Admitted patient mental health-related care

People with mental health problems may require hospitalisation from time to time. Patients can receive specialised psychiatric care in a psychiatric hospital or in a psychiatric unit within a hospital. They can also be admitted to a general ward where workers are not specifically trained to care for the mentally ill. Under these circumstances, the admissions are classified as without specialised psychiatric care.

This section presents information on these admitted patient mental health-related separations. The data are from the National Hospital Morbidity Database (NHMD), a collation of data on admitted patient care in Australian hospitals, and are based on the Admitted Patient Care National Minimum Data Set. As it is not possible to determine how many separations an individual patient has had, the information describes separation events, not patients. For further information see the data source section.

Key points

- Of the 223,261 admitted patient mental health-related separations, specialised psychiatric care was provided for 59.5% (132,917) in 2010–11.
- About 29% of mental health-related separations with specialised psychiatric care were from involuntary admissions.
- The largest numbers and highest rates of mental health-related separations with specialised psychiatric care were for patients aged 35–44.
- Depressive episode and Schizophrenia were the most commonly reported principal diagnoses for separations with specialised psychiatric care (16.7% and 16.1% respectively).
- Mental health-related separations without specialised psychiatric care were predominantly provided by public acute hospitals (90.3%).
- Mental and behavioural disorders due to use of alcohol was the most commonly reported principal diagnosis for separations without specialised psychiatric care (20.4%).
- There were 9.6 seclusion events per 1,000 bed days in public acute hospital services in 2012–13.
- Seclusion rates have fallen, from 15.5 events per 1,000 bed days in 2008–09 to 9.6 in 2012–13.

Overview

A total of 8,852,550 separations were reported from public acute, private acute and public psychiatric hospitals in 2010–11 (AIHW 2012). There were 223,261 admitted patient mental health-related separations reported in 2010–11, accounting for 2.5% of all hospital separations. Of these, 132,917 (59.5%) had specialised psychiatric care and 90,344 (40.5%) did not have specialised psychiatric care. Over the 5 years to 2010–11, the average annual rate of increase for all admitted mental health-related separations was 1.6%.

Reference

AIHW 2012. Australian Institute of Health and Welfare 2012. Australian hospital statistics 2010–11. Health Services Series no.43. Cat. no. HSE 117. Canberra: AIHW.

Specialised admitted patient mental health care by state and territory

For public acute hospitals, compared with the national rate of 3.9 separations per 1,000 population, Queensland had the highest rate of separations with specialised psychiatric care (4.7) and Victoria and Northern Territory the equal lowest (3.5). Nationally, there were 64.2 public acute hospital patient days per 1,000 population. Western Australia had the highest rate of public acute hospital patient days (67.3 per 1,000 population) and Northern Territory the lowest (44.7) (Figure AD.1).

The rate of public psychiatric hospital patient days varied greatly across jurisdictions, from 64.3 patient days per 1,000 population in South Australia to 2.8 days in Tasmania. Queensland reported the highest rate of patient days in private hospitals (29.1 per 1,000 population).

For those jurisdictions where private hospital data can be reported, Queensland had the highest rate of separations with specialised psychiatric care per 1,000 population (1.9) and South Australia the lowest (1.1).

The average length of stay varied across both hospital type and jurisdiction. For public acute hospitals this was from 18.0 days in Western Australia to 12.6 days in Tasmania.

Figure AD.1: Separations with specialised psychiatric care, state and territory, by hospital type, , 2010–11
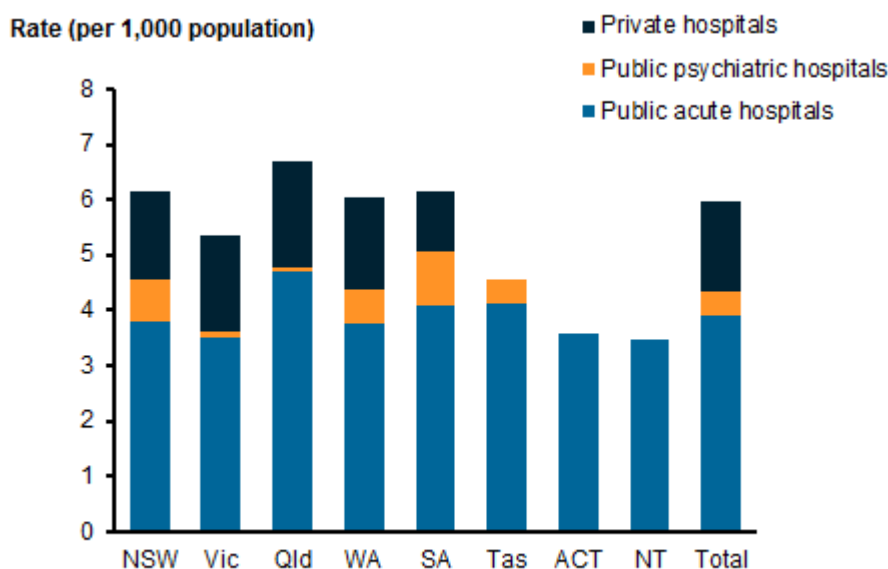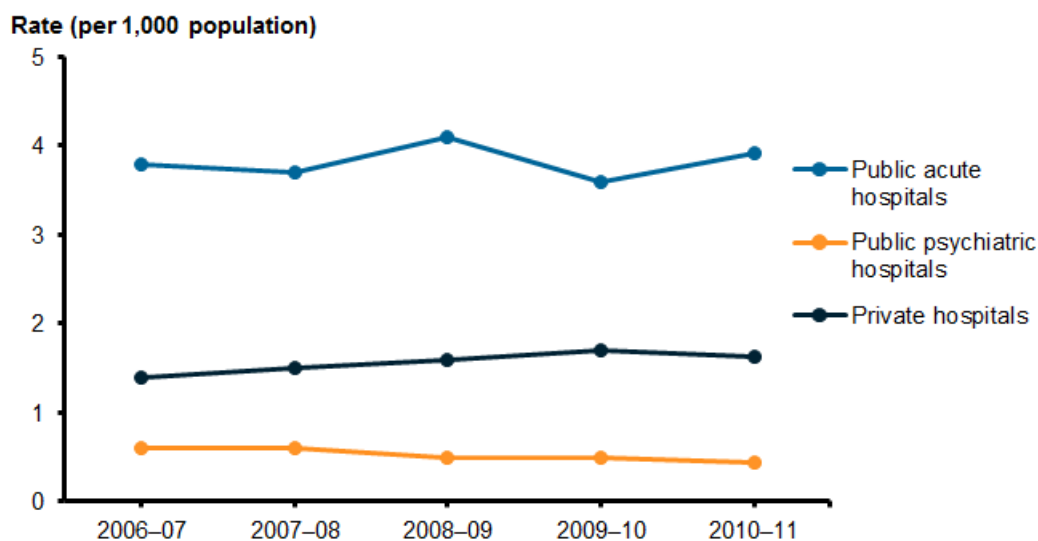

