State and territory community mental health care services

Mental illness is frequently treated in community and hospital-based ambulatory care settings. Collectively, these services are referred to as community mental health care. Data from the National Community Mental Health Care Database (NCMHCD) are used to describe the care provided by these services. The statistical counting unit used in the NCMHCD is a service contact between either a patient or a third party and a specialised community mental health care service provider. For more information about the coverage and data quality of the NCMHCD, see the data source section. For Victoria and Tasmania, industrial action caused a substantial reduction in data coverage in 2011–12 and 2012–13. The observed reductions in both service contact and patient numbers are considered to be primarily due to these missing data and consequently, long term trends in the total number of service contacts are not available for 2011–12 and 2012–13.

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 for the years 2011–12, 2012–13 and 2014–15.

Key points

- Around 8.5 million community mental health care service contacts were recorded in 2014–15.
- The most common principal diagnosis reported for patients receiving service contacts was Schizophrenia, followed by Depressive episode and Bipolar affective disorder.
- The most frequently recorded type of community mental health care service contact was with an individual patient (as opposed to a group session) and a duration of 5–15 minutes.
- Involuntary contacts accounted for about one-eighth (12.5%) of all contacts. The proportion of involuntary contacts decreased from 15.5% in 2010–11 to 12.5% in 2014–15.

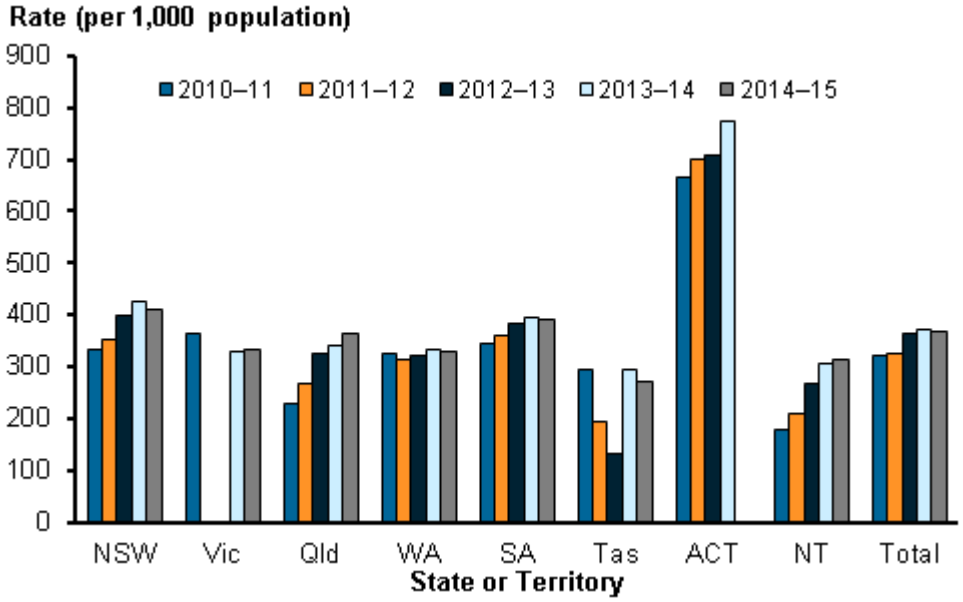
Data in this section was last updated in October 2016.

Community mental health care service provision

Over time

Service contact rates have increased in most jurisdictions since 2010–11 (Figure CMHC.1). The Northern Territory had the greatest annual average increase (15.3%) between 2010–11 and 2014–15, followed by Queensland (12.1%) (Table CMHC.3). Issues with data coverage for Victorian and Tasmanian data in 2011–12 and 2012–13, and the Australian Capital Territory in 2014–15, have had an impact on the ability to perform long term trend analysis for these jurisdictions, as well as at the national level. Consequently, the national rates should be interpreted with caution.

Figure CMHC.1 State and territory community mental health care service contacts, 2010–11 to 2014–15



Note:

The rate for 2011–12, 2012–13 and 2014–15 uses adjusted population data which accounts for missing data, as detailed in the online technical information.

Source: National Community Mental Health Care Database.
Source data: State and territory community mental health care Table CMHC.3 (1.02 MB XLS).

