

Appendix 1: Data sources

Introduction

In order to present a broad picture of mental health-related care in Australia, this report has used data drawn from a variety of AIHW and other data sources. These data sources include AIHW databases such as the National Hospital Morbidity Database (NHMD) and the National Community Mental Health Establishments Database (NCMHED) which were supplied data under the National Health Information Agreement and specified as the NMDSs for Mental Health Care in the *National Health Data Dictionary* Version 10.0. For a description of the component data sets of the NMDSs for Mental Health Care, refer to the next section in this appendix.

The range of the mental health-related care services provided in Australia is broader and more diverse than is currently included in the scope of the NMDSs for Mental Health Care. Therefore, this report presents data from other AIHW data collections such as the National Public Hospital Establishments Database (NPHED), the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity, and the Commonwealth, State and Territory Disability Agreement (CSTDA) Minimum Data Set collection. Data from collections external to the AIHW were also used, including the Australian Bureau of Statistics' (ABS) Private Hospital Establishments Collection (PHEC), and the Department of Health and Ageing (DHA) and Health Insurance Commission (HIC) Medicare and Pharmaceutical Benefits Scheme (MBS and PBS) data collections. Each of these data sources has different characteristics that need to be considered when interpreting the data, as reviewed below.

Overall, there is potential for inconsistency when collections rely on data extracted from the information systems of different state and territory health authorities and private providers. In these situations NMDSs based on agreed data definitions as specified in the *National Health Data Dictionary* are often used to enhance the consistency of the data obtained. However, the quality of NMDS reporting by state and territory health authorities and private providers may be affected by variations from the *National Health Data Dictionary* definitions and differences in scope. The definitions used for originally recording the data may have varied among the data providers and from one year to another. In addition, fine details of the scope of the data collections may vary. Comparisons between different state and territory health authorities, reporting years and sectors should therefore be made with reference to the accompanying text and footnotes.

Service utilisation data can reflect an aspect of the burden of disease in the community but they are not a measure of the incidence or prevalence of specific disease conditions. This is because not all persons with an illness receive the same treatment, and the number and pattern of services received can reflect admission or registration practices, regional differences in service provision and repeat service provision for some chronic conditions. Each state and territory has a particular demographic structure that differs from other jurisdictions. Factors such as the geographic spread of the population and the proportion of Aboriginal and Torres Strait Islander persons can have a substantial effect on the delivery of health care.

Data collections

National Hospital Morbidity Database (NHMD)

The NHMD is a compilation of electronic summary records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data, and data on the diagnoses of the patient, the procedures they underwent in hospital, external causes of injury and poisoning, and the AR-DRG for each hospital separation (see glossary).

Records for 2001–02 are for hospital separations in the period from 1 July 2001 to 30 June 2002. Data on patients who were admitted on any date before 1 July 2001 are included, provided that they separated between 1 July 2001 and 30 June 2002. A record is included for each separation, not for each patient, thus patients who separated more than once in the year have more than one record in the database.

Data relating to admitted patients in almost all hospitals are included. However, the collection covers only public hospitals within the jurisdiction of the state and territory health authorities. Hence, public hospitals not administered by the state and territory health authorities (e.g. some hospitals run by correctional authorities in some jurisdictions and those in off-shore territories) are not included. In addition, there remains a small proportion of private hospitals that do not report to the NHMD. The coverage is described in greater detail in *Australian Hospital Statistics 2001–02* (AIHW 2003a).

This report contains data specified under the NMDS for Admitted Patient Mental Health Care, which represents a subset of the data collated in the NHMD.

Patients receiving specialised mental health care are identified through recording the fact that they had one or more psychiatric care days, i.e. care received in a specialised psychiatric hospital, unit or ward. In acute care hospitals, a 'specialised' episode of care or separation may comprise some psychiatric care days and some days in general care, or psychiatric care days only. An episode of care from a public psychiatric hospital is deemed to comprise psychiatric care days only and to be 'specialised', unless some care was given in a unit other than a psychiatric unit, such as a drug and alcohol unit.

States and territories have confirmed that all public hospitals with specialised psychiatric facilities reported psychiatric care days to the NHMD for 2001–02, with estimates that between 95% and 100% of psychiatric care days were reported.

There are several other data elements that are collected only for patients who have received specialised psychiatric care, and these are shown in Table A1.1. Some jurisdictions, or sectors within jurisdictions, were unable to provide data for all of these data elements.

The majority of data elements were reported for at least 95% of all mental health related separations that received specialised psychiatric care. However, the data element *Marital status* was not reported for 6.6% of public acute hospitals and 8.1% of private hospitals nationally. *Employment status* was not recorded for public acute hospitals in New South Wales and Victoria, for private hospitals in New South Wales, Victoria, South Australia and the Australian Capital Territory, and for public psychiatric hospitals in New South Wales. *Type of usual accommodation* was not recorded for public acute hospitals in Victoria and the Northern Territory, for private hospitals in Victoria, and was not reported for 27.9% of public psychiatric hospital separations nationally. *Mode of admission* was 'Not reported' for 10.9% of public psychiatric hospital separations nationally. For private hospitals, only Queensland

and Western Australia reported all categories for the data element *Mental health legal status*. For private hospitals, *Mental health legal status* was recorded as 'Voluntary' for all mental health-related separations in New South Wales and the Australian Capital Territory, 'Involuntary' in South Australia, and as 'Not reported' in Victoria and Tasmania. Therefore caution should be used in the interpretation of tables that report this data element. Data quality was deemed to be too poor for publication for the data elements *Type of usual accommodation*, *Employment status* and *Referral to further care (psychiatric patient)*.

Current data on source of referral and on the average and median length of stay by AR-DRG which were presented in previous *Mental Health Services in Australia* reports can now be found on the internet at www.aihw.gov.au.

Other mental health-related separations (for which the patient did not receive specialised psychiatric care) were identified by a mental health-related principal diagnosis. These separations did not fall within the scope of the NMDS for Admitted Patient Mental Health Care and therefore information on these data elements may or may not have been collected by the state or territory health authority.

Unless otherwise specified, the state and territory of the hospital is reported, rather than the state or territory of the patient's usual residence. Additional notes are provided in the descriptive commentary throughout this report highlighting data quality and interpretation issues in specific instances. For greater detail on the scope, definitions and quality of data obtained from the NHMD, refer to *Australian Hospital Statistics 2001-02* (AIHW 2003a). Lists of the public psychiatric hospitals and public acute hospitals with specialised psychiatric units contributing to this report can be found on the internet at www.aihw.gov.au.

National Community Mental Health Establishments Database (NCMHED)

This database includes data on the number of community mental health establishments, and their expenditure and staffing. For residential facilities, data on beds and 'separations' are also collected. Within this database, the term separation refers to episodes of non-admitted patient residential care in community-based residential services. The data collated in the NCMHED is specified by the NMDS for Community Mental Health Establishments.

For this NMDS, community mental health care refers to all specialised public mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted patients (except for non-24-hour residential care). The scope is both residential and ambulatory public community mental health care establishments, including adult, aged and adolescent and child community mental health services, and non-admitted services in hospitals such as specialised psychiatric outpatient services. The scope excludes admitted patient mental health care services, support services that are not specialised mental health care services (e.g. accommodation support services) and services provided by non-government organisations. Only residential services that were staffed 24 hours per day were included.

For more information on the NMDS for Community Mental Health Establishments, refer to *Mental Health Services in Australia 2000-01* (AIHW 2003d). A list of the public community mental health establishments contributing to this report can be found on the internet at www.aihw.gov.au.

National Community Mental Health Care Database (NCMHCD)

The NCMHCD includes data on ambulatory service contacts provided by public community mental health establishments. The data collated in the NCMHCD are specified by the NMDS for Community Mental Health Care. NCMHCD contains data on the date of service contact and on the characteristics of the patient ranging from demographic information such as the age and sex to clinically relevant information such as principal diagnosis and mental health legal status (see table A1.3).

The scope for this collection is all ambulatory service contacts provided by the public community mental health establishments that are in-scope for the NMDS for Community Mental Health Establishments. A list of the public community mental health establishments contributing this patient-level data to NCMHCD can be found on the internet at www.aihw.gov.au.

A service contact for the purposes of this collection was defined as a contact between a patient or client and an ambulatory mental health care service (including hospital and community-based services) which result in a dated entry being made in the individual's record.

NCMHCD data are presented in Chapter 3 and Appendix 4. For more information on the NMDS for Community Mental Health Care, refer to *Mental health services in Australia 2000–01* (AIHW 2003d).

National Public Hospital Establishments Database (NPHEd)

The AIHW is the data custodian of the NPHEd, which holds a record for each public hospital in Australia. The data are collected by state and territory health authorities from the routine administrative collections of public acute hospitals, psychiatric hospitals, drug and alcohol hospitals and dental hospitals in all states and territories. The database does not include private hospital data, which are collated by the ABS in the PHEC.

The collection covers only hospitals within the jurisdiction of the state and territory health authorities. Hence, public hospitals not administered by the state and territory health authorities (e.g. some hospitals run by correctional authorities in some jurisdictions and those in off-shore territories) are not included.

Information is included on hospital resources (beds, staff and specialised services), recurrent expenditure, non-appropriation revenue and summary information on services to admitted and non-admitted patients. Limitations have been identified in the financial data reported to the NPHEd. In particular, some states and territories have not yet fully implemented accrual accounting procedures and systems, which means the expenditure and revenue data are a mixture of expenditure/payments and revenue/receipts, respectively. A need for further development has been identified in the areas of capital expenditure, expenditure at the area health service administration level and group services expenditure (e.g. central laundry and pathology services). Refer to *Australian Hospital Statistics 2001–02* for further detail on the data quality for the NPHEd (AIHW 2003a).

