

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 234,008 admitted patient mental health-related separations in 2011–12, 60.6% (141,898) were provided with specialised psychiatric care.
- Involuntary admissions accounted for 29.0% 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.
- Depressive episode and Schizophrenia were the most commonly reported principal diagnoses for separations with specialised psychiatric care (16.6% and 15.0% respectively).
- Mental and behavioural disorders due to use of alcohol was the most commonly reported principal diagnosis for separations without specialised psychiatric care (19.7%).
- Allied health intervention - social work, is the most commonly reported procedure for both separations with and without specialised care (17.0% and 14.7% respectively).

Overview

A total of 9,256,169 separations were reported from public acute, private acute and public psychiatric hospitals in 2011–2012 (AIHW 2013). There were 234,008 mental health-related separations in 2011–12 accounting for 2.5% of all hospital separations. Of these, 141,898 (60.6%) had specialised psychiatric care and 92,110 (39.4%) did not have specialised psychiatric care. Over the 5 years to 2011–12, the average annual rate of increase for all admitted mental health-related separations was 2.4%.

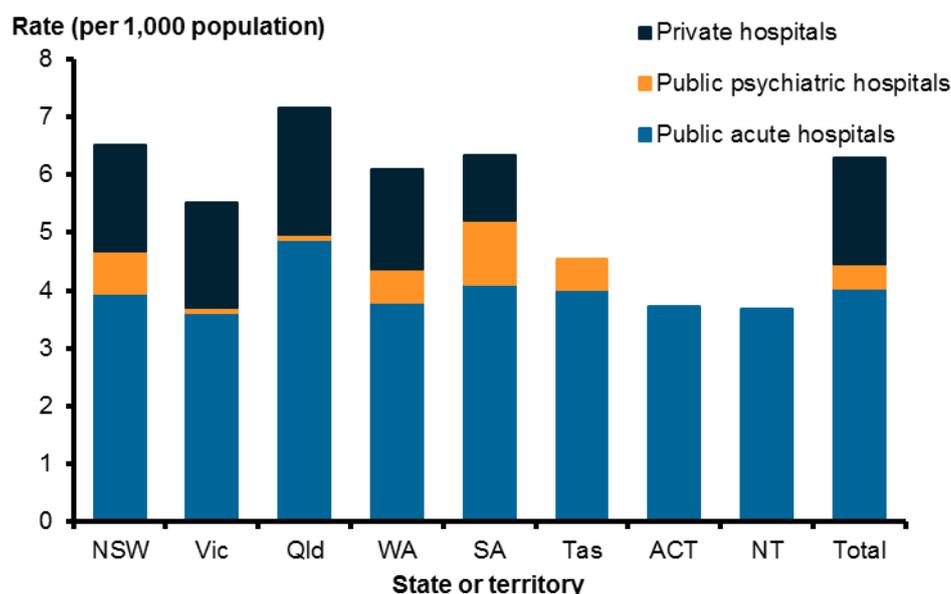
Reference

AIHW 2013. Australian Institute of Health and Welfare 2013. Australian hospital statistics 2011–12. Health services series no. 50. Cat. no. HSE 134. Canberra: AIHW.

Specialised admitted patient mental health care by state and territory

In 2011–12, the national rate of public acute hospital separations with specialised psychiatric care was 4.0 per 1,000 population. Queensland had the highest rate of separations with specialised psychiatric care (4.9) and Victoria had the lowest (3.6) (Figure AD.1).

Figure AD.1: Separations with specialised psychiatric care, state and territory, by hospital type, 2011–12



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.1 (344KB XLS) in the Admitted patient mental health-related care table downloads.

Alt text:

Stacked vertical bar chart with rates of separations with specialised psychiatric care for all jurisdictions by hospital type. The highest rates were in public acute hospitals (4.0 per 1,000 separations), followed by private hospitals (1.8) and public psychiatric hospitals (0.4). Queensland had the highest rate of both public acute and private hospital separations (4.9 and 2.2 respectively). For public psychiatric hospitals South Australia had the highest rate of separations (1.1). Refer to Table AD.1

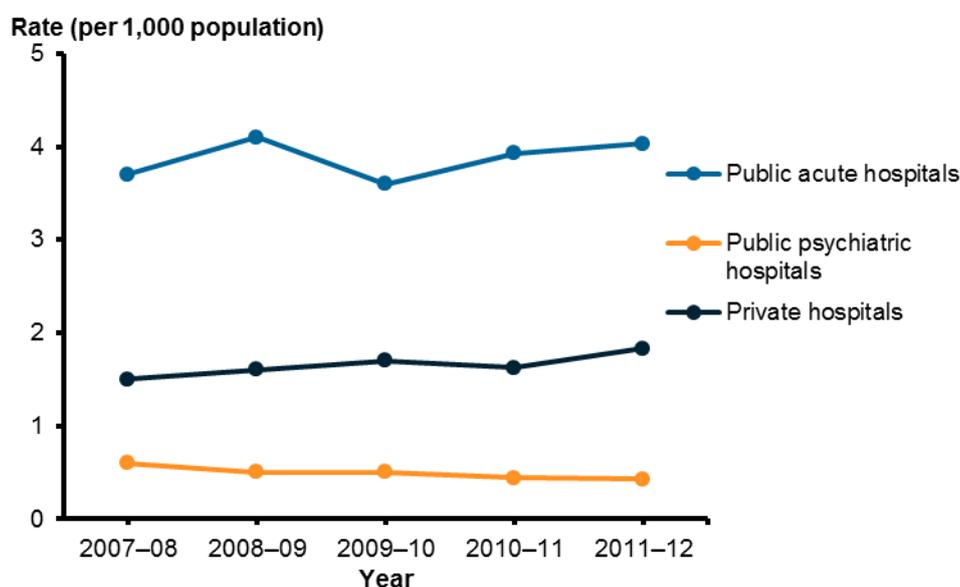
There were 65.2 public acute hospital patient days per 1,000 population in 2011–12. New South Wales had the highest rate of public acute hospital patient days (71.5 per 1,000 population) and the Northern Territory had the lowest (40.4). The rate of public psychiatric hospital patient days varied greatly across jurisdictions, from 71.8 patient days per 1,000 population in South Australia to 4.1 days in Tasmania. Queensland reported the highest rate of patient days in private hospitals (34.7 per 1,000 population).

