

## Profile of 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](#).

### Key points

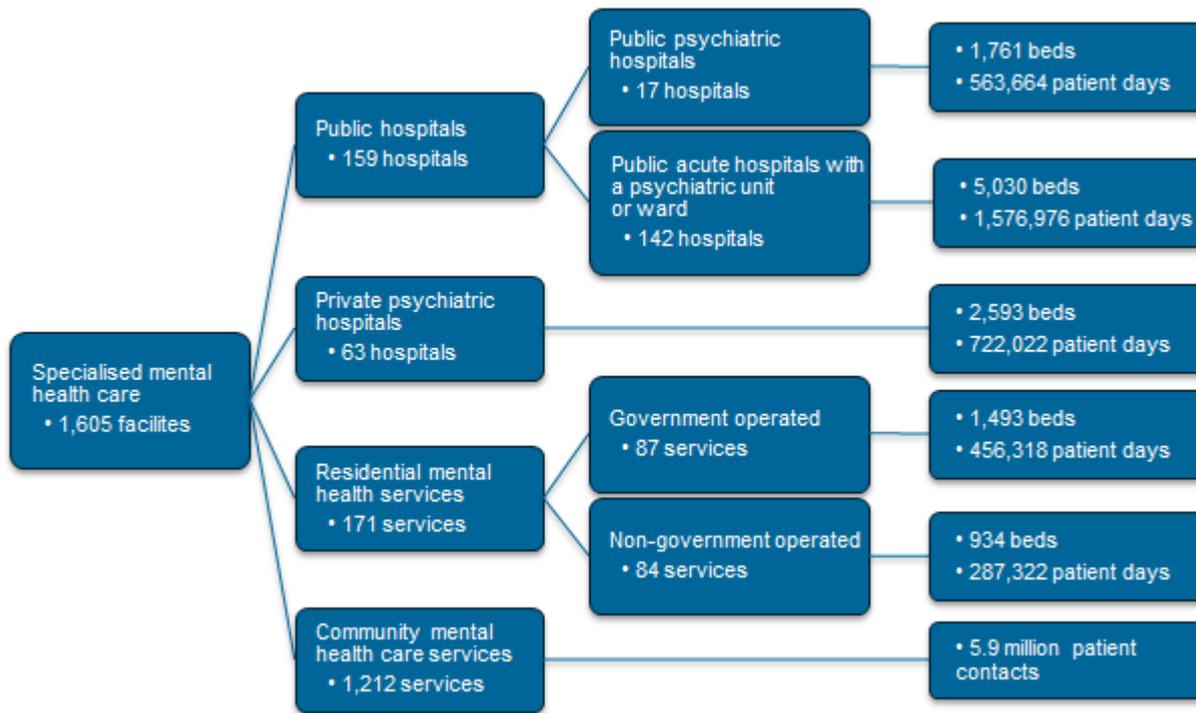
- Specialised mental health services for admitted patients were provided by 159 public hospitals during 2013–14. These facilities employed nearly 14,000 full-time-equivalent staff, had 6,791 specialised mental health beds available, and provided care to admitted patients for over 2.1 million patient days. In addition, 63 private hospitals delivered specialised mental health services, providing 2,593 specialised mental health service beds.
- There were 2,427 residential mental health service beds available during 2013–14, with almost two-thirds operated by government organisations.
- There were over 30,500 full-time-equivalent staff employed in state and territory specialised mental health care services in 2013–14, with over half of these (51%) being nurses. Nationally, this equates to 131 FTE staff per 100,000 population.
- Over the last 2 decades to 2013–14, the number of full-time-equivalent health care providers employed in public sector community mental health services increased from 3,358 in 1993–94 (or 19 per 100,000 population) to 10,711 in 2013–14 (or 46 per 100,000 population), reaching around 41% of all staff across public sector specialised mental health services during 2013–14.

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

### Overview

There were 1,605 specialised mental health care facilities providing care in 2013–14 (Figure FAC.1). There was an annual average increase of 1.5% in the number of non-government operated residential mental health services and a 3.1% increase in community mental health care services between 2009–10 and 2013–14. These increases may reflect the implementation of jurisdictional policies on the provision of mental health services. Refer to the [data source](#) section for further information.

**Figure FAC.1: Number of specialised mental health care facilities, available beds and activity in Australia, 2013–14**



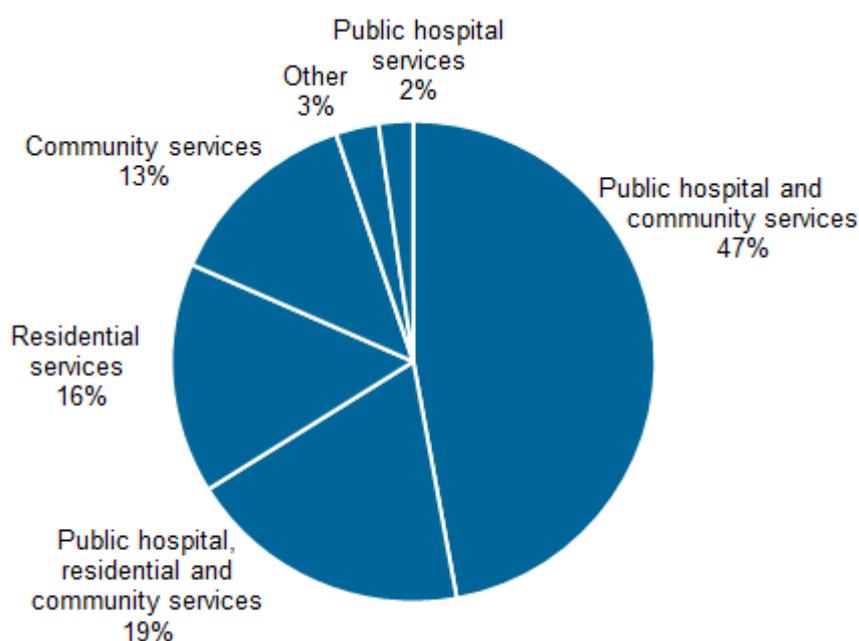
Source: National Mental Health Establishments database.

