Department of Health

Mental Health Establishments Collection (MHEC)

Instructions and Procedures

1 July 2015 – 30 June 2016

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Queensland Government

Further information

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http://meteor.aihw.gov.au/content/index.phtml/itemId/493652

https://mhec.health.qld.gov.au/MHEC

Changes since the 2014/15 collection

Establishment changes:

- Fraser Coast MHSO merged with Wide Bay MHSO
- Cairns Community Care Unit commenced
- Toowoomba Community Care Unit commenced
- Gailes Community Care Unit commenced
- Inglewood Community MSH (80216) ceased reporting in 2014/2015
- Chinchilla Child and Youth Community closed during 2014/2015
- Millmerran Adult Community MSH (80222) ceased reporting in 2014/2015
- Wynnum Community MHS (80751) ceased reporting in 2015/16
- Enoggera Child and Youth Community MHS (80509) became Evolve Child and Youth Community MHS
- Mater Evolve Child and Youth Community MHS (81094) became Mt Gravatt Child and Youth Community Mental Health

MHSO Form Section 2

The additional questions that were added to MHSO Form Section 2 last year have been moved to MHSO Form Sections 3 and 4 to align better with the purpose of the question.

The following Yes/No questions have been added to the following sections:

- Indicate whether a specialised mental health service organisation has formal **mental health consumer** representation at the highest level of governance to include the participation of mental health consumers. (**Now on MHSO Form Section 3)**
- Indicate whether a specialised mental health service organisation has formal **mental health carer** representation at the highest level of governance to include the participation of mental health carers. (**Now on MHSO Form Section 4)**

MHSO Form Section 7

Changes have been made to the NGO Service Types; replacement of the 11 previous service types to allow the collection of nationally consistent information on the mental health NGO sector. The NGO service types are now:

- 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

Please refer to MHSO Form Section 7 (Page 14) to familiarise yourself with the definitions of the above service types.

Data Quality Areas

Establishment Form Section 3 – Inpatient Activity

Average Available Beds

New inpatient services that begin part way through a reporting period must be averaged over the full 12 month period and not the period there were operational.

E.g. A new 20 bed General Acute Inpatient service commenced in February 2016 and all beds were available during this period, the average available beds would be 8 not 20 (Total beds x months available)/12.

Establishment Form Section 4 – Direct Expenditure

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.

Establishment Form Section 5 – FTE

The FTE and labour expenditure for contracted or procured services as described above must also be reported here.

We have also done some work with the FTE definitions including additional definitions for Mental Health Carer Workers and Mental Health Consumer Workers.

Mental Health Carer Workers
Staff employed (or engaged via contract) specifically for their expertise developed from their experience as a mental health carer. Mental health carer workers include, but not limited to, carer consultants, peer support workers, carer support workers, carer representatives and carer advocates.

Mental Health Consumer Workers
Staff employed (or engaged via contract) specifically for their expertise developed from their lived experience of mental illness. Mental health consumer workers include, but not limited to, consumer consultants, peer support workers, peer specialists, consumer companions, consumer representatives, consumer project officers and recovery support workers.

Frequently asked questions

Reporting establishments

Q. The reporting establishment in Appendix A is not appropriate for our HHS/MHSO. What can I do?

A. The reporting structure for the MHEC matches the reporting structure for the Community Mental Health Care Collection. This ensures that dollars and activity are mapped to similar structures for comparative analysis. However, CSCPU may not have been informed of recent local changes. Therefore, if you have concerns about the reporting establishments, please refer the matter to CSCPU for review (see inside front cover for contact details).

Designated psychiatric beds

Q. How do I report designated psychiatric beds in general hospital wards?

A. These beds need to be reported. To calculate expenditure for the costs of maintaining these beds you will need to:

- Look at the total costs associated with running the ward
- Establish the total number of bed days for the ward
- Calculate the percentage of the total bed days
- Use this percentage to apportion mental health expenditure/staffing etc.

For example, if the mental health bed days account for 5% of the total bed days for the ward then the mental health budget should be 5% of the total ward budget. It does not matter whether the HHS passes these costs onto mental health; they still need to be reported for the MHEC.

Staff who work across disciplines/service settings

Q. If we have a nurse who works half as a clinical nurse and half as a manager, how should this be reported? What if the nurse worked in community and inpatient settings?

A. Medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties should be counted entirely under their appropriate occupational categories. Where staff provides patient driven services to more than one service setting, the FTE should be apportioned across the relevant settings on the basis of estimated average hours worked in each setting.

Where a role or part of a role is not involved in direct patient care or clinical services but are typically involved in the operations across all service settings, these should be reported as organisation overhead FTE.

Cross HHS services

Q. My HHS/MHSO provides cross-HHS services. How should I report activity and dollars?

A. The dollars and activity should go together. If the activity is being coded to HHS 1, then the dollars should be reported for HHS 1. Contact your Mental Health Information Manager or system support officer for more information on where cross HHS/MHSO activity is being coded.

Indigenous health workers

Q. What staffing category do I use to code Indigenous Health Workers?

A. For the purposes of MHEC, Indigenous Health Workers (includes Mental Health workers) who are not formally qualified as an allied health worker (e.g. social work, psychology, occupational therapy etc.) should be coded to other personal care staff.

Social work associates

Q. What staffing category do I code social work associates?

A. For the purposes of MHEC, social work associates should be coded to other allied health officers.

Students

Q. What staffing category do I code students (e.g., physio or occupational therapy students) who have not finished their degree?

A. Unpaid students should not be reported. If the student is on the payroll then they should be coded to other allied health officers.

Contracted/Procured Services

Q. *My HHS/MHSO purchases services from a Non-Government Organisation (NGO) to run our Community Care Unit. How should I report this?*

A. Where staff provide services/interventions to patient/clients it is essential to capture FTE and associated salaries/wages separately, since staffing is one of the fundamental measures of state-wide capacity to deliver care. This information may have to be obtained directly from the NGO. When reporting the non-labour expenditure please ensure any labour related expenditure has been excluded.

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 Fourth National Mental Health Plan (the Fourth Plan) was agreed by Australia's Health Ministers in September 2009. The Fourth Plan follows on from the work of the previous three 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.

Central to the Fourth Plan is a commitment by governments to improve accountability and transparency within the mental health sector through a multi-level approach–at the policy level of governments and central mental health administrations; and at the service delivery level. Over the past two decades mental health information, including national mental health data collections, has provided the foundation for system accountability and reporting. 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 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 statewide 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: the National Mental Health Report, the Mental Health Services in Australia, and the Report on Government 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.

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.

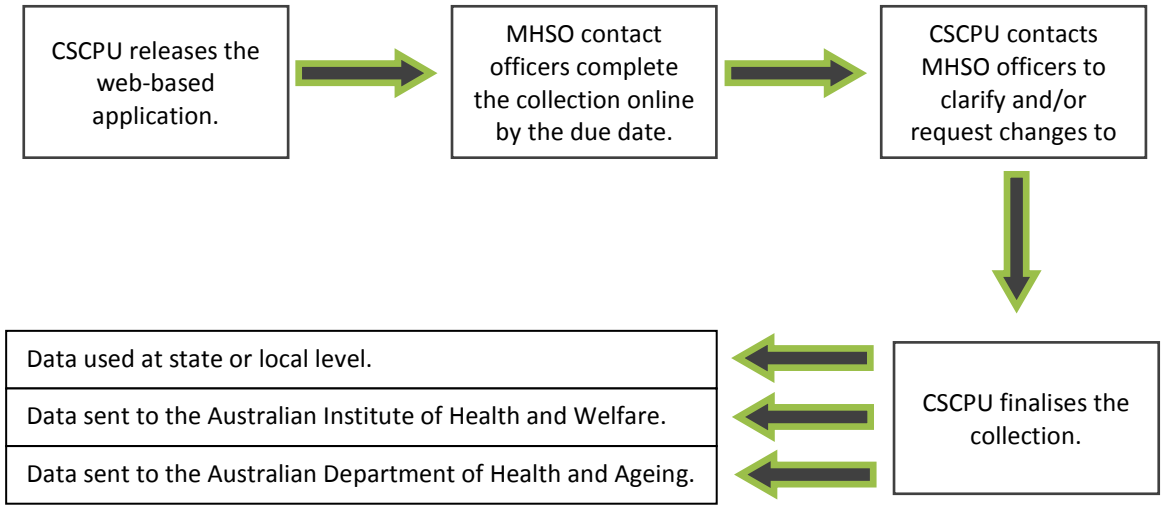
The following information is provided to the Australian Institute of Health and Welfare and the Australian Department of Health and Ageing:

- 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 Establishments Collection Application (MHECA).



Completing the collection

MHE information is collected and reported at the following levels:

- Establishment – also known as 'reporting establishment' and can be made up of a number of different service settings, programs, teams and wards.
- 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 several MHSO included in the same HHS.
- 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 Wide Bay HHS:

HHS	MHSO	ID	Establishment
WIDE BAY	WIDE BAY	00062	BUNDABERG HOSPITAL
		80194	BUNDABERG ADULT COMMUNITY MHS
		80195	BUNDABERG CHILD AND YOUTH COMMUNITY MHS
		80071	NORTH BURNETT COMMUNITY MHS
	FRASER COAST	00071	MARYBOROUGH HOSPITAL
		80989	FRASER COAST ADULT COMMUNITY MHS
		80990	FRASER COAST CHILD AND YOUTH COMMUNITY MHS

In this instance, Wide Bay would complete and submit:

1. The MHSO form for 'Wide Bay' MHSO and 'Fraser Coast' MHSO
2. The establishment form for 'BUNDABERG HOSPITAL'
3. The establishment form for 'BUNDABERG ADULT COMMUNITY MHS'
4. The establishment form for 'NORTH BURNETT COMMUNITY MHS'
5. The establishment form for 'MARYBOROUGH HOSPITAL'
6. The establishment form for 'FRASER COAST ADULT COMMUNITY MHS'
7. The establishment form for 'FRASER COAST CHILD AND YOUTH COMMUNITY MHS'

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

System manual

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

MHSO form section 1

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

Services provided

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

The service settings that may be included in a MHSO are:

Inpatient
An admitted patient 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 inpatient 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 mental health care (DO NOT USE)
For 2013/14 community care units are **not** to be reported as residential mental health care.

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 admitted or 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 population types are described below. 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. This includes Secure Mental Health Rehabilitation Units (referred to as 'medium secure units' within MHEC).

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 under general psychiatry.

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.

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 in the planning, delivery and evaluation of the service.

Note: A 'formal position' means the mental health service consumer representative is a voting member of the committee.

Indicate whether a specialised mental health service organisation has formal **mental health carer** representation at the highest level of governance to include the participation of mental health carers.

Indicate whether a specialised mental health service organisation has formal **mental health consumer** representation at the highest level of governance to include the participation of mental health consumers.

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 that cannot or should not 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.

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 FAMMIS 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** (i.e. overhead labour related expenditure) be apportioned across the reporting establishments in your HHS/MHSO. 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 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 (that is, 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.

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 service.

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 on MHSO Form Section 5.

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 either by Queensland Health to a superannuation fund providing retirement and related benefits to established employees.

Superannuation expenditure should be reported of the associated 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. It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

511210.

Worker's compensation **premiums** should **not** be reported of the associated overhead FTE reported in MHSO Form Section 9. 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 expenditure reported in MHSO Form Section 5 and Establishment Form Section 4.

Sources of funding for expenditure

Please identify the funding sources for expenditure reported in MHSO Form Section 5 and Establishment Form 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 as well as funds appropriated for general or other specific purposes.

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.

Definitions of NGO grant service types

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 (BAC 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 (BAC 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.

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 carers 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 (BAC 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.

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:

- 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 (Metropolitan Health and Aged Care Services Division 2003). Self-help groups are usually formed by peers who have come together for mutual support and to accomplish a specific purpose (Solomon 2004).

