

Admitted patient mental health-related care

People with mental health problems may require hospitalisation from time to time. Patients can receive [specialised psychiatric care](#) in a psychiatric hospital or in a psychiatric unit within a hospital. They can also be admitted to a general ward where workers are not specifically trained to care for the mentally ill. Under these circumstances, the admissions are classified as [without specialised psychiatric care](#).

This section presents information on these [admitted patient](#) mental health-related [separations](#). The data are from the National Hospital Morbidity Database (NHMD), a collation of data on admitted patient care in Australian hospitals, and are based on the Admitted Patient Care National Minimum Data Set. As it is not possible to determine how many separations an individual patient has had, the information describes separation events, not patients. For further information see the [data source](#) section.

Key points

- Of the 241,389 admitted patient mental health-related separations in 2012–13, 60.9% (146,935) were provided with specialised psychiatric care.
- Involuntary admissions accounted for 29.5% of mental health-related separations with specialised psychiatric care.
- The largest numbers and highest rates of mental health-related separations with specialised psychiatric care were for patients aged 35–44 (31,191 or 9.7 per 1,000 population).
- Depressive episode and schizophrenia were the most commonly reported principal diagnoses for separations with specialised psychiatric care (17.0% and 14.5% respectively).
- Mental and behavioural disorders due to use of alcohol was the most commonly reported principal diagnosis for separations without specialised psychiatric care (19.5%).
- Allied health intervention–social work, is the most commonly reported procedure for both separations with and without specialised care (21.8% and 14.4% respectively).
- National seclusion rates have fallen from 13.5 events per 1,000 bed days in 2009–10 to 8.0 in 2013–14.
- The average duration per seclusion event was 6.0 hours in 2013–14.

Overview

A total of 9.37 million separations were reported from public acute, private acute and public psychiatric hospitals in 2012–13 (AIHW 2014). There were 241,389 admitted patient mental health-related separations in 2012–13 accounting for 2.6% of all hospital separations. Of these, 146,935 (60.9%) had specialised psychiatric care and 94,454 (39.1%) did not have specialised psychiatric care. Over the 5 years to 2012–13, the average annual rate of increase for all admitted mental health-related separations was 2.9%.

Reference

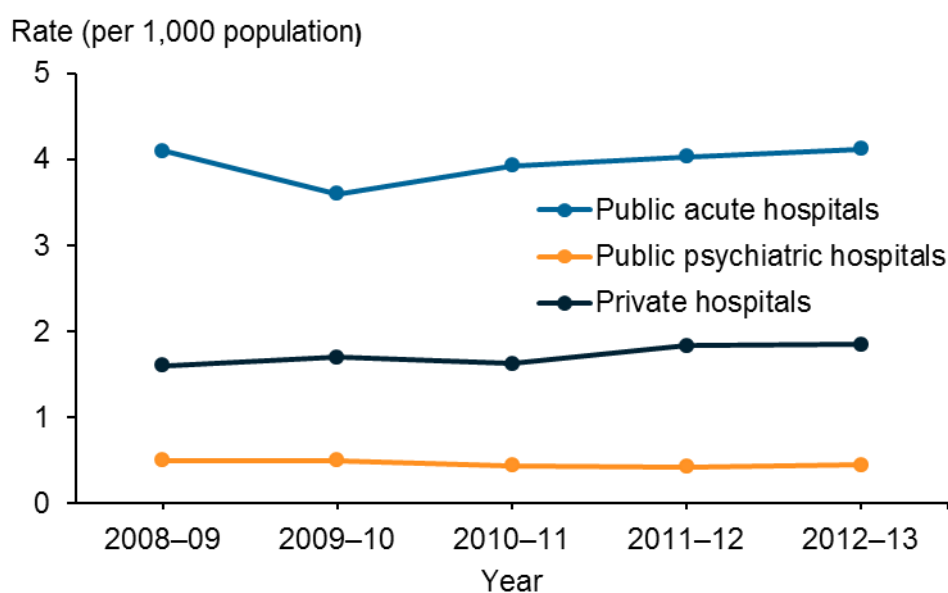
AIHW 2014. Australian hospital statistics 2012–13. Health services series no. 54. Cat. no. HSE 145. Canberra: AIHW.

Specialised admitted patient mental health care service provision

Over time

Between 2008–09 and 2012–13, there was an average annual increase of 2.7% in the number of separations with specialised psychiatric care for all hospital types. The rate of separations per 1,000 population has remained essentially stable over the 5 years to 2012–13 for public acute hospitals. The rate of separations for private hospitals has increased slightly from 1.6 per 1,000 population in 2008–09 to 1.8 in 2012–13. However, the rate of public psychiatric hospital separations with specialised care decreased at an average annual rate of 2.9%.

Figure AD.1: Admitted patient mental health-related separations with specialised psychiatric care, by hospital type, 2008–09 to 2012–13



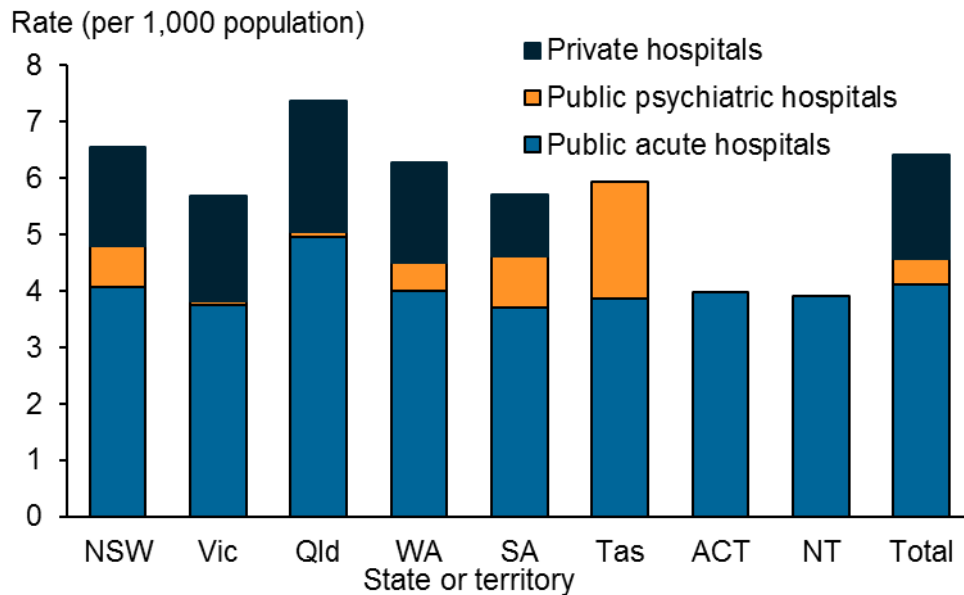
Note: Separations with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.4 (1MB XLS) in the Admitted patient mental health-related care table downloads.