## Specialised mental health service organisations

There were 174 specialised mental health service organisations responsible for the administration of the 1,542 public sector state and territory specialised mental health facilities during 2013–14.

The most common organisation type was comprised of both specialised mental health public hospital services and community mental health care services (82 organisations or 47%) (Figure FAC.2). These organisations accounted for around two-thirds (69%) of both beds and patient days in specialised mental health public hospital services and more than half (57%) of all community mental health care service contacts.

**Figure FAC.2: Specialised mental health organisations, by the type of services managed by the organisation, 2013–14**



*Key:* 'Other' includes organisations that provide both 'residential and community services' and 'public hospital and residential services'.

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

*Source:* National Mental Health Establishments Database. Source data Specialised mental health care facilities Table FAC.4 (1.64 MB XLS).

## Consumer and carer involvement

Specialised mental health organisations employ [mental health consumer workers](#) and [mental health carer workers](#). The definition used to describe this workforce changed for the 2010–11 collection to better capture a variety of contemporary roles. Caution is therefore required when interpreting time series data. See the [key concepts](#) for further information. In addition to these employed workers, specialised mental health organisations report the extent to which [consumer committee representation arrangements](#) are in place.

### Mental health consumer and carer worker employment

The employment of mental health consumer workers and carer workers is an indicator of the engagement of consumers and carers in the delivery of mental health services. Of the 174 specialised mental health service organisations reported nationally in 2013–14, 70 (40%) employed mental health consumer workers and 38 (22%) employed mental health carer workers. South Australia had the highest proportion of mental health organisations employing consumer workers (59%), as well as the highest proportion of organisations employing carer workers (46%). Specialised mental health organisations in the Australian Capital Territory did not employ any mental health consumer or carer workers during 2013–14.

The proportion of mental health consumer workers employed decreased from 28 FTE per 10,000 mental health FTE staff in 2009–10 to 27 FTE in 2013–14. Over the same period, the proportion of mental health carer workers employed decreased from 16 FTE per 10,000 mental health FTE staff in 2009–10 to 14 in 2013–14. Caution is required when interpreting these data due to the small numbers of mental health consumer and carer workers reported.

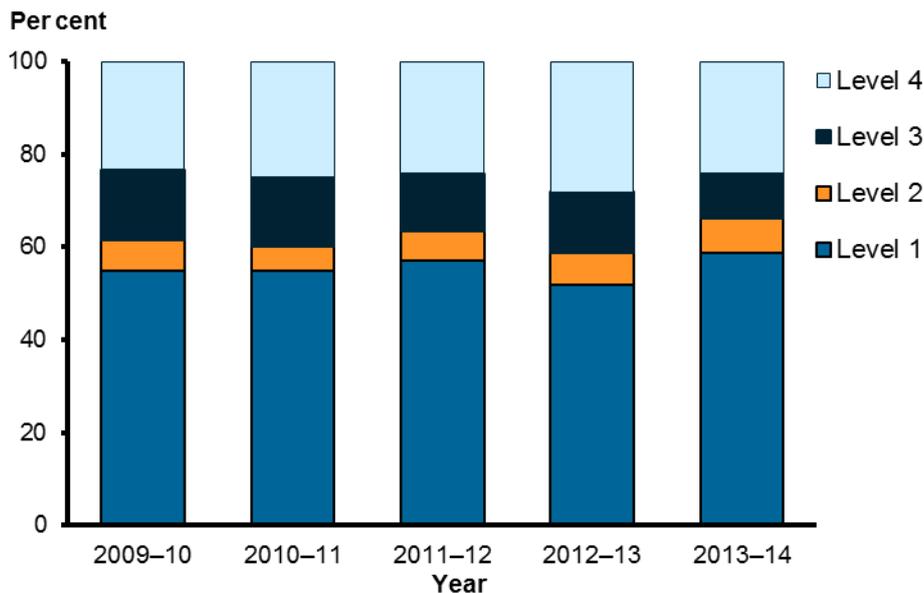
### Consumer committee representation arrangements

In 2013–14, 102 (59%) specialised mental health organisations reported that they have a formal position on their organisation's management committee or that a specific consumer advisory committee exists to provide advice on all relevant mental health services managed (Level 1 in the classification of consumer participation arrangements)—see the [data source](#) section for full descriptions of each level. Levels 2–4 represent successively less consumer committee representation within the organisation.

All mental health service organisations in the Australian Capital Territory reported Level 1 consumer participation arrangements. There is a mix of all other levels in other jurisdictions.

The proportion of specialised mental health service organisations with Level 1 consumer participation arrangements has increased from 55% in 2009–10 to 59% in 2013–14.

