

# **Mental Health Establishments NMDS 2021–22: National Mental Health Establishments Database, 2024; Quality Statement**

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# Mental Health Establishments NMDS 2021–22: National Mental Health Establishments Database, 2024; Quality Statement

## Identifying and definitional attributes

Metadata item type:	Data Quality Statement
METEOR identifier:	785322
Registration status:	<a href="#">AIHW Data Quality Statements</a> , Standard 14/02/2024

## Data quality

Data quality statement summary:	Description
	<p>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).</p> <p>The NMHED includes data from 1992–93 to 2021–22. Since 2005–06 data have been compiled as specified by the MHE NMDS. Prior to this (1992–93 to 2004–05), data were collected through the National Survey of Mental Health Services, managed by the Australian Government Department of Health and Aged Care, and the Community Mental Health Establishments NMDS.</p> <p>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).</p> <p>The MHE NMDS is associated with the Community Mental Health Care NMDS, Residential Mental Health Care NMDS, Admitted Patient Care 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.</p>
	<b>Summary of key issues</b>
	<ul style="list-style-type: none"><li>• The long-term nature of the data contained in the 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.</li><li>• Service level expenditure comparisons between states and territories must take into consideration the service profile mix in each jurisdiction.</li></ul>

<b>Institutional environment:</b>	<p>The Australian Institute of Health and Welfare (AIHW) is an independent corporate Commonwealth entity under the <a href="#">Australian Institute of Health and Welfare Act 1987</a> (AIHW Act), governed by a <a href="#">management board</a>, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW is a nationally recognised information management agency. Its purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians.</p> <p>Compliance with the confidentiality requirements in the AIHW Act, the Privacy Principles in the <a href="#">Privacy Act 1988</a>, (Cth) and AIHW's data governance arrangements ensures that the AIHW is well positioned to release information for public benefit while protecting the identity of individuals and organisations.</p> <p>For further information see the AIHW website <a href="http://www.aihw.gov.au/about-us">www.aihw.gov.au/about-us</a>, which includes details about the AIHW's governance (<a href="http://www.aihw.gov.au/about-us/our-governance">www.aihw.gov.au/about-us/our-governance</a>) and our role and strategic goals (<a href="http://www.aihw.gov.au/about-us/what-we-do">www.aihw.gov.au/about-us/what-we-do</a>).</p> <p>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 <a href="#">National Health Information Agreement</a>, as specified by the MHE NMDS (see 'Interpretability' section below).</p> <p>The services that report to MHE NMDS may also report client level data in accordance with the Community Mental Health Care NMDS (METEOR ID <a href="#">727348</a>), Residential Mental Health Care NMDS (METEOR ID <a href="#">727354</a>), Admitted Patient Care NMDS (METEOR ID <a href="#">728439</a>) and <a href="#">Mental Health National Outcomes and Casemix Collection</a>.</p>
<b>Timeliness:</b>	<p>States and territories are required to supply data annually in accordance with the MHE NMDS specifications. The reference period for the most recent year of data is 2021–22 (METEOR ID <a href="#">727352</a>), that is, services that were operational between 1 July 2021 and 30 June 2022, or part thereof. ACT data for this period was not available at the time of publication</p> <p>The AIHW publishes data from the NMHED in its online product <a href="#">Mental health online report</a> annually.</p>
<b>Accessibility:</b>	<p>The AIHW produces the annual series <i>Mental health online report</i>, primarily as an online publication at <a href="http://www.aihw.gov.au/mental-health">www.aihw.gov.au/mental-health</a>. This includes pdf documents of all sections in the publication, as well as data workbooks and an interactive data portal.</p>
<b>Interpretability:</b>	<p>Metadata information for the MHE NMDS is published in the AIHW's online metadata repository—METEOR.</p> <p>METEOR can be accessed on the AIHW website:</p> <p><a href="http://www.meteor.aihw.gov.au">www.meteor.aihw.gov.au</a></p>
<b>Relevance:</b>	<p>Data published annually in <i>Mental health online report</i> 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.</p> <p>The purpose of the NMHED is to provide a system-wide view of all specialised mental health services, managed or funded by state or territory health authorities.</p> <p>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.</p> <p>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.</p>

**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. As a result, published 2005–06 to 2021–22 data could differ from previously published data.

*New South Wales*

2018–19 Full-time equivalent (FTE) figures are under-reported for NSW due to data on FTE staffing not being provided by the Northern Beaches Hospital. This is a new, privately-operated hospital that provides public mental health services under a public-private partnership agreement with NSW Health. The hospital opened in late October 2018.

*Northern Territory*

Domestic staffing FTE figures are routinely unavailable for the Northern Territory.

*Western Australia*

Data prior to 2010–11 include a small number of emergency department observation beds in one hospital.

**Coherence:**

Data are reported for each year from 1992–93 to 2021–22. Data should be consistent across most jurisdictions and across years within most jurisdictions, with the following exceptions.

*Impact of the COVID-19 pandemic*

Since 2020, the COVID-19 pandemic has affected the delivery of care in health systems and health expenditure. The approach to the reporting of pandemic-related expenditure differed between jurisdictions. For example, some jurisdictions have included the expenditure for COVID screening measures, COVID tests for staff and patients, and the purchase of Personal Protective Equipment and other consumables in the reporting to NMHED, while for others, these costs were not allocated into health portfolios. Restrictions on movement and social distancing requirements may have also had an impact on expenditure, particularly in 2020–21 and 2021–22. Caution should be exercised when making jurisdictional comparisons and time series analysis that include the 2020–21 and 2021–22 period.

