Queensland Government
Queensland Health

Manual of Instructions & Procedures
for the completion of the

Mental Health Establishments Collection (MHEC)

1 July 2009 - 30 June 2010

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Items to note since last year's Collection

The implementation of the web-based Application has changed the format of the Collection.

The Procedure Manual has been changed to reflect this change in format. A System User Manual has been developed to assist navigating the Application.

Indirect Expenditure (MHSO Form Section 5) has a new category 'Service development'.

Please send an email to 'ASMHS' listing the cost centres used in providing each Establishment's direct expenditure (Establishment Form Section 4). In previous years this data has been requested but the Application omits this.

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CHAPTER 1 INTRODUCTION

1.1 PURPOSE OF THE MANUAL

This manual provides instructions and procedures for undertaking the Mental Health Establishments Collection (MHEC) (formerly the Annual Survey of Mental Health Services). It is intended as a reference for all Health Service District personnel and Corporate Office personnel directly involved in the collection, processing and use of this data.

1.2 BACKGROUND

In April 1992, Australian Health Ministers endorsed the National Mental Health Strategy, which foreshadowed a major reform to mental health services over the period 1993-1998 (later endorsed to extend to 2003 and most recently to 2008). In 1992 there was recognition that a lack of quality information and the absence of a consistent national data collection were key historical factors that isolated mental health services from the mainstream health system and would limit the effectiveness of the reform process. As a consequence, the Strategy gave priority to improving the quality and availability of mental health data.

Five information related priorities were set at the beginning of the Strategy (later endorsed and refined in the National Information Priorities and Strategies under the 2nd National Mental Health Plan) and these have shaped mental health information development over the last decade. In addition to this work, Health Ministers identified that an initial priority was to monitor the progress of the Strategy itself. The tool initially used to monitor the progress of States and Territories in reforming mental health services was called the 'National Survey of Mental Health Services (NSMHS)'. This 'survey' involved the collection of establishment level data from all public funded mental health services. It provided a picture of the range, level and costs of services available in each of the States and Territories.

Queensland Health have administered and reported on the NSMHS since 1993.

1.3 INFORMATION DEVELOPMENT

"Who receives what services from whom at what cost and with what effect"[1]

The development of information to guide mental health reform and service delivery has been driven by the quest to report against the parameters captured in the above sentence.

National Minimum Data Sets (NMDS) for mental health have been developed for both admitted patient mental health care and community mental health care at the client and establishment reporting level.

[1] Taken from: 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.

For the 2005-2006 years the NMDS – Mental Health Establishments (NMDS-MHE) replaced the previous NMDS - Community Mental Health Establishments (NMDS-CMHE) data set and National Survey of Mental Health Services (NSMHS).

Data collection for the NMDS-MHE was undertaken in Queensland via the 'Annual Survey of Mental Health Services' and from 2009-2010 via the Mental Health Establishments Collection (MHEC).

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

1.4 LEGISLATION

Queensland Health provides data from the Mental Health Establishments Collection to the Australian Institute of Health and Welfare (AIHW) and the Australian Department of Health and Ageing under the National Healthcare Agreement.

The NMDS – MHE is comprised of:

- 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

This legislative requirement is fulfilled by completion of the NMDS-MHE.

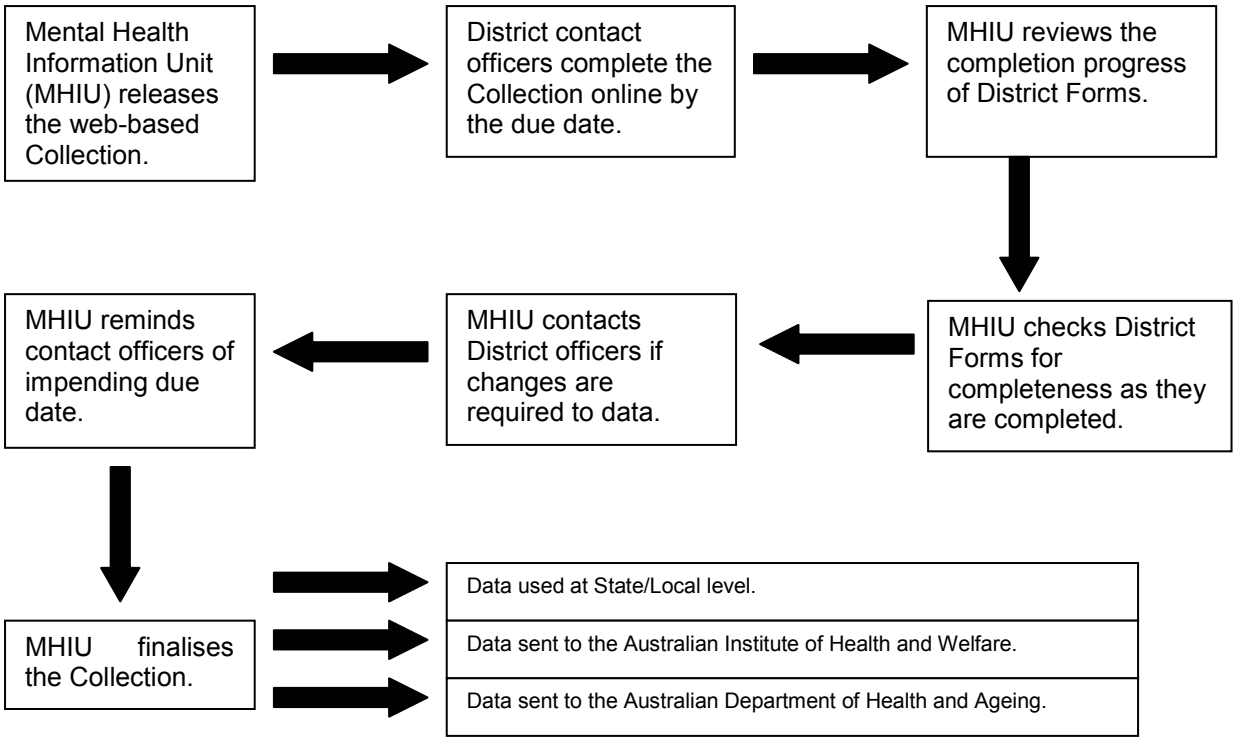
1.5 USE OF MHEC DATA

Data collected for the MHEC provides detailed information on the range, level and cost of services available in Queensland. As an annual collection it can be used to monitor service growth and development at the District, 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 can be used to inform local and state decision-making, support the development of performance indicators and address ad hoc research requirements.

The clinical outcomes collection will complement the survey information and support more informed analysis of service delivery in Queensland.