Unlike the NCMHED, the NPHEd includes the data for *Full-time-equivalent staff*, *Salaries and wages* and the *Non-salary operating costs* subcategory data elements (types of staff and types of non-salary expenditure). The public acute hospital establishments that contain one or more specialised psychiatric units or wards are flagged in NPHEd. However, no financial or staffing data are available for these specialised psychiatric wards, as these data are not provided for separate units or wards.

Additional notes are provided in the descriptive commentary throughout this report highlighting data quality and interpretation issues in specific instances. For greater detail on the scope, definitions and quality of data obtained from the NPHEd, refer to *Australian Hospital Statistics 2000–01* (AIHW 2002a).

A list of the public psychiatric hospitals contributing to this report can be found on the internet at www.aihw.gov.au.

Private Health Establishments Collection (PHEC)

The ABS conducts an annual census of all private acute care hospitals and private psychiatric hospitals licensed by state and territory health authorities and all free-standing day hospital facilities approved by the DHA. The collection contains data on the staffing, finances and activity of these establishments. Differences in accounting policy and practices and the administration of property and fixed asset accounts by parent organisations may have resulted in some inconsistencies in the financial data (ABS 2002b).

The data definitions used in the PHEC are largely based on definitions in the *National Health Data Dictionary*, Version 10.0 (NHDC 2001), which makes comparison between the NPHEd and NCMHEd possible. The ABS definition for private psychiatric hospitals is ‘those establishments that are licensed/approved by each State or Territory health authority and cater primarily for admitted patients with psychiatric or behavioural disorders’. The term ‘cater primarily’ applies when 50% or more of total patient days are for psychiatric patients.

Additional information on the PHEC can be obtained from the annual ABS publication on private hospitals (ABS 2003).

Bettering the Evaluation and Care of Health (BEACH)

The BEACH survey is a collaborative study between the AIHW and the University of Sydney. It is a continuous survey of general practice with three primary aims:

- to provide a reliable and valid data collection process for general practice that is responsive to the needs of information users
- to establish an ongoing database of information on encounters between general practitioners and patients
- to assess patient risk factors and health states and the relationship between these factors and health service activity (Britt et al. 2003).

For each year’s data collection, a random sample of about 1,000 general practitioners each reported details of 100 consecutive general practice encounters of all types on structured paper encounter forms. Each form collects information about the consultation (e.g. date, type of consultation), the patient (e.g. date of birth, sex, reasons for encounter), the patient’s presenting problems (e.g. diagnoses, status of each problem), and the management for each problem (e.g. treatment provided, prescriptions, referrals). Patient risk factors and health state data, and general practitioner characteristics data are also collected. Data for 2002–03 are used in this report.

At least one diagnosis or problem is identified for each encounter, although up to four problems can be reported for each. Problems are coded according to ICPC-2 PLUS, an extension of the International Classification of Primary Care, 2nd edition (ICPC-2), and

classified using ICP-2. Additional information on the BEACH survey can be obtained from *General practice activity in Australia 2002–03* (Britt et al. 2003).

Commonwealth/State Disability Agreement (CSDA) Minimum Data Set collection

The CSDA allocates the responsibility for specific types of disability support services between Australian, state and territory governments. The AIHW manages the CSDA MDS to collate nationally consistent data on services funded under the CSDA and their clients. Data are collected on the service providers and clients on a single 'snapshot' day each year. For 2002, the snapshot day varied between jurisdictions but fell within the May to June period.

The collection covers disability support services receiving funding under the CSDA in 2002. Services that do not receive CSDA funding are specifically excluded. Not every specialist psychiatric disability support service is included in the CSDA MDS collection as some are not funded through the CSDA.

The 2002 collection was the final 'snapshot' based collection. From the 2002–03 reporting period, on-going data are collected for all Commonwealth, State and Territory Disability Agreement -funded (CSTDA) services for the full year.

- In New South Wales, psychiatric disability services are provided by the New South Wales Department of Health and are not included in the CSDA MDS collection.
- South Australia and Tasmania do not report data for psychiatric disability services to the CSDA MDS collection.
- In Victoria, specialist psychiatric and other disability support services are included in the CSDA MDS collection.
- In Queensland, psychiatric disability services funded by Queensland Health are included in the CSDA MDS collection. Non-recurrent grants funded by Queensland Treasury under the Gaming Machine Community Benefit Fund are not.
- In the Australian Capital Territory and the Northern Territory, only some psychiatric disability services are included in the CSDA MDS collection.
- In Western Australia, only some psychiatric disability services are included in the CSDA MDS collection. The Health Department is the main provider of services for people with a psychiatric disability and these services are not included.

However, even in those states where specific psychiatric services are not CSDA-funded, people with a psychiatric disability do receive various CSDA disability support services.

Given these limitations with respect to the coverage of psychiatric disability support services in the CSDA MDS, these data need to be interpreted with caution. Additional information on the data from the CSDA MDS collection can be obtained from the publication *Disability Support Services 2002: National Data on Services Provided under the Commonwealth/State Disability Agreement* (AIHW 2003b).

National Medical and Nursing Labour Force Survey data

The AIHW conducts the National Medical Labour Force Survey and the National Nursing Labour Force Survey, in conjunction with the annual registration renewal of these practitioners with the relevant registration boards in each state and territory. The AIHW has

conducted the medical practitioner survey annually since 1993 and the nursing survey since 1995.

The figures produced from the Medical Labour Force Survey and the Nursing Labour force survey are estimates only. Not all medical practitioners or nurses who were sent a questionnaire responded to the survey, and estimates of the whole medical practitioner and nursing populations are based on survey data weighted to match available registration information.

Coverage in some jurisdictions may exclude some practitioners who registered for the first time during the survey year. Practitioners with conditional registration, usually for a fixed term, are also excluded in many jurisdictions. These conditional registrants include interns and temporary resident doctors, who are not required to renew their registration at the standard renewal date. The latest information on these surveys is provided in *Medical Labour Force 2001* (AIHW 2003c) and the *Nursing Labour Force 2001* (AIHW 2003e) reports.

Medicare data

The Health Insurance Commission (HIC) collects data on all medical services funded through Medicare and provides these data to DHA. Information collected includes the type of service provided (Medicare item number) and the benefit paid by Medicare for the service. The figures presented in this report on services provided by private psychiatrists include only those services that are performed by a registered provider, for services that qualify for Medicare benefit and for which a claim has been processed by the HIC. They do not include services provided to public patients in public hospitals or services that qualify for a benefit under the Department of Veterans' Affairs National Treatment Account.

The state or territory is determined according to the address of the patient who received the service at the time the patient made the claim. The year is determined by the date the service was processed by the HIC, not the date the service was provided.

Time series data presented in this report are based on the mapping of old item numbers to current item numbers. For example, item 144 (private psychiatrist home visit of less than 15 minutes) was renumbered to item 330 during 1996.

Pharmaceutical Benefits Scheme (PBS) data

The HIC collects data on most prescriptions funded through the PBS and provides these data to DHA. Details are collected on the medication prescribed (e.g. type and cost of medication), the prescribing practitioner (e.g. speciality) and the supplying pharmacy (e.g. location). The figures reported in this publication relate to the prescription costs funded by the PBS and the number of prescriptions processed by the HIC. They refer only to paid services processed from claims presented by approved pharmacies. They do not include any adjustments made against pharmacists' claims, any manually paid claims or any benefits paid as a result of retrospective entitlement or refund of patient contributions. Items supplied to general patients, costing less than \$23.10, do not receive a PBS benefit and are therefore not included. The PBS data do not contain Section 100 items, i.e. highly specialised drugs available through hospital pharmacies for outpatients.

The state or territory is determined according to the address of the pharmacy supplying the item. The year is determined as the date the service was processed by the HIC, not the date of prescribing or the date of supply by the pharmacy. The data presented in this report

exclude medications provided to war veterans through the Repatriation Pharmaceutical Benefits Scheme (RPBS).

Internet tables

Tables on the Internet at www.aihw.gov.au include information on the establishments that contributed data and the population data used in this report.

Table A1.1: Data elements^(a) that constitute the NMDS for Admitted Patient Mental Health Care for 2001–02

Data element	Specific to specialised mental health care	Knowledgebase^(b) identifier
Identifiers		
Establishment identifier (made up of)		000050
<i>State identifier</i>		000380
<i>Establishment sector</i>		000379
<i>Region code</i>		000378
<i>Establishment number</i>		000377
Person identifier		000127
Sociodemographic items		
Sex		000149
Date of birth		000036
Country of birth		000035
Indigenous status		000001
Marital status	✓	000089
Employment status	✓	000317
Area of usual residence		000016
Pension status—psychiatric patients	✓	000121
Type of usual accommodation	✓	000173
Service and administrative items		
Care type (previously <i>Type of episode of care</i>)		000168
Previous specialised treatment		000139
Admission date		000008
Separation date		000043
Total leave days		000163
Mode of admission (previously <i>Source of referral to acute hospital or private psychiatric hospital</i>)		000385
Mode of separation		000096
Source of referral to public psychiatric hospital	✓	000150
Referral to further care (psychiatric patients)	✓	000143
Total psychiatric care days	✓ ^(c)	000164
Mental health legal status	✓ ^(c)	000092
Clinical items		
Principal diagnosis		000136
Additional diagnosis		000005
Diagnosis Related Group		000042
Major Diagnostic Category		000088
Intended length of stay		000076

(a) All data elements are defined in the *National Health Data Dictionary*, Version 10.0 (NHDC 2001).

(b) The Knowledgebase: Australia's Health, Community Services and Housing Metadata Registry can be accessed through the AIHW web site at www.aihw.gov.au.

(c) Collected for all patients but relevant only to specialised psychiatric care.

Table A1.2: Data elements^(a) that constitute the NMDS for Community Mental Health Establishments for 2001–02

Data element	Knowledgebase ^(b) identifier
Establishment identifier (made up of)	000050
<i>State identifier</i>	000380
<i>Establishment sector</i>	000379
<i>Region code</i>	000378
<i>Establishment number</i>	000377
Separations ^(c)	000205
Geographic location of establishment	000260
Number of available beds	000255
Total full-time-equivalent staff	000252
Total salaries and wages	000254
Total non-salary operating costs	000360
<i>Payments to visiting medical officers</i>	000236

(a) All data elements are defined in the *National Health Data Dictionary*, Version 10.0 (NHDC 2001).

