

Ambulatory-equivalent mental health-related admitted patient care—public hospitals

[Ambulatory-equivalent mental health-related](#) care is provided to patients in hospital and is broadly comparable to that provided in community mental health care services. These hospitalisations do not involve an overnight stay and, if any mental health-related procedure is recorded, it is one that could have been provided in an ambulatory setting. This type of care may occur with or without [specialised psychiatric care](#). The care can be provided in a public acute, public psychiatric or private hospital (see Mental health care facilities [key concepts](#) section for hospital types).

The data presented in this section are from the National Hospital Morbidity Database (NHMD) and cover ambulatory-equivalent hospital [separations](#) reported from public acute and public psychiatric hospitals in Australia. Private hospital activity is presented separately in the section titled 'Ambulatory-equivalent mental health-related admitted patient care—private hospitals'. More detailed information on public data sources and private hospital data sources are available at the end of respective sections.

Due to the small number of reported ambulatory-equivalent separations from public psychiatric hospitals, these separations have been combined with public acute hospitals for reporting in this section. Where possible, a distinction is made between separations with and without specialised psychiatric care.

Key points

- In 2013–14, there were 28,429 ambulatory-equivalent mental health-related separations in public acute and public psychiatric hospitals, accounting for 0.5% of all public hospital separations.
- Specialised psychiatric care was provided for one-third (33%) of ambulatory-equivalent separations in public hospitals; the majority (67%) did not have specialised psychiatric care.
- The largest number and highest rate of ambulatory-equivalent separations without specialised care were for patients aged 15–24.
- Aboriginal and Torres Strait Islander people accounted for 11% of ambulatory-equivalent separations without specialised mental healthcare, at a rate almost 5 times that of other Australians.
- Other anxiety disorders (including panic disorder, generalised anxiety disorder, mixed anxiety and depressive disorder, other mixed anxiety disorders, other specified anxiety disorders and anxiety disorder unspecified) was the most common principal diagnoses recorded for ambulatory-equivalent separations with specialised care (17%) followed by eating disorders (15%).
- Mental and behavioural disorders due to use of alcohol was the most common for ambulatory-equivalent separations without specialised care (38%) followed by other anxiety disorders.

Overview

In 2013-14, there were about 5.7 million separations reported from Australian public hospitals (AIHW 2015) of which 28,429 were ambulatory-equivalent mental health-related separations in public acute and public psychiatric hospitals (0.5%). Specialised psychiatric care was provided for one-third (33%) of ambulatory-equivalent separations in public hospitals; the majority (67%) did not have specialised psychiatric care.

Nationally, the rate of ambulatory-equivalent mental health-related separations in public hospitals was 12 per 10,000 population. Queensland had the highest rate (17 per 10,000 population) and Tasmania has the lowest (4.9).

