

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 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 2 jurisdictions, there were substantial problems with 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.

Key points

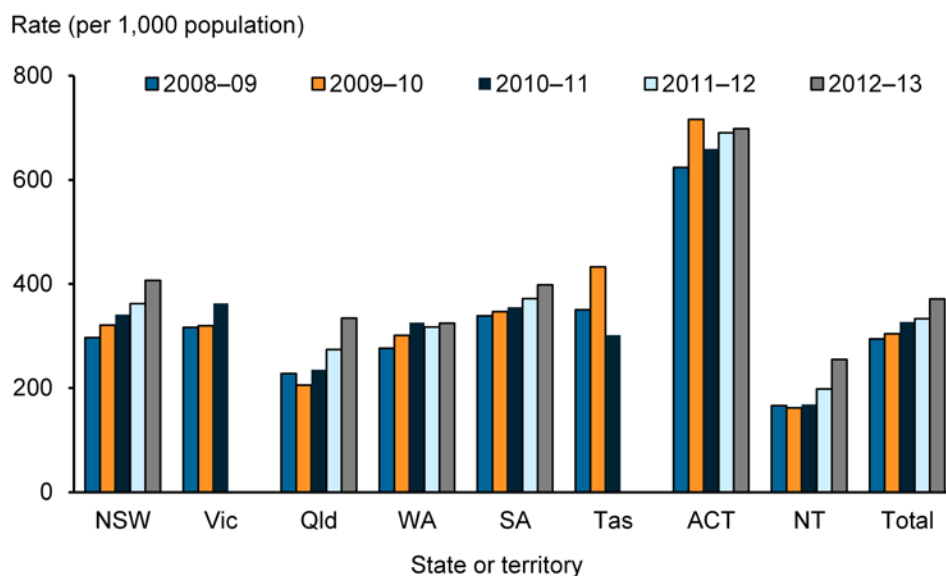
- Over 6.2 million community mental health care service contacts were recorded for over 315,000 patients in 2012–13. As a result of Victoria's non-submission of data in 2012–13, and the substantially reduced figures provided by Tasmania, a comprehensive Australia-wide trend is unavailable. Excluding Victoria and Tasmania, the rate of contacts for all other jurisdictions increased between 2008–09 and 2012–13.
- The most common principal diagnosis reported for patients receiving service contacts was schizophrenia, followed by depressive episode and bipolar affective disorders.
- The most frequently recorded type of community mental health care service contact was with an individual patient (as opposed to in a group session) and a duration of 16–30 minutes.
- Involuntary contacts accounted for about one-seventh (13.2%) of all contacts. The proportion of involuntary contacts decreased from 16.6% in 2008–09 to 13.2% in 2012–13, however, issues with data supply for 2012–13 may have affected this result.

Community mental health care service provision

Over time

Jurisdictional service contact rates have increased since 2008–09 (Figure CMHC.1). The Northern Territory had the greatest annual average increase (11.3%) between 2008–09 and 2012–13, followed by Queensland (10.1%). Issues with data coverage for Victorian and Tasmanian data in 2011–12 and 2012–13 have impacted 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, 2008–09 to 2012–13



Notes:

1. Community mental health care data were not available for Victoria in 2011–12 and 2012–13 due to service level collection gaps resulting from protected industrial action during this period. Victoria also required that no proxy data or estimates be included for Victoria when calculating national totals.
2. Industrial action in Tasmania in 2011–12 and 2012–13 affected the quality and quantity of Tasmania's Community mental health care data and rates are not published for this jurisdiction.
3. Queensland transitioned to a new clinical information system in 2008–09 which impacted on activity data reporting.
4. Total rate for 2011–12 and 2012–13 using adjusted population data which accounts for missing data, as detailed in the online [technical information](#).

