

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](#). Data from the National Community Mental Health Care Database (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. For more information about the coverage and data quality of the NCMHCD, see the [data source](#) section. Staff industrial action has resulted in a substantial reduction in data coverage for two jurisdictions: Victoria (2011–12, 2012–13 and 2015–16) and Tasmania (2011–12 and 2012–13). 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.

See the footnotes in each of the tables for details about the calculation of national rates for the years 2011–12, 2012–13 and 2015–16.

Key points

- Around 9.4 million community mental health care service contacts were provided to around 410,000 patients in 2015–16.
- The most common principal diagnosis recorded for patients during a service contact was *Schizophrenia*, followed by *Depressive episode* and *Bipolar affective 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 a duration of 5–15 minutes.
- Involuntary contacts accounted for about one-eighth (13.5%) of all contacts.

Data in this section was last updated in October 2017.

Community mental health care service provision

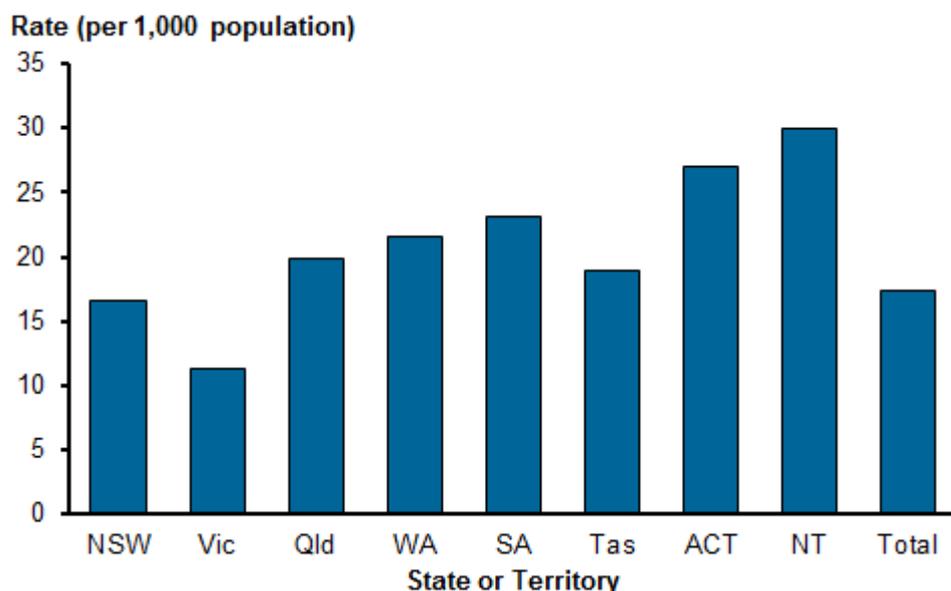
States and territories

Around 9.4 million service contacts were provided to patients in 2015–16. The number of service contacts per 1,000 population varied between states and territories in 2015–16, with the Australian Capital Territory reporting the highest rate (822.1) and Tasmania the lowest (286.6). Differences in jurisdictional data reporting systems may contribute to the observed variation in service contact rates.

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 and 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 2015–16, 96.5% of all service contacts reported were provided to unique patients.

Around 410,000 people received community mental health care in 2015–16. The number of patients per 1,000 population ranged between 11.3 (Victoria) and 29.9 (Northern Territory) (Figure CMHC.1).

Figure CMHC.1 Community mental health care patients, states and territories, 2015–16



Source: National Community Mental Health Care Database.

Source data: State and territory community mental health care Table CMHC.1 (200KB XLS).

