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 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 2016–17. This section was last updated in March 2019.

Key points

161 public hospitals and **68 private hospitals** provided specialised mental health services for admitted patients during 2016–17.

7,175 specialised mental health public hospital beds were available in 2016–17; providing 2.3 million patient days to people in hospital.

3,011 mental health beds were available in private hospitals in 2016–17.

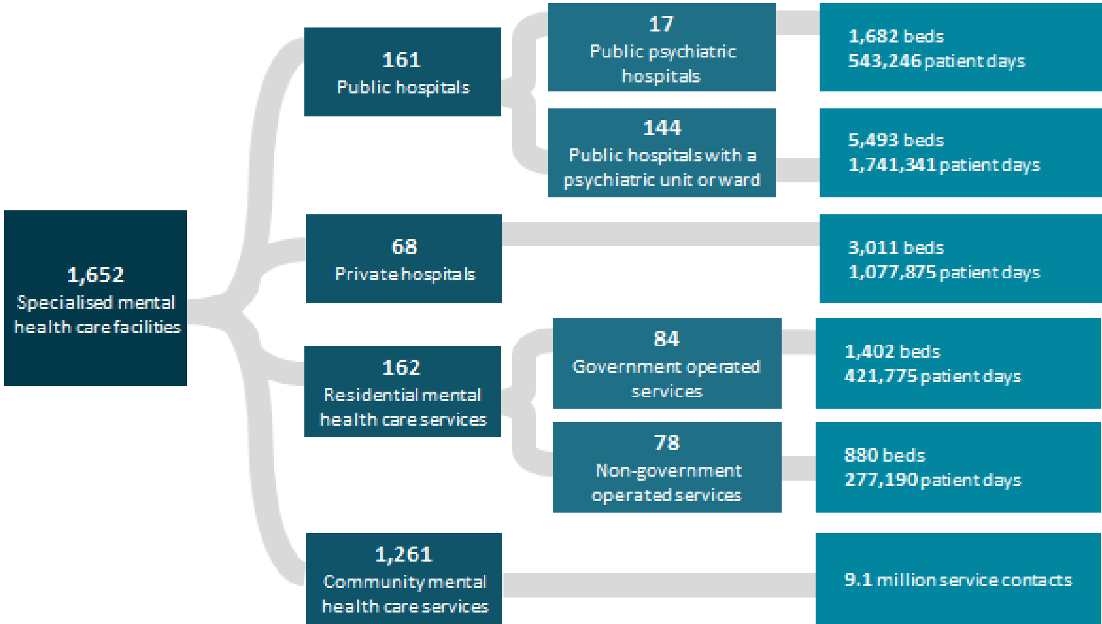
2,281 residential mental health beds were available during 2016–17, with almost two-thirds operated by government organisations.

12,346 full-time-equivalent staff were employed by community mental health care services in 2016–17.

Overview

There were 1,652 specialised mental health care facilities providing care in 2016–17 (Figure FAC.1).

Figure FAC.1: Number of specialised mental health care facilities, available beds and activity in Australia, 2016–17



Sources: Tables FAC.1, FAC.4, FAC. 20 and FAC.24.

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 (SEWB) services for Aboriginal and Torres Strait Islander people (AIHW, 2018). 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 2016–17, there were 88 organisations that provided SEWB services to approximately 16,300 clients (AIHW, 2018). These organisations employed 189 counsellors and were located at various sites across Australia. For more information on the organisation profile, staffing and types of services provided by SEWB services, see the Social and

emotional wellbeing section (chapter 5) of the Aboriginal and Torres Strait Islander health organisations: Online Services Report (2016–17).

Specialised mental health service organisations

There were 170 specialised mental health service organisations responsible for the administration of the 1,584 state and territory specialised mental health facilities (excluding private hospitals) during 2016–17.

The most common organisation type had specialised mental health public hospital services and community mental health care services only within their organisational structure (82 organisations or 48.2%). These organisations accounted for around two-thirds of the beds and patient days (69.9% and 69.8% respectively) provided by specialised mental health public hospital services and almost two thirds (62.4%) of all community mental health care service contacts.

