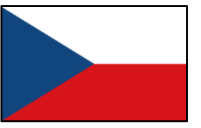
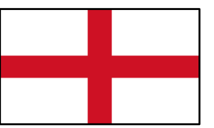
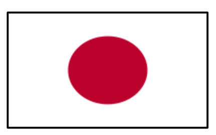
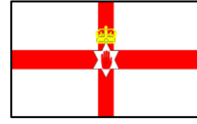
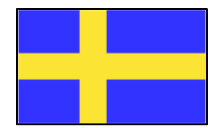
International Mental Health Comparisons 2019

Child and Adolescent, Adult, Older Adult Services







31st October 2019

Raising standards through sharing excellence

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Introduction, background & scope

This report summarises the findings from the 2019 international mental health indicators benchmarking project. The work explores a series of high value indicators in mental health care which have been explored over a number of years by the project's participation group. The work is shaped directly by its participants and is conducted through a framework provided by the International Initiative for Mental Health Leadership (IIMHL), with project management and data analysis support delivered by the UK NHS Benchmarking Network.

The 2019 project builds on previous cycles of project work and explores metrics around mental health expenditure, service access and coverage, provision models, the mental health workforce, and service quality and outcomes. This report provides a composite position that explores service characteristics for all ages, from child and adolescent, through working age adults, and older people.

A total of 14 countries took part in the 2019 project. We are grateful for the active participation of each of these countries and also for the enthusiastic support offered by IIMHL. We would also like to thank the Organisation for Economic Cooperation ad Development (OECD) for the opportunity to contribute to their mental health outcomes work programme which also provided valuable opportunities for raising the profile of the international benchmarking project.

IIMHL initiated a project in 2008 with an aim of developing a consensus framework for mental health quality and performance indicators. This work was led by Professor Harold Pincus and team at Columbia University. The work has continued through to 2019 and published a series of papers that explore the performance schemes used and the opportunities for standardising approaches to performance and quality measurement across a range of countries. Following this work agreement was reached to perform a "deep-dive" into selected high value indicators to explore variation in data, indicators, provision and performance across countries. Results from the first deep-dive were published in February 2017 with a further cycle of benchmarking reporting in May 2018.

The development of robust definitions is central to the project's work. Detailed work was undertaken to agree a set of definitions that are meaningful across countries and use terminology that is consistent with country specific data dictionaries. A data specification was developed which was issued to all participants to support the data collection process. The project has also been keen to ensure that data comparisons are presented in the context of the diversity evident in different country service models. The wider health and care system models used in each country have been referred to in interpreting the data provided.

The project's latest data collection was launched in April 2019. The initial deadline for data submissions was July 2019. A number of data collection extensions were provided to participants to maximise the amount of data that the project could use. Final data submissions were received in August 2019. All data was profiled on receipt and validated with participants to remove any outliers. Analysis was conducted in a number of ways and included the development of benchmarks to compare provision, practice, and performance across countries.

First draft reports were made available to participants in August 2019. Following validation with participants and wider discussion at the IIMHL conference in Washington DC on 9th and 10th September 2019, this final report has now been published.

Interpreting project findings

The project's aims are ambitious given the scope of the project and the extent to which objectives can be influenced by a range of factors present in the characteristics of each country's health system. The extent to which each country's contextual factors will influence the project's findings are identified in outline form in this report. Further input is welcomed from individual countries on how local contextual factors impact on the project's findings. The need to contextualise findings by health system model is an essential part of the process of discussing and understanding project findings. However, the theme of variation is an inevitable part of the project's work and project participants have identified the need to understand and explain the factors that contribute to variation in different country's mental health systems. A large number of reasons exist for variations in provision and performance and some of the main factors contributing to variation are identified below. These factors can be used in applying a framework to the exploration of the project's data and the variation that exists between countries;

- Data quality - including the completeness and accuracy of data submitted by participants
- Service scope - for example, whether data covers all providers operating in a country or just public sector providers where data may be more readily available
- Service definitions – the project uses a standard taxonomy for sub-specialties and bed types which have a high degree of recognition across participants, however, important distinctions exist between countries (for example in Sweden general psychiatry is a recognised broad specialty and bed type rather than a model which separates general adult psychiatry and the specific care of older people with organic illness which is a more typical approach in the UK).
- Service scope – important distinctions exist in service scope which need to be acknowledged. For example, the Netherlands and Sweden have service models which integrate addictions and mental health care, whilst UK models explicitly separate substance misuse care from mental health services.
- Case mix – acuity and case mix present differently across systems and are closely linked to service capacity and eligibility criteria. Countries with more inpatient capacity are observed to provide more inpatient care for people with affective disorders. Countries with more limited bed capacity have a higher percentage of capacity devoted to providing care for people with psychosis.
- Resource levels – countries have access to different levels of resource which impacts directly on each system and effects both inpatient capacity and the extent to which outpatient services and community based support can be provided.
- Clinical processes – the application of nation specific clinical pathways influences each country's position within the benchmarking comparisons. This can include a wide range of factors such as; the impact of different legal systems and detention arrangements, the extent of the scope and provision in the justice / penal system, attitudes and approach to community based care, and the extent to which a range of treatments are available including both psychiatry and psychological therapies.
- Validation – each country has had an opportunity to review and validate the data used in this report and can therefore be interpreted as being generally representative of the country's position.

Participant group and time period for data

Countries provided data on the most recent reporting period available to them.

These are shown on the table opposite.

Country	Time period
Australia	July 2016 – June 2017
Canada	January – December 2018 or April 2017 – March 2018
Czech Republic	January – December 2016
England	April 2018 – March 2019
Ireland	January – December 2018
Japan	April 2018 – March 2019
Netherlands	January - December 2018
New Zealand	July 2017 - 30 June 2018
Northern Ireland	April 2018 – March 2019
Scotland	April 2017 - March 2018
Switzerland	January - December 2018
Sweden	January - December 2018
USA	October 2016 - Sept 2017
Wales	April 2018 – March 2019

Acknowledgements

We would like to thank the following people for their contributions to the project's data collection process.

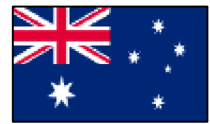
A large number of other people within participant countries and the IIMHL member community also supported the debate on interpretation of project results.

We would also like to thank Emily Hewlett and OECD for their support in the expansion of the project's participant group.

Country	Contributors
Australia	Grant Sara, Amy Young, Gary Hanson
Canada	Harry Kang, Danish Salim, Diana Ridgeway
Czech Republic	Dita Protopopova, Petr Winkler
England	Margaret Oates
Ireland	Philip Flanagan
Japan	Akiko Kikuchi
Netherlands	Dung Ngo
New Zealand	Richard Woodcock, Mark Smith
Northern Ireland	Lauren Church, Stephen Bergin
Scotland	John Mitchell, Fiona Mackenzie
Switzerland	Johanna Friedli
Sweden	Martin Rodholm, Ulrike Deppert
USA	Vera Hollen
Wales	Shane Mills, Adrian Clarke

Country profiles

Countries provided a commentary on their health system to help in the interpretation of their data



Australia

Australia has a universal healthcare system. Within Australia's federated system of government, responsibility for health care is shared. The national (Australian) government funds primary and office-based specialist care and a national subsidised pharmaceutical scheme. State and Territory governments fund and provide hospital care, and some community health services. Private health insurance is incentivised through the taxation system but is not mandatory: around half of Australians currently have private health insurance.

Mental health services are funded and organised as part of general health services: State governments provide admitted, outpatient and emergency hospital care and community mental health care, which are free at the point of service. The Australian government subsidises primary care and office-based "private" psychiatry and psychology services, with demand managed through out of pocket "gap" payments and, for psychologists, caps on the number of subsidised sessions. Private hospitals provide around one quarter of mental health beds, but typically do not provide emergency or involuntary care. Together these arrangements mean that State/Territory governments provide the bulk of care for people living with severe and enduring conditions such as schizophrenia, while primary care and private hospital services provide most care for common mental health conditions such as anxiety and depression. Around 62% of mental health expenditure is by State/Territory governments, 33% by Commonwealth government and 64% by private health insurers.

State/territory government services are typically organised into regions (Local Health Networks) with population-wide responsibilities for defined geographical areas. Recent reform of Commonwealth services has strengthened Australian government-funded regional structures (Primary Health Networks) in order to support better coordination and shared planning between State and Commonwealth sectors. Similar shared arrangements exist for disability support services, which are typically seen as distinct from clinical health services and funded or provided through different structures. Australian and State/Territory governments contract much disability support from non-government or community-managed organisations. These arrangements are being reshaped by the rollout of a National Disability Insurance Scheme (NDIS), which includes people with significant disability due to mental health conditions.

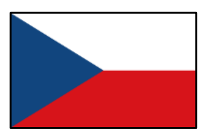
Australian data included in this report is from several sources. Australia has national data collections for hospital data, community mental health data and mental health outcomes measure, and where possible data has been provided from those collections. These collections are confined to services provided by State/Territory governments. There is limited information on private hospital activity (hospital beds and some expenditure) or care by Australian Government funded GP or private psychiatry (expenditure and number of people accessing services), and therefore most metrics within this report relate to State/Territory provided care. Care is needed when comparing to countries with broader data coverage.

Canada

Canada’s health system operates at a number of levels and covers 10 provinces, 3 territories, and also the federal Government.

Both the public and private sectors finance Canada’s health system. Public-sector funding includes payments by governments at the federal, provincial/territorial and municipal levels. Provincial and territorial government health spending accounts for about two thirds of total health expenditure in Canada. A portion of provincial and territorial health spending is funded through health transfer payments from the federal government. Services covered under the Canada Health Act, such as hospitals and physicians, are financed mainly by the public sector (Source: National Health Expenditure Trends, 1975 to 2018, CIHI)

In 2017, the Government of Canada committed funds over 10 years to improve access to mental health and addictions services, and to home and community care. To assess progress in these areas, Canada’s health ministers, informed by sector stakeholders, measurement experts and the public, endorsed a set of pan-Canadian indicators to be developed and reported by the Canadian Institute for Health Information. https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities.html



Czech Republic

The mental health care system in the Czech Republic is divided into health and social care. Health care is provided mainly by psychiatric hospitals, psychiatric departments in general hospitals and outpatient psychiatrists, and is regulated by the Ministry of Health. Every Czech citizen is entitled to receive free health care which is financed via health insurance.

Social care is provided mainly by community mental health care services - which are, however, currently available only to a fraction of those who need it - and by so-called "special regime homes" which mainly accommodate people with dementia. Social care is regulated and financed via the Ministry of Labour and Social affairs and individual Czech regions. The current mental health care reforms aim to shift the focus of care from psychiatric hospitals towards community mental health care.

Mental health care quality/performance indicators had not been monitored, evaluated and used for decision making until recently. However, the MERRPS project was launched in 2017 and aims to change this situation and implement a set of macro-, mezo-, and micro- level indicators that will be used to support evidence-based mental health care development in the Czech Republic. The nation-wide consensus has already been agreed on a number of quality indicators and these are being used for the evaluation of the current mental health care system.

England

England's national mental health system is a core part of the National Health Service (NHS), an inclusive free at point of delivery public health system that covers all of the country's residents. The NHS is a unique healthcare system amongst developed economies and covers the 4 countries of the United Kingdom.

Mental health care is commissioned by the NHS and covers England's whole population. The system is mainly supported by statutory NHS provider organisations, although the private sector also contributes and provides around 20% of the 25,000 mental health and learning disability beds available in England. The private sector tend to focus their provision on more specialist bed types including forensic care. In addition to the 25,000 beds around 700,000 adults are supported on the community caseloads of specialist mental health services in England. Almost all of these people are supported by statutory NHS provider organisations. There are 54 specialist NHS secondary care mental health provider organisations in England, each serving an average catchment population of 1 million people. Around 2% of the population are registered with secondary mental health services. The NHS also has a well developed primary care system which is also free at the point of delivery. General Practitioners provide a first line response for common mental health conditions and refer to secondary care services for access to specialist mental health care. A unique element of England's mental health strategy is the large scale Improving Access to Psychological Therapies (IAPT) initiative which by 2018 had supported an annual total of 1.1 million people in accessing psychological support for common mental health problems.

As a national healthcare system the NHS in England is able to develop national strategies for mental health and oversee the implementation of these strategies with providers. The "Mental Health National Service Framework" published in 1999 outlined an overall strategic objective of moving away from reliance on inpatient beds towards more integrated community services. As a result of this programme and subsequent strategies the English NHS has developed comprehensive community mental health services and significantly reduced the number of inpatient beds. The NHS Long Term Plan, published in January 2019, builds further on these commitments and outlines a national investment programme to further enhance the capacity of mental health services and extend access to specialist care. Amongst the priority areas in the NHS Long Term Plan are commitments to; further extend access to services for common mental health problems through the Improving Access to Psychological Therapies initiative (to 1.9 million people per annum by 2024), expand Perinatal mental health services, improve access to crisis care, expand targeted services for people experiencing first episode psychosis, further enhance the level of specialist care available in the community, and ensure rapid access to services for children and young people. The NHS Long Term Plan is backed by a detailed implementation plan for mental health which outlines details of the workforce and skills requirements to ensure that comprehensive national services are provided. HTTPs://www.longtermplan.nhs.uk/
https://www.longtermplan.nhs.uk/areas-of-work/mental-health/

Ireland

It is estimated that one in four people will experience mental health problems in their lifetime. Mental health problems can range from a low or sad period to a more serious depression, with a small number of people going on to experience severe mental health problems. Most people with mental health problems in the Republic of Ireland can be treated by their General Practitioner, and are referred to Health Service Executive Mental Health Services when necessary.

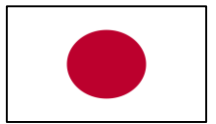
The Health Service Executive provides a wide range of community and hospital based mental health services in Ireland, and these services have seen dramatic changes and developments over the past twenty years. These changes continue, as we move from the hospital model to providing more care in communities and in clients' own homes.

The Mental Health Act, 2001 brings Irish mental health law in line with the European Convention on Human Rights. The Act came into operation in full on 1st November 2006. https://www.mhcirl.ie/for_H_Prof/Mental_Health_Act_2001/

'A Vision for Change' is a national policy, in place since 2006, which sets out the direction for Mental Health Services in Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness. It proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach. An expert group of different professional disciplines, health service managers, researchers, voluntary organisations, and service user groups developed this policy.
https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

The Health Service Executive is governed by the Health Act 2004 http://www.irishstatutebook.ie/eli/2004/act/42/enacted/en/html

The National Service Plan 2018 (NSP 2018) sets out the type and volume of health and social care services to be provided by the Health Service Executive (HSE) in 2018. The plan seeks to balance priorities across all of our services that will deliver on our *Corporate Plan 2015-2017.* Priorities of the Minister for Health and Government are set out in *A Programme for a Partnership Government, 2016* https://www.hse.ie/eng/services/publications/serviceplans/



Japan

Japan has a national universal health care insurance system, and it is mandatory for all Japanese citizens to join some public health insurance. Public health insurance schemes are financed by premiums, the subsidy from the general budget of the government, and co-payment from patients. Health service users pay thirty percent of the medical cost, but public assistance recipients (i.e., those on welfare) are exempted from out-of-pocket payments. For psychiatric outpatient service, patients who need long-term care can apply for a municipal system where co-payment is ten percent with monthly threshold according to income. Psychiatric inpatient service co-payment also has an upper-limit according to the patient's income, and excess payment will be reimbursed at a later time.

Welfare services for persons with disabilities are also financed through tax money. The fee for service is ten percent of the cost with a monthly threshold according to the user's income.

Ninety percent of psychiatric beds in Japan are provided by the private sector. Inpatient beds are functionally differentiated such as psychiatric emergency beds, acute psychiatric care beds, dementia beds, child and adolescent beds, medical complication beds, long-stay psychiatric care beds. Outpatient services are provided by psychiatric hospitals, general and university hospitals, and psychiatric clinics. Japan does not adopt a general practitioner model. Therefore, it is up to the patients to decide which medical facility they want to visit. Most of the psychiatrists working in outpatient services are specialist psychiatrists. It is common for patients with mild to moderate mental health issues to directly visit specialist psychiatrists without being screened by primary- care physicians.

The forensic mental health system in Japan is a parallel health system for mentally disordered offenders who either lacked or were with diminished criminal responsibility at the time of the offense and were decided by the court to be treated under the Medical Treatment and Supervision act. The universal health care system covers the medical expenditure of this system.

Mental health statistics in Japan include yearly cross-sectional patient data on June 30th called "630 Survey", the Patient Survey (extraction survey) every three years, and the National Database of medical fee statements.

Netherlands

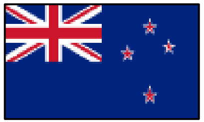
The Netherlands has an insurance based system with managed competition. Within this system there are three markets: the health insurance markets, the health purchasing market and the health provision market.

Mental health care for adults is financed nationally, while youth and long-term mental health care are financed by municipalities/regionally. Mental health care is predominantly provided by private providers. There are integrated mental health and community-based services, and recent years have seen a shift from clinical to outpatient and from specialist to primary care provision.

The Dutch healthcare system is governed and funded by four basic healthcare-related acts:

- Health Insurance Act
- Long-term Care Act
- Social Support Act
- Youth Act

In addition, forensic mental health is governed and funded by the Forensic Care Act.



New Zealand

New Zealand has a population of 4 million and operates a publicly funded mental health system with approximately 70% of funding going to 20 District Health Boards (DHB's) and 30% to Non Governmental Organisations.

New Zealand also has extensive primary care services which provide mental health care which, while subsidised, are not generally free at the point of delivery.

