Queensland Health

Clinical **Excellence** Queensland

Mental Health Establishments (MHEC)

Manual 2024/25

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

Mental Health Establishments Collection (MHEC) Manual 2024/25

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Notes for the 2024/25 collection

Activity Based Funding (ABF) and MHEC

Queensland shifted **community mental health services** onto ABF on **1 July 2024**. For the 2024/25 year, ABF was run alongside the previous funding model, and from 1 July 2025, ABF has become the formal funding model for community mental health services. Residential mental health care remains blockfunded, but the **accuracy and timeliness of MHEC data are now critical** because they impact ABF calculations and future block allocations.

Mandatory Sign-off

Due to the changes associated with mental health funding, from 2024/25 onward, MHEC data can only be *approved* by HHS Chief Finance Officers. It is still a requirement, however, that the data is checked and confirmed by an MHAOD Executive.

Step	Officer	Purpose	Deadline
Endorse	HHS MHAOD Executive	Confirms clinical/service accuracy	Before MHEC submission cut-off
Approve	HHS Chief Finance Officer (CFO)	Certifies completeness and financial validity for ABF	Immediately after endorsement and **within the collection window**

As the Healthcare Purchasing and Funding Branch requires the data before year-end, it is now essential that data is endorsed and approved within the MHEC collection timeframe.

Updated DSS Reports

The DSS reports for MHEC have been rebuilt following the recent replacement of the ABF and finance modules with their new "_T" versions. While every effort has been made to ensure the data is correctly selected in the updated reports, please review the results to confirm they align with your expectations.

MH-HiTH – Accrued Patient Days

The Australian Institute of Health and Welfare (AIHW) uses MHEC data to calculate bed based service occupancy using both bed counts and accrued patient days. As the MH-HiTH program expands, reporting HiTH home days within non HiTH bed-based categories will overstate occupancy results.

To ensure accurate reporting, the Mental Health, Alcohol and Other Drugs Branch (MHAODB) will supply MHEC data suppliers with separate counts for bed-based days

and HiTH days.

Headspace and Head to Health Kids

To assist with reporting associated with bilateral initiatives, services such as headspace and Head to Health Kids are reported separately in MHEC. To support this, new facilities have been established to ensure related funding, staffing, and activity are captured independently.

Key takeaways

1. **Community mental health is ABF funded from 1 July 2024 with 2024/25 being used as a shadow year where the ABF figures were compared with the original funding model; residential mental health care remains block funded. Accuracy and timeliness of MHEC data are now critical.**
2. **Dual signoff is compulsory:** MHAOD Executive endorsement followed by HHS CFO approval.
3. **Use the new DSS _T reports** and validate them against your previous figures.
4. **Report bilateral services separately** via their dedicated facility IDs.
5. **MH-HiTH home days must be reported separately** to avoid overstating bed-based occupancy. MHAODB will provide this data to support MHEC reporting.

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Introduction

Purpose of the manual

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

Scope of the MHEC

The scope of the MHEC is all specialised Mental Health treatment services delivered or funded through HHS or funded by the Department of Health.

Specialised mental health services are those with a **primary** function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

A service is not defined as a specialised mental health service solely because its clients include people affected by a mental disorder or psychiatric disability.

The definition excludes specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.

The scope of the MHEC is restricted to recurrent expenditure. Consequently, capital expenditure is out of scope for this collection.

Use of MHEC data

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

Data collected for the MHEC provides detailed information on the range, level and cost of services available in Queensland. As an annual collection it is used to monitor service growth and development at the HHS, Mental Health Service Organisation (MHSO) and state-wide levels. The data provides yearly updates of information on resource capacity including funding; staffing numbers and discipline mix; and

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[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.

broad activity indicators. This data is also used to inform local and state decision-making, support the development of performance indicators and to address ad hoc research requirements.

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

Data reported for the MHE NMDS is published in the Mental Health Online Report, and the Report on Government Services.

Mandatory requirement

Queensland Health collects MHE information as part of a mandatory reporting requirement in the National Health Information Agreement. The current agreement commenced on 1 October 2013.

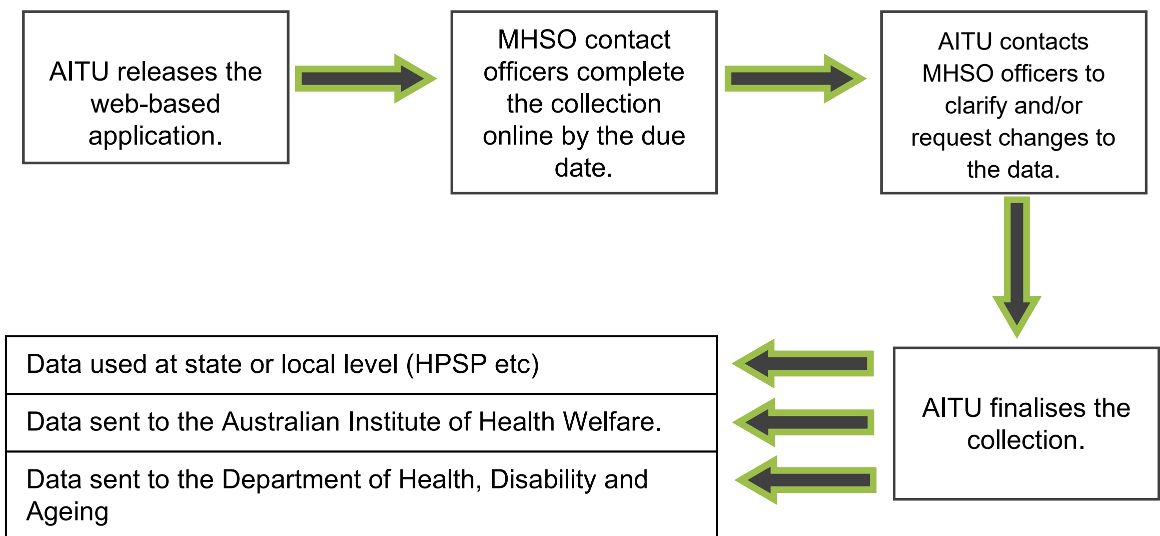
The following information is provided to the Australian Institute of Health and Welfare and the Australian Department of Health and Aged Care:

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

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

Procedures

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



Completing the collection

MHE information is collected and reported at the following levels:

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

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

For HHSs with only one MHSO and multiple reporting establishments, a single MHSO form will be completed, as well as an establishment form for each reporting establishment. For HHSs with multiple MHSOs, an MHSO form will be completed for each MHSO as well as an establishment form for each

reporting establishment. In this instance, HHS level costs associated with the delivery of mental health services will need to be apportioned across the different MHSOs on the basis of a resource allocation method.

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

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

In this instance, South West would complete and submit:

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

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

HHS	MHSO	ID	Establishment
Metro South	Bayside	80998	Bayside Adult Community MHS
		80090	Bayside Child & Youth Community MHS
		00028	Bayside Community Care Unit
		00625	Casuarina Lodge - Wisteria Abi Unit
		00028	Redland Hospital
		01404	Daintree Psychogeriatric Inpatient Unit
	Logan-Beaudesert	83002	Acmena House
		80128	Beenleigh Community MHS
		81010	Browns Plains Community MHS
		80739	Logan Central Adult Community MHS
		80737	Logan Central Child & Youth Community MHS
		00029	Logan Community Care Unit
		00029	Logan Hospital
		83011	Logan Youth Step Up Step Down Unit
	Princess Alexandra	82000	Coorparoo Community Care Unit
		80759	Inala Adult Community MHS

	Hospital	00011	Princess Alexandra Hospital
		81260	Woolloongabba Community MHS

In this instance, Metro South would complete and submit:

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

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

System manual

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

MHSO Form

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

MHSO form section 0

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

Approver

This role is responsible for the formal approval of the MHEC data for the MHSO. From 2024/25, this person must be the HHS Chief Finance Officer (CFO). An approver must be nominated, and Section 0 submitted before the MHEC data at the MHSO and Establishment levels can be completed.

Endorser

This role is responsible for endorsing the MHEC data for the MHSO, confirming it is accurate. Generally, this person is either an Executive Director or Service Director for mental health services within the HHS.

MHSO form section 1

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

Services provided

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

Service Settings

Inpatient

An admitted patient (inpatient) mental health care service is a specialised mental health service that provides overnight care in a psychiatric hospital, a specialised mental health unit in an acute hospital, or Mental Health hospital-in-the-home (MH-HiTH) program. It

includes both acute, sub-acute and non-acute admitted patient services. 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 behavioral 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.

HITH (hospital-in-the-home) provides care in a patient's permanent or temporary residence for conditions requiring clinical governance, monitoring and/or input that would otherwise require treatment in a traditional hospital bed. The HITH program is focused exclusively on admitted inpatient care substitution with the admitting criteria governed by the authorised officer. HITH patients are regarded as hospital inpatients, therefore remain under the care of their governing hospital doctor.

Residential

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

Ambulatory

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

Ambulatory mental health services include:

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

- ambulatory-equivalent same day separations
- hospital based outreach services.
- Crisis support spaces

Target Populations

For a type other than 'General' to be separately selected 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, older people or forensic clients. Therefore, general psychiatry services are those services that are not specialist child and adolescent, young persons, older persons, or forensic services. Note that the appointment of a forensic liaison position into a general psychiatry service does not qualify this service as forensic psychiatry.

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

Child and adolescent psychiatry

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

Young person's psychiatry

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

Older persons psychiatry

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

include a forensic component.

Forensic psychiatry

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

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

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

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

Medium Secure

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

Crisis Stabilisation

Crisis Stabilisation Services provide consumers in mental health crisis with assessment and interventions to assist with managing the crisis and/or need for urgent mental health care in a community, or non-bed based setting for stays up to 23 hours and follow up care. This includes a chair-based crisis stabilisation unit. This definition excludes inpatient crisis stabilisation services.

MHSO form sections 2, 3, 4

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

Section 2: Mental health service consumer and carer representation

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

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

Section 3: Arrangements to promote participation by 'primary consumers'

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

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

Section 4: Arrangements to promote participation by 'carers'

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

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

MHSO form section 5

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

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

Category reports some expenditure

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

Category reports Nil expenditure

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

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

Completing this section

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

Information for section 5 can be obtained from several sources. Your HHS finance officer can run a DSS expenditure report for your HHS or MHSO. Operating budgets, DSS budget reports and S4 HANA reports may also help provide this information.

Indirect non-capital expenditure

There are two general categories of indirect expenditure:

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

Indirect expenditure category definitions

Program administration

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

Organisation-wide support services

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

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

Education and training

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

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

Academic positions

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

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

Mental health research

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

Mental health promotion

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

Service development

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

Superannuation

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

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

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

Worker’s compensation premium

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

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

Unlike Superannuation, Workers Compensation **payments made to employees** should also be

reported in the salary and wages component of MHSO section 9 (Note: The Mental Health Survey FTE report in DSS is set up to enable this by default).

Insurance

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

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

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

Patient transport services

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

Property leasing costs

Refers to the costs of leasing premises used for the provision of mental health services (for example community clinics). Only report leasing expenditure in MHSO form Section 5 if it does not relate to the provision of services by an establishment. If the leasing expenditure relates to the provision of services by an establishment, it must be reported against that establishment in Establishment form Section 4.

Other indirect expenditure

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

MHSO form section 6

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

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

Sources of funding for expenditure

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

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

Queensland Health funding

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

Other State Government funding

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

National Mental Health Strategy funding

Refers to funding allocated by the Commonwealth Government to Queensland to assist in the implementation of the mental health services under the National Mental Health Strategy (which includes the Bilateral Agreement) or the National Healthcare Agreement.

Other Australian Government funding

Refers to revenue paid directly by the Commonwealth Government. This includes nursing home and hostel subsidies for the care of patients in specialised mental health services, and any other special purpose grants including rural health support, education and training funds, and incentive package funds made available under National Agreements. It also includes any reimbursements made directly to the HHS by the Department of Veterans' Affairs (DVA).

Patient revenue

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

Recoveries

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

Other revenue

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

MHSO form section 7

This section reports details of any payments made from HHSs/MHSOs to NGOs during the year, excluding payments made to NGOs providing collaboration services in the staffing and operation of a government funded residential mental health care facility. Payments to collaborative NGOs are captured as part of direct expenditure for the relevant establishment on Establishment form Section 4.

Funding to non-government organisations

A number of HHSs/MHSOs provide funding to NGOs for the provision of specified services for people affected by a mental health issue. Please provide details of any payments made to NGOs during the year.

Do not report this payment expenditure on either MHSO form Section 5 or Establishment form Section 4.

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

Definitions of NGO payment service types

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

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

Counselling – Face-to-face

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

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

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

Distinguishing features:

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

Inclusions:

- Talking therapies
- Grief counselling
- Relationship counselling

Exclusions:

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

Example organisations providing this service type:

- Crisis Support Spaces
- National Association for Loss and Grief

Counselling, support, information and referral – Telephone

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

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

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

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

Distinguishing features:

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

Inclusions:

- Telephone crisis support
- Helplines
- Telephone counselling

Exclusions:

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

Example services providing this service type:

- Lifeline
- Kids Helpline
- Mensline
- Suicide line
- Suicide Call Back Service
- Beyond Blue info line

Counselling, support, information and referral – Online

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

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

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

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

Distinguishing features:

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

Inclusions:

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

Exclusions:

- Occasional services delivered under other service types (eg Group Support Services, Mutual support and self-help) that are incidentally provided via the Internet
- Online services that are delivered as an adjunct for other service types
- Counselling, support, information, and referral services not provided online

Example services providing this service type:

- Kids Helpline
- Beyond Blue
- Reach Out

Self-help – online

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

Distinguishing features*:*

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

Inclusions:

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

Exclusions:

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

Example services providing this service type*:*

- myCompass

Group support activities

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

Distinguishing features:

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

Inclusions:

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

Exclusions:

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

Example services providing this service type:

- Helping Hands
- Group based peer recovery support program

Mutual support and self-help

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

Distinguishing features:

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

Inclusions:

- Self-help
- Warm lines

Exclusions:

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

Example services providing this service type:

- GROW
- Voice Hearers Group
- Phone connection

Staffed residential services

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

Distinguishing features:

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

Inclusions:

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

Exclusions:

- Facilities that are visited via in-reach services provided by NGO staff but where the residence is not regarded as NGO worker's place of employment

- Government funded, NGO operated clinically staffed residential facilities that are staffed 24 hours per day, 7 days a week. These are to be reported as separate establishments. In Queensland, these are the community care units, step-up step-down units and the youth residential rehabilitation services.

Example services providing this service type:

- Consumer operated services
- Transitional recovery services (funded by NGO)

Personalised support – linked to housing

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

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

Distinguishing features:

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

Inclusions:

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

Exclusions:

- Provision of personalised support initiated independently of any housing arrangements (these are reported under Personalised support—other)

- Personalised support services provided to individuals that are targeted only at improving the person's participation in employment, education, or vocational training (these are reported under education, employment and training)
- Staffed residential services (these are reported under staffed residential services)

Example services providing this service type:

- Housing and Support Program (HASP), Queensland

Personalised support – other

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

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

Distinguishing features:

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

Inclusions:

- Outreach support
- In-situ individually tailored support

Exclusions:

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

Example services providing this service type:

- Meals for Mums

- Mental Health Rapid Response Teams
- Culture in Mind
-

Family and carer support

Family and carer support includes services that provide families and carers of people living with a mental illness support, information, education, and skill development opportunities to fulfil their caring role, while maintaining their own health and wellbeing . These services may be provided in the context of early intervention or ongoing support.

