Ambulatory-equivalent admitted patient care

In some circumstances, patients admitted to hospital are provided with care comparable to that provided by community mental health care services. This can be referred to as ambulatory-equivalent mental health-related separations and can be classified as being with or without specialised psychiatric care. This care is provided in either a public acute, public psychiatric or private hospital (see mental health care facilities key concepts section for hospital types).

The data presented in this section are from the National Hospital Morbidity Database (NHMD). More detailed information on the NHMD is available in the data source section.

Key points

- There were 142,247 ambulatory-equivalent mental health-related separations in 2009–10, accounting for 39.0% of mental health-related separations and 1.7% of all hospital separations.
- There was an average annual increase of 4.8% in the total number of ambulatory-equivalent mental health-related separations between 2005–06 and 2009–10.
- Depressive episode (20%) was the most common principal diagnosis recorded for a separation.
- Cognitive Behaviour Therapy was the most common procedure (or intervention) recorded for a mental health-related separation.

Overview

A total of 8,531,003 separations were reported from public acute, private acute and public psychiatric hospitals in 2009–10 (AIHW 2011). Approximately 4.3% (364,814) of these separations were mental health-related, comprising both ambulatory-equivalent and non-ambulatory admitted patient separations. There were 142,247 ambulatory-equivalent mental health-related separations reported in 2009–10, accounting for 1.7% of all hospital separations and 39.0% of all mental health-related separations. Private hospitals provided 83.5% of all ambulatory-equivalent services.

Over the 5 years to 2009–10, the average annual rate of increase for all ambulatory-equivalent mental health-related separations was 4.8%. Nationally, there were 6.3 ambulatory-equivalent mental health-related separations per 1,000 population. Victoria reported the highest rate of separations per 1,000 population (9.0), while South Australia reported the lowest (1.1). Of the 142,247 ambulatory-equivalent mental health-related separations reported in 2009–10, 112,279 separations occurred with specialised care and 29,968 occurred without specialised care.

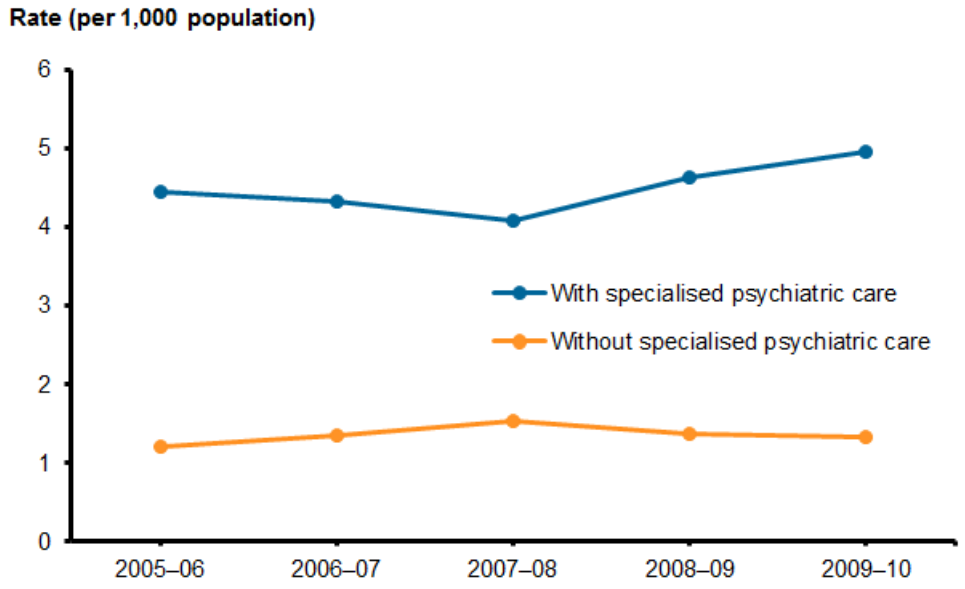
Reference

AIHW 2011. Australian hospital statistics 2009–10. Health services series no. 40. Cat. no. HSE 107. Canberra: AIHW.

Ambulatory-equivalent mental health-related separations over time

The total rate per 1,000 population of ambulatory-equivalent mental health-related separations showed an average annual increase of 2.6% between 2005–06 and 2009–10. The rate per 1,000 population of ambulatory-equivalent mental-health related separations with specialised care and without specialised care showed a similar average annual change between 2005–06 and 2009–10, reporting 2.7% and 2.4% respectively. However, since 2007–08 the rate of separations with specialised psychiatric care has increased while separations without specialised psychiatric care have decreased.

Figure AMB.1: Ambulatory-equivalent mental health-related separation rates, with and without specialised psychiatric care, 2005–06 to 2009–10



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 AMB.2 in the ambulatory-equivalent admitted patient care excel table downloads.