In 2011–12, the national average length of stay for public acute hospitals was 16.4 days. New South Wales had the longest average length of stay and in the Northern Territory the shortest (18.4 and 11.2 days respectively). The greatest variation in average length of stay was for public psychiatric hospitals with Queensland reporting 386.0 days and Tasmania 8.1 days.

Specialised admitted patient mental health care over time

Between 2007–08 and 2011–12, the national annual average rate of mental health-related separations with specialised psychiatric care per 1,000 population was 3.4% for all hospital types (Figure AD.2). There was an annual average increase for public acute hospital and private hospitals (3.4% and 6.6% respectively), but a decrease for public psychiatric hospitals (-7.0%). The rate of mental health-related separations with specialised psychiatric care in public acute hospitals continues to be more than double the separations for private hospitals and over 5 times that for public psychiatric hospitals.

Figure AD.2: Admitted patient mental health-related separations with specialised psychiatric care, by hospital type, 2007–08 to 2011–12



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 (344KBXLS) in the Admitted patient mental health-related care table downloads.

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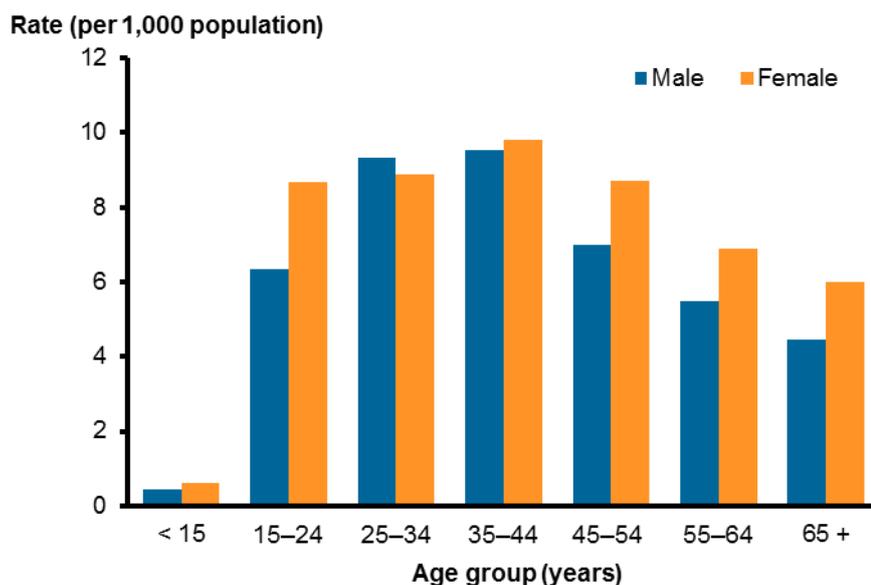
Line chart with 3 lines showing the rate of separations with specialised psychiatric care by hospital type from 2007–08 to 2011–12. Separations across all hospital types has remained relatively stable over time. Public acute hospitals had the most separations with specialised psychiatric care with 3.7 per 1,000 population in 2007–08 to 4.0 in 2011–12, followed by private hospitals (1.5 in 2007–08 to 1.8 in 2011–12) and public psychiatric hospitals (0.6 in 2007–08 to 0.4 in 2011–12). Refer to table AD.4

Specialised admitted mental health care patient characteristics

Patient demographics

In 2011–12, 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 0.5 per 1,000 population respectively) (Figure AD.3). Overall, the separation rate was higher for females than males (6.8 and 5.8 per 1,000 population respectively).

Figure AD.3: Admitted patient separation with specialised psychiatric care rates, by sex and age groups, 2011–12



Alt text:

Bar chart showing the rate of admitted patient separations with specialised psychiatric care, by sex and age-group for 2011–12. Overall, the rate of separations was higher for females than males across all age-groups except for the 25–34 age group. For both sexes, separation rates were very low for the under 15 age group (0.4 per 1,000 population for males and 0.6 for females), and peaked in the 35–44 age group (males 9.5 and females 9.8). Refer to table AD.2

Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Source data for this figure are accessible from Table AD.2. (344KB XLS) in the Admitted patient mental health-related care table downloads

Source: National Hospital Morbidity Database

Aboriginal and Torres Strait Islander people make up about 3.0% of the Australian population (ABS 2012) but are proportionally overrepresented in terms of mental health-related hospitalisations including specialised psychiatric care, accounting for 4.8% of these separations in 2011–12. Indigenous Australians had a separation rate that was over double that of Other Australians (13.9 and 6.1 per 1,000 population respectively). The rate of hospitalisation including specialised psychiatric care decreased with increasing remoteness. The highest rate of separations in 2011–12 was for those living in *Major cities* (6.5 per 1,000 population) and the lowest for those in *Remote* and *Very remote* areas (3.3 per 1,000 population).

