

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 where health care workers may not be specifically trained to care for the mentally ill, such as a drug and alcohol treatment unit. 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 2016-17 tables

PDF – Same day admitted mental health-related care 2016-17 section

Data coverage includes the time period 2012–13 to 2016–17. This section was last updated in October 2018.

Key points

- In 2016–17, there were 64,692 same day admitted mental health-related separations from public hospitals of which 34.3% included specialised psychiatric care.
- About 1 in 5 (20.7%) of same day admitted mental health-related separations with specialised psychiatric care in public hospitals in 2016–17 were involuntary admissions.
- About a quarter (23.0%) of same day, admitted mental health-related separations with specialised psychiatric care in public hospitals had a principal diagnosis of *Depressive episode*.
- Just over 19,200 patients received same day admitted mental health care from private hospitals.
- About 255,800 days of same day care were provided by private hospitals.

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.

There were a total of 3.5 million same day separations from public acute and public psychiatric hospitals in 2016–17. There were 64,692 same day admitted mental health-related separations in 2016–17, accounting for 1 in 50 (1.8%) of all same day public hospital separations. Of these, 22,182 (34.3%) separations involved specialised psychiatric care and 42,510 (65.7%) did not.

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.

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 2016–17, there were 22,182 same day public admitted mental health-related separations with specialised psychiatric care; equivalent to a national rate of 9.1 per 10,000 population.

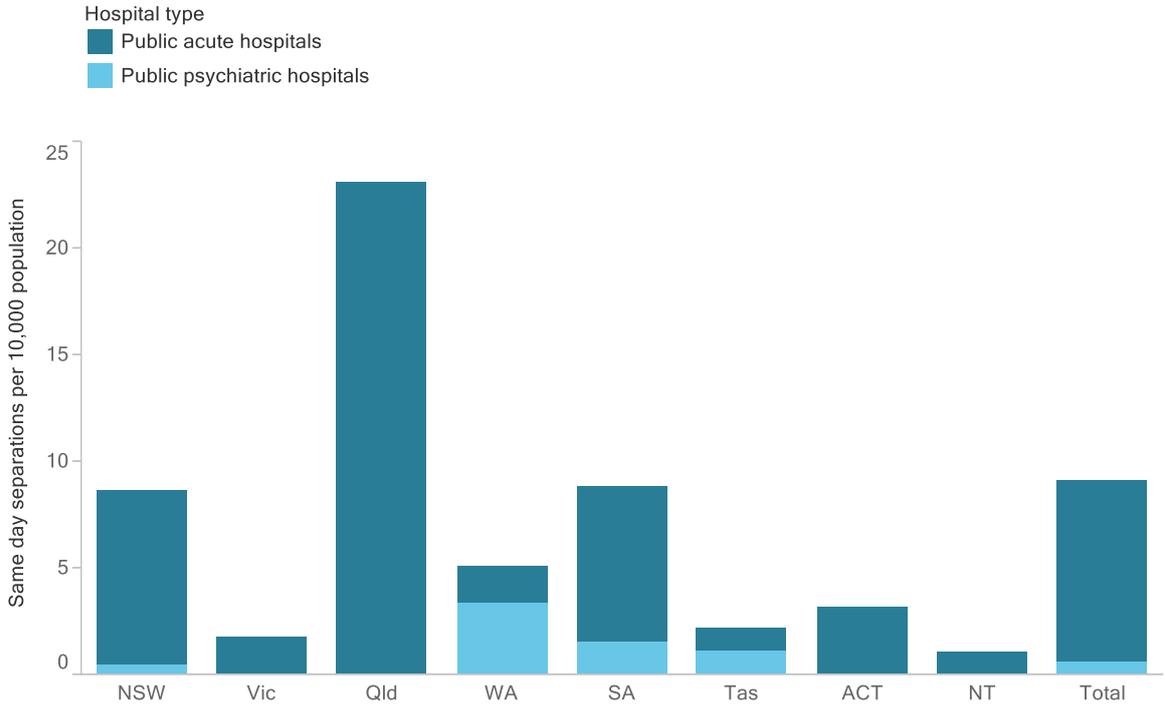
The rate of same day public mental health-related separations with specialised psychiatric care in 2016–17 was highest for Queensland (23.0 per 10,000 population) and lowest for the Northern Territory (1.1) (Figure SD.1).

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 2016–17, more than three-quarters (79.0%) of same day public mental health-related separations with specialised psychiatric care were public patients (e.g. the health service budget or reciprocal health care agreement). This ranged from 99.3% for the South Australia to 49.0% for New South Wales.