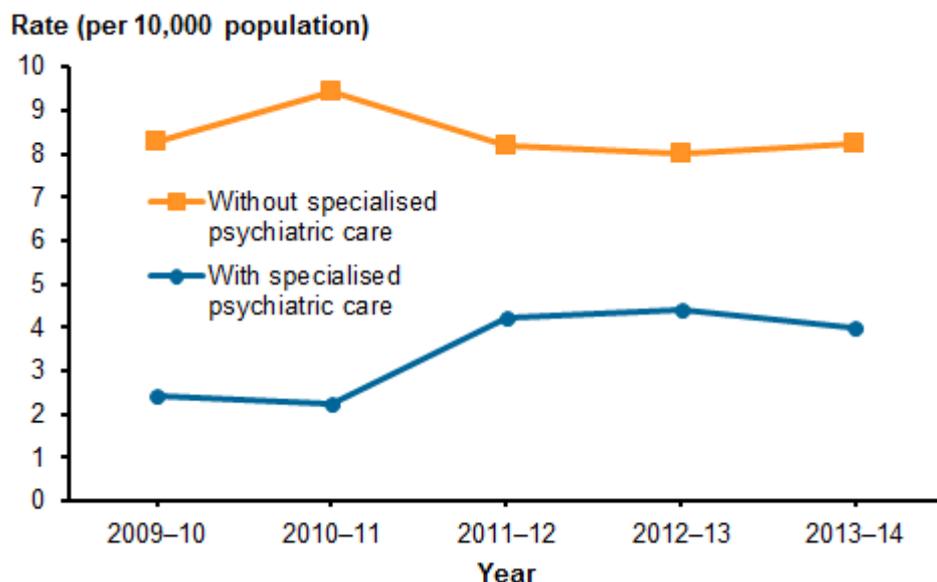
Reference

AIHW 2015. Admitted patient care 2013–14: Australian hospital statistics. Health services series no. 60. Cat. no. HSE 156. Canberra: AIHW.

Ambulatory-equivalent mental health-related separations over time—public hospitals

Over the 5-year period to 2013–14, there was an average annual increase of 4.9% in the number of ambulatory-equivalent mental health-related separations in public hospitals. The rate of ambulatory-equivalent separations without specialised psychiatric care remained relatively stable over the time period, with the exception of 2010–11. In contrast, the rate of ambulatory-equivalent separations with specialised psychiatric care increased from 2.4 per 10,000 population in 2009–10 to 4.0 in 2013–14 (Figure AMB.1).

Figure AMB.1: Ambulatory-equivalent mental health-related separation rates for public hospitals, with and without specialised psychiatric care, 2009–10 to 2013–14



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

Sources: National Hospital Morbidity Database (NHMD). Source data Ambulatory-equivalent mental health-related admitted patient care Table AMB.2 (260KB XLS).

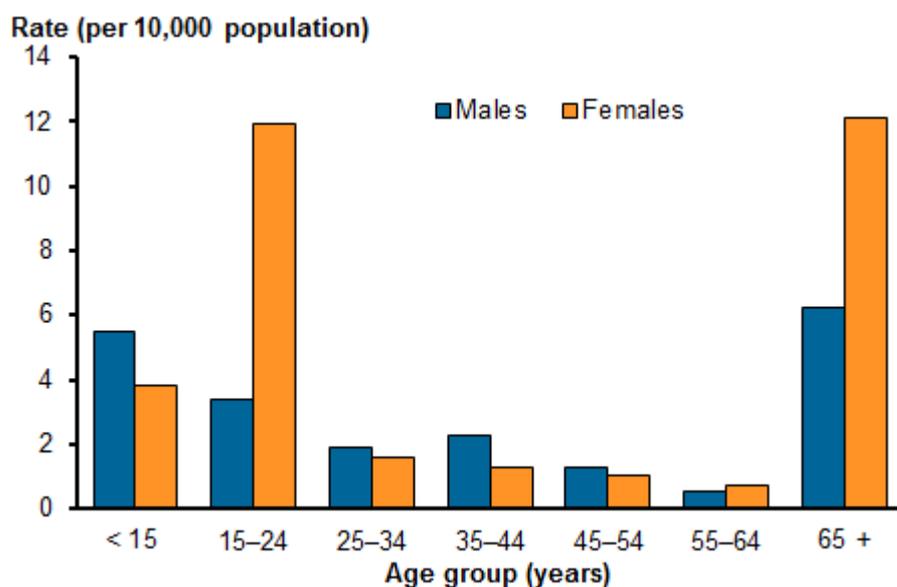
Ambulatory-equivalent mental health-related separation patient characteristics—public hospitals

Demographics

With specialised care

In 2013–14, the rate of ambulatory-equivalent mental health-related separations with specialised care was highest for patients aged 65 and over and lowest for those aged 55–64 (9.4 and 0.6 per 10,000 population respectively) (Figure AMB.2). Overall, females accounted for 60% of ambulatory-equivalent separations, and the rate was higher for females than males (4.8 and 3.2 per 10,000 population respectively). The most marked differences in rates between males and females were seen for patients aged 15–24 and 65 years and over; for these age groups the female rates were markedly higher than male rates.

