State and territory community mental health care services

Mental illness is frequently treated in community and hospital-based outpatient care settings. Collectively, these services are referred to as community mental health care. State and territory health authorities collect a core set of information on government-funded community mental health care services in their jurisdiction for the Community Mental Health Care National Minimum Data Set (CMHC NMDS), which is compiled annually into the National Community Mental Health Care Database (NCMHCD). Data from the 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.

More information about the coverage and data quality of the NCMHCD is available in the data source section. Staff industrial action has resulted in a substantial reduction in data coverage for two jurisdictions in previous years: Victoria (2011–12, 2012–13, 2015–16 and 2016–17) and Tasmania (2011–12 and 2012–13). New South Wales and the Northern Territory also reported reduced data coverage for 2016–17 and 2017–18. Further information on data coverage can be found in the CMHC NMDS data quality statement. 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.

The footnotes in each of the accompanying MS Excel tables have details about the calculation of national rates over time.

Data downloads:

Excel – State and territory community mental health care services tables 2017–18

PDF – State and territory community mental health care services section 2017–18

Data coverage includes the time period 2005–06 to 2017–18. Data in this section was last updated in October 2019.

Key points

- Around 9.5 million community mental health care service contacts were provided to approximately 435,000 patients in 2017–18.
- Aboriginal and Torres Strait Islander patients received community mental health care services at around 3 times the rate of non-Indigenous patients (53.8 compared to 16.1 per 1,000 population) in 2017–18.

- Females aged 12–17 years had the highest community mental health care service contact rate in 2017–18 (872.5 service contacts per 1,000 population).
- The most common specific principal diagnosis recorded for patients during a service contact was *Schizophrenia*, followed by *Depressive episode* and *Schizoaffective 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 had a duration of 5–15 minutes.
- Involuntary contacts accounted for about one-seventh (14.5%) of all contacts.