Distinguishing features:

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

Inclusions:

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

Exclusions:

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

Example programs and services providing this service type:

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

Individual advocacy

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

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

Individual advocates:

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

Distinguishing features:

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

Inclusions:

- Individual advocacy
- Legal advocacy

Exclusions:

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

Example services providing this service type:

- Rights in Action
- Independent Regional Advocacy Service
-

Care coordination

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

Distinguishing features:

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

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

Inclusions:

- Care coordination

Exclusions:

- Care coordination provided as part of delivering another service type

Example programs and initiatives providing this service type:

- Partners In Recovery
- Living Options

Service integration infrastructure

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

Distinguishing features:

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

Inclusions:

- Service coordination

Exclusions:

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

Education, employment and training

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

Distinguishing features:

- The principal purpose is to increase a person's ability to access education, employment, and training
- Delivered one-on-one or as part of a group

- Education and training takes place through a structured program of tuition
- The education and training program can result in the attainment of a formal qualification or award (e.g. a Certificate, Diploma or Degree), however, this need not happen in every program

Inclusions:

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

Exclusions:

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

Example programs providing this service type:

- Break Thru People Solutions
- Individual employment placement and support

Sector development and representation

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

Distinguishing features:

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

Inclusions:

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

Exclusions:

- Individual advocacy (these are reported under Individual advocacy)

Example organisations providing this service type:

- Mental Health Council of Australia (MHCA)
- Mental Health Lived Experience Peak Queensland
- Queensland Alliance for Mental Health
- Mental Health Consumer Network

Mental health promotion

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

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

Distinguishing features:

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

Inclusions:

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

Exclusions:

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

Example organisations providing this service type:

- Beyond Blue
- SANE Australia

Mental illness prevention

Mental illness prevention includes services that work to prevent the onset of mental disorders, to reduce

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

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

Distinguishing features:

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

Inclusions:

- Mental illness prevention activities

Exclusions:

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

MHSO form section 8

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

Supported public housing places

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

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

MHSO form section 9

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

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

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

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

Please note, this information is provided as a guide. Due to differences in role titles and functions across MHSOs, it is not possible to identify which 'roles' are overhead, and which are direct care based solely on the position title. If there are FTE within your service for whom you are unsure of where to allocate them (either in part or full) within the MHEC, please contact the AITU through contact details in the front of this document.

Completing this section

Section 9 should be completed by the HHS and/or mental health finance officer in consultation with the mental health executive director, manager, or team leader (depending on the service).

The information for **MHSO form Section 9** can be obtained via DSS.

Staffing categories

Staffing category definitions for MHSO form Section 9 and Establishment form Section 4 can be found here.

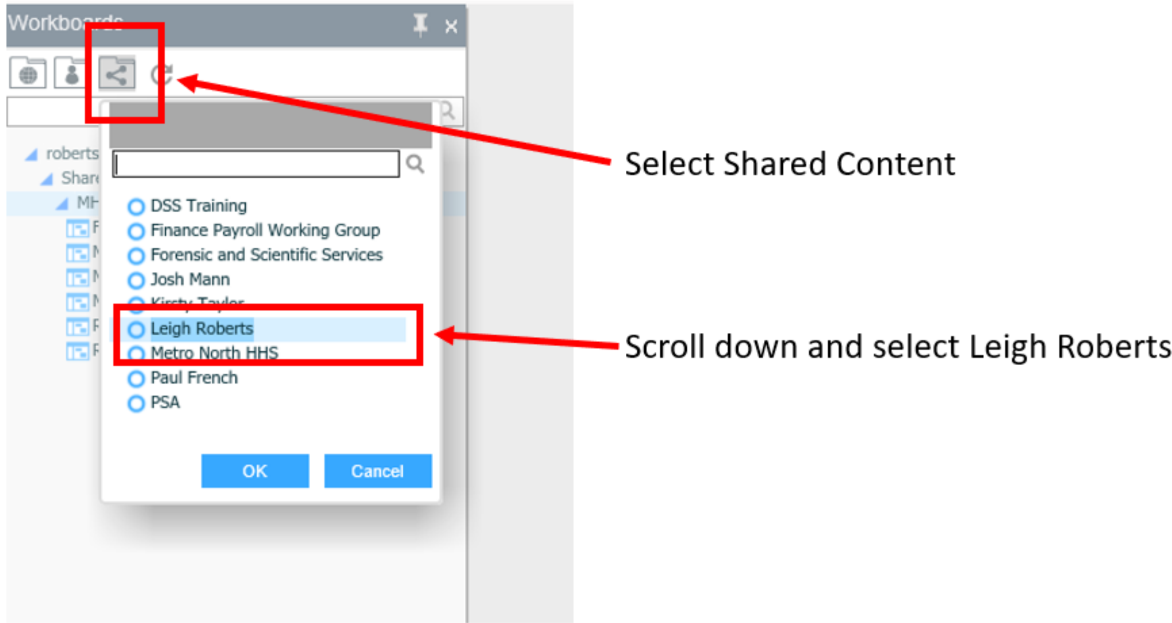
FTE reports for Establishment Form Section 5 and MHSO form Section 9

Accessing MHEC Reports in DSS

Sourcing Paid FTE information via DSS

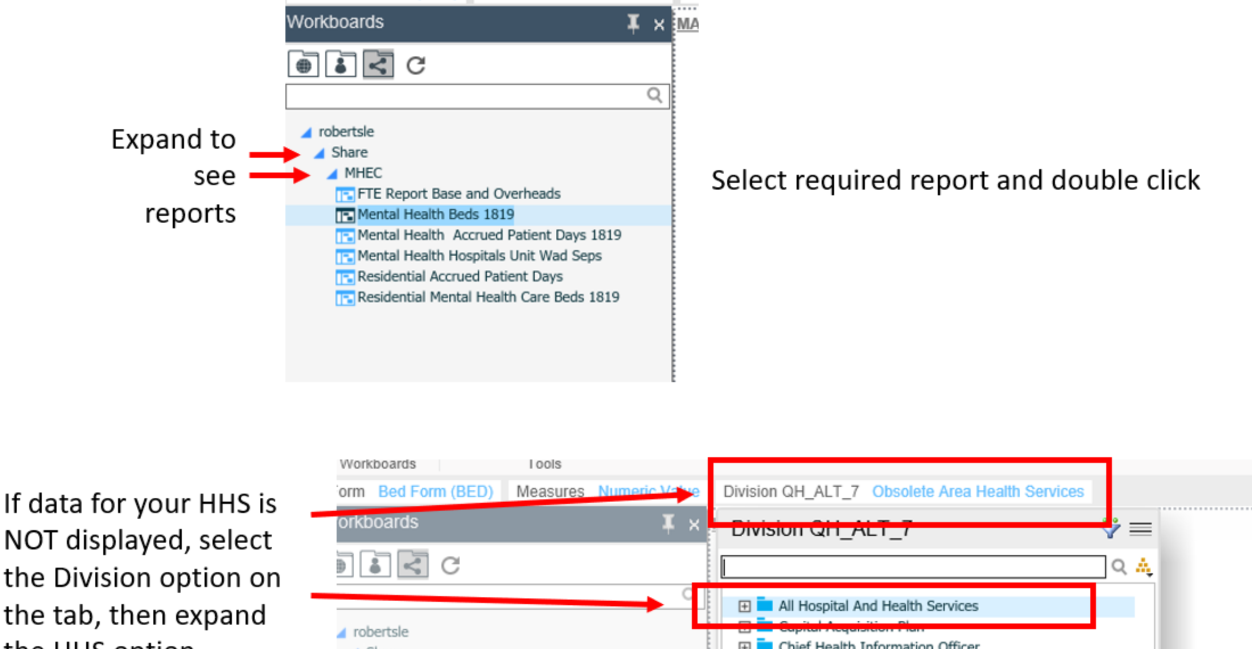
To gain access to the pre-built DSS reports that can be used for MHEC reporting, DSS users must be granted access to the reports by AITU staff. MHEC contacts already nominated by HHSs will have the reports shared with them automatically.

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



4. Expand the list of reports by selecting the arrow next to Share and then MHEC

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

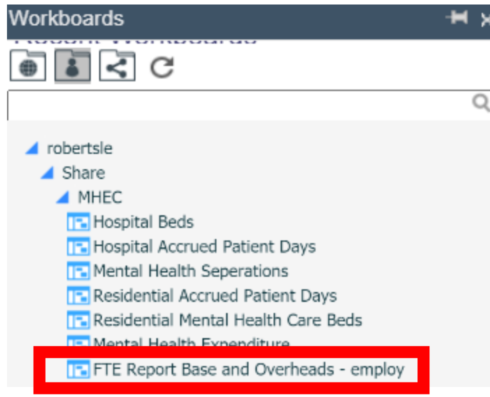


FTE and labour expenditure

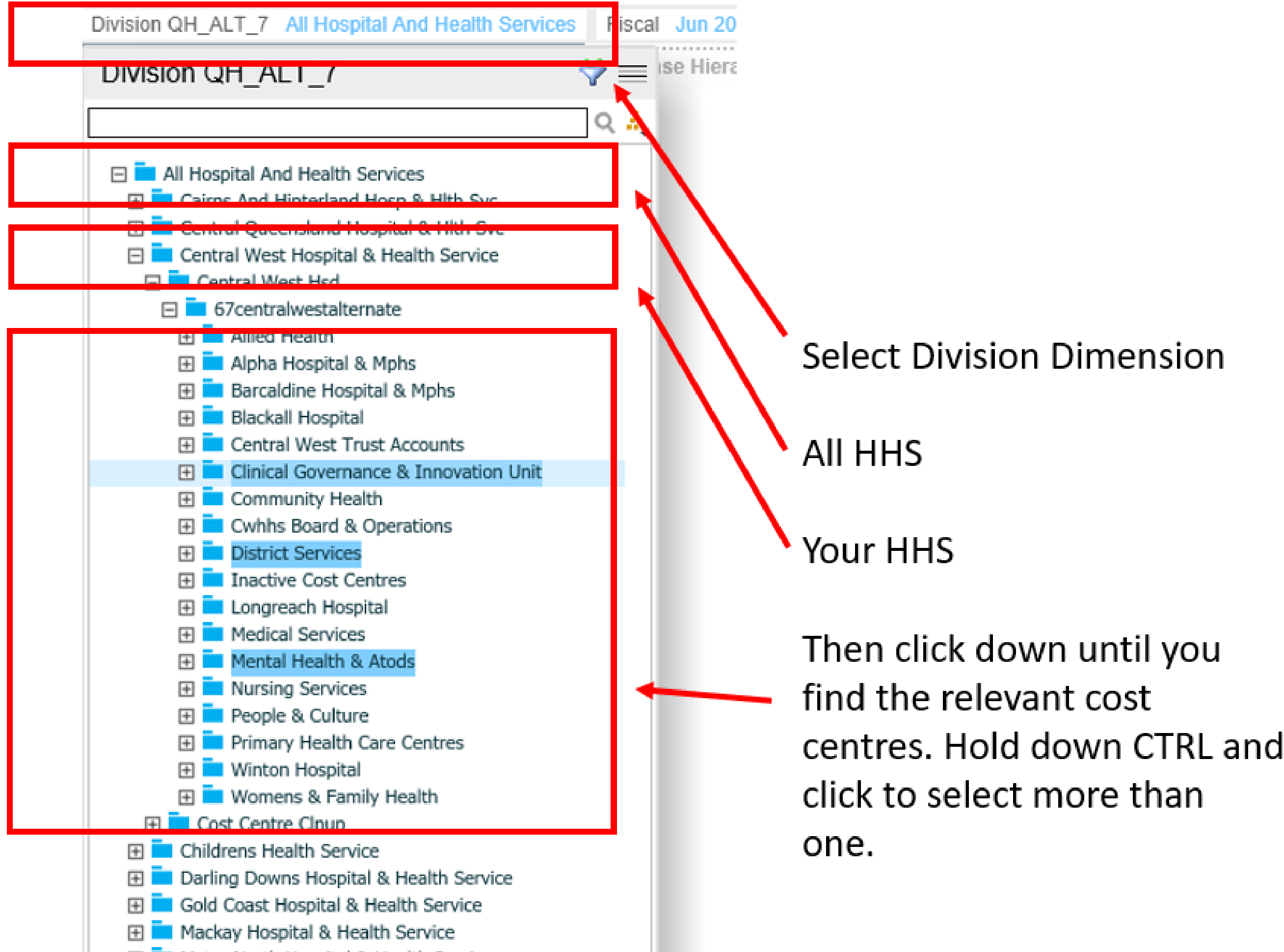
Proforma HR payroll reports have been developed in DSS to ensure consistency of reporting by HHSs.

Login to DSS and follow these instructions:

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

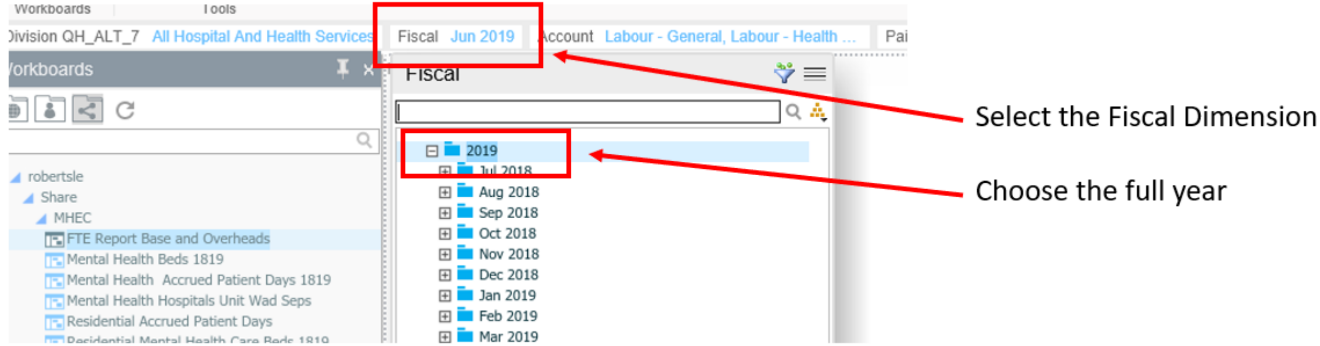


2. Click on the Division Dimension, and in the task bar that appears, select your HHS, and click down through the relevant structures until you find your cost centre or cost centre group. Note: Multiple selections can be made by pressing and holding the Ctrl button while clicking multiple cost structures.

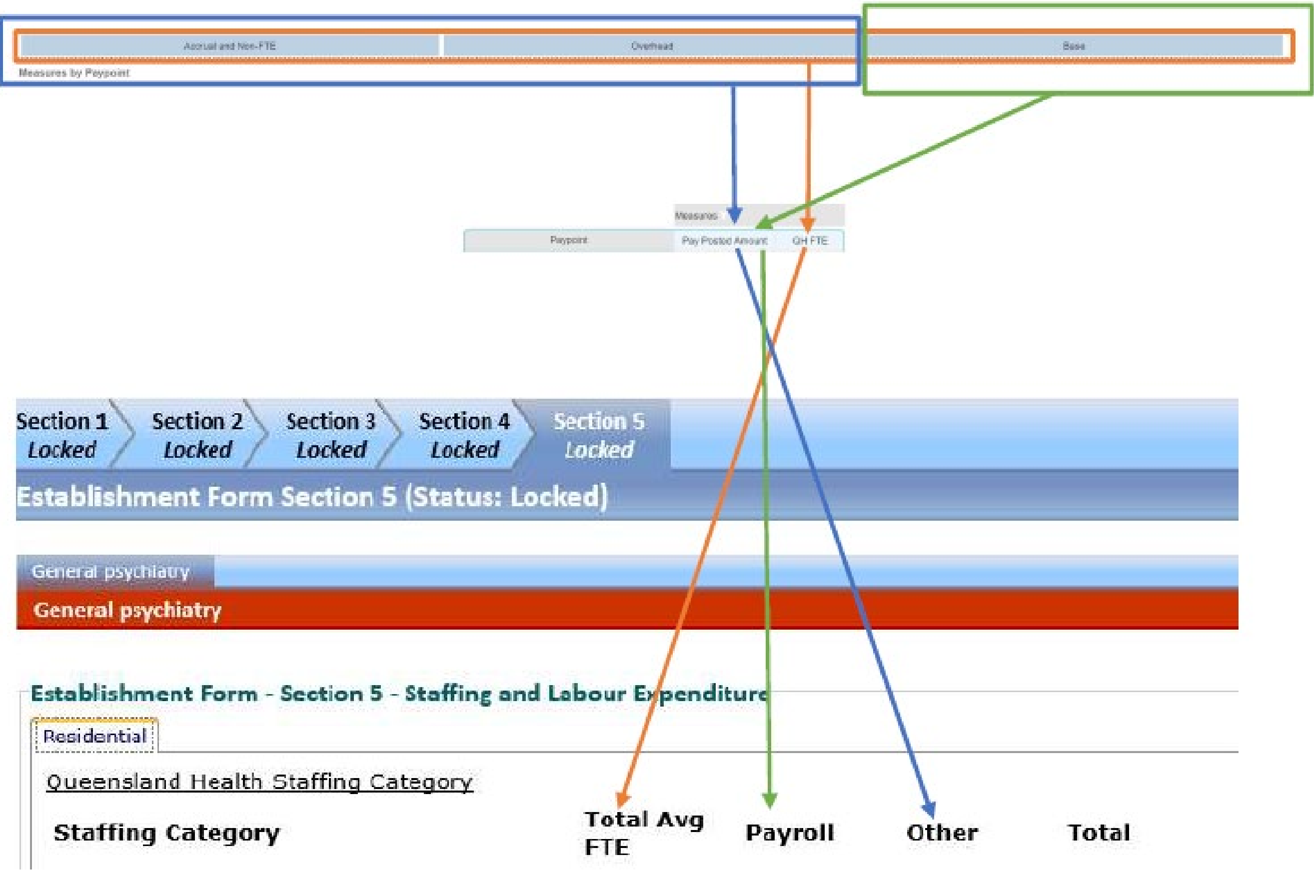


3. Click on the Fiscal Year slicer, select the full year for the Collection and click OK. The other parameters should be correct and generally should not be adjusted.

