

**Mental Health
Establishments Collection
(MHEC)**

**Instructions and
Procedures**

1 July 2011 - 30 June 2012

Further information

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<http://meteor.aihw.gov.au/content/index.phtml/itemId/424725>

Changes since the 2010/11 collection

Establishment changes:

- Darling Downs and West Moreton district has been split into two separate districts. Kingaroy and Cherbourg establishments have been moved from West Moreton MHSO to Toowoomba MHSO.

Changes to information collected:

- For this collection, community care units are to be reported as residential mental health care units. Previously, community care units selected the service type 'non-acute' but will now choose 'residential' as the type of service delivered. There are a number of new data elements to be reported by residential mental health care units:
 - **Specialised mental health service – hours staffed**
The average number of hours per day during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training. Round to the nearest whole hour. Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit.
 - **Episode of residential care – number of episodes of residential care, total**
The sum of the number of episodes of residential care where the residential stay has formally ended during the reference period (not statistically separated, or transferred to another facility, with the patient returning) plus any patients remaining in at end. Remaining in at end means either overnight or longer stay patients actually in the facility or on leave at 11.59pm on the last day of the reference month. Count the number of overnight or longer stay patients as at this.

Other changes:

- The definition of 'available beds' and 'FTE' have been updated to reflect the current definition on the Australian Institute of Health and Welfare's Metadata Online Registry (METeOR).
- Instructions for using the discipline slicer in the DSS Mental Health Survey report have been added to the establishments form section 5 in this manual.
- Users with MHS Executive or district CEO roles in MHECA will receive an email with a summary report of MHSO data once it has been submitted for approval. This enables these users to review the data outside the system rather than navigating through the different sections in the system.

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Purpose of the manual

This manual provides instructions and procedures for undertaking the Mental Health Establishments Collection (MHEC) formerly known as the Annual Survey of Mental Health Services. It is intended as a reference for all health service district personnel and Queensland Health corporate office personnel directly involved in the collection, processing and use of this data.

Background

The Fourth National Mental Health Plan (the Fourth Plan) was agreed by Australia's Health Ministers in September 2009. The Fourth Plan follows on from the work of the previous three national mental health plans in collaboratively shaping mental health sector reform by identifying priority reform areas and committing governments to a set of agreed actions.

Central to the Fourth Plan is a commitment by governments to improve accountability and transparency within the mental health sector through a multi-level approach—at the policy level of governments and central mental health administrations; and at the service delivery level. Over the past two decades mental health information, including national mental health data collections, has provided the foundation for system accountability and reporting. A key action under the Fourth Plan is to further develop information through continuous and collaborative effort between governments, including keeping data sources up to date, as well as filling gaps in the current national collections.

Over the course of the Fourth Plan, further development will be undertaken with the aim of addressing gaps in relation to: measures of consumers' experiences of services, recovery based outcome measures, and collections that cover the growing specialised mental health non-government sector.

National Minimum Data Sets (NMDS) for mental health have been developed for both admitted patient mental health care, community mental health care and residential mental health care at the client and establishment reporting levels. For the 2005-2006 years the Mental Health Establishments (MHE) NMDS replaced the previous Community Mental Health Establishments (CMHE) NMDS and National Survey of Mental Health Services (NSMHS).

Use of MHEC data

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

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

The clinical outcomes collection complements the MHEC information and supports more informed analysis of service delivery in Queensland.

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

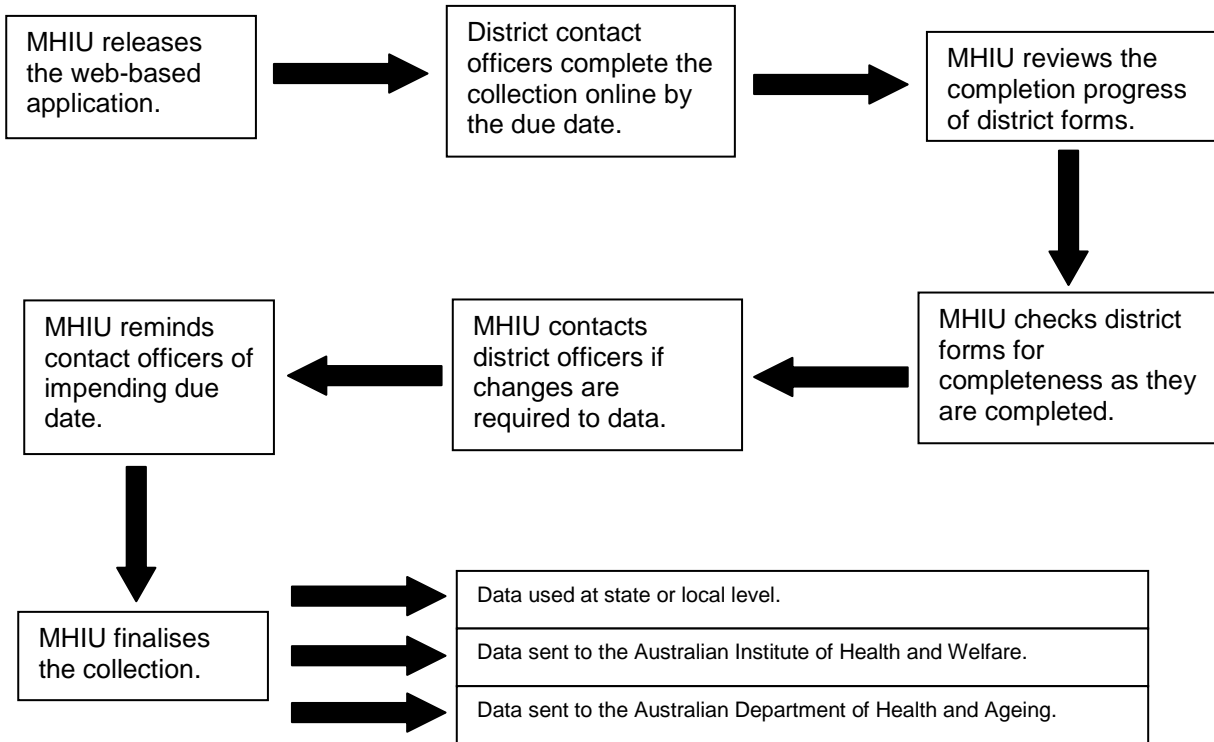
Mandatory requirement

Queensland Health collects MHE information as part of a mandatory requirement in the National Health Information Agreement. The following information is provided to the Australian Institute of Health and Welfare and the Australian Department of Health and Ageing:

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

Procedures

This chapter describes the process for completing the MHEC. The process is summarised in the flow chart below. The Mental Health Information Unit (MHIU) developed a web-based application to support collection of the MHE information, known as the Mental Health Establishments Collection Application (MHECA).



Completing the collection

MHE information is collected and reported at the following levels:

- Establishment – also known as ‘reporting establishment’ and commonly referred to as teams or treating units, this is the lowest level of detail reported.
- MHSO – usually includes a number of different service types (inpatient and community for example) and facilities. There may be several MHSO included in the same district.
- State – the highest level of reporting, only completed by MHIU staff.

Entry of the MHE information occurs through completion of three separate forms which reflect the reporting levels stated above: state, MHSO and establishment forms. The MHSO forms (sections 1 to 8) are to be completed by a representative at the MHSO level, with aggregate data from different establishments included in the MHSO. 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 identifiers.

For districts with only one MHSO and multiple reporting establishments, an MHSO form will be completed, as well as an establishment form for each reporting establishment within the MHSO. For districts with multiple MHSOs, an MHSO form will be completed for each MHSO as well as an establishment form for each reporting establishment within the district.

There are a number of escalation protocols in place to ensure the collection occurs in a timely manner. The MHIU will inform contact officers of the escalation protocols upon commencement of the collection each year.

These are the establishment details for South West MHSO:

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

In this instance, South West would complete and submit:

1. The MHSO form for 'South West' MHSO
2. The establishment form for 'Charleville CMHS'
3. The establishment form for 'Roma Adult CMHS'
4. The establishment form for 'Roma Child and Youth CMHS'

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

System manual

Detailed instructions on how to use MHECA to complete the collection can be found in the [MHECA system user manual](#).

MHSO form section 1

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

Completing this section

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

Services provided

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

The program types listed below describe the possible service settings included in an MHSO.

Inpatient

An admitted patient mental health care service is a specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. It includes both acute and non-acute inpatient services and in Queensland Health this currently includes special care suites. These establishments are devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness.

Residential care

Community care units are reported as residential care. A residential mental health service is a service that is considered by the state, territory or commonwealth funding authorities as a service that:

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

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

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

Ambulatory care

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

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

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

General psychiatry

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

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

Child and adolescent psychiatry

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

Young persons psychiatry

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

Older persons psychiatry

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

Forensic psychiatry

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

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

In Queensland, high 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.

