Same day admitted mental health-related care

Some people's mental health care needs may require care in a hospital setting. The care may be provided in a hospital ward or another facility such as an emergency department or an outpatient clinic. When receiving hospital care, a patient may be admitted to the hospital for part of a day (same day admitted mental health care), a single overnight stay, or for a number of days.

In comparing care across states and territories, it should be noted that models of care differ between jurisdictions and between public and private hospitals. This can affect reported volume of same day admitted care and the inclusion/omission of some types of care. Patients receive specialised psychiatric care in a psychiatric hospital or in a hospital's psychiatric unit. Patients with mental illness may also have a same day admission to other areas of a hospital for medical or surgical care where health care workers may not be specifically trained to care for the mentally ill. These same day admissions to hospitals are classified as without specialised psychiatric care.

In order to provide the most comprehensive view of same day admitted care, two different data sources are used in this section for public and private hospitals (described in detail in each section below). It is important to note that some activity reported as same day admitted care by private hospitals may not require an admission in the public hospital setting, and would instead be reported as Community mental health care in that setting. Therefore, any comparisons of the volume of care provided by public and private hospitals described in this section should be made with caution.

Data downloads:

Excel – Same day admitted mental health-related care 2017-18 tables

PDF – Same day admitted mental health-related care 2017-18 section

Data coverage includes the time period 2006–07 to 2017–18. This section was last updated in October 2019.

Key points

- In 2017–18, there were **61,316 same day** admitted mental health-related separations from public hospitals of which about a third (32.3%) included specialised psychiatric care.
- About **1 in 5** (20.3%) of same day admitted mental health-related separations with specialised psychiatric care in public hospitals in 2017–18 **were involuntary admissions**.
- About **1 in 5** (21.3%) of same day, admitted mental health-related separations with specialised psychiatric care in public hospitals had a **principal diagnosis of *Depressive episode.***
- About **19,800 patients** received same day admitted mental health care from private hospitals.
- About **262,000 days** of same day care were provided by private hospitals.
- For patients aged 18–24 years, there has been a **240.8%** increase between 2006-07 and 2017-18, in the population rate of same day separations with specialised psychiatric care.

Same day admitted mental health care— public hospitals

This section presents information on same day admitted patient mental health-related separations in Australian public hospitals. Data are sourced from the National Hospital Morbidity Database (NHMD); a collation of data on admitted patient care in Australian hospitals defined by the Admitted Patient Care National Minimum Data Set (APC NMDS). The information describes separations. It is possible for individuals to have multiple separations in any given reference period. Further information can be found in the data source section.

Due to the relatively small number of same day admitted patient mental health-related separations from public psychiatric hospitals, these separations have been combined with the public acute hospitals separations for reporting purposes in this section. Where possible, a distinction is made between separations with and without specialised psychiatric care.

There were 3.6 million same day separations from public hospitals in 2017–18, inclusive of acute and psychiatric hospitals. Of these, 61,316 were mental health-related, accounting for roughly 1 in 60 (1.7%) of all same day public hospital separations. About one third of these mental health separations, involved specialised psychiatric care (19,825, or 32.3%).

Specialised same day admitted patient mental health care— public hospitals

Service provision

Specialised same day public admitted mental health care takes place within a designated psychiatric ward/unit, which is staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental illness. It may also be referred to as specialised psychiatric care.

States and territories

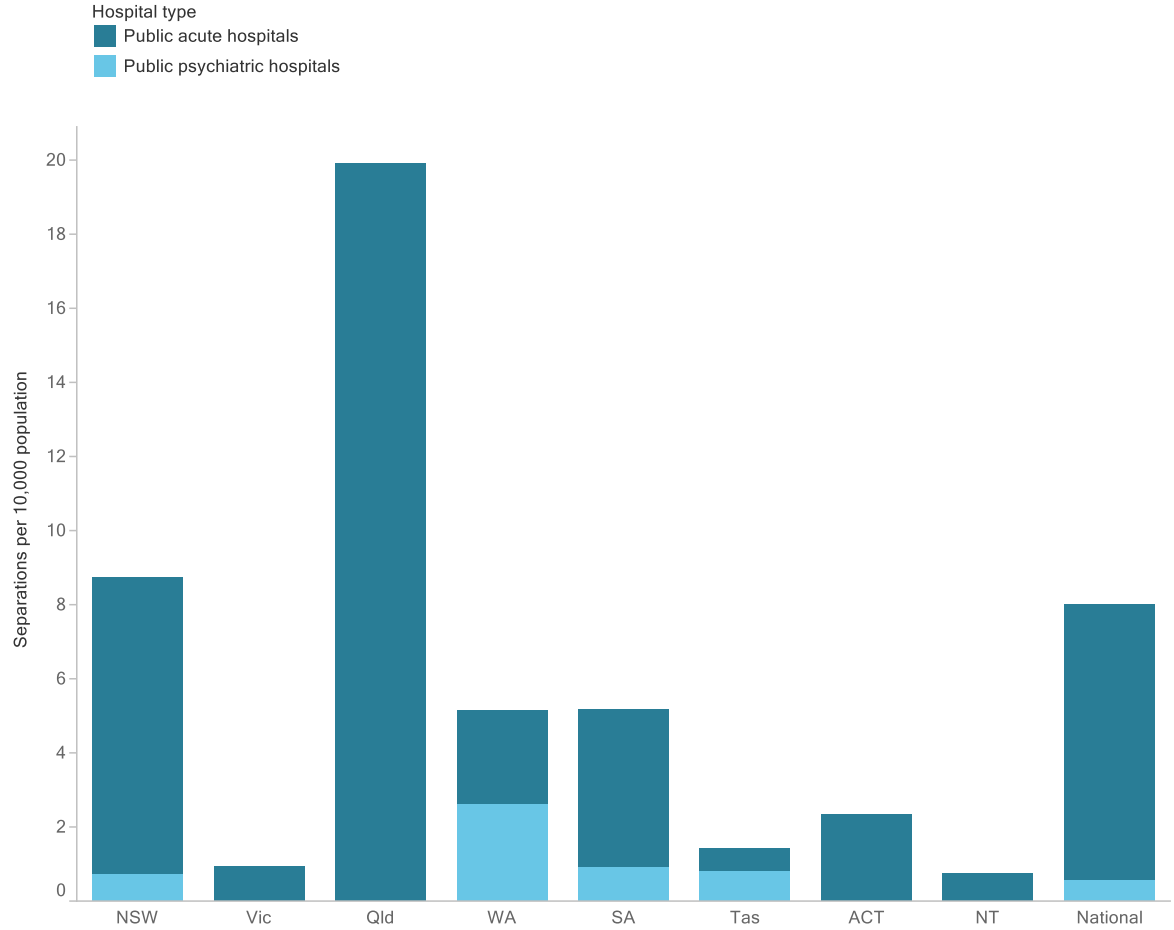
In 2017–18, there were 19,825 same day public admitted mental health-related separations with specialised psychiatric care; equivalent to a national rate of 8.0 per 10,000 population, which is a reduction of about -12% year-on-year. The national rate for public acute hospitals was 7.4 per 10,000 population.

The rate of same day public acute hospital mental health-related separations with specialised psychiatric care was highest for Queensland (19.9 per 10,000 population). Tasmania and Northern Territory reported the lowest rates (0.6 and 0.7 per 10,000 population respectively) (Figure SD.1).