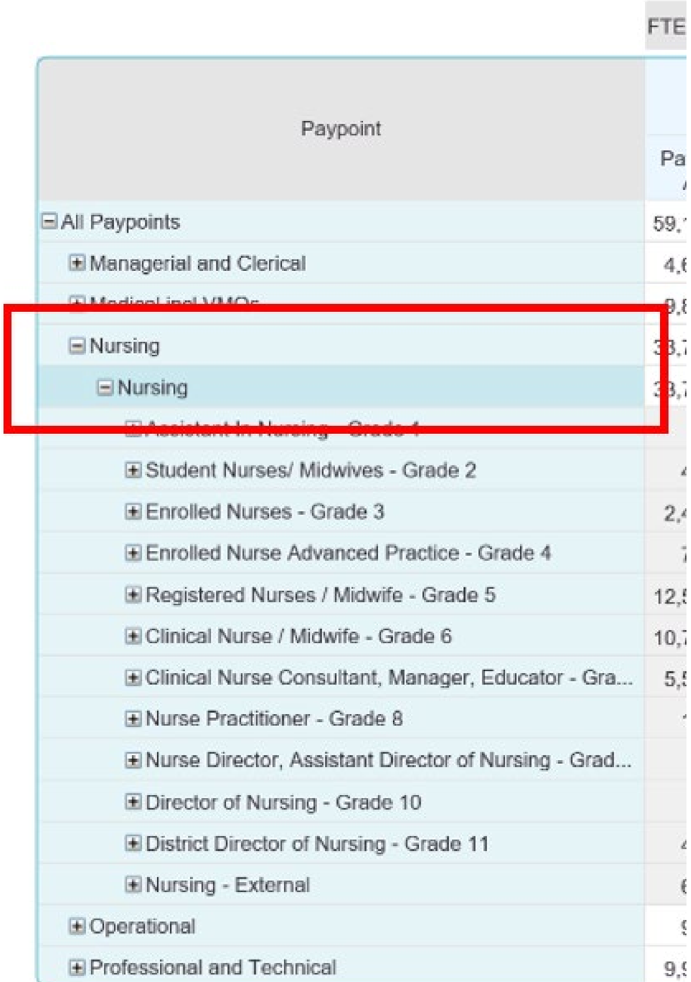
   a. Note: the year slicer in DSS works the following way: 2020/2021 financial year will be selectable as ‘2021’, 2019/2020 will be selectable as ‘2020’ and so on.


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

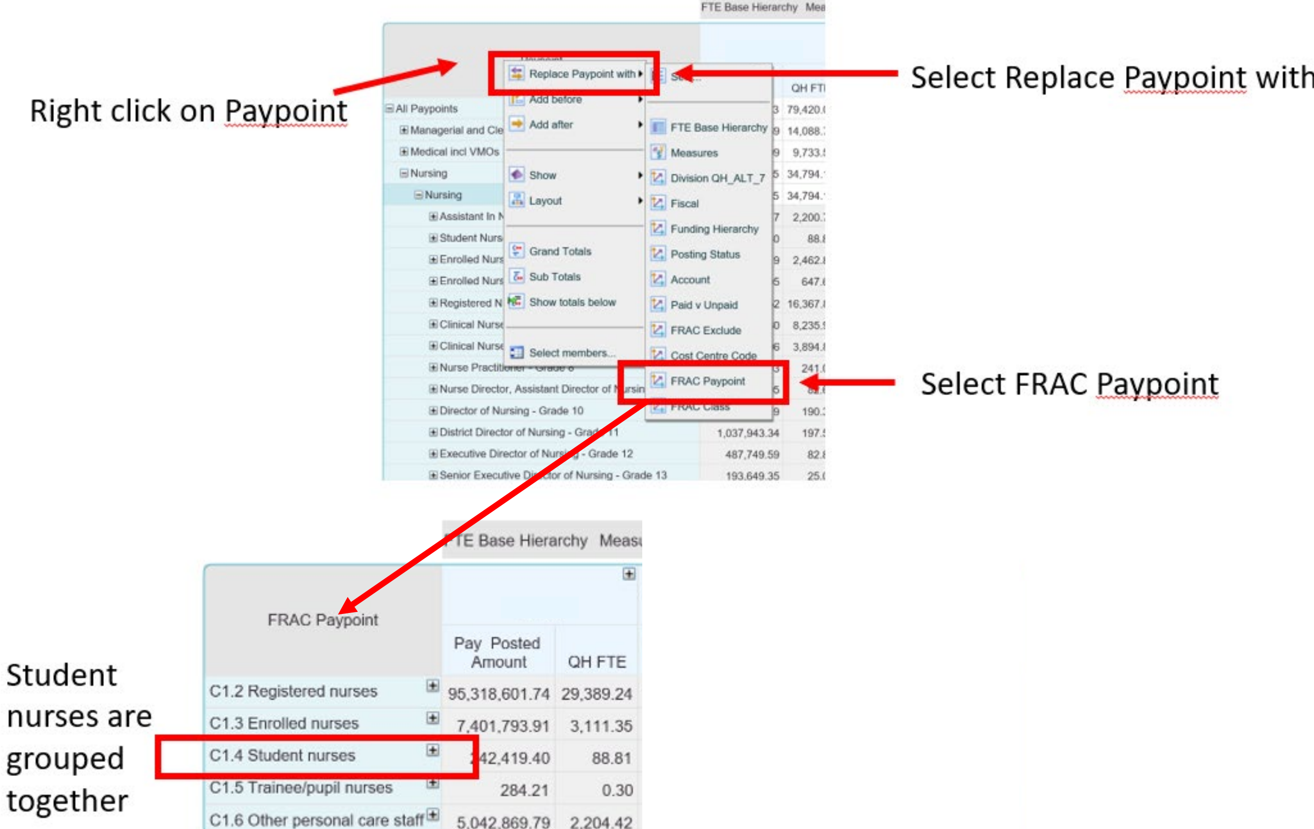
4. The “FTE Report Base and Overheads – Employ” report displayed allows you to populate a number of questions in the MHEC, and allows you to select and deselect the appropriate parameter buttons to retrieve the data for the respective MHEC reporting columns.
   a. All parameter buttons (orange) should be selected for reporting Total Avg FTE.
   b. ‘The Base’ parameter (green) should be used for reporting to the ‘Payroll’ MHEC column.
   c. The ‘Overhead’ and ‘Accrual and Non-FTE’ parameters (blue) should be used for reporting to the ‘Other’ MHEC column.



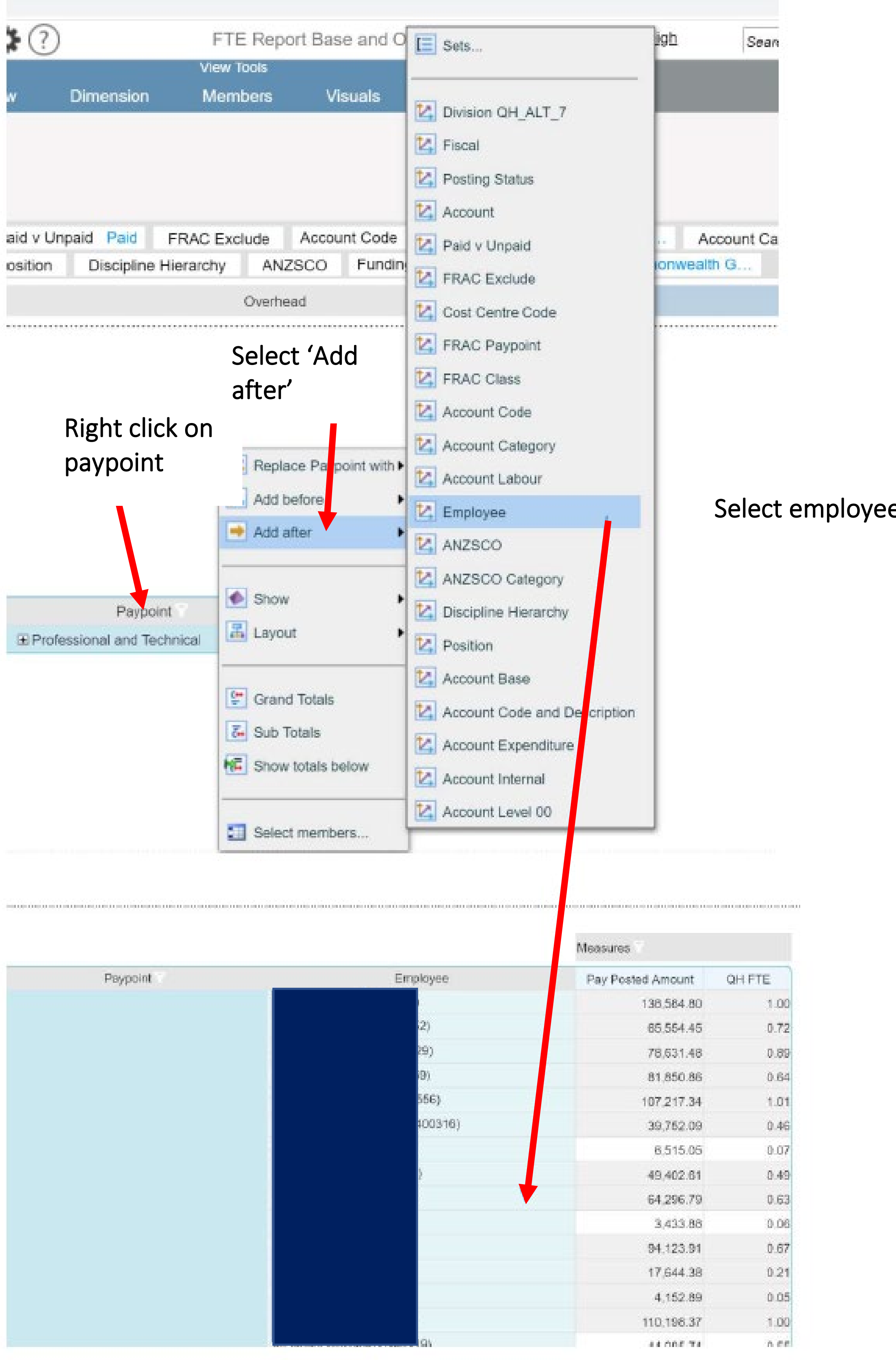
5. For those MHEC staffing categories which require more detail than is provided in the default view of the DSS report (i.e. 'Nursing'), you are able to expand the paypoint category by clicking the + sign next to the paypoint.



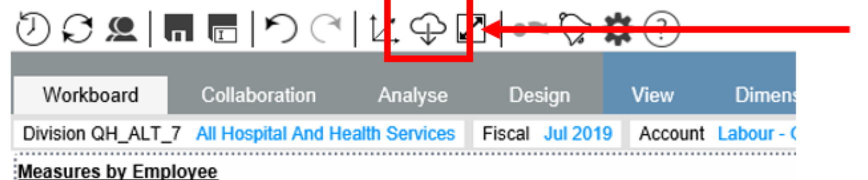
6. Alternatively, you can 'replace' the paypoint dimension in the report and display the FTE data by the FRAC paypoint hierarchy (which groups student nurses for you).



7. For those MHEC staffing categories which still require more detail than the paypoint level (i.e. Health Practitioners), you have the ability to add employee names to allow identification of staff manually. Alternatively, you can use the Discipline slicer (see below).



8. You can export any of the drilled through reports into excel for manipulation by clicking the cloud with the down arrow in the tool bar at the top.



Click the cloud icon to download an Excel or PDF file

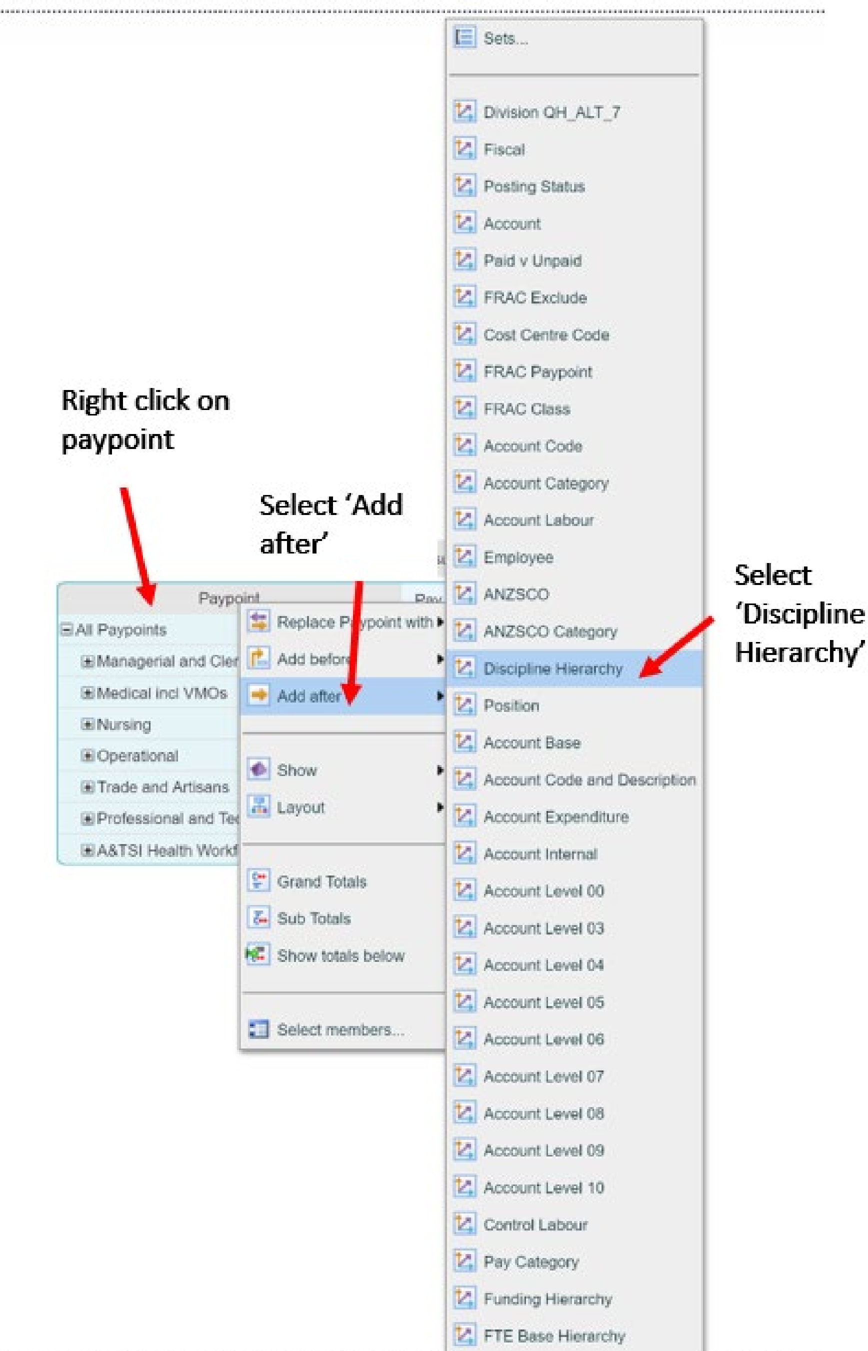
The FTE data for Queensland Health employees in the DSS report is shown as an average for the year. FTE for contract staff should also be an average for the reporting period.