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 2016–17, 76 (44.7%) employed mental health consumer workers and 46 (27.1%) employed mental health carer workers. South Australia had the highest proportion of mental health organisations employing consumer workers (61.9%) and the highest proportion employing carer workers (57.1%).

Nationally, the rate of mental health consumer workers employed increased from 26.6 FTE per 10,000 mental health care provider FTE staff in 2012–13 to 45.2 FTE in 2016–17; an annual average increase of 14.2%. Over the same period, the rate of mental health carer workers employed increased slightly from 14.3 FTE per 10,000 mental health FTE staff in 2012–13 to 15.3 in 2016–17; an annual average increase of

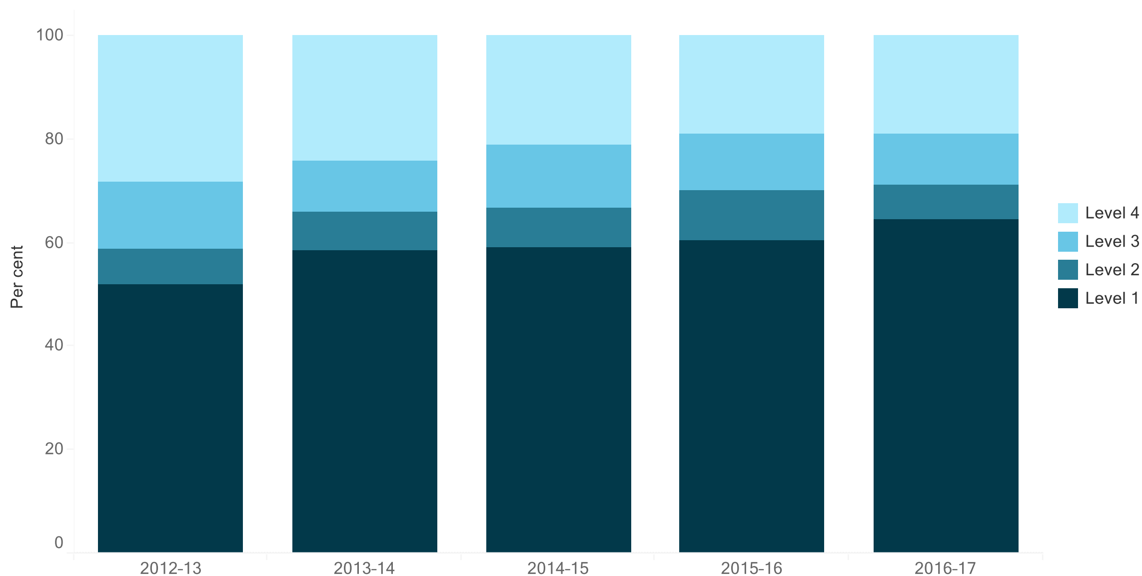
1.6%. Caution is required when interpreting these data since small increase in the numbers of mental health consumer and carer workers may have a relatively large impact on the reported rates.

Consumer committee representation arrangements

In 2016–17, 110 (64.7%) 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 51.9% in 2012–13 to 64.7% in 2016–17 (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 decreased from 28.2% in 2012–13 to 18.8% in 2016–17; and has substantially decreased from 46.7% in 1993–94.

Figure FAC.2: Specialised mental health organisations, by level of consumer committee representation, 2012–13 to 2016–17



Key:
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.
Level 2 Specific consumer advisory committee(s) exist to advise on some mental health services managed.
Level 3 Consumers participate on an advisory committee representing a wide range of interests.
Level 4 No consumer representation on any advisory committee; meetings with senior representatives encouraged.

