Queensland Health

Clinical **Excellence** Queensland

Mental Health Establishments (MHEC)

Manual 2019/20

Improvement | **Transparency** | Patient Safety | Clinician Leadership | Innovation

Queensland Government

Mental Health Establishments Collection (MHEC) Manual 2019/20

Published by the State of Queensland (Queensland Health), June 2020

For more information contact:
Systems & Collections Team, Clinical Systems and Performance, Mental Health Alcohol and Other Drugs Branch, Department of Health, GPO Box 48, Brisbane QLD 4001, email MHEC@health.qld.gov.au, phone 07 3328 9543.

An electronic version of this document is available on request from the Systems and Collections Team.

Disclaimer:

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

Changes for the 2019/20 collection

- Acmena House (83002) commenced reporting
- Caboolture Youth Step Up Step Down Unit (83012) commenced
- Logan Youth Step Up Step Down Unit (83011) commenced
- Perinatal & Infant Mental Health Service (81275) commenced
- Hervey Bay Hospital Mental Health Hospital-in-the-Home commenced
- Jacaranda Place (00752) commenced
- Cairns Youth Residential Rehabilitation Unit (83008) commenced reporting
- Aitkenvale Youth Residential Rehabilitation Unit (83006) commenced reporting
- Annandale Youth Residential Rehabilitation Unit (83007) commenced reporting
- Aspley Youth Residential Rehabilitation Unit (83009) commenced reporting
- Greenslopes Youth Residential Rehabilitation Unit (83010) commenced reporting
- The Townsville Hospital changed name to Townsville University Hospital.

Youth Residential Rehabilitation Services

During the 2019/20 financial year, Youth Residential Rehabilitation Services (YRRSs) commenced reporting in Queensland.

HHS's hosting YRRSs do not have routine access to FTE and expenditure information pertaining to these services. This information will therefore be collected from the operating Non-Government Organisations (NGOs) by the Mental Health Alcohol and Other Drugs Branch (MHAODB) utilising mandated Service Agreement reporting arrangements. Where possible, this information will be supplied to HHSs prior to MHEC survey publishing.

Youth Residential Rehabilitation Services are a service for adolescents with severe or complex mental health needs who require longer-term accommodation and recovery-oriented care and may benefit from rehabilitation in a community setting.

The YRRS spans a gap in service for young people, aged 16 to 21 years, who do not have the skills or expertise for independent living, or a stable place of accommodation. This service focuses on supporting young people to:

- Improve their capacity to manage and be responsible for self-care;
- Enhance their adaptive coping skills and decrease self-harming behaviour;
- Enhance their social and daily living skills to improve their ability to live independently in the community; and

- Develop and maintain links with the community, family, and social networks, education and vocational opportunities.

This service is delivered by a non-government organisation in partnership with Children's Health Queensland, local HHSs and MHAODB.

Medium Secure Target Population

The medium secure target population will be reported at the MHSO level this year. For hospitals in the MHSO that have a Medium Secure unit, this is required to be reported in Section 1 of the MHSO form.

Expenditure and FTE details for the Medium Secure unit will continue to be reported at establishment level.

Note that the addition of Medium Secure at the MHSO level has resulted in the application treating the Medium Secure at the Establishment level as a new target population, disrupting the normal validation process. Please enter "ignore" as the reason for all validations associated with the Medium Secure target population for this collection year.

Using Reports from DSS and S4 HANA

With the introduction of S4 HANA in August 2019, the General Ledger account codes were reviewed. The QH_MHS report in FAMMIS, which matches General Ledger codes to the Direct Expenditure categories, has been rebuilt in S4 HANA using the reviewed General Ledger codes. This report, the Mental Health Expenditure report, has been made available in DSS. Therefore, in 2019/2020, all areas of the MHEC forms can now be entered using reports available in DSS.

Mental Health Hospital in the Home

Hospital in the Home (HITH) patients have been historically reported across Queensland as admitted patients, with an understanding that home care replaces a full hospital admission or a component of a hospital admission. Without a HITH service, the patient would be admitted to hospital for treatment in a traditional hospital bed.

Queensland is introducing a mental health HITH model of care to alleviate bed pressures until additional bed capacity can be brought online. This model will start in the Wide Bay HHS during 2020.

Mental Health Hospital in the Home bed numbers are captured in Section 3 of the Establishment Form, with a new field “Mental Health Hospital in the Home average available beds”.

Staff and Expenditure for Mental Health HITH will be captured in the acute inpatient service setting, under the relevant target population.

Data Quality Areas

Impacts of the global COVID-19 pandemic

The Queensland Health response to the global COVID-19 pandemic has affected delivery of health services in many ways and there may be many unexpected impacts on services and data, some of which may only be discovered while completing the forms. To ensure data is provided as consistently as possible across the state, there will be a team created in Microsoft Teams during the collection period. All people completing the forms are encouraged to present any issues with providing data in the team discussions. This will allow other HHS to provide suggestions and advice; and will also allow for MHAODB, where possible, to provide state-wide guidance for resolving the issue. All HHS staff completing the MHEC forms are encouraged to review the MHEC Team site regularly during the completion of forms.

Implementation of National Standards

From January 2019, Queensland hospitals, including mental health hospitals and wards, are accredited against the second edition of the National Safety and Quality Health Service (NHQHS) standards. Under usual circumstances, an accreditation cycle is 3 years. Some mental health establishments, previously accredited under the National Standards for Mental Health Services, were due to be assessed against the NHQHS in 2020. Through the pandemic, until the Australian Government announces that Australia is in the Recovery Phase, existing accreditation to the NSQHS will be maintained by the Australian Commission on Safety and Quality in Health Care. This excludes any new facilities or any facilities requiring mandatory reassessment.

Any facility that is not excluded will therefore have their current accreditation maintained until further notice. Accreditations will not expire during this time.

If your establishment has been assessed against the NSQHS (2nd edition) and reassessment has been postponed, please report this item as per your current accreditation in MHEC.

If your establishment is due to move from the National Standards for Mental Health Services to the NHQHS (2nd edition) and your assessment has been postponed, please report this item as per your current accreditation for the National Standards for Mental Health Services.

Services run by or in collaboration with Non-Government Organisations

Establishments run by a non-government organisation (NGO) and delivering publicly funded services in partnership with an HHS or the Department of Health (DoH) are in scope for reporting to MHEC. The Youth Residential Rehabilitation Services (YRRS) are in this category. In order to meet the goal of mental health data collection (ie to identify *who* receives *what* from *whom* at what *cost* and with what *effect)* it has been determined that YRRS should be reported by the HHS in which they are located.

Youth Residential Rehabilitation Service	**Facility Code**	**HHS to report data**
Cairns YRRS	83008	Cairins and Hinterland
Aitkenvale YRRS	83006	Townsville
Annandale YRRS	83007	Townsville
Aspley YRRS	83009	Children's Health Queensland
Greenslopes YRRS	83010	Children's Health Queensland

As the service agreements for these services are managed by the Department of Health, data for completing the establishment form for the YRRS establishments will be provided to the relevant HHS by the Mental Health Alcohol and Other Drugs Branch (MHAODB).

For Establishments delivering services in collaboration with an NGO e.g. Gailes Community Care Unit, Toowoomba Community Care Unit and Cairns Community Care Unit and all Step Up Step Down units, there is an ongoing requirement to report NGO Staffing on **Section 5 of the Establishment Form**. This NGO FTE section must contain all the data on paid NGO FTE procured by the MHSO for this Establishment. The total Expenditure of NGO Collaboration FTE must be included in the Contract & related expenditure (including NGO) amount on Section 4. Non-labour related costs reported by the NGO is to be captured under Non-Clinical Supplies and Services.

New Validations will occur when:

1. The total NGO FTE expenditure is higher than the Contract & related expenditure (including NGO) value on Section 4 of the same Establishment Form.

2. The labour related expenditure subtotal on Section 4 does not equal to the sum of both QH and NGO FTE expenditure.

Note that where the service agreement for the NGO is held by the HHS, the data must be supplied by the HHS. It is recommended that during contract negotiations, the HHS should include provisions in the agreement for the provision of required data.

Where the service agreement for an NGO is not held by the HHS, as is the case with some Step Up Step Down units and Youth Residential Rehabilitation Services (YRRS), MHAODB will provide the NGO data to the HHS. This will include both labour and non-labour costs, which must be reported in **Section 4 of the Establishment Form**. Non-labour costs should be recorded under Non-Clinical Supplies and Services. NGO labour costs should be recorded under Contract and Related Expenditure (including NGO). Both costs should be included in **Section 6 of the MHSO Form** as part of the total of expenditure sourced from Queensland Health Funding.

Inter Entity Transfers - Reporting of Programs funded by another HHS

There are state-wide mental health programs where each HHS hires staff and performs the activity under the direction of another HHS; and is then reimbursed by that HHS. Examples of these programs are the Assertive Mobile Youth Outreach Service (AMYOS) and Perinatal and Infant Mental Health (PIMH) programs.

The AMYOS program was rolled out in 2014/2015 as a state-wide service, covering Children's Health Queensland (Brisbane North and South, Bayside, Browns Plains) and other HHS including Darling Downs, Townsville, Cairns and Hinterland, Gold Coast and Central Queensland. In 2017/2018, the program received further funding through Connecting Care to Recovery to extend the program into Wide Bay, Mackay, West Moreton and Sunshine Coast.

The PIMH program has existed since 2017/2018 as the Zero to Four Child and Youth Mental Health Service. It also includes a state-wide component in the e-PIMH and

Strategy and Service Development Unit.

Both programs are funded by Children's Health Queensland (CHQ), and involve local HHSs hiring staff and running the program in accordance with CHQ direction and support. Periodically, the HHS invoices CHQ for reimbursement of the costs involved in running the programs. These transactions are processed as Inter Entity transactions, which are automatically balanced in the general ledger with the use of revenue offsets, ensuring the expenditure is reported once in state-wide reports.

In previous years, the funding HHS (e.g. CHQ) has reported all associated costs as program expenditure in the MHSO form; while the HHS performing the activity has reported the direct expenditure, staffing and activity at the establishment level.

The structure of MHEC reporting does **not** include reporting of revenue offsets, which results in these funds being double reported across the two HHSs.

For MHEC purposes, expenditure and staffing are to be reported with activity. Therefore, in the case of Inter Entity transfers for programs like AMYOS and PIMH, the direct expenditure and staffing is to be reported by the establishment performing the activity. When the expenditure is reimbursed, the reimbursing HHS should not report these funds as expenditure. Any state-wide costs that are incurred and are not reimbursed are to be reported by the MHSO incurring the expenditure (e.g. for AMYOS and PIMH, this would be Children's Health Queensland).

CIMHA and QHAPDC Activity

An excel spreadsheet will be provided to each MHSO highlighting the CIMHA and QHAPDC Activity for the 2019/2020 year prior to the collection being published. This is to assist contact officers to better understand the reported activity in the MHSO in terms of the quantity of POS, accrued patient days and type of service at each facility.

It is intended to be used as a tool to highlight potential discrepancies between service provision and expenditure. Discrepancies themselves do not necessarily reflect reporting errors (activity and expenditure may still be different) however the identification of discrepancies may assist in cross checking where the expenditure occurs.

Contents

Introduction

Purpose of the manual

This manual provides instructions and procedures for undertaking the Mental Health Establishments Collection (MHEC). It is intended as a reference for all Hospital and Health Service (HHS) personnel and Department of Health personnel directly involved in the collection, processing and use of this data.

Background

The Fifth National Mental Health Plan (the Fifth Plan) was endorsed by the Council of Australian Governments Health Council Members in August 2017. The Fifth Plan follows on from the work of the previous four national mental health plans in collaboratively shaping mental health sector reform by identifying priority reform areas and committing governments to a set of agreed actions.

The Fifth Plan includes a commitment to make available key national data to inform regional-level understanding of service gaps, duplication and areas of highest need. This commitment builds on the previous commitment by governments, as part of the Fourth Plan, to improve accountability and transparency within the mental health sector. Over the past two decades mental health information, including national mental health data collections, has provided the foundation for system accountability and reporting; and service planning and performance analysis. A key action of national focus is to further develop information through continuous and collaborative effort between governments, including keeping data sources up to date, as well as filling gaps in the current national collections.

Four National Minimum Data Sets (NMDS) have been developed for the public mental health services. The admitted patient mental health care, community mental health care, and residential mental health care provide data at the client level, whilst the Mental Health Establishments (MHE NMDS) provides data at the establishment level. From 2005/06 the MHE NMDS replaced the previous Community Mental Health Establishments NMDS and National Survey of Mental Health Services.

Use of MHEC data

The development of information to guide mental health reform and service delivery has been driven by the need to discover '*who* receives *what* from *whom* at what *cost* and with what *effect*.'[1]

Data collected for the MHEC provides detailed information on the range, level and cost of services

[1] Leginski, W et al. (1989). Data Standards for Mental Health Decision Support Systems: A Report of the Task Force to Revise the Data Content and System Guidelines of the Mental Health Statistics Improvement Program.

available in Queensland. As an annual collection it is used to monitor service growth and development at the HHS, Mental Health Service Organisation (MHSO) and state-wide levels. The data provides yearly updates of information on resource capacity including funding; staffing numbers and discipline mix; and broad activity indicators. This data is also used to inform local and state decision-making, support the development of performance indicators and to address ad hoc research requirements.

The MHEC complements the range of activity, diagnostic, demographic and outcome information collected to support understanding of mental health service delivery in Queensland.

Data reported for the MHE NMDS is published in the following national publications: Mental Health Services in Australia, and the Report on Government Services.

Mandatory requirement

Queensland Health collects MHE information as part of a mandatory reporting requirement in the National Health Information Agreement. The current agreement commenced on 31 December 2011.

The following information is provided to the Australian Institute of Health and Welfare and the Australian Department of Health and Ageing:

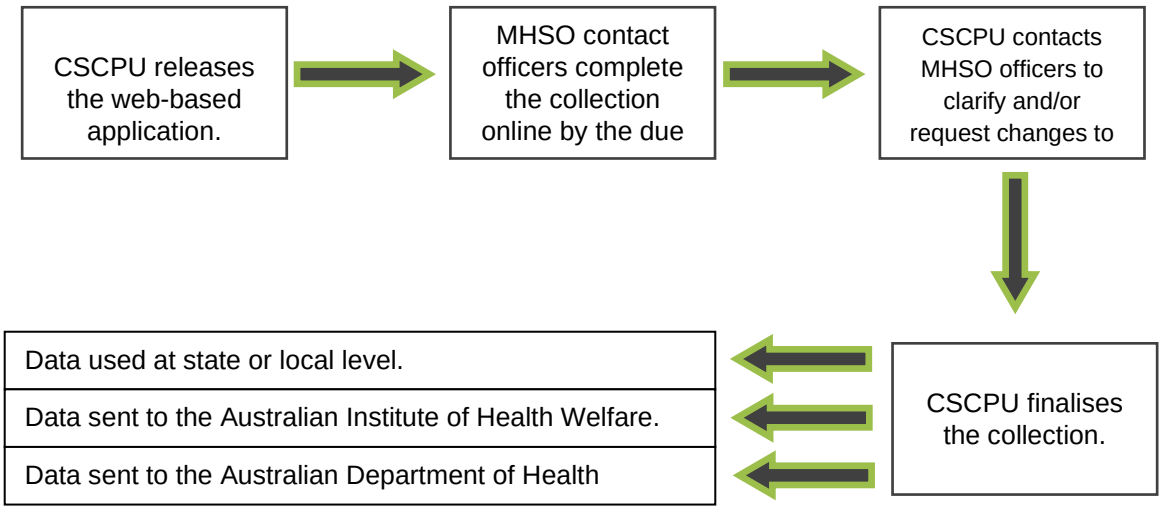
- Establishment identifier
- Full-Time Equivalent (FTE) staff
- Geographic location of establishment
- Non-salary operating costs
- Average number of available beds
- Salaries and wages
- Separations
- Comparability of accounting and funding practices
- Consumer participation in service development
- Indicators of service activity
- Mental health workforce
- Quality of arrangements for monitoring service delivery and financial performance
- Resources associated with state/territory funded mental health services

- Type and volume of services available.

Further information regarding the National Health Information Agreement can be found on the AIHW website.

Procedures

This chapter describes the processes for completing the MHEC. These processes are summarised in the flow chart below. The Clinical Systems, Collection and Performance Unit (CSCPU) developed a web-based application to support collection of the MHE information, known as the Mental Health Alcohol and Other Drugs Establishments Collection Application (MHAODECA).



Completing the collection

MHE information is collected and reported at the following levels:

- **MHSO** – usually includes a number of different service settings (for example, inpatient and community), programs (for example, child and youth and adult) and facilities. There may be more than one MHSO included in the same HHS.
- **Establishment** – also known as 'reporting establishment' and can be made up of a number of different service settings, programs, teams and wards.
- **State** – the highest level of reporting, only completed by CSCPU staff.

Entry of the MHE information occurs through completion of three separate forms which reflect the reporting levels above: state, MHSO and establishment forms. The MHSO forms are to be completed by a representative at the MHSO level, with aggregate data from different establishments included in the MHSO. The establishment forms are to be completed for each 'reporting establishment' within the MHSO. Appendix A shows a list of HHSs, MHSOs, reporting establishments and their corresponding identifiers.

For HHSs with only one MHSO and multiple reporting establishments, a single MHSO form will be completed, as well as an establishment form for each reporting establishment. For HHSs with multiple MHSOs, an MHSO form will be completed for each MHSO as well as an establishment form for each reporting establishment. In this instance, HHS level costs associated with the delivery of mental health services will need to be apportioned across the different MHSOs on the basis of a resource allocation method.

