OECD Health Policy Studies

A New Benchmark for Mental Health Systems

TACKLING THE SOCIAL AND ECONOMIC COSTS OF MENTAL ILL-HEALTH



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Foreword

The burden of mental ill-health is significant. Before the onset of the COVID-19 crisis, an estimated one in two people experienced a mental health condition at some point in their lifetime, and one in five were living with mental ill-health at any given time. Since the start of the COVID-19 crisis, levels of mental distress have increased, with prevalence of anxiety and depression even doubling in some countries.

For more than a decade, the OECD has been highlighting the significant social and economic costs of mental ill-health. Mental ill-health drives economic costs equal to more than 4.2% of GDP, some of which are the direct costs of treatment, but more than a third of which come from indirect costs related to lower employment rates and reduced productivity. These costs are can be avoided, at least in part. A good mental health system helps people to stay in good mental health, and connects those in need to appropriate support, helping people to manage their mental health condition or even fully recover from it.

A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health provides an in-depth analysis of how well countries are delivering the policies and services that matter for good mental health outcomes. The report presents the *OECD Mental Health System Performance Benchmark* which responds to a call made in 2017 by OECD Health Ministers, who asked the OECD to help them better understand mental health performance across countries.

The *Benchmark* is a framework for understanding mental health performance, and includes six dimensions that are critical to mental health performance: from accessible, high-quality and person-centred services, to good prevention and promotion, an integrated and multi-sectoral approach, strong governance and leadership, and a focus on innovation. The *Benchmark* includes 23 indicators, many of which have been newly collected, which help to assess performance across countries along each of these six dimensions. The *Benchmark* is a valuable tool to identify key strengths and weaknesses in mental health system performance, and differences in performance across countries, which are detailed in this report. This report also highlights some of the effective policies that countries are implementing, which are already reducing the burden of mental health conditions on individuals, on societies and on economies.

Yet, overall assessment remains hampered by poor data availability. Countries must invest more in developing stronger and more widely available data on the key dimensions of mental health performance to drive faster and more meaningful improvements. In the years to come, as countries will be able to report a wider and better range of performance indicators, and the OECD will continue to support them in ensuring that these indicators are comparable internationally, the *Benchmark* will become an even stronger tool for measuring and improving mental health system performance. A high-performing mental health system is essential for tackling the high social and economic costs of mental ill-health, and this report helps move countries one step closer to delivering on that goal.

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The preparation and writing of this report was co-ordinated by Emily Hewlett. Chapter 1 was written by Emily Hewlett, Chapters 2 and 3 by José Bijlholt and Emily Hewlett, Chapters 3 and 4 by Emily Hewlett and Yuka Nishina, and Chapters 5 and 6 by Emily Hewlett, with input from José Bijlholt. The OECD Mental Health System Performance Framework was developed by mental health experts and stakeholders from across OECD countries, with co-ordination by Emily Hewlett and Kate Cornford, and with assistance from Lukasz Lech. At the OECD, this report has benefitted significantly from input from Kate Cornford, who helped set the initial conceptual direction of this project, and from advice and input from Frederico Guanais, Rie Fujisawa, Ian Brownwood, Elina Suzuki, Niek Klazinga, David Morgan, Michael Mueller and Duncan MacDonald. The anaylsis of the report, and the range of data reported, has also benefitted significantly from exchanges, insights, and comments from Christopher Prinz and Shunta Takino. Francesca Colombo, Mark Pearson and Stefano Scarpetta provided valuable comments and suggestions at various stages of the project. Hannah Whybrow, Lukasz Lech, and Lucy Hulett provided essential support in the publication process.

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Executive summary

The economic and social costs of mental ill-health are significant. On average, half of people experience a mental health condition at some point in their lifetime. Living with a mental health condition makes it harder to stay in school or employment, harder to study or work effectively, and harder to stay in good physical health. These individual and social costs also have a clear economic dimension – up to 4.2% of GDP – with more than a third of these costs driven by lower rates of employment, and lower productivity at work.

With effective mental health services, and well-targeted and comprehensive mental health policies, these costs can be at least in part avoided. But, most OECD countries have struggled to identify whether their mental health system is delivering effective results. This report, *A New Benchmark for Mental Health Systems,* will help countries to deliver the high-performing mental health systems that are urgently needed.

A benchmark for understanding mental health system performance

The *OECD Mental Health System Performance Benchmark* answers a call from OECD Health Ministers at their meeting at the OECD in 2017 for better tools to understand and improve mental health system performance. The six dimensions of the *Benchmark* were developed by stakeholders and experts from across OECD countries. A high-performing mental health system must:

- Be person-centred, focusing on the individual who is experiencing mental ill-heath;
- Have accessible and high-quality mental health services;
- Take an integrated and multi-sectoral approach to mental health;
- Prevent mental illness and promote mental well-being;
- Have strong leadership and good governance;
- Be future-focused and innovative.

In each dimension, a series of measures of performance were identified or newly collected, to take stock of mental health system performance. At present, OECD countries cannot measure mental health system performance in many of the domains that matter. Of the 23 indicators of the *Benchmark* only two – life satisfaction, and death by suicide – were available for every OECD country, and there are big gaps in OECD's countries ability measure performance in key areas such as levels of stigma, outcomes and functional improvement from treatments, service user and carer experiences, and service coverage.

The state of mental health systems: Significant gaps in performance remain

Despite the remaining gaps in data availability, the *OECD Mental Health System Performance Benchmark* already shows that in all countries, across the six dimensions of the *Benchmark,* there is scope to strengthen performance:

- OECD governments make **person-centred care** a priority in mental health strategies, but nearly 20% of people with a mental health condition reported they were not treated with courtesy and respect during a hospital stay. Only eight countries routinely collect information about people's experiences of and outcomes from mental health care;
- Availability of **accessible and high-quality mental health services** is improving, but 67% of people who wanted mental health care reported they had difficulties getting it, and people with serious mental health conditions still have a much lower life expectancy than the population average;
- When it comes to delivering **an integrated, multi-sectoral approach** systematic integration across mental health, education and employment approaches remains an exception, and not the norm. In all countries people with a mental distress were less likely to be employed, and had a lower level of education, than populations without mental distress;
- **Promoting good mental health and preventing mental illness** is a key part of high performing mental health systems. While the rate of death by suicide is falling, dropping by 21% across OECD countries between 1998 and 2018, during the COVID-19 crisis the prevalence of anxiety and depression doubled in some countries, with young people especially hard-hit;
- A key part of **good mental health system governance and leadership** is acknowledgement of the issues. OECD leaders and Ministers have been speaking out about the importance of mental health. However, while the level of spending on mental health care has increased in OECD countries over the past decade, the share of total health spending dedicated to mental health has only increased significantly in Greece;
- Countries are making their mental health systems more **innovative and future-focused** using new approaches to mental health support such as apps and telemedicine, but a future-focused and innovative mental health system also means ensuring a sustainable workforce, and having a strong data infrastructure to track and improve performance. In both these areas countries are falling short: for example, 11 OECD countries have only one or fewer psychologists per 10 000 population, while all countries struggle to collect a complete set of mental health performance indicators.

Some countries are leading the way with policies to tackle the social and economic costs of mental ill-health

Though there are significant mental health system performance gaps in all countries, there are also countries leading the way in implementing policies to tackle the social and economic costs of mental ill-health. Examples of effective policies to strengthen mental health performance can be found across each of the six dimensions of the OECD *Benchmark*:

- **Person-centred care** is a policy making priority in Ireland, where the office of Mental Health Engagement and Recovery engages service users in the design delivery and evaluation of services, and Australia and New Zealand have focused on peer-delivered services to improve person-centredness;
- To improve **access to services**, for specialist mental health services countries have been using waiting time guarantees or targets (for example, in Denmark), backed by targeted increased funding (in the United Kingdom), while evidence from the Czech Republic highlights that outpatient treatment for severe mental health conditions is an effective *and* cost-effective alternative to inpatient care;
- To strengthen the **cross-sectoral and integrated approach** to mental health, Australia and the United Kingdom collect information from service users on their employment outcomes, and Denmark stands out for having a range of initiatives to bridge mental health and employment

services including “access to the workforce (for somatic and psychiatric patients)” as one of the eight national health care quality goals;

- Children and young people have been a key focus for **promoting good mental health and preventing mental illness**, with countries such as Finland and Iceland which have been focusing on teaching social-emotional skills in schools, and online programmes to support youth mental health in Australia, Norway, and the Netherlands. Canada has made positive mental health promotion a priority with a dedicated Surveillance Framework;
- **Governments and leaders** have prioritised mental health as part of their COVID-19 response plans, and the crisis has galvanised countries to take action: in 2021 Chile – which in 2018 allocated the lowest share of health spending to mental health amongst all OECD countries, at 2.1% of government health spending – announced that the budget for mental health would increase by 310%, and in 2020 Australia doubled entitlement for sessions of psychological therapies. Before the crisis, New Zealand developed the world’s first ‘well-being budget’, England’s anti-stigma campaign (*Time to Change*) has improved awareness and attitudes around mental health, and in Canada leadership by Indigenous communities in delivering better-adapted mental health services serve as an example of a better way to support diverse population groups;
- In recent years there has been an acceleration of **innovative solutions to mental health challenges,** including an explosion in apps and digital tools providing mental health support. In England, these tools are being assessed for effectiveness and listed online to help guide consumers, while in 2020 Canada launched a new portal for mental health resources, Wellness Together Canada, which offers no-cost wellness self-assessment and tracking, self-guided courses, apps, and other resources.