Reference

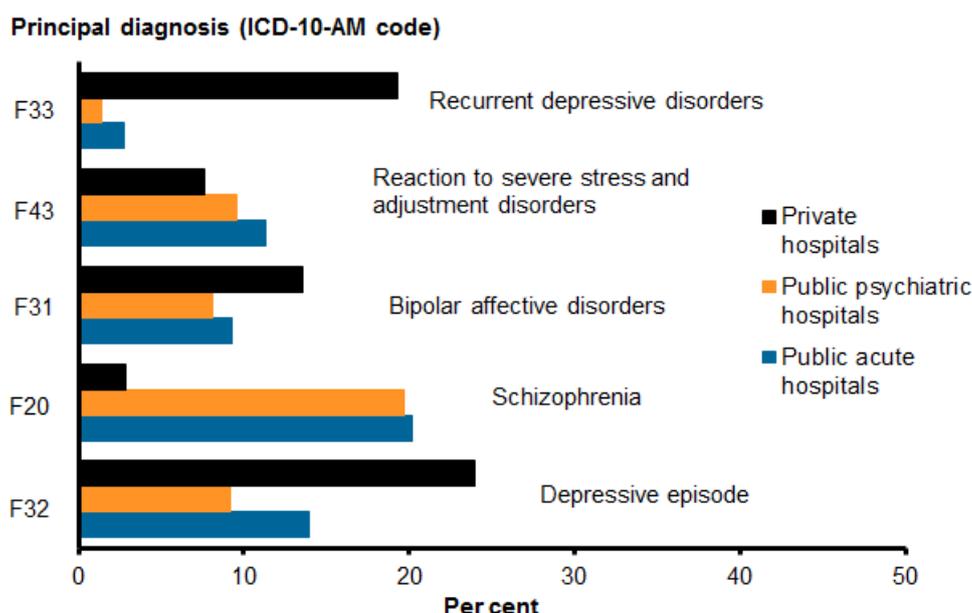
ABS 2012. Australian Bureau of Statistics. Australian demographic statistics. Mar 2012. Cat. No. 3101.0. Canberra: ABS.

Principal diagnosis

In 2011–12, 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 (16.6%, 15.0% and 10.4% 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) (20.1% and 19.7% respectively) compared with less than 1 in 20 for private hospitals (2.9%) (Figure AD.4). About 1 in 4 (24.0%) separations in private hospitals had a principal diagnosis of depressive episode (F32) compared with 13.9% and 9.2% for public acute and public psychiatric hospitals respectively.

Figure AD.4: Admitted patient separations with specialised psychiatric care, 5 most frequently reported principal diagnoses, by hospital type, 2011–12 (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 data for this figure are accessible from Table AD.7 (344KB XLS) in the Admitted patient mental health-related care table downloads.

Source: National Hospital Morbidity Database.

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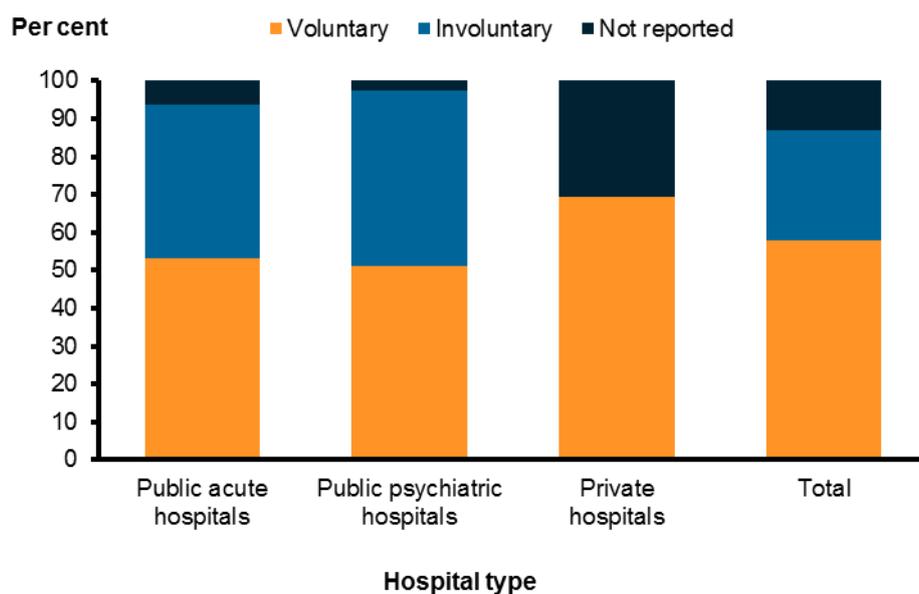
Horizontal bar chart showing the % of separations with specialised psychiatric care for the 5 most frequently reported principal diagnoses, by hospital type. Depressive episode was the most common principal diagnosis (16.6%) followed by schizophrenia (15.0%). For private hospital depressive episode and recurrent depressive disorders were the most common (24.0% and 19.2% respectively). Schizophrenia was the most common diagnosis in public acute (20.1%) and public psychiatric hospitals (19.7%). Refer to table AD.7

Mental health legal status

There were 41,197 involuntary admissions in 2011–12, accounting for 29.0% of all mental health-related separations with specialised psychiatric care. The majority (89.0%) of these occurred in public acute hospitals with 2 in 5 separations involving an involuntary admission for this hospital type.

Involuntary admissions accounted for almost half (46.3%) of all separations in public psychiatric hospitals. For private hospitals, 3 in 1000 (0.3%) separations with specialised psychiatric care were involuntary admissions (Figure AD.5).

Figure AD.5: Admitted patient separations with specialised psychiatric care, by mental health legal status and hospital type, 2011–12



Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Source data for this figure are accessible from Table AD.5 (344KB XLS) in the Admitted patient mental health-related care table downloads.

Source: National Hospital Morbidity Database.

