4 Community mental health care and hospital outpatient services

4.1 Introduction

This chapter presents information on mental health care provided by community mental health care services and hospital outpatient services. The data are derived from the National Community Mental Health Care Database (NCMHCD), which is a collation of data on government-operated specialised mental health services provided to non-admitted patients in community-based and hospital-based ambulatory care settings. These types of services are generally referred to as ***community mental health care***. The statistical unit for the NCMHCD is a ***service contact*** between a client and a specialised mental health service provider. Appendix 1 provides information about the coverage and data quality of this collection.

Key concepts

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.

Service contacts are defined as the provision of a clinically significant service by a specialised mental health service provider(s) 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 period (that is, 2006–07). 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 either be 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.

4.2 States and territories

In 2006–07, there were 5,966,277 community mental health care service contacts reported nationally. Victoria reported the highest number of service contacts (1,830,278) (Table 4.1). However, the Australian Capital Territory had the highest number of service contacts per 1,000 population (602.9).

Five of the jurisdictions—namely Victoria, Queensland, Western Australia, the Australian Capital Territory and the Northern Territory were able to provide an actual count of patients while estimated patient counts were provided for New South Wales, South Australia and Tasmania. The estimated figure was derived from counting the number of unique patient identifiers for each individual provider reporting to the database which means that patients who used services from multiple providers will be counted more than once. Therefore, the estimated patient counts provided cannot be used for comparative purposes to derive estimates of relative access to services.

Of the five jurisdictions which reported actual patient counts, the Australian Capital Territory had the highest number of service contacts per patient (34.4).

Table 4.1: Community mental health care service contacts, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Service contacts	1,828,468	1,830,278	1,050,960	535,809	382,304	93,186	207,487	37,785	5,966,277
Patients[(a)]	n.a.	58,916	72,552	37,730	n.a.	n.a.	6,037	4,771	n.a.
Average service contacts per patient[(a)]	n.a.	31.1	14.5	14.2	n.a.	n.a.	34.4	7.9	n.a.
Estimated number of patients[(b)]	302,553	. .	. .	. .	41,294	8,733	. .	. .	. .
Average service contacts per estimated number of patients[(b)]	6.0	. .	. .	. .	9.3	10.7	. .	. .	. .
					Rate (per 1,000 population)[(c)]				
Service contacts	269.7	353.3	256.7	257.9	249.3	189.2	602.9	172.3	288.0
Patients[(a)]	n.a.	11.4	17.7	18.2	n.a.	n.a.	17.5	21.7	n.a.
Estimated number of patients[(b)]	44.4	. .	. .	. .	27.2	18.3	. .	. .	. .

(a) This refers to the actual number of patients involved in community mental health care service contacts. Supply of these data was optional for states and territories.

(b) This is an estimated number of patients based on the calculation of the number of unique person identifiers for each establishment. The number of patients may be overestimated, as patients registered with more than one establishment are counted separately each time. See Appendix 1 for more information.

(c) Rates were directly age-standardised as detailed in Appendix 2.

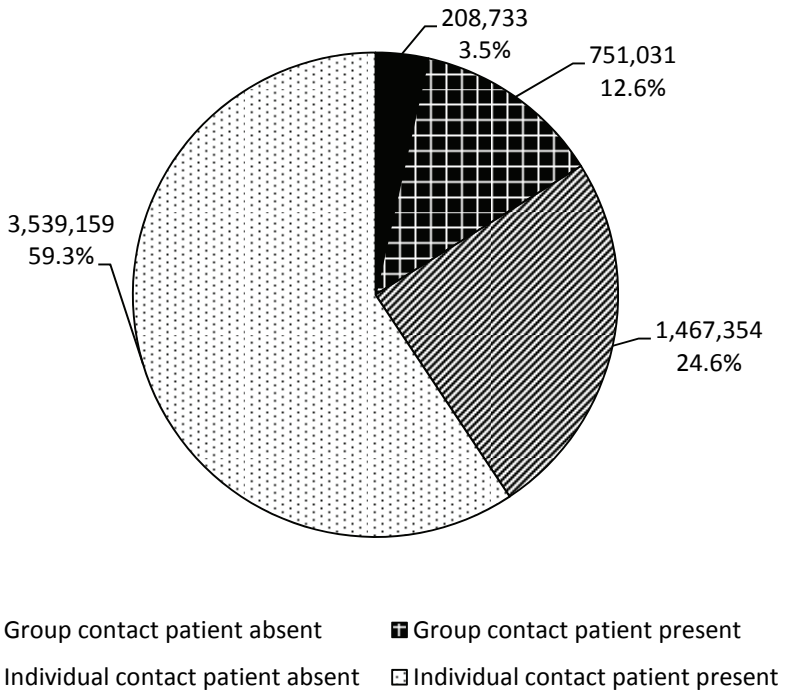
n.a. Not available.