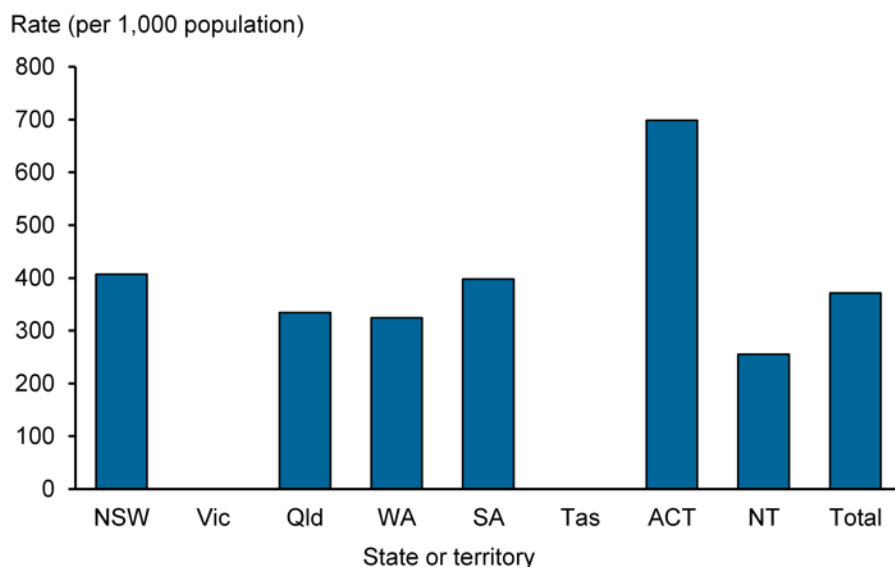
Source: National Community Mental Health Care Database.
Source data Community Mental Health Care Table CMHC.3 (903KB XLS).

By states and territories

Over 315,000 patients with a mental illness were reported to have accessed community mental health care services in 2012–13, resulting in over 6.2 million service contacts between these patients and community mental health care service providers. The continued absence of Victorian data and coverage issues with the Tasmanian data preclude the presentation of a comprehensive national figure (see [DQS for more information](#)). Excluding Victorian and Tasmanian data, the total number of mental health service contacts for the 6 remaining states and territories increased from 5.4 million service contacts in 2011–12 to just under 6.2 million service contacts in 2012–13.

The number of service contacts per 1,000 population varied between the remaining jurisdictions in 2012–13, with the Australian Capital Territory reporting the highest rate (698.5) and the Northern Territory the lowest (255.1) (Figure CMHC.2). However, differences in jurisdictional data reporting systems may contribute to the observed variation in service contact rates. While the Northern Territory recorded the lowest number of service contacts per 1,000 population, it recorded the highest number of patients per 1,000 population (25.4), compared with the national rate of 18.7.

Figure CMHC.2 Community mental health care service contacts, states and territories, 2012–13



Notes:

1. Community mental health care data were not available for Victoria in 2012–13 due to service level collection gaps resulting from protected industrial action during this period. Victoria also required that no proxy data or estimates be included for Victoria when calculating 2012–13 national totals.
2. Industrial action in Tasmania in 2012–13 affected the quality and quantity of Tasmania's Community mental health care data and rates are not published for this jurisdiction.
3. Total rate was calculated using adjusted population data which accounts for missing data, as detailed in the online [technical information](#).

Source: National Community Mental Health Care Database.

Source data Community Mental Health Care Table CMHC.1 (903KB XLS).

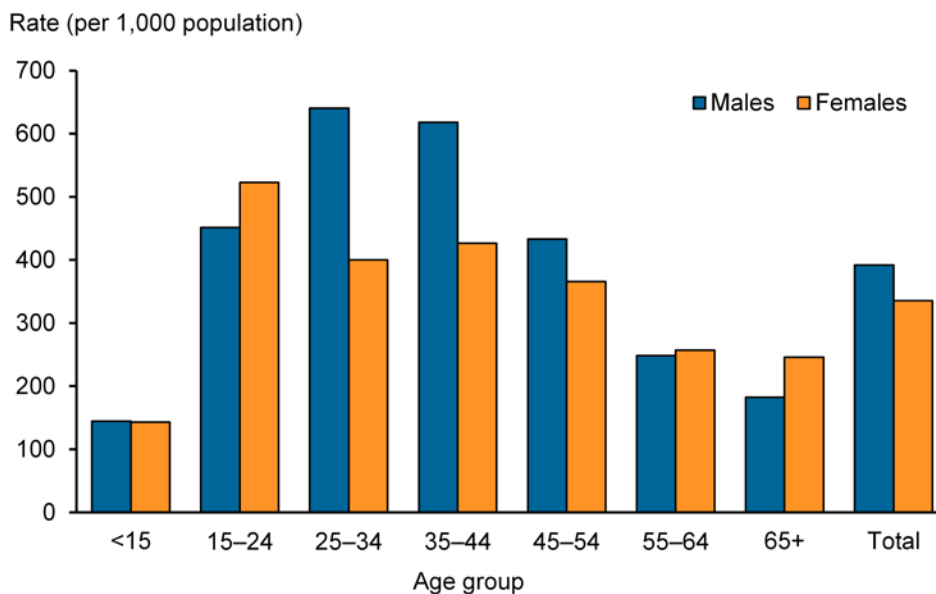
Characteristics of people who use community mental health care services