Alt text:

Vertical bar chart showing the proportion of separations with specialised psychiatric care by legal status and hospital type. For all hospital types the majority of separations were voluntary admissions (public acute hospitals 53.2%; public psychiatric hospitals 51.2%; private hospitals 69.3%), whereas involuntary admissions were more common in public acute (40.6%) and public psychiatric hospitals (46.3%). Refer to Table AD.5

Procedures

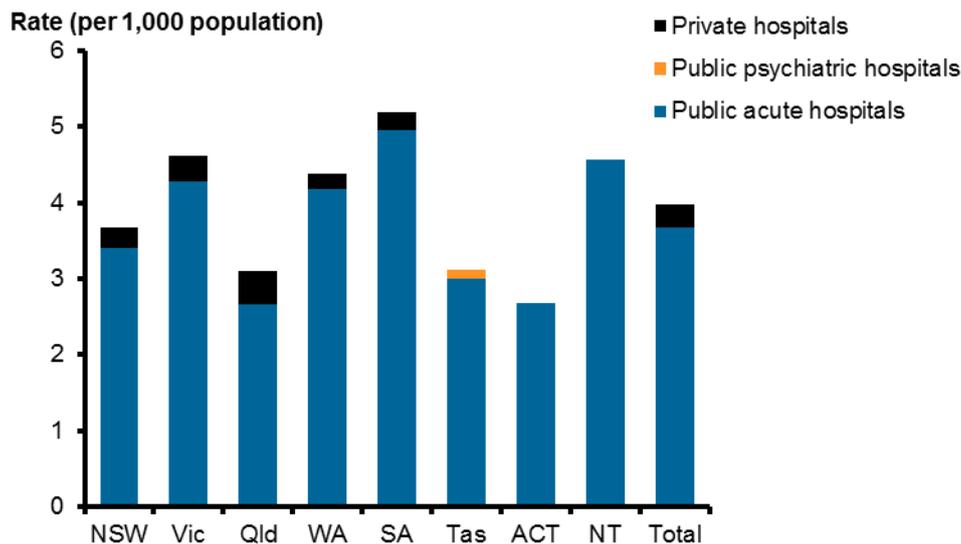
About 2 in 5 (40.4%) of all mental health-related separations with specialised psychiatric care did not have an intervention or procedure recorded. However, it is likely that the interventions (procedures) provided to patients during these mental health-related separations were not able to be coded using 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 was an allied health intervention, including services provided by psychologists (7.4% of interventions), social workers (13.9%) and occupational therapists (8.6%). A frequently reported procedure for separations with specialised care was non-emergency general anaesthesia, accounting for 16.4% of interventions for separations with specialised psychiatric care. This was most likely associated with the administration of electroconvulsive therapy, a form of treatment for depression.

Non-specialised admitted patient mental health care by states and territories

The national rate of public acute hospital separations without specialised psychiatric care was 3.7 per 1,000 population in 2011–12. South Australia had the highest rate of separations without specialised psychiatric care (5.0) and equally Queensland and the Australian Capital Territory had the lowest (2.7) (Figure AD.6). Only Tasmania recorded separations without specialised psychiatric care for public psychiatric hospitals in 2011–12.

Figure AD.6: Separations without specialised psychiatric care, states and territories, by hospital type, 2011–12



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 (344KB XLS) in the Admitted patient mental health-related care table downloads.

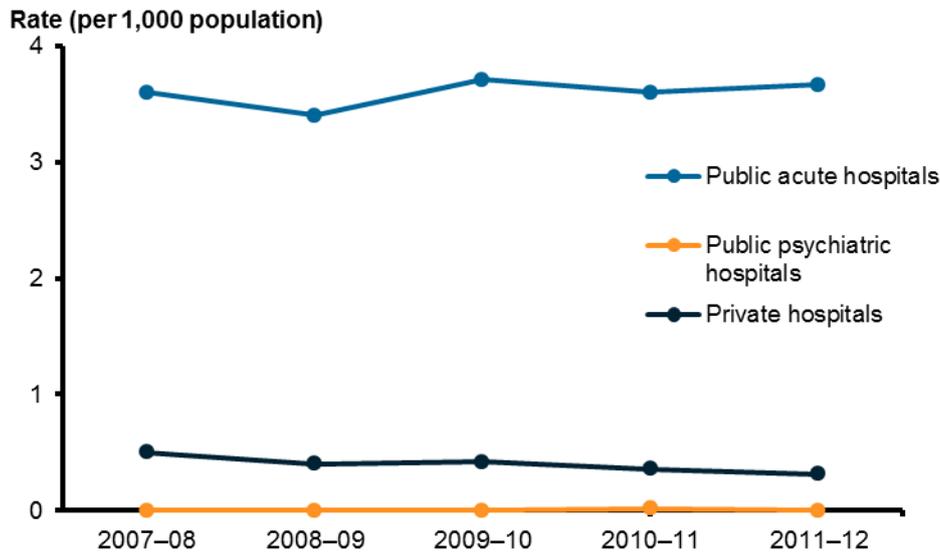
Alt text:

Stacked vertical bar chart showing the rate of separations without specialised care for all states and territories by hospital type. Across all states and territories the highest rate of separations were in public acute hospitals (3.7 separations per 1,000 population), followed by private hospitals (0.3). Only Tasmania recorded separations with specialised psychiatric care in public psychiatric hospitals. Refer to table AD.9.

Non-specialised admitted patient mental health care 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 2007–08 and 2011–12 (Figure AD.7). The rate of public acute hospital separations without specialised care continues to be over 5 times the rate of private hospitals.

Figure AD.7: Admitted patient mental health-related separations without specialised psychiatric care, by hospital type, 2006–07 to 2011–12



Note: Separations with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded. Source data for this figure are accessible from Table AD.10 (344KB XLS) in the Admitted patient mental health-related care table downloads.

Source: National Hospital Morbidity Database.