. . Not applicable.

Source: National Community Mental Health Care Database.

4.3 Type of service contacts

Community mental health care service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. These contacts can be conducted in the presence or the absence of the patient. Figure 4.1 shows the number of service contacts by contact type and patient presence status. The majority (83.9%) of contacts reported were individual contacts. Of these, 70.7% were conducted in the presence of the patients. The pattern is similar for group contacts where there were more group contacts conducted with the patient being present (78.3%) than those without (21.7%).

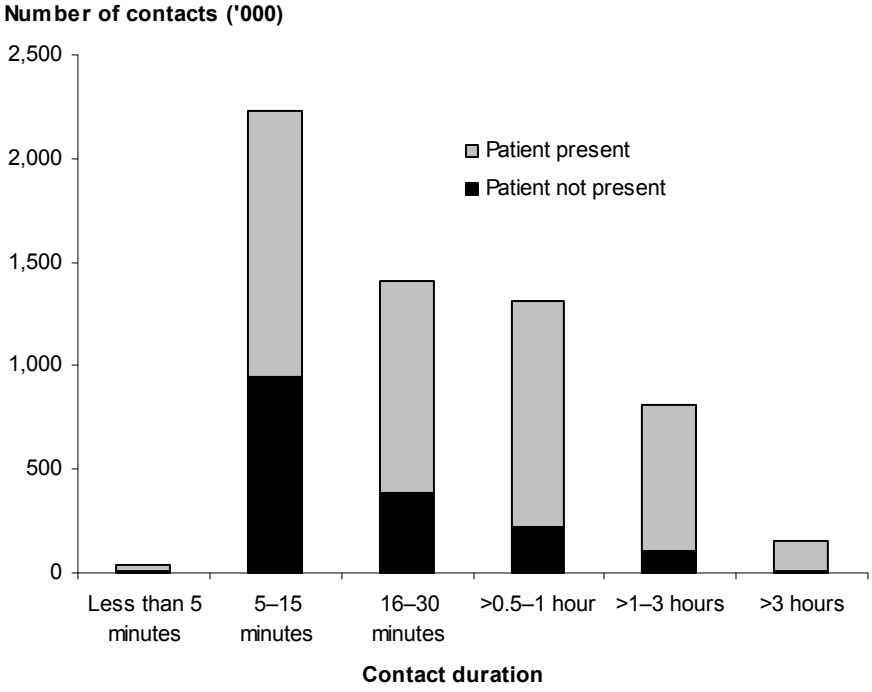


Source: National Community Mental Health Care Database.

Figure 4.1: Community mental health care service contacts, by contact type and patient presence status, 2006–07

4.4 Duration of service contacts

The duration of service contacts ranged from less than 5 minutes to more than 3 hours (Figure 4.2). The most common duration of service contacts was 5–15 minutes, with 37.4% of contacts in this category.



Source: National Community Mental Health Care Database.