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.

Completing these sections

These sections should be completed in consultation with the mental health service executive director, manager or team leader (depending on the service).

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 consumers in the planning and evaluation of services.

A 'formal position' means the consumer representative is a voting member of the committee.

Section 3 arrangements to promote participation by 'primary consumers'

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

A 'primary consumer' is the person with the mental illness or psychiatric disability. If required, a description of other arrangement(s) should be included in the box provided.

For the first statement, if yes is selected please provide details in FTE terms and total salary/payment (excluding superannuation), for the consumer workers 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 consumer worker was employed (or engaged via contract) on a part-time or full-time paid basis and for the expertise developed from their lived experience of mental illness. It does not refer to arrangements where the consumer worker 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.

Mental health consumer workers include the job titles of, but are not limited to: consumer consultants, peer support workers, peer specialists, consumer companions, consumer representatives, consumer project officers, and recovery support workers.

Roles that mental health consumer workers may perform include, but are not limited to: participation in mental health service planning, mental health policy development, mental health service evaluation, training and education of professionals and consumers, mentoring duties, advocacy roles, liaison activities, and peer support roles.

Section 4 arrangements to promote participation by 'carers'

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

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

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 carer worker was employed (or engaged via contract) on a part-time or full-time paid basis and for the expertise developed as a mental health carer. It does not refer to arrangements where the carer worker 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.

Mental health carer workers include the job titles of, but are not limited to: carer consultants, peer support workers, carer support workers, carer representatives, and carer advocates.

Roles that mental health carer workers may perform include, but are not limited to: participation in mental health service planning, mental health policy development, mental health service evaluation, training and education of professionals and carers, mentoring duties, advocacy roles, liaison activities, and carer support roles.

MHSO form section 5

This section relates to gross, non-capital expenditure by the MHSO 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.

Completing this section

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

The information for section 5 can be obtained from a number of sources. Your district finance officer can run a DSS expenditure report for your district or 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.

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 establishment form). 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, for example 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 (that is, not via the MHSOs establishments). An example would be payments to academic departments of psychiatry. However, where such expenditure is considered to be part of service delivery (for example education and training of staff operating out of an establishment), this should be reported against the establishment on establishment form section 4. Excluded from this category are grants made to non-government organisations (NGOs) for the provision of services to people affected by a mental health illness. These are reported in MHSO form section 7.

It is preferable that MHSOs report as much indirect expenditure as possible in establishment form section 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 (e.g. 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.

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, and utilities. These services are generally provided from a central pool of resources managed at the corporate level for all programs/business units of the 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 (for example 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 which are not yet operational and providing activity data.

Superannuation

Refers to indirect superannuation employer contributions paid, or that should be paid, on behalf of employees either by 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 section 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 section 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 section 4.

Property leasing costs

Refers to the costs of leasing premises used for the provision of mental health services (for example community clinics). Only report leasing expenditure in 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 section 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 is not to be included here. This should either be apportioned across the existing buildings or not reported at all.

Distribution of expenditure

Where no expenditure is reported against a particular indirect expenditure category, select the appropriate response for that category. For example, if there is no expenditure to report here because it has already been distributed across the establishments (i.e. included in establishment form section 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.

MHSO form section 6

This section relates to the funding sources for expenditure reported in MHSO form section 5 and all establishment form section 4.

Completing this section

Section 6 should be completed by the district and/or mental health finance officer in consultation with the mental health executive director, manager or team leader (depending on the service).

Sources of funding for expenditure

Please identify the funding sources for expenditure reported in MHSO form section 5 and all establishment form section 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 section 4. Do not report total budget allocations in this section. Only report the portion that was expended.

Queensland Health funding

Refers to State Government funding provided by Queensland Health for the delivery and/or administration of mental health services in your 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.

Department of Veterans' Affairs funding

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

Other Australian Government funding

Refers to revenue paid directly by the Commonwealth. 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.

MHSO form section 7

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

Completing this section

Section 7 should be by the district and/or mental health finance officer in consultation with the mental health executive director, manager or team leader (depending on the service).

Funding to non-government organisations

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

Do not report this grant expenditure on either MHSO form section 5 or establishment form section 4.

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.

MHSO form section 8

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

Completing this section

Section 8 should be completed by the district and/or mental health finance officer in consultation with the mental health executive director, manager or team leader (depending on the service).

Supported public housing places

A number of health service districts make formal local partnership agreements with the Department of Community Housing and Homelessness Services regional offices to provide public housing 'places' for people affected by mental illness or psychiatric disability. Such agreements commit Queensland Health to provide ongoing clinical and disability support 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.

Note – the Department of Communities Housing and Homelessness Services provides statewide data on housing places provided to mentally ill clients who are supported with Queensland Health outreach services. MHIU will cross check that housing places reported are not duplicated by both the Department of Communities and Queensland Health data.

Establishment form sections 1, 2, 3

Section 1: relates to mental health services provided.

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

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

Completing these sections

These sections 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.

This statement should be completed in conjunction with the mental health executive director, manager or team leader (depending on the service).

Section 1 services provided

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

Inpatient – acute

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

Inpatient non-acute

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

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

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

Residential care

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

- has the workforce capacity to provide specialised mental health services; and
- employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:
 - to consumers residing on an overnight basis;
 - in a domestic-like environment; and

- encourages the consumer to take responsibility for their daily living activities.

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

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

Ambulatory care

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

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

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

General psychiatry

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

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

General psychiatry - medium secure

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

Child and adolescent psychiatry

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

the appointment of staff to specifically work with children and adolescents within a broader mental health team.

Young persons psychiatry

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

Older persons psychiatry

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

Forensic psychiatry

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

Section 2 implementation of the National Standards for Mental Health Services

The National Standards for Mental Health Services are endorsed and supported by the National Mental Health Plan and the National Mental Health Policy. The Standards can be used as a guide to service enhancement, continuous quality improvement and to inform consumers and carers. The Standards require all mental health services to work towards accreditation and report on their progress. The Standards form part of the National Accreditation Program for the accreditation of health services.

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

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

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

National Accreditation Mental Health Services Codes

Code	Progress
1	By 30 June, the service had been reviewed 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.

Section 3 inpatient and residential 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 Aged Care Information Management System 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

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

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

Separations

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

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

All three types of separations are to be counted.

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

The number of accrued patient days refers to those days or part days accrued by admitted patients during the reporting period – regardless of a patients' admission and separation dates. Accrued patient days should never exceed bed numbers multiplied by 366 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 2011/12 year are:

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

A patient was admitted on 20 June 2012 and separated on 5 August 2012. If no leave or transfers occurred, counting ends on 30 June 2012 (i.e. end of financial year), so the number of accrued patient days would be 11. Note that the patient's status on 30 June 2012 is that they remain in hospital, so this is an accrued patient day.

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

A patient was admitted on 10 January 2011 and remained in hospital until after 30 June 2012. If no leave or transfers occurred, counting starts on 1 July 2011 and ends on 30 June 2012 so the number of accrued patient days would be 366 (2012 is a leap year). Note that the patient's status on 30 June 2012 is that they remain in hospital, so this is an accrued patient day.

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

The sum of the number of episodes of residential care where the residential stay has formally ended during the reference period (not statistically separated, or transferred to another facility, with the patient returning) plus any patients remaining in at end. Remaining in at end means either overnight

or longer stay patients actually in the facility or on leave at 11.59pm on the last day of the reference month. Count the number of overnight or longer stay patients as at this.

Average hours staffed

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

Establishment form section 4

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

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

Completing this section

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

The 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.

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

See establishment form section 1 for definitions of target population types and program types.

All expenditure that relates to the delivery of services by each establishment should be included in section 4. That is, relevant expenditure that may be included in non-mental health cost centres should be reported. For example, food or drug supplies costed at the health 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 '201X',
2. Enter Period '16'
3. In the Cost centre 'value(s)' field, enter the cost centre/s or hierarchy/s that relate to your respective establishment/s (for separate reports use one cost centre at a time)
4. In the 'Cost element group' field enter 'QH_MHS'
5. Click on the Execute button or press F8 to generate the report.
6. Click on the Expand buttons to the left of the report to show individual account codes. To expand all account code rows go to the Menu item View then Row Hierarchy then Expand all.
7. To print the report, click on the printer icon. In the Print Area window, click on the green tick. In the Print Parameters window, select the printer, click on Print Immediately and then on the Continue button at the bottom.

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

Within the account hierarchy of 'QH_MHS' there is an account grouping called 'Not Assigned'. The account 'intra 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 comply with the 'Total' expenditure cell for the corresponding service setting in section 5.