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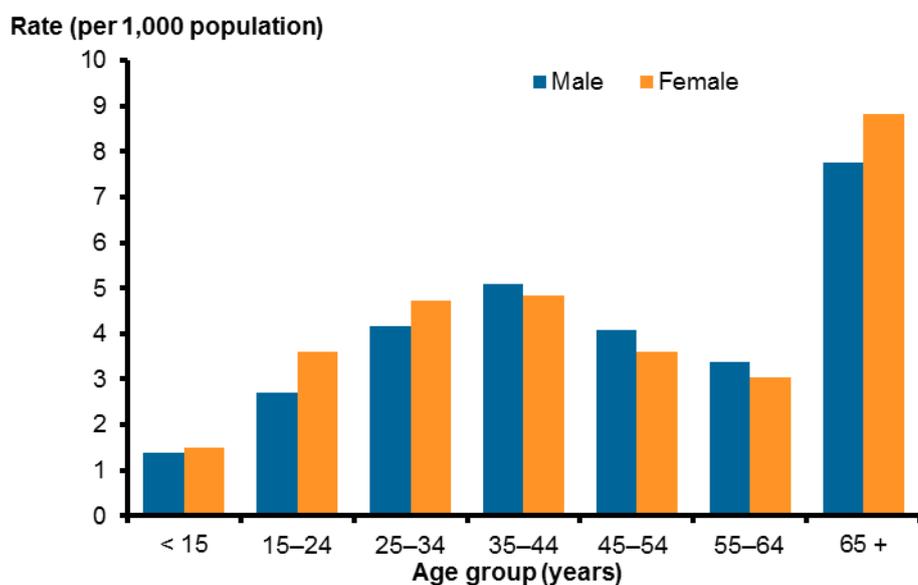
Line chart with 3 lines showing the rate of separations without specialised psychiatric care by hospital type from 2007–08 to 2011–12. Separations across all hospital types has remained relatively stable over time. Public acute hospitals have had the most separations without specialised care over time (3.6 per 1,000 population in 2007–08 to 3.7 in 2011–12), followed by private hospitals (0.5 in 2007–08 to 0.3 in 2011–12). Refer to Table AD.10.

Non-specialised admitted mental health care patient characteristics

Patient demographics

In 2011–12, the highest rate of mental health-related separations without specialised psychiatric care was for patients aged 65 and older (8.3 per 1,000 population) and the lowest 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, 2011–12



Note: Separations with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded. Source data for this figure are accessible from Table AD.2 (344KB XLS) in the Admitted patient mental health-related care table downloads.

Source: National Hospital Morbidity Database.

Alt text:

Vertical bar chart showing the rate of admitted patient separations without specialised psychiatric care, by sex and age-group for 2011–12. Overall, the rate of separations was higher for females in the following age groups: less than 15, 15–24, 25–34 and 65 and over. For both sexes, the rate of separation was lowest for the under 15 age group (1.4 per 1,000 population for males and 1.5 for females) and peaked in the 65 and over age group (7.7 for males and 8.8 for females). Refer to Table AD.2

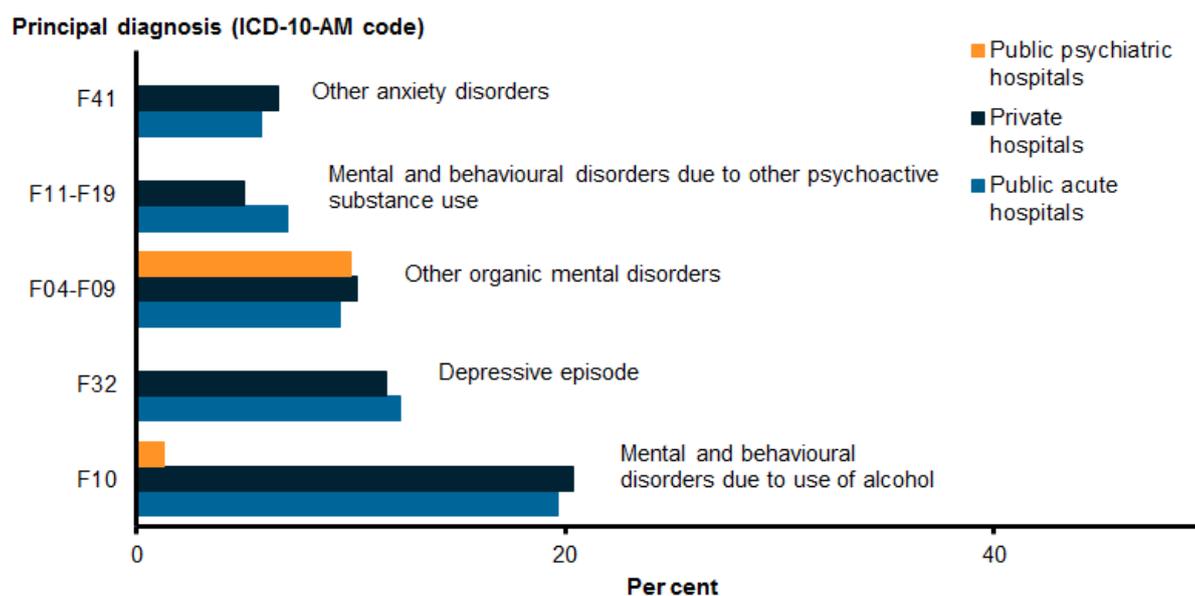
As for separations with specialised psychiatric care, Indigenous Australians are proportionally overrepresented in terms of mental health-related hospitalisations without specialised psychiatric care, accounting for 7.2% of these. Indigenous Australians had a separation rate almost 4 times that of other Australians (14.2 and 3.8 per 1,000 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 2011–12, 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) (19.7%) followed by depressive episode (F32) (12.2%). Almost all separations (91.7%) without specialised psychiatric care occurred in public acute hospitals for the five most frequently reported principal diagnoses (Figure AD.9).

