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. The observed reductions in both service contact and patient numbers are due primarily to these missing data and consequently, long term trends in the total number of service contacts are not available for 2011–12.

Key points

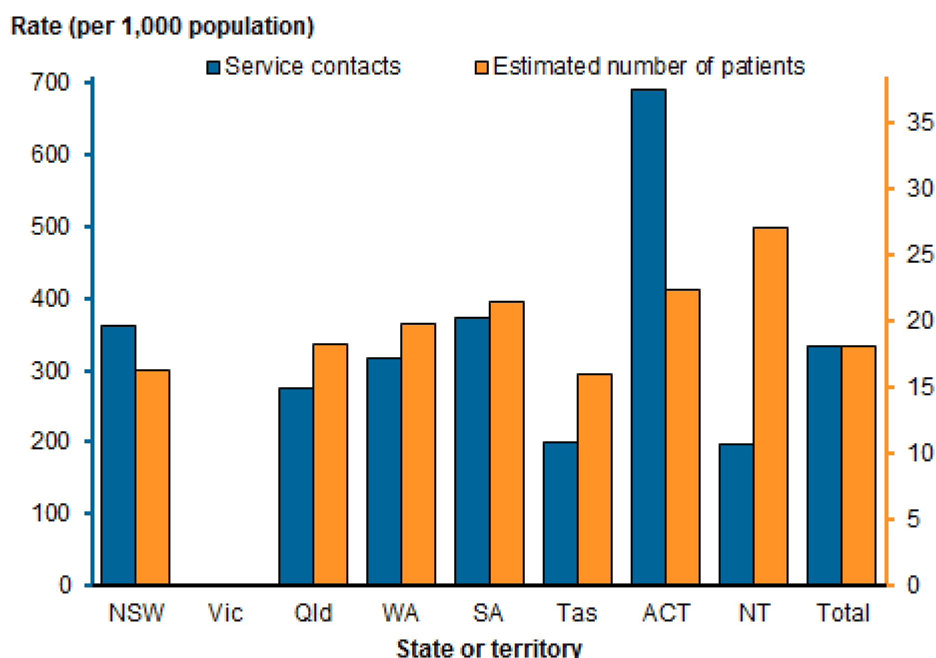
- Over 5.5 million community mental health care service contacts were reported for approximately 300,000 patients in 2011–12. As a result of Victoria's non-submission of data to the collection in 2011–12, we cannot provide a comprehensive Australia-wide trend. Removing Victoria from the analysis, for other states and territories combined, there was a slight increase in both contacts and patients in 2011–12.
- 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 (13.4%) of all contacts. The proportion of involuntary contacts decreased from 16.6% in 2007–08 to 13.4% in 2011–12.

Community mental health care by states and territories

Approximately 300,000 patients were reported to have accessed community mental health care services in 2011–12, resulting in over 5.5 million service contacts between these patients and community mental health care service providers. These figures are down from previous years because no data were reported for Victoria (see DQS for more information), which typically accounts for about a quarter of all community mental health care service contacts in Australia. Removal of Victoria from previous years' data indicates that these decreases are primarily due to missing data and not to changes in the trends of service contact and patient numbers. When Victorian data are excluded from the national total in 2010–11, there were almost 5.2 million service contacts and approximately 290,000 patients.

There was some inter-jurisdictional variation in the number of service contacts per 1,000 population in 2011–12, with the Australian Capital Territory reporting the highest rate (690.4) and the Northern Territory the lowest (198.0) (Figure CMHC.1). However, differences in jurisdictional data reporting systems may contribute to the varying 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 (27.0), compared with the national rate of 18.1.

Figure CMHC.1 Community mental health care service contacts, states and territories, 2011–12



Notes:

1. Community mental health care data were not available for Victoria in 2011–12 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals.

2. Industrial action in Tasmania in 2011–12 has affected the quality and quantity of Tasmania's Community mental health care data.

3. Total rate calculated using a methodology which accounts for missing data, as detailed in the online technical information.