Figure 2:

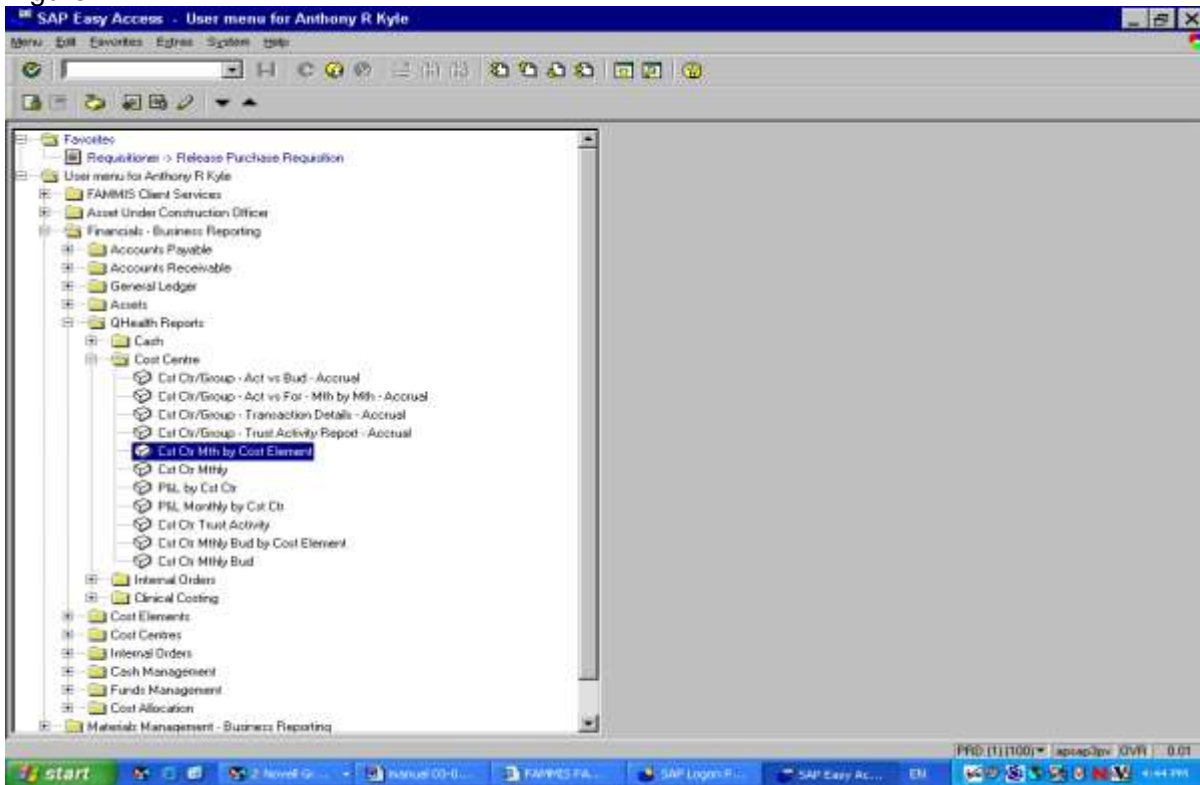
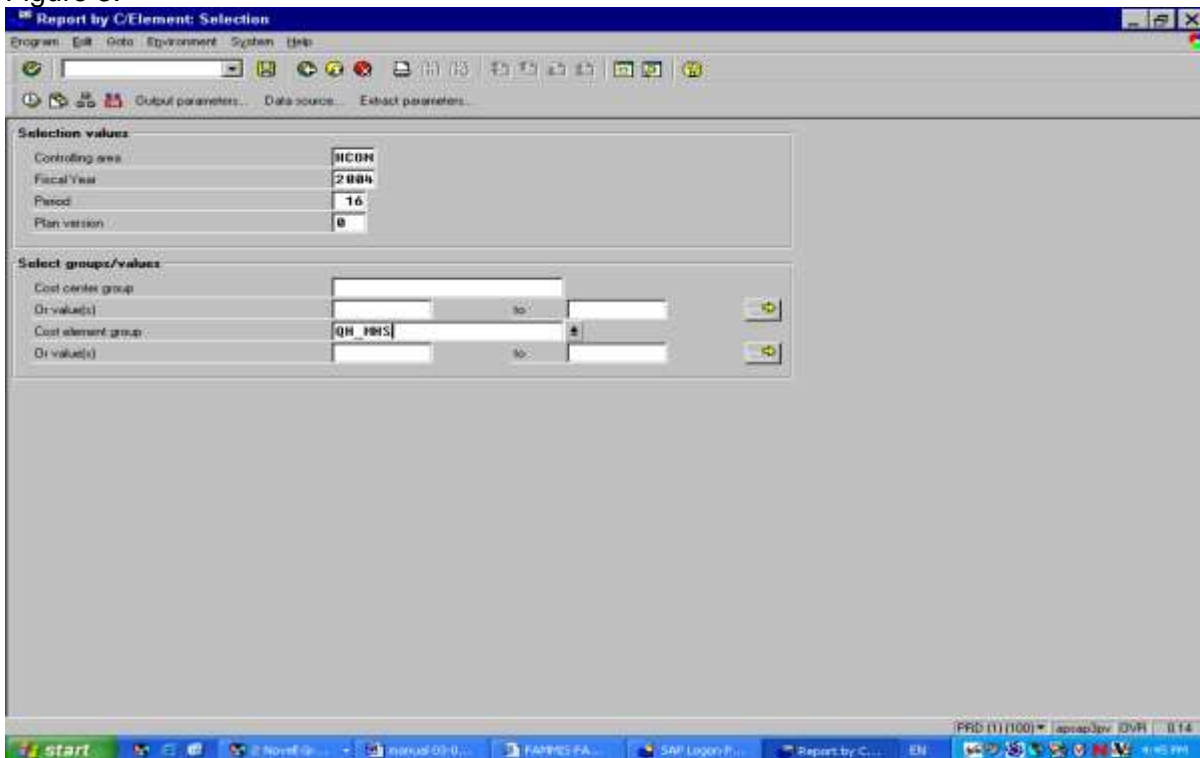


Figure 3:



Expenditure categories

Payroll and related expenditure

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

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

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

Contract and related expenditure (agency/contract staff)

Includes agency/contract staff payments (including overtime and allowances) where the contract is for the supply of labour rather than of products (e.g. photocopy maintenance and domestic cleaning staff).

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

517200-517475

Ex-gratia payments to staff

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

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

506100-506190

Superannuation

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

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

504000-504890

Other labour related expenditure

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

500095, 505000-505190, 577496, 577480

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.

- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Food supplies

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

540000-540090, 563000, 566170-566180, 577475

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Drug supplies

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

550000-559900, 563010, 566130-566140

Clinical supplies and services

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

560000-562015, 563020, 577410, 577492

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Non-clinical supplies and services

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

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

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

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Repairs and maintenance

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

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

536000-536515, 577485, 577495, 577498-577499

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Patient transport services

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

511210.

Insurance

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

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

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

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Depreciation

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

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

590010-590145, 590170

Interest payments

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

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

577000-577025

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.

- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Other expenditure

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

536801-538001, 563030, 563050-563070, 567000-567040, 577470, 590150-590160, 590210, 591298

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

- No transactions (invoice, vendor payment etc) with non-Queensland Health entities should be coded to them.
- The combined balance of such accounts should be zero for the department. Therefore, 577xxx should be used on both DR and CR side of an accounting entry.
- On the same note, if charged districts have a second opinion about a charge, please liaise with charging districts. Do not transfer the amount to a non-577 account.
- No accrual is allowed for these accounts because, as aforementioned, accrued expense is not a 577 account and such accruals will overstate the department's expenditure.

Cost centre code

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

Checklist

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

Establishment form section 5

Section 5 reports (by 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.