CHAPTER 2 PROCEDURES

This chapter describes the process for completing the MHEC. The process is summarised in the flow chart below:



2.1 COMPLETING THE COLLECTION

The implementation of the organisational reporting entity known nationally as Specialised Mental Health Service Organisation (MHSO) and its use as the unit of reporting across the various QH mental health collections was detailed in a memorandum from the Senior Director, Mental Health Branch dated 1 April 2009. Therefore, a Health Service District may consist of one or multiple MHSOs. Accordingly, reporting will be required at the MHSO level for the 2008/09 ASMHS collection.

The Mental Health Establishments Collection Application (MHECA) has been developed as a web-based tool to collect data for the Mental Health Establishments Collection.

As the NMDS – MHE requires data to be reported at the State, Organisation and Establishment levels, the MHECA is based on this structure and data entry is required in 3 separate Forms – the State, MHSO and Establishment Forms.

The State Form is completed by Mental Health Information Unit and does not concern the Districts.

The MHSO Forms (Sections 1 to 8) are to be completed at the Mental Health Service Organisation level.

The Establishment Forms (Sections 1 to 5) are to be completed for each Reporting Establishment within the MHSO

Appendix A shows a list of Districts, MHSOs**,** Reporting Establishments and their corresponding IDs.

Therefore, for Districts with only one MHSO and multiple reporting establishments, a MHSO Form will be completed plus an Establishment Form for each reporting establishment. For Districts with multiple MHSOs, a MHSO Form will be completed for each MHSO plus an Establishment Form for each reporting establishment.

For example, given the below information, South West MHSO would complete and submit:

SOUTH WEST HSD	**SOUTH WEST MHSO**	**SW**	
		80306	CHARLEVILLE CMHS
		80307	ROMA ADULT CMHS
		80308	ROMA CHILD & YOUTH CMHS

- The MHSO Form for 'South West' MHSO
- The Establishment Form for Establishment 'Charleville CMHS'
- The Establishment Form for Establishment 'Roma Adult CMHS'
- The Establishment Form for Establishment 'Roma Child & Youth CMHS'

Please refer to the following sections for instructions on how to complete each Form.

2.2 SYSTEM MANUAL

Detailed instructions on how to use the web-based Mental Health Establishments Collection Application (MHECA) to complete the Collection can be found at the end of this Instructions and Procedures Manual.

CHAPTER 3 MHSO FORM SECTION 1

Relates to the types of mental health services provided by your Health District during the reference period and the funding sources for expenditure on mental health services at the health district and establishment level.

3.1 COMPLETING THIS SECTION

Section 1 should be completed at the Mental Health Service Organisation level.

The District and/or Mental Health Finance Officer in consultation with the Mental Health Executive Director, Manager or Team Leader (depending on the service) should complete Statement 3.

3.2 SERVICES PROVIDED

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

The following **PROGRAM TYPES** describe the mental health service settings at the MHSO level.

Inpatient: 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.

Residential Care: No Mental Health Residential Units exist in Queensland (these cells have been defaulted to No on Section 1.

Ambulatory Care: Refers to all mental health services dedicated to the assessment, treatment, rehabilitation, or care of non-admitted and community patients including, but not limited to, the following:

- Crisis assessment and treatment services
- Mobile assessment and treatment services
- Outpatient clinic services provided by either a hospital or community mental health centre
- Child and adolescent outpatient treatment teams
- Social and living skills programs including day programs
- Day hospitals and living skills centres
- Psychogeriatric assessment teams and day programs

The relevant **TARGET POPULATION TYPES** are described below. For a Type other than General to be separately listed on this Statement 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 medium secure clients. General psychiatry services, therefore, 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. This includes medium secure inpatient facilities.

Child & 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.

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, or be suspected of, a criminal offence or make it likely that they will reoffend in the future without adequate treatment or containment. For the purposes of this collection, this includes all prison-based services but excludes services that are primarily for children, adolescents and older people even where they include a forensic component.

In Queensland, high secure inpatient facilities are to be reported as Forensic Psychiatry while medium secure inpatient facilities 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.

CHAPTER 4 MHSO FORM SECTIONS 2,3,4

These Sections relate to mental health service consumer participation.

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. 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.

4.1 COMPLETING THESE SECTIONS

These Sections should be completed at the Mental Health Service Organisation level in consultation with the mental health service Executive Director, Manager or Team Leader (depending on the service).

4.2 SECTION 2 - CONSUMER REPRESENTATION ON FORMAL COMMITTEES

Identify the statement that **best** describes the formal committee mechanism within your MHSO for participation by Mental Health Service consumers in the planning and evaluation of services.

A “formal position” means that the consumer representative is a voting member of the committee.

4.3 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.

For the first statement, if Yes is selected, please provide details, in FTE terms and total salary/payment (excluding superannuation), for the consumer consultants employed/engaged. Do not include these details in Section 5 as Indirect Expenditure or in Establishment Form Sections 4 or 5.

Employed/engaged implies the person received a salary or contract fee on a regular basis. It does NOT refer to arrangements where the consultant only received reimbursement of expenses or occasional sitting fees for attendance at meetings. In this case expenditure should only be included in Section 5 as Program Administration.

If required, a description of other arrangement(s) should be included in the box provided.

4.4 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.

For the first statement, if Yes is selected, please provide details, in FTE terms and total salary/payment (excluding superannuation), for the carer consultants employed/engaged. Do not include these details in Section 5 as Indirect Expenditure or in Establishment Sections 4 or 5.

Employed/engaged implies the person received a salary or contract fee on a regular basis. It does NOT refer to arrangements where the consultant only received reimbursement of expenses or occasional sitting fees for attendance at meetings. In this case expenditure should only be included in Section 5 as Program Administration.

If required, a description of the other arrangement(s) should be included in the box provided.

CHAPTER 5 MHSO FORM SECTION 5

This Section relates to gross, non-capital expenditure by the Mental Health Service Organisation that is **indirectly** related to the mental health services. 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.

5.1 COMPLETING THIS SECTION

Section 5 should be completed at the Mental Health Service Organisation level.

The District and/or Mental Health Finance Officer in consultation with the Mental Health Executive Director, Manager or Team Leader (depending on the service) should complete this Section.

The information for Section 5 can be obtained from a number of sources. Your District Finance Officer can run a DSS expenditure report for your District/MHSO. District knowledge can then be used to determine what percentage of this expenditure, not already allocated to Mental Health Services, should be reported as indirect expenditure. Operating budgets, DSS budget reports and FAMMIS reports may also help provide this information.

5.2 INDIRECT NON-CAPITAL EXPENDITURE

There are two general categories of indirect expenditure:

1. Expenditure indirectly related to the delivery of mental health services that cannot or should not be apportioned across the reporting establishments in your District/MHSO (and so has not been reported on Statement 5). This includes:

    - Expenditure on District-wide corporate and support services that is not directly related to the provision of mental health services and cannot be apportioned to establishments via some allocation method. These District services are usually provided from a central resource pool and managed at the health district level eg. District administration.