(b) The Knowledgebase: Australia's Health, Community Services and Housing Metadata Registry can be accessed through the AIHW web site at www.aihw.gov.au.

(c) The term 'separations' refers to the number of non-admitted patient separations from residential mental health care establishments.

Table A1.3: Reporting of data elements^(a) that constitute the NMDS for Community Mental Health Care for 2001-02

Data element	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Area of usual residence	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Country of birth	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Date of birth	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Establishment identifier	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Indigenous status	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Marital status	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Mental health legal status	Yes	Yes	Yes	Not permitted to be reported	Yes	Yes	Yes	Yes
Person identifier	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Principal diagnosis	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Service contact date	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sex	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix 2: Codes used to define mental health-related care and medications

With the exception of NCHMED and NCMHCD, the health care data collections used in this report contain data on more than just mental health care, so a mental health-related subset of the data needed to be defined. For some data collections this was relatively simple. For NPHEd and PHEC data, mental health-related care was defined by hospital type (psychiatric hospital) or specialised unit flag (e.g. specialised psychiatric unit in acute care hospital). Medicare and National Medical Labour Force Survey data were defined as mental health-related based on the profession of the medical practitioner (e.g. psychiatrist).

For other data collections, it was necessary to use the classifications in the collections for diagnoses, problems or disabilities to define mental health-related care. The principal and additional diagnosis data in the NHMD are coded using the ICD-10-AM classification, the BEACH data set uses ICPC-2 for coding reasons for encounters (RFEs) and problems, and the CSTDA Minimum Data Set collection uses a simple customised classification to code disabilities. Details are provided below for each classification for which codes were used to define a mental health-related principal or additional diagnosis, a mental health-related problem or RFE, or mental health-related disability.

The definition of a mental health-related medication was based on the ATC classification for PBS data. Details are provided in Table A3.3.

National Hospital Morbidity Database data

The definition of a mental health-related diagnosis included all ICD-10-AM second edition and AR-DRG Version 4.2 codes which were either clinically or statistically relevant to mental health.

This list was developed in consultation with the National Mental Health Working Group Information Strategy Committee and the Clinical Casemix Committee of Australia. The agreed list of codes and further information can be found in *Mental health services in Australia 2000–01* (AIHW 2003d).

Bettering the Evaluation and Care of Health

For the purposes of this report, mental health-related RFEs and problems managed were defined as those included in the ICPC-2 *Psychological* chapter. The same set of codes was used for both RFEs and problems. For a list of the codes used refer to *Mental Health Services in Australia 2000–01* (AIHW 2003d). Additional information on the BEACH survey can be obtained from *General practice activity in Australia 2002–03* (Britt et al. 2003).

Commonwealth/State Disability Agreement Minimum Data Set

The CSDA Minimum Data Set questionnaire has an item that asks the user of a service or their carer 'what is your (the consumer's) primary disability group'. The survey form also asks respondents to tick all applicable other significant disability groups. For both questions, the twelve disability categories are listed in tick-a-box format. These disability categories are as follows:

- Intellectual
- Specific learning disability/ Attention Deficit Disorder (other than Intellectual)
- Autism (including Asperger's syndrome)
- Physical
- Acquired brain injury
- Neurological
- Deafblind (dual sensory)
- Vision
- Hearing
- Speech
- Psychiatric
- Developmental delay (only for a child under 6 years of age).

Data are presented in this report on those consumers with a psychiatric primary disability or a psychiatric disability as one of their other significant disabilities. Additional information on the data from the CSDA Minimum Data Set collection can be obtained from the publication *Disability Support Services 2002: National Data on Services Provided under the Commonwealth/State Disability Agreement* (AIHW 2003b).

Pharmaceutical Benefits Scheme

Prescription data from the PBS are coded using the ATC classification. Table A2.1 contains the list of the codes used to define mental health-related medications. Not all medications included in each code group are used solely for mental health-related conditions. For example, Prochlorperazine (N05AB06) is classified under the ATC classification as an anti-psychotic medication (N05A) but in actual fact is frequently prescribed for anti-nausea treatment. The prescription data from the PBS data collections exclude data on other mental health-related drugs provided through other schemes such as the Highly Specialised Drugs Program (which includes Clozapine for the treatment of schizophrenia).

Table A2.1: Anatomical Therapeutic Chemical codes used to define mental health-related medication prescribed by general practitioners and non-psychiatrist medical specialists in PBS data^(a)

ATC code	Description
N05	Psycholeptics
N05A	Antipsychotics
N05B	Anxiolytics
N05C	Hypnotics & sedatives
N06	Psychoanaleptics
N06A	Antidepressants

Appendix 3: Separations that could be considered equivalent to ambulatory mental health care

The previous four *Mental health services in Australia* reports have presented all same day mental health-related separation data in the chapter on admitted patient care. However it could be considered that some of these data would be more appropriately placed in the chapter on ambulatory care. This is because it has been found that episodes defined as intended same day were more similar to community care than admitted patient care in terms of cost and type of care provided (Buckingham et al 1998).

A definition of those same day mental health-related separations that could be regarded as notionally equivalent to ambulatory mental health care (termed ambulatory care-equivalent mental health-related separations) was developed. This definition was developed for the purposes of re-organising the *Mental health services in Australia* report to include the ambulatory-equivalent mental health-related separation data in the ambulatory mental health care chapter (Chapter 3) rather than the admitted patient care chapters (Chapters 4, 5 and 6).

This appendix provides an overview of the definition of ambulatory-equivalent mental health-related separations used in this report and the data quality concerns that should be noted for interpretation purposes.

Overview of same day mental health-related separations

In 2001-02 there were 118,081 same day mental health-related hospital separations from Australian hospitals. Figure A3.1 presents the number of these separations per 1,000 population by hospital type and jurisdiction. Considerable variation existed between jurisdictions, which may have been the result of differences in reporting, admission practices or in treatment arrangements. The majority of the variation between jurisdictions occurred within the private sector.

Table A3.1 presents the number of same day mental health-related separations by jurisdiction and specialised psychiatric care status. The table shows that there were comparatively few same day public psychiatric hospital separations. For this reason, public hospitals and public psychiatric hospitals separations were combined for the remainder of this appendix. The proportion of same day mental health-related separations that involved specialised psychiatric care ranged from 94.5% in public psychiatric hospitals to 56.5% in public acute care hospitals.

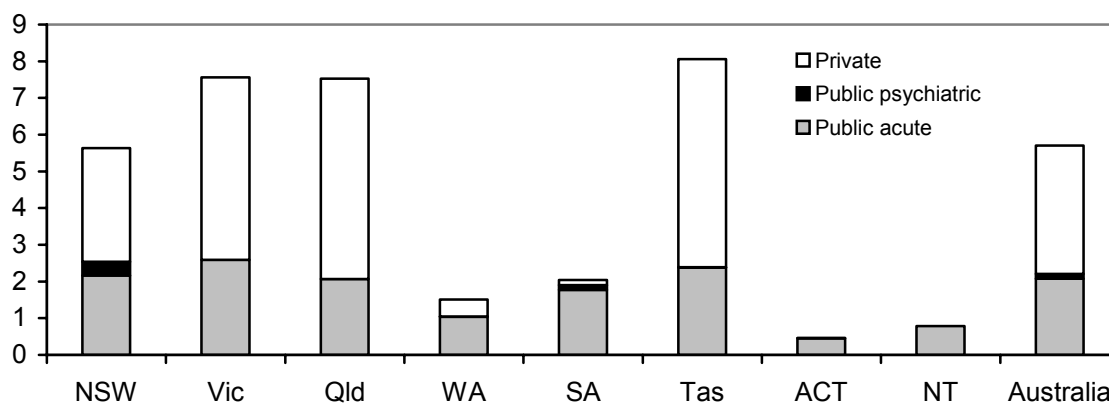


Figure A3.1: Same day mental health-related separations per 1,000 population by hospital type, states and territories, 2001-02

Table A3.1: Same day mental health-related separations by hospital type and specialised psychiatric care status, states and territories, 2001-02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Public acute care hospitals									
Without specialised psychiatric care	6,406	10,921	2,020	1,333	1,741	333	65	100	22,919
With specialised psychiatric care	7,913	1,606	5,549	649	942	789	81	55	17,584
Total	14,319	12,527	7,569	1,982	2,683	1,122	146	155	40,503
Private hospitals									
Without specialised psychiatric care	2,616	1,926	3,516	244	38	1,052	1	.	9,393
With specialised psychiatric care	17,851	22,121	16,494	7,255	175	1,624	.	.	65,520
Total	20,467	24,047	20,010	7,499	213	2,676	1	.	74,913
Public psychiatric hospitals									
Without specialised psychiatric care	147	.	.	.	.	.	.	.	147
With specialised psychiatric care	2,285	.	1	24	202	6	.	.	2,518
Total	2,432	.	1	24	202	6	.	.	2,665
All hospitals									
Without specialised psychiatric care	9,169	12,847	5,536	1,577	1,779	1,385	66	100	32,459
With specialised psychiatric care	28,049	23,727	22,044	7,928	1,319	2,419	81	55	85,622
Total	37,218	36,574	27,580	9,505	3,098	3,804	147	155	118,081

Defining separations that could be considered equivalent to ambulatory mental health care

For this report, ambulatory-equivalent mental health-related separations were defined by excluding those same day separations that were considered unlikely to be the type of activity to be undertaken in mental health ambulatory care. The separations that were excluded from the definition, included the following:

- Electro Convulsive Therapy (ECT) and/or general anaesthesia procedures,
- Other procedures that would be not expected to be undertaken in ambulatory mental health care,
- A mode of separation or mode of admission of death, care type change, left against medical advice or transfer.