Completing this section

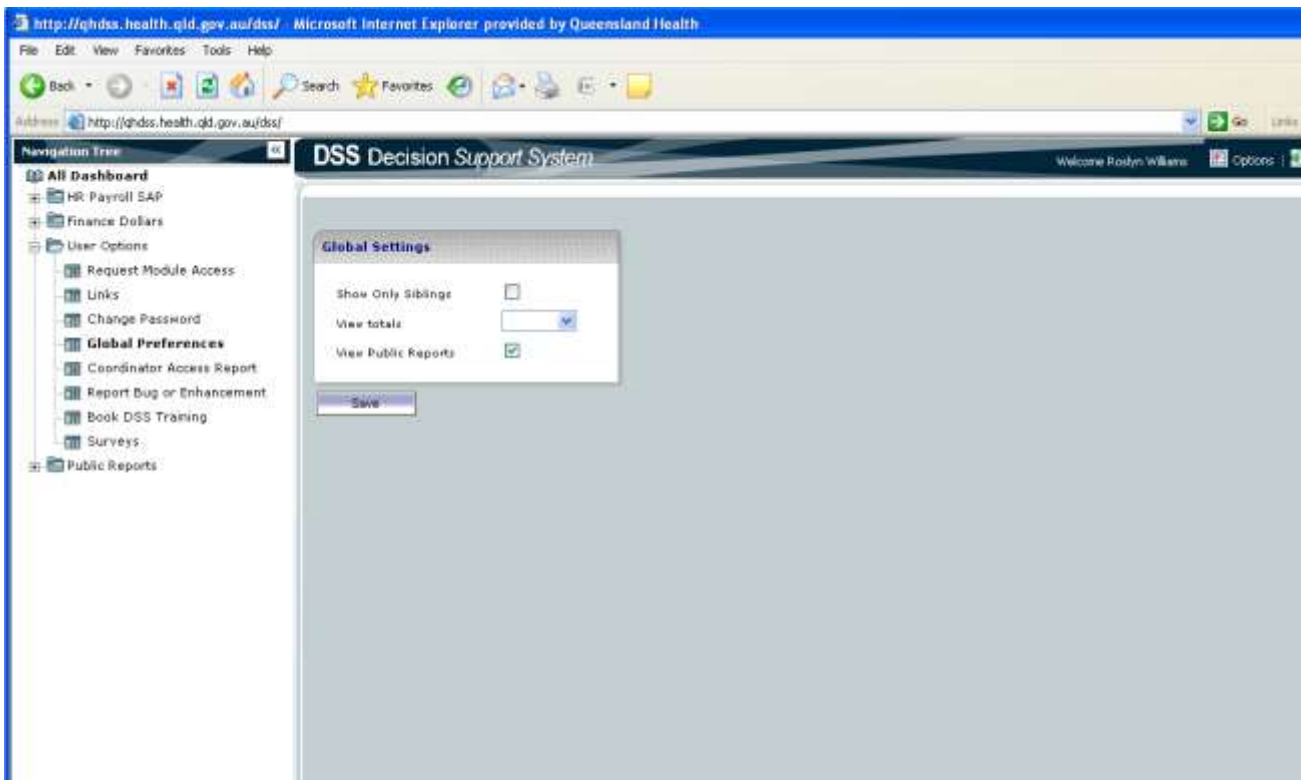
Section 5 should be completed for each establishment within the MHSO. Please refer to Appendix A for a list of MHSOs, establishments and the corresponding establishment ID.

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.

Accessing Public Reports in DSS

To gain access to the 'public reports' folder in DSS:

1. Log into DSS
2. Expand 'User Options'
3. Select 'Global Preferences'
4. Select the tick box next to 'View Public Reports'
5. Select Save
6. Log out, wait approximately 10 minutes, and then log back in. Public reports should be visible in the navigation tree. Call DSS if you encounter any issues.



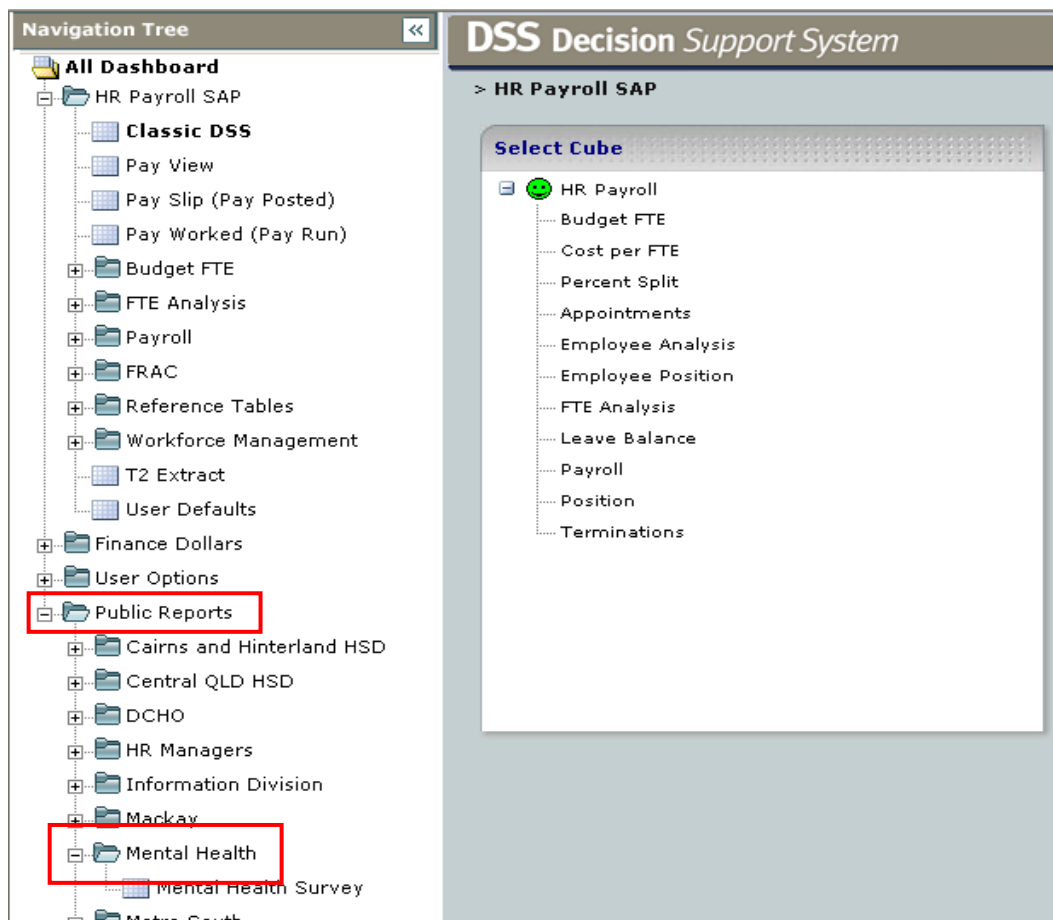
Staffing and labour expenditure

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 will open and the first report will attempt to run with default Division parameters.



2. 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 (note: Multiple selections can be made by pressing and holding the Ctrl button while clicking multiple cost structures).

- Click on the Year slicer, select the year for the Collection and click OK. The other parameters should be correct and generally should not be adjusted.

The screenshot shows a software interface with a 'Slicers' pane at the top. Two slicers are visible: 'Qld Health District' and '2010', both highlighted with red boxes. To the right, a third slicer 'Employ Type Hierarchy' is partially visible. Below the slicers is a window titled 'Division QH_ALT_7' containing a tree view of organizational units. The tree view is expanded to show the following structure:

- Qld Health District
 - Cairns And Hinterland
 - Cairns And Hinterland Hsd
 - Cairns & Hinterland Dhs
 - Allied Health Services
 - Archived Costcentres
 - Chief Finance Officer
 - Chief Operating Officer
 - Allied Health - Cairns Base Hospital
 - Cairns Community & Primary Prev Ser
 - Hacc - Tablelands
 - Comm-Hlt-Hacc Allied Heal
 - Comm-Hlt-Hacc Continen
 - Comm-Hlt-Hacc Herb-Resp
 - Comm-Hlt-Hacc-Home Care
 - Comm-Hlt-Tlands Hacc Ass
 - Moss-Dsmphs Hacc
 - Moss-Hacc Indigenous Serv

At the bottom of the tree view window are three buttons: 'Search...', 'OK', and 'Cancel'. To the right of the tree view, a portion of a table is visible, showing numerical values and labels like 'Amount' and 'Bas'.

Amount	Bas
3,685,744,894.41	
821,537.7	
447,770,981.1	rical
707,239,980.2	
1,540,428,661.0	Nursing

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

Effective Date: Current Date:26/07/2011 1:47:42 PM	Base		Overhead		Base and Overhead	
	Amount	QH FTE	Amount	QH FTE	Amount	QH FTE
All Paypoints	3,885,744,894.16	50,947.35	967,828,003.37	1,361.60	4,653,572,897.83	52,308.95
General	821,537.77	11.92	84,138.37	0.06	906,276.14	11.98
Managerial and Clerical	447,770,981.18	7,502.42	27,413,225.69	39.75	475,184,856.87	7,542.17
Medical incl VMOs	707,239,980.20	5,587.29	487,571,870.43	742.06	1,194,811,950.63	6,329.35
Nursing	1,540,428,661.05	22,479.64	310,559,873.18	344.37	1,850,988,034.23	22,824.01
Operational	393,121,043.82	8,685.46	72,077,895.70	110.79	465,198,639.52	8,796.25
Trade and Artisans	21,883,271.70	399.05	4,073,687.31	17.14	25,956,959.01	416.19
Professional and Technical	574,479,418.74	6,281.58	66,046,812.69	107.42	640,526,231.43	6,389.00