Data included in this report predominantly comes from New Zealand's national data collection system, known as PRIMHD (programme for the integration of mental health data). PRIMHD includes demographic information, outcomes data, legal status, referral details and diagnosis.

Forensic mental health patients in the context of New Zealand are mental health patients who come within four special patient categories. The four special patient categories are:

- patients on short-term remand;
- remand and sentenced prisoners who require assessment and treatment in hospital;
- those who are under disability [Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003];
- those that the court decide are 'not guilty by reason of insanity'.

Services provided may include: high to low-level security, rehabilitation units, community support, prison in reach and court liaison.

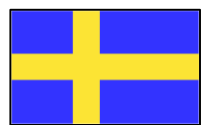
Scotland

Mental health services in Scotland are almost universally provided by the National Health Service which is a free at the point of delivery healthcare system. Health is devolved in Scotland from the rest of the United Kingdom so it is subject to separate legislation, targets and policy. Following the closure of many large psychiatric hospitals, services have been re-provided in the community and the centre of service provision is the community mental health team. This has improved efficiency and provides better care and treatment for patients in their own communities. General adult and old age services are separate with separate teams and admission wards. Addiction services are also separately provided.

In 2016, all local authority social work areas and community health organisations were merged into health and social care partnerships (HSCP). These integrated organisations commission and provide local services for primary care, community mental health and some other community services. Local development plans in each HSCP describe how national health and wellbeing outcomes will be delivered through the reporting of specific indicators.

The Scottish Government published its most recent mental health strategy 2017-2027 and its suicide prevention action plan in 2018. The measurement of outcomes is considered key to this and a suite of 30 measures, applicable to mental health services, are balanced across the 6 quality dimensions of timely, equitable, effective, safe, efficient and person centred care was launched by the Minister for Mental Health in September 2018. In addition a mental health population framework of data that illustrates the mental wellbeing of the nation and its determinants is in the final stages of development. Analysis of past data collection has shown an over collection of process information at the expense of outcomes. Suicide prevention has an ambitious target of a 20% reduction between 2017 – 2022.

A patient safety programme is in its 6th year and mirrors work in primary care and acute settings. This is a collaborative improvement programme with incremental testing of improvement. Data is being reported from some general psychiatric ward at present and the work is likely to expand to cover specialty wards and community transitions. Access improvement programme work applies to the performance of HSCPs and overarching Health Boards in their delivery of psychological therapies and child and adolescent mental health treatment within an 18 week refer to treatment target (90% target). Access targets also apply for substance misuse services.



Sweden

In Sweden the majority of psychiatric care is performed in primary care where the most common diagnoses are adjustment disorder and mild to moderate severity of depressive and anxiety disorders. Addictions are also treated in primary care. For more severe disorders the specialist psychiatry acts as a consultant to primary care. For the most severe patients with schizophrenia and other psychoses, bipolar disorders, severe addiction, eating disorders, neuropsychiatric disorders and combination of these illnesses, specialist psychiatry is the main service providers. Addiction care is typically included within the boundaries of psychiatric services as are old age psychiatry services. Old age services are generally integrated with wider adult services. Since 1995, social services in Sweden have held the responsibility for daily activities and housing support for psychiatric patients.

Mental health care provided by social services is not included in the data presented by Sweden in this report. Forensic care consists to a large extent of patients with a criminal conviction. Around 90 percent of the patients are convicted and 10 percent are high risk civilians.

Approximately 5% of psychiatric care is privately provided with a predominance in the capital Stockholm (15 %). All caregivers are offered the opportunity to take part in national surveys and data collections but participation is lower among private sector providers.

All providers are tax financed and there are very few insurance based systems for specialized psychiatry.

In Sweden 2018 there is a legal arrangement for delayed transfers of care whereby communities have to pay for inpatient care on a daily basis (approx. 4000 SEK/day) for 6 weeks after the doctor in charge has considered them as not in need of psychiatric inpatient care. From 2019 the time limit is a maximum of 3 days in psychiatry. This regulation may affect the length of stay.

Switzerland

Within Switzerland, mental health care is provided by public and private providers. All service providers are organized by an association called Hplus, which represents the interests and concerns of clinics. The funding bodies are all the Health Insurers together with all the Cantons of Switzerland.

The legal basis of the National Quality Measurement system is the Health Care Act of 1994. Within this Act the Federal Council prescribes comparisons between hospitals. Furthermore, the effectiveness of the services they provide must be proven, using scientific methods. It is the responsibility of the funding bodies and service providers to ensure these requirements are met.

For this reason i.e. in order to make this work, funding bodies and service providers founded The National Association of Quality Development in Hospitals and Clinics ANQ in 1999. ANQ is responsible for the 3 sub-divisions of the health care system in Switzerland, meaning Acute Care, Psychiatry and Rehabilitation.

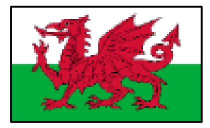
USA

Mental health care in the United States is administered through a decentralized system across fifty states and five territories. Across the Federal Government there are numerous agencies which administer funding for behavioral health programs, such as The Centers for Medicaid and Medicare Services, The Substance Abuse and Mental Health Services Administration, The Veterans Administration, the Department of Education, the Department of Justice, and others. In 2017, The Department of Health and Human Services established the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) in accordance with the provisions of section 6031 of Public Law 114-255, the 21st Century Cures Act. The ISMICC is a public/federal partnership to review current behavioural health programs and practices within the Federal Government and encourage more collaboration between agencies.

An individual residing in the U.S. may receive behavioural healthcare through four primary funding mechanisms, yet one may receive services from more than one sector:

- Private health insurance (72% of the population)
- Public health insurance such as Medicaid, Medicare, Children's Health Insurance Program which are designed for lower-income individuals, elderly persons, and/or those with a disability (36%)
- Veterans (4.6%)
- Safety net services for individuals with no insurance (8.8%)

Managed care arrangements are common across all sectors except for the Veterans Administration. To ensure equitable access to behavioral health services across multiple payment arrangements, the Mental Health Parity and Addiction Equity Act was enacted in 2008. The purpose of the law is to make sure that individuals with mental health or substance use conditions have equal access to treatment services and insurance coverage as patients receiving treatment for physical or medical conditions. The law requires health insurers and group health plans to provide the same level of benefits and services for mental and substance use treatment that they do for other physical conditions. Specifically, annual or lifetime dollar limits cannot be imposed on behavioral health benefits that are less favorable than any such limits imposed on medical or surgical benefits and may not be subject to any separate cost-sharing requirements or treatment limitations. While the parity legislation alone is not enough to ensure equitable access to mental health care, the law provides significant protections against discriminatory practices in behavioral health coverage.



Wales

NHS Wales covers just over 3 million people in a predominantly rural country covering 20,779 sq. km. It directly employs 79,000 people (making the NHS Wales' largest employer) and accounts for 40% of the total Welsh Government budget (approximately £7.3bn). It is made up of 7 Local Health Boards that plan, secure and deliver healthcare services in their geographical areas and 3 NHS Trusts delivering national services (Ambulance, Public health and cancer services). The local health boards work closely with the 22 local authorities.

NHS Wales has developed a 'prudent healthcare' approach with four principles underpinning delivery of health services

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence based practices consistently and transparently.

The three main recent national drivers for mental healthcare include:

The Mental Health (Wales) Measure 2010 This legislation made it mandatory to

- Deliver local primary mental health support services to each GP practice in partnership with local authorities
- Have in a place a care coordinator and a prescribed care and treatment plan for all patients accessing secondary MH services
- Provide a rapid re-assess people who have used specialist mental health services within 3 years without going through the GP
- Offer independent mental health advocacy to all sectioned patients

Together for Mental Health*:* A Strategy for Mental Health and Wellbeing in Wales (2012).This 10 year Strategy is focused around 6 high level outcomes accompanied by comprehensive 3 year delivery plans (the second of which is about to be launched)

Wales has a further closely related programme of work;

Together for Children and Young People. A multi-agency service improvement programme reshaping, remodelling and refocusing the emotional and mental health services provided for children and young people in Wales.

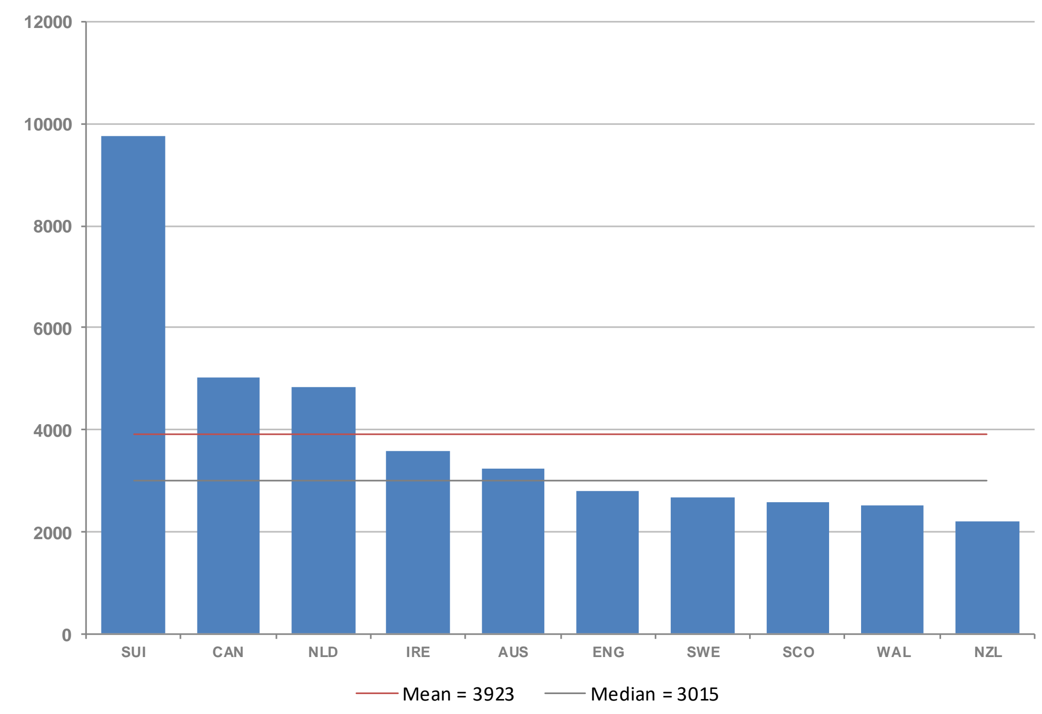
The Mental Health (Wales) Measure 2010 is the first mental health law specific to Wales. It incorporates 6 specific guiding principles which put the service user and/or carers views at the forefront of all care planning and evaluation. The six guiding principles are described within parts 2 and 3 of the code of practice. https://www.rcpsych.ac.uk/pdf/Code%20of%20Practice.pdf

Finance, services and access

Total health expenditure

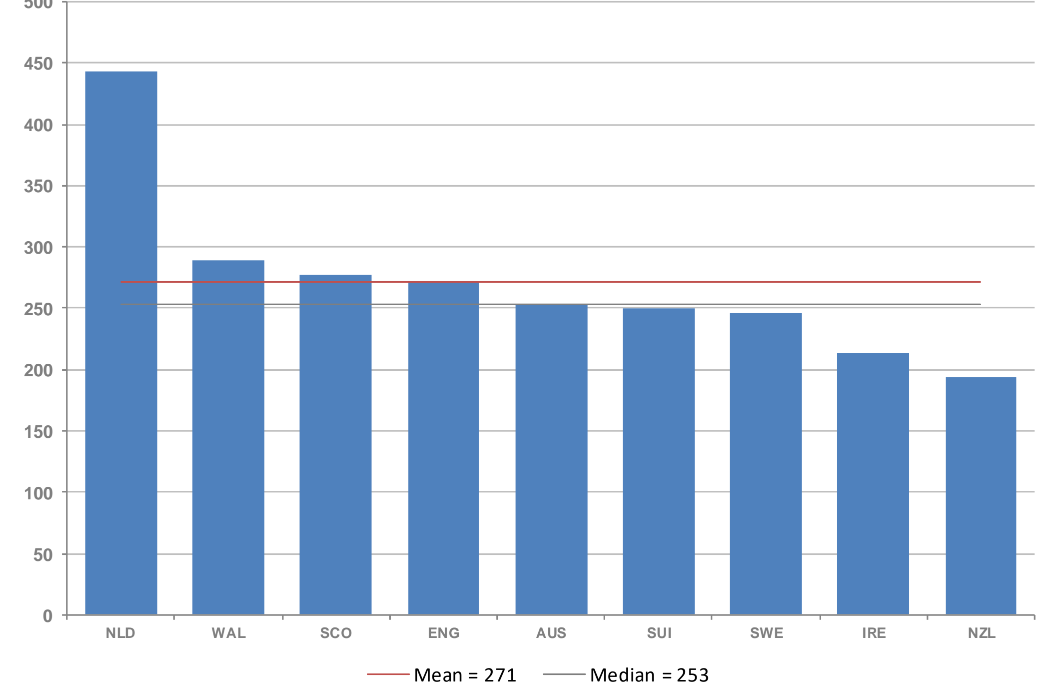
The chart opposite shows total system spend per capita and uses US Dollars as a standardised currency.

10 of the 24 countries were able to provide this data, with Switzerland reporting the highest spend on healthcare at almost $10,000 per capita.



Mental health expenditure

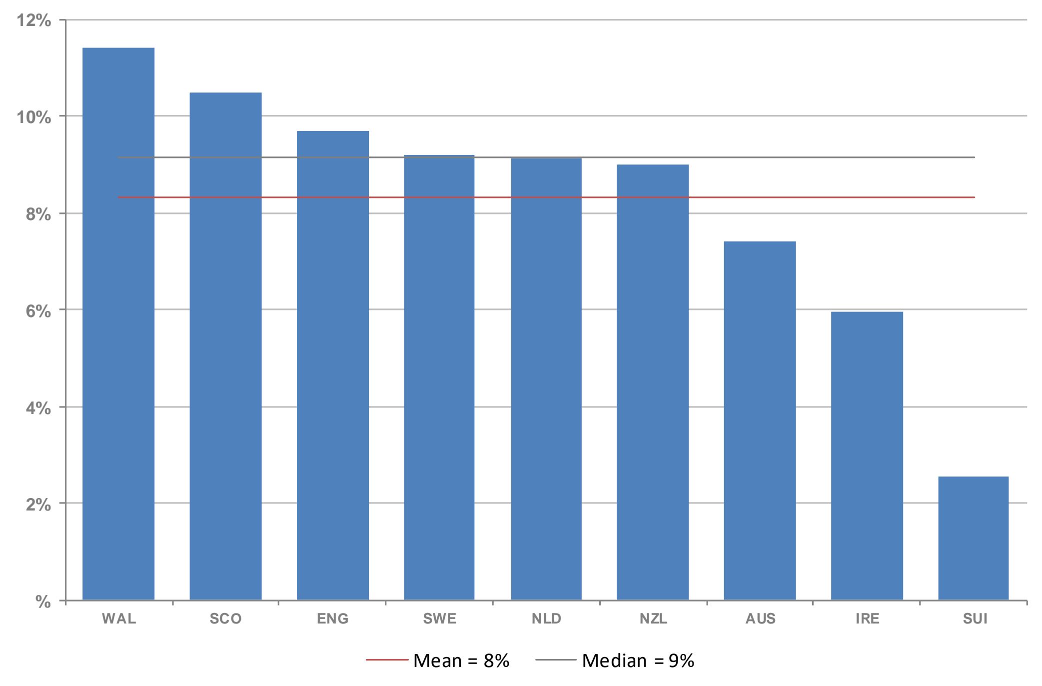
9 countries were able to report specific mental health spend, though it is recognised that variation in service models mean different services are in an out of scope (e.g. substance misuse and learning disabilities). The Netherlands reported the top spend, at almost $450 per capita.



New Zealand figure is for year to June 2018, and does not include the most recent increase in funding through the Wellbeing budget

Mental health expenditure as a proportion of total spend on healthcare

This chart uses a relatively crude arithmetic model to calculate mental health spend as a proportion of total system spend, but is helpful to demonstrate the priority given to mental health services within the wider health economy. Of the 9 countries for whom this data was available, Wales reported the highest proportion of spend on mental health. Although Switzerland was the lowest, this should be seen in the context of higher overall spending on health in the country.



New Zealand figure is for year to June 2018, and does not include the most recent increase in funding through the Wellbeing budget

Scope of services

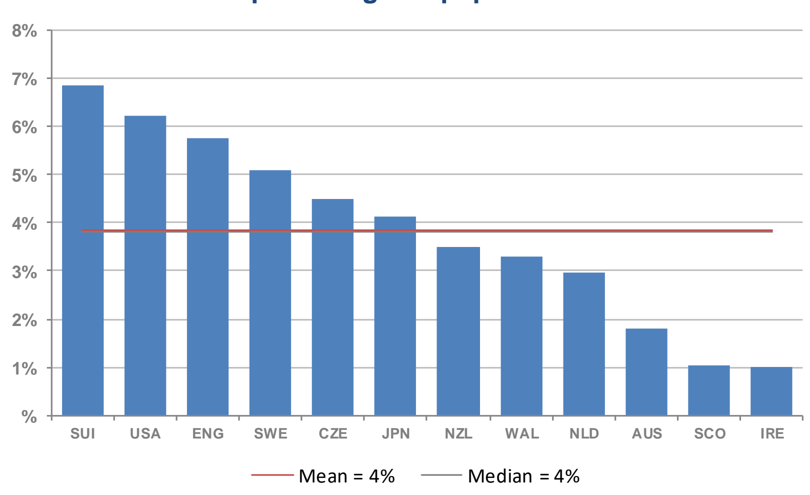
7 countries provided details of which of the following are within the scope of their specialist mental health services. This helps provide additional context for the comparisons which follow.

