

# 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 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. For Victoria and Tasmania, industrial action caused a substantial reduction in data coverage in 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 for 2011–12 and 2012–13.

## Key points

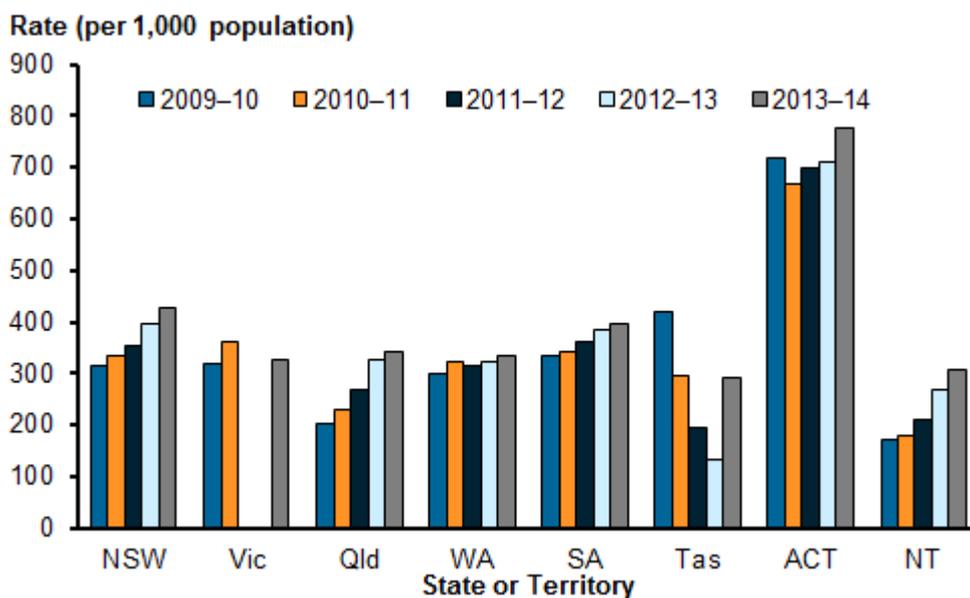
- Around 8.7 million community mental health care service contacts were recorded in 2013–14. The rate of contacts per 1,000 population increased by 5.5% between 2009–10 and 2013–14.
- The most common principal diagnosis reported for patients receiving service contacts was schizophrenia, followed by depressive episode and bipolar affective disorders.
- The most frequently recorded type of community mental health care service contact was with an individual patient (as opposed to in a group session) and a duration of 5–15 minutes.
- Involuntary contacts accounted for about one-seventh (14%) of all contacts. The proportion of involuntary contacts decreased from 16% in 2009–10 to 14% in 2013–14.

# Community mental health care service provision

## Over time

Service contact rates have increased in most jurisdictions since 2009–10 (Figure CMHC.1). The Northern Territory had the greatest annual average increase (16%) between 2009–10 and 2013–14, followed by Queensland (14%). 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 for these jurisdictions, as well as at the national level. Consequently, the national rates should be interpreted with caution.

