Admitted patient mental health-related care

People with mental health problems may require admission to hospital from time to time. Such people in hospitals can receive specialised psychiatric care in a psychiatric hospital or in a psychiatric unit within a hospital. People with mental health problems can also be admitted to other areas where health care workers are not specifically trained to care for the mentally ill. Under these circumstances, the admissions to hospitals are classified as without specialised psychiatric care.

This section presents information on admitted patient mental health-related separations in Australia. 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 (APC NMDS). The information describes separations, it is possible for individuals to have multiple separations. For further information see the data source section.

Key points

- There were 249,672 mental health-related separations in both public and private hospitals in 2013–14. 152,458 (61%) of separations were provided with specialised psychiatric care.
- Involuntary admissions accounted for 29% of mental health-related separations with specialised psychiatric care.
- The largest number and highest rate of mental health-related separations with specialised psychiatric care were for patients aged 35–44 (33,005 or 10.3 per 1,000 population).
- Depressive episode and schizophrenia were the most commonly reported principal diagnoses for separations with specialised psychiatric care (18% and 14% respectively).
- Mental and behavioural disorders due to use of alcohol and depressive episode were the most commonly reported principal diagnoses for separations without specialised psychiatric care (19% and 12% respectively).
- After adjusting for different age structures, Indigenous Australians had a mental health-related separation rate without specialised psychiatric care that was more than 3 times that of other Australians (12 and 3.8 per 1,000 population respectively). A similar pattern can be seen in the rate of mental health-related separation with specialised care, at double the non-Indigenous rate (12 and 6.3 per 1,000 population respectively).
- Generalised allied health interventions was the most commonly reported procedure block for separations both with and without specialised psychiatric care (43% and 37% respectively).
- National seclusion rates have fallen from 11.8 events per 1,000 bed days in 2010–11 to 7.8 in 2014–15.
- The average duration per seclusion event was 5.4 hours in 2014–15.

Overview

A total of 9.7 million separations were reported from public acute, public psychiatric and private hospitals in 2013–14 (AIHW 2015). There were 249,672 mental health-related separations (as above) in 2013–14, accounting for 3% of all hospital separations. Of these, 152,458 (61%) had specialised psychiatric care and 97,214 (39%) did not have specialised psychiatric care. In the 5 years from 2009-10 to 2013–14, there was an average annual rate of increase for all admitted mental health-related separations of 2.9%. The majority of mental health-related separations occurred in public hospitals (73%), followed by private hospitals (23%) and public psychiatric hospitals (4%).

Reference

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

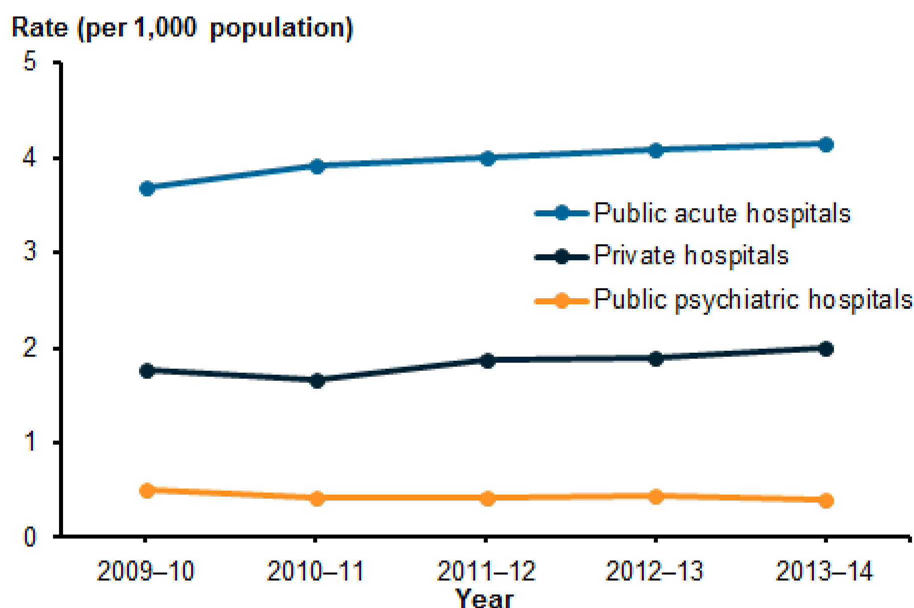
Specialised admitted patient mental health care service provision

Specialised admitted patient mental health care is care that takes place within a designated psychiatric 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 disorder. It is also known as specialised psychiatric care.

Trends

Between 2009–10 and 2013–14, there was an overall average annual increase of 2.4% in the rate of separations with specialised psychiatric care (all hospital types combined). The rate of separations with specialised psychiatric care increased for public acute hospitals and private hospitals, while the rate for public psychiatric hospital separations remained stable (Figure AD.1).

Figure AD.1: Admitted patient mental health-related separations with specialised psychiatric care, by hospital type, 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.

Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.4 (1.24MB XLS).

By states and territories

In 2013–14, there were 152,458 mental health-related separations with specialised psychiatric care, a national rate of 6.5 per 1,000 population.