Figure 4.2: Duration of community mental health care service contacts, 2006–07

4.5 Mental health legal status

Broadly speaking, the state and territory mental health acts provide the legislative cover that safeguards the rights and governs the treatment of patients with mental illness in hospitals and the community. 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. In the National Community Mental Health Care Database, a patient's mental health legal status refers to whether the patient is receiving treatment on a voluntary or involuntary basis. Patients with involuntary mental health legal status are 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'.

Table 4.2 presents the number of service contacts by jurisdiction and the patient's mental health legal status. Nationally, 16.4% of all service contacts were classified as involuntary. Western Australia reported the lowest proportion of involuntary contacts (2.2%), whilst the Australian Capital Territory reported the highest proportion (34.7%). These jurisdictional differences may be a reflection of the different legislative arrangements in place in the jurisdictions.

Table 4.2: Community mental health care service contacts, by mental health legal status, states and territories, 2006–07

Mental health legal status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Involuntary	251,611	474,075	105,008	11,598	59,175	3,284	71,981	2,634	979,366
Voluntary	1,576,857	1,356,203	945,952	524,211	307,771	77,954	135,506	35,106	4,959,560
Not reported	0	0	0	0	15,358	11,948	0	45	27,351
Total	**1,828,468**	**1,830,278**	**1,050,960**	**535,809**	**382,304**	**93,186**	**207,487**	**37,785**	**5,966,277**

Source: National Community Mental Health Care Database.

4.6 Patient demographics

Table 4.3 presents information on the number of service contacts in 2006–07 for various demographic groups. A rate (per 1,000 population) has also been provided to account for differences in the relative size and age structure of the respective populations. As these are reports of service contacts (rather than persons), the rates cannot be interpreted as the number of people with specific characteristics per 1,000 population who received this type of mental health care. Rather, they provide information on the number of service contacts relative to the size of the population subgroup.

The highest number of contacts per 1,000 population was for patients aged 25–34 years (457.7) followed by those aged 35–44 years (392.0). The youngest age group (less than 15 years) was the least represented in both proportions of contacts (7.4%) and contacts per 1,000 population (106.4).

The data on contacts for Aboriginal and Torres Strait Islander peoples compared with non-Indigenous Australians should be interpreted with caution due to uncertainty about the quality of Indigenous identification in the data. Table 4.3 presents national data on Indigenous status, but note that only data from Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory were reported by the states and territories to be of acceptable quality (see Appendix 1 for more information). As a consequence, it is likely that the number of contacts for Indigenous Australians is underestimated. Although there were fewer contacts reported for Indigenous Australians compared with non-Indigenous Australians, when the size and age structure of the two populations were taken into account, there was a higher number of contacts per 1,000 population for Indigenous Australians than for non-Indigenous Australians (629.3 and 253.9, respectively).

More than half of the service contacts were reported by patients who were never married (61.6%) while those who were widowed were least represented (4.0%).

The data show that the typical service contact involves a patient who is an Australian-born non-Indigenous male aged 25–44 years who has never been married and lives in a major city.

Table 4.3: Community mental health care service contacts, by patient demographic characteristics, 2006–07

Patient demographics	Number of service contacts[a]	Per cent of service contacts[b]	Rate (per 1,000 population)[c]
Age (years)			
Less than 15	432,360	7.4	106.4
15–24	979,771	16.8	337.0
25–34	1,328,689	22.8	457.7
35–44	1,203,670	20.6	392.0
45–54	851,645	14.6	295.5
55–64	468,707	8.0	204.1
65+	565,186	9.7	207.2
Sex			
Male	3,124,748	53.5	304.5
Female	2,713,465	46.5	258.1
Indigenous status[d]			
Indigenous Australians	293,235	5.4	629.3
Other Australians	5,150,613	94.6	253.9
Country of birth			
Australia	4,794,990	84.2	321.4
Overseas	897,163	15.8	164.7
Remoteness area of usual residence			
Major cities	3,922,445	68.1	274.0
Inner regional	1,258,018	21.8	325.8
Outer regional	475,002	8.2	251.9
Remote	66,801	1.2	212.6
Very remote	36,937	0.6	220.3
Marital status			
Never married	3,347,233	61.6	. .
Widowed	217,805	4.0	. .
Divorced	507,659	9.3	. .
Separated	333,914	6.1	. .
Married	1,028,781	18.9	. .
Total	**5,966,277**	**100.0**	**288.0**

(a) The number of service contacts for each demographic variable may not sum to the total due to missing and/or not reported data.