1 Key findings and recommendations

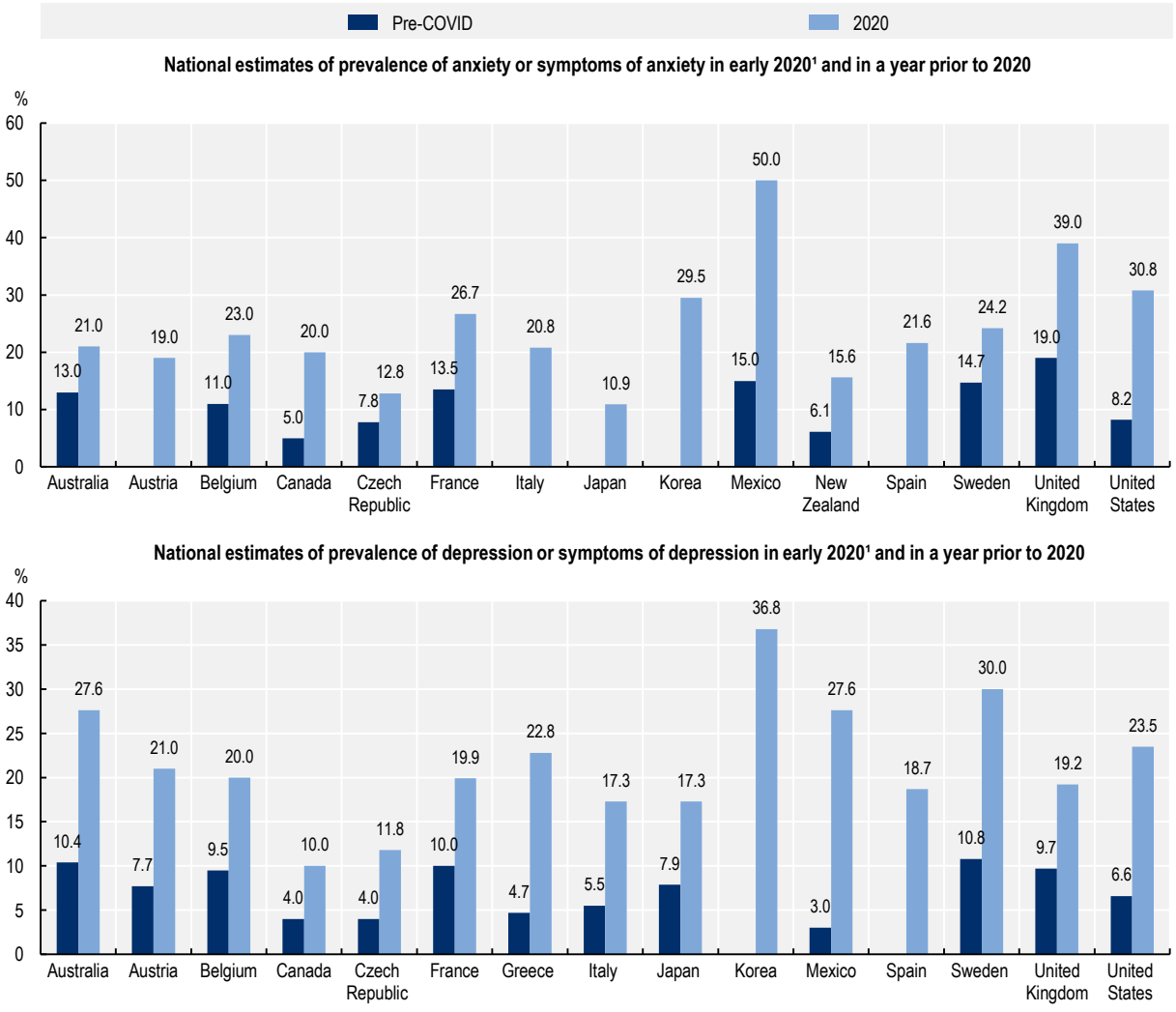
This chapter gives an overview of the main findings of the publication *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health.* The chapter starts by recalling the significant social and economic costs of mental ill-health, and points to evidence that the burden of mental distress has risen during the COVID-19 crisis. The chapter sets out, firstly, how the OECD Mental Health System Performance Benchmark can be used to bring new insights into the strengths and weaknesses of mental health systems. Second, the chapter summarises the main findings in terms of system performance across each of the six principles of the Benchmark, and highlights some of the innovative and effective ways that countries are already working to improve mental health system performance. Finally, this chapter points to some of the next steps for measuring mental health performance, and making the OECD Benchmark an even more valuable tool in the years to come.

Good mental health is essential for people to lead healthy, productive lives, and a cornerstone for strong economies. The burden of mental-ill health is significant; across the OECD countries, up to one in five people are living with a mental health condition at any time, and around one in two people will experience mental ill-health in their lifetime. The economic costs of mental ill-health, including investment in the mental health system, the costs of lower employment and productivity, are equivalent to to more than 4% of GDP (OECD, 2012[1]; OECD/European Union, 2018[2]). For many years in has been clear that mental health provision has not met demand, but overall levels of mental distress had not changed significantly across the past two decades. Data from the Institute for Health Metrics and Evaluation (IHME) and other international sources suggest that prevalence is fairly consistent, and the OECD average has been around 18% since 2002 (IHME, 2018[3]; OECD, 2015[4]).

The COVID-19 crisis across the course of 2020 changed this trend. Overwhelmingly, surveys of OECD populations showed that mental health had worsened in March-April 2020 (Figure 1.1). In Australia 78% of respondents to a survey in late March and early April 2020 reported their mental health had worsened (Newby et al., 2020[5]); in Austria 43.5% of respondents to a survey reported the psychological impacts of the COVID-19 outbreak as moderate or severe (Traunmüller et al., 2020[6]); in the United States 40.9% of 5 470 survey respondents in June 2020 reported an adverse mental or behavioural health condition (Czeisler et al., 2020[7]). Even in Korea and New Zealand, countries widely lauded for their success in containing and supressing the COVID-19 outbreak, mental health status declined: in Korea 40% of survey respondents reported that their mental health had worsened (The Korea Herald, 2020[8]); in New Zealand a survey found that third of respondents experienced psychological distress during the country's April 2020 lockdown (Every-Palmer et al., 2020[9]).

The worsening mental health status of the population across the course of 2020-21 has made strong mental health system performance more important than ever. In many if not most OECD countries, in addition to the deleterious effect that COVID-19 containment measures appear to have had on population mental health, the crisis has increased key risk factors – unemployment, financial insecurity, poverty – for mental illness. It is critical that governments take action to protect mental health, and put in place effective services to treat mental ill-health when it occurs. This report points to gaps where performance needs to be strengthened, but also highlights areas of strength and best practice.

Figure 1.1. The prevalence of anxiety and depression has increased significantly during the COVID-19 crisis



Note: The survey instruments used to measure depression and anxiety differ between countries, and therefore are not directly comparable, and some surveys may have small sample sizes or not use nationally representative samples. Differences in the openness of populations to discussing their mental state also hampers cross-country comparability. To measure the prevalence of symptoms of anxiety, where possible surveys using the GAD 7 instrument have been selected. 2013 data for Sweden uses a cut-off of '8' for the GAD 7, while most other studies use a cut off of ≥10. To measure the prevalence of symptoms of depression, where possible surveys using the PHQ-9 instrument have been selected. 2020 data for Sweden uses a cut-off of '11' for the PHQ-9, while most other studies use a cut off of ≥10.

1. To the extent possible, 2020 prevalence estimates were taken from March-April 2020.

Source: OECD (OECD, 2021[10]), "Tackling the mental health impact of the COVID-19 crisis: An integrated, whole-of-society response", https://doi.org/10.1787/0ccafa0b-en.

Box 1.1. Note on terminology and language

The OECD adopts the World Health Organization's widely-accepted definition of mental health, referring to a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

This report aligns language with ongoing shifts that go hand-in-hand with efforts to raise awareness and address stigma, and to ensure, where possible, language is person-centred, strengths-based, and recovery-focused, and reflects the differing experiences of mental health issues from individual to individual. The broad term "mental ill-health" is used to describe mental and behavioural disorders but also include psychological or mental distress, i.e. symptoms or conditions that do not reach the clinical threshold of a diagnosis within the classification systems but which can account for significant suffering and hardship, and can be enduring and disabling. The terms 'disorders' or 'conditions' are used to apply to symptoms reaching the clinical threshold of a diagnosis according to psychiatric classification systems including disorders such as depression, anxiety, bipolar disorder and schizophrenia amongst many others.

This report recognises that the experience of mental health conditions can be highly fluid – an individual experiencing a moderate depressive episode can worsen and become "severe", just as a severe episode can be stabilised with symptoms lessened or alleviated. This work does not explicitly exclude alcohol or substance abuse disorders, and covers these conditions when appropriate, but does not make these conditions a primary focus as the OECD's current work programme includes relevant ongoing work, for example on preventing harmful alcohol use and opioids.

A framework for benchmarking mental health system performance

High-performing mental health systems have high quality and accessible services, are person-centred, innovative, and multi-sectoral

In 2018, the OECD convened more than 40 mental health experts from across OECD countries, constituting a diverse group of stakeholders with a wide range of experiences and perspectives. These policy makers, experts-by-experience, thought leaders, academics, business and union representatives, clinicians and civil society advocates came together to answer the question "when it comes to mental health, what matters?" Through a day of animated discussion, these experts determined six key principles of mental health performance and a series of sub-principles. These principles and subprinciples make up the OECD Mental Health Performance Benchmarking Framework (Figure 1.2).

Figure 1.2. OECD Mental Health System Performance Framework

1. Focuses on the individual who is experiencing mental ill-health

Individual-centred care should:
- Ensure the individual feels they have ownership of their own care;
- Be respectful and inclusive of the individual, carer (where relevant), and family;
- Ensure care and treatment is tailored to individual needs and preferences;
- Be culturally, age and gender appropriate;
- Empower the individual to realise his or her own potential and contribute to society.

2. Has accessible, high-quality mental health services

Accessible and available high-quality services should:
- Be evidence based;
- Be developed close to the community;
- Be provided in a timely manner;
- Account for and respect the unique needs of vulnerable groups;
- Ensure continuity of care;
- Deliver improvement of individual's condition;
- Be safe.

3. Takes an integrated, multi-sectoral approach to mental health

An integrated, multi-sectoral approach should:
- Pursue a 'mental health in all policies' approach;
- Ensure physical needs are met;
- Involve social protection systems and encourage return to work or education;
- Enable front line actors to connect individuals to appropriate services.

4. Prevents mental illness and promotes mental well-being

Good prevention and promotion policies should:
- Reduce the rate of suicide;
- Ensure mental health literacy;
- Make schools mental health-friendly environments that build resilience;
- Ensure that workplaces foster good mental health;
- Enable front line actors to recognise and respond to mental distress;
- Make it easy for individuals to seek help.