For example, the following table outlines the establishment details for South West HHS:

HHS	MHSO	ID	Establishment
South West	South West	80306	Charleville CMHS
		80307	Roma Adult CMHS
		80308	Roma Child and Youth CMHS

In this instance, South West would complete and submit:

1. The MHSO form for 'South West' MHSO
2. The establishment form for 'CHARLEVILLE CMHS'
3. The establishment form for 'ROMA ADULT CMHS'
4. The establishment form for 'ROMA CHILD AND YOUTH CMHS'

The following table outlines the establishment details for Metro South HHS:

HHS	MHSO	ID	Establishment
Metro South	Bayside	80998	Bayside Adult Community MHS
		80090	Bayside Child & Youth Community MHS
		00028	Bayside Community Care Unit
		00625	Casuarina Lodge - Wisteria Abi Unit
		00028	Redland Hospital
		01404	Daintree Psychogeriatric Inpatient Unit
	Logan-Beaudesert	83002	Acmena House
		80128	Beenleigh Community MHS
		81010	Browns Plains Community MHS

		80739	Logan Central Adult Community MHS
		80737	Logan Central Child & Youth Community MHS
		00029	Logan Community Care Unit
		00029	Logan Hospital
		83011	Logan Youth Step Up Step Down Unit
	Princess Alexandra Hospital	82000	Coorparoo Community Care Unit
		80759	Inala Adult Community MHS
		81260	Woolloongabba Community MHS
		81003	Mount Gravatt Adult MHS
		00011	Princess Alexandra Hospital

In this instance, Metro South would complete and submit:

1. The MHSO forms for Bayside, Logan-Beaudesert and Princess Alexandra Hospital
2. The establishment form for 'Bayside Adult Community MHS'
3. The establishment form for 'Bayside Child & Youth Community MHS'
4. The establishment form for 'Bayside Community Care Unit'
5. The establishment form for 'Casuarina Lodge - Wisteria Abi Unit'
6. The establishment form for 'Redland Hospital'
7. The establishment form for 'Daintree Psychogeriatric Inpatient Unit'
8. The establishment form for 'Acmena House'
9. The establishment form for 'Beenleigh Community MHS'
10. The establishment form for 'Browns Plains Community MHS'
11. The establishment form for 'Logan Central Adult Community MHS'
12. The establishment form for 'Logan Central Child & Youth Community MHS'
13. The establishment form for 'Logan Community Care Unit'
14. The establishment form for 'Logan Hospital'
15. The establishment form for 'Logan Youth Step Up Step Down Unit'
16. The establishment form for 'Coorparoo Community Care Unit'
17. The establishment form for 'Inala Adult Community MHS'
18. The establishment form for 'Mount Gravatt Adult MHS'
19. The establishment form for 'Woolloongabba Community MHS'
20. The establishment form for 'Princess Alexandra Hospital'

The remainder of this manual sets out the instructions on how to complete each different form.

System manual

Detailed instructions on how to use MHAODECA to complete the collection can be found in the MHAODECA system user manual.

MHSO Form

This form relates to the types of mental health services provided by your MHSO during the reference period; the indirect costs relating to administration at the MHSO level; and the funding sources for expenditure on mental health services at the MHSO and establishment level.

MHSO form section 0

This section is for nomination of the person who will approve the MHEC data for the MHSO; and optionally a person who is able to endorse the MHEC data for the MHSO, confirming the accuracy of the data from a service level perspective. MHEC data must be approved before acceptance of all forms for the HHS by CSCPU.

Approver

This role is responsible for the formal approval of the MHEC data for the MHSO. Generally, this person is either an Executive Director or Service Director for mental health services within the HHS. An approver must be nominated, and Section 0 submitted before the MHEC data at the MHSO and Establishment levels can be completed.

Endorser

This role is responsible for endorsing the MHEC data for the MHSO, confirming it is accurate. Generally, this person would be a subject matter expert within the mental health service and has an intimate knowledge of all service delivery settings and program types within the HHS. It is not necessary to specify an endorser, but it is recommended where MHEC forms are not completed by staff in the mental health section of the HHS.

MHSO form section 1

This section provides a matrix to specify the types of mental health services managed by the MHSO, linking the service settings with the target populations.

Services provided

In the table provided indicate with a Yes or No the types of mental health services managed by your MHSO.

Service Settings

Inpatient

An admitted patient (inpatient) mental health care service is a specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. It includes both acute and non-acute admitted patient

services and in Queensland Health this currently includes special care suites. These establishments are devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness.

Residential

A residential mental health care service is a specialised mental health service that employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site to consumers residing on an overnight basis in a domestic like environment; and which encourages consumers to take responsibility for their daily living activities. Residential mental health care is a community based overnight service.

Ambulatory

An ambulatory mental health care service is a specialised mental health service that provides services to people who are not currently admitted to a hospital for psychiatric care; and are not consumers in a residential service. Services are delivered by health professionals with specialist mental health qualifications or training.

Ambulatory mental health services include:

- community-based crisis assessment and treatment teams
- day programs
- mental health outpatient clinics provided by either hospital or community-based services
- child and adolescent outpatient and community teams
- social and living skills programs
- psychogeriatric assessment services
- hospital-based consultation liaison and in-reach services to admitted patients in non-psychiatric and hospital emergency settings
- ambulatory-equivalent same day separations
- home based treatment services
- hospital based outreach services.

Target Populations

For a type other than ‘General’ to be separately listed on this section there must be funding specifically provided for specialist FTE positions and/or operations.

General psychiatry

These services principally target the general adult population (aged 18–64 years) but may provide general services to children, adolescents, older people or forensic clients. Therefore, general psychiatry services are those services that are not specialist child and adolescent, young persons, older persons, or forensic services. Note that the appointment of a forensic liaison position into a general psychiatry service does not qualify this service as forensic psychiatry.

General psychiatry inpatient services include hospital units in which the principal function is the provision of some form of specialised service to the general adult population.

Child and adolescent psychiatry

These services principally target children and adolescents (aged 0–17 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on children and adolescents. For smaller regional services this may be the appointment of staff to specifically work with children and adolescents within a broader mental health team. These services may include a forensic component.

Young person’s psychiatry

These services principally target young people (aged 16–24 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on young persons. These services may include a forensic component.

Older persons psychiatry

These services principally target people in the age group 65 years and over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on aged persons. This service category does not include the treatment of older people by general psychiatry services. These services may include a forensic component.

Forensic psychiatry

These services principally assess, treat and care for mentally disordered individuals whose health condition has led them to commit, or be suspected of, a criminal offence; or make it likely that they will re-offend in the future without adequate treatment or containment.

This includes all prison-based services but excludes services that are primarily for children and adolescents, young persons and older people even where they include a forensic component.

In Queensland, high security inpatient service are to be reported as forensic psychiatry while Secure Mental Health Rehabilitation Units (referred to as 'medium secure units' in MHEC) should be reported as such.

Note that the employment of a forensic liaison officer in a community mental health team should not be reported separately as a specialised forensic service.

Medium Secure

These rehabilitation units provide a safe and structured environment for the medium to long term inpatient treatment and rehabilitation of consumers with persistent and disabling symptoms of mental illness, who cannot be adequately supported in other inpatient or community settings.

MHSO form sections 2, 3, 4

These sections relate to mental health service consumer participation. For the purposes of MHEC, a mental health service consumer refers to *both primary consumers and to carers*. A primary consumer is the person with the mental illness or psychiatric disability who is the main focus of treatment/intervention. A carer is the person (other than the service provider) whose life is affected by virtue of their close relationship with the primary consumer or who has a chosen or contracted caring role with a primary consumer.

Section 2: Mental health service consumer and carer representation

Identify the statement that best describes the extent to which a specialised mental health service organisation has formal committee mechanisms in place to promote the participation of mental health consumers and carers in the planning, delivery and evaluation of the service.

Note: A ‘formal position’ means the mental health service consumer/carer representative is a voting member of the committee.

Section 3: Arrangements to promote participation by ‘primary consumers’

For each statement, select ‘yes’ or ‘no’ to describe arrangements used in your MHSO to promote participation by the primary consumer. Each statement must be addressed.

A ‘primary consumer’ is the person with the mental illness or psychiatric disability who is the main focus of treatment/intervention. If required, a description of other arrangement(s) should be included in the box provided.

Section 4: Arrangements to promote participation by ‘carers’

For each statement, select ‘yes’ or ‘no’ to describe arrangements used in your MHSO to promote participation by the carer. Each statement must be addressed.

A ‘carer’ is the person (other than the service provider) whose life is affected by virtue of their close relationship with the primary consumer, or who has a chosen or contracted caring role with a primary consumer. If required, a description of the other arrangement(s) should be included in the box provided.

MHSO form section 5

This section relates to gross, non-capital expenditure by the MHSO that is indirectly related to the mental health services and cannot or should not be apportioned to specific service settings. Expenditure directly related to the provision of mental health services by establishments should not be reported in this section, but rather in each Establishment Form Section 4. For this reason, it is suggested that MHSO Form Section 5 and establishment forms Section 4 be completed at the same time.

The distributed field must be completed for all indirect expenditure categories. The following tables list the appropriate responses based on whether expenditure is reported in that category.

Category reports some expenditure

Code	Description
No	No expenditure for this category has been reported at the Establishment level.
Yes	Some expenditure for this category has been reported at the Establishment level.

Category reports Nil expenditure

Code	Description
All	All expenditure for this category has been reported at the Establishment level.
Nil	No expenditure for this category has been reported at the Establishment level or included in MHSO Indirect Expenditure.

Non-capital expenditure is any expenditure that does not involve the purchase of assets (property, plant and equipment) greater than $5,000.

Completing this section

Section 5 should be completed by the HHS and/or mental health finance officer in consultation with the mental health executive director, manager or team leader (depending on the service).

The information for section 5 can be obtained from a number of sources. Your HHS finance officer can run a DSS expenditure report for your HHS or MHSO. Operating budgets, DSS budget reports and S4

HANA reports may also help provide this information.

Indirect non-capital expenditure

There are two general categories of indirect expenditure:

1. Expenditure indirectly related to the delivery of mental health services that cannot or **should not** be apportioned across the reporting establishments in your HHS/MHSO (i.e. overhead labour related expenditure). This includes:
    - expenditure on HHS-wide corporate and support services that is not directly related to the provision of clinical mental health services. These HHS services are usually provided from a central resource pool and managed at the HHS level, for example HHS administration / programs and the non-labour related costs that go into running them (IT costs etc.). In cases where HHS has more than one MHSO, overhead costs should be apportioned to MHSO forms on the basis of a resource allocation method.
    - expenditure on administration of state-wide programs where the activity is carried out by other HHS/MHSO and reimbursed by your HHS via Inter Entity transfer. Note that reimbursements should not be reported here, only expenditure related to the overall administration of the program. The reimbursements are considered “distributed” expenditure, and therefore the flag indicating whether some expenditure has been distributed down to establishment level should be set to “yes”.
    - expenditure on other non-clinical labour related expenses such as superannuation, workers compensation premiums and insurance payments that are not directly related to the provision of mental health services by establishments.
2. Mental health expenditure that does not relate to service delivery, such as research, education and training and mental health promotional activities. Also, funds provided by the HHS/MHSO direct to external groups (i.e. not via the MHSOs establishments). An example would be payments to academic departments of psychiatry. However, where such expenditure is considered to be part of service delivery (for example education and training of staff operating out of an establishment), this should be reported against the establishment on Establishment Form Section 4. Excluded from this category are grants made to non-government organisations (NGOs) for the provision of services to people affected by a mental health illness. These are reported in MHSO form section 7.

Indirect expenditure category definitions

Program administration

Refers to costs associated with administration and support of the HHS/MHSO mental health specific program. This includes (but is not limited to) the salary and wages expenditure (outside of workers compensation and superannuation – these are reported discretely) associated with the FTE specifically employed by the MHSO for the purposes of mental health activities. **The 'overhead' FTE associated with this expenditure are to be reported in MHSO Form Section 9.**

Organisation-wide support services

Refers to the costs associated with the administration and support of the HHS/MHSO that are **not** mental health program specific. This should include (but not be limited to) the labour related expenditure (outside of workers compensation and superannuation – these are reported discretely) associated with the FTE deemed to be 'overhead' that are to be reported in MHSO Form Section 9.

Such services could include corporate governance and administration, public relations, hospital administration, shared service providers, human resources, finance, records, information systems/technology, building/grounds maintenance, security, and utilities. These services are generally provided from a central pool of resources managed at the corporate level for all programs/business units of the HHS/MHSO. Expenditure for mental health services should be apportioned based on a resource allocation method.

Education and training

Refers to the cost of education, training and development of staff within the mental health services that is organised and managed by the HHS/MHSO and has not been included in expenditure reported elsewhere. Job specific training and development should be charged to the mental health establishment where the officer works.

Expenditure by the HHS on schools of nursing should be reported on MHSO Form Section 5.

Academic positions

Refers to grants to academic institutions for the establishment and maintenance of academic chairs in psychiatry or related disciplines. This item also includes the costs of other academic positions associated with the professional chair, where these are financed from within the organisation's recurrent budget.

Academic expenditure should be reported in this section only where the academic unit operates

independently. Where an academic unit or position operates as an integral part of a service (for example an acute inpatient unit) the expenditure should be reported against the relevant establishment.

Mental health research

HHS/MHSO funded expenditure on basic or applied research in the mental health field. Research expenditure should be reported in this section only where the research operated independently. Where the research activity occurs as an integral component of service delivery for an establishment, the expenditure should be reported against the relevant establishment section 4 of the establishment form.

Mental health promotion

Refers to expenditure dedicated specifically to mental health promotion objectives. Mental health promotion is defined as activities designed that lead to improvement of the mental health functioning of persons through prevention, education, and intervention activities and services. Reporting expenditure against this item is not intended to be based on costing of activities that, retrospectively, entailed a significant mental health promotion component. Instead, it should be confined to financial allocations that were clearly targeted towards mental health promotion objectives.

Service development

Refers to expenditure on the development of new mental health services funded by the HHS/MHSO which are not yet operational and providing activity data.

Superannuation

Refers to indirect superannuation employer contributions paid, or that should be paid, on behalf of employees, by Queensland Health to a superannuation fund providing retirement and related benefits to established employees.

Superannuation expenditure reported should be related to the overhead FTE reported in MHSO section 9. Superannuation expenditure should **not** be reported in the salary and wages component in MHSO Form Section 9. Note: the Mental Health Survey FTE report in DSS is defaulted to exclude superannuation expenditure.

If the superannuation payments relate to the provision of services by establishments, they must be reported against those establishments in Establishment Form Section 4.

Workers compensation premium

Includes indirect expenditure on worker's compensation insurance payments made by the organisation on behalf of its employees.

Worker's compensation **premiums** should **not** be reported in MHSO form section 9 with the associated overhead FTE. If the worker's compensation premiums relate to the provision of services by establishments, they must be reported against those establishments in Establishment Form Section 4.

Unlike Superannuation, Workers Compensation **payments made to employees** should also be reported in the salary and wages component of MHSO section 9 (Note: the Mental Health Survey FTE report in DSS is set up to enable this by default).

Insurance

Refers to public risk and other insurance amounts paid by the HHS/MHSO with respect to the provision of mental health services within the HHS/MHSO. Only report insurance in MHSO Form Section 5 if it does not relate to the provision of services by establishments. If the insurance relates to the provision of services by establishments, it must be reported against those establishments in Establishment Form Section 4.

Mental Health Act regulation or related legislation (including review tribunals)

Refers to expenditure incurred by the HHS/MHSO due to the establishment and maintenance of Mental Health Act review bodies.

Patient transport services

Refers to the direct cost of transporting patients, including the salaries and wages of transport staff employed by the HHS (where they have not been reported elsewhere i.e. Organisation Wide Support Services or Program Administration). Include payments to ambulance units where these are not reported elsewhere. Only report patient transport expenditure in section 5 if it does not relate to the provision of mental health services by an establishment. If the patient transport relates to the provision of services by an establishment, it must be reported against that establishment in Establishment Form Section 4.

Property leasing costs

Refers to the costs of leasing premises used for the provision of mental health services (for example community clinics). Only report leasing expenditure in MHSO Form Section 5 if it does not relate to the provision of services by an establishment. If the leasing expenditure relates to the provision of services

by an establishment, it must be reported against that establishment in Establishment Form Section 4.

Other indirect expenditure

Refers to any indirect expenditure that is related to the mental health services in your HHS/MHSO but is not related directly to the delivery of these services by establishments. If there is 'other indirect expenditure' then please include a description of this expenditure in the box provided. Depreciation expenditure on written off/vacant buildings is **not** to be included here.

MHSO form section 6

This section relates to the funding sources for the combined expenditure reported in MHSO Form Section 5 and Establishment Form(s) Section 4.

Note that this section contains data regarding funds expended only. It is not expected to match budgets or actual revenue, rather it should match the total expenditure. The purpose of this section is to identify the source of the funds for MHSO actual expenditure.

Sources of funding for expenditure

Please identify the funding sources for the combined expenditure reported in MHSO Form Section 5 and Establishment Form(s) Section 4. This includes expenditure recoveries and patient revenue. If your HHS provides an upfront estimated budget for high cost drugs and then keeps the actual recoveries, the funding source needs to be split between 'state' and 'recoveries'. For example, if $100,000 was expended on drug supplies and $50,000 was received as a government rebate, then $100,000 should be reported on Establishment Form Section 4 as expenditure and the $50,000 rebate should be reported here as recoveries.

The total amount reported should reconcile to the total expenditure reported on MHSO Form Section 5 and Establishment Form Section 4. Do not report total budget allocations in this section. Only report the portion that was expended.

Queensland Health funding

Refers to State Government funding provided by Queensland Health for the delivery and/or administration of mental health services in your HHS/MHSO. This includes specific mental health allocations via Activity Based Funding (including block funded services) as well as funds appropriated for general or other specific purposes. This also includes funding provided directly to NGOs by the Department of Health for the purposes of providing public services in establishments located within the HHS that are run by or in collaboration with NGOs, including Youth Residential Rehabilitation Services and step up step down units. This will also include inter entity transfer money where the HHS is reimbursed for expenditure and staff employed as part of a state-wide program run by another HHS.

Other State Government funding

Refers to funding provided by government departments external to Queensland Health for the delivery and/or administration of mental health services.

National Healthcare Agreement funding

Refers to funding allocated by the Commonwealth Government to Queensland to assist in the implementation of the mental health services.

Department of Veterans' Affairs funding

Refers to block grants or activity-based payments provided by the Department of Veterans' Affairs (DVA) for the provision of mental health services, and payments made for mental health treatment and care of DVA clients.