The principal source of funding for a separation is collected as part of the APC NMDS. However, it should be noted that a separation may be funded by more than one funding source and information on additional funding sources is not available. For public hospitals in 2017–18, slightly more than three-quarters (76.1%) of same day mental health-related separations with specialised psychiatric care were public patients (e.g. the health service budget or reciprocal health care agreement). Of those jurisdictions with published proportions, all except New South Wales reported a proportion of publicly funded separations above 90%, which is substantially higher than the national proportion. New South Wales reported a public patient proportion of 46.3%, with the remainder being largely accounted for by DVA funding (51.8%).

The mode of separation is also collected and provides information on how each separation ended, and for some separations, the place to which the patient was discharged or transferred. In 2017–18, the most common mode of separation for same day public mental health-related separations with specialised psychiatric care was discharge to 'home' (89.9%), which includes discharge to usual residence/own accommodation/welfare institution (including prisons, hostels and group homes providing primarily welfare services). This was similar to the percentage reported for 2016–17.

Figure SD.1: Same day public admitted mental health-related separations with specialised psychiatric care, state and territory, by hospital type, 2017–18



Note:
The Northern Territory and Australian Capital Territory do not have any public psychiatric hospitals.

Source: National Hospital Morbidity Database; Table SD.4.

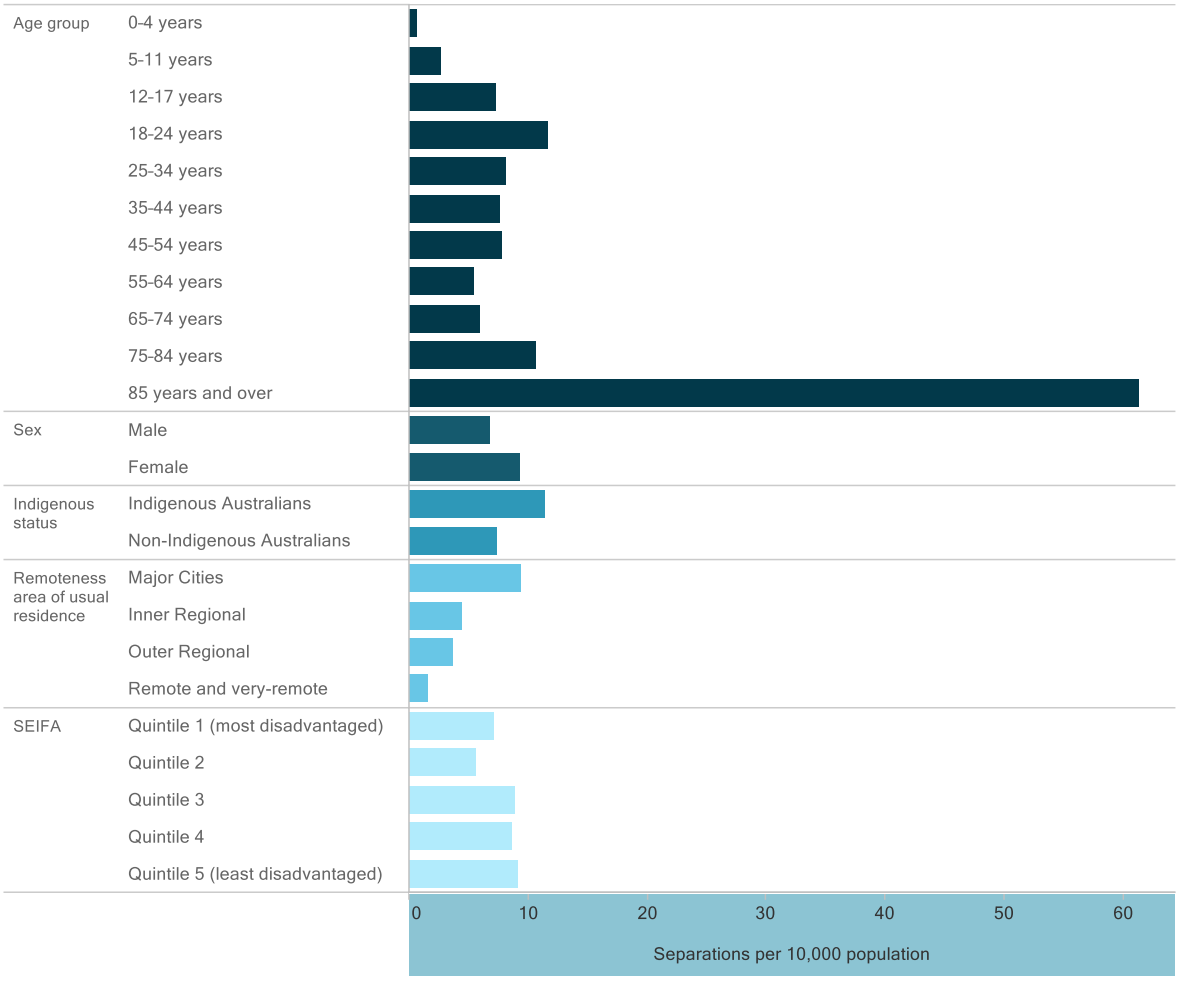
www.aihw.gov.au/mhsa

Source data: Same day public admitted mental health-related care Table SD.4 (685KB XLS).

Patient demographics

In 2017–18, the rate of same day public admitted mental health-related separations with specialised psychiatric care was highest for patients aged 85 years and older and lowest for those aged 0-4 years (61.3 and 0.7 per 10,000 population respectively) (Figure SD.2). Note that previously rates were published for patients aged 65 years and older, and the high rate for patients aged 85 years and older revealed in this report is similar to rates observed over the past few years. Overall, the separation rate was higher for females than males (9.3 and 6.7 per 10,000 population respectively).

Figure SD.2: Same day public admitted mental health-related separations with specialised psychiatric care, by demographic category, 2017-18



Note: Age-standardised rate is shown for Indigenous status.
Source: National Hospital Morbidity Database; Table SD.6.

www.aihw.gov.au/mhsa

Source data: Same day public admitted mental health-related care Table SD.6 (685KB XLS).

There were 872 same day public mental health separations with specialised psychiatric care for Aboriginal and Torres Strait Islander people in 2017–18, which is 11.5 per 10,000 population, which compares to 7.6 per 10,000 population for other patients. Rates standardised on the 2001 age profile were 11.4 and 7.3 per 10,000 population respectively, so the standardised rate for Indigenous people was 1.6 times that of other patients.

