Admitted patient mental health-related care

People with mental illness may require admission to hospital. In hospital, patients can receive specialised psychiatric care in a psychiatric hospital or in a psychiatric unit within a hospital. Patients with mental illness may also be admitted to other areas where health care workers may not be 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 these admitted patient mental health-related separations in Australia. Data are sourced from the National Hospital Morbidity Database (NHMD); a collation of data on admitted patient care in Australian hospitals defined by the Admitted Patient Care National Minimum Data Set (APC NMDS). The information describes separations. It is possible for individuals to have multiple separations in any given reference period. For further information see the data source section.

NHMD data for the Australian Capital Territory were not available for the 2014–15 reporting period. See the footnotes in each of the tables for details about the calculation of national rates.

Key points

- There were more than 254,800 mental health-related separations in public and private hospitals in 2014–15 of which more than 3 in 5 (61.7%) were with specialised psychiatric care.
- Involuntary admissions accounted for almost a third (31.1%) 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 (34,030 or 10.7 per 1,000 population).
- Depressive episode and Schizophrenia were the most commonly reported principal diagnoses for separations with specialised psychiatric care (17.4% and 13.5% respectively).
- Mental and behavioural disorders due to use of alcohol and Other organic mental disorders were the most commonly reported principal diagnoses for separations without specialised psychiatric care (18.4% and 12.9% respectively).
- Indigenous Australians had a mental health-related separation rate without specialised psychiatric care that was more than 3 times that of other Australians (12.0 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 rate seen for other Australians (12.8 and 6.5 per 1,000 population respectively).
- Generalised allied health interventions was the most commonly reported procedure block for both separations with and without specialised psychiatric care (41.3% and 39.6% respectively).
- Nationally, seclusion rates have fallen from 10.6 events per 1,000 bed days in 2011–12 to 8.1 in 2015–16.
- The average duration per seclusion event was 5.3 hours in 2015–16.
- Nationally, there were 9.2 physical restraint events per 1,000 bed days and 1.7 mechanical restraint events per 1,000 bed days in 2015–16.

Data in most of this section were last updated in October 2016. Seclusion data were last updated in February 2017 and restraint data was added in May 2017.

A total of 10.2 million separations from public acute, public psychiatric and private hospitals were reported in 2014–15 (AIHW 2016). There were 254,808 mental health-related separations in 2014–15, accounting for 1 in 40 (2.5%) of all hospital separations. Of these, 157,104 (61.7%) involved specialised psychiatric care and 97,704 (38.3%) did not involve specialised psychiatric care. The majority of mental health-related separations occurred in public acute hospitals (74.0%), followed by private hospitals (22.2%) and public psychiatric hospitals (3.8%) (Table AD.1).

Reference

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

Specialised admitted patient mental health care

Service provision

Specialised admitted patient mental health care takes place within a designated psychiatric ward/unit, which is staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental illness. It is also referred to as specialised psychiatric care.

States and territories

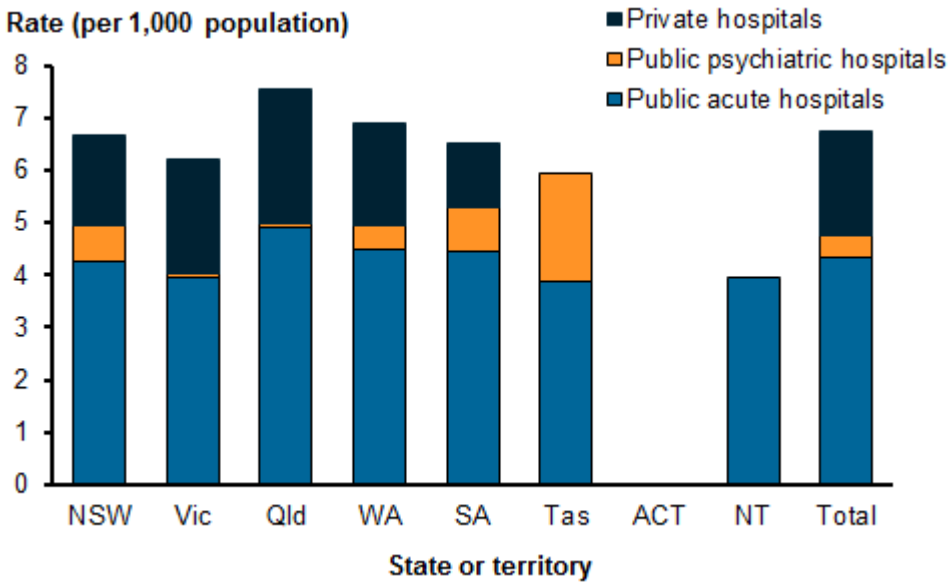
In 2014–15, there were 157,104 mental health-related separations with specialised psychiatric care; equivalent to a national rate of 6.8 per 1,000 population (Table AD.3).

For all states and territories, the rate of mental health-related separations with specialised psychiatric care was higher for public acute hospitals than other hospital types (Table AD.3). Of the 7 reported jurisdictions, Queensland had the highest rate of public acute hospital separations (4.9 per 1,000 population) and Tasmania and the Northern Territory the lowest (3.9) (Figure AD.1).

The rate of mental health-related separations in public psychiatric hospitals was highest for Tasmania (2.1 per 1,000 population) and lowest for both Victoria and Queensland (0.1). The Northern Territory does not have any public psychiatric hospitals.

Among the jurisdictions for which private hospital figures are published, the rate of mental health-related separations in private hospitals was highest for Queensland (2.6 per 1,000 population) and lowest for South Australia (1.2) (Table AD.3).

Figure AD.1: Mental health-related separations with specialised psychiatric care, state and territory, by hospital type, 2014–15



Notes:

1. The Northern Territory does not have any public psychiatric hospitals.
2. Private hospital figures for Tasmania and the Northern Territory are not published because of confidentiality reasons.
3. Data for the Australian Capital Territory were not available for the 2014–15 reporting period. See the footnotes in each of the tables for details about the calculation of national rates.

Source: National Hospital Morbidity Database.

Source data: Admitted patient mental health-related care Table AD.3 (1.19MB XLS).

