

## Ambulatory-equivalent mental health-related admitted patient— private hospitals

Some people's mental health support needs are best met by an overnight stay in a specialised mental health facility; for others, support can be met in an ambulatory, 'outpatient' like setting. In a private hospital context, this type of care is referred to as 'ambulatory' psychiatric care. These hospitalisations do not involve an overnight hospital stay, but rather are provided either on an admitted 'same day' basis or as a home-based admitted patient service. In this section the terms ambulatory and ambulatory-equivalent are used synonymously.

Compared with the public hospital ambulatory psychiatric care data presented elsewhere on this website, the private sector data may include some same-day procedures, such as Electroconvulsive therapy (ECT), which are excluded from the public sector data. Private hospital-based ambulatory psychiatric care is provided in either private hospitals with psychiatric beds or private psychiatric day hospitals (PMHA 2016) (see mental health care facilities [key concepts](#) section for hospital types). In the private hospital ambulatory psychiatric care data sourced from the Private Mental Health Alliance, the counts of episodes include only what are defined as 'clinically substantive' episodes of care by the Private Mental Health Alliance. For this reason, the patient count can be less than the count of episodes. For more information refer to [key concepts](#).

Data presented in this section are sourced from the Private Mental Health Alliance's Centralised Data Management Service (CDMS) and relate to private hospital ambulatory care only. The CDMS fulfils two main objectives. Firstly, it assists participating private hospitals with implementation of their National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures. Secondly, the CDMS provides hospitals and private health funds with a data management service that routinely prepares and distributes standard reports to assist them in the monitoring and evaluation of health care quality (PMHA 2016b). More detailed information on public hospital data source and [private hospital data source](#) are available at the end of respective sections.

### Key points

- In 2014–15, there were 15,060 clinically substantive private hospital-based ambulatory psychiatric [episodes](#) in either private hospitals with psychiatric beds or private psychiatric day hospitals.
- There were 17,723 private ambulatory care psychiatric patients who received 238,555 care days in 2014–15. The average number of care days per patient was 13.5 days.
- The rate of private hospital-based ambulatory psychiatric patients was highest for persons aged 35–44 (11.9 per 10,000 population) compared with a total rate of 7.5 per 100,000.
- Major affective and other mood disorders (47.1%) and Alcohol and other substance use disorders (18.7%) were the two most common principal [diagnostic groups](#) recorded for private hospital-based ambulatory psychiatric episodes.

Data in this section were last updated in October 2016.

## References

PMHA 2016a. Private Hospital-based Psychiatric Services 1 July 2014 to 30 June 2015. Adelaide: PMHA-CDMS.

PMHA 2016b. Private Mental Health Alliance. Viewed 4 May 2016, < <https://pmha.com.au/cdms/Home.aspx> >. Adelaide: PMHA.

## Patient characteristics

### States and territories

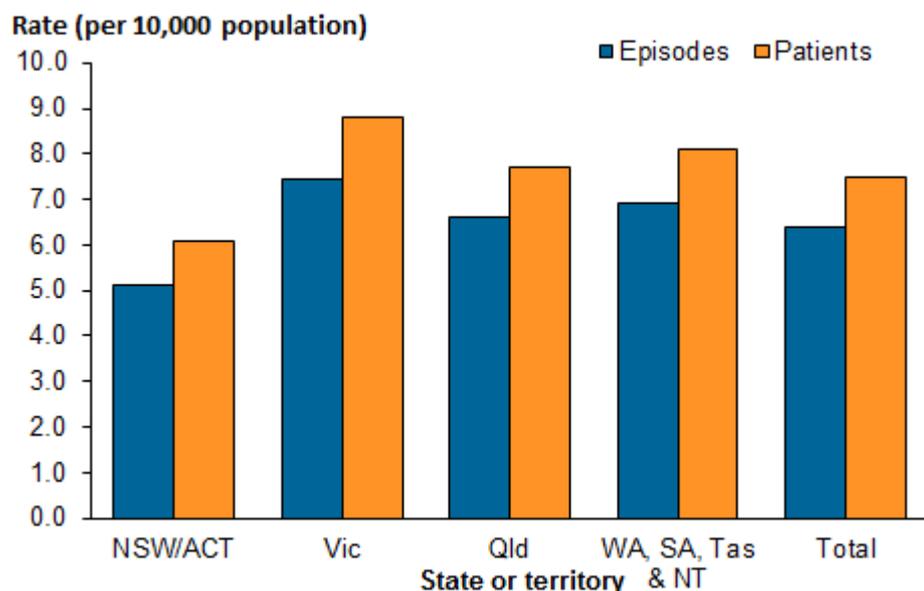
In 2014–15, there were about 4.2 million episodes of care reported from Australian private hospitals (AIHW 2016). There were 238,555 psychiatric ambulatory care days provided to 17,723 patients in 2014–15, which comprised 15,060 episodes of ambulatory care. In the private hospital ambulatory psychiatric care data sourced from the Private Mental Health Alliance, the counts of episodes include only clinically substantive episodes of care. For this reason, the patient counts can be less than counts of episodes (Table PMHA.1).