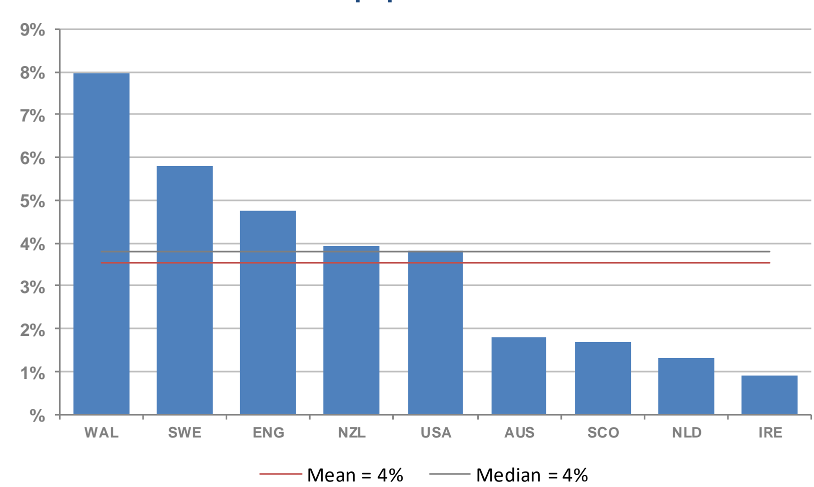
Day Care Services							
Crisis Resolution Team / Home Treatment							
Community Mental Health Teams							
Assertive Outreach Team							
Rehabilitation & Recovery Services							
General Psychiatry							
Psychiatric Liaison							
Psychotherapy Service							
Young Onset Dementia							
Personality Disorder Service							
Early Intervention in Psychosis Team							
Assessment and Brief Intervention							
Memory Services / Dementia Services							

Scope of services

Forensic Services							
Autistic Spectrum Disorder Service							
Peri-Natal Mental Illness / Mother and baby							
Eating Disorders							
Criminal Justice Liaison and Diversion Service							
Prison Psychiatric In reach Service							
Asylum Seekers Service							
Psychiatric Intensive Care							
Continuing Care / Longer Term Complex Care							
Employment Services for mental health service users							
Accommodation Services for mental health service users							
Neurodevelopmental services							
Other mental health services							
Substance Misuse - Drug Services							
Substance Misuse - Alcohol Services							

Access to specialist Mental Health services





Across participants, the mean average position was 4% of adults in a country accessing specialist mental health services during the year. Switzerland reported the highest rates, with almost 7% of adults receiving input from specialist mental health services.

The rates of children and young people accessing specialist mental health services mirror rates for adults, with a mean position of 4% across participants. However, it was Wales who reported the highest rates of children and young people accessing specialist services, with a rate of almost 8% of the CYP population.

*Figure for Japan is proportion of population who attended outpatient mental health appointments during the year; figure for Ireland is people who were new referrals/first appointments during the year

Waiting times – adult services

Countries were asked to describe any waiting time targets in place, for both children and adult mental health services. The figures shown here relate to targets for maximum waiting times from referral to first appointment, and exclude urgent/emergency referrals unless otherwise specified.

Country	Waiting time target
England	75% within 6 weeks, and 95% within 18 weeks (referrals for psychological therapies); 50% enter treatment within 2 weeks (referrals for a first episode of psychosis). Around 90% of patients receive treatment within 18 weeks of referral to specialist mental health services.
Ireland	90% of cases offered an appointment within 12 weeks
Netherlands	4 weeks (first appointment); 10 weeks (start of treatment)
Scotland	90% within 18 weeks (referrals for psychological therapies); 90% within 3 weeks (referrals to drug and alcohol services);
Sweden	90 days
Wales	Referrals seen within 28 days, treatment commencing within 28 days of assessment where needed. Referrals for a dementia assessment seen within 28 days and working diagnosis within 12 weeks following assessment.

Waiting times – children's services

Countries were asked to describe any waiting time targets in place, for both children and adults. The figures shown here relate to targets for maximum waiting times from referral to first appointment, and exclude urgent/emergency referrals unless otherwise specified.

Country	Target
England	4 weeks (eating disorders), 1 week (urgent eating disorders). Around 80% of children receive access to specialist MH services within 18 weeks of referral.
Ireland	78% within 12 weeks; no child waiting longer than 12 months
Netherlands	4 weeks (first appointment); 10 weeks (start of treatment)
New Zealand	80% within 3 weeks; 95% within 8 weeks
Scotland	90% within 18 weeks
Sweden	30 days
Wales	Urgent referrals within 48 hours, routine referrals within 28 days

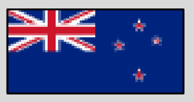
Social determinants of health

The mental health of populations is shaped by wider factors than disease morbidity and service provision. This section of the report explores the importance of having somewhere stable to live, and meaningful employment.

Accommodation and employment

Participants shared details on how data on accommodation and employment figures for people who use mental health services are captured, and what else they know about this cohort.

Case study: New Zealand



Data is collected from specialist services in relation to accommodation and employment status through PRIMHD (national data collection system).

Case study: Netherlands

The majority of the mental health service users receive outpatient treatment, i.e. ambulatory care. They are able to live independently at home and are mostly employed. The group with severe mental illness (about 1.7% of the total population) largely receive care at home. A small group (around 25% of this cohort) receive inpatient care at a facility or sheltered housing and are unable to work.

Accommodation and employment

Case study: Sweden

From 2013-2015 all 290 municipalities performed an inventory of all accommodation with support and daily activities for people with severe mental illnesses. Some areas also perform regularly inventories of homeless people, many of whom suffer from severe mental illnesses with or without disorders due to psychoactive substance use. Mental health services routinely collect information about accommodation and employment status at local level. For the subgroups of patients with schizophrenia, bipolar disorder and psychoactive substance use respectively we have national quality registries available containing these data, even though the degree of coverage varies.

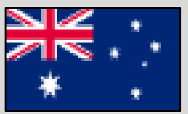
Case study: Scotland

Thought the Scottish household survey, people report the quality of their accommodation. This allows comparisons between returns from people with mental health problems and the general population.

There is an annual population survey that similarly gives unemployment rates. A labour force survey with information on days lost due to mental ill-health.

Accommodation and employment

Case study: Australia



The Fifth National Mental Health and Suicide Prevention Plan includes housing and employment as two indicators against which national performance in priority areas can be measured and reported on.

The 2018 Progress Report provided by the National Mental Health Commission (NMHC) lists the current reporting status for the number of people with mental illness in appropriate housing as requiring further development.

The Progress report also states the number of Australians with mental illness in employment, education or training, in 2014-2015 was 69.9%. This figure was 52.2% for Aboriginal and Torres Strait Islanders.

http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan%202018%20Progress%20report.pdf

Case study: Wales

The MH (Wales) Measure has accommodation and employment as a mandatory requirements. The status for each must be recorded in the Care & Treatment Plan

Accommodation and employment

Case study: Canada

A range of project reports and policy documents have been published on the subjects of accommodation and employment for those with mental illness. These include:

“Turning the Key” by the Mental Health Commission of Canada https://tinyurl.com/Turning-the-key

“Improving the Health of Canadians: Mental Health and Homelessness” by The Canadian Institute for Health Information (CIHI) https://tinyurl.com/Improving-the-health

“By the Numbers: A statistical profile of people with mental health and addiction disabilities in Ontario” by The Ontario Human Rights Commission https://tinyurl.com/by-the-numbers-ontario

“The Aspiring Workforce - Employment and Income for People with Serious Mental Illness” by the Mental Health Commission of Canada https://tinyurl.com/aspiring-workforce

Accommodation

Most countries were not able to report the proportion of people in contact with specialist mental health services who were in settled accommodation. For these purposes, “settled” refers to security of tenure/residence in someone’s usual accommodation, i.e. not a temporary arrangement which might be terminated with little or no notice.

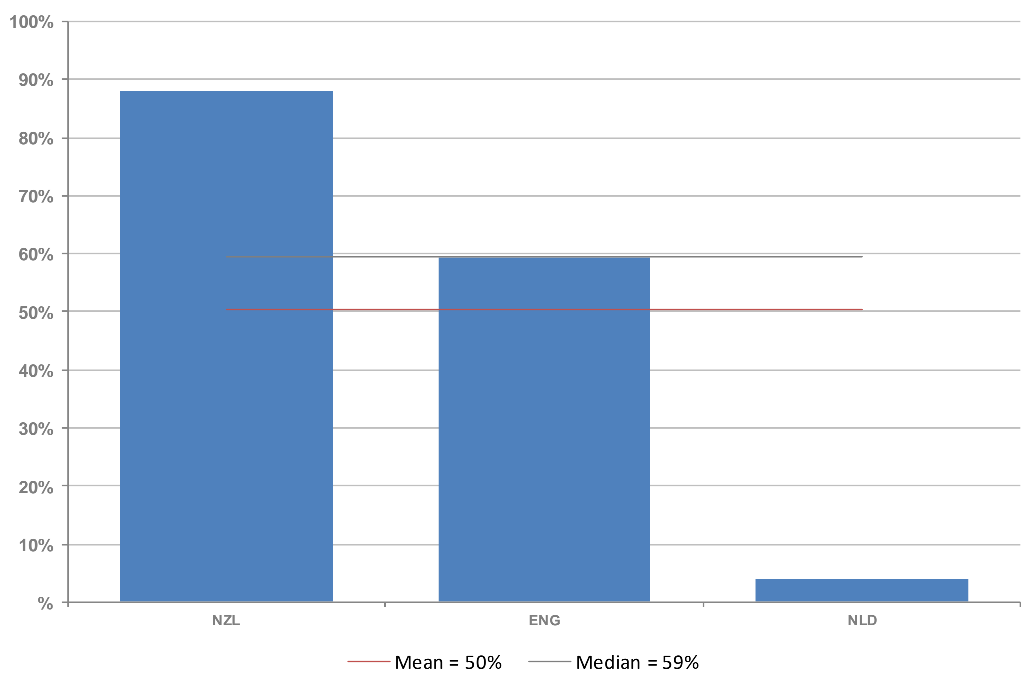


Figure for England is percentage of people on CPA in settled accommodation https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

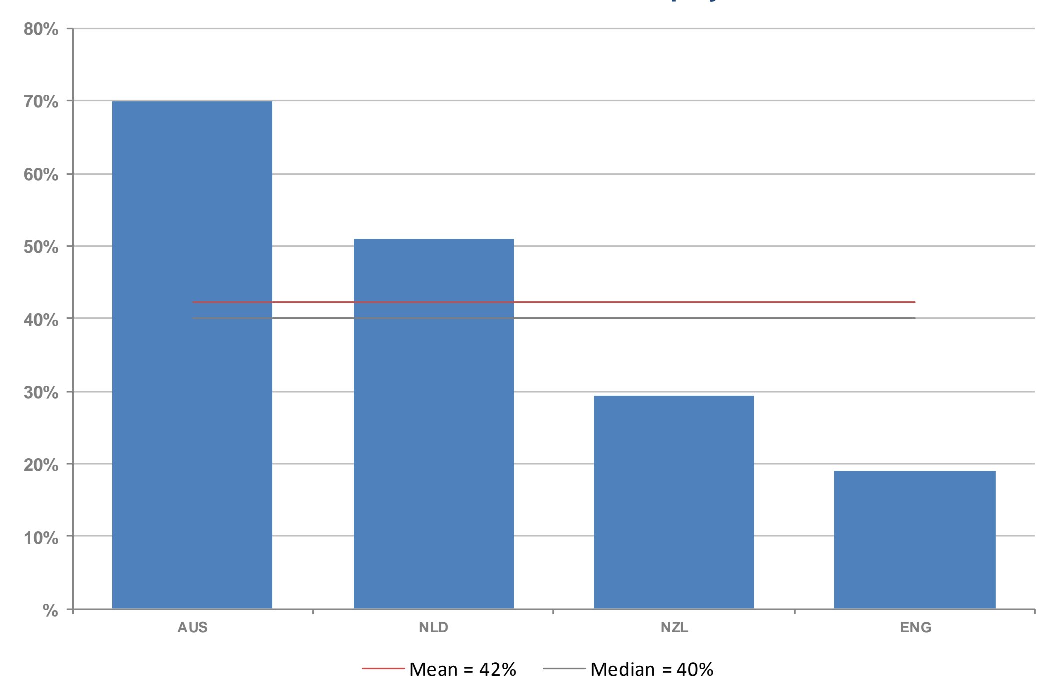
Employment

Many countries were not able to report the proportion of people in contact with specialist mental health services who were in employment.

However, participants shared details of initiatives to support and encourage people with severe mental illness to access and maintain employment.

Individual Placement and Support (IPS) is used in the Netherlands, New Zealand, Sweden, England.

In Sweden IPS is one of several initiatives, including for example "More ways in" supporting employers to employ persons with mental disabilities of different kinds.



Inpatient care – Adults and Older Adults

The provision of specialist inpatient facilities is central to the offer of all developed mental health systems. This section of the report explores the level and type of inpatient care provided and how well used inpatient facilities are. This also provides important context for the subsequent analysis of community based mental health services.

Bed hierarchy

The project adopted a pragmatic approach to applying analysis to different layers of data. Not all countries could collect data at the level of each sub-specialty bed type so a hierarchy of bed types was developed to allow profiling at either main specialty level (e.g. General Psychiatry), or lower sub-specialty level if the data was available (e.g. Psychiatric Intensive Care as a sub-specialty of General Psychiatry). This approach was adopted to support a consistent level of like for like benchmarking definitions using the most appropriate layer of data across countries.

- **Inpatient mental health care**
  - General Psychiatry
    - Adult acute
    - PICU
    - Eating disorders
    - Perinatal
  - Older People
  - Rehabilitation
    - High dependency rehabilitation
    - Longer term complex / continuing care
  - Forensic
    - Low secure
    - Medium secure
    - High secure
  - Child and Adolescent

NHS
Benchmarking Network

General Psychiatry

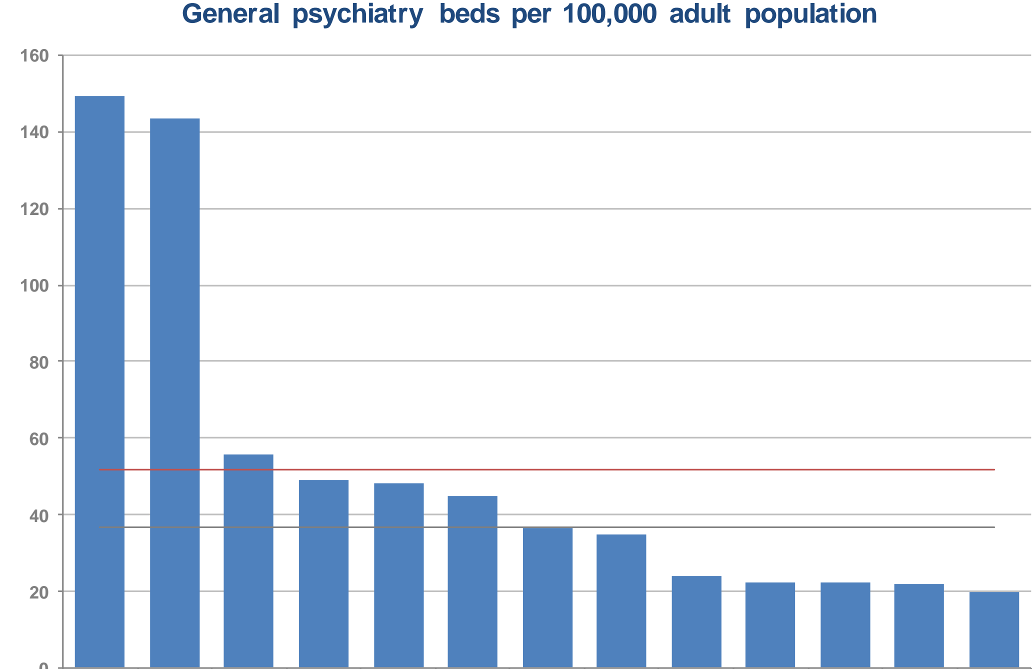
Adult inpatient care

General psychiatry beds

In this context, general psychiatry beds are those inpatient mental health beds for working age adults which may be in a general assessment/treatment unit or specialised by condition such as eating disorders or perinatal. Psychiatric intensive care beds are also included here.

Specialist beds for older people, for long term rehabilitation or for those on a forensic/secure pathway are not included here, and are discussed later in the report.

A total of 13 countries were able to quantify their inpatient capacity. The highest levels of provision are delivered in Japan and the Netherlands. The lowest levels of provision are in Wales, New Zealand, Canada and England.

