Specialised mental health care facilities

On this page:

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 tables link – Specialised mental health care facilities tables

PDF link- Specialised mental health care facilities section

Link - Data source and key concepts related to this section

Data coverage includes the time period 1992–93 to 2019–20. This section was last updated in February 2022.

You may also be interested in:

- Expenditure on mental health-related services
- Community mental health care services
- Residential mental health care services

Key points

- **161 public hospitals** and **68 private hospitals** provided specialised mental health services for admitted patients during 2019-20.
- **7,019** specialised mental health public hospital beds were available in 2019–20; providing 2.3 million patient days to people in hospital.
- **3,494** mental health beds were available in private hospitals in 2019–20.

- **2,438** residential mental health beds were available during 2019–20, with over two-thirds operated by government organisations.
- **13,948 full-time-equivalent staff** were employed by *Community mental health care services* in 2019–20.

There were 1,731 specialised mental health care facilities providing care in 2019–20 (Figure FAC.1.1).

Figure FAC.1.1: Number of specialised mental health care facilities, available beds and activity in Australia, 2019–20

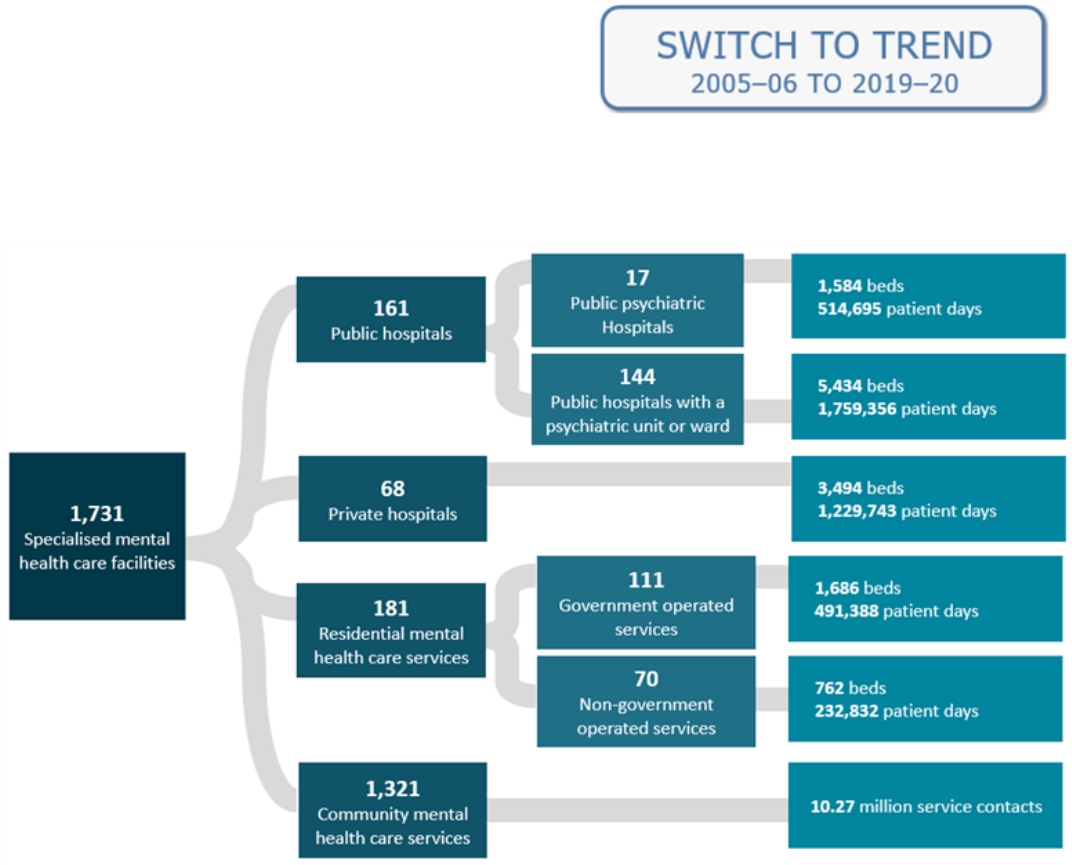


Figure FAC.1.1: Number of specialised mental health facilities , available beds and activity in Australia, 2019–20
http://www.aihw.gov.au/mhsa

Source: Specialised mental health care facilities tables

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 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 Indigenous Australians (AIHW 2021). 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 2019-20, 442 social and emotional wellbeing staff were located across Australia, providing approximately 234,220 client contacts (AIHW 2021). For more information on the organisation profile, staffing and types of services provided by SEWB services, see the *Aboriginal and Torres Strait Islander-specific primary health care: results from the OSR and nKPI collections (2019-20).*

Specialised mental health service organisations

There were 174 specialised mental health service organisations responsible for the administration of the 1,663 state and territory specialised mental health facilities (excluding private hospitals) during 2019–20. Of these, almost two-thirds (111 organisations or 63.8%) provided two or more types of services.

Of organisations that provided 2 or more types of services within an organisational structure, the most common pairing was specialised mental health public hospital services (includes public acute hospitals and public psychiatric hospitals) and *Community mental health care services* (63 or 36.2%). These organisations accounted for about half of the beds and patient days (51.0% and 49.8% respectively) provided by specialised mental health public hospital services and over two-fifths (42.0%) of all community mental health care service contacts.