In 2014–15, the average number of care days per patient was 13.5. The rate of patients per 10,000 population was 7.5, for patient episodes this was 6.4 and for care days this rate was 101.0 (Table PMHA.2).

Some state and territory data from the Private Mental Health Alliance's CDMS is aggregated to maintain privacy for participating hospitals. New South Wales and the Australian Capital Territory are reported together (NSW/ACT) as are Western Australia, South Australia, Tasmania and Northern Territory (WA/SA/Tas/NT). Victoria and Queensland are reported separately.

The rate of patients per 10,000 population ranged from 8.8 in Victoria to 6.1 in NSW/ACT, compared with a total rate of 7.5 (Figure PMHA.1).

**Figure PMHA.1: Private hospital-based ambulatory psychiatric patients and clinically substantive episodes, states and territories, 2014–15**



Source: PMHA CDMS, 2016. Source data: Private hospital-based ambulatory psychiatric services Table PMHA.2 (210 KB XLS).

The number of private ambulatory care patient episodes ranged from 4,381 in Victoria to 3,135 in Queensland. The rate of episodes per 10,000 population ranged from 7.4 in Victoria to 5.1 in NSW/ACT, compared with a total rate of 7.5.

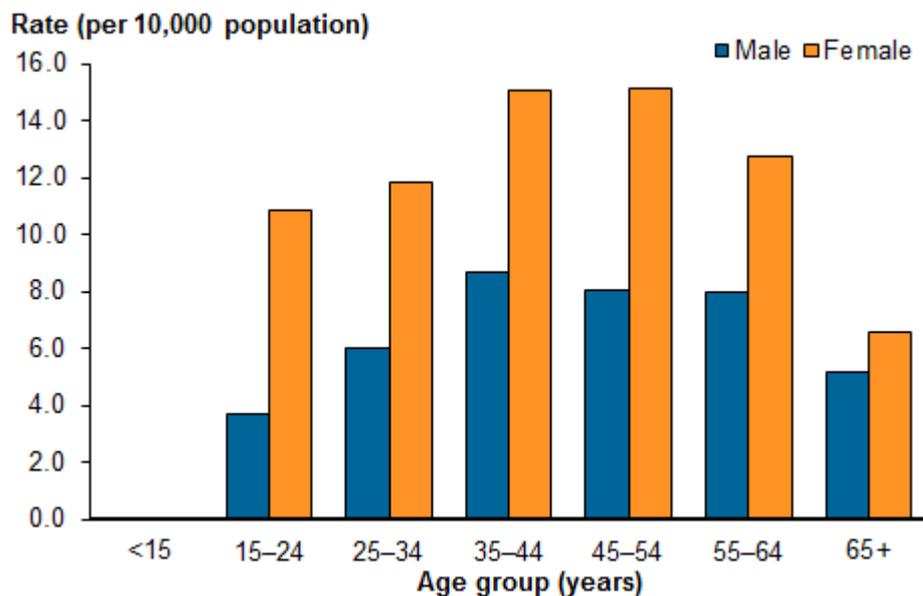
The number of private ambulatory care days ranged from 85,008 in Victoria to 46,955 in Queensland. The rate of ambulatory care days per 10,000 population ranged from 144.4 in Victoria to 74.9 in NSW/ACT. The average number of care days per patient ranged from 16.4 in Victoria to 11.6 in WA, SA, Tas and NT combined (Table PMHA.2).

## Patient demographics

In 2014–15, the rate of private hospital-based ambulatory psychiatric patients was highest for patients aged 35–44 (11.9 per 10,000 population) (Figure PMHA.2). Overall, those aged under 15 were least likely to be private ambulatory psychiatric patients, with the rate increasing gradually until the age of 35–54 and then dropping again.

Females accounted for 65.1% of private ambulatory psychiatric patients. The highest rate of private ambulatory psychiatric patients was for females aged 45–54 (15.2 per 10,000 population) and the highest rate for males occurred for those aged 35–44 (8.7 per 10,000 population) (Table PMHA.3).

