# Admitted patient mental health-related care

**On this page**



## Key points

- There were about **57,260 same day** mental health-related hospitalisations from **public** hospitals in 2020–21, representing about **1%** of all same day hospitalisations.
- In 2020–21, about **20,890** patients received **same day** admitted mental health care from **private** hospitals.
- There were about **280,700 overnight** mental health-related hospitalisations in 2020–21 across both public and private hospitals, representing about **6%** of all overnight hospitalisations.
- The most frequently reported **principal diagnosis** for mental health-related hospitalisations **with** specialised psychiatric care was *Depressive episode* (**20%** of **same day public** hospitalisations and **15%** of **overnight** hospitalisations).
- For public hospitals, the most frequently reported **principal diagnosis** for mental health-related hospitalisations **without** specialised psychiatric care was *Mental and*

*behavioural disorders due to use of alcohol* (**25%** of **same day** hospitalisations, **21%** of **overnight** hospitalisations).

- In **private** hospitals, **45%** of **same day** mental health-related episodes of care reported a principal diagnosis related to *Major Affective and Other Mood Disorders.*


**Summary**

Admitted patients are those who undergo a hospital's formal admission processes. This section presents information on admitted patient mental health-related hospitalisations from Australian public and private hospitals.

To provide the most comprehensive view of mental health-related admitted care, two different data sources are used for private hospitals (described in detail in each section below). When considering the data presented in this section it should be noted that some activity reported as same day admitted care in the private hospitals data may be reported in the public sector data as community mental health care, due to differences in classification criteria. As such, any comparisons of the volume of care provided by public and private hospitals described in this section should be made with caution. Further information can be found in the data source section.

During 2019–20 there was a decline in admitted mental health-related care, likely due to the impact of the COVID-19 pandemic on Australia's hospitals and health care provision from February 2020. In 2020–21, some pandemic-related restrictions were eased, leading to a small increase of some types of hospitalisations.

There were 110 overnight mental health-related hospitalisations and 22 same day public mental health-related hospitalisations per 10,000 population in 2020–21. In private hospitals there were 8 patients per 10,000 population receiving same day mental health-related admitted care.

For jurisdictions where figures are published and across both public and private sectors, the rate of overnight mental health-related hospitalisations *with* specialised psychiatric care was highest for Queensland (72 per 10,000 population), and for those *without* specialised psychiatric care, the rate was highest for South Australia (55).

Queensland had the highest rate of same day public mental health-related hospitalisations *with* specialised psychiatric care (16 per 10,000 population) and the Northern Territory had the highest rate of hospitalisations *without* specialised care (71). In private hospitals, the rate of patients was highest in Queensland (11).

# Spotlight data

## Figure AC.1 Mental health-related admitted care shows seasonal variation across the year

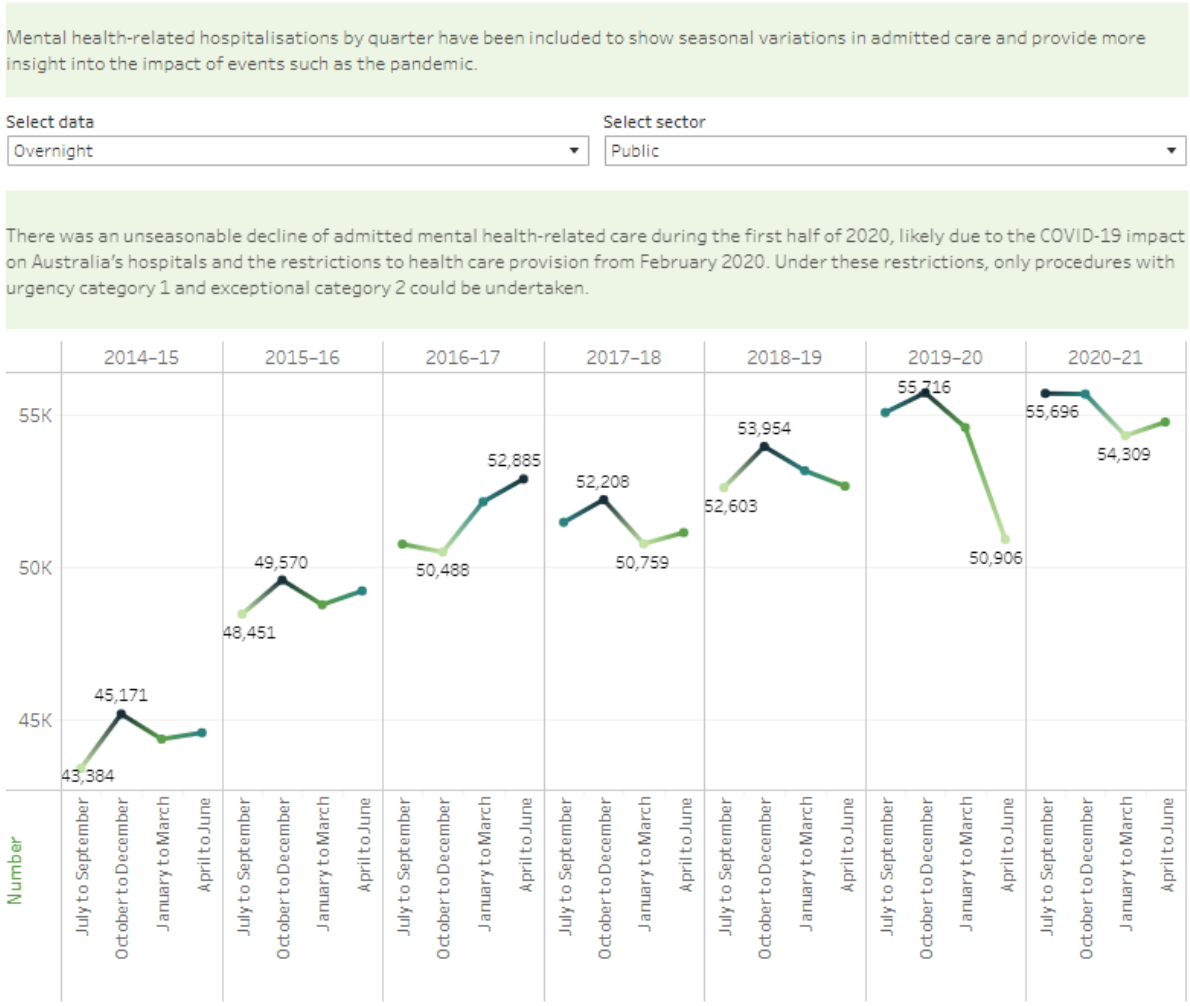



Figure AC.1: Mental health-related admitted care shows seasonal variation across the year

https://www.aihw.gov.au/mhsa

**Data downloads:**

Excel – Same day admitted mental health-related care 2020–21 tables

Excel – Overnight admitted mental health-related care 2020–21 tables

Data coverage includes the time period 2006–07 to 2020–21.

# Introduction

Some people's mental health care needs require care in a hospital setting such as a hospital ward, an emergency department and/or an outpatient clinic. When receiving hospital care, a patient may be admitted to hospital for part of a day (same day admitted mental health care), a single overnight stay, or for a number of days. Care that lasts more than one day is referred to as overnight admitted patient care.

Patients can receive specialised psychiatric care in a psychiatric hospital or in a hospital's psychiatric unit. Patients with mental illness may also be admitted to other areas of the hospital for medical and/or surgical care (e.g. for a heart condition) where health care workers may not be specifically trained to care for the mentally ill. These admissions to hospitals are classified as being without specialised psychiatric care. Private hospital-based same day admitted mental health care is provided in either private hospitals with psychiatric beds or private psychiatric day hospitals (APHA 2021) (information on hospital types can be found in the mental health care facilities key concepts section). Further detail can be found in the data source section.

# Hospitalisations

## Same day

There were almost 3.9 million same day hospitalisations from public acute and psychiatric hospitals in 2020–21. Of these, about 57,260 were mental health-related, which is about 1% of all same day hospitalisations. A quarter of these involved specialised psychiatric care (25%).