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

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

- Clinically-staffed residential services

Example services:

- St Bartholomew's House
- Burnside HASP

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 carers 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
- ARAFEMI

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 Community Housing and Homelessness Services 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 Communities Housing and Homelessness Services 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 Communities 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(s) 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 the functions that 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 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 MHSO, 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

Checklist

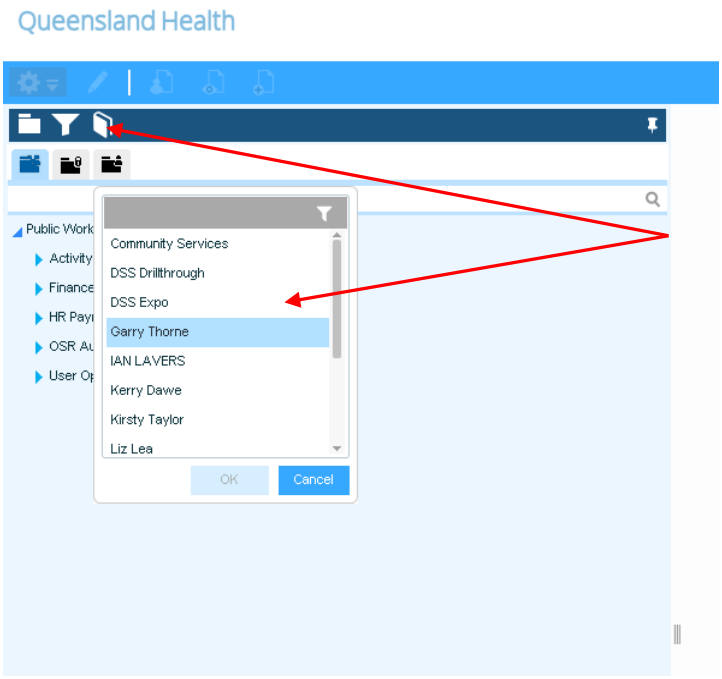
- Superannuation is not included in Section 9 (but is reported discretely in MHSO Form Section 5 for Overhead FTE).
- Workers Compensation **Payments** are included in Section 9 as salary and wages and Workers Compensation **Premiums** are recorded in MHSO Form Section 5.
- Labour related expenditure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

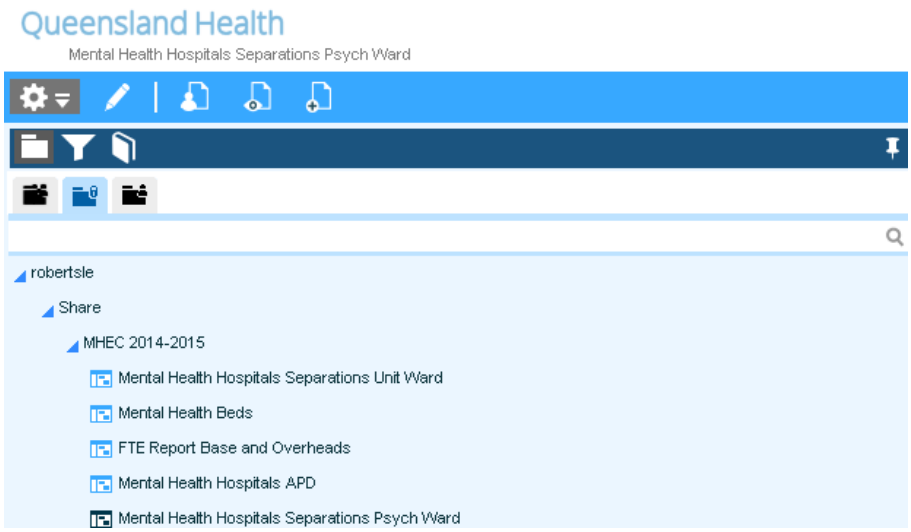
Accessing Useful MHEC Reports in DSS

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 CSCP staff. MHEC contacts already nominated by HHSs will have the reports shared with them automatically.

1. Log into DSS
2. Go to 'Move To Necto's Work Area' in the top right corner.
3. Select 'Shared Content' Folder (see below)
4. A list of user names that have shared reports will be displayed. Double Click on Leigh Roberts (if this name DOES NOT appear - contact CSCP staff).



5. Double Click on displayed reports to run them (see below).

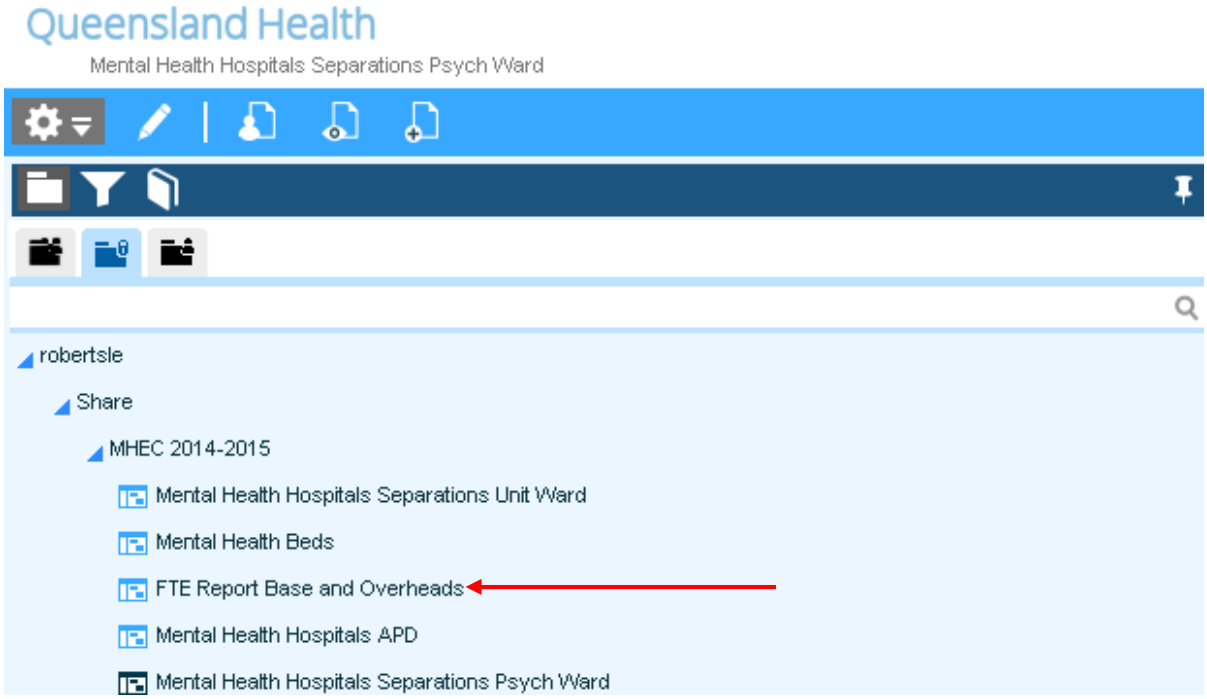


Staffing and labour expenditure

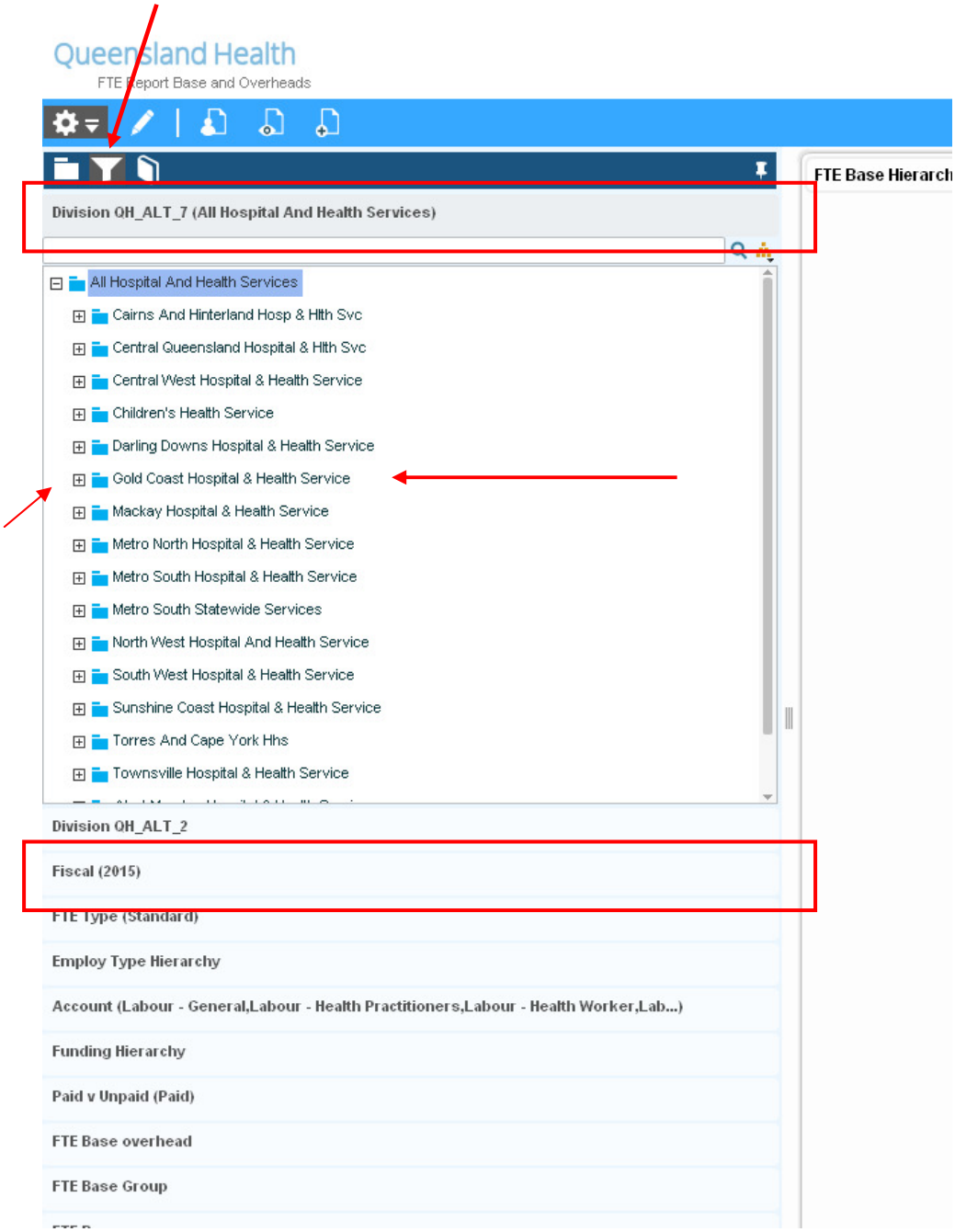
Proforma HR payroll reports have been developed in DSS Necto to ensure consistency of reporting by HHSs.

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.



2. Click on the Filters button, and in the task bar that appears, click on 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 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: 2011/2012 financial year will be selectable as '2012', 2012/2013 will be selectable as '2013' and so on.

