State and territory community mental health services

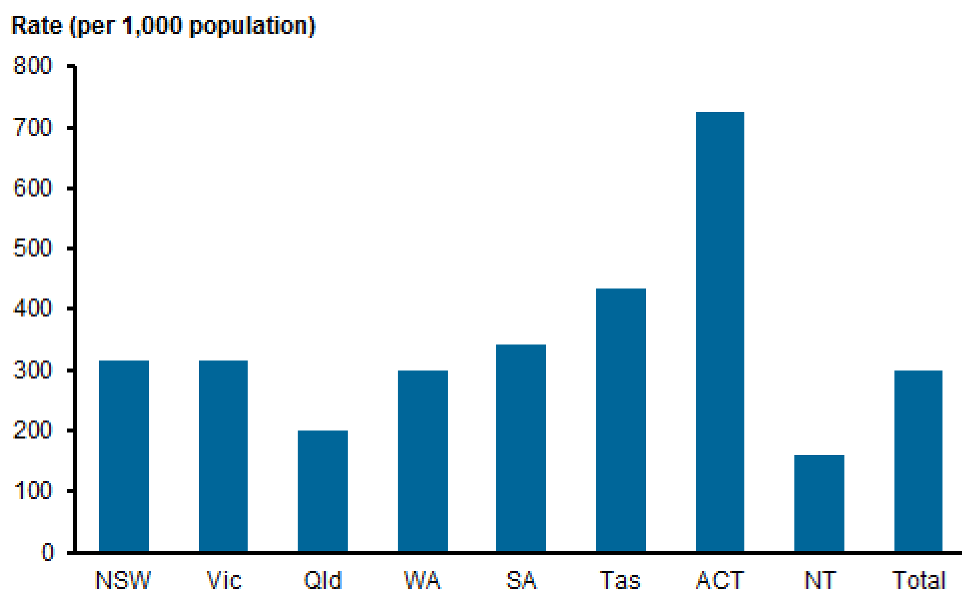
Mental illness is frequently treated in community and hospital-based ambulatory care settings. Collectively, these services are referred to as ***community mental health care***. Data from the National Community Mental Health Care Database (NCMHCD) can be used to describe these services. The statistical counting unit used in the NCMHCD is a ***service contact*** between a patient 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.

Key points

- Over 6.5 million community mental health care service contacts were reported for approximately 339,000 patients in 2009–10.
- The rate of community mental health care service contacts increased by an average of 2.2% per annum between 2005–06 and 2009–10.
- The most common principal diagnosis reported for service contacts was *schizophrenia*, followed by *depression* and *bipolar affective disorder*.
- The most frequently recorded type of community mental health service contact was contact made in the presence of an individual patient (as opposed to a group) with an average duration of 5–15 minutes.
- Involuntary contacts accounted for nearly one-sixth (16%) of all contacts.

Community mental health care by states and territories

Approximately 339,000 patients accessed community mental health care services in 2009–10, resulting in just over 6.5 million service contacts between these patients and community mental health care service providers. This equates to 300 service contacts per 1,000 population (Figure 4.1). There was some inter-jurisdictional variation, with the Australian Capital Territory reporting the highest number of service contacts per 1,000 population (724.8) and the Northern Territory the lowest (161.9). However, it should be noted that 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 (24.6), compared with the national average of 15.4.