In 2020–21, there were about 29,430 clinically substantive episodes of same day admitted mental health care from private hospitals.

**Principal source of funding and type of discharge for a hospitalisation**

The principal source of funding for a separation (hospitalisation) is collected as part of the Admitted Patient Care National Minimum Data Set (APC NMDS). However, it should be noted that a hospitalisation may be funded by more than one funding source and information on additional funding sources is not available. For public hospitals in 2020–21, 93% of same day mental health-related hospitalisations *with* specialised psychiatric care were public patients (e.g. funded by the health service budget or reciprocal health care agreement). Of those jurisdictions with published proportions, all except New South Wales reported a proportion of publicly funded hospitalisations above 90%. New South Wales reported a public patient proportion of 86%, with the remainder being accounted for by Private health insurance funding (12%).

The mode of separation from care is also collected and provides information on how each hospitalisation ended, and for some, the place to which the patient was discharged or transferred. The most common mode of separation for same day public mental health-related hospitalisations *with* specialised psychiatric care was discharge to 'home'

(86%), which includes discharge to usual residence/own accommodation/welfare institution (including prisons, hostels and group homes providing primarily welfare services).

Four in 5 (80%) same day public mental health-related hospitalisations *without* specialised psychiatric care ended with the patient discharged to 'home'. The remaining 20% consisted of transfers to another facility (9%, which includes transfers to another acute hospital), another psychiatric hospital, aged care facilities, and other health accommodation), statistical discharges (which include changes in care type and discharges from leave), and patients leaving against medical advice. Note that information on the place to which a patient was discharged or transferred may not be available for some hospitalisations.

## Overnight

There were about 4.4 million overnight admitted hospitalisations in 2020–21 across both public and private sectors. Of these, about 280,710 were mental health-related, representing about 6% of all overnight hospitalisations. Almost two-thirds of these involved specialised psychiatric care (62%) and more than 3 in 4 occurred in public hospitals (78%).

**Regional reporting and type of discharge for a separation**

Information on overnight mental health-related hospitalisations is reportable at smaller geographic areas than state and territory boundaries. Sub-jurisdictional reporting provides the opportunity to consider differences within jurisdictions. For the analysis presented here, the geographical area is based on the usual residence of the patient rather than the geographical location of the hospital. There are two types of geographical areas which are reported here:

Primary Health Network (PHN) areas – 31 geographic areas covering Australia, with boundaries defined by the Australian Government Department of Health and Aged Care.

Statistical Areas Level 3 (SA3s) – 340 geographic areas covering Australia, with boundaries defined by the Australian Bureau of Statistics.

In 2020–21, the national rate of mental health-related hospitalisations was 110 per 10,000 population. At the PHN level, *Brisbane North* had the highest rate (137), and *Western Sydney* had the lowest (84).

The observed variability in hospitalisation rates between geographical areas may be due to a range of factors including the proportion of the population in an area with a diagnosable mental illness who are admitted to hospital, availability of community-based services and variability in approaches to planning and delivering mental health support services across and within states and territories.

The most common mode of separation (e.g. leaving hospital) for overnight mental health-related hospitalisations *with* specialised psychiatric care in both public (85%) and private (94%) hospitals was discharge to 'home', which includes discharge to usual

residence/own accommodation/welfare institution (including prisons, hostels and group homes providing primarily welfare services).

Note that information on the place to which a patient was discharged or transferred may not be available for some separations.

## States and territories

In comparing across states and territories, it should be noted that models of care differ between jurisdictions and between public and private hospitals. This can affect the reported volume of admitted care and the inclusion or omission of some types of care.

### Specialised admitted patient mental health care

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

**Public hospitals**

In 2020–21, there were 6 same day admitted mental health-related hospitalisations *with* specialised psychiatric care per 10,000 population in public hospitals in Australia. The rate of this type of hospitalisation was highest for Queensland (16).

Nationally, the rate of overnight mental health-related hospitalisations *with* specialised psychiatric care in public acute hospitals was higher than the rate in public psychiatric hospitals (44 and 4 respectively) (Figure AC.2.1).

**Private hospitals**

In 2020–21, there were about 50,180 overnight admitted mental health-related hospitalisations *with* specialised psychiatric care in private hospitals, equivalent to a national rate of 20 per 10,000 population) (Figure AC.2.2).

### Non-specialised admitted patient mental health care

Non-specialised admitted patient mental health care takes place outside a designated psychiatric unit 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, as there were very few hospitalisations without specialised psychiatric care in public psychiatric hospitals in 2020–21.

**Public hospitals**

In 2020–21, the national rate of overnight mental health-related hospitalisations *without* specialised psychiatric care in public hospitals was 38 per 10,000 population.

There were about 42,690 same day public admitted mental health-related hospitalisations *without* specialised psychiatric care, equivalent to a national rate of 17 per 10,000 population (Figure AC.2.1). The majority (96%) were publicly funded.

**Private hospitals**

The national rate of overnight mental health-related hospitalisations *without* specialised psychiatric care in private hospitals was 4 per 10,000 population in 2020–21 (Figure AC.2.2).

## Figure AC.2: Mental health-related admitted care, by state and territory, 2020–21

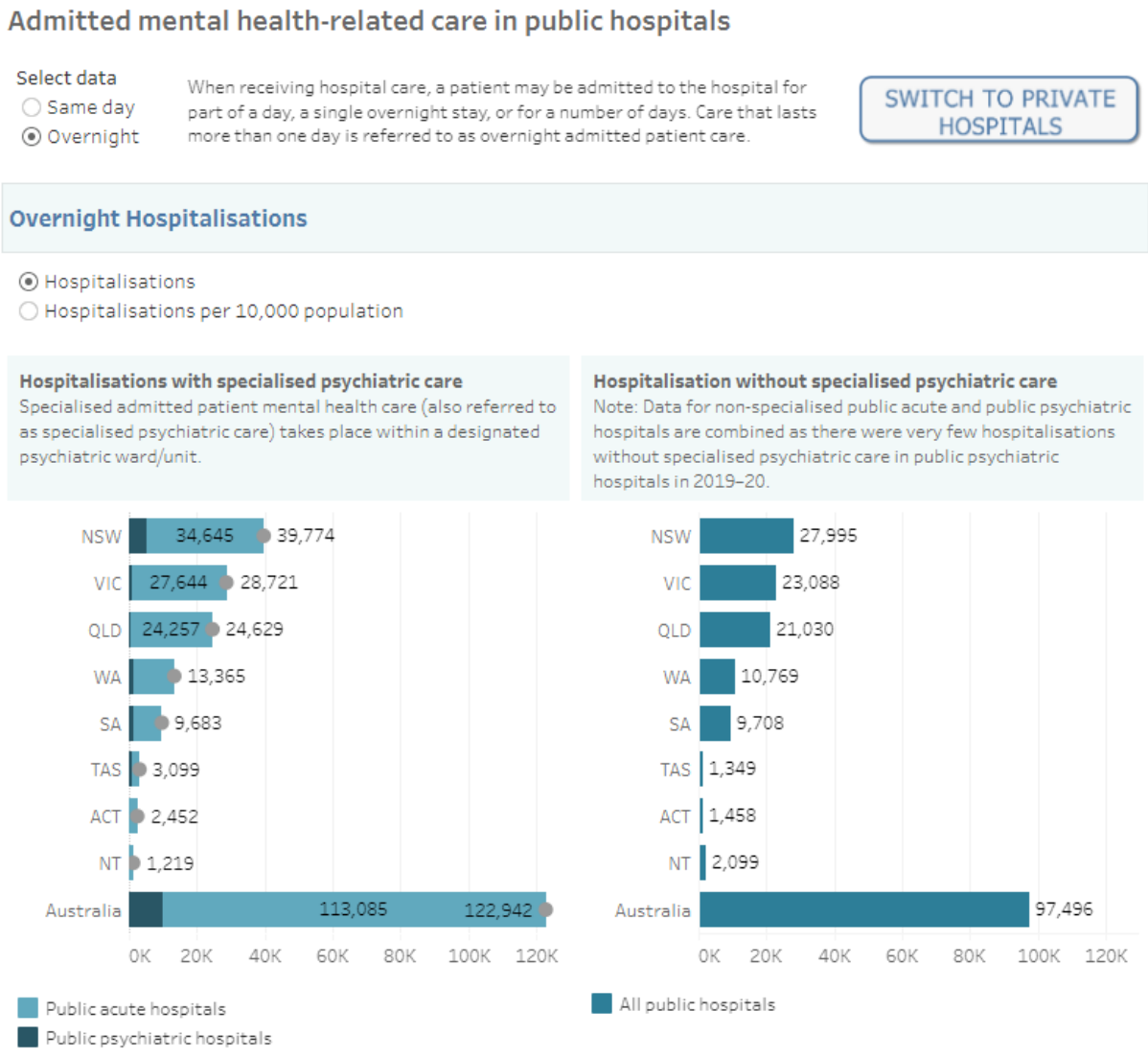



Figure AC.2.1: Mental health-related hospitalisations in public hospitals, states and territories, by hospital type, 2020–21.
https://www.aihw.gov.au/mhsa

