

Community mental health care services

Mental illness is often treated in community and hospital-based outpatient care services provided by state and territory governments. Collectively, these services are referred to as [specialised community mental health care](#) (CMHC) services.

State and territory health authorities collect a core set of information 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. More information about the NCMHCD is available in the [data source](#) section.

Key points

- Around **9.7 million** community mental health care service contacts were provided to approximately 453,000 patients in 2018–19.
- The most common principal diagnosis recorded for patients during a service contact was *Schizophrenia*, followed by *Depressive episode* and *Schizoaffective disorder*.
- Involuntary contacts accounted for about 1 in 7 (**14.0%**) of all contacts.
- 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.

Data downloads and links

Excel – Community mental health care services tables

PDF – Community mental health care services section

Link – Community mental health care interactive data

Link – Data source information and key concepts related to this section.

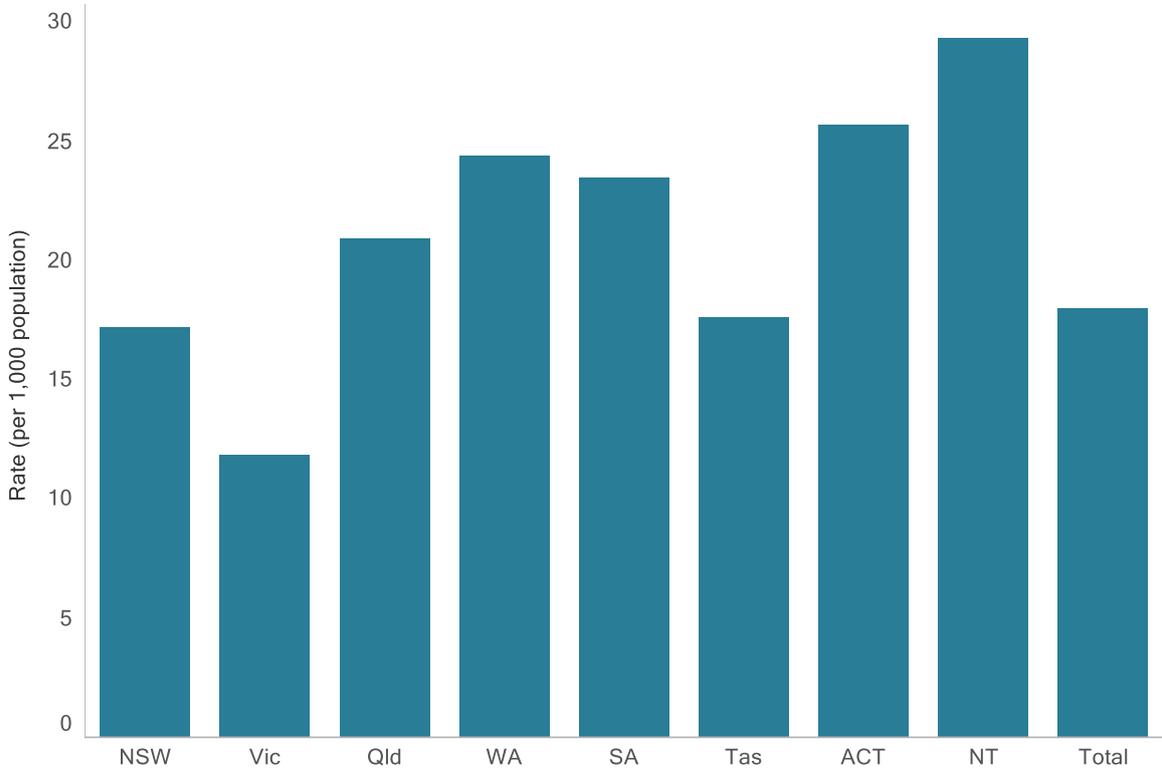
Data coverage includes the time period 2005–06 to 2018–19. Data in this section were last updated in October 2020.