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 to. In 2016–17, the most common mode of separation for

same day public mental health-related separations was discharge to 'home' (89.5%), which includes discharge to usual residence/own accommodation/welfare institution (including prisons, hostels and group homes providing primarily welfare services). For public hospitals, this ranged from 93.5% for Queensland to 51.2% for Western Australia

Figure SD.1: Same day public admitted mental health-related separations with specialised psychiatric care, state and territory, by hospital type, 2016-17



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

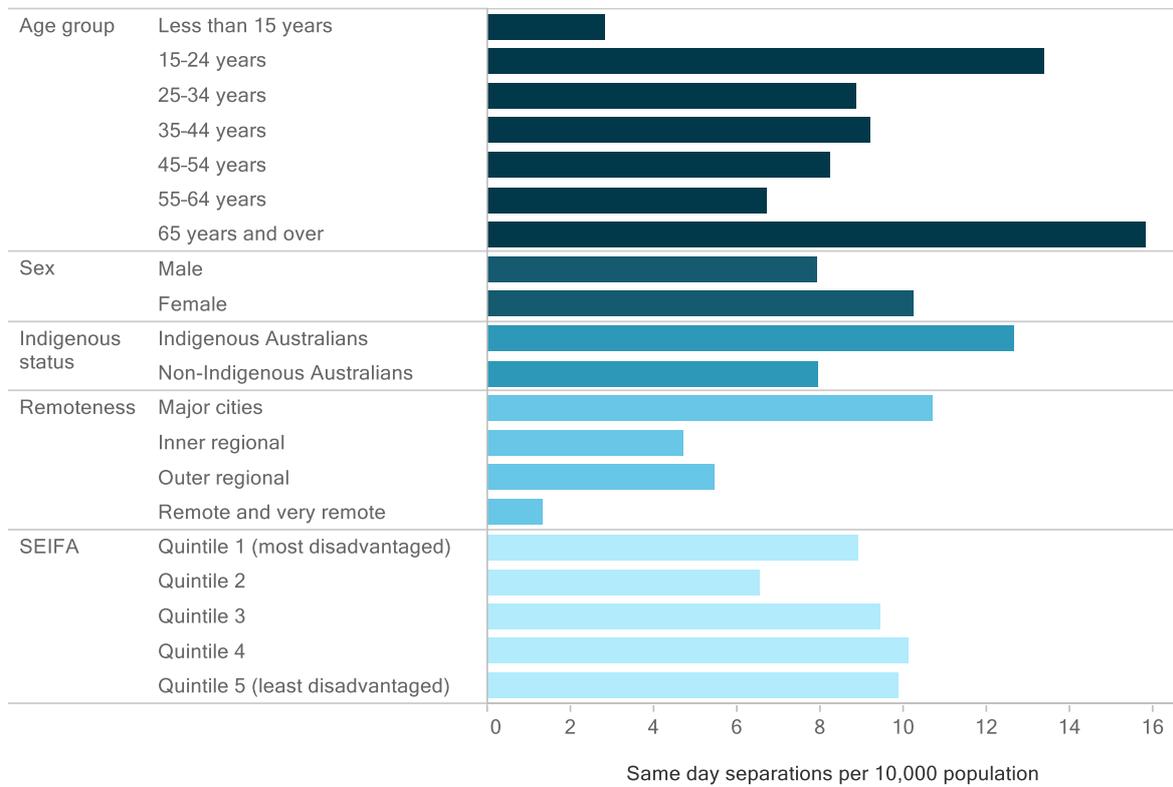
Source: National Hospital Morbidity Database.

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

Patient demographics

In 2016–17, the rate of same day public admitted mental health-related separations with specialised psychiatric care was highest for patients aged 65 years and older and lowest for those aged less than 15 (15.8 and 2.8 per 10,000 population respectively) (Figure SD.2). Overall, the separation rate was higher for females than males (10.3 and 7.9 per 10,000 population respectively).

Figure SD.2: Same day public admitted mental health-related separations with specialised psychiatric care, by demographics, 2016-17



Source: National Hospital Morbidity Database.

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

Aboriginal and Torres Strait Islander people had a rate of same day public mental health-related separations with specialised psychiatric care that was nearly double that of other Australians (12.6 and 8.0 per 10,000 population respectively).

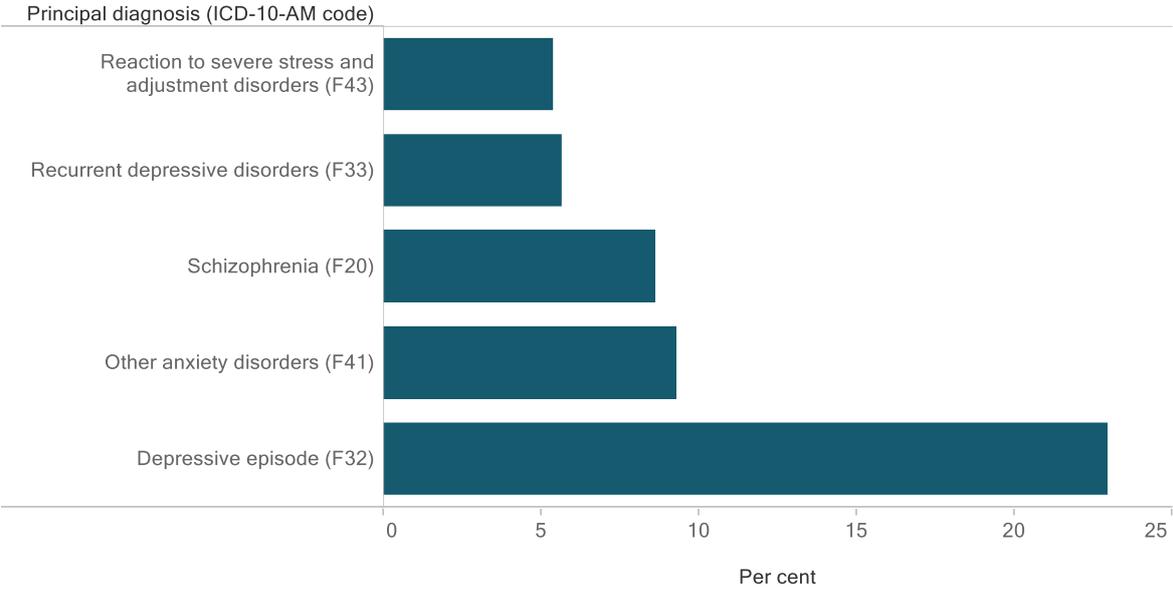
Those patients living in *Major cities* (10.7 per 10,000 population) had the highest rate of same day public mental health-related separations with specialised psychiatric care in 2016–17 whilst those living in *Remote and Very remote* areas (1.3 per 10,000 population) had the lowest.