# Patient demographics

There were variations in rates of mental health-related hospitalisations by age, sex, Indigenous status, remoteness of area of residence, and socioeconomic status of area of residence.

## Same day

Variability in rates of same day mental health-related hospitalisations across demographics was more noticeable by age group than by other demographic factors.

### Age and sex

In 2020–21, the rate of same day public admitted mental health-related hospitalisations *with* specialised psychiatric care was highest for patients aged 18–24 years (13 per 10,000 population). Overall, the hospitalisation rate *with* specialised psychiatric care was higher for females than males (7 and 5 respectively).

Across all ages, the highest rate of same day public mental health-related hospitalisations *without* specialised psychiatric care was for patients aged 18–24 years (25). The hospitalisation rate was similar for males and females (16 and 17 respectively).

For private hospitals, almost two-thirds of same day mental health related hospitalisations were for female patients (65%). The population rate for females was almost twice that for males (11 and 6 respectively). Females aged 18–24 years had the highest patient rate (20) of all age groups (Figure AC.3.2).

### Indigenous status

There were about 980 same day public mental health hospitalisations *with* specialised psychiatric care for Aboriginal and Torres Strait Islander people in 2020–21, or 11 per 10,000 population, which is more than twice the rate for non-Indigenous patients (5).

There were about 4,840 same day public mental health hospitalisations *without* specialised psychiatric care for Indigenous Australians, or 56 per 10,000 population, which is almost four times higher than the rate of 15 for non-Indigenous patients (Figure AC.3.2).

### Remoteness area of usual residence

People living in *Major cities* had the highest rate of same day public mental health-related hospitalisations *with* specialised psychiatric care in 2020–21 (6 per 10,000 population).

In contrast, the rate of same day public mental health-related hospitalisations *without* specialised psychiatric care increased with remoteness. People living in *Remote* and *Very remote* areas had the highest rate (45) (Figure AC.3.2).

The majority of patients receiving same day private admitted mental health care were from *Urban areas*.

## Overnight

Variations in rates of overnight mental health-related hospitalisations across demographics were more noticeable by age group than by other demographic factors.

## Age and sex

In 2020–21, the rate of overnight mental health-related hospitalisations *with* specialised psychiatric care was highest for patients aged 18–24 years (119 per 10,000 population) (Figure AC.3.1). Overall, across all ages, the rate was higher for females than males (72 and 63 respectively), but there is variation across age groups.

The highest rate of overnight mental health-related hospitalisations *without* specialised psychiatric care was for patients aged 85 and older (312). The rate was slightly higher for females than males (44 and 40 respectively) (Figure AC.3.1), but there is variation across age groups.

## Indigenous status

There were 13,270 overnight mental health-related hospitalisations *with* specialised psychiatric care for Indigenous Australians in 2020–21, or 154 per 10,000 population, which is 2.5 times higher than the rate for non-Indigenous patients (63) (Figure AC.3.1).

There were about 8,320 overnight mental health-related hospitalisations *without* specialised psychiatric care for Indigenous Australians, or 97 per 10,000 population, which is 2.5 times higher than the rate of other patients (39).

## Remoteness area of usual residence

Patients living in *Inner regional* areas had the highest rate of overnight mental health-related hospitalisations with specialised psychiatric care in 2020–21 (68 per 10,000 population), whilst those living in *Remote* and *Very remote* areas had the lowest (42).

In contrast, people living in *Remote* and *Very remote* areas had the highest rate of overnight mental health-related hospitalisations *without* specialised psychiatric care (79) (Figure AC.3.1).

## Socioeconomic status

There was variability seen across socioeconomic status. People living in the most disadvantaged socioeconomic quintile (SEIFA Quintile 1) had the highest rate of overnight mental health-related hospitalisations *without* specialised psychiatric care at 45 per 10,000 population.

**Figure AC.3: Mental health-related admitted care, by sex and age group, 2020–21**

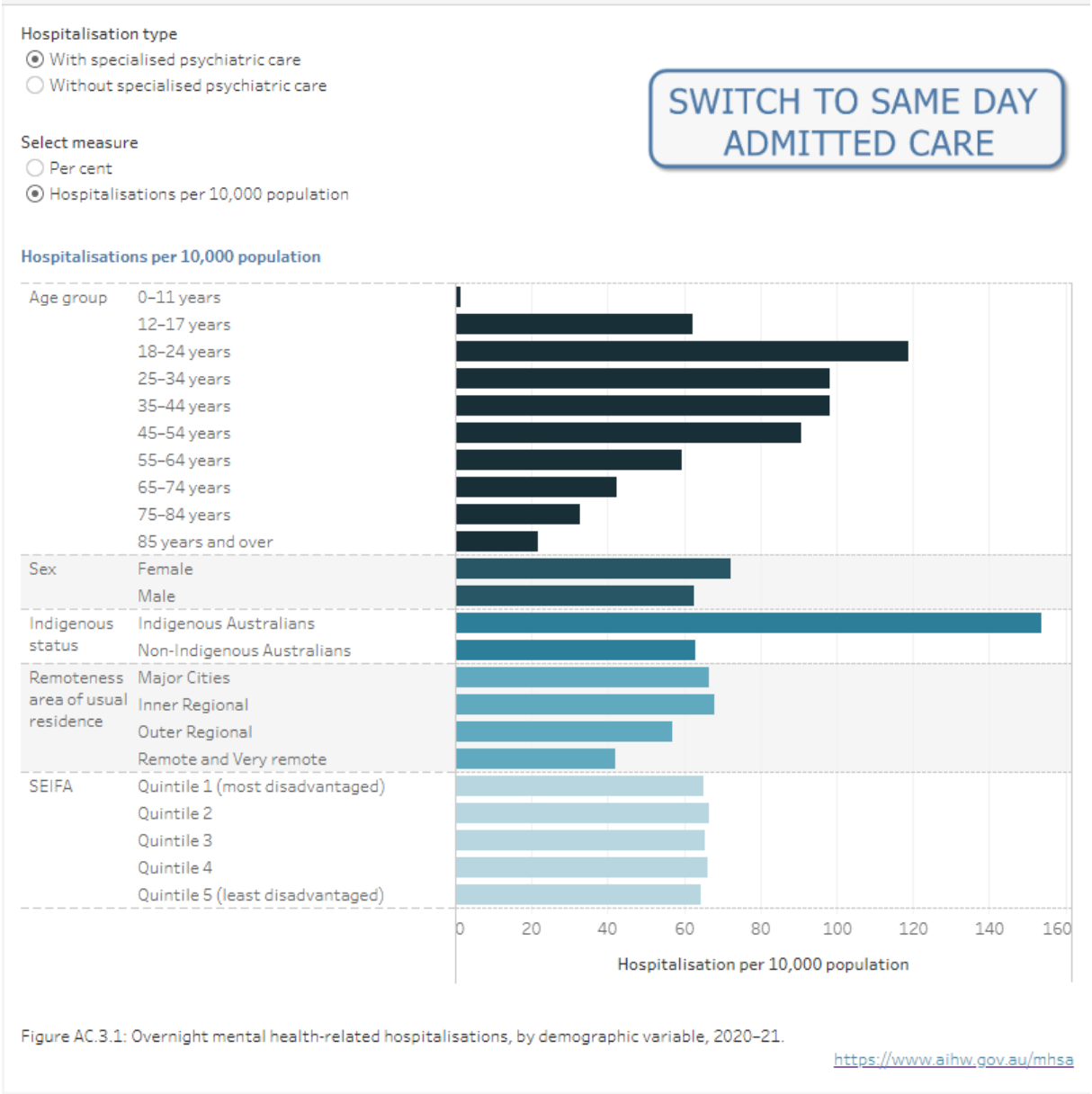



Figure AC.3.1: Overnight mental health-related hospitalisations, by demographic variable, 2020–21.