Services provided

Around 9.7 million [service contacts](#) were provided by community mental health care services to over 453,000 patients in 2018–19. This equates to an average of 21.4 service contacts per patient.

The national average rate of patients receiving services was 18.0 patients per 1,000 population. The rate was highest in the Northern Territory (29.3 patients per 1,000 population) and lowest in Victoria (11.8) (Figure CMHC.1). Differences in jurisdictional data reporting systems may contribute to the observed variation in service contact rates.

Figure CMHC.1: Community mental health care patients, by states and territories, 2018-19



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

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Changes over time

In 2005–06, almost 5.7 million community mental health care service contacts took place across Australia. This increased to around 9.7 million in 2018–19.

The rate of both service contacts and patients per 1,000 population across Australia increased between 2014–15 and 2018–19 at an annual average of 0.8% and 1.5% respectively. However, the annual change over this time varied across jurisdictions, with Tasmania reporting decreases in the rate of both service contacts and patients (-6.2% and -1.8% respectively), New South Wales and the Australian Capital Territory reporting decreases in service contacts (-1.0% and -0.8% respectively), and the Northern Territory reporting a decrease in patients (-0.8%).

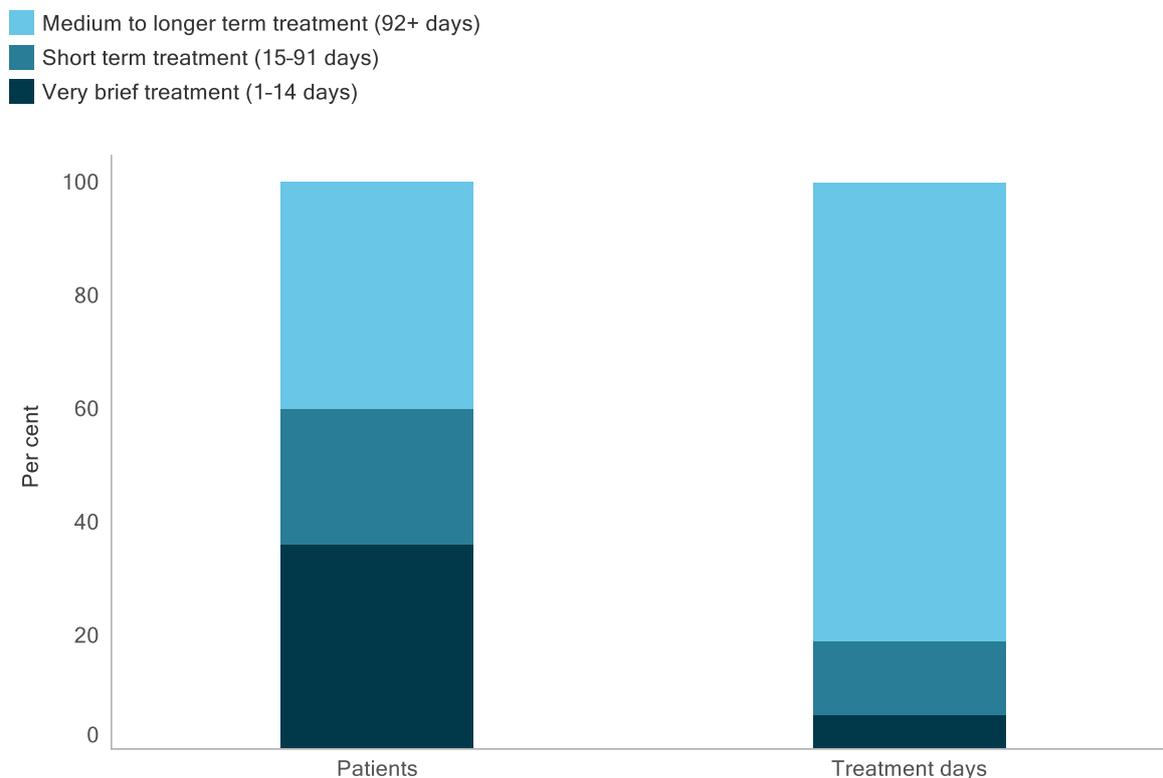
Although the rate of service contacts in the Australian Capital Territory decreased between 2014–15 and 2018–19, it had the highest rate of service contacts of any state or territory in 2018–19 (749.5 per 1,000 population). Tasmania had the lowest rate at 212.1 per 1,000 population.