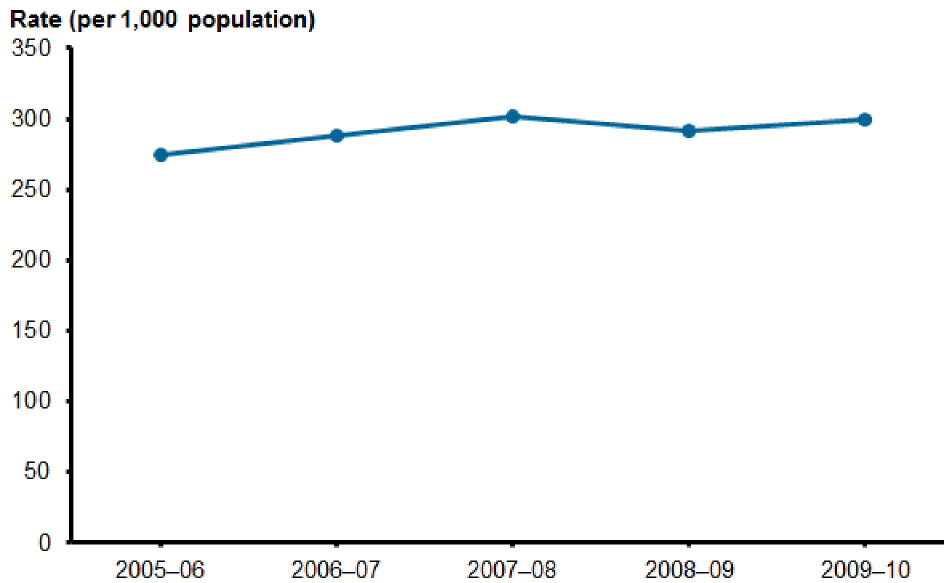


Source: National Community Mental Health Care Database.

Figure 4.1 Community mental health care service contacts, states and territories, 2009–10

Community mental health care change over time

Nationally, the rate of service contacts increased by an annual average of 2.2% over the 5 years to 2009–10 (Figure 4.2). Although there was a decline in the number of service contacts between 2007–08 and 2008–09 at the national level, this was largely the result of Queensland transitioning to a new clinical information system.



Note: Queensland transitioned to a new clinical information system in 2008–09 which impacted on activity data reporting.

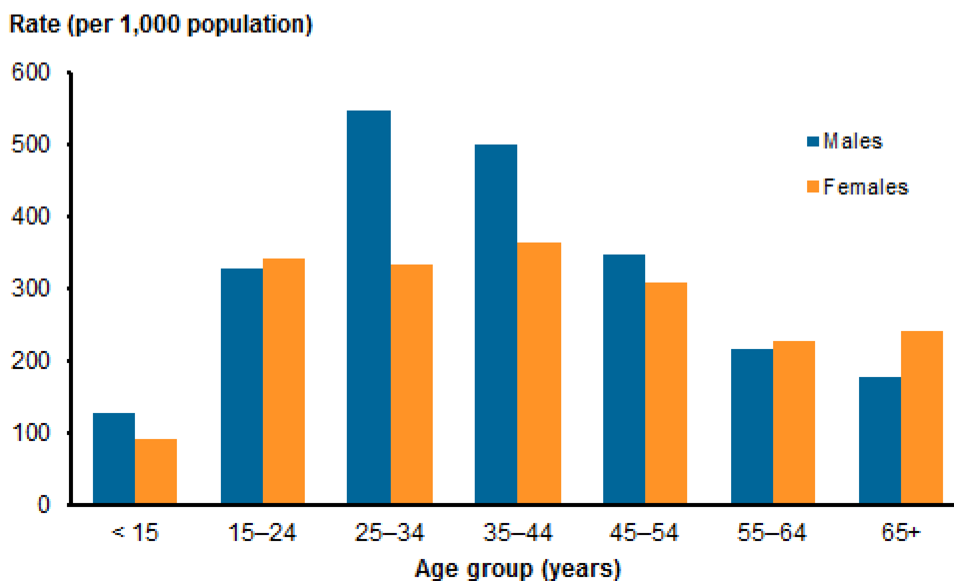
Source: National Community Mental Health Care Database.

Figure 4.2 Community mental health care service contacts, 2005–06 to 2009–10

Characteristics of people who use community mental health care services

Patient demographics

Males accessed services at a higher overall rate in 2009–10 than females (320.5 and 266.4 service contacts per 1,000 population, respectively). However, female rates were higher than male rates after age 55 (Figure 4.3). The highest number of contacts per 1,000 population was for patients aged 25–34 years (441.1). The youngest age group (less than 15 years) was the least represented in both proportion of contacts (7.2%) and contacts per 1,000 population (110.9).