States and territories

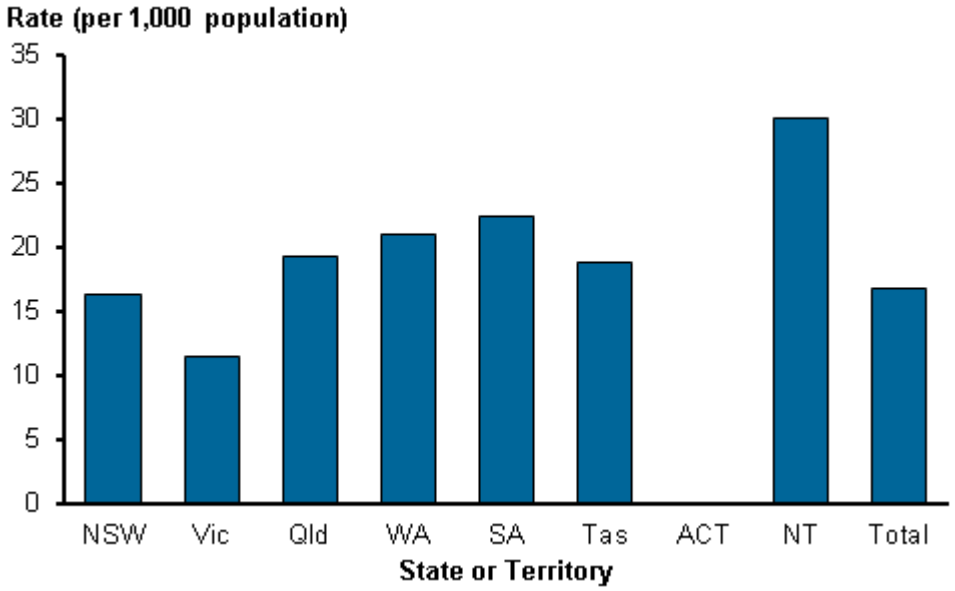
Around 8.5 million service contacts were provided to patients in 2014–15. The number of service contacts per 1,000 population varied between jurisdictions in 2014–15, with New South Wales reporting the highest rate

(409.2) and Tasmania the lowest (273.5). Differences in jurisdictional data reporting systems may contribute to the observed variation in service contact rates (Table CMHC.1).

The number of unique patients provided service contacts is available; however, figures are limited to those records with a unique person identifier, that is, a person has one identifier regardless of how many individual service providers within a state or territory provide services to the client. The ability of jurisdictions to generate unique identifiers varies, as described in the data quality statement for the CMHC NMDS. In 2014–15, 96.0% of all service contacts were provided to unique patients.

The number of patients per 1,000 population ranged between 11.5 (Victoria) and 30.1 (Northern Territory) in 2014–15 (Figure CMHC.2) (Table CMHC.1).

Figure CMHC.2 Community mental health care patients, states and territories, 2014–15



Source: National Community Mental Health Care Database.
Source data: State and territory community mental health care Table CMHC.1 (1.03MB XLS).

Patient characteristics

Patient demographics

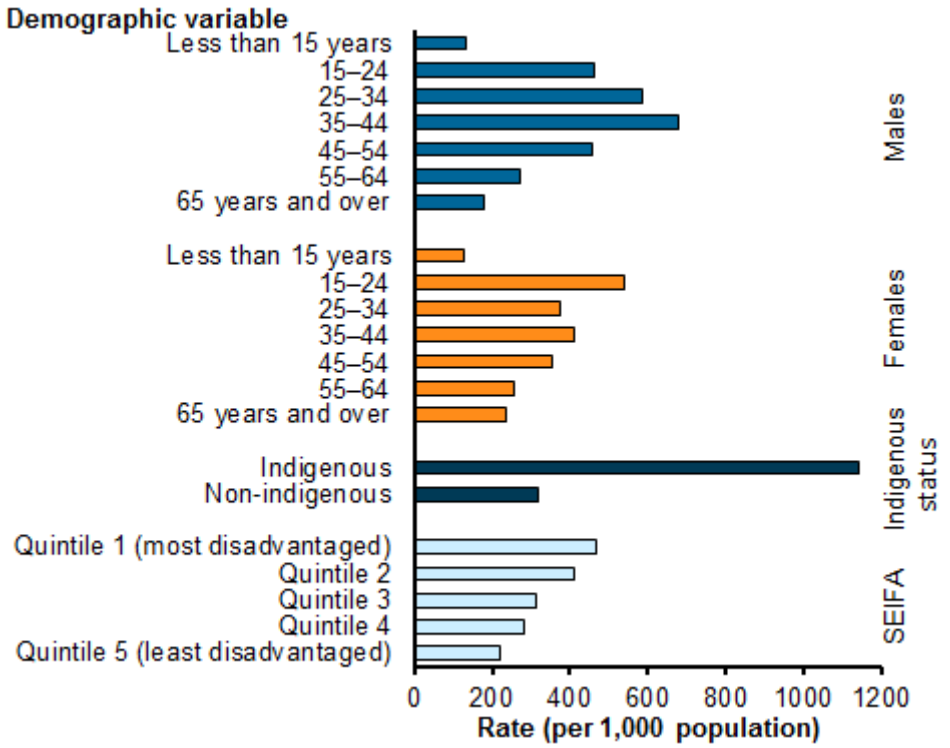
People aged 35–44 received the greatest number of community mental health care contacts (1,729,498), and had the highest rate of service contacts (545.0 per 1,000 population) in 2014–15 (Figure CMHC.3). The youngest age group (less than 15 years) had the lowest number of contacts per 1,000 population (129.8), followed by the oldest age group (65 and over; 210.8) (Table CMHC.5).

