

4 Community mental health care and hospital outpatient services

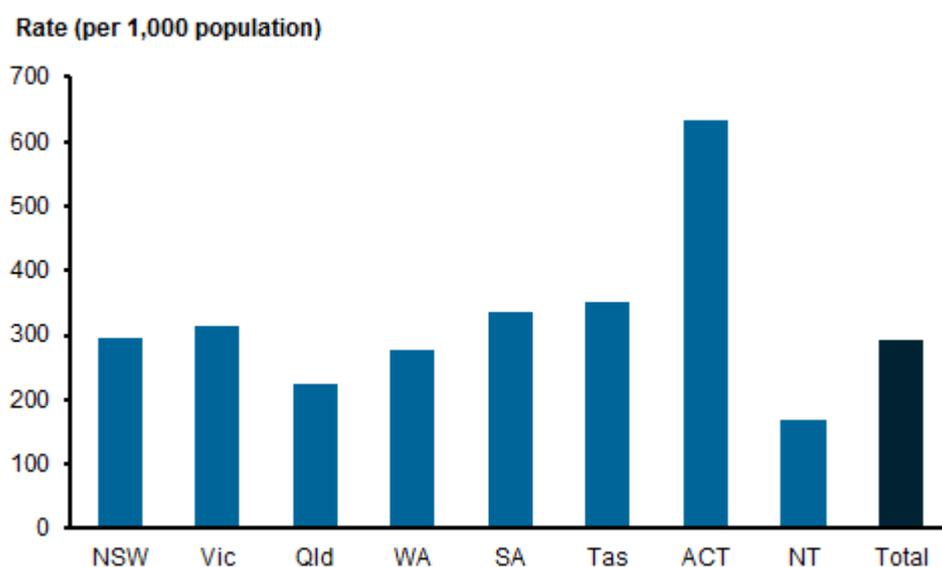
This section presents information on [community mental health care](#). The data are derived from the National Community Mental Health Care Database (NCMHCD); a collation of data on government operated specialised mental health services provided to non-admitted patients in community based and hospital based ambulatory care settings. The statistical unit for the NCMHCD is a [service contact](#) between a client and a specialised mental health care service provider.

Key points

- In 2008–09, there were over 6 million community service contacts recorded for approximately 336,000 patients.
- Since 2004–05, there has been an annual average increase of 5% in the total number of community service contacts recorded.
- The most common service contact was an individual contact in the presence of the patient, with an average duration lasting between 5–15 minutes.
- Involuntary contacts accounted for around 16% of all contacts.
- The most common principal diagnosis reported for service contacts was schizophrenia, followed by depression and bipolar affective disorder.

Community mental health care by States and Territories

There were 6,270,765 community mental health care service contacts reported in 2008–09 for an estimated 336,296 patients. Nationally, there were 291.9 community service contacts reported per 1,000 population were reported (Figure 4.1). The Australian Capital Territory reported the highest number of community service contacts per 1,000 population (632.5) while Northern Territory reported the lowest (167.4). However, the Northern Territory had the highest number of patients per 1,000 population (21.8), compared with the national average of 15.5. The lowest patient rate per 1,000 population was reported in Victoria (10.7).