In 2016–17, the highest rate of same day public mental health-related separations with specialised psychiatric care was for those patients living in the second least disadvantaged socioeconomic quintile (10.1 per 10,000 population) and the lowest rate was for those living in the second most disadvantaged quintile (6.5).

Principal diagnosis

The most frequently reported [principal diagnosis](#) in 2016–17 for same day public mental health-related separations with specialised psychiatric care was *Depressive episode* (ICD-10-AM code: F32) (23.0%), followed by *Other anxiety disorders* (F41) (9.3%) and *Schizophrenia* (F20) (8.6%).

Figure SD.3: Same day public admitted mental health-related separations with specialised psychiatric care (per cent), the 5 most frequently reported principal diagnoses, 2016-17



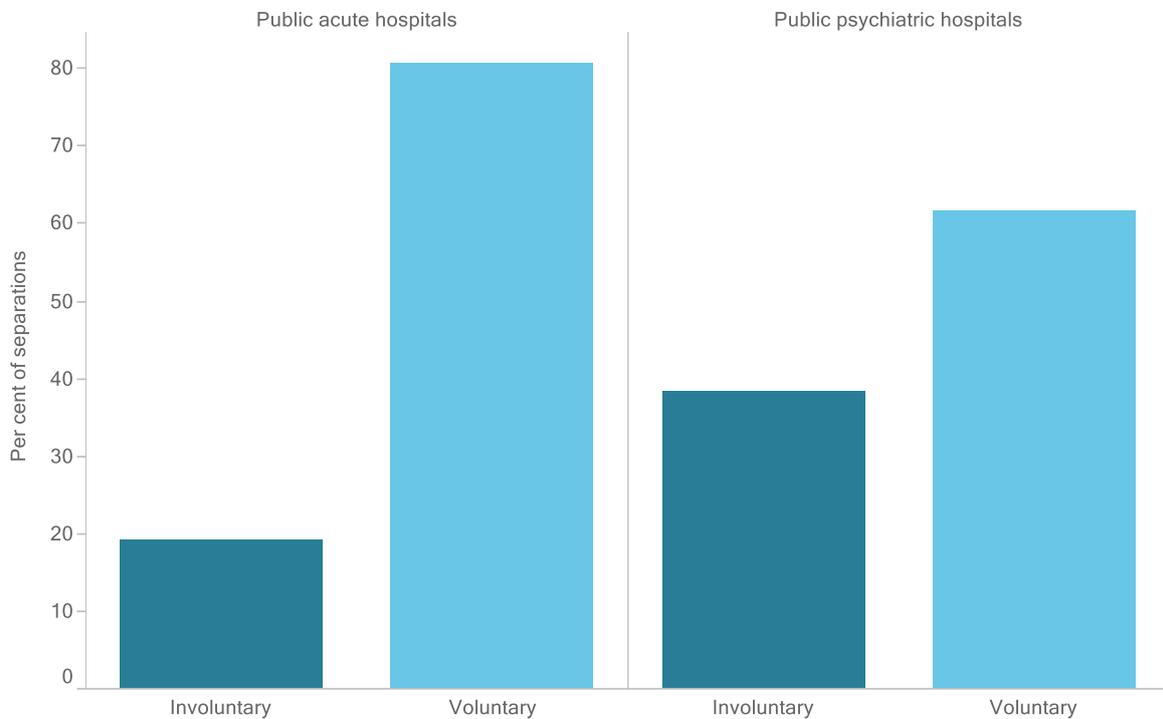
Source: National Hospital Morbidity Database.

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 2016–17, there were 4,550 same day public mental health-related separations with specialised psychiatric care where the mental health legal status was ‘involuntary’— representing roughly a fifth (20.7%) of all same day public mental health-related separations with specialised psychiatric care. The majority of these (3,940 or 86.6%) occurred in public acute hospitals.

Involuntary separations accounted for 19.3% and 38.4% of same day separations with specialised psychiatric care in public acute hospital and public psychiatric hospitals respectively.