Treatment periods

4 in 10 registered patients (40.0% or 181,053 people) had a [length of treatment](#) of 92 days or more (the time between their first and last service contact during the reporting period) in 2018–19.

These patients received the highest proportion of [treatment days](#) (80.8%) from community mental health care services (Figure CMHC.2).

Figure CMHC.2: Patients and total treatment days, by length of treatment period, 2018-19



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

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Patient characteristics

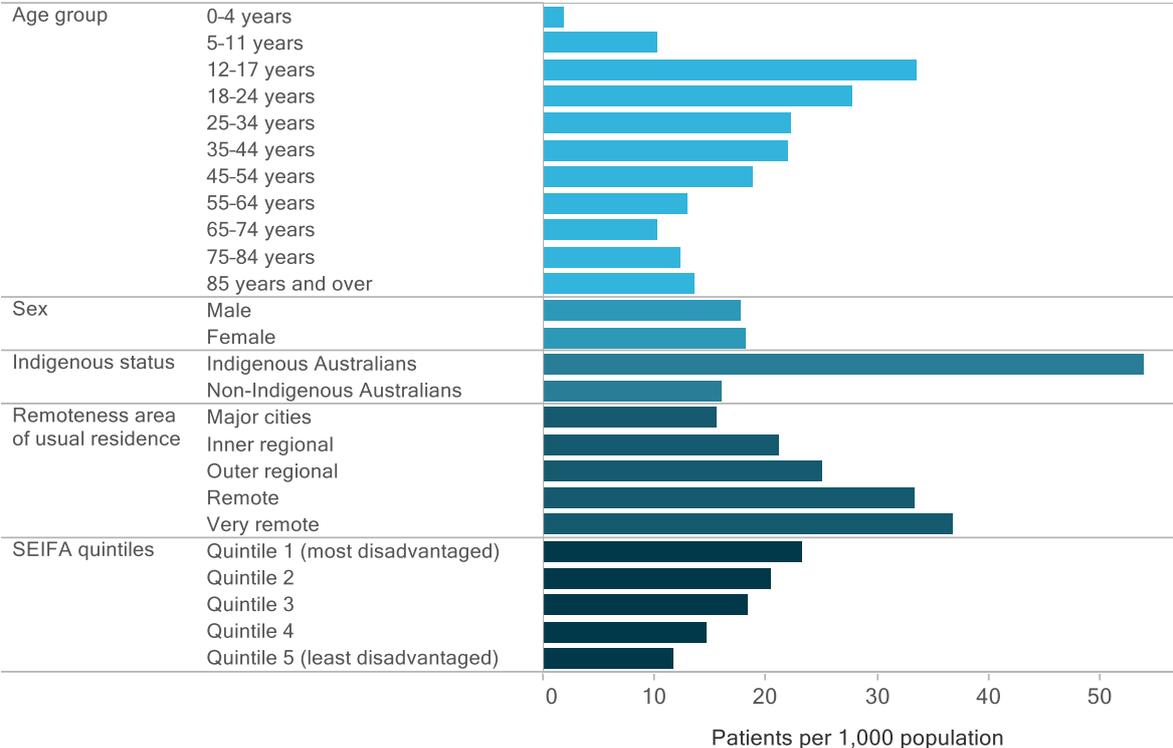
Demographics

In 2018–19, a similar proportion of community mental health care patients were males or females (49.1% and 50.9% respectively). However, males accessed services at a slightly higher rate than females (392.9 and 365.7 per 1,000 population respectively). People aged 12–17 years accounted for the highest rate of both community mental health care patients (33.6 per 1,000 population) and community mental health care service contacts (652.4 per 1,000 population).