Furthermore, more than three-quarters provided specialised *Community mental health care services* (137 or 78.7%). About two-thirds provided specialised mental health public hospital services (114 or 65.5%), and almost half provided *Residential mental health services* (80 or 46.0%).

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 174 specialised mental health service organisations reported nationally in 2019–20, 85 (48.9%) employed mental health consumer workers and 57 (32.8%) employed mental health carer workers. South Australia and Queensland had the highest proportion of organisations employing consumer workers (80.0% and 71.4% respectively) and South Australia had the highest proportion employing carer workers (70.0%).

Nationally, the rate of mental health consumer workers employed increased from 44.3 FTE per 10,000 mental health care provider FTE staff in 2015–16 to 70.4 FTE in 2019–20; an annual average increase of 12.3%. Over the same period, the rate of mental health carer workers employed increased from 17.5 FTE per 10,000 mental health FTE staff in 2015–16 to 25.4 FTE in 2019–20; an annual average increase of 9.7%. Caution is required when interpreting these data though 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 2019–20, 106 (60.9%) 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 60.6% in 2015–16 to 60.9% in 2019–20 (Figure FAC.2); and is substantially higher than the 16.8% in 1993–94, the first year of reported data. Conversely, the proportion of 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 2019–20. This change 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 2019–20, the proportion classified as Level 1 has fluctuated, dipping to 49.3% in 2005–06, peaking at 65.4% in 2008–09, and remaining above 60.0% between 2015–16 and 2019–20 (Figure FAC.2).

Figure FAC.2: Specialised mental health organisations, by level of consumer committee representation, 1993–94 to 2019–20

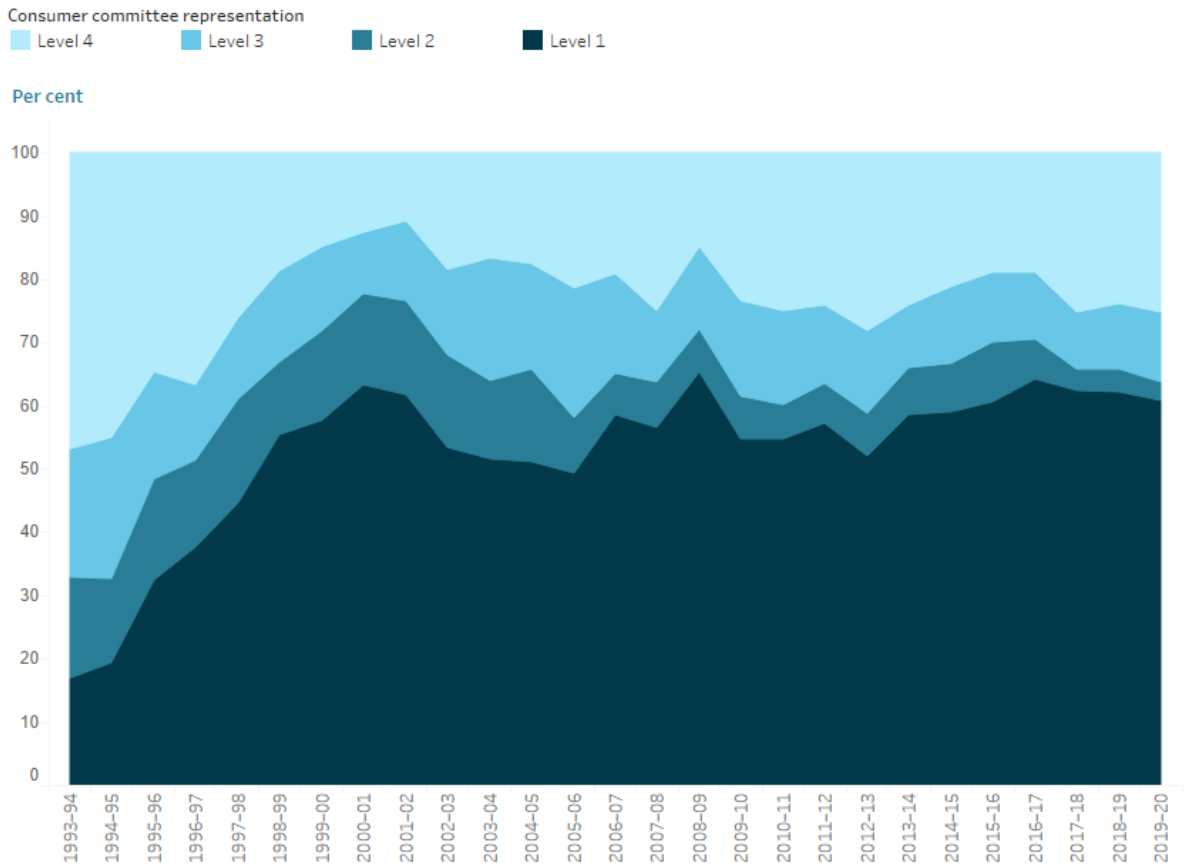


Figure FAC.2: Specialised mental health organisations, by level of consumer committee representation, 1993–94 to 2019–20
http://www.aihw.gov.au/mhsa

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: Specialised mental health care facilities tables 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.