For public acute hospitals, there were 68.2 patient days per 1,000 population for mental health-related separations with specialised psychiatric care in 2014–15 (Table AD.4). New South Wales had the highest rate of public acute hospital patient days (77.0 per 1,000 population) and Tasmania the lowest (41.9). For states with public psychiatric hospitals, the rates varied from 46.4 patient days per 1,000 population in Tasmania to 7.9 days in Victoria. Queensland reported the highest rate of patient days in private hospitals (40.4 per 1,000 population) (Table AD.3).

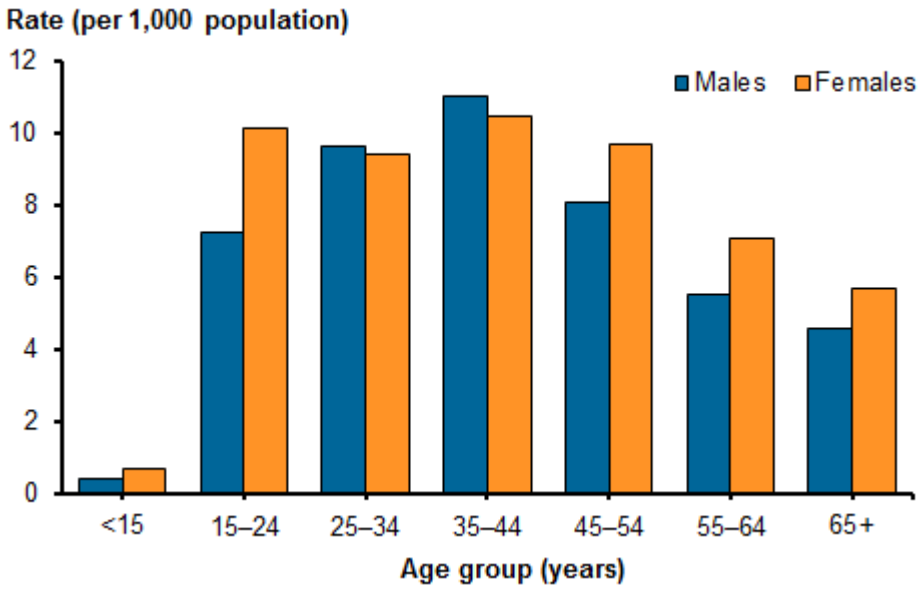
In 2014–15, the national average length of stay for mental health-related patients in public acute hospitals was 15.7 days. New South Wales had the longest average length of stay (18.0 days) and Tasmania the shortest (10.8 days). The greatest variation in average length of stay was for public psychiatric hospitals with Queensland reporting 490.8 days and Tasmania 22.3 days (Table AD.3).

Patient characteristics

Patient demographics

In 2014–15, 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 (10.7 and 0.5 per 1,000 population respectively) (Figure AD.2). Overall, the separation rate was higher for females than males (7.2 and 6.3 per 1,000 population respectively).

Figure AD.2: Mental health-related separations with specialised psychiatric care, by sex and age, 2014–15



Source: National Hospital Morbidity Database.

Source data: Admitted patient mental health-related care Table AD.2 (1.19MB XLS).

Aboriginal and Torres Strait Islander people had a rate of mental health-related separation with specialised psychiatric care that was nearly double that of other Australians (12.8 and 6.5 per 1,000 population respectively) (Table AD.6).

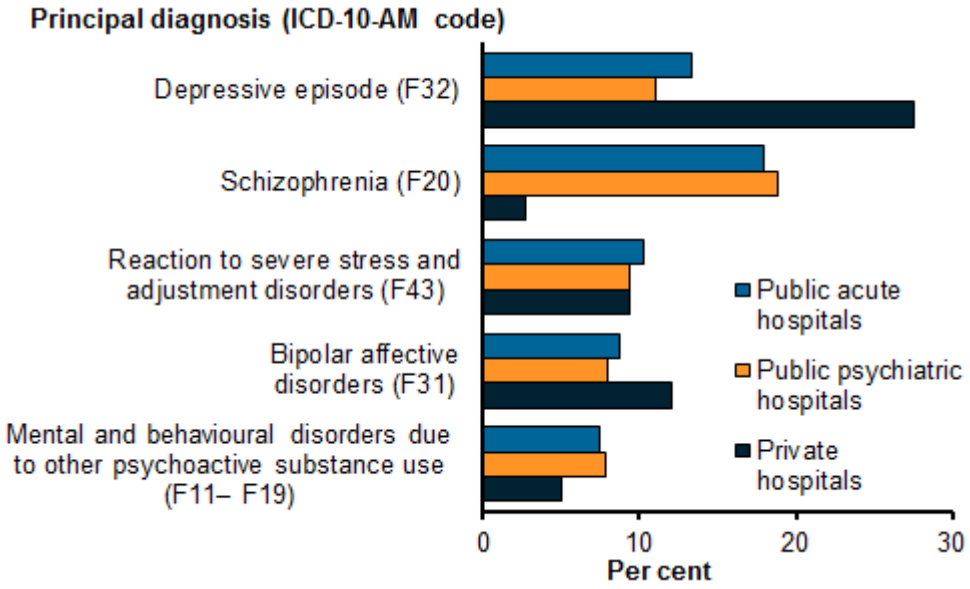
The highest rate of separations in 2014–15 was for those living in *Major cities* (6.9 per 1,000 population) and the lowest for those in *Remote and very remote* areas (3.6 per 1,000 population).

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) (17.4%), followed by Schizophrenia (F20) (13.5%) and Reaction to severe stress and adjustment disorders (F43) (10.0%) (Table AD.7).

The profile of diagnoses varied with hospital type. For example, about 1 in 4 (27.5%) separations with specialised psychiatric care in private hospitals had a principal diagnosis of Depressive episode (F32), compared with 13.4% and 11.0% for public acute and public psychiatric hospitals respectively (Figure AD.3). About 1 in 5 separations in public acute hospitals and public psychiatric hospitals had a principal diagnosis of Schizophrenia (F20) (18.0% and 18.8% respectively), compared with less than 1 in 20 for private hospitals (2.7%).

Figure AD.3: Mental health-related separations with specialised psychiatric care (per cent), the 5 most frequently reported principal diagnoses, by hospital type, 2014–15



Source: National Hospital Morbidity Database.