People living in *Major cities* made up the majority of community mental health care patients (63.3%) and people living in *Very remote* areas made up the smallest proportion at 1.7%. However, the population adjusted rate per 1,000 population was highest for people living in *Very remote* areas (36.8) and people living in *Major cities* has the lowest rate per 1,000 population (15.6).

Aboriginal and Torres Strait Islander patients comprised 10.3% of community mental health care patients in 2018–19, however 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) (Figure CMHC.3).

Figure CMHC.3: Community mental health care service patients, by key demographics, 2018-19



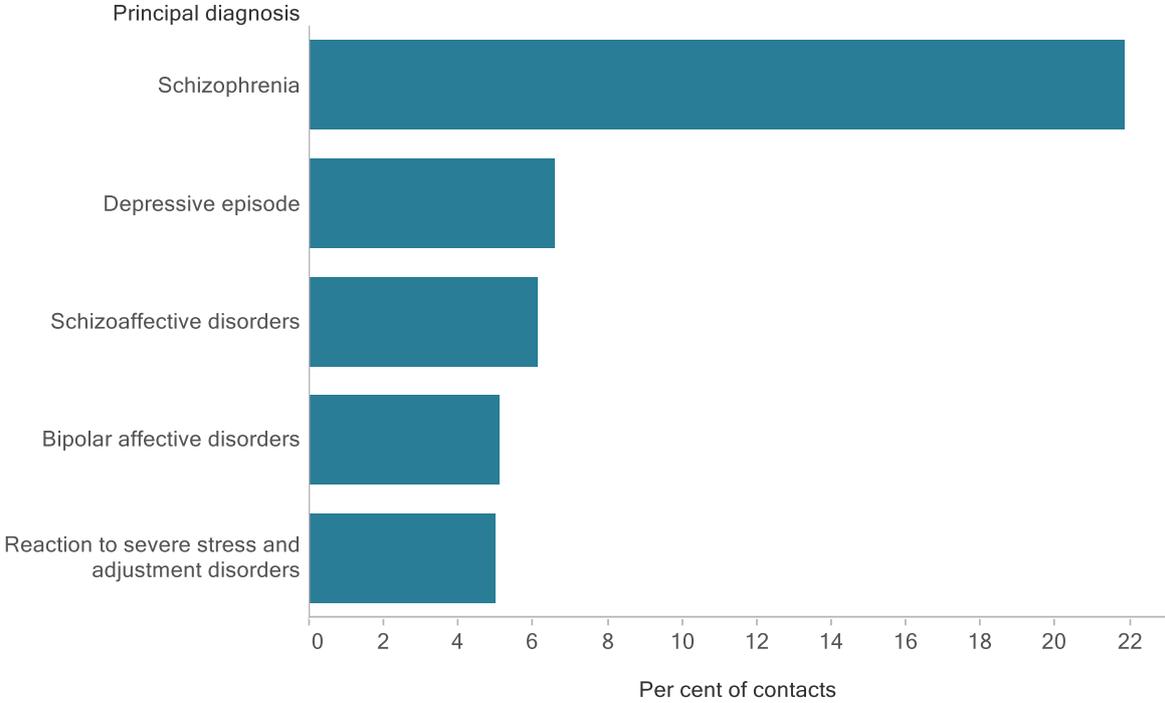
Note: Age-standardised rate is shown for Indigenous Status.
Source: National Community Mental Health Care Database; Table CMHC.8.

Principal diagnosis

In 2018–19, *Schizophrenia* was the most frequently recorded mental health related principal diagnosis for community mental health service contacts (21.9%) (Figure CMHC.4), followed by *Depressive episode* (6.6%), *Schizoaffective disorders* (6.1%) *Bipolar affective disorders* (5.1%) and *Reaction to severe stress and adjustment disorders* (5.0%). A principal diagnosis was reported for 8 out of 10 (8.1 million) community

mental health care service contacts.