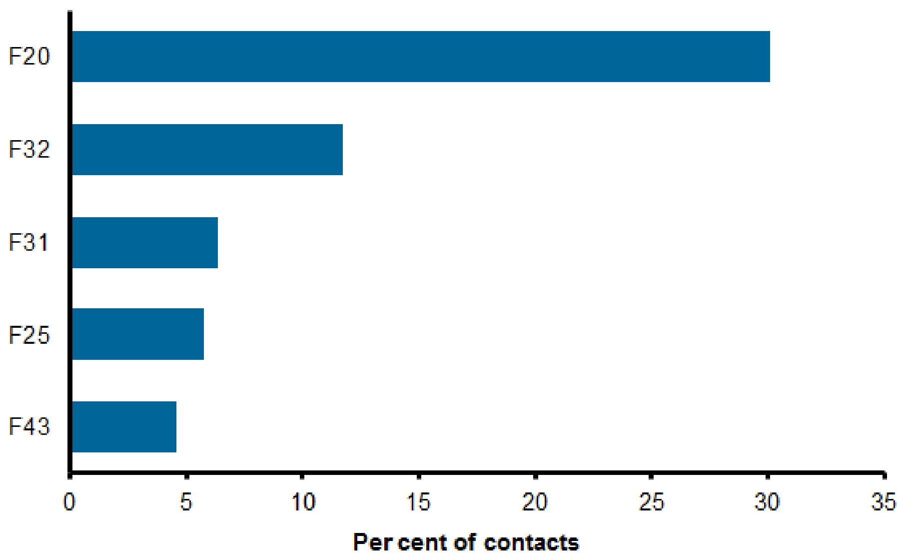
Source: National Community Mental Health Care Database.

Figure 4.3 Community mental health care service contacts, by age group and sex, 2009–10

There were a higher number of contacts per 1,000 population for patients living in *Inner regional* areas (320.2) compared to those in other areas. The rate of contact for Australian-born patients was more than double the rate for those born overseas (340.0 and 152.7, respectively). Nearly two-thirds (62.3%) of the service contacts involved patients with a marital status of *never married*.

Principal diagnosis

A principal diagnosis was reported for more than 9 out of 10 (91.2%, 6,010,748) of all community mental health care service contacts in 2009–10. *Schizophrenia* (ICD-10-AM code F20; 30.1%) was the most frequently recorded principal diagnosis for those contacts where a principal diagnosis was provided (Figure 4.4). This was followed by *depressive episode* (F32; 11.7%) and *bipolar affective disorder* (F31; 6.3%).



Key
F20 Schizophrenia
F32 Depressive episode
F31 Bipolar affective disorders
F25 Schizoaffective disorders
F43 Reaction to severe stress and adjustment disorders

Source: National Community Mental Health Care Database.

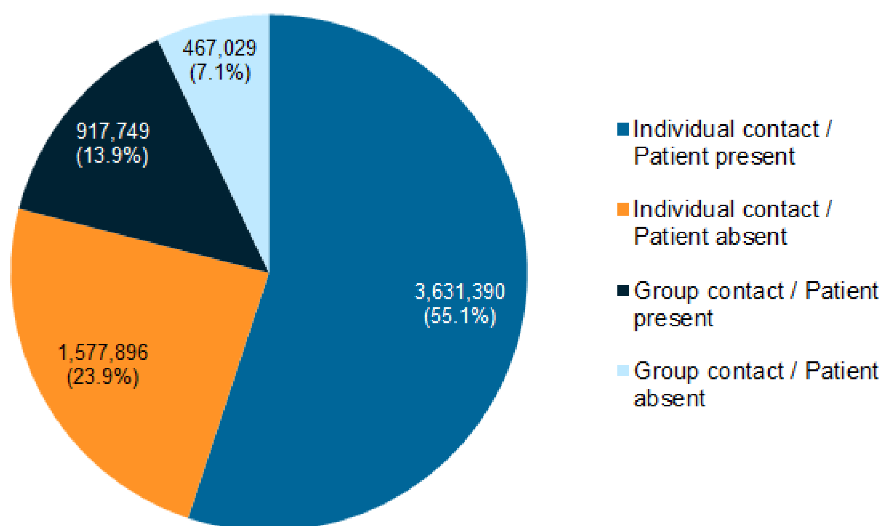
Figure 4.4 Community mental health care service contacts for the 5 most commonly reported mental health-related principal diagnoses, 2009–10