Community mental health care services provision

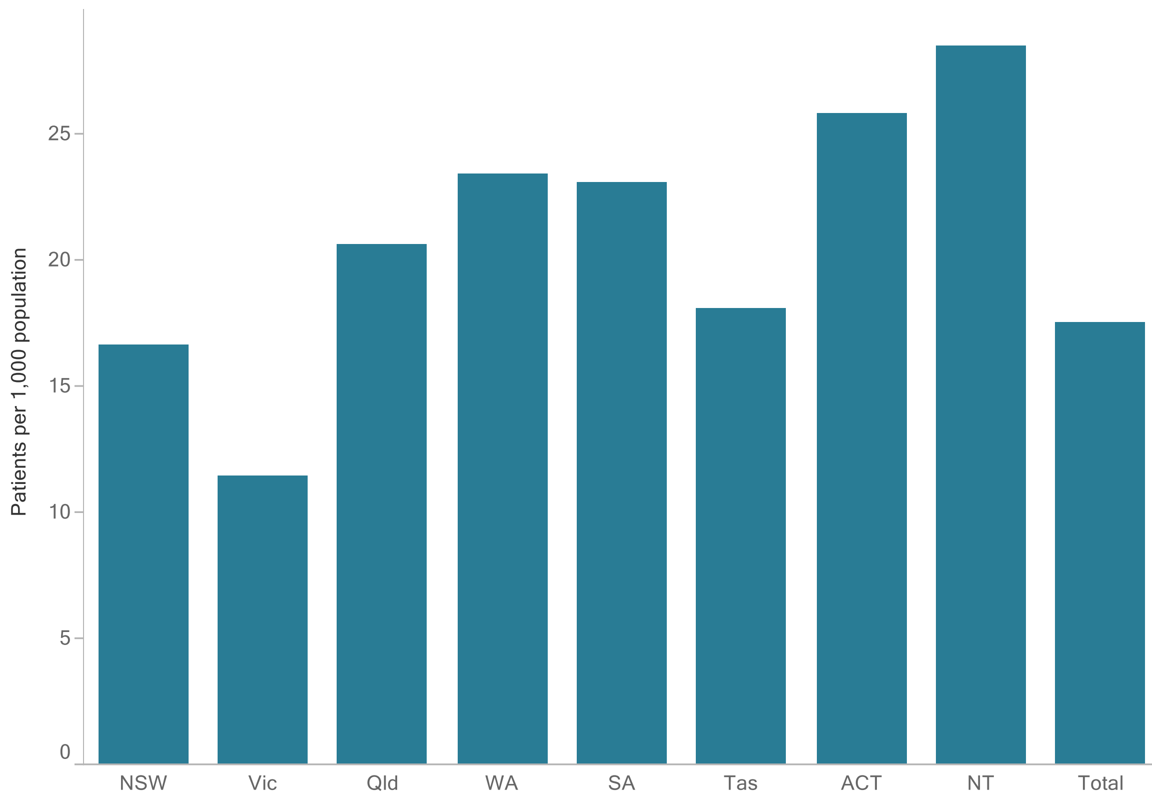
States and territories

Around 9.5 million service contacts were provided by community mental health care services to patients in 2017–18. The number of service contacts per 1,000 population varied between states and territories in 2017–18, with the Australian Capital Territory reporting the highest rate (767.5) and Tasmania the lowest (281.8). Differences in jurisdictional data reporting systems may contribute to the observed variation in service contact rates. Reduced data coverage or under reporting of service contacts may also contribute to variation in service contact rates. For further information see the data quality statement for 2017–18.

The number of unique patients provided with service contacts can be derived from the NCMHCD. However, the patient count is limited to those people registered with state and territory community mental health care systems that have a unique person identifier—that is, a person has one identifier across all individual service providers within a state or territory. The ability of jurisdictions to generate unique person identifiers varies, as described in the data quality statement for the CMHC NMDS. In 2017–18, 96.9% of all service contacts reported were provided to unique patients.

Around 435,000 people received community mental health care in 2017–18. The number of patients per 1,000 population ranged between 11.5 (Victoria) and 28.5 (Northern Territory) (Figure CMHC.1).

Figure CMHC.1: Community mental health care patients, states and territories, 2017-18



Source: National Community Mental Health Care Database; Table CMHC.1.

www.aihw.gov.au/mhsa

Source data: State and territory community mental health care Table CMHC.1 (172KB XLS).

Treatment periods

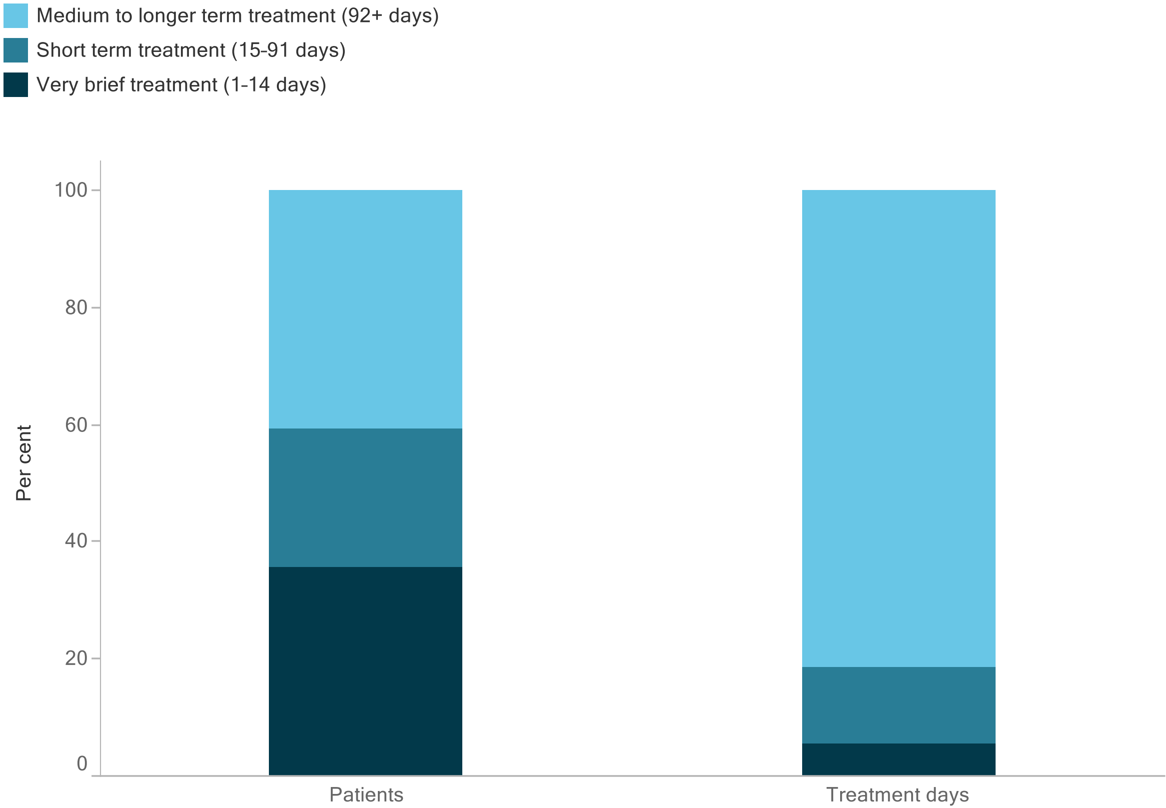
Two important measures of the amount of treatment provided to registered patients can be derived from the NCMHCD:

1. Length of treatment period—the total amount of time between the first and last service contact for each patient during the reporting period. Treatment periods are defined in this report as very brief (1-14 days), short term (15–91 days) and medium to longer term (92+ days).
2. Number of treatment days provided—the number of days during the reporting period that an individual patient received one or more service contacts. The number of treatment days are grouped as follows in Table CMHC.24; 1–9 days, 10–19 days, 20–29 days, 30–39 days and 40+ days.

Overall, around 2 in 5 patients (40.6% or 176,524 registered patients) had a medium to longer term length of treatment period (92+ days). Medium to longer term treatment

periods also involved the most treatment days (81.4% of treatment days) (Figure CMHC.2). Around a third of patients (35.6% or 154,968 registered patients) had a very brief length of treatment period (1–14 days) and received 5.7% of the total number of treatment days.

Figure CMHC.2: Proportion of patients and total treatment days, by length of treatment period, 2017-18



Source: National Community Mental Health Care Database; Table CMHC.24.

www.aihw.gov.au/mhsa

Source data: State and territory community mental health care Table CMHC.24 (172KB XLS).

Patient characteristics

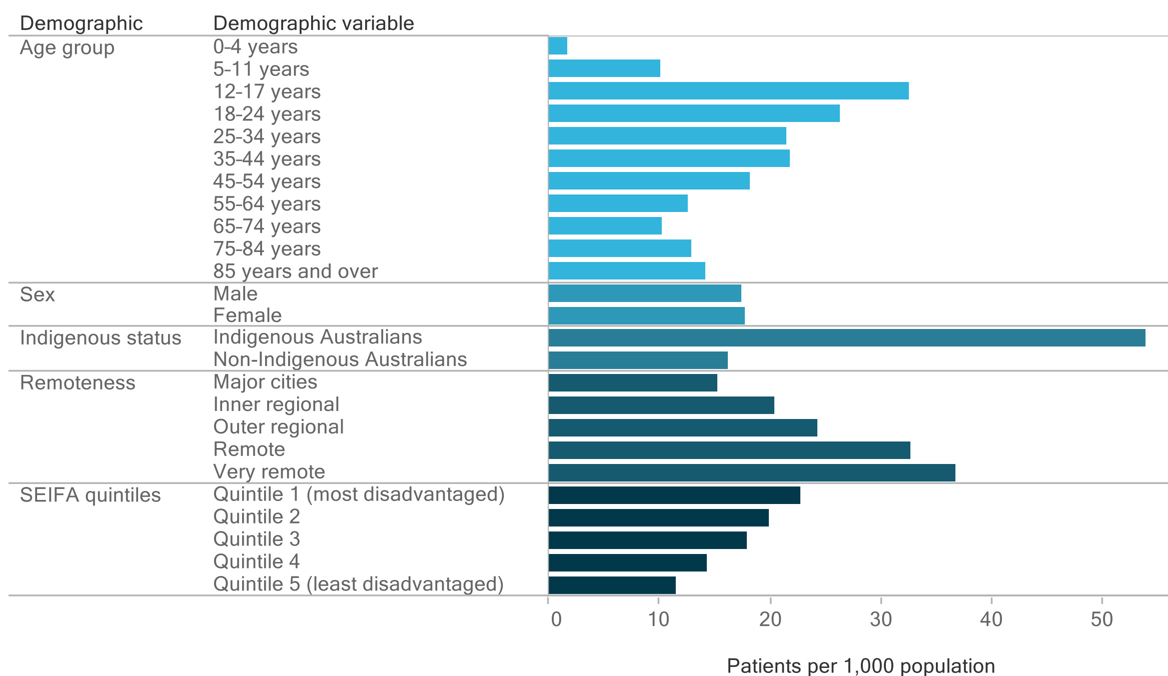
Patient demographics

Aboriginal and Torres Strait Islander patients comprised 9.7% of community mental health care patients in 2017–18. The rate of Indigenous patients per 1,000 population was more than three times the rate of non-Indigenous patients (53.8 compared to 16.1) (see Figure CMHC.3).