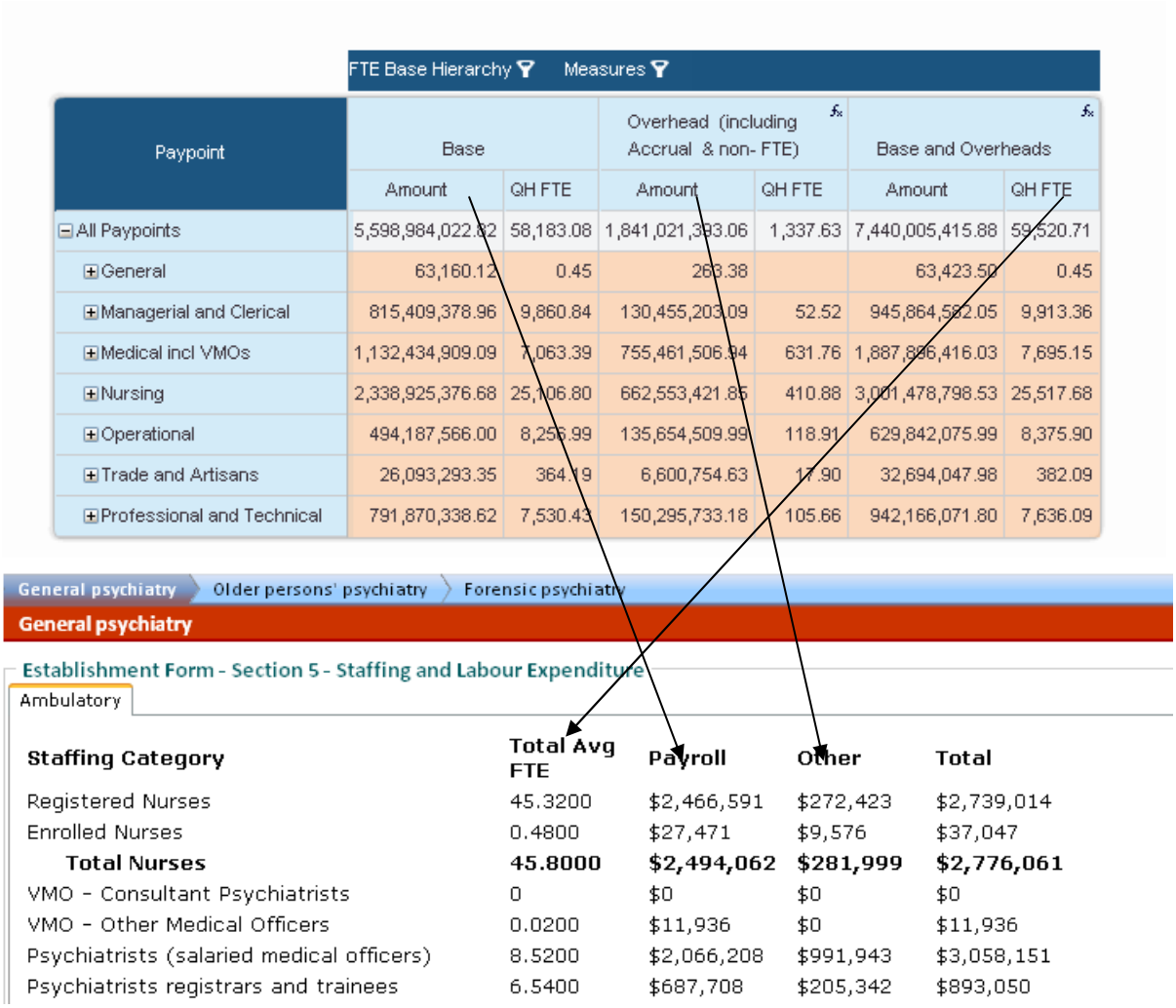


4. The FTE Report Base and Overheads report displayed allows you to populate a number of questions in the MHEC.

   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 MHECA Payroll expenditure column.

   c) The Overhead Amount Column is to be used for populating the MHECA Other expenditure column



FTE Base Hierarchy | Measures

Paypoint	Base		Overhead (including Accrual & non- FTE)		Base and Overheads	
	Amount	QH FTE	Amount	QH FTE	Amount	QH FTE
All Paypoints	5,598,984,022.82	58,183.08	1,841,021,393.06	1,337.63	7,440,005,415.88	59,520.71
General	63,160.12	0.45	263.38		63,423.50	0.45
Managerial and Clerical	815,409,378.96	9,860.84	130,455,203.09	52.52	945,864,582.05	9,913.36
Medical incl VMOs	1,132,434,909.09	7,063.39	755,461,506.94	631.76	1,887,896,416.03	7,695.15
Nursing	2,338,925,376.68	25,106.80	662,553,421.85	410.88	3,001,478,798.53	25,517.68
Operational	494,187,566.00	8,256.99	135,654,509.99	118.91	629,842,075.99	8,375.90
Trade and Artisans	26,093,293.35	364.19	6,600,754.63	17.90	32,694,047.98	382.09
Professional and Technical	791,870,338.62	7,530.43	150,295,733.18	105.66	942,166,071.80	7,636.09

General psychiatry | Older persons' psychiatry | Forensic psychiatry

General psychiatry

Establishment Form - Section 5 - Staffing and Labour Expenditure

Ambulatory

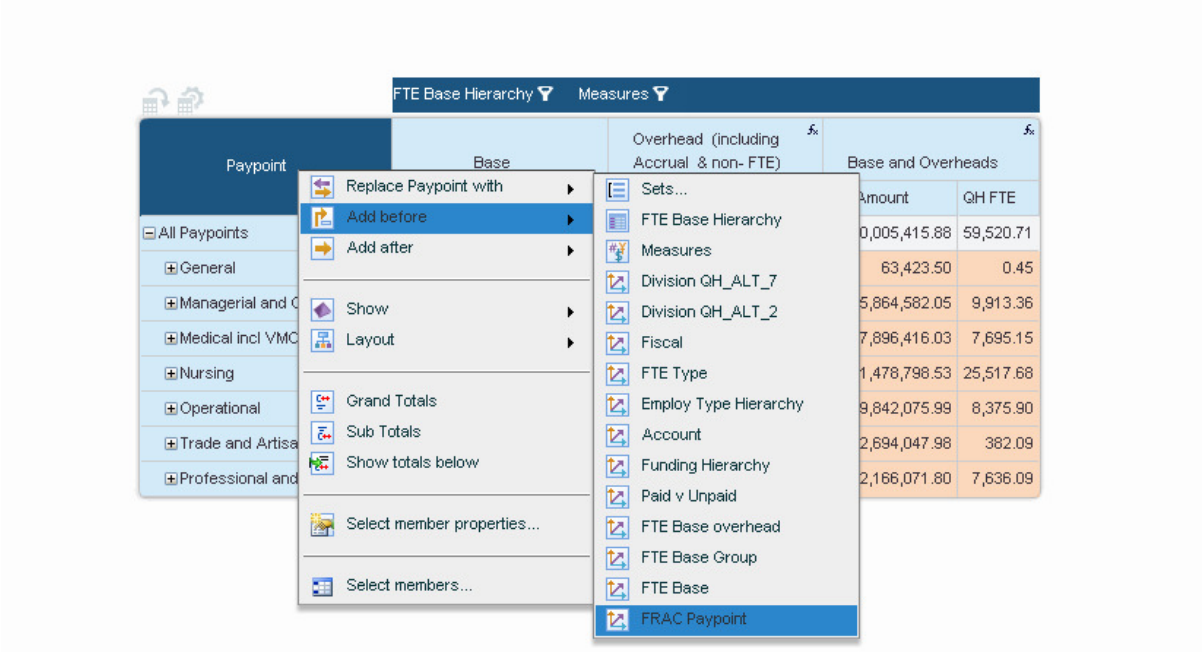
Staffing Category	Total Avg FTE	Payroll	Other	Total
Registered Nurses	45.3200	$2,466,591	$272,423	$2,739,014
Enrolled Nurses	0.4800	$27,471	$9,576	$37,047
Total Nurses	**45.8000**	**$2,494,062**	**$281,999**	**$2,776,061**
VMO - Consultant Psychiatrists	0	$0	$0	$0
VMO - Other Medical Officers	0.0200	$11,936	$0	$11,936
Psychiatrists (salaried medical officers)	8.5200	$2,066,208	$991,943	$3,058,151
Psychiatrists registrars and trainees	6.5400	$687,708	$205,342	$893,050

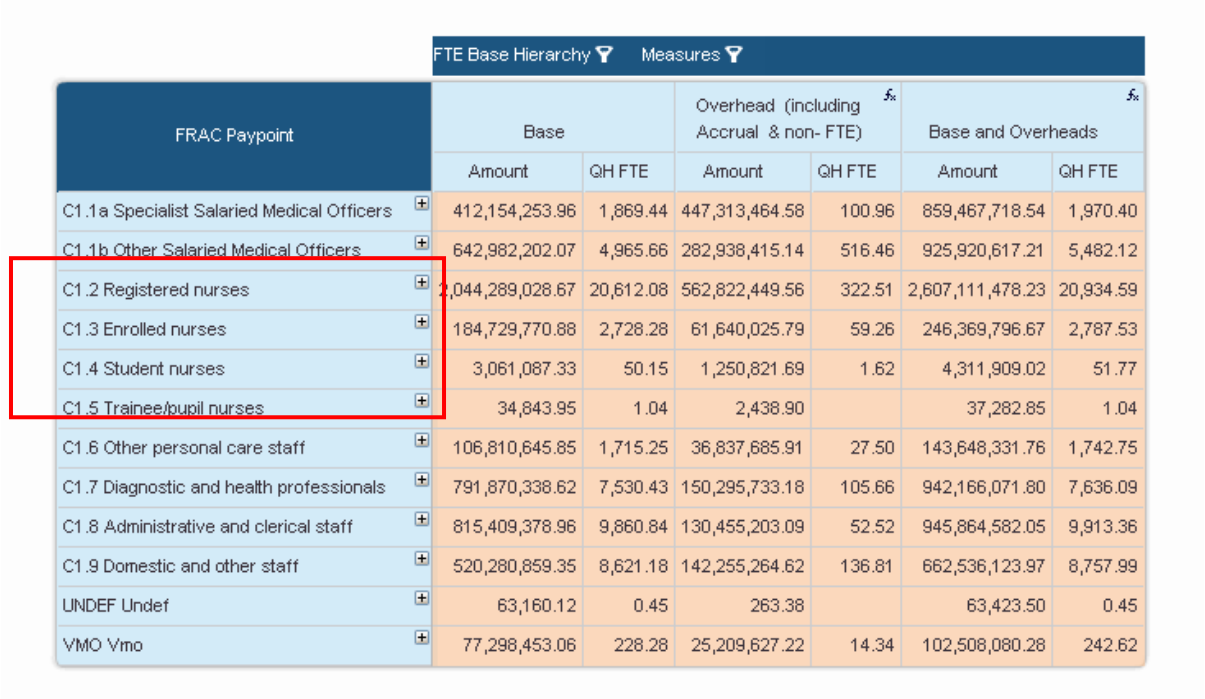
5. For those MHEC staffing categories which require more detail than is provided in the default view of the DSS report (i.e. 'Nursing') you are able to expand the paypoint category by clicking the + sign next to the paypoint.

FTE Base Hierarchy ▼ Measures ▼

Paypoint	Base		Overhead (including Accrual & non- FTE)		Base and Overheads	
	Amount	QH FTE	Amount	QH FTE	Amount	QH FTE
⊟All Paypoints	5,598,984,022.82	58,183.08	1,841,021,393.06	1,337.63	7,440,005,415.88	59,520.71
⊞General	63,160.12	0.45	263.38		63,423.50	0.45
⊞Managerial and Clerical	815,409,378.96	9,860.84	130,455,203.09	52.52	945,864,582.05	9,913.36
⊞Medical incl VMOs	1,132,434,909.09	7,063.39	755,461,506.94	631.76	1,887,896,416.03	7,695.15
⊟Nursing	2,338,925,376.68	25,106.80	662,553,421.85	410.88	3,001,478,798.53	25,517.68
⊟Nursing	2,338,925,376.68	25,106.80	662,553,421.85	410.88	3,001,478,798.53	25,517.68
⊞Assistant In Nursing - Grade 1	105,682,905.99	1,702.51	36,832,728.62	27.49	142,515,634.61	1,730.00
⊞Student Nurses/ Midwives - Grade 2	3,061,087.33	50.15	1,250,821.69	1.62	4,311,909.02	51.77
⊞Enrolled Nurses - Grade 3	153,727,543.29	2,305.78	51,724,844.51	50.12	205,452,387.80	2,355.90
⊞Enrolled Nurse Advanced Practice - Grade 4	30,488,685.91	417.03	9,914,552.17	9.13	40,403,238.08	426.16
⊞Registered Nurses / Midwife - Grade 5	991,799,796.97	11,152.58	330,692,158.29	202.90	1,322,491,955.26	11,355.47
⊞Clinical Nurse / Midwife - Grade 6	587,222,718.18	5,857.96	158,375,329.94	84.90	745,598,048.12	5,942.86
⊞Clinical Nurse Consultant, Manager, Educator - Gra...	319,886,087.18	2,572.29	57,841,104.75	26.21	377,727,191.93	2,598.50
⊞Nurse Practitioner - Grade 8	18,446,339.24	138.03	3,943,445.25	0.60	22,389,784.49	138.63
⊞Nurse Director, Assistant Director of Nursing - Gra...	35,523,795.27	232.94	4,938,095.08	0.14	40,461,890.35	233.09
⊞Director of Nursing - Grade 10	22,875,236.30	155.18	3,679,855.79	0.30	26,555,092.09	155.48
⊞District Director of Nursing - Grade 11	2,277,879.64	12.91	503,596.85		2,781,476.49	12.91
⊞Executive Director of Nursing - Grade 12	1,558,347.92	6.42	296,025.82		1,854,373.74	6.42
⊞Trainee Assistant in Nursing	34,843.95	1.04	2,438.90		37,282.85	1.04
⊞Nursing - Undefined	0.00				0.00	
⊞Nursing - External	66,340,109.51	501.99	2,558,424.19	7.48	68,898,533.70	509.46
⊞Operational	494,187,566.00	8,256.99	135,654,509.99	118.91	629,842,075.99	8,375.90
⊞Trade and Artisans	26,093,293.35	364.19	6,600,754.63	17.90	32,694,047.98	382.09
⊞Professional and Technical	791,870,338.62	7,530.43	150,295,733.18	105.66	942,166,071.80	7,636.09

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).