By states and territories

In 2012–13, the national rate of public acute hospital separations with specialised psychiatric care was 4.1 per 1,000 population. Queensland had the highest rate of separations with specialised psychiatric care (4.9) and both South Australia and Victoria the lowest (3.7) (Figure AD.2).

Figure AD.2: Separations with specialised psychiatric care, state and territory, by hospital type, 2012–13



Notes:

1. Rates were directly age-standardised as detailed in the technical information.
2. The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.
3. Private hospital figures for Tasmania, the Australian Capital Territory and the Northern Territory are not published for confidentiality reasons.
4. Separations with a care type of Newborn (without qualified days), Hospital boarders and Posthumous organ procurement have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.3 (1MB XLS) in the Admitted patient mental health-related care table downloads.

There were 67.1 public acute hospital patient days per 1,000 population in 2012–13. New South Wales had the highest rate of public acute hospital patient days (77.5 per 1,000 population) and the Northern Territory the lowest (48.2). The rate of public psychiatric hospital patient days varied greatly across jurisdictions, from 42.4 patient days per 1,000 population in South Australia to 8.1 days in Victoria. Queensland reported the highest rate of patient days in private hospitals (37.2 per 1,000 population).

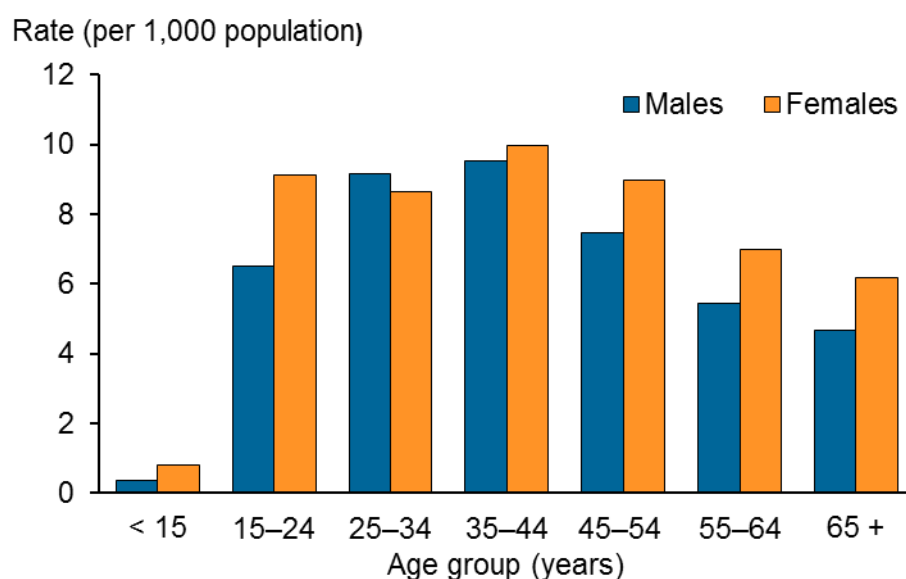
In 2012–13, the national average length of stay for public acute hospitals was 16.6 days. New South Wales had the longest average length of stay and the Northern Territory the shortest (19.5 and 12.4 days respectively). The greatest variation in average length of stay was for public psychiatric hospitals with Queensland reporting 350.9 days and Tasmania 18.7 days.

Specialised admitted mental health care patient characteristics

Patient demographics

In 2012–13, the rate of mental health-related separations with specialised psychiatric care was highest for patients aged 35–44 and lowest for those aged under 15 (9.7 and 0.6 per 1,000 population respectively) (Figure AD.3). Overall, the separation rate was higher for females than males (6.9 and 5.9 per 1,000 population respectively).

Figure AD.3: Admitted patient separation with specialised psychiatric care rates, by sex and age groups, 2012–13



Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.4 (1MB XLS) in the Admitted patient mental health-related care table downloads.

Aboriginal and Torres Strait Islander people make up about 3.0% of the Australian population (ABS 2013) but are proportionally overrepresented in terms of mental health-related hospitalisations including specialised psychiatric care, accounting for 4.9% of these separations in 2012–13. Indigenous Australians had a separation rate that was double that of Other Australians (12.7 and 6.3 per 1,000 population respectively). The highest rate of separations in 2012–13 was for those living in *Inner regional* areas (6.7 per 1,000 population) and the lowest for those in *Remote* and *very remote* areas (3.5 per 1,000 population).

Reference

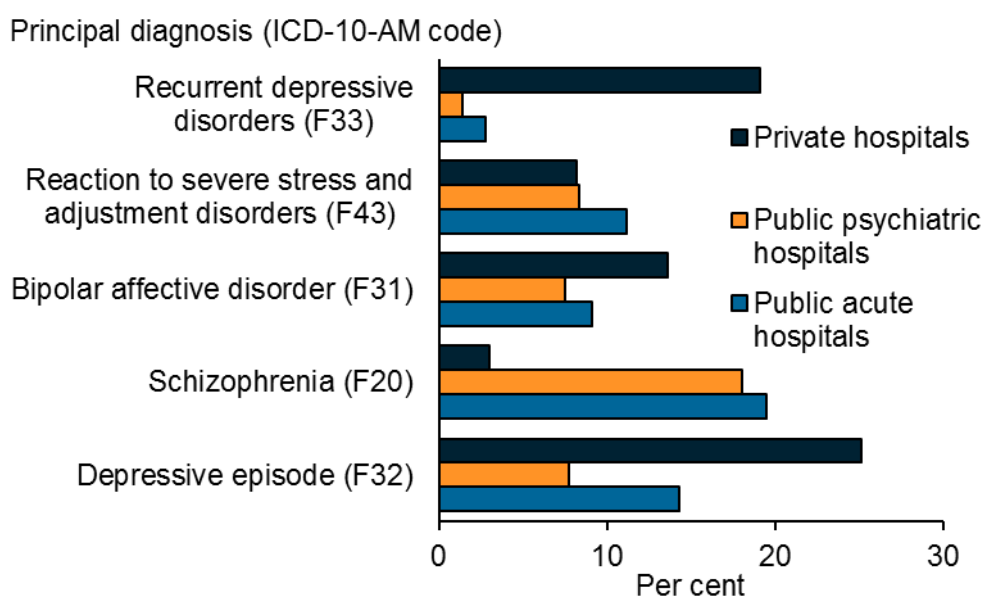
ABS 2013. Australian Bureau of Statistics. Australian demographic statistics, Jun 2013. Cat. no. 3101.0. Canberra: ABS.

Principal diagnosis

In 2012–13, the most frequently reported [principal diagnoses](#) for a separation with specialised psychiatric care was depressive episode (ICD-10-AM code: F32), followed by schizophrenia (F20) and bipolar affective disorders (F31) for all hospital types (17.0%, 14.5% and 10.3% respectively).