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

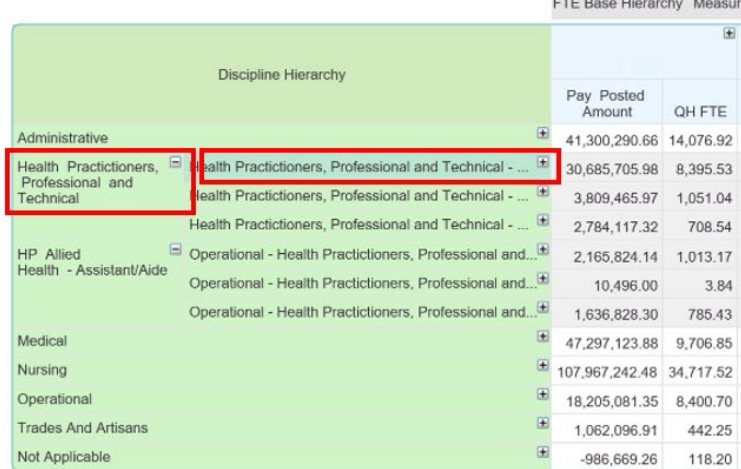
Discipline slicer

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

1. Add discipline to the report

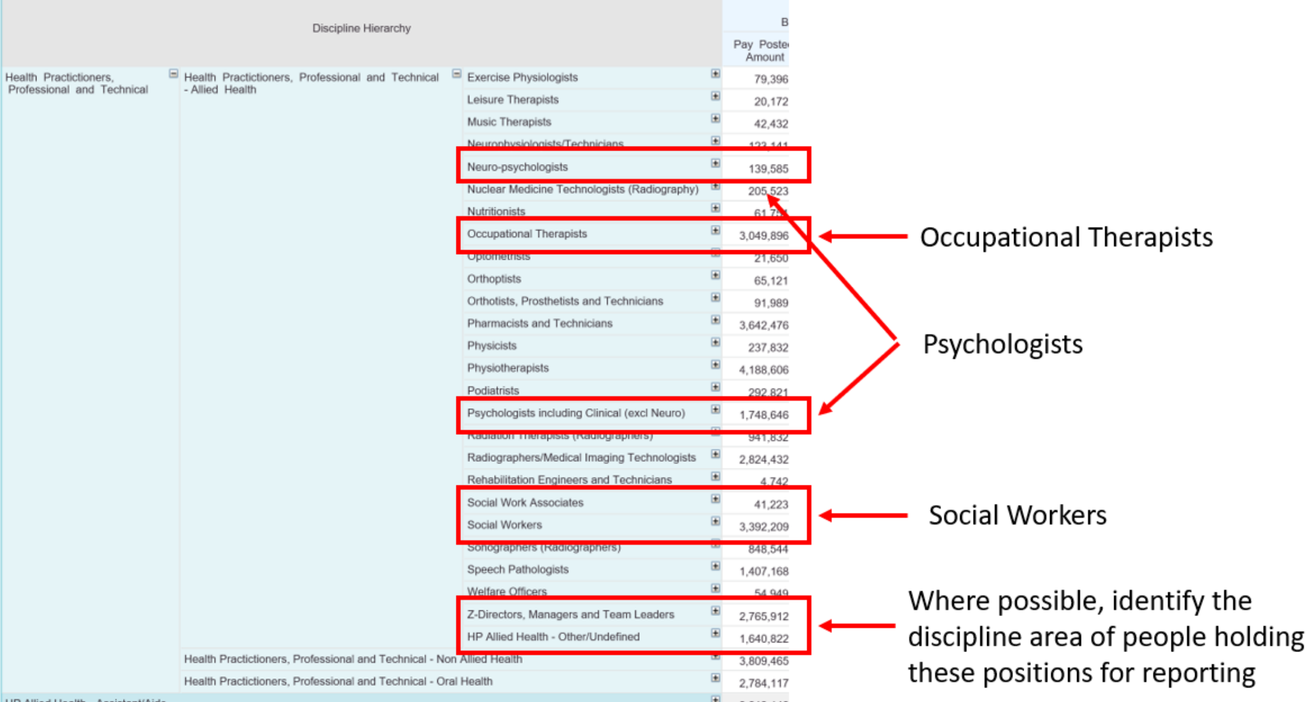


2. By expanding the Health Practitioners, Professional and Technical and the HP Allied Health – Assistant/Aide dimensions, then the Allied Health subsets, additional detail can be obtained.



Discipline Hierarchy		FTE Base Hierarchy: Pay Posted Amount	Measures: QH FTE
Administrative		41,300,290.66	14,076.92
Health Practictioners, Professional and Technical	Health Practictioners, Professional and Technical - ...	30,685,705.98	8,395.53
	Health Practictioners, Professional and Technical - ...	3,809,465.97	1,051.04
	Health Practictioners, Professional and Technical - ...	2,784,117.32	708.54
HP Allied Health - Assistant/Aide	Operational - Health Practictioners, Professional and...	2,165,824.14	1,013.17
	Operational - Health Practictioners, Professional and...	10,496.00	3.84
	Operational - Health Practictioners, Professional and...	1,636,828.30	785.43
Medical		47,297,123.88	9,706.85
Nursing		107,967,242.48	34,717.52
Operational		18,205,081.35	8,400.70
Trades And Artisans		1,062,096.91	442.25
Not Applicable		-986,669.26	118.20

Expand Health Practitioner discipline, then expand the Allied Health subset



Discipline Hierarchy			Pay Posted Amount
Health Practictioners, Professional and Technical	Health Practictioners, Professional and Technical - Allied Health	Exercise Physiologists	79,396
		Leisure Therapists	20,172
		Music Therapists	42,432
		Neurophysiologists/Technicians	123,141
		Neuro-psychologists	139,585
		Nuclear Medicine Technologists (Radiography)	205,523
		Nutritionists	[illegible]
		Occupational Therapists	3,049,896
		Optometrists	21,650
		Orthoptists	65,121
		Orthotists, Prosthetists and Technicians	91,989
		Pharmacists and Technicians	3,642,476
		Physicists	237,832
		Physiotherapists	4,188,606
		Podiatrists	292,821
		Psychologists including Clinical (excl Neuro)	1,748,646
		Radiation Therapists (Radiographers)	941,832
		Radiographers/Medical Imaging Technologists	2,824,432
		Rehabilitation Engineers and Technicians	4,742
		Social Work Associates	41,223
		Social Workers	3,392,209
		Sonographers (Radiographers)	848,544
		Speech Pathologists	1,407,168
		Welfare Officers	54,949
		Z-Directors, Managers and Team Leaders	2,765,912
		HP Allied Health - Other/Undefined	1,640,822
	Health Practictioners, Professional and Technical - Non Allied Health		3,809,465
	Health Practictioners, Professional and Technical - Oral Health		2,784,117

Consumer and Carer Worker identification

The Queensland Health Mental Health Framework Peer Workforce Support & Development 2019 provides guidance to ensure peer positions are filled by people with a lived experience of mental illness or caring for someone with a mental illness. It recommends that the following statements will be included in all role descriptions as part of the role fit:

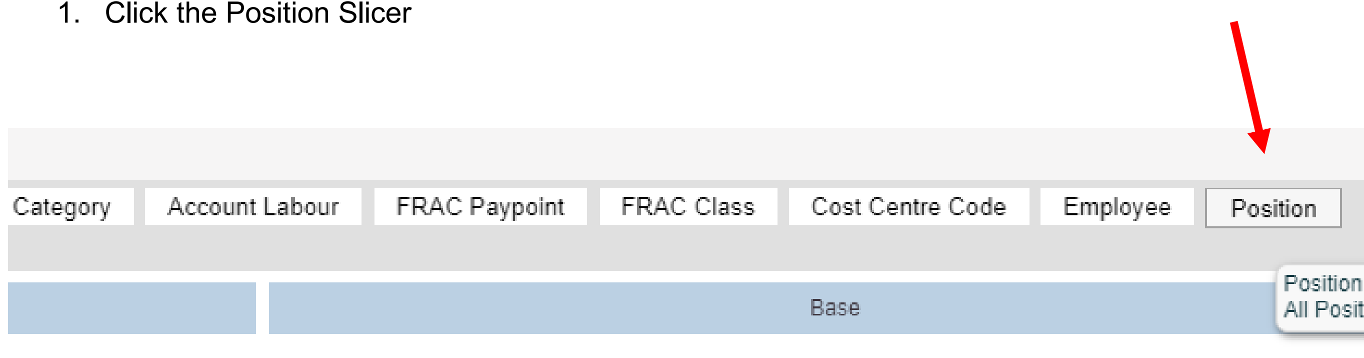
- Peer Worker: The essential requirements of this role are having a personal lived experience of mental health issues and recovery and experience as a mental health consumer (public or private)

- Carer Peer Worker: The essential requirements for this role are having a personal lived experience of caring for someone with mental health issues who has been a consumer of mental health services

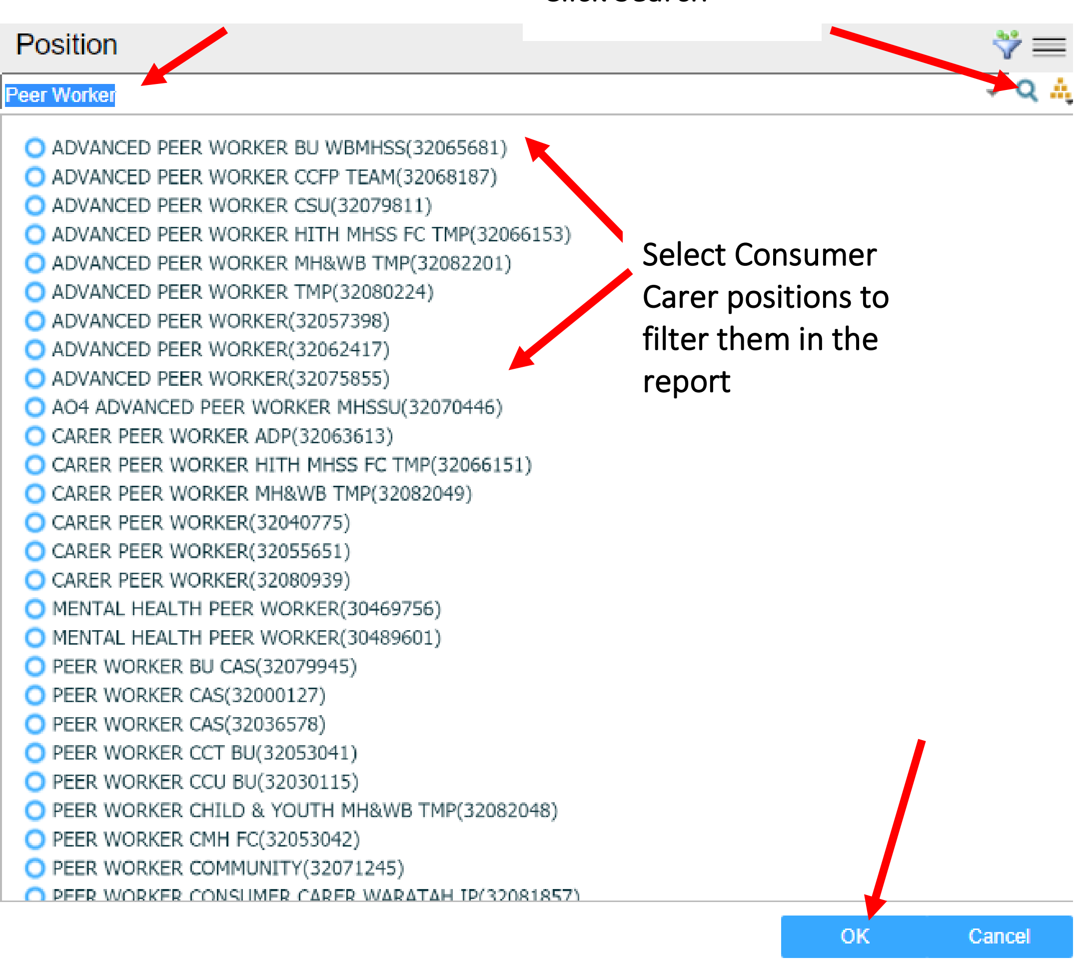
(public or private).

To help identify Peer workers (both consumer and carer), follow the steps detailed below:

1. Click the Position Slicer



Search for key position name key words to filter them in the report

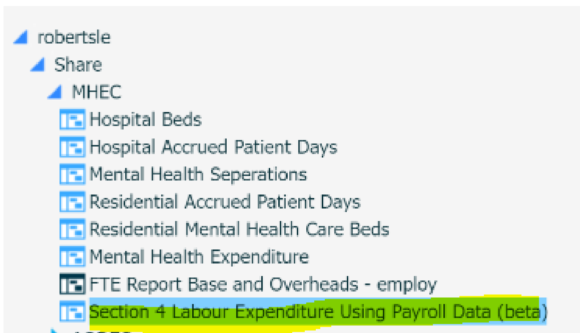


Paid FTE and Expenditure Reconciliation

To ensure consistency between reported labor related expenditure, and paid FTE, the DSS report

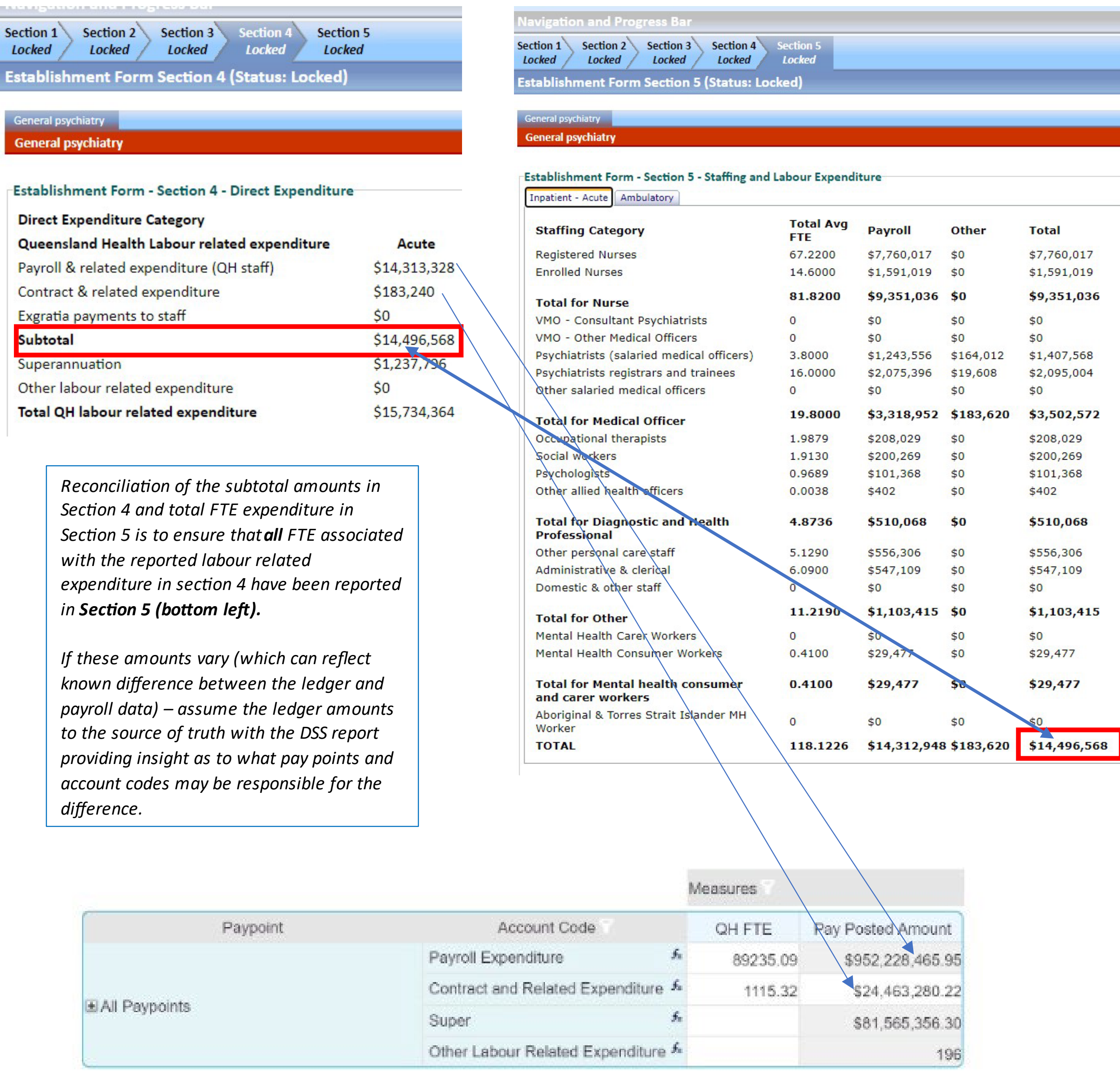
'*Section 4 Labor Expenditure Using Payroll Data*' has been created.

