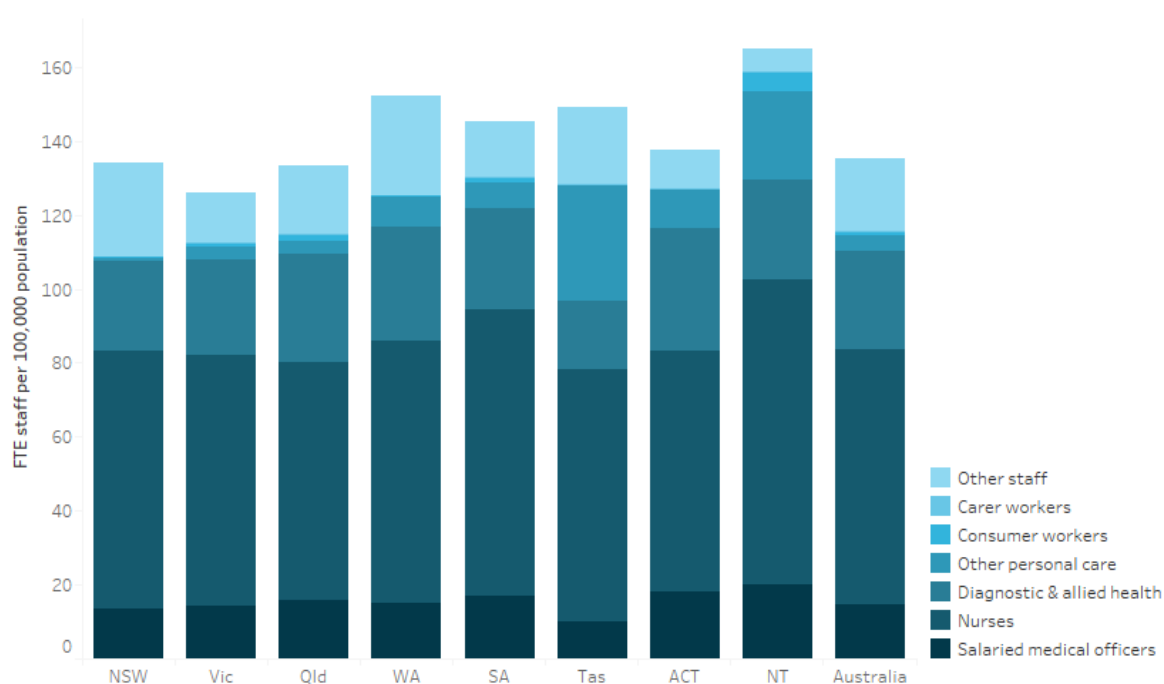
### State and territory specialised mental health care services

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 care services*.

In 2017–18, of the 33,503 full-time-equivalent (FTE) [staff](#) employed in state and territory specialised mental health care services, about half were nurses (17,060 FTE or 50.9%) with the majority registered nurses (14,660 FTE). Diagnostic and allied health professionals (6,604 FTE or 19.7%) made up the second largest group of staff, comprising mostly social workers (2,314 FTE) and psychologists (1,883 FTE). Salaried medical officers made up 10.8% of FTE staff, with similar numbers of consultant psychiatrists and psychiatrists (1,559 FTE), and psychiatry registrars and trainees (1,720 FTE).

In 2017–18, there were 135.2 FTE staff per 100,000 population nationally employed in specialised mental health care services (Figure FAC.7). The Northern Territory (164.8) had the highest number of FTE staff per 100,000 population, while Victoria (125.8) had the lowest. Nurses were the largest full-time-equivalent staff category across all jurisdictions.

Figure FAC.7: Full-time-equivalent staff per 100,000 population by staffing category, states and territories, 2017–18



Source: National Mental Health Establishments database; Table FAC.36.

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The number of FTE staff per 100,000 population employed in specialised mental health care services has increased gradually from 2013–14 to 2017–18 at an average annual increase of 0.8%. The labour force categories *Other personal care* and *Other staff* decreased somewhat over this time period. The number of FTE consumer workers increased from 0.3 to 0.7 per 100,000 population over this time period.

## 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. In 2012–13, the *Organisational overhead* setting was introduced for greater national consistency in reporting and greater clarity about staff delivering care to patients. The *Organisational overhead* setting consists of the components of specialised mental health service organisations not directly involved in the delivery of patient care services in the admitted patient, residential or community mental health care service settings, or in the operations of those settings. The definition does not imply that these roles do not have an impact on service delivery. For example, a chief operating officer not directly

providing patient care, nor involved in the operation of services in a specific service setting, would be reported in the *Organisational overhead* setting. The reporting methodology for the new *Organisational overhead* setting is taking time for states and territories to implement (see Table FAC.39 for detailed time series data).