    - Expenditure on superannuation, workers compensation 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 District/MHSO direct to external groups (ie. not via the MHSO's mental health establishments). An example would be payments to academic departments of psychiatry. However, where such expenditure is

considered to be part of service delivery (eg. 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.

It is preferable that MHSOs report as much indirect expenditure as possible in Establishment Form Sections 4 (as opposed to reporting it here). If not already charged to mental health cost centres, a proportion of District-wide administration costs relating to services provided to the mental health service should be calculated and added to the expenditure reported by FAMMIS for Establishment Form Sections 4. This also applies to District/MHSO Mental Health Program administration costs. For analysis purposes (eg. calculating bed day costs), any indirect expenditure reported on Section 5 will be distributed across establishments based on the proportion of direct expenditure each establishment reports.

5.3 INDIRECT EXPENDITURE CATEGORY DEFINITIONS

Program Administration: Refers to costs associated with administration and support of the District/MHSO Mental Health Program (eg. program management salaries) provided at the mental health program level. Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program. **Most, if not all, of these costs should be apportioned across the mental health reporting establishments in your District/MHSO and hence reported in Establishment Form Section 4.**

Organisation-wide Support Services: Refers to the District-wide costs of administration and other support services provided at the District/MHSO level. Such services include corporate governance and administration, public relations, hospital administration, shared service providers, human resources, finance, records, information systems/technology, building/grounds maintenance, security, utilities. These services are generally provided from a central pool of resources managed at the corporate level for all programs/business units of the health district. **Again, it is preferable that these costs be apportioned across the mental health reporting establishments in your District/MHSO and hence reported in Establishment Form Section 4.**

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 District/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 health district 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.

Report academic expenditure in this section only where the academic unit operates independently. Where an academic unit or position operates as an integral part of a service (eg. an acute inpatient unit), the expenditure should be reported against the relevant service.

Mental Health Research: Refers to expenditure on basic or applied research in the mental health field funded by the health district.

Report research expenditure 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 to 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 organisation that 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 the District/MHSO or Corporate Office, to a superannuation fund providing retirement and related benefits to established employees.

Only report superannuation in Section 5 if it does not relate in any way to the provision of services by mental health establishments. If the superannuation payments relate to the provision of services by establishments, they must be reported against those establishments in Establishment Form Sections 4. For this reason, this category should be rarely reported against.

Workers Compensation: Refers to worker's compensation premiums and payments made by the organisation on behalf of its employees.

Only report worker's compensation premiums in Section 5 if they do not relate in any way to the provision of services by establishments. If the worker's compensation premiums relate to the provision of services by establishments, they must be reported against those establishments in Establishment Form Sections 4.

Insurance: Refers to public risk and other insurance amounts paid by the health district with respect to the provision of mental health services within the health district.

Only report insurance in Section 5 if it does not relate in any way 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 Sections 4.

Mental Health Act Regulation or related legislation (Including Review Tribunals): Refers to expenditure incurred by the District/MHSO due to the establishment and maintenance of Mental Health Act review bodies.

Patient Transport Services: Refers to the direct cost of transporting patients, excluding the salaries and wages of transport staff employed by the health district. Include payments to ambulance units where these are not reported elsewhere.

Only report patient transport expenditure in Section 5 if it does not relate in any way 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 Sections 4.

Property Leasing Costs: Refers to the costs of leasing premises used for the provision of mental health services (eg. community clinics).

Only report leasing expenditure in Section 5 if it does not relate in any way 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 Sections 4.

Other Indirect Expenditure: Refers to any indirect expenditure that is related to the mental health services in your District/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 are not to be included here. This should either be apportioned across the existing buildings or not reported at all.

5.4 ACTUAL OR ESTIMATED GROSS NON-CAPITAL EXPENDITURE

For each indirect expenditure category, provide the expenditure (in whole dollars) for that category. It is essential that there is no double counting of expenditure in MHSO Form Section 5 or in Establishment Form Sections 4.

5.5 DISTRIBUTION OF EXPENDITURE

Where no expenditure is reported against a particular indirect expenditure category, select the appropriate response for that category. Eg. If there is No expenditure to report here because it has already been distributed across the establishments (i.e. included in Establishment Form Sections 4), then select the ALL response. Or, if there is No expenditure to report here because there has been no expenditure on this category, then select the NIL response.

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CHAPTER 6 MHSO FORM SECTION 6

This Section relates to the funding sources for expenditure reported in MHSO Form Section 5 and all Establishment Form Sections 4.

6.1 COMPLETING THIS SECTION

Section 6 should be completed at the Mental Health Service Organisation level.

The District and/or Mental Health Finance Officer in consultation with the Mental Health Executive Director, Manager or Team Leader (depending on the service) should complete this Section.

6.2 SOURCES OF FUNDING FOR EXPENDITURE

Please identify the funding sources for expenditure reported in MHSO Form Section 5 and all Establishment Form Sections 4. This includes expenditure recoveries and patient revenue. If your Health Service District 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 all Establishment Form Sections 4. Do not report total budget allocations in this section. Only report the portion that was expended.

Queensland Health Funding: Refers to State funding provided by Queensland Health for the delivery and/or administration of mental health services in your health district. This includes specific mental health allocations 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 to Queensland to assist in the implementation of the mental health services.

Dept. 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. 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 Australian Health Care Agreements.

Patient Revenue: Refers to revenue paid directly by patients, or by third parties on behalf of patients, under care of the district's 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 health district that has not been reported in this section.

CHAPTER 7 MHSO FORM SECTION 7

This Section reports details of any grants made from Districts/Mental Health Service Organisations to non-government organisations (NGOs) during the year.

7.1 COMPLETING THIS SECTION

Section 7 should be completed at the Mental Health Service Organisation level.

The District and/or Mental Health Finance Officer in consultation with the Mental Health Executive Director, Manager or Team Leader (depending on the service) should complete this Section.

7.2 FUNDING TO NON-GOVERNMENT ORGANISATIONS

A number of Districts/MHSOs provide funding to non-government organisations (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 Statewide level.

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

7.3 DEFINITIONS OF NGO GRANT SERVICE TYPES

Accommodation services: Grants for the provision of housing services that are linked to support services for people affected by a mental health issue. These include the following subtypes:

Crisis/interim accommodation **-** Short-term accommodation which may be staffed up to 24 hours a day, seven days a week for people affected by a mental health issue. Accommodation is facility based/residential with an average of 4-8 beds. Length of stay is generally limited to a maximum of three months.

Headleasing - Provides a supportive landlord service that assists tenants to access and maintain suitable accommodation and maintains their tenancies and which is linked to support.

Long term supported accommodation – Secure/tenured long-term accommodation with staff support as necessary or desired.

Residential rehabilitation **-** Short to long-term residential facility based accommodation provided to people with high needs. Staff support is provided.

Transitional supported accommodation **-** Short to medium accommodation (3-12 months) that is provided in a residential/facility based setting.