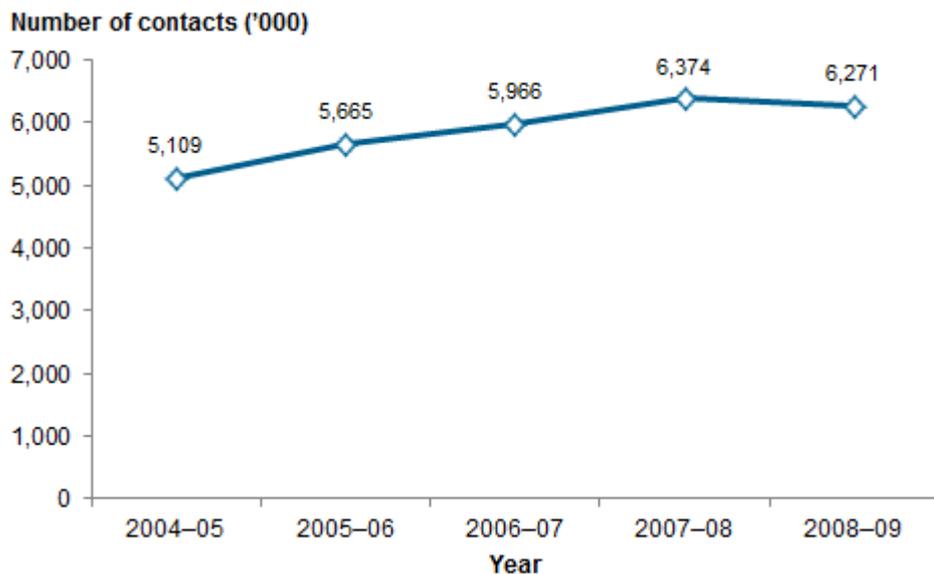
Note: Queensland transitioned to a new clinical information system in 2008–09 which impacted negatively on activity data reporting.

Source: National Community Mental Health Care Database, and state and territory community mental health care data.

Figure 4.1 Community mental health care service contact rates by states and territories, 2008–09

Community mental health care change over time

The number of service contacts reported to the NCMHCD has increased over the 5 years to 2008–09, at an annual average rate of 5.3% per year (Figure 4.2). However, in 2008–09, there was a 1.6% decrease in the number of contacts reported compared with 2007–08. This was largely due to one jurisdiction transitioning to a new clinical information system, which impacted their reporting of activity data in 2008–09.



Note: Queensland transitioned to a new clinical information system in 2008–09 which impacted negatively on activity data reporting.

Source: National Community Mental Health Care Database.

Figure 4.2 Community mental health care service contacts over time, 2004–05 to 2008–09

Characteristics of people who use community mental health care services

Patient demographics

The highest number of service contacts per 1,000 population was for patients aged 25–34 years (440.2). The youngest age group (less than 15 years) was the least represented in both proportion of contacts (7.3%) and contacts per 1,000 population (108.0).

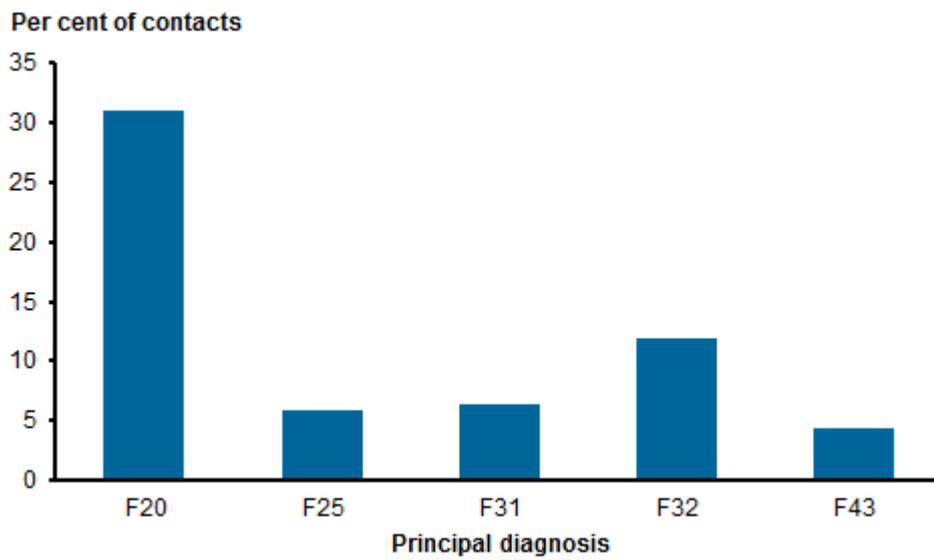
When taking population numbers into account there was a higher rate of contacts per 1,000 population for patients in Inner regional areas (308.9) compared to other areas. The rate of contact for Australian-born patients was more than double the rate for those born overseas (327.3 and 152.4 respectively).