Amount of treatment received

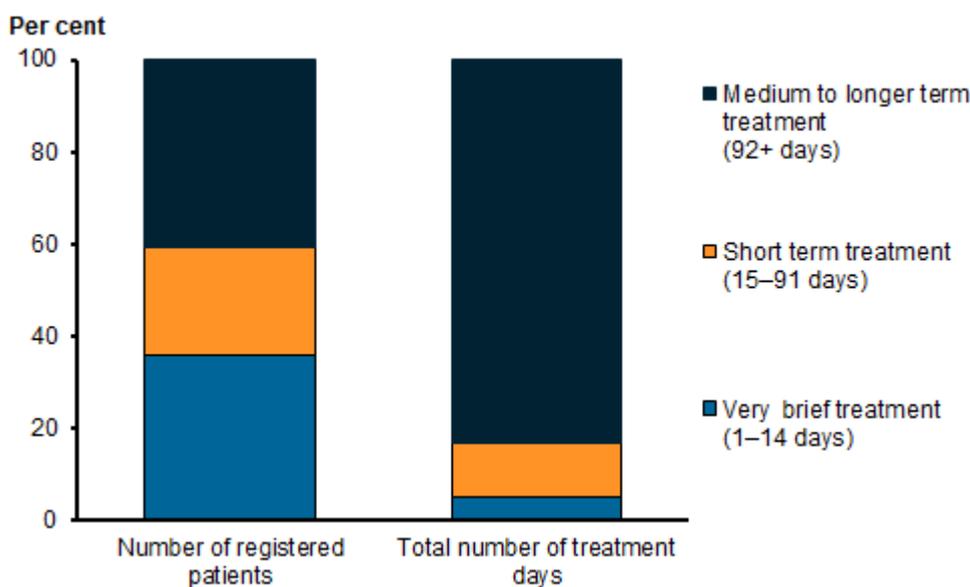
Two important measures of the amount of treatment provided to registered patients can be derived from the NCMHCD:

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).

- Number of treatments days provided—the number of days during the reporting period that an individual patient received one or more service contact. The number of treatment days are grouped as follows in Table CMHC.22; 1–9 days, 10–19 days, 20–29 days, 30–39 days and 40+ days.

Overall, around 2 in 5 patients (40.8% or 168,981 registered patients) had a medium to longer term length of treatment period (92+ days) and received the majority (83.3%) of treatment days in 2015–16 (Figure CMHC.2). Around a third of patients (35.9% or 148,875 registered patients) had a very brief length of treatment period (1–14 days) and received 5.2% of the total number of treatment days.

Figure CMHC.2 Number of patients and total treatment days (per cent), by length of treatment period, 2015–16

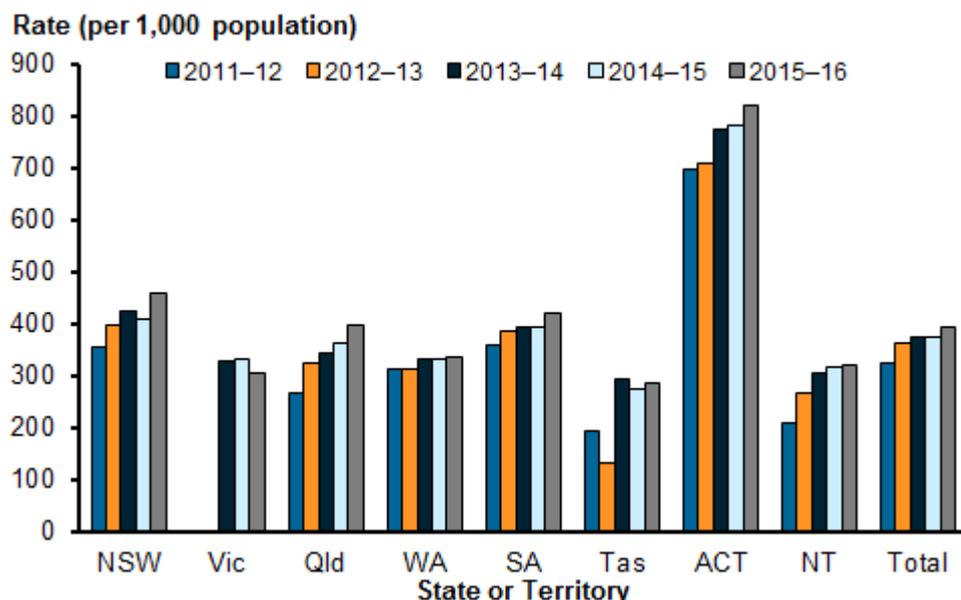


Source: National Community Mental Health Care Database.
Source data: State and territory community mental health care Table CMHC.22 (200KB XLS).