Intended length of stay was also examined for the purpose of excluding those separations where the length of stay was intended to be overnight. However the quality of the data for this data element was assessed as insufficient for this. The data related to each of these exclusions and the intended length of stay data are reported below.

Procedures

Procedures undertaken during a same day separation provide useful information for defining what could be an ambulatory-equivalent mental health-related separation. ECT, general anaesthesia and other procedures unlikely to occur in mental health ambulatory care were used to exclude separations from the definition of an ambulatory-equivalent separation category.

There were 65,203 same day mental health-related separations with no procedure codes reported. This was 55% of all same day mental health-related separations for 2001–02.

ECT and general anaesthesia

The two most frequently reported procedures for same day mental health-related separations were ECT and general anaesthesia procedures. In 2001–02 there were 11,928 same day mental health-related separations with ECT and/or general anaesthesia code reported. Over 95% of the separations with ECT also had general anaesthesia recorded and 97% of the separations with general anaesthesia also had ECT. The rate per 1,000 population of these separations that included ECT varied between jurisdictions, with this procedure most commonly reported by public hospitals.

Procedures that would be expected to be undertaken in ambulatory mental health care

There were a small number of procedures that were identified as equivalent to the ambulatory mental health care provided by specialised community mental health services. The identified procedures were the following *Non-Invasive, cognitive and interventions, not elsewhere classified* (Chapter 19) codes:

- 1822 Assessment of personal care and other activities of daily/independent living
- 1823 Psychobehavioural or psychosocial assessment

- 1829 Neuropsychological assessment
- 1867 Counselling or education relating to personal care & other activities of daily/independent living
- 1868 Psychosocial counselling
- 1869 Other counselling or education
- 1872 Alcohol and drug rehabilitation
- 1873 Psychological therapies
- 1874 Psychosocial therapies
- 1875 Skills training in relation to learning, knowledge and cognition
- 1878 Skills training for personal care & other activities of daily/independent living
- 1879 Other psychobehavioural or psychosocial therapies, skills training
- 1916 Generalised allied health interventions as follows:
 - 95550-01 Allied health intervention, social work
 - 95550-02 Allied health intervention, occupational therapy
 - 95550-10 Allied health intervention, psychology

There were a total of 33,124 same day separations that reported at least one of these procedures in 2001–02. There was considerable difference in the codes reported by jurisdictions. Some of this difference can be explained by differences in coding practice (some of which is optional in the coding standards), including the use of the general 95550–10 *Allied health intervention, psychology* codes rather than more specific codes such as 96001–00 *Psychological skills training*. However, there was still variation in the proportions of these codes used between jurisdictions and between the public and private sectors. At this stage it is unclear if these were due to differences in practice or reporting.

Procedures that would be not expected to be undertaken in ambulatory mental health care

In 2001–02 there were 1,298 separations that reported procedures that would not be expected to be undertaken in ambulatory mental health care (Tables A3.2 and A3.3). For many of these, the link between a mental health condition or psychiatric care and the procedure appears tenuous (e.g. endoscopies). It is possible that some of these records were due to data errors.

Mode of admission and separation

Separations that had a mode of admission or separation that included death, care type change or transfer are identified as being unlikely to be similar to ambulatory mental health care. For this reason, separations that included these were excluded from the definition of an ambulatory-equivalent mental health-related separation.

For 2001–02 there were 3,200 mental health-related same day separations with a mode of admission of care type change or transfer (Table A3.4), while 1,812 had a mode of admission of not reported.

There were 9,058 separations where the mode of separation was not *Other* (i.e. the patient was not discharged to usual residence etc), including 6,201 separations where the patient

was transferred to another hospital and 1,989 where the patient left against medical advice (Table A3.4).

Table A3.2: Same day mental health-related separations with procedures not expected to be undertaken in ambulatory mental health care, excluding those separations with ECT and general anaesthesia procedures, by sector and psychiatric care days, 2001-02

Code	Description	Public hospitals			Private hospitals			Total		
		Specialised psychiatric care			Specialised psychiatric care			Specialised psychiatric care		
		With out	With	Total	With out	With	Total	With out	With	Total
1-86	Nervous System	29	0	29	2	0	2	31	0	31
160-256	Eye and Adnexa	1	1	2	0	0	0	1	1	2
300-333	Ear and Mastoid Process	0	0	0	0	1	1	0	1	1
370-422	Nose, Mouth and Pharynx	16	0	16	2	0	2	18	0	18
450-490	Dental Services	2	0	2	1	0	1	3	0	3
520-569	Respiratory System	18	1	19	0	0	0	18	1	19
600-767	Cardiovascular System	3	1	4	1	0	1	4	1	5
800-817	Blood and Blood-Forming Organs	0	0	0	1	0	1	1	0	1
850-1011	Digestive System	11	1	12	38	0	38	49	1	50
1040-1128	Urinary System	7	0	7	1	0	1	8	0	8
1160-1203	Male Genital Organs	0	1	1	0	0	0	0	1	1
1330-1347	Obstetric Procedures	19	0	19	0	0	0	19	0	19
1360-1579	Musculoskeletal System	1	0	1	0	0	0	1	0	1
1600-1718	Dermatological and Plastic Procedures	48	36	84	2	0	2	50	36	86
1780-1799	Chemotherapeutic and Radiation Oncology	0	3	3	0	0	0	0	3	3
1820-1916	Non-invasive, Cognitive and Interventions, nec	333	118	451	114	23	137	447	141	588
1940-2016	Imaging Services	430	14	444	18	0	18	448	14	462
	<i>Total</i>	<i>918</i>	<i>176</i>	<i>1,094</i>	<i>180</i>	<i>24</i>	<i>204</i>	<i>1,098</i>	<i>200</i>	<i>1,298</i>
	No procedure reported	15,344	15,371	30,715	1,814	32,674	34,488	17,158	48,045	65,203
	Total									

Table A3.3: Same day mental health-related separations with procedures not expected to be undertaken in ambulatory mental health care, excluding those separations with ECT and general anaesthesia procedures, states and territories, 2001-02

Code	Description	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1-89	Nervous System	13	8	5	4	1	0	0	0	31
160-256	Eye and Adnexa	1	0	1	0	0	0	0	0	2
300-333	Ear and Mastoid Process	0	0	1	0	0	0	0	0	1
370-422	Nose, Mouth and Pharynx	0	1	8	3	6	0	0	0	18
450-490	Dental Services	2	0	0	1	0	0	0	0	3
520-569	Respiratory System	2	5	8	1	2	1	0	0	19
600-767	Cardiovascular System	3	0	1	0	1	0	0	0	5
800-817	Blood and Blood-Forming Organs	0	1	0	0	0	0	0	0	1
850-1011	Digestive System	3	27	12	1	7	0	0	0	50
1040-1128	Urinary System	2	3	1	2	0	0	0	0	8
1160-1203	Male Genital Organs	0	0	0	0	0	0	1	0	1
1330-1347	Obstetric Procedures	4	9	1	2	3	0	0	0	19
1360-1579	Musculoskeletal System	0	1	0	0	0	0	0	0	1
1600-1718	Dermatological and Plastic Procedures	11	13	29	18	8	3	3	1	86
1780-1799	Chemotherapeutic and Radiation Oncology	3	0	0	0	0	0	0	0	3
1820-1916	Non-invasive, Cognitive and Interventions, nec	208	178	94	36	45	22	4	1	588
1940-2016	Imaging Services	144	179	85	18	16	8	4	8	462
	<i>Total</i>	<i>396</i>	<i>425</i>	<i>246</i>	<i>86</i>	<i>89</i>	<i>34</i>	<i>12</i>	<i>10</i>	<i>1,298</i>
	No procedure reported	17,311	26,869	13,655	2,200	2,005	2,925	100	138	65,203
	Total	17,707	27,294	13,901	2,286	2,094	2,959	112	148	66,501

Intended length of stay

The intended length of stay was considered as an option for defining same day mental health-related separations that could be regarded as equivalent to ambulatory mental health care. It was envisaged that the definition of an ambulatory-equivalent mental health-related separation could exclude those separations where the intended length of stay was overnight.

The AIHW has undertaken a detailed evaluation of the data supplied for the 2000–01 for the NMDS for Admitted Patient Care (AIHW in press). The evaluation found that the *Intended length of stay* data element was rarely analysed (as there is a far greater interest in the actual length of stay), that it was no longer used for grouping to Diagnosis Related Groups and there were also questions raised over its quality.

For same day mental health-related separations there were both differences between jurisdictions and differences between the mental health-related separations and all separations (Table A3.5). For mental health-related separations the proportion of same day separations that were intended to be same day ranged from 21% to 91%. Given this variation at a total and mental health specific-level it was assessed as unlikely that it will be reliable enough for use in the definition.

Summary

Ambulatory-equivalent mental health-related separations were defined by excluding those separations that involved ECT, general anaesthesia or other procedures unlikely to be undertaken by ambulatory mental health care or had a mode of separation or admission of death, care type change, left against medical advice or transfer.

The total remaining after all of these exclusions was 97,798 separations (out of a total of 118,081 separations). Data on those separations considered as possibly equivalent to ambulatory mental health care are presented by jurisdiction, sector and specialised psychiatric care status in Table 3.19. The number of these separations was comparatively high for private hospitals and for specialised psychiatric care. Data on those separations assessed as not equivalent to ambulatory mental health care are presented Table 4.2.

The ambulatory-equivalent mental health-related separations per 1,000 population are presented in Figure A3.2. Victoria, Queensland and Tasmania had relatively more of these separations per 1,000 population than other jurisdictions.

For the purposes of interpretation it is important to note that there were 65,203 same day mental health-related separations with no procedure codes reported (55% of all same day mental health-related separations). Most of the separations without procedure codes were classified as ambulatory-equivalent, except a few excluded due to a mode of separation or admission of death, care type change, left against medical advice or transfer. It was assumed that these separations included psycho-social interventions that were not recorded.