Advocacy services: Grants for the provision of services that provide assistance to people affected by a mental health issue to access their human and legal rights and promote reform.

Community awareness/health promotion services: Grants for the provision of services aimed at raising awareness about mental health/illness and those affected

by mental health issues through the provision of information and/or education to the community, in order to enhance the community's capacity to support people affected by a mental health issue.

Counselling services: Grants for the provision of services by professionals and non-professionals that provide emotional support, psychological support, assistance with achieving goals and the strengthening of community and social networks for people affected by a mental health issue.

Independent living skills support services: Grants for the provision of services that provide encouragement and support of people living with a mental health issue to participate actively in their day to day living in a community.

Other and unspecified mental health services: Grants for the provision of mental health services not elsewhere classified and grants not allocatable to specific service types.

Prevocational training services: Grants for the provision of training and skill development services to individuals affected by a mental health issue to facilitate their progress into employment of their choice.

Psychosocial support services: Grants for the provision of services that work in partnership with the individual affected by a mental health issue and their carers to provide a range of support and skill development options addressing key issues in attainment of mental health and social competence goals.

Recreation services: Grants for services that provide and/or facilitate a range of leisure and social opportunities to people affected by a mental health issue to enhance their social competence.

Respite services: Grants for the provision of services that allow a planned break from the usual caring environment.

Self-help support groups services: Grants for the provision of opportunities for people affected by a mental health issue to learn from and support each other.

CHAPTER 8 MHSO FORM SECTION 8

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

8.1 COMPLETING THIS SECTION

Section 8 should be completed at the Mental Health Service Organisation level.

The District and/or Mental Health Finance Officer in consultation with the Mental Health Executive Director, Manager or Team Leader (depending on the service) should complete this Section.

8.2 SUPPORTED PUBLIC HOUSING PLACES

A number of Health Service Districts make formal local partnership agreements (LPAs) with the Department of Housing 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 within their homes, including outreach services.

If your District/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.

CHAPTER 9 ESTABLISHMENT FORM SECTIONS 1,2,3

Section 1 relates to 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 and to.

9.1 COMPLETING THESE SECTIONS?

These Sections should be completed for each Establishment within the MHS Organisation. Please refer to Appendix A for a list of MHSOs, Establishments and the corresponding Establishment Id.

This Statement should be completed in conjunction with the Mental Health Executive Director, Manager or Team Leader (depending on the service).

9.2 SECTION 1 - SERVICES PROVIDED

In the table provided, indicate with a Yes or No, the types of mental health services managed by this Establishment.

PROGRAM TYPES - mental health service settings at the Establishment level are described below.

Inpatient - Acute: 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.

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: No Mental Health Residential Units exist in Queensland (these cells have been defaulted to No on Section 1.

Ambulatory Care: Refers to all mental health services dedicated to the assessment, treatment, rehabilitation, or care of non-admitted and community patients including, but not limited to, the following:

- Crisis assessment and treatment services
- Mobile assessment and treatment services
- Outpatient clinic services provided by either a hospital or community mental health centre
- Child and adolescent outpatient treatment teams
- Social and living skills programs including day programs
- Day hospitals and living skills centres
- Psychogeriatric assessment teams and day programs

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.

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. General psychiatry services, therefore, 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 & 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.

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.

9.3 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 a MHS Organisation 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 by an external accreditation agency and was judged to have met all of the National Standards. (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.

9.4 SECTION 3 - INPATIENT SERVICES ACTIVITY DETAILS

The information for this Section can be obtained from a number of sources. Ideally, the information should be obtained from HBCIS (your local Health Information Services may be able to help you with this request). The ACIMS Monthly Activity Report, Clinical Benchmarking Separations, local data collections and Transition 2 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.

Available Beds: The average number of beds that are immediately available for use by an admitted patient or resident if required. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period. Please report only the beds for which you have been funded.

The annual average bed numbers should be calculated by adding each months figures, divide by 12 and rounded to the nearest whole number. Previously this data item was calculated using the number of beds available at 30 June of the reporting period. Beds which were temporarily unavailable because of renovations, strikes etc, but which would normally be available, should be included.

In many cases the number of available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resource levels, and the latter referring to the maximum number of beds allowed for the establishment.

When reporting the number of available beds located in a stand-alone hospital, include all available beds on the facility's campus, whether they are in wards or other types of accommodation.

Do not include beds that are designated for intellectual disability or drug and alcohol 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.

Accrued Patient Days (ie. '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. Accrued Patient Days should NEVER exceed bed numbers X 365 days.

This statement 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 2003/04 year are:

- A patient was admitted on 1 May 2003 and separated on 6 July 2003. If no leave or transfers occurred, counting starts on 1 July 2003, so the number of accrued patient days would be 5. Note that 6 July 2003 (the day of separation) is not counted.

- A patient was admitted on 20 June 2004 and separated on 5 August 2004. If no leave or transfers occurred, counting ends on 30 June 2004 (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 2004 is that they remain in hospital, so this is an accrued patient day.

- A patient was admitted on 1 March 2004 and separated on 31 March 2004. If no leave or transfers occurred, counting starts on 1 March 2004, so the number of accrued patient days would be 30.

- A patient was admitted on 10 January 2003 and remained in hospital until after 30 June 2004. If no leave or transfers occurred, counting starts on 1 July 2003 and ends on 30 June 2004 so the number of accrued patient days would be 365. Note that the patient's status on 30 June 2004 is that they remain in hospital, so this is an accrued patient day.

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CHAPTER 10 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 system.

Directions for running the FAMMIS report to ensure consistent reporting across financial years is detailed below.

10.1 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 District and/or Mental Health Finance Officer in consultation with the Executive Director, Manager or Team Leader (depending on the service) should complete this Section.

10.2 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). Districts/MHSOs that are funded by the Departments of Corrective Services or Communities or Child Safety 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 district (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 District, MHSO or Establishment should be reported by that District, 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 2):

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 3)

1. Enter the correct fiscal year '200X',
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.
   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.
6. 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 district 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 Section 4. 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 agree with the 'Total' expenditure cell for the corresponding service setting in Section 5.