Figure AMB.2: Ambulatory-equivalent mental health-related separation rates for public hospitals, with specialised care, by sex and age, 2013–14



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

Sources: National Hospital Morbidity Database (NHMD). Source data Ambulatory-equivalent mental health-related admitted patient care Table AMB.5 (260KB XLS).

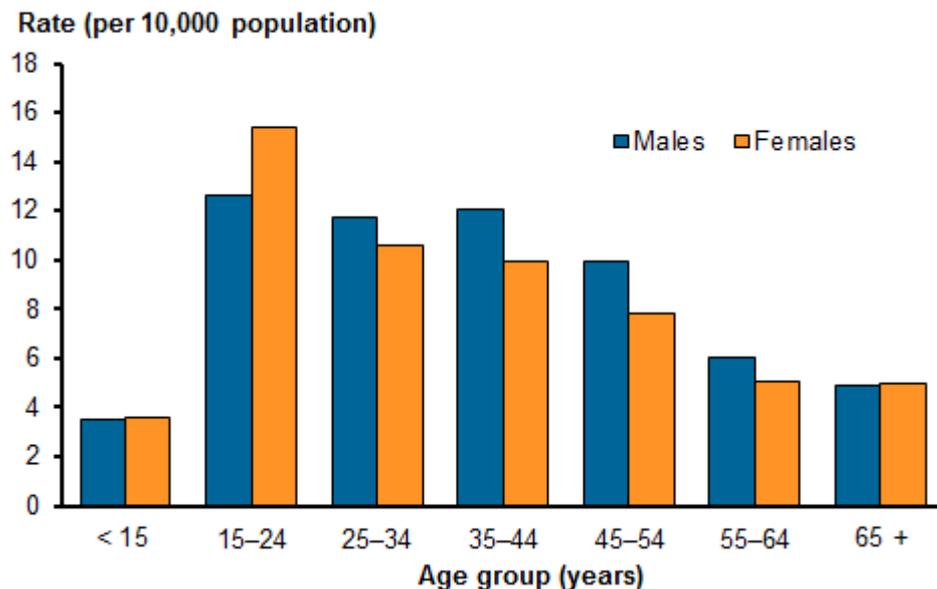
Aboriginal and Torres Strait Islander people accounted for 4.5% of ambulatory-equivalent separations with specialised care. The rates of ambulatory-equivalent separations among Indigenous Australians and other Australians were 5.0 and 3.8 per 10,000 population respectively. After adjusting for different age-structures, the rate of separations of Australian-born patients was almost 3 times that of those born overseas (4.9 and 1.7 per 10,000 population respectively). The majority of people who had an ambulatory-equivalent separation with specialised care lived in *Major cities* (91%), with 5.2 separations per 10,000 population.

Without specialised care

Overall, males and females had similar rates of ambulatory-equivalent separations without specialised care (8.5 and 8.0 respectively). The highest rate of ambulatory-equivalent mental health-related separations

without specialised care was for patients aged 15–24 (14 per 10,000 population) and the lowest was for those aged under 15 (3.5) (Figure AMB.3).

Figure AMB.3: Ambulatory-equivalent mental health-related separation rates for public hospitals, without specialised care, by sex and age, 2013–14



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

Sources: National Hospital Morbidity Database (NHMD). Source data Ambulatory-equivalent mental health-related admitted patient care Table AMB.6 (260KB XLS).

Indigenous Australians represented 11% of ambulatory-equivalent separations without specialised care. After adjusting for different age-structures, the rate of ambulatory-equivalent separations without specialised care among Indigenous Australians was almost 5 times as high as that of other Australians (35.6 and 7.5 per 10,000 population respectively).