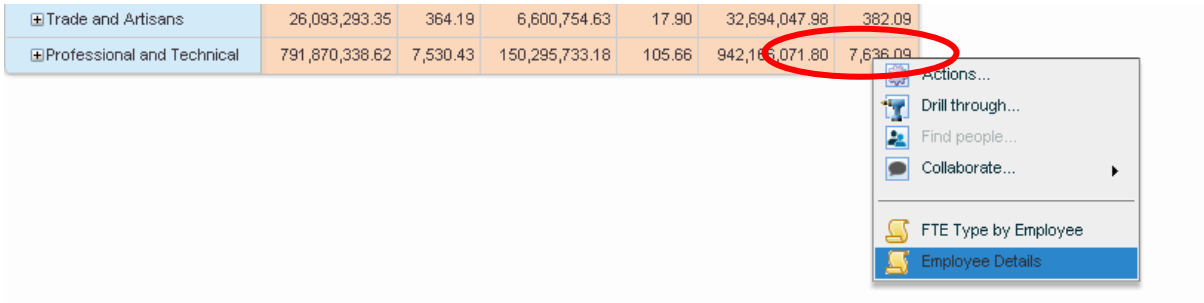




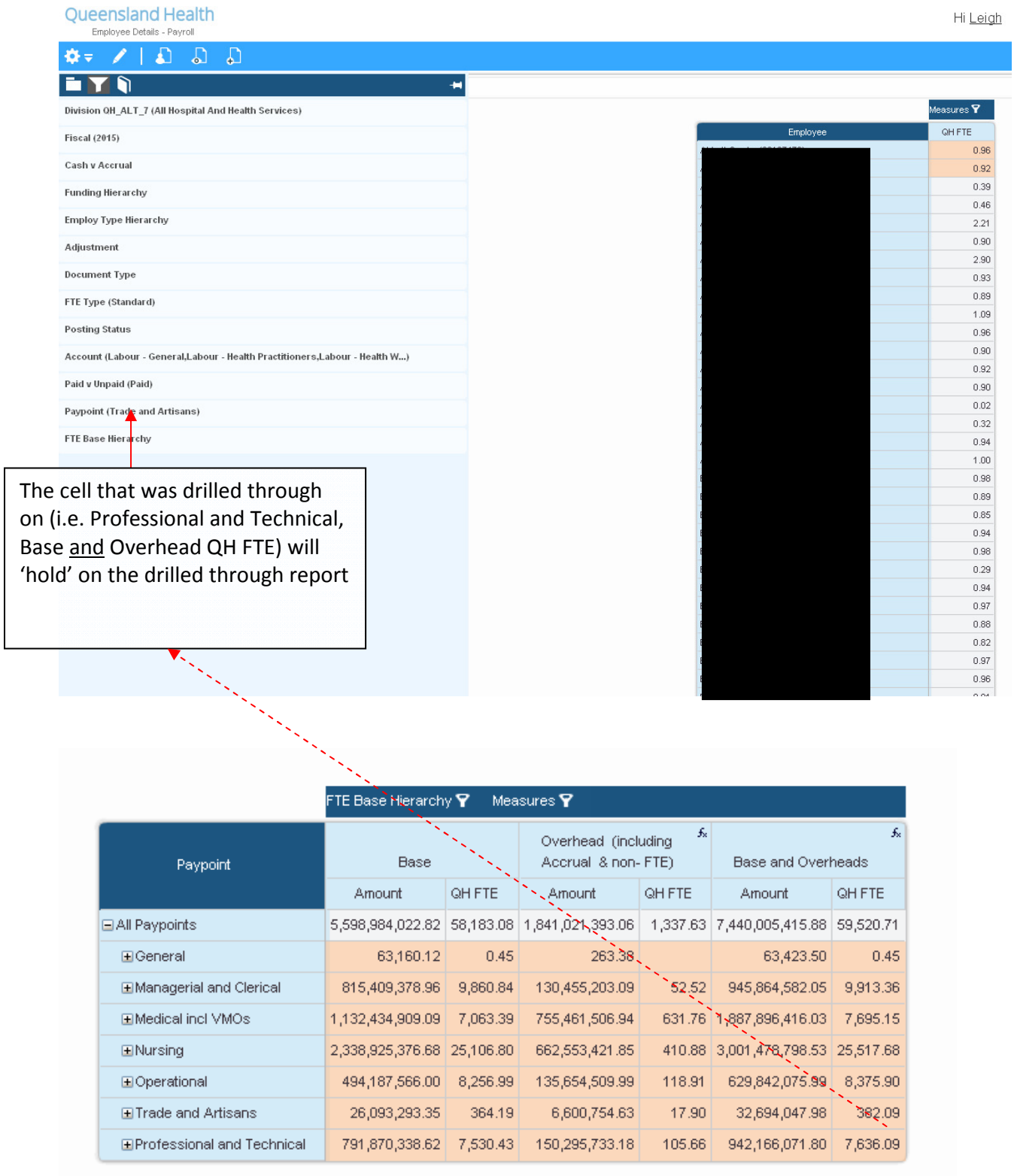
FTE Base Hierarchy ▼ Measures ▼

FRAC Paypoint	Base		Overhead (including Accrual & non- FTE)		Base and Overheads	
	Amount	QH FTE	Amount	QH FTE	Amount	QH FTE
C1.1a Specialist Salaried Medical Officers	412,154,253.96	1,869.44	447,313,464.58	100.96	859,467,718.54	1,970.40
C1.1b Other Salaried Medical Officers	642,982,202.07	4,965.66	282,938,415.14	516.46	925,920,617.21	5,482.12
C1.2 Registered nurses	2,044,289,028.67	20,612.08	562,822,449.56	322.51	2,607,111,478.23	20,934.59
C1.3 Enrolled nurses	184,729,770.88	2,728.28	61,640,025.79	59.26	246,369,796.67	2,787.53
C1.4 Student nurses	3,061,087.33	50.15	1,250,821.69	1.62	4,311,909.02	51.77
C1.5 Trainee/pupil nurses	34,843.95	1.04	2,438.90		37,282.85	1.04
C1.6 Other personal care staff	106,810,645.85	1,715.25	36,837,685.91	27.50	143,648,331.76	1,742.75
C1.7 Diagnostic and health professionals	791,870,338.62	7,530.43	150,295,733.18	105.66	942,166,071.80	7,636.09
C1.8 Administrative and clerical staff	815,409,378.96	9,860.84	130,455,203.09	52.52	945,864,582.05	9,913.36
C1.9 Domestic and other staff	520,280,859.35	8,621.18	142,255,264.62	136.81	662,536,123.97	8,757.99
UNDEF Undef	63,160.12	0.45	263.38		63,423.50	0.45
VMO Vmo	77,298,453.06	228.28	25,209,627.22	14.34	102,508,080.28	242.62

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 (drillthrough) to the base employee list to allow users to categorise staff manually.
8. Click on the cell you are looking to retrieve more detailed data for and click on the drillthrough option presented

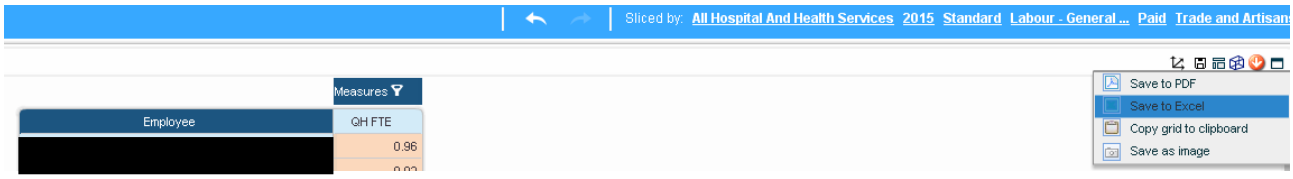


9. DSS will open the drilled through report detailing QH FTE OR Amount columns (depending on which one was clicked) for the Base, Overhead or Base and Overhead categories.



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 floppy disk icon on the top right corner.



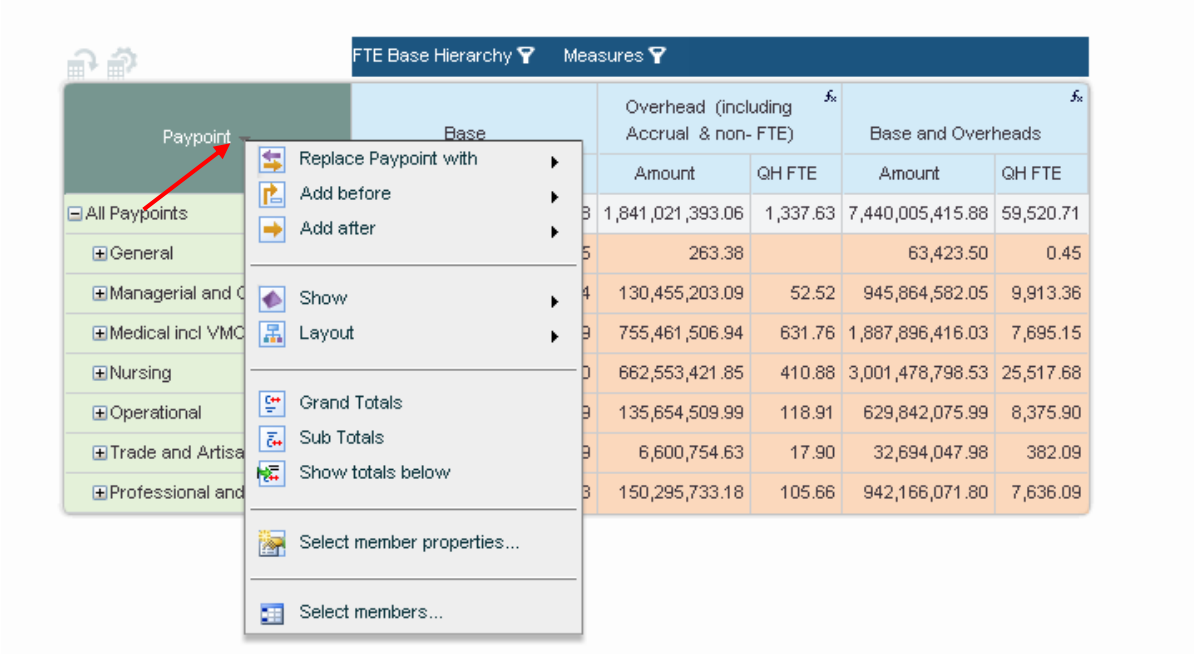
The FTE data for Queensland Health employees in the DSS report is shown as an average for the year. FTE for contract staff should also be an average for the reporting period.

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

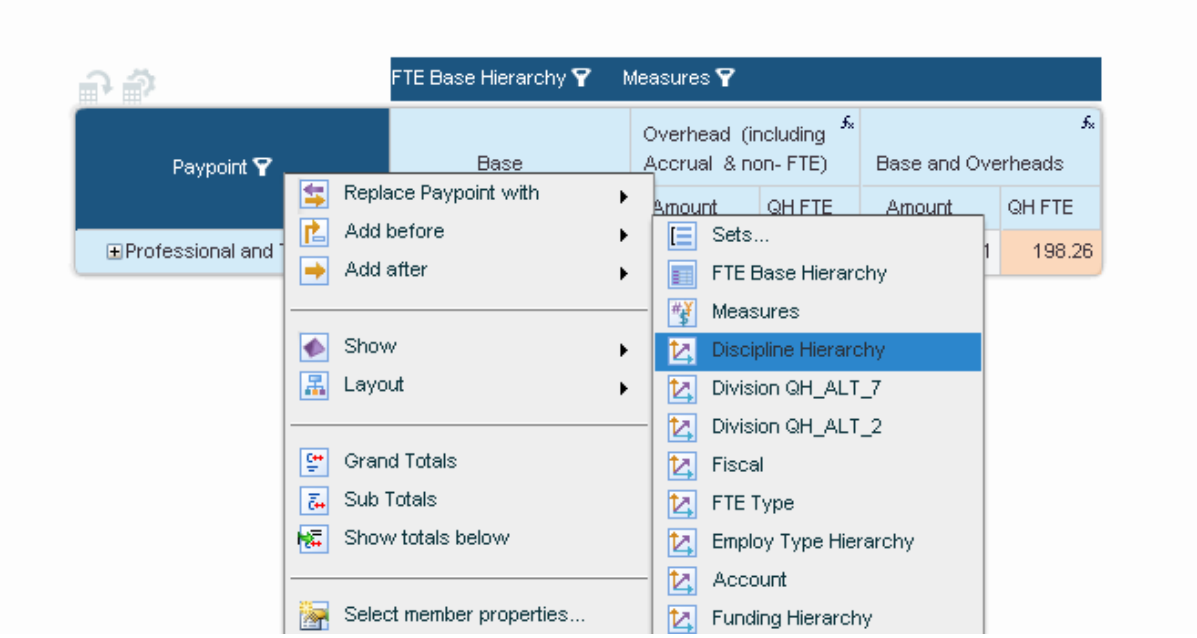
Discipline slicer in the DSS Mental Health Survey report

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.).