**Figure CMHC.1 State and territory community mental health care service contacts, 2009–10 to 2013–14**



*Notes:*

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

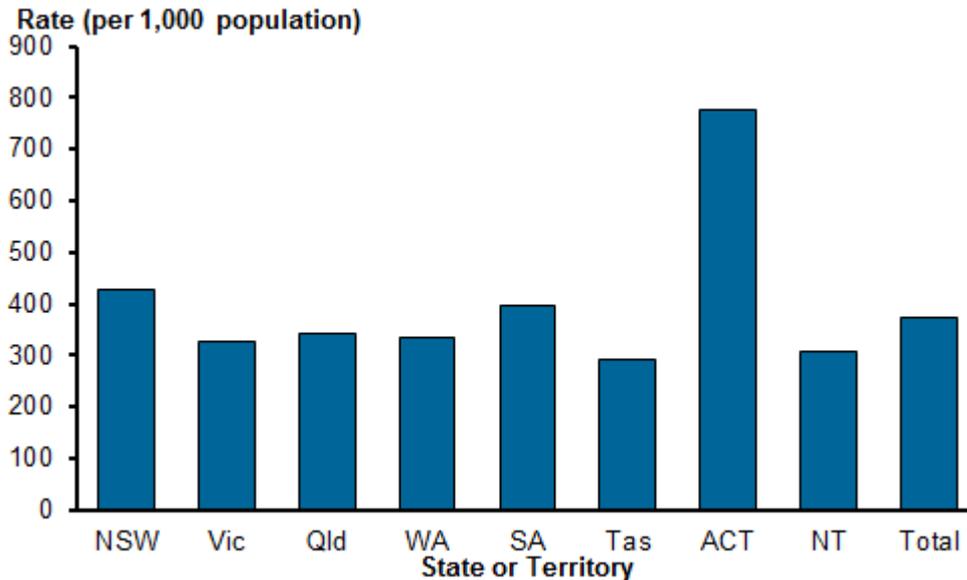
Source: National Community Mental Health Care Database.  
Source data Community Mental Health Care Table CMHC.3 (1,529KB XLS).

## By states and territories

Around 8.7 million service contacts were provided to patients with a mental illness in 2013–14, an increase on the last comparable year—7.2 million service contacts in 2010–11. Due to the absence of Victorian data and coverage issues with the Tasmanian data in 2011–12 and 2012–13, data at the national level are not comparable for these years.

The number of service contacts per 1,000 population varied between jurisdictions in 2013–14, with the Australian Capital Territory reporting the highest rate (775) and Tasmania the lowest (293) (Figure CMHC.2). However, differences in jurisdictional data reporting systems may also contribute to the observed variation in service contact rates.

**Figure CMHC.2 Community mental health care service contacts, states and territories, 2013–14**



Source: National Community Mental Health Care Database.  
 Source data Community Mental Health Care Table CMHC.1 (1,529KB XLS).

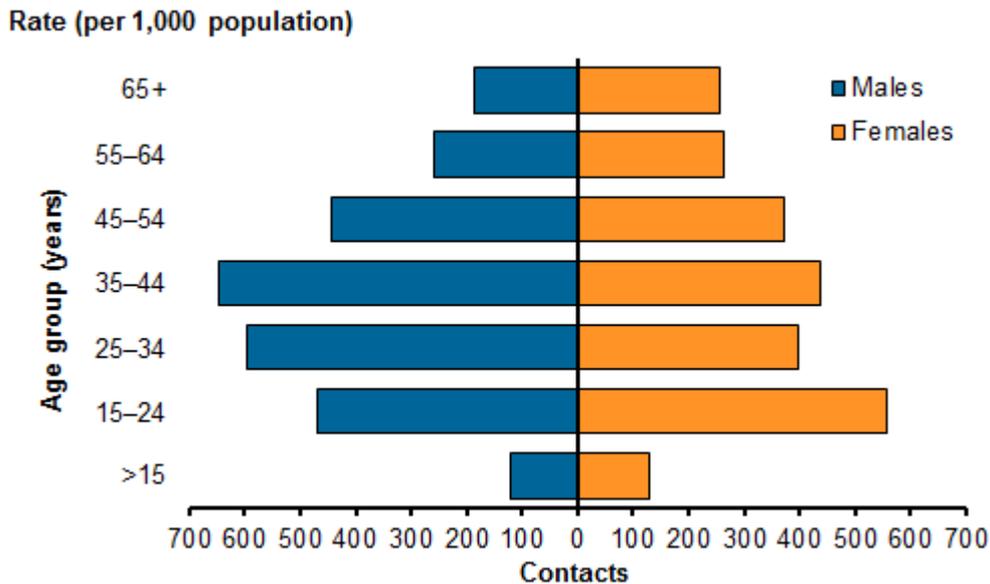
## Characteristics of people who use community mental health care services

### Patient demographics

People aged 35–44 received the greatest number of community mental health care contacts (1,743,630), and had the highest rate of service contacts (542 per 1,000 population) in 2013–14. The youngest and oldest age groups (less than 15 and 65 and over, respectively) had the lowest number of service contacts per 1,000 population (127 and 224, respectively).