Over time

After taking population changes into account, service contact rates increased in most jurisdictions since 2011–12 (Figure CMHC.3). The Northern Territory had the greatest annual average increase (11.3%) between 2011–12 and 2015–16, followed by Queensland and Tasmania (both 10.4%). Issues with data coverage for Victorian and Tasmanian data in 2011–12 and 2012–13 and 2015–16 (Victoria only), have had an impact on the ability to perform long term trend analysis for these jurisdictions, as well as at the national level. Consequently, the national rates should be interpreted with caution.

Figure CMHC.3 State and territory community mental health care service contacts, 2011–12 to 2015–16



Note:

The total rate for 2011–12 and 2012–13 uses adjusted population data which accounts for missing data, as detailed in the online [technical information](#).

Source: National Community Mental Health Care Database.

Source data: State and territory community mental health care Table CMHC.2 (200KB XLS).

Patient characteristics

Patient demographics

Patients aged 35–44 received the most community mental health care contacts (1,918,718), and had the highest rate of service contacts (593.6 per 1,000 population) in 2015–16 (Figure CMHC.4). The youngest age group (less than 15 years) had the lowest number of contacts per 1,000 population (140.5), followed by the oldest age group (65 and over; 214.8).

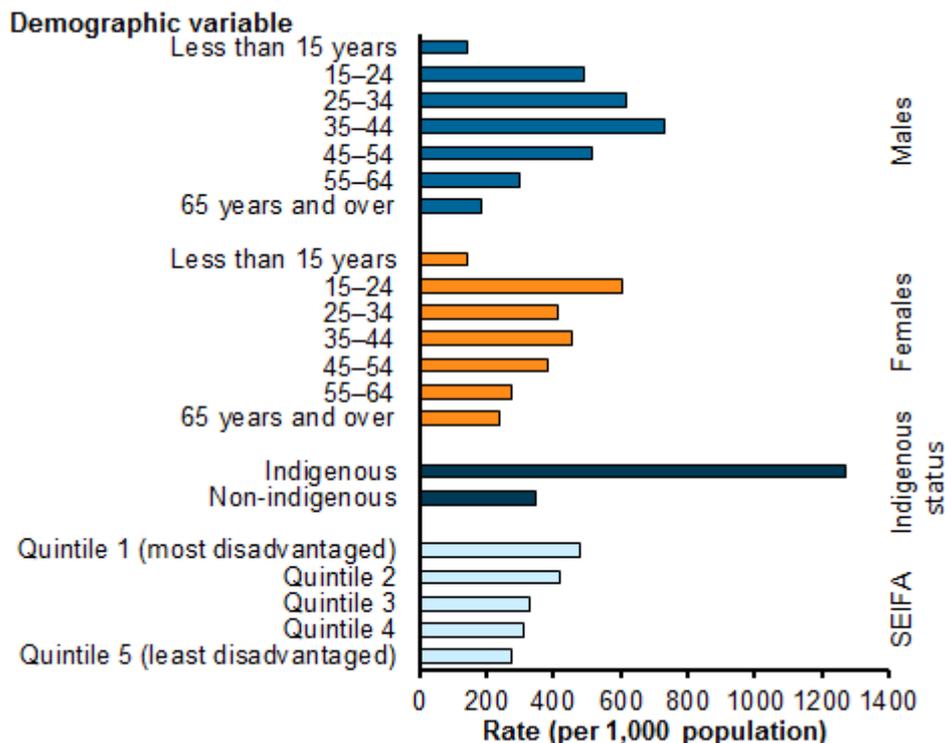
In 2015–16, males accessed services at a higher rate (417.0 service contacts per 1,000 population) than females (352.3). The highest male contact rate was reported for the 35–44 age group (733.5), while for females the highest contact rate was for the 15–24 age group (603.2).

One in 10 (10.0%) community mental health care service contacts with a recorded Indigenous status were provided to Aboriginal and Torres Strait Islander people. Indigenous Australians accessed services at just over 3.7 times the non-Indigenous rate (1,271.9 for Indigenous and 347.2 for non-Indigenous Australians per 1,000 population). Indigenous status was missing or not reported for 7.0% of all contacts in 2015–16.