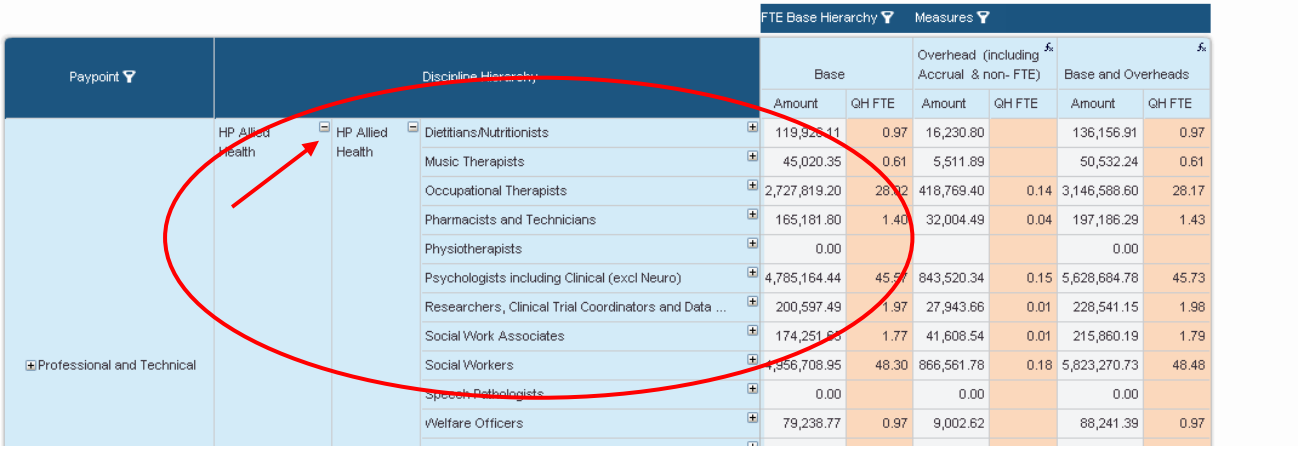
1. To display FTE information by discipline click on the Paypoint dimension down arrow



2. Click the ‘Add after’ option and then click on Discipline Hierarchy.



3. By expanding the HP Allied Health Discipline Hierarchy dimension, additional detail can be obtained.



Establishment form sections 1, 2, 3

Section 1: relates to mental health services provided.

Section 2: refers to the progress made on implementing the national standards for mental health services.

Section 3: refers to available beds and patient activity at the reporting establishment level.

Section 1: Services provided

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 focussed 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 focussed 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 focussed on preventing deterioration and reducing impairment. Improvement is expected to occur slowly.

Residential care (DO NOT USE)
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 admitted or 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 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.

General psychiatry - 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.

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.

Section 2: Implementation of the National Standards for Mental Health Services

The National Standards for Mental Health Services are endorsed and supported by the National Mental Health Plan and the National Mental Health Policy. 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	Progress
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 above)
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 above)
3	By 30 June, the service was in the process of being reviewed by an external accreditation agency but the outcomes were not known. (see notes above)
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. (see notes above)
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. (see notes above)
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. (see notes above)
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. (see notes above)
8	The National Standards are not applicable to this service. This code should only be used for 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.

Section 3: Inpatient and residential services activity details

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 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 cannot exceed seven 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 2011/12 year are:

A patient was admitted on 1 July 2011 and separated on 6 July 2011. If no leave or transfers occurred, counting starts on 1 July 2011, so the number of accrued patient days would be 5. Note that 6 July 2011 (the day of separation) is not counted.

A patient was admitted on 20 June 2012 and separated on 5 August 2012. If no leave or transfers occurred, counting ends on 30 June 2012 (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 2012 is that they remain in hospital, so this is an accrued patient day.

A patient was admitted on 1 March 2012 and separated on 31 March 2012. If no leave or transfers occurred, counting starts on 1 March 2012, so the number of accrued patient days would be 30.

A patient was admitted on 10 January 2011 and remained in hospital until after 30 June 2012. If no leave or transfers occurred, counting starts on 1 July 2011 and ends on 30 June 2012 so the number of accrued patient days would be 366 (2012 is a leap year). Note that the patient's status on 30 June 2012 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). Services where community care units set up remote wards will need to identify the bed days for these establishments under their parent facility id (See Appendix B)

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 MHECA.

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

MHEC Service Type to Standard Unit Code Guide:

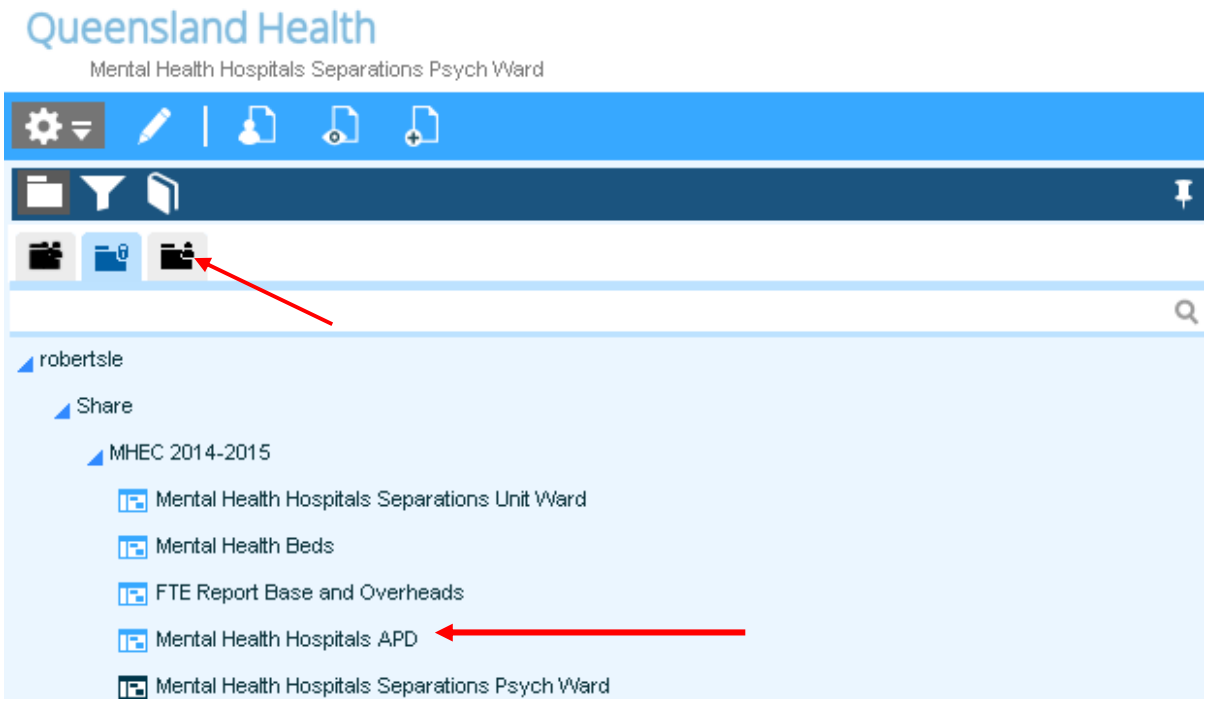
MHEC Service Type	Standard Unit Code	Standard Unit Code Description	Facility specific mappings Gold Coast / Robina Hospitals
Child and Youth Acute	PYCA	Psychiatric Child Acute Unit	
	PYCW	Psychiatric Child Acute Unit in Paediatric Ward	
Child and Youth Acute	PYYA	Psych Adolescent Acute Unit	Young Persons 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	

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:

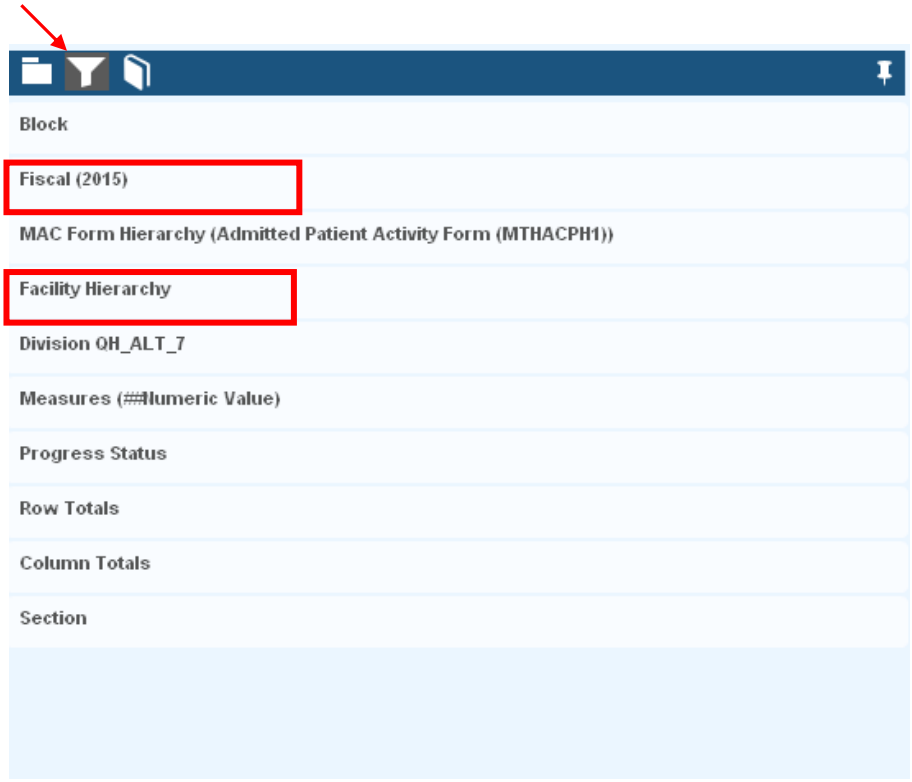
DSS Support Desk Phone Numbers: 3406 6736, 3406 6738, 3406 6821 and 3406 6735.
Operating Hours: 8:00 AM to 4:30 PM Monday to Friday

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 Mental Health Hospitals APD report.



2. Click on the Filters button and in the task bar that appears select the relevant facility / establishment along with the appropriate financial year. 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.