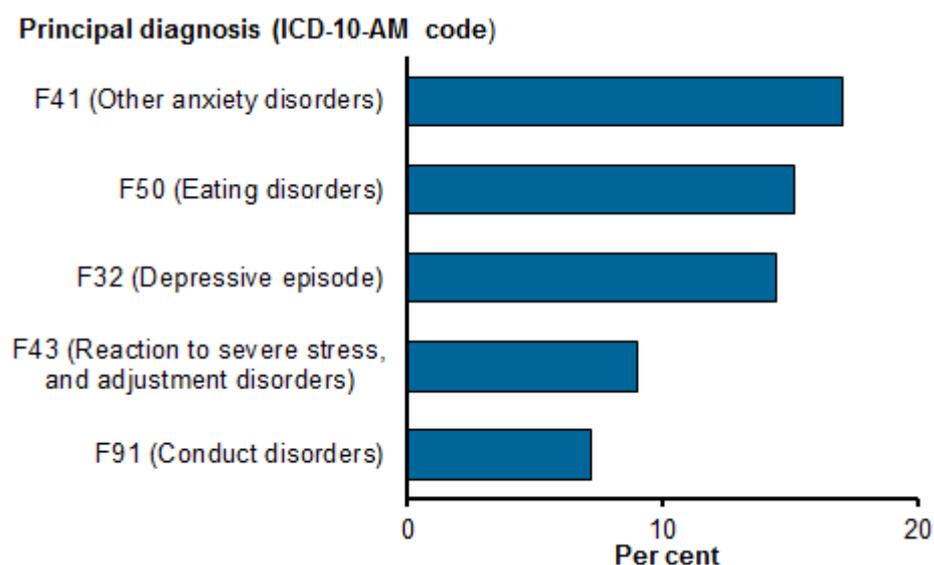
Those living in *Remote* and *very remote* areas had the highest rate of separations without specialised care (19 and 25 per 10,000 population respectively).

Ambulatory-equivalent mental health-related principal diagnosis—public hospitals

With specialised care

In 2013–14, the most common principal diagnosis for ambulatory-equivalent separations with specialised care was Other anxiety disorders (ICD-10-AM code F41 which includes panic disorder, generalised anxiety disorder, mixed anxiety and depressive disorder, other mixed anxiety disorders, other specified anxiety disorders and anxiety disorder unspecified) (1,577 or 17%), followed by Eating disorders (F50) and Depressive episode (F32) (15% and 14% respectively) (Figure AMB.4).

Figure AMB.4: Ambulatory-equivalent mental health-related separations in public hospitals, for the 5 most commonly reported principal diagnoses, with specialised care, 2013–14



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

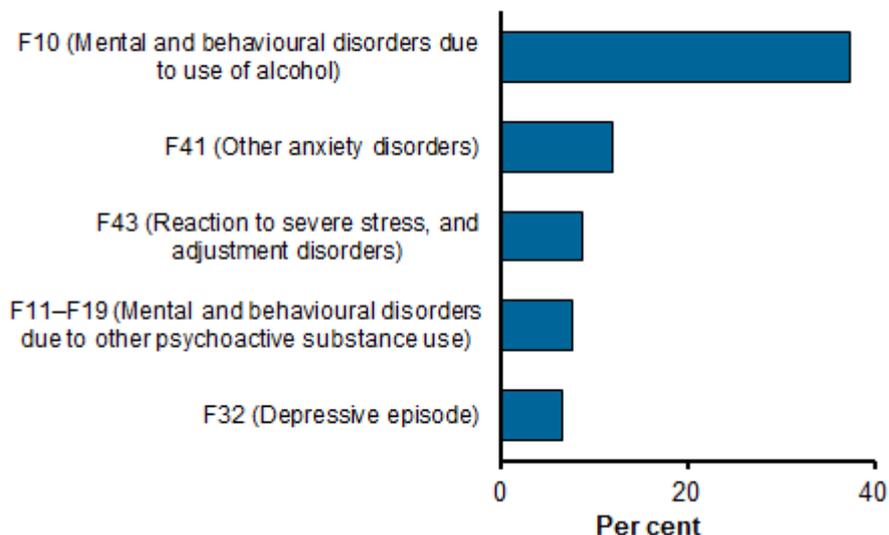
Sources: National Hospital Morbidity Database (NHMD). Source data Ambulatory-equivalent mental health-related admitted patient care Table AMB.7 (260KB XLS).