Males accessed services at a higher rate than females in 2013–14 (386 and 341 service contacts per 1,000 population, respectively) (Figure CMHC.3). The highest male contact rate was reported for the 35–44 age group (648 contacts per 1,000 population), while for females the highest contact rate was for the 15–24 age group (559).

**Figure CMHC.3 Community mental health care service contacts, by age group and sex, 2013–14**



Notes:

1. Crude rates are based on the estimated Australian resident population on 31 December 2013.

Source: National Community Mental Health Care Database.

Source data Community Mental Health Care Table CMHC.15 (1,529KB XLS).

Just under 1 in 10 (8.9%) 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 3.3 times the non-Indigenous rate (1,067 and 324 per 1,000 population, respectively). (Indigenous status was missing or not reported for 9.2% of all contacts in 2013–14).

In 2013–14, the majority of all service contacts were provided to patients who live in *Major cities* (64% of all contacts). Patients who live in *Remote* areas accessed services at the highest rate (384 per 1,000 population) followed by those living in *Inner regional areas* (381).

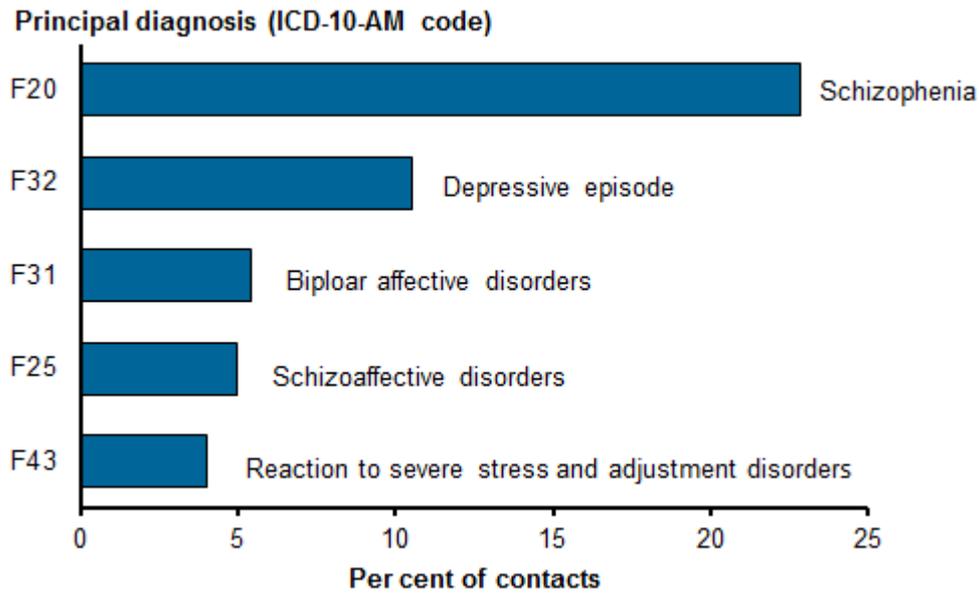
Approximately 25% of community mental health care contacts were for people living in areas classified as being in the lowest (most disadvantaged) socioeconomic status quintile. Residents in the most disadvantaged areas also had the highest rate of community mental health care contacts (473 per 1,000 population). People living in areas classified as being the highest (least disadvantaged) socioeconomic quintile had the lowest number of community mental health care contacts (1,088,966) and rate (235) per 1,000 population).

## 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). Further information on this is included in the [technical information](#) section.

Schizophrenia (ICD-10-AM code F20; 23%) 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; 11%) and mental disorder, not otherwise specified (F99; 8%). A principal diagnosis was reported for 9 out of 10 (just under 7.9 million contacts) of all community mental health care service contacts in 2013–14.