The profile of diagnoses varied with hospital type. For example, about 1 in 5 separations with specialised psychiatric care in public acute hospitals and public psychiatric hospitals had a principal diagnosis of schizophrenia (F20) (19.4% and 18.0% respectively) compared with less than 1 in 20 for private hospitals (3.0%) (Figure AD.4). About 1 in 4 (25.1%) separations in private hospitals had a principal diagnosis of depressive episode (F32) compared with 14.3% and 7.8% for public acute and public psychiatric hospitals respectively.

Figure AD.4: Admitted patient separations with specialised psychiatric care, the 5 most frequently reported principal diagnoses, by hospital type, 2012–13 (per cent of separations for hospital type)



Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

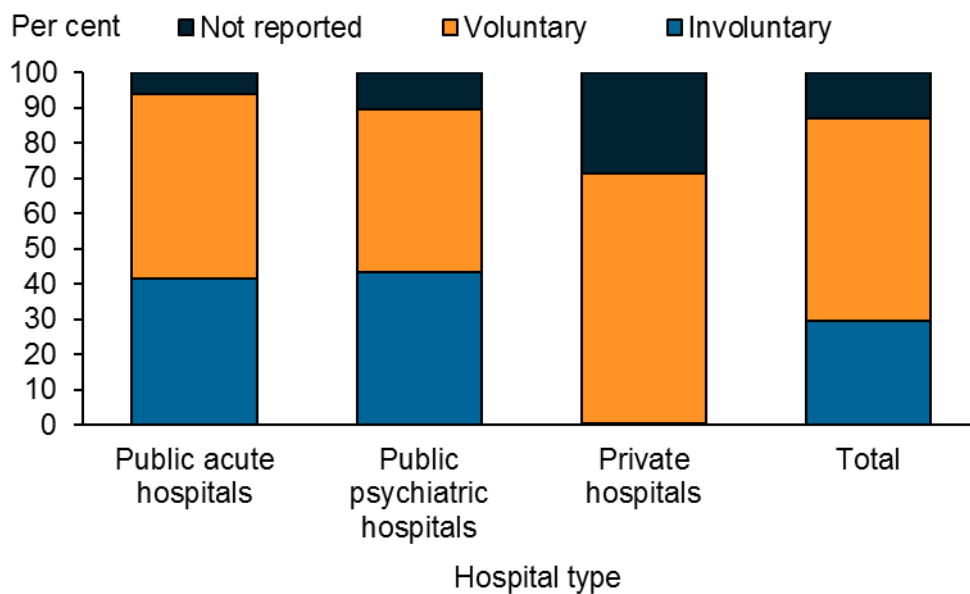
Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.7 (1MB XLS) in the Admitted patient mental health-related care table downloads.

Mental health legal status

There were 43,370 involuntary admissions in 2012–13, accounting for 29.5% of all mental health-related separations with specialised psychiatric care. The majority (89.6%) of these occurred in public acute hospitals with 2 in 5 separations involving an involuntary admission for this hospital type.

Involuntary admissions accounted for more than 2 in 5 (43.1%) separations in public psychiatric hospitals. For private hospitals, 4 in 1,000 (0.4%) separations with specialised psychiatric care were involuntary admissions, but it should be noted that 28.8% of private hospital separations for 2012–13 did not have a mental health legal status recorded (Figure AD.5).

Figure AD.5: Admitted patient separations with specialised psychiatric care, by mental health legal status and hospital type, 2012–13



Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.5 (1MB XLS) in the Admitted patient mental health-related care table downloads.

Procedures

About 2 in 5 (39.5%) of all mental health-related separations with specialised psychiatric care did not have an intervention or procedure recorded. However, it is likely that the interventions (procedures) provided to patients during these mental health-related separations were not able to be coded using the existing procedure classification system. For example, the administration of mental health-related medications is not explicitly included in the current classification system; the Australian Classification of Health Interventions (ACHI).

A frequently reported intervention (procedure) for all admitted patient mental health-related separations with specialised psychiatric care was an allied health intervention, including services provided by social workers (14.2%), occupational therapists (8.1%) and psychologists (6.8% of interventions). A frequently reported procedure for separations with specialised care was non-emergency general anaesthesia, accounting for 15.4% of all procedures for separations with specialised psychiatric care. This was most likely associated with the administration of electroconvulsive therapy, (ECT) a form of treatment for depression.

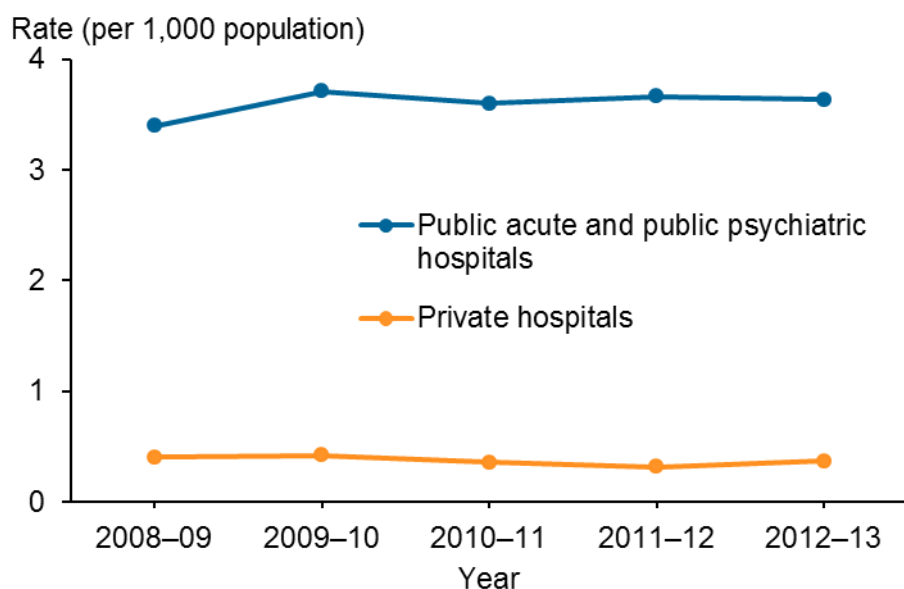
Non-specialised admitted patient mental health care service provision

Over time

The rate of mental health-related separations per 1,000 population without specialised psychiatric care remained relatively stable for all hospital types between 2008–2009 and 2012–2013 (Figure AD.6). The rate of public acute hospital separations without specialised care continues to be over 9 times the rate of private hospitals. These separations did not include specialised psychiatric care but are still classified as mental health-related because of the reported principal diagnosis.

The reasons for the difference in the rates between public and private hospitals cannot be gleaned from the data source, but may be due to differences in the patient populations between sectors, different service delivery profiles, differences in coding practices and so forth.