Ambulatory-equivalent mental health-related separation patient characteristics

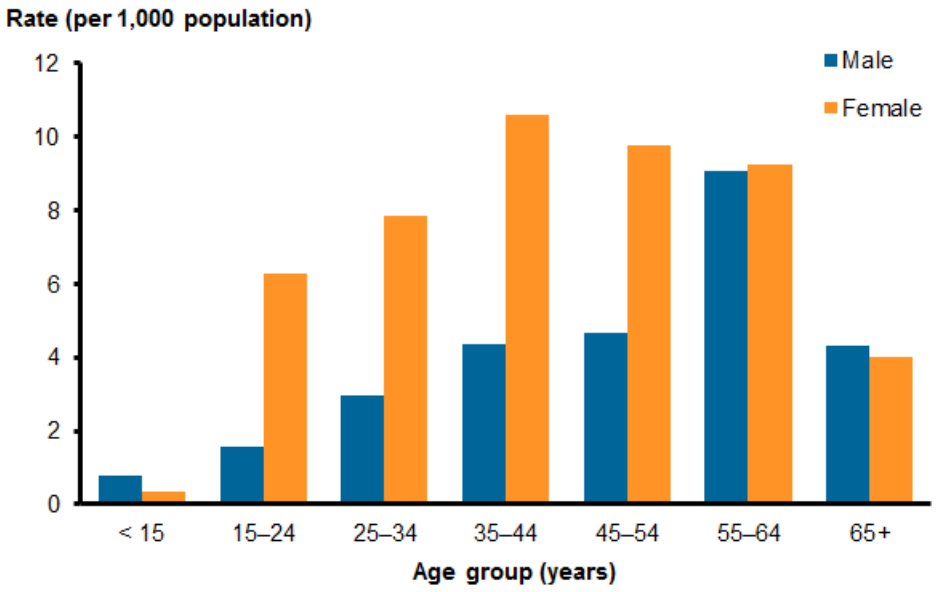
Demographics

With specialised care

The highest number of ambulatory-equivalent mental health-related separations with specialised care was for patients aged 35–44 (23,732 or 21.1%). However, the highest rate of separations was for patients aged 55–64 (9.2 per 1,000 population).

The rate of separations with specialised care for females was higher than that for males (6.4 and 3.5 per 1,000 population respectively). The higher proportion of female mental health-related separations was prominent in those aged 15–54. The rate of separations of Australian-born patients was more than double that of those born overseas (5.6 and 2.3 per 1,000 population respectively). While Indigenous Australians accounted for only 0.6% of separations with specialised care, they experienced a separation rate of 1.4 per 1,000 population.

Figure AMB.2: Ambulatory-equivalent mental health-related separation rates, with specialised care, by sex and age group, 2009–10



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 AMB.5 in the ambulatory-equivalent admitted patient care excel table downloads.

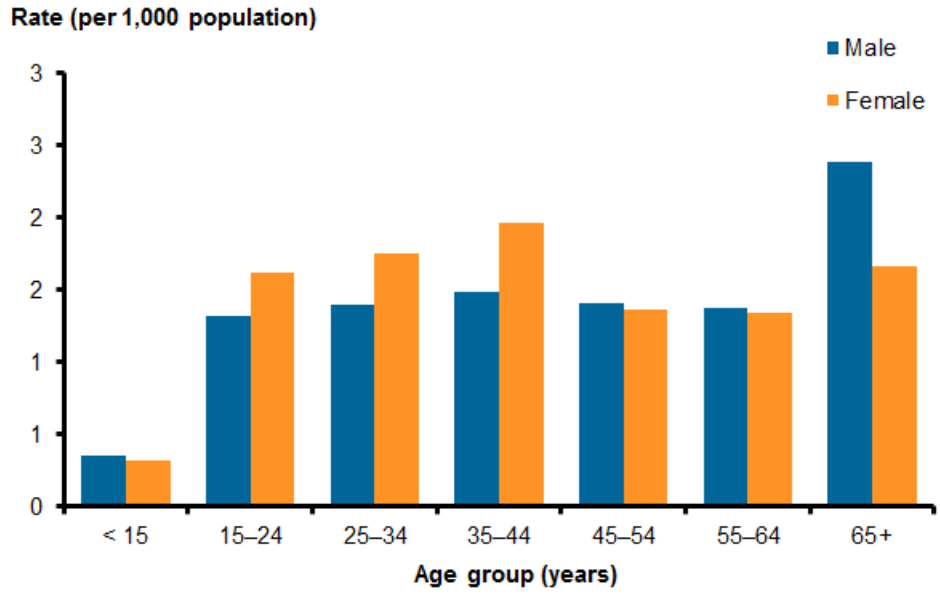
Without specialised care

The highest number and rate of ambulatory-equivalent mental health-related separations without specialised care was for patients aged 65 and over (5,902 or 19.7% and 2.0 per 1,000 population respectively).