**Figure FAC.3: Specialised mental health organisations, by level of consumer committee representation, 2009–10 to 2013–14**



*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. Source data Specialised mental health care facilities Table FAC.8 (1.64 MB XLS).

## National standards for mental health services

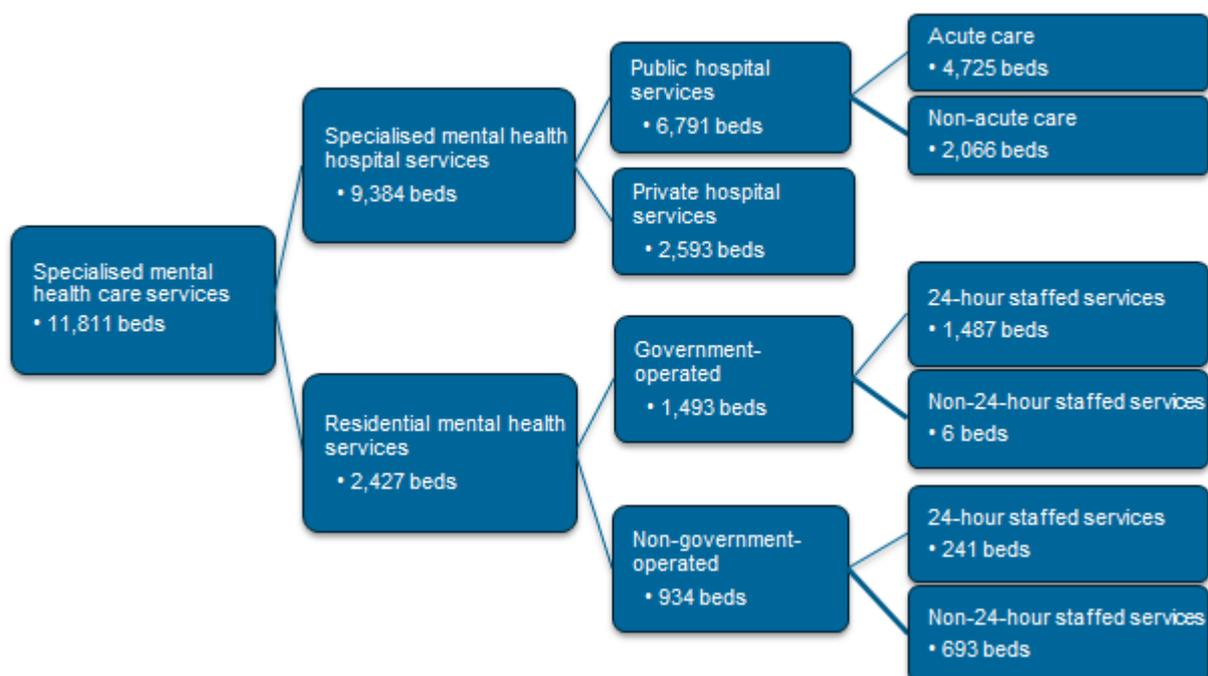
Services provided by specialised mental health organisations are measured against the [National Standards for Mental Health Services](#) (the National Standards). There are 8 levels available to describe the degree to which a [specialised mental health service unit](#) meets the National Standards. See the [data source](#) section for the full description of all 8 levels. For reporting purposes, the data presented are grouped into 4 levels as described in [data source](#) section under Reporting levels for National Standards.

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. Using this approach, 67% of all service units were reviewed by an external accreditation agency such as the Australian Council on Healthcare Standards (ACHS) and the Quality Improvement Council (QIC) and met the National Standards (Level 1). The Australian Capital Territory and the Northern Territory were the only jurisdictions to report all service units meeting Level 1, although over 80% of service units in Queensland and Western Australia met Level 1 standards. Victoria reported the highest proportion of service units meeting Level 4 (26%) and Tasmania was the only jurisdiction to report all service units at Level 3.

## Specialised mental health beds and patient days

There were 11,811 specialised mental health beds available nationally during 2013–14, with 6,791 beds provided by public hospital services, 2,593 by private hospitals, and an additional 2,427 by residential mental health services (Figure FAC.4).

**Figure FAC.4: Distribution of specialised mental health beds in Australia, 2013–14**



Source: National Mental Health Establishments database.

### Public sector specialised mental health hospital beds

There were 6,791 public sector specialised mental health hospital beds available in 2013–14 in Australia. Almost three quarters of these (74% or 5,030 beds) were in specialised psychiatric units or wards within public acute hospitals, with the remainder in public psychiatric hospitals (1,761 beds).

New South Wales had the highest number of beds per 100,000 population in 2013–14 (36), while the Northern Territory had the lowest (17), compared to the national rate of 29 per 100,000 population.