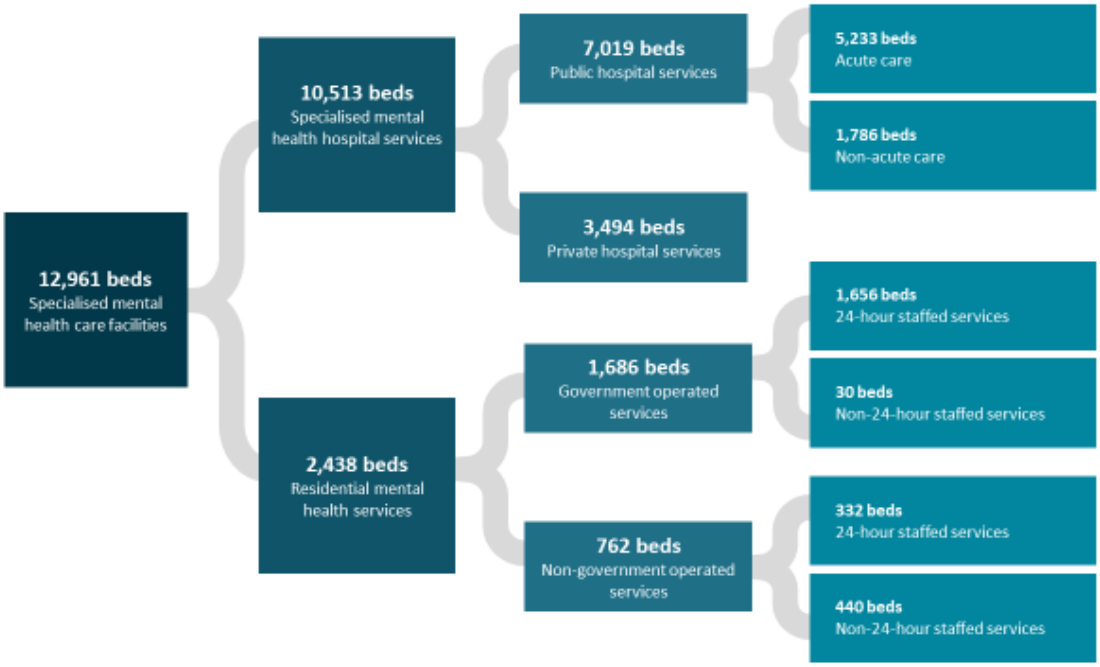
To accurately reflect the proportion of mental health services meeting the various National Standards levels, the expenditure reported for each service unit is used to calculate the proportion of services meeting the four reporting levels. In this way, the relative size of a service unit is accounted 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 so state and territory results may vary from year to year.

Using this approach, 88.0% 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 2019–20. The jurisdictions reporting the highest proportion of service units meeting Level 1 were South Australia (100%), Queensland (98.9%), Western Australia (97.6%) and Tasmania (97.5%). 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 2019–20, there were 12,961 specialised mental health beds available nationally, with 7,019 beds provided by public hospital services, 3,494 by private hospitals, and 2,438 by *Residential mental health care services* (Figure FAC.3).

Figure FAC.3: Distribution of specialised mental health beds in Australia, 2019-20



Source: Specialised mental health care facilities tables

Public sector specialised mental health hospital beds

In 2019–20, there were 7,019 public sector specialised mental health hospital beds available in Australia. About three quarters of these (77.4% or 5,434 beds) were in specialised psychiatric units or wards within public acute hospitals, with the remainder in public psychiatric hospitals (1,584 beds).

New South Wales (33.2) had the highest rate of beds per 100,000 population in 2019–20, while the Northern Territory had the lowest (17.5), compared to the national rate of 27.5.

