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 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 7.1 million community mental health care service contacts were reported for approximately 350,000 patients in 2010–11.

- The rate (per 1,000 population) of community mental health care service contacts increased by an average of 3.2% per annum between 2006–07 and 2010–11.

- The most common principal diagnosis reported for service contacts was *schizophrenia*, followed by *depressive episode* 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 session) with a duration of 5–15 minutes.

- Involuntary contacts accounted for around one-seventh (14.8%) of all contacts. The proportion of involuntary contacts decreased from 16.5% of contacts reporting a mental health legal status in 2006–07 to 15.5% in 2010–11.

Community mental health care by states and territories

Approximately 350,000 patients accessed community mental health care services in 2010–11, resulting in over 7.1 million service contacts between these patients and community mental health care service providers. This equates to 326.8 service contacts per 1,000 population (Figure CMHC.1). There was some inter-jurisdictional variation, with the Australian Capital Territory reporting the highest number of service contacts per 1,000 population (659.9) and the Northern Territory the lowest (168.1). 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 (24.2), compared with the national average of 16.0.

Figure CMHC.1 Community mental health care service contacts, states and territories, 2010–11
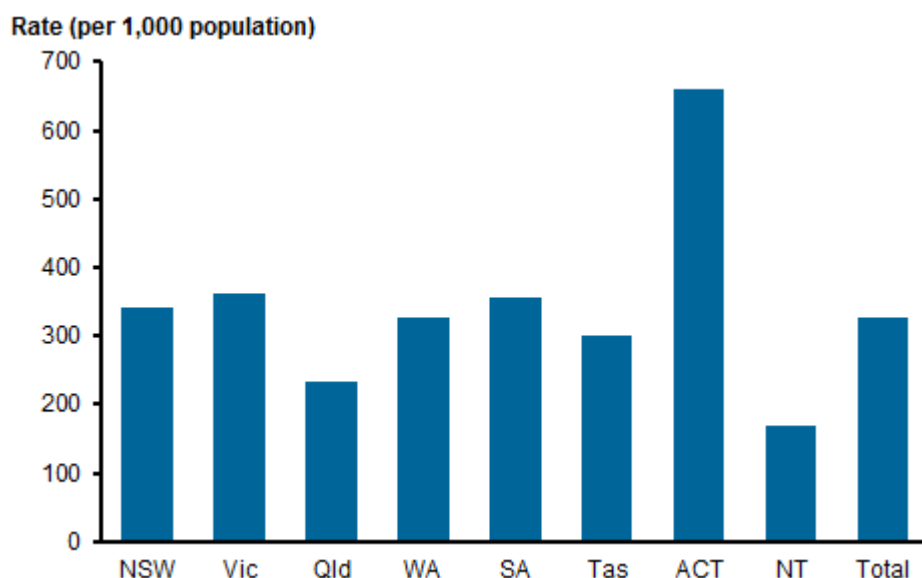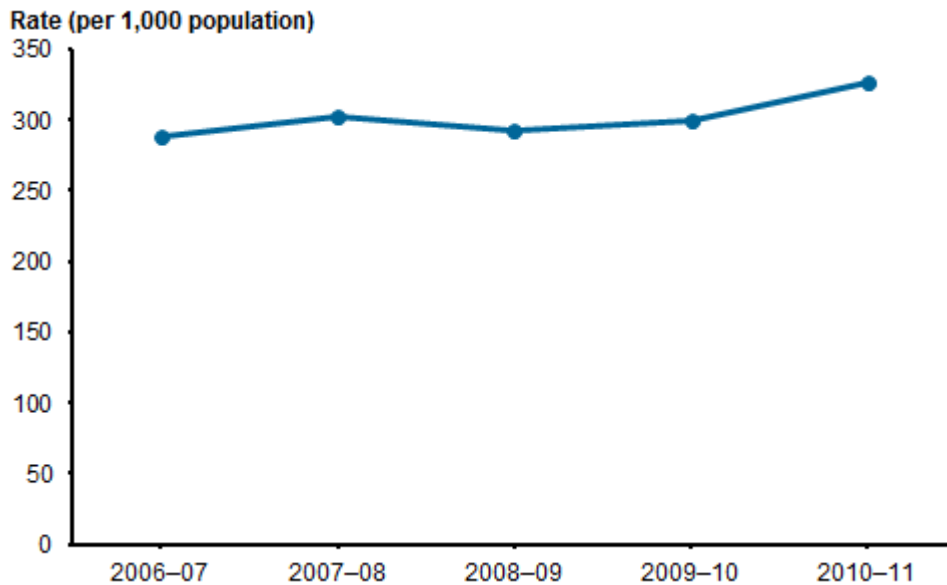

Source: National Community Mental Health Care Database. Source data for this figure are accessible from Table CMHC.1 (635KB XLS) of the State and territory community mental health care services excel tables.