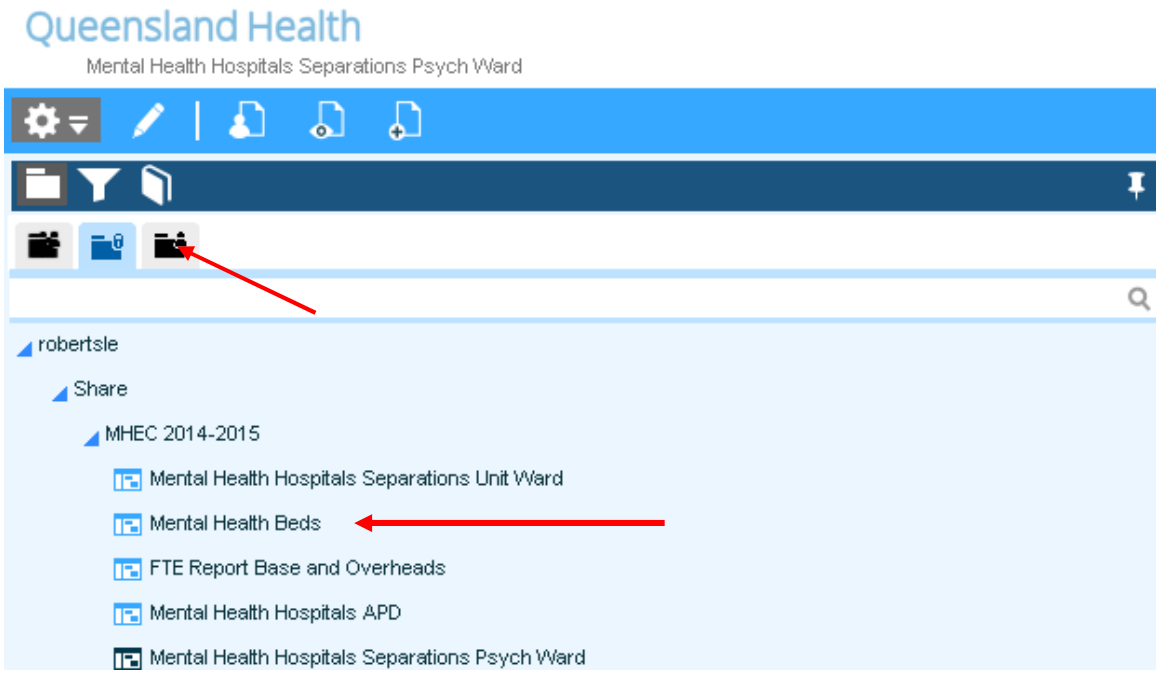
Sourcing Available Beds Information

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.

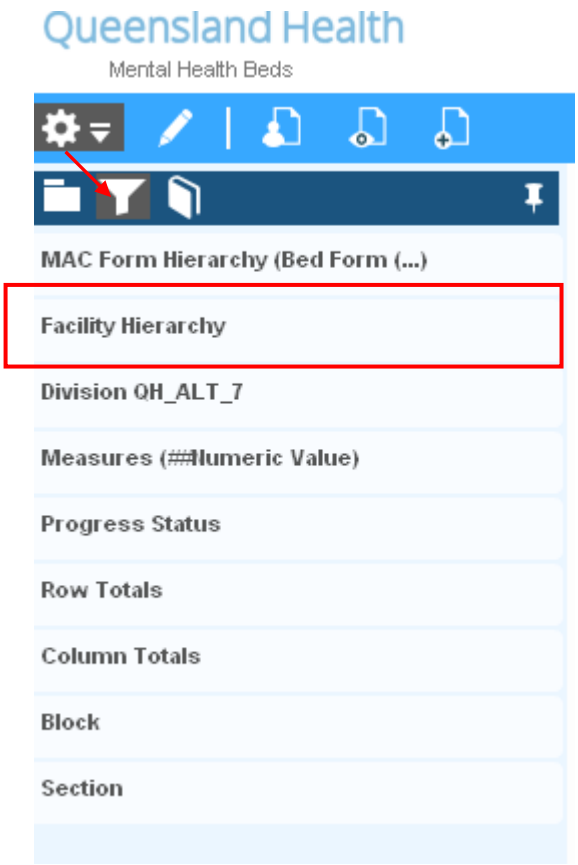
To access the data contained in the Average Available Beds report, you will need to negotiate access to the “Activity Based Funding Module” within DSS.

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

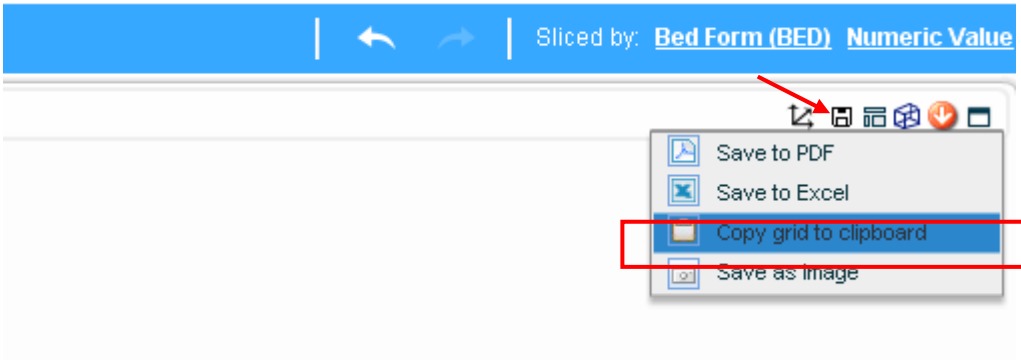
1. In the 'Shared Content' folder access reports shared by Leigh Roberts or Nicole Denkel. Double click on the Mental Health Beds report.



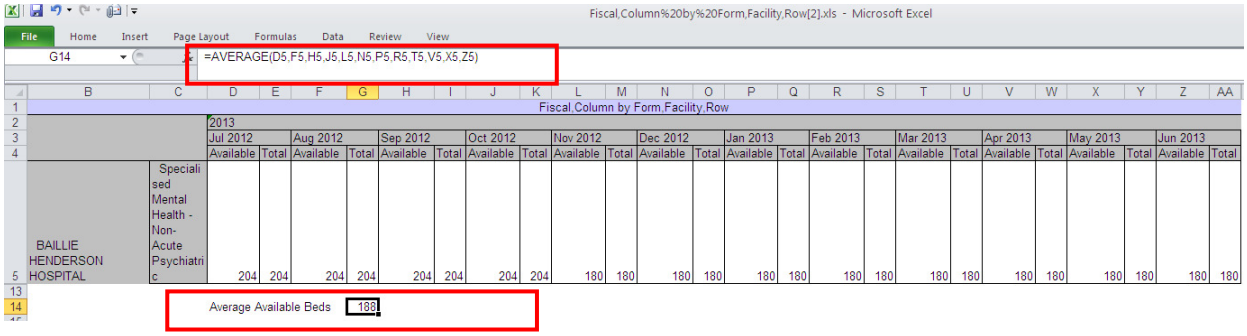
2. Click on the Filters button and in the task bar that appears select the relevant facility / establishment. Beds data will now be viewable.



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, copy grid to clip board.



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.

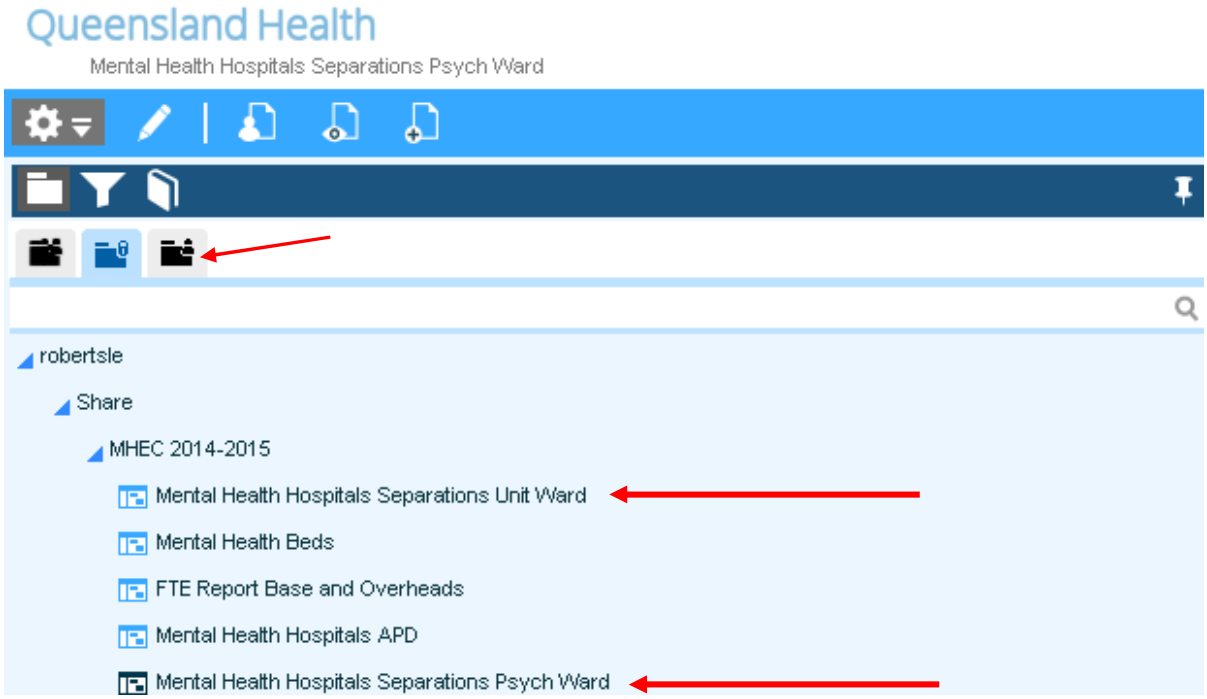
Sourcing Separations Information

The reports 'Mental Health Hospitals Separations Unit Ward' and 'Mental Health Hospitals Separations Psych Ward' have been created to assist in the reporting of this information for HBCIS sites.

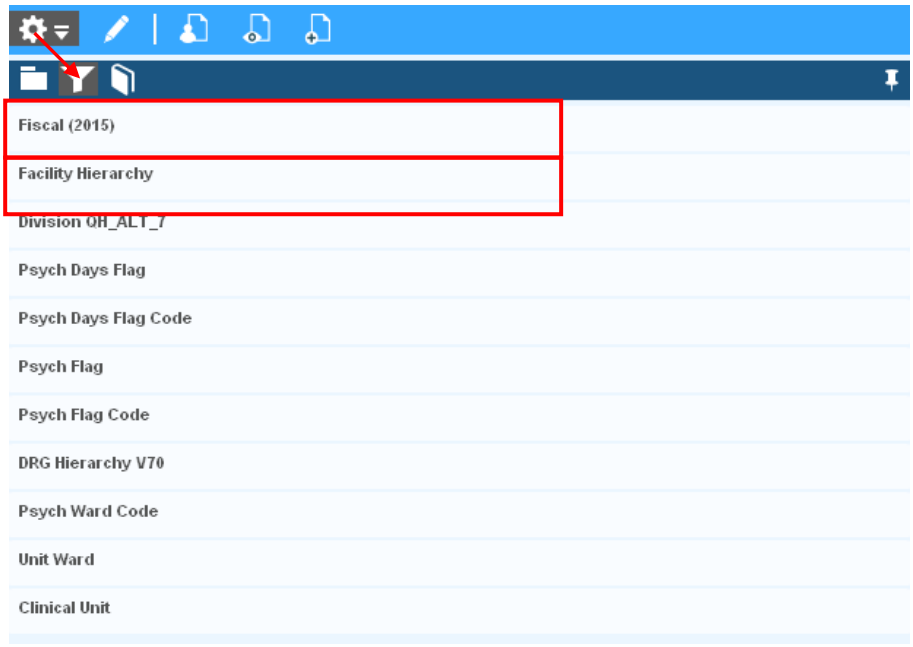
The Mental Health Hospitals Separations Psych Ward report enables users to access the separation counts by the Psych Ward hierarchy dimension available in DSS (derived from HBCIS data). Note: Because the Psych Ward hierarchy in DSS has not been grouped into the target populations and programs types available in MHEC, some manipulation of this data may be required.

Login to DSS and follow these instructions:

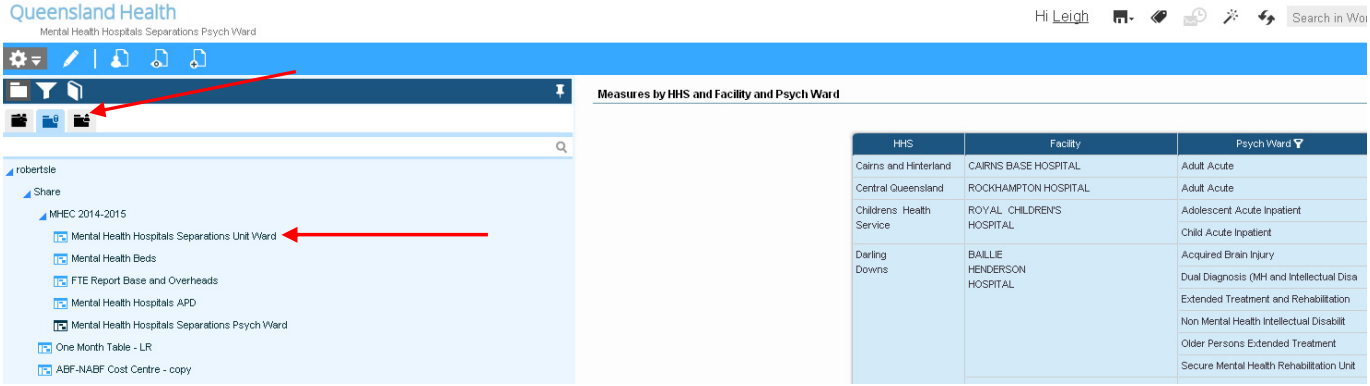
1. In the 'Shared Content' folder access reports shared by Leigh Roberts. Double click on the Mental Health Hospitals Separations Psych Ward' report.