Approximately a quarter (26.4% or 2,277,210) of community mental health care contacts were for people living in areas classified as being in the lowest (most disadvantaged) socioeconomic status quintile. Residents in the most disadvantaged areas also had the highest rate of community mental health care contacts (479.3 per 1,000 population). People living in areas classified as being the highest (least disadvantaged)

socioeconomic quintile had the lowest number of community mental health care contacts (1,297,305) and rate (273.0 per 1,000 population).

Figure CMHC.4 Community mental health care service contact rates, by demographic variables, 2015–16



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

Source data: State and territory community mental health care Tables CMHC.3 and CMHC.7 (200KB XLS).

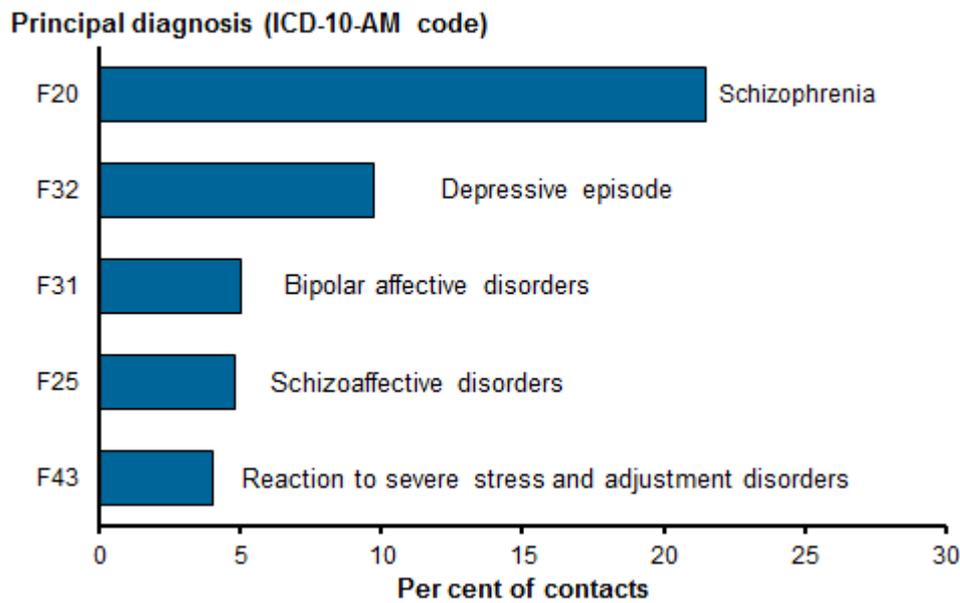
In 2015–16, the majority of all service contacts were provided to patients living in *Major cities* (69.1% of contacts with a reported remoteness area). Patients living in *Remote* areas accessed services at the highest rate (405.9 per 1,000 population) followed by those living in *Outer regional* areas (400.7).

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). See the [data source](#) section for further information on principal diagnosis data quality issues.

Of the 5 most commonly reported specific mental health-related principal diagnoses, *Schizophrenia* (ICD-10-AM code F20; 21.5%) was the most frequently recorded principal diagnosis in 2015–16 (Figure CMHC.5). This was followed by *Depressive episode* (F32; 9.7%) and *Bipolar affective disorder* (F31; 5.0%). A principal diagnosis was reported for almost 9 out of 10 (about 8.3 million) of all community mental health care service contacts.

Figure CMHC.5 Community mental health care service contacts, for 5 commonly reported mental health-related principal diagnoses, 2015–16



Note:

There are jurisdictional variances in the way principal diagnosis is reported (see the online data source of the Community mental health care section).