It is important to note that there could have been some misclassification with this process. Therefore the ambulatory and non-ambulatory-equivalent split should be seen as indicative, not exact. This is particularly the case because of the large number of admitted patient separations with no procedure code reported (i.e. a decision to admit was made however the absence of procedure could be caused by missing data).

Table A3.4: Mode of admission and mode of separation for same day mental health-related separations, states and territories, 2001-02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Mode of admission									
Admitted patient transferred from another hospital	400	1,944	111	116	93	426	2	2	3,094
Statistical admission – episode type change	7	79	13	.	1	6	.	.	106
Other	36,811	34,551	27,456	9,389	2,829	1,735	145	153	113,069
Unknown	.	.	.	.	175	1,637	.	.	1,812
Total	37,218	36,574	27,580	9,505	3,098	3,804	147	155	118,081
Mode of separation									
Unknown / not supplied	0	0	0	0	10	0	0	0	10
Discharge/transfer to an(other) acute hospital	965	2,450	626	81	476	486	11	17	5,112
Discharge/transfer to a Residential Aged Care service, unless this is the usual place of residence	28	17	97	2	11	10	1	0	166
Discharge/transfer to an(other) psychiatric hospital	653	0	8	208	218	0	0	2	1,089
Discharge/transfer to other health care accommodation (includes mother craft hospitals)	30	29	53	1	13	63	0	7	196
Statistical discharge – type change	30	393	25	9	2	5	0	4	468
Left against medical advice/discharge at own risk	1,176	156	344	181	108	17	2	5	1,989
Statistical discharge from leave	0	0	12	9	0	1	0	0	22
Died	3	0	2	1	0	0	0	0	6
Other (includes discharge to usual residence / own accommodation/ welfare institution)	34,333	33,529	26,413	9,013	2,260	3,222	133	120	109,023
Total	37,218	36,574	27,580	9,505	3,098	3,804	147	155	118,081

Table A3.5: Intended length of stay for same day mental health-related separations by state and territory, 2001-02

Intended length of stay	NSW	Vic	Qld	WA	SA	Tas	ACT	NT Australia	
Intended same day	30,517	33,358	20,478	7,558	1,835	2,704	83	33	96,566
Intended overnight	6,686	3,216	7,102	1,947	1,263	1,087	64	122	21,487
Not reported	15	0	0	0	0	13	0	0	28
Total	37,218	36,574	27,580	9,505	3,098	3,804	147	155	118,081
% of same day separations that were intended to be same day	82.0	91.2	74.2	79.5	59.2	71.1	56.5	21.3	81.8

Table A3.6: Same day mental health-related separations by ambulatory-equivalent status, by state and territory, 2001-02

Category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT Australia	
Non-ambulatory-equivalent	5,539	7,285	3,987	976	1,442	945	56	53	20,283
Ambulatory-equivalent	31,679	29,289	23,593	8,529	1,656	2,859	91	102	97,798
Total	37,218	36,574	27,580	9,505	3,098	3,804	147	155	118,081
% of same day separations that were considered ambulatory-equivalent	85.1	80.1	85.5	89.7	53.5	75.2	61.9	65.8	82.8

Table A3.7: Summary of exclusions undertaken to generate ambulatory-equivalent and non-ambulatory-equivalent mental health-related separation by hospital type and specialised psychiatric care status, 2001–02

Reason for exclusion	Public hospitals			Private hospitals			Total		
	Specialised psychiatric care			Specialised psychiatric care			Specialised psychiatric care		
	With out	With	Total	With out	With	Total	With out	With	Total
Mode of admission	2,099	1,233	3,332	267	1,413	1,680	2,646	2,366	5,012
Mode of separation	6,645	1,793	8,438	93	527	620	6,738	2,320	9,058
Procedure for ECT or GA	5,543	3,724	9,267	324	2,337	2,661	5,867	6,061	11,928
Number excluded	11,183	5,485	16,668	664	2,951	3,615	11,847	8,436	20,283

Note: The sum of the rows does not equal the number excluded as a separation may be included in more than one reason for exclusion.

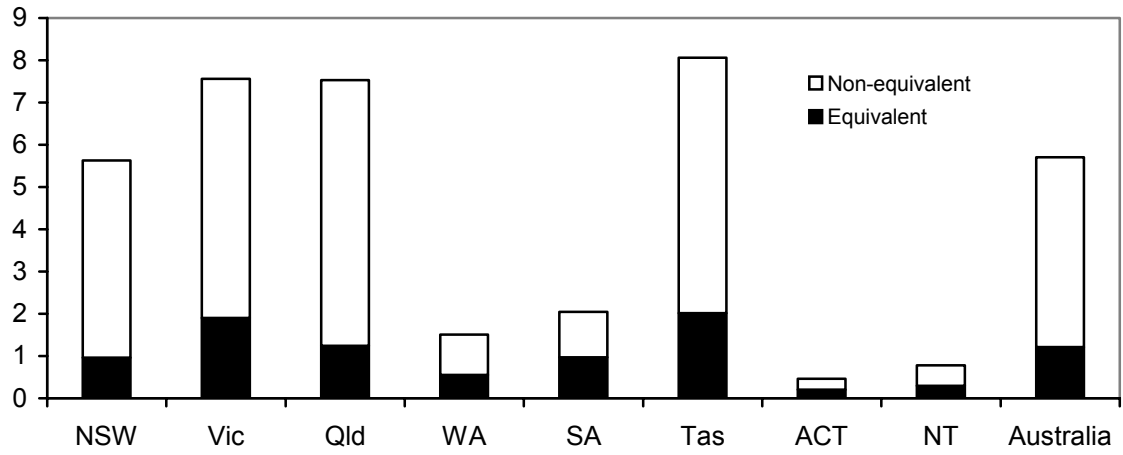


Figure A3.2: Ambulatory-equivalent and non-ambulatory-equivalent mental health-related separations per 1,000 population, states and territories, 2001-02

Appendix 4: State and territory ambulatory mental health care and admitted patient data

This appendix presents state and territory data on ambulatory mental health care and admitted patient mental health care.

Ambulatory mental health care

Coverage

In the first month of the data collection period, 206 establishments contributed data to the NCMHCD. The number of establishments rose to a maximum of 217 in February and April and totalled 220 for the entire collection year. South Australia collected and reported data for 13 country establishments for the first time in 2001–02, but was unable to provide data for the first half of the collection period (July to December) for these establishments.

There were 22 ambulatory mental health care establishments that contributed data to the NCMHED but did not contribute any data to the NCMHCD. These included two services in Queensland, eight services in South Australia, 11 services in Tasmania and one in the Australian Capital Territory. Data were not available from New South Wales and Victoria was unable to provide final data to the NCMHED.

The collection was also affected by under-reporting of service contacts for those establishments that did report. There were 1,108,505 service contacts reported in the last and most complete quarter of collection. Had coverage been at this level for the whole year, there would have been approximately 4.43 million service contacts reported compared with the 4.20 million actually reported. Although the last quarter had the highest number of service contacts for Australia as a whole, the fourth quarter was not the highest reporting quarter for several jurisdictions. When the highest reporting quarter for individual jurisdictions is multiplied by four, the total estimated number of service contacts increases to 4.49 million. When the highest reporting quarter for each individual establishment is multiplied by four, the total estimated number of service contacts increases to **X million**. This estimate does not include an estimate of non-reporting establishments.

Definition of service contacts

Review of the 2000–01 data identified inconsistencies in the definition of a service contact actually used across jurisdictions. Variation between states' and territories' reporting practices have been identified with respect to:

- whether a service contact can be reported if the patient has not provided personal details.

- how many service contacts are to be reported when there are multiple service providers and/or multiple patients present at the service contact (e.g. group sessions).
- whether a patient receiving numerous services during one day should be recorded as one or more service contacts.
- what extent telephone and written correspondence are included as service contacts.
- whether indirect contacts such as contacts between service providers should be included.
- whether consultation–liaison activities (i.e. specialist mental health providers who liaise with general hospital units when they treat patients with mental disorders) are included as service contacts.

These issues are expanded on in the AIHW Working Paper (AIHW **in press**).

Although it is anticipated that the data collected will allow records for service contacts within individual establishments to be linked for individual patients so that estimates of number of patients treated can be made, this has not been undertaken for this report. A discussion of the extent to which this may be possible is included in the Working Paper.

In 2001–02 there were 4.2 million service contacts reported for public hospital-based outpatient services and community-based ambulatory mental health care services, at a rate of 215.3 contacts per 1,000 population.

Indigenous status

Variation in the number and rate per 1,000 population of Aboriginal and Torres Strait Islander service contacts among the states and territories shown in Table 3.18 could reflect varying accuracy of Indigenous identification, varying coverage of service contacts in total or service contacts for Indigenous people, or varying accuracy of denominator data on the size of the Indigenous population.

The NCMHCD data reported for the 'Both Aboriginal and Torres Strait Islander' category is suspected to be affected by data entry error, misinterpretation of the category to include South Sea Islander and non-Australian indigenous persons (e.g. Maoris) and use of the category as an 'Indigenous, not further specified' category. Therefore the number of mental health care service contacts for clients in this category may be overstated for most jurisdictions, excluding the Northern Territory. The number of mental health care service contacts in the Northern Territory is known to reflect proportions of persons in the population.

This assumption is supported by a recent audit undertaken by Queensland Health of Community Mental Health clients with an Indigenous status of 'Both Aboriginal and Torres Strait Islander' for 2002–03. This data quality audit found that over half of the clients were reclassified to a different Indigenous status category due to the above-mentioned issues. The extent of the problem in other jurisdictions is unknown.

Jurisdictions were asked to consider the general quality of their Aboriginal and Torres Strait Islander status data. Below are outlined the responses to this query provided by state and territory health authorities for the NCMHCD 2001–02. Information on the quality of Aboriginal and Torres Strait Islander status data for 2001–02 was not available for New South Wales, Victoria, Western Australia, or the Australian Capital Territory.