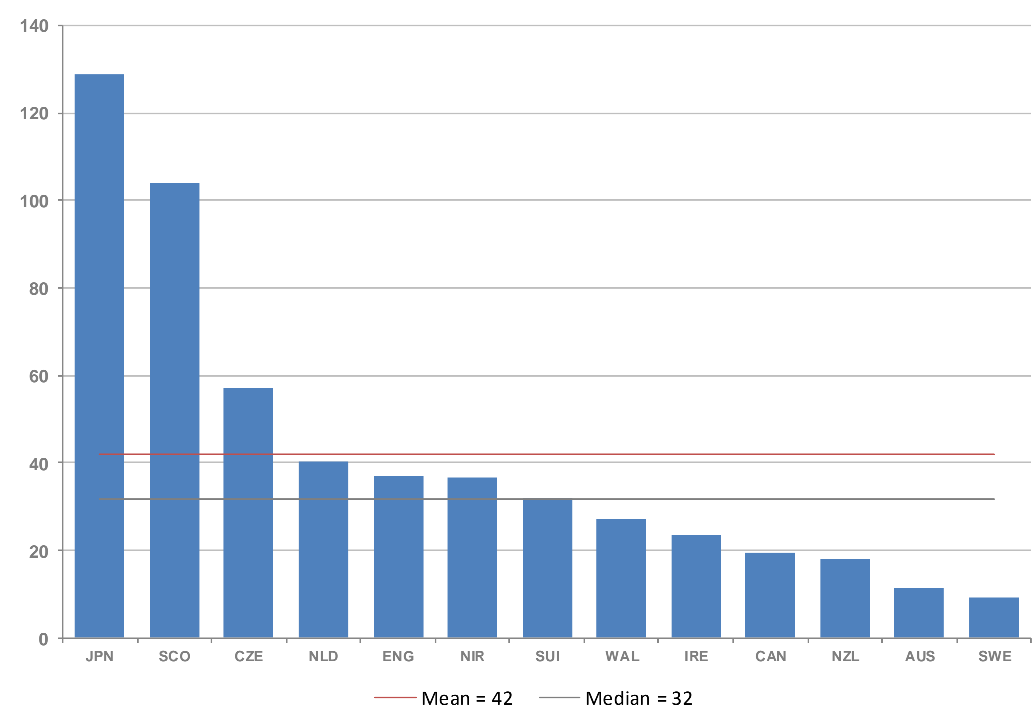


General psychiatry average length of stay

There are differences in individual countries in the reporting of length of stay, with figures either including leave or excluding leave (or both) available.

Where countries can differentiate between general psychiatry bed types, this data relates to Adult Acute beds (rather than intensive care or specialist eating disorder or perinatal provision). There are wide differences between countries, with Japan and Scotland reporting lengths of stay of over 3 months on average, compared to under two weeks for Sweden and Australia.

The range may owe something to the different service models in place across countries, but also to differences in service a delivery and the the clinical models underpinning this, in terms of how patients are assessed and treated. The different legal arrangements in place for detention also impact on length of stay and the flexibility available to ensure rapid treatment and planned discharge into community based care.

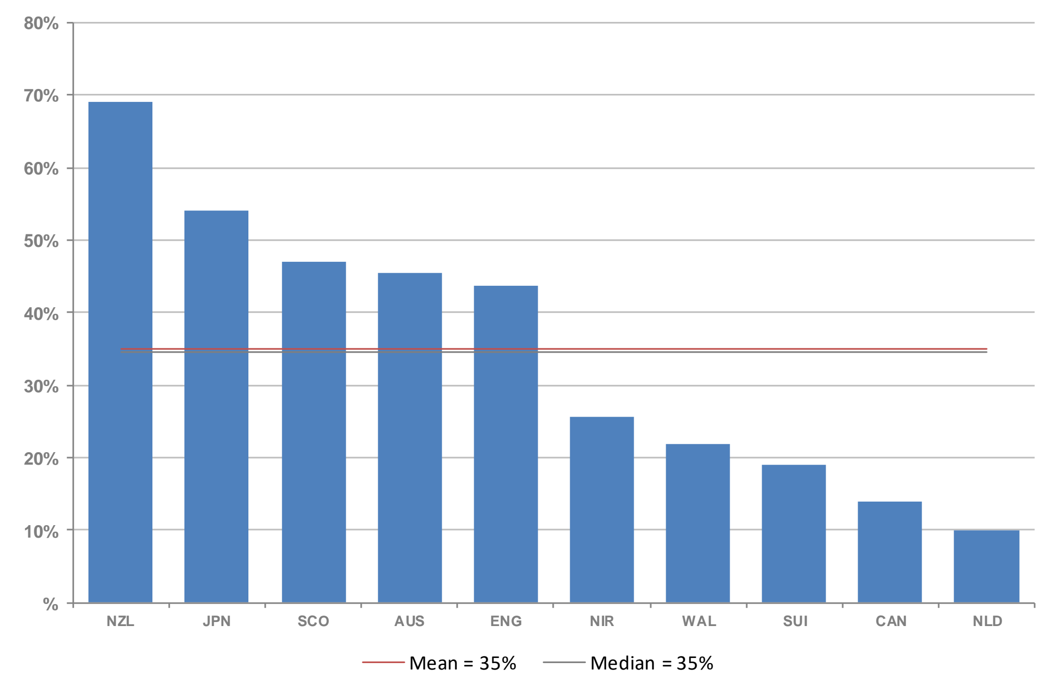


Figures for Australia, Sweden and Ireland are excluding leave

General psychiatry involuntary admissions

The detention rate shows the proportion of admissions to inpatient beds which were for patients who were detained under local Mental Health Act legislation at the time of their admission, i.e. involuntary admissions. New Zealand reports the highest rate of detentions, at almost 70% of admissions. The Netherlands report the lowest, at around 10%. Many factors may impact on the proportion of involuntary patients on a ward, including overall bed numbers, with countries with fewer beds typically reporting greater levels of detentions among those beds, showing priority of admission will be granted to patients whose admission is mandated by law.

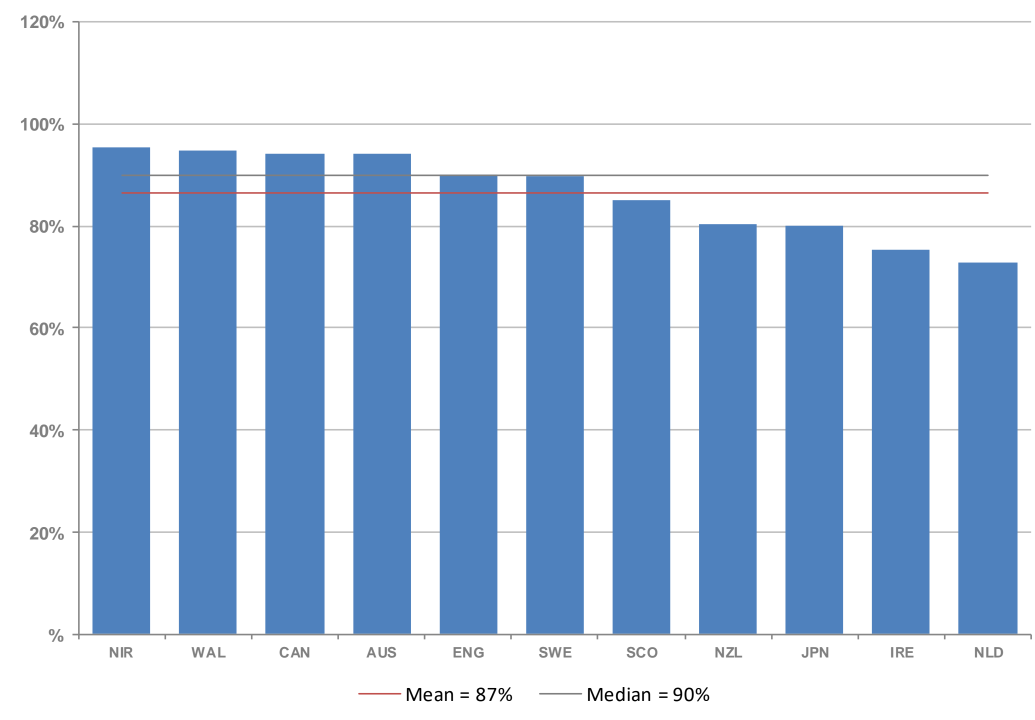
Countries with fewer beds generally have a concentration of acuity in admitted patient care. Countries with larger numbers of beds generally report fewer detentions as a proportion of all admissions and are able to dilute the acuity of the admitted patient care cohort.



General psychiatry bed occupancy

Bed occupancy can be measured excluding or including patients who are out of the hospital on a period of authorised leave. Annualised figures show highest levels of bed occupancy in England and Wales.

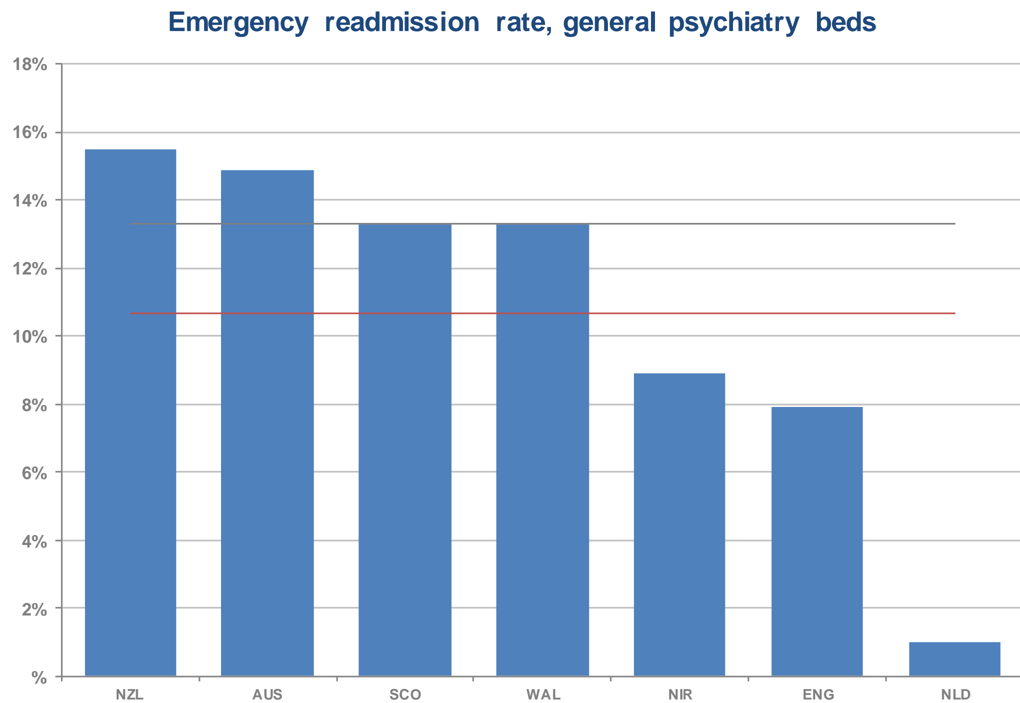
Bed occupancy shows much less variation than other indicators in this project, confirming that bed availability is normally the main driver of inpatient admission rates.



Figures for Scotland, Japan, Ireland and the Netherlands are including leave

General psychiatry emergency readmissions

Emergency readmissions are unplanned readmissions for patients who have been recently discharged from inpatient psychiatric care, typically in the previous 28 – 30 days. Such readmissions do not include planned follow up admissions, or a return of patients from a period of leave. This metric shows broad uniformity between a number of countries. The Netherlands consistently reports the lowest readmission rates.

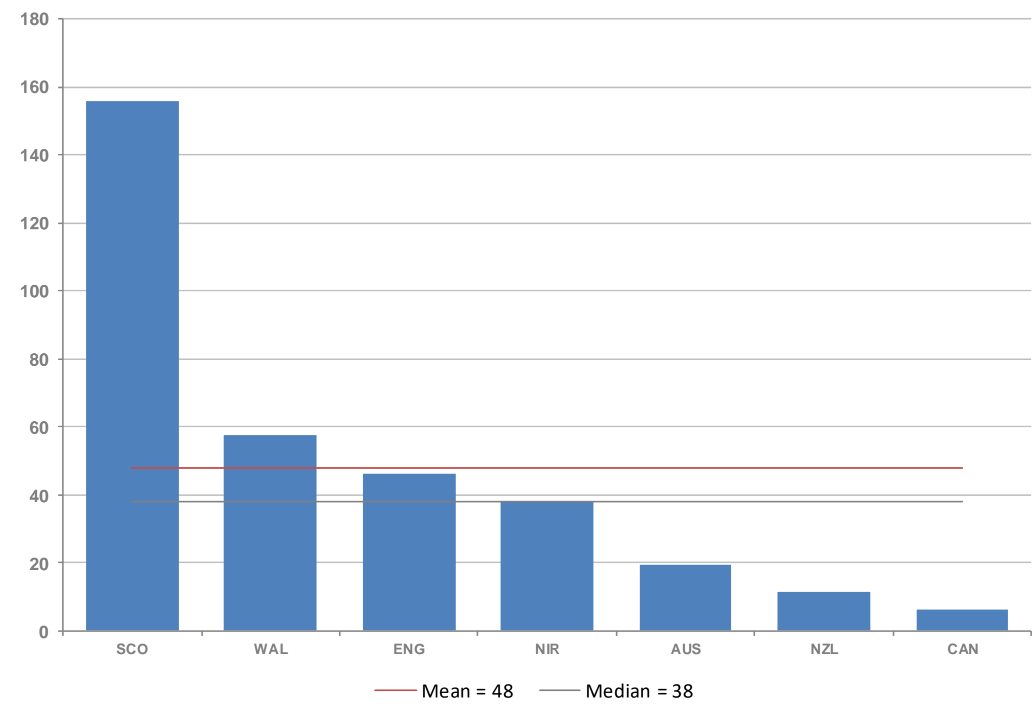


Inpatient care for older people

Old age beds

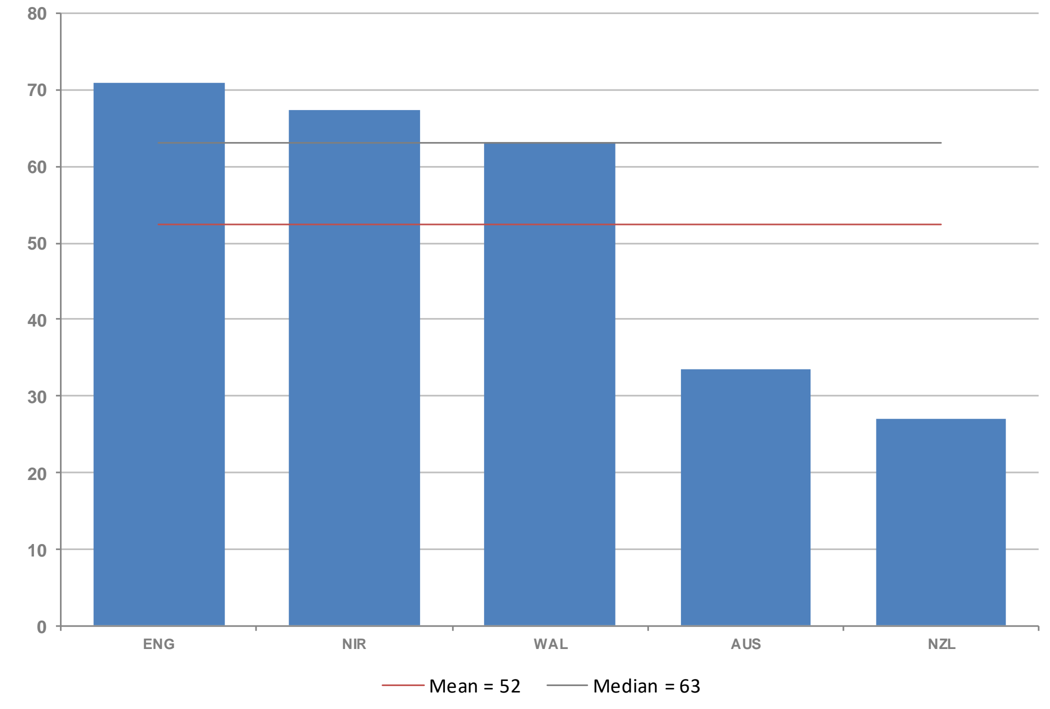
Older adult beds are those for acute admission for older people (typically those age 65+). These beds may provide a forum for assessment or treatment, but do not generally support specialist longer term rehabilitation or continuing care of an extended duration, which are captured in rehabilitation beds.

A total of 7 countries were able to provide data on old age psychiatry beds. Country level data reveals a wide range in provision levels, which may reflect the different service models in place across countries. A number of themes play out in these service models including whether beds are provided on an age specific basis, how functional and organic mental illness are supported and the extent to which countries have substituted community based care in place of inpatient services. Scotland reports the highest level of older adult beds relative to population size, while Canada reports the lowest figures.



Old age average length of stay

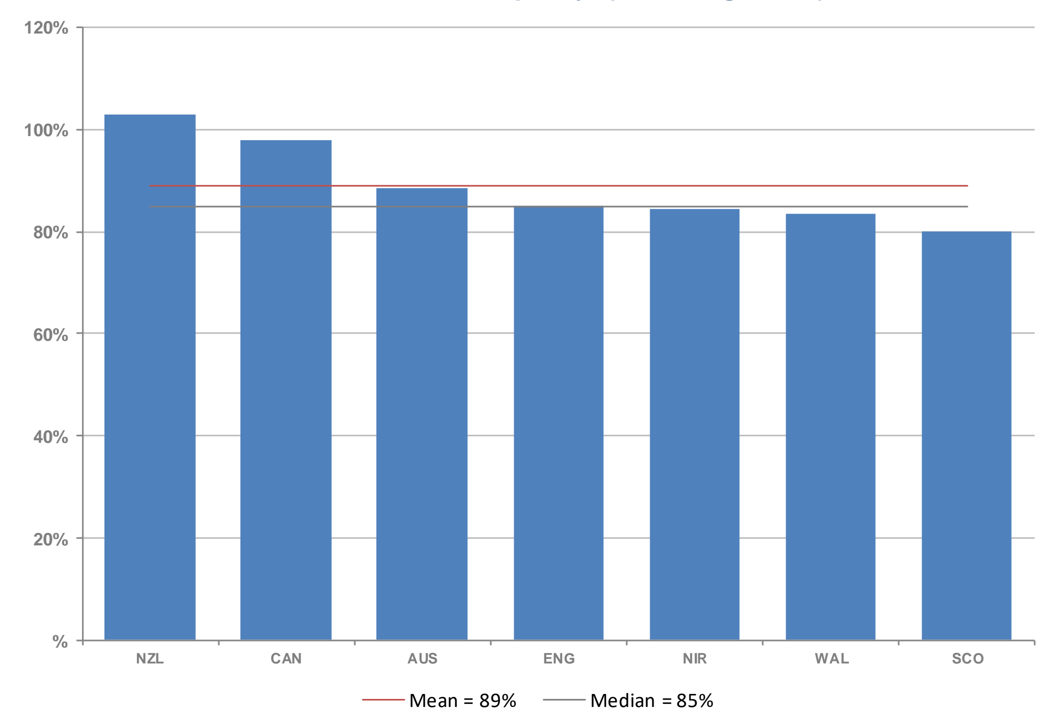
Length of stay for older adults is typically longer than admissions for working age adults in similar assessment/treatment beds. Longer lengths of stay in old age beds may be influenced by co-morbidities around physical healthcare and frailty. A total of 5 countries were able to identify national average length of stay in old age psychiatry beds. Length of stay is highest in the UK countries, with Australia and New Zealand demonstrating interesting shorter stay models.