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

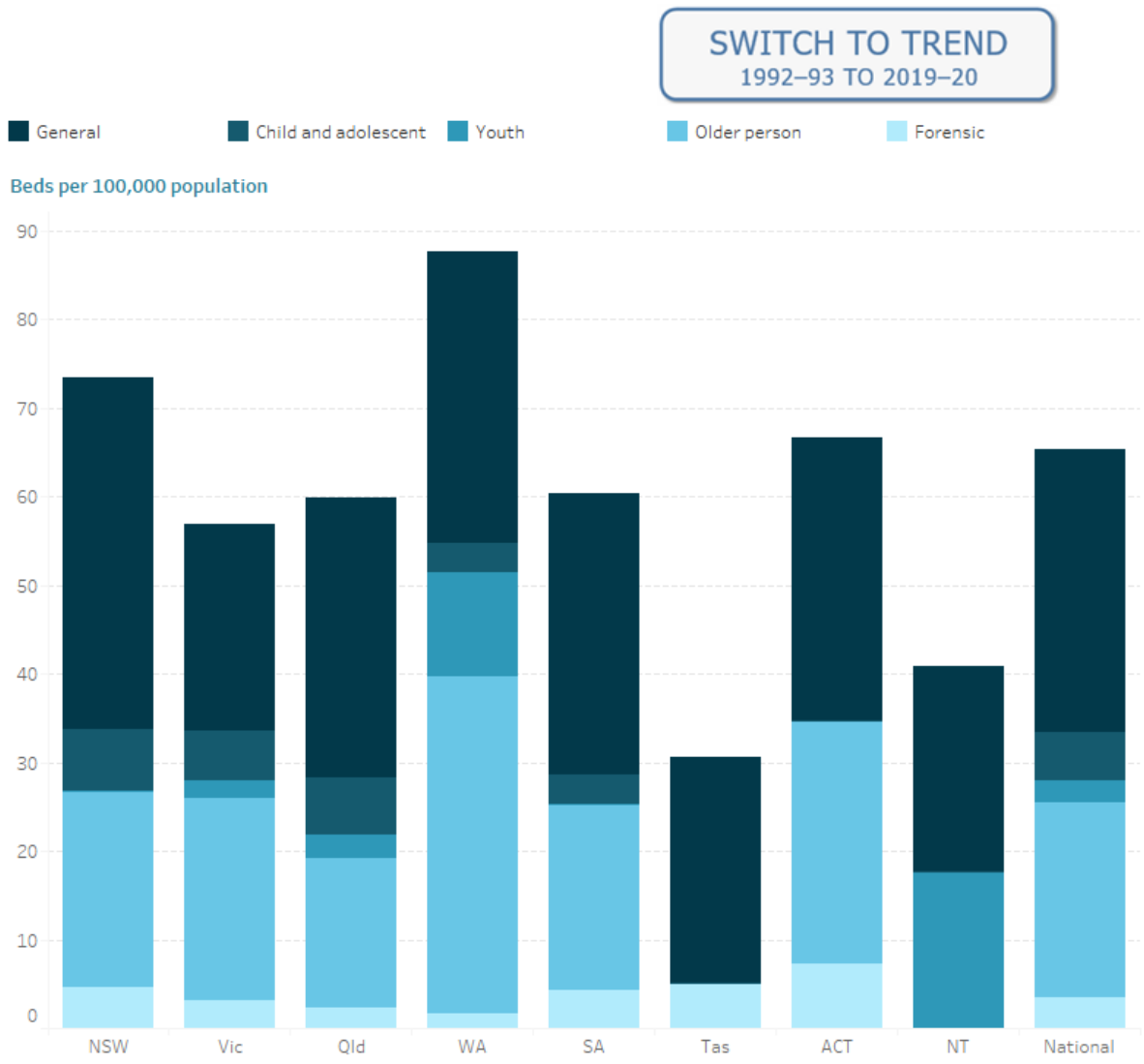
Target population

During 2019–20, the majority of public sector specialised mental health hospital beds (5,044 or 71.9%) were in *General* services, 911 beds (13.0%) were in *Older person* services, 680 (9.7%) were in *Forensic* services and 312 (4.4%) were in *Child and adolescent* services. A small number of beds were located in *Youth* services (71 beds or 1.0%); a service category that was introduced in 2011–12.

The proportion of specialised mental health hospital beds for each target population category varied across states and territories, reflecting the different service profile adopted in each jurisdiction. The majority of beds were in services classified as *General*, accounting for at least 66.3% of beds in each jurisdiction.

New South Wales had the highest rate of hospital beds per 100,000 population for both *General* services (39.7) and *Child and adolescent* services (7.0) compared to the national rates of 31.9 and 5.5 respectively (Figure FAC.4). Western Australia (38.1) had the highest rate of *Older person* hospital beds per 100,000 population (national average 22.1) and the Australian Capital Territory (7.2) had the highest rate of *Forensic* hospital beds (national average 3.4). The Northern Territory reported the highest rate of *Youth* beds (17.7) compared to the national rate of 2.4.

Figure FAC.4: Public sector specialised mental health hospital beds, by target population, states and territories, 2019–20



Source: Specialised mental health care facilities tables FAC.14 & FAC.23

Program type

Almost three-quarters (5,233 beds or 74.6%) of all public sector specialised mental health hospital beds across Australia were in Acute services during 2019–20 (Figure FAC.3).

The proportion of acute beds differed among the target population groups. The majority of *General* beds (75.9%), *Child and adolescent* beds (87.2%), *Youth* beds (100.0%), and *Older person* beds (81.7%) were in Acute services in 2019–20, compared with less than half of *Forensic* beds (46.9%).

Residential mental health service beds

In 2019–20, there were 2,438 residential mental health service beds available nationally. These can be 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 1,686 (69.1%). About three quarters (1,968 or 80.7%) 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 (1,656 beds). By contrast, non-24-hour staffed residential beds were predominantly provided by the non-government sector. More than two-thirds (1,648 beds or 67.6%) of all residential beds were in *General* services with more of these beds in 24-hour staffed facilities (1,306 or 79.2%) than in non-24-hour staffed facilities (342 or 20.8%).

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 between 2017–18 and 2019-20. 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 2019–20, there were 9.5 residential mental health beds per 100,000 population nationally. Amongst jurisdictions, Tasmania (30.3) had the highest rate while New South Wales (0.5) 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. For all other jurisdictions, 24-hour staffed services provided more beds.

Victoria (48.2) had the highest rate of residential mental health beds per 100,000 population in *Older persons* 24-hour staffed care services. Tasmania had the highest rate of residential beds per 100,000 population in *General services* for both 24-hour staffed care (22.4) and non-24-hour staffed care (16.9). New South Wales (0.5 beds per 100,000

population) was the only state or territory that reported residential mental health service beds for *Child and adolescent* services in 2019–20. Four jurisdictions reported specialised *Youth* services, with Victoria reporting 17.6 beds per 100,000 population, Queensland 5.1, Western Australia 5.5 and the Australian Capital Territory 21.0.