https://www.aihw.gov.au/mhsa

# Procedures

In 2020–21, *Generalised allied health interventions* and *Cerebral Anaesthesia* were among the 5 most commonly reported procedure blocks across all hospitalisation types and sectors for which data is available (information on procedures associated with same day private mental health-related hospitalisations is not reported). *Cerebral anaesthesia* is most likely associated with the administration of *Electroconvulsive therapy* (ECT), a frequently reported procedure for hospitalisations *with* specialised psychiatric care, and

a form of treatment for depression, which was the most common principal diagnosis for hospitalisations *with* specialised psychiatric care in public hospitals.

## Same day

The most frequently reported procedure blocks for same day public mental health-related hospitalisations *with* specialised psychiatric care in 2020–21 were *Cerebral anaesthesia* and *Electroconvulsive therapy* (ECT) (each made up 37% of procedures and were associated with 32% of hospitalisations) (Figure AC.4.2). The most frequent allied health interventions *with* specialised care were as follows:

### Frequently reported allied health interventions for same day public specialised care

| Allied health intervention procedure | Per cent of procedures |
|---|---|
| *Psychology* | 34% |
| *Social work* | 30% |
| *Occupational therapy* | 12% |

For same day public hospitalisations *without* specialised psychiatric care, the most frequently reported procedure block was *Cerebral anaesthesia* (34% of procedures, associated with 22% of hospitalisations) (Figure AC.4.2). The most frequent allied health interventions *without* specialised care were as follows:

### Frequently reported allied health interventions for same day public non-specialised care

| Allied health intervention procedure | Per cent of procedures |
|---|---|
| *Social work* | 48% |
| *Pharmacy* | 14% |
| *Physiotherapy* | 11% |

## Overnight

The most frequently reported procedure block for overnight mental health-related hospitalisations *with* specialised psychiatric care in 2020–21 was *Generalised allied health interventions* (45% of procedures and associated with 63% of hospitalisations) (Figure AC.4.1). *Cerebral anaesthesia* was associated with 5% of hospitalisations but it was the third most frequently reported procedure block (10% of procedures). The most frequent allied health interventions *with* specialised care were as follows:

**Frequently reported allied health interventions for overnight specialised care**

| Allied health intervention procedure | Per cent of procedures |
|---|---|
| *Social work* | 25% |
| *Pharmacy* | 19% |
| *Occupational therapy* | 17% |

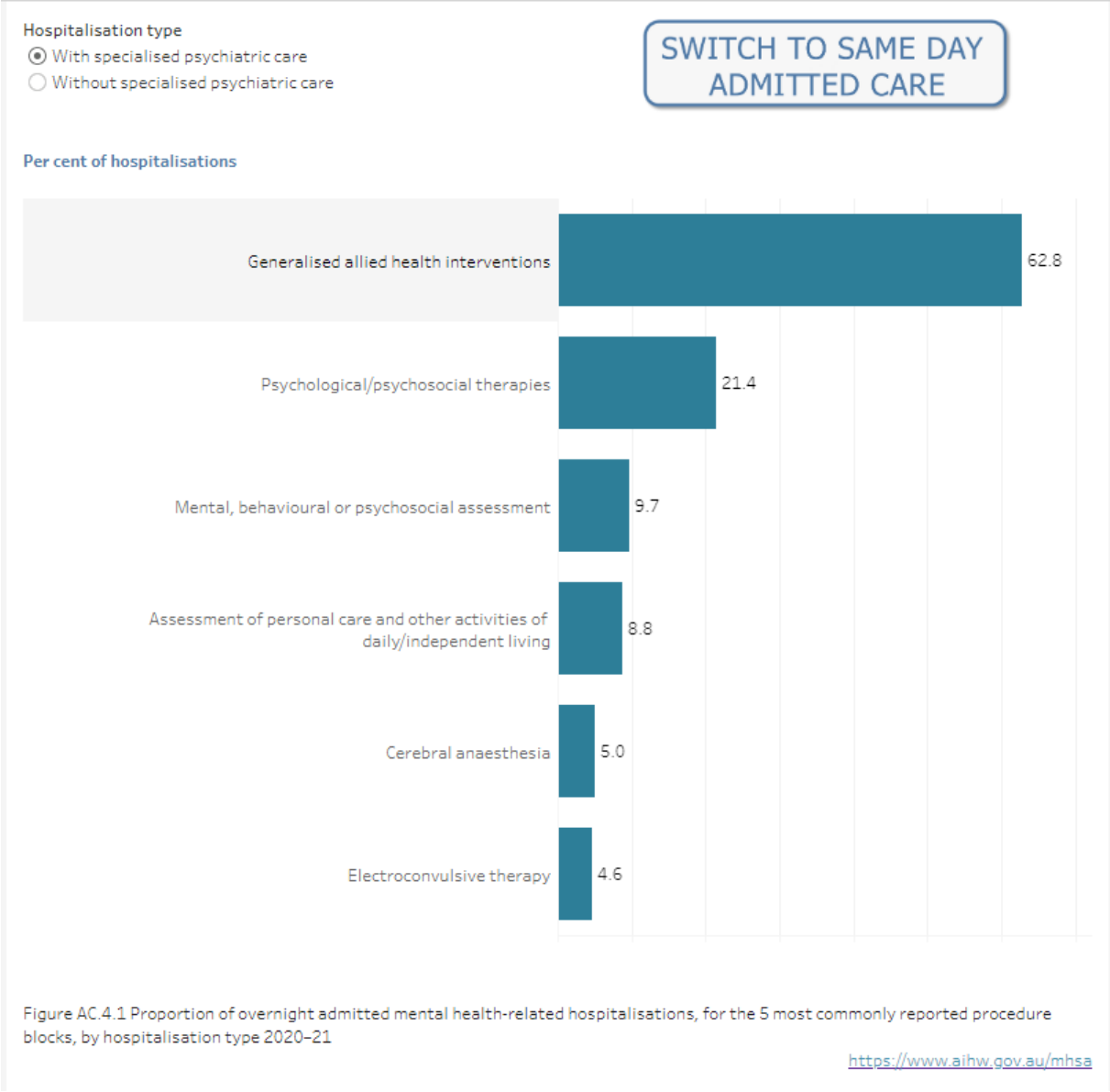
Almost three-quarters (72%) of overnight mental health-related hospitalisations *without* specialised psychiatric care recorded at least 1 procedure in 2020–21. The most frequently reported procedure block was *Generalised allied health intervention* (71%), which was recorded for more than half of these hospitalisations (59%) (Figure AC.4.1).

The most frequent allied health interventions *without* specialised care were as follows:

**Frequently reported allied health interventions for overnight non-specialised care**

| Allied health intervention procedure | Per cent of procedures |
|---|---|
| *Social work* | 21% |
| *Physiotherapy* | 20% |
| *Pharmacy* | 16% |

**Figure AC.4: Proportion of admitted mental health-related hospitalisations, for the 5 most commonly reported procedure block, by hospitalisation type, 2020–21**




# Principal diagnosis

Where a distinction of specialised mental health-related care is made in both overnight and same day public admitted care (with or without specialised psychiatric care), *Depressive episode* was among the most frequently reported principal diagnoses in *specialised* care; while in *non-specialised* care it was *Mental and behavioural disorders due to use of alcohol*.