5. Has strong leadership and good governance

Good leadership and governance for mental health should:
- Make mental health a high-level national priority;
- Reduce stigma around mental illness;
- Invest in delivering a high-performing mental health system;
- Prioritise efficient and effective distribution of resources;
- Promote equity geographically, between population groups, and between mental disorders.

6. Is future-focused and innovative

A future-focused and innovative approach should:
- Ensure all services are based on based available evidence;
- Invest in mental health research;
- Promote innovative solutions to mental health challenges;
- Build mental health workforce capacity for future generations;
- Deliver care and services in the most effective and efficient way;
- Build strong information systems for mental health.

Source: OECD (2019[11]), OECD Mental Health Performance Framework, https://www.oecd.org/health/health-systems/OECD-Mental-Health-Performance-Framework-2019.pdf.

It is clear from the Framework that OECD countries view mental health performance as extending beyond the traditional mental health system. A high-performing mental health system must include accessible and high quality services, as well as a person-centred, integrated and multi-sectoral approach, strong leadership, innovation and research, and services and policies that are culturally, age and gender appropriate. These are priorities that also affirm the ambitions of the OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy (Box 1.2).

Box 1.2. OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy

Recognising that mental ill-health demands interventions that are cross-sectoral in scope and complementary in nature, in 2015 the OECD Council adopted the OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy, that includes a detailed set of policy principles, with all OECD countries adhering to the Recommendation along with a number of non-members.

This recommendation is the recognition by OECD countries that good policies can make a significant difference when it comes to preventing mental illness at all ages, including in youth and adolescence, in supporting those experiencing mental illness to stay in the workplace and supporting those who have left employment to return to the labour market. The OECD Recommendation contains a detailed set of policy principles to address the impact of mental ill-health on employment, education, health and social outcomes. These policy principles encourage adherents to embrace approaches to mental health policy including seeking to "promote mental well-being, prevent mental health conditions, and provide appropriate and timely services which recognise the benefits of meaningful work for people living with mental health conditions".

Source: OECD (2015[12]), *Recommendation of the Council on Integrated Mental Health, Skills and Work Policy*, http://legalinstruments.oecd.org.

Measuring mental health performance

At present, OECD countries lack the capacity to measure mental health system performance in many of the domains that matter – as identified in the OECD Mental Health Performance Benchmarking Framework (Figure 1.2). The OECD Mental Health Performance Benchmarking Project and data collection has made available new mental health indicators – for example follow-up after discharge, or repeat contacts with emergency departments. However, the range of available indicators still don't tell us enough about the domains of performance that matter for mental health.

The OECD Mental Health System Performance Benchmark now includes 23 indicators, but only two – life satisfaction, and death by suicide – were available in more than 90% of OECD countries. There is still a big gap in terms of indicators that tell us about levels of stigma, about outcomes and functional improvement from treatments, about patient and carer experiences, about positive mental health, and about service coverage. In some cases (stigma, positive mental health, and experience measures) such data is available in some countries at a national level but not comparable internationally; in other cases such data is available in only a very few or even no countries, currently. For three indicators – patient-reported outcomes, attitudes towards mental health, and use of telemedicine to deliver mental health services – were included even though it is not possible, at this point, to report them in a consistent way across even a few countries, as these indicators would be critical for better understanding performance.

No OECD mental health system delivers excellent performance across the board

Tables 1.1, 1.2 and 1.3 present the OECD Mental Health System Performance Benchmark, including most recently available data at the time of publication. From the Benchmark, it is clear that no OECD country has a high-performing mental health system in all of the areas of the Benchmark. In some areas, even the countries which are doing best cannot really be considered to be delivering excellent performance; for example, even in the countries with the lowest rates of unmet need for mental health care, 30% or more

of the population report some unmet need for mental health care. In all countries, though, it is clear from the available indicators to populate the Benchmark that both understanding and improving mental health performance are limited by a lack of relevant data. Though some countries stand out as having rich and relevant sources of mental health data – including Australia, England, Denmark, Ireland, the Netherlands, and Norway – there is a need to accelerate the use of outcome measures and patient-reported measures.

A close examination of the available data on mental health performance, an examination of mental health policies and practices, and a review of available academic literature reveals some key trends:

- Mental health has been a long-neglected area, but this is beginning to change; **significant attention from some governments and leaders** – in Australia, in Canada, in New Zealand, in Norway, in the United Kingdom – is testament to global momentum around mental health. In some cases this has been accompanied by new high-level strategies or funding, in all instances such signals can be an important way to **raise awareness and reduce stigma**. However, despite growing attention to mental health, and in some cases increases in funding and service provision, OECD countries on average have **not significantly increased funding for mental health**;
- Even before the COVID-19 crisis, promoting good mental health and preventing mental illness was critical, but the rising levels of mental distress make it even more important for countries to **ensure that policies are in place to support mental resilience, reduce mental health stigma and increase mental health literacy.** Countries such as Finland and Iceland have been focusing on teaching social-emotional skills in schools, and online programmes are also being used to support youth mental health in Australia, Norway, and the Netherlands. More than half of OECD countries have national or regional mental health awareness programmes, and though few have been evaluated over time, where they have – for example England's '*Time to Change*' - a positive impact on attitudes to mental health was found;
- In many countries there have been **clear efforts to increase access to mental health services** and reduce waiting times, especially for talking therapies. Digital technologies, including **telephone and online talking therapies and app-based courses** on mindfulness or coping skills, or self-management are a booming area further accelerated by COVID-19, and can help reduce unmet need for mental health support, which is high. Many represent good value-for-money;
- Data on quality and outcomes of care, for example on excess mortality or repeat hospital admissions or emergency department contacts, point to **shortcomings in continuity of care and ongoing difficulties with improving outcomes**, especially for **people with severe mental health conditions**;
- **Person-centred and integrated policies and services are priorities** in many OECD countries, but are proving **harder to deliver in practice**. In many respects, the mental health sector has led the way in prioritising voice, choice, and co-production for service users but more needs to be done to ensure that person-centred care is not tokenistic, and **increased co-production – where service users contribute significantly to the design and even delivery of mental health services –** stands out as one way to do this;
- The **COVID-19 crisis has also reinforced the importance of integrated, multi-sectoral mental health policies, which focus on strengthening mental well-being**. Young people, unemployed people, and people experiencing financial difficulties face significant mental distress. Mental health services will need to be scaled-up to meet this demand, but many people would benefit from low-threshold support such as app- or phone-based wellness activities, peer support or community group support structures, or exercise programmes as well as or even instead of medical care, and interventions in schools, workplaces, unemployment services, health care and social care institutions can be invaluable. It is clear from this work on Benchmarking, as well as from the I**nterim Report on the Implementation of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy,** that examples of initiatives to integrate services can be found

across OECD countries, especially in youth support systems. Despite this, **systematic inclusion of work or employment outcomes** in mental health service delivery and of mental health outcomes in employment support services remains a**n exception, and not the norm**;

- Focusing on the **future of mental health systems demands a dual focus on innovation, and on sustainability and improving existing services**. Many countries are focusing on innovative ways – primarily using **apps and other digital technologies** – to increase access to mental health support. A **sustainable mental health system also requires enough human resources**, and mental health workers per capita **vary significantly** across OECD countries. Workforce innovation is a priority in some countries, with growing leadership by **peer workers** in Australia and New Zealand, and efforts across many countries to increase **the mental health knowledge and skills of front line workers** such as teachers, paramedics, and emergency department staff.

Table 1.1. OECD Mental Health System Performance Benchmark – Principles 1 and 2: Person-centred, high quality and accessible services

	Principle 1. Focuses on the individual who is experiencing mental ill-health				Principle 2. Accessible, high-quality mental health services					
	• individual ownership of care • respectful of user, carer, family • treatment tailored to individual's wishes, age, gender, culture • empowers the individual				*• evidence-based • community-based • timely • accounts for needs of vulnerable groups • continuity of care • delivers improvement • is safe •*					
Benchmarking Indicators	Care Plans in mental health service involve[1]:		Patient-reported outcomes – OECD PROM Pilot	People with a mental health problem who reported being treated with courtesy and respect by doctors and nurses during hospitalisation [%][2] [3]	Unmet needs for mental health care due to financial, wait times, or transport [%][4]	Repeat admissions to inpatient care [3 or more times in 1 year, %][1]	Number of people in who accessed specialist mental health services, per 1 000 population[1]	Mental health services covered in full or in part by basic health[1]		
	Service User	Carer or Representative						Psychological Therapies	Drug or Alcohol Counselling	Outpatient Services
OECD	22	20	---	80.6%	67.20%	12.11%	31.5	25	25	25
Australia	✓		---	84%				PART	PART	FULL
Austria	✓	✓	---		56.70%			PART	FULL	FULL
Belgium	✓	✓	---			4.80%		PART	PART	PART
Canada	✓	✓	---	78%		12.80%	37.2	PART	PART	PART
Chile			---							
Colombia			---							
Costa Rica			---							
Czech Republic			---		59.70%			FULL	FULL	FULL
Denmark	✓	✓	---		75.80%	34.50%	21.9	PART	FULL	FULL
Estonia	✓	✓	---					PART	FULL	FULL
Finland			---		59.50%					
France			---	89%	66.00%					
Germany			---	76%	73.50%					
Greece	✓	✓	---		70.00%		4.6	PART	FULL	PART
Hungary			---		70.60%					
Iceland	✓	✓	---		79.50%			PART	PART	PART
Ireland	✓	✓	---		84.30%		7.6	FULL	FULL	FULL
Israel	✓	✓	---			12.30%		FULL	PART	FULL

Italy		✓	---		70.50%		16.9	FULL	FULL	FULL
Japan	✓	✓	---				36.2	PART	PART	PART
Korea	✓	✓	---					FULL	FULL	FULL
Latvia	✓	✓	---		79.10%	9.00%		FULL	FULL	FULL
Lithuania	✓	✓	---		29.60%	11.00%		FULL	FULL	FULL
Luxembourg	✓		---		82.50%	12.20%		PART	PART	PART
Mexico			---				0.2	PART	PART	PART
Netherlands	✓	✓	---	81%		7.00%	58.9	FULL	FULL	FULL
New Zealand	✓		---	88%			38.5			
Norway	✓	✓	---	95%	47.60%	22.10%	47.8	PART	PART	PART
Poland	✓	✓	---		75.20%	4.70%	39.7	FULL	FULL	FULL
Portugal			---		63.50%					
Slovak Republic			---		29.20%					
Slovenia	✓	✓	---		88.00%	6.50%		FULL	FULL	FULL
Spain			---		64.50%					
Sweden			---	88%	73.20%		59			
Switzerland			---	81%				PART	PART	PART
Turkey	✓	✓	---			8.40%		FULL	FULL	FULL
United Kingdom*	✓	✓	---	64%	79.90%		41.1	FULL	FULL	FULL
United States			---	82%						

Note: Where data for at least nine countries was available, a colour-code is used in the tables to divide countries in three groups to indicate whether each country was above average (upper third), around average (middle third), and below average (bottom third). Above average performance is shaded in green, around average performance is shaded in orange, and below average performance is shaded in red. In the cases where categorical variables from the OECD Mental Health Performance Benchmarking Policy Questionnaire were used colour coding was not applied.