Patient demographics

People aged 25–34 received the greatest number of community mental health care contacts (1,291,641), however, people aged 35–44 had the highest rate of service contacts per 1,000 population (522.0) in 2012–13. The youngest and oldest age groups (less than 15 and 65 and over, respectively) had the lowest number of service contacts per 1,000 population.

Males accessed services at a higher rate than females in 2012–13 (391.9 and 335.8 service contacts per 1,000 population, respectively) (Figure CMHC.3). When service contact rates are considered by both age group and sex, the highest male contact rate of 640.5 was reported for the 25–34 age group, while for females the highest contact rate was 523.1 for the 15–24 age group.

Figure CMHC.3 Community mental health care service contacts, by age group and sex, 2012–13



Notes:

1. Community mental health care data were not available for Victoria in 2012–13 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that no proxy data or estimates be included for Victoria when calculating national totals.
2. Industrial action in Tasmania in 2012–13 affected the quality and quantity of Tasmania's Community mental health care data.
3. Rates were calculated using adjusted population data which accounts for missing data, as detailed in the online [technical information](#).

Source: National Community Mental Health Care Database.
Source data Community Mental Health Care Table CMHC.13 (903KB XLS).

Around one in ten (10.5%) of all community mental health care service contacts with a recorded Indigenous status were provided to Aboriginal and Torres Strait Islander people, however, Indigenous status was missing or not reported for 9.6% of all contacts in 2012–13. When population size is taken into account, Indigenous Australians accessed services at 3.2 times the non-Indigenous rate (998.8 and 313.1 per 1,000 population, respectively).

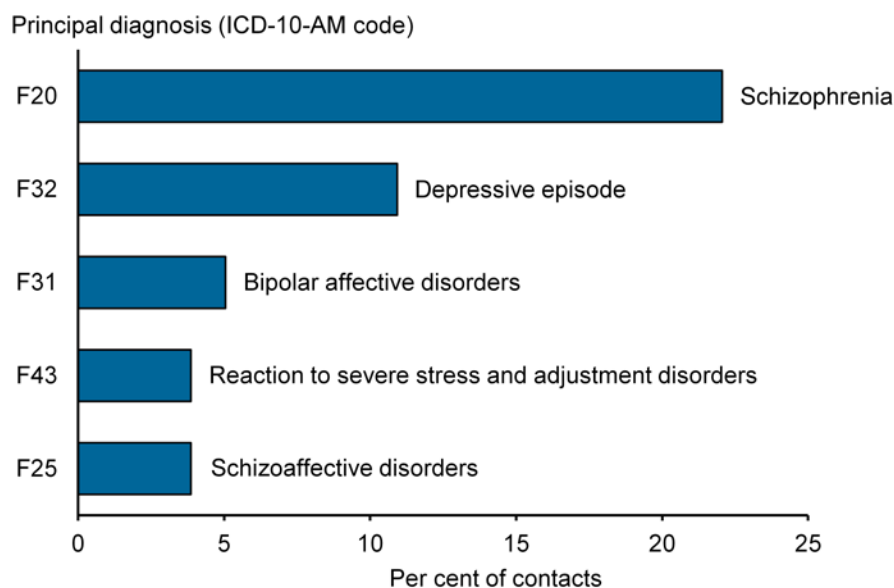
The majority (68.6%) of all service contacts were provided to patients who live in *Major cities* in 2012–13. When population size is considered, patients who live in *Inner regional* areas accessed services at the highest rate per 1,000 population (402.4) followed by those living in *Remote* areas (369.1).