People living in *Major cities* make up the majority of the patient population receiving community mental health services (63.3%), however, when the population was taken into account, the rate for those living in *Major cities* (15.3 per 1,000 population) was the lowest of the remoteness areas of usual residence. Patients living in *Very remote* areas had the highest rate per 1,000 population (36.7) (Figure CMHC.3).

People living in the least disadvantaged areas (socioeconomic quintile 5) had the lowest service rate (11.5 per 1,000 population). This rate increased with increasing socioeconomic disadvantage, with patients living in the most disadvantaged areas (socioeconomic quintile 1) receiving services at the highest rate (22.8 per 1,000 population) (Figure CMHC.3).

Figure CMHC.3: Community mental health care service patients, by demographic variable, 2017-18



Note: Rates are crude rates, except Indigenous Status, which is directly age-standardised, as detailed in the technical notes.

Source: National Community Mental Health Care Database; Table CMHC.8.

www.aihw.gov.au/mhsa

Source data: State and territory community mental health care Table CMHC.8 (172KB XLS).

The highest rate of service contacts in 2017–18 was for patients aged 12–17 (656.7 per 1,000 population). The two youngest age groups (0–4 years and 5–11 years) had the lowest number of contacts per 1,000 population (16.9 and 137.9 per 1,000 population respectively).

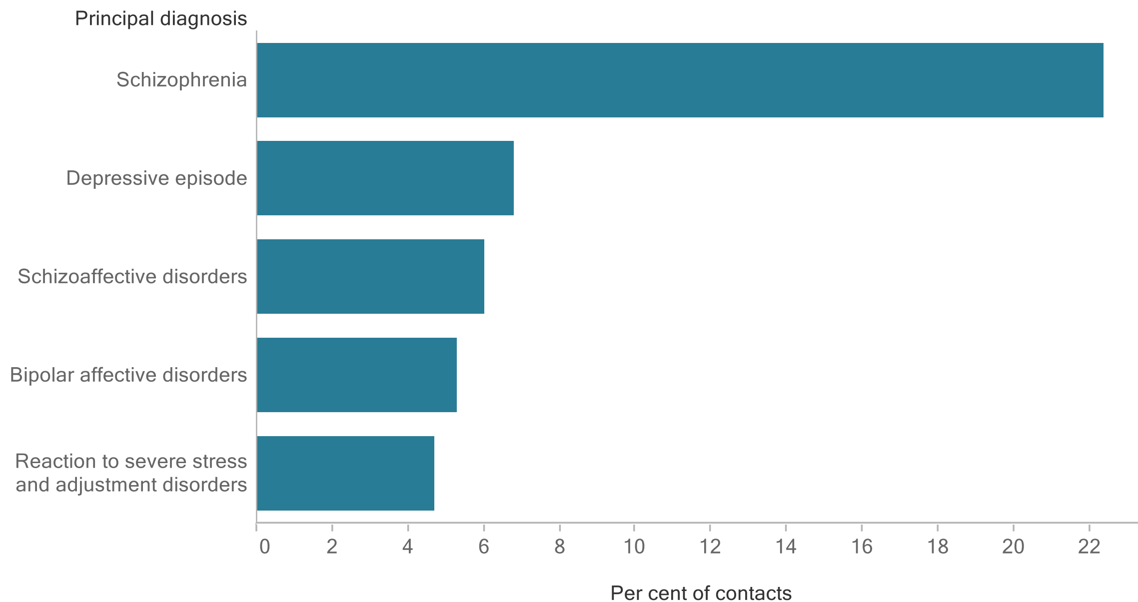
In 2017–18, males accessed services at a higher rate (388.9 service contacts per 1,000 population) than females (367.7). The highest male contact rate was reported for the 35–44 age group (630.6 per 1,000 population), while for females the highest contact rate was for the 12–17 age group (872.5).