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

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

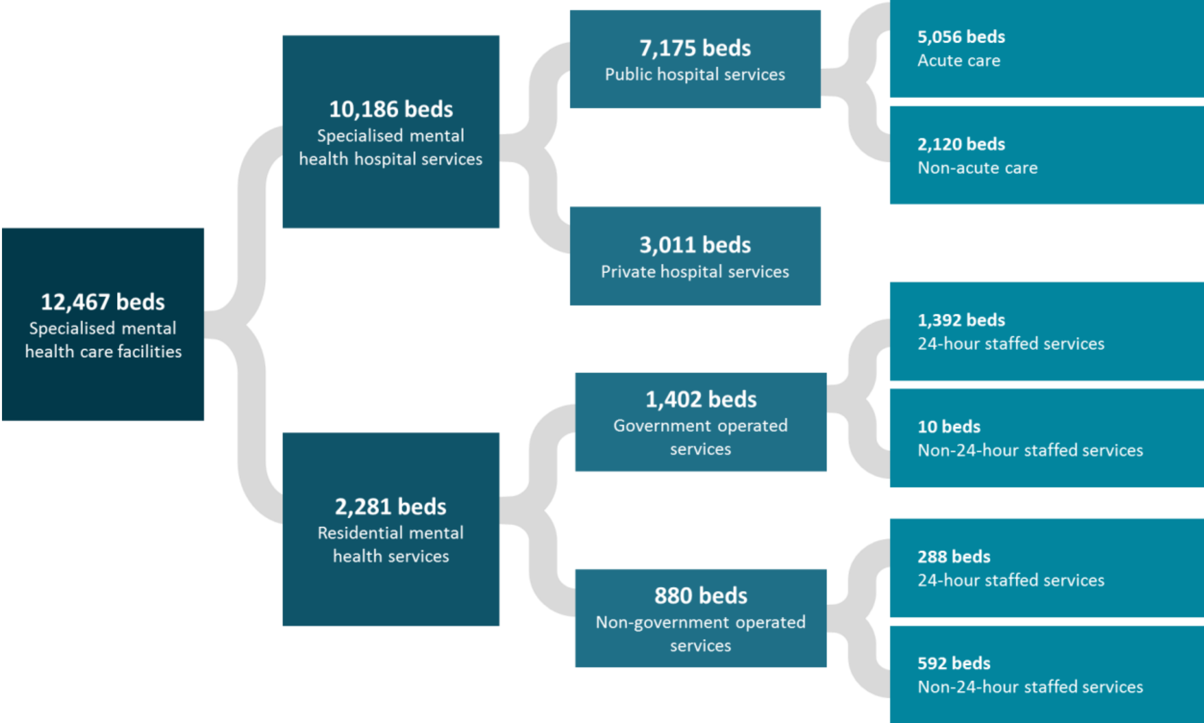
process is cyclical in nature and therefore state and territory results may vary greatly from year to year.

Using this approach, 83.2% 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 2016–17. The Australian Capital Territory was the only jurisdiction to report all service units meeting Level 1, although a large proportion of service units in Queensland (94.0%), New South Wales (91.3%) and Western Australia (87.9%) also met Level 1 standards. 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 2016–17, there were 12,467 specialised mental health beds available nationally, with 7,175 beds provided by public hospital services, 3,011 by private hospitals, and 2,281 by residential mental health services (Figure FAC.3).

Figure FAC.3: Distribution of specialised mental health beds in Australia, 2016–17



Sources: Tables FAC.12, FAC. 20 and FAC.24.

Public sector specialised mental health hospital beds

In 2016–17, there were 7,175 public sector specialised mental health hospital beds available in Australia. Three quarters of these (76.5% or 5,493 beds) were in specialised psychiatric units or wards within public acute hospitals, with the remainder in public psychiatric hospitals (1,682 beds).

New South Wales (35.5) had the highest number of beds per 100,000 population in 2016–17, while the Northern Territory had the lowest (17.5), compared to the national rate of 29.4 beds per 100,000 population.