More than half of the service contacts were reported by patients who were never married (62.1%) while those who were widowed were least represented (3.6%).

Principal diagnosis

In 2008–09, a specified principal diagnosis was reported for 89.5% (5,610,746) of community mental health care service contacts. Figure 4.3 shows the most common principal diagnosis, *Schizophrenia* (F20), was reported for 31.0% of all contacts where a principal diagnosis was recorded. This was followed by *Depressive episode* (F32; 11.9%) and *Bipolar affective disorder* (F31; 6.4%).

In regard to the characteristics of community mental health care service contacts for the five most commonly reported principal diagnoses; *Depressive episode* had both the highest proportion of contacts which lasted more than 1 hour (34.6%) and the lowest proportion of contacts lasting 15 minutes or less (25.4%). The diagnosis of *Depressive episode* also had the highest rate of group contacts (33.1%) and the lowest proportion of service contacts in the absence of the patient (25.7%).



Notes:

F20 Schizophrenia

F25 Schizoaffective disorders

F31 Bipolar affective disorders

F32 Depressive episode

F43 Reaction to severe stress and adjustment disorders

Source: National Community Mental Health Care Database.

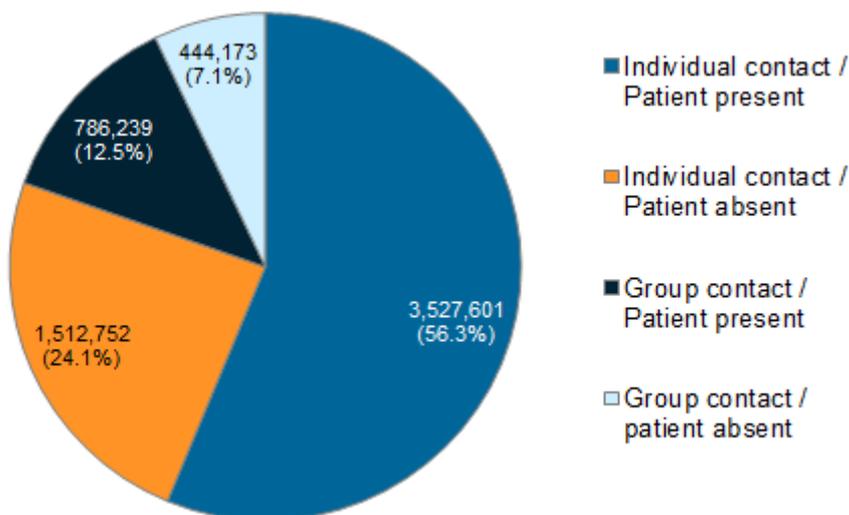
Figure 4.3 Community mental health care service contacts, for the five most commonly reported principal diagnosis, 2008–09

Characteristics of community mental health care service contacts

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. Service contacts 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.

The majority (80.4%) of contacts reported in 2008–09 were individual contacts (Figure 4.4). Looking at individual contacts, 70.0% were conducted in the presence of the patients. This pattern is similar for group contacts. More group contacts were conducted with the patient being present (63.9%) compared to those without (36.1%).