Males and females experienced similar rates of separations without specialised care (1.3 and 1.4 per 1,000 population respectively). The rate of separations without specialised care of Australian-born patients was more than twice that of those born overseas (1.5 and 0.7 per 1,000 population respectively). Indigenous

Australians represented 4.9% of separations without specialised care and had a separation rate over twice that of Other Australians (2.9 and 1.3 per 1,000 population respectively).

Figure AMB.3: Ambulatory-equivalent mental health-related separation rates, without specialised care, by sex and age group, 2009–10



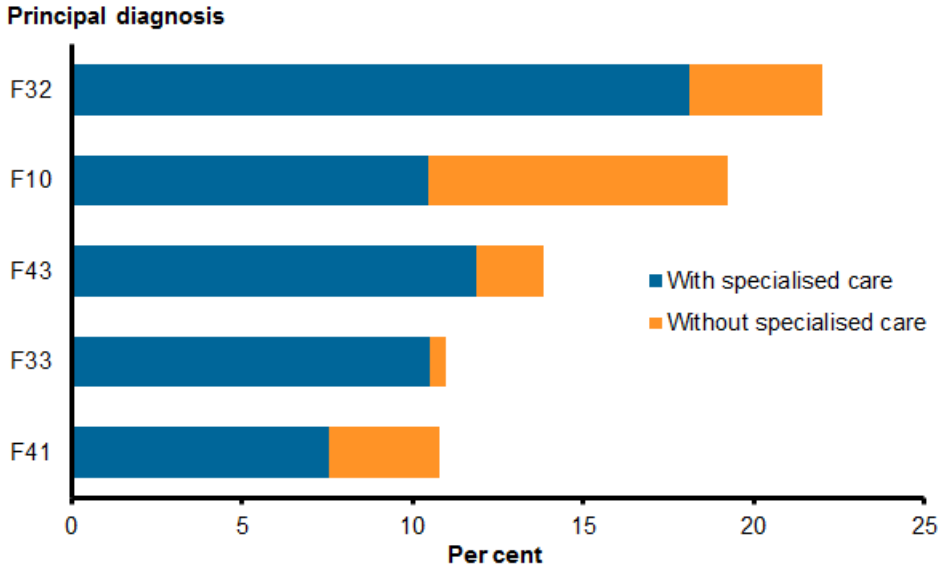
Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AMB.6 in the ambulatory-equivalent admitted patient care excel table downloads.

Principal diagnosis

In 2009–10, the principal diagnosis of depressive episode (F32) accounted for the largest number of ambulatory-equivalent separations with specialised care (27,832 or 18.1%). However, for separations without specialised care, mental and behavioural disorders due to use of alcohol (F10) (8.8%) was the leading principal diagnosis (Figure AMB.4).

Figure AMB.4: Ambulatory-equivalent mental health-related separations for the 5 most commonly reported principal diagnoses, 2009–10



Key

F32 Depressive episode
F10 Mental and behavioural disorders due to use of alcohol
F43 Reaction to severe stress and adjustment disorders
F41 Other anxiety disorders
F33 Recurrent depressive disorders

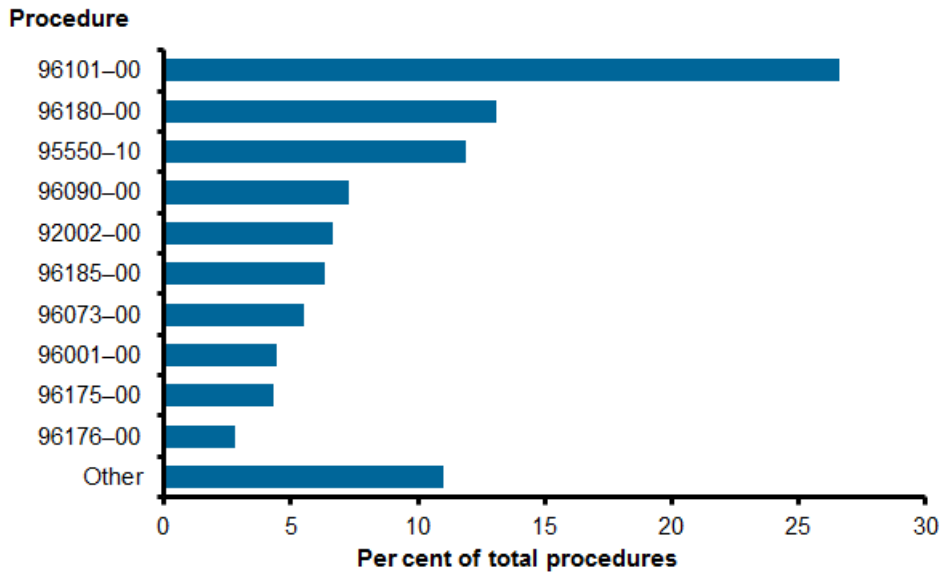
Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AMB.7 in the ambulatory-equivalent admitted patient care excel table downloads.