**Figure CMHC.4 Community mental health care service contacts, for 5 commonly reported mental health-related principal diagnoses, 2013–14**



*Notes:*

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

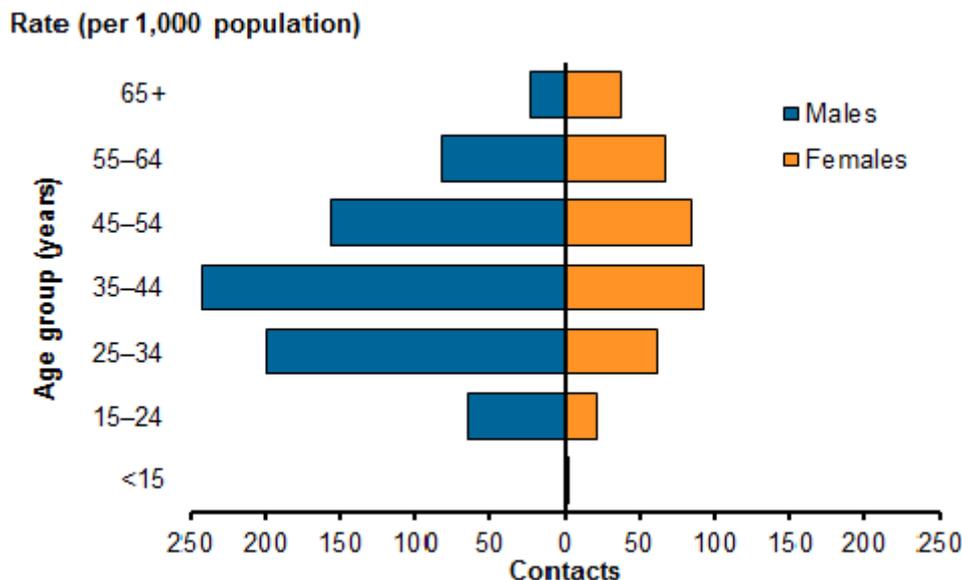
*Source:* National Community Mental Health Care Database.  
 Source data Community Mental Health Care Table CMHC.23 (1,529KB XLS).

## Schizophrenia

Amongst clients with a principal diagnosis of schizophrenia, those aged 35–44 received the greatest number of community mental health care contacts (536,675). This group also had the highest rate of service contacts (167 per 1,000 population) in 2013–14. The youngest and oldest age groups (less than 15 years and 65 years and over) had the lowest rates of contacts.

Males with a diagnosis of schizophrenia accessed services at a higher rate than females in 2013–14 (105 and 49 service contacts per 1,000 population, respectively). 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 the males aged 35–44 years (243 contacts per 1,000 population).

**Figure CMHC.5 Community mental health care service contacts with a principal diagnosis of Schizophrenia, age group and sex, by 2013–14**



Notes:

1. Crude rates based on the estimated Australian resident population on 31 December 2013. *Source:* National Community Mental Health Care Database

*Source:* National Community Mental Health Care Database.

Source data Community Mental Health Care Table CMHC.26 (1,529KB XLS).

For other commonly reported principal diagnoses, rates of service contacts differed between males and females and by age group. In 2013–14:

- rates of service contacts for depressive episode were highest for females in the 15–24 age group (67 contacts per 1,000)
- females with a diagnosis of bipolar affective disorder, accessed services at a higher rate than males (21 and 15 service contacts per 1,000 population, respectively)
- rates of service contacts for reaction to severe stress and adjustment disorder were highest for females in the 15–24 age group, where the service contact rate for females was more than double the rate for males (38 and 17 per 1,000 population respectively)
- amongst clients with a principal diagnosis of schizoaffective disorders, those aged 35–44 had the highest rate of service contacts (36 per 1,000 population).