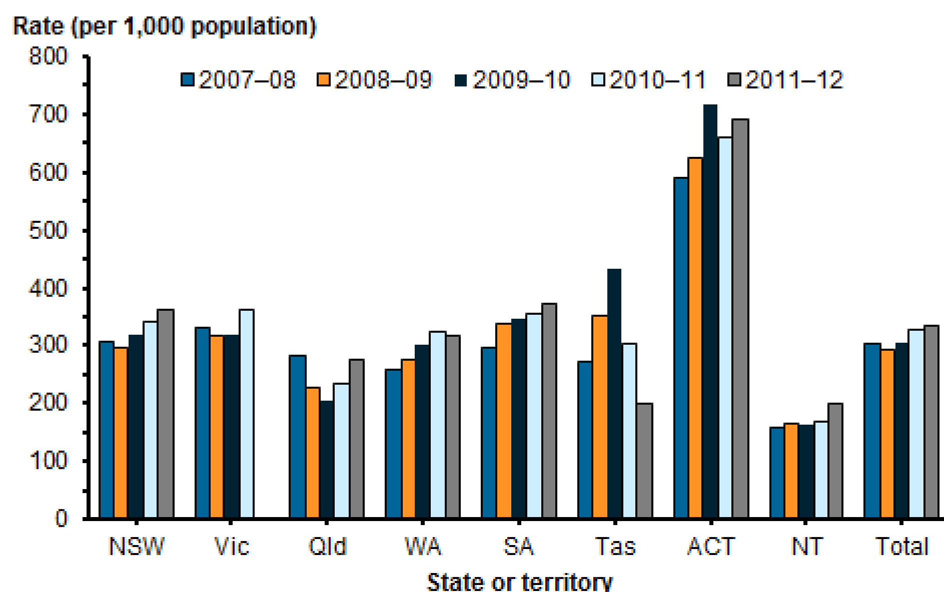
Source: National Community Mental Health Care Database.
Source data for this figure are accessible from Table CMHC.1 (903KB XLS) in the Community Mental Health Care excel table downloads.

Alternative text:
Vertical bar chart showing community mental health care rates for service contacts and estimated number of patients for states and territories in 2011–12. NT reported the lowest rate of service contacts but the highest patient rate (198.0 and 27.0 per 1,000 population, respectively). The ACT reported (690.4 & 22.4), followed by SA (371.8 & 21.4), NSW (362.0 & 16.3), WA (316.8 & 19.7), QLD (274.1 & 18.3) and Tas (200.9 & 16.0). Nationally they were 333.2 & 18.1, respectively. Refer to Table CMHC.1.

Community mental health care over time

Jurisdictional service contact rates have generally increased since 2007–08, with the exception of Queensland (Figure CMHC.2). Issues with data coverage for Victorian and Tasmanian data in 2011–12 have impacted the ability to perform long term trend analysis for these jurisdictions, as well as at the national level. Consequently, these data should be interpreted with caution. The data show that, in most cases, within a jurisdiction relatively small changes in the rate of service contacts per 1,000 population have occurred over the 5 years to 2011–12. The exception to this is in Tasmania where relatively large changes in rates are evident between 2007–08 and 2010–11.

Figure CMHC.2 State and territory Community mental health care service contacts, 2007–08 to 2011–12



Notes:

1. Community mental health care data were not available for Victoria in 2011–12 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals.

2. Industrial action in Tasmania in 2011–12 has affected the quality and quantity of Tasmania's Community mental health care data.

3. Queensland transitioned to a new clinical information system in 2008–09 which impacted on

activity data reporting.

4. Total rate for 2011-12 used a methodology which accounts for missing data, as detailed in the online technical information.

Source: National Community Mental Health Care Database.
Source data for this figure are accessible from Table CMHC.3 (903KB XLS) in the Community Mental Health Care excel table downloads.

Alt text:
Clustered bar graph showing community mental health care contact rates per 1,000 population for states and territories from 2007–08 to 2011–12. The trend analysis shows that, for most jurisdictions, the rate had been increasing over time, with the exception of Queensland, and changes were relatively small within a jurisdiction. The national rate ranged between 294.2 in 2008–09 and 333.2 in 2011–12. Refer to Table CMHC.3

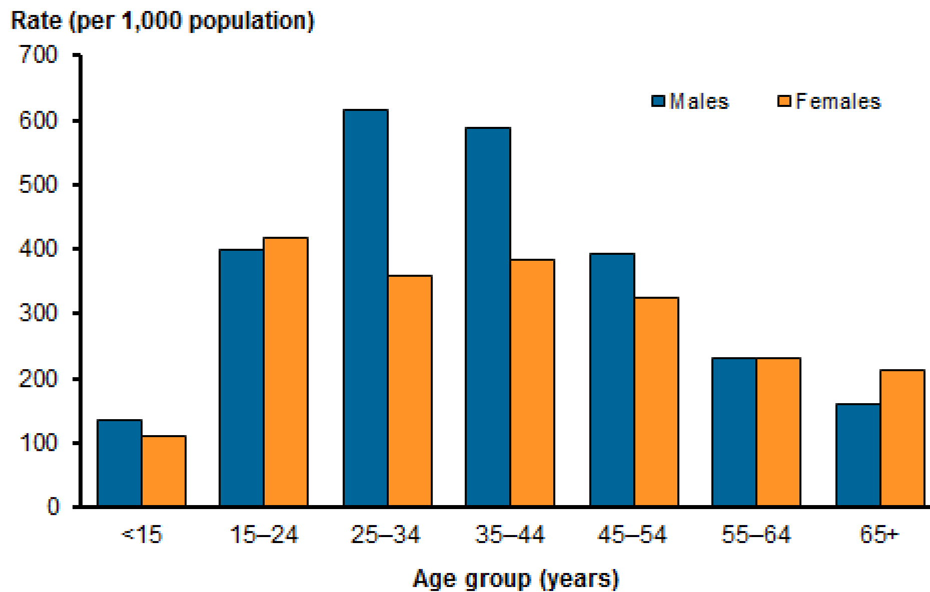
Characteristics of people who use community mental health care services