Other Australian Government funding

Refers to revenue paid directly by the Commonwealth Government. This includes nursing home and hostel subsidies for the care of patients in specialised mental health services, and any other special purpose grants including rural health support, education and training funds, and incentives package funds made available under the National Health Care Agreements.

Patient revenue

Refers to revenue paid directly by patients, or by third parties on behalf of patients, under care of the HHSs mental health services. Note that this excludes DVA payments in respect of specific patients or the Commonwealth nursing home or hostel subsidies, which should be reported as other Commonwealth funds.

Recoveries

Refers to revenue relevant to mental health services that is in the nature of recovery of expenditure incurred. This includes income from the provision of meals and accommodation, use of facilities, etc.

Other revenue

Refers to all other revenue from mental health services received by the HHS/MHSO that has not been reported in this section.

MHSO form section 7

This section reports details of any grants made from HHSs/MHSOs to NGOs during the year.

Funding to non-government organisations

A number of HHSs/MHSOs provide funding to NGOs for the provision of specified services for people affected by a mental health issue. Please provide details of any grants made to NGOs during the year. These NGO grants should be reported here; however they can only be reported to the Commonwealth at the state-wide level.

Do not report this grant expenditure on either MHSO Form Section 5 or Establishment Form Section 4.

This excludes payments to NGOs for collaboration services in government funded residential facilities. These payments should be reported in Section 4 of the relevant establishment form, and the NGO provided staff should be reported in Section 5 of the relevant establishment form.

Definitions of NGO grant service types

The NGO Service Types allow the collection of nationally consistent information on the mental health NGO sector. The NGO service types are:

- Counselling—face-to-face
- Counselling, support, information and referral—telephone
- Counselling, support, information and referral—online
- Self-help—online
- Group support activities
- Mutual support and self-help
- Staffed residential services
- Personalised support—linked to housing
- Personalised support—other
- Family and carer support
- Individual advocacy
- Care coordination
- Service integration infrastructure
- Education, employment and training
- Sector development and representation
- Mental health promotion

- Mental illness prevention

Counselling – Face-to-face

Counselling services operate through a range of mediums including face-to-face, telephone and online. This service type is intended only for services providing face-to-face counselling.

Counselling services provide a structured process that is concerned with addressing and resolving specific problems, making decisions, working through feelings and inner conflicts, or improving relationships with others (British Association for Counselling 1986). Counselling facilitates personal growth, development, self-understanding and the adoption of constructive life practices.

The counselling process will depend on the individual counsellor, the individual client and the specific issue.

Distinguishing features:

- Delivered face-to-face
- Primarily centre-based
- Includes individual, family and group counselling

Inclusions:

- Talking therapies
- Grief counselling
- Relationship counselling

Exclusions:

- Counselling delivered in the context of other service types e.g., Personalised support, carer support programs

Example organisations:

- National Association for Loss and Grief (NALAG)

Counselling, support, information and referral – Telephone

Counselling, support, information and referral services can be provided both via telephone and online. This service type is intended only for those services provided via telephone.

Counselling services provide a structured process that is concerned with addressing and resolving specific problems, making decisions, working through feelings and inner conflicts, or improving relationships with others. Counselling facilitates personal growth, development, self-understanding and the adoption of constructive life practices.

The counselling process will depend on the individual counsellor, the individual client and the specific issue.

Mental health support, information and referral services are those that provide support for people experiencing mental illness and which offer reliable referrals, information and self-help resources to empower people to take steps towards maintaining mental health and emotional wellbeing (Lifeline 2012).

Distinguishing features:

- Delivered via telephone
- Primarily delivered on a one-on-one basis

Inclusions:

- Telephone crisis support
- Helplines
- Telephone counselling

Exclusions:

- Occasional services delivered under other service types that are incidentally provided via the telephone
- Telephone support services that are delivered as an adjunct for other service types, e.g. after hours carer support lines, warm lines
- Counselling, support, information and referral services not provided by telephone

Example services:

- Lifeline
- Kids Helpline
- Mensline
- Suicide line

- Suicide Call Back Service
- Beyond Blue info line

Counselling, support, information and referral – Online

Counselling, support, information and referral services can be provided both via telephone and online. This service type is intended only for services provided online.

Counselling services provide a structured process that is concerned with addressing and resolving specific problems, making decisions, working through feelings and inner conflicts, or improving relationships with others. Counselling facilitates personal growth, development, self-understanding and the adoption of constructive life practices.

The counselling process will depend on the individual counsellor, the individual client and the specific issue.

Mental health support, information and referral services are those that provide support for people experiencing mental illness and which offer reliable referrals, information and self-help resources to empower people to take steps towards maintaining mental health and emotional wellbeing.

Distinguishing features:

- Primarily delivered on a one-on-one basis
- Primarily delivered via an interactive ‘chat’ style modality

Inclusions:

- Synchronous online chat
- Automated referral systems
- Email
  Note: Email-based activity is not intended to be measured under the Mental health non-government organisation establishments DSS at this stage.

Exclusions:

- Occasional services delivered under other service types that are incidentally provided via the Internet

- Online services that are delivered as an adjunct for other service types
- Counselling, support, information and referral services not provided online

Example services:

- Kids Helpline
- Beyond Blue
- Reach Out

Self-help – online

Self-help—online includes structured interactive online programs which take people, who have a lived experience of mental illness, through exercises to help them develop skills to handle life's challenges more effectively. Unlike *Counselling, support, information and referral—online*, services which fall under *Self-help—online* never involve interaction with another person, only interaction with the online program's content.

Distinguishing features*:*

- Population-based (rather than individually-tailored)
- Conducted online
- Not individually facilitated by another person
- Available 24 hours a day

Inclusions**:**

- Cognitive behaviour therapy - CBT-based programs
- IPT-based programs

Exclusions:

- Mutual support and self-help activities which incidentally occur online, e.g. online support groups (these services are not currently reported in the MH NGOE NMDS)

Example services*:*

- myCompass

Group support activities

Group support activities includes services that aim to improve the quality of life and psychosocial functioning of mental health consumers, through the provision of group-based social, recreational or prevocational activities. In contrast to services in the Mutual support and self-help service type, Group support activities are led by a member of the NGO.

Distinguishing features:

- Delivered to groups of consumers simultaneously
- Primarily engage consumers in one or more social, recreational, prevocational or physical activities
- Centre-based or conducted in community environments
- Led by an NGO employee or representative

Inclusions**:**

- Neighbourhood, community and drop-in centres
- Structured and unstructured community day programs
- Leisure and recreation activities
- Psychoeducational programs
- Clubhouses

Exclusions:

- Self-help and mutual support activities delivered on a group basis (these are reported under *Mutual support and self-help*)
- Group-based programs focused on assisting clients gain employment, education or vocational training (these are reported under *Education, employment and training*)

Example services:

- Helping Hands
- Pananga Clubhouse

Mutual support and self-help

Mutual support and self-help includes services that provide information and peer support to people with a lived experience of mental illness. People meet to discuss shared experiences, coping strategies and to provide information and referrals. Self-help groups are usually formed by peers who have come together for mutual support and to accomplish a specific purpose. (METeOR 2014)

Distinguishing features:

- Group-based services
- Comprising individuals with common experience and interest
- Led by one or more volunteer/unpaid consumer peers
- Provided on a face-to-face basis or through interactive online forums. Please note, while this service type can be conducted though interactive online forums, the online activity is not intended to be measured under the Mental health non-government organisation establishments NMDS.

Inclusions:

- Self-help
- Warm lines

Exclusions:

- Services that, while delivered by peers, are better categorised in other service types, e.g. peer-led employment-oriented services; personalised support services provided by peer workers
- Services where the peer-leader is employed by the NGO (these services will be reported under other service types, e.g. Personalised support or Group support activities)
- Mutual support and self-help activities provided for and/or by carers and/or families of people with mental illness (these are reported under Family and carer support)
- Online, population-based self-help programs (these are reported under Self-help—online)

Example services:

- GROW
- Voice Hearers Group
- Phone connection

Staffed residential services

Staffed residential services are those that provide overnight accommodation in a domestic-style environment, which is staffed for a minimum of 6 hours a day and at least 50 hours per week. Accommodation may be provided on a short, medium or long term basis.

Distinguishing features:

- Deliver services in a setting that provides overnight accommodation to consumers
- Domestic-style environment
- Consumers are encouraged to take responsibility for their daily living activities
- Staff are on-site for a minimum of 6 hours a day and at least 50 hours per week

Inclusions:

- Residential rehabilitation
- Residential respite
- Crisis residential services
- Transitional residential services
- Step-up step-down services (funded by the NGO)

Exclusions:

- Facilities that are visited via in-reach services provided by NGO staff but where the residence is not regarded as NGO worker's place of employment
- Government funded, NGO operated clinically-staffed residential services that are staffed 24 hours per day, 7 days a week. These are to be reported as separate establishments. In Queensland, these are the community care units, step-up step-down units and the youth residential rehabilitation services.

Example services:

- Consumer operated services
- Transitional recovery services

Personalised support – linked to housing

Personalised support services are flexible services tailored to a mental health consumer's individual and changing needs. They include a range of one-on-one activities provided by a support worker directly to mental health consumers in their homes or local communities (Department of Communities 2011).

Personalised support—linked to housing includes services that provide personalised psychosocial support that is coordinated with provision of social housing or privately negotiated housing at the point of entry into the program (but not necessarily tied to such indefinitely).

Distinguishing features:

- Primarily delivered on a one-on-one, face-to-face basis
- Primarily delivered in the consumer's home or own environment
- Provision of personalised support is coordinated with provision of social housing or a privately negotiated housing place at the point of entry into the program (but not necessarily tied to such indefinitely)
- Services are tailored to the needs of the individual consumer
- May be of varying intensity (e.g. high, medium, low)

Inclusions:

- Coordinated housing and support
- Cluster housing programs
- Long term supported housing

Exclusions:

- Provision of personalised support initiated independently of any housing arrangements (these are reported under Personalised support—other)
- Personalised support services provided to individuals that are targeted only at improving the person's participation in employment, education or vocational training (these are reported under Education, employment and training)
- Staffed residential services (these are reported under Staffed residential services)

Example services:

- Housing and Accommodation Support Initiative (HASI), New South Wales
- Housing and Support Program (HASP), Queensland
- Housing and Accommodation Support Partnership (HASP), South Australia

Personalised support – other

Personalised support services are flexible services tailored to a mental health consumer's individual and changing needs. They include a range of one-on-one activities provided by a support worker directly to mental health consumers in their homes or local communities (Department of Communities 2011).

Personalised support—other includes services that provide personalised psychosocial support that is independent of housing arrangements (e.g. provision of social housing or privately negotiated housing) at the point of entry into the program.

Distinguishing features:

- Primarily delivered on a one-on-one, face-to-face basis
- Primarily delivered in the consumer's home or own environment
- Provision of personalised support is initiated independently of any housing arrangements
- Services are tailored to the needs of the individual consumer
- May be of varying intensity (e.g. high, medium, low)

Inclusions:

- Outreach support
- In-situ individually tailored support

Exclusions:

- Provision of personalised support that is coordinated with provision of social housing or privately negotiated housing at the point of entry into the program (these are reported under Personalised support—linked to housing)
- Personalised support services provided to individuals that are targeted only at improving the person's participation in employment, education or vocational training (these are reported under Education, employment and training)

Example services:

- Personal Helpers and Mentors (PHaMs) service
- Home Based Outreach Support (HBOS), Victoria
- Individual Psychosocial Rehabilitation and Support Services (IPRSS), South Australia

Family and carer support

Family and carer support includes services that provide families and carers of people living with a mental illness support, information, education and skill development opportunities to fulfil their caring role, while maintaining their own health and wellbeing (Mission Australia 2012). These services may be provided in

the context of early intervention or ongoing support.

Distinguishing features:

- Explicitly targeted at carers and families
- Includes all services focused on family and carer support except staffed residential respite services. Therefore, this includes services that, if they were not targeted at families and carers, would be reported in other service types.

Inclusions:

- Family and carer programs
- In-home and/or day respite for carers
- Family-focused early intervention services
- After hours carer support lines

Exclusions:

- Residential respite services (these are reported under Staffed residential services)

Example programs and services:

- National Respite for Carers Program
- Young Carer Program
- Family Mental Health Support Services
- ARAFMI (Association for the Relatives and Family of the Mentally Ill)

Individual advocacy

Individual advocacy includes services that seek to represent the rights and interests of people with a mental illness, on a one-to-one basis, by addressing instances of discrimination, abuse and neglect.

Individual advocates work with people with mental illness on either a short-term or issue-specific basis.

Individual advocates:

- work with people with mental illness requiring one-to-one advocacy support
- develop a plan of action (sometimes called an individual advocacy plan), in partnership with the person with a mental illness, that maps out clearly defined goals

- educate people with mental illness about their rights
- work through the individual advocacy plan in partnership with the person with a mental illness (FaHCSIA 2012).

Distinguishing features:

- One-on-one services
- Primary service provided is advocacy
- Development of a plan of action
- Educate people with a mental illness about their rights

Inclusions:

- Individual advocacy
- Legal advocacy

Exclusions:

- Systemic advocacy (these are reported under Sector development and representation)
- Individual advocacy in the context of delivery of other mental health support services to the consumer

Example services:

- Mental Health Advocacy Service, New South Wales
- Mental Health Legal Centre, Victoria
- Mental Health Law Centre, Western Australia

Care coordination

Care coordination services provide a single point of contact (via a Care Facilitator) for people (and their families/carers) with lived experience of mental illness and complex care needs. Care Facilitators will be responsible for ensuring all of the patients' care needs, clinical and non-clinical and as determined by a nationally consistent assessment tool, are being met (Commonwealth of Australia 2012).

Distinguishing features:

- The principal service provided is the coordination of access to a range of services required by the individual

- Where other support services are delivered, they are incidental to the principal care coordination role

Inclusions:

- Care coordination

Exclusions:

- Care coordination provided as part of delivering another service type

Example programs and initiatives:

- Care Coordination for People with a Severe Mental Illness and Multiple Needs, Victoria
- Partners In Recovery
- Living Options

Service integration infrastructure

Service integration infrastructure includes services that provide infrastructure integration to establish a 'one stop shop' service platform that brings together an appropriate range of mental health-related services, both existing and new, which aim to improve the mental well-being and social participation of people with mental illness.

Distinguishing features:

- Provides the administrative and capital infrastructure to facilitate the co-location of mental health-related services, rather than coordination of care for individual consumers
- The focus is the coordination of services, rather than on direct service provision

Inclusions:

- Service coordination

Exclusions:

- Care coordination for individual consumers (these are reported under Care coordination)
- Any type of service delivery to individual consumers

Example services:

- Headspace

Education, employment and training

Education, employment and training includes services where the principal function is to provide or support people with lived experience of mental illness, in gaining education, employment and/or training.

Distinguishing features:

- The principal purpose is to increase a person's ability to access education, employment and training
- Delivered one-on-one or as part of a group
- Education and training takes place through a structured program of tuition
- The education and training program can result in the attainment of a formal qualification or award (e.g. a Certificate, Diploma or Degree), however, this need not happen in every program

Inclusions:

- Supported education
- Employment and vocationally-focused group programs
- Individual employment placement and support
- Social enterprises

Exclusions:

- Where education is provided as part of delivering another service type

Example programs:

- Break Thru People Solutions
- Individual employment placement and support

Sector development and representation

Mental health sector development and representation services engage with a wide variety of issues regarding the sustainability and development of the mental health sector. This includes information dissemination, advocacy, policy analysis, program development and sector capacity building (Family and Community Services 2012).

Distinguishing features:

- Short, medium and long-term initiatives

- Initiatives are intended to benefit the mental health sector, rather than an individual organisation
- Services are not provided to individual clients but are targeted at developing and/or representing client service delivery organisations operating in the NGO sector

Inclusions:

- Sector-wide advocacy activities
- Workforce development
- Research and evaluation
- Policy activities

Exclusions:

- Individual advocacy (these are reported under Individual advocacy)

Example organisations:

- Mental Health Council of Australia (MHCA)
- NSW Consumer Advisory Group (NSW CAG)
- Mental Health Consumer Network
- Victorian Mental Illness Awareness Council (VMIAC)
- Mental Health Coordinating Council (MHCC), New South Wales

Mental health promotion

Mental health promotion includes services that operate on a population level which aim to raise awareness of mental health issues, improve mental health literacy, reduce stigma and discrimination and maximise the population's mental health and well-being. Mental health promotion may include programs targeted to population segments, based on age (e.g. early childhood) or setting (e.g. school or workplace), as well as initiatives to educate the general population.

This category also includes community-wide activities that provide information and education designed to enhance community understanding, increase the likelihood of identifying and addressing mental health problems and promote good mental health. These programs may be targeted towards specific at-risk communities or communities affected by disaster or trauma.

Distinguishing features:

- Provision of information and education
- Population-based
- Typically long-term initiatives

Inclusions:

- Mental health promotion activities
- Mental health awareness raising initiatives
- Anti-discrimination and stigma reduction activities

Exclusions:

- Mental illness prevention activities (these are reported under Mental illness prevention)

Example organisations:

- Beyond Blue
- SANE Australia

Mental illness prevention

Mental illness prevention includes services that work to prevent the onset of mental disorders, in order to reduce the incidence and prevalence of mental illness in the community. Mental illness prevention activities are directed at reducing known risk factors and/or preventing people that display early signs of mental illness from developing a diagnosable mental illness. These activities can be either population-wide or targeted at vulnerable segments of the community.

In contrast to mental health promotion, which seeks to enhance the population's mental health, Mental illness prevention aims to prevent the development of mental illness.

Distinguishing features:

- Population-based
- Vulnerable segments of the community
- Typically long-term activities

Inclusions:

- Mental illness prevention activities

Exclusions:

- Mental health promotion activities (these are reported under mental health promotion)

MHSO form section 8

This section reports the number of public housing places supported by mental health services during the year.

Supported public housing places

A number of HHS/MHSOs make formal local partnership agreements with the Department of Housing and Public Works regional offices to provide public housing 'places' for people affected by mental illness or psychiatric disability. Such agreements commit Queensland Health to provide ongoing clinical and disability support to consumers within their homes, including outreach services.