Private hospital-based same day admitted mental health care is provided in either private hospitals with psychiatric beds or private psychiatric day hospitals (APHA 2021).

In the private sector, *Major affective and other mood disorders* was reported as diagnostic group of principal diagnosis in almost half (45%) of same day mental health-related episodes of care.

## Same day

The 5 most frequently reported principal diagnoses in 2020–21 for same day public mental health-related hospitalisations *with* specialised psychiatric care were:

- *Depressive episode* (20% of hospitalisations)
- *Schizophrenia* (9%)
- *Eating disorders* (8%)
- *Reaction to severe stress and adjustment disorders* (6%)
- *Specific personality disorders* (6%) (Figure AC.5.2).

For same day public mental health-related hospitalisations *without* specialised psychiatric care, the most frequently reported principal diagnosis was *Mental and behavioural disorders due to use of alcohol* (25%).

The most common mental health diagnostic group of clinically significant episodes in same day private care was *Major affective and other mood disorders* (45% of episodes) (Figure AC.5.2).

## Overnight

The most frequently reported principal diagnoses in 2020–21 for an overnight mental health-related hospitalisation *with* specialised psychiatric care were:

- *Depressive episode* (15%)
- *Schizophrenia* (13%)
- *Reaction to severe stress and adjustment disorders* (11%).

The most frequently reported principal diagnosis for overnight mental health-related hospitalisations *without* specialised psychiatric care was *Mental and behavioural disorders due to use of alcohol* (21% in public hospitals and 24% in private hospitals).

The profile of diagnoses in overnight mental health-related care *with* specialised psychiatric care varies significantly with hospital type (Figure AC.5.1). See examples below.

**Proportion of overnight mental health-related hospitalisations with specialised psychiatric care, by hospital type, 2020–21**

| Principal diagnosis | Public acute hospitals | Public psychiatric hospitals | Private hospitals |
|---|---|---|---|
| *Schizophrenia* | 17% | 23% | 2% |
| *Depressive episode* | 11% | 6% | 25% |
| *Mental and behavioural disorders due to use of alcohol* | 2% | 4% | 13% |

**Figure AC.5: Mental health-related admitted care, by principal diagnosis, 2020–21**

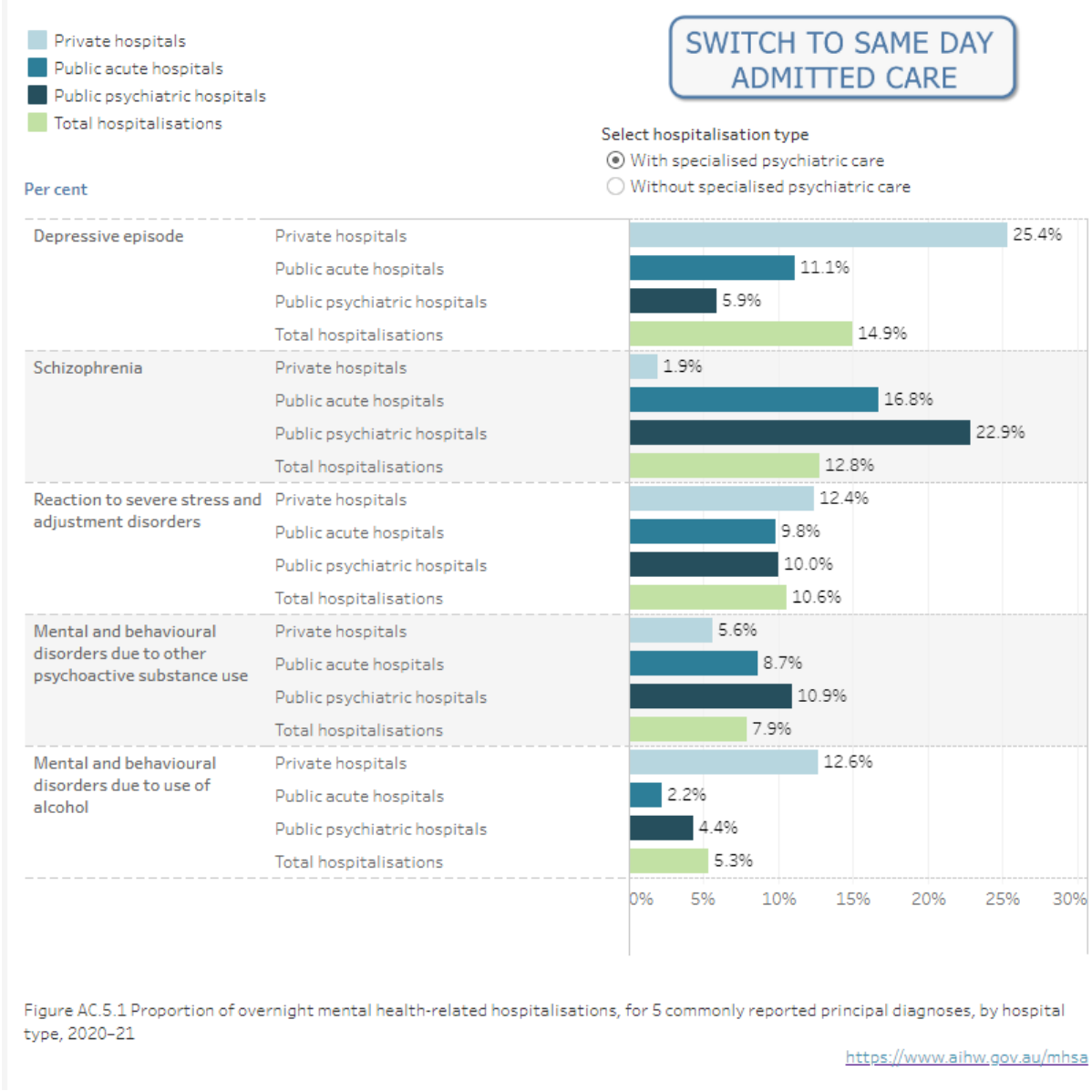



Figure AC.5.1 Proportion of overnight mental health-related hospitalisations, for 5 commonly reported principal diagnoses, by hospital type, 2020–21

https://www.aihw.gov.au/mhsa

# Changes over time

In public hospitals, the population rate of overnight mental health-related hospitalisations has been steadily increasing since 2010–11 (an average annual change of 2% over this period). For same day public hospitalisations, the population rate has been relatively steady over the same period.

While the number of same day hospitalisations with specialised psychiatric care in public acute hospitals has been decreasing since 2016–17 (at an average annual change of 10%), the number of overnight hospitalisations of this type in public acute hospitals has

been slowly increasing over the same period (at an average annual change of 1%). (Figure AC.6.1).

The number of procedure blocks associated with same day hospitalisations *with* specialised psychiatric care in public acute hospitals has slowly decreased since 2016–17 (at an average annual change of 3%), and those associated to overnight hospitalisations *with* specialised psychiatric care have rapidly increased over the same period (at an average annual change of 11%).

In private hospitals, overnight mental health-related hospitalisations have increased steadily between 2010–11 and 2020–21 at an average annual rate of 5%. For same day private hospital care, data is reported on number of episodes and patients. The number of private same day episodes of care has increased from about 28,120 in 2016–17 to 29,430 in 2020–21.