In 2001–02 the quality of indigenous status data in Queensland has improved through removal of the default system, through coder education strategies and through discussions with the Queensland Indigenous Information Strategy Team.

The Department of Health and Human Services Tasmania indicated that the proportion of patients who are identified as being of indigenous origin is equivalent to the proportion of identified indigenous people in the population. Anecdotal evidence indicates that there may be undercounting due to patients not willing to self identify, patients uncertain about their status, and clinicians not asking the appropriate questions. The broad debate in Tasmania about the legitimacy of people's identification as Indigenous has complicated the Indigenous identification issues for mental health data collections.

The Department of Human Services South Australia indicated that whilst processes have been established to collect Indigenous status, there are no mechanisms in place to ensure that information collected is validated appropriately. Therefore, the quality of the data item is uncertain at this stage. Regarding the coverage of service contacts for Indigenous persons, health services tend to be based in metropolitan areas or major towns or cities in regional areas, with one health service in a main regional city having a specific focus of servicing the Indigenous population for that area. Contact services for the more remote northerly locations within South Australia tend to be provided by services outside the scope of the Community Mental Health Care NMDS or involve jurisdiction overlap with the Northern Territory. The provision of services to these remote northern areas of South Australia are managed through offices in Alice Springs. It is acknowledged that Indigenous identification processes need to be improved to ensure that Indigenous peoples in South Australia receive appropriate service responses across Community Mental Health Care.

The Department of Health Northern Territory reported that in general, the identification of indigenous persons is considered reliable.

Principal Diagnosis

State and territory health authorities have expressed concern about the ability of small community facilities to accurately code principal diagnosis, the availability of appropriate clinicians to assign principal diagnoses and the application of diagnosis to a period of care rather than to an individual service contact. New South Wales report diagnosis at each contact. Queensland were unable to report principal diagnosis for 2001–02.

Admitted patient mental health care

The remaining tables in this appendix provide more detailed state and territory information on admitted patient mental health care.

Tables A4.3 to A4.12 provide information by state and territory for mental health-related separations with specialised psychiatric care which were not considered ambulatory-equivalent. These tables include counts of separations, patient days and psychiatric care days by principal diagnosis, AR-DRGs and procedures. Please see chapter 5 for the national data on these separations.

Tables A4.13 to A4.20 provide information by state and territory for mental health-related separations without specialised psychiatric care which were not considered ambulatory-equivalent. These tables include counts of separations and patient days by principal

diagnosis, AR-DRGs and procedures. Please see chapter 6 for the national data on these separations.

Tables A4.21 and A4.22 present information on the principal diagnosis groupings for ambulatory-equivalent mental health-related hospital separations (see Appendix 3) with and without specialised psychiatric care by state and territory. Please see Chapter 3 for the national data on these separations.

Variation between jurisdictions

As noted in Chapters 3, 4, 5 and 6 there was some variation between jurisdictions in the distribution of separations and patient days between different service provider types, and between same day and overnight separations. Overall, there was also variation in the number of mental health-related admitted patient and residential care separations per 1,000 population, and patient days per 1,000 population for hospitals. Tables 4.2 and 4.3 show, for example, the relatively high rates of separations for public community mental health care establishments for Tasmania compared with other jurisdictions. In Victoria, the relatively low rates for patient days for public psychiatric hospitals cannot be directly compared to rates in other jurisdictions since the one Victorian public psychiatric hospital is a forensic hospital.

These patterns can be influenced by a number of factors such as:

- the availability of admitted patient mental health care services in each state and territory;
- the availability of community-based residential mental health care facilities;
- differing admission practices;
- differences in the types of establishments that are categorised as hospitals; and
- the spread of the population in remote, regional and major city areas, and other demographic characteristics of the population.

As a result of these differences, there can be variation in the proportions of separations reported for the different provider types, for same day stays, and/or for which specialised psychiatric care was reported. Comparison between jurisdictions therefore needs to be undertaken with care. Information on the differences between states and territories in the scope of services provided for ambulatory mental health care are described elsewhere in this appendix while the differences between states and territories for admitted patients is presented in Box 4.2.

Table A4.1: Community mental health service contacts by sex and age group, states and territories, 2001–02^(a)

Sex and age	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Males									
Less than 15	36,953	86,941	63,873	22,273	11,117	2,661	7,596	1,202	232,616
15–24	75,282	139,109	60,872	29,184	21,731	3,063	19,353	3,919	352,513
25–34	107,914	211,086	84,165	44,047	37,353	5,798	21,283	5,634	517,280
35–44	105,132	154,809	69,587	40,360	37,012	5,513	18,284	5,509	436,206
45–54	65,287	109,389	46,324	29,314	19,478	3,686	7,322	1,494	282,294
55–64	29,494	50,747	24,841	13,372	8,402	1,201	2,922	869	131,848
65+	20,698	90,614	24,596	16,426	12,307	1,511	2,902	375	169,429
<i>Total males^(b)</i>	<i>441,642</i>	<i>842,720</i>	<i>374,258</i>	<i>195,096</i>	<i>147,400</i>	<i>23,631</i>	<i>79,663</i>	<i>19,029</i>	<i>2,123,439</i>
Females									
Less than 15	22,690	45,119	37,690	12,511	5,665	1,756	5,067	508	131,006
15–24	70,338	120,542	60,493	26,400	15,509	3,269	18,377	1,960	316,888
25–34	85,492	147,948	59,988	35,566	23,284	4,711	12,784	2,646	372,419
35–44	91,895	155,072	61,905	41,595	27,089	4,917	14,003	2,781	399,257
45–54	65,877	107,662	47,092	33,109	20,456	4,319	11,803	1,909	292,227
55–64	39,974	65,807	25,327	18,951	14,823	2,048	6,812	399	174,141
65+	39,244	161,045	39,133	32,191	25,001	3,532	5,933	252	306,331
<i>Total females^(b)</i>	<i>416,580</i>	<i>803,227</i>	<i>331,628</i>	<i>200,417</i>	<i>131,827</i>	<i>24,636</i>	<i>74,819</i>	<i>10,491</i>	<i>1,993,625</i>
Total^(b)									
Less than 15	70,024	132,060	101,571	34,784	17,182	4,417	12,663	1,710	374,411
15–24	156,609	259,651	121,365	55,584	37,478	6,332	37,730	5,906	680,655
25–34	209,654	359,061	144,153	79,613	60,768	10,512	34,067	8,325	906,153
35–44	211,247	309,881	131,492	81,955	64,126	10,435	32,287	8,290	849,713
45–54	139,563	217,051	93,416	62,423	39,938	8,006	19,125	3,403	582,925
55–64	73,903	116,554	50,168	32,323	23,228	3,252	9,734	1,268	310,430
65+	62,518	251,659	63,730	48,617	37,336	5,050	8,835	627	478,372
Total^(b)	942,307	1,645,974	705,895	395,513	280,056	48,286	156,108	29,592	4,203,731

(a) These data should be interpreted with caution due to incomplete coverage and inconsistencies in the definition of a service contact used between jurisdictions. For more information refer to Appendix 4.

(b) Includes service contacts for which sex and/or age group was not reported.

Table A4.2: Community mental health service contacts by principal diagnosis, states and territories, 2001-02^(a)

	Principal diagnosis	NSW^(c)	Vic	Qld^(c)	WA	SA	Tas	ACT	NT	Australia	Per cent
F00-F03	Dementia	4,666	50,242	n.a.	11,931	7,771	2,267	1,269	13	78,159	2.2
F04-F09	Other organic mental disorders	1,604	8,010	n.a.	7,533	1,895	153	2,368	71	21,634	0.6
F10	Mental and behavioural disorders due to use of alcohol	5,378	14,196	n.a.	3,473	1,010	93	1,032	353	25,535	0.7
F11-F19	Mental and behav disorders due to other psychoactive substances use	8,712	26,248	n.a.	8,555	2,265	245	3,310	573	49,908	1.4
F20	Schizophrenia	217,955	538,666	n.a.	101,813	96,522	12,947	48,924	2,692	1,019,519	29.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,330	24,687	n.a.	7,916	6,080	164	3,168	183	43,528	1.2
F22	Persistent delusional disorders	1,060	20,476	n.a.	5,074	3,831	32	3,004	120	33,597	1.0
F23	Acute and transient psychotic disorders	55,259	18,192	n.a.	7,036	5,362	1,319	1,841	160	89,169	2.5
F25	Schizoaffective disorders	2,412	113,264	n.a.	11,230	19,547	2,715	8,450	529	158,147	4.5
F30	Manic episode	571	4,874	n.a.	7,673	2,921	170	1,090	13	17,312	0.5
F31	Bipolar affective disorders	39,961	129,088	n.a.	29,428	27,102	2,948	11,176	490	240,193	6.9
F32	Depressive episode	87,850	148,269	n.a.	48,672	29,618	4,864	11,853	1,906	333,032	9.5
F33	Recurrent depressive disorders	1,068	39,745	n.a.	13,328	4,754	143	4,173	205	63,416	1.8
F34	Persistent mood (affective) disorders	434	14,203	n.a.	8,745	2,261	191	2,089	134	28,057	0.8
F38, F39	Other and unspecified mood (affective) disorders	2,044	2,248	n.a.	2,107	834	28	1,166	109	8,536	0.2
F40	Phobic anxiety disorders	3,047	3,485	n.a.	2,562	2,167	161	542	84	12,048	0.3
F41	Other anxiety disorders	31,306	25,353	n.a.	14,641	6,627	2,427	2,304	394	83,052	2.4
F42	Obsessive-compulsive disorders	474	7,315	n.a.	4,450	2,008	672	1,662	50	16,631	0.5
F43	Reaction to severe stress and adjustment disorders	20,234	81,072	n.a.	29,995	10,634	1,772	2,096	1,489	147,292	4.2
F44	Dissociative (conversion) disorders	1,158	546	n.a.	737	110	83	19	1	2,654	0.1