Notes:

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 due to confidentiality reasons.

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

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.3 (330KB XLS) in the Admitted patient mental health-related care table downloads.

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Specialised admitted patient mental health care over time

The rate of mental health-related separations per 1,000 population with specialised psychiatric care occurring in public acute hospital continues to be over double that occurring in private hospitals and more than three times that for public psychiatric hospitals (Figure AD.2). Between 2006–07 and 2010–11, for all hospital types, the rate of mental health-related separations per 1,000 population with specialised psychiatric care remained relatively stable.

Figure AD.2: Admitted patient mental health-related separations with specialised psychiatric care, by hospital type, 2006–07 to 2010–11

Note: Separations with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded.
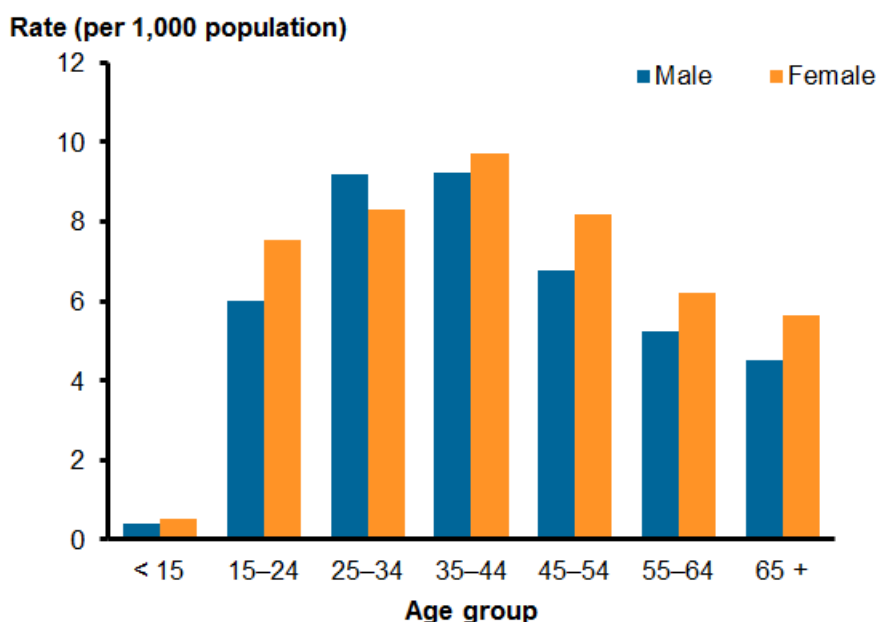
Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.1 (330KBXLS) in the Admitted patient mental health-related care table downloads.

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Specialised admitted patient mental health care patient characteristics

Patient demographics

In 2010–11 the highest rate of separations was for patients aged 35–44 and the lowest for those aged less than 15 (9.5 and 0.5 per 1,000 population respectively) (Figure AD.3). The overall separation rate was higher for females than males (6.3 and 5.7 per 1,000 population respectively).

Figure AD.3: Admitted patient separation with specialised psychiatric care rates, by sex and age groups, 2010–11

Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Source data for this figure are accessible from Table AD.6. (330KB XLS) in the Admitted patient mental health-related care table downloads

*Source*: National Hospital Morbidity Database.

Over half of the separations (53.1%) involved those with a marital status of never married and 3 in 10 (29.7%) involved those who were married (including de facto). Those living in *Major cities* had the highest rate of separations (6.2 per 1,000 population) compared to other remoteness areas. While Indigenous Australians made up only 4.7% of all admitted patient mental health-related separations, they had a separation rate more than double that of Other Australians (12.9 and 5.8 per 1,000 population respectively).