**Figure AC.6: Mental health-related admitted care over time, 2020–21**

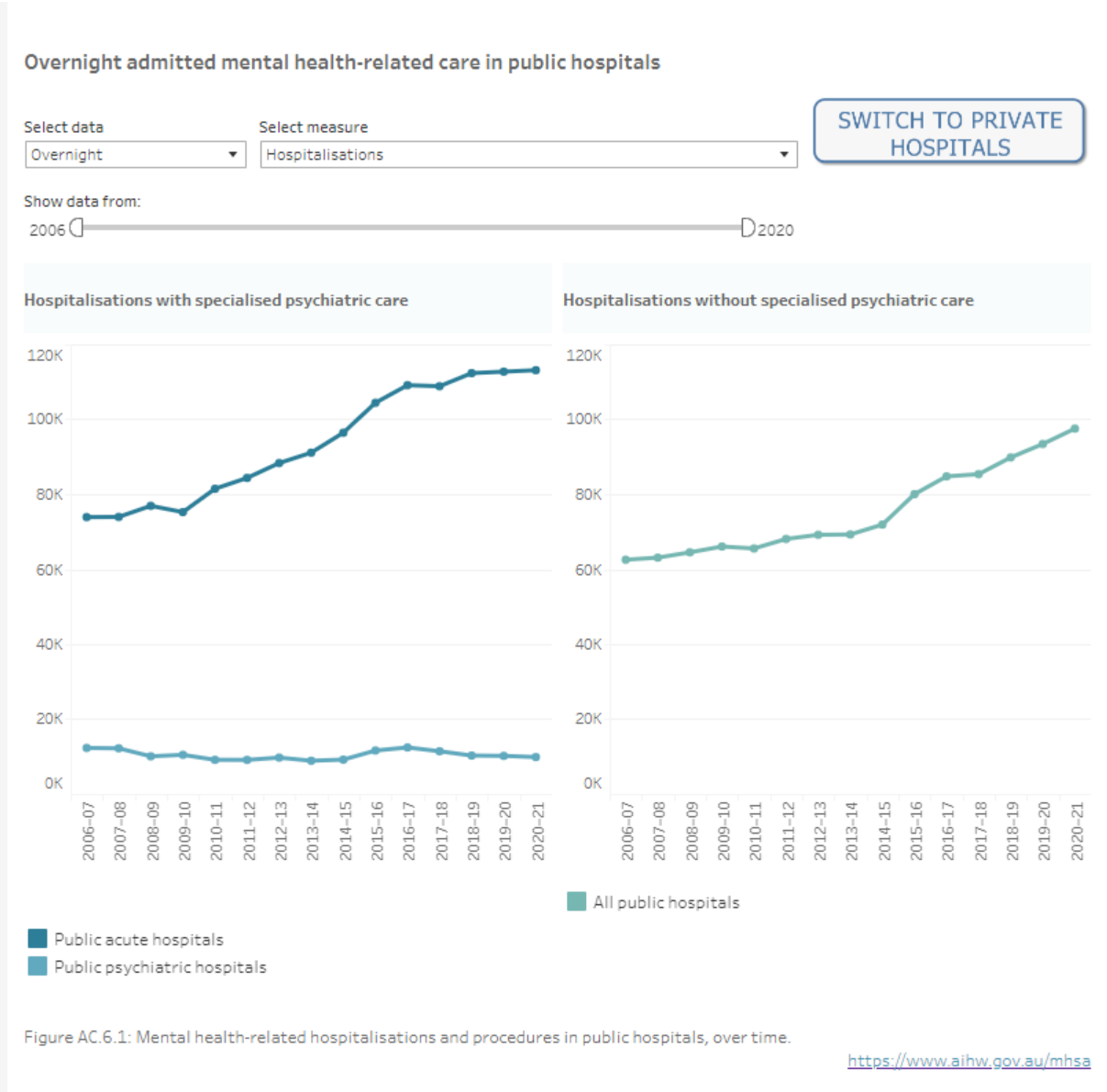



Figure AC.6.1: Mental health-related hospitalisations and procedures in public hospitals, over time.

https://www.aihw.gov.au/mhsa

## Same day

While the number of same day public hospitalisations *with* specialised psychiatric care increased at an average annual rate of 3% from 2010–2011 to 2020–21 (from about 10,640 to 14,570), the number of this type of hospitalisations in public acute hospitals has shown more variability across the years (decreasing in some years) than in public psychiatric hospitals. The number of same day public mental health-related hospitalisations *without* specialised psychiatric care increased at an average rate of 1% over the same period (from about 37,430 in 2010–11 to 42,690 in 2020–21) (Figure AC.6.1).

Long-term trends of same day mental health-related hospitalisations varied by age and sex.

### People aged 18–24 years

Since 2010–11, for males aged 18–24 years, the hospitalisation rate *with* specialised psychiatric care increased from 3 to 9 per 10,000 population (with an average annual change of 10%), while for females aged 18–24 years, the hospitalisation rate increased from 4 to 18 (with an average annual change of 18%). For those aged 18–24 years, females showed a hospitalisation rate twice that of males (Figure AC.7.2).

### People aged 85 years and over

The number of hospitalisations (including non-mental health) for persons aged 85 and over increased by an average annual change of 9% between 2007–08 and 2011–12 (AIHW 2012). Since 2013–14, all types of hospitalisations for people aged 85 and over increased at a faster rate than the average population growth for this age group (average annual increase of 5% from 2013–14 to 2017–18 compared to 4% population growth). In 2017–18, people aged 65 and over, who made up 15% of Australia's population, accounted for 42% of hospitalisations and 48% of patient days (AIHW 2018).

Even though the rate of same day public hospitalisation for people aged 85 and over has been decreasing at an average annual change of 5% for specialised care and 12% for non-specialised care between 2010–11 and 2020–21, the rate of same day public mental health-related hospitalisations per 10,000 population for this age group has been among the highest between 2010–11 and 2019–20. In particular, the rate for people aged 85 and over who received *specialised psychiatric care* in public hospitals decreased from 46 in 2019–20 to 4 in 2020–21 (Figure AC.7.2). This represents a decrease of 92% since 2019–20. This change has been largely driven by a shift from an admitted care setting to non-admitted care, for example, outpatient clinics and/or community mental health care.

Since 2016–17 the total number of same day private mental health patients has increased from about 19,590 to 20,890 in 2020–21, an increase of 7%. The number of episodes increased at a different proportion (from about 28,120 to 29,430, or a 5% increase) (Figure AC.6.2). Over the same period there has been essentially no change in the overall average care days per patient.

## Overnight

The rate of overall overnight mental health-related hospitalisations with and without specialised psychiatric care per 10,000 population has been steadily increasing in the past decade (average annual increase between 2010–11 and 2020–21 of 4% for both).

Overnight hospitalisations *with* specialised psychiatric care in public acute hospitals have been increasing at a faster rate than public psychiatric hospitals (average annual increase between 2010–11 and 2020–21 of 3% and 1% respectively) (Figure 6.1). A

similar pattern is observed for procedures associated with this type of hospitalisations (average annual increase between 2010–11 and 2020–21 of 12% and 4% respectively).

Long-term trends of overnight mental health-related hospitalisations varied by age and sex.

### People aged 12–17 years

Overnight hospitalisation rates *with* specialised psychiatric care for people aged 12–17 years have almost doubled from 35 to 62 hospitalisations per 10,000 population since 2010–11. This increase is largely accounted for by hospitalisations of female patients. The hospitalisation rate *with* specialised psychiatric care for females aged 12–17 years was more than 3 times the rate of males aged 12–17 years (95 per 10,000 population and 31 respectively). This represents an average annual change of 8% for females and 3% for males between 2010–11 to 2020–21 (Figure AC.7.1).

While the overnight hospitalisation rate *without* specialised psychiatric care of female patients aged 12–17 years has increased between 2010–11 and 2020–21 (from 28 to 53), the rate for male patients has decreased by an average annual change of 1% over the same period. Across both sexes, the overnight hospitalisation rate *without* specialised psychiatric care for people aged 12–17 years has increased (average annual increase of 5% between 2010–11 and 2020–21).

### People aged 18–24 years

For people aged 18–24 years receiving specialised psychiatric care, the hospitalisation rate *with* specialised psychiatric care has almost doubled since 2010–11 (from 69 to 119 in 2020–21), largely due to hospitalisations of female patients (with an average annual increase between 2010–11 and 2020–21 of 7% compared with 4% average annual increase for male patients) (Figure AC.7.1).

### People aged 85 years and over:

Hospitalisation rates *with* specialised psychiatric care for people aged 85 years and over has decreased by an annual of 4% between 2010–11 and 2020–21. For each year examined, and for each sex, the rate of overnight mental health-related hospitalisations *without* specialised care per population was highest for older adults (75–84 years, and 85+ years).