*England, [1]People with a mental health problem are people who responded 'yes' to adults who responded "yes" to "Have you ever been told by a doctor that you have depression, anxiety or other mental health problems", hospitalisation is not necessarily for mental health reasons; [2]Share of those with mental distress who wanted help, but could not get it due to financial or wait times or transport;

Source: [3]OECD (2020[13]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires; [4]OECD based on Commonwealth Fund International Health Policy Survey 2020 (forthcoming[14]) and (2016[15]), [5]EHIS-2, GEDA – see OECD (forthcoming[16]), *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation*.

Table 1.2. OECD Mental Health System Performance Benchmark – Principles 3 and 4: Integrated and multi-sectoral, prioritises prevention and promotion

	Principle 3. Takes an integrated, multi-sectoral approach to mental health • mental health in all policies • physical health needs met • involves social protection systems • promotes return to work or education • front line actors to connect individuals to appropriate services •									Principle 4. Prevents mental illness and promotes mental well-being • reduce suicide • ensure mental health literacy • mental health friendly schools that build resilience • workplaces foster good mental health • easy to seek help •					
Benchmarking Indicators	Rate of higher education (ISCED three educational groups) of those with mental distress to those without other disabilities or mental distress [Value of 100 means that people with mental distress are equally likely have higher education as those without][3]	Employment rate of those with mental distress to those without other disabilities or mental distress [Value of 100 means that people with mental distress are equally likely to be employed as those without][3]	Mental health training is provided to front line actors[1]							Life Satisfaction (Average score) – OECD Better Life Index[4]	Death by suicide, rate per 100 000 population[2]	Services that can be accessed without referral[1]:			
			Teachers	Emergency Department Staff	Paramedics	General Practitioners/Family Doctors	Fire Department	Police	Unemployment Staff/Counsellors			Self-referral directly to services	National telephone hotline	Web-based information	Emergency Department
OECD	78.7	79.8	19	21	16	23	18	19	16	7.2	11.07	24	19	19	20
Australia			✓				✓	✓	✓	7.6	12.80	✓	✓	✓	✓
Austria	74.9	76.2	✓	✓	✓	✓	✓	✓	✓	8.0	12.40	✓			
Belgium	71.0	78.0	✓	✓	✓	✓	✓	✓	✓	7.6	15.90	✓			
Canada	81.9	85.4	✓	✓	✓	✓	✓	✓	✓	8.1	11.00	✓	✓	✓	✓
Chile	65.4	81.1								-	10.70				
Colombia										8.3	5.70				
Costa Rica										-	5.70				
Czech Republic	79.7	87.4		✓		✓		✓	✓	7.4	12.40	✓	✓	✓	✓
Denmark	83.3	73.8		✓		✓	✓	✓	✓	8.0	9.40	✓	✓	✓	✓
Estonia	84.6	84.4	✓	✓	✓	✓	✓	✓	✓	7.0	13.60	✓	✓	✓	✓
Finland	86.7	75.1	✓	✓		✓				8.1	14.60				
France	90.1	85.5								7.3	12.30				

Germany	62.7	84.0								7.4	9.50				
Greece	79.0	76.8	✓	✓		✓				6.4	4.00	✓			
Hungary	59.1	68.4								6.5	15.10				
Iceland	64.6	71.8	✓	✓	✓	✓	✓	✓		7.9	9.70				
Ireland	87.0	83.0	✓	✓	✓	✓	✓	✓	✓	8.1	9.30	✓	✓	✓	✓
Israel	74.1	78.2		✓	✓	✓	✓			-	5.50	✓	✓		✓
Italy	86.0	90.0		✓						7.1	5.50	✓		✓	✓
Japan	95.8	96.4	✓			✓	✓	✓		-	14.90	✓		✓	✓
Korea			✓	✓	✓	✓	✓	✓		6.1	23.00	✓	✓	✓	✓
Latvia	90.9	81.7	✓			✓				6.7	18.10	✓	✓	✓	✓
Lithuania	86.7	83.1	✓	✓	✓	✓	✓	✓		6.7	22.20	✓	✓	✓	✓
Luxembourg	67.4	85.1								7.6	7.20	✓	✓		✓
Mexico			✓			✓		✓		8.0	5.50				
Netherlands	77.4	76.0	✓	✓	✓	✓	✓	✓	✓	7.8	10.60	✓	✓	✓	✓
New Zealand	84.6	82.1	✓	✓	✓	✓	✓	✓	✓	7.8	11.70	✓	✓	✓	✓
Norway	67.3	68.8		✓	✓	✓				8.0	11.60	✓	✓	✓	
Poland	85.2	77.0	✓	✓	✓	✓				7.8	11.10	✓	✓	✓	✓
Portugal	74.6	82.4								6.7	8.80				
Slovak Republic	69.5	78.2								7.1	9.70				
Slovenia	103.1	79.5	✓	✓	✓	✓	✓	✓	✓	7.3	17.30	✓	✓	✓	✓
Spain										7.3	7.00				
Sweden	81.4	78.0								7.9	11.40				
Switzerland	76.3	87.5	✓	✓	✓	✓	✓	✓	✓	8.0	11.20	✓	✓	✓	✓
Turkey				✓		✓	✓	✓	✓	5.7	2.60	✓	✓	✓	✓
United Kingdom	64.4	69.9	✓	✓	✓	✓	✓	✓	✓	7.6	7.30	✓	✓	✓	✓
United States	86.5	74.7								-	14.50				

Note: Where data for at least nine countries was available, a colour-code is used in the tables to divide countries in three groups to indicate whether each country was above average (upper third), around average (middle third), and below average (bottom third). Above average performance is shaded in green, around average performance is shaded in orange, and below average performance is shaded in red. In the cases where categorical variables from the OECD Mental Health Performance Benchmarking Policy Questionnaire were used colour coding was not applied.

Source: [1]OECD (2020[13]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires; [2]OECD (2020[17]), OECD Health Statistics; [3]EHIS-2, CCHS, SHS (2012), GEDA, INHIS-3, GSS, NHIS (2013), CSLC, ENCAVI – see OECD (forthcoming[16]), *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation*; [4]OECD (2020[18]), Better Life Index.

Table 1.3. OECD Mental Health System Performance Benchmark – Principles 5 and 6: Mental health leadership and governance that prioritises innovation and sustainability

	Principle 5. Has strong leadership and governance				Principle 6. A future-focused and innovative approach					
	• make mental health a high-level national priority • reduce stigma around mental illness • invest in mental health • efficient and effective use of resources • promote equity - geographically, between populations, between disorders•				*• services based on best available evidence • invest in research • promote innovative solutions • build a sustainable workforce • good mental health data •*					
Benchmarking Indicator	Spending on mental health as % of total government health spending [1] [2]	Levels of stigma attitudes towards mental health		National strategy for key population groups – one or more [1]	Use of telemedicine in mental health services – indicator not internationally available	Workforce capacity [per 1 000 population] [1] [2] [3]			Availability of mental health indicators [1] [4]	
		National or regional attitudes or stigma survey[1]	Attitudes towards mental health – indicator not internationally available			Psychiatrists	Psychologists	Mental Health Nurses	National Mental Health Data Set	OECD HCQO Mental Health Indicators
OECD	6.7%	22		19		0.18	0.53	0.52	19	22
Australia	7.6%	✓	---	✓	---	0.17	1.03	0.91	✓	
Austria		✓	---	✓	---	0.18	1.18		✓	
Belgium			---	✓	---	0.17	0.10	1.26	✓	✓
Canada	10.6%	✓	---	✓	---	0.18	0.49	0.69	✓	✓
Chile	2.1%		---	✓	---	0.10				✓
Colombia		✓	---		---					
Costa RIca										
Czech Republic	4.0%	✓	---	✓	---	0.15	0.03	0.31	✓	✓
Denmark		✓	---	✓	---	0.19	1.62		✓	✓
Estonia	2.9%		---		---	0.19	0.06	0.23		
Finland	5.6%		---		---	0.24	1.09			✓
France	15.0%		---		---	0.23	0.49	0.98		
Germany	11.3%		---		---	0.27	0.50			
Greece	3.9%		---	✓	---	0.26	0.09	0.13	✓	
Hungary			---		---	0.15	0.02	0.34		
Iceland	5.7%	✓	---	✓	---	0.21	1.37	0.00	✓	✓
Ireland	6.0%	✓	---		---	0.19			✓	

Israel			---		---	0.16	0.88			✓
Italy	3.4%		---	✓	---	0.17	0.04	0.23		
Japan	6.2%	✓	---		---	0.13	0.03	0.84	✓	
Korea	3.8%	✓	---	✓	---	0.08			✓	✓
Latvia	5.3%	✓	---	✓	---		0.67	0.23	✓	✓
Lithuania	4.9%	✓	---		---	0.23	0.16	0.50	✓	✓
Luxembourg			---		---	0.21	0.59			
Mexico			---		---	0.01			✓	
Netherlands	8.3%	✓	---	✓	---	0.24			✓	✓
New Zealand	7.0%	✓	---	✓	---	0.19	0.86	0.75		✓
Norway	13.5%	✓	---	✓	---	0.26	1.40	0.66	✓	✓
Poland	4.4%	✓	---		---	0.09	0.16	0.31	✓	✓
Portugal		✓	---		---	0.13				✓
Slovak Republic		✓	---		---					✓
Slovenia		✓	---	✓	---	0.15	0.09	0.36		✓
Spain			---		---	0.11	0.55	0.03		✓
Sweden	9.0%		---		---	0.23	0.99	0.51		✓
Switzerland		✓	---	✓	---	0.52	0.26		✓	✓
Turkey		✓	---	✓	---	0.05	0.03	1.50		
United Kingdom	10.3%	✓	---	✓	---	0.19	0.36	0.53	✓	✓
United States			---		---	0.14	0.30	0.04		

Note: Where data for at least nine countries was available, a colour-code is used in the tables to divide countries in three groups to indicate whether each country was above average (upper third), around average (middle third), and below average (bottom third). Above average performance is shaded in green, around average performance is shaded in orange, and below average performance is shaded in red.