Figure 2:

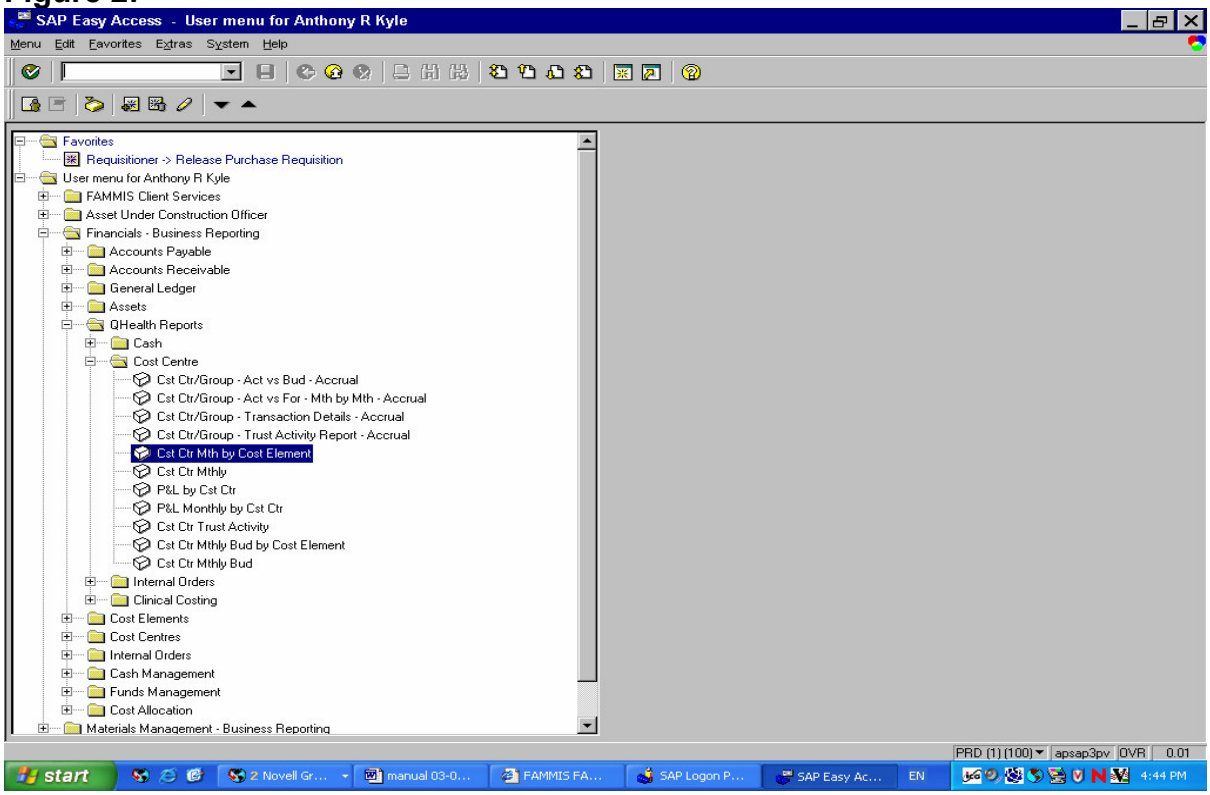
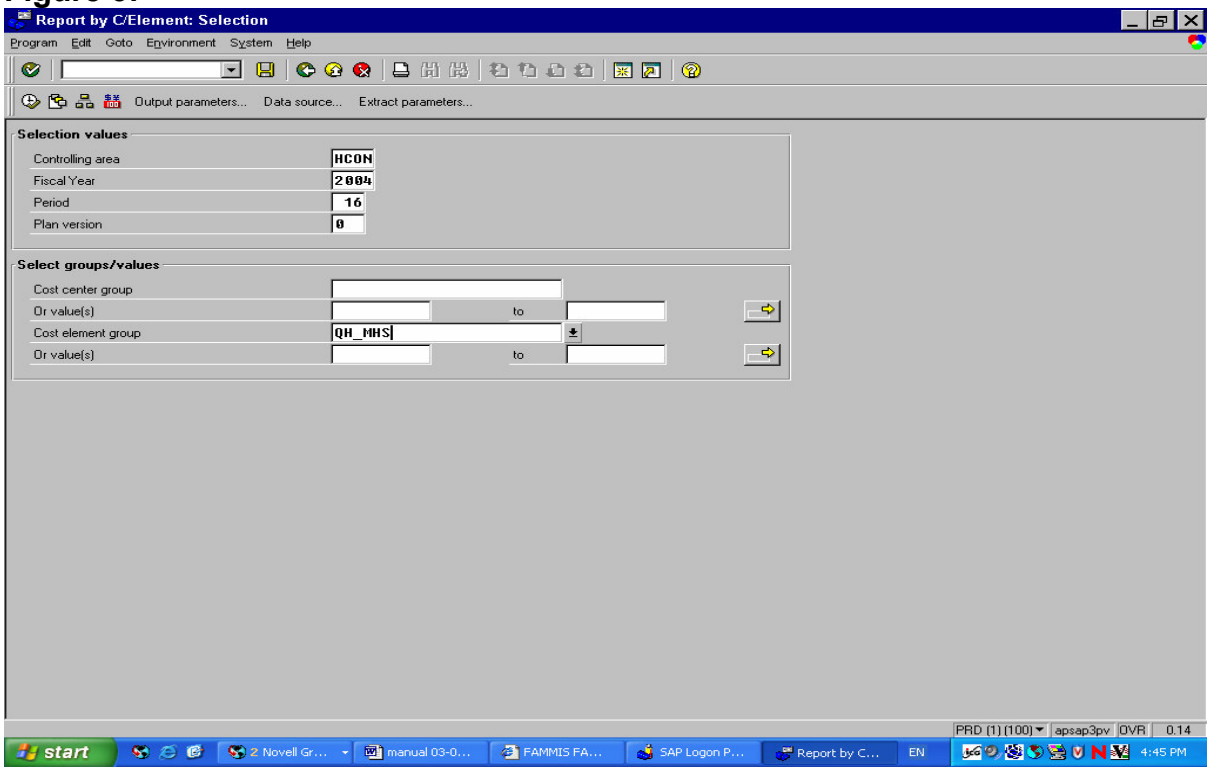


Figure 3:



10.3 EXPENDITURE CATEGORIES

Payroll and Related Expenditure: Includes salary/wages for QH employees and contracted employees including leave payments, workers compensation salary payments, redundancy payments, salary recoveries, overtime, higher duties and all allowances.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

500000-500090, 501000-503690, 506000-506090, 507000-507070

Contract and Related Expenditure (Agency/Contract Staff): Includes agency/contract staff payments (including overtime and allowances) where the contact is for the supply of labour rather than of products (eg. photocopy maintenance and domestic cleaning staff).

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

517200-517470, 577480, 577496

Exgratia Payments to Staff: Includes payments to staff that are above normal award conditions eg. 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.

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 District or Corporate Office, to a superannuation fund providing retirement and related benefits to established employees.

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.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

500095, 505000-505190

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

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

540000-540090, 563000, 566170-566180, 577475

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

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).

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

560000-562015, 563020, 577410, 577492

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).

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

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.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

536000-536515, 577485, 577495, 577498-577499

Patient Transport Services: Includes expenditure on the direct cost of transporting patients, excluding the salaries and wages of transport staff employed by the health district.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

528000-528625

Worker's Compensation Premium: Includes expenditure on worker's compensation insurance payments made by the organisation on behalf of its employees.

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 district with respect to the provision of mental health services within the health district.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

511200-511205, 511215-511220.