In contrast to hospitalisations *with* specialised psychiatric care, hospitalisation rate *without* specialised psychiatric care for people aged 85 years and over has increased by an annual average of 6% between 2010–11 and 2020–21. For this age group, males have had a consistently higher hospitalisation rate than the females.

## Figure AC.7: Mental health-related admitted care over time, by age and sex 2020–21

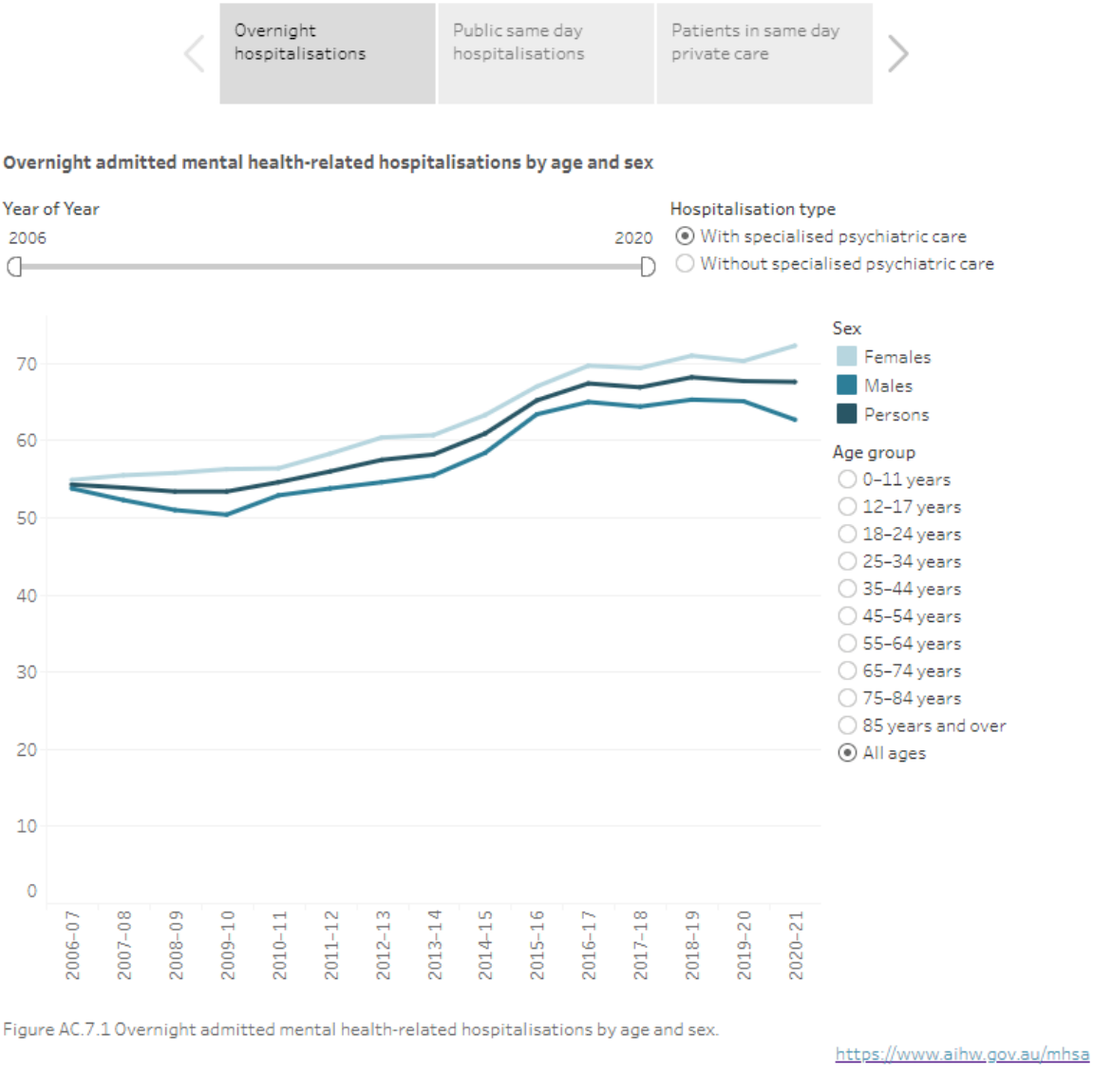



Figure AC.7.1 Overnight admitted mental health-related hospitalisations by age and sex.

https://www.aihw.gov.au/mhsa

### Patient days and length of stay

For public acute hospitals and public psychiatric hospitals, there were 687 and 188 patient days per 10,000 population respectively for overnight mental health-related hospitalisations *with* specialised psychiatric care in 2020–21. Among jurisdictions for which figures are published, the highest rate for patient days for public acute hospitals was in the Australian Capital Territory (1,006) while the highest for public psychiatric hospitals was in Tasmania (499). Queensland reported the highest rate of patient days in private hospitals (502) (Figure AC.8.1).

In 2020–21, the national average length of stay for overnight mental health-related hospitalisations *with* specialised psychiatric care in public acute hospitals was about 16

days, which is similar to the 2019–20 figure (15) (Figure AC.8.2). Please refer to the data source for information on patient day fluctuations over the period between 2014–15 and 2017–18.