(b) The percentages shown do not include service contacts for which the demographic information, including Indigenous status, was missing and/or not reported.

(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.

(d) These data should be interpreted with caution due to the varying quality of Indigenous identification across jurisdictions (see Appendix 1).

. . Not applicable.

Source: National Community Mental Health Care Database.

4.7 Principal diagnosis

Principal diagnosis refers to the diagnosis established after study to be chiefly responsible for the service contact. Table 4.4 presents the number of service contacts for principal diagnosis groups for 2006–07. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM). Further information on this classification is included in Appendix 3. Note that these data should be interpreted with caution due to variability in the data collection and coding practices in relation to principal diagnosis across Australia (for more information, see Appendix 1).

In 2006–07, a principal diagnosis was specified for 89.5% (5,340,739) of community mental health care service contacts. The most common principal diagnosis reported was *Schizophrenia* (F20), reported for 31.8% of all contacts. This was followed by *Depressive episode* (F32; 11.0%) and *Bipolar affective disorder* (F31; 6.7%).

Figure 4.3 shows the characteristics of community mental health care service contacts for the five most commonly reported principal diagnoses classified as mental and behavioural disorders. The proportion of contacts with duration lasting more than one hour was highest for *Depressive episode* (F32; 22.5%), which also recorded the lowest percentage of contacts lasting 15 minutes or less (31.2%).

There were more group contacts for the diagnosis of *Depressive episode* (F32; 21.1%) and *Reaction to severe stress and adjustment disorders* (F43; 14.8%). The latter diagnosis was also the one with the highest percentage of service contacts in the absence of the patient (31.4%).

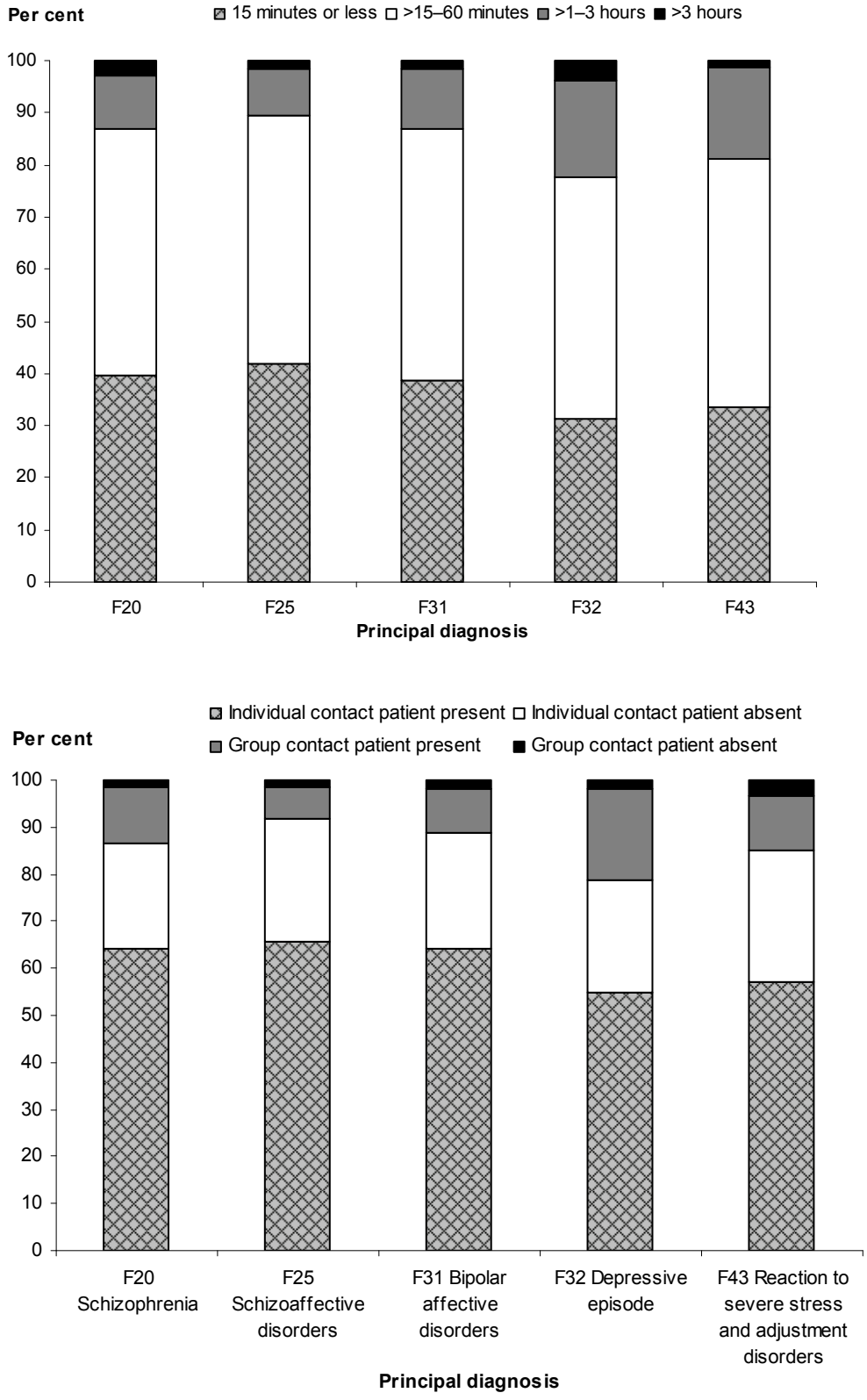
Table 4.4: Community mental health care service contacts, by principal diagnosis in ICD-10-AM groupings, 2006–07