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). The data quality statement for the CMHC NMDS has further information on principal diagnosis data quality issues.

Of the 5 most commonly reported specific mental health-related principal diagnoses in 2017–18, *Schizophrenia* (ICD-10-AM code F20; 22.4%) was the most frequently recorded (Figure CMHC.4). This was followed by *Depressive episode* (F32; 6.8%) and *Schizoaffective disorder* (F25; 6.0%). A principal diagnosis was reported for about 8 out of 10 (almost 8.0 million) of all community mental health care service contacts.

Figure CMHC.4: Proportion of community mental health care service contacts, for 5 commonly reported mental health-related principal diagnoses, 2017-18



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; Table CMHC.15.

www.aihw.gov.au/mhsa

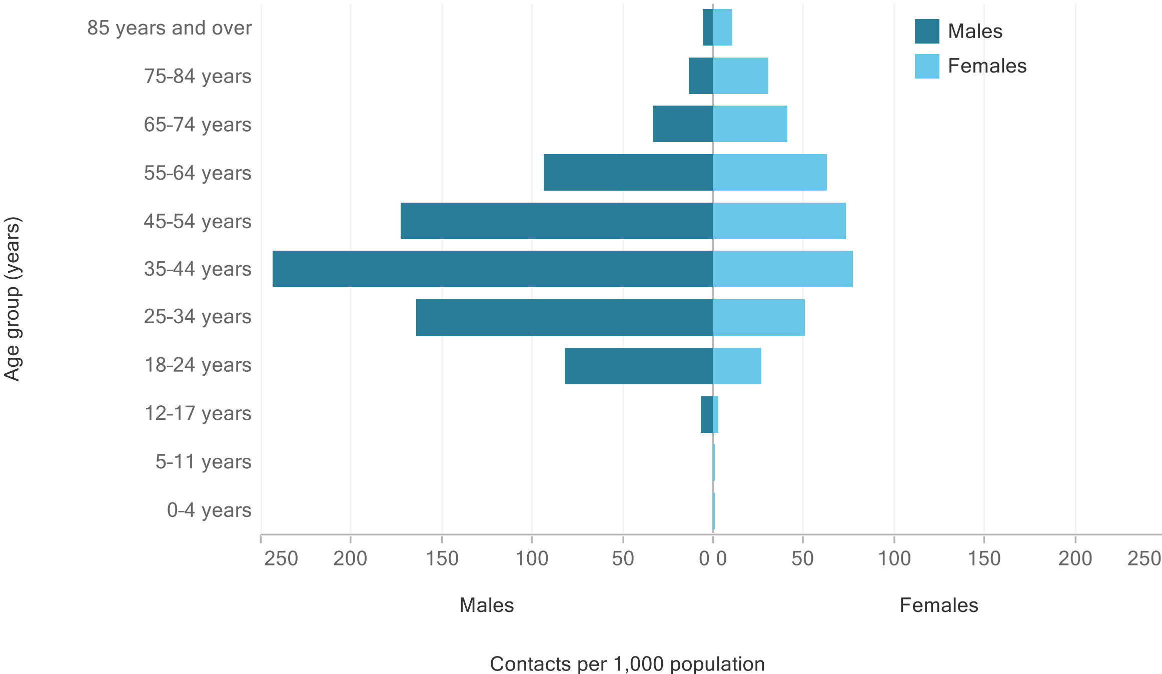
Source data: State and territory community mental health care Table CMHC.15 (172KB XLS).

Most commonly reported specific principal diagnosis: Schizophrenia

Among patients with a principal diagnosis of *Schizophrenia*, those aged 35–44 received the greatest number of community mental health care contacts (526,431 or 29.5%).

Males with a diagnosis of *Schizophrenia* received services at a higher rate (101.8 service contacts per 1,000) than females (42.8 service contacts per 1,000) in 2017–18.
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 males aged 35–44 years (243.0 contacts per 1,000 population). The difference between males and females is most likely due to the observed sex difference in prevalence of *Schizophrenia.* The Prevalence, impact and burden section has further information.

Figure CMHC.5: Service contacts for patients with a principal diagnosis of Schizophrenia, by age group and sex, 2017–18



Note: Crude rates based on the estimated Australian resident population on 31 December 2017.