2. Select the appropriate Facility from the facility hierarchy slicer; select the Financial Year from the fiscal year slicer.



3. Because the Psych Ward hierarchy in DSS has not been grouped into the target populations and programs types available in MHEC, some users may wish to retrieve separations data by the local ward or unit code. To do so, open the shared content folder and double click the 'Mental Health Hospitals Separations Unit Ward' report.



Episode of residential care – number of episodes of residential care, total (DO NOT USE)

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 month. Count the number of overnight or longer stay patients as at this.

Average hours staffed (DO NOT USE)

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.

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 FAMMIS 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 the FAMMIS report 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.

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 assoicated 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, Department of Communities or Child Safety Services to provide mental health services to prisons or youth detention centres should include this expenditure 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.

The FAMMIS cost element (account) group hierarchy called ‘QH_MHS’ has been created to assist in extracting expenditure data for section 4.

To run an expenditure report using ‘QH_MHS’ apply the following instructions after logging into the FAMMIS production module (see Figure 1):

1. Double click on ‘Financials – Business Reporting’,
2. Double click on ‘QHealth Reports’,
3. Double click on ‘Cost Centre’
4. Double click on ‘Cst Ctr Mth by Cost Element’.

In the screen ‘Report by Cost Element: Selection’ (see Figure 2):

1. Enter the correct fiscal year ‘201X’,
2. Enter Period ‘16’
3. In the Cost centre ‘value(s)’ field, enter the cost centre/s or hierarchy/s that relate to your respective establishment/s (for separate reports use one cost centre at a time)
4. In the ‘Cost element group’ field enter ‘QH_MHS’
5. Click on the Execute button or press F8 to generate the report.
6. Click on the Expand buttons to the left of the report to show individual account codes. To expand all account code rows go to the Menu item View then Row Hierarchy then Expand all.
7. To print the report, click on the printer icon. In the Print Area window, click on the green tick. In the Print Parameters window, select the printer, click on Print Immediately and then on the Continue button at the bottom.

The generated report will have a number of columns. The balances listed in the column headed ‘Act 1-16’ are to be used to populate section 4 along with any additional mental health expenditure from other non-mental health cost centres..

Within the account hierarchy of ‘QH_MHS’ there is an account grouping called ‘Not Assigned’. The account ‘intra HHS expenses’ (577460), suspense and clearing accounts have been mapped to this grouping.

Any balances that appear against the ‘Not Assigned’ 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 ‘Not Assigned’ 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.

Figure 1: Accessing the QH_MHS Hierarchy

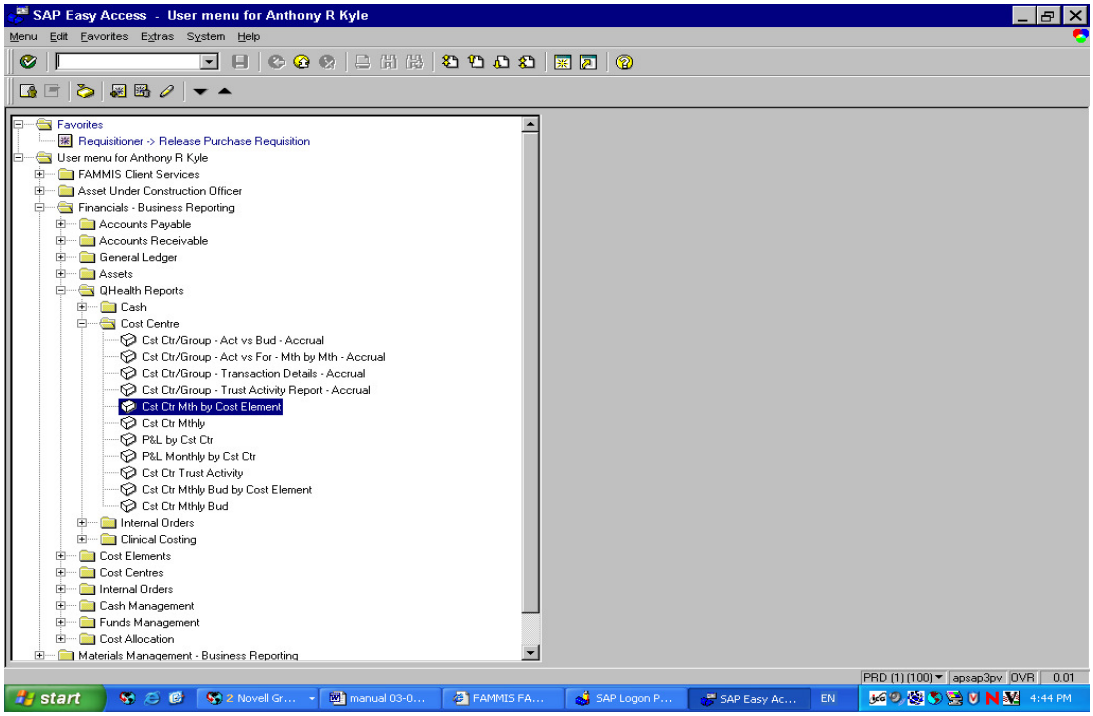
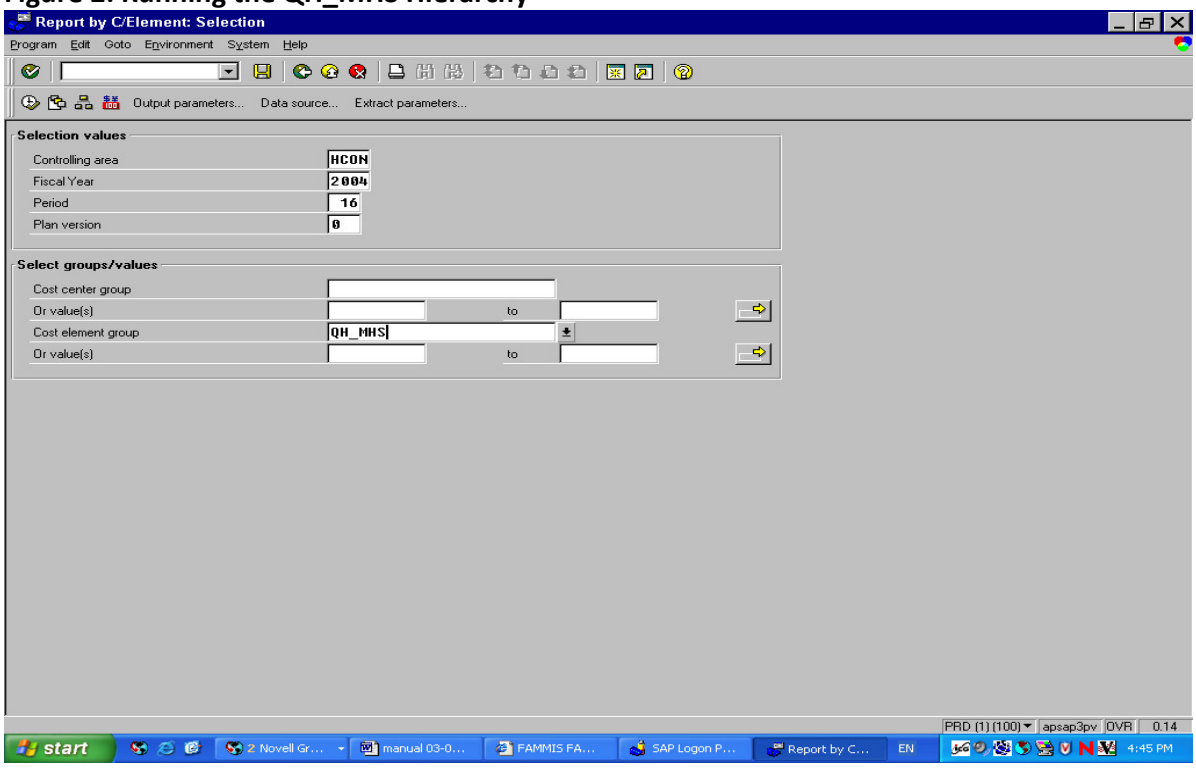


Figure 2: Running the QH_MHS Hierarchy



Expenditure categories

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.

This expenditure is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

500000-500090, 501000-503690, 506000-506090, 507000-507070, 509000-509380, 503800-503880, 514035, 514000, 503800-503880, 509000-509380, 503700-503780, 503900-503980, 516005-516080

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).

This expenditure is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

517100 - 517195, 517200-517475,

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.

This expenditure is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

506100-506190

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.

This expenditure is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

504000-504890

Other labour related expenditure
Includes payroll tax, fringe benefits tax and salary sacrifice. It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

500095, 505000-505190, 577496, 577480, 517196

As per instruction from the Financial Accounting Team, Queensland Health: ''577xxx' accounts are used for intra-departmental 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.

Food supplies
Includes expenditure on all food and beverages. Do not include kitchen expenses such as utensils, cleaning materials, cutlery, and crockery. This expenditure is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

540000-540090, 563000, 566170-566180, 577475

As per instruction from the Financial Accounting Team, Queensland Health: ‘‘577xxx’ accounts are used for intra-departmental charging only, this means:

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- 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.

Drug supplies
Includes expenditure on all drugs, including the cost of containers. This expenditure is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

550000-559900, 563010, 566130-566140

Clinical supplies and services
Includes expenditure on all consumables of a medical or surgical nature (excluding drug supplies and equipment repairs). It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

560000-562015, 563020, 577410, 577492, 560270, 566002, 566003, 565060

As per instruction from the Financial Accounting Team, Queensland Health: ‘‘577xxx’ accounts are used for intra-departmental charging only, this means:

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- 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.

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 expenditure is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

510800-510850, 530000-530010, 565000-566120, 566150-566160, 574040-574051, 577493, 566004, 511021

As per instruction from the Financial Accounting Team, Queensland Health: ‘‘577xxx’ accounts are used for intra-departmental 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.

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.

It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

536000-536515, 577485, 577495, 577498-577499

As per instruction from the Financial Accounting Team, Queensland Health: ''577xxx' accounts are used for intra-departmental 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.

Patient transport services
Includes expenditure on the direct cost of transporting patients, excluding the salaries and wages of transport staff employed by the health HHS. It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

528000-528625, 566011

Worker's compensation premium
Includes expenditure on worker's compensation insurance payments made by the organisation on behalf of its employees. It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

511210.

Insurance
Includes expenditure on public risk and other insurance amounts paid by the health HHS with respect to the provision of mental health services within the health HHS. It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

511200-511205, 511215-511220, 566009

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.

It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

510000-510655, 511000-511030, 511400-514030, 514040-517050, 518000-524035, 530000, 563040, 570100-570150, 574000-574039, 574052-574055, 574060-574140, 577030-577390, 577400, 577415-577455, 577460, 577490, 577494, 577497, 577465, 566040,

As per instruction from the Financial Accounting Team, Queensland Health: ''577xxx' accounts are used for intra-departmental 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.

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.

It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

590010-590145, 590170

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).

It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

577000-577025

As per instruction from the Financial Accounting Team, Queensland Health: ''577xxx' accounts are used for intra-departmental 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.

Other expenditure

Includes expenditure not allocated under any of the other categories on this statement and is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

536801-538001, 563030, 563050-563070, 567000-567040, 577470, 590150-590160, 590210, 591298, 566050, 570028, 570029, 570031, 570032, 570033, 570034

As per instruction from the Financial Accounting Team, Queensland Health: ‘‘577xxx’ accounts are used for intra-departmental 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.

Cost centre code

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

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.