1. Double click on the *Section 4 Labor Expenditure Using Payroll Data (beta)*



2. Using the slicer menu above the report screen, select 'Division QH_ALT_7' and select your Hospital and Health Service, and drill down the cost centre structure to select the appropriate cost centres required

3. Using the same menu, select the relevant financial year
4. Compare the sum of the Pay Posted Amount with the labour related expenditure totals reported in sections 4. If there is a large discrepancy, further investigation is required.



Navigation and Progress Bar

Section 1 Locked | Section 2 Locked | Section 3 Locked | Section 4 Locked | Section 5 Locked

Establishment Form Section 4 (Status: Locked)

General psychiatry

General psychiatry

Establishment Form - Section 4 - Direct Expenditure

Direct Expenditure Category	
Queensland Health Labour related expenditure	**Acute**
Payroll & related expenditure (QH staff)	$14,313,328
Contract & related expenditure	$183,240
Exgratia payments to staff	$0
Subtotal	$14,496,568
Superannuation	$1,237,796
Other labour related expenditure	$0
Total QH labour related expenditure	$15,734,364

*Reconciliation of the subtotal amounts in Section 4 and total FTE expenditure in Section 5 is to ensure that **all** FTE associated with the reported labour related expenditure in section 4 have been reported in **Section 5 (bottom left).***

If these amounts vary (which can reflect known difference between the ledger and payroll data) – assume the ledger amounts to the source of truth with the DSS report providing insight as to what pay points and account codes may be responsible for the difference.

Navigation and Progress Bar

Section 1 Locked | Section 2 Locked | Section 3 Locked | Section 4 Locked | Section 5 Locked

Establishment Form Section 5 (Status: Locked)

General psychiatry

General psychiatry

Establishment Form - Section 5 - Staffing and Labour Expenditure

Inpatient - Acute | Ambulatory

Staffing Category	Total Avg FTE	Payroll	Other	Total
Registered Nurses	67.2200	$7,760,017	$0	$7,760,017
Enrolled Nurses	14.6000	$1,591,019	$0	$1,591,019
Total for Nurse	**81.8200**	**$9,351,036**	**$0**	**$9,351,036**
VMO - Consultant Psychiatrists	0	$0	$0	$0
VMO - Other Medical Officers	0	$0	$0	$0
Psychiatrists (salaried medical officers)	3.8000	$1,243,556	$164,012	$1,407,568
Psychiatrists registrars and trainees	16.0000	$2,075,396	$19,608	$2,095,004
Other salaried medical officers	0	$0	$0	$0
Total for Medical Officer	**19.8000**	**$3,318,952**	**$183,620**	**$3,502,572**
Occupational therapists	1.9879	$208,029	$0	$208,029
Social workers	1.9130	$200,269	$0	$200,269
Psychologists	0.9689	$101,368	$0	$101,368
Other allied health officers	0.0038	$402	$0	$402
Total for Diagnostic and Health Professional	**4.8736**	**$510,068**	**$0**	**$510,068**
Other personal care staff	5.1290	$556,306	$0	$556,306
Administrative & clerical	6.0900	$547,109	$0	$547,109
Domestic & other staff	0	$0	$0	$0
Total for Other	**11.2190**	**$1,103,415**	**$0**	**$1,103,415**
Mental Health Carer Workers	0	$0	$0	$0
Mental Health Consumer Workers	0.4100	$29,477	$0	$29,477
Total for Mental health consumer and carer workers	**0.4100**	**$29,477**	**$0**	**$29,477**
Aboriginal & Torres Strait Islander MH Worker	0	$0	$0	$0
TOTAL	**118.1226**	**$14,312,948**	**$183,620**	**$14,496,568**

Paypoint	Account Code	QH FTE	Pay Posted Amount
All Paypoints	Payroll Expenditure	89235.09	$952,228,465.95
	Contract and Related Expenditure	1115.32	$24,463,280.22
	Super		$81,565,356.30
	Other Labour Related Expenditure		196

MHSO form checklist

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

- MHSO form Section 5 total is greater than or equal to the total of MHSO form Section 9
- Consumer and Carer Peer Workers and Aboriginal and Torres Strait Islander Mental Health Workers identified and reported in the correct categories.

Establishment Form

Establishment form section 1: Services provided

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

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

Complete this section only after you have completed the controller matrix in MHSO Form Section 1. This will ensure only services available within the MHSO are enabled for the Establishment Form Section 1.

Program Types

Inpatient – acute

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

Inpatient acute care includes hospital in the home services.

Inpatient non-acute

Refers to all other admitted patient care services including sub-acute, rehabilitation and extended care services.

Sub-acute services provide short to medium term care to individuals experiencing mental illness requiring support beyond what the community care can provide. This includes early relapse, supervised medication adjustments, or recovery from acute episodes.

Rehabilitation services have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short

to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

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

Residential care

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

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

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

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

Ambulatory care

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

- community-based crisis assessment and treatment teams
- day programs

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

Target Populations

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 designed and provided for the selected target population.

General psychiatry

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

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

Child and adolescent psychiatry

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

Young person's psychiatry

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

Older persons psychiatry

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

Forensic psychiatry

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

Forensic services include:

- Community Forensic Outreach Service (CFOS)
- Prison Mental Health Services (PMHS)
- Statewide High Security Inpatient Service (HSIS)
- Extended Forensic Treatment and Rehabilitation Unit (EFTRU)
- Services provided by the Queensland Forensic Mental Health Service, including:
    - Police Communications Centre Mental Health Liaison Service (PCC MHLS)
    - Mental Health Support of Police Negotiators (MHSPN)
    - Court Liaison Service (CLS)
    - Social and Emotional Wellbeing in Correctional Centres (Indigenous Mental Health Intervention Program – IMHIP)

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.

Crisis Stabilisation Service

Crisis Stabilisation Services provide consumers in mental health crisis with assessment and interventions to assist with managing the crisis and/or need for urgent mental health care in a community or non-bed based setting for stays up to 23 hours and follow up care. This includes a chair-based crisis stabilisation unit.

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

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

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

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

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

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

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

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

National Accreditation Mental Health Services Codes

Code	Description
1	By 30 June, the service had been reviewed and was judged to have met all of the National Standards as determined by the accrediting

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

Code 1: The service unit had been reviewed and was judged to have met all of the applicable National Standards for Mental Health Services as determined by the accrediting agency

For more information on the determination of applicable National Standards for Mental Health Services please refer to the Australian Commission on Safety and Quality in Health Care website (http://www.safetyandquality.gov.au/our-work/mental-health/national-standards-in-mental-health/). Note that although most of the gaps relating to mental health have been addressed in the 2nd edition of the National Safety and Quality Health Service (NSQHS) standards, there are still some standards in the National Standards for Mental Health Services that are not included in the NSQHS. Service units that are accredited against NSQHS only should select Code 2.

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

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

Services.

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

This code should only be used for:

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

Establishment form section 3: Inpatient and residential services activity details

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

Accrued patient days

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

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

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

- For any given date, either an accrued patient day or a leave day may be counted, but not both.
- Accrued patient days are not accrued when the patient is out of hospital on leave, even though a bed may be 'held' for the patient during their absence.
- For patients admitted and separated on different dates, count one accrued patient day for the day of admission – do not count an accrued patient day for the day of separation.
- For patients admitted and separated on the same day, count one accrued patient day – do not count any leave days. The number of days accrued is one.
- A same day patient cannot go on overnight leave.

- A period of leave for a hospital patient cannot exceed seven days. A period of leave for a residential consumer on transition cannot exceed 42 days.
- Normally, the day of going on leave is counted as a leave day, and the day of returning from leave is counted as an accrued patient day.
- When, on the same date, a patient is admitted and goes on leave, count this day as an accrued patient day. When, on the same date, a patient returns from leave and again goes on leave, count this day as a leave day. When, on the same date, a patient returns from leave and is separated, do not count this day as either an accrued patient day or a leave day.

Some examples of accrued patient day calculations are:

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

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

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

A patient was admitted on 10 January of the previous financial year and remained in hospital until after 30 June and into this financial year. If no leave or transfers occurred, counting starts on 1 July of this financial year and ends on 30 June of this financial year so the number of accrued patient days would be 365 (or 366 in a leap year). Note that the patient's status on 30 June is that they remain in hospital, so this is an accrued patient day.

Sourcing Accrued Patient Day Information – HBCIS sites

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

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

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

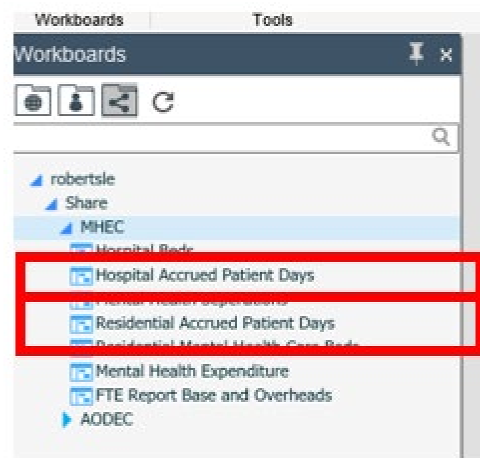
Child and Youth Acute	PYCA	Psychiatric Child Acute Unit
	PYCW	Psychiatric Child Acute Unit in Paediatric Ward
Child and Youth Acute	PYYA	Psych Adolescent Acute Unit (Young Persons Acute in Gold Coast HHS)
	PYYW	Psychiatric Adolescent Acute Unit in Adult Ward
Forensic Acute	PYFA	Psychiatric Forensic Acute
Forensic Non Acute	PYSH	Psychiatric Adult Ext - Extended High Security Unit
General Acute	PYAA	Psychiatric Adult Acute Unit
	PYAM	Psychiatric Adult – Mother and Baby
	PYAW	Psychiatric Adult Special Care Suite
General Non Acute	PYAQ	Psychiatric Adult Extended - Acquired Brain Damage Unit
	PYDD	Psychiatric Adult Extended - Dual Diagnosis Unit
	PYET	Psychiatric Adult Extended - Treatment Rehab Unit
General Residential	PYRA	Psychiatric Adult Residential
	PYSA	Psychiatric Adult – Step Up Step Down
Medium Secure Non Acute	PYSM	Psychiatric Adult Ext - Extended Secure Medium Unit
Older Persons Acute	PYGE	Psychogeriatric - Acute
Older Persons Non Acute	PYPG	Psychiatric Adult Extended - Psychogeriatric Unit
	PYGS	Psychiatric Older Persons Sub-Acute
Young Persons Acute	PYOA	Psychiatric Young Persons (Youth) Acute Unit
Young Persons Non Acute	PYRY	Psychiatric Adolescent Extended – Treatment and Rehabilitation
Young Persons Residential	PYSY	Psychiatric Youth Step Up Step Down

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

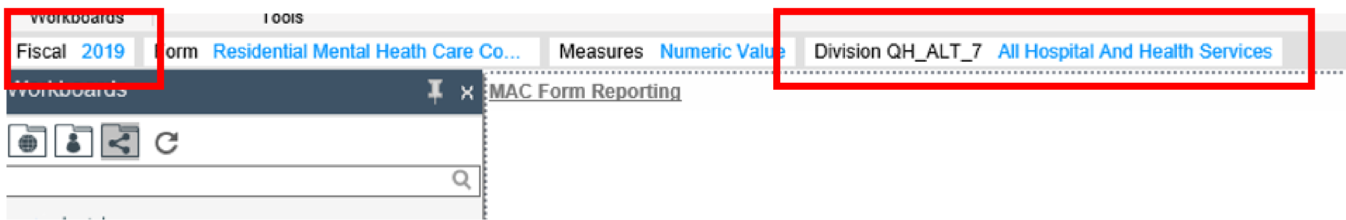
DSS Support Desk Phone Numbers: 1300 275 377 Hours: 8:00 AM to 4:30 PM Monday to Friday

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

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



2. Make sure your HHS is selected, and Fiscal is set to the current financial year based on the end of the year (ie 2021/22 would be 2022) Do not select June of the required year, as this will give June data only. The Accrued Patient Days Information will now be viewable. IMPORTANT: for establishments that have a MH-HITH program, **exclude** the hospital-in-the-home accrued days as these are captured separately (see hospital-in-the-home below).



Non HBCIS sites

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

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

Available beds

For inpatient and residential services, this means the number of beds available to provide overnight accommodation for patients; not including neonatal cots (non-special-care) or beds occupied by hospital-in-the-home patients, averaged over the counting period. Note hospital-in-the-home beds are captured separately (see hospital-in-the-home below).

Example:

A hospital conducts a monthly bed count. Unit A containing 20 beds is closed for six months for a planned renovation. During this period a temporary 10 bed Unit (B) is established and the necessary

resources are provided. The annual average number of available beds for Unit A is the average of the twelve counts i.e. (20 beds X 6 months) + (0 beds X 6 months) divided by 12 counting periods = 10 beds.

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

The annual average number of available beds for the hospital (including both Unit A and Unit B) is (20 beds X 6 months) + (0 beds X 6 months) + (0 beds X 6 months) + (10 beds X 6 months) divided by 12 counting periods = 15 beds.

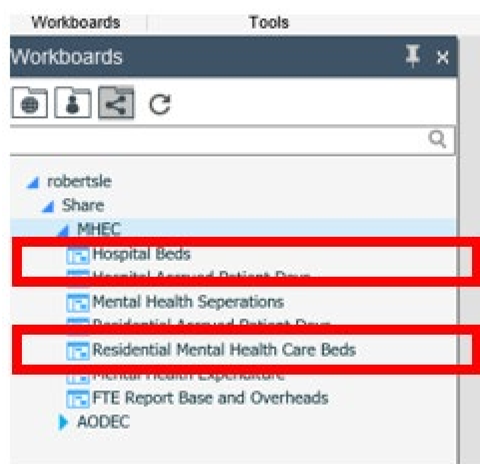
Sourcing Available Beds Information

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

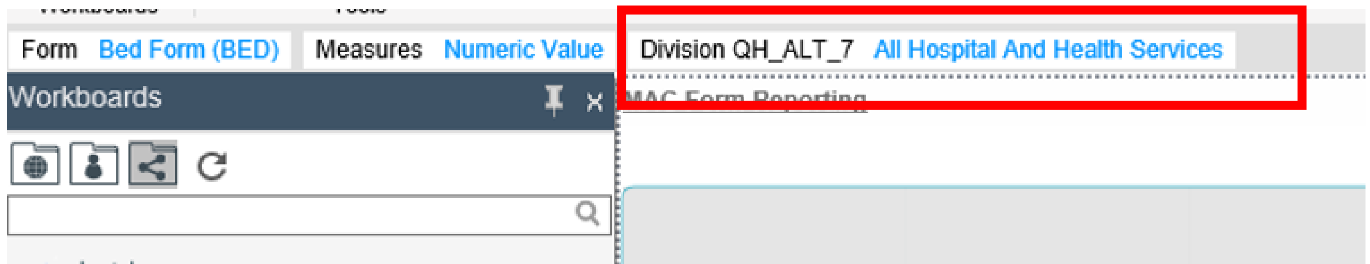
To access the data contained in the Average Available Beds report, you will need to negotiate access to the “Activity Based Funding Module” within DSS.