Principal diagnosis		Number of service contacts	Per cent of specified principal diagnoses
F00–F03	Dementia	78,756	1.5
F04–F09	Other organic mental disorders	32,350	0.6
F10	Mental and behavioural disorders due to use of alcohol	49,550	0.9
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	104,650	2.0
F20	Schizophrenia	1,696,141	31.8
F21, F24, F28, F29	Schizotypal and other delusional disorders	76,459	1.4
F22	Persistent delusional disorders	40,037	0.7
F23	Acute and transient psychotic disorders	82,093	1.5
F25	Schizoaffective disorders	299,574	5.6
F30	Manic episode	17,289	0.3
F31	Bipolar affective disorders	358,497	6.7
F32	Depressive episode	586,605	11.0
F33	Recurrent depressive disorders	93,501	1.8
F34	Persistent mood (affective) disorders	43,046	0.8
F38, F39	Other and unspecified mood (affective) disorders	9,915	0.2
F40	Phobic anxiety disorders	26,846	0.5
F41	Other anxiety disorders	150,693	2.8
F42	Obsessive-compulsive disorders	33,623	0.6
F43	Reaction to severe stress and adjustment disorders	231,253	4.3
F44	Dissociative (conversion) disorders	4,693	0.1
F45, F48	Somatoform and other neurotic disorders	6,405	0.1
F50	Eating disorders	43,120	0.8
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	6,611	0.1
F60	Specific personality disorders	184,017	3.4
F61–F69	Disorders of adult personality and behaviour	19,851	0.4
F70–F79	Mental retardation	18,267	0.3
F80–F89	Disorders of psychological development	40,676	0.8
F90	Hyperkinetic disorders	29,580	0.6
F91	Conduct disorders	39,440	0.7
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	72,277	1.4
	Other[(a)]	864,924	16.2
Subtotal with specified principal diagnosis		*5,340,739*	*100.0*
F99	Mental disorder, not otherwise specified	250,514	. .
	Not reported	375,024	. .
Subtotal with unspecified principal diagnosis		*625,538*	*. .*
Total		**5,966,277**	**. .**

(a) Includes all reported diagnoses that are not in the *Mental and behavioural disorders* chapter (Chapter 5) of ICD-10-AM (codes F00–F99).