Principal diagnosis

The most frequently reported principal diagnoses for a separation with specialised psychiatric care for all hospital types were depressive episode (F32) (16.7%), followed by schizophrenia (F20) (16.1%) and bipolar affective disorders (F31) (10.4%) in 2010–11.

The profile of diagnoses varies with hospital type. For example, over 4 in 5 (84.7%) of the diagnoses of schizophrenia (F20) in 2010–11 were from public acute hospitals, followed by public psychiatric hospitals and private hospitals (10.0% and 5.4% respectively) (Figure AD.4).

Figure AD.4: Admitted patient separations with specialised psychiatric care, 5 most frequently reported principal diagnoses, by hospital type, 2010–11
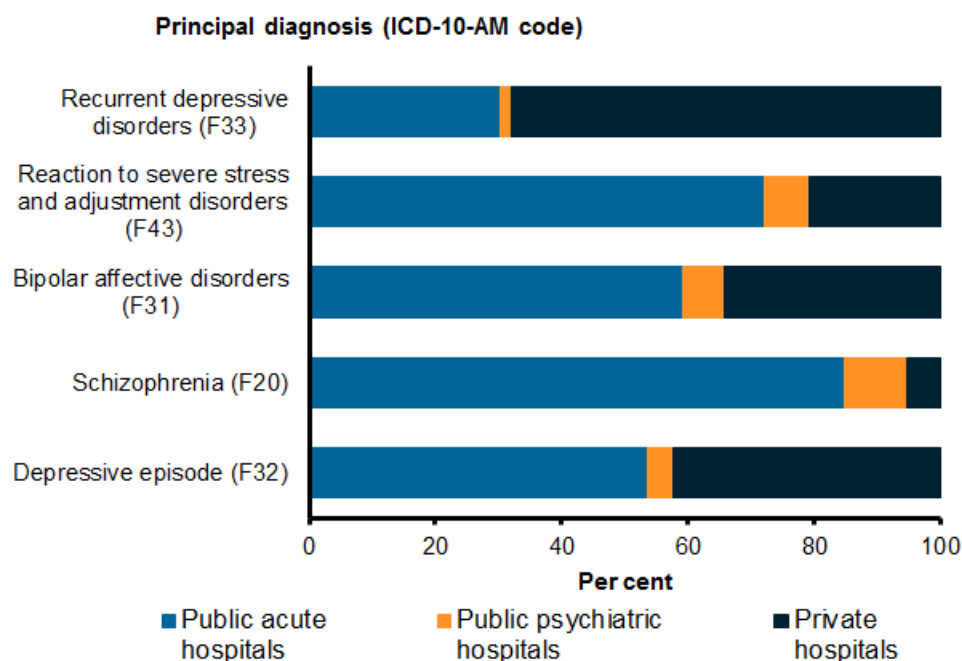
Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Source data for this figure are accessible from Table AD.7 (330KB XLS) in the Admitted patient mental health-related care table downloads.

Source: National Hospital Morbidity Database.

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Specialised admitted patient mental health care separation characteristics

Mental health legal status

Of all admitted patient separations with specialised psychiatric care in 2010–11, over 1 in 4 (29.0%) were for patients who had an involuntary admission. Involuntary admissions represented about 2 in 5 separations with specialised psychiatric care in public acute hospitals, with the majority (87.1%) of involuntary separations occurring in this hospital type (33,638 of 38,617). Involuntary admitted patient separations comprised half (50.0%) of public psychiatric hospitals separations, while less than 1 in 100 (0.6%) of private hospital separations with specialised psychiatric care were involuntary admissions (Figure AD.5).

Figure AD.5: Admitted patient separations with specialised psychiatric care, by mental health legal status and hospital type, 2010–11
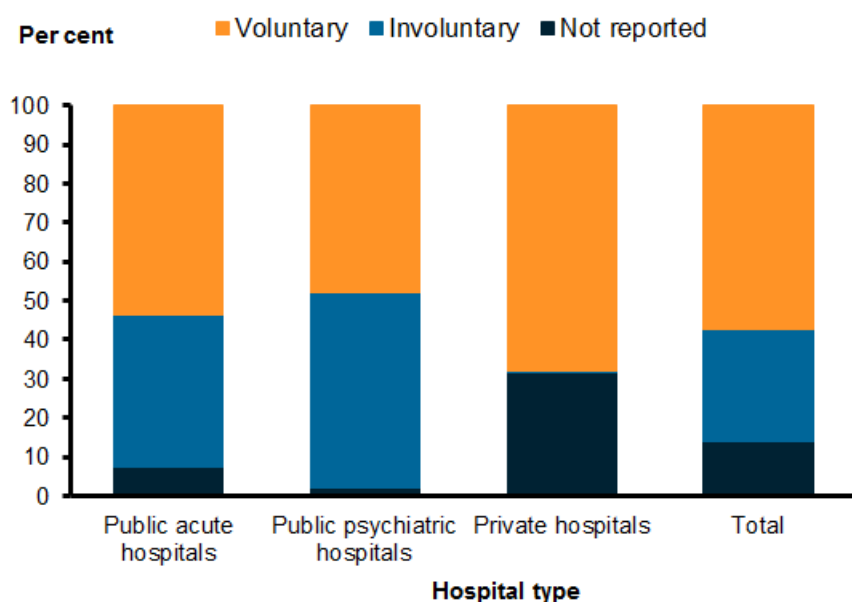
Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Source data for this figure are accessible from Table AD.5 (330KB XLS) in the Admitted patient mental health-related care table downloads.