Figure AD.6: Admitted patient mental health-related separations without specialised psychiatric care, by hospital type, 2008–09 to 2012–13



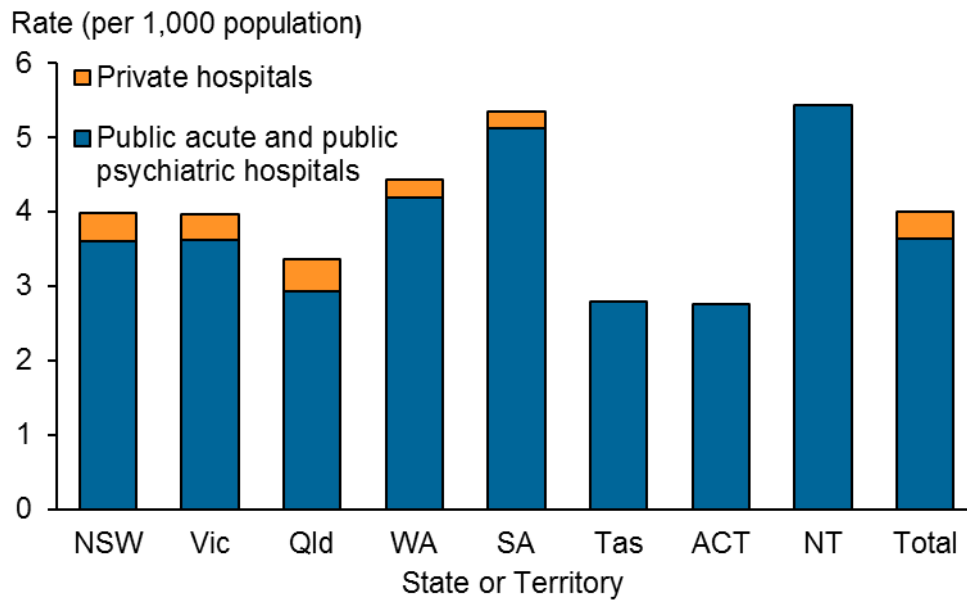
Note: Separations with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.10 (1MB XLS) in the Admitted patient mental health-related care table downloads.

By states and territories

The national rate of public acute and public psychiatric hospital separations without specialised psychiatric care was 3.6 per 1,000 population in 2012–13. The Northern Territory had the highest rate of separations without specialised psychiatric care in public acute and public psychiatric hospitals (5.4) and the Australian Capital Territory had the lowest (2.7) (Figure AD.7).

Figure AD.7: Separations without specialised psychiatric care, states and territories, by hospital type, 2012–13



Notes:

1. Rates were directly age-standardised as detailed in the technical information.
2. The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.
3. Private hospital figures for Tasmania, the Australian Capital Territory and the Northern Territory are not published for confidentiality reasons.
4. Separations with a care type of *Newborn* (without qualified days) and records for Hospital boarders and Posthumous organ procurement have been excluded.

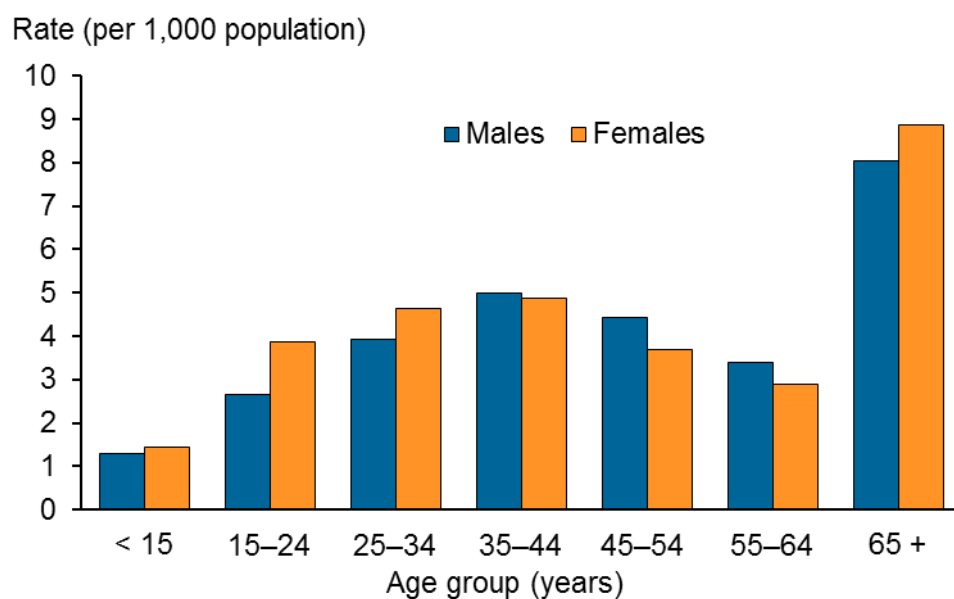
Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.9 (1MB XLS) in the Admitted patient mental health-related care table downloads.

Non-specialised admitted mental health care patient characteristics

Patient demographics

In 2012–13, the highest rate of mental health-related separations without specialised psychiatric care was for patients aged 65 and older (8.5 per 1,000 population) and the lowest was for those aged under 15 (1.4 per 1,000 population) (Figure AD.8). Overall, the separation rate was higher for females than males (4.3 and 3.9 per 1,000 population respectively).

Figure AD.8: Admitted patient separation rates without specialised psychiatric care, by sex and age group, 2012–13



Note: Separations with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded.

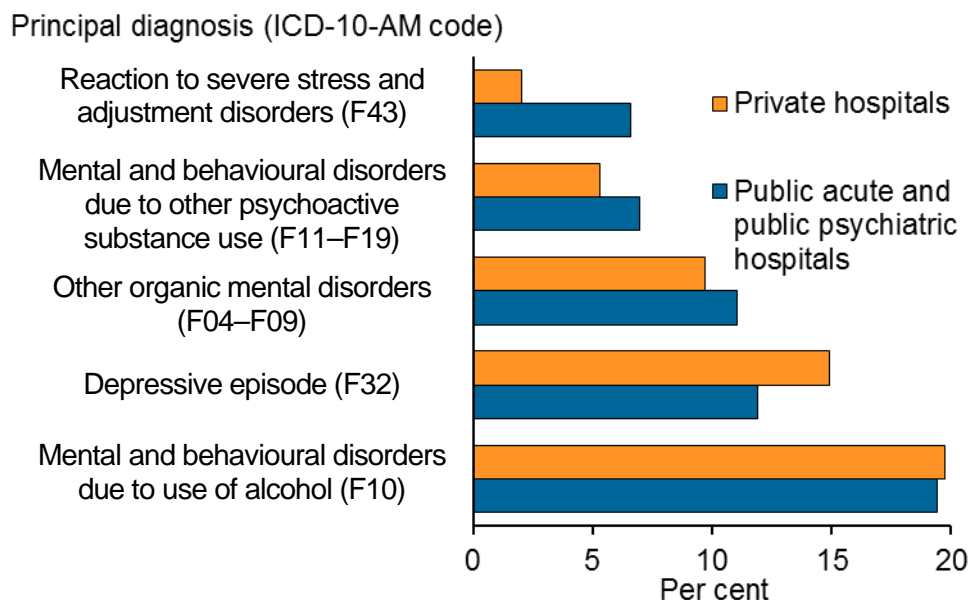
Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.2 (1MB XLS) in the Admitted patient mental health-related care table downloads.

