Mental Health Establishments NMDS 2017–18: National Mental Health Establishments Database, 2020; Quality Statement

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Identifying and definitional attributes

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Data quality

Data quality statement summary:

- The long term nature of the data contained in the National Mental Health Establishments Database (NMHED) means any analysis must consider all of the coherence caveats included in this quality statement. These specify classification changes from year to year. For example, changes to the classification of services from hospital to residential services.
- Service level expenditure comparisons between states and territories must take into consideration the service profile mix in each jurisdiction.

Description

The National Mental Health Establishments Database (NMHED) contains data on specialised mental health care services managed or funded by state or territory health authorities in Australia. The NMHED is specified by the Mental health establishments (MHE) National Minimum Data Set (NMDS) (see link).

The NMHED includes data from 1992–93 to 2017–18. Since 2005–06 data have been compiled as specified by the MHE NMDS. Prior to this (1992–92 to 2004–05), data were collected through the National Survey of Mental Health Services, managed by the Australian Government Department of Health, and the Community Mental Health Establishments NMDS.

The NMHED includes information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, service contacts and episodes).

The Mental Health Establishments (MHE) NMDS is associated with the Community Mental Health Care NMDS, Residential Mental Health Care NMDS, Admitted Patient NMDS and the Mental Health National Outcomes and Casemix Collection, which are used to collect data about clients and care provided by specialised mental health services.

Institutional environment:

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent corporate Commonwealth Entity established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national data sets based on data from each jurisdiction, to analyse these data sets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988*, (Cth) ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au.

Mental health services may be required to provide data to state and territory health authorities through a variety of administrative arrangements, contractual requirements or legislation. States and territories use these data for service planning, monitoring and internal and public reporting. In addition, state and territory health authorities supply data for the NMHED under the terms of the National Health Information Agreement (see link), as specified by the MHE NMDS (see 'Interpretability' section below).

The services that report to MHE NMDS may also report client level data in accordance with the Community Mental Health Care NMDS (METeOR ID 645692), Residential Mental Health Care NMDS (METeOR ID645718), Admitted patient NMDS (METeOR ID641349) and Mental Health National Outcomes and Casemix Collection (see link).

Timeliness:

States and territories are required to supply data annually in accordance with the MHE NMDS specifications. The reference period for this data set is 2017–18, that is, services that were operational between 1 July 2017 and 30 June 2018, or part thereof. Data for the 2017–18 reference period were supplied to the AIHW in April (WA, Victoria, NSW, ACT), May (Queensland, Tasmania, SA) and June (NT) 2019.

The AIHW publishes data from the NMHED in its online product Mental health services in Australia annually.

Accessibility:

The AIHW produces the annual series *Mental health services in Australia*, primarily as an online publication at https://www.aihw.gov.au/mhsa. This includes pdf documents of all sections in the publication, as well as data workbooks and an interactive data portal.

In addition, a companion hard copy In brief summary document is produced and is available from the Digital and Media Communications Unit of the AIHW.

Interpretability:

Metadata information for the MHE NMDS is published in the AIHW's online metadata repository—METeOR.

METeOR can be accessed on the AIHW website:

https://meteor.aihw.gov.au

Data published annually in *Mental health services in Australia* include additional important caveat information to ensure appropriate interpretation of the analyses presented by the AIHW. Readers are advised to take note of footnotes and caveats specific to individual data tables that influence interpretability of specific data.

Relevance:

The purpose of the NMHED is to collect national data to provide a system-wide view of all specialised mental health services, managed or funded by state or territory health authorities.

Specialised psychiatric care (and associated costs) provided to patients admitted to wards/units that are not specialised public mental health inpatient units is not in scope.

Coverage of specialised mental health services, managed or funded by state and territory health authorities, is considered complete by states and territories, subject to any specific caveats in the Coherence section.

Accuracy:

States and territories are primarily responsible for the quality of the data they provide. The AIHW undertakes extensive validation after files are submitted for review. Validation is conducted in two stages: (1) The compliance stage is managed by the AIHW and is concerned with ensuring that the file is structurally compliant. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency.