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Community mental health care change over time

Nationally, the rate of service contacts increased by an annual average of 3.2% over the 5 years to 2010–11 (Figure CMHC.2). The apparent decline in the number of service contacts between 2007–08 and 2008–09 at the national level was largely the result of Queensland transitioning to a new clinical information system.

Figure CMHC.2 Community mental health care service contacts, 2006–07 to 2010–11

Note: Queensland transitioned to a new clinical information system in 2008–09 which impacted on activity data reporting.
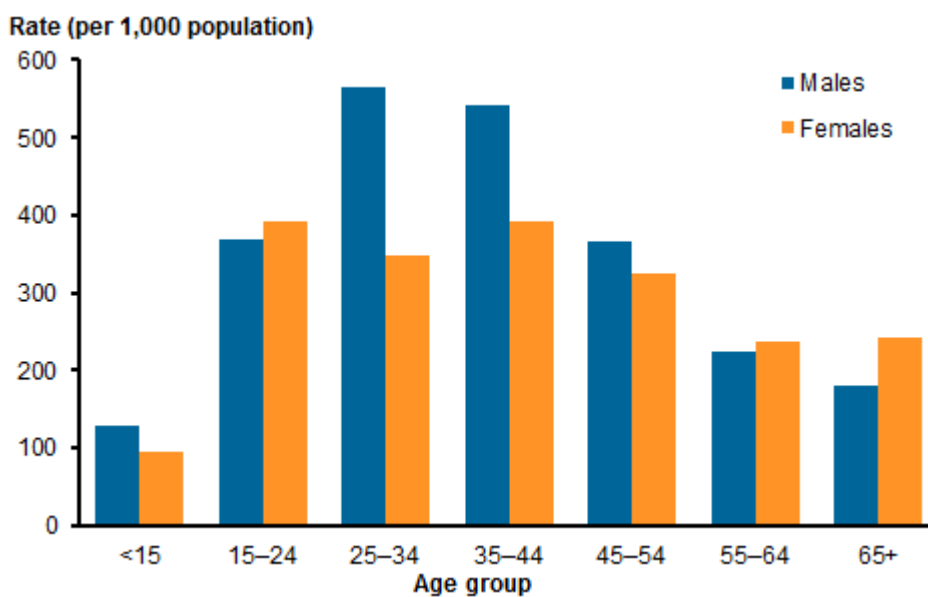
Source: National Community Mental Health Care Database. Source data for this figure are accessible from Table CMHC.8 (635KB XLS) of the State and territory community mental health care services excel tables.

Characteristics of people who use community mental health care services

Patient demographics

Males accessed services at a higher rate in 2010–11 than females (339.1 and 284.6 service contacts per 1,000 population, respectively). However, female rates were higher than male rates in the 15–24 age group and after age 55 (Figure CMHC.3). The highest number of contacts per 1,000 population was for patients aged 35–44 (465.7). The youngest age group (less than 15) was the least represented in both proportion of contacts (6.9%) and contacts per 1,000 population (112.8). The 35–44 years age group (4.4%) had the greatest per annum increase in number of contacts per 1,000 population for the five years to 2010–11.

Figure CMHC.3 Community mental health care service contacts, by age group and sex, 2010–11
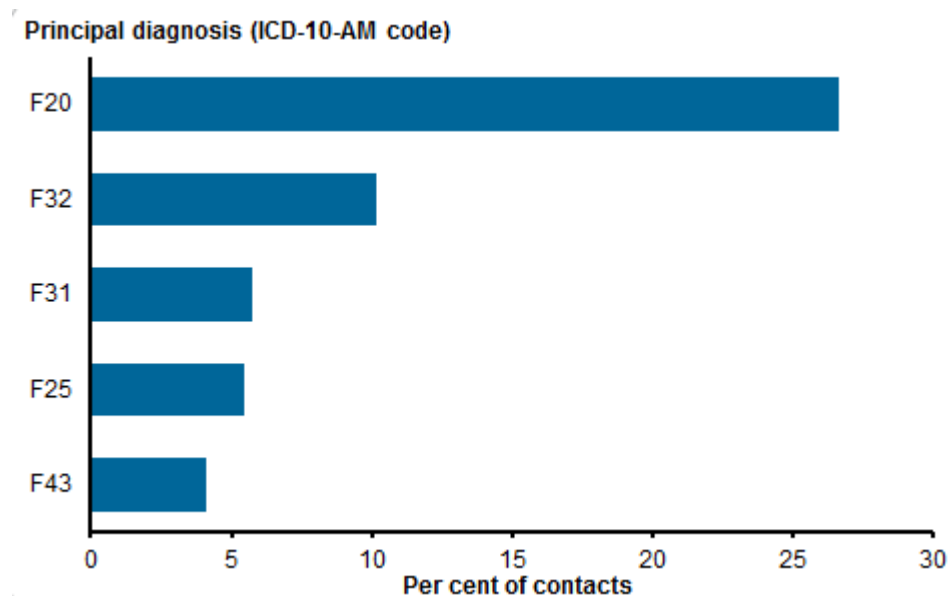