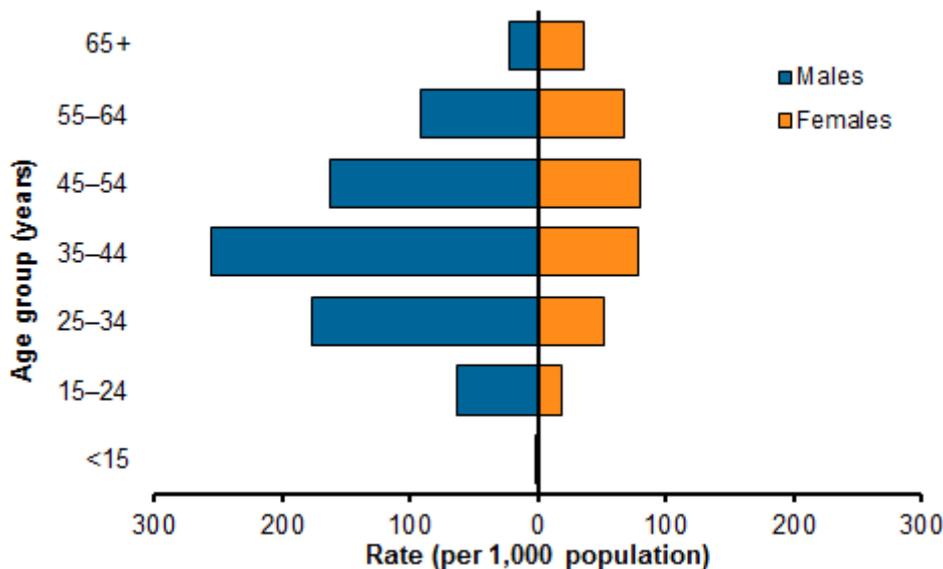
Source: National Community Mental Health Care Database.

Source data: State and territory community mental health care Table CMHC.14 (200KB XLS).

Most commonly reported principal diagnosis: Schizophrenia

Amongst patients with a principal diagnosis of *Schizophrenia*, those aged 35–44 received the greatest number of community mental health care contacts (537,312 or 30.2%). This group also had the highest rate of service contacts (166.2 per 1,000 population) in 2015–16. Males with a diagnosis of *Schizophrenia* received services at a higher rate (104.2 service contacts per 1,000) than females (44.6 service contacts per 1,000) in 2015–16. As illustrated in Figure CMHC.6, when service contact rates are considered by both age group and sex, the highest rate of contacts was for males aged 35–44 years (254.9 contacts per 1,000 population). The difference between males and females is most likely due to the observed difference in prevalence of *Schizophrenia* in both groups. See the [Prevalence, impact and burden](#) section for further information.

Figure CMHC.6 Rate of community mental health care service contacts with a principal diagnosis of Schizophrenia, by age group and sex, 2015–16



Note:

Crude rates based on the estimated Australian resident population on 31 December 2015.

Source: National Community Mental Health Care Database.

Source data: State and territory community mental health care Table CMHC.16 (200KB XLS).

Other most commonly reported principal diagnoses

For the other most commonly reported specific principal diagnoses, rates of service contacts differed between males and females and by age group. In 2015–16:

- rates of service contacts for *Depressive episode* were highest for males in the 35–44 age group (62.9 contacts per 1,000 population)
- females with a diagnosis of *Bipolar affective disorder* received service contacts at a higher rate than males (19.8 and 14.9 service contacts per 1,000 population)
- rates of service contacts for *Reaction to severe stress and adjustment disorder* (a stress-related disorder) were highest for females in the 15–24 age group at 37.7 per 1,000 population, which was more than double the service contact rate for males of the same age group (18.1 per 1,000 population)
- amongst patients with a principal diagnosis of *Schizoaffective disorders*, males and females aged 35–44 had the highest rate of service contacts (38.0 and 37.5 per 1,000 population).