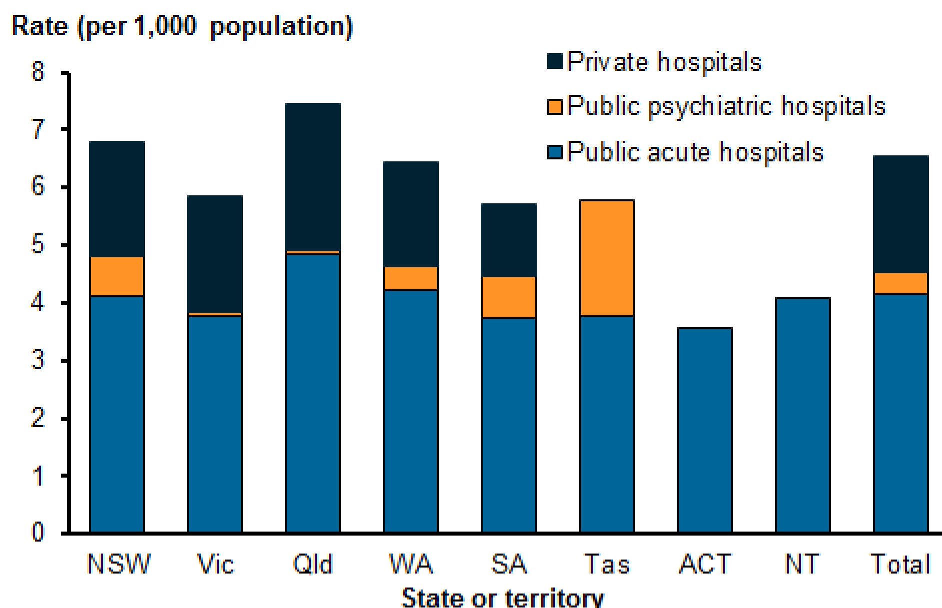
In all states and territories, the mental health-related separation rate with specialised psychiatric care was higher for public acute hospitals than for the other hospital types (Private hospital figures for Tasmania, the Australian Capital Territory and the Northern Territory are not published for confidentiality reasons although they are included in the national total). Of the eight jurisdictions, Queensland had the highest rate of public

acute hospital separations (4.8 per 1,000 population) and the Australian Capital Territory had the lowest rate (3.6) (Figure AD.2).

The rate of mental health-related separations in public psychiatric hospitals was the highest for Tasmania (2.0 per 1,000 population) and the lowest for Victoria and Queensland (both 0.1). The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.

Among the jurisdictions for which the private hospital figures are published, the rate of mental health-related separations in private hospitals was the highest for Queensland (2.5 per 1,000 population) and the lowest for South Australia (1.2).

Figure AD.2: Separations with specialised psychiatric care, state and territory, by hospital type, 2013–14



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 Admitted patient mental health-related care Table AD.3 (1.24MB XLS).

For public acute hospitals, there were 67 patient days per 1,000 population for mental health-related separations in 2013–14. New South Wales had the highest rate of public acute hospital patient days (77 per 1,000 population) and the Northern Territory the lowest (45). For public psychiatric hospitals, the patient days varied from 46 patient days per 1,000 population in Tasmania to 9.2 days in Victoria. Queensland reported the highest rate of patient days in private hospitals (39 per 1,000 population).

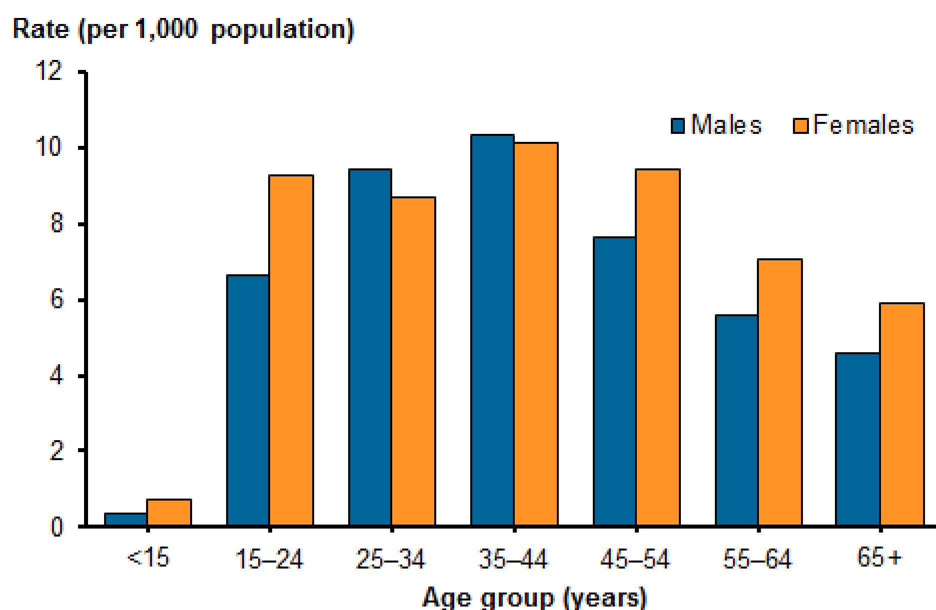
In 2013–14, the national average length of stay for public acute hospitals was 16 days. New South Wales had the longest average length of stay and the Northern Territory the shortest (19 and 11 days respectively). The greatest variation in average length of stay was for public psychiatric hospitals with Queensland reporting 402 days and Tasmania 23 days.

Specialised admitted mental health care patient characteristics

Patient demographics

In 2013–14, 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 (10 and 0.5 per 1,000 population respectively) (Figure AD.3). Overall, the separation rate was higher for females than males (7.0 and 6.1 per 1,000 population respectively).

Figure AD.3: Admitted patient separation with specialised psychiatric care rates, 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.

Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.2 (1.24MB XLS).

After adjusting for different age structures, Aboriginal and Torres Strait Islander people had a mental health-related separation rate with specialised psychiatric care that was almost double that of other Australians (12 and 6.3 per 1,000 population respectively). Indigenous Australians were overrepresented in mental health-related separations with specialised psychiatric care, accounting for 4.8% of such separations in 2013–14; by comparison, they comprised 3.0% of the Australian population in 2013 (ABS 2013).

The highest rate of separations in 2013–14 was for those living in *Major cities* (6.7 per 1,000 population) and the lowest for those in *Remote and very remote* areas (3.4 per 1,000 population).