Almost half (14,881 FTE or 44.4%) of state and territory specialised mental health care services staff were employed in public hospital specialised mental health services. *Community mental health care services* employed the next largest number of FTE staff (12,870 or 38.4%). Since 1993–94, the number of FTE staff employed in specialised mental health admitted patient hospital services has ranged between around 11,000 to 15,000 FTE while FTE employed by *Community mental health care services* has tripled (from 4,197 in 1993–94 to 12,870 in 2017–18).

## Service Setting

Across the history of reporting, the population rate of FTE staff employed by *Hospital admitted patient services* has ranged between 58.2 and 76.8 FTE per 100,000 population, and has been stable, at about 60, for the last 6 reporting periods. The population rate of FTE staff employed by *Community mental health care services* increased every year from 1993–94 to 2011–12 (from 23.7 to 57.7 FTE per 100,000 population), and then levelled off in the low 50s for the last 6 reporting periods. The population rate of FTE staff employed by *Residential mental health care services* has been broadly stable over the past 18 reporting periods (typically just below 10 FTE per 100,000 population). *Organisational overhead* service settings have been reported as a service setting since 2012–13, with FTE per 100,000 population ranging between 9.8 and 14.2.

## Health care providers

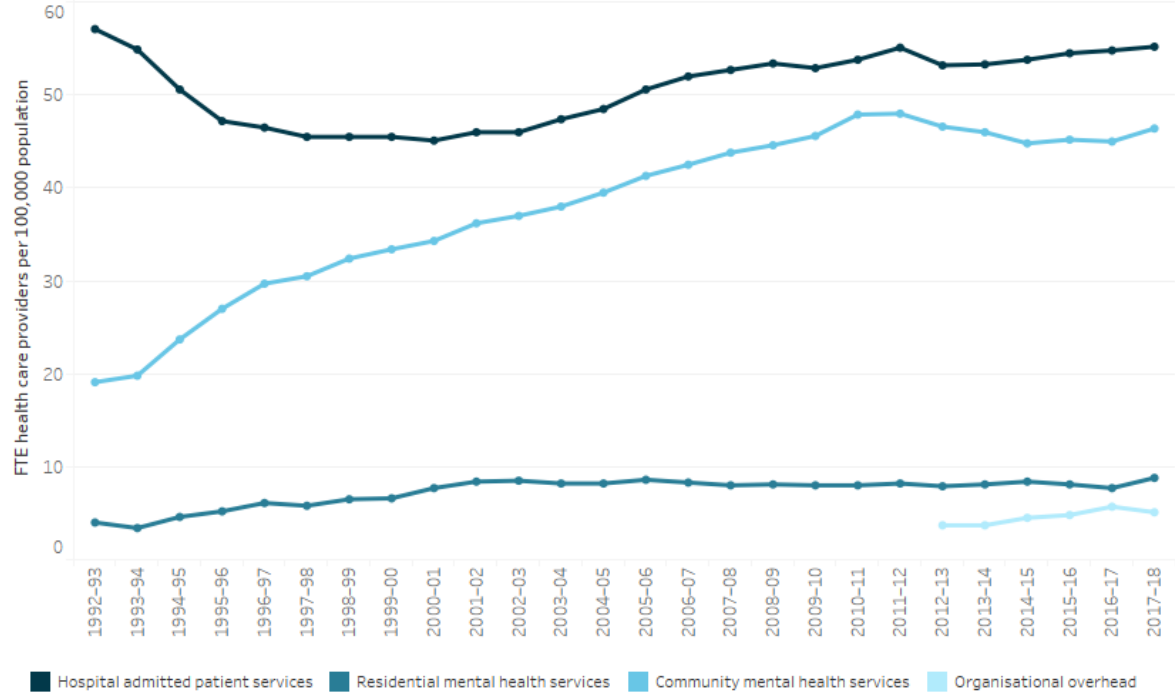
[Health care providers](#) include the staffing categories of salaried medical officers, nurses, diagnostic and allied health professionals, mental health consumer and carer workers and other personal care staff. These staff can be described at the overall organisational level, by service setting and by target population.

In 2017–18, public hospital specialised mental health services employed 55.2 FTE health care providers per 100,000 population (Figure FAC.8). *Community mental health care services* employed 46.4 FTE health care providers per 100,000 population in 2017–18 and *Residential mental health care services* employed 8.8.

Between 1992–93 and 2017–18 FTE health care providers per 100,000 population was consistently highest for Hospital admitted patient service settings, ranging between 45.1 and 57.1 (in 2000–01 and 1992–93 respectively). The rate was consistently second highest for Community mental health care service settings, which increased from 19.1 to 46.4 between 1992–93 and 2017–18, peaking at 48.0 in 2011–12. The rate for Residential

mental health care service settings increased from 4.0 to 8.8 between 1992–93 and 2017–18, with a low of 3.4 in 1993–94. The Organisational overhead setting was reported on from 2012–13, with a rate ranging between 3.7 and 5.7 during the past 6 reporting periods.