Characteristics of service contacts

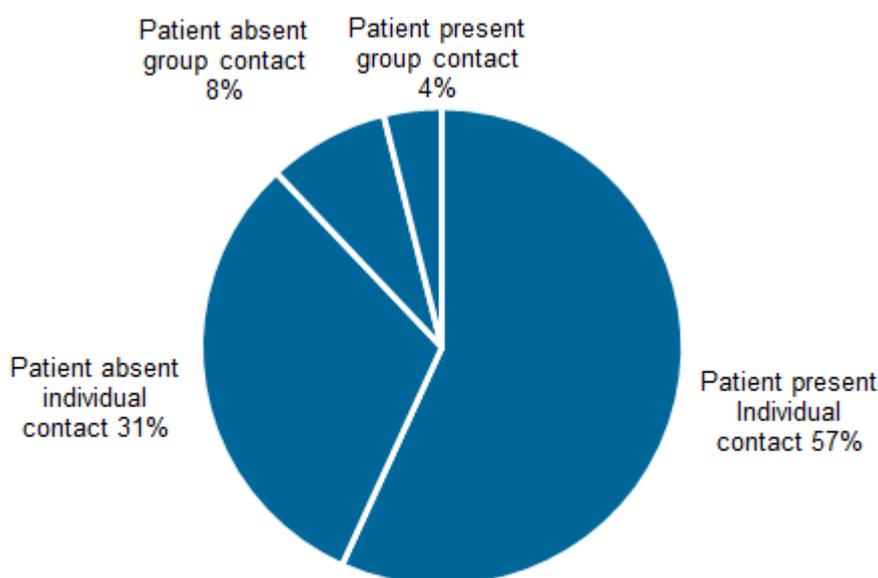
Type of service contacts

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 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 of service contacts reported in 2015–16 involved individual sessions (88.0%) (Figure CMHC.7). More than half (56.8%) 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 be present for an individual contact were those diagnosed with a *Depressive episode* (67.1%) or a *Schizoaffective disorder* (62.0%). Patients with *Schizophrenia* had the highest proportion of group contacts (13.3%). Patients with a *Reaction to severe stress and adjustment disorder* had the highest proportion of service contacts where the patient was absent (42.2%).

Figure CMHC.7 Community mental health care service contacts, by session type and participation status, 2015–16



Source: National Community Mental Health Care Database.

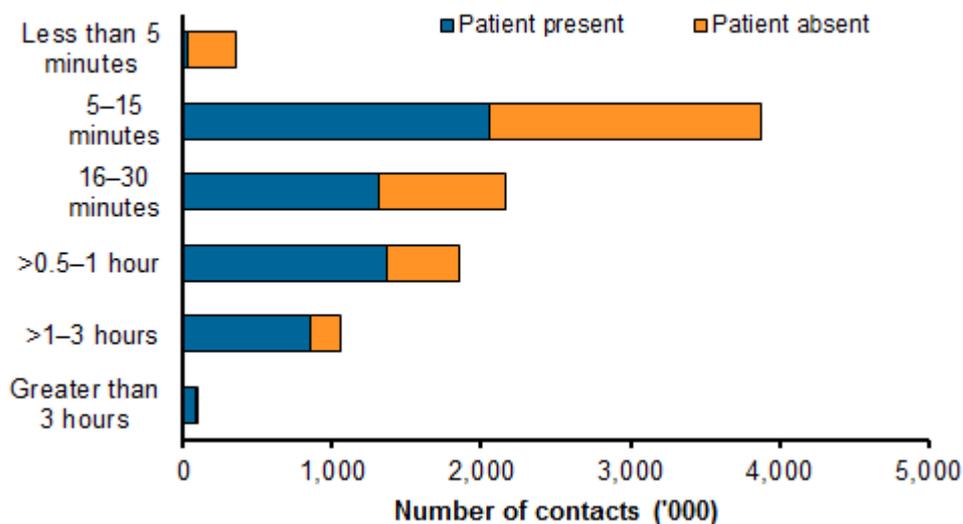
Source data: State and territory community mental health care Table CMHC.17 (200KB XLS).

Duration of service contacts

The duration of service contacts ranged from less than 5 minutes to over 3 hours. The average service contact duration was 36 minutes in 2015–16. More than a third of contacts were between 5–15 minutes (41.2%, or about 3.9 million) and around a quarter of contacts were between 16–30 minutes (23.0%; or about 2.2 million) (Figure CMHC.8). Service contacts with the patient present were on average longer in duration, averaging 42 minutes, than those with the patient absent averaging 25 minutes.

Figure CMHC.8 Community mental health care service contacts, by session duration and participation status, 2015–16

Contact duration



Source: National Community Mental Health Care Database.

Source data: State and territory community mental health care Table CMHC.19 (200KB 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 (14.1%). 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 (4.3% or less for each principal diagnosis).