Source: National Community Mental Health Care Database; Table CMHC.18.

www.aihw.gov.au/mhsa

Source data: State and territory community mental health care Table CMHC.18 (172KB XLS).

Other most commonly reported principal diagnoses

The other commonly reported principal diagnoses also differed by age group and sex in 2017–18:

- *Schizophrenia* was the most commonly reported principal diagnosis for service contacts among patients aged 25–34, 35–44, 45–54 and 55–64. For all other age groups the most common diagnosis was *Mental disorder not otherwise specified* (F99).
- *Depressive episode* was the most commonly reported specific principal diagnosis (F00–F98) for service contacts among patients aged 75–84 and 85 years and over. Rates of service contacts for *Depressive episode* were highest for females in the 12–17 age group (67.4 contacts per 1,000 population).
- For patients with a principal diagnosis of *Schizoaffective disorders,* males and females aged 35–44 had the highest rate of service contacts (42.3 and 41.7 per 1,000 population).
- Females with a diagnosis of *Bipolar affective disorder* received service contacts at a slightly higher rate than males (19.5 and 14.2 service contacts per 1,000 population).
- Rates of service contacts for patients with the stress-related disorder - *Reaction to severe stress and adjustment disorder* were highest for females in the 12–17 age group at 77.3 per 1,000 population, almost three times the service contact rate for males of the same age group (27.9 per 1,000 population).

Characteristics of service contacts

Type of service contacts

Community mental health care service contacts can be conducted either individually or in a group session. Service contacts can also 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 (94.2%) of service contacts reported in 2017–18 involved individual sessions, and 5.8% of contacts were group sessions. More than half (52.2%) of all contacts were individual sessions where the patient participated in the service contact (termed patient present).

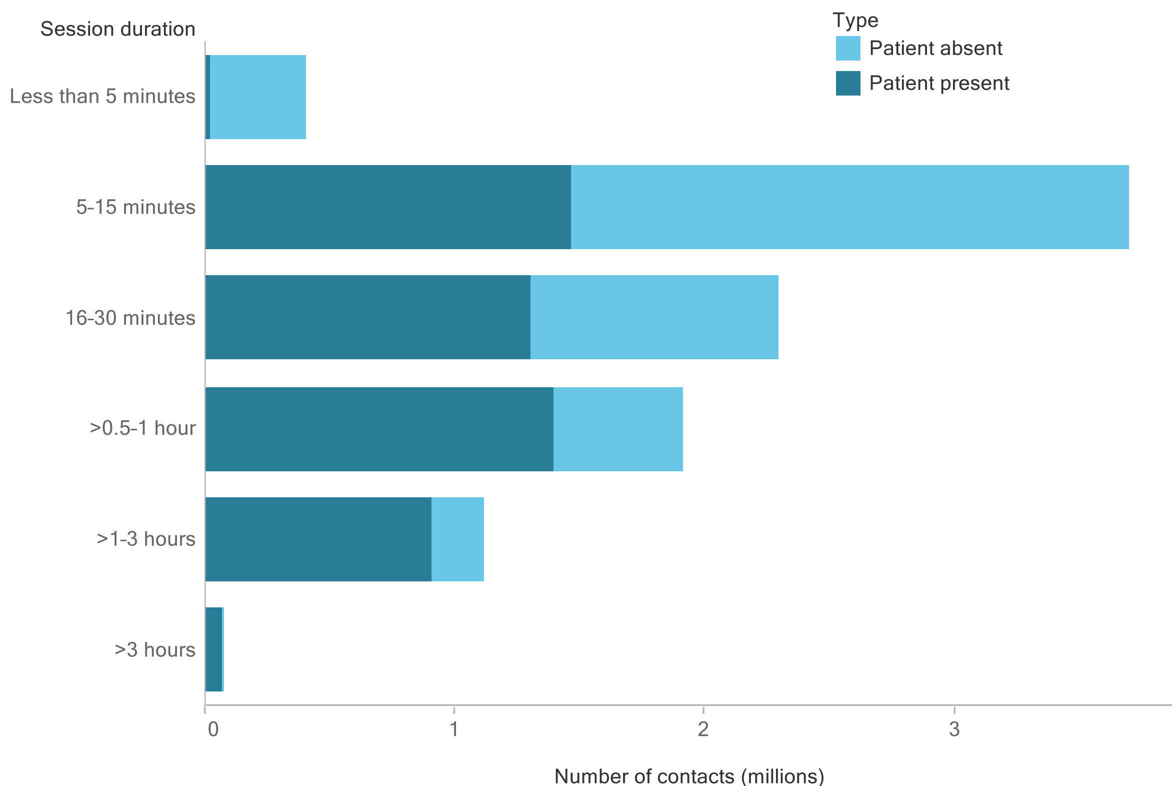
Of the 5 most common specific principal diagnoses, the patients most likely to have an individual contact, where the patient was present, were those diagnosed with a *Schizoaffective disorder* (62.1%) or *Schizophrenia* (61.8%). Patients with the stress-related