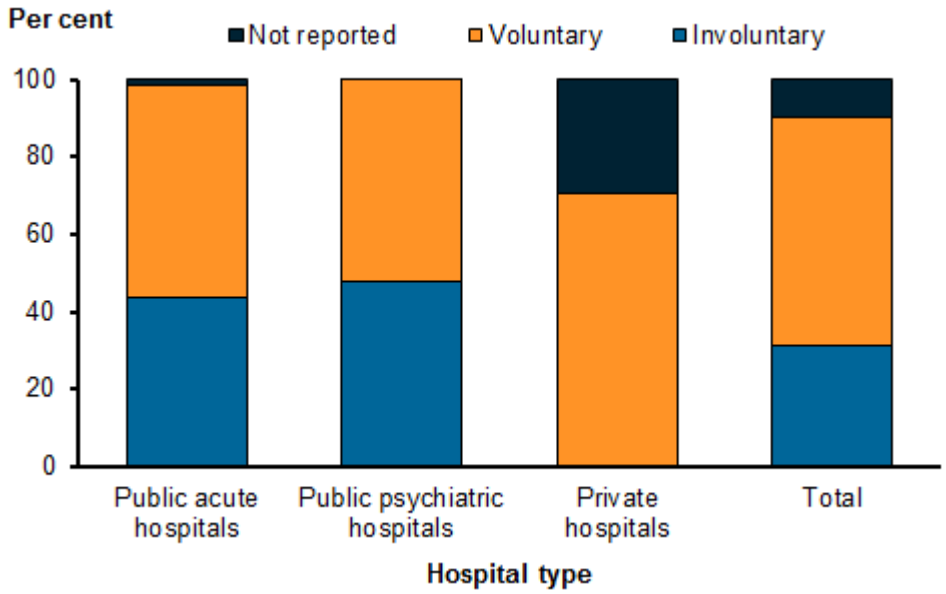
Source data: Admitted patient mental health-related care Table AD.7 (1.19MB XLS).

Mental health legal status

Mental health legal status refers to whether or not a person was treated in hospital involuntarily under the relevant state or territory mental health legislation. In 2014–15, there were 48,857 mental health-related separations with specialised psychiatric care where the mental health legal status was 'involuntary'—representing about a third (31.1%) of these separations. The majority of these (44,137 or 90.3%) occurred in public acute hospitals (Table AD.5).

In private hospitals, very few separations (0.2%) 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 (29.7%) (Figure AD.4). Involuntary separations accounted for 43.7% and 48.0% of separations with specialised psychiatric care in public acute hospital and public psychiatric hospitals respectively.

Figure AD.4: Mental health-related separations with specialised psychiatric care (per cent), by mental health legal status and hospital type, 2014–15



Source: National Hospital Morbidity Database.

Source data: Admitted patient mental health-related care Table AD.5 (1.19MB XLS).

Procedures

The most frequently reported procedure block for separations with specialised psychiatric care was Generalised allied health interventions, which was recorded for over 2 in 5 (41.3%) separations (Table AD.8). Of these allied health interventions, Procedures provided by social workers were the most common (30.2% of allied health interventions), followed by Occupational therapists (18.5%) and Psychologists (16.2%) (Table AD.9).

The next most frequently reported procedure block was Cerebral anaesthesia (general anaesthesia), which was recorded for 12.5% 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 the most common principal diagnosis for separations with specialised psychiatric care.

Non-specialised admitted patient mental health care

Service provision

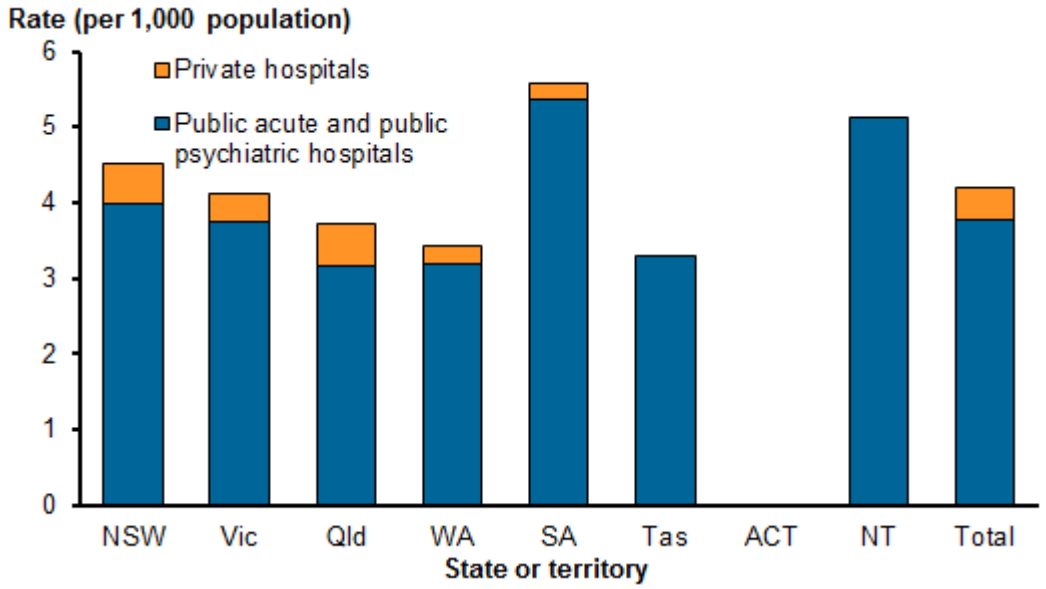
Non-specialised admitted patient mental health care takes place outside a designated psychiatric unit, as mentioned earlier, but for which the principal diagnosis is considered to be mental health-related. A list of mental health related principal diagnoses is available in the technical information section. 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 2014–15 (see Table AD.1).

States and territories

In 2014–15, the national rate of public acute and public psychiatric hospital separations without specialised psychiatric care was 3.8 per 1,000 population. South Australia had the highest rate (5.4 per 1,000 population) while Queensland and Western Australia had the lowest (3.2) (Table AD.10).