Patient demographics

People aged 25–34 comprised the highest proportion of community mental health care contacts (21.9%) and had the highest number of contacts per 1,000 population (489.5) in 2011–12. The youngest and oldest age groups (less than 15 and 65+, respectively) were the least represented in both the proportion and number of contacts per 1,000 population.

Males accessed services at a higher rate than females in 2011–12 (363.1 and 287.6 service contacts per 1,000 population, respectively). When service contact rates are considered by both age group and sex, male rates were higher than female rates in all age groups except the 15–24 and 65+ age groups (Figure CMHC.3). The highest male contact rate of 617.0 was reported for the 25–34 age group while for females the highest contact rate of 417.5 was reported for the 15–24 age group.

Figure CMHC.3 Community mental health care service contacts, by age group and sex, 2011–12



Notes:

1. Community mental health care data were not available for Victoria in 2011–12 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals.

2. Industrial action in Tasmania in 2011–12 has affected the quality and quantity of Tasmania's Community mental health care data.

3. Rates were calculated using a methodology which accounts for missing data, as detailed in the online technical information.

Source: National Community Mental Health Care Database.
Source data for this figure are accessible from Table CMHC.13 (903KB XLS) in the Community Mental Health Care excel table downloads.

Alternative text:

Vertical bar chart comparing the rate per 1,000 population of community mental health care service contacts of males and females, across age groups in 2011–12. Males aged 25–34 accessed at the highest rate of 617.0, followed by 35–44 (586.7), 15–24 (398.2), 45–54 (392.2), 55–64 (231.1), 65+ (161.2) & <15 (136.6). For females, the younger age group 15–24 reported the highest rate of 417.5, followed by 35–44 (381.9), 25–34 (359.4), 45–54 (324.7), 55–64 (232.3), 65+ (212.5) & <15 (109.8). Refer to Table CMHC.13.

Aboriginal and Torres Strait Islander people represented 10.3% of all community mental health care service contacts. However, when population size is taken into account Indigenous Australians accessed services at 3.7 times the non-Indigenous rate (1007.7 and 272.8 per 1,000 population, respectively).

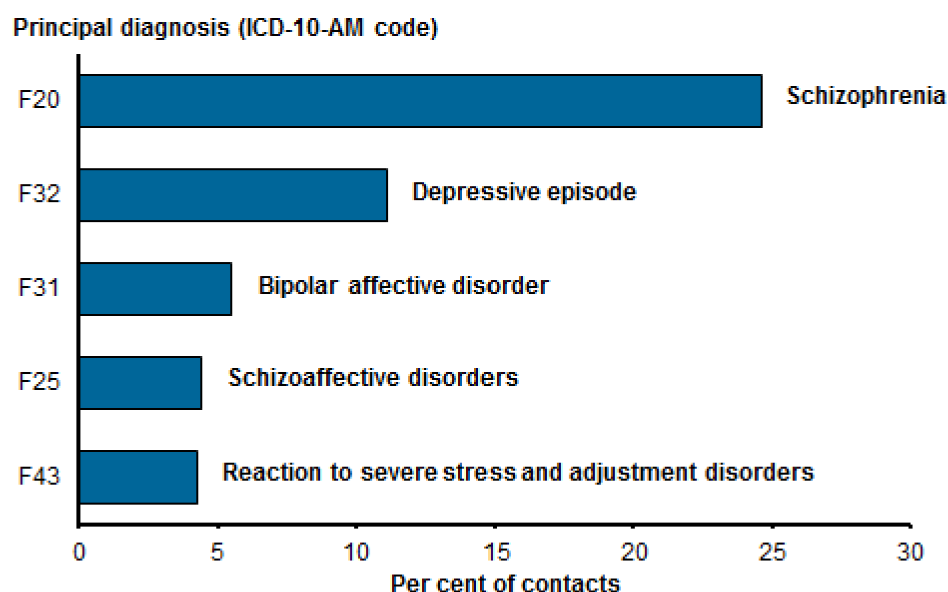
Patients who live in *Inner regional* areas accessed services at the highest rate per 1,000 population (333.2) followed closely by those living in *Major cities* (322.1). The greatest proportion of people accessing community mental health care services live in *Major cities* (68.9%) followed by those in *Inner regional* areas (18.9%). Therefore the level of infrastructure supporting these community mental health services would be expected to reflect these proportional differences.