. . Not applicable.

Source: National Community Mental Health Care Database.



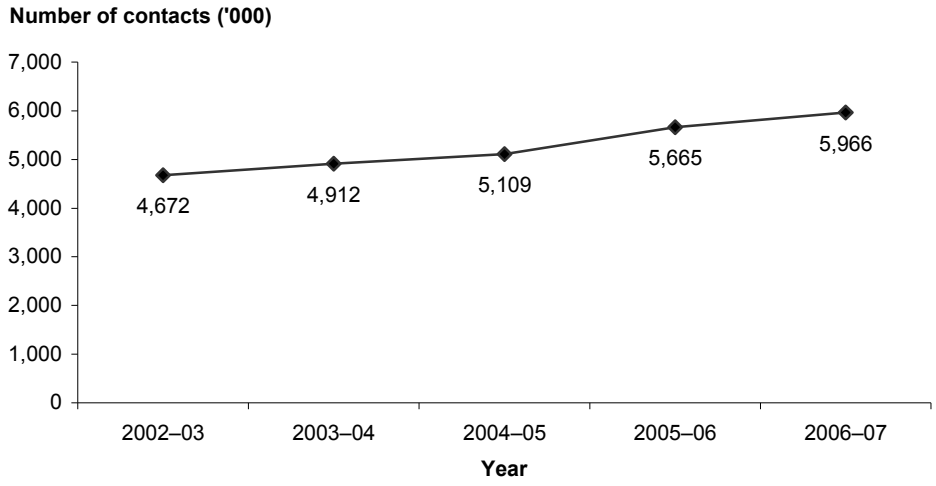
Source: National Community Mental Health Care Database.

Figure 4.3: Community mental health care service contacts for the five most commonly reported principal diagnoses, by duration, contact type and patient presence status, 2006–07

4.8 Change over time, 2002–03 to 2006–07

The number of service contacts reported to the NCMHCD has increased over the five years to 2006–07 (Figure 4.4). In 2006–07, there was a 5.3% increase in the number of contacts reported compared with 2005–06. Note that these increases may reflect increases in the actual number of community mental health care services and/or improvements in data coverage. Not all jurisdictions were able to provide estimates of data coverage for the 2006–07 data. Consequently, it is not possible to determine conclusively what contribution the expanded data coverage may have made to the observed increase in the total number of service contacts being reported. State and territory estimates of coverage for 2006–07 are listed below:

- New South Wales estimated that their coverage for 2006–07 was similar to 2005–06, which was around 70% of full coverage.
- Victoria estimated that 100% of in-scope services have reported service contact data for 2006–07. Estimates of data coverage for 2005–06 were not available.
- Queensland estimated that 100% of in-scope services reported service contact data for 2006–07.
- Western Australia reported a significant growth in the number of service contacts in 2006–07 due to the introduction of a new reporting tool. Estimates of data coverage for 2005–06 were not available.
- South Australia estimated their 2006–07 coverage to be 70% with the figure derived as the number of organisations with incomplete or no patient level data for this NMDS divided by the number of organisations reporting community services via the national survey of mental health services for 2005–06. In 2005–06, the estimated coverage was 91%.
- Tasmania reported their coverage to be 88%. No estimated coverage was provided for 2005–06.
- The Australian Capital Territory reported their coverage to be 99.7%. In 2005–06 the estimated coverage was 98.9%.
- The Northern Territory reported 100% coverage for 2006–07. In 2005–06, the coverage was 90%.



Source: National Community Mental Health Care Database.

Figure 4.4: Community mental health care service contacts, 2002–03 to 2006–07

4.9 Additional data

Additional tables containing data on community mental health care service contacts are available from the Australian Institute of Health and Welfare website (see Section 1.5 for details).