Reference

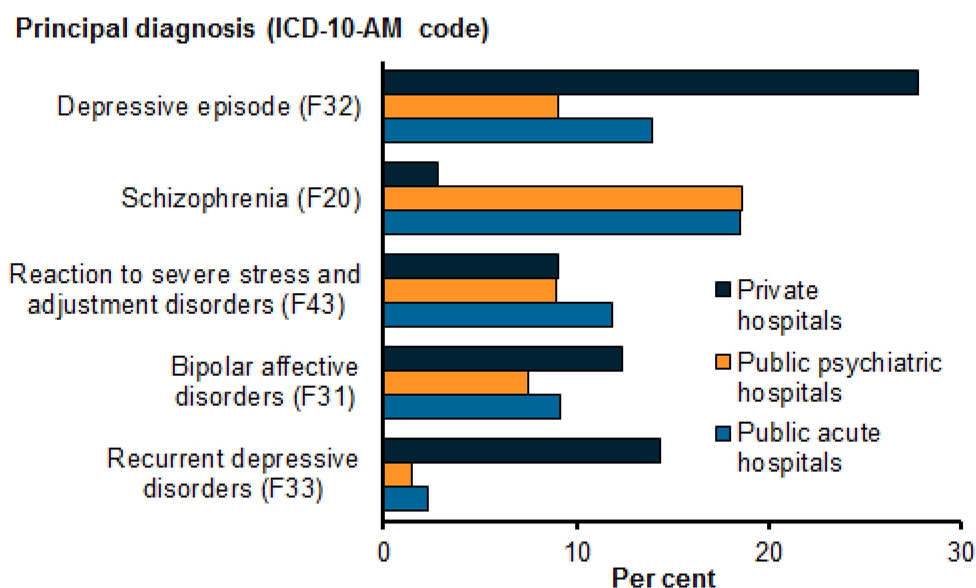
ABS 2013. Australian Bureau of Statistics. Australian demographic statistics, Jun 2013. Cat. no. 3101.0. Canberra: ABS.

Principal diagnosis

When considering all hospital types together, the most frequently reported principal diagnosis for a separation with specialised psychiatric care was depressive episode (ICD-10-AM code: F32), followed by schizophrenia (F20) and reaction to severe stress and adjustment disorders (F43) (18%, 14% and 11% respectively).

The profile of diagnoses varied with hospital type. For example, about 1 in 4 (28%) separations with specialised psychiatric care in private hospitals had a principal diagnosis of depressive episode (F32), compared with 14% and 9% for public acute and public psychiatric hospitals respectively (Figure AD.4). About 1 in 5 separations in public acute hospitals and public psychiatric hospitals had a principal diagnosis of schizophrenia (F20) (both 19%), compared with less than 1 in 20 for private hospitals (2.8%).

Figure AD.4: Admitted patient separations with specialised psychiatric care, the 5 most frequently reported principal diagnoses, by hospital type, 2013–14 (per cent of separations for hospital type)



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

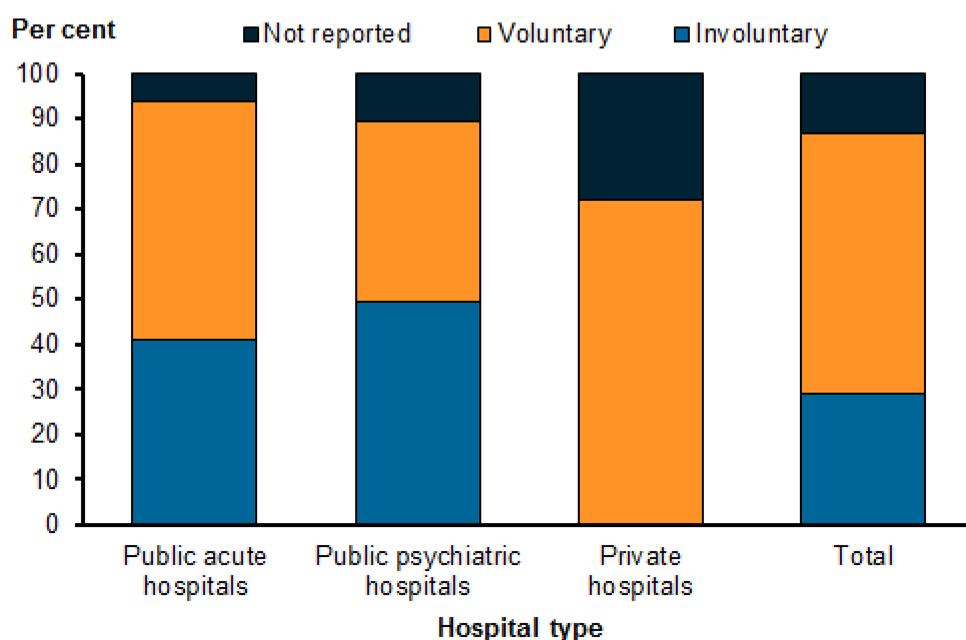
Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.7 (1.24MB XLS).

Mental health legal status

Mental health legal status refers to whether or not a person was treated in hospital on an involuntary basis under the relevant state or territory mental health legislation. In 2013–14, there were 44,408 hospital separations with specialised psychiatric care where the mental health legal status was 'involuntary'—this represented 29% of all admitted patient mental health-related separations with specialised psychiatric care. The majority of these (39,787 or 90%) occurred in public acute hospitals.

In private hospitals, very few separations (0.1%) with specialised psychiatric care were for patients treated on an involuntary basis, although a high proportion of private hospital separations did not have a mental health legal status recorded (28%) (Figure AD.5). Involuntary separations accounted for 41% and 49% of separations with specialised psychiatric care in public acute hospital and public psychiatric hospitals.

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

Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.5 (1.24MB XLS).

Procedures

The most frequently reported procedure block for separations with specialised psychiatric care was Generalised allied health interventions, which was recorded for 41% of separations. Of these allied health interventions, services provided by social workers were the most common (33% of allied health interventions), followed by occupational therapists and psychologists (19% and 18% of allied health interventions).

The next most frequently reported procedure block was Cerebral anaesthesia (general anaesthesia), which was recorded for 14% of separations with specialised psychiatric care. Cerebral anaesthesia was most likely associated with the administration of electroconvulsive therapy (ECT), a form of treatment for depression, which was recorded for 13% of separations with specialised psychiatric care.