Indigenous Australians are proportionally over-represented in terms of mental health-related hospitalisations without specialised psychiatric care, accounting for 7.5% of these. Indigenous Australians had a separation rate more than 3 times that of other Australians (12.9 and 3.8 per 1,000 population respectively). Those living in *Remote and very remote* areas had the highest rate of separations (8.2 per 1,000 population), however, they only made up 4.5% of total separations.

Principal diagnosis

In 2012–13, the most frequently reported principal diagnoses for separations without specialised psychiatric care were mental and behavioural disorders due to use of alcohol (ICD-10-AM code F10) (19.5%) followed by depressive episode (F32) (12.2%). Almost all separations (91.2%) without specialised psychiatric care for the 5 most frequently reported principal diagnoses occurred in public acute and public psychiatric hospitals (Figure AD.9).

Figure AD.9: Admitted patient separations without specialised psychiatric care, by the 5 most frequently reported principal diagnoses, 2012–13



Note: Separations with a care type of Newborn (without qualified days) and records for Hospital boarders and Posthumous organ procurement have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.12 (1MB XLS) in the Admitted patient mental health-related care table downloads.

Procedures

Over half (55.1%) of mental health-related separations without specialised psychiatric care reported at least one procedure in 2012–13. A frequently reported procedure (intervention) for all admitted patient mental health-related separations without specialised psychiatric care was an allied health intervention, including services provided by social workers (14.4%), physiotherapists (12.7%) and occupational therapists (8.8% of procedures).

Use of restrictive practices during admitted patient care

Seclusion

[Seclusion](#) is defined as the confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented. The purpose, duration, structure of the area and awareness of the patient are not relevant in determining what is or is not seclusion.

Seclusion also applies if the patient agrees to or requests confinement and cannot leave of their own accord. However, if voluntary isolation or 'quiet time' alone is requested and the patient is free to leave at any time then this social isolation or 'time out' is not considered seclusion.

While seclusion can be used to provide safety and containment at a time when this is considered necessary to protect patients, staff and others, it can also be a source of distress not only for the patient but for support persons, representatives, other patients, staff and visitors. Wherever possible, alternative, less restrictive ways of managing a patient's behaviour should be used, and the use of seclusion minimised.

Background

In 2005, Health Ministers endorsed the *National safety priorities in mental health: a national plan for reducing harm*, Australia's first national statement about safety improvement in mental health. This plan identified 4 priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion'.

In line with the plan, there have been a number of initiatives aimed at reducing seclusion and restraint in public mental health facilities. However, despite these initiatives, there is at present no formal, routine nationally agreed data collection and reporting framework for seclusion and restraint to monitor reform progress. To collect this information, a number of ad hoc seclusion data collections for specialised mental health public acute hospital services have been conducted by the Safety and Quality Partnership Standing Committee (SQPSC), of the Mental Health Drug and Alcohol Principal Committee (MHDAPC), in partnership with the relevant state and territory authorities.

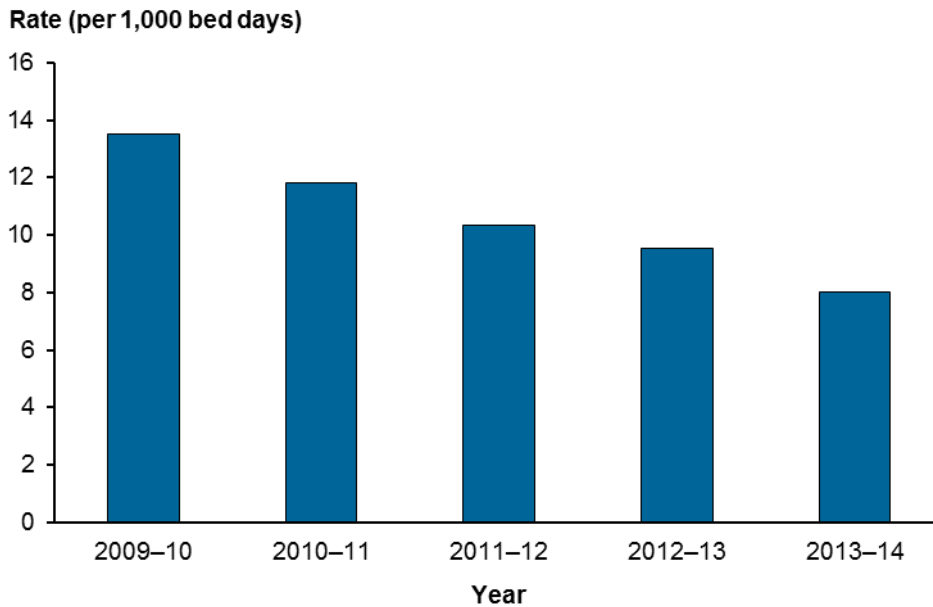
The Australian Health Ministers Advisory Council (AHMAC) mental health committees are in the process of formalising the ad hoc SQPSC seclusion data collection arrangements within a routine, national collection and reporting framework. The Mental Health Information Strategy Standing Committee (MHISSC) is working with AIHW to develop an aggregate mental health Seclusion and Restraint Data Set Specification (SECREST DSS). The SECREST DSS will standardise the national collection of both seclusion and restraint data (and provide a more detailed data set) from the 2015–16 collection period.

National seclusion data were first collected in 2008-09, with these data published for the first time in 2013. A number of enhancements have been made to the collection, and for the first time in 2014 additional data such as seclusion duration and target population are reported in this section.

Overview

Nationally, there were 8.0 seclusion events per 1,000 bed days in 2013–14. The national rate of seclusion has gradually decreased over time. In 2009–10 there were 13.5 seclusion events per 1,000 bed days and the rate of seclusion has steadily decreased over the last 5 years to 8.0 in 2013–14 (Figure AD.10). This represents an average annual reduction of 12.2% over the 5 year period.