Source: National Community Mental Health Care Database. Source data for this figure are accessible from Table CMHC.2 (635KB XLS) of the State and territory community mental health care services excel tables.

The highest number of contacts per 1,000 population were for clients who live in *Inner regional* areas (336.6). Aboriginal and Torres Strait Islander people had a contact rate more than 3 times the non-Indigenous rate (870.9 and 276.7 per 1,000 population respectively). The rate of contacts for Australian-born patients was more than double the rate for those born overseas (357.6 and 169.4, respectively). Nearly two-thirds (62.4%) 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 (95.9% or nearly 6.9 million contacts) of all community mental health care service contacts in 2010–11. *Schizophrenia* (ICD-10-AM code F20; 26.6%) 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; 10.1%) and *bipolar affective disorder* (F31; 5.8%).

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Figure CMHC.4 Community mental health care service contacts, by the 5 most commonly reported mental health-related principal diagnoses, 2010–11

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. Source data for this figure are accessible from Table CMHC.18 (635KB XLS) of the State and territory community mental health care services excel tables.

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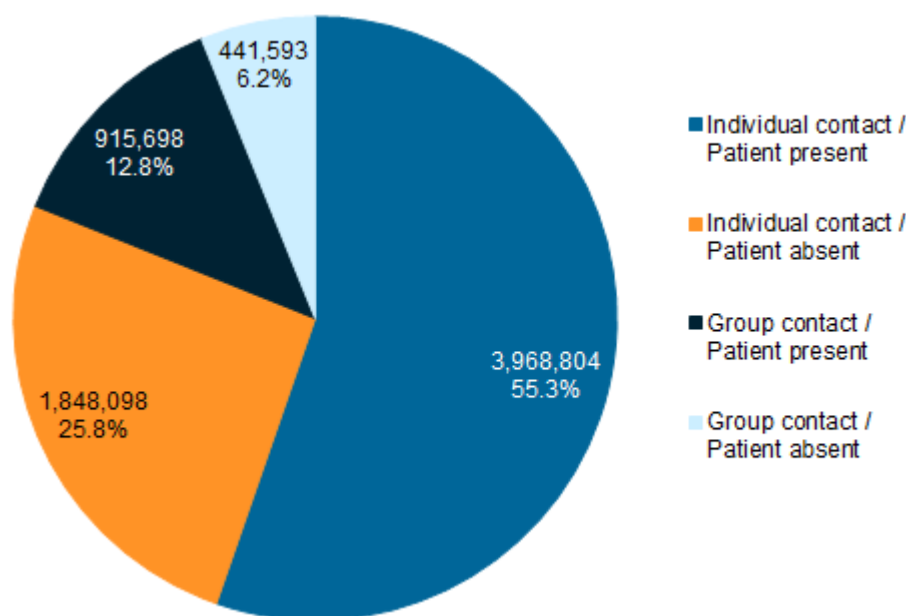Mental health services in Australia

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 (81.1%) of contacts reported in 2010–11 were individual contacts (Figure CMHC.5). Approximately 70% of both individual contacts and group contacts were conducted with the patient present. Of the top five diagnoses, patients with a *depressive episode* diagnosis had the highest proportion of group contacts (31.5%) and the lowest proportion of service contacts with the patient absent (27.5%).