## Characteristics of community mental health care service contacts

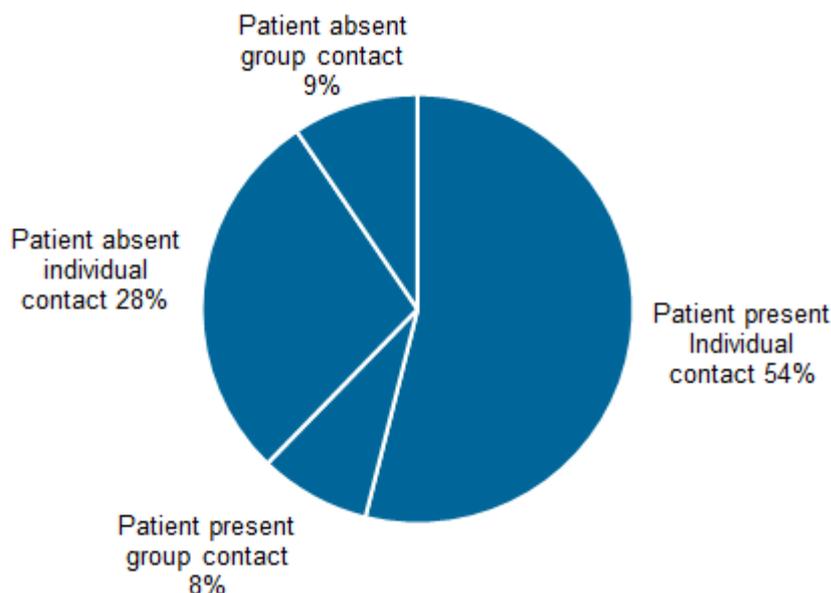
### Type of service contacts

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 video link, or using other forms of direct communication. 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 2013–14 involved individual sessions (82%) (Figure CMHC.6). More than half (54%) of all contacts were individual sessions where the patient was present.

Of the 5 most common principal diagnoses, patients with schizophrenia and schizoaffective disorders were most likely to be present for an individual contact (62% and 64%, respectively). Patients with a depressive episode had the highest proportion of group contacts (24%). Patients with a reaction to severe stress and adjustment disorders had the highest proportion of service contacts where the patient was absent (41%).

**Figure CMHC.6 Community mental health care service contacts, by session type and participation status, 2013–14**



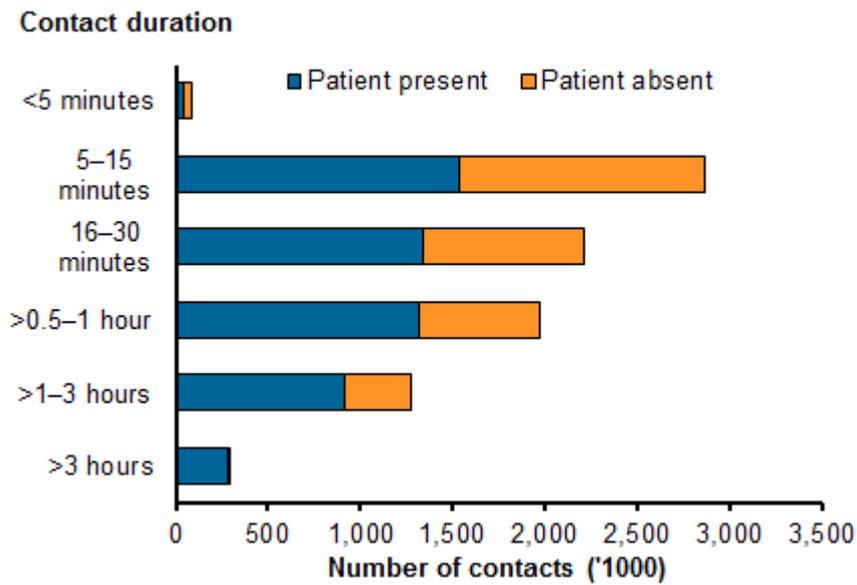
Source: National Community Mental Health Care Database.  
Source data Community Mental Health Care Table CMHC.6 (1,529KB XLS).

### Duration of service contacts

The duration of service contacts range from less than 5 minutes to over 3 hours. The average service contact duration was 47 minutes in 2013–14. About one-third of contacts were between 5–15 minutes (33%, 2.8 million) and one-quarter of contacts were between 16–30 minutes (25%; 2.2 million) (Figure CMHC.7). Service contacts with the patient present (55 minutes) were on average longer in duration than those with the patient absent (55 and 34 minutes respectively).

Of the 5 commonly reported principal diagnoses, depressive episode had the highest proportion of contacts lasting over 1 hour (25%). Service contacts lasting less than 5 minutes were rarely conducted with patients who had 1 of the 5 most frequently recorded principal diagnoses (1% or less for each principal diagnosis).