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

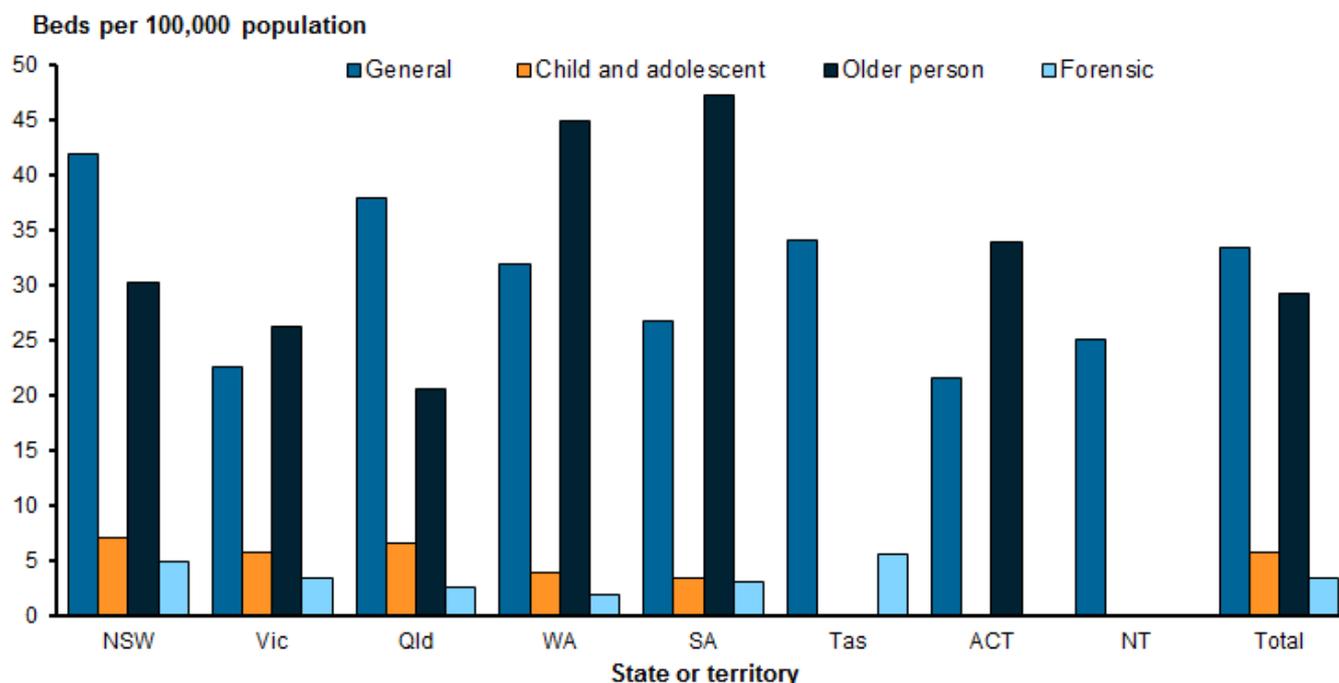
#### Target population

The majority of public sector specialised mental health hospital beds (4,883 or 72%) were within General services during 2013–14. A further 15% of specialised mental health hospital beds were within Older person services, 9.1% were in Forensic services and 4.4% were in Child and adolescent services.

New South Wales had the highest number of hospital beds per 100,000 population for both General services (42) and Child and adolescent services (7.1) compared to the national rates of 33 and 6 per 100,000 population respectively (Figure FAC.5). South Australia (47) had the highest number of Older person hospital

beds per 100,000 population (national average 29) and Tasmania (5.5) had the most hospital beds per 100,000 population within Forensic services (national average 3.4).

**Figure FAC.5: Public sector specialised mental health hospital beds per 100,000 population, by target population, states and territories, 2013–14**



Source: National Mental Health Establishments Database. Source data Specialised mental health care facilities Table FAC.14 (1.64 MB XLS).

### Program type

More than two-thirds (4,725 beds or 70%) of all public sector specialised mental health hospital beds across Australia were in Acute services during 2013–14.

The proportion of acute beds differed across the target population groups. More than four out of five (86%) Child and adolescent beds were in Acute services in 2013–14, compared with 73% of General beds, 65% of Older person beds and 45% of Forensic beds.

### Residential mental health service beds

There were 2,427 residential mental health service beds nationally in 2013–14. 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 for each jurisdiction.

Over two-thirds (1,728 or 71%) 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 (1,487 beds). The total number of beds in government operated services was 1,493 (62%). Over two-thirds (1,677 or 69%) of all residential beds were in General services with more beds in 24-hour staffed facilities (989 or 59%) than in non-24-hour staffed facilities (688 or 41%).

Nationally there were 10 residential mental health beds per 100,000 population (Figure FAC.6). Of those jurisdictions reporting residential mental health beds, Tasmania (30) had the highest number per 100,000 population, while New South Wales (2.1) had the lowest. This national rate does not include Queensland as this jurisdiction does not report residential mental health services. Refer to the [data source](#) section for further information.

Victoria (72) had the highest number of residential mental health beds per 100,000 population providing 24-hour staffed care for Older persons. Tasmania provided the highest number of residential beds per 100,000 population for General services with both 24-hour staffed care (16) and non-24-hour staffed care (24). New South Wales (1.1 beds per 100,000 population) was the only jurisdiction that reported residential mental health service beds for Child and adolescent services. Data for Youth services are reported separately for the second time in this data release, with the Australian Capital Territory (21 per 100,000 population), Western Australia (5.1) and Victoria (2.8) reporting specialised Youth services.

**Figure FAC.6: Residential mental health service beds per 100,000 population, by hours staffed, states and territories, 2013–14**



Note: The total rate does not include Queensland as this jurisdiction does not report residential mental health services.