Table A4.2 (continued): Community mental health service contacts by principal diagnosis, states and territories, 2001–02^(a)

	Principal diagnosis	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT	NT	Australia	Per cent
F45,F48	Somatoform and other neurotic disorders	1,927	2,604	n.a.	1,475	408	80	227	58	6,779	0.2
F50	Eating disorders	4,142	7,401	n.a.	3,045	116	344	186	67	15,301	0.4
F51-F59	Other behav syndromes associated w phys dist & phys factors	250	2,127	n.a.	1,833	233	142	613	3	5,201	0.1
F60	Specific personality disorders	11,820	63,198	n.a.	13,200	7,033	1,379	6,356	487	103,473	3.0
F61-F69	Disorders of adult personality and behaviour	510	3,107	n.a.	1,777	1,584	110	831	137	8,056	0.2
F70-F79	Mental retardation	1,829	5,059	n.a.	1,998	473	167	787	11	10,324	0.3
F80-F89	Disorders of psychological development	980	14,733	n.a.	1,811	1,204	104	450	63	19,345	0.6
F90	Hyperkinetic disorders	3,413	10,157	n.a.	3,267	332	482	886	140	18,677	0.5
F91	Conduct disorders	5,644	22,435	n.a.	2,200	2,094	324	503	111	33,311	1.0
F92-F98	Other & unspec disorders w onset childhood adolescence	2,358	28,295	n.a.	9,607	2,153	395	4,762	175	47,745	1.4
F99	Mental disorder not otherwise specified	205,750	3,702	n.a.	16,200	28,413	1	28,971	208	283,245	8.1
	Other	35,256	2,481	n.a.	12,201	2,694	1,230	0 ^(c)	0 ^(c)	53,862	1.5
	Not reported	181,905	210,496	n.a.	0	0	10,134	0	18,563	421,098	12.0
	Total	942,307	1,645,974	n.a.	395,513	280,056	48,286	156,108	29,592	3,497,836	100.0

(a) These data should be interpreted with caution due to evidence of under reporting of service contacts and inconsistencies in the definition of a service contact actually used across jurisdictions. These data should be interpreted with caution due to differences in the statistical unit used by jurisdictions when reporting Principal Diagnosis.

(b) Queensland were unable to report Principal diagnosis for 2001–02.

(c) The Australian Capital Territory and Northern Territory reported Principal diagnosis using the 'Mental and behavioural disorders' chapter of the ICD-10-AM classification only.

Abbreviations: behav—behavioural, subst—substances, w—with, phys—physical, dist—disturbances, dis—diseases, nerv sys—nervous system, complic—complicating, preg—pregnancy, child—childbirth, puerp—puerperium, gen—general, influ—influencing, n.a. not available.

Appendix 5: National Survey of Mental Health Services

The National Survey of Mental Health Services (NSMHS) is an annual collection of establishment-level data from publicly funded hospital and community mental health care services in all states and territories.

The Survey, first collected in 1993, was designed to fulfil reporting requirements under the previous Medicare Agreements and to enable progress to be monitored against the 38 policy objectives of the National Mental Health Policy. It requires the states and territories to collect information including expenditure, staffing, service types and activity levels relating to public mental health services within their jurisdiction. The future of the NSMHS following the end of the Second Mental Health Plan in June 2003 is currently being reviewed.

Summary data from the NSMHS are reported in the National Mental Health Report series (DHA 2002). Data from the NSMHS for 2000–01 and 2001–02 have yet to be published.

A number of basic differences exist between data from NSMHS and data from NPHEd, NMHD and NCMHED. An overview of the reasons for these differences is presented below.

Comparison with NCMHED data

There is alignment in the scope of the NCMHED and the NSMHS data collection, with the exception of New South Wales. In New South Wales, the NSMHS data collection includes all services described by Area Health Services as providing specialist mental health services. For NCMHED only those specialist mental health services, which are part of the Mental Health financial program are included. For one Area this has had the effect of excluding most non-admitted child and adolescent services. NCMHED data provided by New South Wales also exclude all Confused and Disturbed Elderly (CADE) services, with the exception of the New England CADE (New South Wales' only mental health program-financed CADE). For the NSMHS, however, New South Wales reports data for all CADEs. This difference in scope affects the comparability of New South Wales FTE staffing and recurrent expenditure data between the NCMHED and the NSMHS. A list of public community mental health establishments that report to NCMHED is available on the AIHW's web site.

Comparison with NCMHCD data

The National Survey of Mental Health Services (NSMHS) collects service contact data for community mental health services. The estimate of 4.27 million service contacts from NCMHCD in 2000–01 is lower than the 5.67 million service contacts reported to the National Survey of Mental Health Services in 1999–00. The NSMHS counts of service contacts were greater than NCMHCD for all jurisdictions except Tasmania and the Australian Capital Territory.

Variation between the two collections can be expected because of differences in their scope and coverage, and definitional differences. Information in the *National Mental Health Report*

2002 indicated that there were data quality concerns for 1999–00 (DHA 2002). The concept of a service contact in the NCMHCD collection differs from the service contact definition in the NSMHS in that only same day services that are non-admitted are considered part of the scope of NCMHCD. The NSMHS includes same day admitted services as service contacts. It is likely that there were 14,490 ambulatory-equivalent and 6,278 non-ambulatory-equivalent same day admissions with specialised psychiatric care included in the NSMHS collection for 2001–02 that were not in the NCMHCD for 2001–02 (from Tables 3.19 and 4.1). There may be other differences reflecting the variation in the definition used in the NCMHCD and between 1999–00 and 2001–02.

NCMHCD coverage for New South Wales, Queensland, South Australia, Tasmania and the Australian Capital Territory is incomplete as evidenced by the 29 establishments contributing to NCMHED but not reporting service contacts to the NCMHCD collection. Under-reporting is also in evidence since monthly service contact numbers for establishments fluctuated, particularly in New South Wales and Queensland. Definitional differences such as those outlined for service contacts may also be reflected in the higher counts in the NCMHCD in 2000–01 than in the NSMHS for 1999–00 for Tasmania and the Australian Capital Territory.

Comparison with NPHEd data

The fundamental difference between the hospital data reported to the NSMHS and that reported to NPHEd is the different manner in which hospital establishments are classified to the different data definitions used in the two collections. This makes comparison problematic.

In previous years, the difference in the number of hospitals reported as public psychiatric hospitals to the NPHEd and NSMHS (DHA 2002) was greatest for Victoria. For the NSMHS collection, six Victorian hospital establishments were classified as public psychiatric hospitals (reflecting actual locations). For NPHEd, one of these establishments was classified as a public psychiatric hospital and the rest were classified as campuses of acute care hospitals (reflecting hospital management arrangements). A list of public community mental health establishments that report to NCMHED is available on the AIHW's web site (see page 239).

Hospitals reported to NPHEd can also include community-based, non-admitted patient services that are managed by the hospital, but are located elsewhere. Within the NSMHS these services are classified as distinct service units and data on them are reported as for community-based services only.

Glossary

For further information on the terms used in this report, refer to the definitions in use in 2001–02 in the *National Health Data Dictionary*, Version 10.0.

<i>Aboriginal and Torres Strait Islander status</i>	<p>Aboriginal or Torres Strait Islander status of the person according to the following definition:</p> <p>An Aboriginal or Torres Strait Islander person is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.</p>
<i>Acute</i>	Having a short and relatively severe course.
<i>Acute care hospitals</i>	<p>Establishments which provide at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the State or Territory health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.</p> <p>Public acute hospitals are funded by the State or Territory health authority. Private acute care hospitals are not controlled by the State or Territory health authority.</p>
<i>Additional diagnoses</i>	Conditions or complaints either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility. Additional diagnoses give information on factors that result in increased length of stay, more intensive treatment or the use of greater resources.
<i>Administrative and clerical staff</i>	Staff engaged in administrative and clerical duties. Civil engineers and computing staff are included in this category. Medical staff and nursing staff, diagnostic and health professionals, and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded.
<i>Administrative expenditure</i>	All expenditure incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation).
<i>Admitted patient</i>	A patient who undergoes a hospital's formal admission to receive treatment and/or care.

<i>Ambulatory-equivalent separation</i>	A separation that could be considered to be equivalent to ambulatory mental health care. These include mental health-related separations with procedures that would be expected to be undertaken in ambulatory mental health care, with no procedure recorded or with a mode of separation or mode of admission of death, care type change, left against medical advice or transfer.
<i>Area of usual residence</i>	The geographic location of the patient's usual residence. The location is included in the National Hospital Morbidity Database in Statistical Local Area format but aggregated to Remoteness Areas and Statistical Divisions for this report.
<i>Australian Bureau of Statistics Private Health Establishments Collection (ABS PHEC)</i>	This collection includes data from all private acute and psychiatric hospitals licensed by State and Territory health authorities and all free-standing day hospital facilities approved by the Australian Government Department of Health and Ageing. The data items and definitions are based on the <i>National Health Data Dictionary</i> . Information is collected for items such as bed supply, usage, length of stay, type of patients, staff and expenditure.
<i>Australian Refined Diagnosis Related Groups (AR-DRGs)</i>	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital. Diagnosis Related Groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.
<i>Available beds</i>	Beds immediately available for use by admitted patients or residents as required. This term includes occupied and unoccupied beds.
<i>Average length of stay</i>	The average number of patient days for admitted patient overnight separations.
<i>Care type</i>	<p>The care type defines the overall nature of the clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous (other care).</p> <p><i>Acute care</i> is care in which the clinical intent or treatment goal is to manage labour (obstetric); cure illness or provide definitive treatment of injury; perform surgery; relieve symptoms of illness or injury (excluding palliative care); reduce severity of an illness or injury; protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and/or perform diagnostic or therapeutic procedures.</p> <p><i>Rehabilitation care</i> is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multidisciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure.</p>

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames.