disorder - *Reaction to severe stress and adjustment disorder* had the highest proportion of service contacts where the patient was absent (48.2%).

Duration of service contacts

The duration of service contacts ranged from less than 5 minutes to over 3 hours. In 2017–18, the average service contact duration was 35 minutes. More than a third of contacts were between 5–15 minutes (38.9%, or about 3.7 million) and around a quarter of contacts were between 16–30 minutes (24.2%, or about 2.3 million) (Figure CMHC.6). Service contacts with the patient present were on average longer in duration, averaging 46 minutes, than those with the patient absent (23 minute average).

Figure CMHC.6: Community mental health care service contacts, by session duration and participation status, 2017-18



Source: National Community Mental Health Care Database; Table CMHC.21.

www.aihw.gov.au/mhsa

Source data: State and territory community mental health care Table CMHC.21 (172KB XLS).

Of the 5 most commonly reported specific principal diagnoses, *Reaction to severe stress and adjustment disorders* had the highest proportion of contacts lasting over 1 hour

(13.5%). Service contacts lasting less than 5 minutes were not commonly conducted with patients who had 1 of the 5 most frequently recorded specific principal diagnoses (5.2% or less for each principal diagnosis).

Contact duration over time

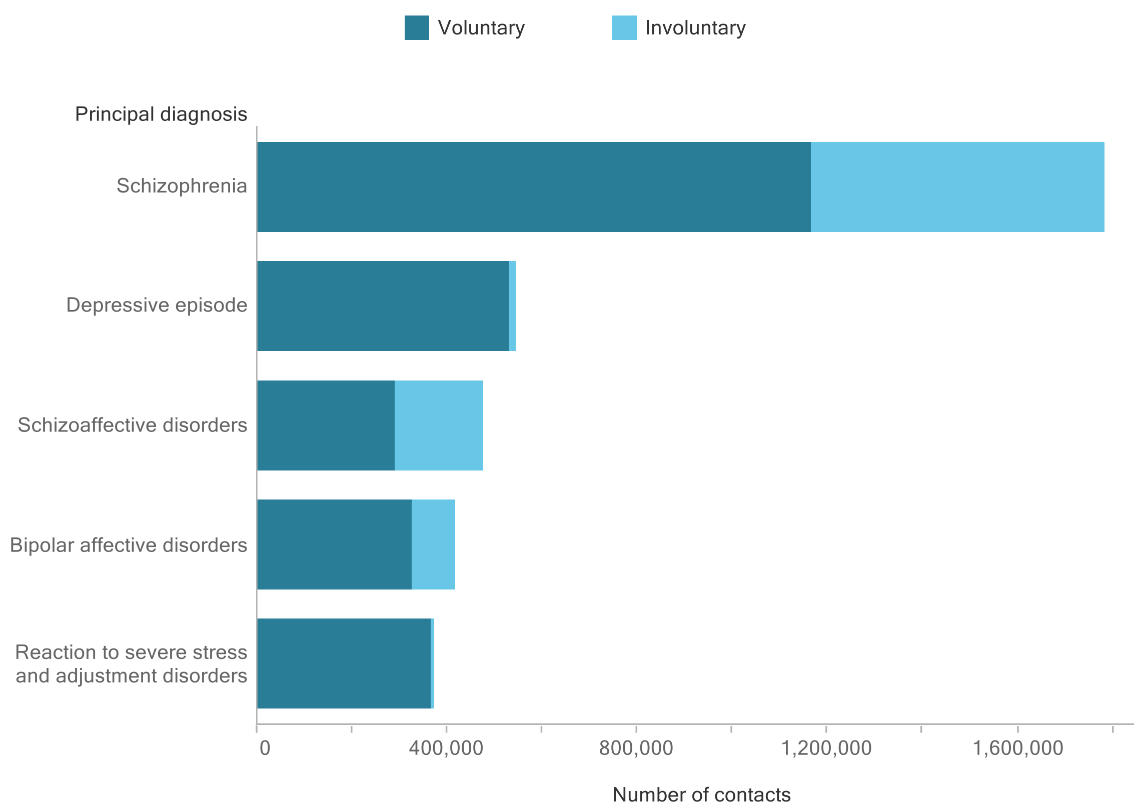
Issues with some jurisdictions' data coverage in 2011–12 and 2012–13 (Victoria and Tasmania), 2015–16 (Victoria), 2016–17 (Victoria, New South Wales and the Northern Territory), and 2017–18 (New South Wales and the Northern Territory) have impacted on the ability to undertake long term trend analysis for these jurisdictions, as well as at the national level.