Child & adolescent psychiatry
 Child & adolescent psychiatry

Establishment Form - Section 5 - Staffing and Labour Expenditure

Ambulatory

Staffing Category	Total Avg FTE	Payroll	Other	Total
Registered Nurses	4.4400	\$214,786	\$92,051	\$306,837
Enrolled Nurses	0	\$0	\$0	\$0
Total Nurses	4.4400	\$214,786	\$92,051	\$306,837
VMO - Consultant Psychiatrists	0	\$0	\$0	\$0
VMO - Other Medical Officers	0	\$0	\$0	\$0
Psychiatrists (salaried medical officers)	3.6700	\$719,149	\$308,207	\$1,027,356
Psychiatrists registrars and trainees	1.0000	\$53,479	\$35,652	\$89,131
Other salaried medical officers	0	\$0	\$0	\$0
Total Medical Officers	4.6700	\$772,628	\$343,859	\$1,116,487
Occupational therapists	0.7600	\$41,932	\$17,971	\$59,903

Effective Date: Current Date: 25/07/2011 1:47:42 PM	Base		Overhead		Base and Overhead	
	Amount	QH FTE	Amount	QH FTE	Amount	QH FTE
All Paypoints	3,685,744,894.46	50,947.35	967,828,003.37	1,361.60	4,653,572,897.83	52,308.95
General	821,537.77	11.92	84,738.37	0.06	906,276.14	11.98
Managerial and Clerical	447,770,981.18	7,502.42	27,413,825.69	39.75	475,184,806.87	7,542.17
Medical Incl VMOs	707,239,980.20	5,587.29	487,571,970.43	742.06	1,194,811,950.63	6,329.35
Nursing	1,540,428,661.05	22,479.64	310,559,373.18	344.37	1,850,988,034.23	22,824.01
Nursing	1,540,428,661.05	22,479.64	310,559,373.18	344.37	1,850,988,034.23	22,824.01
Assistant in Nursing - Grade 1	4,825,889.09	1,803.89	21,352,430.23	25.58	95,878,319.32	1,829.47
Student Nurses/ Midwives - Grade 2	1,896,866.07	39.85	557,612.47	0.61	2,454,478.54	40.46
Enrolled Nurses - Grade 3	118,801,420.71	2,412.15	30,673,203.98	45.22	149,474,624.69	2,457.38
Enrolled Nurse Advanced Practice - Grade 4	18,555,461.51	348.42	4,626,940.36	8.10	23,182,401.87	356.52
Registered Nurses / Midwife - Grade 5	639,548,121.78	8,865.38	160,843,543.27	153.89	800,391,665.05	10,019.07
Clinical Nurse / Midwife - Grade 6	372,287,339.94	5,074.51	69,504,160.10	75.20	441,791,500.04	5,149.71
Clinical Nurse Consultant, Manager, Educator - Grade 7	205,853,878.69	2,267.20	18,793,124.48	30.22	224,647,003.17	2,297.43
Nurse Practitioner - Grade 8	5,167,800.05	52.00	576,071.27	0.90	5,743,871.32	53.70
Nurse Director, Assistant Director of Nursing - Grade 9	24,017,958.30	214.38	677,265.90	0.13	24,695,224.20	214.52
Director of Nursing - Grade 10	17,552,373.43	166.66	1,039,667.39	1.10	18,592,040.82	167.76
District Director of Nursing - Grade 11	2,028,335.95	15.70	150,534.45	0.00	2,178,870.40	15.70
Executive Director of Nursing - Grade 12	1,130,224.00	6.82	83,343.16		1,213,567.16	6.82
Trainee Assistant in Nursing	91,974.55	3.01	1,075.62		93,050.17	3.01
Nursing - Undefined	60,402.96	0.60	4,047.04		64,450.00	0.60
Nursing - External	59,010,716.02	408.27	1,576,353.46	3.62	60,587,069.48	411.89
Operational	393,121,043.82	8,695.46	72,077,595.70	110.79	465,198,639.52	8,796.25

- Those MHEC staffing categories which require more detail than is provided in the default view of the DSS report (i.e. 'Nursing') you are able to expand the paypoint category by clicking the + sign next to the paypoint.
- For those MHEC staffing categories which still require more detail than the paypoint level (i.e. Health Practitioners), you have the ability to drill down (drillthrough) to the base employee list to allow you to categorise staff.
- Right click on the cell you are looking to retrieve more detailed data for and click on the drillthrough option presented

Operational	484,164.61	9.92	41,294.63	0.03	525,459.24	9.35
Professional and Technical	6,955,934.66	82.69	571,501.37	0.15	7,477,436.05	82.83

Drill down

Drill up

Drillthrough...

Exceptions ▶

- You will be prompted by DSS to select a Drillthrough to Execute; choose the Employee Details option and press OK.

Select Drillthrough To Execute [X]

Drill To Base Data

Employee by FTE by Type

Employee Details

Where:

Order By:

OK Cancel

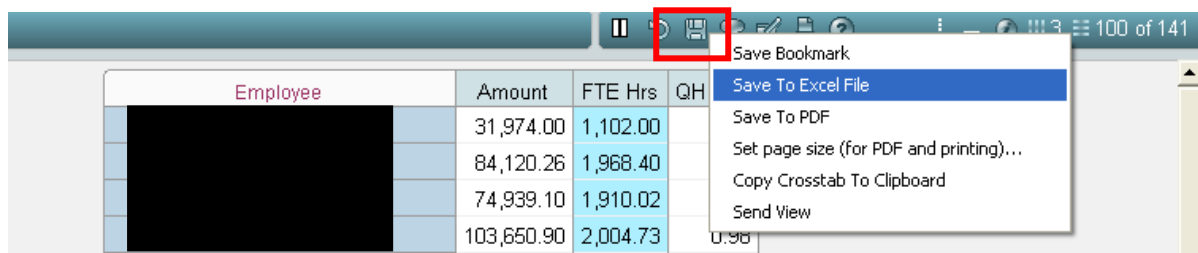
- DSS will open the drilled through report detailing QH FTE and Amount columns (by employee) for the Base, Overhead or Base and Overhead categories.

The cell that was drilled through on (i.e. Professional and Technical, Base and Overhead) will 'hold' on the drilled through report

Effective Date: Current Date: 26/07/2011 3:01:37 PM	Base		Overhead		Base and Overhead	
	Amount	QH FTE	Amount	QH FTE	Amount	QH FTE
All Paypoints	33,903,865.61	420.74	8,295,103.85	8.43	42,198,969.46	429.17
General	7,492.77	0.07	-189.47		7,303.30	0.07
Managerial and Clerical	2,777,886.41	45.44	132,255.20	0.06	2,910,141.61	45.50
Medical incl VMOs	8,114,470.81	64.61	4,409,872.83	4.81	12,524,343.64	69.41
Nursing	15,563,916.33	218.62	3,190,369.29	3.38	18,754,285.62	222.00
Operational	484,164.61	9.32	41,294.63	0.03	525,459.24	9.35
Professional and Technical	6,955,934.68	82.69	521,501.37	0.15	7,477,436.05	82.83

- To work out the Total Avg FTE for Social Workers and Occupational Therapists you would right click on the Base and Overhead Amount or QH FTE Cells for the Professional and Technical paypoint. To work out the Payroll amount for the same paystream you would click on the 'Base' Amount Cell for Professional and Technical staff.

You can export any of the drilled through reports into excel for manipulation by clicking the floppy disk icon on the top right corner.



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

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.