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting, e.g. at home or in a nursing home by a relative or carer, that is unavailable in the short term.

Other care types include *Palliative care, Geriatric evaluation and management, Newborn care, Organ procurement posthumous and Hospital boarders*. Further detail on these care types is presented in the *National Health Data Dictionary*.

Country of birth

The country in which the patient was born. The category 'Other English-speaking country' includes United Kingdom, Ireland, New Zealand, United States of America and Canada. All other countries, apart from Australia, were included in the 'Non-English-speaking' category.

Diagnostic and allied health professionals

Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians but excludes civil engineers and computing staff.

Domestic and other staff

Staff engaged in the provision of food and cleaning services. They include domestic staff, such as food services managers, engaged mainly in administrative duties. This category also includes all staff not elsewhere included (mainly maintenance staff, tradespersons and gardening staff).

Domestic services expenditure

The costs of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs.

Drug supplies expenditure

The cost of all drugs including the cost of containers.

<i>Encounter</i>	Any professional interchange between a patient and a general practitioner.
<i>Enrolled nurses</i>	Second-level nurses who are enrolled in all states and territories except Victoria where they are registered by the State registration board to practise in this capacity. The category includes general enrolled nurses and specialist enrolled nurses (e.g. mothercraft nurses in some states and territories).
<i>Episode of care</i>	An episode of care is a phase of treatment for an admitted patient. It may correspond to a patient's entire hospital stay, or the hospital stay may be divided into separate episodes of care of different types. See <i>Separation</i> .
<i>External cause</i>	Environmental event, circumstance and/or condition as the cause of injury, poisoning and/or other adverse effect.
<i>Food supplies expenditure</i>	The cost of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery.
<i>Full-time-equivalent staff</i>	Full-time-equivalent units are on-job hours worked and hours of paid leave (sick, recreation, long-service, workers compensation) by/for a staff member (or contract employee where applicable) divided by the number of hours normally worked by a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement.
<i>Involuntary mental health legal status</i>	Involuntary patients are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.
<i>Medical and surgical supplies expenditure</i>	The cost of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs.
<i>Mental health legal status</i>	Whether a person is treated on an involuntary basis under the relevant State or Territory mental health legislation, at any time during an episode of care for an admitted patient or treatment of a patient/client by a community-based service during a reporting period.
<i>Mental health-related principal diagnosis</i>	A separation is defined as having a mental health-related principal diagnosis if the principal diagnosis falls within the range of ICD-10-AM diagnosis codes listed in Appendix 3 of <i>Mental Health Services in Australia, 2000-01</i> .

<i>Mode of separation</i>	The status of the person at separation (discharge, transfer or death) and, where applicable, the place to which the person is released.
<i>National Hospital Morbidity Database (NHMD)</i>	The National Hospital Morbidity Database is a compilation of electronic summary records collected in admitted patient morbidity data collection systems in Australian hospitals. Data relating to admitted patients in almost all hospitals are included: public acute hospitals, public psychiatric hospitals, private acute hospitals, private psychiatric hospitals and private free-standing day hospital facilities. The data supplied for the database are based on the patient-level data items of the NMDS for Admitted Patient Health Care and the NMDS for Admitted Patient Mental Health Care. They include demographic, administrative and length-of-stay data, and data on the diagnoses of the patient, the procedures the patient underwent in hospital, and external causes of injury and poisoning.
<i>National Public Hospital Establishments Database (NPHEd)</i>	The National Public Hospital Establishments Database holds a record for each public hospital in Australia. It is collated from the routine administrative collections of public acute hospitals, psychiatric hospitals, drug and alcohol hospitals and dental hospitals in all states and territories. Information is included on hospital resources, recurrent expenditure, non-appropriation revenue and services to admitted and non-admitted patients. Data on capital expenditure and depreciation are also collected for each jurisdiction. The collection is based on the establishment-level activity and resource data elements, and the system-level data elements of the National Minimum Data Set for Public Hospital Establishments.
<i>National Community Mental Health Establishments Database (NCMHED)</i>	The National Community Mental Health Establishments Database holds a record for each public community mental health establishment in Australia. It is collated from the routine administrative collections of public community mental health establishments in all states and territories. Information is included on beds, staffing, recurrent expenditure, and services for residential care clients. The collection is based on the establishment-level activity and resource data elements of the National Minimum Data Set for Community Mental Health Establishments.
<i>Non-admitted patients</i>	Patients who do not undergo a hospital's formal admission process and who receive care from a recognised non-admitted patient service/clinic of a hospital.
<i>Non-admitted patient occasion of service</i>	Occurs when a patient attends a functional unit of the health service establishment for the purpose of receiving services such as examination, consultation and treatment, but is not admitted. A visit for administrative purposes is not an occasion of service.
<i>Not published (n.p.)</i>	Not available for separate publication but included in the totals where applicable.

<i>Other personal care staff</i>	This category includes attendants, assistants or home assistants, home companions, family aides, ward helpers, wardspersons, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.
<i>Other recurrent expenditure</i>	Recurrent expenditure not included elsewhere in any of the recurrent expenditure categories.
<i>Other revenue</i>	All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments). This includes revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors.
<i>Overnight separation</i>	The term used to refer to separations where the patient separates from hospital one or more nights after admission (i.e. who is admitted to and separated from the hospital on different dates). The length of an overnight separation is calculated by subtracting the date the patient is admitted from the date of the separation and deducting total leave days.
<i>Patient days</i>	The number of full or partial days stay for patients who were admitted for an episode of care and who underwent separation. A patient who is admitted and separated on the same day is allocated one patient day.
<i>Patient transport expenditure</i>	The direct cost of transporting patients, excluding salaries and wages of transport staff.
<i>Payments to visiting medical officers</i>	All payments made to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid or fee-for-service basis.
<i>Previous specialised treatment</i>	Whether the patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided. For this report, the specialty area referred to in the definition is specialised psychiatric care.
<i>Primary disability</i>	The disability category identified by the consumer or carer in the CSTDA MDS as the disability most affecting their everyday life.
<i>Principal diagnosis</i>	The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at ambulatory care service).
<i>Private hospital</i>	Privately owned and operated hospital, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute and psychiatric hospitals are included.

<i>Private psychiatric hospital</i>	These are devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These hospitals are licensed/approved by each state or territory health authority and cater primarily for patients with psychiatric or behavioural disorders.
<i>Procedure</i>	A clinical intervention that is surgical in nature, carries a procedural risk, carries an anaesthetic risk, requires specialised training and/or requires special facilities or equipment only available in the acute care setting.
<i>Psychiatric care days</i>	Psychiatric care days are the number of days or part-days a patient spent in a specialised psychiatric unit or ward. All leave days, including the day the patient went on leave, are excluded.
<i>Psychiatric hospitals</i>	Establishments devoted primarily to the treatment and care of in-patients with psychiatric, mental or behavioural disorders.
<i>Reason for encounter</i>	The subjective reasons given by the patient for seeing or contacting the general practitioner. These can be expressed in terms of symptoms, diagnoses or the need for a service.
<i>Recoveries</i>	All revenue received that is in the nature of a recovery of expenditure incurred. This includes: <ul style="list-style-type: none"> • income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors) • income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital • other recoveries such as those relating to inter-hospital service where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost.
<i>Recurrent expenditure</i>	Expenditure which recurs continually or frequently (e.g. salaries). It is contrasted with capital expenditure, such as the cost of hospital buildings and diagnostic equipment, for which expenditure is made infrequently.
<i>Registered nurses</i>	Nurses with at least a 3-year training certificate and nurses holding postgraduate qualifications. Registered nurses must be registered with a State or Territory registration board.
<i>Repairs and maintenance expenditure</i>	The costs incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating buildings and minor additional works.

Remoteness Area

A classification of the remoteness of a location using the Australian Standard Geographical Classification Remoteness Structure, based on the Accessibility / Remoteness Index of Australia (ARIA) which measures the remoteness of a point based on the physical road distance to the nearest urban centre.

The classifications are

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote
- Migratory.
- **Capital cities:** statistical division
- **Other metropolitan centres:** urban centres with a population of 100,000 or more
- **Large rural centres** (index of remoteness < 10.5): urban centres with a population between 25,000 and 99,999
- **Small rural centres** (index of remoteness < 10.5): urban centres with a population between 10,000 and 24,999
- **Other rural areas** (index of remoteness < 10.5): urban centres with a population less than 10,000
- **Remote centres** (index of remoteness > 10.5): urban centres with a population greater than 4,999
- **Other remote areas** (index of remoteness > 10.5): urban centres with a population less than 5,000.

Rural, remote and metropolitan region

For more information see *Rural, Remote and Metropolitan Areas Classification, 1991 Census Edition* (DPIE & DSHS 1994).

Salaried medical officers

Medical officers engaged by the hospital on a full-time or part-time salaried basis.

Same day patients

Admitted patients who are admitted and separate on the same date.

Separation

The term represents the completed episode of care, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). 'Separation' also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing the type of care (statistical separation). When the term is used in the context of the residential mental health care, the term refers to periods of non-admitted patient mental health care.

<i>Service contact</i>	A contact between a patient and an ambulatory mental health care service (including hospital outpatient services and community-based mental health services) which results in a dated entry being made in the patient's medical record.
<i>Source of referral to public psychiatric hospital</i>	Source from which the person was transferred/referred to the public psychiatric hospital.
<i>Specialised psychiatric service</i>	A facility or unit dedicated to the treatment or care of patients with psychiatric conditions.
<i>Statistical separation</i>	The administrative process by which a hospital records the cessation of an episode of care for a patient within one hospital stay.
<i>Superannuation payments</i>	Contributions paid or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a State or Territory health authority, to a superannuation fund providing retirement and related benefits to establishment employees.
<i>Visiting medical officer</i>	A medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee-for-service basis.

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