*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* services in a jurisdiction that has separate *Child and adolescent* and *Older persons* services (for example, New South Wales and Victoria), may not be comparable to the average cost in a jurisdiction that has *General* services only (for example, Northern Territory).

*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.

*Aboriginal and Torres Strait Islander mental health workers* was added as a new staffing category in 2020–21. Queensland previously reported this FTE under *Other personal care* FTE. New South Wales, Western Australia and South Australia previously reported *Aboriginal and Torres Strait Islander mental health workers* FTE under the *Other diagnostic and health professionals* staffing category. Prior to and in 2020–21, Western Australia captured *Aboriginal and Torres Strait Islander mental health workers* FTE as part of the *Diagnostic and allied health professionals* staffing category at the setting level.

#### *Primary Health Network (PHN)-funded state managed services*

PHN funded state managed mental health services are reported in the Community Mental Health Care (CMHC) and MHE NMDSs by Victoria and South Australia; Western Australia reports these services in CMHC only. Other states and territories do not currently report on these services to either NMDS.

#### *National Mental Health Service Standards accreditation*

Services for several jurisdictions were assessed under service accreditation standards that differ from the National Standards for Mental Health Services (NSMHS) as specified in the MHE NMDS.

- From 2011–12 onwards, Victorian data report compliance against the 2010 NSMHS as services transition from accreditation against the 1996 NSMHS.
- From 2016–17 onwards, services within the Northern Territory were assessed under service accreditation standards which do not include certification for NSMHS. Caution should be exercised when conducting time series analyses.
- From 2017–18, services in the Australian Capital Territory have been accredited against the NSQHS, which meets some but not all of the NSMHS. Caution should be exercised when conducting time series analyses. Please refer to [Specialised mental health service unit—implementation of National Standards for Mental Health Services status, code N](#) (METEOR ID [722190](#)) for further information.

#### *New South Wales*

In 2020–21, changes in reporting methodology have resulted in an increase in *Consumer workers* FTE in New South Wales.

In 2021–22, NSW data included HASI Plus in residential mental health services, which were previously reported as supported housing places.

#### *Victoria*

From 1999–2000 onwards in Victoria, residential mental health service beds provided by Prevention and Recovery Care (PARC) units were classified as government operated and reported as such in the Facilities section. However, reporting differs in the Expenditure section with 70% of the expenditure for these services deemed to be Non-Government Organisation expenditure and beds included as delivered by Non-Government Organisations in the Expenditure analysis

Data between November 2020 and November 2021 may have been affected by protected industrial activity, impacting the collection of non-clinical and administrative data and recording of ambulatory mental health service activity and consumer outcome measures. Affected data reported during this period should be

interpreted with caution.

### *Queensland*

Long term analysis of admitted and residential services in Queensland 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 1999–2000. Commencing in 1999–2000, 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 1999–2000 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 MHE NMDS data collection, Queensland 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 progressively reclassified a number of services as residential and commenced reporting to the Residential Mental Health Care (RMHC) NMDS.

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.

In 2013–14, a review of services resulting in the reclassification of beds from non-acute *Older persons* admitted services to non-mental health care.

From 2018–19 onwards, the number of supported housing places reported by Queensland reflects changes resulting from the transition of clients to the National Disability Insurance Scheme (NDIS).

### *Western Australia*

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.

FTE staff data was unavailable for one service in Western Australia from 2015–16 to 2020–21. From 2021–22, that service started FTE staff data reporting. Therefore year-on-year staffing comparison figures will be impacted. Direct care FTE staff for the service are estimated to be about 70 FTE in 2015–16, about 120 FTE in 2016–17, and about 125 FTE from 2017–18 to 2020–21. Comparisons between staffing and expenditure should be made with caution.

### *Australian Capital Territory (ACT)*

From 2017–18 the ACT made a number of changes to its supported housing program resulting in the jurisdiction reporting zero places. This number may be revised or increased in the future.

### *Northern Territory*

The Northern Territory advised the following for 2021–22:

- Updated methodology for reporting expenditure. Time series trends for the Northern Territory should be treated with some caution.
- Reclassified residential service superannuation from indirect expenditure to non-salary expenditure, changing a classification applied in 2020–21.
- Inclusion of a labour hire classification and updates to reporting methodology have resulted in reductions in FTE for the nursing, diagnostic health professionals, and medical categories, and an increase in *Other personal care* FTE. Time series trends for the Northern Territory should be treated with some caution.

- Reclassified consumer workers as carer workers, reversing a reclassification applied in 2020–21.

## Data products

**Implementation start date:** 01/07/2021

## Source and reference attributes

**Submitting organisation:** Australian Institute of Health and Welfare

## Relational attributes

### Related metadata references:

Supersedes [Mental Health Establishments NMDS 2020–21: National Mental Health Establishments Database, 2023; Quality Statement](#)  
[AIHW Data Quality Statements](#), Superseded 14/02/2024

See also [Mental health establishments NMDS 2021–22 Health](#), Superseded 17/12/2021