Figure FAC.5: Residential mental health service beds per 100,000 population, by hours staffed and target population, states and territories, 2019–20

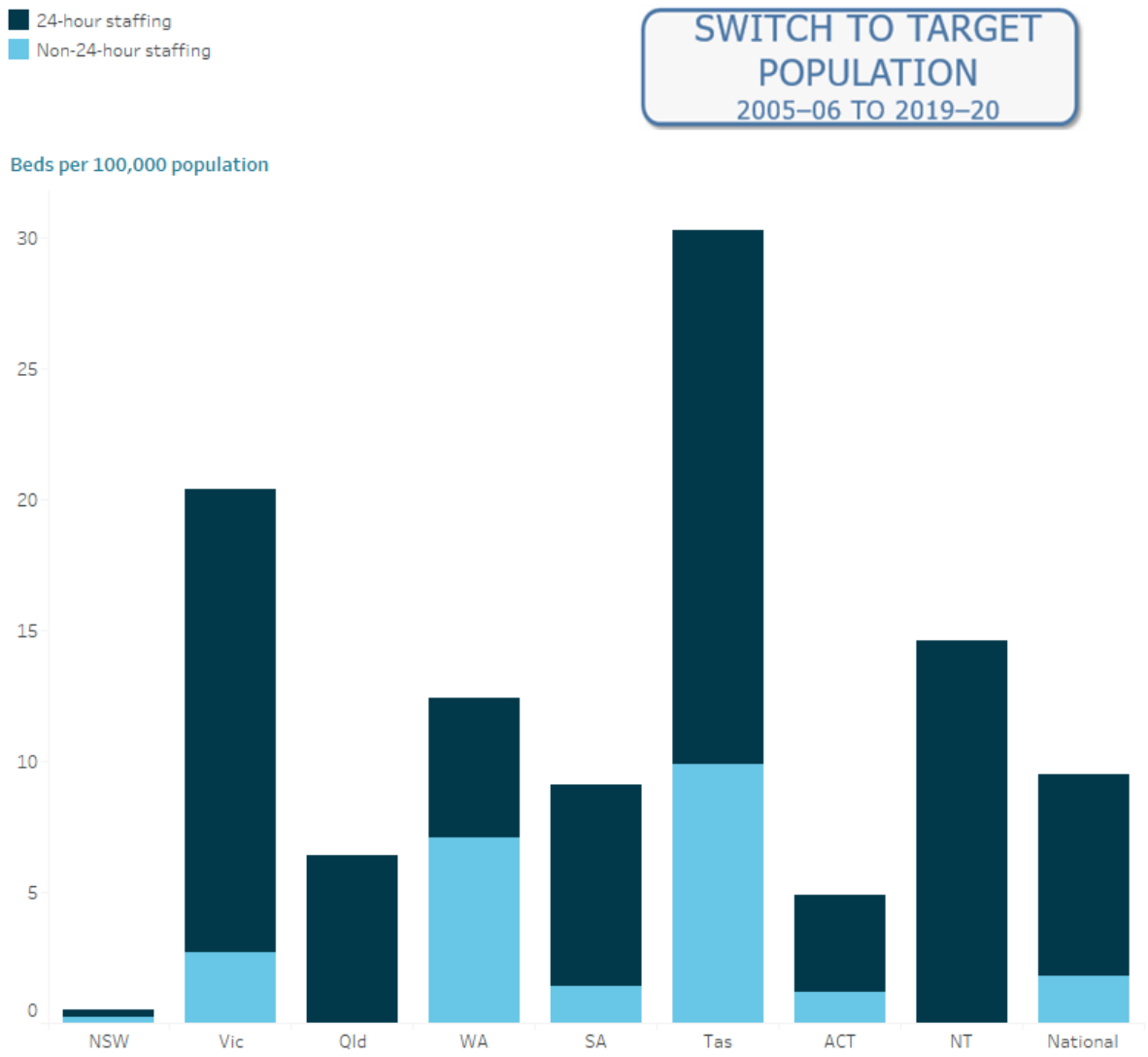


Figure FAC.5.1: Residential mental health service beds, by hours staffed, states and territories, 2019–20

http://www.aihw.gov.au/mhsa

Source: Specialised mental health care facilities tables FAC.19

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 rate of 24-hour staffed public sector beds per 100,000 population (39.8) in 2019–20, followed by Tasmania (39.4), while Queensland (31.9) and the Northern Territory (32.1) had the lowest rates, compared with the national average of 35.2 (Figure FAC.6). In New South Wales (21.8), Victoria (18.7), Queensland (17.1), Western Australia (26.7), South Australia (21.9) and Northern Terriotory (17.5) the highest rate was provided by acute hospital services. In Tasmania 24-hour staffed residential services (20.4) had the highest rate.

Figure FAC.6: Specialised mental health hospital beds per 100,000 population, by 24-hour care setting, states and territories, 2019–20