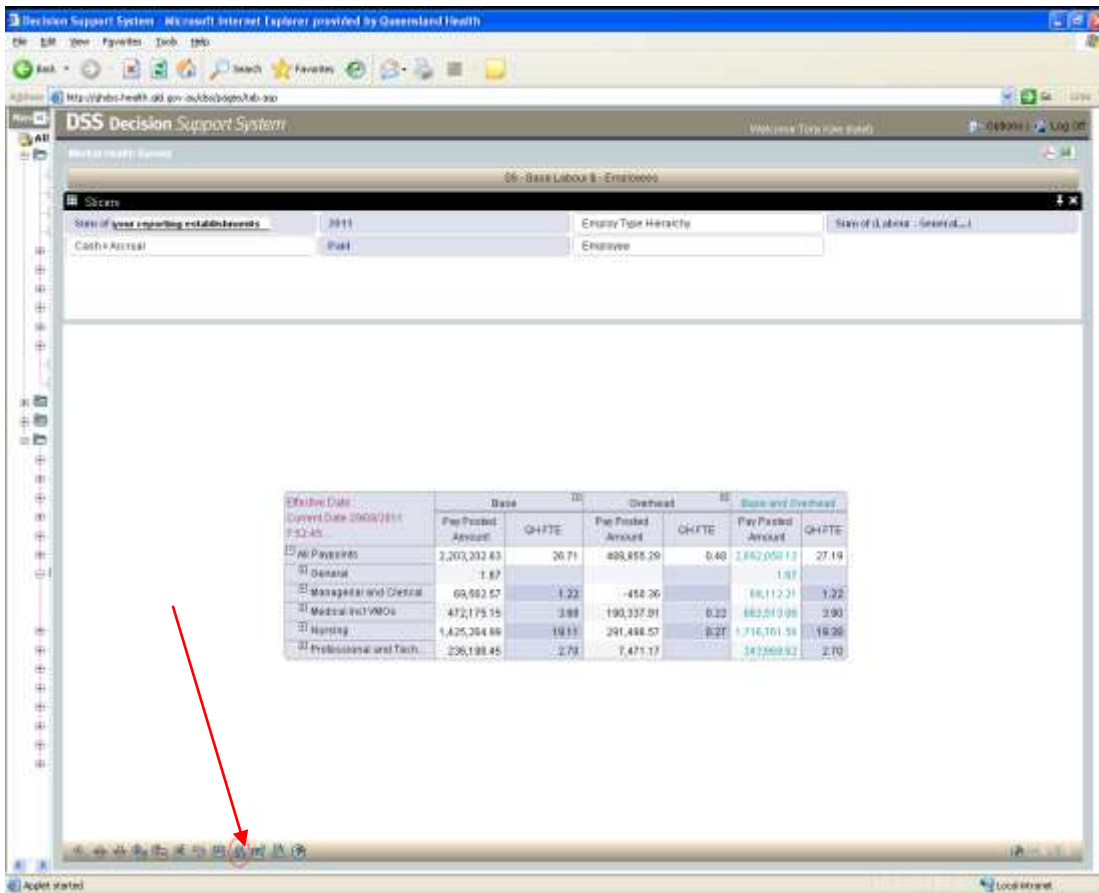
Do not include superannuation, payroll tax or fringe benefits tax in the expenditure total.

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.

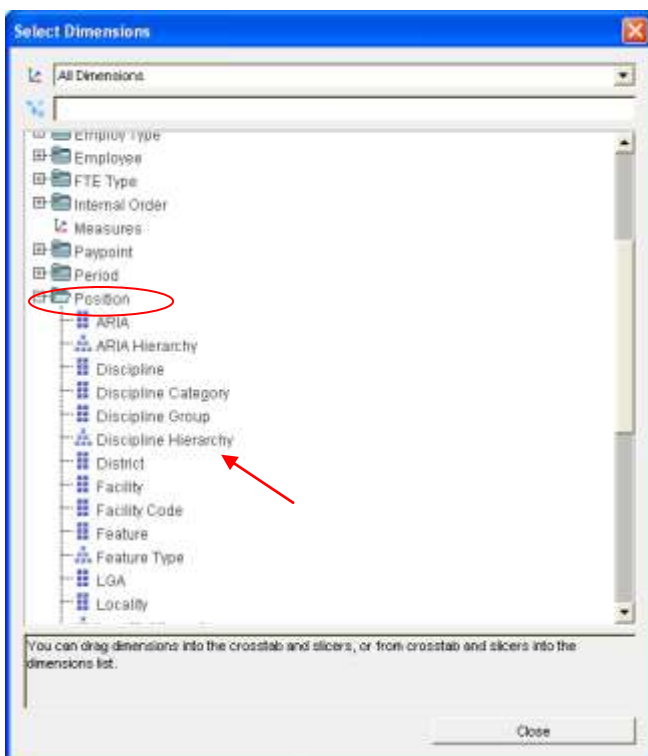
Discipline slicer in the DSS Mental Health Survey report

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

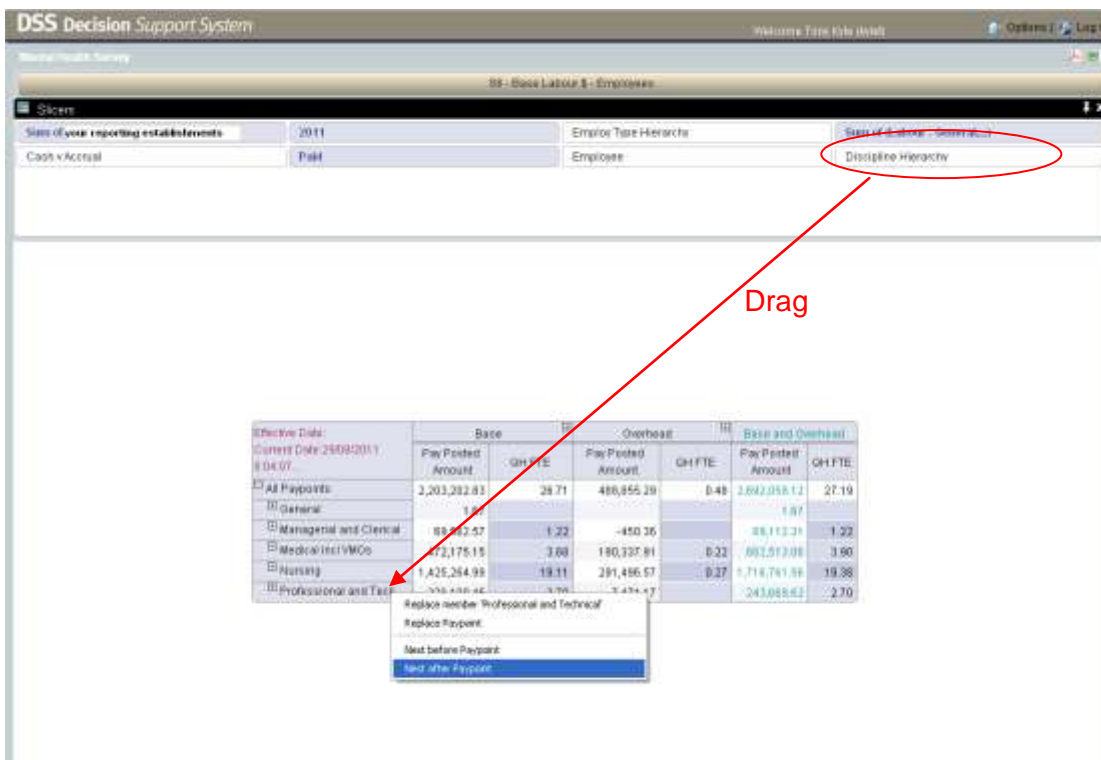
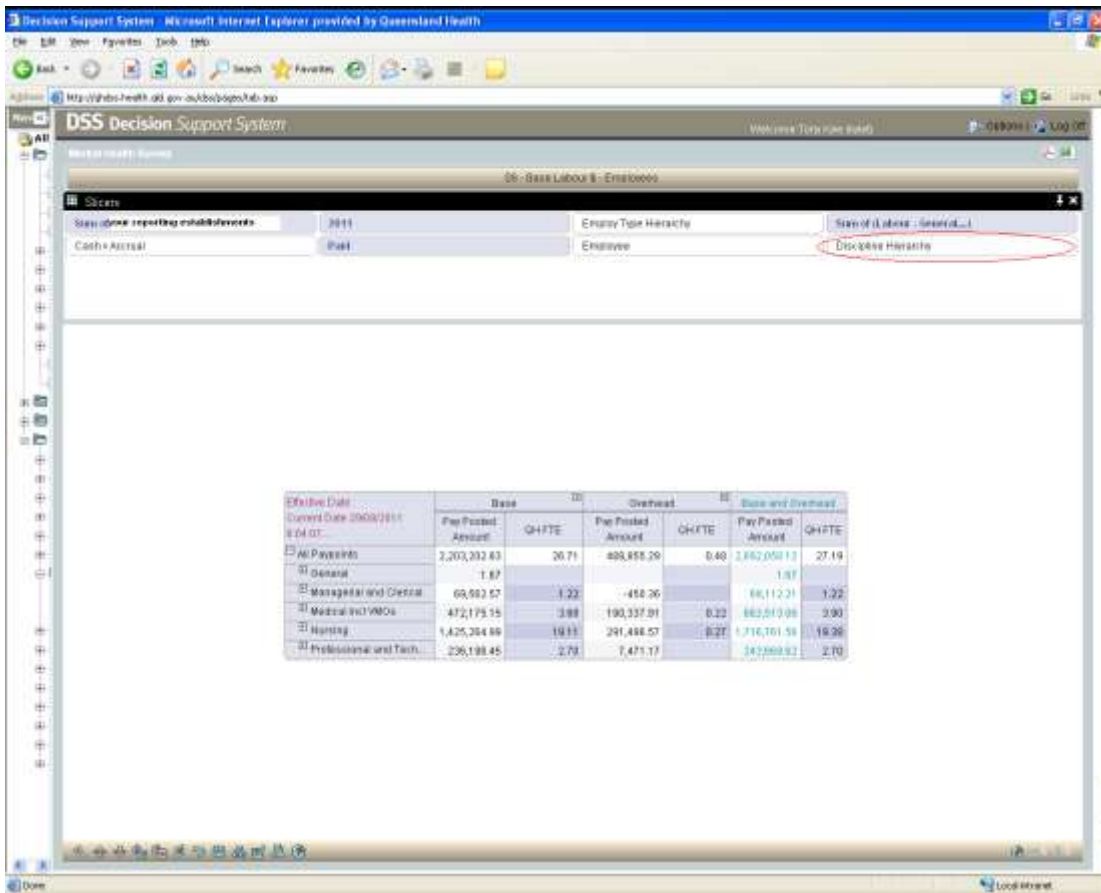
1. Bring up your crosstab, click on the Dimensions icon at the bottom of the screen (the cubes).