The rate of mental health-related separations without specialised psychiatric care in private hospitals for Tasmania, and the Northern Territory are not published for confidentiality reasons. In all other reported jurisdictions, the rates were less than 1 separation per 1,000 population (Figure AD.5).

Figure AD.5: Mental health-related separations without specialised psychiatric care, states and territories, by hospital type, 2014–15



Notes:

1. The Northern Territory does not have any public psychiatric hospitals.
2. Private hospital figures for Tasmania and the Northern Territory are not published for confidentiality reasons.
3. Data for the Australian Capital Territory were not available for the 2014–15 reporting period. See the footnotes in each of the tables for details about the calculation of national rates.

Source: National Hospital Morbidity Database.

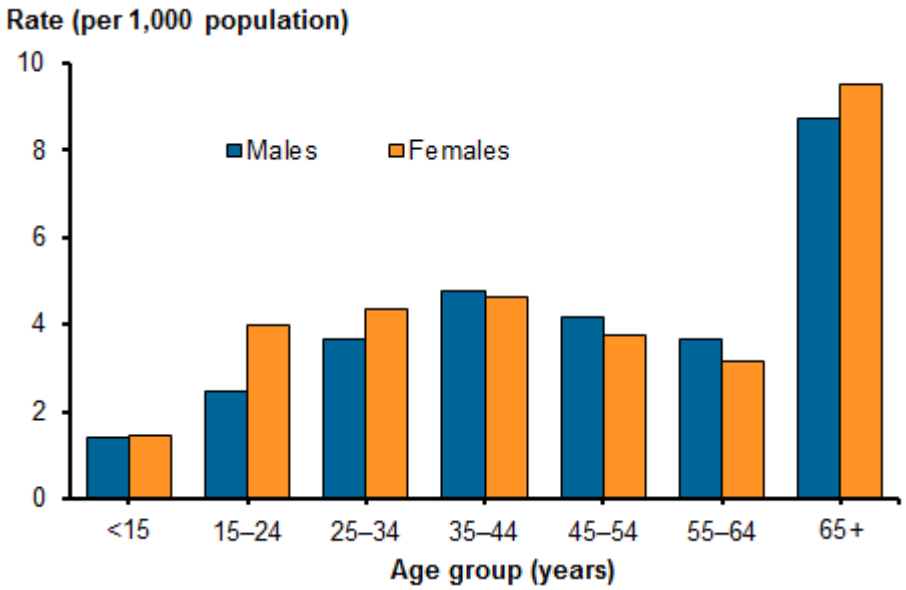
Source data: Admitted patient mental health-related care Table AD.10 (1.19MB XLS).

Patient characteristics

Patient demographics

In 2014–15, the highest rate of mental health-related separations without specialised psychiatric care was for patients aged 65 and older (9.2 per 1,000 population) and the lowest for those aged under 15 (1.4 per 1,000 population) (Figure AD.6). The separation rate was higher for females than males (4.4 and 4.0 per 1,000 population respectively).

Figure AD.6: Mental health-related separations without specialised psychiatric care, by sex and age, 2014–15



Source: National Hospital Morbidity Database.

Source data: Admitted patient mental health-related care Table AD.2 (1.19MB XLS).

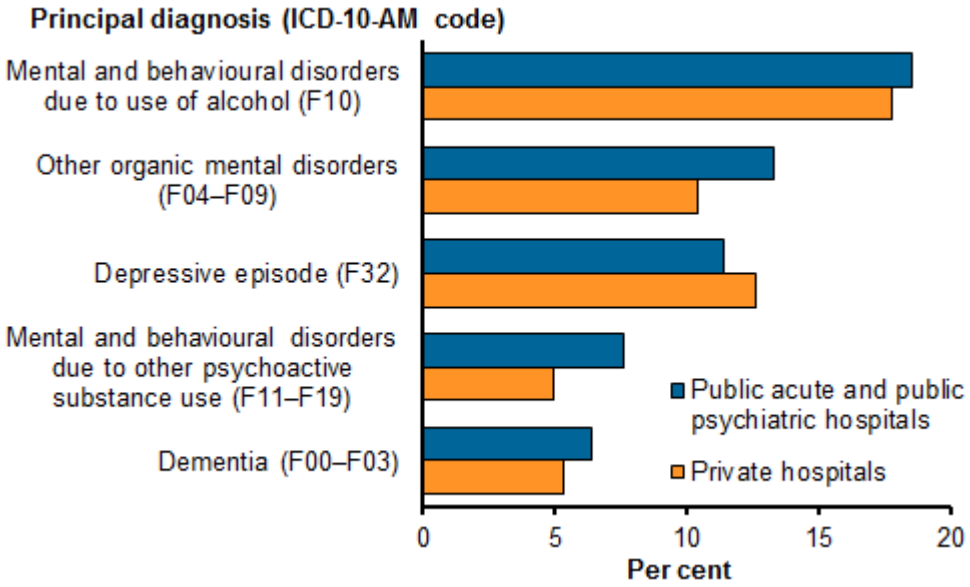
The extent of overrepresentation of Aboriginal and Torres Strait Islander people in mental health-related separations without specialised psychiatric care is greater than that seen for separations with specialised care. In 2014–15, Indigenous Australians had a rate of mental health-related separations without specialised psychiatric care that was more than 3 times that of other Australians (12.0 and 3.8 per 1,000 population respectively) (Table AD.12).

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 (3.8 per 1,000 population in *Major cities*, 4.3 per 1,000 population in *Inner regional* areas, 5.5 per 1,000 population in *Outer regional* areas).

Principal diagnosis

In 2014–15, the most frequently reported principal diagnosis for separations without specialised psychiatric care were Mental and behavioural disorders due to use of alcohol (ICD-10-AM code F10) (18.5% in public hospitals and 17.7% in private hospitals), followed by Other organic mental disorders (13.2% in public and 10.4% in private hospitals) (Figure AD.7).

Figure AD.7: Mental health-related separations without specialised psychiatric care (per cent), by the 5 most frequently reported principal diagnoses, 2014–15



Source: National Hospital Morbidity Database.

Source data: Admitted patient mental health-related care Table AD.13 (1.19MB XLS).