If your HHS/MHSO was party to any of these formal agreements during the year, please provide the number of public housing 'places' supported. Place refers to the number of beds in the house that are provided for mental health clients. It also refers to the capacity as at 30 June, not throughput over the entire year. Note – the Department of Housing and Public Works provides state-wide data on housing places provided to mentally ill clients who are supported with Queensland Health outreach services. CSCPU will cross check that housing places reported are not duplicated by both the Department of Housing and Public Works and Queensland Health data.

MHSO form section 9

MHSO Form Section 9 seeks to discretely identify paid FTE not directly involved in the delivery of patient care services or directly involved in the day-to-day operations of specific service settings and programs. This **can** include employed / engaged consumer workers and carer workers where they are deemed overhead. **Note that this does not imply that these roles do not have an impact on service delivery or patient outcomes.** The following examples are provided to support collection of this information.

- A Team Leader of an Acute Care Team is generally involved in both direct patient care and in the day-to-day operation of a specific service setting and program and should be reported on the relevant Establishment Form.
- An administration officer for a particular inpatient unit would be deemed to be involved in the day-today operations of the service and should be reported on the relevant Establishment Form.
- Project roles (such as state-wide or multi-HHS project positions) would generally be deemed an 'overhead' FTE and should be reported on Section 9 of the MHSO Form.
- A Mental Health Information Manager would generally be deemed to be an 'overhead' FTE as they (a) provide support across an entire MHSO and are not aligned to a specific service setting and program, (b) are not involved in direct patient care, and (c) are not involved in the day-to-day operations of specific service types. Consequently, they should be reported on Section 9 of the MHSO Form.

There are some roles that, depending on their functions, may be reported differently across MHSOs, or require partitioning across MHSO Form Section 9 and the relevant Establishment Form. For example

- An Executive Director may have a significant workload associated with financial/administrative/ governance functions and not be directly providing patient care, nor involved in the day-to-day operation of services in a specific service setting and program. In this instance, the FTE would be deemed overhead and should be reported in Section 9. However, if the Executive Director also provides direct patient care as a component of their role then the FTE (and associated expenditure) should be partitioned across MHSO Form section 9 and the relevant Establishment Form.

Please note, this information is provided as a guide. Due to differences in role titles and functions across MHSOs, it is not possible to identify which 'roles' are overhead and which are direct care based solely on the position title. If there are FTE within your service for whom you are unsure of where to allocate them

(either in part or full) within the MHEC, please contact the CSCPU through contact details in the front of this document.

MHSO form checklist

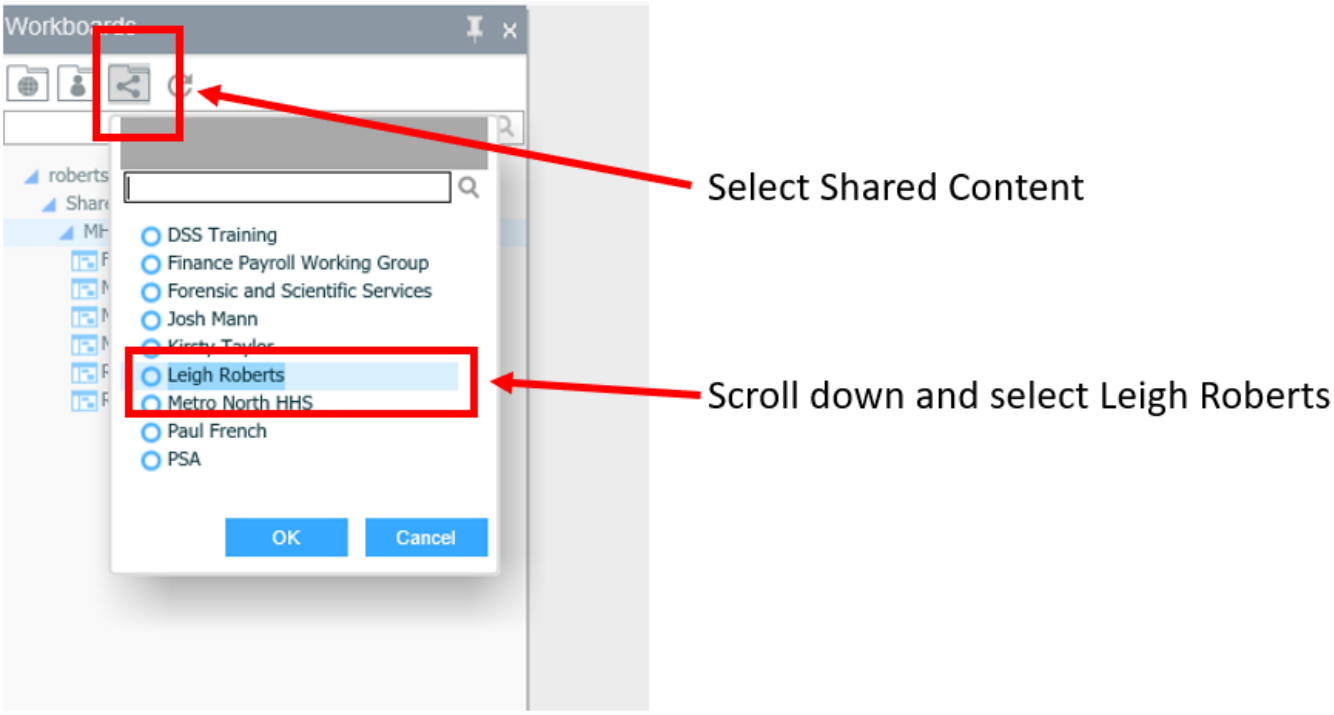
- Superannuation is not included in Section 9 (but is reported discretely in MHSO Form Section 5 for Overhead FTE).
- Workers Compensation **Payments** are included in Section 9 as salary and wages and Workers Compensation **Premiums** are recorded in MHSO Form Section 5.
- Labour related expenditure associated with Overhead FTE is reported in MHSO Form Section 5 in Program Administration, Organisation Wide Support Services or Education and Training etc. AS WELL AS in MHSO section 9.
- MHSO Form Section 5 total is greater than or equal to the total of MHSO Form Section 9

Useful DSS reports for FTE reporting

Accessing Useful MHEC Reports in DSS

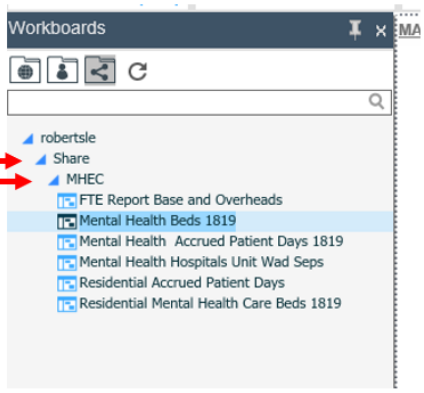
To gain access to the pre-built DSS reports that can be used for MHEC reporting, DSS users must be granted access to the reports by CSCPU staff. MHEC contacts already nominated by HHSs will have the reports shared with them automatically.

1. Log into DSS
2. Go to the Workboards panel and select Shared Content (see below).
3. A list of usernames that have shared reports will be displayed. Double Click on **Leigh Roberts** (if this name DOES NOT appear - contact CSCPU).



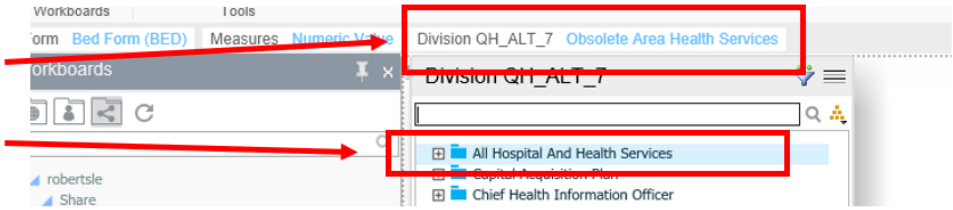
4. Expand the list of reports by selecting the arrow next to Share and then MHEC
5. Double Click on displayed reports to run them (see below).

Expand to see reports



Select required report and double click

If data for your HHS is NOT displayed, select the Division option on the tab, then expand the HHS option

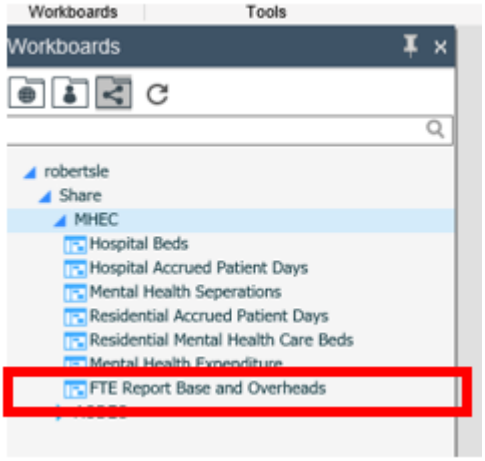


Staffing and labour expenditure

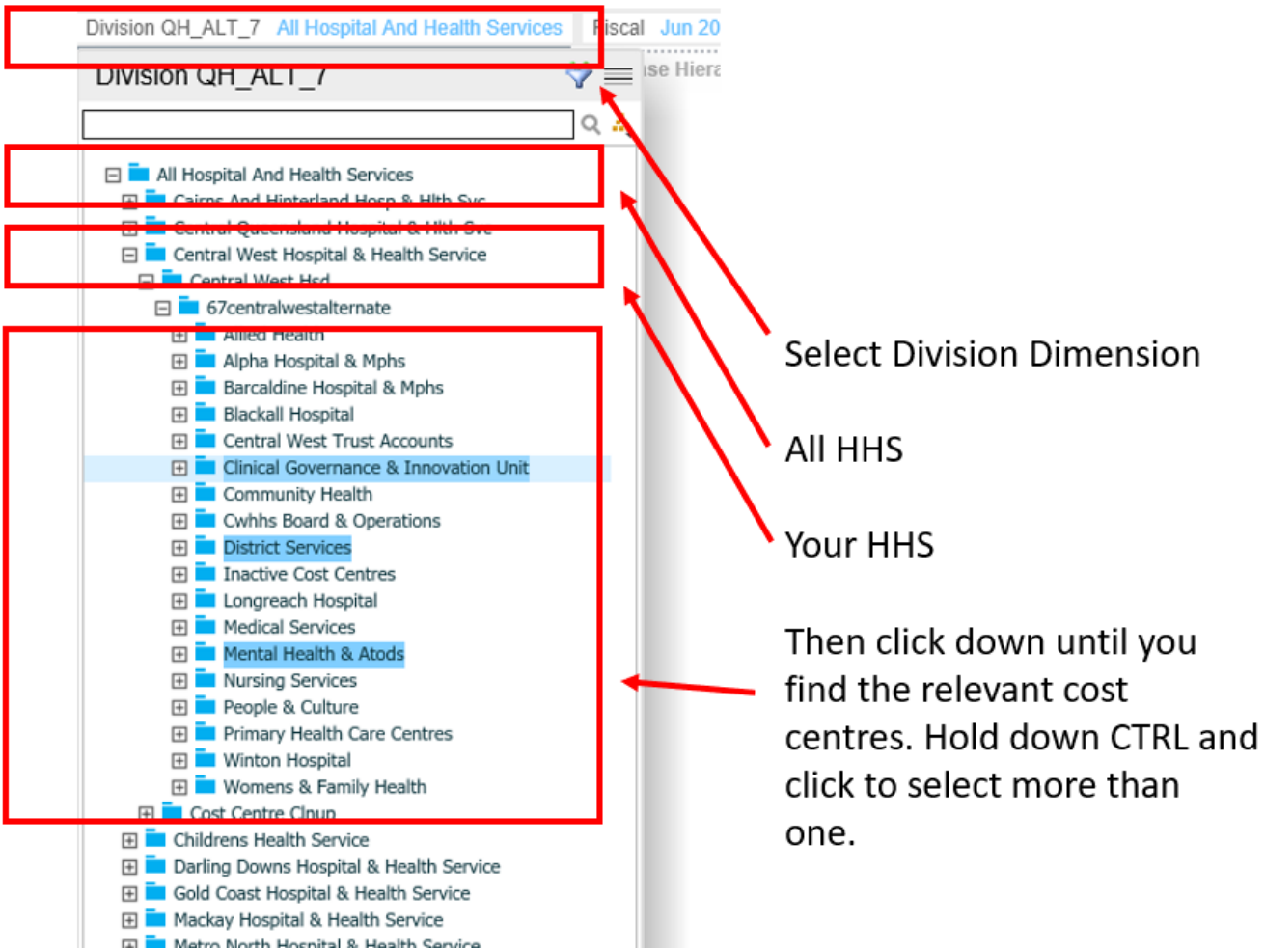
Proforma HR payroll reports have been developed in DSS to ensure consistency of reporting by HHSs.

Login to DSS and follow these instructions:

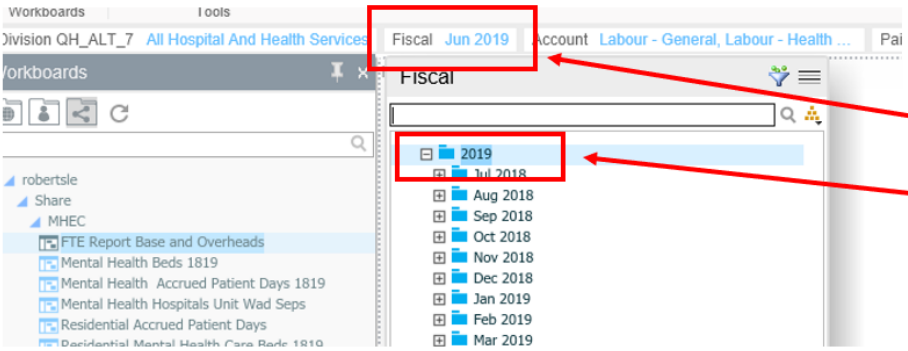
1. In the 'Shared Content' folder, access reports shared by Leigh Roberts. Double click on the FTE Report Base and Overheads report and allow the report to load. If necessary, update the Division to your HHS.



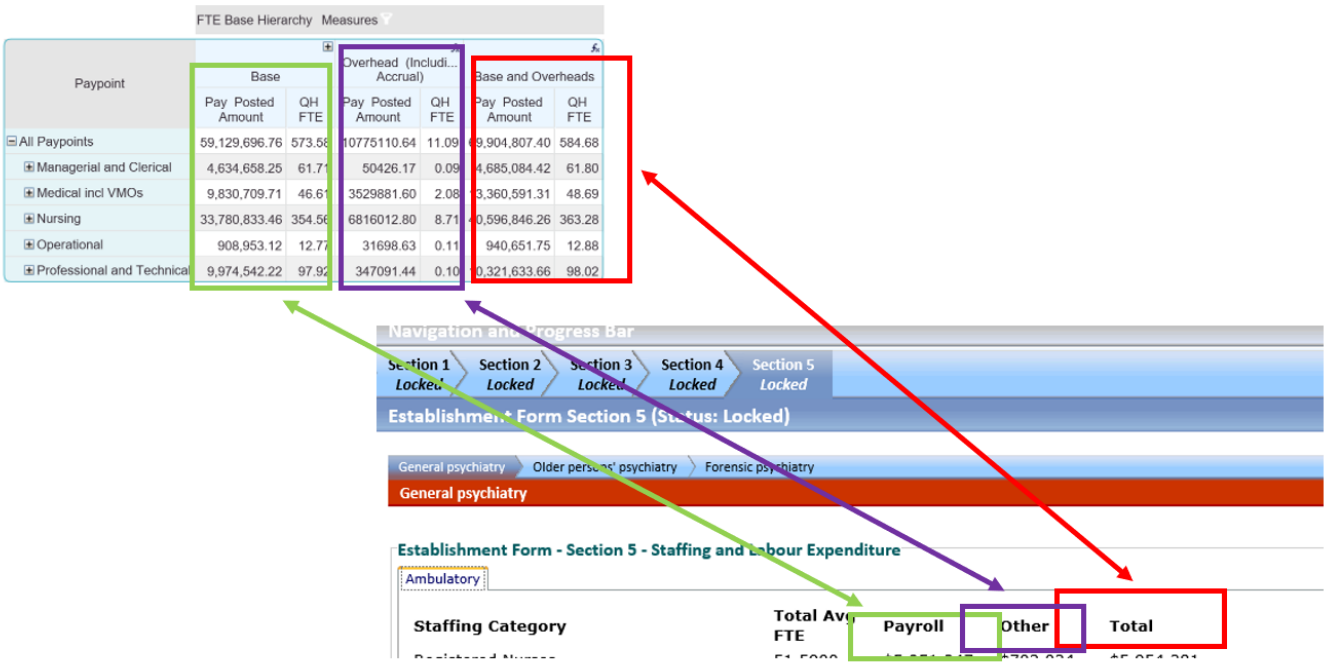
2. Click on the Division Dimension, and in the task bar that appears, select your HHS and click down through the relevant structures until you find your cost centre or cost centre group. Note: Multiple selections can be made by pressing and holding the Ctrl button while clicking multiple cost structures.



3. Click on the Fiscal Year slicer, select the full year for the Collection and click OK. The other parameters should be correct and generally should not be adjusted.
    a. Note: the year slicer in DSS works the following way: 2018/2019 financial year will be selectable as '2019', 2019/2020 will be selectable as '2020' and so on.