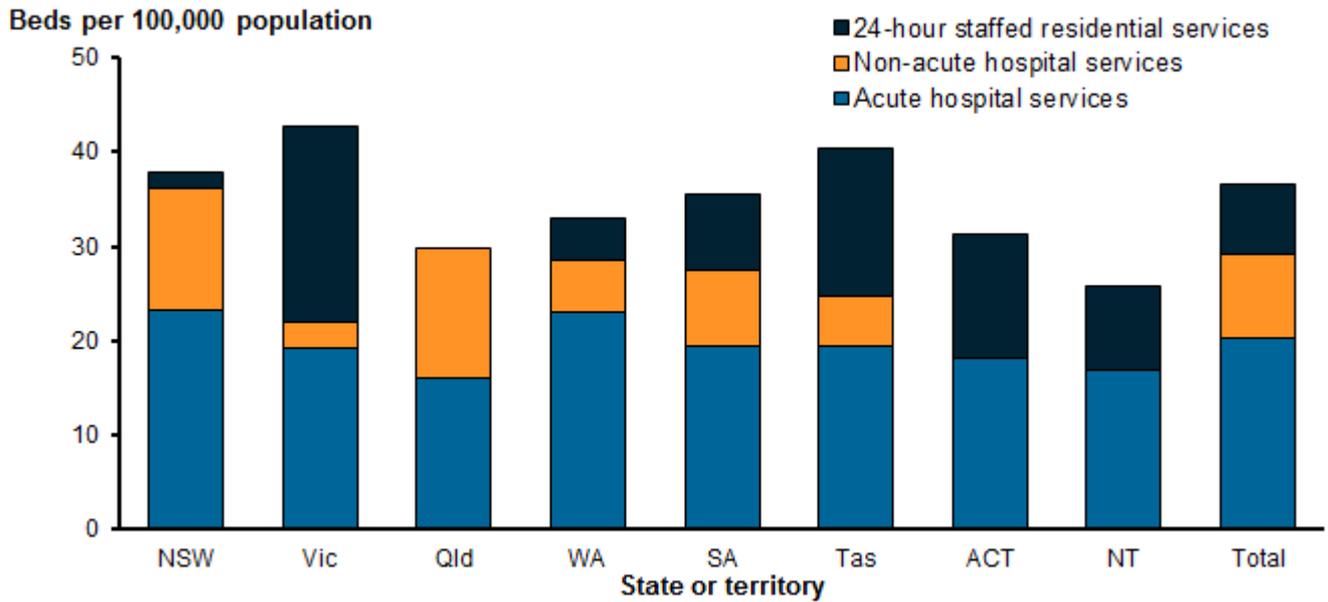
Source: National Mental Health Establishments Database. Source data Specialised mental health care facilities Table FAC.17 (1.64 MB XLS).

### 24-hour staffed public sector care

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

Victoria had the highest number of 24-hour staffed beds available per 100,000 population (43) in 2013–14, closely followed by Tasmania (40), while the Northern Territory had the lowest (26), compared with a national average of 37 (Figure FAC.7).

**Figure FAC.7: Specialised mental health beds per 100,000 population, by 24-hour care setting, states and territories, 2013–14**



Source: National Mental Health Establishments Database. Source data Specialised mental health care facilities Table FAC.23 (1.64 MB XLS).

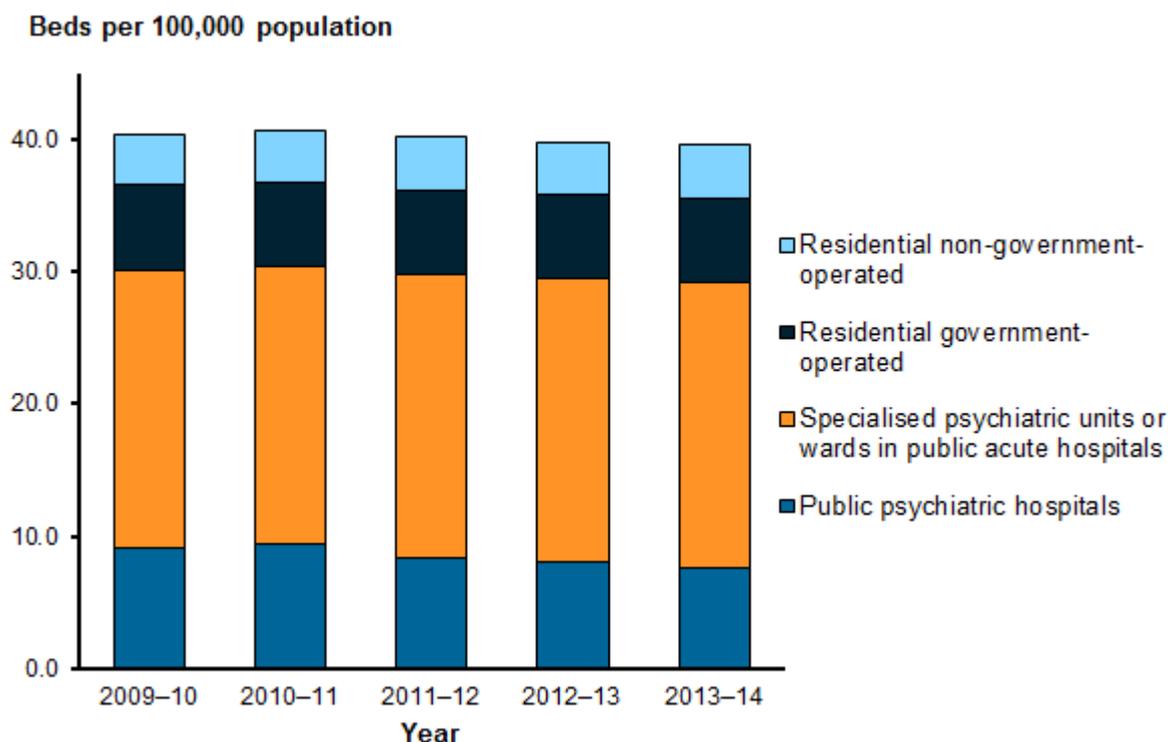
### Private hospital specialised mental health beds

There were 2,593 available beds (11 per 100,000 population) in private psychiatric hospitals in 2013–14, including specialised units or wards in private hospitals.