Without specialised care

The most common principal diagnoses for ambulatory-equivalent separations without specialised care was Mental and behavioural disorders due to use of alcohol (F10) (7,169 or 38 %), Other anxiety disorders (F41) (12%) and Reaction to severe stress and adjustment disorders (F43) (8.9%) (Figure AMB.5).

Figure AMB.5: Ambulatory-equivalent mental health-related separations in public hospitals, for the 5 most commonly reported principal diagnoses, without specialised care, 2013–14

Principal diagnosis (ICD-10-AM code)



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

Sources: National Hospital Morbidity Database (NHMD). Source data Ambulatory-equivalent mental health-related admitted patient care Table AMB.8 (260KB XLS).

Procedures for ambulatory-equivalent mental health-related separations

In 2013–14, 8.6% of all public hospital ambulatory-equivalent mental health-related separations included at least 1 [procedure](#). In total, 2,528 procedures were recorded for separations with and without specialised psychiatric care. The most frequently recorded procedure was allied health intervention-social work, accounting for 41% of all recorded procedures, followed by alcohol detoxification (21%) and mental/behavioural assessment (20%).

Data sources

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of electronic summary separation records from admitted patient morbidity data collections in Australian hospitals. The NHMD is compiled from data supplied by each of the 8 state and territory health authorities. 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.

The 2013–14 collection contains data for hospital separations that occurred between 1 July 2013 and 30 June 2014. Admitted patient stays that began before 1 July 2013 are included if the separation date fell within the collection period (2013–14). A record is generated for each separation rather than each patient. Therefore, patients who separated more than once in the reference year have more than one record in the database.

Data relating to admitted patients in almost all hospitals are included. The coverage is described in greater detail in *Admitted patient care 2013–14: Australian hospital statistics* (AIHW 2015).

Specialised mental health care is identified as 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.

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 made with care. The principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted patient care. In 2013–14 diagnoses were recorded using the 8th edition of the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM). Further information on this is provided in the online [technical information](#) section.

Procedures are classified according to the *Australian Classification of Health Interventions (ACHI), 8th edition*. Further information on this classification is included in the online [technical information](#) section. More than one procedure can be reported for a separation and not all separations have a procedure reported.

Reference

AIHW 2015. Admitted patient care 2013–14: Australian hospital statistics. Health services series no. 60. Cat. no. HSE 156. Canberra: AIHW

Key Concepts

Ambulatory-equivalent mental health-related admitted patient care—public hospitals

Key Concept	Description
Ambulatory-equivalent	<p>A separation is classified as ambulatory-equivalent for this report if each of the following applies:</p> <ul style="list-style-type: none">• the separation was a same day separation (that is, admission and separation occurred on the same day)• no procedure or other intervention was recorded, or any procedure recorded was identified as probably able to be provided in ambulatory mental health care (see the Classification Codes section for a list of procedures identified in this way)• the mode of admission did not include a care type change or transfer, and the mode of separation did not include a transfer (to another facility), a care type change, the patient leaving against medical advice or death.
Mental health-related	<p>A separation is classified as mental health-related if:</p> <ul style="list-style-type: none">• 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 (see the Classification Codes section for the full list of applicable diagnoses), or• it included any specialised psychiatric care.
Procedure	<p>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.</p>
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</p>

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.