The profile of diagnoses was similar for public acute and private hospitals. Separations from public psychiatric hospitals were only recorded by Tasmania for 2011–12.

Figure AD.9: Admitted patient separations without specialised psychiatric care, by the 5 most frequently reported principal diagnoses, 2011–12



Note: Separations with a care type of Newborn (without qualified days) and records for Hospital boarders and Posthumous organ procurement have been excluded. Source data for this figure are accessible from Table AD.12 (344KB XLS) in the Admitted patient mental health-related care table downloads.

Source: National Hospital Morbidity Database.

Alt text: Horizontal bar chart with % of separations without specialised psychiatric care for the 5 most frequently reported principal diagnoses, by hospital type. Overall, Mental and behavioural disorders due to use of alcohol was the most common principal diagnosis (19.7%). For public psychiatric hospitals other organic mental disorders was the most common (10.0%). Mental and behavioural disorders due to use of alcohol was the most common in private and public acute hospitals (20.3% and 19.6%). Refer to Table AD.12

Procedures

Over half (55.6%) of mental health-related separations without specialised psychiatric care reported at least one procedure in 2011–12. The most frequently reported procedure was allied health intervention, social work (14.5% of procedures), followed by allied health intervention, physiotherapy (12.5%).

Use of restrictive practices during admitted patient care

Health Ministers endorsed the *National safety priorities in mental health: a national plan for reducing harm* (the plan), Australia's first national statement about safety improvement in mental health, in 2005. The plan identified 4 national priority areas for national action including 'reducing use of, and where possible eliminating, restraint and [seclusion](#)' (see [key concepts](#) for definitions).

In line with the plan, the National Mental Health Seclusion and Restraint Project (2007–2009), known as the Beacon Project, was developed as a collaborative initiative to establish demonstration sites as centres of excellence aimed at reducing seclusion and restraint in public mental health facilities. Key to this work has been translating international lessons and initiatives to the Australian environment and the development and implementation of policies, guidelines and staff training based on good practice. Project outcomes were positive, with several Beacon sites reporting significant reductions in the use, and/or duration of seclusion, thus providing the foundation for further change.

To maintain the collaborative approach and momentum from the Beacon Project, states and territories agreed to host ongoing annual National Mental Health Seclusion and Restraint forums. These forums have provided opportunities to showcase initiatives, report on progress, share lessons with external stakeholders and identify areas for further focus.

More recently, the National Mental Health Commission has formed a multi-disciplinary research team and core reference group of experts to examine best practice in reducing, and where possible eliminating, restraint and seclusion. The project scope is broader than the original Beacon Project, extending scrutiny beyond hospitals to the use of restrictive practices in community, custodial and ambulatory settings. Consultation with people with a lived experience and their families, clinicians and people working in services, are considered key to the national project, especially in determining the extent of restrictive practices.

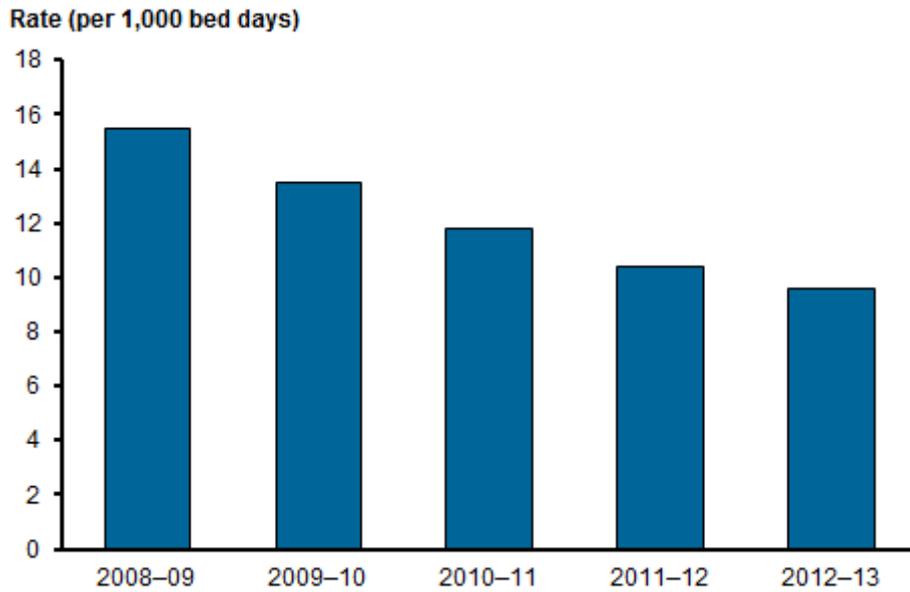
Seclusion

At present there remains no formal, routine nationally agreed data collection and reporting framework for seclusion and restraint, despite these ongoing initiatives. However, 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 for presentation at the national forums and are reported here.

Data from the 2012 national forum were publicly released for the first time in June 2013 under special agreement with data custodians. The Australian Health Ministers' Advisory Council (AHMAC) has since agreed to the annual public release of the ad hoc national and state/territory seclusion data presented at the national forums. Coinciding with the 2013 national forum held in Canberra, the data presented on this website extends the period of available data to 2012–13 and updates historical data. Work is ongoing to investigate jurisdictional capacity to routinely supply seclusion and restraint data in line with agreed national definitions.

Nationally there were 9.6 seclusion events per 1,000 bed days in public acute specialised mental health hospital services in 2012–13 (Figure AD.10). See the [Specialised mental health facilities](#) section for further information about these hospital services. The national seclusion rate has fallen since 2008–09, from 15.5 seclusion events per 1,000 bed days in 2008–09 to 9.6 in 2012–13, representing an average annual reduction of 11.3% over the 5 year period.