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). Further information on this is included in the [technical information](#) section.

A principal diagnosis was reported for nearly 9 out of 10 (88.0% or just over 5.5 million contacts) of all community mental health care service contacts in 2012–13. Schizophrenia (ICD-10-AM code F20; 22.1%) was the most frequently recorded principal diagnosis for those contacts with a recorded principal diagnosis code (Figure CMHC.4). This was followed by depressive episode (F32; 10.9%) and bipolar affective disorders (F31; 5.0%).

Figure CMHC.4 Community mental health care service contacts, by the 5 most commonly reported mental health-related principal diagnoses, 2012–13



Notes:

1. Community mental health care data were not available for Victoria in 2012–13 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that no proxy data or estimates be included for Victoria when calculating national totals.
2. Industrial action in Tasmania in 2012–13 affected the quality and quantity of Tasmania's Community mental health care data.

Source: National Community Mental Health Care Database.
Source data Community Mental Health Care Table CMHC.19 (903KB XLS).

Characteristics of community mental health care service contacts

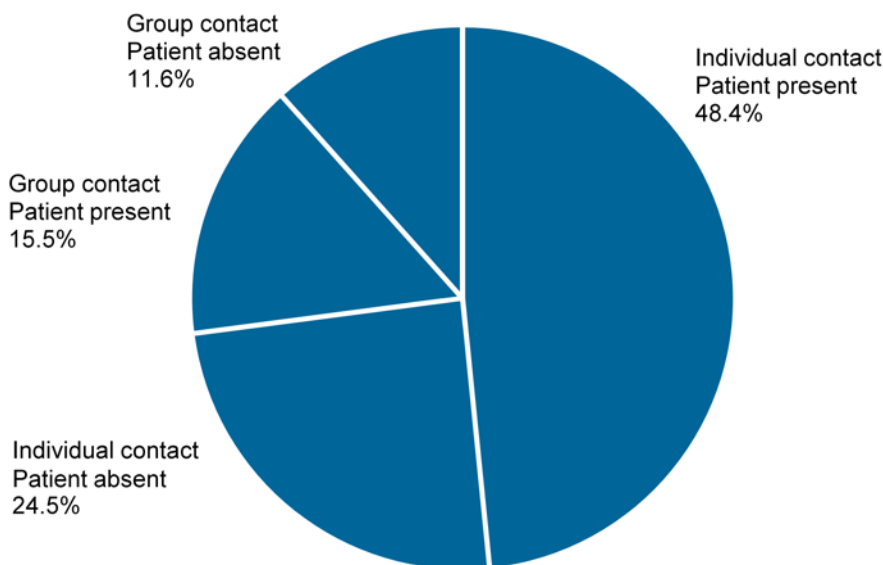
Type of service contacts

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 video link, or using other forms of direct communication. 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 2012–13 involved individual sessions (72.9%) (Figure CMHC.5). About half (48.4%) of all contacts were individual sessions where the patient was present.

Of the 5 most common principal diagnoses, patients with schizophrenia and schizoaffective disorders were most likely to be present for an individual contact (58.0% and 61.0%, respectively). Patients with a depressive episode had the highest proportion of group contacts (40.9%). Patients with a reaction to severe stress and adjustment disorders had the highest proportion of service contacts where the patient was absent (39.8%).

Figure CMHC.5 Community mental health care service contacts, by session type and participation status, 2012–13



Notes:

1. Community mental health care data were not available for Victoria in 2012–13 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that no proxy data or estimates be included for Victoria when calculating national totals.
2. Industrial action in Tasmania in 2012–13 affected the quality and quantity of Tasmania's Community mental health care data.