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, 2016-17



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

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 anaesthesia* (both 23.4%). *Cerebral anaesthesia* is a form of general anaesthesia 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 next most frequently reported procedure block was *Generalised allied health interventions*, which was recorded for 1 in 14 (6.9%) of these separations. Of these allied health interventions, procedures provided by *Social work* were the most common (38.3%

of allied health interventions), followed by *Psychology* (23.1%) and *Occupational therapy* (16.1%).

Non-specialised admitted patient mental health care

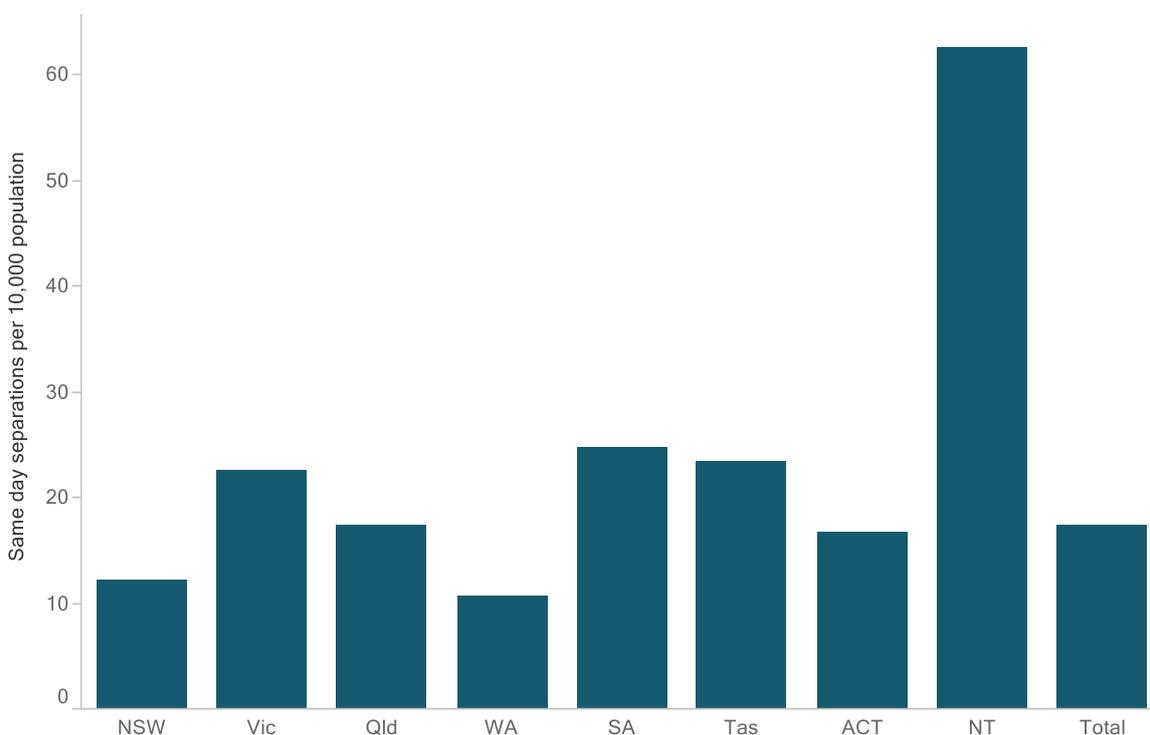
Service provision

Non-specialised admitted patient mental health care takes place outside of a designated psychiatric unit, as mentioned earlier, 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 usually combined in this section as there were very few separations without specialised psychiatric care in public psychiatric hospitals in 2016–17.

States and territories

In 2016–17, the national rate of same day public mental health-related separations without specialised psychiatric care was 17.4 per 10,000 population. The Northern Territory had the highest rate (62.6 per 10,000 population) while Western Australia had the lowest (10.7) (Figure SD.5).

Figure SD.5: Same day public admitted mental health-related separations without specialised psychiatric care, states and territories, 2016-17



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

Source: National Hospital Morbidity Database.

Source data: Same day public admitted mental health-related care Table SD.12 (685KB XLS).

For public hospitals in 2016–17, the majority (93.8%) of same day public mental health-related separations without specialised psychiatric care had a funding source of Public patients (e.g. the health service budget or reciprocal health care agreement). This ranged from 98.4% for South Australia to 90.2% for New South Wales.

In 2016–17 the most common mode of separation for same day public mental health-related separations without specialised psychiatric care was discharge to ‘home’ (73.9%), which includes discharge to usual residence/own accommodation/welfare institution (including prisons, hostels and group homes providing primarily welfare services), followed by separation to an(other) acute hospital (15.4%). This ranged from 94.8% for Tasmania to 61.8% for New South Wales.