Non-specialised admitted patient mental health care service provision

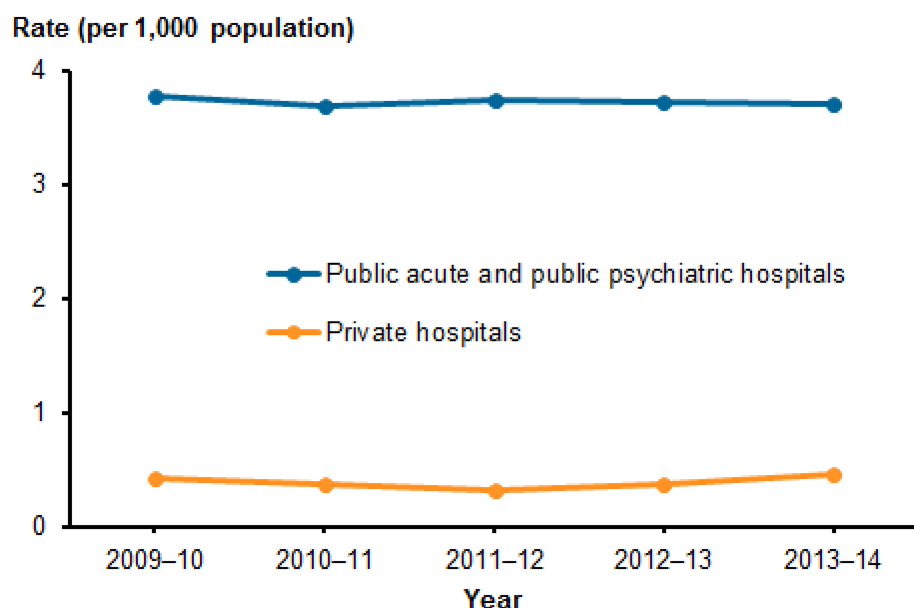
Non-specialised admitted patient mental health care is care which takes place outside a designated psychiatric unit as mentioned earlier but for which the principal diagnosis is considered to be mental health-related. A list of mental health related principal diagnoses is available in the technical information section. Data for public acute and public psychiatric hospitals are combined in this section as there were very few separations without specialised psychiatric care in public psychiatric hospitals in 2013–14 (see Table AD.1).

Trends

When considering all hospital types together, the rate of mental health-related separations per 1,000 population without specialised psychiatric care remained stable between 2009–10 and 2013–14 (fluctuating between 4.1 and 4.2 per 1,000 population across the 5-year period).

The separation rate for public hospitals (public acute and public psychiatric hospitals combined) continued to be several times higher than the separation rate for private hospitals across the 5 years to 2013–14 (Figure AD.6). The reasons for the difference in the rates between public and private hospitals are likely to be due to differences in the patient populations between sectors, different service delivery profiles, differences in coding practices and so forth.

Figure AD.6: Admitted patient mental health-related separations without specialised psychiatric care, by hospital type, 2009–10 to 2013–14



Notes:

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

2. Due to small number of separations for public psychiatric hospitals, the two public hospital types have been combined to allow for more meaningful reporting.

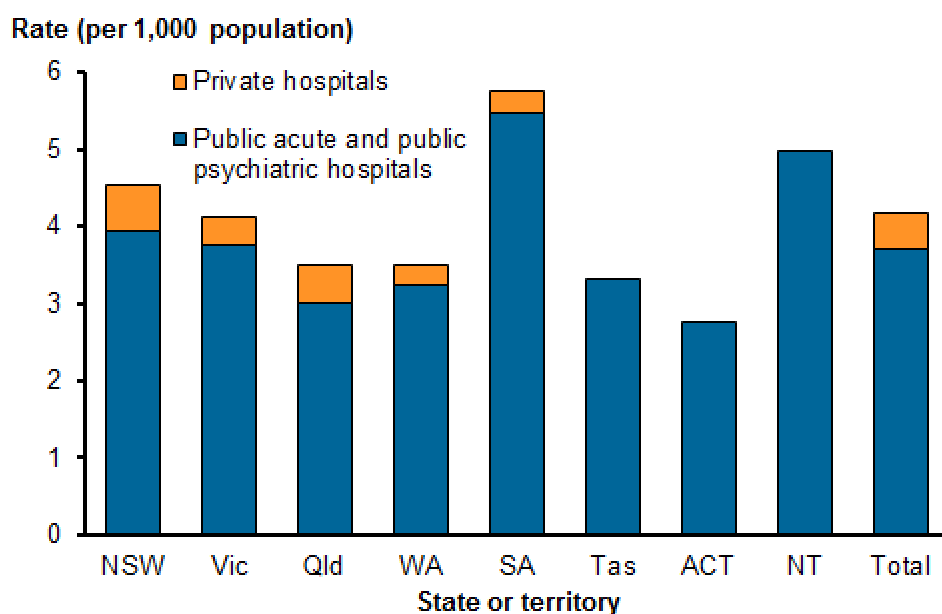
Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.11 (1.24MB XLS).

By states and territories

In 2013–14, the national rate of public acute and public psychiatric hospital separations without specialised psychiatric care was 3.7 per 1,000 population. South Australia had the highest rate (5.5 per 1,000 population) and the Australian Capital Territory had the lowest (2.8) (Figure AD.7).

The rate of mental health-related separations without specialised psychiatric care in private hospitals for Tasmania, the Australian Capital Territory and the Northern Territory are not published for confidentiality reasons. In all other states, the separation rates were less than 1 per 1,000 (Figure AD.7).

Figure AD.7: Separations without specialised psychiatric care, states and territories, by hospital type, 2013–14



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.