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.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

510000-510655, 511000-511030, 511400-517050, 518000-524035, 530000, 563040, 570000-570150, 574000-574039, 574052-574055, 574060-574140, 577030-577390, 577400, 577415-577455, 577460, 577490, 577494, 577497, 577465

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 (eg, computer software code) are amortised this should also be included in expenditure.

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 (eg, interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (ie, dividends on shares).

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

577000-577025

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

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

10.4 COST CENTRE CODE

It is important that the cost centre code(s) used to provide the expenditure data are included. The MHEC application does not cater for this so **it is requested that you email these cost centres** to Mental Health Information Unit to assist with any queries that may arise about the returns.

10.5 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 emailed.

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CHAPTER 11 ESTABLISHMENT FORM SECTION 5

Section 5 reports, by target population/program type 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 District.

11.1 COMPLETING THIS SECTION

Section 5 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 District and/or Mental Health Finance Officer in consultation with the Human Resource Manager and either the Executive Director, Manager or Team Leader (depending on the service) should complete this Section.

11.2 STAFFING & LABOUR EXPENDITURE

For definitions of target population types and program types refer to the section in this manual for Establishment Form Section 1.

Proforma HR Payroll reports have been developed in DSS Panorama to ensure consistency of reporting by Districts.

Login to DSS and follow these instructions:

1. In the Navigation Tree panel, click on the 'Public Reports' directory, then the 'Mental Health' sub-directory and then 'Mental Health Survey'. A new window opens with the following four reports listed in the Briefing Book panel and the first report will attempt to run with default Division parameters.
   a) S6 – Base Labour $ - Employees
   b) S6 – FTE & Labour $ - Employees
   c) S6 – FTE – Base – Other - Labour $
   d) S6 – Other Labour $ - Employee list
2. Double-click on a report to run it. It will open to the right using default Division parameters.
   Click on the Division slicer button and in the window that appears click on the relevant structures till you find your cost centre or cost centre group, click on it then click OK. This will now appear in the slicer button and the report will automatically re-run.
   Click on the Year slicer button, select the year for the Collection and click OK.
   Click on the Paypoint slicer button, select the relevant staff category and click OK.
   The other parameters should be correct.
3. Report c) provides a summary of FTE and related labour expenditure by specified Paypoint (Payroll category) then breaks that up into base labour and other labour.

4. Report b) provides a list by employee name with FTE and related labour expenditure specified by Paypoint (Payroll category). More detailed reports to provide data required for Section 5 are below.
5. Report a) provides a list by employee name with base labour data to complete the 'Payroll' column of Section 5. For some Paypoints, eg. Allied Health, you will need to drill down to employee names and this report allows for this.
6. Report d) provides a list by employee name with other labour related data to complete the 'Other' column of Section 5. For some Paypoints, eg. Allied Health, you will need to drill down to employee names and this report allows for this.

To print reports, go to the printer icon in the tool bar at the bottom of the screen.

The FTE numbers reported in Section 5 should include all workers employed in the provision of mental health services regardless of whether they are directly employed as staff or engaged on a contract basis. Except for the FTE details for consumer and carer consultants provided in MHSO Sections 3 and 4 which should NOT be included in this Section.

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

When staff provide services to more than one service setting (for example, medical staff who provide services within inpatient settings and attend a community mental health service), FTE staff numbers should be apportioned between the relevant settings on the basis of estimated average hours worked in each setting.

Do not include superannuation, payroll tax or fringe benefits tax in the expenditure total.

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.

11.3 EXPENDITURE CATEGORIES

Payroll and Contract Expenditure: Includes expenditure on departmental salaries/wages (including sick leave), on agency/contract wages and on intra-departmental medical services.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

500000-500090, 503500-503590, 517200-517280, 577480

Other Related Expenditure (excluding superannuation): Includes expenditure on higher duties, leave loading, overtime, allowances, annual leave, long service leave, other leave, redundancy payments, exgratia payments to staff, salary recoveries and intra-departmental pharmacy on-cost.

Based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

501000-503490, 503600-503690, 506000-507070, 517310-517470, 577496

11.4 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 Queensland Registration Board.

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 (eg Director of Nursing, Assistant Director of Nursing).

Enrolled Nurses: Refers to nurses who are enrolled with the State registration board. Includes general enrolled nurses and specialist enrolled nurses (eg mothercraft nurses).

Visiting Medical Officers – Consultant Psychiatrists: Refers to visiting medical officers who are registered to practice psychiatry under Queensland's Medical Registration Board. 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.

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.

Psychiatrists – Salaried Medical Officers: Refers to salaried medical officers who are registered to practice psychiatry under Queensland's Medical Registration Board.

Psychiatry Registrars & 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 who 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 the Queensland Registration Board.

Other Allied Health Officers: Refers to qualified staff (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 would be physiotherapists, pharmacists, speech pathologists, and dietitians.

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 & 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 & 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.

11.5 CHECKLIST

- ✓ Superannuation is not included.
- ✓ For a service setting, the Total expenditure is equal to the Labour Related Expenditure Sub-Total for the same service setting in Section 4.
- ✓ Where data is significantly different to previous financial year, explanation notes should be included in the validation reason box.

CHAPTER 12 FREQUENTLY ASKED QUESTIONS

10.1 REPORTING ESTABLISHMENTS

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

A. The reporting structure for the ASMHS 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, Corporate Office may not have been informed of recent local changes. Therefore, if you have concerns about the reporting establishments, please refer the matter to Corporate Office for review (see inside front cover for contact details).

10.2 SPECIAL CARE SUITES & DESIGNATED PSYCHIATRIC BEDS

Q. How do I report special care suites or 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 proportion 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 District passes these costs onto Mental Health, they still need to be reported for the survey.

10.3 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 provide 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.

10.4 CROSS DISTRICT SERVICES

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

A. The dollars and activity should go together. If the activity is being coded to District 1, then the dollars should be reported for District 1. Contact your Mental Health Information Manager/System Support Officer for more information on where cross District/MHSO activity is being coded.

10.5 INDIGENOUS HEALTH WORKERS

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

A. On advice from the Australian Government, Indigenous Health Workers who are not formally qualified as an allied health worker (eg. social work, psychology, occupational therapy etc.) should be coded to Other Personal Care Staff.

10.6 SOCIAL WORK ASSOCIATES

Q. What staffing category do I code Social Work Associates?

A. On advice from the Australian Government, Social Work Associates should be coded to Other Allied Health Officers.

10.7 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.