Characteristics of community mental health care service contacts

Type of service contacts

Community mental health care service contacts can be conducted face-to-face, via telephone or video link, or using other forms of direct communication. They can be conducted 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.

More than three-quarters (79.0%) of contacts reported in 2009–10 were individual contacts (Figure 4.5). Approximately 70% of individual contacts were conducted with the patient present compared to two-thirds (66.3%) for group contacts. Patients with a *depressive episode* diagnosis had the highest proportion of group contacts (33.8%) and the lowest proportion of service contacts with the patient absent (26.4%).

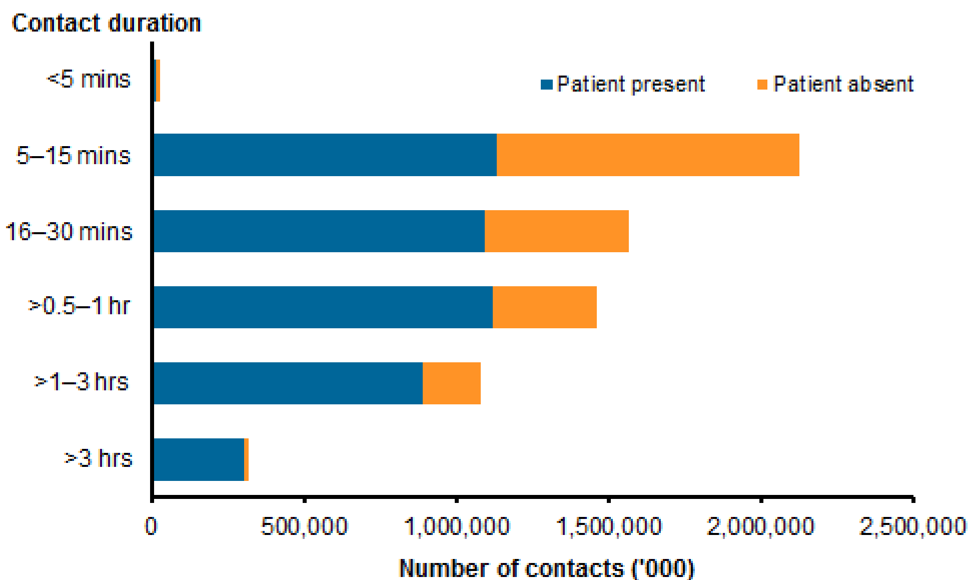


Source: National Community Mental Health Care Database.

Figure 4.5 Community mental health care service contacts, by contact type and patient presence status, 2009–10

Duration of service contacts

The duration of service contacts in 2009–10 ranged from less than 5 minutes to more than 3 hours (Figure 4.6), with about one-third (32.3%) of contacts being 5–15 minutes. 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. The most frequently recorded principal diagnosis for contacts lasting more than 1 hour was *schizophrenia*.



Source: National Community Mental Health Care Database.

Figure 4.6 Community mental health care service contacts, by contact duration and patient presence status, 2009–10

Mental health legal status

Nearly 1 in 6 (15.5%, 1,023,294) community mental health care service contacts in 2009–10 involved a client with an involuntary *mental health legal status*. Western Australia reported the lowest proportion of involuntary contacts (3.7%; 24,835), while the Australian Capital Territory reported the highest proportion (36.1%; 92,973). However, it should be noted that these jurisdictional differences may reflect the different legislative arrangements in place in the jurisdictions.