Contact duration over time

Issues with data coverage for Victorian and Tasmanian data in 2011–12 and 2012–13 and 2015–16 (Victoria only), have impacted on the ability to perform long term trend analysis for these jurisdictions, as well as at the national level. The average time per contact has steadily declined over time, from 65 minutes per contact in 2011–12, to 36 minutes per contact in 2015–16. This analysis should be interpreted with caution. The absence of Victorian data in 2011–12 and 2012–13 is likely to have affected average duration, especially for the 2011–12 collection period, as Victoria reported lower than average contact times compared to other states and territories. The average contact duration excluding Victoria for 2015–16 was 37 minutes. .

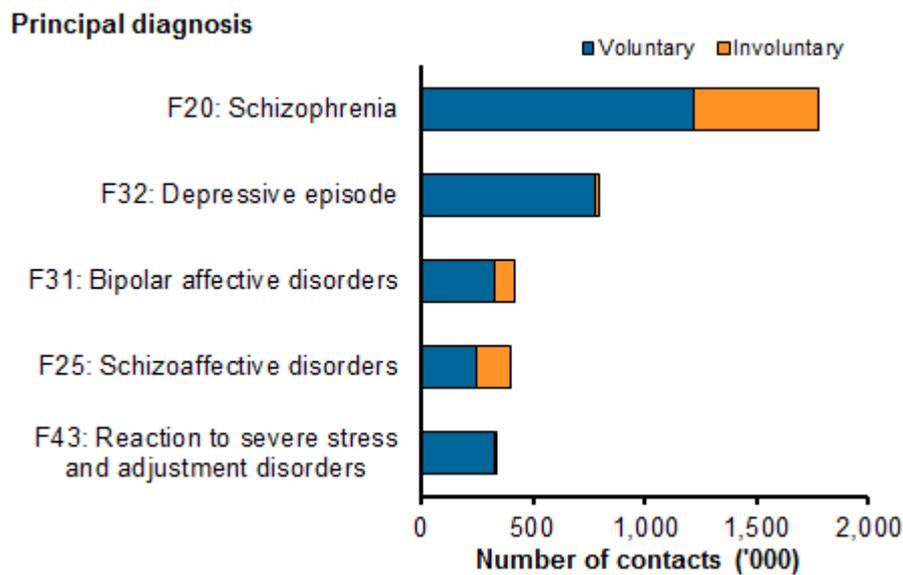
Since 2013–14, the number of short-duration contacts (under 5 minutes) has increased 4-fold, from 86,742 to 350,695. This increase is mostly due to a change in Queensland’s reporting system during the 2014–15 reporting period, which allowed for contact duration to be recorded individually for each consumer reviewed in group sessions. Short-duration contacts, excluding Queensland, increase by around 6.9% between 2013–14 and 2015–16.

Mental health legal status

About 1 in 7 (13.5%, 1,223,941) community mental health care service contacts in 2015–16 involved a patient with an involuntary [mental health legal status](#). Western Australia reported the lowest proportion of involuntary contacts (1.7%), while the Australian Capital Territory reported the highest (37.6%). 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 (37.0%), followed by *Schizophrenia* (31.5%) and *Bipolar affective disorder* (20.7%). Lower proportions of involuntary mental health legal status service contacts were seen in patients with a principal diagnosis of a *Depressive episode* (2.7%) and *Reaction to severe stress and adjustment disorders* (2.0%).

Figure CMHC.9 Community mental health care service contacts, by principal diagnosis and mental health legal status, 2015–16



Source: National Community Mental Health Care Database
 Source data: State and territory community mental health care Table CMHC.25 (200KB XLS).

Improvements in the reporting of legal status and issues with data coverage for Victorian and Tasmanian data in 2011–12 and 2012–13, have had an impact on the ability to perform long term trend analysis of the rate of involuntary contacts. Consequently, the national rates over time should be interpreted with caution.

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. See the [facilities](#) section for additional information about Community mental health care services.

Services targeted toward the General Population provided 65.4% of all [treatment days](#), Forensic services (see the [target population](#) definition) accounted for 13.8%, and Child and Adolescent services accounted for 13.1% in 2015–16. Services targeted towards Older Persons (6.3%) and Youth (1.4%) 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 (see the Facilities section, Table FAC.40).

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. See the [Community mental health care NMDS 2016–17: National Community Care Database, 2017 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 445778): Child and adolescent services focus on those aged under 18 years. Older person services focus on those aged 65 years and over. 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. 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. 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.