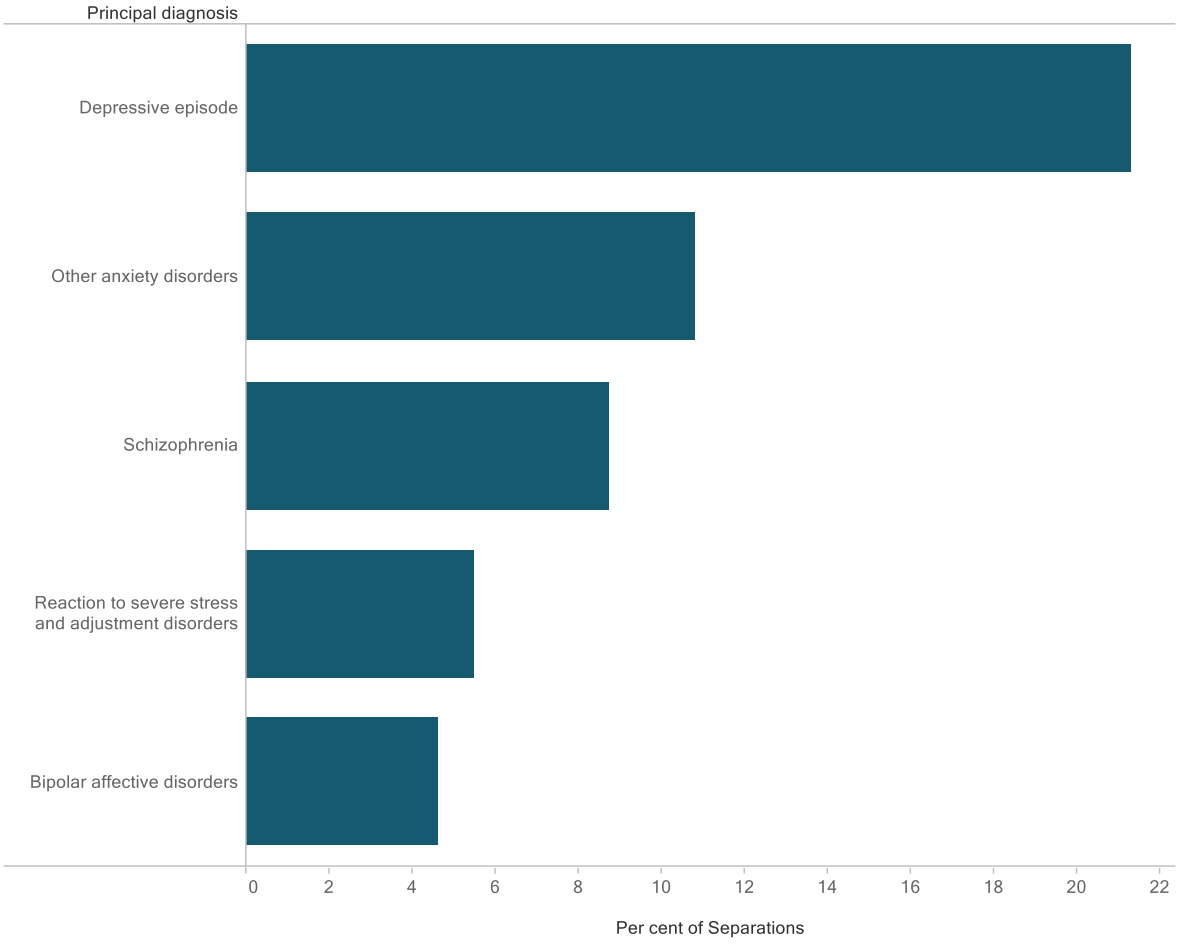
People living in *Major cities* having the highest rate of same day public mental health-related separations with specialised psychiatric care, at 9.4 per 10,000 population. People living in *Remote and Very remote* areas had a rate of 1.6 per 10,000 population.

The three highest SEIFA quintiles (less disadvantaged) had somewhat higher separations per population (8.6 per 10,000 population and higher) than the two lowest SEIFA quintiles (7.1 per 10,000 population and lower).

Principal diagnosis

The most frequently reported principal diagnoses in 2017–18 for same day public mental health-related separations with specialised psychiatric care were *Depressive episode* (ICD-10-AM code: F32) (21.3%), followed by *Other anxiety disorders* (F41) (10.8%) and *Schizophrenia* (F20) (8.7%) (Figure SD.3). These were similar to the percentages reported in
2016–17.

Figure SD.3: Proportion of same day public admitted mental health-related separations with specialised psychiatric care, for 5 commonly reported principal diagnoses, 2017–18



Source: National Hospital Morbidity Database; Table SD.7.

www.aihw.gov.au/mhsa

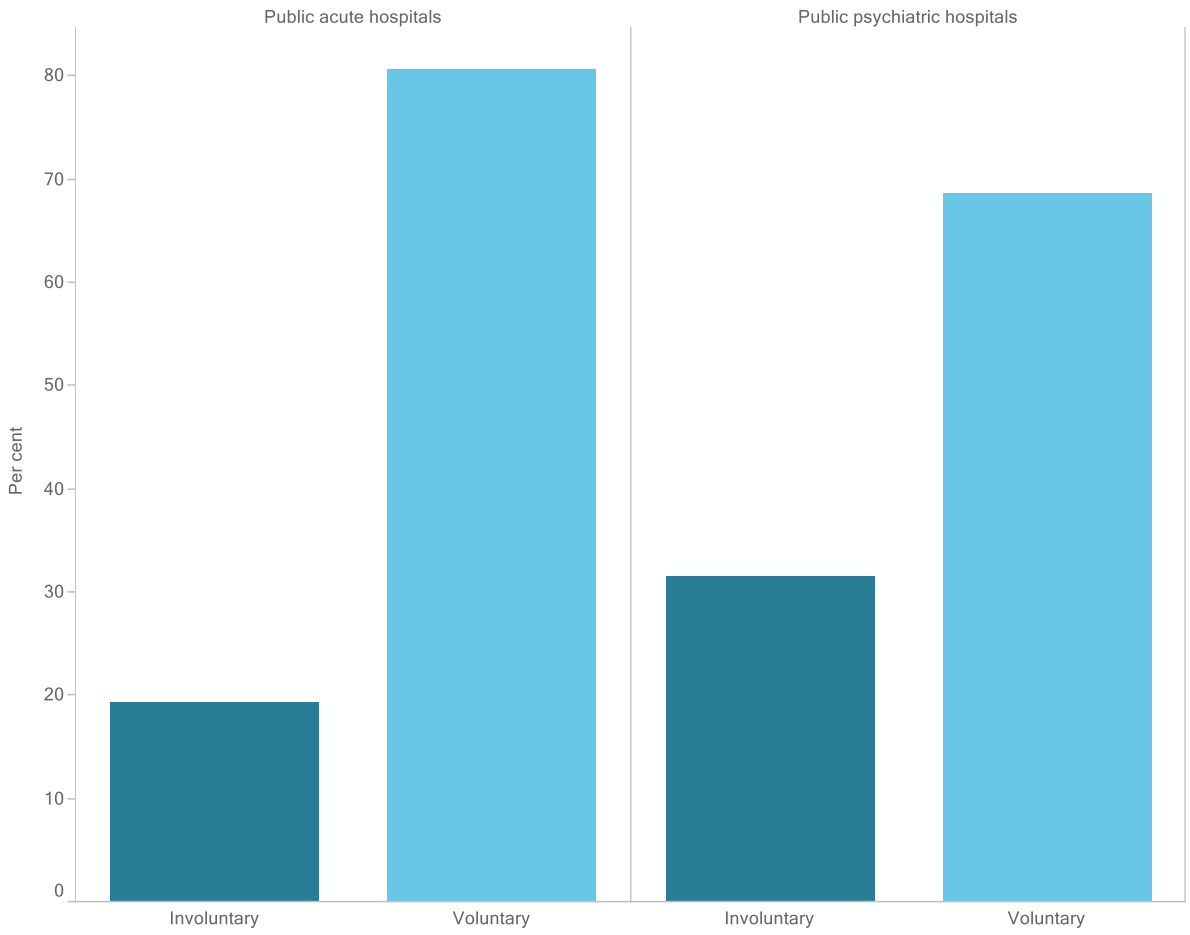
Source data: Same day public admitted mental health-related care Table SD.7 (685KB XLS).

Mental health legal status

Mental health legal status refers to whether or not a person was treated in hospital involuntarily under the relevant state or territory mental health legislation. In 2017–18, there were 3,985 same day public mental health-related separations with specialised psychiatric care where the mental health legal status was 'involuntary'— representing roughly a fifth (20.3%) of all same day public mental health-related separations with specialised psychiatric care. The majority of these (3,524 or 88.4%) occurred in public acute hospitals.

Involuntary separations accounted for 19.4% and 31.4% of same day separations with specialised psychiatric care in public acute hospital and public psychiatric hospitals respectively (Figure SD.4).