Procedures for ambulatory-equivalent mental health-related separations

In 2009–10, 42.0% of all mental health-related separations included at least one procedure. In total, 65,552 procedures were reported, averaging 1.1 procedures per separation where a procedure was recorded. The most frequently reported procedure was cognitive behaviour therapy (26.6%), followed by other psychotherapies or psychosocial therapies (13.1%) and allied health intervention, psychology (11.9%) (Figure AMB.5).

Figure AMB.5: The 10 most frequently reported procedures for ambulatory-equivalent mental health-related separations, 2009–10



Key

96101–00	Cognitive behaviour therapy
96180–00	Other psychotherapies or psychosocial therapies
95550–10	Allied health intervention, psychology
96185–00	Supportive psychotherapy, not elsewhere classified
96073–00	Substance addiction counselling or education
96090–00	Other counselling or education
92002–00	Alcohol rehabilitation
96001–00	Psychological skills training
96175–00	Mental/behavioural assessment
95550–02	Allied health intervention, occupational therapy

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 AMB.8 in the ambulatory-equivalent admitted patient care excel table downloads.

Data source

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of electronic summary separation records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data for each hospital separation. Clinical information such as diagnoses, procedures undergone and external causes of injury and poisoning are also recorded.

The 2009–10 collection contains data for hospital separations that occurred between 1 July 2009 and 30 June 2010. Admitted patient stays that began before 1 July 2009 are included if the separation date fell within the collection period (2009–10). A record is generated for each separation rather than each patient. Therefore, patients who separated more than once in the reference year have more than one record in the database.

Data relating to admitted patients in almost all hospitals are included. The coverage is described in greater detail in *Australian hospital statistics 2009–10* (AIHW 2011).

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, and there are state and territory differences in the scope of services provided for admitted patients. Differences in the data presented by jurisdictions may reflect different service delivery practices, differences in admission practices or differences in the types of establishments categorised as hospitals. Interpretation of the differences between jurisdictions therefore needs to be done with care.

The scope of the data collection and the definitions used by the data providers may vary from year to year. Consequently, caution should be exercised when making comparisons between reporting years.

Tasmania moved to a new state wide public hospital patient information system in 2009–10 which involved changes to reporting processes and tools. As a result, for the 2009–10 data, all separations and patient days were reported as occurring without specialised care for public acute hospitals.

Principal diagnosis refers to the diagnosis established after observation by medical staff to be chiefly responsible for the patient's episode of admitted care. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM). Further information on this is provided in the online technical information section.

Procedures are classified according to the *Australian Classification of Health Interventions (ACHI), 5th edition*. Further information on this classification is included in the online technical information section. More than one procedure can be reported for a separation and not all separations have a procedure reported.

Reference

AIHW 2011. Australian hospital statistics 2009–10. Health services series no. 40. Cat. no. HSE 107. Canberra: AIHW.

Key Concepts

Ambulatory-equivalent mental health-related admitted patient care

Key Concept	Description
Ambulatory-equivalent	A separation is classified as **ambulatory-equivalent** for this report if each of the following applies: • the separation was a same day separation (that is, admission and separation occurred on the same day) • no procedure or other intervention was recorded, or any procedure recorded was identified as probably able to be provided in ambulatory mental health care (see the Classification Codes section for a list of procedures identified in this way) • the mode of admission did not include a care type change or transfer, and the mode of separation did not include a transfer (to another facility), a care type change, the patient leaving against medical advice or death.
Mental health-related	A separation is classified as **mental health-related** if: • it had a mental health-related principal diagnosis which, for admitted patient care, is defined as a principal diagnosis that is either a diagnosis that falls within the section on Mental and behavioural disorders (Chapter 5) in the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification (ICD-10-AM) classification (codes F00–F99) or a number of other selected diagnoses (see the Classification Codes section for the full list of applicable diagnoses), or • it included any specialised psychiatric care.
Separation	A **separation** is defined as the process by which an episode of care for an admitted patient in hospital ceases. For more information, see Admitted patient mental health-related care section.
Specialised psychiatric care	A separation is *classified* as having **specialised psychiatric care** if the patient was reported as having spent 1 or more days in a specialised psychiatric unit or ward.