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

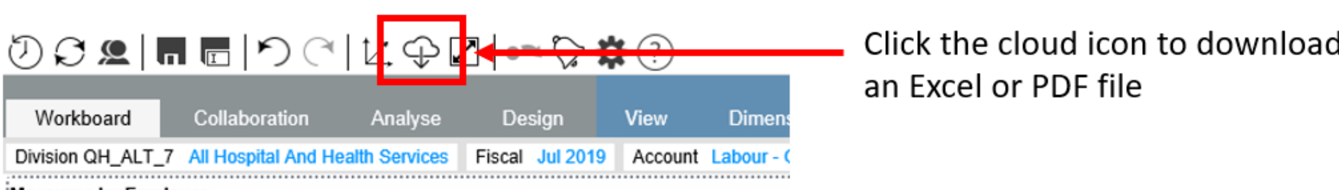
1. In the ‘Shared Content’ folder access reports shared by Leigh Roberts. Double click on the Hospital Beds report or the Residential Mental Health Care Beds report.



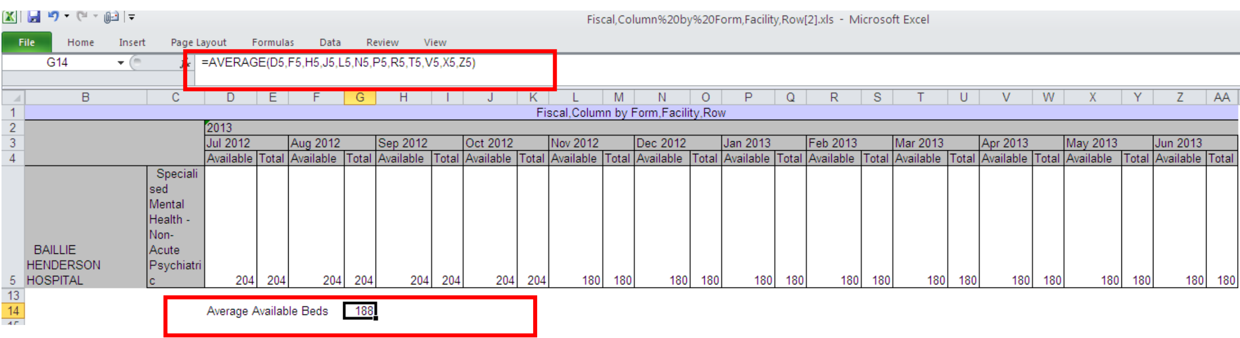
2. Ensure the Division filter shows your HHS. Beds data will now be viewable.


Form Bed Form (BED)
Measures Numeric Value
Division QH_ALT_7 All Hospital And Health Services
Workboards
MAC Form Reporting

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



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



Separations

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

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

2. A statistical separation following leave is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following leave of absence that exceeded seven consecutive days.

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

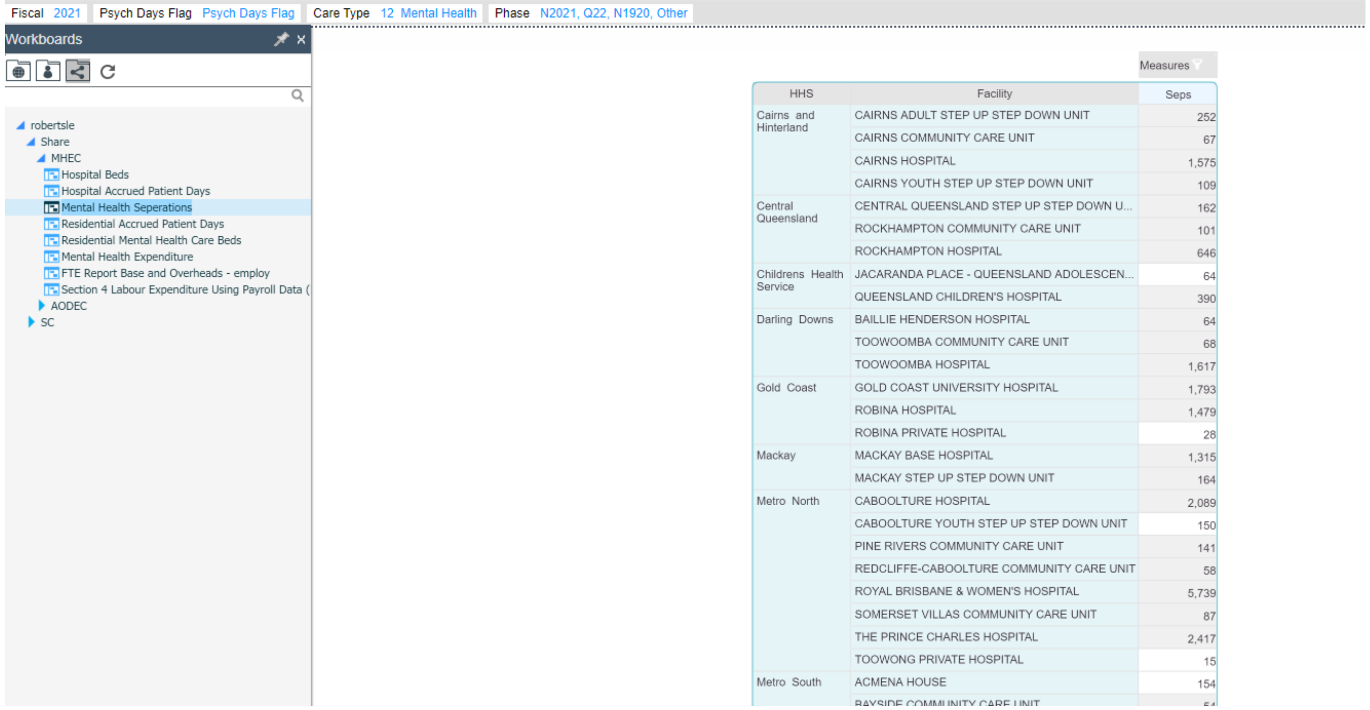
All three types of separations are to be counted. Note **exclude** hospital-in-the-home separations are these are captured separately (see hospital-in-the-home below).

Sourcing Separations Information

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

Login to DSS and follow these instructions:

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



HHS	Facility	Seps
Cairns and Hinterland	CAIRNS ADULT STEP UP STEP DOWN UNIT	252
	CAIRNS COMMUNITY CARE UNIT	67
	CAIRNS HOSPITAL	1,575
	CAIRNS YOUTH STEP UP STEP DOWN UNIT	109
Central Queensland	CENTRAL QUEENSLAND STEP UP STEP DOWN U...	162
	ROCKHAMPTON COMMUNITY CARE UNIT	101
	ROCKHAMPTON HOSPITAL	646
Childrens Health Service	JACARANDA PLACE - QUEENSLAND ADOLESCEN...	64
	QUEENSLAND CHILDREN'S HOSPITAL	390
Darling Downs	BAILLIE HENDERSON HOSPITAL	64
	TOOWOOMBA COMMUNITY CARE UNIT	68
	TOOWOOMBA HOSPITAL	1,617
Gold Coast	GOLD COAST UNIVERSITY HOSPITAL	1,793
	ROBINA HOSPITAL	1,479
	ROBINA PRIVATE HOSPITAL	28
Mackay	MACKAY BASE HOSPITAL	1,315
	MACKAY STEP UP STEP DOWN UNIT	164
Metro North	CABOOLTURE HOSPITAL	2,089
	CABOOLTURE YOUTH STEP UP STEP DOWN UNIT	150
	PINE RIVERS COMMUNITY CARE UNIT	141
	REDCLIFFE-CABOOLTURE COMMUNITY CARE UNIT	58
	ROYAL BRISBANE & WOMEN'S HOSPITAL	5,739
	SOMERSET VILLAS COMMUNITY CARE UNIT	87
	THE PRINCE CHARLES HOSPITAL	2,417
	TOOWONG PRIVATE HOSPITAL	15
Metro South	ACMENA HOUSE	154

2. Make sure the filters show Fiscal year (ie the end year of the financial year, such that 2021/22 would be 2022. Do not select June at the end of the financial year. IMPORTANT: If the establishment has a MH-HITH program, exclude the hospital-in-the-home separations as these are captured separately (see hospital-in-the-home below).

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

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

Episodes of Residential Care are made up of one or more episodes of care from HBCIS. As part of the

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

Average hours staffed

The average number of hours **per day** during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training. Round to the nearest whole hour. Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend. It excludes periods where the service unit is only staffed by a resident sleepover staff member (where that staff member is not appropriately trained or is not expected to provide any services overnight) or any period where staff are present but not employed on site at the service unit. Note that if a sleepover staff member is employed to be in the facility at night as a trained employee, or as a peer worker, this should be included in the average hours staffed.

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

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

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

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

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

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

A comprehensive HITH Guideline addressing all recommendations for HITH is available at the following address: [Hospital in the Home | Queensland Health guideline | Queensland Health]

HITH MH Available Beds

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

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

Mental Health Hospital in the Home beds are not reported separately in MAC from other Hospital in the Home beds, and this figure must therefore be sourced separately from the MAC based DSS reports. There are currently no formal state-wide reports capturing the number of available MH HITH beds.

Mental Health Hospital-in-the-Home beds should be reported in the relevant field on the MHEC form only. They should not be included in the available beds figure.

HITH MH Separations

HITH separation processes are the same as standard separation processes for admitted patients in the ward. As with acute separations, HITH separations will include:

1. A formal separation where 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 change of care type, ie if the patient changes care type due to a non-mental health acute condition.

Note that a HITH separation is counted when the patient is HITH at the time of discharge. Where a patient starts as a HITH patient but is transferred to the mental health ward during treatment, this separation will be counted as an acute separation. A patient starting in the mental health ward who is then transferred to HITH care and is separated while HITH should be counted as a HITH separation.

HITH MH Accrued Patient Days

The number of accrued patient days refers to those days or part days accrued by HITH patients during the reporting period – regardless of a patients' admission and separation dates. This will include all days a patient was treated as a HITH patient. Where a patient was transferred between HITH and the acute mental health ward, only the days where the patient was HITH should be reported here. Calculations for HITH MH accrued patient days follow the same rules as those for acute admitted patients.

Establishment form section 4

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

For facilities run in collaboration with and NGO, this includes the NGO direct expenditure.

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

Completing this section

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

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

For contracted or procured services which exist outside of the QH payroll and X-man payment processes the associated salary expenditure needs to be sourced and then added to the relevant Labour and Related Expenditure category. FTE associated with these staff will need to be reported on Establishment Section 5.

For publicly funded residential mental health services that are run by or in collaboration with a non-government organisation (NGO), section 4 of the establishment form includes separate categories for entry of expenditure associated with the NGO.

Where the service contract for the NGO is with the HHS (and not the Department of Health), the data must be supplied by the HHS. It is recommended that during contract negotiations, HHSs should include provisions in service agreements for the provision of required data.

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

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 program type (e.g. inpatient acute). HHSs/MHSOs that are funded by the Department of Corrective Services or the Department of Child Safety, Youth and Women to provide mental health services to prisons or youth detention centres should include this expenditure here. Services that are reimbursed from other HHS via Inter Entity Transfer should also include expenditure and staffing here.

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

All expenditure that relates to the delivery of services by each establishment should be included in section 4. That is, relevant expenditure that may be included in non-mental health cost centres should be reported. For example, food or drug supplies costed at the health HHS (or hospital) level that relates to mental health service delivery must be apportioned across the various establishments (and not included on MHSO Form Section 5).

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

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

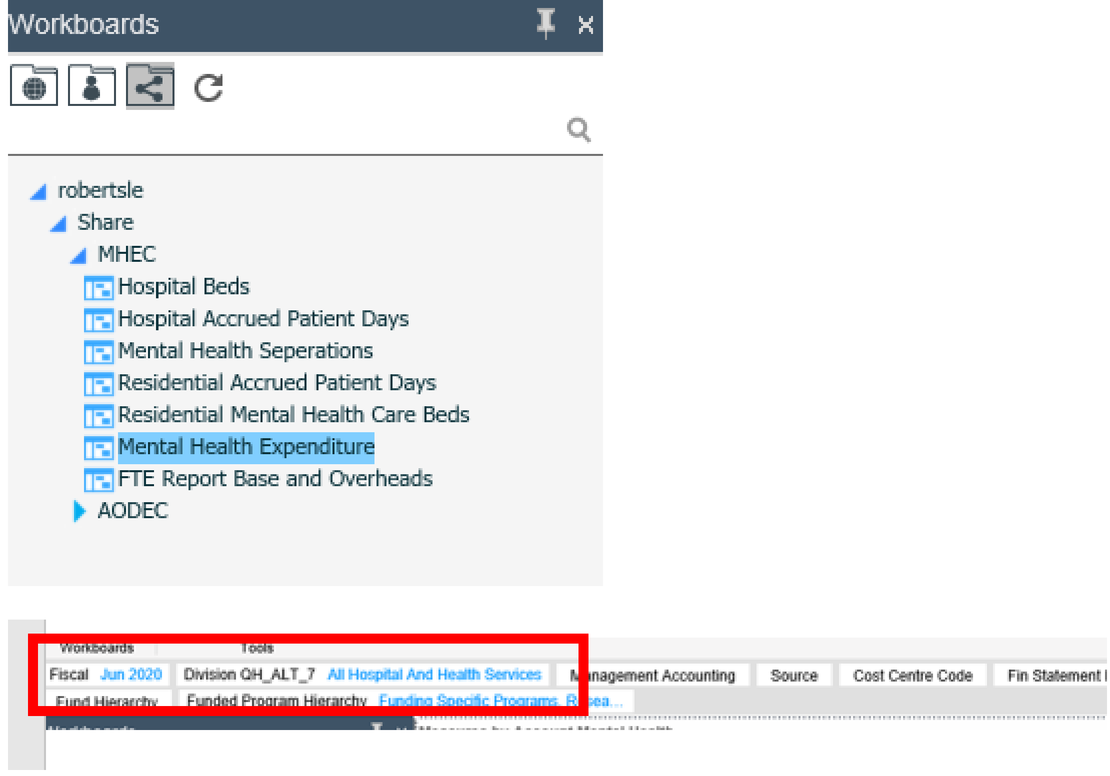
A Mental Health general ledger expenditure hierarchy (Account Mental Health) has been created in S4 HANA and DSS to assist in extracting expenditure data for section 4. It has been used to build the Mental Health Expenditure report created and shared by Leigh Roberts in DSS.

Sourcing Expenditure Information

The Mental Health Expenditure report has been created to assist in the reporting of this information.

Login to DSS and follow these instructions:

1. In the 'Shared Content' folder access reports shared by Leigh Roberts. Double click on the Mental Health Expenditure report and ensure the fiscal year identified by the end year eg 2022/23 would be 2023 is selected (not June at the end of the year); and that your HHS/MHSO is selected in the Division



Any balances that appear against the ‘Accounts not in Rollup’ grouping must be disbursed to the appropriate sections of Establishment Form Section 4 or MHSO Form Section 5. You may need to drill down in the ‘Accounts not in rollup’ grouping to locate the exact account code and/or refer to invoices.

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

Expenditure categories

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

Note that payments made by the HHS to NGOs for the provision of collaborative and operational services on Residential Mental Health Care Establishments should be recorded as NGO expenditure under the relevant 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. Salary/wages for collaborative NGO employees is to be provided under the NGO expenditure section.

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. maintenance and domestic cleaning staff).

Ex-gratia payments to staff

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

Superannuation

Includes superannuation employer contributions paid, or that should be paid, on behalf of establishment employees, either by the HHS or corporate office, to a superannuation fund providing retirement and related benefits to established employees. Superannuation paid by collaborative NGOs to their staff should be recorded in the NGO expenditure section.

Other labour related expenditure

Includes payroll tax, fringe benefits tax and salary sacrifice. Other labour related expenditure incurred by collaborative NGOs for NGO staff should be recorded in the NGO expenditure section.

Food supplies

Includes expenditure on all food and beverages. Do not include kitchen expenses such as utensils, cleaning materials, cutlery, and crockery. Food supplies purchased by collaborative NGOs as part of the provision of services should be recorded in the NGO expenditure section.

Drug supplies

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

Clinical supplies and services

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

Non-clinical supplies and services

Includes expenditure on all non-clinical supplies and services, including electricity, other fuel and power, domestic services and kitchen expenses (excludes salary, wages and contract staff, food costs and equipment replacement and repair costs). Non-clinical supplies and services procured by collaborative NGOs as part of the provision of services should be recorded in the NGO expenditure section.