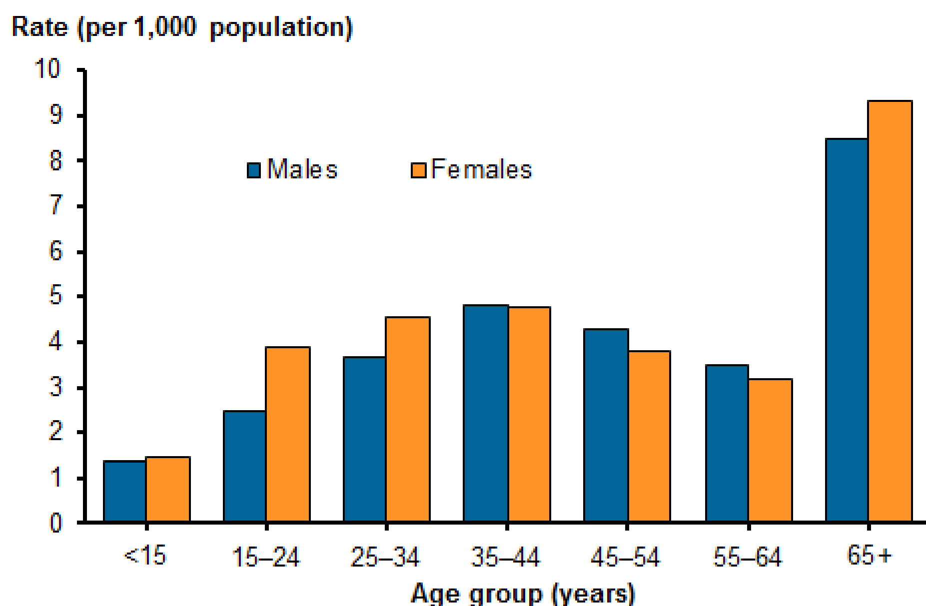
Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.10 (1.24MB XLS).

Non-specialised admitted mental health care patient characteristics

Patient demographics

In 2013–14, the highest rate of mental health-related separations without specialised psychiatric care was for patients aged 65 and older (8.9 per 1,000 population) and the lowest was for those aged under 15 (1.4 per 1,000 population) (Figure AD.8). Overall, the separation rate was higher for females than males (4.4 and 3.9 per 1,000 population respectively).

Figure AD.8: Admitted patient separation rates without specialised psychiatric 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.

Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.2 (1.24MB XLS).

The extent of overrepresentation of Aboriginal and Torres Strait Islander people in mental health-related separations without specialised psychiatric care is greater than in separations with specialised care. In 2013–14, Indigenous Australians accounted for 7.0% of all mental health-related separations without specialised psychiatric care; by comparison, Indigenous Australians made up 3.0% of the Australian population in 2013 (ABS 2013). After adjusting for different age-structures, Indigenous Australians had a mental health-related separation rate without specialised psychiatric care that was more than 3 times that of other Australians (12 and 3.8 per 1,000 population respectively).

Although *Remote and very remote* areas accounted for a small proportion of mental health-related separations without specialised psychiatric care (4.1%), those who live in these areas had the highest rate of such separations (7.6 per 1,000 population) compared with other areas (3.7 per 1,000 population in *Major cities*, 4.4 per 1,000 population in *Inner regional* areas, 5.6 per population in 1,000 population in *Outer regional* areas).

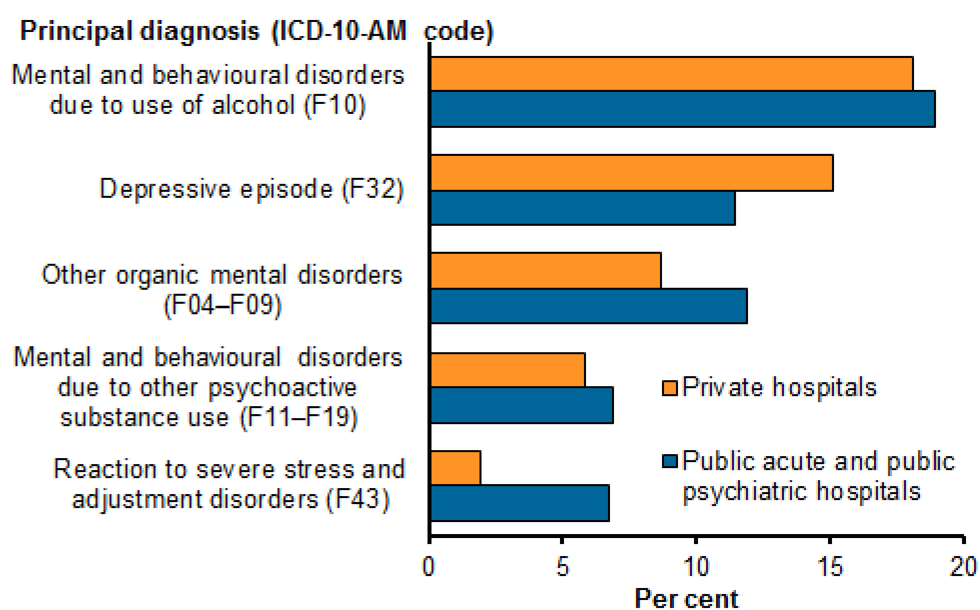
Reference

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

Principal diagnosis

In 2013–14, 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% in public hospitals and 18% in private hospitals), followed by Depressive episode (F32) (11% in public and 15% in private hospitals) (Figure AD.9).

Figure AD.9: Admitted patient separations without specialised psychiatric care, by the 5 most frequently reported principal diagnoses, 2013–14



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

Source: National Hospital Morbidity Database. Source data Admitted patient mental health-related care Table AD.13 (1.24MB XLS).

Procedures

Over half (61%) of mental health-related separations without specialised psychiatric care recorded at least 1 procedure in 2013–14. The most frequently reported procedure block was Generalised allied health intervention, which was recorded for 37% of all separations without specialised psychiatric care. Allied health interventions were most frequently for social work (25% of allied health procedures), followed by physiotherapy and occupational therapy (19% and 18% of allied health procedures respectively).