In 2014–15, males accessed services at a higher rate (389.3 service contacts per 1,000 population) than females (323.4). The highest male contact rate was reported for the 35–44 age group (678.3), while for females the highest contact rate was for the 15–24 age group (540.1) (Table CMHC.6).

Just under 1 in 10 (9.7%) community mental health care service contacts with a recorded Indigenous status were provided to Aboriginal and Torres Strait Islander people. Indigenous Australians accessed services at just over 3.5 times the non-Indigenous rate (1,142.6 for Indigenous and 319.3 for non-Indigenous Australians per 1,000 population). Indigenous status was missing or not reported for 8.2% of all contacts in 2014–15 (Table CMHC.7).

Approximately a quarter (25.7%) of community mental health care contacts were for people living in areas classified as being in the lowest (most disadvantaged) socioeconomic status quintile. Residents in the most disadvantaged areas also had the highest rate of community mental health care contacts (466.1 per 1,000 population). People living in areas classified as being the highest (least disadvantaged) socioeconomic quintile had the lowest number of community mental health care contacts (984,614) and rate (220.7 per 1,000 population) (Table CMHC.10).

Figure CMHC.3 Community mental health care service contact rates, by demographic variables in 2014–15



Note:

Crude rates are based on the estimated Australian resident population on 31 December 2014.

Source: National Community Mental Health Care Database
Source data: State and territory community mental health care Tables CMHC.5, CMHC.6 and CMHC.10 (1.02MB XLS).

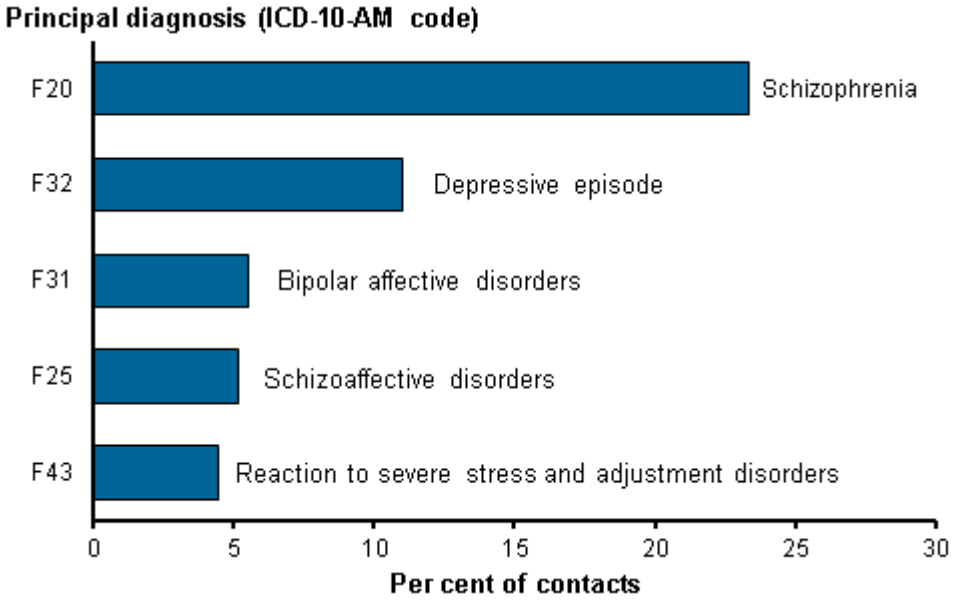
In 2014–15, the majority of all service contacts were provided to patients living in *Major cities* (62.4% of all contacts). Patients living in *Very remote* areas accessed services at the highest rate (403.5 per 1,000 population) followed by those living in *Remote* areas (394.9) (Table CMHC.8).