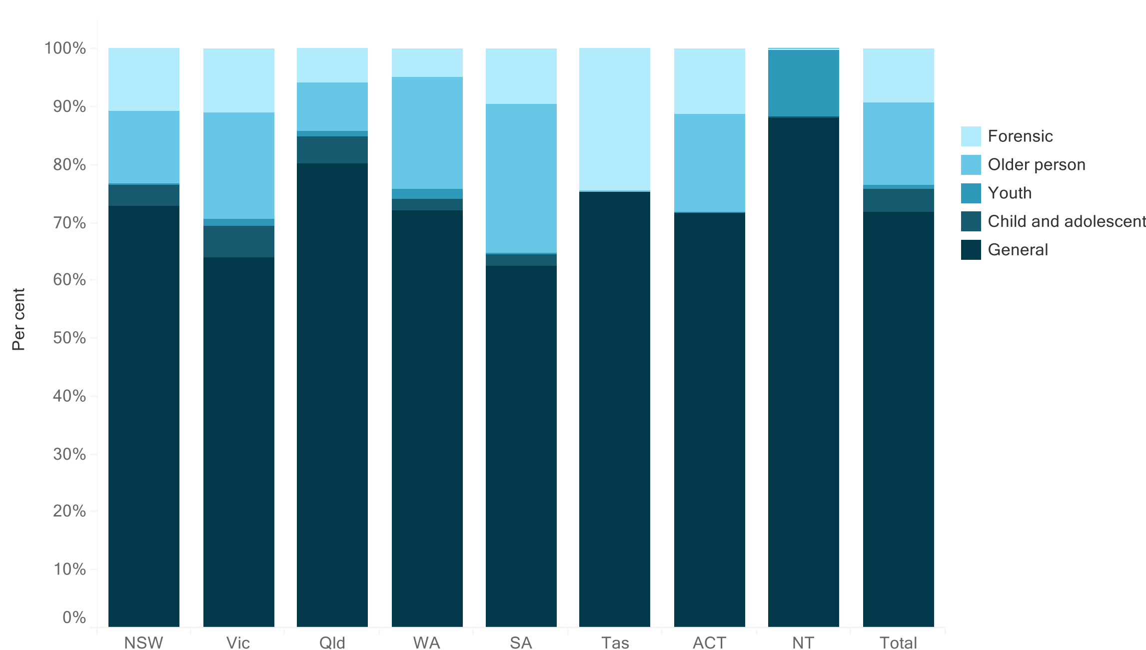
Public sector specialised mental health hospital beds can also be described by the target population or program type category of the specialised mental health service unit, or a combination of both.

Target population

During 2016–17, the majority of public sector specialised mental health hospital beds (5,166 or 72.0%) were in *General* services, 1,022 beds (14.2%) were in *Older person* services, 658 (9.2%) were in *Forensic* services and 279 (3.9%) were in *Child and adolescen*t services. A small number of beds were located in *Youth* services (50 beds or 0.7%); 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 62.5% 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, 2016–17



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 (41.7) and *Child and adolescent* services (6.3) compared to the national rates of 34.0 and 5.1 per 100,000 population respectively. South Australia (44.3) had the highest number of *Older person* hospital beds per 100,000 population (national average 27.4) and Tasmania (5.6) had the most *Forensic* hospital beds per 100,000 population (national average 3.5). The Northern Territory reported the highest number of *Youth* beds per 100,000 population (16.9) compared to the national rate of 1.7 per 100,000 population.

Program type

More than two-thirds (5,056 beds or 70.5%) of all public sector specialised mental health hospital beds across Australia were in Acute services during 2016–17 (Figure FAC.3).

The proportion of acute beds differed among the target population groups. The majority of *Child and adolescent* beds (90.0%), *General* beds (72.1%), *Youth* beds (100.0%) *Older person* beds (70.7%) were in Acute services in 2016–17, compared with less than half of *Forensic* beds (46.4%).