In the cases where categorical variables from the OECD Mental Health Performance Benchmarking Policy Questionnaire were used colour coding was not applied.Source: [1]OECD (2020[13]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires; [2]WHO (2018[19]), Mental Health Atlas 2017; [3]National sources; [4]OECD (2020[17]), OECD Health Statistics.

Principle 1. Person-centred approach: a policy priority that is not sufficiently implemented in routine care

Person-centred mental health is a policy priority in many OECD countries, but proving harder to deliver in practice

In many respects, the mental health sector has led the way compared to other parts of the health system in prioritising mental health service users' voices. Mental health service users are represented in national groups in 85% of OECD countries, and the majority of countries (22 out of 27 responses) require involvement of service user or a representative in their mental health care (e.g. in designing their personal care plan) in at least some settings. Much more needs to be done to ensure that person-centred care is not tokenistic, and increased co-production, where service users contribute significantly to the design and even delivery of mental health services, stands out as one way to do this – Australia, Canada, England and Ireland stand out as countries leading the way in co-produced strategies, policies and services.

Service users of mental health care are increasingly involved in shared decision-making processes around their care, including through the use of personal care plans, engagement in discussion and decisions about how services are run, for instance through service user councils in inpatient settings. Personal mental health care plans with clinicians and service users working together to agree care and treatment decisions, while using evidence-based practices, are one way of incorporating the service users' preferences and values into their care (Slade, 2017[20]; Liverpool et al., 2020[21]), and are used in the majority of OECD countries. The degree of service user engagement also appears to differ.

Collecting patient-reported information on experiences of care is another way to focus attention on delivering person-centred care, and can garner information about how positive or otherwise experiences of care are for the care consumer. A number of countries have large-scale national surveys of mental health service users, for example New Zealand's 'Ngā Poutama survey for consumers' was administered in 2018. In countries including Australia, Canada, Denmark, Norway, Israel, and the United Kingdom service users are one of the principal assessors of whether care delivered is effective, safe, and high quality using tools such as Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMS).

However, patient-reported measures show some signs of gaps between the widely held policy principle of person-centred mental health care, and the experience of mental health service users. In 2020, as in 2016, responses to the the Commonwealth Fund International Health Policy Survey in 11 countries showed that people who reported having a mental health problem were less likely to report being treated with courtesy and respect during a hospital stay than people without a mental health problem (includes hospital stays for any health condition, not only mental health care) (The Commonwealth Fund, forthcoming[14]). On average, there was a 10 percentage point gap between people who did not report a mental health problem and reported being treated with courtesy and respect, and people with a mental health problem. In Germany, the Netherlands, the United States, and Canada the gap exceeded 10 percentage points, and in the United Kingdom it was 20.3 percentage points. And while the majority of OECD countries required, or strongly recommended, service users' involvement in care design of care plans, in many countries this is required in principle but does not always happen, or depends on the care setting. For example in Japan medical practitioners are obliged to draw up an inpatient-care plan and deliver it to the patient or the family with adequate explanation of care, which addresses a certain level of involvement but not an active role in decision-making processes.

Moving from consultation to co-production is key for increasing person-centredness of mental health policy and services

To secure more person-centred mental health systems, there is a need to move from light-touch consultation with service users, to leadership in the sector by mental health service users, working with people with lived experience in designing mental health services, and in delivering services. Countries including England and Ireland have begun this process, elevating the voices of mental health service users and promoting co-produced mental health services as a key way to enhance person-centredness. One acute mental health ward in England used a process of co-design between recent service-users and health workers on the ward to change some key aspects of the way the ward was run, including the removal of an existing triage system and improving feedback from service users to staff (Springham and Robert, 2015[22]). After this process, the number of complaints on the ward dropped significantly, and were lower than two neighbouring wards. Ireland's Health Services (HSE) recognises the value of personal lived mental health experience in developing more recovery oriented services, and has developed a structure – the office of Mental Health Engagement and Recovery – to engage service users and family members/carer's in the design delivery and evaluation of services. A key part of this is the establishment of 35 service user local engagement service improvement forums to involve service users and family carers (OECD, 2020[13]; HSE, 2019[23]).

Experiences of and outcomes from mental health services don't just vary between OECD countries, they also vary within them. Individuals' age, gender, ethnicity, socio-economic status, and sexual orientation can all intersect with their mental health needs and service preferences, and can all have an impact on experiences and outcomes from mental health care. Though many countries may have strategies for priority population groups, the comparatively poor outcomes for such groups point to a need to further increase, or at least remain committed to, scaling-up appropriate support and services designed for and with minority and priority groups (see also, Principle 5).

Principle 2. Accessible and high-quality care: service availability has been scaled-up, but still doesn't meet demand

Unmet need for mental health care is an enduring concern across countries, despite efforts to scale up services

Unmet need for mental health care is an enduring challenge across all OECD countries. The 'treatment gap' for mental health services has long been acknowledged, and estimated to exceed 50% worldwide. In OECD countries, available indicators point to an enduring gap in need for treatment and access to it. On average, 63.7% of working-age people in OECD countries who wanted to receive mental health care, indicated that they have difficulty accessing it for financial or geographical reasons, or because of long waits (Table 1.1).

Some countries reported unmet needs for mental health care for financial reasons were far higher than for other health needs, including in Denmark (13.3%), Portugal (31.1%), and Iceland (33.1%) (Eurostat, 2014[24]). In these countries the rates of unmet mental health care needs were double or even triple the average rates for all medical care; in Iceland 8.1% of respondents reported financial barriers to accessing medical services, compared to 33.1% for mental health services. More recent 2018 data from Canada also suggests some considerable unmet needs for care; only 50% of persons who reported needing counselling or therapy had their needs fully met, and people in the lowest income group were more likely to report unmet needs (Statistics Canada, 2019[25]). In some countries, it appears that the COVID-19 crisis has increased unmet need for mental health care. In August 2020, 9.2% of surveyed adults in the United States reported that they needed counselling or therapy but did not get it in the four previous weeks, while in 2019 4.3% of adults reported that over the past year they could not receive counselling or therapy due to cost in the past 12 months (Centers for Disease Control and Prevention, 2020[26]).

During the COVID-19 crisis, there have been significant disruptions to the delivery of mental health services. A WHO survey in Q2 2020 found that more than 60% of countries worldwide reported disruptions in mental health services: 67% saw disruptions to counselling and psychotherapy; 65% to critical harm reduction services; and 35% to reported disruptions to emergency interventions (WHO, 2020[27]). While many countries – 70% worldwide (ibid) – pivoted rapidly to delivering services through telemedicine formats, and maintained access to some critical in-person services, referrals into mental health services fell. For example, in the Netherlands in the first wave of the pandemic the number of referrals to mental health care fell between 25 and 80%, demand for treatment has dropped 10-40%; billable hours have decreased 5-20%; bed occupancy has dropped 9% (GZZ Netherland, 2020[28]). The number of treatment hours for youth mental health care fell 20% in Q2 2020 (ibid). The crisis may have increased unmet need for mental health care; in a survey conducted in March-May 2020 by the Commonwealth Fund, 68% of adults in the United Kingdom and 69% of adults in the United States reported that they needed and wanted to get mental health care, but were not able to (The Commonwealth Fund, 2020[29]).

In many countries, there have been significant efforts to increase availability of mental health services in recent years, to deliver more and more services in community settings (outside of hospitals) and to deliver services in a timely manner. Countries have been increasing the volume of services, introducing targeted funds for priority services, and tracking time waited for services. Increasing access to talking therapies has been another way that countries have sought to better meet mental health needs, especially for common mental disorders such as depression and anxiety. In particular, there has been significant activity around services for mild-to-moderate conditions, including psychological therapies, counselling, group therapy, and general advice for example provided by General Practitioners or available online. Most respondents to the OECD Policy Questionnaire (OECD, 2020[13]) indicated that psychological therapies delivered by a psychologist were covered in full or part, and in most countries a range of other services were also covered in full or part (Table 1.1). In addition in 12 countries indicated that primary care practitioners are providing some form of talking therapy, for example brief psychological therapy. Sixty-two Norwegian municipalities have established '*Rask psykisk helsehjelp* – Prompt mental health care' to improve access to psychological therapy by offering low threshold services without referral, cost or long waiting times, supported by the government with a grant scheme since 2013.

However, there is significant variation in type of mental health services available in countries: inpatient beds per population varied more than 50-fold across countries, while rate of outpatient contacts varied more than 100-fold. All OECD countries either already deliver the majority mental health services outside of inpatient settings, or have the transition to more community-based care models as a policy priority, in line with the OECD Mental Health Performance Framework and other international strategies, notably the WHO Mental Health Action Plan (WHO, 2013[30]). Between 2000 and 2017 the average number of psychiatric beds per 1 000 population fell from 0.9 to 0.68, with particularly significant falls in Ireland (1.41 to 0.34), Finland (1.03 to 0.39), the Netherlands (1.56 to 0.91) and Latvia (1.86 to 1.25) (OECD, 2020[17]). The number of beds rose only Norway, Germany and Korea. In Japan, the number of psychiatric beds is nearly 4 times higher than the OECD average, bed occupancy is 90%, and more than 60% of patients stay for a year or more (WHO, 2018[31]).

It is more difficult to understand the extent to which countries have replaced hospital-based services with care in the community, and how available and evidence-based the care provided in community settings is. A limited amount of data does point, again, towards significant variation in available resources. In Mexico and Greece, for example, it appears that community care capacity either in outpatient clinics or through community teams is very limited.