10.8 MY QUESTION IS NOT HERE!

Q. Who can I contact if my question is not listed here?

A. Contact details relating to various subject matter areas are listed inside the front cover of this manual.

CHAPTER 13 APPENDIX A

HEALTH SERVICE DISTRICT	MHSO ORGANISATION	ID #	MENTAL HEALTH REPORTING ESTABLISHMENT DURING 2008/2009
CAIRNS AND HINTERLAND (CAH)	**CAIRNS (CA)**	**0118**	
		00214	CAIRNS BASE HOSPITAL
		80040	CAIRNS ADULT COMMUNITY MHS
		80073	CAIRNS CHILD & YOUTH COMMUNITY MHS
		80076	INNISFAIL COMMUNITY MHS
		80104	TABLELANDS COMMUNITY MHS
CAPE YORK (CYK)	**CAPE YORK (CY)**	**0119**	
		80075	COOKTOWN COMMUNITY MHS
		80080	CAPE YORK COMMUNITY MHS
CENTRAL QUEENSLAND (CTQ)	**CENTRAL QUEENSLAND (CQ)**	**0113**	
		00141	ROCKHAMPTON HOSPITAL CAMPUS
		80586	ROCKHAMPTON ADULT COMMUNITY MHS
		80596	ROCKHAMPTON CHILD & YOUTH COMMUNITY MHS
		00692	ROCKHAMPTON EVENTIDE PSYCHOGERIATRIC UNIT
		80103	BILOELA COMMUNITY MHS
		80072	EMERALD COMMUNITY MHS
		80595	GLADSTONE COMMUNITY MHS
CENTRAL WEST (CTW)	**CENTRAL WEST (CW)**	**0114**	
		80070	LONGREACH COMMUNITY MHS
MATER PUBLIC HOSPITALS (MTR)	**MATER HOSPITAL (MA)**	**0109**	
		00002	MATER CHILDREN'S HOSPITAL CAMPUS
		80719	GREENSLOPES CHILD & YOUTH COMMUNITY MHS
		80720	INALA CHILD & YOUTH COMMUNITY MHS
		80744	YERONGA CHILD & YOUTH COMMUNITY MHS
CHILDREN'S HEALTH SERVICES (CHS)	**ROYAL CHILDREN'S HOSPITAL (RC)**	**0108**	
		00007	ROYAL CHILDREN'S HOSPITAL CAMPUS
		80101	PINE RIVERS CHILD & YOUTH COMMUNITY MHS
		80491	NUNDAH CHILD & YOUTH COMMUNITY MHS
		80509	ENOGGERA CHILD & YOUTH COMMUNITY MHS
		80512	SPRING HILL CHILD & YOUTH COMMUNITY MHS
		81005	NORTH WEST PUBLIC COMMUNITY HEALTH CENTRE
DARLING DOWNS-WEST MORETON (DWM)	**TOOWOOMBA (TW)**	**0106**	
		00104	TOOWOOMBA HOSPITAL CAMPUS
		00701	BAILLIE HENDERSON HOSPITAL CAMPUS
		80092	TOOWOOMBA PSYCHOGERIATRIC COMMUNITY MHS
		80804	TOOWOOMBA ADULT COMMUNITY MHS
		80829	TOOWOOMBA CHILD & YOUTH COMMUNITY MHS
		80097	WARWICK COMMUNITY MHS
		80216	INGLEWOOD COMMUNITY MHS
		80217	GOONDIWINDI COMMUNITY MHS
		80221	STANTHORPE COMMUNITY MHS
		80222	MILMERRAN ADULT COMMUNITY MHS
		80831	CHINCHILLA COMMUNITY MHS
		80832	DALBY COMMUNITY MHS
	WEST MORETON (WM)	**0107**	
		00015	IPSWICH HOSPITAL CAMPUS
		00751	THE PARK – CENTRE FOR MENTAL HEALTH
		80099	IPSWICH CHILD & YOUTH COMMUNITY MHS
		80254	GOODNA ADULT COMMUNITY MHS
		80255	IPSWICH ADULT COMMUNITY MHS
		80096	CHERBOURG COMMUNITY MHS
		80207	KINGAROY COMMUNITY MHS
GOLD COAST (GOL)	**GOLD COAST (GC)**	**0104**	
		00050	GOLD COAST HOSPITAL – SOUTHPORT CAMPUS
		80119	PALM BEACH ADULT COMMUNITY MHS
		80122	SOUTHPORT ADULT COMMUNITY MHS
		80126	BURLEIGH CHILD & YOUTH COMMUNITY MHS
		80127	SOUTHPORT CHILD & YOUTH COMMUNITY MHS
		81008	RIVERWALK COMMUNITY MHS
MACKAY (MAC)	**MACKAY (MK)**	**0121**	
		00172	MACKAY BASE HOSPITAL
		80087	BOWEN COMMUNITY MHS
		80372	MACKAY ADULT COMMUNITY MHS
		80373	MACKAY CHILD & YOUTH COMMUNITY MHS
		80955	WHITSUNDAY COMMUNITY MHS
		80987	MORANBAH COMMUNITY MHS