Workboards
Tools
Division QH_ALT_7
All Hospital And Health Services
Fiscal Jun 2019
Account Labour - General, Labour - Health ...
Workboards
robertsle
Share
MHEC
FTE Report Base and Overheads
Mental Health Beds 1819
Mental Health Accrued Patient Days 1819
Mental Health Hospitals Unit Wad Seps
Residential Accrued Patient Days
Fiscal
2019
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Jan 2019
Feb 2019
Mar 2019
Select the Fiscal Dimension
Choose the full year

4. The FTE Report Base and Overheads report displayed allows you to populate a number of questions in the MHEC.
   a) The Base and Overheads QH FTE column is to be used for populating the Total Avg FTE column.
   b) The Base Amount Column is to be used for populating the MHEC Payroll expenditure column.
   c) The Overhead Amount Column is to be used for populating the MHEC Other expenditure column

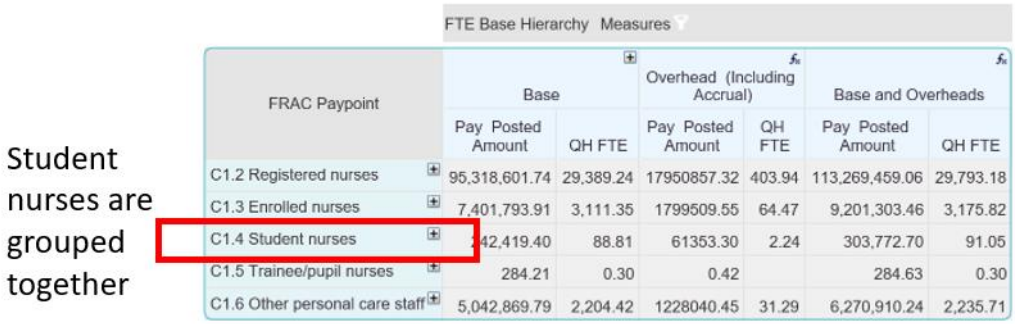


5. For those MHEC staffing categories which require more detail than is provided in the default view of the DSS report (i.e. 'Nursing') you are able to expand the paypoint category by clicking the + sign next to the paypoint.

FTE Base Hierarchy Measures

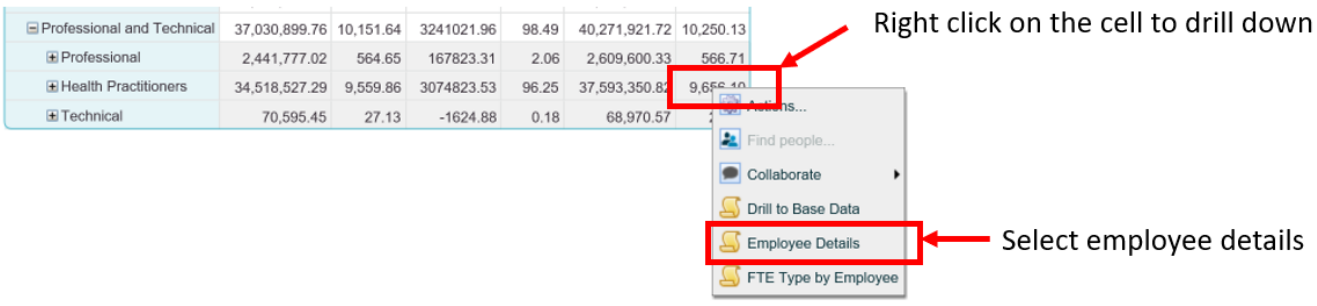
Paypoint	Base		Overhead (Includi... Accrual)		Base and Overheads	
	Pay Posted Amount	QH FTE	Pay Posted Amount	QH FTE	Pay Posted Amount	QH FTE
All Paypoints	59,129,696.76	573.58	10775110.64	11.09	69,904,807.40	584.68
Managerial and Clerical	4,634,658.25	61.71	50426.17	0.09	4,685,084.42	61.80
Medical incl VMOs	9,830,709.71	46.61	3529881.60	2.08	13,360,591.31	48.69
Nursing	33,780,833.46	354.56	6816012.80	8.71	40,596,846.26	363.28
Nursing	33,780,833.46	354.56	6816012.80	8.71	40,596,846.26	363.28
Assistant In Nursing - Grade 1	1,160.87	0.02	4.05		1,164.92	0.02
Student Nurses/ Midwives - Grade 2	429,565.32	6.04	156176.49	0.41	585,741.81	6.45
Enrolled Nurses - Grade 3	2,414,298.72	35.55	751713.05	1.11	3,166,011.77	36.67
Enrolled Nurse Advanced Practice - Grade 4	774,998.07	10.60	196814.36	0.39	971,812.43	11.00
Registered Nurses / Midwife - Grade 5	12,539,614.49	141.23	3478013.65	3.19	16,017,628.14	144.42
Clinical Nurse / Midwife - Grade 6	10,796,546.35	107.40	1875377.16	3.49	12,671,923.51	110.89
Clinical Nurse Consultant, Manager, Educator - Gra...	5,527,588.12	45.33	335292.57	0.09	5,862,880.69	45.42
Nurse Practitioner - Grade 8	135,388.85	0.98	4070.07		139,458.92	0.98
Nurse Director, Assistant Director of Nursing - Grad...	4,656.65	0.02	-2112.69		2,543.96	0.02
Director of Nursing - Grade 10	44,528.33	0.22	947.38		45,475.71	0.22
District Director of Nursing - Grade 11	465,195.99	3.48	19624.41	0.02	484,820.40	3.50
Nursing - External	647,291.70	3.68	92.30		647,384.00	3.68
Operational	908,953.12	12.77	31698.63	0.11	940,651.75	12.88
Professional and Technical	9,974,542.22	97.92	347091.44	0.10	10,321,633.66	98.02

6. Alternatively you can 'replace' the paypoint dimension in the report and display the FTE data by the FRAC paypoint hierarchy (which groups student nurses for you).

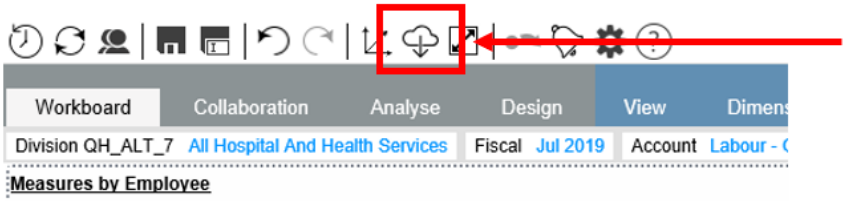


7. For those MHEC staffing categories which still require more detail than the paypoint level (i.e. Health Practitioners), you have the ability to drill down (drill through) to the base employee list to allow users to categorise staff manually. Alternatively, you can use the Discipline slicer (see below).

8. Right click on the cell you are looking to retrieve more detailed data for and click on the drill through option presented



9. DSS will open a new window containing the drilled through report detailing QH FTE OR Amount columns (depending on which one was clicked) for the Base, Overhead or Base and Overhead categories. It will contain the details along with the name and employee number of each person employed in the selected cell.
10. To work out the Total Avg. FTE for Social Workers and Occupational Therapists you would drill through on the Base and Overhead Amount or QH FTE Cells for the Professional and Technical paypoint. To work out the Payroll amount for the same pay stream you would click on the 'Base' Amount Cell for Professional and Technical staff.
11. You can export any of the drilled through reports into excel for manipulation by clicking the cloud with the down arrow in the tool bar at the top.



Click the cloud icon to download an Excel or PDF file

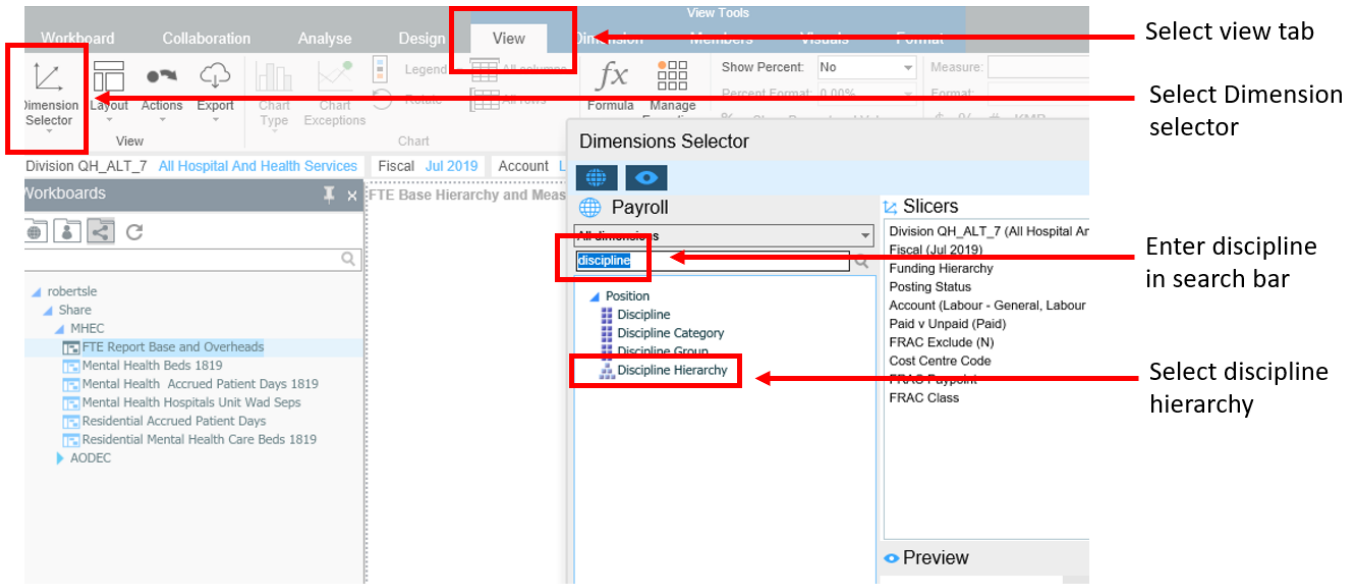
The FTE data for Queensland Health employees in the DSS report is shown as an average for the year. FTE for contract staff should also be an average for the reporting period.

Do not include superannuation, payroll tax or fringe benefits tax in the expenditure total (this is currently inherent in the report design).

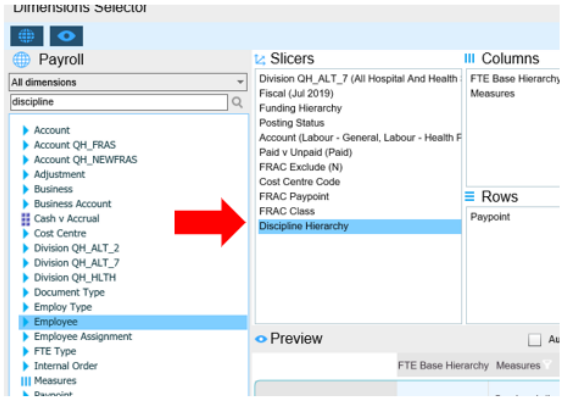
Discipline slicer in the DSS Mental Health Survey report

It is important to note that the MHEC collects FTE and associated expenditure by paypoint **and not** position. The following instructions have been provided as it is potentially useful to categorise the different positions under the Health Practitioner (HP) pay streams into the categories the MHEC requires (social worker etc.).

1. To display FTE information by discipline click on the View tab, then the Dimension Selector. Search for Discipline and select discipline hierarchy.

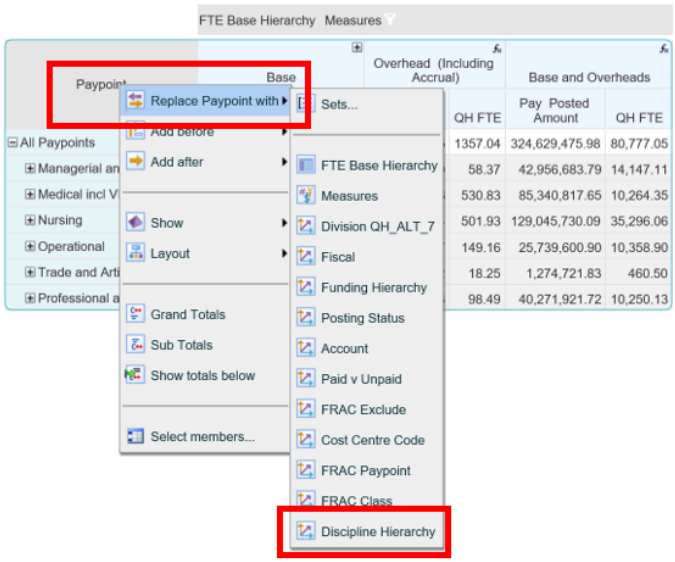


2. Click on Discipline Hierarchy and drag it across to Slicers, click on OK. Discipline Hierarchy is now available in the Replace Paypoint with choices (ie right click on Paypoint, select Replace Paypoint with, select Discipline Hierarchy).



Drag Discipline Hierarchy over to Slicers and select OK

Then right click Paypoint, select Replace Paypoint with, select Discipline Hierarcy

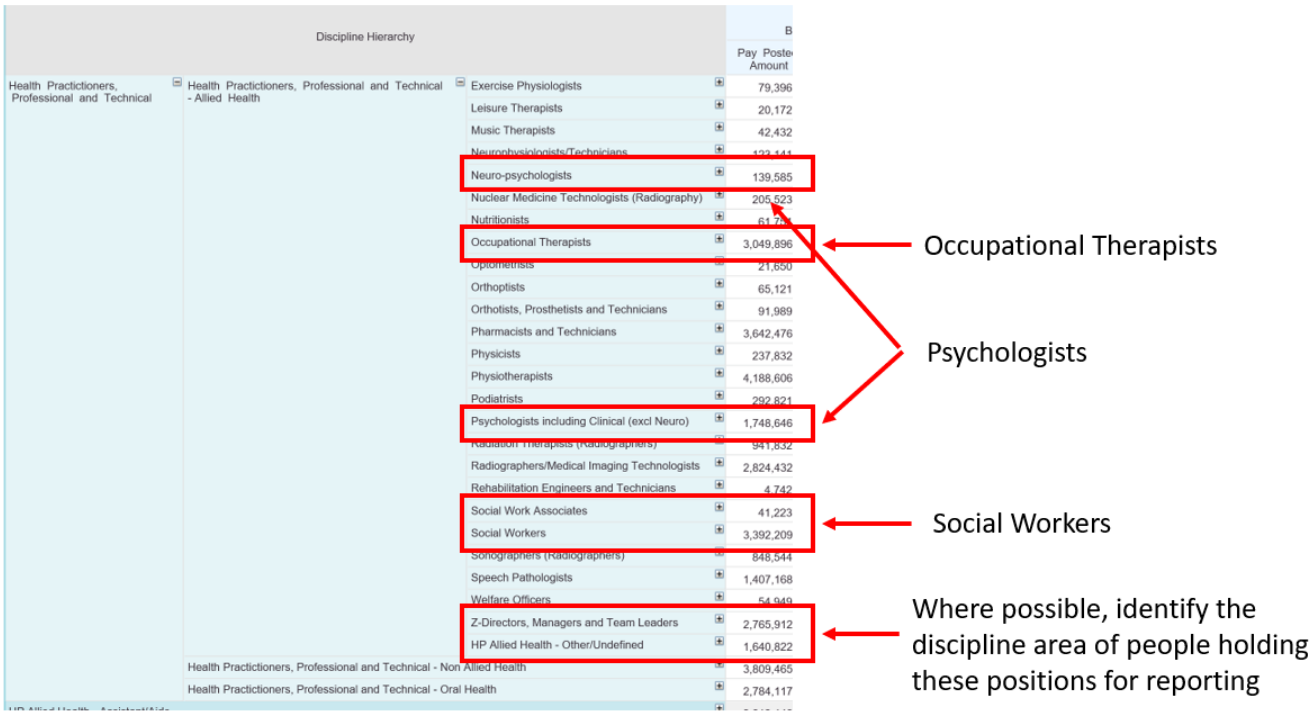


3. By expanding the Health Practitioners, Professional and Technical and the HP Allied Health – Assistant/Aide dimensions, then the Allied Health subsets, additional detail can be obtained.

FTE Base Hierarchy Measures

Discipline Hierarchy		Base		Overhead (Including Accrual)		Base and Overheads	
		Pay Posted Amount	QH FTE	Pay Posted Amount	QH FTE	Pay Posted Amount	QH FTE
Administrative		41,300,290.66	14,076.92	2054759.67	58.47	43,355,050.33	14,135.39
Health Practictioners, Professional and Technical	Health Practictioners, Professional and Technical - ...	30,685,705.98	8,395.53	2886962.67	90.10	33,572,668.65	8,485.63
	Health Practictioners, Professional and Technical - ...	3,809,465.97	1,051.04	279234.54	7.30	4,088,700.51	1,058.34
	Health Practictioners, Professional and Technical - ...	2,784,117.32	708.54	132427.37	1.09	2,916,544.69	709.63
HP Allied Health - Assistant/Aide	Operational - Health Practictioners, Professional and...	2,165,824.14	1,013.17	142406.55	9.75	2,308,230.69	1,022.92
	Operational - Health Practictioners, Professional and...	10,496.00	3.84	3.44		10,499.44	3.84
	Operational - Health Practictioners, Professional and...	1,636,828.30	785.43	35776.72	3.49	1,672,605.02	788.92
Medical		47,297,123.88	9,706.85	38326427.01	530.65	85,623,550.89	10,237.50
Nursing		107,967,242.48	34,717.52	21023177.42	501.17	128,990,419.90	35,218.69
Operational		18,205,081.35	8,400.70	3551456.73	135.83	21,756,538.08	8,536.53
Trades And Artisans		1,062,096.91	442.25	214020.92	18.25	1,276,117.83	460.50
Not Applicable		-986,669.26	118.20	45219.21	0.95	-941,450.05	119.15

Expand Health Practitioner discipline, then expand the Allied Health subset


Discipline Hierarchy
Pay Poste Amount
Health Practictioners, Professional and Technical
Health Practictioners, Professional and Technical - Allied Health
Exercise Physiologists 79,396
Leisure Therapists 20,172
Music Therapists 42,432
Neuro-psychologists 139,585
Nuclear Medicine Technologists (Radiography) 205,523
Occupational Therapists 3,049,896
Orthoptists 65,121
Orthotists, Prosthetists and Technicians 91,989
Pharmacists and Technicians 3,642,476
Physicists 237,832
Physiotherapists 4,188,606
Podiatrists 292,821
Psychologists including Clinical (excl Neuro) 1,748,646
Radiographers/Medical Imaging Technologists 2,824,432
Social Work Associates 41,223
Social Workers 3,392,209
Speech Pathologists 1,407,168
Z-Directors, Managers and Team Leaders 2,765,912
HP Allied Health - Other/Undefined 1,640,822
Health Practictioners, Professional and Technical - Non Allied Health 3,809,465
Health Practictioners, Professional and Technical - Oral Health 2,784,117
Occupational Therapists
Psychologists
Social Workers
Where possible, identify the discipline area of people holding these positions for reporting

Establishment Form

Establishment form section 1: Services provided

This section relates to mental health services provided by the Establishment.