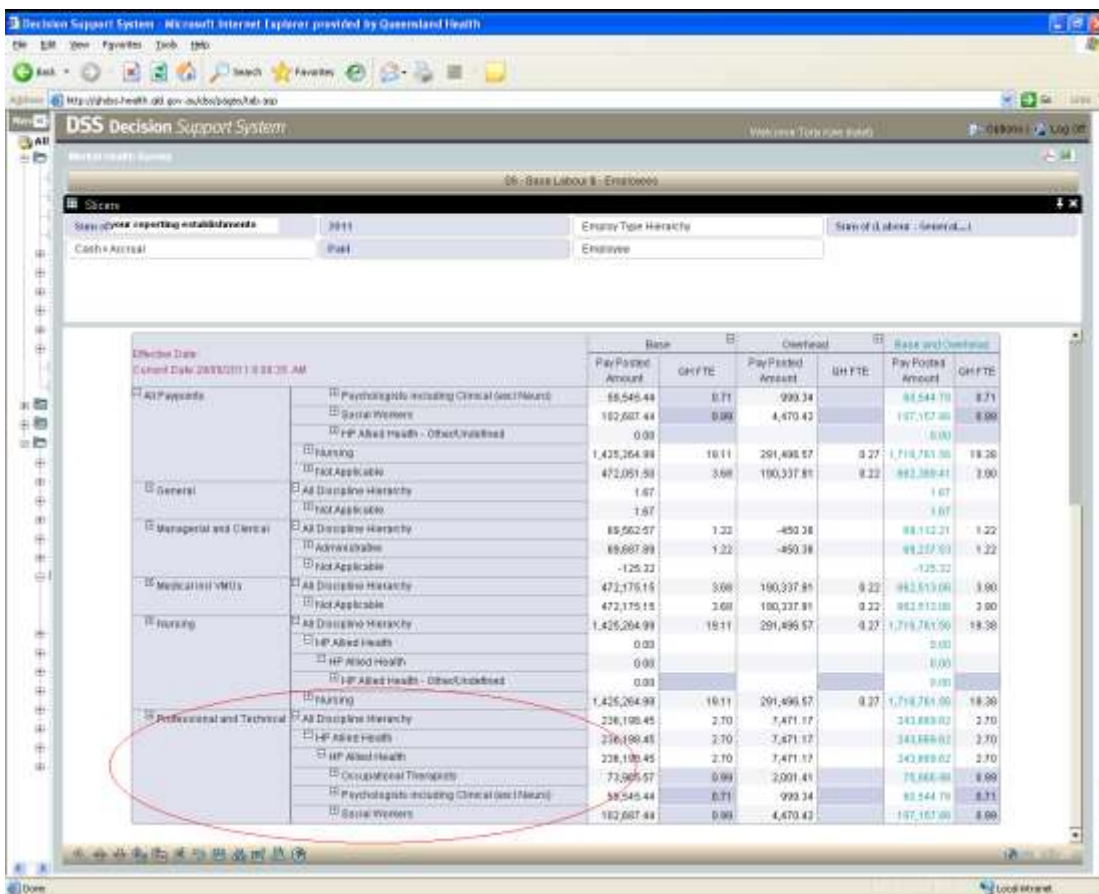
2. Expand 'Position', click and drag 'Discipline Hierarchy' over to the slicer area at the top of the screen



3. Click on Discipline Hierarchy slicer and drag into crosstab and 'Nest After Paypoint'



4. You will then be able to filter from a smaller subset for the HP stream.



Expenditure categories

Payroll and contract expenditure

Includes expenditure on departmental salaries/wages (including sick leave or family responsibilities), annual leave, long service leave, other leave and external agency/contract wages. It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

500000-500090, 503500-503590, 517200-517280, 503300-503390, 503600-503690, 517200-517280

Other related expenditure (excluding superannuation)

Includes expenditure on overtime, allowances, penalties, redundancy payments, other payments, external agency commissions and allowances. It is based on the following FAMMIS account codes drawn from the Corporate Chart of Accounts:

501000-502490, 502900 – 502990, 502500 – 502580, 502600- 502680, 506000-506090, 517310-517475

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 (e.g. 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. Do not include locums here as they are agency staff and should be reported under the appropriate discipline.

Visiting medical officers – other medical officers

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

Psychiatrists – salaried medical officers

Refers to salaried medical officers who are registered to practice psychiatry under Queensland's Medical Registration Board.

Psychiatry registrars and trainees

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

Other – salaried medical officers

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

Occupational therapists

Refers to staff who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists.

Social workers

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

Psychologists

Refers to staff who are registered as psychologists with 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 of such are 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 and clerical staff

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

Domestic and other staff

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

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.

Frequently asked questions

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

Special care suites and 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 MHEC.

Staff who work across disciplines/service settings

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

A. Medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties should be counted entirely under their appropriate occupational categories. Where staff 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.

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 or system support officer for more information on where cross district/MHSO activity is being coded.

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.

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.

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.

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.

Appendix A Mental Health Establishments Structure 2011-12

DISTRICT	MHSO	ESTABLISHMENT	EST. ID	
METRO SOUTH (MST)(86)	BAYSIDE (BY) (0101)	REDLAND HOSPITAL	00028	
		BAYSIDE CHILD AND YOUTH COMMUNITY MHS	80090	
		BAYSIDE ADULT COMMUNITY MHS	80998	
		REDLAND ADULT COMMUNITY MHS	80091	
		WYNNUM ADULT COMMUNITY MHS	80751	
		CASUARINA LODGE – WISTERIA ABI UNIT	00625	
		DAINTREE PSYCHOGERIATRIC INPATIENT UNIT	00610	
	LOGAN- BEAUDESERT (LB) (0102)	LOGAN HOSPITAL	00029	
		BEENLEIGH ADULT COMMUNITY MHS	80128	
		BROWNS PLAINS COMMUNITY MHS	81010	
		LOGAN CENTRAL CHILD AND YOUTH COMMUNITY MHS	80737	
		LOGAN CENTRAL ADULT COMMUNITY MHS	80739	
	PRINCESS ALEXANDRA HOSPITAL (PA) (0103)	PRINCESS ALEXANDRA HOSPITAL	00011	
		COORPAROO COMMUNITY CARE UNIT	82000	
		INALA ADULT COMMUNITY MHS	80759	
		BURKE STREET COMMUNITY MHS	81001	
		MOUNT GRAVATT ADULT MHS	81003	
	GOLD COAST (GOL)(92)	GOLD COAST (GC) (0104)	GOLD COAST HOSPITAL – SOUTHPORT AND ROBINA	00050
			PALM BEACH ADULT COMMUNITY MHS	80119
			SOUTHPORT ADULT COMMUNITY MHS	80122
BURLEIGH CHILD AND YOUTH COMMUNITY MHS			80126	
SOUTHPORT CHILD AND YOUTH COMMUNITY MHS			80127	
RIVERWALK COMMUNITY MHS			81008	
SOUTH WEST (STW)(93)	SOUTH WEST (SW) (0105)	CHARLEVILLE COMMUNITY MHS	80306	