Principal diagnosis

The principal diagnosis recorded for patients who have a community mental health care service contact is based on the broad categories listed in the Mental and behavioural disorders chapter (Chapter 5) of the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM edition). See the data source section for further information on principal diagnosis data quality issues.

Of the 5 most commonly reported mental health-related principal diagnoses, Schizophrenia (ICD-10-AM code F20; 23.4%) was the most frequently recorded principal diagnosis (Figure CMHC.4). This was followed by Depressive episode (F32; 11.0%) and Bipolar affective disorder (F31; 5.5%). A principal diagnosis was reported for almost 9 out of 10 (just over 7.3 million) of all community mental health care service contacts in 2014–15 (Table CMHC.14).

Figure CMHC.4 Community mental health care service contacts, for 5 commonly reported mental health-related principal diagnoses, 2014–15



Note:

There are jurisdictional variances in the way principal diagnosis is reported (see the online data source of the Community mental health care section).

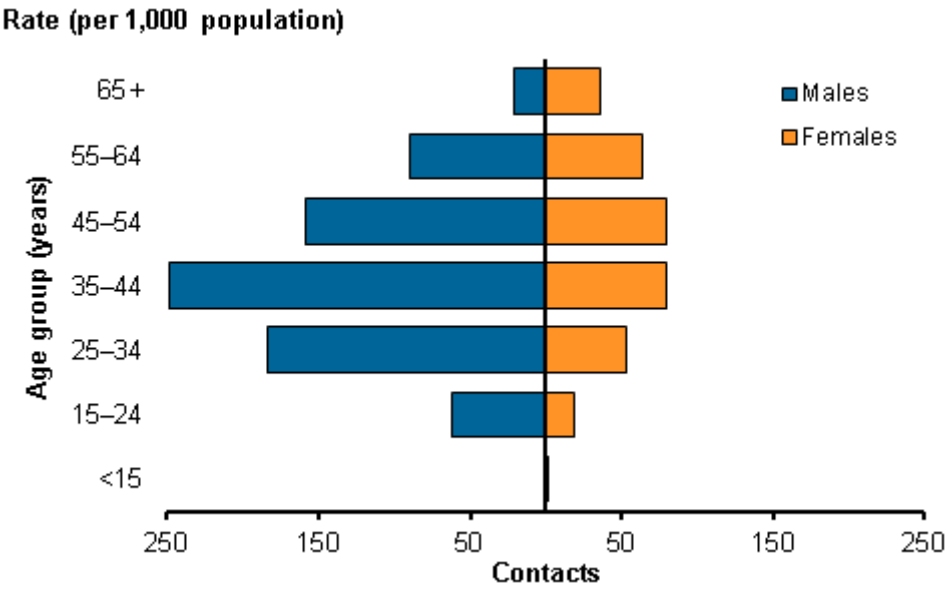
Source: National Community Mental Health Care Database.
Source data: State and territory community mental health care Table CMHC.14 (1.02MB XLS).

Most commonly reported principal diagnosis: Schizophrenia

Amongst clients with a principal diagnosis of Schizophrenia, those aged 35–44 received the greatest number of community mental health care contacts (517,924 or 30.1%). This group also had the highest rate of service contacts (163.2 per 1,000 population) in 2014–15. In 2014–15, males with a diagnosis of Schizophrenia received services at a higher rate (103.7 service contacts per 1,000) than females (44.5 service contacts per 1,000). As illustrated in Figure CMHC.5, when service contact rates are considered by both age group and sex, the highest rate of contacts was for the males aged 35–44 years (248.3 contacts per 1,000 population) (Table CMHC.17). The difference between males and females is most likely due to the

observed difference in prevalence of Schizophrenia in both groups. See the Prevalence, impact and burden section for further information.