Source: National Hospital Morbidity Database.

Procedures

About 2 in 5 (41.7%) of all mental-health related separations with specialised psychiatric care did not have an intervention or procedure recorded. However, it is likely that the interventions (procedures) provided to patients during these mental health-related separations were not able to be coded using the existing procedure classification system. For example, the administration of mental health-related medications is not explicitly included in the current classification system.

A frequently reported intervention (procedure) for all admitted patient mental health-related separations was an allied health intervention, including services provided by social workers and occupational therapists. A frequently reported procedure for separations with specialised care was non-emergency general anaesthesia.

This was most likely associated with the administration of electroconvulsive therapy, a form of treatment for depression.

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

For public acute hospitals, compared with the national rate of 3.6 separations per 1,000 population, South Australia had the highest rate of separations without specialised psychiatric care (4.9) and Australian Capital Territory the lowest (2.4). Nationally, there were 17.2 public acute hospital patient days per 1,000 population. South Australia had the highest rate of public acute hospital patient days (20.7 per 1,000 population) and Queensland the lowest (12.3) (Figure AD.6).

For those jurisdictions where private hospital data can be reported, Queensland had the highest rate of separations without specialised psychiatric care per 1,000 population (0.5) and New South Wales the lowest (0.2).

Figure AD.6: Separations without specialised psychiatric care, states and territories, by hospital type, 2010–11
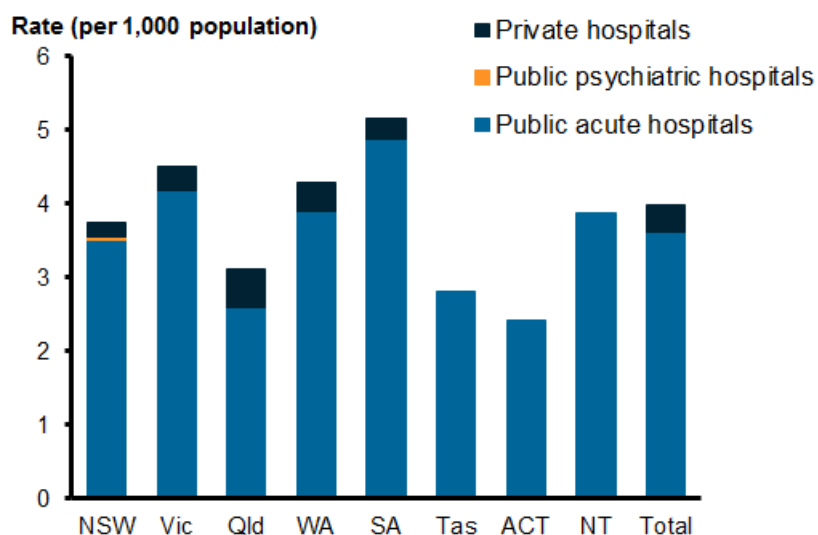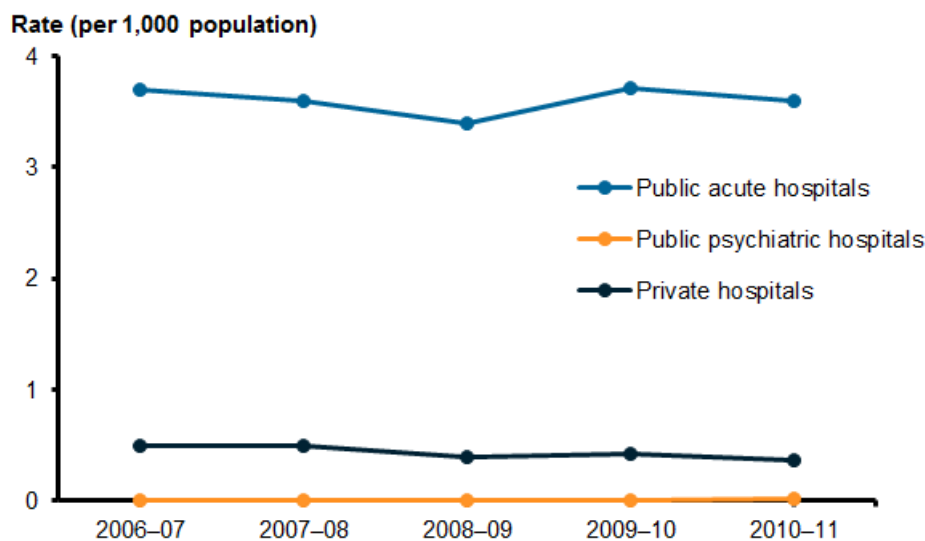

Notes:

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 due to confidentiality reasons.

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

Source: National Hospital Morbidity Database. Source data for this figure are accessible from Table AD.9 (330KB XLS) in the Admitted patient mental health-related care table downloads.