Patient demographics

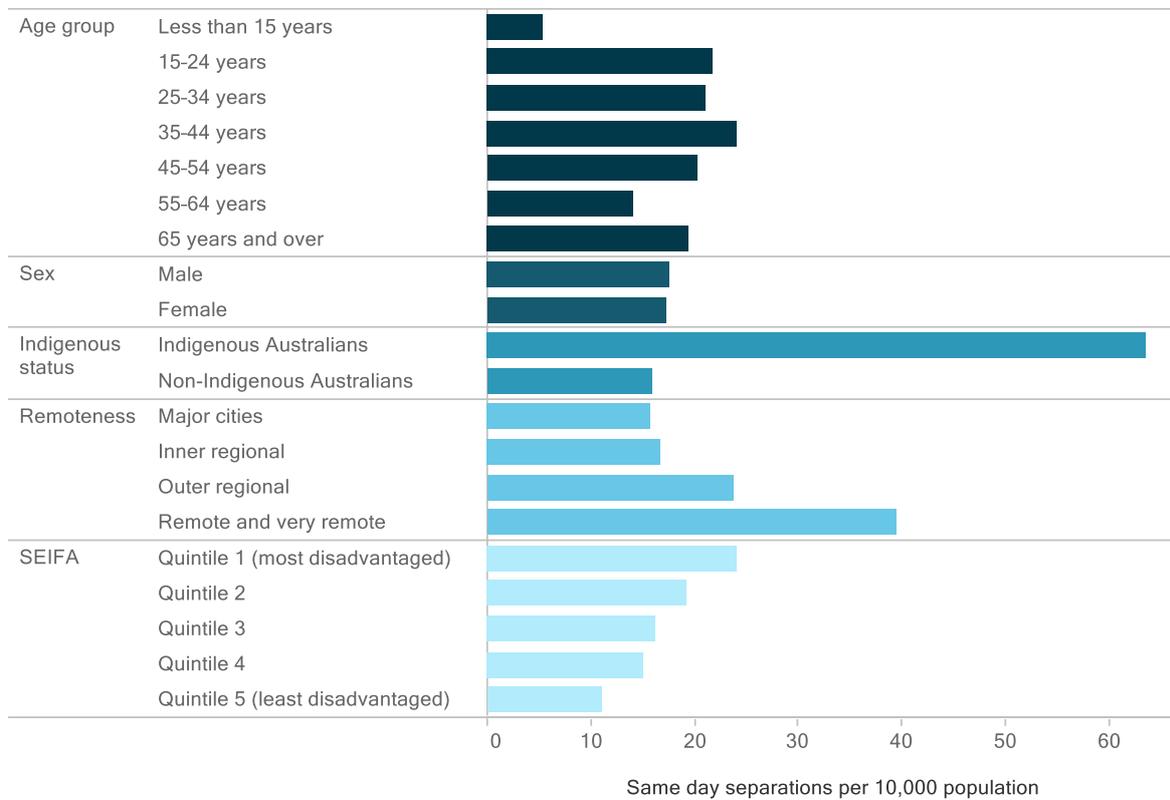
In 2016–17, the highest rate of same day public mental health-related separations without specialised psychiatric care was for patients aged 35 to 44 years (24.0 per 10,000 population) and the lowest for those aged under 15 (5.4 per 10,000 population) (Figure SD.6). The separation rate was slightly higher for males than females (17.6 and 17.2 per 10,000 population respectively).

Aboriginal and Torres Strait Islander people had a rate of same day public mental health-related separations without specialised psychiatric care that was four times that of other Australians (63.5 and 15.9 per 10,000 population respectively).

The highest rate of same day public mental health-related separations without specialised psychiatric care in 2016–17 was for those living in *Remote and Very remote* areas (39.4 per 10,000 population) and the lowest for those in *Major cities* (15.8 per 10,000 population).

In 2016–17, the highest rate for same day public mental health-related separations without specialised psychiatric care was for those living in the most disadvantaged areas (socioeconomic quintile 1) (24.0 per 10,000 population) and the lowest rate was seen for those living in the least disadvantaged quintile (11.1).

Figure SD.6: Same day public admitted mental health-related separations without specialised psychiatric care, by demographics, 2016-17



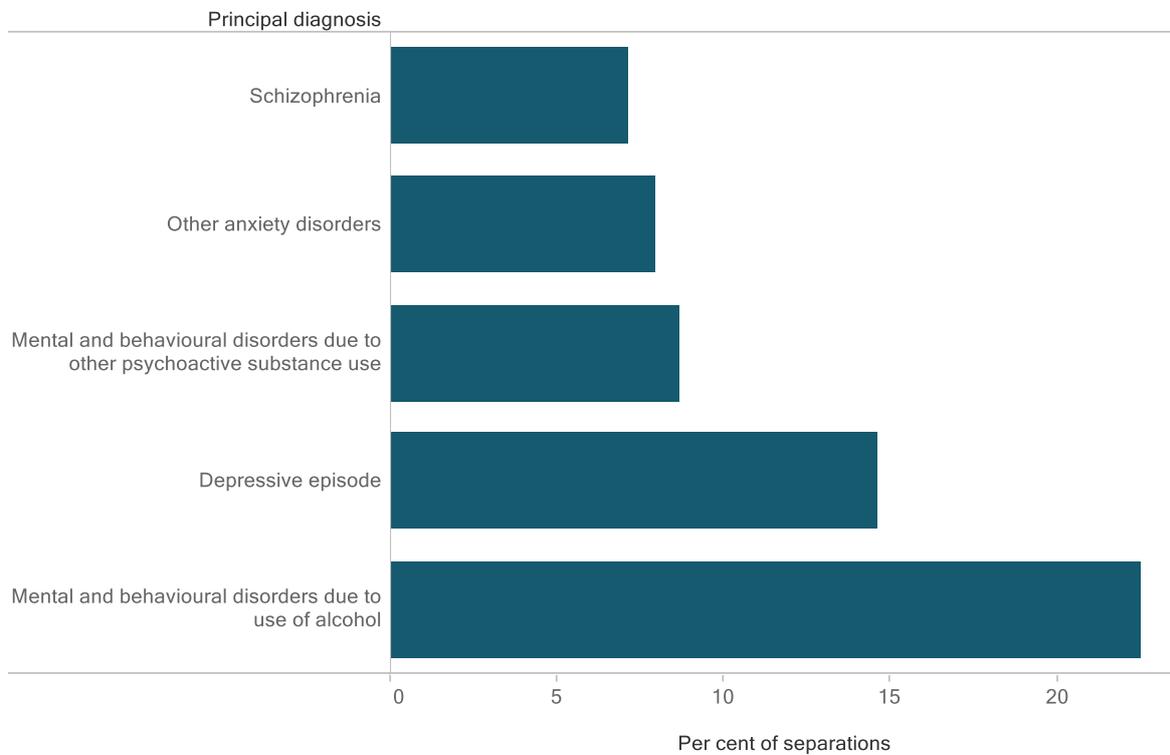
Source: National Hospital Morbidity Database.