Procedures

About 3 in 5 (62.4%) of mental health-related separations without specialised psychiatric care recorded at least one procedure in 2014–15. The most frequently reported procedure block was Generalised allied health intervention, which was recorded for 2 in 5 (39.6%) separations without specialised psychiatric care (Table AD.14). Allied health interventions were most frequently for Social work (23.5% of allied health procedures), followed by Physiotherapy (22.2%) and Occupational therapy (16.1%) (Table AD.15).

The next most frequently reported procedure block was Cerebral anaesthesia (general anaesthesia), which was recorded for 11.3% 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 the third most common principal diagnosis for separations without specialised psychiatric care.

Use of restrictive practices during admitted patient care

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 four priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion'. The plan recognised that seclusion and restraint are a serious infringement of an individual's rights, and can cause psychological trauma and physical injury to consumers and to health-care staff.

In response, there have been a number of initiatives aimed at reducing seclusion and restraint in public mental health facilities. The Australian Health Ministers Advisory Council's (AHMAC) Safety and Quality Partnership Standing Committee (SQPSC) and Mental Health Information Strategy Standing Committee (MHISSC), in partnership with state and territory authorities, developed a national seclusion data collection and reporting framework and implemented a Mental Health Seclusion and Restraint National Best Endeavours Dataset Specification from the 2015–16 collection period. Most seclusion and restraint occurs in acute specialised mental health hospital service setting, therefore quality improvement initiatives and data collection and reporting have focused on that setting.

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.

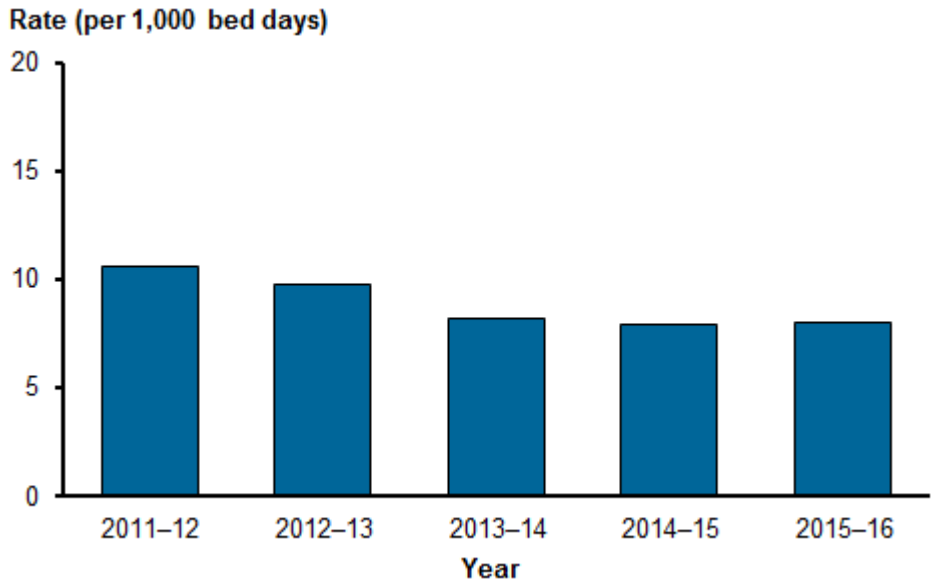
While seclusion can be used to provide safety and containment at a time when this is considered necessary to protect patients, staff and others, it can also be a source of distress not only for the patient but for support persons, representatives, other patients, staff and visitors. Wherever possible,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

Seclusion and restraint may be used across the range of mental health services; however, the focus of the data collections has been limited to the acute specialised mental health hospital service setting, since this service setting has been the focus of many of the quality improvement initiatives.

Overview

Nationally, there were 8.1 seclusion events per 1,000 bed days in 2015–16; a decrease from 10.6 in 2011–12 (Figure AD.8). This represents an average annual reduction of 6.7% over the 5-year period. (Table AD.18).

Figure AD.8: Rate of seclusion events, public sector acute mental health hospital services, 2011–12 to 2015–16



Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.18. (1.19MB XLS)

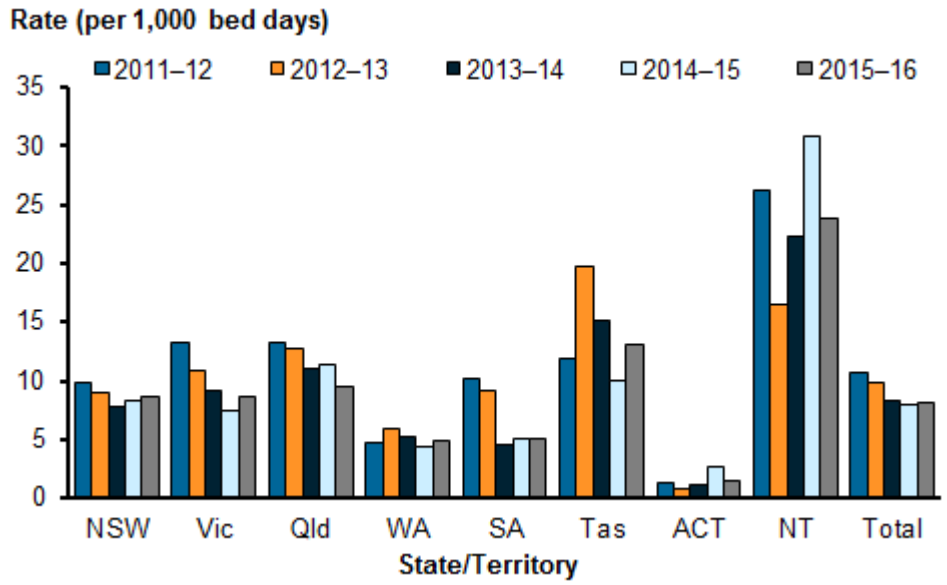
States and territories

Over time

In 2015–16, the Northern Territory had the highest rate of seclusion with 23.9 seclusion events per 1,000 bed days and the Australian Capital Territory had the lowest (1.6). Seclusion rates have fallen for 5 of the 8 states and territories between 2011–12 and 2015–16 (Figure AD.9). (Table AD.18).

Data for smaller jurisdictions should be interpreted with caution as small changes in the number of seclusion events can have a marked impact on the overall seclusion rate. For further data quality information see the data source section.