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.

Repairs and maintenance expenditure incurred by collaborative NGOs on equipment provided by the NGO should be recorded in the NGO expenditure section.

Patient transport services

Includes expenditure on the direct cost of transporting patients, excluding the salaries and wages of transport staff employed by the HHS. Patient transport costs incurred by collaborative NGOs should be recorded in the NGO expenditure section.

Worker's compensation premium

Includes expenditure on worker's compensation insurance premiums made by the organisation on behalf of its employees. It does not include Worker's compensation payments made to staff or reimbursed to the HHS. Worker's compensation insurance premiums paid by collaborative NGOs on behalf of NGO staff should be recorded in the NGO expenditure section.

Insurance

Includes expenditure on public risk and other insurance amounts paid by the HHS with respect to the provision of mental health services within the HHS. Expenditure on insurance taken out by a collaborative NGO as part of their services should be recorded in the NGO expenditure section.

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. Other administrative expenses incurred by collaborative NGOs as part of providing services should be recorded in the NGO expenditure section.

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 this expenditure category. Depreciation and amortisation on assets provided by collaborative NGOs as part of their service contract should be recorded in the NGO expenditure section.

Interest payments

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

Other expenditure

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

expenditure incurred by collaborative NGOs as part of the provision of services should be recorded in the NGO expenditure section. This may include monies that have been provided to the NGO but not yet expended by the NGO.

Cost centre code

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

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

Section 4 Checklist

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

Establishment form section 5

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

Completing this section

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

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

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

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

Sourcing Expenditure Information

Refer to section MHSO form Section 9

Expenditure categories

Payroll and contract expenditure

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

Other related expenditure (excluding superannuation)

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

Staffing categories

The staff categories used in section 5 do not coincide with Queensland Health classifications. However, these categories are required by the Australian Institute of Health and Welfare and the Australian Department of Health to maintain consistency in the collection of mental health data throughout Australia. The DSS reports (see FTE Reports above) provide data at paypoint summary and employee levels. Hopefully this information will assist in allocating FTE to staffing categories. It is suggested that the percentage of time spent on the various activities be used as a basis for the values you enter against

the relevant staffing categories.

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

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

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

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

Registered nurses

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

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

Enrolled nurses

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

Visiting medical officers – consultant psychiatrists

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

Visiting medical officers – other medical officers

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

Psychiatrists – salaried medical officers

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

Psychiatry registrars and trainees

Refers to medical officers who are recognised 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 registered to practice psychiatry nor a recognised trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Occupational therapists

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

Social workers

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

Psychologists

Refers to staff who are registered as psychologists with Ahpra.

Other allied health officers

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

Other personal care staff

Refers to attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants, and nursing assistants (AIN's) engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or undergoing training in nursing or allied health professions. It excludes peer workers, who should be reported as mental health consumer or carer workers and Aboriginal and Torres Strait Islander Mental Health Care Workers.

Administrative and clerical staff

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

Domestic and other staff

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

Mental Health Carer Workers

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

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

Mental Health Consumer Workers

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

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

Aboriginal and Torres Strait Islander Mental Health Workers

Refers to persons specifically employed to provide mental health care support and services to Aboriginal and Torres Strait Islander peoples. These mental health professionals have recognised qualifications and/or work experience in Aboriginal and Torres Strait Islander Mental Health and/or Aboriginal and Torres Strait Islander Health.

Roles that Aboriginal and Torres Strait Islander mental health workers may perform include, but are not limited to:

- enhancing accessibility of culturally appropriate mental health services for Aboriginal and Torres Strait Islander people
- active involvement and engagement in the provision of mental health services to Aboriginal and Torres Strait Islander people, their families and communities
- Advocating and engaging Aboriginal and Torres Strait Islander people in the planning, development and evaluation of mental health services for Aboriginal and Torres Strait Islander communities
- providing advice to colleagues and wider community on culturally appropriate support to Aboriginal and Torres Strait Islander people in relation to planning and provision of mental health services.

Section 5 Checklist

- Superannuation is not included.
- For a target population and program type settings, the total expenditure in Section 5 is equal to the labour related expenditure sub-total for the same target population and program type setting in Establishment form Section 4 (including the NGO labour related expenditure where the establishment is run in collaboration with an NGO).
- On the advice of the Financial Accounting Team, in those cases where the expenditure figures reported by S4 HANA and DSS do not agree, you should take the S4 HANA amounts as correct and adjust the DSS amounts accordingly.
- Where data is significantly different to the previous financial year, explanation notes should be included in the validation reason box.

Glossary of terms

Accrued patient days

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

Acute inpatient service

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

exacerbation of symptoms. This includes hospital in the home services.

Ambulatory care

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

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

Available beds

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

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

Capital expenditure

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

expenditure is excluded from reporting in MHEC.

Carer

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

Child and adolescent psychiatry services

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

Crisis Stabilisation

Crisis Stabilisation Services provide consumers in mental health crisis with assessment and interventions to assist with managing the crisis and/or need for urgent mental health care.

Direct expenditure

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

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

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

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

Forensic psychiatry services

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

Full-time equivalent

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

occupation where applicable). Hours of unpaid leave are to be excluded.

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

General psychiatry services

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

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

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

Hospital-in-the-home (mental health)

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

Hospital-in-the-home mental health accrued patient days

The number of accrued patient days refers to those days or part days accrued by HITH patients during the reporting period. This will include all days a patient was treated as a HITH patient. Where a patient was transferred between HITH and the acute mental health ward, only the days where the patient was treated as a HITH patient are included.

Hospital-in-the-home mental health beds

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

Hospital-in-the-home mental health separations

HITH separations include:

1. A formal separation where 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 change of care type, ie if the patient changes care type due to a non-mental health acute condition.

Note that a HITH separation is counted when the patient is HITH at the time of discharge. Where a patient starts as a HITH patient but is transferred to the mental health ward during treatment, this separation will be counted as an acute separation. A patient starting in the mental health ward who is then transferred to HITH care and is separated while HITH should be counted as a HITH separation.

Indirect Expenditure
Expenditure indirectly related to the delivery of mental health services that cannot or should not be apportioned across the reporting establishments in your HHS/MHSO (e.g. overhead labour related expenditure).

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

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

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

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

Non-acute inpatient services
Refers to all other admitted patient care services including sub-acute, rehabilitation and extended care services, however, excludes community care units, youth residential rehabilitation services and step up step down units (which should be reported as ‘residential care’).

Sub-acute services provide short to medium term care to individuals experiencing mental illness requiring support beyond what the community care can provide. This includes early relapse, supervised medication adjustments, or recovery from acute episodes.

Rehabilitation services have a primary focus on intervention to reduce functional impairments that limit

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

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

Older persons' psychiatry services

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

Primary consumer

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

Residential care services

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

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

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

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

- individuals with experience in mental health or disability relevant to providing mental health consumers with appropriate services.

Separations

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

- *A formal separation:*
  - is the normal administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. This will be because the patient is discharged, or is transferred to another health care accommodation, or has died.
- *A statistical separation following leave:*
  - is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following leave of absence that exceeded seven consecutive days from a hospital, or 42 consecutive days for a residential mental health care establishment.
- *A statistical separation on type change:*
  - is the administrative process by which a hospital records the completion of treatment and/or care and accommodation following a care type change.

All three types of separations are to be counted.

Specialised mental health service – hours staffed

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

Staffing categories

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

Young person's psychiatry services

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

Appendix A: Mental Health Establishments Structure 2024-2025

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

HHS	MHSO	ESTABLISHMENT	EST. ID
Cairns And Hinterland	Cairns	Cairns Adult Community MHS	80040
		Cairns Adult Step Up Step Down Unit	83001
		Cairns Child & Youth Community MHS	80073
		Cairns Community Care Unit	82008
		Cairns Hospital	00214
		Cairns Youth Residential Rehabilitation Unit	83008
		Cairns Youth Step Up Step Down Unit	83005
		Headspace Cairns	80156
		Innisfail Community MHS	80076
		Tablelands Community MHS	80104
Central Queensland	Central Queensland	Biloela Community MHS	80103
		Central Queensland Step Up Step Down Unit	83004
		Emerald Community MHS	80072
		Gladstone Community MHS	80595
		Headspace Emerald	80059
		Headspace Gladstone	80060
		Headspace Rockhampton	80143
		Rockhampton Adult Community MHS	80586
		Rockhampton Base Hospital	00141
		Rockhampton Child & Youth Community MHS	80596
		Rockhampton Community Care Unit	82010
Central West	Central West	Longreach Community MHS	80070
Children's Health Queensland	Children's Health Queensland	Chermisde Galleria Child & Youth Community MHS	81250
		Eating Disorders Child & Youth Community MHS	80719
		Everton Park Youth Residential Rehabilitation Unit	83009
		Evolve Child & Youth Community MHS	80509
		Greenslopes Youth Residential Rehabilitation Unit	83010
		Grey Street Child & Youth Community MHS	80523
		Head to Health Kids Brisbane North	80145
		Head to Health Kids Brisbane South	80134
		Headspace Children’s Health Queensland	80138

HHS	MHSO	ESTABLISHMENT	EST. ID
		Inala Child & Youth Community MHS	80720
		Jacaranda Place	00752
		Queensland Children's Hospital	00202
		Mt Gravatt Child and Youth Community MHS	81094
		North West Child & Youth Community MHS	81095
		Nundah Child & Youth Community MHS	81270
		Perinatal & Infant Mental Health Service	81275
		Pine Rivers Child & Youth Community MHS	80101
		Yeronga Child & Youth Community MHS	80744
Darling Downs	Toowoomba	Baillie Henderson Hospital Campus	00701
		Cherbourg Community MHS	80096
		Chinchilla Community MHS	80831
		Dalby Community MHS	80832
		Goondiwindi Community MHS	80217
		Headspace Southern Downs	80142
		Headspace Toowoomba	80141
		Kingaroy Community MHS	80207
		Millmerran Adult Community MHS	80222
		Stanthorpe Community MHS	80221
		Toowoomba Adult Community MHS	80804
		Toowoomba Child & Youth Community MHS	80829
		Toowoomba Community Care Unit	82009
		Toowoomba Hospital	00104
		Toowoomba Psychogeriatric Community MHS	80092
		Warwick Community MHS	80097
Gold Coast	Gold Coast	Gold Coast University Hospital	00936
		Gold Coast Transitional Recovery Service (TRS)	83014
		Head to Health Kids Gold Coast	80135
		Headspace Gold Coast	80137
		Palm Beach Adult Community MHS	80119
		Robina Community MHS	81236
		Robina Hospital	00934
		Southport Adult Community MHS	81263
		Southport Child & Youth Community MHS	80127
		Varsity Lakes Community MHS	80157
Mackay	Mackay	Headspace Mackay	80146

HHS	MHSO	ESTABLISHMENT	EST. ID
		Mackay Adult Community MHS	80372
		Mackay Base Hospital	00172
		Mackay Child & Youth Community MHS	80373
		Mackay Step Up Step Down Unit	83000
		Moranbah Community MHS	80987
		Whitsunday Community MHS	80955
Mater Public Hospitals	Mater Hospital	Mater Adult Hospital	00001
Metro North	Redcliffe-Caboolture	Caboolture Adult Community MHS	80439
		Caboolture Hospital	00030
		Caboolture Satellite Health Centre	15003
		Caboolture Youth Residential Rehabilitation Service	83016
		Caboolture Youth Step Up Step Down Unit	83012
		Headspace Caboolture	80150
		Redcliffe Adult Community MHS	80443
		Redcliffe Caboolture Crisis Assessment & Treatment Community MHS	80259
		Redcliffe-Caboolture Adult Community MHS	80997
		Redcliffe-Caboolture Child & Youth Community MHS	80994
		Redcliffe-Caboolture Community Care Unit	82002
	Royal Brisbane And Women's Hospital	Community Forensic MHS	80493
		Inner North Brisbane Community MHS	80498
		Royal Brisbane & Women's Hospital	00201
		Somerset Villas Community Care Unit	82003
		Spring Hill Community MHS	80043
	The Prince Charles Hospital	Chermside Adult Community MHS	80521
		Nundah Community MHS	81002
		Pine Rivers Community Care Unit	82001
		Pine Rivers Community MHS	80522
		The Prince Charles Hospital	00004
Metro South	Bayside	Bayside Adult Community MHS	80998
		Bayside Child & Youth Community MHS	80090
		Bayside Community Care Unit	82005
		Casuarina Lodge - Wisteria Abi Unit	00625
		Headspace Bayside	80152
		Redland Hospital	00028
		Daintree Psychogeriatric Inpatient Unit	01404

HHS	MHSO	ESTABLISHMENT	EST. ID
	Logan-Beaudesert	Acmena House	83002
		Beenleigh Community MHS	80128
		Browns Plains Community MHS	81010
		Headspace Beaudesert	80148
		Headspace Logan	80151
		Logan Central Adult Community MHS	80739
		Logan Central Child & Youth Community MHS	80737
		Logan Community Care Unit	82006
		Logan Hospital	00029
		Logan Steps Transitional Living and Suport	83015
		Logan Youth Step Up Step Down Unit	83011
	Princess Alexandra Hospital	Coorparoo Community Care Unit	82000
		Headspace Inala	80147
		Inala Adult Community MHS	80759
		Inala Child and Youth Community MHS	80133
		Woolloongabba Community MHS	81260
		Princess Alexandra Hospital	00011
North West	Mt Isa	Doomadgee Community MHS	80084
		Headspace Mount Isa	80149
		Mornington Island Community MHS	80051
		Mt Isa Community MHS	80918
		Normanton Community MHS (Closed)	81141
South West	South West	Charleville Community MHS	80306
		Headspace Roma	80155
		Roma Adult Community MHS	80307
		Roma Child & Youth Community MHS	80308
		St George Community MHS	81288
Sunshine Coast	Sunshine Coast	Caloundra Community MHS	80063
		Glenbrook Residential Aged Care Facility	00612
		Gympie Community MHS	80412
		Headspace Gympie	80140
		Headspace Maroochydore	80139
		Maroochydore Community MHSS HUB	80435
		Mountain Creek Community Care Unit	82004
		Nambour Adult Community MHS	80437
		Nambour Hospital	00049

HHS	MHSO	ESTABLISHMENT	EST. ID
		Sunshine Coast University Hospital	00032
		Sunshine Coast CSTARS	83013
		Sunshine Coast Community Mobile Intensive	80291
	Wandi Nerida	Wandi Nerida	00354
Torres & Cape	Torres & Cape	Bamaga Community MHS	80074
		Cape York Community MHS	80080
		Cooktown Community MHS	80075
		Thursday Island Community MHS	80078
		Torres and Cape Community MHS	80052
		Weipa Community MHS	80042
Townsville	Townsville	Aitkenvale Youth Residential Rehabilitation Unit	83006
		Burdekin Community MHS	81233
		Charters Towers Community MHS	80086
		Charters Towers Community Care Unit	82014
		Eventide Nursing Home - Pandanus Psychogeriatric Unit	00693
		Headspace Townsville	80136
		Ingham Community MHS	81113
		Kirwan Rehabilitation Unit	00715
		Palm Island Community MHS	80085
		Townsville Adult Community Forensic MHS	80996
		Townsville Adult Community MHS	80995
		Townsville Child & Youth Community MHS	80939
		Townsville Community Care Unit	82012
		Townsville University Hospital	00200
West Moreton	West Moreton	Gailes Community Care Unit	82011
		Goodna Adult Community MHS	80254
		Goodna Child & Youth Community MHS	80144
		Ipswich Adult Community MHS	80255
		Ipswich Child & Youth Community MHS	80099
		Ipswich Hospital	00015
		The Park - Centre For Mental Health	00751
Wide Bay	Wide Bay	Bundaberg Adult Community MHS	80194
		Bundaberg Child & Youth Community MHS	80195
		Bundaberg Hospital	00062
		Fraser Coast Adult Community MHS	80989
		Fraser Coast Child & Youth Community MHS	80990

HHS	MHSO	ESTABLISHMENT	EST. ID
		Headspace Bundaberg	80154
		Headspace Fraser Coast	80153
		Hervey Bay Hospital	00069
		Maryborough Hospital	00071
		Wide Bay Community Care Unit	82007
		Wide Bay Mental Health & Specialised Services	81271
		Wide Bay Rural Community MHS	80071
		Wide Bay Step Up Step Down Unit	83003