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Non-specialised admitted patient mental health care over time

The rate of mental health-related separations per 1,000 population without specialised psychiatric care occurring in public acute hospital continues to be over three times that occurring in private hospitals. Between 2006–07 and 2010–11, for all hospital types, the rate of mental health-related separations per 1,000 population with specialised psychiatric care remained relatively stable. (Figure AD.7).

Figure AD.7: Admitted patient mental health-related separations without specialised psychiatric care, by hospital type, 2006–07 to 2010–11

Note: Separations with a care type of *Newborn* (without qualified days), and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Source data for this figure are accessible from Table AD.10 (330KB XLS) in the Admitted patient mental health-related care table downloads.

*Source*: National Hospital Morbidity Database.

Non-specialised admitted patient mental health care patient characteristics

Patient demographics

In 2010–11 the highest rate of separations without specialised psychiatric care was for patients aged 65 and older and the lowest for those aged less than 15 (8.4 and 1.4 per 1,000 population respectively) (Figure AD.8). The overall separation rate was higher for females than males (4.2 and 3.9 per 1,000 population respectively).

Figure AD.8: Admitted patient separation rates without specialised psychiatric care, by sex and age group, 2010–11
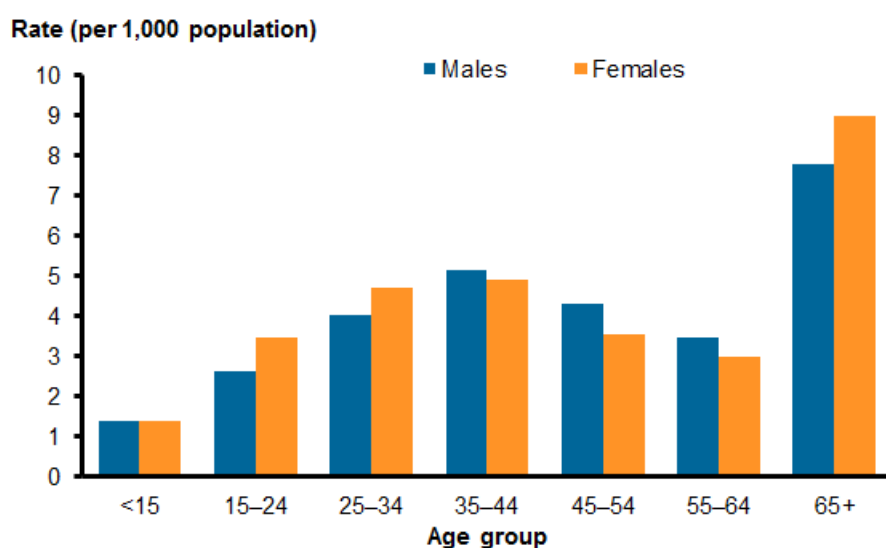
Rate (per 1,000 population)

Note: Separations with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded. Source data for this figure are accessible from Table AD.2 (330KB XLS) in the Admitted patient mental health-related care table downloads.

*Source*: National Hospital Morbidity Database.

About 2 in 5 separations (41.9%) involved those with a marital status of never married and over a third (35.2%) involved those who were married *(including de facto)*. Those living in *Remote* and Very remote areas had the highest rate of separations (8.0 per 1,000 population) compared to other remoteness areas. While Indigenous Australians made up only 7.2% of separations, they had a separation rate almost four times that of other Australians (14.2 and 3.8 per 1,000 respectively).

Principal diagnosis

The most frequently reported principal diagnoses in a separation without specialised psychiatric care for all hospital types were mental and behavioural disorders due to use of alcohol (F10) (20.4%) followed by

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depressive episode (F32) (12.9%) in 2010–11. Essentially all separations without specialised psychiatric care occurred in public acute hospitals for the five most frequently reported principal diagnoses (Figure AD.9).

Figure AD.9: Admitted patient separations without specialised psychiatric care, by the 5 most frequently reported principal diagnoses, 2010–11
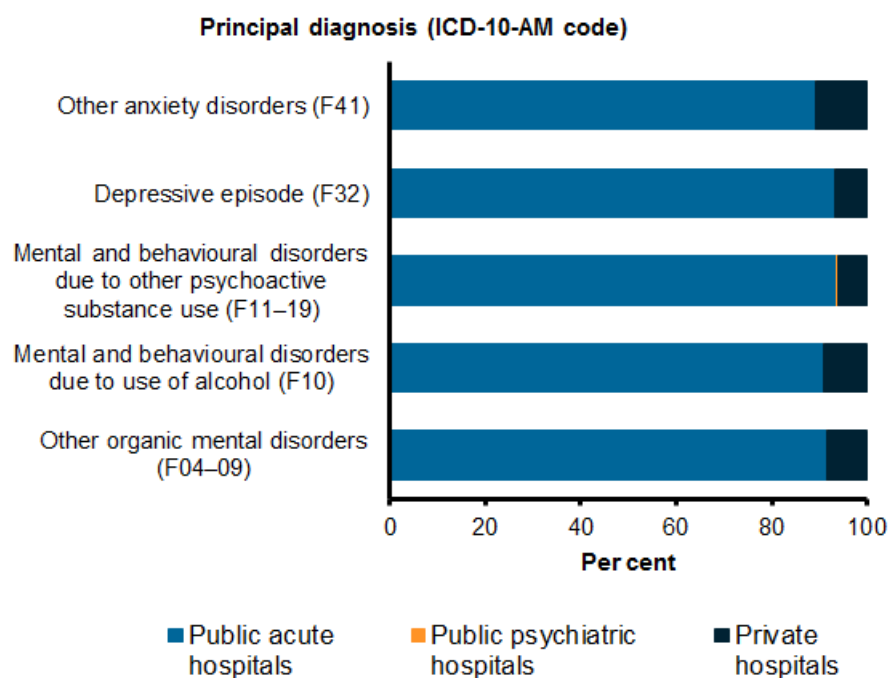
Note: Separations with a care type of Newborn (without qualified days) and records for Hospital boarders and Posthumous organ procurement have been excluded. Source data for this figure are accessible from Table AD.11 (330 KB XLS) in the Admitted patient mental health-related care table downloads