Figure AD.9: Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2011–12 to 2015–16



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. Due to increased use of community-based treatment, Victoria has fewer beds per capita than other jurisdictions resulting in higher acuity thresholds for admissions. As such, it may be useful to view the rate of seclusion events in a broader population context (rates per capita). Similarly, 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. (1.19MB XLS)

Frequency and duration

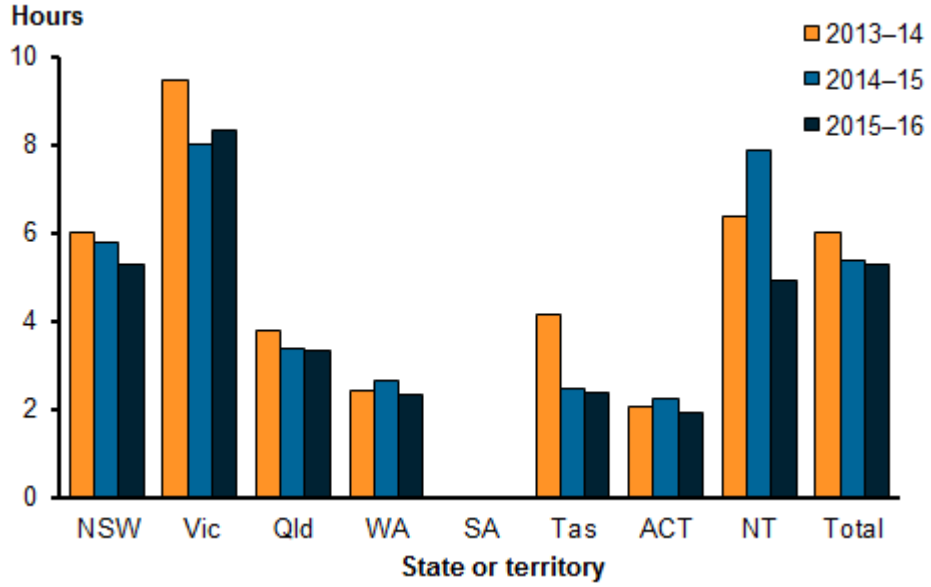
Frequency and duration of seclusion events were collected for the first time in 2013–14.

One in 20 (5.0%) episodes of care provided by Australian public sector specialised acute hospital services involved a seclusion event in 2015–16, a slight decrease from 2013–14 (5.4%). The Northern Territory had the highest proportion of episodes with a seclusion event (10.8%), 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 2015–16 which remains largely unchanged compared to 2013–14 (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. (Table AD.18).

The average duration of a seclusion event excluding Forensic services was 5.3 hours in 2015–16, 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 8.3 hours per seclusion event. The Australian Capital Territory had the shortest, of 1.9 hours (Figure AD.10). (Table AD.18).

Figure AD.10: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services (excluding Forensic events), states and territories, 2014–15 to 2015–16



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. Due to increased use of community-based treatment, Victoria has fewer beds per capita than other jurisdictions resulting in higher acuity thresholds for admissions. Higher acuity on admission may be reflected in an inflated average duration for seclusion events compared to other jurisdictions.

Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.18. (1.19 MB XLS)

Target population

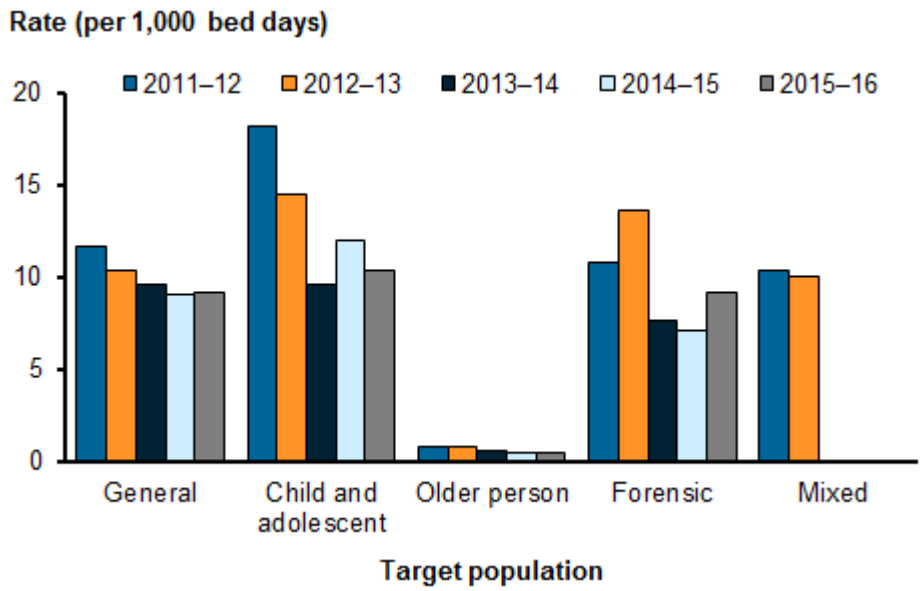
Seclusion data can also be presented by the target population of the acute specialised mental health hospital service where the seclusion event occurred. Around three quarters (78.7%) of in-scope care (total number of bed days) was provided in General services. Older person services accounted for 13.5% followed by Forensic (4.2%) and Child and adolescent (3.6%) services. (Table AD.19).

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 should therefore be approached with caution.

Over time

The highest rate of seclusion was for Child and adolescent services with 10.3 seclusion events per 1,000 bed days, followed by General services (9.2), Forensic services (9.2) and Older person services (0.5). Although a reduction in seclusion rates for the 5 years to 2015–16 was observed for all target population categories, some variability is apparent from year to year (Figure AD.11). (Table AD.19).

Figure AD.11: Rate of seclusion events, public sector acute mental health hospital services, by target population, 2011–12 to 2015–16



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.