Appendix B: General Ledger Account Codes

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

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

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

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

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

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

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

Direct Expenditure Category	Relevant General Ledger Account Codes
Payroll and Related Expenditure	Salary and wages: 500000-500095 Overtime, penalties, allowances and leave • Overtime 501010-501090 • Penalties 502010-502090 • Allowances 502210-502490 & 502910-502990 • Annual leave 503010-503090 • LSL 503300-503390 • Sick leave 503510-503590 • PD Leave 503635 & 503810-503890 • Other leave 503610-503630 & 503640-503690 Workcover reimbursement 503700-503790 Redundancies 506000-506090 Rec leave in recognition, long service leave 508000-508890 Salary recoveries 509000-509390 Package Benefits 512120-512135 Salary overpayments 514000, 514035, 514090 Salary and wages adjustments 516005-516090 & 516099
Contract and Related Expenditure	Contract operational staff 517100 – 517191 & 517199 Temporary non-operations services payroll, overtime and allowances 517210-517480 & 517610-517680 & 517705-517790 & 514090 Fee-based contractors 517500-517505
Ex-gratia payments to staff	Ex-gratia payments 506100-506120
Superannuation	Employer superannuation contributions 504000-504190 Manual Adjustments to Superannuation 516070-516490 Contractor superannuation contributions 517510
Other labour related expenditure	Salary sacrifice 500095 Payroll and fringe benefits tax 505000-505200 Contract operational staff fringe benefits tax 517196 Reclassified leave and super 516100-516500

Direct Expenditure Category	Relevant General Ledger Account Codes
Food supplies	Other supplies food and drink related 565010 Inventory write off catering 563000
Drug supplies	Drug supplies 550076-559950 Inventory write off pharmacy 563010, 563040 Inter entity pharmacy 566001 Intra company pharmacy 577425, 577426
Clinical supplies and services	Clinical supplies 560000-562000 Fee for service – private health providers 565060 Inter entity clinical supplies 566002, 566003, 566012 Intra Company clinical supplies 577400-577403, 577435, 577436 InterEntity outsourced delivery clinical 566017 InterEntity Tissue Bank 566018
Non-clinical supplies and services	Private Security Services 510215 Building Cleaning and other services 510220 Electricity and other energy sources 510800-510850 Private patient incentives 511021 General and domestic supplies 565000 & 565030-565055 Inter-entity non-clinical supplies 566000 & 566004-566010 & 566016 Professional Services 566060 Inventory Issued 566120 Indigenous Health Services 566121, 566122 Trade Discounts and Rebates 566135 Intra Company non-clinical supplies 577420, 577421, 577446
Repairs and maintenance	Repairs and maintenance 536000-536500 Intra company parts – BTS and repairs 577405, 577406, 536330, 536355

Direct Expenditure Category	Relevant General Ledger Account Codes
Patient transport service	Patient transport services 528000-528150 Aero-medical service 566011 Intra Company Aero-medical 577450, 577451
Workers compensation premium	Workcover expense 511210, 511211 Contract operational staff Workcover 517195
Insurance	Insurance excluding Workcover 511215-511220 Inter-entity Insurance payments 566009 Intra company insurance 577430, 577431
Other administrative expenses	Advertising, building, IT and non-clinical consultancy 510000-510010, 510200-510210, 510400-510420, 510600-510640 Fees including bank fees 511000-511020, 511025-511030, 510035 Legal, motor vehicle, library, general administration, freight, office supplies 511410-513850 Bad, doubtful and waived debts, corporate card fees, debt collection 514010-514030,514040-515005 Agency fees 517010-517050 Donations, sponsorships, functions, travel and accommodation 518000-524000 Minor assets 530000 QTC Administration 577030 Intra company IT, telecoms, office supplies 566019-566023, 577407-577428, 577440, 577441, 577470, 577475-577500, 577445
Depreciation	Depreciation 590050-590120, 590150 Amortisation 590130-590135, 590150-590190
Interest payments	Interest 577015, 577020, 577021, 577050

Direct Expenditure Category	Relevant General Ledger Account Codes
Other expenditure	Temporary site accommodation 536600 Inventory Write-off and loss 563060-563090 Cost of goods sold 564000 Inter entity non-capital expenses 566013, 566014 Payment Discounts 566130, 566055 Intra company general supplies and services 577480, 577485, 577500, 577475 Stock and Loss adjustments, impairment and revaluations 590200-599865 Grants Returned 519090 Service Procurement 565061-565069 Quarantine Fees 514091-514901 Funding Expenses 540010-540090 Grants 570020-570095

Frequently Asked Questions

How do I report programs funded by another HHS?

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

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

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

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

Why does the MHAODB supply a spreadsheet with CIMHA and QHAPDC Activity?

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

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

How do I report services run by or in collaboration with Non-

Government Organisations?

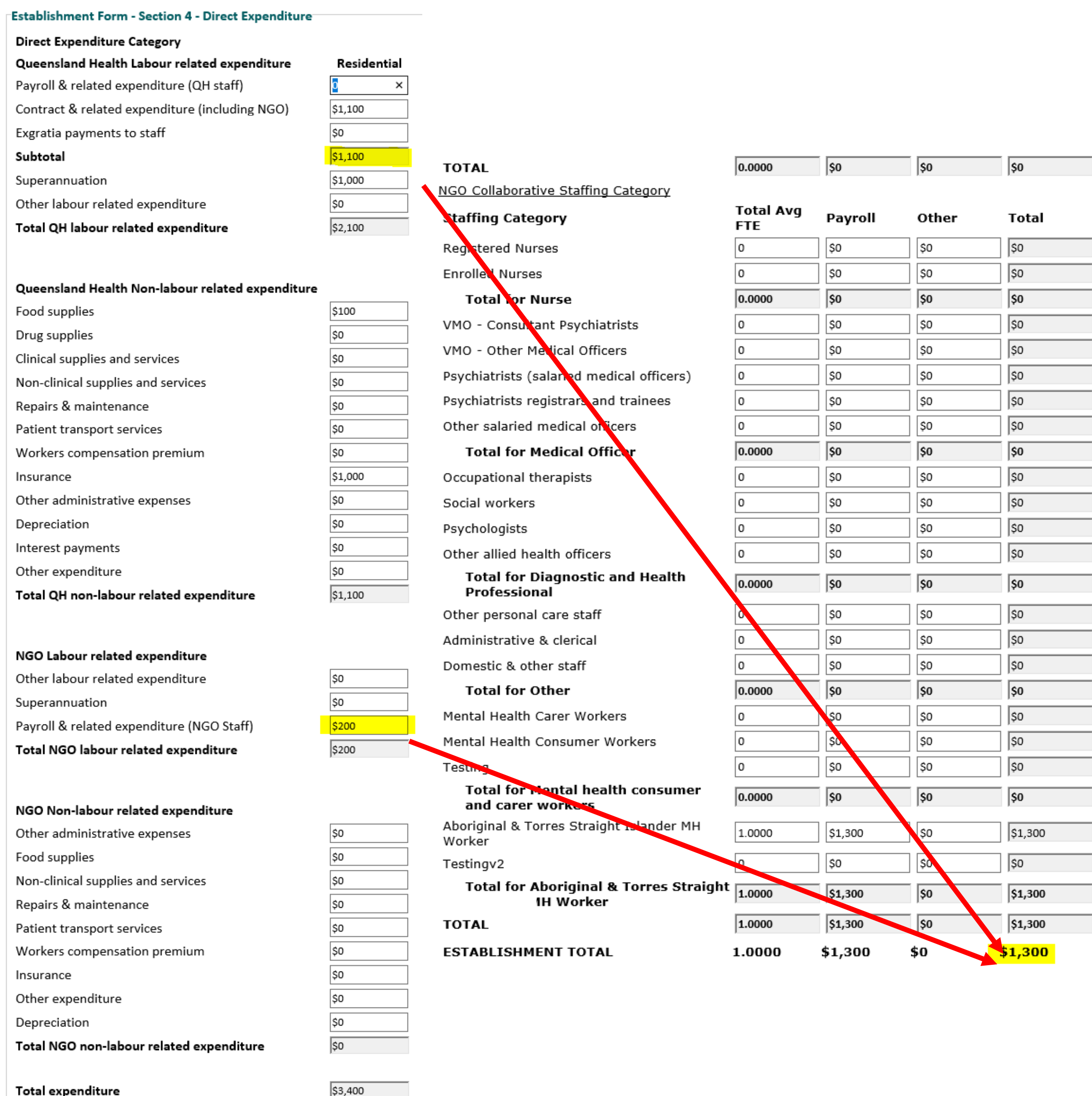
Establishments run by or in collaboration with a non-government organisation (NGO) that deliver publicly funded mental health bed-based services in partnership with an HHS or the Department of Health (DoH), are in scope for reporting to MHEC NMDS. The Youth Residential Rehabilitation Services (YRRS)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

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

For Establishments delivering services in collaboration with an NGO there is an ongoing requirement to report NGO expenditure and Staffing on **Sections 4 and 5 of the Establishment form**. These NGO sections must contain all the data on labour, non labour related expenditure and FTE procured by the MHSO for this Establishment.

Expenditure should also be included in **Section 6 of the MHSO form** as part of the total of expenditure sourced from Queensland Health Funding.

NB: The direct labour related expenditure (total of *Payroll & related expenditure (QH staff)*, *Contract & related expenditure, Exgratia payments* and *Payroll & related expenditure (NGO staff))* reported in **Establishment form Section 4** (depicted below) must reconcile to the grand total of **Establishment form Section 5**



Establishment Form - Section 4 - Direct Expenditure

Direct Expenditure Category	
Queensland Health Labour related expenditure	**Residential**
Payroll & related expenditure (QH staff)	0
Contract & related expenditure (including NGO)	$1,100
Exgratia payments to staff	$0
Subtotal	$1,100
Superannuation	$1,000
Other labour related expenditure	$0
Total QH labour related expenditure	$2,100
Queensland Health Non-labour related expenditure	
Food supplies	$100
Drug supplies	$0
Clinical supplies and services	$0
Non-clinical supplies and services	$0
Repairs & maintenance	$0
Patient transport services	$0
Workers compensation premium	$0
Insurance	$1,000
Other administrative expenses	$0
Depreciation	$0
Interest payments	$0
Other expenditure	$0
Total QH non-labour related expenditure	$1,100
NGO Labour related expenditure	
Other labour related expenditure	$0
Superannuation	$0
Payroll & related expenditure (NGO Staff)	$200
Total NGO labour related expenditure	$200
NGO Non-labour related expenditure	
Other administrative expenses	$0
Food supplies	$0
Non-clinical supplies and services	$0
Repairs & maintenance	$0
Patient transport services	$0
Workers compensation premium	$0
Insurance	$0
Other expenditure	$0
Depreciation	$0
Total NGO non-labour related expenditure	$0
Total expenditure	$3,400

TOTAL	0.0000	$0	$0	$0
NGO Collaborative Staffing Category				
Staffing Category	**Total Avg FTE**	**Payroll**	**Other**	**Total**
Registered Nurses	0	$0	$0	$0
Enrolled Nurses	0	$0	$0	$0
Total for Nurse	0.0000	$0	$0	$0
VMO - Consultant Psychiatrists	0	$0	$0	$0
VMO - Other Medical Officers	0	$0	$0	$0
Psychiatrists (salaried medical officers)	0	$0	$0	$0
Psychiatrists registrars and trainees	0	$0	$0	$0
Other salaried medical officers	0	$0	$0	$0
Total for Medical Officer	0.0000	$0	$0	$0
Occupational therapists	0	$0	$0	$0
Social workers	0	$0	$0	$0
Psychologists	0	$0	$0	$0
Other allied health officers	0	$0	$0	$0
Total for Diagnostic and Health Professional	0.0000	$0	$0	$0
Other personal care staff	0	$0	$0	$0
Administrative & clerical	0	$0	$0	$0
Domestic & other staff	0	$0	$0	$0
Total for Other	0.0000	$0	$0	$0
Mental Health Carer Workers	0	$0	$0	$0
Mental Health Consumer Workers	0	$0	$0	$0
Testing	0	$0	$0	$0
Total for Mental health consumer and carer workers	0.0000	$0	$0	$0
Aboriginal & Torres Straight Islander MH Worker	1.0000	$1,300	$0	$1,300
Testingv2	0	$0	$0	$0
Total for Aboriginal & Torres Straight IH Worker	1.0000	$1,300	$0	$1,300
TOTAL	1.0000	$1,300	$0	$1,300
ESTABLISHMENT TOTAL	**1.0000**	**$1,300**	**$0**	**$1,300**

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

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

How do I report episodes of residential care?

Residential Mental Health Care is community based overnight care in a residential setting. This care may include hospital visits for complementary services (eg ECT) or complementary treatment in other facilities where the consumer is expected to return to the original residential mental health care facility for ongoing treatment.

In Queensland, residential mental health care facilities capture consumer information in HBCIS, where they are set up as a separate campus on the hospital HBCIS instance. This means that when a consumer is sent to hospital for continued treatment of their current condition, the residential facility must discharge the consumer and readmit them after they return from their hospital stay. This results in two separate HBCIS episodes when the consumer is continuing treatment for their original condition and is therefore formally in a single residential episode.

When loading residential mental health care information into our systems, AITU have an automatic process that looks for this scenario and stiches the two (or more) HBCIS episodes back into a single residential stay. Therefore, to get a more accurate figure for episodes of residential care, HHS staff should source this information from AITU or from the Mental Health Addiction Portal (MHAP).

Mental Health and Alcohol and Other Drug Services are integrated in my HHS, how is this reported?

Expenditure associated with integrated services

There should be no ‘overlap’ between expenditure and workforce reported to the Mental Health Establishments Collection and Alcohol and other Drug establishments Collection.

The MHEC should exclude specialist drug and alcohol services except where they are specifically established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.

Specialist AOD treatment services are those with a ***primary*** function of assessment, withdrawal management, psychosocial interventions, brief intervention, rehabilitation, medication-assisted treatment and police and court diversion programs for people experiencing problematic substance use, particularly those with moderate to severe use or dependence.

Where staff / team provides services to both AOD and Mental Health Sectors equally, the FTE and associated expenditure should be apportioned across the MHEC and AODEC.

Staff who work across disciplines/service settings

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

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

How do I report Nurse Navigators?

Nurse Navigators are to be reported in the **Establishment form(s) in Section 5** as Registered Nurses. They are to be distributed accordingly across the establishments where they are located. For Example, if you had a Nurse Navigator who worked Monday to Thursday at Redland Hospital and Friday at Bayside Adult Community you would put 0.8 at Redland Hospital and 0.2 at Bayside.

Nurse navigator roles are clinical roles held by experienced nurses with expert clinical knowledge and in-depth understanding of the health system, whose focus is to support patients with complex health care needs. These nurses have the breadth and depth of clinical skills required to identify and monitor the health care requirements of high needs patients, identify the appropriate action required and to facilitate timely access to appropriate services.

Nurse navigators play a key role in supporting and coordinating a patient's entire health care journey, rather than focusing on just a specific disease or condition. This role is underpinned by the principles of delivering coordinated and patient-centred care, creating partnerships across different health providers and sectors, improving patient outcomes and enabling improvements across the system.

How to report available beds for newly opened inpatient services?

New inpatient services that begin part way through a reporting period must have appropriate reporting measures i.e. Average Available Beds and FTE averaged over the full 12-month period and not just for the period they were operational.

E.g. A new 20 bed General Acute Inpatient service commenced in February 2018 and all beds were available during this period, the average available beds would be 8 not 20 (Total beds x months available)/12.

Do I report Independent Patient Rights Advisors?

No. All Independent Patient Rights Advisers (IPRAs) are reported at the State level and are not generally against Mental Health Cost Centres. Do not report any IPRA FTE or expenditure on either the MHSO or Establishment forms.

Are mental health nursing home beds Residential or Inpatient for the purposes of MHEC reporting?

Specialised Mental health beds in Nursing home facilities are reported to the MHEC as Inpatient non acute services.

How do I report expenditure associated with a new service (that has not opened yet)?

If there is expenditure on a service that will not open until a future financial year, that expenditure is categorised as indirect service development costs and should be reported on the MHSO form under Service Development.