The next most frequently reported procedure block was Cerebral anaesthesia (general anaesthesia), which was recorded for 12% of separations without specialised psychiatric care. Cerebral anaesthesia was most likely associated with the administration of electroconvulsive therapy (ECT), a form of treatment for depression, which was recorded for 10% of separations without specialised psychiatric care.

Use of restrictive practices during admitted patient care

Seclusion

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

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

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

Background

In 2005, Health Ministers endorsed the *National safety priorities in mental health: a national plan for reducing harm*, Australia's first national statement about safety improvement in mental health. This plan identified 4 priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion'. Seclusion may be used across the range of mental health services, however, is most commonly used in the acute specialised mental health hospital service setting. Subsequently, this service setting has been the focus of quality improvement initiatives.

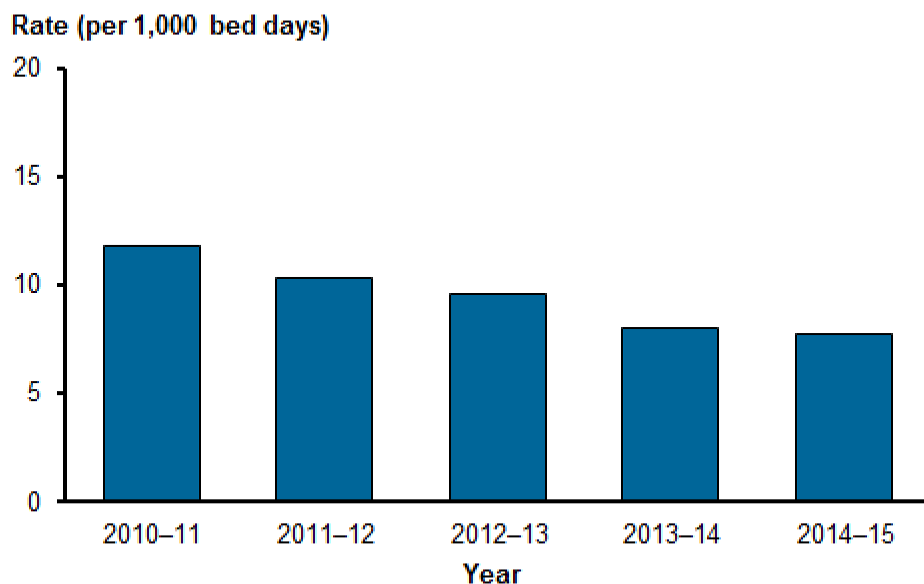
In line with the 2005 plan, there have been a number of initiatives aimed at reducing seclusion and restraint in public mental health facilities. Since 2008–09, a number of ad hoc seclusion data collections for specialised mental health public acute hospital services have been conducted by the Australian Health Ministers Advisory Council's (AHMAC) Safety and Quality Partnership Standing Committee (SQPSC) in partnership with the relevant state and territory authorities.

More recently, the AHMAC mental health committees have formalised a routine, national seclusion data collection and reporting framework. The Seclusion and Restraint Data Set Specification will standardise the national collection of both seclusion and restraint data (and provide a more detailed data set) from the 2015–16 collection period.

Overview

Nationally, there were 7.8 seclusion events per 1,000 bed days in 2014–15; a decrease from 11.8 in 2010–11 (Figure AD.10). This represents an average annual reduction of 10.0% over the 5-year period.

Figure AD.10: Rate of seclusion events, public sector acute mental health hospital services, 2010–11 to 2014–15



Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.18. (1.24MB XLS)

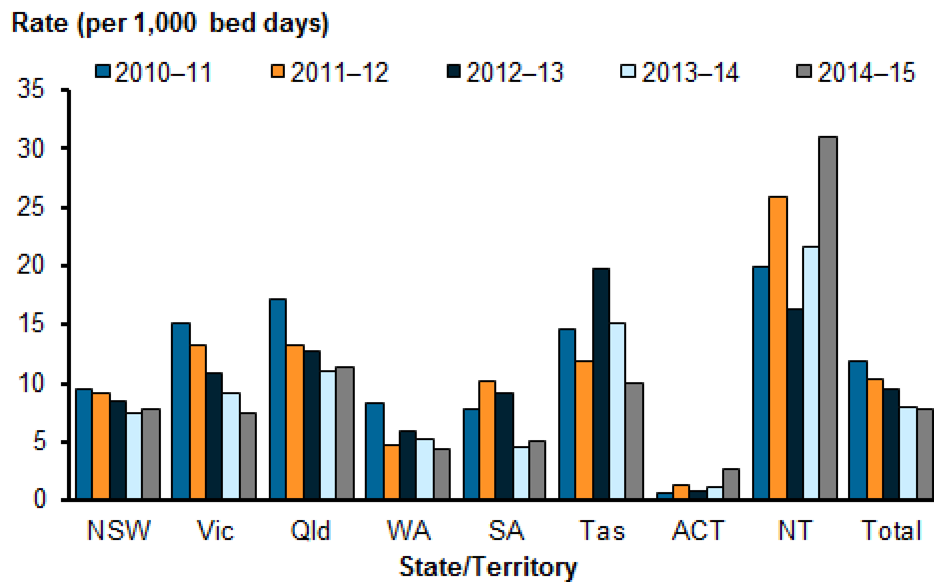
States and territories

Over time

In 2014-15, the Northern Territory had the highest rate of seclusion with 31.0 seclusion events per 1,000 bed days and the Australian Capital Territory had the lowest (2.7). Seclusion rates have fallen for 6 of the 8 jurisdictions between 2010–11 and 2014–15 (Figure AD.11).

Data for smaller jurisdictions should be interpreted with caution as small changes in the number of seclusion events can have marked impact on the overall jurisdictional rate. Further jurisdictional-specific information about seclusion data is available in the accompanying data quality statement.