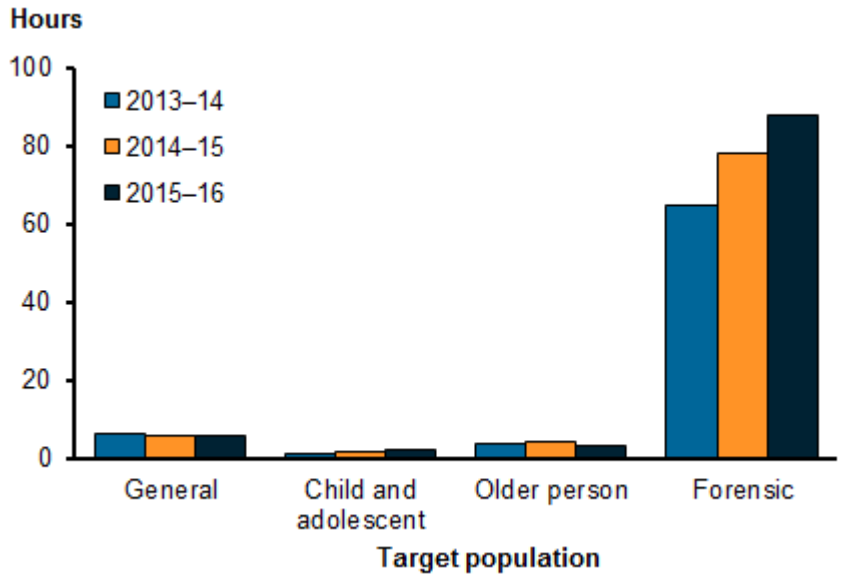
Source data Admitted patient mental health-related care Table AD.19 (1.19MB XLS)

Frequency and duration

Forensic services reported the highest proportion of episodes of care involving seclusion events, with 22.2% of all mental health-related episodes involving seclusion. This was followed by General (5.1%), Child and adolescent (3.9%), and Older person (0.8%) services, with all rates relatively stable when compared with 2013–14. (Table AD.19).

Forensic services had the highest frequency of seclusion, with 3.0 seclusion events per episode when seclusion was used at least once during an episode of care. Seclusion events that occurred in Forensic services also had the longest average duration; 87.9 hours per seclusion event, which is much greater than all other target population categories (1.9 to 5.5 hours). This may also be partly due to the way seclusion is recorded in Forensic services. General services reported an average time of 5.5 hours per seclusion event, followed by Older person (2.9 hours) and Child and adolescent (1.9 hours) services. The average time of the seclusion event decreased for General services and Older person services, and increased for Child and adolescent services and Forensic services between 2013–14 and 2015–16 (Figure AD.12). (Table AD.19).

Figure AD.12: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services, by target population, 2014–15 to 2015–16



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 (1.19MB 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 the seclusion dataset located in *Very Remote* areas.

In 2015–16, hospitals located in *Major Cities* had a seclusion rate of 7.9 events per 1,000 bed days. This rate was higher than that for *Inner Regional* facilities (7.7), and lower than that for *Outer Regional* and *Remote* area facilities combined (11.2). The proportion of mental health-related admitted care episodes with a seclusion event was similar across facilities in all areas (around 5%).

On average, seclusion events in facilities in *Inner Regional* areas were longer in duration (6.4 hours) than those in *Major Cities* (5.1) and *Outer Regional and Remote* areas (4.9). (Table AD.20).

Restraint

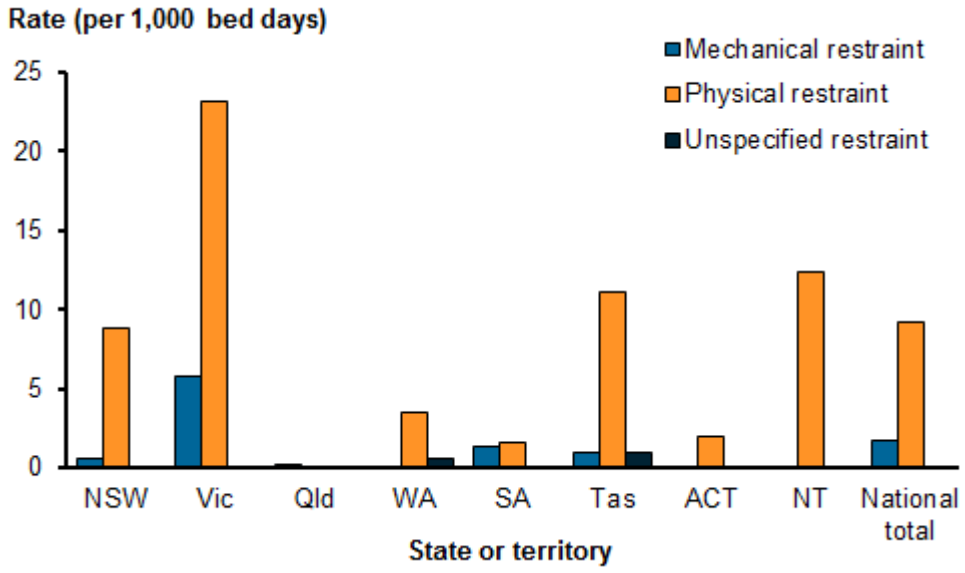
Restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical means.

Data on restraint is being presented for the first time in 2017. Caution is needed in interpreting this data and comparing results; see the Data source section for further information. States and territories have different policy and legislative requirements regarding restraint and have therefore had different processes and systems for collecting data, different definitions of restraint and differences in the types of restraint which are reported. States and territories have worked together to begin to align their collections through the development of a national data collection, the Mental Health Seclusion and Restraint National Best Endeavours Data Set (SECREST NBEDS).

Data for two forms of restraint are specified by the SECREST NBEDS: mechanical restraint (for example, using devices such as belts, or straps); and, physical restraint (for example, the application by health care staff of hands-on immobilisation techniques). Unspecified restraint, that is, the type of restraint is unknown, was a very small component in 2015–16. Data improvement initiatives are expected to remove the need for an unspecified restraint category from 2016–17 onwards.

Nationally, there were 9.2 physical restraint events per 1,000 beds days; mechanical restraint was less common (1.7 events per 1,000 bed days) (Figure AD.13). Data on mechanical restraint was not reported by NT, and data on physical events restraint was not reported by Queensland. Of states with data, Victoria had the highest rate of mechanical and physical restraint events (5.8 and 23.2 events per 1,000 bed days, respectively). This is likely to be the result of higher acuity admission thresholds due to lower per capita bed numbers inflating the results on a per bed day basis.