Source: National Hospital Morbidity Database.

Non-specialised admitted patient mental health care separation characteristics

Procedures

Over half (56.2%) of mental health-related separations without specialised psychiatric care reported at least one procedure in 2010–11. The most frequently reported procedure was allied health intervention, social work (13.7% of procedures), followed by allied health intervention, physiotherapy (11.9%).

Use of restrictive practices during admitted patient care

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

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

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

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

Seclusion

At present there remains no formal, routine nationally agreed data collection and reporting framework for seclusion and restraint, despite these ongoing initiatives. However, a number of ad hoc seclusion data collections for specialised mental health public acute hospital services have been conducted by the Safety and Quality Partnership Standing Committee (SQPSC), of the Mental Health Drug and Alcohol Principal Committee (MHDAPC), in partnership with the relevant state and territory authorities for presentation at the national forums and are reported here.

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

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

Figure AD.10: Rate of seclusion events, public sector acute mental health hospital services, 2008–09 to 2012–13
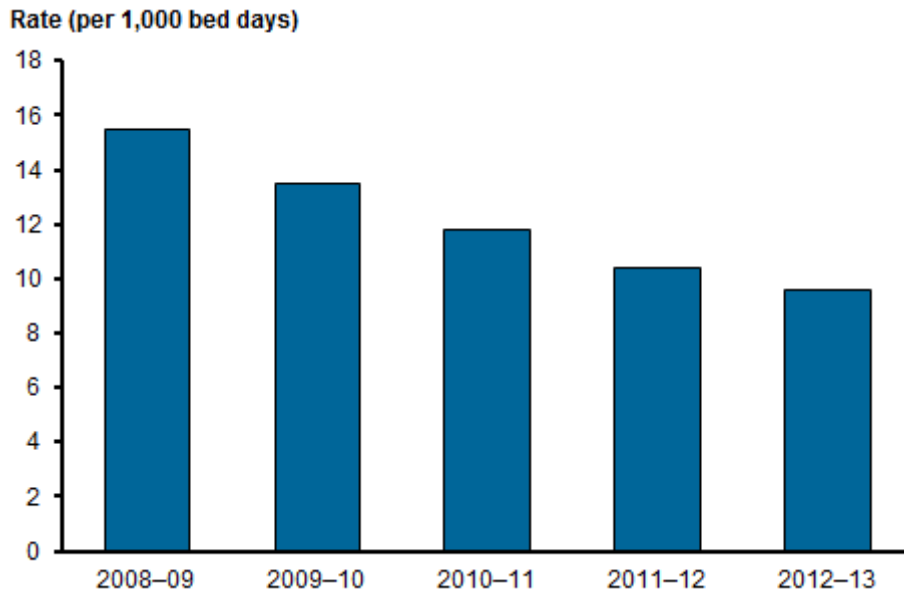
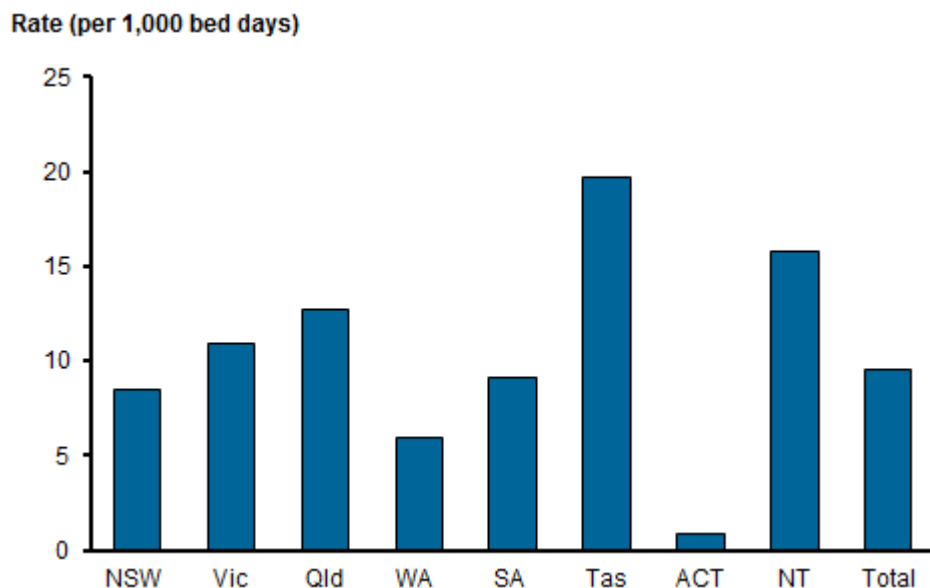*Source:* State and territory governments, unpublished.