Figure AD.11: Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2010–11 to 2014–15



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

Source: State and territory governments, unpublished.
Source data Admitted patient mental health-related care Table AD.18. (1.24MB XLS)

Frequency and duration

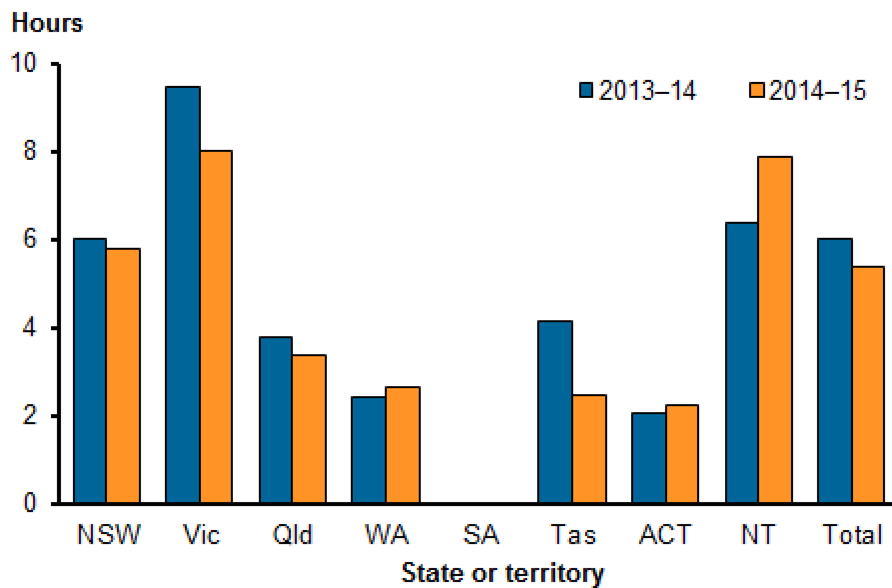
Frequency and duration of seclusion events were collected for the first time in 2013–14.

One in 20 (5.0%) episodes of care provided by Australian public sector specialised acute hospital services involved a seclusion event in 2014–15, a slight decrease from 2013–14 (5.3%). The Northern Territory had the highest proportion of episodes with a seclusion event (9.7%), while South Australia had the lowest (2.7%). The average number of seclusion events for patients who were secluded was 2.0 events per admitted care episode in 2014–15 which was relatively unchanged from the 2013–14 result (2.1). The Australian Capital Territory was unable to provide the number of admitted patient care episodes and as such is excluded from the national proportion of seclusion events per episode.

The average duration of a seclusion event excluding Forensic services was 5.4 hours in 2014–15, down from 6.0 hours in 2013–14. Forensic services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. Forensic service data has been excluded as forensic seclusion events are typically of longer duration, and substantially skew the overall duration average. Data for South Australia is also excluded from the national average duration due to its use of a 4 hour block recording methodology.

Victoria reported the longest average seclusion duration with an average of 8.0 hours per seclusion event. The Australian Capital Territory had the shortest, of 2.2 hours (Figure AD.12).

Figure AD.12: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services (excluding Forensic events), states and territories, 2013–14 to 2014–15



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

Source: State and territory governments, unpublished.
Source data Admitted patient mental health-related care Table AD.18. (1.24MB XLS)

Target population

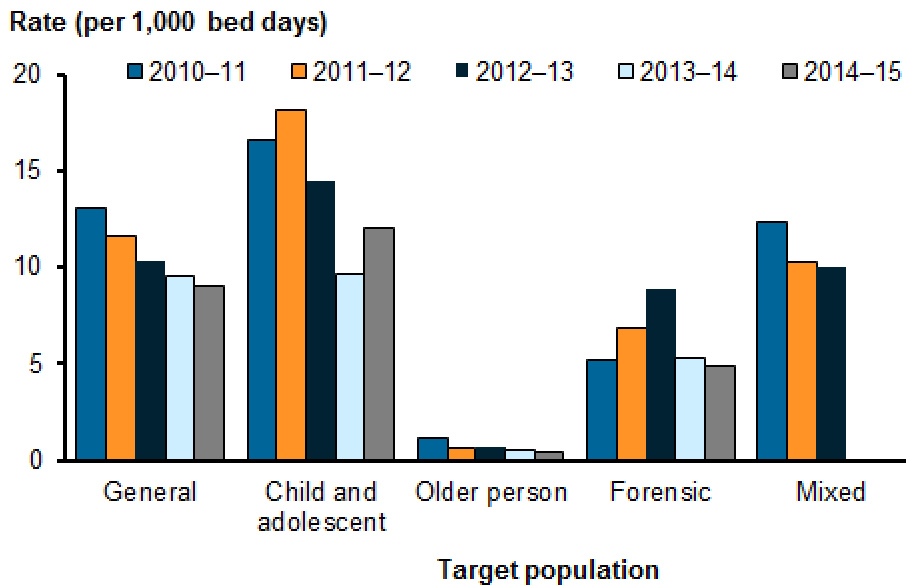
Seclusion data can also be presented by the target population of the acute specialised mental health hospital service where the seclusion event occurred. Around three quarters (76.8%) of in-scope care (total number of bed days) was provided in General services. Older person services accounted for 13.5% followed by Forensic (5.9%) and Child and adolescent (3.8%) services.

However, data should be interpreted with caution as this methodology uses the target population of the service unit, that is, the age group that the service is intended to serve, not the age of each individual patient. Also, in 2013–14, improvements were made to the reporting of target population categories. The mixed category was removed as an option for reporting. Data for the Mixed category was most commonly a mix of General, Child and adolescent and/or Older person services. Time series data by target population must therefore be approached with caution.

Over time

The highest rate of seclusion was for Child and adolescent services with 12.0 seclusion events per 1,000 bed days, followed by General services (9.1), Forensic services (4.9) and Older person services (0.4). Although a reduction in seclusion rates for the 5 years to 2014–15 was observed for General, Child and adolescent, Older person and Forensic services, some variability is apparent from year to year (Figure AD.13).