Old age bed occupancy

In the four UK countries, bed occupancy for older adults is lower than that of working age adult services. However, this is not the case for New Zealand and Canada.

Countries in the study with higher bed numbers for older adults (relative to population size) reported lower bed occupancy.



Figures for Scotland are including leave

Benchmarking Network

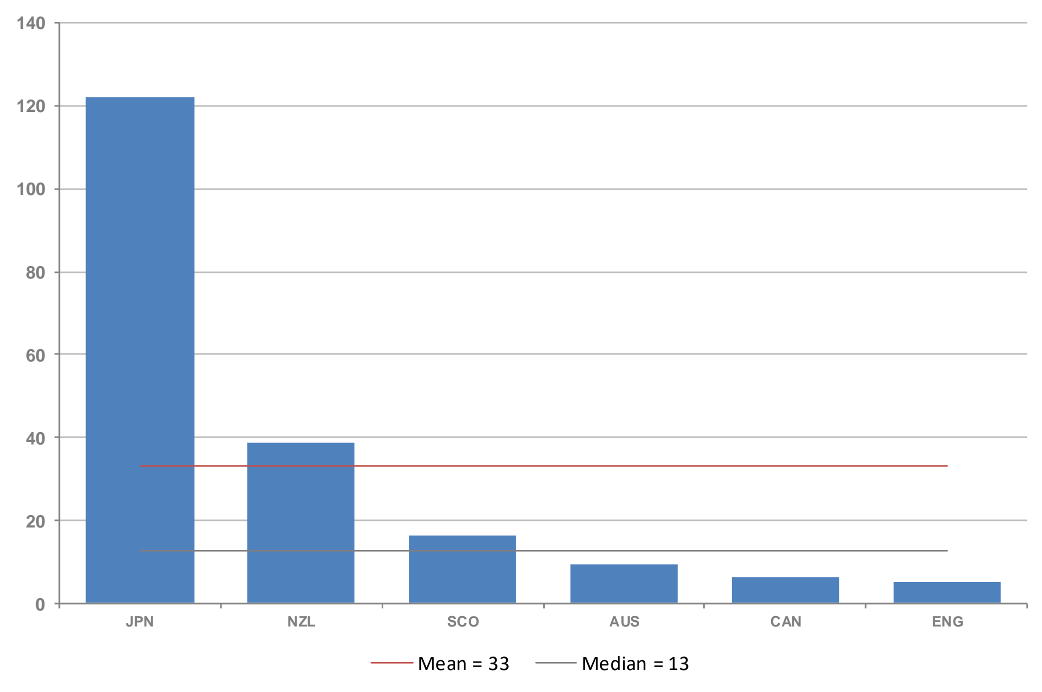
Other inpatient care – rehabilitation and forensic beds

A range of specialist mental health beds are typically provided in most countries. This section of the report explores the provision of long term rehabilitation beds and facilities for forensic patients.

Rehabilitation inpatient beds

Rehabilitation beds were identified by a total of six countries. The inclusion of Japan in the 2019 benchmarking project changes the shape of the comparisons, with substantially higher numbers of beds identified in the Japanese service model. The median average of 13 beds per 100,000 population is not skewed by the impact of the Japanese service model.

New Zealand and Scotland also demonstrate above average bed numbers, whilst Australia, Canada and England report the lowest levels of capacity among the countries who reported inpatient facilities for long-term psychiatric rehabilitation.

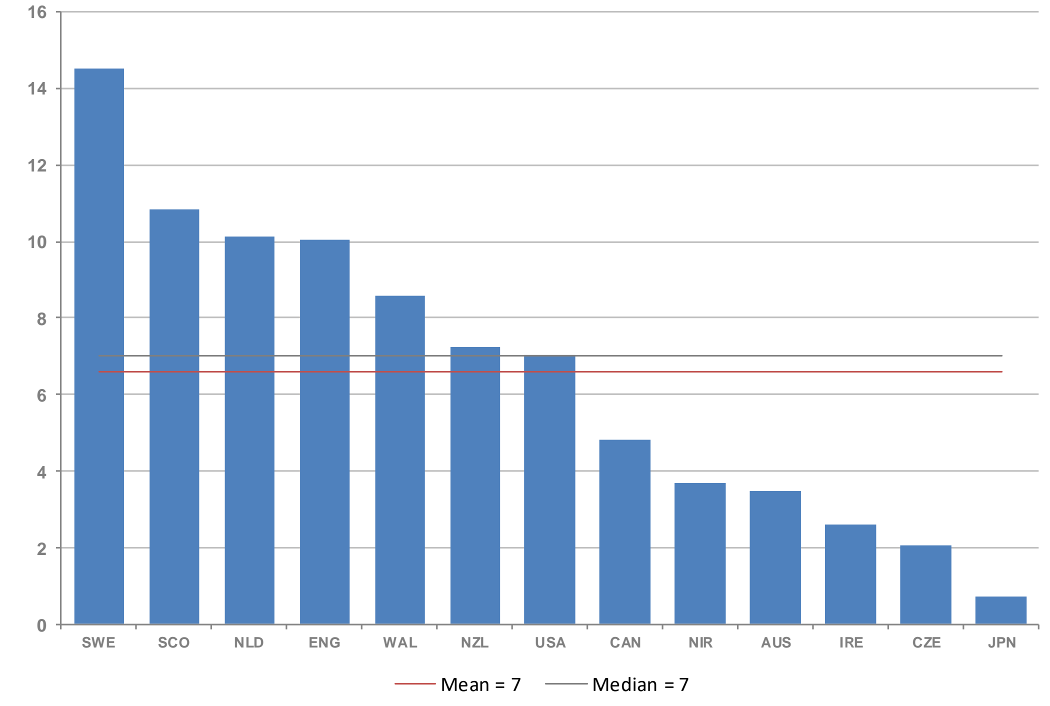


NHS Benchmarking Network

Forensic inpatient beds

In most countries, forensic beds are those linked to the criminal justice system and support offenders or those identified as likely to offend or re-offend. In many countries, a prisoner who has an identified severe mental illness may be transferred out of prison and into a secure mental health hospital.

A total of 13 countries were able to report data on the extent of forensic provision. Both mean and median averages are 7 inpatient beds per 100,000 population. The highest levels of provision are reported in Sweden, Scotland, Netherlands and England. The lowest levels of provision are reported by Japan, Czech Republic and the Republic of Ireland.



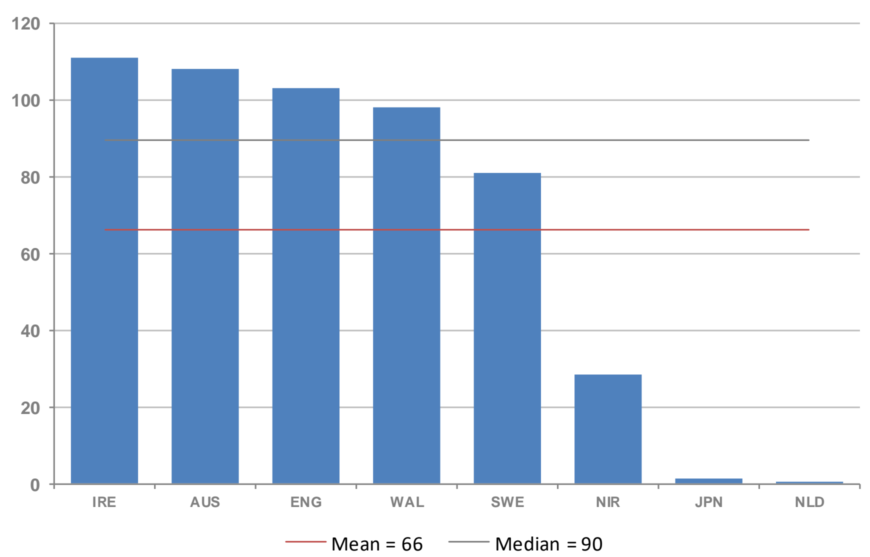
In Japan, forensic psychiatric beds support patients who are deemed “not guilty by reason of insanity” at the time of their offence. Figure for Japan does not include patients in medical prisons (which support inmates with pressing physical and mental healthcare needs).

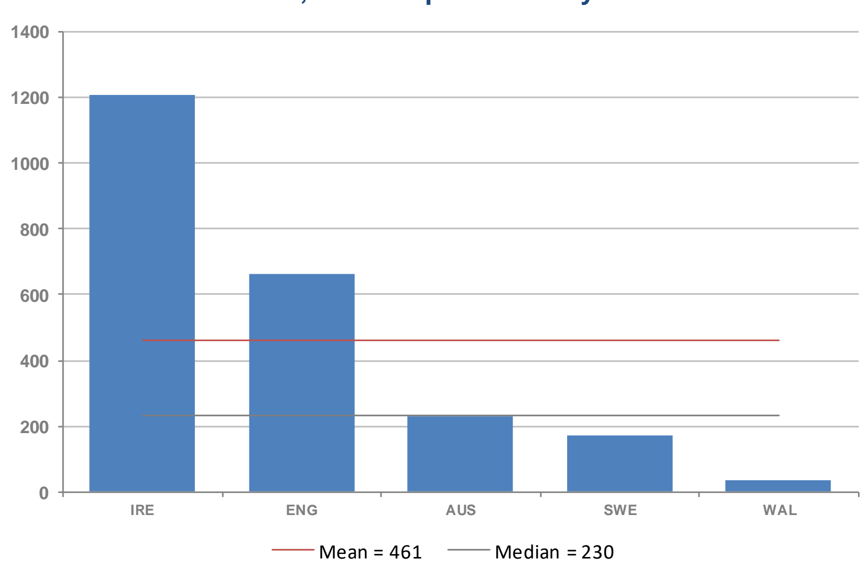
Benchmarking Network

Inpatient incidents

Use of restrictive interventions in bed based services

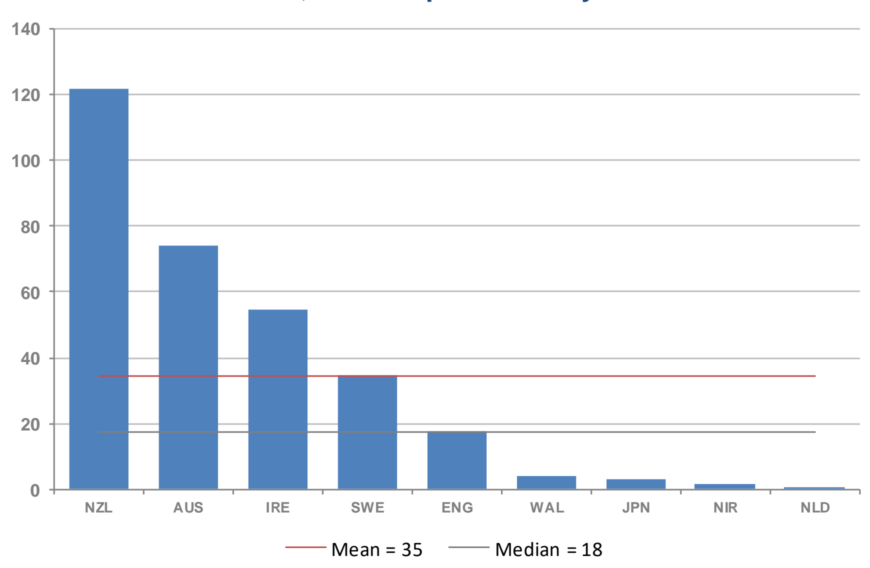
Use of restraint

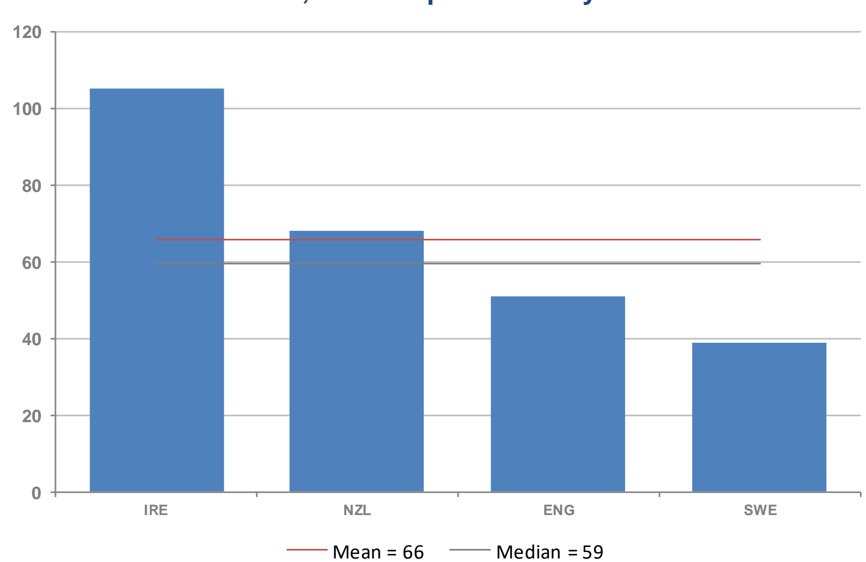




There are variations in the way restraint is captured between countries. Some participants reported local monitoring of prone restraint, mechanical restraint and pharmacological restraint, but the figures here include all positions and methods of restraint. Rates of restraint are noticeably higher in children's beds, with an average of 230 uses per 10,000 occupied bed days, compared to 90 uses per 10,000 occupied bed days in adult services.

Use of seclusion





Seclusion may be part of a planned response to challenging behaviour, or used to de-escalate an emerging situation. Rates are higher in children's services, however only 4 countries were able to provide data for these beds.

Community mental health support and out-of-hospital care

Adults and older adults

Outpatient attendances

Outpatient care for mental health is a service model used in some countries, but not all. Where it is used, and countries are able to quantify this data, on average around 4% of the population (4439 per 100,000 population) attend clinics over the course of a year.

In countries which do not operate an outpatient model, out of hospital care is typically provided by community based mental health teams. These are discussed on the next page.

Scotland and the Czech Republic report the highest level of capacity and provision in the outpatient clinic environment.

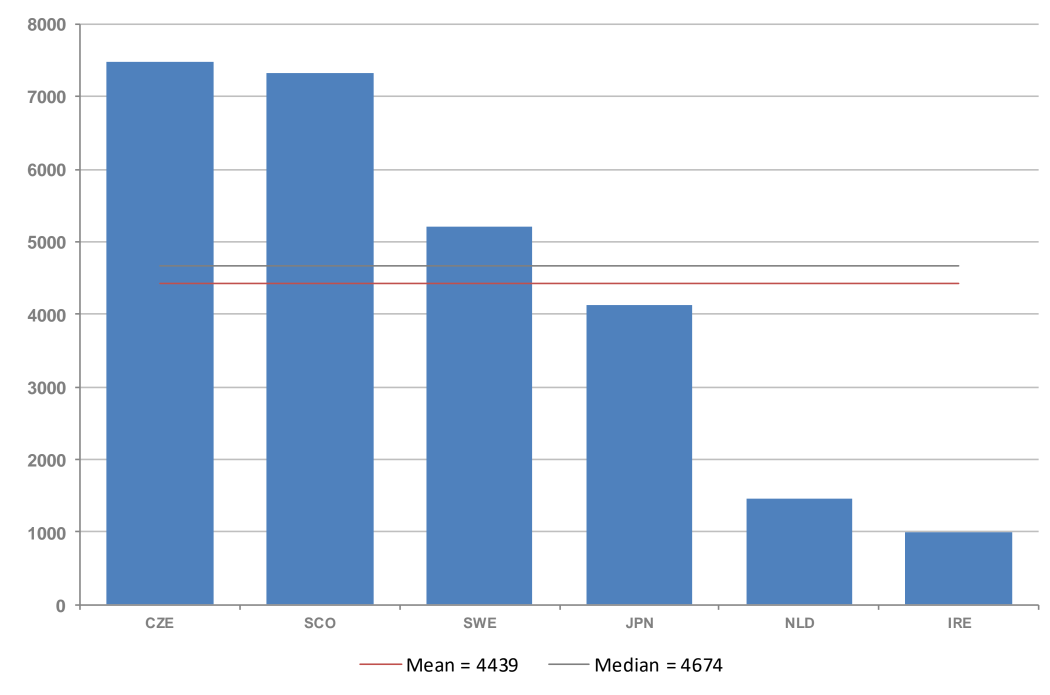
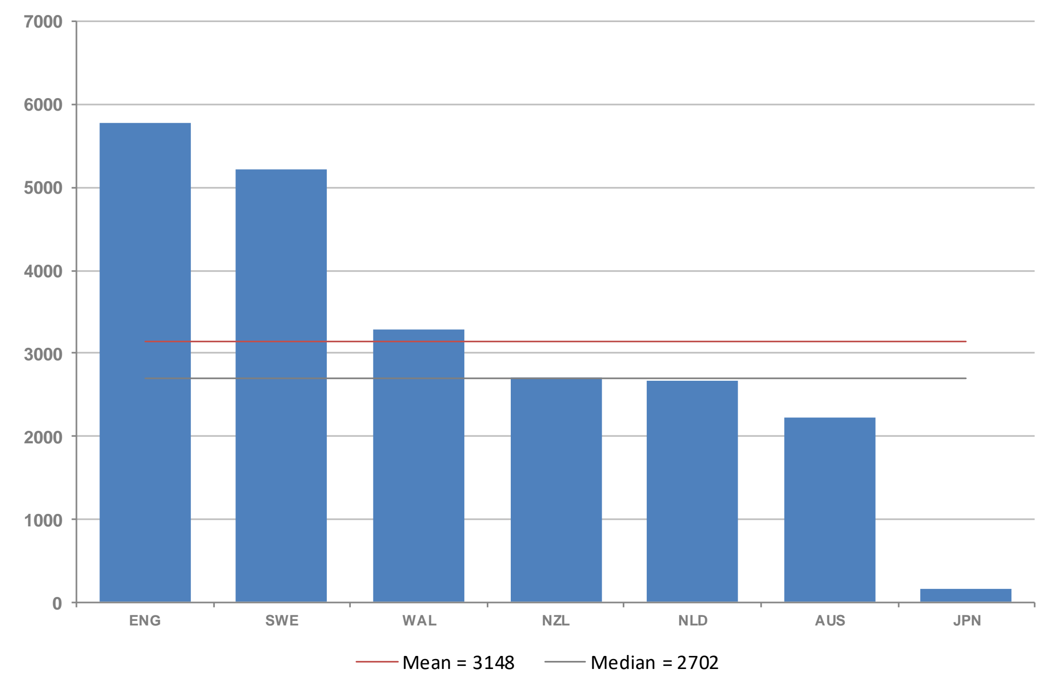