Figure AD.10: Rate of seclusion events, public sector acute mental health hospital services, 2009–10 to 2013–14



Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.16. (1MB XLS)

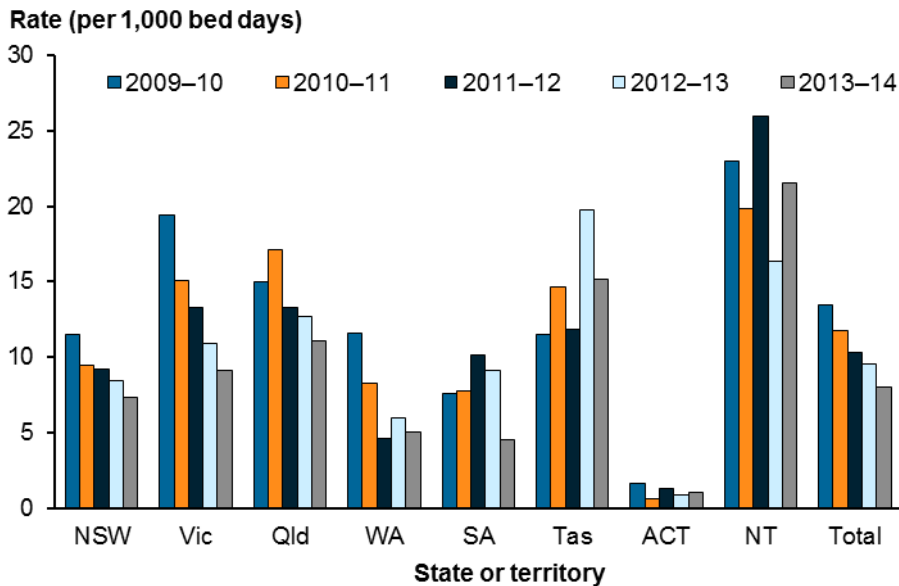
States and territories

Over time

In 2013–14, the Northern Territory had the highest rate of seclusion with 21.6 seclusion events per 1,000 bed days and the Australian Capital Territory had the lowest (1.1). Overall, seclusion rates have fallen for 7 of the 8 jurisdictions between 2009–10 and 2013–14 (Figure AD.11). Western Australia (-18.8%) reported the greatest annual average reduction in seclusion rates over the 5 year period, followed by Victoria (-17.2%).

Tasmania (7.2%) was the only jurisdiction to report an increased seclusion rate since 2009-10, however, the 2012–13 and 2013–14 figures were affected by a small number of clients having a greater than average number of seclusion events. Data for smaller jurisdictions such as Tasmania should be interpreted with caution as small changes in the number of seclusion events can have marked impact on the overall jurisdictional rate. Further jurisdictional-specific information about seclusion data is available in the accompanying data quality statement.

Figure AD.11: Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2009–10 to 2013–14



Notes: The increase in the state-wide Tasmanian seclusion rate for 2012-13 and 2013-14 data is due to a small number of clients having an above average number of seclusion events. Victoria has fewer beds per capita than other jurisdictions, and as such, it may be useful to view the rate of seclusion events in a broader population context (rates per capita). Due to the low ratio of beds per person in the NT compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per patient day compared with reporting on a population basis. Due to the low number of beds in the Northern Territory, high rates of seclusion for a few individuals has a disproportional effect on the rate of seclusion reported.

Source: State and territory governments, unpublished.
 Source data Admitted patient mental health-related care Table AD.16. (1MB XLS)

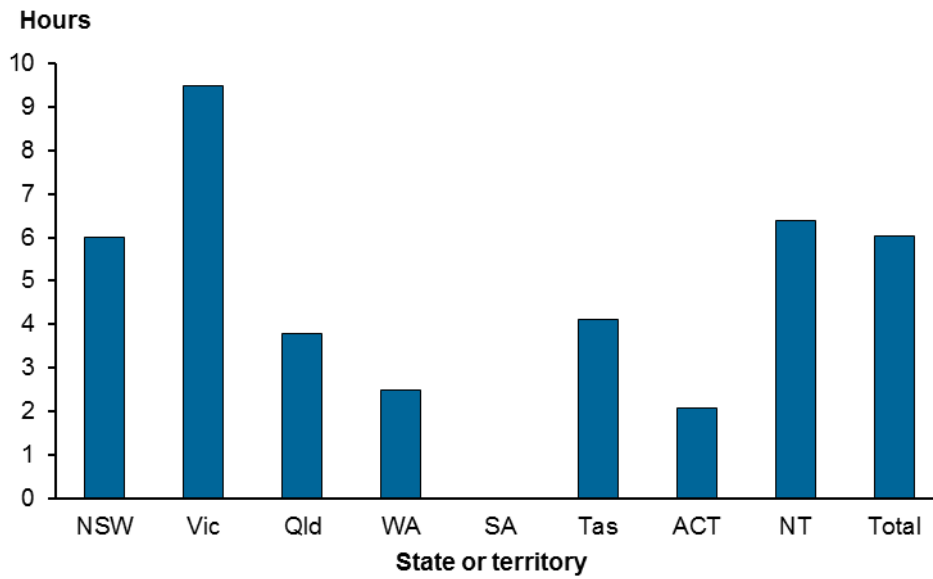
Frequency and duration

About 1 in 20 (5.3%) mental health-related admitted patient care episodes in Australian public hospitals reported a seclusion event in 2013-14. The Northern Territory had the highest proportion of episodes with a seclusion event (7.6%), while South Australia had the lowest (3.9%). Nationally, of those patients who had been secluded, the average number of seclusion events was 2.1 per admitted care episode. The Australian Capital Territory was unable to provide the number of admitted patient care episodes and as such is excluded from this national proportion of seclusion events per episode.

In 2013-14, the average duration of a seclusion event was 6.0 hours. This national average includes events in general, child and adolescent and older person units only. Forensic services, services provided primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment, are not included in this average, as forensic seclusion events are typically of longer duration, and substantially skew the overall average.

Victoria reported the longest average seclusion duration with an average of 9.5 hours per seclusion event. The Australian Capital Territory had the shortest, with 2.1 hours (Figure AD.12). South Australia captures duration in 4 hour blocks. Due to this differing methodology, South Australia is not included in the national average duration.

Figure AD.12: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services (excluding forensic events), by state or territory, 2013–14



Note: Due to longer duration times in Forensic settings, these events have been excluded from this analysis. South Australia report seclusion duration in 4 hour blocks. Therefore, the average seclusion duration cannot be calculated for this figure. Queensland and the Northern Territory do not report any acute forensic services, however forensic patients can and do access acute care through general units.