Figure CMHC.4: Proportion of community mental health care service contacts, for five of the most commonly reported mental health-related principal diagnoses, 2018-19



Source: National Community Mental Health Care Database; Table CMHC.15.

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Characteristics of service contacts

Type of service contacts

Community mental health care service contacts can be conducted as either individual or group sessions. 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 in the presence of the patient, 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 2018–19 involved individual contact sessions (94.7%) and 5.3% of contacts were group sessions. More than half of all contacts were individual sessions (52.2%), where the patient participated in the service contact (termed patient present).

Target population

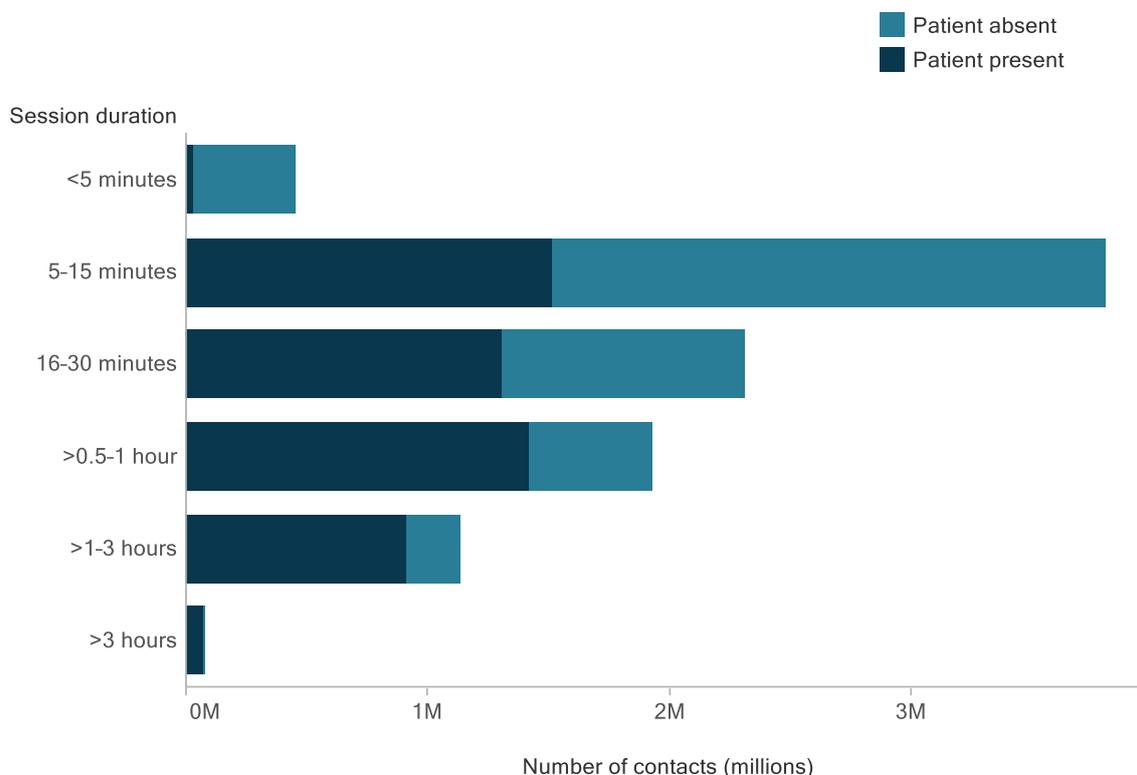
Services targeted toward the *General* population made up 69.6% of all treatment days in 2018–19 followed by *Child and adolescent* (14.9%), *Forensic* (7.0%), *Older person* (6.9%), and *Youth* services (1.7%). Services targeted towards *Forensic*, *Older person*, and *Youth* populations accounted for much smaller proportions of treatment days than the *General* population and *Child and adolescent* services. These results largely mirror the relative size (as measured by the number of full-time-equivalent staff) for each of the community mental health care service target population categories at ([Specialised mental health care facilities](#) section, Table FAC.41).