In the table provided, indicate with a 'yes' or 'no' the types of mental health service types managed by this establishment. Mental health service types at the establishment level are described below.

Program Types

Inpatient – acute

These admitted patient care services provide specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms.

Inpatient non-acute

Refers to all other admitted patient care services including rehabilitation and extended care services.

Rehabilitation services have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Extended care services provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment. Improvement is expected to occur slowly.

Residential care

A residential mental health service is a service that is considered by the state, territory or commonwealth

funding authorities as a service that:

- has the workforce capacity to provide specialised mental health services; and
- employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:
  - to consumers residing on an overnight basis;
  - in a domestic-like environment; and
  - encourages the consumer to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week). Suitably trained residential mental health care staff may include:

- individuals with Vocational Education and Training (VET) qualifications in community services, mental health or disability sectors;
- individuals with tertiary qualifications in medicine, social work, psychology, occupational therapy, counselling, nursing or social sciences; and
- individuals with experience in mental health or disability relevant to providing mental health consumers with appropriate services.

Ambulatory care

An ambulatory mental health care service is a specialised mental health service that provides services to people who are not currently admitted to a mental health inpatient service and are not residing in mental health residential care. Services are delivered by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include:

- community-based crisis assessment and treatment teams
- day programs
- mental health outpatient clinics provided by either hospital or community-based services
- child and adolescent outpatient and community teams
- social and living skills programs
- psychogeriatric assessment services

- hospital-based consultation-liaison and in-reach services to admitted patients in non-psychiatric and hospital emergency settings
- ambulatory-equivalent same day separations
- home based treatment services
- hospital based outreach services.

Target population types are described below. For a type other than 'general' to be separately listed in this section there must be funding specifically provided for specialist FTE positions and/or operations.

Target Populations

General psychiatry

These services principally target the general adult population (aged 18–64 years) but may provide general services to children, adolescents, the aged or medium secure clients. Therefore, general psychiatry services are those services that are not specialist child and adolescent, older persons, or forensic services. Note that the appointment of a forensic liaison position into a general psychiatry service does not qualify this service as forensic psychiatry.

General psychiatry inpatient services include hospital units in which the principal function is the provision of some form of specialised service to the general adult population.

Child and adolescent psychiatry

These services principally target children and adolescents (aged 0–17 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on children and adolescents. For smaller regional services this may be the appointment of staff to specifically work with children and adolescents within a broader mental health team.

Young person's psychiatry

These services principally target young people (aged 16–24 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on young persons.

Older persons psychiatry

These services principally target people in the age group 65 years and over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on aged persons. This service category does not include the treatment of older people by

general psychiatry services.

Forensic psychiatry

These services principally assess, treat and care for mentally disordered individuals whose condition has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated or contained. For the purposes of this collection, forensic psychiatry services also include all prison-based services. In Queensland, high secure inpatient facilities should be reported as forensic. Note that the employment of a forensic liaison officer in a community mental health team should not be reported separately as a specialised forensic service.

Medium secure

These rehabilitation units provide a safe and structured environment for the medium to long term inpatient treatment and rehabilitation of consumers with persistent and disabling symptoms of mental illness, who cannot be adequately supported in other inpatient or community settings.

Establishment form section 2: Implementation of the National Standards for Mental Health Services

This section captures the progress made on implementing the national standards for mental health services; or for capturing progress made on accreditation against the national safety and quality health service standards (second edition).

The National Standards for Mental Health Services 2010 are endorsed and supported by the National Mental Health Plan and the National Mental Health Policy.

From July 2019, health service organisations are assessed against the second edition of the National Safety and Quality Health Service (NSQHS) standards. The NSQHS (2nd edition) was developed by the Australian Commission on Safety and Quality in Health Care in consultation with the Australian Government, State and Territory partners, consumers, the private sector and other stakeholders. It aims to address gaps identified in the first edition, including mental health. It also updates the evidence for actions, consolidates and streamlines standards and actions to make them clearer and easier to implement. It is not mandatory for health services in Queensland to be accredited to both the NSQHS (2nd edition) and the national standards for mental health services, although accreditation to both is encouraged.

The Standards can be used as a guide to service enhancement, continuous quality improvement and to inform consumers and carers. The Standards require all mental health services to work towards

accreditation and report on their progress. The Standards form part of the National Accreditation Program for the accreditation of health services.

Each establishment within an MHSO should have the same accreditation level. When undergoing a re-accreditation process, if a service has previously been accredited and this accreditation is still current, you should use the prior accreditation level achieved (codes 1 or 2) until the process is complete.

If a prior accreditation period has expired or the service has not previously been accredited, then codes 3 to 7 should be used until an accreditation process is complete.

For each service setting, select the appropriate code that indicates the progress at 30 June of the collection year in implementing the National Standards for each mental health service.

National Accreditation Mental Health Services Codes

Code	Description
1	By 30 June, the service had been reviewed and was judged to have met all of the National Standards as determined by the accrediting agency. (see notes below)
2	By 30 June, the service had been reviewed by an external accreditation agency and was judged to have met some but not all National Standards. (see notes below)
3	By 30 June, the service was in the process of being reviewed by an external accreditation agency, but the outcomes were not known.
4	By 30 June, the service was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review.
5	By 30 June, the service 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	By 30 June, the service had not commenced preparations for a review by an external accreditation agency, but it was intended to be undertaken in the future.
7	At 30 June, it had not been resolved whether the service would undertake a review by an external accreditation agency under the National Standards.
8	The National Standards are not applicable to this service. (see notes below)

Code 1: The service unit had been reviewed and was judged to have met all of the applicable

National Standards for Mental Health Services as determined by the accrediting agency

For more information on the determination of applicable National Standards for Mental Health Services please refer to the Australian Commission on Safety and Quality in Health Care website (http://www.safetyandquality.gov.au/our-work/mental-health/national-standards-in-mental-health/).

Code 2: The service unit had been reviewed by an external accrediting agency and was judged to have met some but not all of the current National Standards for Mental Health Services.

This code should be used when the service has been accredited against the National Safety and Quality Health Service standards, which meets some but not all of the National Standards for Mental Health Services.

Code 8: The National Standards for Mental Health Services are not applicable to this service unit.

This code should only be used for:

- non-government organisation mental health services and private hospitals (that receive some government funding to provide specialised mental health services) where implementation of National standards for Mental Health Services has not been agreed with the relevant state or territory; or
- those aged care residential services (e.g. psychogeriatric nursing homes) in receipt of funding under the Aged Care Act and subject to Australian Government residential aged care reporting and service standards requirements.

Establishment form section 3: Inpatient and residential services activity details

This section refers to available beds and inpatient/residential activity at the reporting establishment level.

Accrued patient days (i.e. 'occupied bed days')

The number of accrued patient days refers to those days or part days accrued by admitted patients or residential consumers during the reporting period – regardless of a patients' admission and separation dates.

This Section collects bed activity related to accrued patient days, not patient activity. For example, if a patient who is eligible for extended rehabilitation is admitted to an acute bed due to all rehabilitation beds being occupied, then this activity is reported as an acute bed day.

Please use the following rules when calculating the number of accrued patient days.

- For any given date, either an accrued patient day or a leave day may be counted, but not both.

- Accrued patient days are not accrued when the patient is out of hospital on leave, even though a bed may be 'held' for the patient during their absence.
- For patients admitted and separated on different dates, count one accrued patient day for the day of admission – do not count an accrued patient day for the day of separation.
- For patients admitted and separated on the same day, count one accrued patient day – do not count any leave days. The number of days accrued is one.
- A same day patient cannot go on overnight leave.
- A period of leave for a hospital patient cannot exceed seven days. A period of leave for a residential consumer on transition cannot exceed 42 days.
- Normally, the day of going on leave is counted as a leave day, and the day of returning from leave is counted as an accrued patient day.
- When, on the same date, a patient is admitted and goes on leave, count this day as an accrued patient day. When, on the same date, a patient returns from leave and again goes on leave, count this day as a leave day. When, on the same date, a patient returns from leave and is separated, do not count this day as either an accrued patient day or a leave day.

Some examples of accrued patient day calculations for the 2019/20 year are:

A patient was admitted on 1 July 2019 and separated on 6 July 2019. If no leave or transfers occurred, counting starts on 1 July 2019, so the number of accrued patient days would be 5. Note that 6 July 2019 (the day of separation) is not counted.

A patient was admitted on 20 June 2020 and separated on 5 August 2020. If no leave or transfers occurred, counting ends on 30 June 2020 (i.e. end of financial year), so the number of accrued patient days would be 11. Note that the patient's status on 30 June 2020 is that they remain in hospital, so this is an accrued patient day.

A patient was admitted on 1 March 2020 and separated on 31 March 2020. If no leave or transfers occurred, counting starts on 1 March 2020, so the number of accrued patient days would be 30.

A patient was admitted on 10 January 2019 and remained in hospital until after 30 June 2020. If no leave or transfers occurred, counting starts on 1 July 2019 and ends on 30 June 2020 so the number of accrued patient days would be 366 (2020 is a leap year). Note that the patient's status on 30 June 2020 is that they remain in hospital, so this is an accrued patient day.

Sourcing Accrued Patient Day Information – HBCIS sites

The information for Accrued Patient Days can be obtained from a number of sources. If available, the information should ideally be obtained from the Mental Health APDs report in DSS.

The Mental Health APDs report aims to assist data suppliers to report consistent and accurate accrued patient day information. The report sources data from the Monthly Activity Collection (MAC), so it will be available only for the facilities in scope (HBCIS sites). The Mental Health APDs report is constructed by converting the Queensland Health standard unit codes into the inpatient program type and target population combinations used in MHEC.

The following table provides a guide for mapping the Queensland Health Standard Unit Codes to the identified MHEC Service Types.

MHEC Service Type	Standard Unit Code	Standard Unit Code Description	Facility specific mappings Gold Coast / Robina Hospitals
Child and Youth Acute	PYCA	Psychiatric Child Acute Unit	
	PYCW	Psychiatric Child Acute Unit in Paediatric Ward	
Child and Youth Acute	PYYA	Psych Adolescent Acute Unit	Young Persons Acute
	PYYW	Psychiatric Adolescent Acute Unit in Adult Ward	
Forensic Non Acute	PYSH	Psychiatric Adult Ext - Extended High Security Unit	
General Acute	PYAA	Psychiatric Adult Acute Unit	
	PYAW	Psychiatric Adult Special Care Suite	
General Non Acute	PYAQ	Psychiatric Adult Ext - Acquired Brain Damage Unit	
	PYDD	Psychiatric Adult Extended - Dual Diagnosis Unit	
	PYET	Psychiatric Adult Extended - Treatment Rehab Unit	
	PYRA	Psychiatric Adult Residential	
Medium Secure Non Acute	PYSM	Psychiatric Adult Ext - Extended Secure Medium Unit	
Older Persons Acute	PYGE	Psychogeriatric - Acute	
Forensic Acute	PYFA	Forensic Acute	
Older Persons Non Acute	PYPG	Psychiatric Adult Extended - Psychogeriatric Unit	
General Residential	PYRA	Psychiatric Adult Residential (CCUs)	

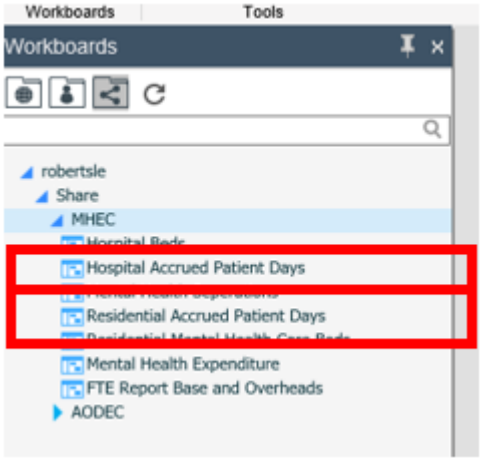
MHEC Service Type	Standard Unit Code	Standard Unit Code Description	Facility specific mappings Gold Coast / Robina Hospitals
	PYSA	Psychiatric Adult Step Up Step Down	
Young Persons Residential	PYSY	Psychiatric Youth Step Up Step Down	

To access the data contained in the Mental Health APDs Report, you will need to negotiate access to the "Activity Based Funding Module" within DSS. If you require assistance in accessing this module please contact the DSS helpdesk:

DSS Support Desk Phone Numbers: 1300 275 377 Hours: 8:00 AM to 4:30 PM Monday to Friday

Once you have access to the ABF Module, login to DSS and follow these instructions:

1. In the 'Shared Content' folder access reports shared by **Leigh Roberts**. Double click on the Hospital Accrued Patient Days (Acute Wards or Psychiatric Hospitals) OR the Residential Accrued Patient Days (Residential facilities) reports.



2. Make sure your HHS is selected, and Fiscal is set to 2020 (not June 2020). The Accrued Patient Days Information will now be viewable.

Non HBCIS sites

The Aged Care Information Management System monthly activity report, clinical benchmarking separations, local data collections and Transition II teams may also be of assistance.

For each inpatient psychiatric service at the hospital provide the number of available beds, the number of separations, and number of accrued patient days separately for acute and non-acute units by target population.

Available beds

For inpatient services, this means the number of beds available to provide overnight accommodation for patients; other than neonatal cots (non-special-care) and beds occupied by hospital-in-the-home patients, averaged over the counting period.

Example:

A hospital conducts a monthly bed count. Unit A containing 20 beds is closed for six months for a planned renovation. During this period a temporary 10 bed Unit (B) is established and the necessary resources are provided. The annual average number of available beds for Ward A is the average of the twelve counts i.e. (20 beds X 6 months) + (0 beds X 6 months) divided by 12 counting periods = 10 beds.

The annual average number of available beds for Ward B is (0 beds X 6 months) + (10 beds X 6 months) divided by 12 counting periods = 5 beds.

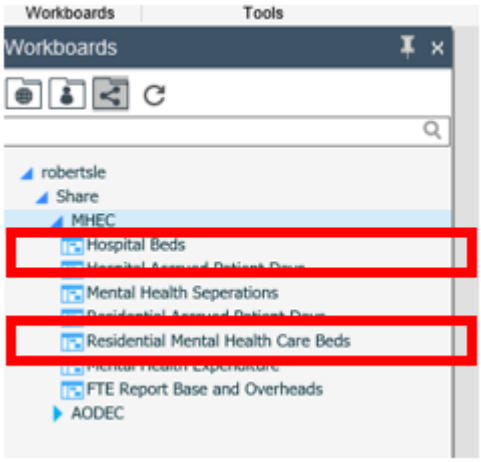
Sourcing Available Beds Information

A Mental Health Average Available Beds report (sourced from the MAC) has again been made available to assist in reporting this information. This report can be used as a guide to reconcile the total number of beds reported for each facility and also to determine the period of time that beds have been deemed temporality unavailable during the year.

To access the data contained in the Average Available Beds report, you will need to negotiate access to the “Activity Based Funding Module” within DSS.

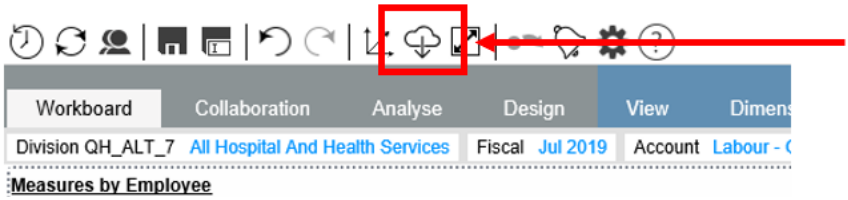
Once you have access to the ABF Module, login to DSS and follow these instructions:

1. In the ‘Shared Content’ folder access reports shared by Leigh Roberts. Double click on the Hospital Beds report or the Residential Mental Health Care Beds report.



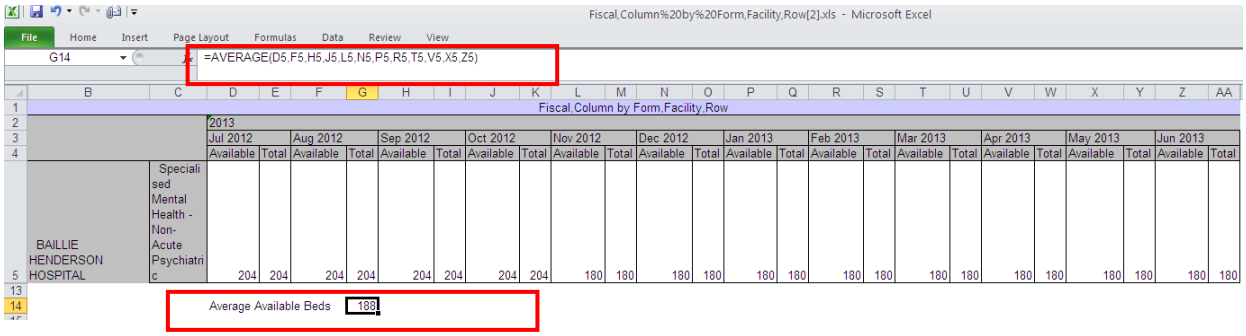
2. Ensure the Division filter shows your HHS. Beds data will now be viewable.

3. DSS is unable to provide an average available beds formula for the financial year, so this exercise must be completed in Microsoft Excel. To transfer data to Excel, Select the Export button from the toolbar.



Click the cloud icon to download an Excel or PDF file

4. Paste the data into Excel. You will be able to use the Average function to calculate the average of the number of available beds for each month across the financial year. Note: Be sure to take the average of the 'Available' Column for each month as in some cases beds will be classified as "Temporary Unavailable'.



Separations

A separation is the process by which an admitted patient completes an episode of care. A separation can be either:

1. A formal separation is the normal administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. This will be because the patient is discharged, or is transferred to another health care accommodation, or has died.
2. A statistical separation following leave is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following leave of absence that exceeded seven consecutive days.
3. A statistical separation on type change is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following a care type change.

All three types of separations are to be counted.