Source: State and territory governments, unpublished.
 Source data Admitted patient mental health-related care Table AD.18. (1MB XLS)

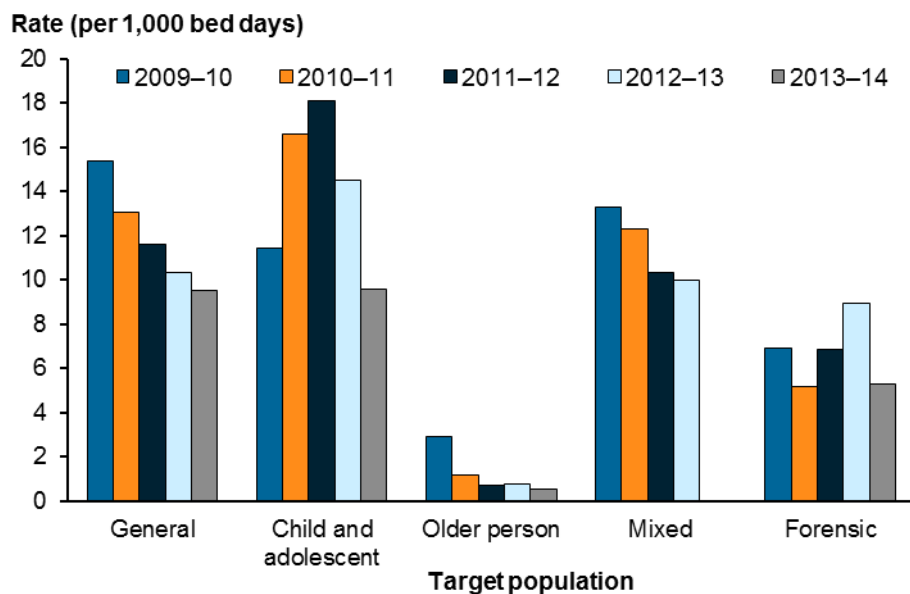
Target population

Seclusion data can also be presented by the target population of the acute specialised mental health hospital service where the seclusion event occurred. However, data should be interpreted with caution as this methodology uses the target population of the service unit, not the target population of the patient.

Over time

In 2013–14, the highest rate of seclusion was for child and adolescent and general services with 9.6 and 9.5 seclusion events per 1,000 bed days, respectively. Older person services had the lowest rate of seclusion events (0.5). Overall, there has been a decrease in seclusion events across all target populations between 2009–10 and 2013–14. Seclusion rates in older person services (-34.4%) had the greatest average annual reduction in seclusion rates over the 5 year period, followed by general services (-11.3%). Although a reduction in seclusion rates was observed for forensic and child and adolescent services (-6.4% and -4.3% respectively), some variability is apparent from year to year (Figure AD.13).

Figure AD.13: Rate of seclusion events, public sector acute mental health hospital services, by target population, 2009–10 to 2013–14



Note: In 2013–14, improvements were made to the reporting of target population categories. The mixed category is no longer reported as all seclusion events can now be disaggregated into other target population categories. Queensland and the Northern Territory do not report any acute forensic services, however forensic patients can and do access acute care through general units.

Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.17 (1MB XLS)

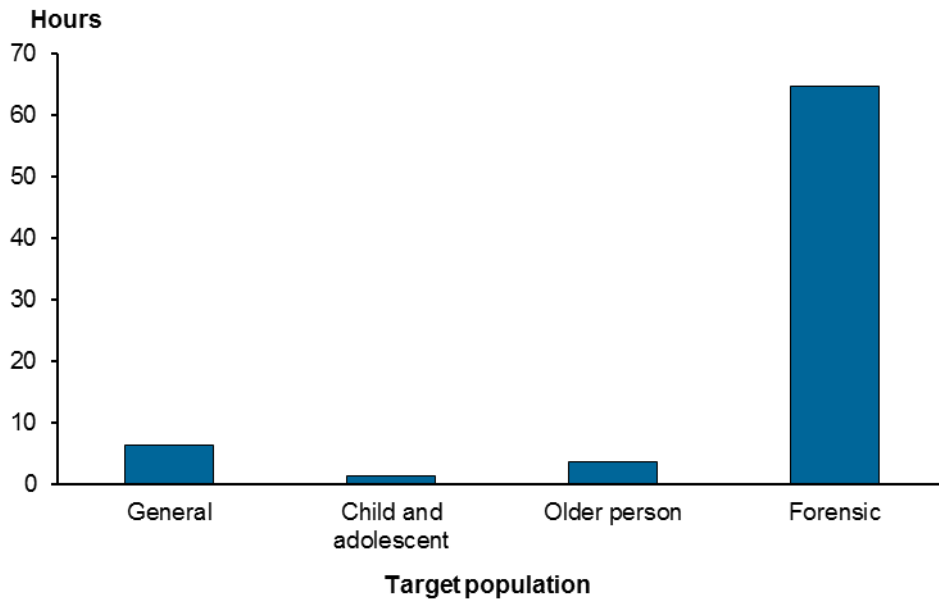
Frequency and duration

In 2013–14, forensic services reported the highest proportion of seclusion events per episode, with 9.0% of all mental health-related admitted patient care episodes reporting a seclusion event. This was followed by general (5.5%), child and adolescent (3.8%), and older person (1.0%) services.

Of those patients who had been secluded in a forensic service, the average number of seclusion events was 3.1 per admitted care episode. The average frequency for child and adolescent services seclusion events was slightly lower with 2.5 per admitted care episode, followed by general and older person services (2.0 and 1.9 respectively).

Seclusion events that occurred in forensic services had an average duration of 64.7 hours per seclusion event, which is much greater than all other target population categories. General services reported an average time of 6.3 hours per seclusion event, followed by older person (3.5 hours) and child and adolescent (1.3 hours) services (Figure AD.14).

Figure AD.14: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services, by target population, 2013–14



Note: South Australia report seclusion duration in 4 hour blocks. Therefore, average duration seclusion figures do not include South Australia. Queensland and the Northern Territory do not report any acute forensic services, however forensic patients can and do access acute care through general units.

Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.19 (1MB XLS)

Remoteness

Due to the small number of hospitals located in *Outer Regional* and *Remote* areas, for the purpose of remoteness analysis these categories have been combined. There were no hospitals in this dataset located in *Very Remote* areas.

In 2013–14, hospitals located in *Major Cities* had a seclusion rate of 7.6 events per 1,000 bed days. This rate was lower than that for *Inner Regional* facilities (9.7) and *Outer Regional* and *Remote* area facilities combined (11.3). The proportion of mental health-related admitted care episodes with a seclusion event was similar across facilities in all areas.

On average, seclusion events in facilities in *Major Cities* were longer in duration (6.4 hours) than those in *Outer Regional* and *Remote* (6.1) and *Inner regional* (4.4) areas.

Data source

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of episode-level records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data for each hospital separation. Clinical information such as diagnoses, procedures undergone and external causes of injury and poisoning are also recorded. For further details on the scope and quality of data in the NHMD, please refer to the Data quality statement: [National Hospital Morbidity Database 2012–13](#).