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 and Ageing 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.

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 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).

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 eligible for membership of the Australian Association of Occupational Therapists.

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.

Administrative and clerical staff
Refers to staff engaged in administrative and clerical duties. Medical, nursing, diagnostic and health professional 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, cleaners and gardening staff). Staff involved in direct client care should not be coded to this category.

Mental Health Carer Workers
Staff employed (or engaged via contract) specifically for their expertise developed from their experience as a mental health carer. Mental health carer workers include, but not limited to, carer consultants, peer support workers, carer support workers, carer representatives and carer advocates.

Mental Health Consumer Workers
Staff employed (or engaged via contract) specifically for their expertise developed from their lived experience of mental illness. Mental health consumer workers include, but not limited to, consumer consultants, peer support workers, peer specialists, consumer companions, consumer representatives, consumer project officers and recovery support workers.

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.
- On the advice of the Financial Accounting Team, in those cases where the expenditure figures reported by FAMMIS and DSS do not agree, you should take the FAMMIS 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.

Appendix A: Mental Health Establishments Structure 2015-16

Data structures displayed here in some circumstances are unique the collection requirements of the MHEC. Community Care Units are reported under their parent establishment ID for National reporting.

HHS	MHSO	ESTABLISHMENT	EST. ID
METRO SOUTH	BAYSIDE	REDLAND HOSPITAL	00028
		BAYSIDE CHILD AND YOUTH COMMUNITY MHS	80090
		BAYSIDE ADULT COMMUNITY MHS	80998
		CASUARINA LODGE – WISTERIA ABI UNIT	00625
		DAINTREE PSYCHOGERIATRIC INPATIENT UNIT	00610
		BAYSIDE COMMUNITY CARE UNIT	00028
	LOGAN-BEAUDESERT	LOGAN HOSPITAL	00029
		BEENLEIGH COMMUNITY MHS	80128
		BROWNS PLAINS COMMUNITY MHS	81010
		LOGAN CENTRAL CHILD AND YOUTH COMMUNITY MHS	80737
		LOGAN CENTRAL ADULT COMMUNITY MHS	80739
		LOGAN COMMUNITY MHS	81234
		LOGAN COMMUNIT Y CARE UNIT	00029
	PRINCESS ALEXANDRA HOSPITAL	PRINCESS ALEXANDRA HOSPITAL	00011
		COORPAROO COMMUNITY CARE UNIT	00011
		INALA ADULT COMMUNITY MHS	80759
		BURKE STREET COMMUNITY MHS	81001
		MOUNT GRAVATT ADULT MHS	81003
GOLD COAST	GOLD COAST	PALM BEACH ADULT COMMUNITY MHS	80119

HHS	MHSO	ESTABLISHMENT	EST. ID
		ASHMORE ADULT COMMUNITY MHS	80122
		SOUTHPORT CHILD AND YOUTH COMMUNITY MHS	80127
		ROBINA HOSPITAL	00934
		ROBINA COMMUNITY MHS	81236
		GOLD COAST UNIVERSITY HOSPITAL	00936
SOUTH WEST	SOUTH WEST	CHARLEVILLE COMMUNITY MHS	80306
		ROMA ADULT COMMUNITY MHS	80307
		ROMA CHILD AND YOUTH COMMUNITY MHS	80308
DARLING DOWNS	TOOWOOMBA	TOOWOOMBA HOSPITAL	00104
		TOOWOOMBA COMMUNITY CARE UNIT	00104
		BAILLIE HENDERSON HOSPITAL CAMPUS	00701
		TOOWOOMBA ADULT COMMUNITY MHS	80804
		TOOWOOMBA PSYCHOGERIATRIC COMMUNITY MHS	80092
		TOOWOOMBA CHILD AND YOUTH COMMUNITY MHS	80829
		CHINCHILLA COMMUNITY MHS	80831
		DALBY COMMUNITY MHS	80832
		WARWICK COMMUNITY MHS	80097
		GOONDIWINDI COMMUNITY MHS	80217
		STANTHORPE COMMUNITY MHS	80221
		CHERBOURG COMMUNITY MHS	80096
		KINGAROY COMMUNITY MHS	80207

HHS	MHSO	ESTABLISHMENT	EST. ID
WEST MORETON	WEST MORETON	IPSWICH HOSPITAL	00015
		GAILES COMMUNITY CARE UNIT	00015
		THE PARK – CENTRE FOR MENTAL HEALTH	00751
		IPSWICH CHILD AND YOUTH COMMUNITY MHS	80099
		GOODNA ADULT COMMUNITY MHS	80254
		IPSWICH ADULT COMMUNITY MHS	80255
CHILDREN'S HEALTH QUEENSLAND	CHILDREN'S HEALTH QUEENSLAND	LADY CILENTO CHILDREN'S HOSITAL	00202
		PINE RIVERS CHILD AND YOUTH COMMUNITY MHS	80101
		NUNDAH CHILD AND YOUTH COMMUNITY MHS	80491
		EVOLVE CHILD AND YOUTH COMMUNITY MHS	80509
		GREY STREET CHILD & YOUTH COMMUNITY MHS	80523
		NORTH WEST CHILD & YOUTH COMMUNITY MHS	81095
		GREENSLOPES CHILD AND YOUTH COMMUNITY MHS	80719
		MT GRAVATT CHILD AND YOUTH COMMUNITY MHS	81094
		INALA CHILD AND YOUTH COMMUNITY MHS	80720
		YERONGA CHILD AND YOUTH COMMUNITY MHS	80744
METRO NORTH	THE PRINCE CHARLES HOSPITAL	THE PRINCE CHARLES HOSPITAL	00004
		CHERMSIDE ADULT COMMUNITY MHS	80521
		PINE RIVERS COMMUNITY MHS	80522
		NUNDAH COMMUNITY MHS	81002
		PINE RIVERS COMMUNITY CARE UNIT	00004
	REDCLIFFE-	CABOOLTURE HOSPITAL	00030

HHS	MHSO	ESTABLISHMENT	EST. ID
	CABOOLTURE	REDCLIFFE CABOOLTURE CRISIS ASSESSMENT & TREATMENT COMMUNITY MHS	80259
		CABOOLTURE ADULT COMMUNITY MHS	80439
		REDCLIFFE ADULT COMMUNITY MHS	80443
		REDCLIFFE-CABOOLTURE CHILD AND YOUTH COMMUNITY MHS	80994
		REDCLIFFE-CABOOLTURE ADULT COMMUNITY MHS	80997
		REDCLIFFE-CABOOLTURE COMMUNITY CARE UNIT	00030
	ROYAL BRISBANE AND WOMEN'S HOSPITAL	ROYAL BRISBANE AND WOMEN'S HOSPITAL	00201
		COMMUNITY FORENSIC MHS	80493
		INNER NORTH BRISBANE COMMUNITY MHS	80498
		SOMERSET VILLAS COMMUNITY CARE UNIT	00201
CENTRAL QUEENSLAND	CENTRAL QUEENSLAND	ROCKHAMPTON BASE HOSPITAL	00141
		ROCKHAMPTON COMMUNITY CARE UNIT	00141
		ROCKHAMPTON ADULT COMMUNITY MHS	80586
		ROCKHAMPTON CHILD AND YOUTH COMMUNITY MHS	80596
		ROCKHAMPTON EVENTIDE PSYCHOGERIATRIC UNIT	00692
		BILOELA COMMUNITY MHS	80103
		EMERALD COMMUNITY MHS	80072
		GLADSTONE COMMUNITY MHS	80595
CENTRAL WEST	CENTRAL WEST	LONGREACH COMMUNITY MHS	80070
SUNSHINE COAST	SUNSHINE COAST	NAMBOUR HOSPITAL	00049
		SUNSHINE COAST COMMUNITY MOBILE INTENSIVE MENTAL HEALTH SERVICE	80291
		MAROOCHYDORE ADULT	80435

HHS	MHSO	ESTABLISHMENT	EST. ID
		COMMUNITY MHS	
		NAMBOUR ADULT COMMUNITY MHS	80437
		SUNSHINE COAST CHILD AND YOUTH COMMUNITY MHS	80438
		MOUNTAIN CREEK COMMUNITY CARE UNIT	00049
		GYMPIE COMMUNITY MHS	80412
		SUNSHINE COAST CLINICAL SUPPORT UNIT	81229
		GLENBROOK RESIDENTIAL AGED CARE	00612
WIDE BAY	WIDE BAY	BUNDABERG HOSPITAL	00062
		WIDE BAY COMMUNITY CARE UNIT	00062
		BUNDABERG ADULT COMMUNITY MHS	80194
		BUNDABERG CHILD AND YOUTH COMMUNITY MHS	80195
		WIDE BAY RURAL COMMUNITY MHS	80071
		MARYBOROUGH HOSPITAL	00071
		FRASER COAST ADULT COMMUNITY MHS	80989
		FRASER COAST CHILD AND YOUTH COMMUNITY MHS	80990
CAIRNS AND HINTERLAND	CAIRNS	CAIRNS HOSPITAL	00214
		CAIRNS COMMUNITY CARE UNIT	00214
		CAIRNS ADULT COMMUNITY MHS	80040
		CAIRNS CHILD AND YOUTH COMMUNITY MHS	80073
		INNISFAIL COMMUNITY MHS	80076
		TABLELANDS COMMUNITY MHS	80104
TORRES & CAPE	TORRES & CAPE	CAPE YORK COMMUNITY MHS	80080
		COOKTOWN COMMUNITY MHS	80075
		BAMAGA COMMUNITY MHS	80074

HHS	MHSO	ESTABLISHMENT	EST. ID
		THURSDAY ISLAND COMMUNITY MHS	80078
MACKAY	MACKAY	MACKAY BASE HOSPITAL	00172
		MACKAY ADULT COMMUNITY MHS	80372
		MACKAY CHILD AND YOUTH COMMUNITY MHS	80373
		WHITSUNDAY COMMUNITY MHS	80955
		MORANBAH COMMUNITY MHS	80987
TOWNSVILLE	TOWNSVILLE	TOWNSVILLE HOSPITAL	00200
		KIRWAN MH REHABILITATION UNIT	00715
		PALM ISLAND COMMUNITY MHS	80085
		TOWNSVILLE CHILD AND YOUTH COMMUNITY MHS	80939
		TOWNSVILLE ADULT COMMUNITY MHS	80995
		TOWNSVILLE ADULT FORENSIC COMMUNITY MHS	80996
		CHARTERS TOWERS REHABILITATION UNIT	00703
		CHARTERS TOWERS COMMUNITY MHS	80086
		EVENTIDE NURSING HOME – PANDANUS PSYCHOGERIATRIC UNIT	10202
		BURDEKIN COMMUNITY MHS	81233
		INGHAM COMMUNITY MHS	81113
NORTH WEST	MT ISA	MORNINGTON ISLAND COMMUNITY MHS	80051
		DOOMADGEE COMMUNITY MHS	80084
		MT ISA COMMUNITY MHS	80918
		NORMANTON COMMUNITY MHS	81141

Appendix B: Community Care Unit Mappings

MHEC Data		National Reporting	
Establishment ID	Unit Name	Code	Name
82002	Redcliffe-Caboolture Community Care Unit	00030	Caboolture Hospital
82003	Somerset Villas Community Care Unit	00201	Royal Brisbane and Women's Hospital
82001	Pine Rivers Community Care Unit	00004	The Prince Charles Hospital
82004	Mountain Creek Community Care Unit	00049	Nambour Hospital
82000	Coorparoo Community Care Unit	00011	Princess Alexandra Hospital
82005	Bayside Community Care Unit	00028	Redland Hospital
82006	Logan Community Care Unit	00029	Logan Hospital
82007	Wide Bay Community Care Unit	00062	Bundaberg Base Hospital
82008	Cairns Community Care Unit	00214	Cairns Hospital
82009	Toowoomba Community Care Unit	00104	Toowoomba Hospital
82010	Rockhampton Community Care Unit	00141	Rockhampton Base Hospital
82011	Gailes Community Care Unit	00015	Ipswich Hospital

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 focussed 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 admitted or 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.

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 inpatient 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 Sections 4 and 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 month. 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 when on the job (or contract employee where applicable) 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 the aged. 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, and medium secure).

General psychiatry – 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.

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

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 a 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 does exclude 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 focussed 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 focussed 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.
- *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 used in Establishment Form Section 5 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.