## Available beds over time

The number of public sector specialised mental health hospital beds and residential mental health service beds increased from 8,838 beds in 2009–10 to 9,218 beds in 2013–14. The combined number of hospital and residential specialised mental health beds per 100,000 population remained stable across the 2009–10 to 2013–14 period (at around 40 beds per 100,000 population; Figure FAC.8).

**Figure FAC.8: Public sector specialised mental health hospital beds and residential mental health service beds per 100,000 population, 2009–10 to 2013–14**



Source: National Mental Health Establishments Database. Source data Specialised mental health care facilities Table FAC.13, 22 (1.64 MB XLS).

## Public sector specialised mental health hospital beds

There was an average annual decrease of 3.2% in the number of public psychiatric hospital beds between 2009–10 and 2013–14 (from 2,002 beds in 2009–10 to 1,761 beds in 2013–14). This was offset by an increase in the number of beds in specialised psychiatric units or wards in public acute hospitals (2.3%) over the same period (from 4,597 beds in 2009–10 to 5,030 beds in 2013–14). Overall, this resulted in an average annual increase (0.7%) in the number of public sector specialised mental health hospital beds between 2009–10 and 2013–14. However, 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 2009–10 to 2013–14.

## Residential mental health service beds

The number of specialised residential mental health service beds increased over the 5 years from 2,239 beds in 2009–10 to 2,427 beds in 2013–14.

The majority of non-24-hour staffed beds were provided by the non-government sector and this proportion has been increasing over time. There has been an average annual increase of 2.7% in the number of non-government organisation delivered beds per 100,000 population over the 5 years to 2013–14. See the [data source](#) section for additional information.

## Patient days

### Public sector specialised mental health hospital services

Over 2 million [patient days](#) were provided by public hospital specialised mental health services during 2013–14. Almost three-quarters (74%) of all patient days were in specialised psychiatric units or wards in public acute hospitals. New South Wales (115) had the highest number of patient days per 1,000 population, while the Northern Territory (49) had the lowest, compared with the national rate of 92.

### Residential mental health services

Residential mental health services provided about 744,000 patient days during 2013–14. About two-thirds (71%) of all patient days were for residents of 24-hour staffed services. Tasmania (127) had the highest number of patient days per 1,000 population within General services, while New South Wales (8.2) had the lowest; compared with the national rate of 35 (per 1,000 population).

### Private hospital specialised mental health services

Specialised mental health services in private hospitals provided about 722,000 patient days during 2013–14, equating to 31 days per 1,000 population. However, in contrast to public sector services, this figure also includes same-day separations.

# Staffing of state and territory specialised mental health care facilities

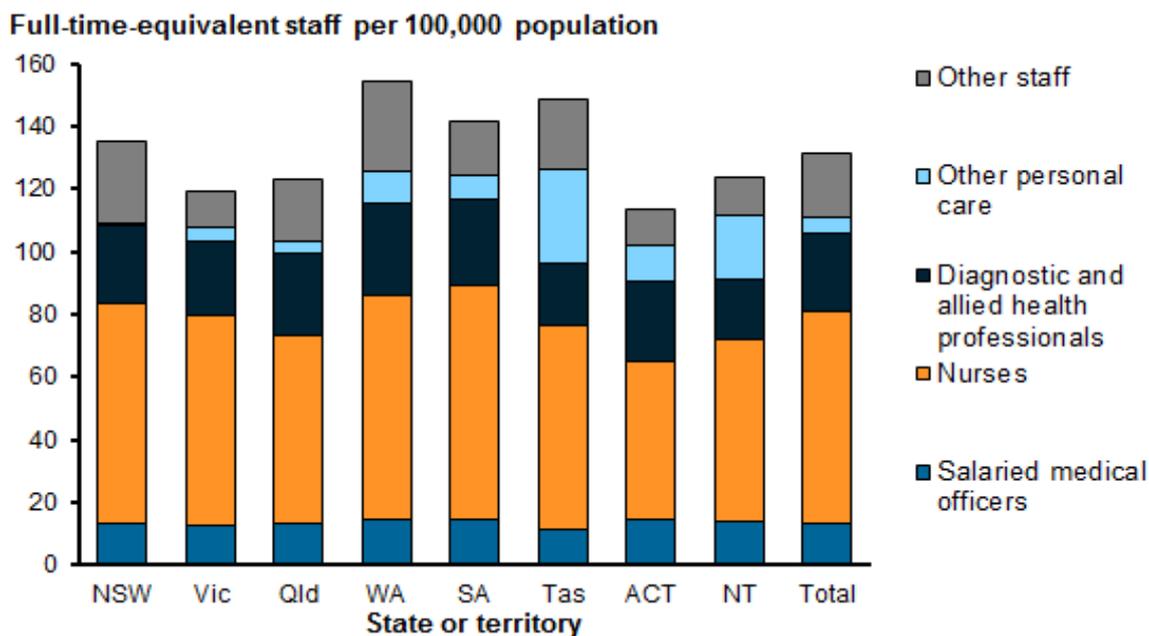
## State and territory specialised mental health care services