HEALTH SERVICE DISTRICT	MHSO ORGANISATION	ID #	MENTAL HEALTH REPORTING ESTABLISHMENT DURING 2008/2009
METRO NORTH (MNT)	**RBWH RB)**	**0112**	
		00201	ROYAL BRISBANE & WOMEN'S HOSPITAL CAMPUS
		80493	COMMUNITY FORENSIC MHS
		80498	INNER NORTH BRISBANE COMMUNITY
		10212	SOMERSET VILLAS COMMUNITY CARE UNIT
	REDCLIFFE-CABOOLTURE (RE)	**0111**	
		00016	REDCLIFFE HOSPITAL CAMPUS (COOINDA HOUSE)
		00030	CABOOLTURE HOSPITAL CAMPUS
		80259	REDCLIFFE CABOOLTURE ASSESSMENT & ACUTE CARE SERVICES
		80439	CABOOLTURE ADULT COMMUNITY MHS
		80443	REDCLIFFE ADULT COMMUNITY MHS
		80994	REDCLIFFE-CABOOLTURE CHILD & YOUTH COMMUNITY MHS
		80997	REDCLIFFE-CABOOLTURE ADULT COMMUNITY MHS
		10211	REDCLIFFE-CABOOLTURE COMMUNITY CARE UNIT
	THE PRINCE CHARLES HOSPITAL (PC)	**0110**	
		00004	PRINCE CHARLES (THE) HOSPITAL CAMPUS
		80521	CHERMSIDE ADULT COMMUNITY MHS
		80522	PINE RIVERS COMMUNITY MHS
		81002	NUNDAH COMMUNITY MHS
		00691	FLINDERS HOUSE PSYCHOGERIATRIC UNIT
		00601	JACANA ABI UNIT – EVENTIDE
		10210	PINE RIVERS COMMUNITY CARE UNIT
METRO SOUTH (MST)	**BAYSIDE (BY)**	**0101**	
		00028	REDLANDS HOSPITAL CAMPUS
		80090	BAYSIDE CHILD & YOUTH COMMUNITY MHS
		80091	REDLAND ADULT COMMUNITY MHS
		80998	BAYSIDE ADULT COMMUNITY MHS
		80751	WYNNUM ADULT COMMUNITY MHS
		00625	CASUARINA LODGE – WISTERIA ABI UNIT
		00610	DAINTREE PSYCHOGERIATRIC INPATIENT UNIT
	LOGAN-BEAUDESERT (LB)	**0102**	
		00029	LOGAN HOSPITAL CAMPUS
		80128	BEENLEIGH ADULT COMMUNITY MHS
		80737	LOGAN CENTRAL CHILD & YOUTH COMMUNITY MHS
		80739	LOGAN CENTRAL ADULT COMMUNITY MHS
		81010	BROWNS PLAINS COMMUNITY MHS
	PRINCESS ALEXANDRA HOSPITAL (PA)	**0103**	
		00011	PRINCESS ALEXANDRA HOSPITAL CAMPUS
		80756	WEST END ADULT COMMUNITY MHS
		80759	INALA ADULT COMMUNITY MHS
		81001	BURKE STREET COMMUNITY MHS
		81003	MOUNT GRAVATT ADULT MHS
MT ISA (MTI)	**MT ISA (MI)**	**0123**	
		80051	MORNINGTON ISLAND COMMUNITY MHS
		80084	DOOMADGEE COMMUNITY MHS
		80918	MT ISA COMMUNITY MHS
SOUTH WEST (STW)	**SOUTH WEST (SW)**	**0105**	
		80306	CHARLEVILLE COMMUNITY MHS
		80307	ROMA ADULT COMMUNITY MHS
		80308	ROMA CHILD & YOUTH COMMUNITY MHS
SUNSHINE COAST – WIDE BAY (SWB)	**FRASER COAST (FC)**	**0117**	
		00071	MARYBOROUGH HOSPITAL
		80989	FRASER COAST ADULT COMMUNITY MHS
		80990	FRASER COAST CHILD & YOUTH COMMUNITY MHS
	SUNSHINE COAST (SC)	**0124**	
		00049	NAMBOUR GENERAL HOSPITAL (Including HIBISCUS HOUSE PSYCHOGERIATRIC UNIT)
		80291	SUNSHINE COAST COMMUNITY INITIATIVE
		80435	MAROOCHYDORE ADULT COMMUNITY MHS
		80437	NAMBOUR ADULT COMMUNITY MHS
		80438	SUNSHINE COAST CHILD & YOUTH COMMUNITY MHS
		10213	MOUNTAIN CREEK COMMUNITY CARE UNIT
		80412	GYMPIE COMMUNITY MHS
	WIDE BAY (WB)	**0116**	
		00062	BUNDABERG BASE HOSPITAL
		80194	BUNDABERG ADULT COMMUNITY MHS

HEALTH SERVICE DISTRICT	MHSO ORGANISATION	ID #	MENTAL HEALTH REPORTING ESTABLISHMENT DURING 2008/2009
		80195	BUNDABERG CHILD & YOUTH COMMUNITY MHS
		80071	NORTH BURNETT COMMUNITY MHS
TOWNSVILLE (TVL)	**TOWNSVILLE (TV)**	**0122**	
		00200	THE TOWNSVILLE HOSPITAL CAMPUS
		00715	KIRWAN MH REHABILITATION UNIT
		80085	PALM ISLAND COMMUNITY MHS
		80939	TOWNSVILLE CHILD & YOUTH COMMUNITY MHS
		80995	TOWNSVILLE ADULT COMMUNITY MHS
		80996	TOWNSVILLE ADULT COMMUNITY FORENSIC MHS
		00703	CHARTERS TOWERS REHABILITATION UNIT
		80086	CHARTERS TOWERS COMMUNITY MHS
		00693	EVENTIDE NURSING HOME – PANDANUS PSYCHOGERIATRIC UNIT
		80088	AYR COMMUNITY MHS
TORRES STRAIT – NORTHERN PENINSULA (TST)	**TORRES STRAIT (TS)**	**0120**	
		80074	BAMAGA COMMUNITY MHS
		80078	THURSDAY ISLAND COMMUNITY MHS

Appendix A

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CHAPTER 14 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 Service: Refers to all mental health services dedicated to the assessment, treatment, rehabilitation, or care of non-admitted and community patients including, but not limited to, the following:

- Crisis assessment and treatment services
- Mobile assessment and treatment services
- Outpatient clinic services provided by either a hospital or community mental health centre
- Child and adolescent outpatient treatment teams
- Social and living skills programs including day programs
- Day hospitals and living skills centres
- Psychogeriatric assessment teams and day programs

Descriptions of ambulatory service types can be found in Chapter 6 of this manual.

Available Beds: An available bed is a bed that is immediately available for use by an admitted patient or resident if required. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period.

Beds which were temporarily unavailable because of renovations, strikes etc, but which would normally be available, should be included. In many cases the number of available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resource levels, and the latter referring to the maximum number of beds allowed for the establishment. When reporting the number of available beds located in a stand-alone hospital, include all available beds on the facility's campus, whether they are in wards or other types of accommodation. Do not include beds that are designated for intellectual disability or drug and alcohol services and report only those beds for which you have been funded.

Capital Expenditure is 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 District can assist in queries concerning asset recognition.

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.

Child & 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.

Consumer refers to both a primary consumer and to a carer.

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 district (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.

Forensic Psychiatry 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.

General Psychiatry Services: principally target the general adult population (aged 18-64 years) but may provide services to children, adolescents or the aged. General psychiatry services, therefore, 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 (eg, post-natal depression, anxiety disorders, 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.

Indirect expenditure: two general categories:

a) Expenditure indirectly related to District mental health services that cannot be apportioned across the reporting Establishments in your health district (and so has not been reported on Establishment Form Section 4). This includes:

- Expenditure on corporate services and other support services that is not directly related to the provision of mental health services by establishments. These services are usually provided from a central resource pool and managed at the health district level. Eg. District administration, human resources, finance, records, information technology, building/grounds maintenance, security, utilities.

- Expenditure on salary on-costs (such as superannuation and workers compensation payments) and on insurance payments that are not directly related to the provision of mental health services by Establishments.

b) Expenditure on mental health that may not relate to direct service delivery, such as research, education and training and mental health promotional activities. Also report funds provided by the health district directly to external groups (ie. not via the health district's mental health establishments) from allocations made by Corporate Office. An example would be grants by the health district to academic departments of psychiatry from funds allocated by Corporate Office. However, where such expenditure is considered to be part of service delivery (eg. education and training of staff operating out of an establishment), this should be reported against the establishment on Establishment Form Section 4.

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: refers to both primary consumers and to carers. A primary consumer is the person with the mental illness or psychiatric disability. 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.

Non-Acute Inpatient Services:
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.

Older Persons' Psychiatry 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: is the person with the mental illness or psychiatric disability.

Residential Care Services: Currently no Mental Health Residential Units are reported by Queensland Health.

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.

Staffing categories descriptions used in Establishment Form Section 5 can be found in that section.