Duration of service contacts

The duration of community mental health care service contacts ranges from less than 5 minutes to over 3 hours. In 2018–19, the average service contact duration of sessions was 35 minutes. Nearly 4 in 10 contacts were 5–15 minutes in duration (39.2%, or 3.8 million) and almost 1 in 4 contacts were 16–30 minutes in duration (23.8%, or 2.3 million) (Figure CMHC.5). Service contacts with the patient present were on average twice as long in duration than service contacts where the patient was absent (average 46 and 23 minutes respectively).

Of the five most commonly reported principal diagnoses (*Schizophrenia*, *Depressive episode*, *Bipolar affective disorders*, *Reaction to severe stress and adjustment disorders*, and *Schizoaffective disorders*), *Reaction to severe stress and adjustment disorders* had the highest proportion of contacts lasting over 1 hour (13.8%).

Figure CMHC.5: Community mental health care service contacts, by session duration and participation status, 2018-19



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

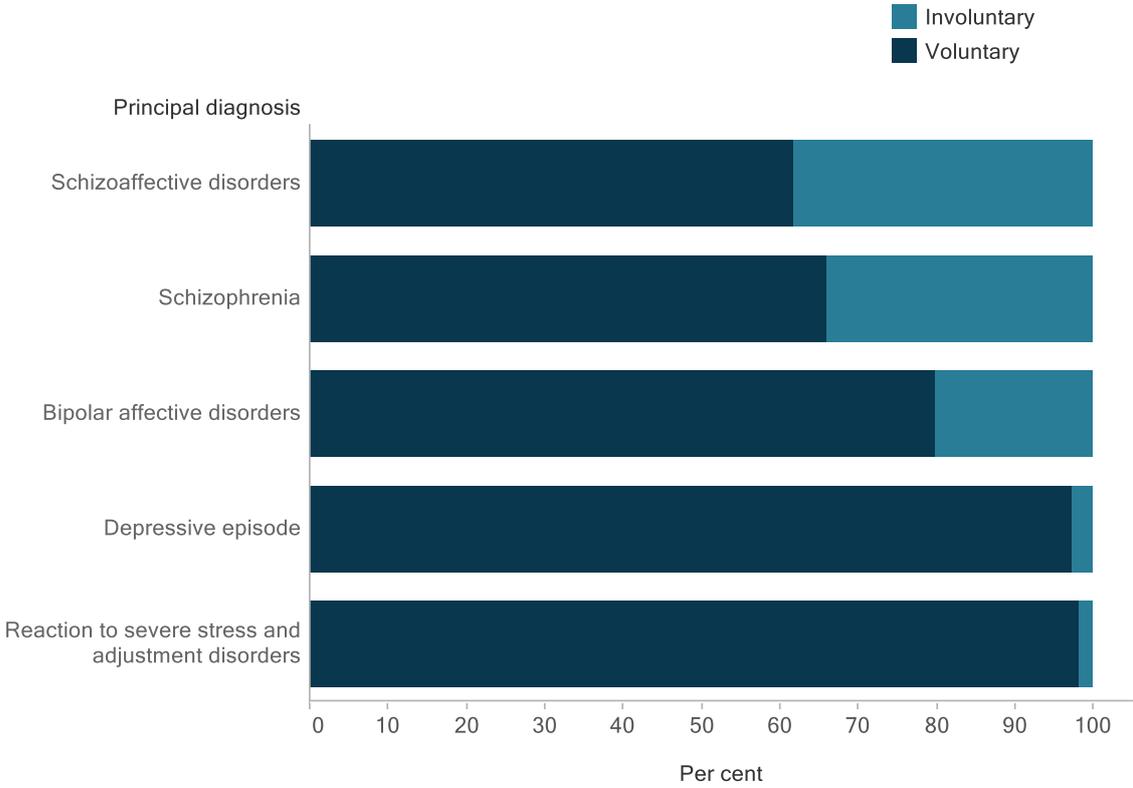
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Mental health legal status