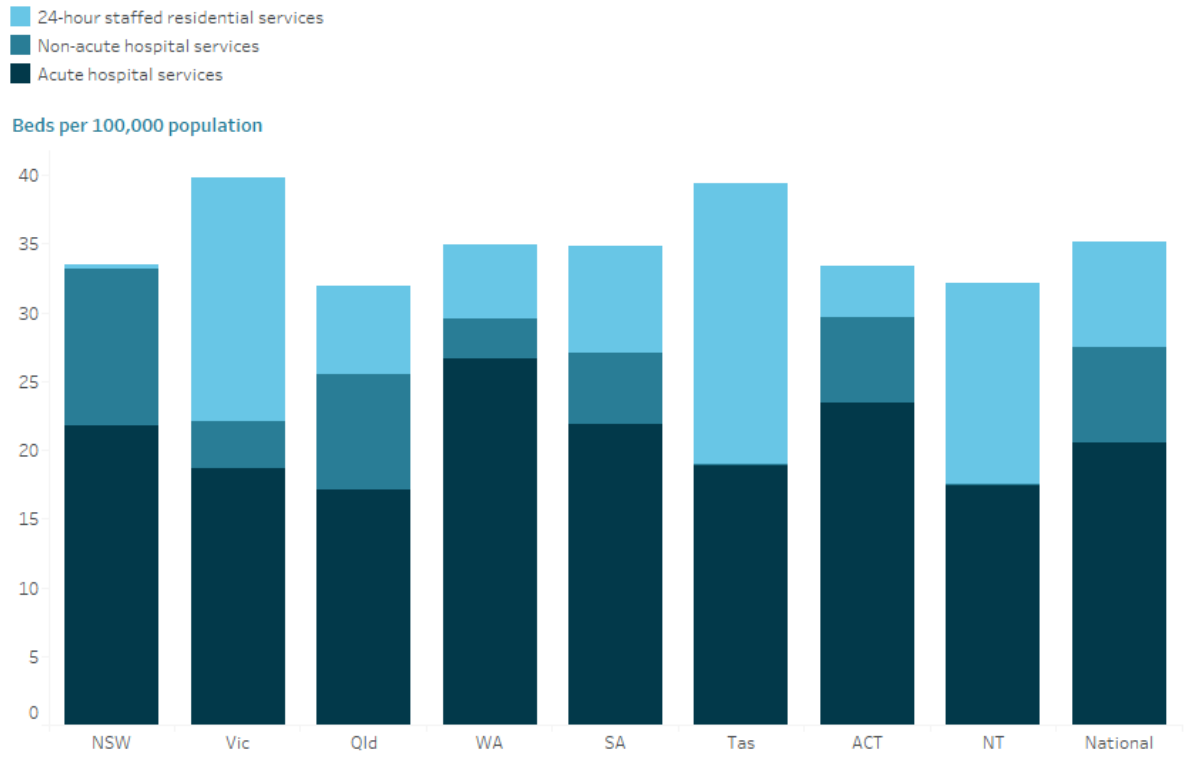


Figure FAC.6: Specialised mental health hospital beds per 100,000 population, by 24-hour care setting, states and territories, 2019–20

http://www.aihw.gov.au/mhsa

Source: Specialised mental health care facilities tables FAC.23

Private hospital specialised mental health beds

There were 3,494 available beds (13.7 per 100,000 population) in private psychiatric hospitals in 2019–20, 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 9,440 beds in 2015–16 to 9,457 beds in 2019–20. The combined rate of hospital and residential specialised mental health beds per 100,000 population has declined since reporting began in 1992–93 from 50.2 to 35.2 in 2019–20.

Public sector specialised mental health hospital beds

There was a decrease in the number of public psychiatric hospital beds reported from 1,698 beds in 2015–16 to 1,584 beds in 2019–20. 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 5,360 in 2015–16 to 5,434 in 2019–20). Time series comparisons should be approached with caution.

Residential mental health service beds

The number of specialised residential mental health service beds increased from 2,383 in 2015–16 to 2,438 in 2019–20. 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 provide supported housing places for people with a mental illness, with 4,360 available in 2019–20. Western Australia (51.1 per 100,000 population) had the highest rate of supported housing places , compared with the national average of 17.1. 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

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.

Public sector specialised mental health hospital services

Around 2.3 million patient days were provided by public hospital specialised mental health services during 2019–20. Over three-quarters (77.4%) were in specialised psychiatric units or wards in public acute hospitals, mirroring the number of beds for this service type. New South Wales (103.9) had the highest rate of patient days per 1,000 population, while Tasmania (58.1) had the lowest, compared with the national rate of 89.0.

Residential mental health care services

During 2019–20, *Residential mental health care services* provided just over 720,000 patient days. About four-fifths (80.4%) of all patient days were for residents of 24-hour staffed services. Tasmania (128.7) had the highest rate of patient days per 1,000 population in *General* services, while New South Wales (2.3) had the lowest; compared with the national rate of 31.8.

Private hospital specialised mental health services

During 2019–20, private specialised mental health hospital services provided about 1.2 million patient days, equating to 48.1days 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 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 2019–20, there were 139.6 FTE staff per 100,000 population nationally employed in specialised mental health care services (Figure FAC.7).

The Northern Territory (207.0) had the highest rate of FTE staff per 100,000 population, while Victoria (132.4) had the lowest. Nurses were the largest full-time-equivalent staff category across all jurisdictions.

In 2019–20, of the 35,686.3 FTE staff employed in state and territory specialised mental health care services, about half were nurses (18,196.7 FTE or 51.0%) with the majority registered nurses (15,665.3 FTE or 43.9%). Diagnostic and allied health professionals

(7,133.9 FTE or 20.0%) made up the second largest group of staff, comprising mostly social workers (2,574.6 FTE) and psychologists (1,993.3 FTE). Salaried medical officers made up 10.9% of FTE staff, with similar numbers of consultant psychiatrists and psychiatrists (1,719.3 FTE), and psychiatry registrars and trainees 1,855.4 FTE).