Figure AD.13: Rate of seclusion events, public sector acute mental health hospital services, by target population, 2010–11 to 2014–15



Note: Queensland and the Northern Territory do not report any acute Forensic services, however forensic patients can and do access acute care through General units.

Source: State and territory governments, unpublished.

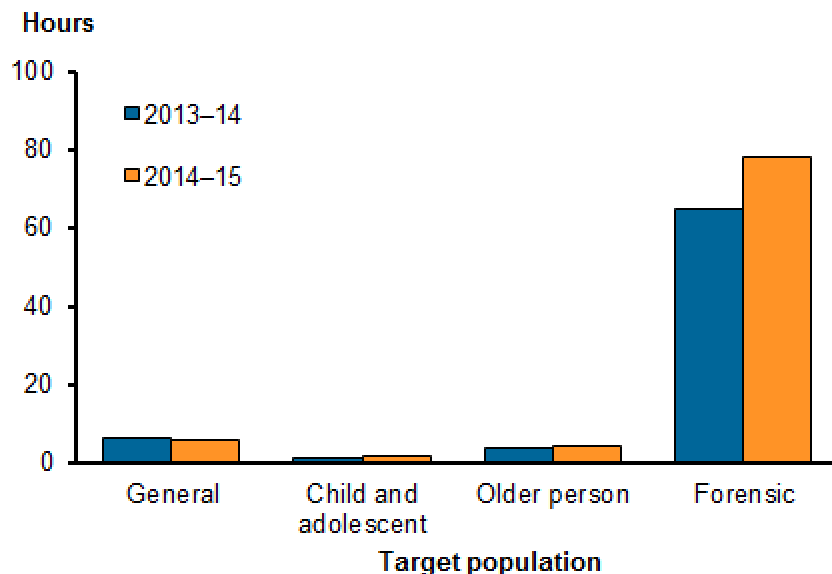
Source data Admitted patient mental health-related care Table AD.19 (1.24MB XLS)

Frequency and duration

Forensic services reported the highest proportion of episodes of care involving seclusion events, with 9.0% of all mental health-related episodes involving seclusion. This was followed by General (5.3%), Child and adolescent (3.9%), and Older person (0.8%) services, with all rates relatively stable compared with 2013–14.

Child and adolescent services had the highest frequency of seclusion, with 2.8 seclusion events per episode when seclusion was used at least once during an episode of care. Seclusion events that occurred in Forensic services had the longest average duration; 78.1 hours per seclusion event, which is much greater than all other target population categories (1.6 to 5.6 hours). This may also be partly due to the way seclusion is recorded in Forensic services. General services reported an average time of 5.6 hours per seclusion event, followed by Older person (4.4 hours) and Child and adolescent (1.6 hours) services. Average time of the seclusion event decreased for General services, increased for Forensic services, and was similar for the other target population groups between 2013–14 and 2014–15 (Figure AD.14).

Figure AD.14: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services, by target population, 2013–14 to 2014–15



Note: Data for South Australia is excluded from the national average duration due to its use of a 4 hour block recording methodology. Queensland and the Northern Territory do not report any acute Forensic services, however forensic patients can and do access acute care through General units.

Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.19 (1.24MB XLS)

Remoteness

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

In 2014–15, hospitals located in *Major Cities* had a seclusion rate of 7.2 events per 1,000 bed days. This rate was lower than that for *Inner Regional* facilities (8.0) and *Outer Regional* and *Remote* area facilities combined (17.8). The proportion of mental health-related admitted care episodes with a seclusion event was similar across facilities in all areas.

On average, seclusion events in facilities in *Major Cities* were longer in duration (9.1 hours) than those in *Outer Regional and Remote* (5.8) and *Inner regional* (5.1) areas.

Data source

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of episode-level records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data for each hospital separation. Clinical information such as diagnoses, procedures undergone and external causes of injury and poisoning are also recorded. For further details on the scope and quality of data in the NHMD, refer to the Data quality statement: National Hospital Morbidity Database 2013–14.

Further information on admitted patient care for the 2013–14 reporting period can be found in the *Australian hospitals 2013–14*: *at a glance* report (AIHW 2015). The 2013–14 collection contains data for hospital separations that occurred between 1 July 2013 and 30 June 2014. Admitted patient episodes of care/ separations 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, 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 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 across states and territories. Interpretation of the differences between jurisdictions therefore needs to be made 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 8th edition)(NCCC 2012). Further information on this is included in the technical information section.

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

Seclusion data quality information

Variations in jurisdictional legislation may result in exceptions to the definition of a seclusion event as presented in the key concepts section. Data reported by jurisdictions may therefore vary and jurisdictional comparisons should be made with caution. The estimated acute bed coverage for 2014–15 seclusion data was over 95% based on acute beds admitted units reported to the Mental Health Establishments National Minimum Data Set in 2013–14.

Information about jurisdictional specific caveats and policy is included in the accompanying data quality statement.

Restraint

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

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

Reference

AIHW 2015. Australian hospitals 2013–14: at a glance. Health services series no. 61. Cat. no. HSE 157. Canberra: AIHW.

NCCC (National Casemix and Classification Centre) 2012. 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), 8th edn. Wollongong: University of Wollongong.

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: • 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: ○ 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. The length of stay for an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of 1 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. Procedures are grouped together in blocks (**Procedure blocks**) based on the area of the body, health professional or intervention involved.
Psychiatric care days	**Psychiatric care days** are the number of days or part days the person received care as an admitted patient in a designated psychiatric unit or ward.
Restraint	**Restraint** is defined as the restriction of an individual's freedom of movement by physical or mechanical means. **Mechanical restraint** The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint. **Physical restraint** The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment.

Seclusion	**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: 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. 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. 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. See the data source section for information about jurisdictional consistency with this definition.
Separation	**Separation** is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). 'Separation' also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care. Each record includes information on patient length of stay. A same-day separation occurs when a patient is admitted and separated from the hospital on the same date. An overnight separation occurs when a patient is admitted to and separated from the hospital on different dates. 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.
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.
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).