**FAC.8: Full-time-equivalent health care providers per 100,000 population, state and territory specialised mental health service units, by service setting, 1992–93 to 2017–18**



Source: National Mental Health Establishments database; Table FAC.43. www.aihw.gov.au/mhsa

## Private hospital specialised mental health services

Staffing provided in private hospital specialised mental health services are not available for 2017–18. These data were previously provided by the Australian Bureau of Statistics through its Private Hospitals Establishment Collection (PHEC), but this survey was discontinued in 2016–17. The [data source](#) section provides further information.

## 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 provided 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 worker 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, and 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 Quality Statements](#) for National Minimum Data Sets (NMDSs) are published annually on the Metadata Online Registry ([METeOR](#)). Statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence.

## 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 made to previous versions of *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.

### Data Source FAC.1 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 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 8 levels used to describe the extent to which a service unit has implemented the National Standards, as shown in the table below.

### Data Source FAC.2 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 as determined by the accrediting agency.
2	The service unit had been reviewed by an external accrediting 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 accrediting agency but the outcomes were not known.
4	The service unit was booked for review by an external accrediting 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 accrediting agency for review.
6	The service unit had not commenced the preparations for review by an external accrediting 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 accrediting agency under the National standards.
8	The National standards are not applicable to this service unit.

*Source:* National Standards for Mental Health Services status (see METeOR ID: [573549](#)).

## Reporting levels for national standards

To match definitions in the National Key Performance Indicator set for Mental Health Services, the data presented are restricted to 4 levels. Level 1 represents code 1, Level 2 represents code 2, Level 3 represents codes 3 and 4 and Level 4 represents codes 5–7. Code 8 is excluded as the standards do not apply to these units.

The national standards for mental health services were revised in 2010 ([DoH 2010](#)). In addition to these mental health-specific national standards, other national standards have been published and implemented against which mental health services may also be measured. Work is ongoing to improve the method for reporting the standards against which a service is measured.

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

All New South Wales Confused and Disturbed Elderly (CADE) 24-hour staffed *Residential mental health care services* were reclassified as specialised mental health non-acute 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 re-classified 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 the above hyperlink for further information about the NSW HASI program.

From 2017–18 New South Wales supported housing places reflect changes resulting from the conclusion of the Commonwealth National Partnership Agreement (NPA) on Mental Health Services. The NSW Government continued funding until Dec 2017 to allow for transition to alternative support arrangements (including the NDIS) for up to 200 people in NPA funded supported housing places.

## **Rate calculations**

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

- *General services*: persons aged 18–64.
- *Child and adolescent services*: persons aged 0–17.
- *Youth services*: persons aged 16–24.
- *Older persons*: persons aged 65 and over.
- *Forensic services*: persons aged 18 and over.

Crude rates were calculated using the Australian Bureau of Statistics estimated resident population (ERP) at the midpoint of the data range (for example, rates for 2017–18 data were calculated using ERP at 31 December 2017). Historical rates have been recalculated

using revised ERPs based on the 2011 Census of Population and Housing, as detailed in the online technical information.

## Private Health Reporting

### Private Health Establishments Collection

From 1992–93 to 2016–17 (excluding 2007–08) the ABS conducted a census of all private hospitals licensed by state and territory health authorities and all freestanding day hospitals facilities approved by the Commonwealth Department of Health. As part of that census, data on the staffing, finances and activity of these establishments were collected and compiled in the Private Health Establishments Collection. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2018).

The data definitions used in the Private Health Establishments Collection are largely based on definitions in the *National health data dictionary* (NHDD) published on the AIHW's Metadata Online Registry (METeOR) website (AIHW, 2015). 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 2018). 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. For further technical information, see the Private psychiatric hospital data section of the *National mental health report 2013* (DoH 2013).

The last data were collected for the 2016–17 period. Increases in psychiatric beds were the result of improvements in methodology to apportion the data between psychiatric and alcohol/drug treatment wards, new establishments reporting for the first time, and a general increase in psychiatric beds in establishments that have reported psychiatric units in the past. Caution is required when comparing data for 2010–11 to other years as the survey was altered such that psychiatric units could no longer be separately identified from alcohol/drug treatment units. Therefore, the data for beds, patient days, separations and staffing were estimates based on reported 2010–11 data and trends observed in previous years. Data from the Private Mental Health collection suggest that these data may be underestimates (PMHA 2013).