Quality and outcomes of care remains a major challenge – both to measure, and to improve

Where data on mental health care quality and outcomes is available, it points to ongoing shortcomings in service delivery. The OECD indicators on inpatient suicide and suicide after discharge also point to

shortcomings in many countries when it comes to safety in hospital settings, and continuity of care. Inpatient suicide is a "never" event, which should be closely monitored as an indication of how well inpatient settings are able to keep patients safe from harm. Most countries report inpatient suicide rates below 10 per 10 000 patients, but Denmark is an exception, with rates of over 10 (OECD, 2020[17]). Suicide rates after hospital discharge can be an indicator of the quality of care in the community, as well as co-ordination between inpatient and community settings. Across OECD countries, suicide rates among patients who had been hospitalised in the previous year was as low as 10 per 10 000 patients in Iceland and the United Kingdom but higher than 50 per 10 000 in the Netherlands, Slovenia and Lithuania (OECD, 2020[17]).

Attempts to collect new information on care quality in the Data Questionnaire for this project included indicators on care continuity (follow-up after discharge), care in the community (repeat emergency department visits, repeat inpatient admissions) and quality of care in inpatient settings (use of seclusion, use of restraint). Only a few countries were able to report on each of these indicators.

However, even based on limited available data across countries there are signs of the ongoing challenge of providing high quality, consistent care. The proposed benchmarking indicator on 'percentage of people admitted to inpatient care for mental health, who were admitted at least 3 times in year' shows an average of more than 10% of patients were repeatedly admitted to inpatient care for mental health in a year (OECD, 2020[13]). Repeat admissions can be part of a care plan, but in many cases can point to repeated crisis events. Repeated emergency department visits for mental health reasons can be another signal of gaps in community care coverage; in Denmark and Israel approximately 10% of people who attended the emergency department for mental health reasons, attended at least four times in 2018, and in New Zealand this rose to 16%. Follow-up after discharge from inpatient care was reported by nine countries (Australia, Israel, Italy, Lithuania, Norway, New Zealand, Sweden, Turkey, the United Kingdom (England)). The percentage of patients followed up within the mandated period ranged from 34.7% in Italy to and impressive 95.8% in the United Kingdom, where follow-up within 7 days is required after discharge from some services.

Scaling-up available to mental health services is critical for increasing access

Talking therapies can be an evidence-based intervention for a range of mental health conditions, from high prevalence disorders such as depression and anxiety, to conditions such as eating disorders, obsessive compulsive disorder, bipolar disorder and schizophrenia. Efforts to scale-up access to talking therapies include stand-along schemes such as the IAPT programme in England, as well as trials to reimburse talking therapies in France (Coldefy and Gandré, 2018[32]; NHS Digital, 2019[33]; NHS Digital, 2019[34]; L'Assurance Maladie, 2018[35]).

For severe mental illnesses, for example psychosis, rapid intervention after the onset of symptoms can significantly change an individuals' outcome in the short and long term. This approach can have a positive impact when intervention comes early in the disease pathway, as well as when it comes early in the life course; many severe mental illnesses begin in the late teens or early twenties, making timely support for young people particularly critical.

In the last decade, OECD countries have undertaken initiatives to implement projects that focus on early detection and intervention for people at risk to developed severe mental health disorders. Among others, Australia, Canada, France, Ireland, Israel, Italy, the United Kingdom and the United States have all taken steps to move towards to integrated youth mental health care by implementing initiatives based on integrated care models (Cocchi et al., 2018[36]; Hetrick et al., 2017[37]). To improve early intervention in mental health care one initiative that Canada has pursued, since 2018, is the ACCESS (Adolescents/young adult Connections to Community-driven, Early, Strengths-based and Stigma-free services) Open Minds programme. This pan-Canadian project aims to transform mental health services for young people aged 11 to 25 years and to evaluate the impact of this transformation on individual and system outcomes. The

programme focuses on reducing unmet needs, through early identification of at-risk individuals, providing rapid access (within 72 hours) to an assessment, facilitating referral to an appropriate care service within 30 days (Malla et al., 2018[38]).

Principle 3. Integrated and multi-sectoral approach: in practice integration remains the exception, and not the norm

The COVID-19 crisis calls for a re-doubling of efforts to integrate mental health, work, and education policy

Cross-sectoral mental health policy, and especially integrated mental health, employment, education and skills policy, is even more critical in light of the COVID-19 crisis. Across most OECD countries, people with mental health problems struggle more with education, and are less likely to be in employment, than the general population (Table 1.2). On average, the employment rate for persons with a mental health condition was 20% less than for those without, rising to 30% in Hungary, Norway, and the United Kingdom (OECD, forthcoming[16]). Across the OECD, students with mental health conditions are 35% more likely to have repeated a grade (ibid). This is not the case for all countries. In Slovenia, Portugal, Poland, and Colombia, this group of students is slightly less likely to have repeated a grade, while in the United Kingdom there is no difference between the two groups. On the other side of the spectrum, students with mental health conditions in Greece, Estonia, Denmark and Iceland are all at least 75% more likely to have repeated a grade (ibid).

Across all countries that are tracking population well-being across 2020 during the COVID-19 crisis, mental health status amongst people who are unemployed, facing economic difficulties, and young people, has been markedly worse than the general population (OECD, 2021[10]). Often, the mental health of these population groups has worsened faster than the general population. At the same time as mental health status declined, there were significant disruptions to mental health support and services delivered in schools, workplaces, unemployment centres and other settings outside of specialist mental health care. Worldwide, 78% of countries reported at least partial disruptions to school programmes, and 75% to workplace mental health services (WHO, 2020[27]).

The COVID-19 crisis underlines the importance of integrated mental health and somatic health care: early signs point to both possible lasting psychological impacts for COVID-19 patients, especially those who experienced long hospitalisations or those living with 'long COVID', as well as increased risks of contracting COVID-19 and experiencing complications for individuals living with severe mental illnesses. It was already clear that the health outcomes of people living with severe mental illness are significantly worse than the general population, in part due to increased risk of death by suicide, but also due to increased risk of cardiovascular disease, diabetes, and cancer. The OECD HCQO indicator on excess mortality for measures the difference between the mortality rate for the general population, and those who have had a diagnosis of schizophrenia or bipolar disorder. An "excess mortality" value that is greater than one implies that people with mental disorders face a higher risk of death than the rest of the population. In 2015-17, excess mortality ranged from 1.3 in Lithuania to 6.1 in Norway for people who had lived with schizophrenia (OECD, 2019[39]). Inversely, people living with chronic diseases, such as cardiovascular disease or diabetes, are at increased risk of mental disorders such as depression (Holt, De Groot and Golden, 2014[40]; Glassman, 2007[41]).

Some impressive efforts to improve mental health knowledge of key front-line actors but inconsistent implementation

Broad and significant efforts exist to improve the mental health knowledge of key front-line actors, and to support connections between front line services such as police, emergency departments, and teachers, with mental health services. Provision of training for different front line actors is included as a performance

indicator in Table 1.2. Training for front line actors can reduce stigma around mental health conditions, help actors spot signs of mental distress and react with sensitivity, and direct people in need towards appropriate mental health services. Many countries provide at least some mental health training for front line actors, in particular for teachers, GPs, and police, but less often for paramedics, the fire department, and unemployment counsellors or staff. Teachers, in particular, receive significant training in England, Canada, Latvia and Lithuania.

However, in response to the Policy Questionnaire, most countries indicated that only 'some training' was provided to these front line actors, and coverage tended to be through relatively ad-hoc courses, or depend on local or regional initiatives. For example in Australia some programmes are specific to States, such as a programme for teachers in Victoria or for Fire and Rescue workers in New South Wales. In England in 2016-17 90% of schools and colleges offered training to at least some of their staff around how to support pupils' mental health and well-being while 47% offered training to all staff (Marshall et al., 2017[42]; OECD, 2020[13]). In Canada, Yukon health professionals, including physicians, will receive education and training to provide compassionate and culturally sensitive transgender care, and the Mental Health Commission of Canada (MHCC) launched new mental health literacy training specific to police through a new agreement with the Ontario Provincial Police (OPP). There are also differences between the substance of the training that is provided to front line actors. For example in Latvia front line actors were mostly covered in general awareness raising campaigns, even if there were some targeted educational seminars for example on bullying and emotional welfare for teachers.

Integration of mental health, skills, and work policy is uneven, and tools to make integrated care more systematic could be more widely used

As of 2019-20, five years after the introduction of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, the importance of a multi-sectoral, integrated approach to mental health performance is well-accepted amongst OECD countries (OECD, forthcoming[16]), *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation*. The Interim Report on the Implementation of the Recommendation has found that in recent years, a number of Respondents have introduced mental health plans with a focus on mental health policies that are integrated with education, employment, social and health policy (OECD, forthcoming[16]). 19 of 26 respondents to the OECD Mental Health Benchmarking Policy Questionnaire have national programmes/strategies for developing integrated cross-government approaches to mental health governance, and in at least 24 countries Ministries other than the Ministry of Health have a dedicated mental health strategy, plan or work programme. In Denmark, the Ministry of Employment developed a broad political agreement from April 2019 on a new and improved working environment effort including initiatives to support improvement of mental health at work, from regulation on psychosocial risks at the work place, to a focus on education of managers and employees in how to take care of the psychosocial working environment. In England, the government has established an Inter-Ministerial Group for Mental Health which includes representatives from other government departments, and at least six government departments – from education to digital affairs to environment, food and rural affairs – have established strategies or actions covering mental health.

Good examples of initiatives to integrate services across sectors can be found across OECD countries, and across sectors. It is clear from the *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation* report that reforms are being introduced to ensure that social protection systems, and mental health services, promote recovery and encourage return to work or education (OECD, forthcoming[16]). For example, Hungary, Latvia, Denmark and the United Kingdom have programmes or practices that support students to stay in school or transition to work. In Canada, Finland and Estonia changes are being made to work capacity assessments to facilitate partial return to work including after sickness leave with a mental health condition. Furthermore, Australia, Denmark, Ireland, Italy and New Zealand have been implementing or testing Individual Placement and Support (IPS), a proven

evidence-based practice in which multidisciplinary mental health teams including an employment specialist provide co-ordinated health and employment support for jobseekers.