Figure AD.13: Rate of restraint events, public sector acute mental health hospital services, states and territories, 2015–16



Note: Victoria has fewer beds per capita than other jurisdictions resulting in higher acuity thresholds for admissions. Higher acuity on admission is likely to be reflected in an apparent higher rate of restraint per bed day compared with reporting on a population basis.

Source: State and territory governments, unpublished.

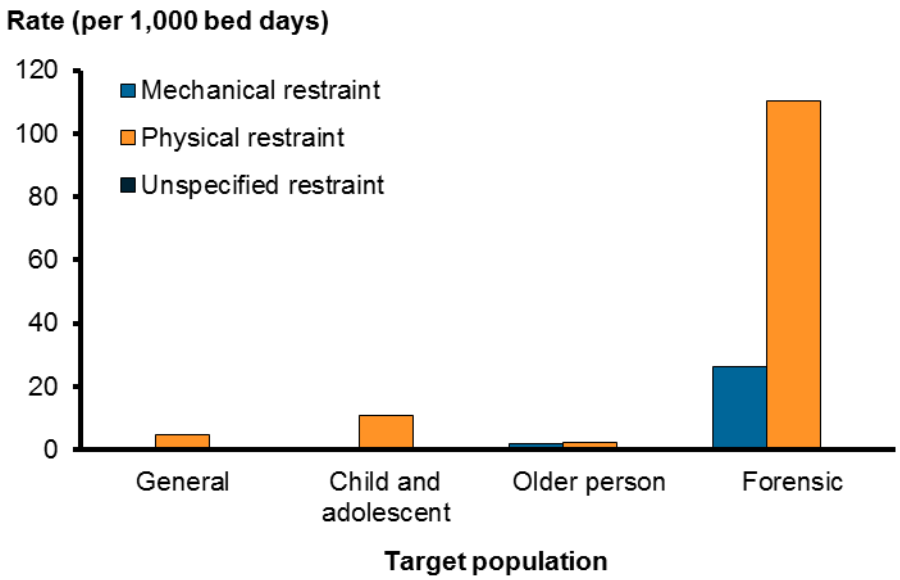
Source data Admitted patient mental health-related care Table AD. 21 (1.19MB XLS)

Alt text: Bar chart showing the rate of mechanical, physical and unspecified restraint events in public sector acute mental health hospital services in each state and territory for 2015-16. NSW 0.6 mechanical & 8.8 physical, Vic 5.8 & 23.2, Qld 0.2 & 0, WA 0, 3.5 & 0.6 unspecified, SA 1.4 & 1.7, Tas 1.0, 11.1 & 1.0, ACT 0 & 2.0, NT 0 & 12.4. Refer to Table AD.21

Target population

Restraint data can also be presented by the target population of the acute specialised mental health hospital service where the restraint event occurred. In 2015–16, the use of restraint (both physical and mechanical) was more common in Forensic services than other service types (Figure AD.14). The physical restraint rate for Forensic services (110.2 events per 1,000 beds days) was over 10 times the rate for Child and adolescent services (10.9) and 20 times the rate for General services (5.0). The rate of mechanical restraint was also highest in Forensic services.

Figure AD.14: Rate of restraint events, public sector acute mental health hospital services, by target population, 2015–16



Source: State and territory governments, unpublished.

Source data Admitted patient mental health-related care Table AD.22 (1.19MB XLS)

ALT text Bar chart showing the rate of mehanical, physical and unspecified restraint events in public sector acute mental helath hospital services by target population in 2015–16. General mechanical 0.4, physical 5.0 & unspecified 0.1, Child & adolescent 0.2 & 10.9, Older person 1.9, 2.3 & 0.1, Forensic 26.2, 110.2. Refer to Table AD.22

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 and the Admitted patient care NMDS 2014–15.

Further information on admitted patient care for the 2014–15 reporting period can be found in the Admitted patient care 2014-15: Australian hospital statistics (AIHW 2016). The 2014–15 collection contains data for hospital separations that occurred between 1 July 2014 and 30 June 2015. Admitted patient episodes of care/separations that began before 1 July 2014 are included if the separation date fell within the collection period (2014–15). 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 between states and territories. Interpretation of the differences between states and territories therefore needs to be made with care. The principal diagnosis refers to the diagnosis established after observation by medical staff to be chiefly responsible for the patient's episode of admitted patient care. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM 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 state and territory 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 2015–16 seclusion data was over 95% based on acute beds admitted units reported to the Mental Health Establishments National Minimum Data Set in 2014–15.

State and territory specific information is included in the accompanying Data quality statement.

Restraint data quality information

Variations in state and territory legislation and reporting requirements may result in differences in the reporting of restraint events, as presented in the key concepts section. Further, changes in legislative and reporting requirements mean that data quality can be compromised as new data systems take time to become embedded in routine practice. Data reported by states and territories therefore may vary in terms of the reporting of restraint events and data quality. Comparisons should be made with caution.

New South Wales

Several services were considered as being out of scope for reporting restraint data, including a number of Forensic services in operation in NSW. Data scope is consistent with scope of services reported in other NSW local publications.

Victoria

Victoria reports the total number of "bodily restraint" events in their Chief Psychiatrist's Annual Report and Mental Health Annual Report series, alongside other additional contextual information and specific commentary on the use of restraint. The approach removes duplicate events where physical and mechanical restraint were used at the same time during a single event. Victorian data should not be added to generate a total result for the state.

Queensland

The Mental Health Act 2016 came into effect in March 2017. For the 2015–16 collection, physical restraint events were not recorded. Data for physical restraint events is expected for the 2017–18 reporting period.

Western Australia

Investment in data collection methodologies resulted in improvements to data quality for 2015–16. Despite these investments, a small component of restraint data was reported as Unspecified restraint type. Data improvements are anticipated to remove the need for the unspecified category from 2016–17 onwards.

Tasmania

Data collection systems in Tasmania were undergoing change during the 2015–16 collection period. It is anticipate that the 2016–17 collection will be able to separately identify all restraint events as either mechanical or physical restraint.

References

AIHW 2016. Admitted patient care: Australian hospital statistics 2014–15: Health services series no. 68. Cat. no. HSE 172. 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: o 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 o 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 was 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 a small number 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).