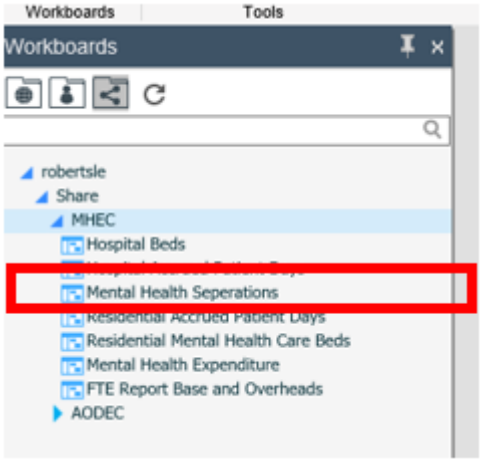
Sourcing Separations Information

The Mental Health Separations report has been created to assist in the reporting of this information for

HBCIS sites.

Login to DSS and follow these instructions:

1. In the ‘Shared Content’ folder access reports shared by Leigh Roberts. Double click on the Mental Health Separations report.



2. Make sure the filters show Fiscal 2020 (not June 2020).

Episode of residential care – number of episodes of residential care, total

The sum of the number of episodes of residential care where the residential stay has formally ended during the reference period (not statistically separated, or transferred to another facility, with the patient returning) plus any patients remaining in at end. Remaining in at end means either overnight or longer stay patients actually in the facility or on leave at 11.59 pm on the last day of the reference month. Count the number of overnight or longer stay patients as at this.

Episodes of Residential Care are made up of one or more episodes of care from HBCIS. As part of the process for preparing the Residential Mental Health Care National Minimum Data Set (RMHC NMDS), HBCIS episodes are stitched into a complete residential stay based on separation modes and original source of referral. The resulting number of Residential Stays is currently not available in HBCIS or DSS, and as such, this field will be completed by CSCPU staff.

Average hours staffed

The average number of hours **per day** during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training. Round to the nearest whole hour. Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit.

Hospital-in-the-Home Mental Health (HITH MH) Available Beds

The number of bed equivalents where there is necessary provision of human and financial resources to deliver mental health care to patients in hospital-in-the-home care, averaged for the year.

Mental health hospital-in-the-home care is provision of care to hospital mental health admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

The criteria for inclusion as hospital-in-the-home (mental health) include but are not limited to:

- without hospital-in-the-home care being available patients would be accommodated in the hospital psychiatric inpatient ward
- the treatment forms all or part of an episode of care for a psychiatric admitted patient
- the hospital medical record is maintained for the patient
- there is adequate provision for crisis care.

Selection criteria for the assessment of suitable patients include but are not limited to:

- the hospital deems the patient requires mental health care professionals funded by the hospital to take an active part in their treatment
- the patient does not require continuous 24-hour assessment, treatment or observation
- the patient agrees to this form of treatment
- the patient's place of residence is safe and has carer support available
- the patient's place of residence is accessible for crisis care
- the patient's place of residence has adequate communication facilities and access to transportation.

Mental Health Hospital-in-the-Home beds are calculated based on the capacity of the hospital staff available to provide specialised mental health services for patients within their home. The place of residence can be permanent or temporary. The number of mental health hospital-in-the-home beds should be collected at least monthly at the same time on the same day. To improve accuracy data should be collected more frequently (e.g. daily) at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average. Staffing of the unit must be consistent with other admitted patient mental health care services. Mental health hospital-in-the-home care is not a substitute for care provided by residential mental health care services or ambulatory mental health care services.

Establishment form section 4

Section 4 relates to the reporting (by target population/program type setting) of expenditure directly related to the provision of mental health services by establishments. This includes direct expenditure that is reported by S4 HANA in mental health cost centres and indirect expenditure that may be distributed for survey purposes to mental health cost centres by some manual allocation systems.

Directions for running reports to ensure consistent reporting across financial years is detailed below.

Completing this section

Section 4 should be completed for each establishment within the MHSO. Please refer to Appendix A for a list of MHSOs, establishments and the corresponding establishment ID.

The HHS and/or mental health finance officer in consultation with the executive director, manager or team leader (depending on the service) should complete this section.

For contracted or procured services which exist outside of the QH payroll and X-man payment processes (i.e. psychosocial support services purchased from a Non-Government Organisation (NGO) for a Community Care Unit); the associated salary data needs to be added to the relevant Labour and Related Expenditure category, excluding Ex-gratia payments to staff. This information will need to be sourced directly from the NGO where the services have been purchased.

When reporting non-labour related expenditure for contracted or procured services, ensure that any labour related expenditure has been excluded.

Direct expenditure

In section 4 indicate the expenditure on mental health services delivered by each establishment in your MHSO. Where the reporting establishment delivered more than one service, separate expenditure should be reported for each target population type (e.g. general psychiatry) and service type (e.g. inpatient acute). HHSs/MHSOs that are funded by the Department of Corrective Services or the Department of Child Safety, Youth and Women to provide mental health services to prisons or youth detention centres should include this expenditure here. Services that are reimbursed from other HHS via Inter Entity Transfer should also include expenditure and staffing here.

See Establishment Form Section 1 for definitions of target population types and program types.

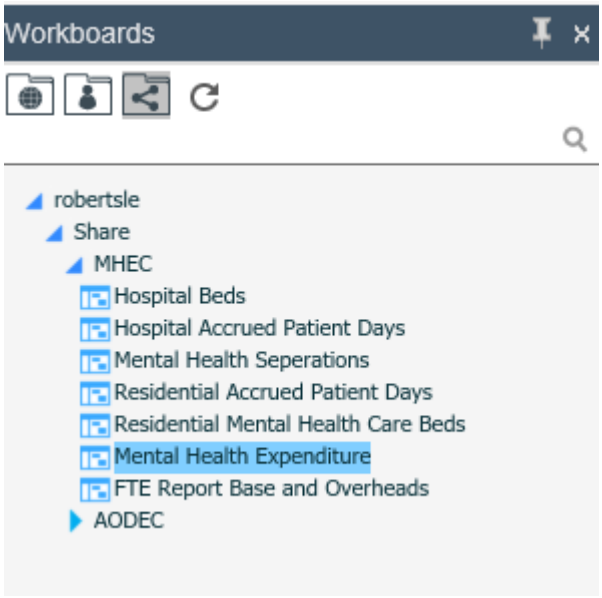
All expenditure that relates to the delivery of services by each establishment should be included in section 4. That is, relevant expenditure that may be included in non-mental health cost centres should be reported. For example, food or drug supplies costed at the health HHS (or hospital) level that relates to

mental health service delivery must be apportioned across the various establishments (and not included on MHSO Form Section 5).

Expenditure relating to services provided in another HHS, MHSO or establishment should be reported by that HHS, MHSO or establishment even if the expenditure costs have been transferred to your establishment. Your establishment's expenditure should then be reduced accordingly.

Report gross expenditure, not net expenditure. For example, if $100,000 was expended on drug supplies and $50,000 was received as a government rebate, then $100,000 should be reported on section 4 and the $50,000 rebate should be reported on MHSO section 6 under Sources of Funding - Recoveries.

A Mental Health general ledger expenditure hierarchy (QH_MHS) has been created in S4 HANA and DSS to assist in extracting expenditure data for section 4. It has been used to build the Mental Health Expenditure report created and shared by Leigh Roberts in DSS.



To run the Mental Health Expenditure report, log in to DSS and select Leigh Roberts from the shared reports. Open the Mental Health Expenditure report and ensure the fiscal year 2020 is selected (not June 2020); and that your HHS/MHSO is selected in the Division.

Any balances that appear against the 'Accounts not in Rollup' grouping must be disbursed to the appropriate sections of Establishment Form Section 4 or MHSO Form Section 5. You may need to drill

down in the ‘Accounts not in rollup’ grouping to locate the exact account code and/or refer to invoices.

The figure reported in the ‘Subtotal’ cell for labour related expenditure for each target population/program type setting, should comply with the ‘Total’ expenditure cell for the corresponding service setting in Establishment Form Section 5.

Expenditure categories

Appendix B contains details of General Ledger account codes from the Corporate Chart of Accounts and can be used to identify which codes are relevant to the categories described below.

Payroll and related expenditure

Includes salary/wages for Queensland Health employees and contracted employees including leave payments, workers compensation salary payments, redundancy payments, salary recoveries, overtime, higher duties and all allowances.

Contract and related expenditure (agency/contract staff)

Includes agency/contract staff payments (including overtime and allowances) where the contract is for the supply of labour rather than of products (e.g. photocopy maintenance and domestic cleaning staff). It also includes NGO staff in a facility that is run by or in collaboration with an NGO, such as step up step down units and youth residential rehabilitation services.

Ex-gratia payments to staff

Includes payments to staff that are above normal award conditions, for example a bonus or ‘golden handshake’. These are not income taxed at the time of payment but need to be declared by the employee for tax purposes.

Superannuation

Includes superannuation employer contributions paid, or that should be paid, on behalf of establishment employees, either by the HHS or corporate office, to a superannuation fund providing retirement and related benefits to established employees.

Other labour related expenditure

Includes payroll tax, fringe benefits tax and salary sacrifice.

Food supplies
Includes expenditure on all food and beverages. Do not include kitchen expenses such as utensils, cleaning materials, cutlery, and crockery.

Drug supplies
Includes expenditure on all drugs, including the cost of containers.

Clinical supplies and services
Includes expenditure on all consumables of a medical or surgical nature (excluding drug supplies and equipment repairs).

Non-clinical supplies and services
Includes expenditure on all non-clinical supplies and services, including electricity, other fuel and power, domestic services and kitchen expenses (excludes salary, wages and contract staff, food costs and equipment replacement and repair costs).

This includes the NGO non-labour related expenditure in an establishment that provides public services and is run by or in collaboration with an NGO.

Repairs and maintenance
Includes expenditure on maintaining, repairing, replacing equipment, providing additional equipment, maintaining and renovating buildings, and minor additional works. It does not include capital works.

Patient transport services
Includes expenditure on the direct cost of transporting patients, excluding the salaries and wages of transport staff employed by the HHS.

Worker's compensation premium
Includes expenditure on worker's compensation insurance premiums made by the organisation on behalf of its employees.

Insurance
Includes expenditure on public risk and other insurance amounts paid by the HHS with respect to the provision of mental health services within the HHS.

Other administration expenses
Includes expenditure relating to management expenses or administrative support - other than insurance and workers' compensation. This includes rates, taxes, printing, telephone, stationery and shared

service provider fees.

Depreciation

Depreciation represents the costing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets (e.g. computer software code) are amortised, this should also be included in expenditure.

Interest payments

Includes payments made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (i.e. dividends on shares).

Other expenditure

Includes expenditure not allocated under any of the other categories on this statement.

Cost centre code

It is important that the cost centre code(s) used to provide the expenditure data are included. The MHEC allows these codes to be entered in the field at the bottom of this section.

Note that the Establishment form cannot be submitted if no cost centre code(s) have been entered.

Section 4 Checklist

- Superannuation cells do not have zero expenditure.
- Where data is significantly different to the previous financial year, explanation notes should be included in the validation reason box.
- Cost centre codes are entered.

Establishment form section 5

Section 5 reports (by service setting) the full time equivalent (FTE) staff numbers and labour related expenditure to support the mental health services delivered by each establishment in your health HHS.

Completing this section

Section 5 can be completed by following the same procedure followed for MHSO Form Section 9. Please refer to the instructions detailed there for completing this section.

For establishments that are run by or in collaboration with a non-government organisation (NGO), section 5 of the establishment form includes a section for entering FTE and related expenditure for staff provided by the NGO.

Where the service contract for the NGO is with the HHS, the data must be supplied by the HHS. It is recommended that during contract negotiations, the HHS should include provisions in the agreement for the provision of required data.

Where the service contract for an NGO is not held by the HHS, as is the case with the Step Up Step Down units and Youth Residential Rehabilitation Services, MHAODB will provide the NGO data to the HHS.

Expenditure categories

Payroll and contract expenditure

Includes expenditure on departmental salaries/wages (including sick leave or family responsibilities), annual leave, long service leave, other leave and external agency/contract wages.

Other related expenditure (excluding superannuation)

Includes expenditure on overtime, allowances, penalties, redundancy payments, other payments, external agency commissions and allowances.

Staffing categories

The staff categories used in section 5 do not coincide with Queensland Health classifications. However, these categories are required by the Australian Institute of Health and Welfare and the Australian Department of Health in order to maintain consistency in the collection of mental health data throughout Australia. The DSS reports provide data at paypoint summary and employee levels. Hopefully this information will assist in allocating FTE to staffing categories. It is suggested that the percentage of time

spent on the various activities be used as a basis for the values you enter against the relevant staffing categories.

Where staff work across more than one establishment, program type and/or target population, use either timesheets or a percentage allocation to allocate FTE into the correct areas.

A percentage allocation is a valuable tool when staff consistently work between multiple service units.

When staff are temporarily moved to alternative service units for backfill or temporary additional support, the use of time sheets to allocate FTE may be more beneficial.

Where staff members have a base from which they operate and are required to travel to provide services to other establishments, the percentage or actual travel time should be included in the other establishment. For example, a staff member is based at the hospital, but spends one afternoon each week working from a community health clinic and must travel to the clinic. The travel time should be included in the FTE allocation for the community health clinic.

Registered nurses

Refers to persons with at least a three-year training certificate or tertiary qualification and certified as a registered nurse with the Australian Health Practitioner Regulation Agency (Ahpra).

This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse, nurse practitioner, nurse navigator and nurse educator. Include nurses engaged in administrative duties, no matter what the extent of that engagement (e.g. director of nursing, assistant director of nursing).

Enrolled nurses

Refers to nurses who are enrolled with Ahpra. Includes general enrolled nurses and specialist enrolled nurses (e.g. mothercraft nurses). This category also includes student nurses who are enrolled with Ahpra and are undertaking paid duties in a vacation employment program. Student nurses completing unpaid work experience should **not** be included.

Visiting medical officers – consultant psychiatrists

Refers to visiting medical officers who are registered to practice psychiatry under Ahpra. Visiting medical officers provide medical services to public patients on an honorary, sessional, or fee-for-service basis. The working of 30 hours per week constitutes one (1) FTE. Do not include locums here as they are agency staff and should be reported under the appropriate discipline.

Visiting medical officers – other medical officers

Refers to medical officers, other than psychiatrists, who provide medical services to public patients on an honorary, sessional, or fee-for-service basis. Do not include locums here as they are agency staff and should be reported under the appropriate discipline.

Psychiatrists – salaried medical officers

Refers to salaried medical officers who are registered to practice psychiatry under Ahpra.

Psychiatry registrars and trainees

Refers to medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Other – salaried medical officers

Refers to salaried medical officers who are neither a psychiatrist nor a psychiatry registrar/trainee.

Occupational therapists

Refers to staff who have completed a course of recognised training and are registered as occupational therapists with Ahpra.

Social workers

Refers to staff that have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists

Refers to staff who are registered as psychologists with Ahpra.

Other allied health officers

Refers to qualified staff registered with the appropriate board (other than medical or nursing staff, occupational therapists, social workers, and psychologists) who were engaged in duties of a diagnostic, professional, or technical nature. Examples of such are physiotherapists, pharmacists, speech pathologists, and dieticians.

Other personal care staff

Refers to attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants, and nursing assistants (AIN's) engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or undergoing training in nursing or allied health professions. This also includes indigenous health workers who are not qualified as allied health workers.

It excludes peer workers, who should be reported as mental health consumer or carer workers.

Administrative and clerical staff

Refers to staff engaged in administrative and clerical duties. Medical, nursing, diagnostic and health professional, peer workers and domestic staff wholly or partly involved in administrative and clerical duties are excluded and should be counted under their appropriate occupational categories. Civil engineers and computing staff should be included in the administrative and clerical staff category.

Domestic and other staff

Staff involved in the provision of food and cleaning services. This category also includes all staff not elsewhere included (maintenance staff, tradespeople, security, cleaners and gardening staff). Staff involved in direct client care should not be coded to this category.

Mental Health Carer Workers

A mental health peer worker (carer peer worker) is someone employed (or engaged via contract) on the basis of their personal lived experience of supporting family or friends with mental illness. This lived experience is an essential qualification for their job, in addition to other skills and experience required for the particular role they undertake.

In the Queensland Health Mental Health Framework Peer Workforce Support & Development 2019, mental health carer roles are identified as: Carer Peer Worker; Advanced Carer Peer Worker; Senior Carer Peer Coordinator; Team Leader Peer Workforce (Carer) and Peer Assistant (Carer). These roles are paid from the Administration (AO) pay scale. Mental health carer workers may also include roles such as carer consultants, peer support workers, carer support workers, carer representatives and carer advocates.

Mental Health Consumer Workers

A mental health peer worker (consumer peer worker) is someone employed (or engaged via contract) on the basis of their personal lived experience of mental illness and recovery. This lived experience is an essential qualification for their job, in addition to other skills and experience required for the particular role they undertake.

In the Queensland Health Mental Health Framework Peer Workforce Support & Development 2019, mental health carer roles are identified as: Peer Worker; Advanced Peer Worker; Senior Peer Coordinator; Team Leader Peer Workforce (Peer) and Peer Assistant (Peer). These roles are paid from the Administration (AO) pay scale. Mental health consumer workers may also include roles such as consumer consultants, peer support workers, peer specialists, consumer companions, consumer

representatives, consumer project officers and recovery support workers.

Section 5 Checklist

- Superannuation is not included.
- For a service setting, the total expenditure is equal to the labour related expenditure sub-total for the same service setting in Establishment Form Section 4.
- For a service setting with NGO collaborative staff, the total expenditure for NGO staff is less than or equal to the Contract and related expenditure (agency/contract staff).
- On the advice of the Financial Accounting Team, in those cases where the expenditure figures reported by S4 HANA and DSS do not agree, you should take the S4 HANA amounts as correct and adjust the DSS amounts accordingly.
- Where data is significantly different to previous financial year, explanation notes should be included in the validation reason box.

Glossary of terms

Accrued patient days ('occupied bed days')

The number of patient days refers only to those days or part days accrued by admitted patients during the reporting period – regardless of patients' admission and separation dates.

Acute inpatient service

These services provide specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms.