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

Of the 30,544 full-time-equivalent (FTE) [staff](#) employed in state and territory specialised mental health care services in 2013–14, half were nurses (15,647 FTE or 51%) with most of these registered nurses (13,497 FTE). Diagnostic and allied health professionals (5,884 FTE or 19%) made up the second largest group of staff, comprising mostly social workers (1,998 FTE) and psychologists (1,831 FTE). Salaried medical officers made up 10% of staff, with similar numbers of consultant psychiatrists and psychiatrists (1,386 FTE), and psychiatry registrars and trainees (1,481 FTE).

Nationally there were 131 FTE staff per 100,000 population employed in specialised mental health care services in 2013–14 (Figure FAC.9). Western Australia (154) had the highest number of FTE staff per 100,000 population, while the Australian Capital Territory (114) had the lowest.

**Figure FAC.9: Full-time-equivalent staff per 100,000 population by staffing category, states and territories, 2013–14**



Source: National Mental Health Establishments Database. Source data Specialised mental health care facilities Table FAC.36 (1.64 MB XLS).

There was an average annual growth of 0.5% in the number of FTE staff per 100,000 population in specialised mental health care services between 2009–10 and 2013–14 across all labour force categories.

## 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. Note that this 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.

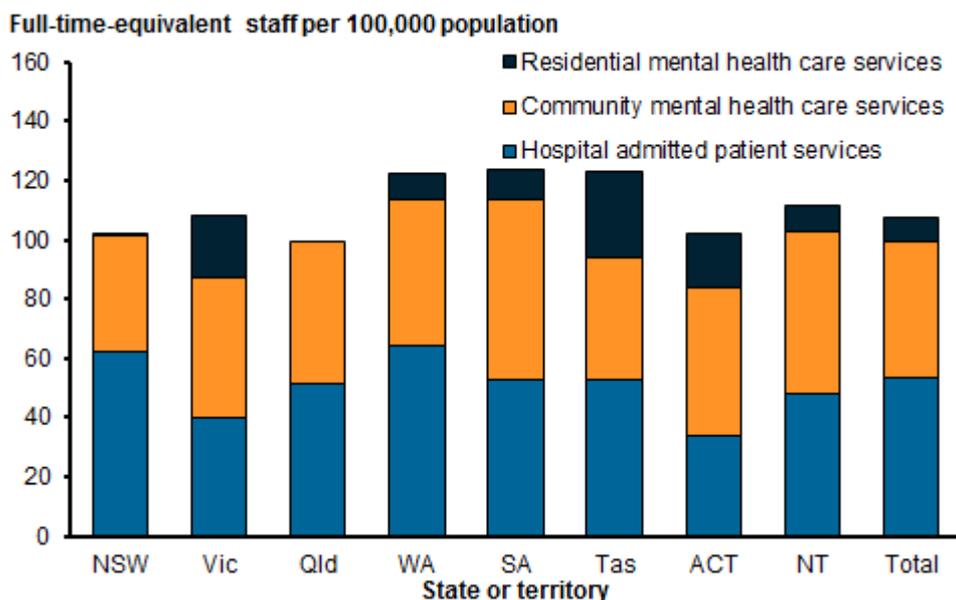
Almost half (13,824 FTE or 45%) of state and territory specialised mental health care services staff were employed in specialised mental health admitted patient hospital services. Community mental health care services employed the next largest number of FTE staff (12,212 or 40%). **Health care providers** are those staff reported against patient care staffing categories including 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.

Over the last 2 decades to 2013–14, the number of FTE staff employed in public sector community mental health services increased from 4,197 in 1993–94 (or 20 per 100,000 population) to 12,212 in 2013–14 (or 46 per 100,000 population), reaching around 40% of all staff across public sector specialised mental health services during 2013–14 (see Tables FAC.39 and FAC.42).

Public hospital specialised mental health services employed 53 FTE health care providers per 100,000 population in 2013–14. The rate was highest for General services (61 per 100,000 population), followed by Older persons services (46) (see Table FAC 40).

Community mental health care services employed 46 health care providers FTE per 100,000, with General services (50) recording the highest rate, followed by Child and adolescent services (38 per 100,000 population). Residential mental health services employed 8 health care providers FTE per 100,000 population. (Figure FAC.10). The reporting methodology for the new organisational overhead setting will take time to implement and ensure consistency in reporting between the jurisdictions (see Table FAC.40).

**Figure FAC.10: Full-time-equivalent health care providers per 100,000 population, specialised mental health service units, by service setting, states and territories, 2013–14**



Source: National Mental Health Establishments Database. Source data Specialised mental health care facilities Table FAC.40 (1.64 MB XLS).

## Private hospital specialised mental health services

There were 2,490 FTE staff employed by specialised psychiatric services in private hospitals during 2013–14, equating to 11 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. See [data source](#) section for further information.