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

Principal diagnosis

In 2016–17, 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) (22.5%), followed by *Depressive episode* (F32) (14.6%) (Figure SD.7).

Figure SD.7: Proportion of same day public admitted mental health-related separations without specialised psychiatric care, for 5 commonly reported principal diagnoses, 2016-17



Source: National Hospital Morbidity Database; Table SD.14.

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

Procedures

The most frequently reported procedure block for same day public mental health-related separations without specialised psychiatric care was Cerebral anesthesia (22.6% of separations) followed by Electroconvulsive therapy (21.3%). 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 next most frequently reported procedure block was Generalised allied health interventions, which was recorded for 1 in 16 (6.8%) of these separations. Of these allied health interventions, Social work procedures were the most common (49.5% of allied health interventions), followed by Physiotherapy (12.7%) and Occupational therapy (10.3%).

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 2018) (visit 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.

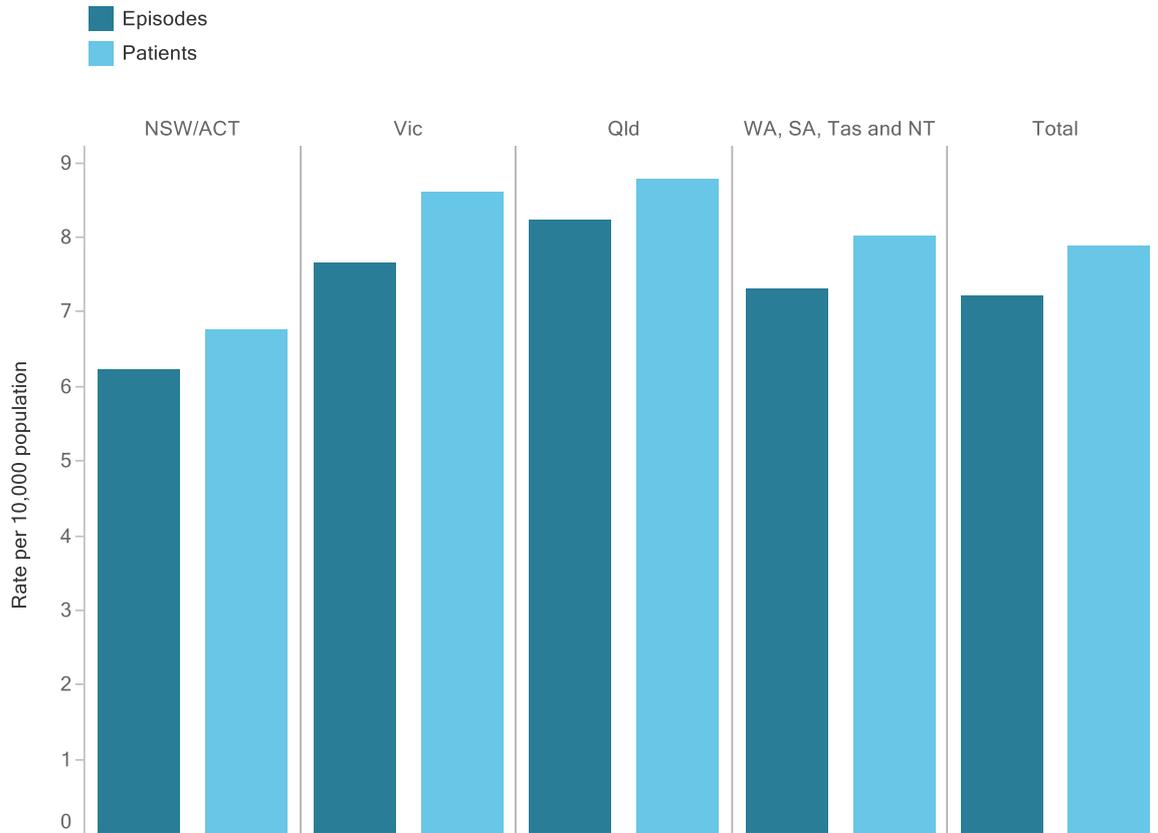
States and territories

In 2016–17, 19,248 patients received 255,760 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 7.9 patients per 10,000 population and 104.9 care days per 10,000 population.