Figure SD.4: Proportion of same day public admitted mental health-related separations with specialised psychiatric care, by mental health legal status and hospital type, 2017–18



Source: National Hospital Morbidity Database; Table SD.5.

www.aihw.gov.au/mhsa

Source data: Same day public admitted mental health-related care Table SD.5 (685KB XLS).

Procedures

The most frequently reported procedure block for same day public mental health-related separations with specialised psychiatric care was *Electroconvulsive therapy* and *Cerebral anesthesia* (both at 32.3% of procedures, and both associated with 21.9% of separations). *Cerebral anesthesia* is a form of general anesthesia most likely associated with the administration of electroconvulsive therapy, a form of treatment for

depression, which was the most common principal diagnosis for separations with specialised psychiatric care.

The third most frequently reported procedure block was *Generalised allied health interventions* (14.0% of procedures and 7.4% of separations). Of these allied health interventions, procedures provided by *Social work* were the most common (34.9% of allied health interventions), followed by *Psychology* (28.5%) and *Dietetics* (15.8%).

Non-specialised admitted patient mental health care

Service provision

Non-specialised admitted patient mental health care takes place outside of a designated psychiatric unit, but for which the principal diagnosis is considered to be mental health-related. A list of mental health related principal diagnoses is available in the technical information section. Data for public acute and public psychiatric hospitals are combined in this section as there were very few separations without specialised psychiatric care in public psychiatric hospitals in 2017–18.

States and territories

In 2017–18, the majority (93.4%) of public hospital same day mental health-related separations without specialised psychiatric care were publically funded in 2017–18. Individual jurisdictions varied from the national proportion by up to about 8 percentage points, with New South Wales reporting the lowest proportion (86.0%), and Northern Territory and South Australia reporting the highest proportions (97.9% and 97.6% respectively).

About three quarters (74.3%) of same day public mental health-related separations without specialised psychiatric care were discharges to 'home', which includes discharge to usual residence/own accommodation/welfare institution (including prisons, hostels and group homes providing primarily welfare services). The remaining quarter consisted of transfers to another facility (15.2%, which includes transfers to another hospital, aged care facilities, and other health accommodation), statistical discharges (7.3%, which include changes in care type, and discharges from leave), patients leaving against medical advice (3.1%), and deaths (0.1%). There were some substantial variations in this breakdown between individual jurisdictions, for example, New South Wales reported a

relatively high proportion of statistical discharges (31.0%), and a relatively small proportion of discharges to 'home' (56.0%). Victoria and South Australia reported relatively high proportions of transfers (22.0% and 21.3% respectively). Western Australia, Northern Territory, and New South Wales reported the highest proportions of patients leaving against medical advice (6.8%, 5.9%, and 5.1% respectively).

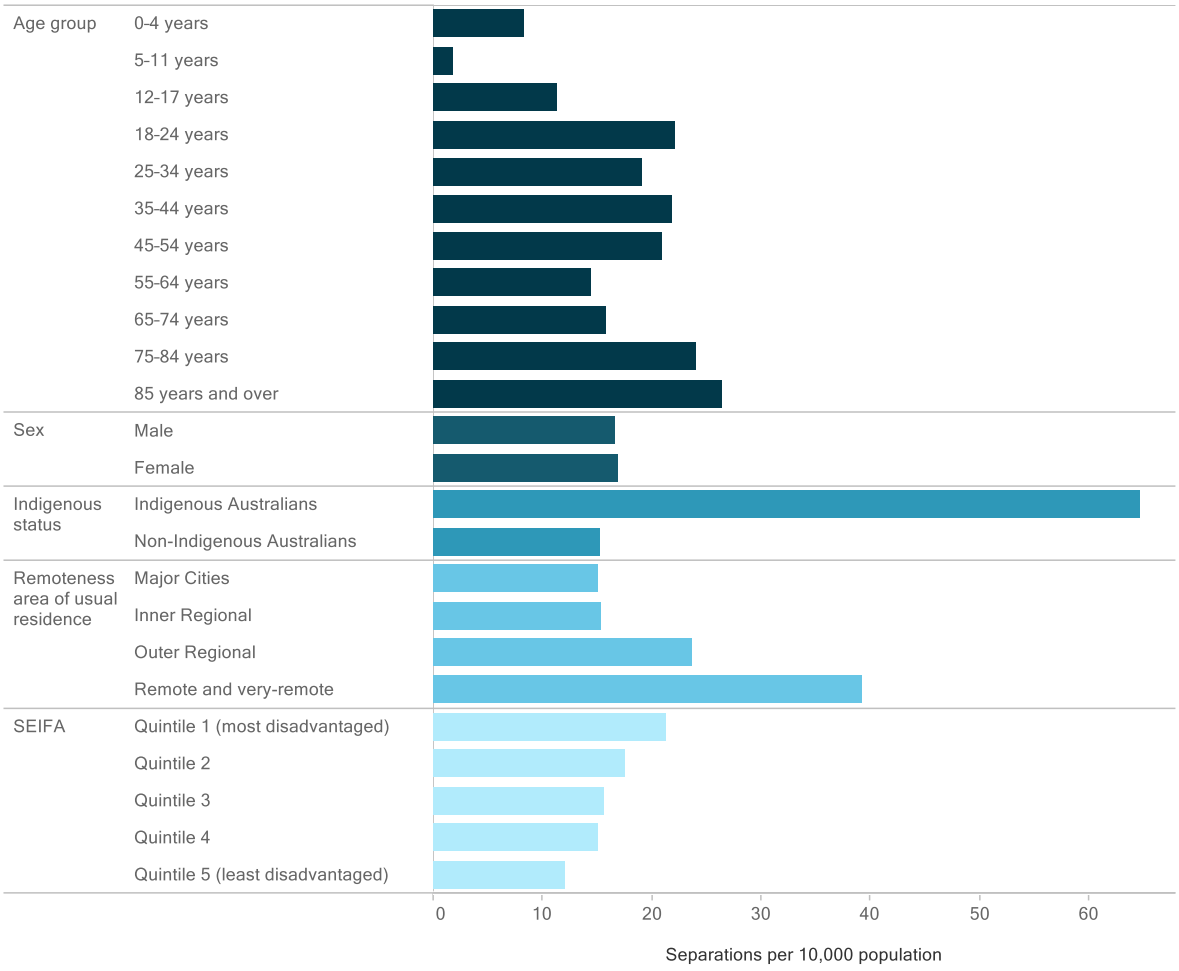
Patient demographics

In 2017–18, the highest rate of same day public mental health-related separations without specialised psychiatric care was observed for patients aged 85 years and over (26.4 per 10,000 population) and the lowest for those aged 5 to 11 years (1.8 per 10,000 population) (Figure SD.5). The separation rate was similar for males and females (16.6 and 16.9 per 10,000 population respectively).

There were 4,209 same day public mental health separations without specialised psychiatric care for Indigenous people in 2017–18, which is 55.3 per 10,000 population, which compares to 15.4 per 10,000 population for other patients. Rates standardised on the 2001 age profile were 64.7 and 15.2 per 10,000 population respectively, so the standardised rate for Indigenous people was 4.3 times that of other patients.