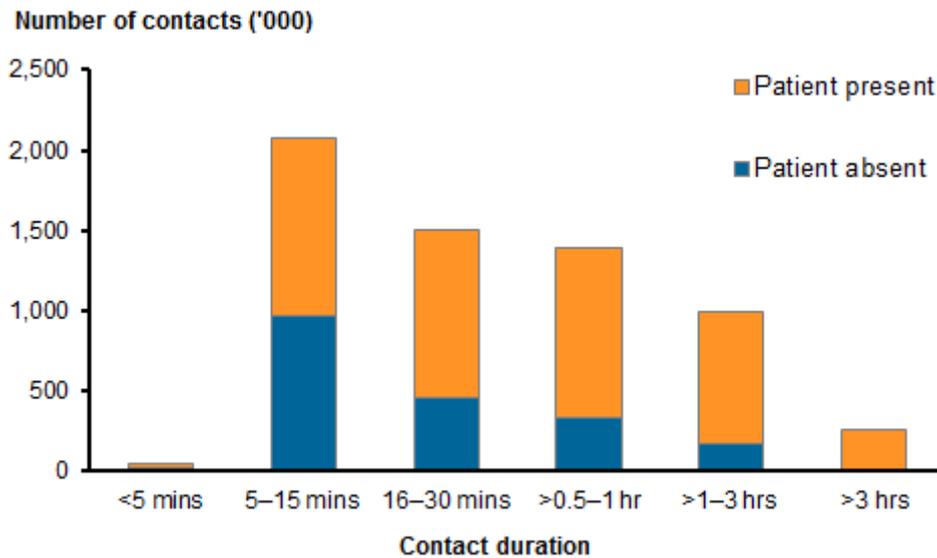


Source: National Community Mental Health Care Database.

Figure 4.4 Community mental health care service contacts, by contact type and patient presence status, 2008–09

Duration of service contacts

The duration of service contacts in 2008–09 ranged from less than 5 minutes to more than 3 hours (Figure 4.5). The most common duration of service contact was 5–15 minutes, with 33% of contacts reported in this category.



Sources: National Community Mental Health Care Database.

Figure 4.5 Community mental health care service contacts, by contact duration and patient presence status, 2008–09

Mental health legal status

Nationally, 16.3% (1,019,406) of community mental health care service contacts were classified as involuntary. Western Australia reported the lowest proportion of involuntary contacts (3.1%; 19,168), while the Australian Capital Territory reported the highest proportion (34.7%; 77,442).

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 (CMHC) NMDS. Data collated include information relating to each individual service contact provided by the relevant mental health services. 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 services mentioned above that are included in the Mental Health Establishments (MHE) NMDS which was inaugurated in 2005–06. 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 for the purposes of this collection is defined 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, 2008–09). 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.

It should be noted 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.

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 2008–09 as follows:

- New South Wales, Tasmania, the Australian Capital Territory and the Northern Territory considered the quality of the Indigenous status data to be acceptable.
- Victoria considered the quality of the 2007–08 Indigenous data was not acceptable due to lack of consistency in data entry across its services. In 2008–09, there has been an increasing focus on collecting Indigenous data more accurately.
- Queensland reported that the quality of Indigenous data is acceptable at the broad level; that is, in distinguishing Indigenous Australians and other Australians. However, they believe that 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 2008–09 was acceptable. However, the data could be improved with the appropriate resources, training and reporting standards.
- South Australia indicated that there has been limited analysis of the quality of Indigenous status data. Therefore, the quality of these data is uncertain at this stage.

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:

1. differences among states and territories in the classification used
 - five of the state and territory health authorities used the complete ICD-10-AM classification to code principal diagnosis
 - New South Wales used a combination of National Centre for Classification in Health (NCCH) ICD-10-AM Mental Health Manual; International Classification of Diseases and Related Health Problems, 10th revision, Primary Care (ICD-10-PC); and local codes where there were no ICD-10-PC equivalents
 - Queensland used a combination of ICD-10-AM and NCCH ICD-10-AM Mental Health Manual
 - Northern Territory used the NCCH ICD-10-AM Mental Health Manual
2. differences according to the size of the facility (for example, large versus small) in the ability to accurately code principal diagnosis
3. 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)
4. differences according to whether the principal diagnosis is applied to an individual service contact or to a period of care. New South Wales and the Australian Capital Territory mainly report the current diagnosis for each service contact rather than a principal diagnosis for a longer period of care. The remaining jurisdictions mainly report principal diagnosis as applying to a longer period of care.