Figure CMHC.5 Community mental health care service contact rates with a principal diagnosis of Schizophrenia, age group and sex, by 2014–15



Note:

Crude rates based on the estimated Australian resident population on 31 December 2014.

Source: National Community Mental Health Care Database.
Source data: State and territory community mental health care Table CMHC.17 (1.02MB XLS).

Other most commonly reported principal diagnoses

For the other most commonly reported principal diagnoses, rates of service contacts differed between males and females and by age group. In 2014–15:

- rates of service contacts for Depressive episode were highest for females in the 15–24 age group (61.4 contacts per 1,000 population)
- females with a diagnosis of Bipolar affective disorder received service contacts at a higher rate than males (20.2 and 14.8 service contacts per 1,000 population)
- rates of service contacts for Reaction to severe stress and adjustment disorder were highest for females in the 15–24 age group at 38.8 per 1,000 population, which was more than double the service contact rate for males of the same age group (19.0 per 1,000 population)
- amongst patients with a principal diagnosis of Schizoaffective disorders, males and females aged 35–44 had the highest rate of service contacts (36.8 and 37.4 per 1,000 population) (Table CMHC.17).

Characteristics of service contacts

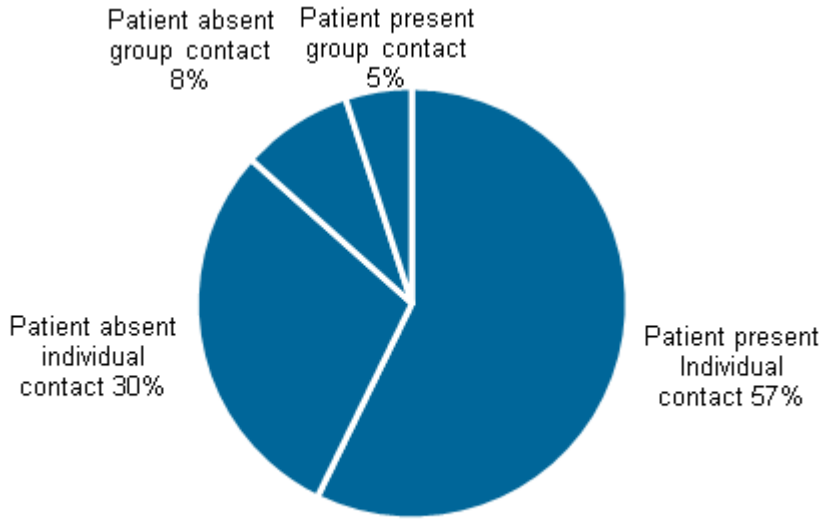
Type of service contacts

Community mental health care service contacts can be conducted either with an individual or in a group session. Service contacts can be face-to-face, via telephone, or using other forms of direct communication such as video link. They can be conducted either in the presence of the patient, or with a third party, such as a carer or family member, and/or other professional or mental health worker.

The majority of service contacts reported in 2014–15 involved individual sessions (86.6%) (Figure CMHC.6). More than half (57.2%) of all contacts were individual sessions where the patient was present (Table CMHC.18).

Of the 5 most common principal diagnoses, the patients most likely to be present for an individual contact were those diagnosed with a Depressive episode (65.0%) or a Schizoaffective disorder (63.2%). Patients with a Depressive episode had the highest proportion of group contacts (12.8%). Patients with a Reaction to severe stress and adjustment disorder had the highest proportion of service contacts where the patient was absent (41.1%) (Table CMHC.19).

Figure CMHC.6 Community mental health care service contacts, by session type and participation status, 2014–15