Nevertheless, the average time per contact has steadily declined over the five years to 2017–18, from 47 minutes per contact in 2013–14 to 35 minutes per contact in 2017–18. Since 2013–14, the number of short-duration contacts (under 5 minutes) has increased 4-fold, from 86,742 to 402,195. This increase is mostly due to a change in Queensland's reporting system during the 2014–15 reporting period, which allows for contact duration to be recorded individually for each consumer seen in group sessions. This system change affects the national average duration of contacts.

Mental health legal status

About 1 in 7 (14.5%, 1,340,130) community mental health care service contacts in 2017–18 involved a patient with an involuntary mental health legal status. Western Australia reported the lowest proportion of involuntary contacts (3.4%), while the Australian Capital Territory reported the highest (34.5%). These differences most likely reflect the different legislative arrangements in place amongst the jurisdictions.

Of the 5 most commonly reported specific principal diagnoses, *Schizoaffective disorders* accounted for the highest proportion of contacts involving a patient with an involuntary mental health legal status (39.5%), followed by *Schizophrenia* (34.7%) and *Bipolar affective disorder* (21.9%). Lower proportions of involuntary mental health legal status service contacts were seen in patients with a principal diagnosis of a *Depressive episode* (2.6%) and *Reaction to severe stress and adjustment disorders* (1.8%) (Figure CMHC.7).



Source data: State and territory community mental health care Table CMHC.27 (172KB XLS).

Over the 5 years to 2017–18, the number of community mental health care service contacts with an involuntary legal status increased by an average of 4.2% each year. The proportion of involuntary contacts increased for 4 of the 5 most commonly reported specific principal diagnoses over this time period, however a reduction in the proportion of involuntary contacts was observed for patients with the principal diagnosis of *Reaction to severe stress and adjustment disorders* (an average decrease of 7.4% each year).

Note that national rates over time should be interpreted with caution. Improvements in the reporting of legal status and issues with data coverage for Victorian and Tasmanian data in 2011–12 and 2012–13 and changes to South Australian legislation and data collection methods for involuntary care in 2010–11 have had an impact on the ability to undertake long term trend analysis of the rate of involuntary contacts.

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.* Additional information about Community mental health care services can be found in the Specialised mental health care facilities section.

Services targeted toward the *General* population provided 69.7% of all treatment days in 2017–18, and *Child and Adolescent* services accounted for 15.2%. Services targeted towards *Older Person* (6.9%), *Forensic* (6.5%) and *Youth* (1.6%) populations accounted for much smaller proportions of treatment days. 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 (Specialised mental health care facilities section, Table FAC.41).

Data source

National Community Mental Health Care Database

Data Quality Statements for National Minimum Data Sets (NMDSs) are published annually in AIHW's Metadata Online Registry (METeOR). These statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence. Visit the Community mental health care NMDS 2017–18: National Community Care Database, 2019 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 493010): 1. Child and adolescent services focus on those aged under 18 years.

	2. Older person services focus on those aged 65 years and over. 3. 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. 4. 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. 5. 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 Mental Health Establishments Database.
Treatment day	**Treatment day** refers to any day on which one or more service contacts (direct or indirect) are recorded for a registered patient (that is, a patient identifier number is assigned to a uniquely identified person) during an ambulatory care episode.