Residential mental health service beds

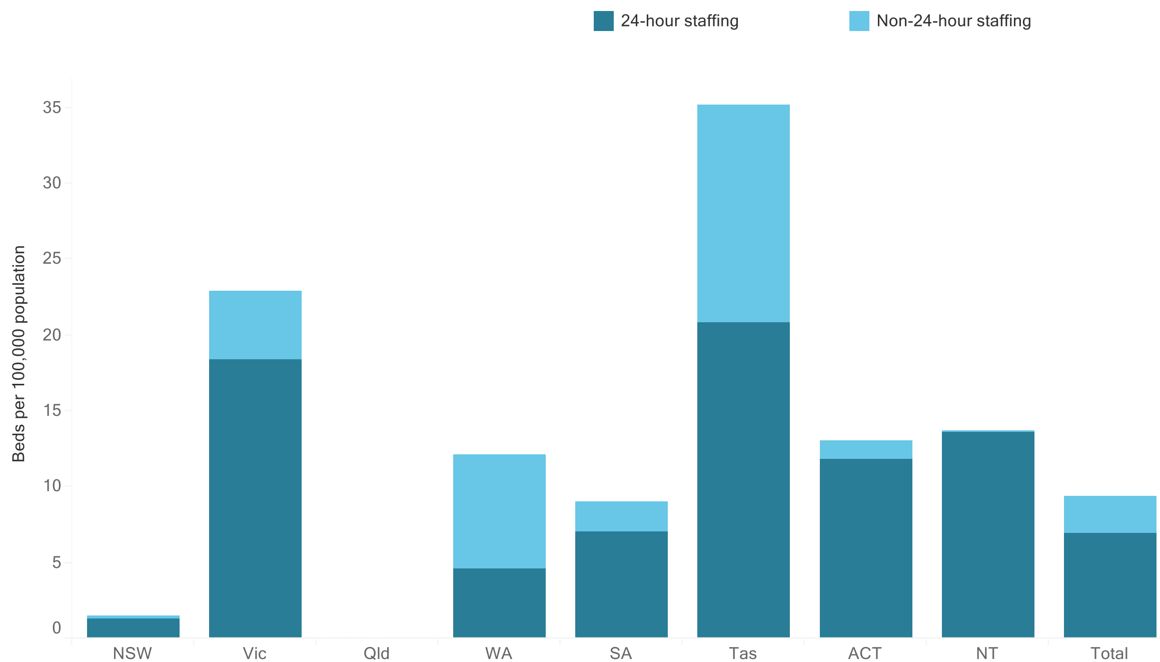
In 2016–17, there were 2,281 residential mental health service beds available nationally. These can be further characterised by the level of staffing provided, target population and the service operator (government or non-government), reflecting the service profile mix in each state or territory.

The total number of beds in government-operated services was 1,402 (61.5 %). Three quarters (1,680 or 73.6%) 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 (1,392 beds). By contrast, non-24-hour staffed residential beds were predominately provided by the non-government sector. More than two-thirds (1,566 beds or 68.7%) of all residential beds were in *General* services with more of these beds in 24-hour staffed facilities (1,068 or 68.2%) than in non-24-hour staffed facilities (499 or 31.8%).

In the Australian Capital Territory, there has been a decline in the reported number of non-24 hour staffed residential beds, from 40 to 5 beds. 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. The AIHW is investigating options for reporting NDIS services provision.

In 2016–17, there were 9.4 residential mental health beds per 100,000 population nationally. Of those jurisdictions reporting residential mental health beds, Tasmania (35.2) had the highest number per 100,000 population, while New South Wales (1.5) had the lowest (Figure FAC.5). Queensland does not currently report residential mental health services. Refer to the data source section for further information.

Figure FAC.5: Residential mental health service beds per 100,000 population, by hours staffed, states and territories, 2016-17



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

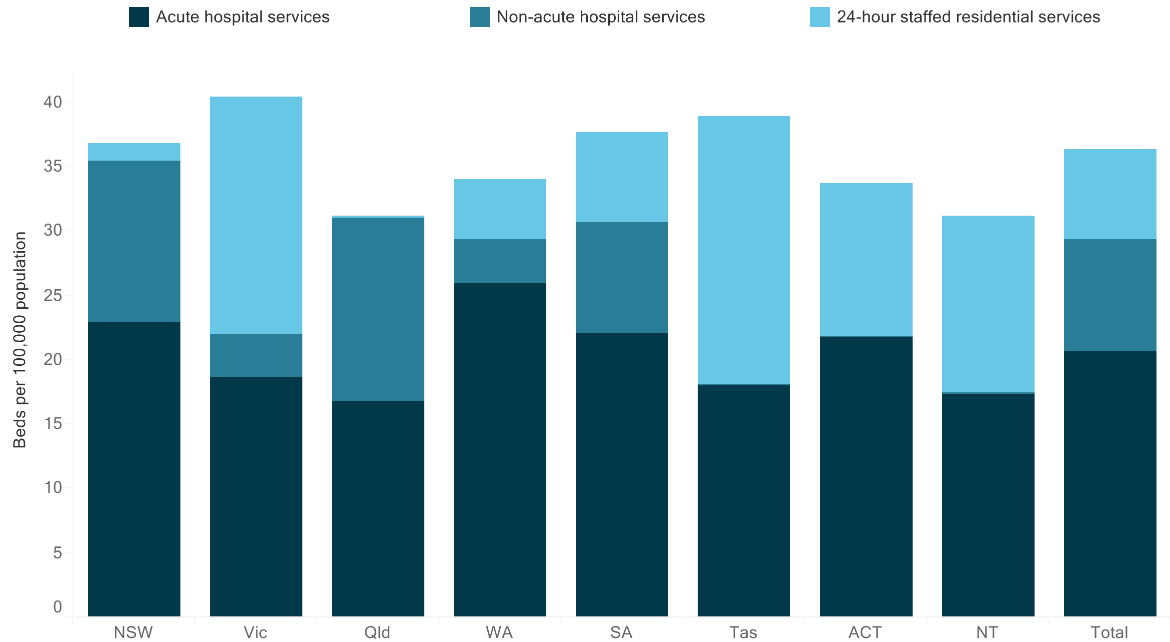
Victoria (52.2) had the highest number of residential mental health beds per 100,000 population in *Older persons* 24-hour staffed care services. Tasmania had the highest number of residential beds per 100,000 population in *General* services for both 24-hour staffed care (24.6) and non-24-hour staffed care (24.3). 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 2016–17. Data for *Youth* services are reported separately for the third time in this release, with Western Australia (5.4 beds per 100,000 population), Victoria (17.5), and the Australian Capital Territory (20.5) reporting specialised *Youth* services.