The rates of patients per 10,000 population ranged from 6.7 in the combined New South Wales/Australian Capital Territory to 8.8 in Queensland in 2016–17. (Figure SD.8).

There were 17,603 [clinically substantive episodes](#) of care provided in 2016–17, ranging from 3,687 in the combined Western Australia/South Australia/Tasmania/Northern Territory to 5,116 in the combined New South Wales/Australian Capital Territory. The rate of episodes per 10,000 population ranged from 6.2 in the combined New South Wales/Australian Capital Territory to 8.2 in Queensland. (Figure SD.8).

Figure SD.8: Patients and episodes of care for same day private admitted mental health care, states and territories, 2016-17



Source: PPHDRAS, 2018.

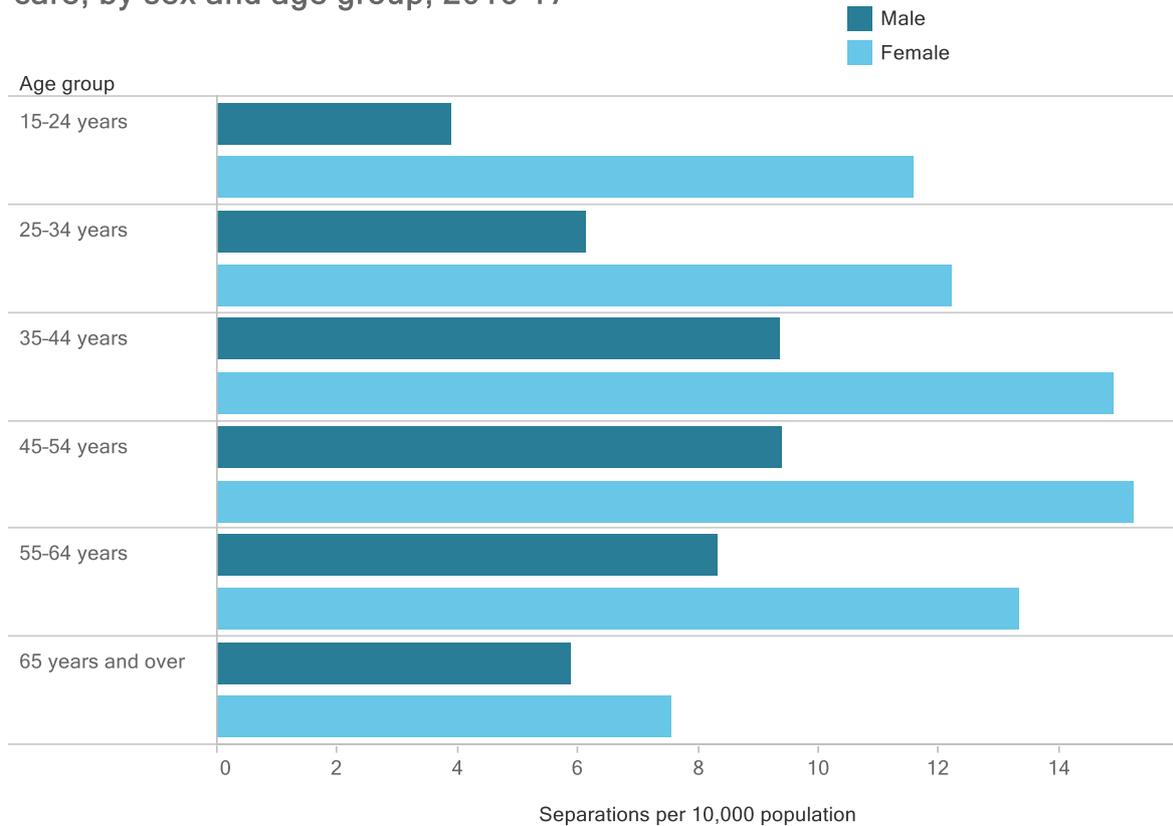
Source data: Same day admitted mental health care Table SD.20 (685KB XLS).

Patient demographics

In 2016–17, the rate of patients receiving same day admitted private mental health care was highest for people aged 45–54 (12.4 per 10,000 population) (Figure SD.9). Patients aged under 15 were least likely to receive private hospital same day care, with the rate increasing gradually until the age of 45–54 after which the rate decreased by age group.

Almost two-thirds (64.2%) of patients receiving same day admitted private mental health care were female. The rate of female patients was more than one and a half times the rate of males (10.0 patients per 10,000 population and 5.7, respectively). The highest patient rate for males was for the 35–44 and 45–54 age groups (9.4 patients per 10,000 population), while the highest patient rate for females was for the 45–54 age group (15.2).

Figure SD.9: Patients receiving same day private admitted mental health care, by sex and age group, 2016-17



Source: Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service, 2018; Table SD.21.