About 1 in 7 (14.0%, 1,314,493) community mental health care service contacts in 2018–19 involved a patient with an involuntary [mental health legal status](#). Western Australia reported the lowest proportion of involuntary contacts (3.1%), while the Queensland reported the highest (24.3%) (Figure CMHC.6). These differences most likely reflect the different legislative arrangements in place amongst the jurisdictions. More information can be found in the CMHC NMDS [Data Quality Statement](#).

In 2018–19, of the 5 most commonly reported principal diagnoses, the highest proportion of contacts involving a patient with an involuntary mental health legal status was seen for patients diagnosed with *Schizoaffective disorders* (38.3% involuntary), followed by *Schizophrenia* (34.0%), *Bipolar affective disorder* (20.1%), *Depressive episode* (2.7%), and *Reaction to severe stress and adjustment disorders* (1.9%).

Figure CMHC.6: Community mental health care service contacts, by principal diagnosis and mental health legal status, 2018-19



Source: National Community Mental Health Care Database; Table CMHC.27.

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Data source

National Community Mental Health Care Database

State and territory health authorities collect a core set of information 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). 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.

Data quality over time

Differences in jurisdictional data reporting systems, reduced data coverage or under-reporting of service contacts may contribute to variation in service contact rates. Staff industrial action has resulted in a substantial reduction in data coverage for two jurisdictions in some years: Victoria (2011–12, 2012–13, 2015–16 and 2016–17) and Tasmania (2011–12, 2012–13 and 2018–19). New South Wales and the Northern Territory also reported reduced data coverage for 2016–17, 2017–18 and 2018–19. The observed reductions in both service contact and patient numbers are considered to be primarily due to these missing data. Consequently, long term trends in the total number of service contacts are not available. Further information on data coverage can be found in the CMHC NMDS [Data Quality Statement](#).

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 environment, timelines, accessibility, interpretability, relevance, accuracy and coherence of the Institution. Visit the [Community mental health care NMDS 2018–19: National Community Care Database, 2020 Quality Statement](#). Data quality statements for previous years are also accessible in METeOR.

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

Patient count

The number of unique patients provided with service contacts can be derived from the NCMHCD. However, the patient count is limited to people registered with state and territory community mental health care systems that have a unique person identifier; 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 2018–19, 96.8% of all service contacts reported were provided to unique patients.

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.
Length of treatment period	Length of treatment period is the total amount of time between the first and last service contact for each registered patient during the reporting period. Treatment periods are defined in this report as <i>Very brief</i> (1-14 days), <i>Short term</i> (15–91 days) and <i>Medium to longer term</i> (92+ days).
Mental health legal status	The state and territory mental health acts and regulations provide legislation 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 state and territory jurisdictions but all legislation contains 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”.
Principal diagnosis	The principal diagnosis reported 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 <i>International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification</i> (ICD-10-AM edition). The data quality statement for the CMHC NMDS has further information on principal diagnosis data quality issues.
Service contacts	Service contacts are 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 residents 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 patient can have one or more service contacts over

the relevant financial year period. Service contacts are not restricted to face-to-face communication and 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, other professional or mental health worker, or other service provider.

Target population Some specialised mental health service data are categorised using 5 **target population** groups (see METeOR identifier [682403](#)):

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 will be likely to reoffend without adequate treatment or containment.
4. General services targets 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 care beds for aged persons are jointly funded by the Australian federal 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 (identified by a patient identifier number assigned to a uniquely identified person) during an ambulatory care episode.

The number of treatment days are grouped as follows in Table CMHC.24; 1–14 days, 15–91 days and 92+ days.