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

Alt text:

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

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Jurisdictional rates ranged from 1.3 seclusion events per 1,000 bed days in the Australian Capital Territory, to 25.7 in the Northern Territory in 2011–12 (Figure AD.11).

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

Rate (per 1,000 bed days)

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

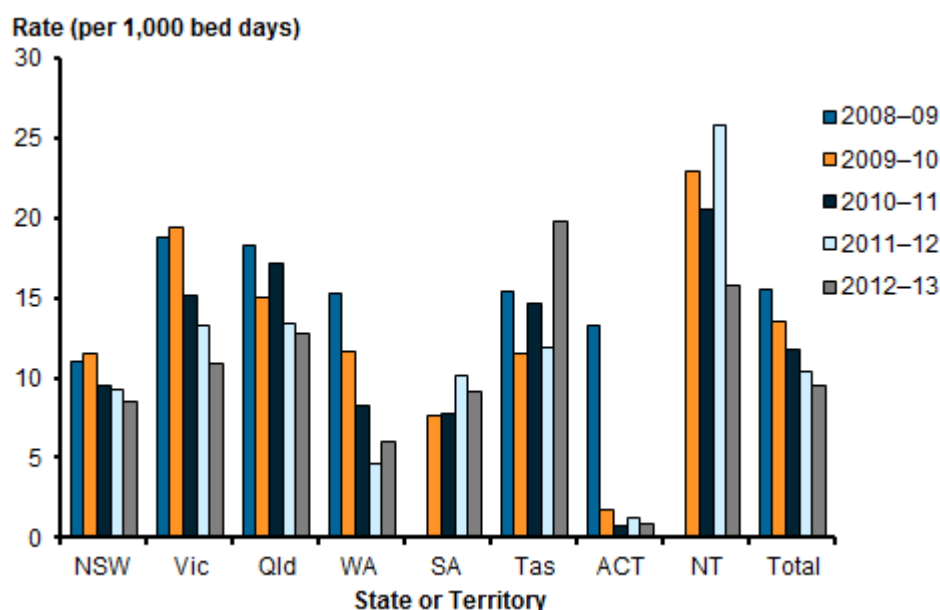*Source:* State and territory governments, unpublished.
Source data for this figure are accessible from Table AD.16 in the Admitted patient mental health-related care table downloads

Alt text:

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

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

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

n.a. Not available (blank).

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

Source: State and territory governments, unpublished.
Source data for this figure are accessible from Table AD.16 in the Admitted patient mental health-related care table downloads
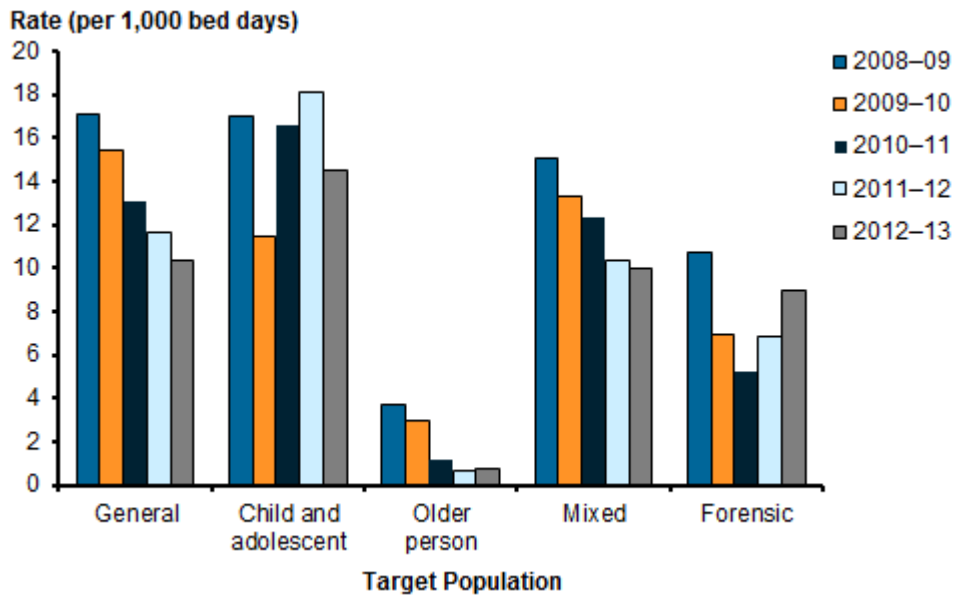
Alt text:

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

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

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

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

Source: State and territory governments, unpublished.
Source data for this figure are accessible from Table AD.17 in the Admitted patient mental health-related care table downloads

Alt text:

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

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Data source

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of episode-level records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data for each hospital separation. Clinical information such as diagnoses, procedures undergone, and external causes of injury and poisoning are also recorded. For further details on the scope and quality of data in the NHMD, please refer to the Australian hospital statistics 2010–11 report http://www.aihw.gov.au/publication-detail/?id=10737421633 (AIHW 2012)

The 2010–11 collection contains data for hospital separations that occurred between 1 July 2010 and 30 June 2011. Admitted patient stays that began before 1 July 2010 are included if the separation date fell within the collection period (2010–11). 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.