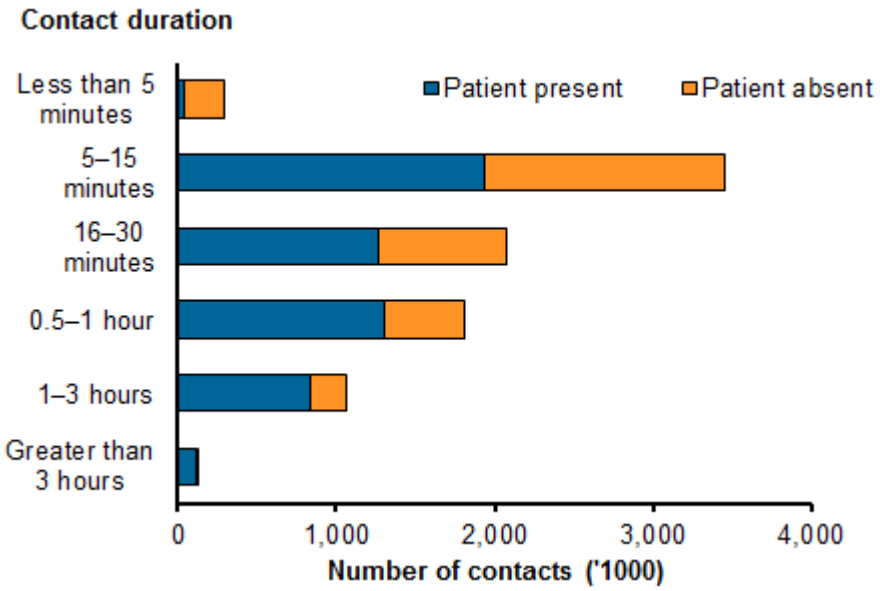
Source: National Community Mental Health Care Database.
Source data: State and territory community mental health care Table CMHC.18 (1.02MB XLS).

Duration of service contacts

The duration of service contacts ranged from less than 5 minutes to over 3 hours. The average service contact duration was 38 minutes in 2014–15. More than a third of contacts were between 5–15 minutes (38.6%, 3.3 million) and around a quarter of contacts were between 16–30 minutes (23.6%; 2.0 million)

(Figure CMHC.7). Service contacts with the patient present were on average longer in duration, averaging 45 minutes, than those with the patient absent averaging 28 minutes (Table CMHC.20).

Figure CMHC.7 Community mental health care service contacts, by session duration and participation status, 2014–15



Source: National Community Mental Health Care Database.
Source data: State and territory community mental health care Table CMHC.20 (1.02MB XLS).

Of the 5 commonly reported principal diagnoses, Reaction to severe stress and adjustment disorders had the highest proportion of contacts lasting over 1 hour (15.0%). Service contacts lasting less than 5 minutes were not commonly conducted with patients who had 1 of the 5 most frequently recorded principal diagnoses (3.1% or less for each principal diagnosis) (Table CMHC.21).

Contact duration over time

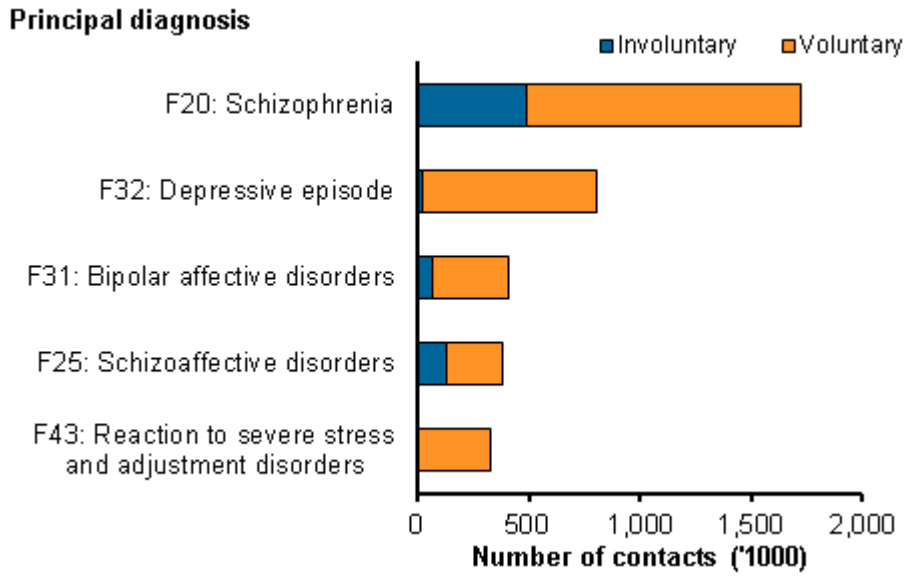
The average time per contact has varied over time, from 53 minutes per contact in 2010–11, to a peak of 65 minutes per contact in 2011–12 before falling to 38 minutes per contact in 2014–15 (Table CMHC.22). Between 2010–11 and 2014–15, the average annual change over five years of short-duration contacts (under 5 minutes) increased by 61.5%. This increase was likely to have been largely driven by a change in Queensland's reporting system during the 2014–15 reporting period, which allowed for contact duration to be recorded individually for each consumer reviewed in group sessions. The absence of Victorian data in 2011–12 and 2012–13 is also likely to have affected average duration, as Victoria reported lower than average contact times in previous years. Consequently, this analysis should be interpreted with caution.