The rate per population of same day public mental health-related separations without specialised psychiatric care increased with increasing remoteness, and with increasing socioeconomic disadvantage, which contrasts with the inverse patterns observed for separations *with* specialised psychiatric care. People living in *Major cities* had the lowest rate (15.1 per 10,000 population), and people living in *Remote and Very remote* areas had the highest rate (39.3 per 10,000 population). Populations of the most disadvantaged SEIFA quintile had the highest rate (21.4 per 10,000 population), and populations of the least disadvantages quintile had the lowest rate (12.1 per 10,000 population)

Figure SD.5: Same day public admitted mental health-related separations without specialised psychiatric care, by demographic category, 2017–18



Note: Age-standardised rate is shown for Indigenous status.
Source: National Hospital Morbidity Database; Table SD.6.

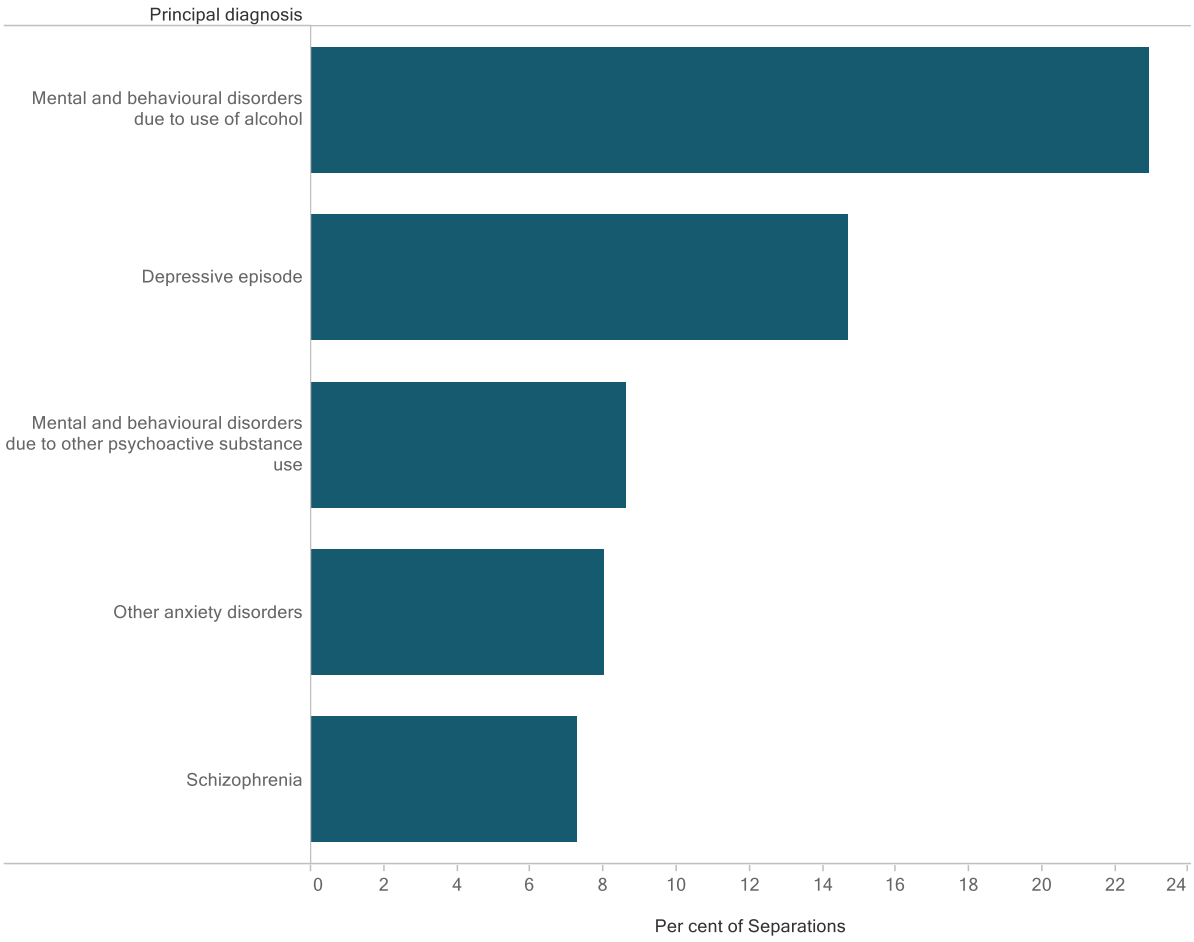
www.aihw.gov.au/mhsa

Source data: Same day public admitted mental health-related care Table SD.6 (685KB XLS).

Principal diagnosis

In 2017–18, the most frequently reported principal diagnosis for same day public mental health-related separations without specialised psychiatric care were *Mental and behavioural disorders due to use of alcohol* (ICD-10-AM code F10) (22.9%), followed by *Depressive episode* (F32) (14.7%) (Figure SD.6).

Figure SD.6: Proportion of same day public admitted mental health-related separations without specialised psychiatric care, for 5 commonly reported principal diagnoses, 2017–18



Source: National Hospital Morbidity Database; Table SD.7.

www.aihw.gov.au/mhsa

Source data: Same day public admitted mental health-related care Table SD.7 (685KB XLS).

Procedures

The most frequently reported procedure block for same day public mental health-related separations without specialised psychiatric care was *Cerebral anesthesia* (36.5% of procedures, and associated with 24.3% of separations), followed by *Electroconvulsive therapy* (34.3% of procedures, and associated with 22.7% of separations). Cerebral anesthesia is a form of general anesthesia most likely associated with the administration of electroconvulsive therapy, a form of treatment for

depression, which was the second most common principal diagnosis for separations without specialised psychiatric care.

The third most frequently reported procedure block was *Generalised allied health interventions* (12.2% of procedures, and associated with 6.9% of separations). Of these allied health interventions, *Social work* procedures were the most common (49.2% of allied health interventions), followed by *Physiotherapy* (12.6%) and *Occupational therapy* (10.1%).

Changes over time

For the time span 2006–07 to 2017–18, notable changes in the population rates of same day mental health separations included:

- For patients aged 5–11 years, the separation rate with specialised psychiatric care decreased by 80.9%, (13.6 and 2.6 per 10,000 population, in 2006-07 and 2017-18 respectively), while rates without specialised psychiatric care were consistently below 2 in this time range.
- For patients aged 18–24 years, the separation rate with specialised psychiatric care increased from 3.4 to 11.7 per 10,000 population between 2006-07 and 2017-18, while rates without specialised care were higher, but comparatively steady over this time span.
- For patients aged 45–54 years, separation rates with and without specialised care increased by 79.2% and 58.7% respectively, over this time span.

Same day admitted mental health care — private hospitals

Private hospital-based same day admitted mental health care is provided in either private hospitals with psychiatric beds or private psychiatric day hospitals (APHA 2019) (the mental health care facilities key concepts section for information on hospital types). Private hospital same day admitted mental health care data is sourced from the Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS) and is not comparable with data from the NHMD.

Some state and territory data from the PPHDRAS is aggregated to maintain privacy for participating hospitals. New South Wales and the Australian Capital Territory are reported together (NSW/ACT) as are Western Australia, South Australia, Tasmania and Northern Territory (WA/SA/Tas/NT). Victoria and Queensland are reported separately.

Remoteness area is coded in accordance with the Australian Bureau of Statistics' (ABS) Australian Statistical Geography Standard (ASGS) Remoteness Structure to the following categories: *Major cities*, *Inner regional*, *Outer regional*, *Remote*, and *Very remote*. Due to the

relatively small number of patients in outer regional, remote or very remote areas, only Urban (defined as *Major cities*) versus Non-urban (everywhere else) is reported.

Counts of episodes include only clinically substantive episodes of care. Episodes that are of brief duration (1 or 2 contacts only) and episodes during which contacts were sparse (average interval between contacts 6 weeks or greater) are excluded from the count. Consequently, the count of episodes can in some cases be less than the count of unique patients.