However, systematic inclusion of work or employment outcomes in mental health service delivery, or mental health outcomes in employment support services, is not the norm. Most countries did not include employment or labour market outcomes in mental health service outcomes frameworks, or only included them for some care settings. The lack of integration is most apparent in social protection systems despite the well-known high prevalence of mental ill-health among social benefit recipients and employment service users. Initiatives related to liaison services between services, and mental health support for people using unemployment services are more common. At the service user-level Australia and England collect information on employment through their service outcomes framework, the National Outcomes and Casemix Collection (NOCC) in Australia, and the NHS Outcomes Framework in England.

Denmark stands out as a country with strong integration of mental health and employment services, and outcomes, with a range of initiatives to bridge mental health and employment services, and the inclusion of "access to the workforce (for somatic and psychiatric patients)" as one of the eight national health care quality goals. The Danish Ministry of Health has established a partnership of 48 members ranging from employee and employer organisations from the private and public sector to participants from patient organisations. The partnership, 'Sammen om mental sundhed' (which roughly translates to 'Together on Mental Health'), commenced in 2015 as a cross-sectoral effort, bridging the health and employment sectors, in order to pool knowledge and experience, and to create an overview of existing knowledge and tools within the field of mental health in the workplace.

Principle 4. Promoting mental well-being and preventing mental ill-health: the COVID-19 crisis has highlighted the importance of good mental well-being, and gaps in support

Mental health policies should focus on promoting positive mental health

Some countries are also focusing on positive mental health, and building well-being, across the life course. In Canada, there are two frameworks for *positive* mental health – for adults and for adolescents – developed by the Public Health Agency of Canada (PHAC). The 'Positive Mental Health Surveillance Indicator Framework' framework addresses mental health from a strengths-based perspective, covering positive mental health outcomes, risks, and protective factors, furnished by data from ongoing Canadian surveys. For example, the framework uses indicators such as population rating of their own mental health and life satisfaction to measure positive mental health outcomes, as well as items on discrimination and stigma, on political participation, on school and neighbourhood environment, health status and physical activity (Government of Canada, 2020[43]; Orpana et al., 2016[44]; Public Health Agency of Canada, 2017[45]). In 2019 New Zealand announced the world's first 'well-being budget', which focused on 'taking mental health seriously', improving child well-being, supporting Māori and Pacific populations, and building a productive nation. This ambition is backed with 445 million NZD for mental health services, 40 million NZD for suicide prevention, and commitments to put more nurses in secondary schools, tackle homelessness, and spend 320 million NZD addressing family and sexual violence.

Focusing on promoting good mental health amongst children and young people is particularly critical. Even prior to the COVID-19 pandemic, reviews of available evidence have suggested some rising rates of self-reported mental distress, especially amongst adolescents (Choi, 2018[46]; Collishaw, 2015[47]; Blomqvist et al., 2019[48]). Studies have pointed towards higher rates of internalised mental health symptoms especially amongst girls, higher rates of teenagers reporting 'feeling low' in the international HBSC survey or reporting feelings of anxiety about school work in the OECD's PISA study, and some instances of rising rates of self-harm and suicidal ideation (Choi, 2018[46]; OECD, 2018[49]; McManus et al., 2019[50]; OECD, 2017[51]; McManus et al., 2019[50]). More time spent online, and stresses and pressures arising from significant social media use, have also been pointed to as areas of new concern for children and

adolescents' mental health, even if academic evidence for these trends remains partial (OECD, 2018[49]; Kowalski et al., 2014[52]). Other literature suggests that an apparent increase in prevalence might be due to growing awareness and help-seeking behaviours children and young people and their parents, a broader classification of disorders, or more assiduous recording practices (Choi, 2018[46]; Comeau et al., 2019[53]). During the COVID-19 pandemic, young people's mental health has also worsened faster than that of the general population (OECD, 2021[54]).

Every year, a small number of children and some young people die by suicide. Based on data submitted to the OECD, and available in the WHO Mortality Database, there does not appear to have been an overall rise in deaths by suicide amongst children and young people in recent years. Between 2000 and 2015, the average number of death by suicides amongst young people aged 15 to 25 fell by 31%, but rose by 10% or more in a small number of countries (Australia, Luxembourg, Mexico, the Netherlands, New Zealand, Sweden, and the United States). In Australia, death by suicide are particularly high amongst young Aboriginal and Torres Strait Islander populations, for young people with serious and complex mental ill-health, and have been rising for females (Stefanac et al., 2019[55]; Orygen, 2016[56]). Data submitted to the OECD for the years 2009-18 suggest that death by suicide amongst Australian adolescents (age 15-19) rose across this time period, including in the most recent years (OECD, 2020[13]). Death by suicide amongst children and young people appears, as for adults, correlated with mental ill-health, access to lethal means, and previous suicide attempts, which point to a need for overall strengthening of access robust mental health care (McKean et al., 2018[57]; McKean et al., 2018[57]; Pettit, Buitron and Green, 2018[58]; Im, Oh and Suk, 2017[59]; McGillivray et al., 2020[60]). Some evidence also supports school-based interventions for suicide prevention; in ten European countries the Youth Aware of Mental Health (YAM) programme has been associated with a 55% reduction in incident suicide attempts and 50% fewer cases of severe suicidal ideation after 12 months, and is now being evaluated in Australia (McGillivray et al., 2020[60]).

Countries are focusing on promoting good mental health in early life

Many of the protective factors for good mental health go beyond the scope of mental health systems or programmes designed specifically to strengthen or protect mental health. Social, economic and cultural factors, such as employment status, income, physical health, experiences during childhood and adolescence, all have a significant impact upon mental health across the life course (Patel et al., 2018[61]). Interventions to improve socio-economic status, security, and reduce inequality, especially in childhood, can well be seen through a lens of building positive mental health. At the same time, programmes or interventions designed to promote mental well-being and prevent mental ill-health have also been shown to make a meaningful impact and represent good value-for-money (McDaid, Hewlett and Park, 2017[62]).

Interventions to promote good mental-health and prevent mental ill-health are very effective, most cost-effective, in infancy, childhood, and adolescence (McDaid, Hewlett and Park, 2017[62]; Patel et al., 2018[61]; Knapp, McDaid and Parsonage, 2011[63]). Some interventions, such as the Penn Resiliency Program or Zippy's Friends have been adapted across multiple countries or settings (Choi, 2018[46]; Wells, Barlow and Stewart-Brown, 2003[64]). Online programmes such as MoodGYM in Australia and Norway, the Netherland's Master Your Mood Online, online stress prevention and coping skills training in Germany and In One Voice in Canada have been various associated with improvements in symptoms of depression and anxiety, improved mental health literacy and knowledge about stress and coping (Clarke, Kuosmanen and Barry, 2014[65]). In 2020 most OECD countries reported that programmes to build mental health literacy and well-being, reduce stigma, and advance social-emotional learning were in place in some or all schools. When asked what percentage of schools had some programme in place, or by age 15 what percentage of children had received at least two hours of mental health education, most countries were unable to answer but responses ranged from 100% of children in 100% of schools (in Iceland), to 60-70% of schools (in England and Estonia) (OECD, 2020[13]).

Steps to promote mental resilience in the face of the COVID-19 pandemic should be maintained

Across the course of 2020, it became increasingly clear that the COVID-19 crisis was having a significant impact on population mental well-being. The rapidity and scope of the response by OECD countries, and the steps taken to protect mental well-being, were striking. There is ever reason to support the maintenance of some if not most of these new mental health resources well beyond the end of 2020 and the COVID-19 pandemic.

OECD countries took rapid, concrete steps to make mental health support more available in 2020, especially through low-threshold resources such as internet and phone-based information and support. Phone and online mental support service are available for the general population in most if not all OECD countries, including issuing specific mental health guidance, and setting up support phone lines, or online platforms (OECD, 2020[66]). In Australia, AUD 74 million over 2019-20 and 2020-21 is invested to bolster phone and online support services, digital peer-support, a mental health and well-being programme for frontline health workers, and expanding some existing services (Australia, 2020[67]). In France, a phone hotline where people can get psychological support is widely promoted, including in each COVID-19 press briefing held by the government, and early 2021 the French government announced new entitlement to reimbursed sessions of psychological support. In New Zealand, three online mental health tools including a health journal app and an e-therapy programme are available for free, while the government launched two additional mental health support programmes – Getting Through Together and Sparklers at Home – and a set of well-being activities and resources for parents to use with children at home (Government of New Zealand, 2020[68]).

Principle 5. Strong mental health leadership and governance: mental health has risen to the forefront of governments' agendas, and investment improvements is now needed

Mental health is now a priority area for many governments, and has been prioritised in COVID-19 responses

Attention to mental health from governments, society, news and media, has clearly increased over the past decade. Momentum has been building across OECD countries, and indeed globally, when it comes to mental health. In 2013, mental health was included in Goal 3 of the Sustainable Development Goals (SDGs); in 2015, OECD countries all signed up to the Recommendation of the OECD Council on Integrated Mental Health, Skills and Work Policy; in September 2018, at the Third UN High-level Meeting on Non-communicable Diseases, mental disorders were recognised by the WHO as one of the major drivers of death and disability; in October 2018, at the first Global Ministerial Mental Health Summit was held on 10 October 2018. Public figures and celebrities have increasingly been speaking out about their experiences of mental ill-health. Analysis from the United Kingdom shows that mentions of 'mental health' and related terms in The Guardian newspaper increased five-fold in the 10 years up to 2017.

During the COVID-19 crisis, too, governments have prioritised mental health as part of their COVID-19 response plans. Action taken in Denmark, Norway and Canada are just three examples amongst many. In Denmark in April 2020 it was agreed that 215 million DKK would be used for initiatives for vulnerable groups, including mental health counselling, and in Norway mental health and psychosocial support were included as part of the national COVID-19 response plan with a particular focus on vulnerable groups, and additional funded allocated to keep services and low-threshold services open for people with mental health problems while maintaining anti-infection measures. From the first weeks of the pandemic, Canada has also prioritised mental health support, launching the online portal 'Wellness Together Canada' on 15 April 2020 to connect Canadians to peer support workers, social workers, and psychologists for confidential online or phone chats, promote self-assessment and other self-guided resources. Canada also allocated

surge funding to the Canada Suicide Prevention Service and the Kids Help Phone distress lines, as well as including self-care advice in the Canada COVID-19 app used to record potential COVID-19 symptoms.