Although there are national standards for the reporting of mental health services data, differences in financial accounting, counting and classification practices may affect the comparability of these data.

Data are subject to ongoing historical validation. Due to this ongoing validation, published 2005–06 to 2016–17 data could differ from previously published data.

Coherence:

Data are reported for each year from 1992–93 to 2017–18. Data should be consistent across most jurisdictions and across years within most jurisdictions, with the following exceptions.

Youth admitted beds

Prior to 2014–15, *Youth* beds were rolled up into the *General* category, due to small numbers. From 2014–15 these beds have been reported separately. Patient days, and patient day costs relating to *Youth* units are rolled up into the *General* category, for all years.

Admitted patient cost per bed day comparisons

Costs per inpatient bed day by target population and program type may not be comparable across jurisdictions. Classification of expenditure into target populations and program type is based on the classification of services in accordance with the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a Child and adolescent, Youth, Older persons' or Forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the cost per patient day for General mental health services in a jurisdiction that has separate Child and adolescent and Older persons services (for example, NSW and Victoria), may not be comparable to the average cost in a jurisdiction that has General services only (for example, NT).

Full-time-equivalent (FTE) staffing

Data collected for specific professional categories are only available from 1994–95. Data prior to 2005–06 may exclude small numbers of staff employed by specialised mental health service organisations.

In 2012–13, the Organisational overhead setting was introduced. The category includes FTE staff not directly involved in the delivery of patient care services in the admitted patient, residential or community mental health care service settings, or in the operations of those settings. This does not imply that these roles do not have an impact on service delivery. The introduction of this new category may have resulted in an observed decreased FTE in the other service setting categories for some jurisdictions, and may not have been consistently applied both within and between jurisdictions.

FTE data for a small number of residential services reported by Victoria, Western Australia, South Australia, the Australian Capital Territory and Northern Territory as Youth or Forensic residential services were included in the General category at the request of those jurisdictions.

New South Wales

For NSW, Confused and Dementia Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007–08 onwards, including expenditure. Long term analysis of admitted and residential services must take this change into consideration.

Housing and Accommodation Support Initiative (HASI) services provided in New South Wales are considered out-of-scope as residential services according to the Mental Health Establishments NMDS.

The quality of the NSW 2010–11 MHE NMDS was affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010–11 financial year. Data quality issues were limited to the 2010–11 dataset.

In 2013–14, NSW restructured all Hospital, Cluster and Organisation entities resulting in a decrease in the reported number of organisations.

The number of supported housing places reported by New South Wales in 2017–18 reflect changes resulting from the conclusion of the Commonwealth National Partnership Agreement (NPA) on Mental Health Services. The NSW Government continued funding until Dec 2017 to allow for transition to alternative support arrangements (including the NDIS) for up to 200 people in NPA funded places.

Victoria

For Victoria, 70% of the expenditure reported by Prevention and Recovery Care (PARC) units has been deemed to be Non-Government Organisation expenditure, contrasting with data presented in the Facilities section, where beds, mental health care days, etc. are shown as government operated services.

A restructure at the region level occurred during 2016–17, so comparisons over time should be made with caution. Several services opened and closed during the reporting period.

A review of admitted patient services resulted in the reclassification of beds between the acute and non-acute categories for the 2016–17 collection, in line with MeTEOR changes.