Further detail can be found in the data source section.

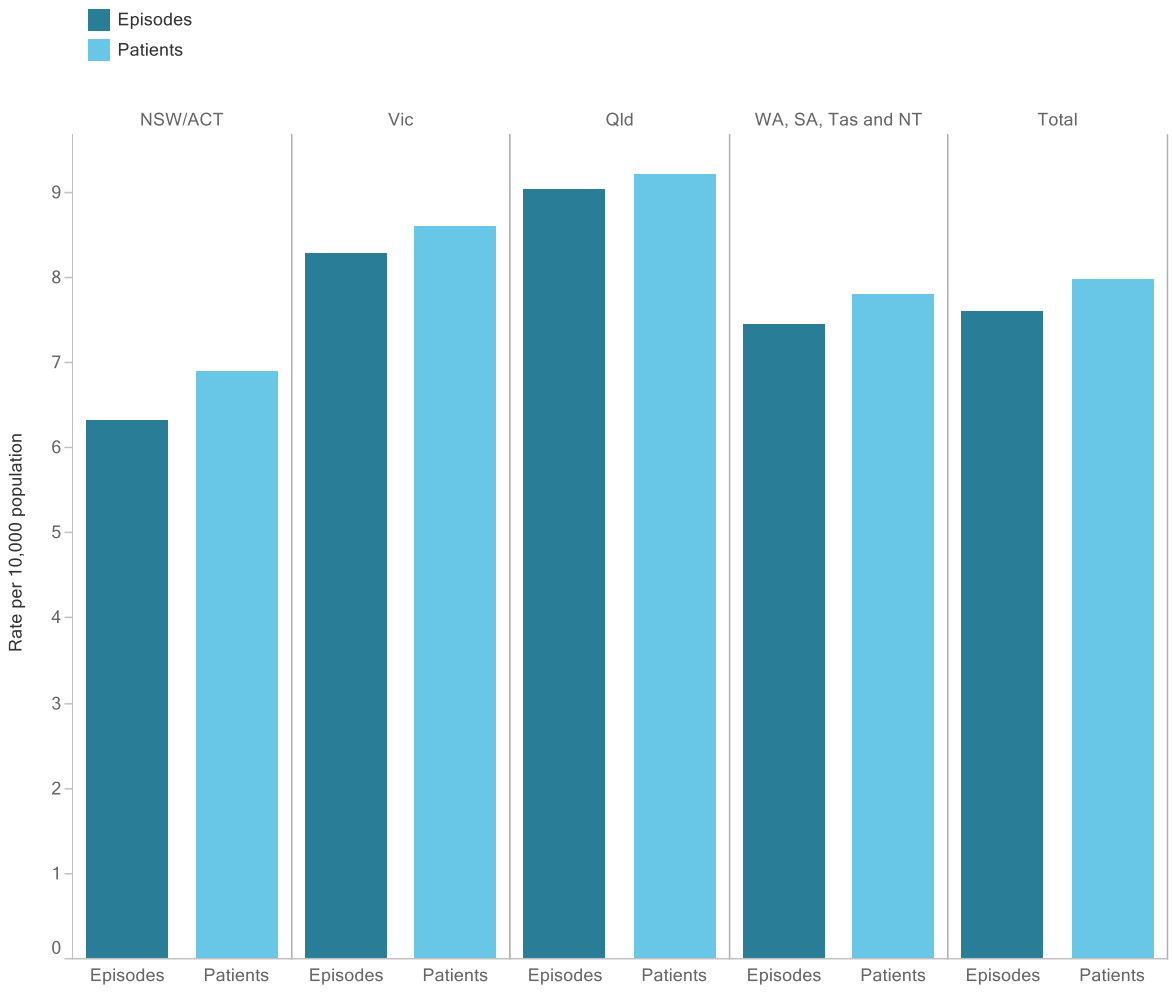
States and territories

In 2017–18, 19,763 patients received 262,172 same day mental health-related days of care from private hospitals; an average number of 13.3 care days per patient. These figures equate to 8.0 patients per 10,000 population and 105.8 care days per 10,000 population.

The rates of patients per 10,000 population ranged from 6.9 in New South Wales/Australian Capital Territory (combined) to 9.2 in Queensland in 2017–18. (Figure SD.7).

There were 18,814 clinically substantive episodes of care provided in 2017–18, which is a rate of 7.6 per 10,000 population. By jurisdiction, this rate ranged from 6.3 in New South Wales/Australian Capital Territory (combined) to 9.0 in Queensland. (Figure SD.7).

Figure SD.7: Patients and episodes of care for same day private admitted mental health care, by states and territories, 2017-18



Source: Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service, 2019; Table SD.13.

www.aihw.gov.au/mhsa

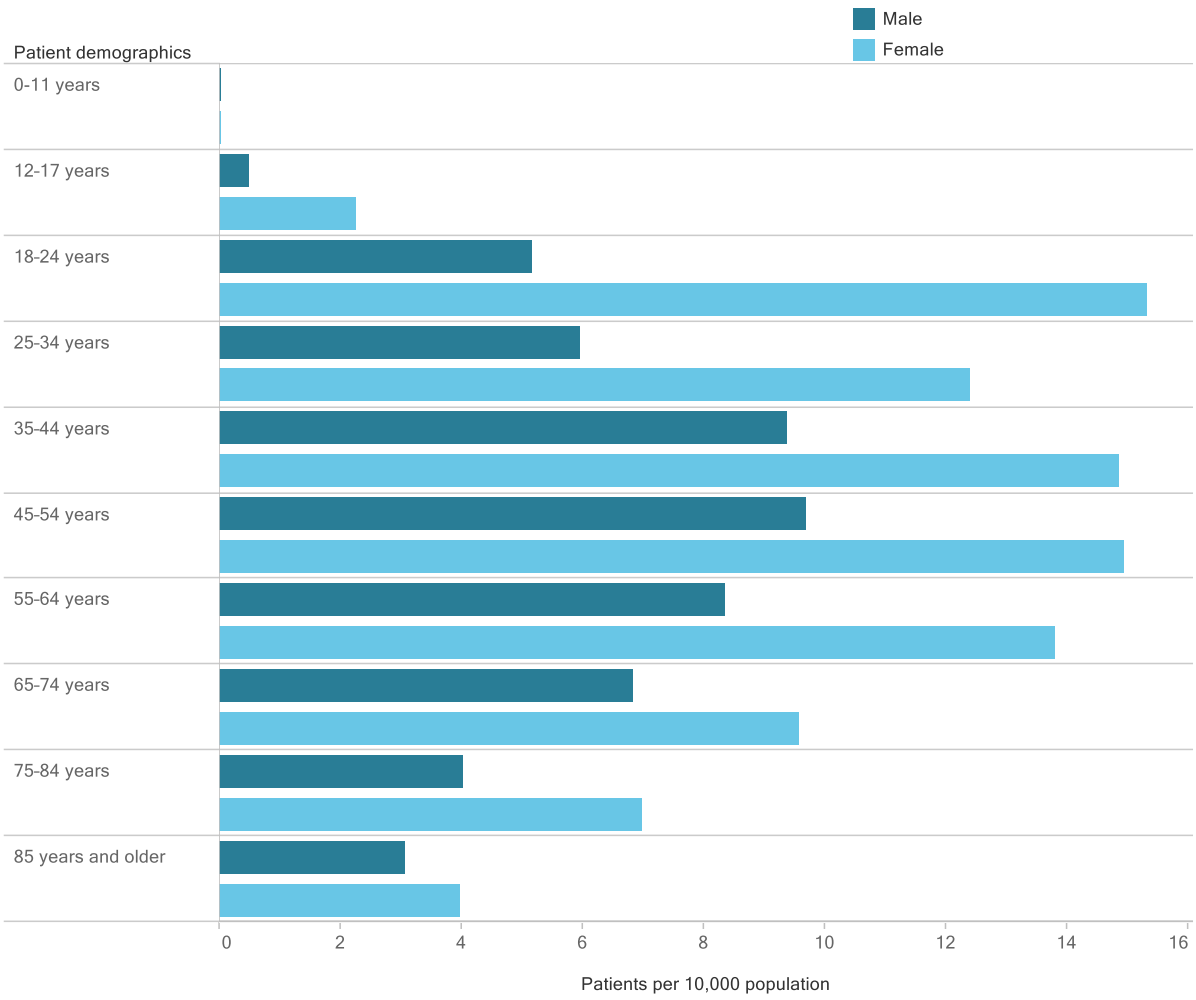
Source data: Same day admitted mental health care Table SD.13 (685KB XLS).