## Figure AC.8: Overnight mental health-related admitted care, patient days, 2020–21

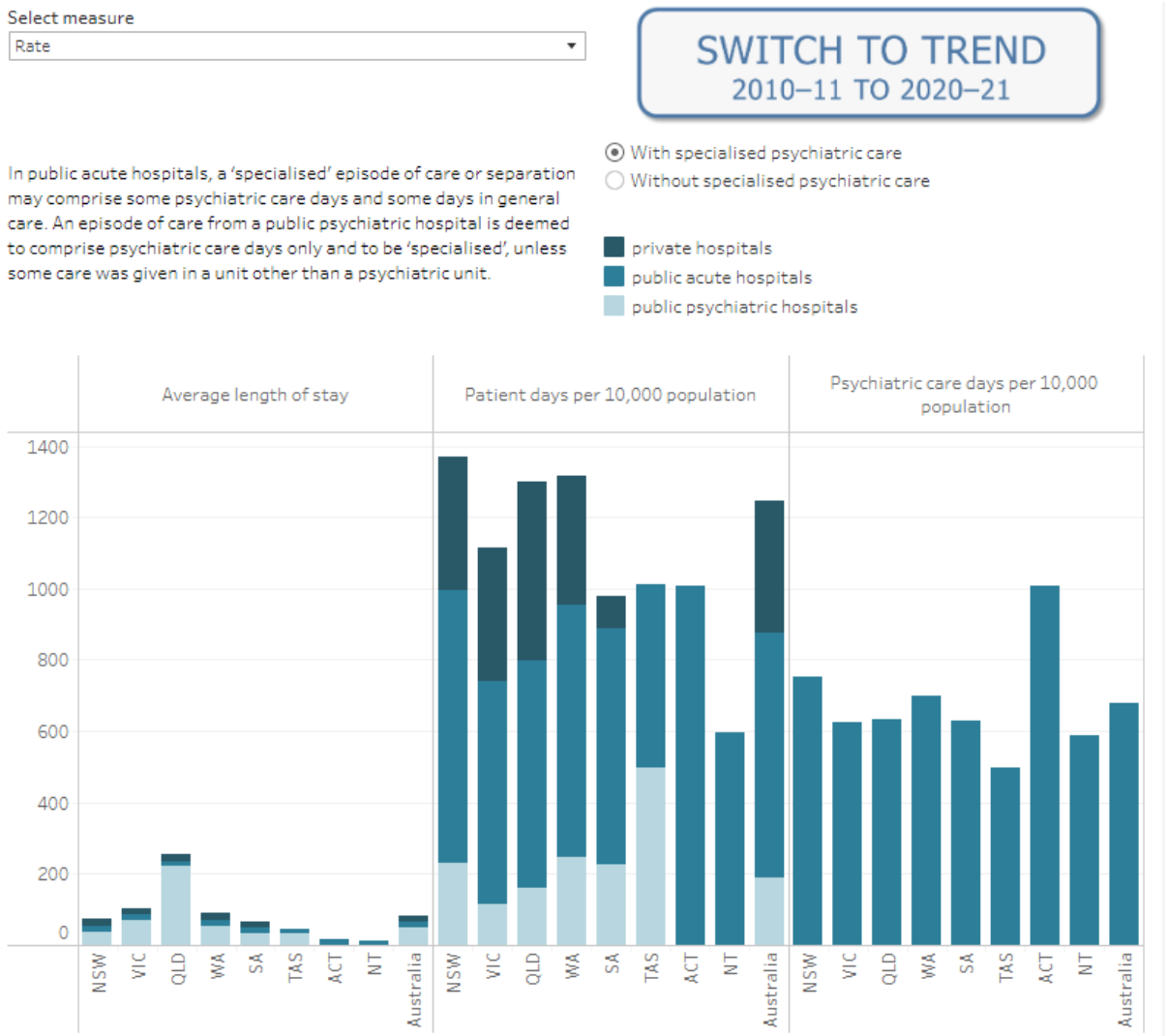



Figure AC.8.1: Overnight mental health-related admitted care, patient days and psychiatric care days, 2020–21.
https://www.aihw.gov.au/mhsa

# Data sources

## Same day admitted mental health care — private hospitals

Private hospital same day admitted mental health care data is sourced from the Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS) and is not comparable with data from the NHMD.

Some state and territory data from the PPHDRAS 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.

Remoteness area is coded in accordance with the Australian Bureau of Statistics' (ABS) Australian Statistical Geography Standard (ASGS) Remoteness Structure to the following categories: *Major cities, Inner regional, Outer regional, Remote* and *Very remote*. Due to the relatively small number of patients in *Outer regional, Remote* or *Very remote* areas, only Urban (defined as *major cities*) versus Non-urban (everywhere else) is reported.

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.

## National Hospital Morbidity Database

Overnight admitted mental health care data and public same day admitted mental health care 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).* It is possible for individuals to have multiple separations (hospitalisations) in any given reference period.

Due to the relatively small number of admitted patient mental health-related hospitalisations without specialised psychiatric care from public psychiatric hospitals, these have been combined with the public acute hospitals for reporting purposes in the admitted care without specialised psychiatric care section.

The 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 hospitalisation. 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 in *Admitted patients: 2020–21.*

Further information on admitted patient care for the 2020–21 reporting period can be found in the report *Admitted patients 2020–21* (AIHW 2022). The 2020–21 collection

contains data for hospitalisations that occurred between 1 July 2020 and 30 June 2021. Admitted patient episodes of care/hospitalisations that began before 1 July 2020 are included if the separation date fell within the collection period. A record is generated for each hospitalisation rather than each patient. Therefore, those patients who had more than one hospitalisation in the reference year will 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 during that separation. 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. For 2020–21, diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 11th revision, Australian Modification* (ICD-11-AM 11th edition) (ACCD 2021). Further information on this is included in the technical information section.

For 2020–21, procedures are classified according to the *Australian Classification of Health Interventions, 11th 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 hospitalisations have a procedure reported.

The large decline in patient days associated with public hospital mental health-related hospitalisations from 2016–17 to 2017–18 followed large increases from 2014–15 to 2016–17. These fluctuations are likely to be related to the introduction of the *Mental health* care type from 1 July 2015. For example, to change the care type of patients receiving mental health care, Queensland (2015–16) and New South Wales (2016–17) discharged and readmitted patients, causing the rise in hospitalisations and patient days counted in those years. The rise in patient days is substantially impacted by long stay mental health patients, who can individually account for hundreds, or in some cases thousands, of days. The subsequent decline in patient days seen in 2017–18 is impacted by days accrued before the change in care type being counted in an earlier year.

## Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service

The Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS), previously known as the Private Mental Health Alliance

Centralised Data Management Service (PMHA CDMS), was launched in Australia in 2001 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 PPHDRAS 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.

The PPHDRAS 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 PPHDRAS 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. The PPHDRAS also maintains training resources for hospitals and a database application which enables hospitals to submit de-identified data to the PPHDRAS. The PPHDRAS produces an annual statistical report. In 2019–20, the PPHDRAS accounted for 98% of all private psychiatric beds in Australia (APHA 2021).

The classification of diagnostic groups used by the PPHDRAS is based on the ICD-10 principal diagnosis assigned to the episode of care at discharge. There are eight 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 ASGS Remoteness classification of the Postcode of their Area of usual residence, at the first day of care within the financial year. In cases whether the Area of usual residence was missing from that first day's record, the first valid value for the patient is used. 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 PPHDRAS 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.

---

**You may also be interested in:**

- Specialised mental health care facilities
- Community mental health care services
- Residential mental health care services

## References


AIHW (Australian Institute of Health and Welfare) (2012) *Australian hospital statistics 2011–12*, Health services series, AIHW, accessed 12 August 2022.

AIHW (2018) *Hospitals at a glance 2017–18*, Health services series, AIHW, accessed 12 August 2022.

AIHW (2022) *Admitted patients 2020–21,* Health services series, AIHW, accessed 12 August 2022.

ACCD (Australian Consortium for Classification Development) (2021) *The international statistical classification of diseases and related health problems, 11th revision, Australian modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), 11th ed*., University of Sydney.

APHA (Australian Private Hospitals Association) (2021) *Private Hospital-based Psychiatric Services 1 July 2019 to 30 June 2020*, APHA.

## Key Concepts

| Key Concept | Description |
|---|---|
| **Average length of stay** | Average length of stay is the average number of patient days for admitted patient hospitalisations. |
| **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). |
| **Clinically substantive episode** | A period of care from admission to separation that has more than 2 contacts and where contacts are of less than 6 weeks intervals. |
| **Diagnostic group** | The classification of **diagnostic groups** 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. Further details of these diagnostic groups can be found in the data source section. |
| **Episode** | An **episode** of care in Private hospitals involves a period of care from admission to separation. Counts of episodes include only clinically substantive episodes of care (a period of care from admission to separation that has greater than 2 contacts and where contacts are of less than 6 weeks intervals). 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. |
| **Hospitalisation** | **Hospitalisation** 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). |
| **Mental health-related** | A hospitalisation is classified as **mental health-related** if:<br>• it had a mental health-related principal diagnosis which, for admitted patient care, is defined as a principal diagnosis that is either a diagnosis that falls within the section on Mental and behavioural disorders (Chapter 5) |

| | |
|---|---|
| | in the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification (ICD-10-AM) classification (codes F00–F99) or a number of other selected diagnoses (the Classification Codes section for the full list of applicable diagnoses), or<br>• it included any specialised psychiatric care. |
| **Overnight admitted patient care** | For this report **overnight admitted patient hospitalisations** refers to those hospitalisations when a patient undergoes a hospital's formal admission process, completes an episode of care, is in hospital for more than 1 day and 'separates' from the hospital. Same-day hospitalisations are reported separately in admitted patient 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 hospitalisation 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 hospitalisation 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 hospitalisations are relatively brief, the amount of information delivered 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. |
| **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. |
| **Hospitalisation** | **Hospitalisation** 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). |
| **Same day admitted mental health care** | The definition of **same day admitted mental health care** is slightly different between the two data sources.<br>A separation for Public hospitals is classified as same day admitted mental health care if the following applies:<br>• the separation was a same day separation (that is, admission and separation occurred on the same day).<br>An admission for Private hospitals is classified as same day admitted mental health care based on data reported as 'Same day episode' including:<br>• hospital-based same day admissions<br>• single overnight for same day admissions for ECT<br>• hospital-in-the-home or outreach care visits to patient's homes recorded as same day admissions. |
| **Separation** | '**Separation**' 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. |

| | |
|---|---|
| **Specialised psychiatric care** | A separation is classified as having **specialised psychiatric care** if the patient was reported as having spent 1 or more days in a specialised psychiatric unit or ward. |
| **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 hospitalisations 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 (technical information). |

This section was last updated in December 2022.