Figure AD.10: Rate of seclusion events, public sector acute mental health hospital services, 2008–09 to 2012–13



Source: State and territory governments, unpublished.

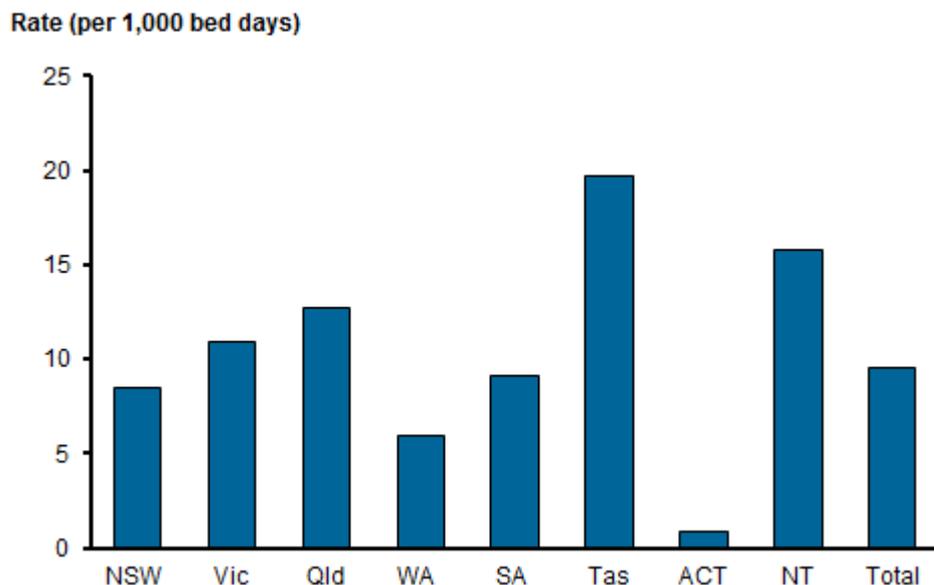
Source data for this figure are accessible from Table AD.16 (344KB XLS) in the Admitted patient mental health-related care table downloads

Alt text:

A vertical bar chart showing that the national rate of seclusion events per 1,000 bed days has progressively decreased over the 5 years from 2008–09 to 2012–13. The highest rate was in 2008–09 (15.5), followed by 2009–10 (13.5), 2010–11 (11.8), 2011–12 (10.4) and 2012–13 (9.6). Refer to Table AD.16

Jurisdictional rates ranged from 0.9 seclusion events per 1,000 bed days in the Australian Capital Territory, to 19.7 in Tasmania in 2012–13 (Figure AD.11).

Figure AD.11: Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2012–13



Note: The increase in the state-wide Tasmanian seclusion rate for 2012-13 data is due to a small number of clients having an above average number of seclusion events.

Source: State and territory governments, unpublished.

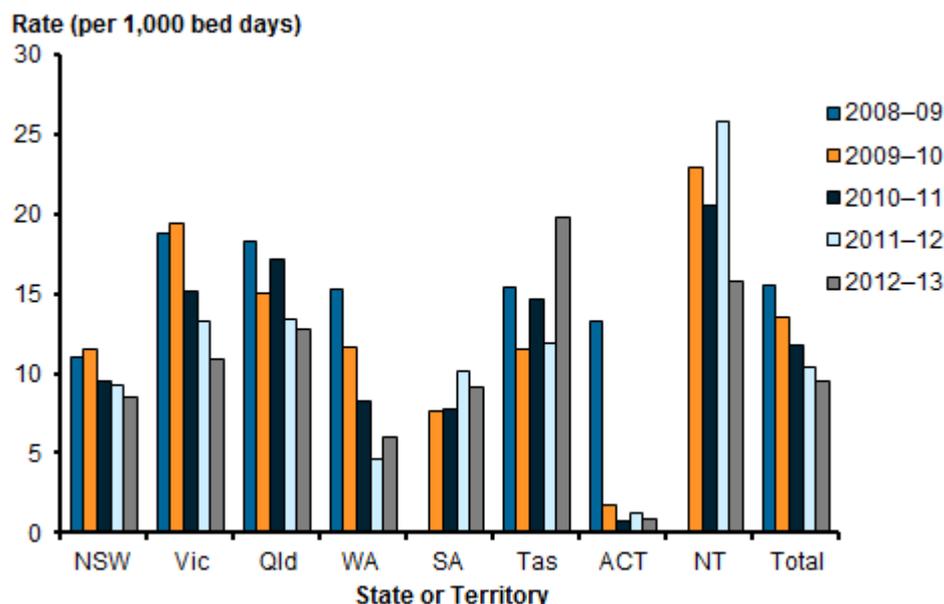
Source data for this figure are accessible from Table AD.16 (344KB XLS) in the Admitted patient mental health-related care table downloads

Alt text:

A vertical bar chart showing the rate of seclusion events per 1,000 bed days for all jurisdictions in 2012–13. Tasmania had the highest rate (19.7), followed by NT (15.8), Qld (12.7), Vic (10.9), SA (9.1), NSW (8.5), WA (6.0) and ACT (0.9). Refer to Table AD.16

Seclusion rates have fallen for most jurisdictions between 2008–09 and 2012–13 (Figure AD.12). The Australian Capital Territory (-49.1%) reported the greatest annual average reduction in seclusion rates over the 5 year period, followed by Western Australia (-21.0%). Tasmania (6.5%) was the only jurisdiction to report an increased seclusion rate, however, the 2012–13 figure was impacted by a small number of clients having a greater than average number of seclusion events. Data were not available for South Australia and the Northern Territory for the 2008–09 collection period. Data for smaller jurisdictions should be interpreted with caution as small changes in the number of seclusion events can have marked impact on the jurisdictional rate. Further jurisdictional-specific information about seclusion is available in the [data source](#) section.