Figure for Ireland is people who were new referrals/first appointments during the year

Community team caseloads

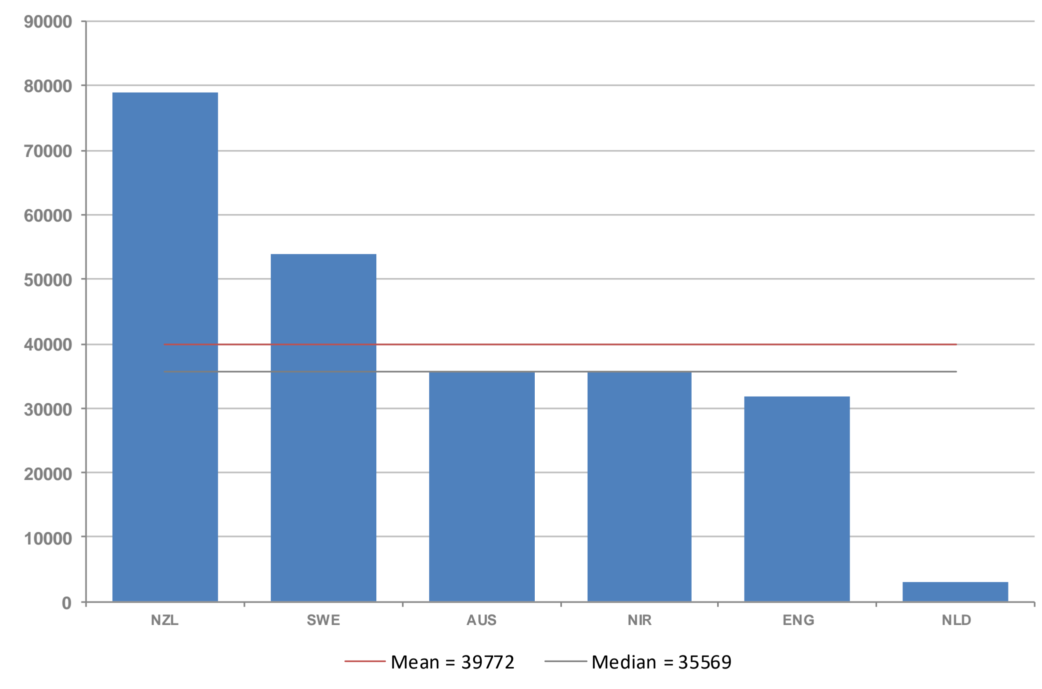
Community based care can operate in a number of environments including community clinics, outreach centres, other community locations and also in people's homes. Countries reported a range of support for people with mental health problems, from general practitioners and other primary care support to specialist community, outpatient and inpatient services for those with greater levels of need. Community mental health teams support people through out of hospital care. Many people on these caseloads may live in their own homes and be employed or in education.

England reported the greatest number of people in this category, supporting over 5,000 people on community team caseloads per 100,000 population (this includes people accessing the IAPT psychological therapies programme). Japan reported different models, with enhanced outpatient services (previous page) but then smaller numbers of people on community caseloads. The overall average reported by the seven countries who cited the community team care models is equal to 2702 people receiving specialist community care per 100,000 population, or 2.7% of the total adult population.



Community team contacts

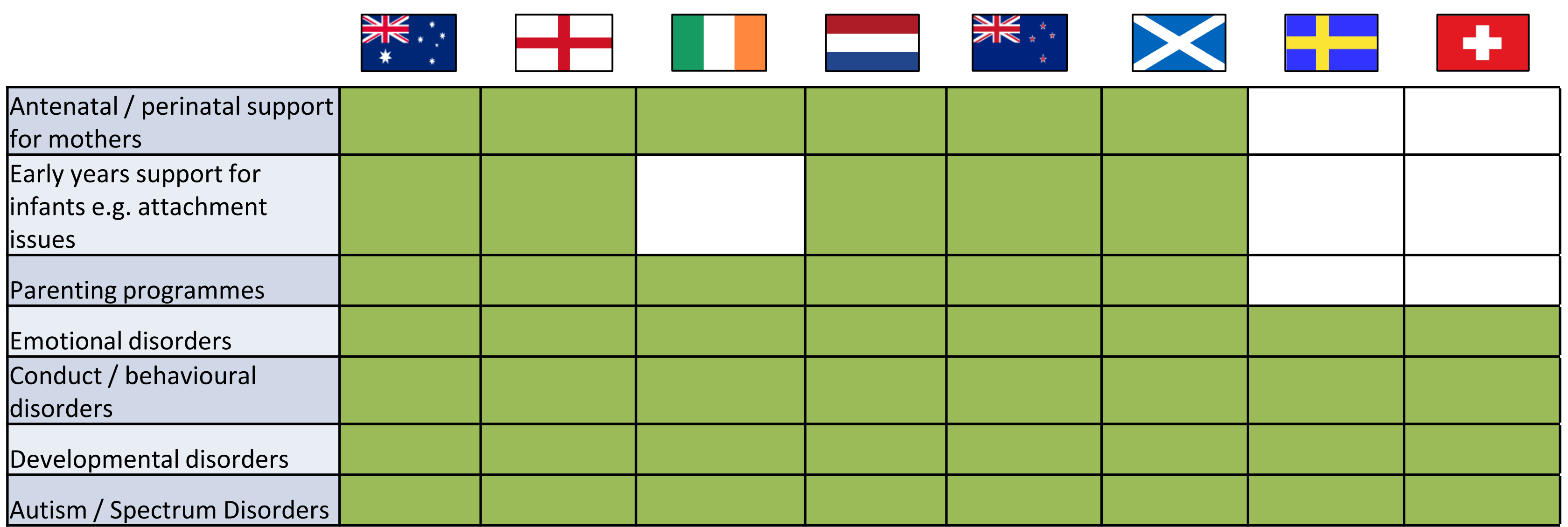
Six countries were also able to provide data on the number of community contacts delivered by community team staff. On average, 35,569 patient contacts were delivered per 100,000 population. This equates to around 16 contacts per patient on caseload (if reported caseloads are representative of typical patient flow over the course of a year). The highest levels of community team contacts are provided in New Zealand, Sweden and Australia.



Child and adolescent mental health services

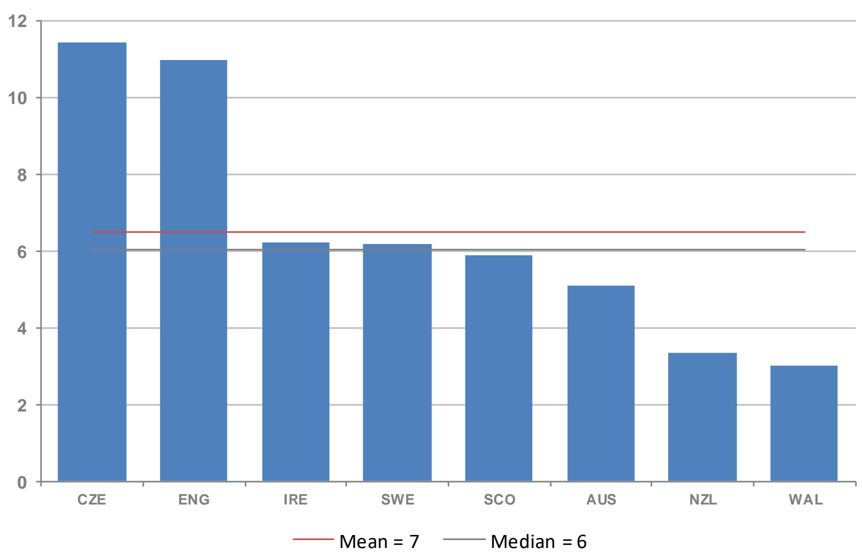
Analysis of child and adolescent mental health services was undertaken for the first time in 2018 when 14 countries provided data through the IIMHL / NHS Benchmarking Network project. The next section of this report updates the results from the 2018 project with latest data from participant countries.

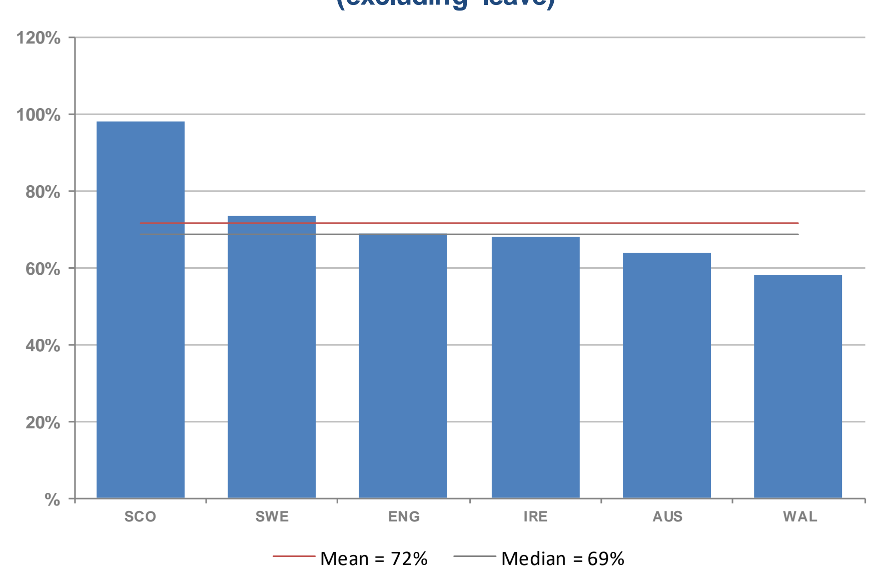
Scope of services



8 countries provided additional information on child and adolescent mental health service models. Most countries provide a comprehensive, all age youth service although a small number (including Sweden and Switzerland) do not offer antenatal, early years or parenting support through their child and adolescent mental health services.

Children and young people's beds

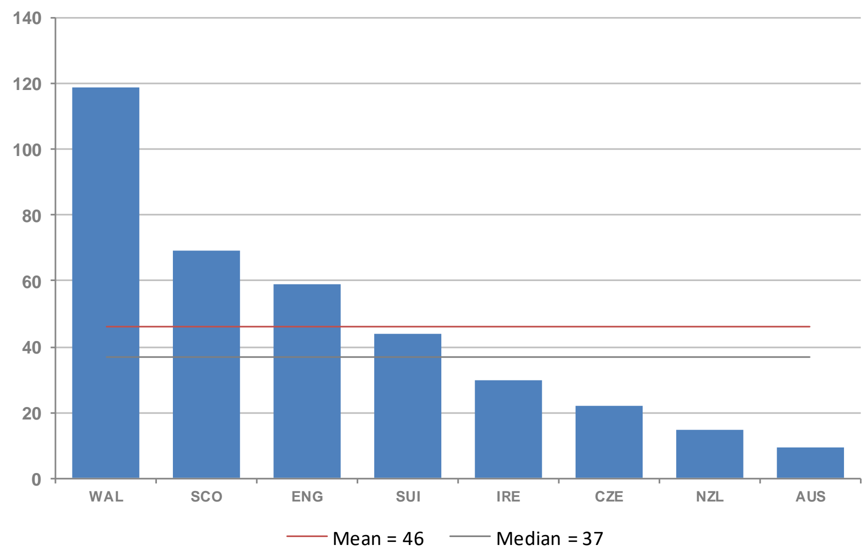




Inpatient beds for children and young people provide targeted, specialist support to this age group. Numbers are low when compared to adult beds, and show that in most countries, inpatient care is not the common model for children and young people with developing mental health problems. An average of 7 beds are provided per 100,000 people in the CYP population group. Child and adolescent mental health beds are typically less occupied than adult, old age and forensic beds. Scotland demonstrate high bed occupancy but all other countries report occupancy of lower than 80%.

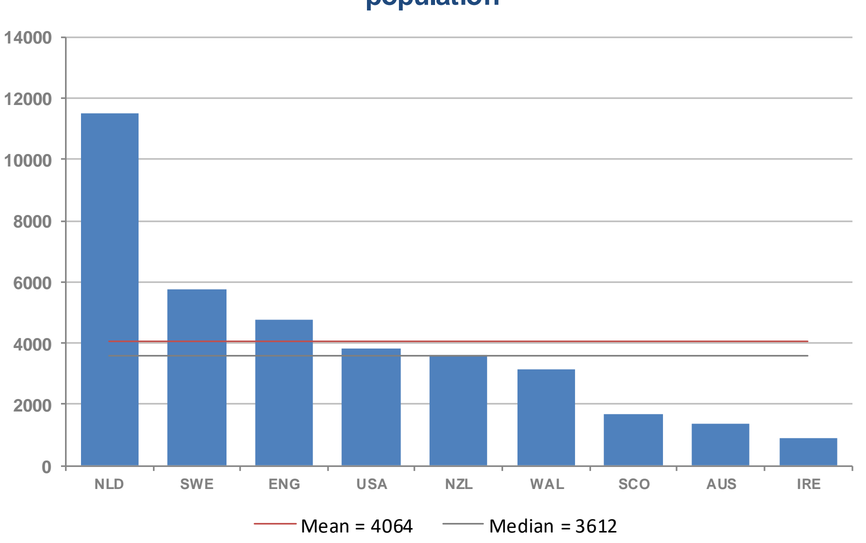
Children and young people's length of stay

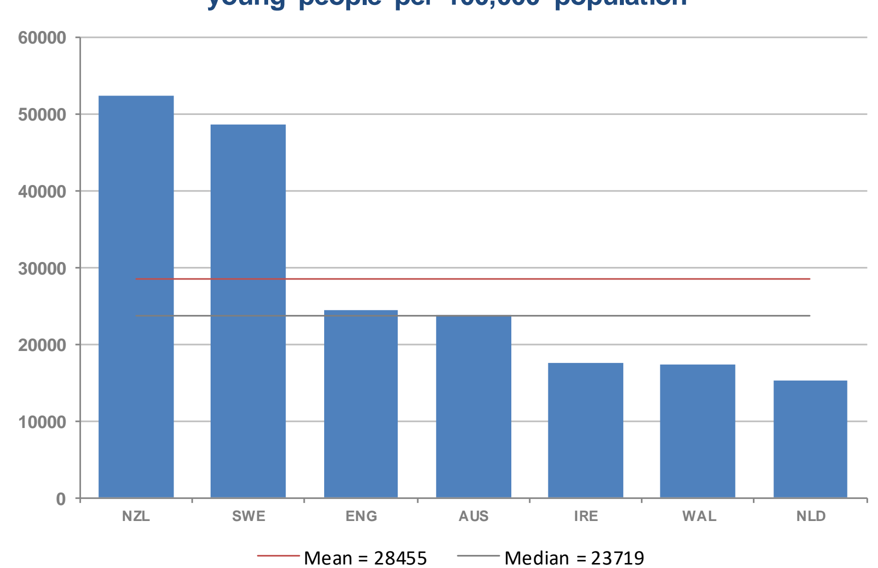
Average length of stay in child and adolescent inpatient facilities average 37 days, although this included substantial variation from 9 days (Australia) to 119 days (Wales). UK countries demonstrated longer lengths of stay, which are also higher than in parallel adult acute psychiatric services.