Mental health legal status

About 1 in 8 (12.5%, 1,018,586) community mental health care service contacts in 2014–15 involved a patient with an involuntary mental health legal status. Western Australia reported the lowest proportion of involuntary contacts (3.0%), while Queensland reported the highest (23.7%) (Table CMHC.23). These differences may reflect the different legislative arrangements in place amongst the jurisdictions.

Of the 5 most commonly reported principal diagnoses, Schizoaffective disorders accounted for the highest proportion of contacts involving a patient with an involuntary mental health legal status (33.9%), followed by Schizophrenia (28.4%) and Bipolar affective disorder (17.9%). Lower proportions of involuntary mental health legal status service contacts were seen in patients with a principal diagnoses of a Depressive episode (2.5%) and Reaction to severe stress and adjustment disorders (2.1%) (Table CMHC.25).

Figure CMHC.8 Community mental health care service contacts, by principal diagnosis and legal status, 2014–15



Source: National Community Mental Health Care Database
Source data: State and territory community mental health care Table CMHC.25 (1.02MB XLS).

There were reductions in the number and rate of involuntary contacts among the 5 most commonly reported principal diagnoses between 2010–11 and 2014–15 (Table CMHC.26). Importantly, the absence of data for the Australian Capital Territory for 2014–15 has had an impact on the national rate given that the ACT typically has a high rate of contacts provided to patients with an involuntary mental health legal status. Also, improvements in the reporting of legal status and issues with data coverage for Victorian and Tasmanian data in 2011–12 and 2012–13, have had an impact on the ability to perform long term trend analysis of the rate of involuntary contacts. Consequently, the national rates should be interpreted with caution.

Target population

Target population refers to the population group that is primarily targeted by a community mental health care service. Community mental health care services are described by 5 ~~target population~~ categories: General,

Child and Adolescent, Youth, Older Person and Forensic. See the Facilities section for additional information about Community mental health care services.

In 2014–15, services targeted toward the General Population provided 64.7% of all treatment days, Forensic services accounted for 14.3%, and Child and Adolescent services accounted for 13.4%. Services targeted towards Older Persons (6.4%) and Youth (1.3%) populations accounted for much smaller proportions of treatment days (Table CMHC.11). These results largely mirror the relative size (as measured by the number of staff) for each of the Community mental health care service target population categories (see the Facilities section, Table FAC.40).

Data source

National Community Mental Health Care Database

Data Quality Statements for National Minimum Data Sets (NMDSs) are published annually on the Metadata Online Registry (METeOR). Statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence. See the Community mental health care NMDS 2014–15: National Community Care Database, 2015 Quality Statement. Previous years' data quality statements are also accessible in METeOR.

Key concepts

State and territory community mental health care services

Key Concept	Description
Community mental health care	**Community mental health care** refers to government-funded and -operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.
Mental health legal status	The state and territory mental health acts and regulations provide the legislative cover that safeguards the rights and governs the treatment of patients with mental illness in admitted patient care, residential care and community-based services. The legislation varies between the state and territory jurisdictions but all contain provisions for the assessment, admission and treatment of patients on an involuntary basis, defined as 'persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care'.
Service contacts	**Service contacts** are defined as the provision of a clinically significant service by a specialised mental health service provider for patient/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any one patient can have one or more service contacts over the relevant financial year period. Service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. Service contacts can also be either with the patient or with a third party, such as a carer or family member, and/or other professional or mental health worker, or other service provider.
Target population	Some specialised mental health services data are categorised using 5 **target population** groups (see METeOR identifier 445778): Child and adolescent services focus on those aged under 18 years. Older person services focus on those aged 65 years and over. Forensic health services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. General services provides services to the adult population, aged 18 to 64, however, these services may also provide assistance to children, adolescents or older people. Youth services target children and young people generally aged 16–24 years. Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However,

	not all states or territories report such jointly funded beds through the National
Treatment day	**Treatment day** refers to any day on which one or more service contacts (direct or indirect) are recorded for a registered client (that is, a patient identifier number is assigned to a uniquely identified person) during an ambulatory care episode.