Specialised mental health care is identified by the patient having one or more psychiatric care days recorded—that is, care was received in a specialised psychiatric unit or ward. In acute care hospitals, a 'specialised' episode of care or separation may comprise some psychiatric care days and some days in general care. An episode of care from a public psychiatric hospital is deemed to comprise psychiatric care days only and to be 'specialised', unless some care was given in a unit other than a psychiatric unit, such as a drug and alcohol unit.

In interpreting the NHMD data presented in this report, note that mental health care for admitted patients in Australia is provided in a large and complex system. Although there are national standards for data on admitted patient care, the results presented here may be affected by variations in admission and reporting practices across states and territories. Interpretation of the differences between jurisdictions therefore needs to be done with care. Principal diagnosis refers to the diagnosis established after observation by medical staff to be chiefly responsible for the patient's episode of admitted patient care. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM edition). Further information on this is included in the technical information section.

Procedures are classified according to the *Australian Classification of Health Interventions, 5th 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 mental health 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. Accordingly, jurisdictional comparisons should be made with caution.

New South Wales: New South Wales does not have a centralised database for the collection of seclusion data. Services report seclusion rates regularly to the NSW Ministry of Health. Services are required to maintain local seclusion registers, which may be audited by NSW Official Visitors who function with legislative authority to raise issues in relation to patient safety, care or treatment. Seclusion rates are a Key

Performance Indicator (KPI) in regular performance reporting to NSW Local Health Districts. Importantly, NSW seclusion rates include bed days for some forensic services managed by correctional facilities.

Victoria: Both the National Beacon Projects and the Creating Safety Project supported Victorian services to review their use of seclusion and employ different strategies to support reduction of seclusion, with targets set in the Statement of Priorities to support health services reduce seclusion events. In Victoria, variation between health services will improve over time, with a new Mental Health Act being developed and a reduction in the use of restrictive practices.

Western Australia: It should be noted that Western Australia does not have a centralised data base for the collection of seclusion data. Services provided seclusion data from their own data bases. The WA Mental Health Commission is seeking to update the software used to record seclusion events with the introduction of a new Mental Health Bill 2013 in the legislative assembly.

South Australia: Recent data reporting improvements will impact on South Australian data. Importantly, bed days used to calculate South Australia's seclusion rates are estimated based on 100% occupied bed numbers, which are fluctuating in relation to new infrastructure projects. During 2010–11, a substantial number of seclusion events in one particular hospital were for a small number of patients with over half of these patient-requested events. This may have impacted on the overall seclusion rate reported for the state for 2010–11.

South Australia was unable to supply seclusion data for 2008–09.

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

Australian Capital Territory: When interpreting these data, the relative small size of the Australian Capital Territory should be noted, with a total of between 60 and 65 acute inpatient beds reported between 2008–09 and 2012–13.

ACT activities initiated as part of the Beacon Site project included the implementation of a clinical review committee inclusive of clinical staff, consumers and carer representation to review episodes of seclusion for systemic issues on a case-by-case basis. This has led to a number of reforms over several years that have had a direct impact on the use of seclusion and its reduction to the low levels now reported.

Work is progressive and ongoing as part of a larger process of providing a place of improved safety and security, both for people experiencing an acute episode of mental ill health leading to an inpatient admission, visitors and for the staff who work in this challenging environment.

Northern Territory: The Northern Territory was unable to supply seclusion data for 2008–09.

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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.

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. 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.
Procedure	**Procedure** refers to a clinical intervention that is surgical in nature, carries an anaesthetic risk, requires specialised training and/or requires special facilities or services available only in an acute care setting. Procedures therefore encompass surgical procedures and non-surgical investigative and therapeutic procedures, such as X-rays. Patient support interventions that are neither investigative nor therapeutic (such as anaesthesia) are also included.

Psychiatric care days	**Psychiatric care days** are the number of days or part days the person received care as an admitted patient in a designated psychiatric unit or ward.
Seclusion	**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 accurate 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.
Target population	Some specialised mental health services data are categorised using 5 **target population** groups (see METeOR identifier 493010): • Child and adolescent services focus on those aged under 18. • Older person programs focus on those aged 65 and over. • Forensic health 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. • General provides services to the adult population, aged 18 to 64; however, these services may also provide assistance to children, adolescents or older people. • Youth services target children and young people generally aged 16–24.

	Although Mixed is not 1 of the 5 defined target population groups, it is referenced to include services that may include multiple target population categories in any combination (for example, Older person and Child and adolescent) where further disaggregation of the data is not available. It is anticipated that Jurisdictions will undertake further work to disaggregate Mixed services in the future.

Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However, not all states or territories report such jointly funded beds through the National Mental Health Establishments Database. |
| **Without specialised psychiatric care** | A separation is classified as **without specialised psychiatric care** if the patient did not receive any days of care in a specialised psychiatric unit or ward. Despite this, these separations are classified as mental health related because the reported principal diagnosis for the separation is either one that falls within the Mental and behavioural disorders chapter (Chapter 5) in the ICD-10-AM classification (codes F00–F99) or is one of a number of other selected diagnoses (see the technical information). |

Australian Institute of Health and Welfare
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