**Figure CMHC.7 Community mental health care service contacts, by session duration and participation status, 2013–14**



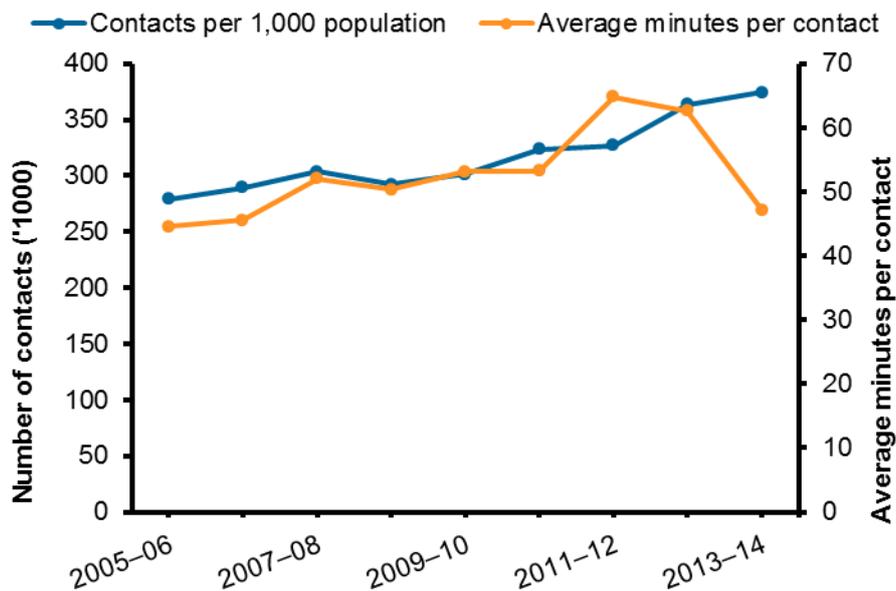
Source: National Community Mental Health Care Database.  
 Source data Community Mental Health Care Table CMHC.8 (1,529KB XLS).

**Contact rates and duration over time**

The rate of contacts has increased reasonably steadily over time (Figure CMHC.8), increasing from 279 to 374 contacts per 1,000 population from 2005–06 to 2013–14.

The average time per contact has varied over the same period, from 45 minutes per contact in 2005–06, to a peak of 65 minutes per contact in 2011–12 before falling to 47 minutes per contact in 2013–14 (Figure CMHC.8). The absence of Victorian data in 2011–12 and 2012–13 is likely to have affected average duration, as Victoria reported lower than average contact times in previous years; as such this analysis should be interpreted with caution.

**Figure CMHC.8 Community mental health care service contacts, rates and duration, 2013–14**



**Notes:**

1. Crude rates are calculated as at the 31 December of the reference year. For more information see the [technical information](#).

Source: National Community Mental Health Care Database.  
 Source data Community Mental Health Care Table CMHC.2 and CMHC.10 (1,529KB XLS).

### Mental health legal status

About 1 in 7 (14%, 1,135,024) community mental health care service contacts in 2013–14 involved a patient with an involuntary [mental health legal status](#). Western Australia reported the lowest proportion of involuntary contacts (2.7%), while the Australian Capital Territory reported the highest (36%). These differences largely reflect different legislative arrangements in place among the jurisdictions.

Of the 5 commonly reported principal diagnoses, schizoaffective disorders accounted for the highest proportion of contacts involving a patient with an involuntary mental health legal status (37%), followed by schizophrenia (31%) and bipolar affective disorders (20%). Depressive episode and reaction to severe stress and adjustment disorders had lower proportions of involuntary contacts (2.6% and 2.5%, respectively).

### Data source

#### National Community Mental Health Care Database

Data Quality Statements for National Minimum Data Sets (NMDSs) are published annually on the Metadata Online Registry (METeOR). Statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence. [See the Community mental health care NMDS 2013–14: National Community Care Database, 2014 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
<b>Community mental health care</b>	<b>Community mental health care</b> 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.
<b>Mental health legal status</b>	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'.
<b>Service contacts</b>	<b>Service contacts</b> 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.