Patient demographics

The majority of same day private mental health related separations were female patients. The population rate of these separations for females was 1.8 times that for males (10.2 vs. 5.7 per 10,000 population).

Examining separation rates for age and sex groups shows a tendency for lower rates in children (<18 years) and older persons (65+ years) compared to other age groups. Females aged 18–24 years had the highest separation rate (15.3 per 10,000 population) of all age groups (figure SD.8).

Figure SD.8: Patients receiving same day private admitted mental health care, by sex and age group, 2017–18



Source: Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service, 2019; Table SD.14.

www.aihw.gov.au/mhsa

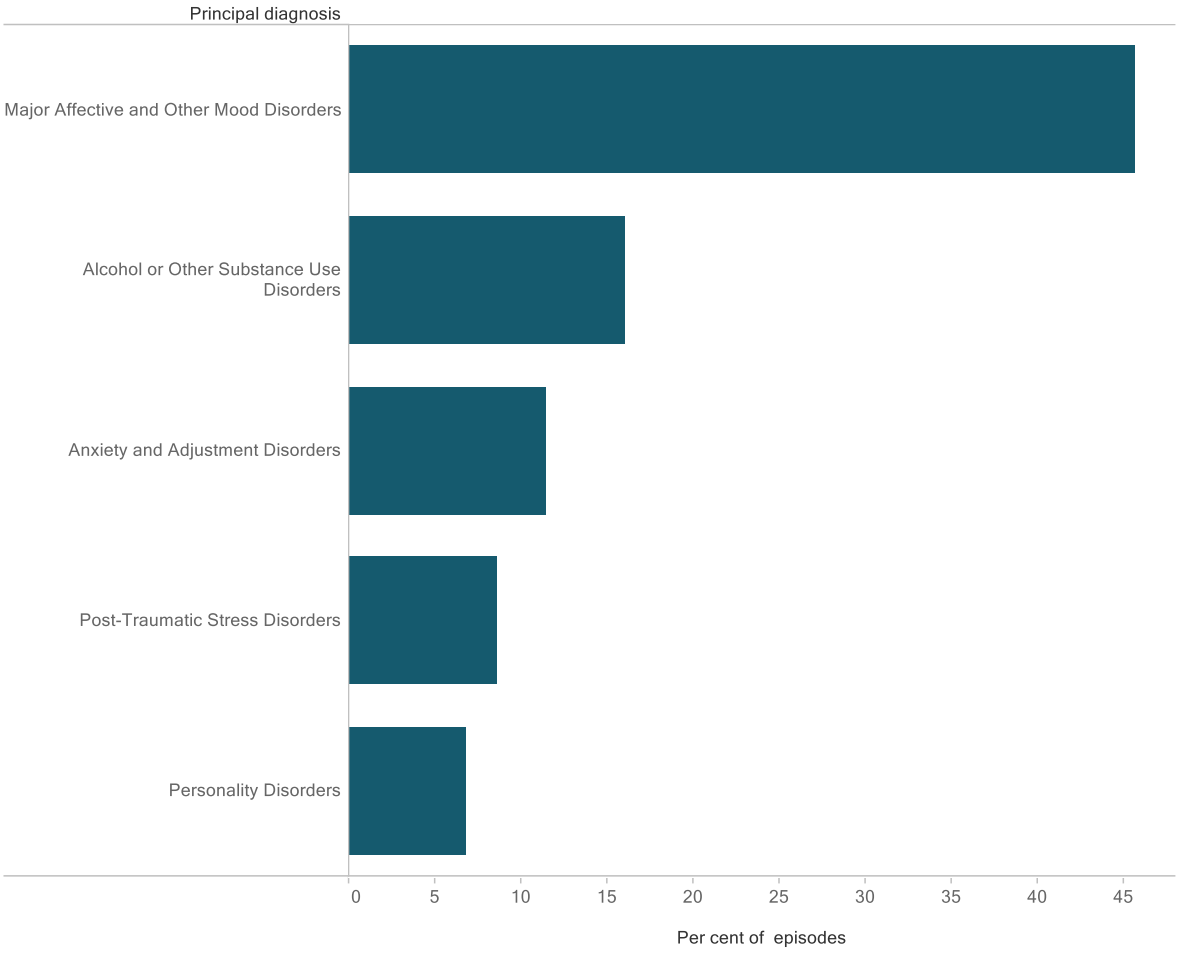
Source data: Same day admitted mental health care Table SD.14 (685KB XLS).

In 2017–18, the majority of patients (86.3%) receiving same day private admitted mental health care were from urban areas. Amongst the jurisdiction groups analysed, this ranged between 78.4% (WA, SA, Tas, and NT combined) and 91.5% (Vic).

Principal diagnosis

In 2017–18, the most common mental health diagnostic group of clinically significant episodes of care was *Major affective and other mood disorders* (45.7%), followed by *Alcohol and other substance use disorders* (16.0%) and *Anxiety and Adjustment disorders* (11.5%) (Figure SD.9).

Figure SD.9: Proportion of same day private admitted mental health care episodes, for the 5 most commonly reported mental health diagnostic groups, 2017-18



Source: Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service, 2019; Table SD.15.

www.aihw.gov.au/mhsa

Source data: Same day admitted mental health care Table SD.15 (685KB XLS).

Data sources

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, refer to the data quality statement in Admitted patient care: Australian Hospital Statistics 2017–18.

Further information on admitted patient care for the 2017–18 reporting period can be found in the report *Admitted patient care 2017-18: Australian hospital statistics* (AIHW 2019). The 2017–18 collection contains data for hospital separations that occurred between 1 July 2017 and 30 June 2018. Admitted patient episodes of care/separations that began before 1 July 2017 are included if the separation date fell within the collection period (2017–18). 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 during that separation. In public acute 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.

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 between states and territories. Interpretation of the differences between states and territories therefore needs to be made with care. The 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. For 2017–18, diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM 10th edition) (ACCD 2016). Further information on this is included in the technical information section.

For 2017–18, procedures are classified according to the *Australian Classification of Health Interventions, 10th 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.

Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service

The Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS), previously known as the Private Mental Health Alliance Centralised Data Management Service (PMHA CDMS), was launched in Australia in 2001 to support private hospitals with psychiatric beds to routinely collect and report on a nationally agreed suite of clinical measures and related data for the purposes of monitoring, evaluating and improving the quality of and effectiveness of care. The PPHDRAS works closely with private hospitals, health insurers and other funders (e.g. Department of Veterans' Affairs) to provide a detailed quarterly statistical reporting service on participating hospitals' service provision and patient outcomes.