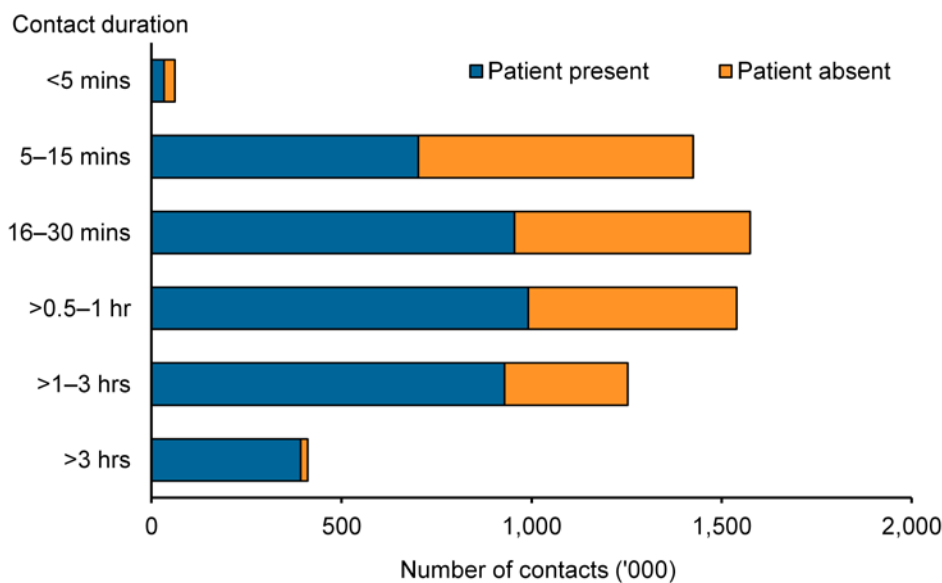
Source: National Community Mental Health Care Database.
Source data Community Mental Health Care Table CMHC.5 (903KB XLS).

Duration of service contacts

The duration of service contacts range from less than 5 minutes to over 3 hours. The average service contact duration was 63 minutes in 2012–13. About one-quarter of contacts were 16–30 minutes (25.1%, 1.6 million) with a similar proportion reported for contacts lasting over half an hour to 1 hour (24.6%) (Figure CMHC.6). Service contacts with the patient present (76 minutes) were more likely to be longer in duration than those with the patient absent (40 minutes). The average duration has increased over time, from 50 minutes in 2008–09 to 63 minutes in 2012–13, however, average contact durations are likely to be affected by the absence of Victorian data. These data should be interpreted with caution.

Of the 5 most common principal diagnoses, depressive episode most frequently recorded contacts lasting over 1 hour (41.2%). Service contacts lasting less than 5 minutes were rarely conducted with patients who had 1 of the 5 most frequently recorded principal diagnoses (1% or less).

Figure CMHC.6 Community mental health care service contacts, by session duration and participation status, 2012–13



Notes:

1. Community mental health care data were not available for Victoria in 2012–13 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that no proxy data or estimates be included for Victoria when calculating national totals.
2. Industrial action in Tasmania in 2012–13 affected the quality and quantity of Tasmania's Community mental health care data.

Source: National Community Mental Health Care Database.
Source data Community Mental Health Care Table CMHC.7 (903KB XLS).

Mental health legal status

About 1 in 8 (13.2%, 810,000) community mental health care service contacts in 2012–13 involved a patient with an involuntary [mental health legal status](#). Western Australia reported the lowest proportion of involuntary contacts (3.3%), while the Australian Capital Territory reported the highest (38.4%). However, it should be noted that these jurisdictional differences may be a reflection of different legislative arrangements in place among the jurisdictions.

Of the 5 most commonly reported principal diagnoses, schizoaffective disorders had the highest proportion of contacts involving a patient with an involuntary mental health legal status (36.5%). Schizophrenia had the next highest proportion (30.1%), followed by bipolar affective disorders (21.6%). Depressive episode and reaction to severe stress and adjustment disorders had lower proportions of involuntary contacts (3.1% and 2.9%, respectively).

Data source

National Community Mental Health Care Database

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 2012–13: National Community Care Database, 2014 Quality Statement](#). Previous years' 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.