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 just over 9 out of 10 (91.4% or nearly 5.1 million contacts) of all community mental health care service contacts in 2011–12. Schizophrenia (ICD-10-AM code F20; 24.6%) 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; 11.2%) and bipolar affective disorders (F31; 5.5%). This order remains the same as 2010–11, despite data coverage issues.

Figure CMHC.4 Community mental health care service contacts, by the 5 most commonly reported mental health-related principal diagnoses, 2011–12



Notes:

1. Community mental health care data were not available for Victoria in 2011–12 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals.

2. Industrial action in Tasmania in 2011–12 has affected the quality and quantity of Tasmania's Community mental health care data.

Source: National Community Mental Health Care Database.
Source data for this figure are accessible from the Table CMHC.19 (903KB XLS) in the Community Mental Health Care excel table downloads.

Alternative text:

Horizontal bar chart showing the 5 most frequently reported principal diagnoses for community mental health care service contacts in 2011–12. The principal diagnosis that was most frequently reported was schizophrenia (24.6%), followed by depressive episode (11.2%), bipolar affective disorders (5.5%), schizoaffective disorders (4.4%) and reaction to severe stress and adjustment disorders (4.3%). Refer to Table CMHC.19.

Characteristics of community mental health care service contacts

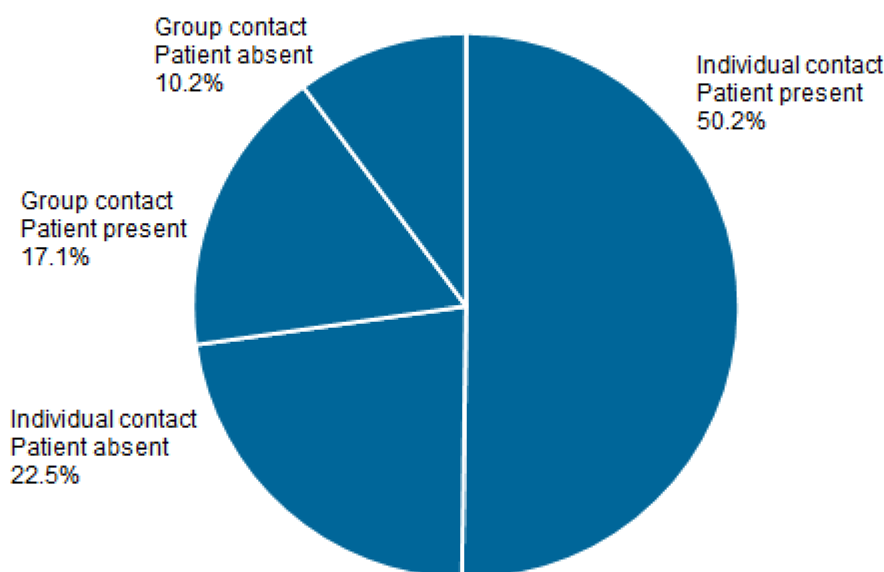
Type of service contacts

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 2011–12 involved individual sessions (72.8%). About half (50.2%) of all contacts were individual sessions where the patient was present (Figure CMHC.5). About two thirds (67.3%) of individual and group contacts were conducted with the patient present.

Of the 5 most common principal diagnoses, patients with a depressive episode had the highest proportion of group contacts (42.3%) and also the highest proportion of contacts in which the patient attended the session (74.4%). Patients with reaction to severe stress and adjustment disorders had the highest proportion of service contacts where the patient was absent (36.1%) and the majority were individual sessions (27.5%).

Figure CMHC.5 Community mental health care service contacts, by session type and participation status, 2011–12



Notes:

1. Community mental health care data were not available for Victoria in 2011–12 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals.

2. Industrial action in Tasmania in 2011–12 has affected the quality and quantity of Tasmania's Community mental health care data.

Source: National Community Mental Health Care Database.
Source data for this figure are accessible from Table CMHC.5 (903KB XLS) in the Community Mental

Health Care excel table downloads.