The PPHDRAS fulfils two main objectives. Firstly, it assists participating private hospitals with implementation of their National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures. Secondly, the PPHDRAS provides hospitals and private health funds with a data management service that routinely prepares and distributes standard reports to assist them in the monitoring and evaluation of health care quality. The PPHDRAS also maintains training resources for hospitals and a database application which enables hospitals to submit de-identified data to the PPHDRAS. The PPHDRAS produces an annual statistical report. In 2017–18, the PPHDRAS accounted for 98% of all private psychiatric beds in Australia.

The classification of diagnostic groups used by the PPHDRAS is based on the ICD-10 principal diagnosis assigned to the episode of care at discharge. There are 8 clinical groupings of the ICD-10 diagnoses relating to mental and behavioural disorders, they are as follows:

- Schizophrenia, Schizoaffective and Other Psychotic Disorders. This group includes ICD-10 diagnoses of: *Psychotic disorders due to psychoactive substance use* (F1x.5 and F1x.7), *Schizophrenia* (F20), *Schizotypal disorders* (F21), *Delusional disorders* (F22 and F24), *Acute and transient psychotic disorders* (F23), *Schizoaffective disorders* (F25), and *Other nonorganic psychotic disorders* (F28 and F29).
- Major Affective and Other Mood Disorders. This group includes ICD-10 diagnoses of *Manic episodes and bipolar affective disorders with current episode manic* (F30, F31.0, F31.1 and F31.2), *Depressive episodes, bipolar disorders with current episode depressed or mixed*, and *Recurrent depressive disorders* (F31.3, F31.4, F31.5, F31.6, F31.7, F31.8, F31.9, F32 and F33), and *Persistent mood disorders including cyclothymia and dysthymia*, and *Other mood disorders* (F34, F38 and F39).
- Post Traumatic and Other Stress-related Disorders. This group includes ICD-10 diagnoses of *Reactions to severe stress including acute stress reactions* (F43.0, F43.8

and F43.9), *Adjustment disorders with brief depressive reactions* (F43.20), *Adjustment disorders with prolonged depressive reactions* (F43.21), *Other adjustment disorders* (F43.22 and F43.28) and *Posttraumatic stress disorders* (F43.1).

- Anxiety Disorders. This group includes ICD-10 diagnoses of *Anxiety disorders including phobic anxiety*, *Panic disorder*, *Generalised anxiety disorder* and *Other neurotic disorders* (F40, F41 and F48), and *Dissociative disorders* (F44). It does not include *Obsessive Compulsive Disorders* (F42) or *Somatoform Disorders* (F45) which are classified elsewhere.
- Alcohol and Other Substance Use Disorders. This group includes ICD-10 diagnoses of *Alcohol* and *Other psychoactive substance intoxication*, *harmful, use, dependence and withdrawal* (F1x.0, F1x.1, F1x.2, F1x.3, F1x.4, F1x.8 and F1x.9).
- Eating Disorders. This group includes ICD-10 diagnoses of *Anorexia nervosa* and *Atypical anorexia nervosa* (F50.0 and F50.1), and *Eating disorders other than anorexia nervosa* (F50.2, F50.3, F50.4- and F50.9).
- Personality Disorders. This group includes ICD-10 diagnoses of *Paranoid and schizoid personality disorders* (F60.0 and F60.1), *Dissocial personality disorders including antisocial personality disorder* (F60.2), *Emotionally unstable personality disorders* (includes borderline and impulsive) (F60.3), *Histrionic*, *Anankastic* (obsessive-compulsive), *Anxious*, and *Dependent personality disorders* (F60.4, F60.5, F60.6 and F60.7), and *Other personality disorders* (F60.8, F60.9, F61.0, F61.1, F62, F63, F68 and F69).
- Other Disorders, Not Elsewhere Classified. This group includes all remaining psychiatric and other diagnoses including: *Organic Disorders* (F00 through F09 and F1x.6); *Obsessive Compulsive Disorders* (F42); *Somatoform disorders* (F45*); Behavioural Syndromes Associated with Physiological Disturbances* and *Physical Factors* (F51, F53, F54, and F59); *Sexual Disorders* (F52, F64, F65 and F66); *Mental Retardation* (F70, F71, F72, F73, F78 and F79); *Disorders of Psychological Development* (F80, F81, F82, F83, F84, F88 and F89); *Disorders of Childhood and Adolescence* (F90, F91, F92, F93, F94, F95 and F98.0); *Other Disorders*, including ICD-10 diagnoses of *Mental disorders*, not otherwise specified (F99) and all other valid non-psychiatric diagnoses (i.e., diagnoses not grouped under either MDC 19 or MDC 20 in AR-DRG 4).

The classification of patients into urban versus non-urban groups was based on the ASGC Remoteness classification of the Postcode of their Area of usual residence, at the first day of care within the financial year. In cases whether the Area of usual residence

was missing from that first day's record, the first valid value for the patient is used. Patients, whose Area of usual residence was in ASGC group *Major cities* were classified as "Urban", whilst those in the remaining groups (*Inner regional*, *Outer regional*, *Remote* and *Very remote*) were classified as "Non-urban".

Statistics for States and Territories were aggregated in accordance with PPHDRAS policy which, in order to ensure the privacy and confidentiality of both patients and providers, prohibits individual State or Territory statistics being reported in cases where the number of Hospitals is less than 5. As a consequence, statistics for the Australian Capital Territory are aggregated with those for New South Wales; whilst those for South Australia, Western Australia, Tasmania and Northern Territory are also aggregated.

References

AIHW (Australian Institute of Health and Welfare) 2019. Admitted patient care 2017–18: Australian hospital statistics. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW.

ACCD (Australian Consortium for Classification Development) 2016. The international statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), 10th edn. Sydney: University of Sydney.

APHA (Australian Private Hospitals Association) 2019 Private Hospital-based Psychiatric Services 1 July 2017 to 30 June 2018. Canberra: APHA.

Key Concepts

Key Concept	Description
Diagnostic group	The classification of **diagnostic group**s is based on the ICD-10 principal diagnosis assigned to the episode of care at discharge. There are 8 clinical groupings of the ICD-10 diagnoses relating to mental and behavioural disorders. Further details of these diagnostic groups, can be found in the data source section.
Episode	An **episode** of care in Private hospitals involves a period of care from admission to separation. Counts of episodes include only clinically substantive episodes of care. Episodes that are of brief duration (1 or 2 contacts only) and episodes during which contacts were sparse (average interval between contacts 6 weeks or greater) are excluded from the count. Consequently, the count of episodes can in some cases be less than the count of unique patients.
Mental health-related	A separation is classified as mental health-related if: • it had a mental health-related principal diagnosis which, for admitted patient care, is defined as a principal diagnosis that is either 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) classification (codes F00–F99) or a number of other selected diagnoses (the Classification Codes section for the full list of applicable diagnoses), or • it included any specialised psychiatric care.

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.
Same day admitted mental health care	The definition of same day admitted mental health care is slightly different between the two data sources. A separation for **Public hospitals** is classified as same day admitted mental health care if the following apply: • the separation was a same day separation (that is, admission and separation occurred on the same day), An admission for **Private hospitals** is classified as same day admitted mental health care based on data reported as 'Same day episode' including: • Hospital-based same day admissions, • Single overnight for same day admissions for ECT, • Hospital-in-the-home or outreach care visits to patient's homes recorded as same day admissions.
Separation	**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.
Specialised psychiatric care	A separation is classified as having **specialised psychiatric care** if the patient was reported as having spent 1 or more days in a specialised psychiatric unit or ward.
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 (technical information).