Data source

National Community Mental Health Care Database

Scope

The National Community Mental Health Care Database (NCMHCD) contains data on all ambulatory mental health service contacts provided by government-operated community mental health care services as specified by the Community Mental Health Care National Minimum Data Set (CMHC NMDS). Examples of data elements are demographic characteristics of patients such as age and sex, and clinical information like principal diagnosis and mental health legal status. Detailed data specifications for the CMHC NMDS can be found in METeOR, the AIHW's online metadata registry.

The scope for this collection is all government-operated community mental health care services that are included in the Mental Health Establishments NMDS. A list of the government-operated community mental health care services that contribute patient-level data to the NCMHCD can be found in the Excel data tables for this section.

A mental health service contact is defined for the purposes of this collection as the provision of a clinically significant service by a specialised mental health service provider for patients/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 period (that is, 2009–10). 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, or other professional or mental health workers or other service providers.

Note that there are variations across jurisdictions in the scope and definition of a service contact. For example, New South Wales, Queensland, South Australia and Tasmania may include written correspondence as service contacts while others do not. Data on contacts with unregistered clients are not included by all jurisdictions.

Quality of Indigenous identification

Data from the NCMHCD on Indigenous status should be interpreted with caution. Among the jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown.

States and territories provided information on the quality of the Indigenous data for 2009–10 as follows:

- New South Wales, Tasmania, and the Australian Capital Territory considered the quality of the Indigenous status data to be acceptable.
- Victoria reported that the quality of Indigenous status data was acceptable. However, there are areas for improvement in the collection of Indigenous status based on the National best practice guidelines for collecting Indigenous status in health data sets (AIHW 2010).
- Queensland reported that the quality of Indigenous status data was acceptable at the broad level, that is, in distinguishing Indigenous Australians and other Australians. However, there are quality issues regarding the coding of more specific details (that is, *Aboriginal*, *Torres Strait Islander*, or *Both Aboriginal and Torres Strait Islander*).

- Western Australia reported that the quality of Indigenous status data for 2009–10 was acceptable. However, the data could be improved with the appropriate resources, training and reporting standards.
- Northern Territory considered the quality to be below the previous year's standard. This is thought to result from lack of compliance with non-mandated data collection items by new external (non-mental health) health service provider data entry. The issue had previously been identified through internal audit processes and specific training initiatives have been undertaken to address the problem.
- South Australia indicated that there has been limited analysis of the quality of Indigenous status data. Therefore, the quality of these data is uncertain at this stage.

Principal diagnosis data quality

The quality of principal diagnosis data in the NCMHCD may also be affected by the variability in collection and coding practices across jurisdictions. In particular, there are:

- differences among states and territories in the classification used:

– New South Wales, Victoria, Western Australia and Tasmania used the *ICD-10-AM 6th Edition* to code principal diagnosis

– South Australia used a combination of *ICD-10-AM 4th Edition* and NCCH *ICD-10-AM Mental Health Manual 1st Edition*

– Australian Capital Territory used the *ICD-10-AM 5th Edition*

– Queensland used a combination of *ICD-10-AM 6th Edition* and NCCH *ICD-10-AM Mental Health Manual 1st Edition*

– Northern Territory used the NCCH *ICD-10-AM Mental Health Manual 1st Edition*

- differences according to the size of the facility (for example, large versus small) in the ability to accurately code principal diagnosis
- differences in the availability of appropriate clinicians to assign principal diagnoses (diagnoses are generally to be made by psychiatrists, whereas service contacts are mainly provided by non-psychiatrists)
- differences according to whether the principal diagnosis is applied to an individual service contact or to a period of care. New South Wales and the Australian Capital Territory report the current diagnosis for each service contact rather than a principal diagnosis for a longer period of care. The remaining jurisdictions report principal diagnosis as applying to a longer period of care.

References

Australian Institute of Health and Welfare 2010. National best practice guidelines for collecting Indigenous status in health data sets. Cat. no. ISW 29. Canberra: AIHW.

Key concepts

Community mental health care and hospital outpatient services

Key Concept	Description
Community mental health care	***Community mental health care*** refers to government-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