Figure CMHC.5 Community mental health care service contacts, by session type and participation status, 2010–11
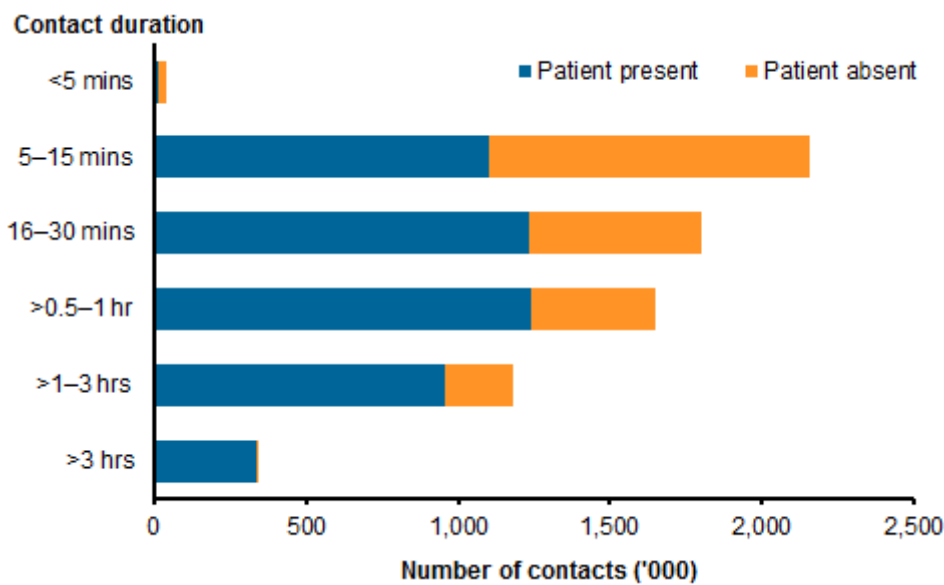

Source: National Community Mental Health Care Database. Source data for this figure are accessible from Table CMHC.4 (635KB XLS) of the State and territory community mental health care services excel tables.

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Duration of service contacts

The duration of service contacts in 2010–11 ranged from less than 5 minutes to more than 3 hours (Figure CMHC.6), with an average contact duration of 53 minutes. About one-third of contacts were 5–15 minutes (30.1%). 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*, however; of the 5 most commonly reported principal diagnoses, *depressive episode* had the longest average contact duration of 75 minutes.

Figure CMHC.6 Community mental health care service contacts, by session duration and participation status, 2010–11

Source: National Community Mental Health Care Database. Source data for this figure are accessible from Table CMHC.10 (635KB XLS) of the State and territory community mental health care services excel tables.

Mental health legal status

About 1 in 7 (14.8%, 1,060,286) community mental health care service contacts in 2010–11 involved a client with an involuntary mental health legal status. Western Australia reported the lowest proportion of involuntary contacts (3.4%; 25,762), while the Australian Capital Territory reported the highest proportion (37.1%; 90,053). However, it should be noted that these jurisdictional differences may reflect the different legislative arrangements in place in the jurisdictions.

Of the top five most commonly reported principal diagnoses, *schizoaffective disorders* had the highest proportion of contacts involving a client with an involuntary mental health legal status (35.8%), with a similar proportion reported for the principal diagnosis of *schizophrenia* (31.4%). *Reaction to severe stress and adjustment disorders* had the lowest proportion of involuntary contacts (3.4%).

The proportion of contacts with reported mental health legal status has changed over time (see table 4.11 of the accompanying data workbook). However, when the reported data are considered, the number of contacts for clients with an involuntary mental health legal status has decreased from 16.5% in 2006–07 to 15.5% in 2010–11.

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, 2010–11). 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. Victoria reported unregistered clients for the first time in 2010–11.

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 2010–11 as follows:

- New South Wales considered the quality of the Indigenous status data to be acceptable but noted there were areas of improvement, particularly to reduce the number of contacts with an *unknown* status. A review of data collection practices will be performed during 2012.

- Victoria considered the quality of Indigenous status data was acceptable for registered clients. Unregistered clients were reported for the first time for 2010–11 collection and were recorded as *Not stated/Inadequately described*. 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 considered 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 2010–11 was acceptable. However, the data could be improved with the appropriate resources, training and reporting standards.

- Tasmania reported the quality of Indigenous status data for 2010–11 was acceptable. However, systematic changes to reporting practices in the near future are likely to improve the quality of the data.

- The Northern Territory considered the quality of the Indigenous status data to be acceptable. Continued focus on training initiatives and improved data collection practices will likely increase the quality of the Indigenous status data.

- South Australia reported that the quality of Indigenous status data was acceptable, noting that variations across service units are considered acceptable within operational bounds.

- The Australian Capital Territory reported that the quality of the Indigenous data was acceptable.

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:

  - Victoria, Queensland, Western Australia and Tasmania used the *ICD-10-AM 7th Edition* to code principal diagnosis

  - New South Wales used a combination of *ICD-10-PC* and NCCH *ICD-10-AM Mental Health Manual 1st Edition*

  - The Australian Capital Territory 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*

  - The Northern Territory used the *ICD-10-AM 3rd 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 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