Figure AD.12: Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2008–09 to 2012–13.



n.a. Not available (blank).

Note: The increase in the state-wide Tasmanian seclusion rate for 2012–13 data is due to a small number of clients having an above average number of seclusion events.

Source: State and territory governments, unpublished.

Source data for this figure are accessible from Table AD.16 (344KB XLS) in the Admitted patient mental health-related care table downloads

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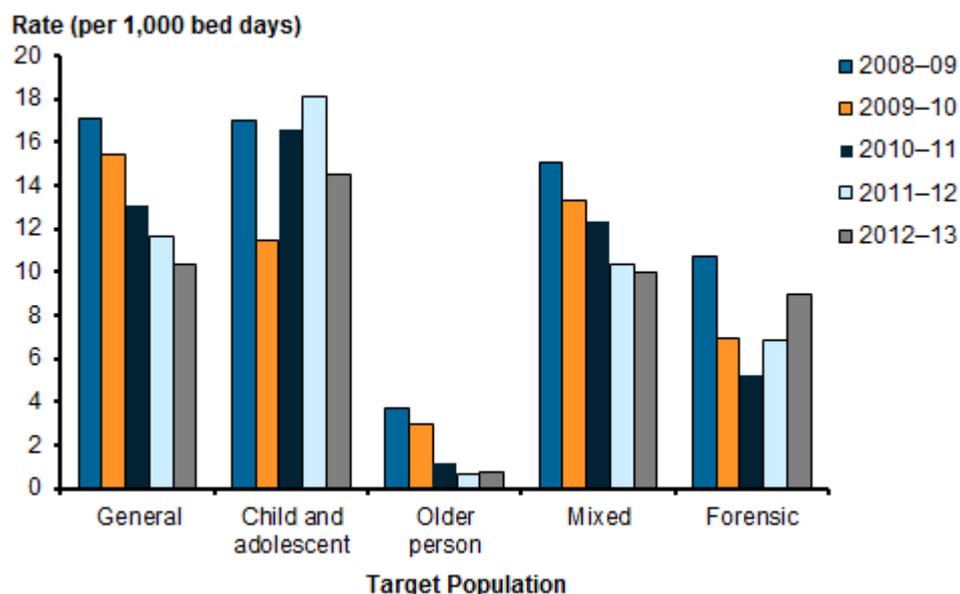
A clustered bar chart showing the seclusion rate per 1,000 bed days for all jurisdictions over the 5 years from 2008–09 to 2012–13. The majority of jurisdictions show a decreasing rate of seclusion events from 2008–09 to 2012–13; NSW (11.0 to 8.5), Vic (18.8 to 10.9), Qld (18.2 to 12.7), WA (15.3 to 6.0) and ACT (13.3 to 0.9). Both SA and NT have data available from 2009–10 to 2012–13; NT shows a decrease in the rate of seclusion events per 1,000 bed days (22.9 to 15.8), while SA shows an increase (7.6 to 9.1). The rate also increased in Tas from 2008–09 (15.4) to 2012–13 (19.7). Refer to Table AD.16.

Seclusion data can also be presented by the [target population](#) of the acute specialised mental health hospital service where the seclusion event occurred. Nationally, child and adolescent units had a higher rate of seclusion events (14.5 per 1,000 bed days) compared with general units (10.3) in 2012–13 (Figure AD.13). However, it is important to note that many child and adolescent services are included in the mixed category, which can refer to any combination of older person, forensic, general, youth and child and adolescent services. Work is currently underway to improve the data collection methodology to enable these services to

be separately identified, removing the mixed category, thus improving data for the various target population categories.

There was a decline in seclusion rates across all target population categories between 2008–09 and 2012–13. General (-11.8%) and mixed (-9.8%) services had similar average annual reductions in seclusion rates over the 5 year period. Seclusion rates in older person services (-33.2%) also decreased. Although a reduction in seclusion rates was observed for Forensic (-4.6%) and Child and adolescent (-3.9) services, some variability was observed over time.

Figure AD.13: Rate of seclusion events, public sector acute mental health hospital services, by target population, 2008–09 to 2012–13



Source: State and territory governments, unpublished.

Source data for this figure are accessible from Table AD.17 (344KB XLS) in the Admitted patient mental health-related care table downloads

Alt text:

A clustered bar chart showing a decreasing rate of seclusion events per 1,000 bed days for all target populations from 2008–09 to 2012–13; General (17.1 to 10.3), Child and adolescent (17.0 to 14.5), Older person (3.7 to 0.7), Mixed (15.1 to 10.0) and Forensic (10.8 to 8.9). Refer to Table AD.17.

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 2011–12 at the following link. <http://meteor.aihw.gov.au/content/index.phtml/itemId/529483>.

Further information on admitted patient care for the 2011–12 reporting period can be found in the Australian hospital statistics 2011–12 report <http://www.aihw.gov.au/publication-detail/?id=60129543133> (AIHW 2013). The 2011–12 collection contains data for hospital separations that occurred between 1 July 2011 and 30 June 2012. Admitted patient stays that began before 1 July 2011 are included if the separation date fell within the collection period (2011–12). 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.

Reference

AIHW 2013. Australian Institute of Health and Welfare 2013. Australian hospital statistics 2011–12. Health Services Series no. 50. Cat. no. HSE 134. 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.
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>
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>
Specialised psychiatric care	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.
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</p>

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.

General provides services to the adult population, aged 18 to 64; however, these services may also provide assistance to children, adolescents or older people.

Youth services target children and young people generally aged 16–24.

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 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](#)).