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 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 (40.5) in 2016–17, followed closely by Tasmania (38.9), while the Northern Territory and Queensland had the lowest (both 31.2), compared with the national average of 36.3 (Figure FAC.6).

Figure FAC.6: Specialised mental health beds per 100,000 population, by 24-hour care setting, states and territories, 2016-17



Source: National Mental Health Establishments database; Table FAC.23.

Private hospital specialised mental health beds

There were 3,011 available beds (12.3 per 100,000 population) in private psychiatric hospitals in 2016–17, 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 9,124 beds in 2012–13 to 9,456 beds in 2016–17. The combined number of hospital and residential specialised mental health beds per 100,000 population remained relatively stable across the 2012–13 to 2016–17 period, with 39.8 beds per 100,000 population being reported in 2012–13 and 38.8 in 2016–17.

Public sector specialised mental health hospital beds

There was a decrease in the number of public sector psychiatric hospital beds reported from 1,831 beds in 2012–13 to 1,682 beds in 2016–17. 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 4,937 beds in 2012–13 to 5,493 beds in 2016–17). Overall, the number of hospital beds per 100,000 population has remained stable over the same period, with approximately 30 beds per 100,000 population across the 5-year period from 2012–13 to 2016–17.

Residential mental health service beds

The number of specialised residential mental health service beds decreased over the 5 years from 2,356 beds in 2012–13 to 2,281 beds in 2016–17; however, residential beds per 100,000 population remained stable at around 10.

Supported housing places

In addition to the services described above, jurisdictions also provide supported housing places for people with a mental illness. There were 5,194 supported housing places available in 2016–17 for people with a mental illness. Western Australia (59.1) had the highest number of supported housing places per 100,000 population, compared with the national average of 21.3 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 2.3 million patient days were provided by public hospital specialised mental health services during 2016–17. Almost three-quarters (76.2%) 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 (112.9) had the highest number of patient days per 1,000 population, while the Northern Territory (54.1) had the lowest, compared with the national rate of 93.6.

Residential mental health services

During 2016–17, residential mental health services provided nearly 700,000 patient days. About two-thirds (73.2%) of all patient days were for residents of 24-hour staffed services. Tasmania (149.0.) had the highest number of patient days per 100,000 population in *General* services, while New South Wales (5.7) had the lowest; compared with the national rate of 31.6.