Further information on admitted patient care for the 2012–13 reporting period can be found in the *Australian hospital statistics 2012–13* report ([AIHW 2014](#)). The 2012–13 collection contains data for hospital separations that occurred between 1 July 2012 and 30 June 2013. Admitted patient stays that began before 1 July 2012 are included if the separation date fell within the collection period (2012–13). A record is generated for each separation rather than each patient. Therefore, those patients who separated from hospital more than once in the reference year have more than one record in the database.

Specialised mental health care is identified by the patient having one or more psychiatric care days recorded—that is, care was received in a specialised psychiatric 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. 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.

In interpreting the NHMD data presented in this report, note that mental health care for admitted patients in Australia is provided in a large and complex system. Although there are national standards for data on admitted patient care, the results presented here may be affected by variations in admission and reporting practices across states and territories. Interpretation of the differences between jurisdictions therefore needs to be done with care. Principal diagnosis refers to the diagnosis established after observation by medical staff to be chiefly responsible for the patient's episode of admitted patient care. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM 7th edition). Further information on this is included in the [technical information](#) section.

Procedures are classified according to the *Australian Classification of Health Interventions, 7th edition*. Further information on this classification is included in the [technical information](#) section. More than one procedure can be reported for a separation and not all separations have a procedure reported.

Seclusion

Variations in jurisdictional legislation may result in exceptions to the definition of a seclusion event as presented in the key concepts section. Data reported by jurisdictions may therefore vary and jurisdictional comparisons should be made with caution. The estimated acute bed coverage for 2013–14 seclusion data was over 95% based on acute beds reported to the Mental Health Establishments National Minimum Data Set in 2012–13.

Information about jurisdictional specific caveats and policy is included in the accompanying [data quality statement](#).

Restraint

Restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical means.

The AIHW is currently working with the AHMAC mental health committees to develop a national restraint data collection to facilitate the potential development and reporting of a national restraint indicator.

Reference

AIHW 2014. Australian hospital statistics 2012–13. Health services series no. 54. Cat. no. HSE 145. Canberra: AIHW

Key Concepts

Admitted patient mental health-related care

Key Concept	Description
Admitted patient	For this report admitted patient separations refers to those non-ambulatory separations when a patient undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital, excluding ambulatory-equivalent separations. Ambulatory-equivalent separations are reported separately in the ambulatory-equivalent admitted patient care section of this report.
Average length of stay	Average length of stay is the average number of patient days for admitted patient separations.
Care type	The care type defines the overall nature of a 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 organ procurement (other care).
Mental health related	A separation is classified as mental health related for the purposes of this report if: <ul style="list-style-type: none">• it had a mental health related principal diagnosis, which, for admitted patient care in this report, is defined as a principal diagnosis that is either:<ul style="list-style-type: none">○ a diagnosis that falls within the section on Mental and behavioural disorders (Chapter 5) in the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification (ICD-10-AM) (codes F00–F99), or○ a number of other selected diagnoses (see the technical information for a full list of applicable diagnoses), and/or• it included any specialised psychiatric care.
Patient day	Patient day means the occupancy of a hospital bed (or chair in the case of some same day patients) by an admitted patient for all or part of a day. Patient day statistics can be used to provide information on hospital activity that, unlike separation statistics, account for differences in length of stay. The patient day data presented in this report include days within hospital stays that occurred before 1 July provided that the separation from hospital occurred during the relevant reporting period (that is, the financial year period). This has little or no impact in private and public acute hospitals, where separations are relatively brief, throughput is relatively high and the patient days that occurred in the previous year are expected to be approximately balanced by the patient days not included in the counts because they are associated with patients yet to separate from the hospital and therefore yet to be reported. However, some public psychiatric hospitals provide very long stays for small numbers of patients and, as a result, would have comparatively large numbers of patient days recorded that occurred before the relevant reporting period and may not be balanced by patient days associated with patients yet to separate from the hospital.
Principal diagnosis	The principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted patient care.

Procedure	Procedure refers to a clinical intervention that is surgical in nature, carries an anaesthetic risk, requires specialised training and/or requires special facilities or services available only in an acute care setting. Procedures therefore encompass surgical procedures and non-surgical investigative and therapeutic procedures, such as X-rays. Patient support interventions that are neither investigative nor therapeutic (such as anaesthesia) are also included.
Psychiatric care days	Psychiatric care days are the number of days or part days the person received care as an admitted patient in a designated psychiatric unit or ward.
Restraint	Restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical means. <u>Mechanical restraint:</u> The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint. <u>Physical restraint:</u> The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment.

Seclusion	<p>Seclusion is defined as the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. Key elements include that:</p> <ol style="list-style-type: none"> 1. The consumer is alone. 2. The seclusion applies at any time of the day or night. 3. Duration is not relevant in determining what is or is not seclusion. 4. The consumer cannot leave of their own accord. <p>The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement.</p> <p>The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition.</p> <p>See the data source section for information about jurisdictional consistency with this definition.</p>
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Separation	<p>Separation is the term used to refer to the episode of admitted patient 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 care 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 type of care. Each record includes information on patient length of stay. A same-day separation occurs when a patient is admitted and separated from the hospital on the same date. An overnight separation occurs when a patient is admitted to and separated from the hospital on different dates. The numbers of separations and patient days can be a less reliable measure of the activity for establishments such as public psychiatric hospitals, and for patients receiving care other than acute care, for which more variable lengths of stay are reported.</p>
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Specialised psychiatric care	<p>A separation is classified as having specialised psychiatric care if the patient was reported as having one or more days in a specialised psychiatric unit or ward.</p>
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Target population	<p>Some specialised mental health services data are categorised using 5 target population groups (see METeOR identifier 493010):</p> <p>Child and adolescent services focus on those aged under 18.</p> <p>Older person programs focus on those aged 65 and over.</p> <p>Forensic health services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment.</p> <p>General provides services to the adult population, aged 18 to 64; however, these services may also provide assistance to children, adolescents or older people.</p> <p>Youth services target children and young people generally aged 16–24.</p> <p>Although Mixed is not 1 of the 5 defined target population groups, it is referenced to include services that may include multiple target population categories in any combination (for example, Older person and Child and adolescent) where further</p>
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disaggregation of the data is not available. It is anticipated that Jurisdictions will undertake further work to disaggregate Mixed services in the future.

Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However, not all states or territories report such jointly funded beds through the National Mental Health Establishments Database.

Without specialised psychiatric care

A separation is classified as **without specialised psychiatric care** if the patient did not receive any days of care in a specialised psychiatric unit or ward. Despite this, these separations are classified as mental health related because the reported principal diagnosis for the separation is either one that falls within the Mental and behavioural disorders chapter (Chapter 5) in the ICD-10-AM classification (codes F00–F99) or is one of a number of other selected diagnoses (see the [technical information](#)).