Ambulatory care

An ambulatory mental health care service is a specialised mental health service that provides services to people who are not currently admitted to a mental health inpatient service and are not resident in a mental health residential care facility. Services are delivered by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include:

- community-based crisis assessment and treatment teams
- day programs
- mental health outpatient clinics provided by either hospital or community-based services
- child and adolescent outpatient and community teams
- social and living skills programs
- psychogeriatric assessment services
- hospital-based consultation-liaison and in-reach services to admitted patients in non-psychiatric and hospital emergency settings
- ambulatory-equivalent same day separations
- home based treatment services

- hospital based outreach services.

Available beds

For inpatient services, this means the number of beds available to provide overnight accommodation for patients, other than neonatal cots (non-special-care) and beds occupied by hospital-in-the-home patients, averaged over the counting period.

Residential mental health beds are available only if they are suitably located and equipped to provide residential mental health care and the necessary financial and human resources can be provided. Average available residential mental health beds are the average bed counts conducted during the year as required. Both occupied and unoccupied residential mental health beds are included.

Capital expenditure

Expenditure on the initial purchase of assets (property, plant, and equipment greater than $5,000). These assets need to have a useful life in excess of 12 months and be controlled by the department. Computer software with development costs greater than $50,000 should also be included as a capital asset. The asset officer in each HHS can assist in queries concerning asset recognition.

Carer

The person (other than the service provider) whose life is affected by virtue of their close relationship with the primary consumer, or who has a chosen or contracted caring role with a primary consumer.

Child and adolescent psychiatry services

Principally target children and adolescents (aged 0–17 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on children and adolescents.

Direct expenditure

Includes both direct and indirect expenditure that is directly associated with the delivery of services by each establishment. For example, administration expenditure at the health HHS (or hospital) level that relates to mental health service delivery must be apportioned across the various establishments (and not included in MHSO Form Section 5).

Expenditure categories are found in the section for Establishment Form Section 4 and Section 5.

Episode of residential care – number of episodes of residential care, total

The sum of the number of episodes of residential care where the residential stay has formally ended during the reference period (not statistically separated, or transferred to another facility, with the patient

returning) plus any patients remaining in at end. Remaining in at end means either overnight or longer stay patients actually in the facility or on leave at 11.59pm on the last day of the reference year. Count the number of overnight or longer stay patients as at this.

Forensic psychiatry services

These services principally assess, treat and care for mentally disordered individuals whose condition has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated or contained. For the purposes of this collection, forensic psychiatry services also include all prison-based services. In Queensland, high secure facilities should be reported as forensic.

Full-time equivalent

Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member (or contract employee where applicable) when on the job under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

General psychiatry services

These services principally target the general adult population (aged 18–64 years) but may provide services to children, adolescents or older persons. Therefore, general psychiatry services are those services that cannot be described as specialist child and adolescent, older persons, or forensic services.

General psychiatry inpatient services include hospital units in which the principal function is the provision of some form of specialised service to the general adult population (e.g. post-natal depression, anxiety disorders).

General psychiatry residential services include residential mental health facilities that do not target a specific population (eg do not target young persons).

Hospital-in-the-home mental health beds

The number of bed equivalents where there is necessary provision of human and financial resources to deliver mental health care to patients in hospital-in-the-home care, averaged for the year.

Mental health hospital-in-the-home care is provision of care to hospital mental health admitted patients in

their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

Inpatient services

Refers to specialised psychiatric hospitals or specialist psychiatric units located within general hospitals (includes special care suites, etc.). It includes both acute and non-acute inpatient services.

Medium secure

These rehabilitation units provide a safe and structured environment for the medium to long term inpatient treatment and rehabilitation of consumers with persistent and disabling symptoms of mental illness, who cannot be adequately supported in other inpatient or community residential or ambulatory settings.

Mental health service consumer

For the purposes of the MHEC, this refers to both *primary consumers* and to *carers*.

Mental health service organisation (MHSO)

The concept of specialised mental health service organisation describes the entity within an HHS that is responsible for the clinical governance, administration and financial management of mental health service units providing integrated and coordinated specialised mental health care to a defined catchment population.

Non-acute inpatient services

Refers to all other admitted patient care services including rehabilitation and extended care services, however excludes community care units (which should be reported as 'residential care').

Rehabilitation services have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Extended care services provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment. Improvement is expected to occur slowly.

Older persons' psychiatry services

These services principally target people in the age group 65 years and over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged persons. This service category does not include the treatment of older people by general psychiatry services.

Primary consumer

A person with a mental illness or psychiatric disability who is the main focus of treatment/intervention.

Residential care services

A residential mental health service is a service that is considered by the state, territory or commonwealth funding authorities as a service that:

- has the workforce capacity to provide specialised mental health services; and
- employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:
  - to consumers residing on an overnight basis;
  - in a domestic-like environment; and
  - encourages the consumer to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week). Suitably trained residential mental health care staff may include:

- individuals with Vocational Education and Training (VET) qualifications in community services, mental health or disability sectors;
- individuals with tertiary qualifications in medicine, social work, psychology, occupational therapy, counselling, nursing or social sciences; and
- individuals with experience in mental health or disability relevant to providing mental health consumers with appropriate services.

Separations

A separation is the process by which an admitted patient completes an episode of care. A separation can be either:

- *A formal separation:*

- is the normal administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. This will be because the patient is discharged, or is transferred to another health care accommodation, or has died.

- *A statistical separation following leave:*
  - is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following leave of absence that exceeded seven consecutive days from a hospital, or 42 consecutive days for a residential mental health care establishment.
- *A statistical separation on type change:*
  - is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following a care type change.

All three types of separations are to be counted.

Specialised mental health service – hours staffed

The average number of hours per day during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training. Round to the nearest whole hour. Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit.

Staffing categories

Descriptions are used in Establishment Form Section 5 and can be found in that section.

Young person's psychiatry services

These services principally target young people (aged 16–24 years). Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the service on young persons. These services may include a forensic component.

Appendix A: Mental Health Establishments Structure 2019-20

Data structures displayed here in some circumstances are unique the collection requirements of the MHEC.

HHS	MHSO	ESTABLISHMENT	EST. ID
Cairns And Hinterland	Cairns	Cairns Adult Community MHS	80040
		Cairns Adult Step Up Step Down Unit	83001
		Cairns Child & Youth Community MHS	80073
		Cairns Community Care Unit	82008
		Cairns Hospital	00214
		Cairns Youth Residential Rehabilitation Unit	83008
		Cairns Youth Step Up Step Down Unit	83005
		Innisfail Community MHS	80076
		Tablelands Community MHS	80104
Central Queensland	Central Queensland	Biloela Community MHS	80103
		Central Queensland Step Up Step Down Unit	83004
		Emerald Community MHS	80072
		Gladstone Community MHS	80595
		Rockhampton Adult Community MHS	80586
		Rockhampton Base Hospital	00141
		Rockhampton Child & Youth Community MHS	80596
		Rockhampton Community Care Unit	82010
Central West	Central West	Longreach Community MHS	80070
Children's Health Queensland	Children's Health Queensland	Aspley Youth Residential Rehabilitation Unit	83009
		Chermside Galleria Child & Youth Community MHS	81250
		Evolve Child & Youth Community MHS	80509
		Greenslopes Child & Youth Community MHS	80719
		Greenslopes Youth Residential Rehabilitation Unit	83010
		Grey Street Child & Youth Community MHS	80523
		Inala Child & Youth Community MHS	80720
		Jacaranda Place	00752
		Queensland Children's Hospital	00202

HHS	MHSO	ESTABLISHMENT	EST. ID
		Mt Gravatt Child and Youth Community MHS	81094
		North West Child & Youth Communit y MHS	81095
		Nundah Child & Youth Community MHS	81270
		Perinatal & Infant Mental Health Service	81275
		Pine Rivers Child & Youth Community MHSd	80101
		Yeronga Child & Youth Community MHS	80744
Darling Downs	Toowoomba	Baillie Henderson Hospital Campus	00701
		Cherbourg Community MHS	80096
		Chinchilla Community MHS	80831
		Dalby Community MHS	80832
		Goondiwindi Community MHS	80217
		Kingaroy Community MHS	80207
		Millmerran Adult Community MHS	80222
		Stanthorpe Community MHS	80221
		Toowoomba Adult Community MHS	80804
		Toowoomba Child & Youth Community MHS	80829
		Toowoomba Community Care Unit	82009
		Toowoomba Hospital	00104
		Toowoomba Psychogeriatric Community MHS	80092
		Warwick Community MHS	80097
Gold Coast	Gold Coast	Gold Coast University Hospital	00936
		Palm Beach Adult Community MHS	80119
		Robina Community MHS	81236
		Robina Hospital	00934
		Southport Adult Community MHS	81263
		Southport Child & Youth Community MHS	80127
Mackay	Mackay	Mackay Adult Community MHS	80372
		Mackay Base Hospital	00172
		Mackay Child & Youth Community MHS	80373
		Mackay Step Up Step Down Unit	83000
		Moranbah Community MHS	80987
		Whitsunday Community MHS	80955

HHS	MHSO	ESTABLISHMENT	EST. ID
Mater Public Hospitals	Mater Hospital	Mater Adult Hospital	00001
Metro North	Redcliffe-Caboolture	Caboolture Adult Community MHS	80439
		Caboolture Hospital	00030
		Caboolture Youth Step Up Step Down Unit	83012
		Redcliffe Adult Community MHS	80443
		Redcliffe Caboolture Assessment & Acute Care Services	80259
		Redcliffe-Caboolture Adult Community MHS	80997
		Redcliffe-Caboolture Child & Youth Community MHS	80994
		Redcliffe-Caboolture Community Care Unit	82002
	Royal Brisbane And Women's Hospital	Community Forensic MHS	80493
		Inner North Brisbane Community MHS	80498
		Royal Brisbane & Women's Hospital	00201
		Somerset Villas Community Care Unit	82003
	The Prince Charles Hospital	Chermside Adult Community MHS	80521
		Nundah Community MHS	81002
		Pine Rivers Community Care Unit	82001
		Pine Rivers Community MHS	80522
		The Prince Charles Hospital	00004
Metro South	Bayside	Bayside Adult Community MHS	80998
		Bayside Child & Youth Community MHS	80090
		Bayside Community Care Unit	82005
		Casuarina Lodge - Wisteria Abi Unit	00625
		Redland Hospital	00028
		Daintree Psychogeriatric Inpatient Unit	01404
	Logan-Beaudesert	Acmena House	83002
		Beenleigh Community MHS	80128
		Browns Plains Community MHS	81010
		Logan Central Adult Community MHS	80739
		Logan Central Child & Youth Community MHS	80737
		Logan Community Care Unit	82006
		Logan Hospital	00029
		Logan Youth Step Up Step Down Unit	83011

HHS	MHSO	ESTABLISHMENT	EST. ID
	Princess Alexandra Hospital	Coorparoo Community Care Unit	82000
		Inala Adult Community MHS	80759
		Woolloongabba Community MHS	81260
		Princess Alexandra Hospital	00011
North West	Mt Isa	Doomadgee Community MHS	80084
		Mornington Island Community MHS	80051
		Mt Isa Community MHS	80918
South West	South West	Charleville Community MHS	80306
		Roma Adult Community MHS	80307
		Roma Child & Youth Community MHS	80308
Sunshine Coast	Sunshine Coast	Glenbrook Residential Aged Care Facility	00612
		Gympie Community MHS	80412
		Maroochydore Community MHAS HUB	80435
		Mountain Creek Community Care Unit	82004
		Nambour Adult Community MHS	80437
		Nambour Hospital	00049
		Sunshine Coast University Hospital	00032
		Sunshine Coast Community Mobile Intensive	80291
Torres & Cape	Torres & Cape	Bamaga Community MHS	80074
		Cape York Community MHS	80080
		Cooktown Community MHS	80075
		Thursday Island Community MHS	80078
Townsville	Townsville	Aitkenvale Youth Residential Rehabilitation Unit	83006
		Annandale Youth Residential Rehabilitation Unit	83007
		Burdekin Community MHS	81233
		Charters Towers Community MHS	80086
		Charters Towers Rehabilitation Unit	00703
		Eventide Nursing Home - Pandanus Psychogeriatric Unit	00693
		Ingham Community MHS	81113
		Kirwan Mh Rehabilitation Unit	00715
		Palm Island Community MHS	80085
		Townsville Adult Community Forensic MHS	80996

HHS	MHSO	ESTABLISHMENT	EST. ID
		Townsville Adult Community MHS	80995
		Townsville Child & Youth Community MHS	80939
		Townsville University Hospital	00200
West Moreton	West Moreton	Gailes Community Care Unit	82011
		Goodna Adult Community MHS	80254
		Ipswich Adult Community MHS	80255
		Ipswich Child & Youth Community MHS	80099
		Ipswich Hospital	00015
		The Park - Centre For Mental Health	00751
Wide Bay	Wide Bay	Bundaberg Adult Community MHS	80194
		Bundaberg Child & Youth Community MHS	80195
		Bundaberg Hospital	00062
		Fraser Coast Adult Community MHS	80989
		Fraser Coast Child & Youth Community MHS	80990
		Hervey Bay Hospital	00069
		Maryborough Hospital	00071
		Wide Bay Community Care Unit	82007
		Wide Bay Rural Community MHS	80071
		Wide Bay Step Up Step Down Unit	83003

Appendix B: General Ledger Account Codes

Direct expenditure categories are based on the General Ledger account codes drawn from the Corporate Chart of Accounts, as captured in the table below.

General Ledger expense codes 570000 – 570095 are related to Grants and should be reported in the MHSO form in sections 8 and 9. General Ledger expense codes 540010 – 540090 are related to funding expenses and should be reported in MHSO Section 5.

General Ledger expense codes 530010 and 530020 relate to capital expenditure and **should not** be reported in MHEC.

General Ledger expense codes 580000 – 589000 are related to Suspense accounts and should not be reported in MHEC. These expenses will be reported when transferred to the correct accounts.

As per instruction from the Financial Accounting Team, Queensland Health: ‘‘577xxx’ accounts are used for intra-company (ie between public entities) charging only, this means:

- No transactions (invoice, vendor payment etc.) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged HHSs have a second opinion about a charge, please liaise with charging HHSs. Do not transfer the amount to a non-577 account.

No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department’s expenditure.

Direct Expenditure Category	Relevant General Ledger Account Codes
Payroll and Related Expenditure	Salary and wages: 500000-500095 Overtime, penalties, allowances and leave • Overtime 501010-501080 • Penalties 502010-502080 • Allowances 502210-502480 & 502910-502980 • Annual leave 503010-503080 • LSL 503300-503380 • Sick leave 503510-503580 • PD Leave 503635 & 503810-503880 • Other leave 503610-503630 & 503640-503680 Workcover reimbursement 503700-503775 Redundancies 506100-506080 Rec leave in recognition, long service leave 508000-508880 Salary recoveries 509000-509375 Salary overpayments 514000, 514035 Salary and wages adjustments 516005-516080 & 516099
Contract and Related Expenditure	Contract operational staff 517100 – 517190 & 517199 Temporary non-operations services payroll, overtime and allowances 517210-517480 & 517610-517680 & 517705-517780 & 514090 Fee-based contractors 517500-517505
Ex-gratia payments to staff	Ex-gratia payments 506100-506120
Superannuation	Employer superannuation contributions 504000-504180 Contractor superannuation contributions 517510
Other labour related expenditure	Salary sacrifice 500095 Payroll and fringe benefits tax 505000-505200 Contract operational staff fringe benefits tax 517196

Direct Expenditure Category	Relevant General Ledger Account Codes
Food supplies	Other supplies food and drink related 565010 & 577470 Inventory write off catering 563000
Drug supplies	Drug supplies 550076-559950 Inventory write off pharmacy 563010, 563040 Inter entity pharmacy 566001 Intra company pharmacy 577425, 577426
Clinical supplies and services	Clinical supplies 560000-562000 Fee for service – private health providers 565060 Inter entity clinical supplies 566002, 566003, 566012 Intra Company clinical supplies 577400-577403, 577435, 577436
Non-clinical supplies and services	Building Cleaning and other services 510220 Electricity and other energy sources 510800-510850 Private patient incentives 511021 General and domestic supplies 565000 & 565030-565055 Inter-entity non-clinical supplies 566000 & 566004-566008 & 566016 Professional Services 566060 Inventory Issued 566120 Indigenous Health Services 566121, 566122 Trade Discounts and Rebates 566135 Intra Company non-clinical supplies 577420, 577421, 577446
Repairs and maintenance	Repairs and maintenance 536000-536500 Intra company parts – BTS and repairs 577405, 577406, 536330, 536355

Direct Expenditure Category	Relevant General Ledger Account Codes
Patient transport service	Patient transport services 528000-528145 Aero-medical service 566011 Intra Company Aero-medical 577450, 577451
Workers compensation premium	Workcover expense 511210, 511211 Contract operational staff Workcover 517195
Insurance	Insurance excluding Workcover 511215-511220 Inter-entity Insurance payments 566009 Intra company insurance 577430, 577431
Other administrative expenses	Advertising, building, IT and non-clinical consultancy 510000-510010, 510200-510210, 510400510420, 510600-510640 Fees including bank fees 511000-511020, 511025-511030, 510035 Legal, motor vehicle, library, general administration, freight, office supplies 511410-513850 Bad, doubtful and waived debts, corporate card fees, debt collection 514010-514030,514040-515005 Agency fees 517010-517050 Donations, sponsorships, functions, travel and accommodation 518000-524000 Minor assets 530000 QTC Administration 577030 Intra company IT, telecoms, office supplies 577410-577416, 577440, 577441, 577475-577500, 577445
Depreciation	Depreciation 590050-590120, 590150 Amortisation 590130-590135, 590150-590190
Interest payments	Interest 577015, 577020, 577021, 577050

Direct Expenditure Category	Relevant General Ledger Account Codes
Other expenditure	Inventory Write-off and loss 563060-563090 Cost of goods sold 564000 Inter entity non-capital expenses 566013, 566014 Payment Discounts 566130, 566055 Intra company general supplies and services 577480, 577485, 577500, 577475 Stock and Loss adjustments, impairment and revaluations 590200-599865 Grants Returned 519090 Service Procurement 565061-565069 Quarantine Fees 514091-514901 Funding Expenses 540010-540090 Grants 570020-570095