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## Private Psychiatric Hospitals Data Reporting and Analysis Service

The Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS), previously known as the Private Mental Health Alliance Centralised Data Management Service (PMHA CDMS), was launched in Australia in 2001

to support private hospitals with psychiatric beds to routinely collect and report on a nationally agreed suite of clinical measures and related data for the purposes of monitoring, evaluating and improving the quality of and effectiveness of care. The PPHDRAS works closely with private hospitals, health insurers and other funders (e.g. Department of Veterans' Affairs) to provide a detailed quarterly statistical reporting service on participating hospitals' service provision and patient outcomes.

The PPHDRAS fulfils two main objectives. Firstly, it assists participating private hospitals with implementation of their National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures. Secondly, the PPHDRAS provides hospitals and private health funds with a data management service that routinely prepares and distributes standard reports to assist them in the monitoring and evaluation of health care quality. The PPHDRAS also maintains training resources for hospitals and a database application which enables hospitals to submit de-identified data to the PPHDRAS. The PPHDRAS produces an annual statistical report. In 2017–18, the PPHDRAS accounted for 98% of all private psychiatric beds in Australia.

From 2017–18, all private hospital data is sourced from PPHDRAS. Data on expenditure and Staffing (FTE) are not collected in PPHADRAS.

## Population data

Population estimates used to calculate population rates were sourced from the Australian Bureau of Statistics.

## 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 <a href="#">374151</a> ). Data prior to 2005–06 were 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>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.

**Consumer committee representation arrangements**

Specialised mental health organisations report the level of **consumer committee representation arrangements**. 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. The [data source](#) section provides information on the levels available.

**Government-operated residential mental health services**

**Government-operated residential mental health services** are specialised *Residential mental health care 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.

**Health care providers**

**Health care providers** refers to the following staffing categories: salaried medical officers, nurses, diagnostic and allied health professionals, other personal care staff and mental health consumer and carer workers.

**Mental health carer worker**

**Mental health carer workers** are employed (or engaged via contract) on a part-time or full-time basis specifically for their expertise developed from their experience as a mental health carer (METeOR identifier [450730](#)). Mental health carer workers include the job titles of, but not limited to, carer consultants, peer support workers, carer support workers, carer representatives and carer advocates. Roles that mental health carer workers may perform include, but are not limited to, mental health policy development, advocacy roles and carer support roles.

**Mental health consumer worker**

**Mental health consumer workers** are employed (or engaged through contracts) on a part-time or full-time basis specifically due to the expertise developed from their lived experience of mental illness (METeOR identifier [450727](#)). Mental health

consumer workers include the job titles of, but not limited to, consumer consultants, peer support workers, peer specialists, consumer companions, consumer representatives, consumer project officers and recovery support workers. Roles that mental health consumer workers may perform include, but are not limited to, participation in mental health service planning, mental health service evaluation and peer support roles.

**National standards for mental health services**

The **National standards for mental health services** (DoH 2010) were developed under the *First National Mental Health Plan* and are applicable to individual service units. There are 8 levels available to describe a service unit's status (METeOR identifier 573549). The [data source](#) section provides information for the full description of all 8 levels and information relating to the revised 2010 national standards (Health 2010). For reporting purposes, the data are collated into the following 4 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.
- Level 3: the service unit was in the process of being reviewed by an external accreditation agency but the outcomes are not known; or the service unit is booked for review by an external accreditation agency.
- Level 4: the service unit does not meet the criteria detailed in levels 1 to 3.

**Non-government-operated residential mental health services**

**Non-government-operated residential mental health services** are specialised *Residential mental health care services* which meet the same criteria as government-operated *Residential mental health care 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 care 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



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organisations specifically for mental health-related programs and initiatives and are reported separately to expenditure reported for non-government-operated *Residential mental health care services*.

**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 care 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 either the number of patient days reported to the National Hospital Morbidity Database (Admitted patient mental health-related care section) or 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. From 2017–18, all private hospital data is sourced from the Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS). Data on expenditure and Staffing (FTE) are not collected in PPHADRAS. Up to 2016–17, data were 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 2018](#)), that is, providing 50% or more of the total patient days for psychiatric patients. The data published in this section also include psychiatric units or wards in private hospitals. Further information can be found in the [data source](#) section.

**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*; *Residential mental health care services*, including government and non-government-operated services; and at the *Organisational overhead* setting. The *Organisational overhead* setting level has been included from 2012–13 capturing staff employed by specialised mental health service organisations, performing organisational management roles.

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**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 care 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, that is, the total hours actually worked divided by the number of normal hours worked by a full-time staff member (METeOR identifier [269172](#)).

**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 [390929](#)). 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 5 **target population** groups (refer to METeOR identifier [493010](#)):

- *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* programs provide services to the adult population, aged 18 to 64; however, these services may also provide assistance to children, adolescents or older people.

- *Youth* services target children and young people generally aged 16–24 years.

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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