Figures for Scotland, Switzerland and Ireland are including leave

Community care for children and young people





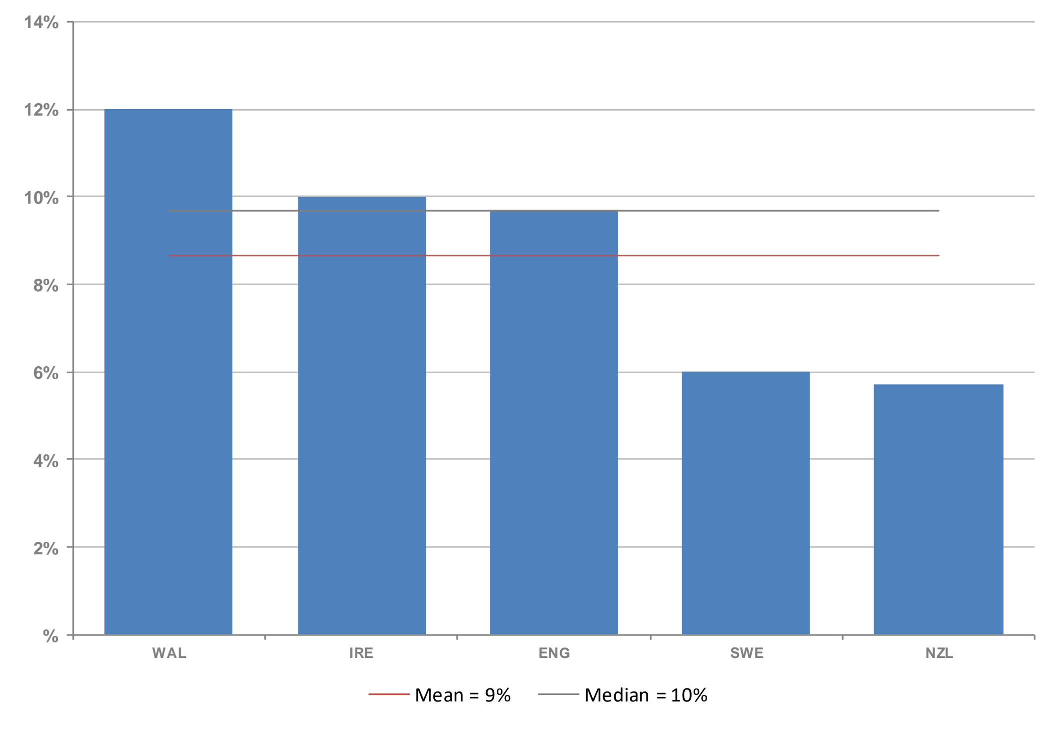
Most children and young people with mental health needs are supported through community based provision. Highest rates are in the Netherlands and Sweden, which report over 10% and 5% respectively of children being able to access specialist mental health care. New Zealand report around 4% of children accessing mental health service each year, close to the participant country average, but report the highest overall service contact rate with over 50,000 contacts delivered per 100,000 children per annum (rates that are also paralleled by Sweden).

Figure for Ireland is children who were new referrals/first appointments during the year

Non-attendance rates for children and young people

Non-attendance rates for children and young people's mental health services are of particular importance, due to the reliance on parents and guardians to facilitate attendance, provide transport and so on in many cases.

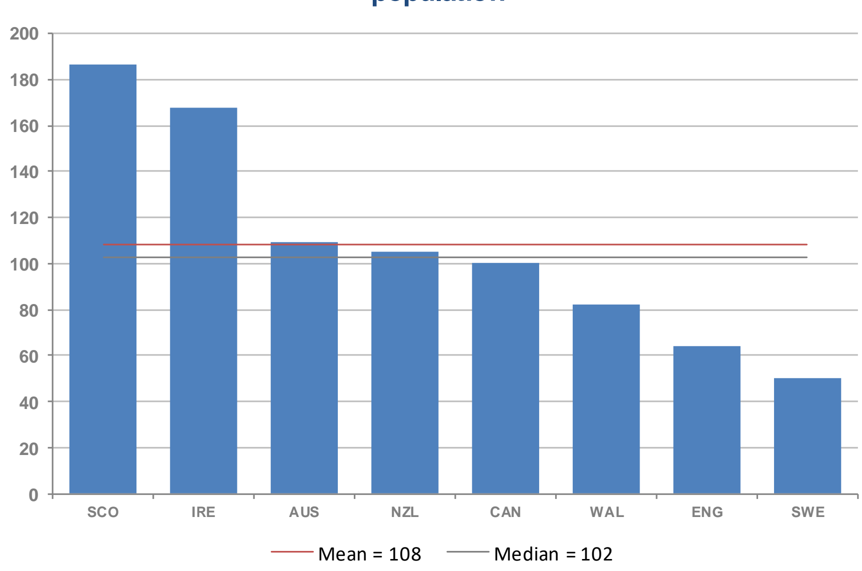
Rates average 10% for all appointments in the most recent cycle of benchmarking.

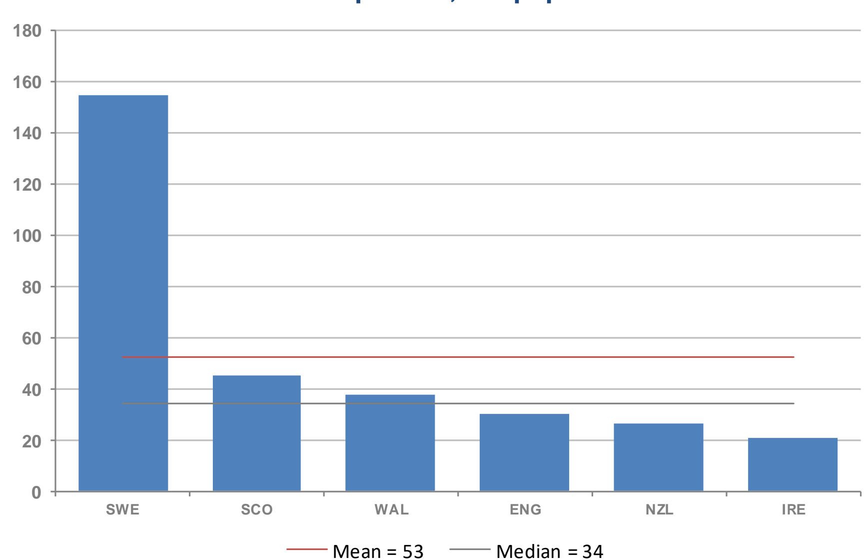


Mental health workforce

The project also received the mental health workforce size and shape in each country. All countries reported issues about the supply and availability of a skilled mental health workforce.

Mental health nursing

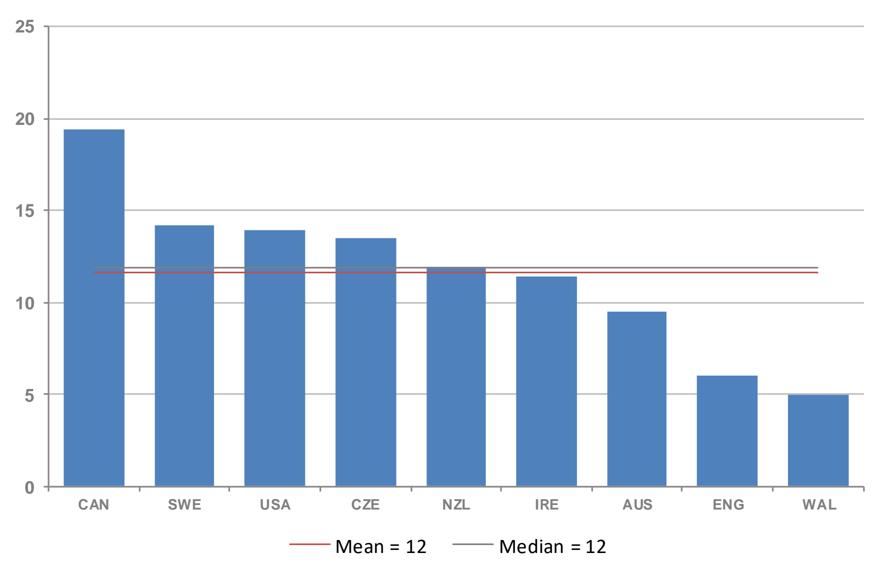


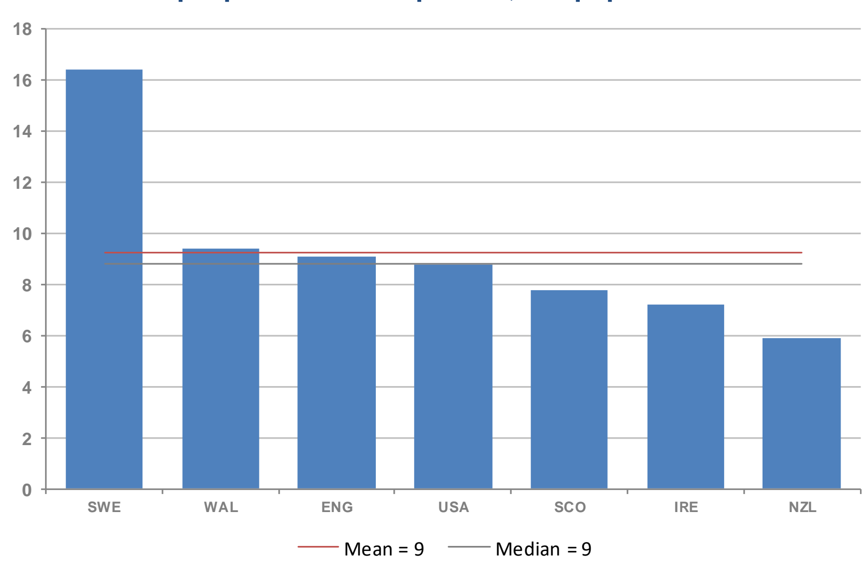


Total specialist mental health nurse levels are shown here. The left hand chart illustrates numbers of nurses working in adult and older adult mental health services per 100,000 population, with an average position of 108. Within children's services, there are 53 full time equivalent specialist mental health nurses per 100,000 population.

Figure for Scotland is nurses in an inpatient setting

Psychiatry





Although there is variation in the setting in which they work, overall rates of Consultant Psychiatrists working in mental health services are relatively similar between countries. The mean and median positions are both equivalent to 12 full time Psychiatrists working in adult mental health services per 100,000 population. For children's services, there are 9 full time equivalent Psychiatrists per 100,000 population.

Outcomes

The project explored the extent to which outcome metrics are used in mental health systems. The project reviewed CROM, PROM, and PREM indicators and also profiled arrangements in place in individual countries.

Clinician reported outcome measures (CROM)

The completeness of recording of outcome metrics can be viewed as a process measure but is also a pre-requisite for the subsequent evaluation of outcomes. HoNOS and HoNOSCA are the most widely reported CROMs. The tables below show data for 4 countries who used these tools with children and adults.

	Children		Adults		Older Adults	
	% of secondary care patients with HoNOSCA recorded	% of those with HoNOSCA recorded who showed significant/reliable improvement	% of secondary care patients with HoNOS recorded	% of those with HoNOS recorded who showed significant/reliable improvement	% of secondary care patients with HoNOS recorded	% of those with HoNOS recorded who showed significant/reliable improvement
	29%	59%	23%	73%	44%	68%
	55%	65%	57%	63%	64%	45%
	67%		73%			
			70%		70%	

Figure for England is percentage of people on CPA with HONOS recorded.
https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

Patient reported outcome measures (PROM)

The use of PROM measures creates a powerful patient perspective on the relative value of mental health services. PROMs directly relate to patient views on a number of themes including; achievement of goals, level of functioning, and change in symptoms. The extended use of PROMs in all aspects of healthcare is central to the challenge of value based healthcare and is recognised by a large number of national and international bodies (including the Organisation for Economic Cooperation and Development).

Children	
Measures used	% of secondary care patients with outcome data recorded
Strengths and Difficulties Questionnaire (child and parent)	
HoNOSCA-SR	40%

Adults / Older Adults	
Measures used	% of secondary care patients with outcome data recorded
Mental Health Inventory (MHI-38) Behaviour and Symptoms Identification Scale (BASIS-32) Kessler-10 Plus (K-10+)	
BSCL (SCL)	31%

Outcome measures

Case study: Sweden

A variety of different tools, depending on the register / condition:

Register name	Condition	Register coverage	Outcome measure/s
BUSA	ADHD	7% of relevant patients	ASRS v1.1.
Q-BUP	Psychiatric care for children	26% of relevant patients	KIDSSCREEN-10, SDQ and HoNOSCA
SBR	Addiction	27% of relevant patients	EQ-SD, AUDIT and DUDIT.
RättspsyK	Forensic care	85% of relevant patients	VAS for self-rated perceived psychological and physical health, quality of life and risk of recurrence of crime.
RIKSÄT	Eating disorders	>95% of clinics	CIA and EDE-Q
BipoläR	Bipolar disorders	18% of relevant patients	HRQoL, EQ-5D and AUDIT.
SibeR	Internet treatment	5 clinics	HRQoL, EQ-5D, MADRS-S, PDSS-SR, LSAS-SR, PHQ-9

Patient reported experience measures

Case study: Sweden

A variety of different tools, depending on the register / condition:

Register name	Condition	Register coverage	Experience measure/s
BUSA	ADHD	7% of relevant patients	GAF and CGAS
RIKSÄT	Eating disorders	>95% of clinics	TSS-2, GAF and CGI
BipoläR	Bipolar disorders	18% of relevant patients	Participation, information, sleep, treatment and GAF

Outcome measures

Case study: New Zealand

ADOM (Alcohol and Drug Outcome Measure) is a self-rated, clinician facilitated outcome tool. It has 20 questions over three sections:

- Section 1: Alcohol and other drug use frequency and amounts
- Section 2: Lifestyle and wellbeing
- Section 3: Recovery

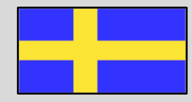
This is a mandated tool and validated for use in outpatient, community settings with people 18 years and over. ADOM is undertaken at treatment start, at 12-week intervals and at treatment end.

From July 2015 when ADOM was first mandated, to March 2019 there have been over 29,000 start collections, all collections are fed into PRIMHD.

ADOM has been used to show treatment efficacy and reports using ADOM data have been published nationally, as well as research leading to several articles in peer reviewed journals.

Service user voice

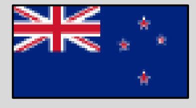
Case study: Sweden



Most clinics in Sweden use user councils in order to solicit the user's perspective. A user council can be made up of users and/or parents, guardians or relatives. Clinics have set up individual structures to incorporate the user councils and their views within the management and decisions making processes locally.

All county councils and regions in Sweden have been involved in the National Patient Survey since 2009. The work is coordinated by the Swedish Association of Local Authorities and Regions. By repeating measurements they have continuously collected knowledge about patients' views on the care received. National joint surveys are conducted every two years in primary care, Somatic outpatient and inpatient, emergency, psychiatric outpatient and inpatient care, outpatient and inpatient care for children and child psychiatry.

Case study: New Zealand



Mārama Real Time Feedback is a tablet-based consumer experience survey used across most DHBs in New Zealand. People that access services are asked to touch screen on 7 standard questions and up to two locally based questions, this data is fed into a repository and aggregated to provide consumer experience scores that can be used by individual services and/or regions to improve service delivery.

Suicide

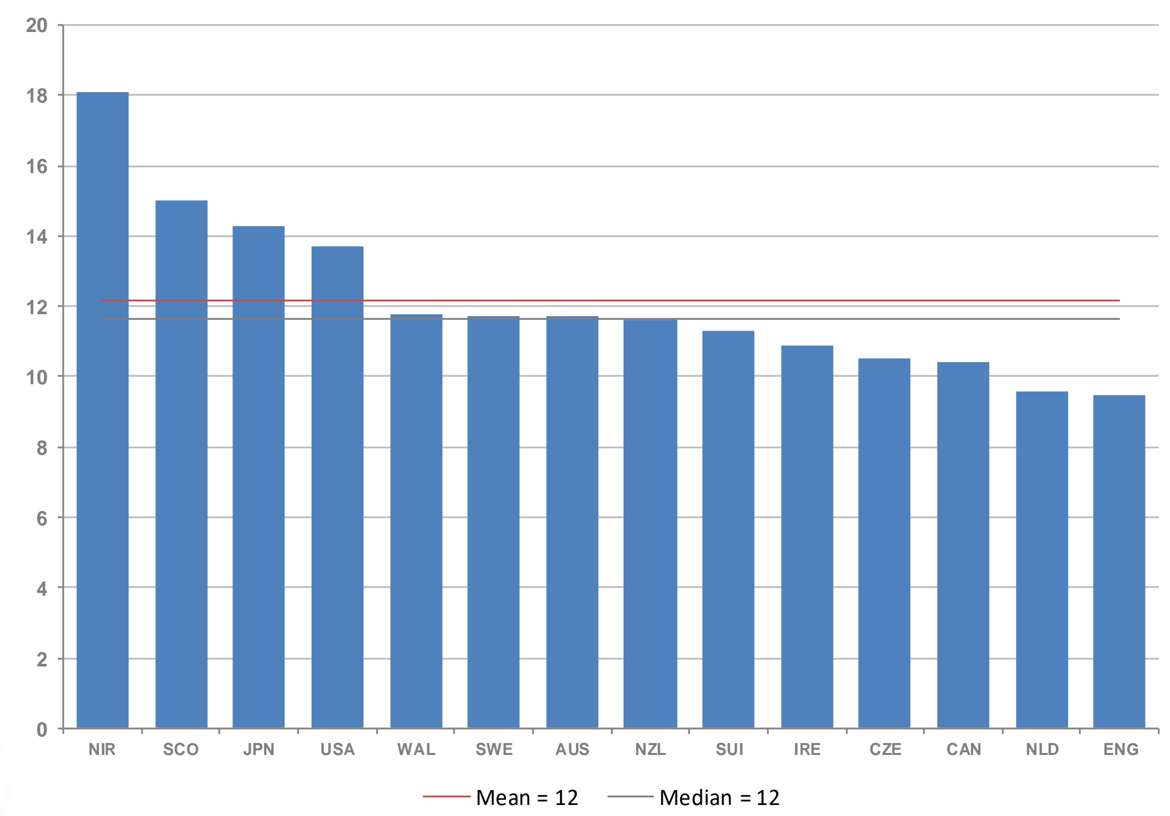
The chart shows 2016 figures for Age Standardised suicide rates per 100,000 population.