Figure FAC.7: Full-time-equivalent staff per 100,000 population by staffing category, states and territories, 2019–20

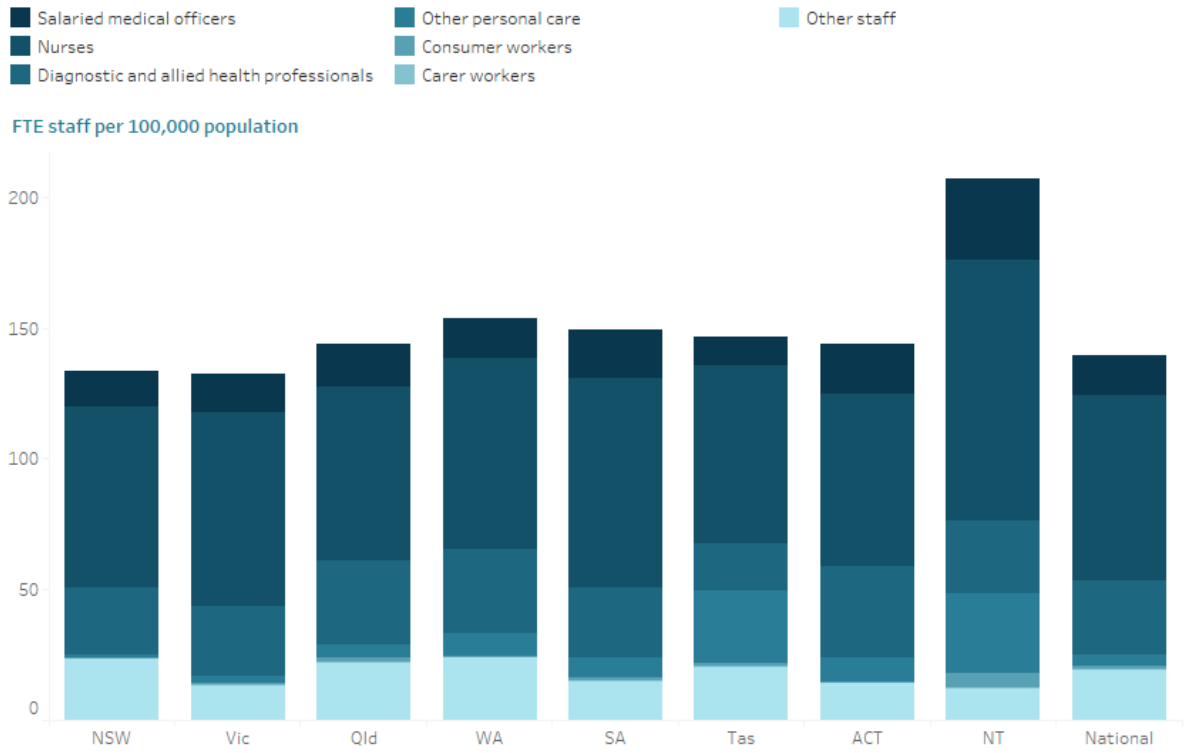


Figure FAC.7: Full-time-equivalent staff per 100,000 population by staffing category, states and territories, 2019–20

http://www.aihw.gov.au/mhsa

Source: Specialised mental health care facilities tables FAC.37

The rate of FTE staff per 100,000 population employed in specialised mental health care services has increased between 2015–16 and 2019–20 at an average annual increase of 1.2%. The labour force category *Other staff* decreased by an annual 1.6% over this time period. The rate of FTE consumer workers increased from 0.5 to 0.8 over this 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.

More than two-fifths (15,718 FTE or 44.1%) 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 (13,948 FTE or 39.1%). Since 1993–94, the number of staff employed in specialised mental health admitted patient hospital services has ranged between around 11,000 FTE to around 16,000 FTE, while the number employed by *Community mental health care services* has tripled (from 4,197 FTE in 1993–94 to 13,948 FTE in 2019–20).

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 8 reporting periods. The 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), and then levelled off in the low 50s for the last 8 reporting periods. The rate of FTE staff employed by *Residential mental health care services* has been broadly stable over the past 20 reporting periods (typically between just below 9 and 10 FTE). *Organisational overhead* service settings have been reported as a service setting since 2012–13, with the rate ranging between 9.8 and 14.2 FTE.

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 2019–20, public hospital specialised mental health services employed 56.7 FTE health care providers per 100,000 population (Figure FAC.8). *Community mental health care services* employed 49.0 FTE health care providers per 100,000 population in 2019–20 and *Residential mental health care services* employed 8.9.

Between 1992–93 and 2019–20 the FTE rate 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 peaking at 49.0 in 2019–20. The rate for *Residential mental health care service* settings increased from 4.0 to 9.0 between 1992–93 and 2019–20, with a low of 3.4 in 1993–94. The *Organisation overhead* setting was reported on from 2012–13, with a rate ranging between 3.7 and 5.7 during the past 8 reporting periods.