**Figure PMHA.2: Private hospital-based ambulatory psychiatric patients, by sex and age group, 2014–15**



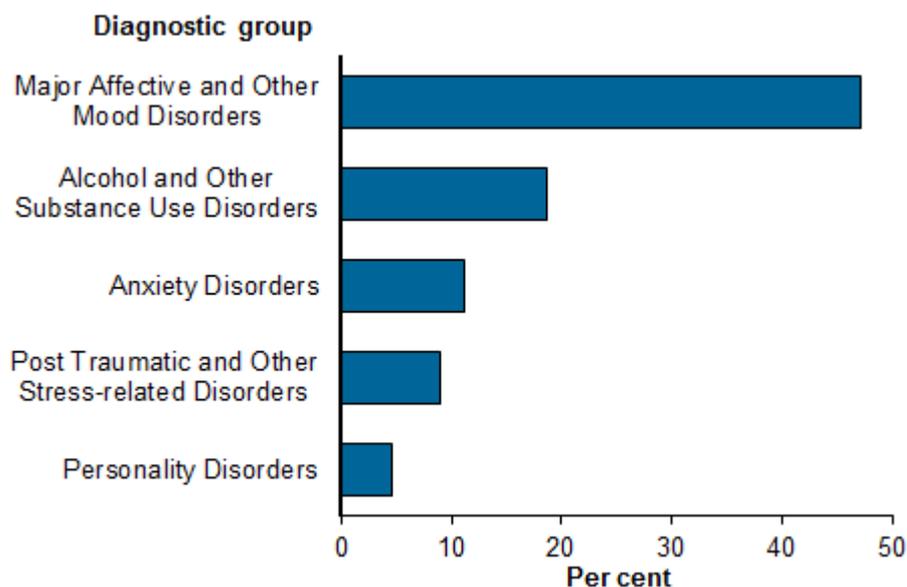
Source: PMHA CDMS, 2016. Source data: Private hospital-based ambulatory psychiatric services Table PMHA.3 (210 KB XLS).

About 9 out of 10 (86.9%) patients who received private hospital-based psychiatric ambulatory care in 2014–15 resided in urban areas, accounting for the majority of episodes (87.1%) and number of care days (88.7%) (Table PMHA.2).

## Principal diagnosis

In 2014–15, Major affective and other mood disorders was the mental health [diagnostic group](#) resulting in the largest number of private hospital-based ambulatory psychiatric episodes (47.1%), followed by Alcohol and other substance use disorders (18.7%) (Figure PMHA.3).

**Figure PMHA.3: Private hospital-based ambulatory psychiatric episodes, for the 5 most commonly reported mental health diagnostic groups, 2014–15**



Source: PMHA CDMS, 2016. Source data: Private hospital-based ambulatory psychiatric services Table PMHA.4 (210 KB XLS).

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## Reference

AIHW 2016. Admitted patient care 2014–15: Australian hospital statistics. Health services series no. 68. Cat. no. HSE 172. Canberra: AIHW.

## Data sources

### Private Mental Health Alliance Centralised Data Management Service (PMHA CDMS)

The PMHA's CDMS was launched in Australia in 2001 to support private hospitals with psychiatric beds to support private hospitals with psychiatric beds to routinely collect and report on a nationally agreed suite of clinical measures and related data for the purposes of monitoring, evaluating and improving the quality of and effectiveness of care. The CDMS works closely with private hospitals, health insurers and other funders (e.g. Department of Veterans' Affairs) to provide a detailed quarterly statistical reporting service on participating hospitals' service provision and patient outcomes. Hospitals and health insurers use the information to monitor and evaluate service provision. To support private hospitals in maintaining these reporting requirements, the CDMS also maintains training resources for hospitals and a database application which enables hospitals to submit de-identified data to the CDMS. The CDMS produces an annual statistical report. In 2014-15, the CDMS accounted for 98% of all private psychiatric beds in Australia.

Up until 30 June 2016, the CDMS was managed by the PMHA and operated by the Australian Medical Association under an Agreement for Services, with funding from participating private hospitals, private health insurance funds and the Australian Government. From 1 July 2016, the CDMS entered into an interim governance arrangement with the AMA and the Australian Government pending re-negotiation of funding and governance arrangements.

The classification of diagnostic groups used by the CDMS is based on the ICD-10 principal diagnosis assigned to the episode of care at discharge. There are 8 clinical groupings of the ICD-10 diagnoses relating to mental and behavioural disorders, they are as follows:

- Schizophrenia, Schizoaffective and Other Psychotic Disorders. This group includes ICD-10 diagnoses of: Psychotic disorders due to psychoactive substance use (F1x.5 and F1x.7), Schizophrenia (F20), Schizotypal disorders (F21), Delusional disorders (F22 and F24), Acute and transient psychotic disorders (F23), Schizoaffective disorders (F25), and Other nonorganic psychotic disorders (F28 and F29).
- Major Affective and Other Mood Disorders. This group includes ICD-10 diagnoses of Manic episodes and bipolar affective disorders with current episode manic (F30, F31.0, F31.1 and F31.2), Depressive episodes, bipolar disorders with current episode depressed or mixed, and recurrent depressive disorders (F31.3, F31.4, F31.5, F31.6, F31.7, F31.8, F31.9, F32 and F33), and Persistent mood disorders including cyclothymia and dysthymia, and other mood disorders (F34, F38 and F39).
- Post Traumatic and Other Stress-related Disorders. This group includes ICD-10 diagnoses of Reactions to severe stress including acute stress reactions (F43.0, F43.8 and F43.9), Adjustment disorders with brief depressive reactions (F43.20), Adjustment disorders with prolonged depressive reactions (F43.21), Other adjustment disorders (F43.22 and F43.28) and Posttraumatic stress disorders (F43.1).
- Anxiety Disorders. This group includes ICD-10 diagnoses of Anxiety disorders including phobic anxiety, panic disorder, generalised anxiety disorder and other neurotic disorders (F40, F41 and F48), and Dissociative disorders (F44). It does not include Obsessive Compulsive Disorders (F42) or Somatoform Disorders (F45) which are classified elsewhere.
- Alcohol and Other Substance Use Disorders. This group includes ICD-10 diagnoses of Alcohol and Other psychoactive substance intoxication, harmful, use, dependence and withdrawal (F1x.0, F1x.1, F1x.2, F1x.3, F1x.4, F1x.8 and F1x.9).
- Eating Disorders. This group includes ICD-10 diagnoses of Anorexia nervosa and atypical anorexia nervosa (F50.0 and F50.1), and Eating disorders other than anorexia nervosa (F50.2, F50.3, F50.4- and F50.9).

- Personality Disorders. This group includes ICD-10 diagnoses of Paranoid and schizoid personality disorders (F60.0 and F60.1), Dissocial personality disorders including antisocial personality disorder (F60.2), Emotionally unstable personality disorders (includes borderline and impulsive) (F60.3), Histrionic, anankastic (obsessive-compulsive), anxious, and dependent personality disorders (F60.4, F60.5, F60.6 and F60.7), and Other personality disorders (F60.8, F60.9, F61.0, F61.1, F62, F63, F68 and F69).
- Other Disorders, Not Elsewhere Classified. This group includes all remaining psychiatric and other diagnoses including: Organic Disorders (F00 through F09 and F1x.6); Obsessive Compulsive Disorders (F42); Somatoform disorders (F45); Behavioural Syndromes Associated with Physiological Disturbances and Physical Factors (F51, F53, F54, and F59); Sexual Disorders (F52, F64, F65 and F66); Mental Retardation (F70, F71, F72, F73, F78 and F79); Disorders of Psychological Development (F80, F81, F82, F83, F84, F88 and F89); Disorders of Childhood and Adolescence (F90, F91, F92, F93, F94, F95 and F98.0); Other Disorders, including ICD-10 diagnoses of Mental disorders, not otherwise specified (F99) and all other valid non-psychiatric diagnoses (i.e., diagnoses not grouped under either MDC 19 or MDC 20 in AR-DRG 4).

The classification of patients into urban versus non-urban groups was based on the ASGC Remoteness classification of the Postcode of their Area of usual residence. Patients, whose Area of usual residence was in ASGC group *Major cities* were classified as "Urban", whilst those in the remaining groups (*Inner regional, Outer regional, Remote* and *Very remote*) were classified as "Non-urban".

Statistics for States and Territories were aggregated in accordance with CDMS policy which, in order to ensure the privacy and confidentiality of both patients and providers, prohibits individual State or Territory statistics being reported in cases where the number of Hospitals is less than 5. As a consequence, statistics for the Australian Capital Territory are aggregated with those for New South Wales; whilst those for South Australia, Western Australia, Tasmania and Northern Territory are also aggregated.

## Key concepts

### Ambulatory-equivalent mental health-related admitted patient care-private hospitals

Key Concept	Description
<b>Ambulatory</b>	<p>An episode is classified as <b>ambulatory</b> for this report if the episode was a same day separation (that is, admission and separation occurred on the same day).</p> <p>The terms ambulatory and ambulatory-equivalent are used synonymously in this section.</p>
<b>Diagnostic group</b>	<p>The classification of <b>diagnostic groups</b> is based on the ICD-10 principal diagnosis assigned to the episode of care at discharge. There are 8 clinical groupings of the ICD-10 diagnoses relating to mental and behavioural disorders. For further details of these diagnostic groups, see the <a href="#">data source section</a>.</p>
<b>Episode</b>	<p>An <b>episode</b> of care involves a period of care from admission to separation. Counts of episodes include only clinically substantive episodes of care. Episodes that are of brief duration (1 or 2 contacts only) and episodes during which contacts were sparse (average interval between contacts 6 weeks or greater) are excluded from the count. Consequently, the count of episodes can in some cases be less than the count of unique patients.</p>