## Supported housing places

In addition to the services described above, jurisdictions also provide [supported housing places](#) for people with a mental illness. There were 5,321 supported housing places available in 2013–14 for people with a mental illness. Western Australia (55) had the highest number of supported housing places per 100,000 population, compared with the national average of 23 places per 100,000 population. Caution is required when comparing rates across jurisdictions as not all jurisdictional mental health housing support schemes are in-scope for the Mental Health Establishment NMDS. See [data source](#) section for 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. See the [Mental health establishments NMDS 2013–14: National Mental Health Establishments Database, 2015; Quality Statement](#).

### 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.

#### DataSource FAC.1 Levels of consumer participation arrangements

Level	Description
-------	-------------

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.

### Consumer and carer participation strategies

Western Australia has advised that the data presented in tables FAC.5–FAC.10 do not represent consumer and carer participation strategies used in Western Australia. High priority is given to the involvement of consumers and carers at a state, regional and health service level in developing a responsive mental health service. Several key consumer and carer advisory groups are supported and provided with financial assistance. Collectively, these groups provide advice and representations on consumer and carer issues. Data for consumer arrangements are for public sector services only.

### 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 2013–14, as shown in the table below.

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

---

7 It had not been resolved whether the service unit would undertake review by an external accreditation agency under the national standards.

---

8 The national standards are not applicable to this service unit.

---

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

### 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 2012–13 data were calculated using ERP at 31 December 2012). Historical rates have been recalculated using revised ERPs based on the 2011 Census of Population and Housing, as detailed in the online technical information. Previously, rates from 1992–93 to 1995–96 were calculated using ERP at 30 June of the earlier reference year (for example, rates for 1992–93 were calculated using ERP at 30 June 1992). December ERP data became available in 2012–13 and rates

were recalculated using the December ERPs so comparisons with earlier versions of the data tables are not valid.

## References

[DoH](#) (Department of Health) 2010. National Standards for Mental Health Services. Canberra: Commonwealth of Australia. Viewed December 2015.

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

---

## 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 2015).

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. 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 2015). 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 2013–14 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).

## References

ABS 2015. Private hospitals, Australia, 2013–14. ABS cat. no. 4390.0. Canberra: ABS.

AIHW 2012. National Health Data Dictionary 2012 version 16. Cat. no. HWI 119. Canberra: AIHW.

DoH (Department of Health) 2013. National mental health report: tracking progress of mental health reform in Australia, 1993–2011. Canberra: Commonwealth of Australia.

PMHA 2013. Private Hospital-based Psychiatric Services 1 July 2011 to 30 June 2012. PMHA-CDMS annual statistical report for the 2011–2012. Private Mental Health Alliance.

[National health data dictionary \(NHDD\) Version 16](#). Viewed November, 2015.

---

## Key concepts

### Specialised mental health care facilities

Key Concept	Description
<b>Beds</b>	The number of available specialised mental health <b>beds</b> refers to the average number of beds that are immediately available for use by an admitted patient within the mental health facility over the financial year, estimated using monthly figures (METeOR identifier <a href="#">374151</a> ). Data prior to 2005–06 were sourced from the National Survey of Mental Health Services, which reported the total number of beds available as at 30 June. Comparison of historical data should therefore be approached with caution.
<b>Carer</b>	A <b>carer</b> is a person whose life is affected by virtue of a family or close relationship and caring role with a mental health consumer.
<b>Community mental health care services</b>	<b>Community mental health care services</b> include hospital outpatient clinics and non-hospital community mental health care services, such as crisis or mobile assessment and treatment services, day programs, outreach services, and consultation/liaison services.
<b>Consumer</b>	A <b>consumer</b> is a person who is currently utilising, or has previously utilised, a mental health service. Mental health service consumers include persons receiving care for their own, or another person's mental illness or psychiatric disability.
<b>Consumer committee representation arrangements</b>	Specialised mental health organisations report the level of <b>consumer committee representation arrangements</b> . To be regarded as having a formal position on a management or advisory committee, the consumer representative needs to be a voting member (METeOR identifier <a href="#">288855</a> ). This is independent to the employment of consumer and carer consultants. See <a href="#">data source</a> section for the levels available.
<b>Government-operated residential mental health services</b>	<b>Government-operated residential mental health services</b> are specialised residential mental health services that: <ul style="list-style-type: none"><li>• are operated by a state or territory government</li><li>• employ mental health-trained staff on-site for a minimum of 6 hours per day and at least 50 hours per week</li><li>• 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</li><li>• encourage the resident to take responsibility for their daily living activities.</li></ul>
<b>Health care providers</b>	<b>Health care providers</b> 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.
<b>Mental health carer worker</b>	<b>Mental health carer workers</b> 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 <a href="#">450730</a> ). 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 [287800](#)). See the [data source](#) section 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 2013), 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. See [data source](#) for additional information.

**Program type**

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

**Psychiatric units or wards**

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

**Public acute hospital**

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

**Public psychiatric hospital**

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

**Service setting**

Staffing of specialised mental health service units is reported as **service setting** level data for three specialist mental health service types. These settings are admitted patient services in public psychiatric hospitals and public acute hospitals with specialised psychiatric units or wards; community mental health care services; 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 (see 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 provides 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.

**References**

ABS 2015. Private hospitals, Australia, 2013–14. ABS cat. no. 4390.0. Canberra: ABS.

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

Health (Department of Health) 2010. National Standards for Mental Health Services. Canberra: Commonwealth of Australia. Viewed November 2014.