Figure FAC.8: Full-time-equivalent health care providers per 100,000 population, by service setting, state and territory specialised mental health service units, 1992–93 to 2019–20

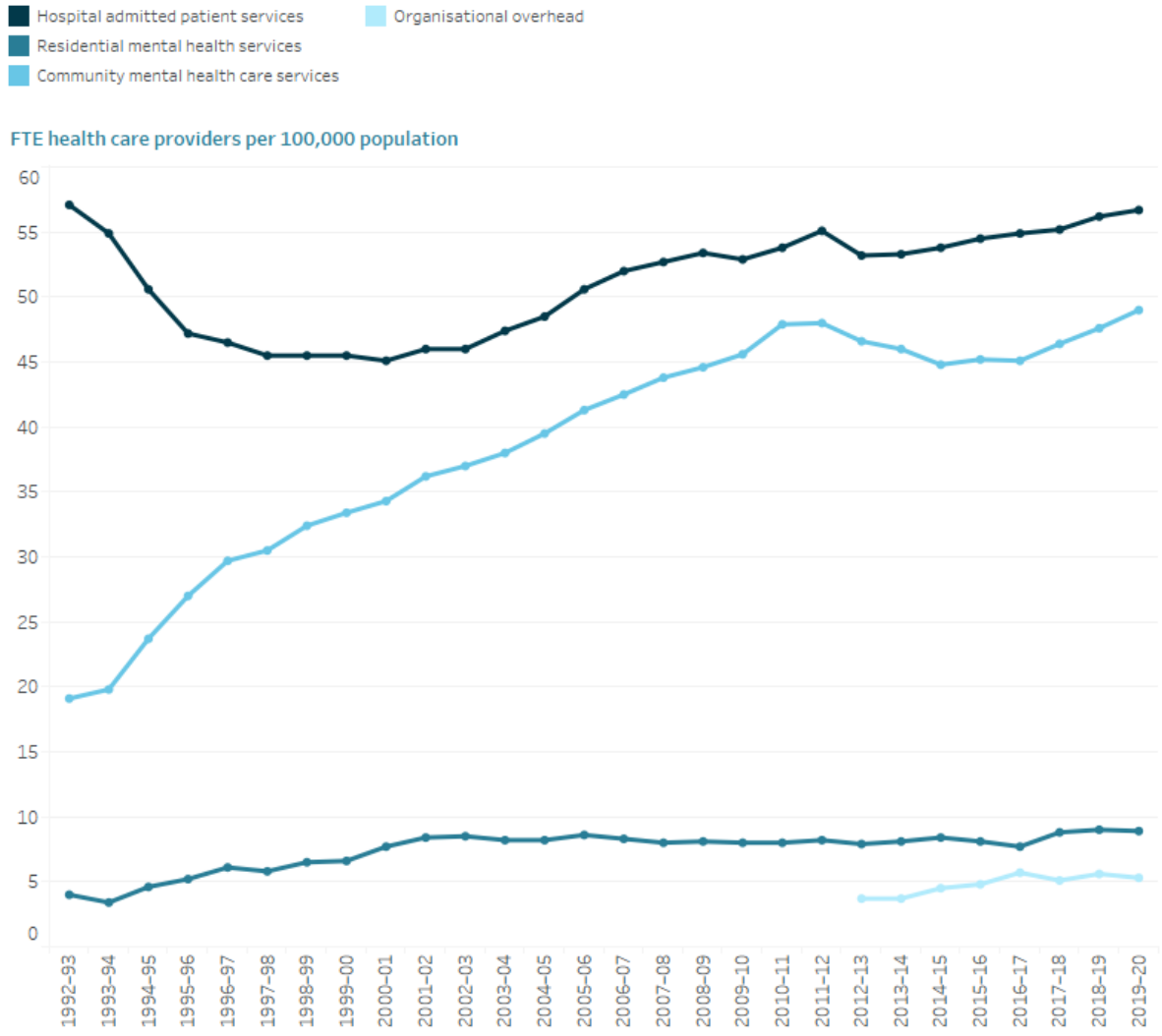


Figure FAC.8: Full-time-equivalent health care providers per 100,000 population, by service setting, state and territory specialised mental health service units, 1992–93 to 2019–20

http://www.aihw.gov.au/mhsa

Source: Specialised mental health care facilities tables FAC.43

Data source

On this page:

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 assesses the data for consistency in the current collection and across historical data. The validation process applies a range 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 Mental Health Community Living Programs

New South Wales has been developing the NSW Housing Accommodation Support Initiative (HASI) since it was established in 2002. 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.

In 2016, Community Living Supports (CLS) commenced to support more people with severe mental illness to access the same type of support provided in HASI.

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.

Both HASI and CLS are reported as Specialised mental health service—supported mental health housing places (METeOR identifier 390929). These programs are out of scope as Residential mental health care services (METeOR identifier 373049). See the above hyperlink for further information about the NSW HASI program.

Public sector specialised mental health beds

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.

Organisational overhead setting

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).

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 person*s: 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 2018–19 data were calculated using ERP at 31 December 2018). 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 hospital specialised mental health services staffing

Staffing provided in private hospital specialised mental health service are no longer available. 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.

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 Australian Government Department of Health. As part of that census, data on the staffing, finances and activity of these establishments were collected and compiled in the PHEC. Additional information on the PHEC can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2018). The data definitions used in the PHEC 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).

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 2019–20, the PPHDRAS accounted for 98% of all private psychiatric beds in Australia (APHA 2020).

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

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 616014). 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.
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 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 717103). 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 722190). The data source section provides information for the full description of all 8 levels and information relating to the revised 2010 national standards (DOH 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 and was

	judged to have met some but not all of the National Standards for Mental Health Services. • 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 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 (Overnight 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 PPHDRAS. 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.
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 682403): • *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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