DISTRICT	MHSO	ESTABLISHMENT	EST. ID
		ROMA ADULT COMMUNITY MHS	80307
		ROMA CHILD AND YOUTH COMMUNITY MHS	80308
DARLING DOWNS (DD) (96)	TOOWOOMBA (TW) (0106)	TOOWOOMBA HOSPITAL	00104
		BAILLIE HENDERSON HOSPITAL CAMPUS	00701
		TOOWOOMBA ADULT COMMUNITY MHS	80804
		TOOWOOMBA PSYCHOGERIATRIC COMMUNITY MHS	80092
		TOOWOOMBA CHILD AND YOUTH COMMUNITY MHS	80829
		CHINCHILLA COMMUNITY MHS	80831
		DALBY COMMUNITY MHS	80832
		WARWICK COMMUNITY MHS	80097
		INGLEWOOD COMMUNITY MHS	80216
		GOONDIWINDI COMMUNITY MHS	80217
		STANTHORPE COMMUNITY MHS	80221
		MILLMERRAN ADULT COMMUNITY MHS	80222
		CHERBOURG COMMUNITY MHS	80096
		KINGAROY COMMUNITY MHS	80207
WEST MORETON (WM) (97)	WEST MORETON (WM) (0107)	IPSWICH HOSPITAL	00015
		THE PARK – CENTRE FOR MENTAL HEALTH	00751
		IPSWICH CHILD AND YOUTH COMMUNITY MHS	80099
		GOODNA ADULT COMMUNITY MHS	80254
		IPSWICH ADULT COMMUNITY MHS	80255
CHILDREN'S HEALTH SERVICES (CHS)(88)	ROYAL CHILDREN'S HOSPITAL (RC) (0108)	ROYAL CHILDREN'S HOSPITAL	00007
		PINE RIVERS CHILD AND YOUTH COMMUNITY MHS	80101
		NUNDAH CHILD AND YOUTH COMMUNITY MHS	80491
		ENOGGERA CHILD AND YOUTH COMMUNITY MHS	80509
		SPRING HILL CHILD AND YOUTH COMMUNITY MHS	80512

DISTRICT	MHSO	ESTABLISHMENT	EST. ID
		NORTH WEST PUBLIC COMMUNITY HEALTH CENTRE	81005
	MATER HOSPITAL (MA) (0109)	MATER CHILDREN'S PUBLIC HOSPITAL	00002
		GREENSLOPES CHILD AND YOUTH COMMUNITY MHS	80719
		MATER EVOLVE CHILD AND YOUTH COMMUNITY MHS	81094
		INALA CHILD AND YOUTH COMMUNITY MHS	80720
		YERONGA CHILD AND YOUTH COMMUNITY MHS	80744
METRO NORTH (MNT)(87)	THE PRINCE CHARLES HOSPITAL (PC) (0110)	THE PRINCE CHARLES HOSPITAL	00004
		ASPLEY ADULT COMMUNITY MHS	80517
		CHERMSIDE ADULT COMMUNITY MHS	80521
		FLINDERS HOUSE PSYCHOGERIATRIC UNIT	00691
		JACANA ABI UNIT – EVENTIDE	00601
		PINE RIVERS COMMUNITY MHS	80522
		NUNDAH COMMUNITY MHS	81002
		PINE RIVERS COMMUNITY CARE UNIT	82001
	REDCLIFFE-CABOOLTURE (RE) (0111)	COOINDA HOUSE	00615
		CABOOLTURE HOSPITAL	00030
		REDCLIFFE CABOOLTURE ASSESSMENT AND ACUTE CARE SERVICES	80259
		CABOOLTURE ADULT COMMUNITY MHS	80439
		REDCLIFFE ADULT COMMUNITY MHS	80443
		REDCLIFFE-CABOOLTURE CHILD AND YOUTH COMMUNITY MHS	80994
		REDCLIFFE-CABOOLTURE ADULT COMMUNITY MHS	80997
		REDCLIFFE-CABOOLTURE COMMUNITY CARE UNIT	82002
	ROYAL BRISBANE AND WOMEN'S HOSPITAL (RB) (0112)	ROYAL BRISBANE AND WOMEN'S HOSPITAL	00201
		COMMUNITY FORENSIC MHS	80493
		INNER NORTH BRISBANE COMMUNITY MHS	80498
		SOMERSET VILLAS COMMUNITY CARE UNIT	82003

DISTRICT	MHSO	ESTABLISHMENT	EST. ID
CENTRAL QUEENSLAND (CTQ)(89)	CENTRAL QUEENSLAND (CQ) (0113)	ROCKHAMPTON BASE HOSPITAL	00141
		ROCKHAMPTON ADULT COMMUNITY MHS	80586
		ROCKHAMPTON CHILD AND YOUTH COMMUNITY MHS	80596
		ROCKHAMPTON EVENTIDE PSYCHOGERIATRIC UNIT	00692
		BILOELA COMMUNITY MHS	80103
		EMERALD COMMUNITY MHS	80072
		GLADSTONE COMMUNITY MHS	80595
CENTRAL WEST (CTW)(90)	CENTRAL WEST (CW) (0114)	LONGREACH COMMUNITY MHS	80070
SUNSHINE COAST (96)	SUNSHINE COAST (SC) (0124)	NAMBOUR HOSPITAL	00049
		SUNSHINE COAST COMMUNITY INITIATIVE	80291
		MAROOCHYDORE ADULT COMMUNITY MHS	80435
		NAMBOUR ADULT COMMUNITY MHS	80437
		SUNSHINE COAST CHILD AND YOUTH COMMUNITY MHS	80438
		MOUNTAIN CREEK COMMUNITY CARE UNIT	82004
		GYMPIE COMMUNITY MHS	80412
		GLENBROOK RESIDENTIAL AGED CARE	00612
WIDE BAY (97)	WIDE BAY (WB) (0116)	BUNDABERG HOSPITAL	00062
		BUNDABERG ADULT COMMUNITY MHS	80194
		BUNDABERG CHILD AND YOUTH COMMUNITY MHS	80195
		NORTH BURNETT COMMUNITY MHS	80071
	FRASER COAST (FC) (0117)	MARYBOROUGH HOSPITAL	00071
		FRASER COAST ADULT COMMUNITY MHS	80989
		FRASER COAST CHILD AND YOUTH COMMUNITY MHS	80990
CAIRNS AND HINTERLAND (CAH)(80)	CAIRNS (CA) (0118)	CAIRNS HOSPITAL	00214
		CAIRNS ADULT COMMUNITY MHS	80040
		CAIRNS CHILD AND YOUTH COMMUNITY MHS	80073
		INNISFAIL COMMUNITY MHS	80076

DISTRICT	MHSO	ESTABLISHMENT	EST. ID
		TABLELANDS COMMUNITY MHS	80104
CAPE YORK (CYK)(81)	CAPE YORK (CY) (0119)	CAPE YORK COMMUNITY MHS	80080
		COOKTOWN COMMUNITY MHS	80075
TORRES STRAIT - NORTHERN PENINSULA (TST)(84)	TORRES STRAIT (TS) (0120)	BAMAGA COMMUNITY MHS	80074
		THURSDAY ISLAND COMMUNITY MHS	80078
MACKAY (MAC)(82)	MACKAY (MK) (0121)	MACKAY BASE HOSPITAL	00172
		BOWEN COMMUNITY MHS	80087
		MACKAY ADULT COMMUNITY MHS	80372
		MACKAY CHILD AND YOUTH COMMUNITY MHS	80373
		WHITSUNDAY COMMUNITY MHS	80955
		MORANBAH COMMUNITY MHS	80987
TOWNSVILLE (TVL)(85)	TOWNSVILLE (TV) (0122)	TOWNSVILLE HOSPITAL	00200
		KIRWAN MH REHABILITATION UNIT	00715
		PALM ISLAND COMMUNITY MHS	80085
		TOWNSVILLE CHILD AND YOUTH COMMUNITY MHS	80939
		TOWNSVILLE ADULT COMMUNITY MHS	80995
		TOWNSVILLE ADULT FORENSIC COMMUNITY MHS	80996
		AYR COMMUNITY MHS	80088
		CHARTERS TOWERS REHABILITATION UNIT	00703
		CHARTERS TOWERS COMMUNITY MHS	80086
		EVENTIDE NURSING HOME – PANDANUS PSYCHOGERIATRIC UNIT	10202
		MT ISA (MTI)(83)	MT ISA (MI) (0123)
MORNINGTON ISLAND COMMUNITY MHS	80051		
DOOMADGEE COMMUNITY MHS	80084		

Glossary of terms

Accrued patient days ('occupied bed days')

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

Acute inpatient service

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

Ambulatory care

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

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

Available beds

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

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

Capital expenditure

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

Carer

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

Child and adolescent psychiatry services

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

Consumer

This 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.

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

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

Forensic psychiatry services

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

Full-time equivalent

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

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

General psychiatry services

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

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

General psychiatry – medium secure

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

Indirect expenditure

There are two general categories:

1. 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. For example district administration, human resources, finance, records, information technology, building/grounds maintenance, security, and 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.
2. 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 (i.e. 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 (e.g. education and training of staff operating out of an establishment), it 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.

Mental health service organisation (MHSO)

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

Non-acute inpatient services

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

Rehabilitation services have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focussed on disability and the

promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

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

Older persons' psychiatry services

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

Primary consumer

A person with a mental illness or psychiatric disability.

Residential care services

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

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

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

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

Separations

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

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

- *A statistical separation on type change*
 - is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following a care type change.

All three types of separations are to be counted.

Specialised mental health service – hours staffed

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

Staffing categories

Descriptions used in establishment form section 5 can be found in that section.

Young persons psychiatry services

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