Private hospital specialised mental health services

During 2016–17, private specialised mental health hospital services provided about 1.1 million patient days, equating to 44.2 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

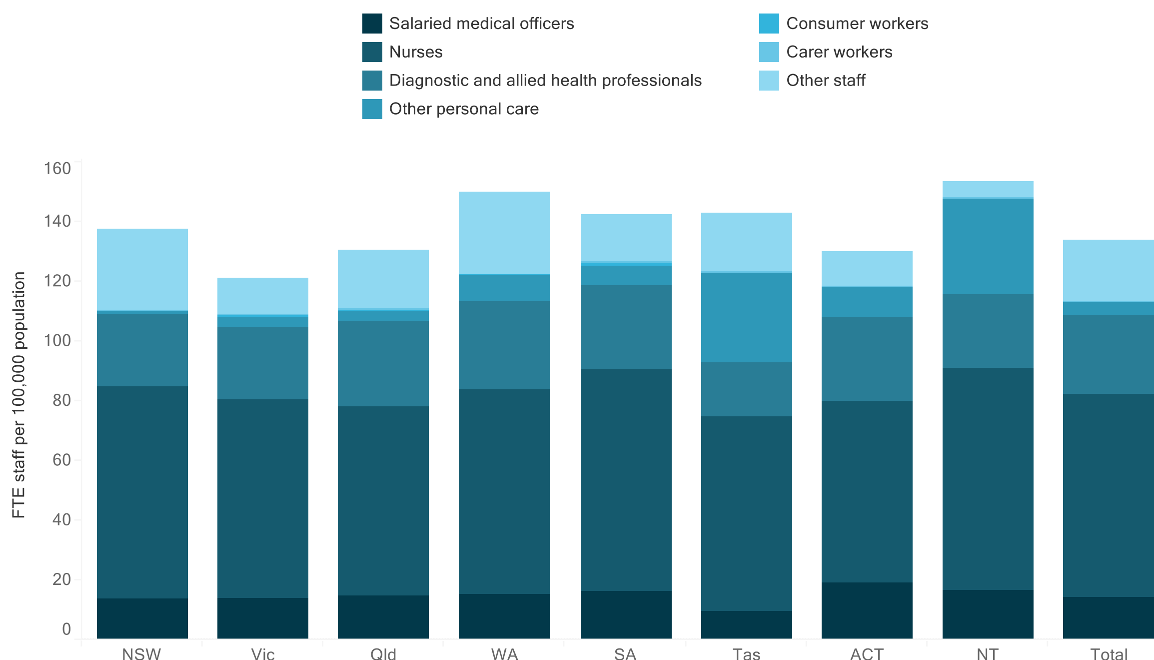
State and territory specialised mental health care services

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 services.

In 2016–17, of the 32,573 full-time-equivalent (FTE) staff employed in state and territory specialised mental health care services, half were nurses (16,603 FTE or 51.0%) with the majority registered nurses (14,286 FTE). Diagnostic and allied health professionals (6,310 FTE or 19.4%) made up the second largest group of staff, comprising mostly social workers (2,115 FTE) and psychologists (1,832 FTE). Salaried medical officers made up 10.7% of FTE staff, with similar numbers of consultant psychiatrists and psychiatrists (1,447 FTE), and psychiatry registrars and trainees (1,670 FTE).

In 2016–17, there were 133.6 FTE staff per 100,000 population nationally employed in specialised mental health care services (Figure FAC.7). The Northern Territory (153.2) had the highest number of FTE staff per 100,000 population, while Victoria (120.9) had the lowest.

Figure FAC.7: Full-time-equivalent staff per 100,000 population by staffing category, states and territories, 2016-17



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

Alt-text: Vertical stacked bar chart showing full-time-equivalent staff per 100,000 population by staffing category and states and territories in 2016–17. NSW (137.6), Vic (120.9), Qld (130.3), WA (149.7), SA (142.5), Tas (143.1), ACT (129.7), NT (153.2) and Total (133.6). Nurses made up the majority of full-time-equivalent staff across all jurisdictions. Refer to Table FAC.36.

The number of FTE staff per 100,000 population employed in specialised mental health care services has remained relatively stable between 2012–13 and 2016–17 across most labour force categories, apart from consumer workers. The number of FTE consumer workers increased from 0.3 to 0.5 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).