This data considers whole population suicide rates and is not exclusive to those in contact with mental health services. Data from the UK suggests that approximately 26% of suicides annually are from those in contact with specialist mental health services.

This data was not provided through the data collection process, but sourced from the following portals:

http://apps.who.int/gho/data/node.main.MHSUICIDEASDR?lang=en

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registrations *(UK countries)*



Conclusions

Conclusions

We would like to express our thanks to participant countries for their involvement in the latest cycle of international mental health benchmarking. The work confirms the opportunity for international collaboration and the momentum that exists for the use of evidence in developing strategies for mental health care both across and within countries.

The project's work has been interesting on a number of levels and has engaged countries in the debate about mental health data, definitions, interpretation and analysis. The ability to discuss evidence relating to mental health systems and provision provides a fascinating insight into the challenges facing developed economies in responding to mental health needs in an optimal manner. There are multiple factors that impact on country positions on the different metrics within the project but one of the more relevant common themes is perhaps an increasing sense of stigma reduction in accessing mental health services. This issue is evident in many aspects of the analysis and perhaps plays out most visibly in children and young people's mental health, where there is a shared discourse on the need to respond to perceptions of demand growth and a recognition of mental health being the new morbidity in child health.

The project reveals interesting variations in the comparative data. The reasons for this variation are numerous and include issues around; data completeness, data quality, ability to produce data in line with the project's definitions, the contextual position of each country's health system, resource levels, and performance variations that might exist both within and between countries. Further observations on the project's findings are welcomed from both participants and commentators.

The project's findings show coherence in a number of areas. The inclusion of data relating to children and young people, working age adults, and older people is helpful in enabling a holistic discussion about mental health demand and provision across participant countries. Perhaps the strongest elements of the analysis relate to the data on usage of general psychiatric services. Within this main specialty area, data on; admissions, readmissions, average length of stay, and bed utilisation perhaps offer the most robust comparisons. The use of restrictive practices in the inpatient environment is also a shared area of focus across countries. The extent of provision of specialist mental health services in the community is also a key line of enquiry that remains of central interest to participants. The provision of service quality and outcome metrics also offers key context for interpreting comparative data. The inclusion of strategic measures around relative health system spend are also valuable and highlight variation in national baseline investment levels between countries. This financial data alongside wider data on service access, provision models, quality and outcomes, offers a stimulus to discussions on value based healthcare in mental health.

We are optimistic that the platform provided by the project's work can be extended in future years to include additional countries as well as enabling a wider discourse with international organisations, policy makers, and professional bodies. The NHS Benchmarking Network would hope to provide additional facilitation support to the project and would value feedback from participants on the value of the project's work. We have found the experience of working with countries to be rewarding and stimulating as has the process of discussion enabled by the IIMHL leadership exchange and supporting match structures. For further information about any aspects of the project's work please contact Stephen Watkins s.watkins@nhs.net or Zoe Morris zoe.morris@nhs.net.

Appendix A

Further reading

Some links may be in local language where English version is not available online

Mental health policies

National (or state-wide) mental health policies

https://www.rijksoverheid.nl/onderwerpen/geestelijke-gezondheidszorg/basis-ggz-en-gespecialiseerde-ggz

http://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en

http://gov.wales/topics/health/nhswales/mental-health-services/policy/dementia/?lang=en

https://gweddill.gov.wales/docs/dhss/publications/110302dementiaen.pdf

https://www.goodpractice.wales/t4cyp

http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG_0_1.pdf

Clinical pathways

National (or regional) clinical pathways for mental health conditions

https://www.vardochinsats.se/

https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways

https://www.nice.org.uk/

Data and metrics

National and regional indicator sets for mental health services

https://www.uppdragpsykiskhalsa.se/assets/uploads/2019/05/VUP_2019.pdf

https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-indicators

Appendix B

Project data specification

INTERNATIONAL MENTAL HEALTH BENCHMARKING 2019

COUNTRY

Completed Data collection templates should be returned to Zoe Morris at zoe.morris@nhs.net by 15th July 2019

Reporting period

Please provide data for your most recent financial year, and indicate here which 12 month time period this is e.g. January - December 2018 or April 2018 to March 2019 for example

Population Denominators

	Children	Adults	Older Adults (if separate to adults)	Country Totals
Please describe your age band for each category (e.g. Children = 0-16 years)				
Please provide the national population for this age group				

National Policy

	Children	Adults	Older Adults (if separate to adults)	*Any Additional Comments by Country*
Do you have a national (or state-wide) mental health policy for this age group? If yes, please provide a link to where it is published online				
Do you have any national (or state-wide) targets relating to access e.g. maximum waiting times for treatment? If yes, please describe (including waiting times)				
Do you have a national / regional published indicator set for mental health services? (please provide hyperlink if available)				
Do you have national / regional published clinical pathways for mental health conditions? (please provide hyperlinks if available)				
Do you have a process of national or regional quality ratings for providers? If yes, please describe.				
What is your main clinical nomenclature for recording care needs? E.g. ICD, DSM etc				

Mental Health Service Access

Number of people who accessed specialist mental health services in 2018/19 *(specialist excludes general primary care services)*				
Number of people who accessed primary care based mental health services in 2018/19				

Finance Summary

Please detail the currency you are using for these questions			
	Children	Adults	Total
Total country expenditure on healthcare 2018/19 (currency listed above)			
Total country expenditure on mental health services 2018/19 (currency listed above) - including addiction services			
Total country expenditure on mental health services 2018/19 (currency listed above) - excluding addiction services			
Percentage of Total healthcare expenditure on mental healthcare in 2018/19 (currency listed above) - including addiction services			
Percentage of Total healthcare expenditure on mental healthcare in 2018/19 - (currency listed above) - excluding addiction services			
Expenditure per capita on mental health services 2018/19 (currency listed above) - including addiction services			
Expenditure per capita on mental health services 2018/19 (currency listed above) - excluding addiction services			

Finance Detail

	Children	Adults	Total
Primary Care mental health services (excluding prescribing)			
Specialist mental health care (see definition below)			
Total Mental Health services	-	-	-
Primary care mental health prescribing			
Specialist mental health care prescribing			
Total Mental Health prescribing	-	-	-
Substance misuse expenditure inc. prescribing			
Total expenditure - Mental Health & Substance Misuse (services and prescribing)	-	-	-

Scope of **Specialist Mental Health Services**, including inpatient care, community care, and secondary care prescribing	Please answer "Yes" if they are within scope in your country	
Day Care Services		Yes / No dropdown
Crisis Resolution Team / Home Treatment		Yes / No dropdown
Community Mental Health Teams		Yes / No dropdown
Assertive Outreach Team		Yes / No dropdown
Rehabilitation & Recovery Services		Yes / No dropdown
General Psychiatry		Yes / No dropdown
Psychiatric Liaison		Yes / No dropdown
Psychotherapy Service		Yes / No dropdown
Young Onset Dementia		Yes / No dropdown
Personality Disorder Service		Yes / No dropdown
Early Intervention in Psychosis Team		Yes / No dropdown
Assessment and Brief Intervention		Yes / No dropdown
Memory Services / Dementia Services		Yes / No dropdown
Forensic Services		Yes / No dropdown
Autistic Spectrum Disorder Service		Yes / No dropdown
Peri-Natal Mental Illness / Mother and baby		Yes / No dropdown
Eating Disorders		Yes / No dropdown
Criminal Justice Liaison and Diversion Service		Yes / No dropdown
Prison Psychiatric Inreach Service		Yes / No dropdown
Asylum Seekers Service		Yes / No dropdown
Psychiatric Intensive Care		Yes / No dropdown
Continuing Care / Longer Term Complex Care		Yes / No dropdown
Employment Services for mental health service users		Yes / No dropdown
Accommodation Services for mental health service users		Yes / No dropdown
Neurodevelopmental services		Yes / No dropdown
Other mental health services		Yes / No dropdown

Excess Mortality

Excess mortality; Age-Sex Standardised Ratio (ages 15-74)	
Estimated national position on average years of life lost for people suffering from severe mental illness (from local data sources)	
Service user population to whom this refers e.g. primary care or secondary care service users	
Please give the source of these figures e.g. nationally reported (include link where possible); independent research study etc	

Are any other measures being used, for example life expectancy? Please give details.	

If you have additional information on excess mortality by different ethnic groups and/or by disease, please provide details	

Social Determinants of Health

Question	Response
What do you know about the accommodation and employment status of mental health service users in your country?	
Do services routinely collect the accommodation status of patients in contact with services?	
Proportion of patients in contact with specialist community mental health services who are in settled accommodation	
Proportion of patients in contact with inpatient mental health services who are in settled accommodation	
Do services routinely collect the employment status of patients in contact with them?	
Proportion of patients in contact with community mental health services who are in employment	
Proportion of patients in contact with inpatient mental health services who are in employment (at the point of admission)	
Do you have any national initiatives relating to supporting people with severe mental illness into employment? If yes, please detail.	
Do you have any data on people with mental ill health receiving state benefits, for example people receiving state benefits for a mental illness condition, or proportion of all state benefit recipients who are estimated to have a mental illness (even if this is not the main reason for their benefit claim)? Please give details and context (e.g. national, regional, state wide measures)	
Do you have any local initiatives relating to physical healthcare support / liaison for mental health service users. For example, a standard around physical healthcare checks on an annual basis, or at the point of admission to inpatient care? Please give details.	

CORE DATA SPECIFICATION (repeated from 2018 project)

	Acute inpatient	Psychiatric intensive care unit (PICU)	Perinatal Mental Health	Eating Disorders	Sub Total General Psychiatry (Adults)		Old Age Psychiatry Services	Longer Term Care / Rehabilitation services
Activity								
Number of inpatient beds								
Number of available bed days 2018/19								
Number of occupied bed days 2018/19 excluding leave								
Number of occupied bed days 2018/19 including leave								
Number of admissions to inpatient mental health care 2018/19								
Emergency readmission rate %								
Number of discharges from inpatient mental health care 2018/19								
Detention rate % (percentage of admissions that were involuntary, i.e. admissions that were mandated under local mental health act legislation)								
Mean average length of stay including leave								
Mean average length of stay excluding leave								
Median average length of stay including leave								
Median average length of stay excluding leave								
Restrictive practices								
Number of times seclusion was used 2018/19								
Number of patients who were placed in seclusion 2018/19								
Number of times involuntary sedative medication was used without consent i.e. rapid tranquilisation								
Number of times restraint was used 2018/19								
Number of patients who were restrained 2018/19								
Number of times prone restraint was used 2018/19								
Number of patients who were restrained in a prone position 2018/19								
If you have a national or regional/state level definition of restraint, please provide here (or link to publication)								
If you collect any data relating to differences in use of restrictive practices against certain groups e.g. ethnicity / indigenous groups / gender please detail here and/or provide links to local publications on this area								

Number of Consultant Psychiatrists i.e. fully qualified Psychiatrists no longer in formal training (Full-Time Equivalent) Inpatient Care			
Number of Qualified Mental Health Nurses and Qualified Nurses Practising in Mental Health Services (Full-Time Equivalent) Inpatient Care			
Number of Consultant Psychiatrists i.e. fully qualified Psychiatrists no longer in training (Full-Time Equivalent) Total (all care settings)			
Number of Qualified Mental Health Nurses and Qualified Nurses Practising in Mental Health Services (Full-Time Equivalent) Total (all care settings)			

Outpatient Clinics for Mental Health	Working age adults	Older adults	Total
Number of individual patients who attend outpatient clinics in 2018/19			
Number of face to face contacts delivered 2018/19			

Specialist Community Mental Health Services (all Team Types)	Working age adults	Older adults	Total
Non attendance rate for first appointments - %			
Non attendance rate for follow up appointments - %			
Non attendance rate for all appointments - %			
Number of individual patients under the care of community teams 2018/19			
Number of face to face contacts delivered 2018/19			
Number of non face to face contacts delivered 2018/19			
Total number of contacts delivered 2018/19			
Additional services for number of people with common mental health problems - total number of patients receiving care in year			
Additional services for number of people with common mental health problems - total number of contacts delivered in year			

Percentage of patients who received a follow up within the locally mandated or locally recommended period following discharge from inpatient care (e.g. follow up within 7 days or 14 days of discharge)			
What is the period of time you have reported on above? E.g. 7 days, 14 days or other			

CORE DATA SPECIFICATION - FORENSIC CARE

Forensic Care is typically described as locked facilities providing care to service users principally with an offending history and / or sent to the facility by the Justice system

Please describe the scope of your Forensic inpatient mental health care i.e. Is it for service users who are part of a criminal justice pathway? Do you have different levels of security e.g. medium secure / high secure? Is it provided by public or private providers or both?	
Number of Prison places in country at 31st March 2019 (or most recently available data)	

	Forensic Inpatient Care
Activity	
Number of inpatient beds	
Number of available bed days 2018/19	
Number of occupied bed days 2018/19 excluding leave	
Number of occupied bed days 2018/19 including leave	
Number of admissions to inpatient mental health care 2018/19	
Emergency readmission rate %	
Number of discharges from inpatient mental health care 2018/19	
Detention rate % (percentage of admissions that were involuntary, i.e. admissions that were mandated under local mental health act legislation)	
Mean average length of stay including leave	
Mean average length of stay excluding leave	
Median average length of stay including leave	
Median average length of stay excluding leave	
Quality	
Number of times seclusion was used 2018/19	
Number of patients who were placed in seclusion 2018/19	
Number of times restraint was used 2018/19	
Number of patients who were restrained 2018/19	
Number of times prone restraint was used 2018/19	
Number of patients who were restrained in a prone position 2018/19	
Forensic Outpatient Services and Community Teams	
Number of patients on caseload in latest year	
Number of patient contacts in latest year	
Forensic Patient Sheltered Housing Places	
Number of Forensic sheltered housing places available in latest year	

Children and Young People's Mental Health

Defining "Children's Mental Health"		Comments
Which of the following are categorised as children's mental health in your country?		Please answer yes or no. Some of these services may be classed as paediatrics / general child health, learning disabilities or other in your country. We are trying to understand the scope of "children's mental health" in each country and what is included / excluded within local definitions.
Antenatal / perinatal support for mothers		
Early years support for infants e.g. attachment issues		
Parenting programmes		
Emotional disorders		
Conduct / behavioural disorders		
Developmental disorders		
Autism / Spectrum Disorders		

Hospital Care	
	Inpatient psychiatric beds for children / young people
Number of hospital beds for children's mental health	
Number of admissions 2018/19	
Number of available bed days 2018/19	
Number of occupied bed days (excluding leave) 2018/19	
Number of occupied bed days (including leave) 2018/19	
Acute average length of stay (excluding leave) - days	
Acute average length of stay (including leave) - days	
Number of incidences of use of restraint 2018/19	
Number of incidences of use of prone restraint 2018/19	
Number of incidences of use of seclusion 2018/19	
Do you feel demand has been increasing, decreasing or staying the same in the last 10 years? Please provide data relating to numbers of admissions or changes in bed numbers if available.	

Community Care	
If you have specialist mental health services for children in the community:	
Number of children who accessed specialist community mental health support during 2018/19	
Number of contacts delivered to children in the community during 2018/19	
Median average waiting time from referral to assessment	
Median average waiting time from referral to start of treatment	
Non attendance rate for first appointments - %	
Non attendance rate for follow up appointments - %	
Non attendance rate for all appointments - %	
Do you feel demand has been increasing, decreasing or staying the same in the last 10 years? Please provide data relating to numbers of referrals or activity if you have this.	

Education	
Please describe the role education (schools / colleges) play in children's mental health provision e.g. detection, mental health promotion, in-house counselling. This may be a formal requirement or a widely adopted approach.	

Suicide		Comments
Number of suicides for 0-18 year olds inclusive (2018/19 or most recent 12 months available)		Whole population suicides for this age group, not just in children known to mental health services. Please provide latest available annual data position.
Suicides per 100,000 population aged 0-18 inclusive (2018/19 or most recent 12 months available)		
Please detail if these are confirmed or suspected, and the time period being reported.		

Workforce	
Proportion of primary schools have an in-house counsellor / other mental health professional - %	
Proportion of secondary schools have an in-house counsellor / other mental health professional - %	

Number of FTE working in children's mental health	Hospitals	Specialist community care	Schools / education	Other	Total
Consultant Psychiatrists					
Registered nurses					
Clinical Psychologists					
Other Clinical Therapists and Practitioners					
Workforce metrics	Hospitals	Specialist community care	Schools / education	Other	
If available, please provide details relating to challenges or successes in relation to workforce metrics over the last 10 years, such as recruitment and retention, vacancies, skills shortages					

Outcome measures

Please provide details of local outcome measures in use in mental health

		Tools used	% of secondary care patients with outcome data recorded	% of secondary care patients with outcome data recorded who showed significant/reliable improvement	Any other comments, evidence or good practice to share e.g. timing of outcome measures (sessional or pre- and post-treatment)
CROMS - Clinician Reported Outcome Measures	Children				
	Working age adults				
	Older adults				
	All age				
PROMS - Patient Reported Outcome Measures	Children				
	Working age adults				
	Older adults				
	All age				

PREMS - Patient Reported Experience Measures	Children				
	Working age adults				
	Older adults				
	All age				

Please summarise how patient user voice (or child and/or parents and guardians) is routinely incorporated into planning and evaluation	Children	
	Working age adults	
	Older adults	
	All age	

Good Practice / Shared Learning

If you have any policies or guidance in these areas you would like to share, please provide details of reference sources and innovations

Children
Adults
Forensic Care
Addictions Care
Physical healthcare (for mental health service users)
Co-morbidities