Alternative text:

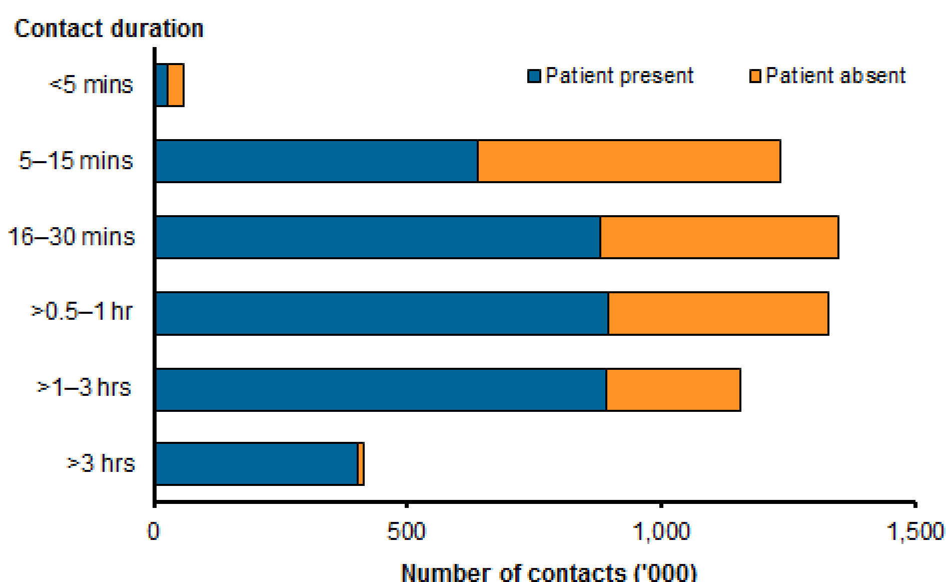
Pie chart showing community mental health care session type by participation status (whether the patient was present or absent), as a proportion of all service contacts. Service contacts in an individual setting with the patient present accounted for 50.2% of service contacts. Individual contacts in which the patient was absent accounted for 22.5%. Group service contacts were more often conducted with the patient present (17.1%) as opposed to when they were absent (10.2%). Refer to Table CMHC.5.

Duration of service contacts

The duration of service contacts can range from less than 5 minutes to over 3 hours. The average service contact duration was 65 minutes in 2011–12. About one-quarter of contacts were 16–30 minutes (24.3%, 1.3 million) with a similar proportion reported for contacts lasting over half an hour to 1 hour (24.0%) (Figure CMHC.6). Apart from those of less than 5 minutes, service contacts with the patient present were more likely to be longer in duration than those with the patient absent. Service contacts with the patient present averaged 77 minutes, where service contacts with the patient absent averaged 39 minutes.

Of the 5 most common principal diagnoses, depressive episode most frequently recorded contacts lasting over 1 hour (43.3%), and had the longest average contact duration of 94 minutes. 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). Average contact durations have been impacted by the non-submission of Victorian data with contact durations being higher than in previous years. These data should be interpreted with caution.

Figure CMHC.6 Community mental health care service contacts, by session duration and participation status, 2011–12



Notes:

1. Community mental health care data were not available for Victoria in 2011–12 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals.

2. Industrial action in Tasmania in 2011–12 has affected the quality and quantity of Tasmania's Community mental health care data.

Source: National Community Mental Health Care Database.
Source data for this figure are accessible from Table CMHC.7 (903KB XLS) in the Community Mental Health Care excel table downloads.

Alternative text:

Stacked horizontal bar chart showing the duration of community mental health service contacts by session duration and participation status (whether the patient was present or absent in 2011–12). The duration ranged from less than 5 minutes to greater than 3 hours. The most frequent duration was 16–30 minutes with 65.2% of patients present. Contacts lasting more than 3 hours had the highest patient presence (96.7%) and with those lasting less than 5 minutes had the lowest (45.5%). Refer to Table CMHC.7.

Mental health legal status

About 1 in 7 (13.4%, 720,646) community mental health care service contacts in 2011–12 involved a patient with an involuntary mental health legal status. Western Australia reported the lowest proportion of involuntary contacts (3.4%; 25,032), while the Australian Capital Territory reported the highest (38.6%; 99,658). However, it should be noted that these jurisdictional differences may reflect the different legislative arrangements in place in these 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 (33.7%). Schizophrenia had the next highest proportion (28.3%). Both Depressive episode and Reaction to severe stress and adjustment disorders had the lowest proportion of involuntary contacts (3.3%).

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 2011–12: National Community Care Database, 2014 Quality Statement.

Key concepts

Community mental health care and hospital outpatient 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