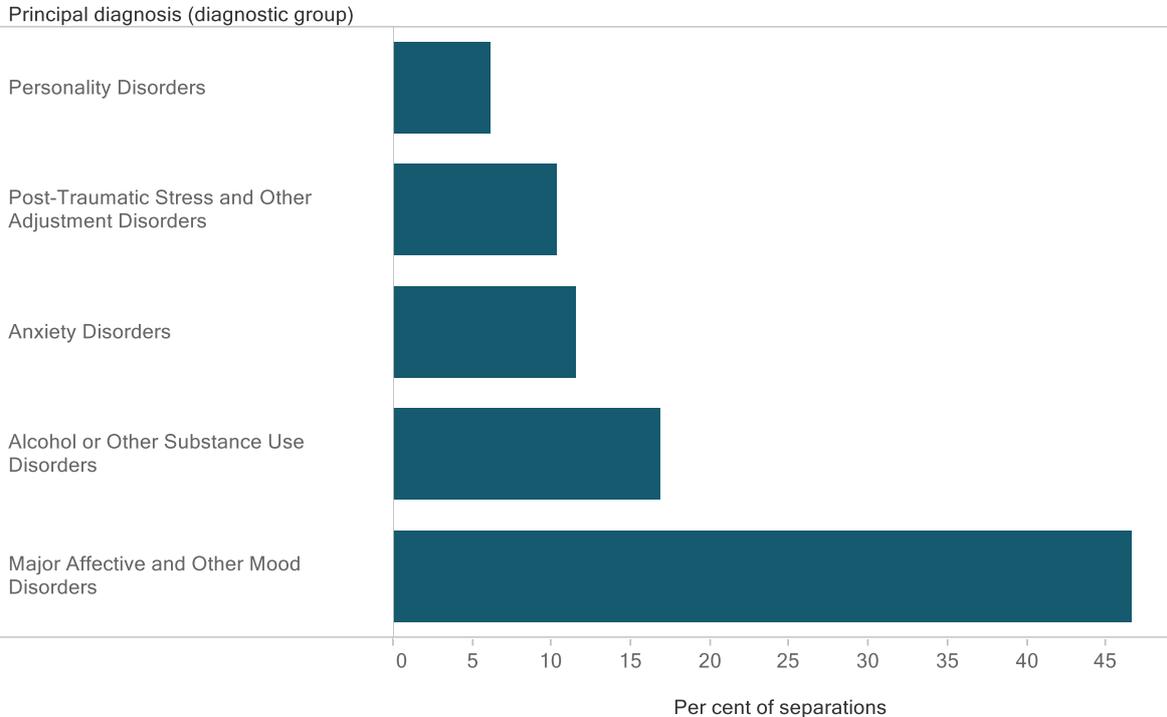
Source data: Same day admitted mental health care Table SD.21 (685KB XLS).

In 2016–17, the majority of patients (86.0%) receiving same day private admitted mental health care would normally reside in urban areas.

Principal diagnosis

In 2016–17, almost half (46.6%) of clinically significant episodes of care were provided to patients with a *Major affective and other mood disorders* mental health [diagnostic group](#), followed by *Alcohol and other substance use disorders* (16.8%) and *Anxiety disorders* (11.5%) (Figure SD.10).

Figure SD.10: Proportion of same day private admitted mental health care episodes, for the 5 most commonly reported mental health diagnostic groups, 2016-17



Source: Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service, 2018; Table SD.22.

Source data: Same day admitted mental health care Table SD.22 (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 2016–17](#).

Further information on admitted patient care for the 2016–17 reporting period can be found in the report *Admitted patient care 2016-17: Australian hospital statistics* (AIHW 2018). The 2016–17 collection contains data for hospital separations that occurred between 1 July 2016 and 30 June 2017. Admitted patient episodes of care/separations that began before 1 July 2016 are included if the separation date fell within the collection period (2016–17). 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. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM 9th edition) (ACCD 2015). Further information on this is included in the [technical information](#) section.

Procedures are classified according to the *Australian Classification of Health Interventions, 9th 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 2016–17, 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 where 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 2018. Admitted patient care: Australian hospital statistics 2016–17:. Cat. No. HSE 201. Canberra: AIHW.

Australian Private Hospitals Association (2018) Private Hospital-based Psychiatric Services 1 July 2016 to 30 June 2017. Canberra: APHA.

ACCD (Australian Consortium for Classification Development) 2015. 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), 9th edn. Sydney: University of Sydney.

Key Concepts

Key Concept	Description
Diagnostic group	The classification of diagnostic groups 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: <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 (visit 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	The definition of same day admitted mental health care is slightly different between the two data sources.

<p>care</p>	<p>A separation for Public hospitals is classified as same day admitted mental health care if the following apply:</p> <ul style="list-style-type: none"> • the separation was a same day separation (that is, admission and separation occurred on the same day), <p>An admission for Private hospitals is classified as same day admitted mental health care based on data reported as 'Same day episode' including:</p> <ul style="list-style-type: none"> • 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.
<p>Separation</p>	<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.</p>
<p>Specialised psychiatric care</p>	<p>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.</p>
<p>Without specialised psychiatric care</p>	<p>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</p>

	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 (visit the technical information).
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