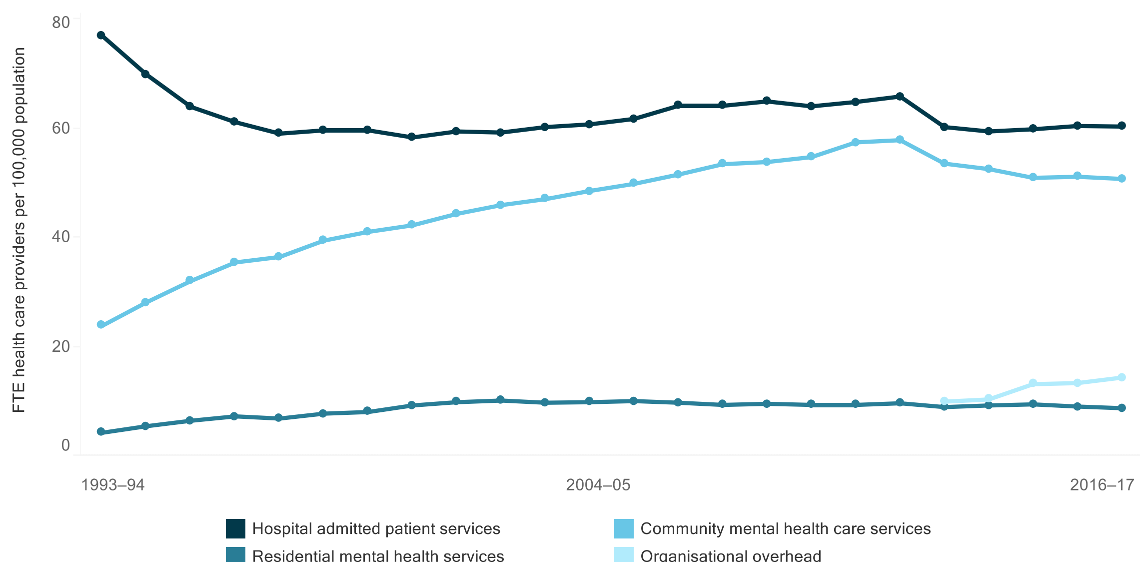
Almost half (14,676 FTE or 45.1%) of state and territory specialised mental health care services staff were employed in public hospital specialised mental health services. Community mental health care services employed the next largest number of FTE staff (12, 346 or 37.9%). Since 1993–94, the number of FTE staff employed in specialised mental health admitted patient hospital services has remained relatively stable (approximately 13,000 to nearly 15,000 FTE staff) while those employed by community mental health services has increased nearly threefold (around 4,000 in 1993–94 to over 12,000 in 2016–17).

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 2016–17, public hospital specialised mental health services employed 54.9 FTE health care providers per 100,000 population (Figure FAC.8). Community mental health care services employed 45.1 FTE health care providers per 100,000 population in 2016–17 and Residential mental health services employed 7.7.

FAC.8: Full-time-equivalent health care providers per 100,000 population, specialised mental health service units, by service setting, states and territories, 1993-94 to 2016-17



Source: National Mental Health Establishments database; Table FAC.40.

Alt-text: Line graph showing the number of FTE health care providers per 100,000 population employed by specialised mental health service units, by service setting and states and territories from 1993–94 to 2016–17. The number of FTE health care providers employed by hospital admitted patient services decreased between years 1993–94 and 1997–98 but since 1998–99 has remained relatively stable across the time period. The number of FTE health care providers employed in residential services have increased since 1993–94 and has remained relatively stable since 2007–08. FTE employed in community mental health services has remained relatively stable over the past 10 years. Organisational overhead service settings began reporting FTE health care providers in 2012–13. Refer to Table FAC.40.

Private hospital specialised mental health services

During 2016–17, specialised psychiatric services in private hospitals employed 3,541 FTE staff, equating to 14.5 FTE staff employed per 100,000 population. 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. Comparison with previous years' data should be made with caution due to changes in collection methodology. 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 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 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 during 2016–17, 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 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.

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 2016–17 data were calculated using ERP at 31 December 2016). 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 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 the Commonwealth Department of Health. 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. 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 most recent 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).

Key concepts

Specialised mental health care facilities

Key Concept	Description
Beds	The number of available specialised mental health **beds** 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 374151). 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.
Carer	A **carer** is a person whose life is affected by virtue of a family or close relationship and caring role with a mental health consumer.
Community mental health care services	**Community mental health care services** 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	A **consumer** 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.
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 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** (DHFS 1996) 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 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 and are reported separately to expenditure reported for non-government-operated residential mental health 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 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. 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 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 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.

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, 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 445778): • *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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