Queensland

Long term analysis of admitted and residential services in Qld must take the following reporting changes into consideration:

- Caution is required when interpreting trends in Queensland for hospital admitted patient services and community residential services from 1999–00. Commencing in 1999–00, Queensland opened a number of services that fall within the national definition of residential mental health services, but reported these facilities as hospital admitted patient services. For the years 1999–00 to 2004–05, under the National Survey of Mental Health Services (NSMHS), these services were reclassified by the Australian Government as residential mental health services to achieve consistency with national definitions and across jurisdictions. Following the introduction in 2005–06 of the Mental Health Establishments NMDS data collection, Queensland has continued to report these facilities as hospital admitted patient services. In contrast to the

earlier years' data, no service reclassification has been made and the data for all years from 2005–06 are presented as reported by Queensland. From 2017-18, Queensland has commenced reporting to the Residential Mental Health Care (RMHC) NMDS. As part of this change, some admitted patient services have been reclassified as residential.
- A number of services previously classified as forensic were reclassified as general services in 2009–10 to more accurately reflect the function of these services.
- In 2013–14, a review of services resulting in the reclassification of beds from non-acute Older persons services to non-mental health care.

FTE data for a small number of Youth hospital services have been reported in the General category at the request of Queensland.

Queensland provides Older persons' mental health inpatient services using a number of different service models; however, the majority of Older persons' acute care is reported through General units, which limits comparability with jurisdictions that report these services differently. Queensland does not report any Forensic services; however, forensic patients can and do access acute care through General units.

Queensland implemented a new methodology to calculate FTE for the 2009–10 collection period, resulting in a reduction in reported FTE. Changes in reporting practises in Queensland may have resulted in a decrease in Consumer workers FTE in 2012–13. Consideration of these issues change should be made when conducting time series analysis.

In 2016–17, Queensland noted the increase in indirect expenditure, particularly superannuation costs. Queensland stated that these indirect expenditure costs more accurately reflect the state-wide indirect expenditure than previous years. Queensland stated that the increase in Organisational Overhead FTE in 2016–17 more accurately reflects the staffing profile than previous collection years.

Western Australia

For WA data, a review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010–11 collection, to more accurately reflect the function of these services. Several residential services reported as 24-hour staffed services in 2009–10 transitioned to a non-24-hour staffed model of care as of 1 July 2010. Long term analysis of admitted services must take these changes into consideration.

FTE staff data has been unavailable for one service in Western Australia since 2015–16, impacting time series staffing figures. Direct care FTE staff for the service are estimated to be about 70 FTE in 2015–16, around 120 FTE in 2016–17, and about 125 FTE in 2017–18. Comparisons between staffing and expenditure should be made with caution.

Tasmania

In 2014–15, Tasmania reclassified 27 non-acute admitted beds to residential beds, reflecting a change in function of the unit. Long term analysis of admitted and residential services must take this change into consideration.

In 2016–17, Tasmania noted a small reduction in ambulatory service contacts due a decrease in the number of recorded contacts for one organisation.

Australian Capital Territory

In 2016–17, ACT advised that a number of non-24 hour residential services are now funded under the National Disability Insurance Scheme (NDIS), which ACT now consider out-of-scope for reporting to the Mental Health Establishments NMDS. This has resulted in a significant reduction in non-24 hours staffed residential beds (from 45 to 5), and small decreases in patient days and residential FTE. Therefore, time-series comparisons and comparisons between jurisdictions should be made with caution.

A new forensic service unit opened part way through 2016–17. As this was a new service unit, low occupancy and high costs has resulted in an increased patient day cost for forensic services in the ACT in both 2016–17 and 2017–18.

Following a system-wide data review in 2018, ACT Health is continuing to improve its data quality.

Northern Territory

In 2016–17 and 2017–18, services within the Northern Territory were assessed under service accreditation standards which do not include certification for National standards for mental health services. Caution should be exercised when conducting time series analyses. Domestic staffing FTE figures are routinely unavailable for the NT.

Data products

Implementation start date: 01/07/2018

Source and reference attributes

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Mental Health Establishments NMDS 2016–17: National Mental Health Establishments Database, 2019; Quality Statement
AIHW Data Quality Statements, Standard 21/03/2019

Has been superseded by Mental Health Establishments NMDS 2018–19: National Mental Health Establishments Database, 2021; Quality Statement
AIHW Data Quality Statements, Standard 29/01/2021

See also Mental health establishments NMDS 2017–18
Health, Superseded 25/01/2018