Overall mental health spending is increasing, but not significantly

There remain significant methodological challenges in collecting and comparing mental health spending, in particular scope of what services are included, whether all age groups are included, whether dementia is included, and whether government expenditure or all expenditure is included. Despite these methodological challenges the range in levels of mental health spending is clear; in 2018, mental health spending ranged from around 4% of total health spending (in Chile, Estonia, Greece and Poland) to 13.5% in Norway and 15% in France (OECD, 2020[13]; WHO, 2018[19]). Only five countries (United Kingdom, Canada, Germany, Norway, France) reported spending more than 10% of health spending on mental health.

A number of countries, including New Zealand, England (increase of GBP 1.4 billion between 2015/16 and 2017/18) and Australia (AUD 736.6 in 2019), have pointed significant increases in mental health funding in recent years (OECD, 2020[13]). National expenditure, reported in national currency, increased in all countries in the last decade, by with an average annual growth in mental health spending of more than 6% in Lithuania and Israel. However, overall government spending on health has also been increasing, and as a percentage of this total health spending the increases in resources for mental health have not been particularly significant. Generally spending on mental health as a percentage of total health spending has not increased significantly, and in some countries – Japan, Norway, New Zealand, the United Kingdom, Lithuania – declined.

Some reviews of spending have pointed to real-terms falls in mental health spending even when governments have publically committed to increasing investments. A 2018 review in England, where parity of esteem for mental health has been a guiding principle, funding gaps for NHS mental health providers and NHS acute providers appear to continue, and some mental health providers have seen funding fall (The King's Fund, 2018[69]).

Decisive action to reduce stigma around mental illness is critical, but is infrequently measured

Greater awareness around mental health can help people experiencing non-specific mental distress to seek out ways to protect their mental well-being, for example through self-help or informal support networks, and those experiencing more acute or enduring mental distress to seek professional help (Patel et al., 2018[61]). The need to "foster mental well-being and improve awareness and self-awareness of mental health conditions" is also part of the OECD Council Recommendation on Integrated Mental Health, Skills and Work Policy.

Stigma – labelling, stereotyping thoughts, prejudice, and discrimination (Link and Phelan, 2001[70]) – includes stigmatising attitudes or behaviours in society towards those with mental health issues, as 'self-stigmatisation' or 'internalised stigma' whereby people may have a negative view of mental health conditions that reduces help-seeking and leads people to 'hide' their mental health condition. Indeed, stigma attached to mental health issues is one of the most significant barriers to help-seeking (Clement et al., 2015[71]; Thornicroft, 2008[72]). High levels of internalised stigma have also been found to reduce adherence to treatment and reduce openness to therapeutic interventions, and even reduce the efficacy of some treatments (Shrivastava, Johnston and Bureau, 2012[73]; Kamaradova et al., 2016[74]; Ansari et al., 2020[75]; Rüsch et al., 2009[76]). In Slovenia, for example, it is reported that only 41.5% of those with psychological problems had sought professional help, a treatment gap that may well be exacerbated by stigma around to mental health issues (Roskar et al., 2017[77]); in 2014, 88% of the working-age surveyed population in Slovenia also reported some unmet need for mental health care (Table 1.1). Population-level interventions such as stigma prevention, awareness raising and mental health literacy promotion are in

place in many OECD countries; 19 out of 28 countries reported that they had at least one national programme that focuses on improving general population understanding or knowledge of mental health/mental illness, or reducing stigma (OECD, 2020[13]).

Reducing mental health stigma is a priority in OECD countries, but inconsistently measured over time. 22 countries reported that they have a national, regional or local survey to measure attitudes or level of stigma around mental health issues. However, each country has measured national stigmatising attitudes with different indicators, making comparison of levels of stigmatising attitudes across countries very challenging. Where multiple surveys have been undertaken over time, they can show changes in attitudes towards mental health. Australia's national surveys of attitudes to mental health, which focused on mental health literacy, stigma, and perceived discrimination, have been performed three times since 1995 and have shown a fall in stigmatising attitudes and an increase in mental health literacy over time (Reavley, Too and Zhao, 2015[78]).

Some population groups are significantly more vulnerable to mental illness and mental health services must be tailored to support their unique needs

Multiple population groups have been identified as being particularly vulnerable to mental ill-health, and many have poorer experiences and outcomes of, and less access to, mental health care. Such population groups vary across countries, and include but are not limited to the LGBTQI+ community, indigenous populations, certain ethnic groups including ethnic minorities, older adults, and refugees (Mitrou et al., 2014[79]; Zehetmair et al., 2018[80]; Catalan-Matamoros et al., 2016[81]; Soysal et al., 2017[82]; McCann and Brown, 2017[83]; Meyer, 2003[84]; WHO, 2020[85]). Most OECD countries reported having mental health strategies or plans in place addressing the specific needs of nationally defined population groups. Strategies addressing children and young people are most common (15 countries), followed by older adults and LGBTQI+ communities (7 and 8 countries, respectively). The OECD Mental Health Performance Benchmarking Data Questionnaire included a data sheet requesting data broken down by population group, for example rate of service contacts for nationally defined population groups (OECD, 2020[13]). As of May 2020, only 4 countries (Australia, Canada, Japan, and the United Kingdom) were able to provide partial data covering a range of groups, including aboriginal populations, data by ethnic group, foreign-born population.

Though many countries have strategies for priority population groups, the comparatively poor outcomes for such groups points to a need to further increase, or at least remain committed to, scaling-up appropriate support and services designed for and with minority and priority groups. To take one pertinent example, in Australia, Canada, New Zealand and the United States and indeed worldwide indigenous populations have higher rates of suicide and psychological distress, suffering from symptoms of anxiety and depression (Hajizadeh et al., 2019; Hatcher et al., 2017). Indigenous Australians shows rates of anxiety and depression between 50% and three times as high compared to the non-Indigenous population (Anthony F Jorm Sarah J Bourchier, 2012[86]). Suicide rates are twice as high compared to the non-Indigenous population, and four times as high for youth (Tighe et al., 2017[87]). Suicide rates among the Inuit, one of the three distinct Indigenous groups in Canada, are among the highest in the world and up to ten times higher than the average suicide rate in Canada (Harder et al., 2012[88]; Kral, 2016[89]). At the same time, a 2019 paper examining suicide mortality among First Nations, Métis, and Inuit people in Canada found that there was considerable heterogeneity across communities; while suicide rates amongst some communities were high, just over 60% of First Nations bands had experienced no suicides between 2011 and 2016, and among the 50 Inuit communities, 11 communities had a suicide rate of zero between 2011 and 2016 (Kumar and Tjepkema, 2019[90]).

Furthermore, countries need to go beyond strategies focused on priority groups and towards accessible, co-produced services. Fostering a supportive community with focus on local culture, such as support by social or familial network, connection to culture, development of self-identity are all related with better

mental health outcomes in Indigenous populations, resulting in less suicidal ideation (Harder et al., 2012[88]; Hatcher, Crawford and Coupe, 2017[91]; Tighe et al., 2017[87]). Canada has pursued this approach with "Culture as a Treatment"", where mental health agencies serve specific cultural practices such as talking circles, pipe ceremonies and smudging (Gone, 2013[92]). In Australia, Indigenous mental health policies focus on self-determination and community governance, reconnection and community life to enhance emotional well-being for Indigenous communities (Dudgeon et al., 2014[93]).

Principle 6. A future-focused and innovative approach: COVID-19 has accelerated mental health innovation, but workforce shortages are a limiting factors in improving mental health system performance

Data availability makes workforce planning and international comparisons very challenging

There is significant variation in the types of mental health resources that are available across OECD countries. For resources for which data is most easily available, which is proposed as a performance indicator – numbers of psychiatrists, psychiatric beds – show wide variation. The number of psychiatrists per 1 000 population in 2017 ranged from 0.01 in Mexico, 0.05 in Turkey, 0.08 in Korea or 0.09 in Chile, to 0.25 or more in Greece, Norway and Germany, and 0.52 in Switzerland (OECD, 2020[17]).

Other categories of mental health workforce play a critical role in delivering mental health services, including mental health nurses and psychologists, but also social workers, counsellors, General Practitioners or family doctors, occupational therapists, paramedics, and more. In many countries diverse teams of mental health professionals work together to deliver care. However, it is extremely difficult to collect workforce data for these diverse categories of mental health workforce; at the national level, this data is not routinely reported in all countries, and internationally there are significant comparability challenges. There are differences between countries in terms of how workforce data is reported (for example, full-time equivalent, all registered professionals, including or excluding private sector or non-hospital workers), as well as in terms of how mental health professionals are classified. For example, when it comes to psychologists there is significant variation in how psychologists are accredited, with some countries having single national accreditation systems for psychologists, and other countries having multiple accreditations or no nationally endorsed accreditation.

These comparability issues are a significant challenge for understanding the capacity and sustainability of the mental health workforce in OECD countries. However, given the diversity of different workforce categories involved in delivering mental health care, it is clear that reporting the rate of psychiatrists alone does not give a sufficiently good picture of the mental health workforce. Keeping in mind the comparability challenges, a scan of available workforce data, drawn from national sources and the WHO 2017 Mental Health Atlas, suggests wide variations. In 2017 estimated total mental health workers ranged from 0.09 in Chile to 2.15 in Australia per 1 000 population. Based on national sources, the number of psychologists per 1 000 population ranged from 0.03 or less in Hungary, the Czech Republic, Turkey and Japan, to 0.095 in Estonia, to 1.4 in Norway and more than 1.6 in Denmark (Association of Estonian Psychologists, 2019[94]; Statistics Norway, 2020[95]; The Ministry of Health, 2017[96]).

Use of digital tools increase access to services

Mental health is an area where innovation has been sluggish in recent decades; there has been quite widespread disengagement from the pharmaceutical sector, and investment in research has been low compared to other areas of disease. In Europe, the three year ROAMER project ran from 2015 to 2018 to create a roadmap for mental health, and found that mental health and well-being were under-represented both relative to the burden of disease in terms of DALYs, and to other health-related fields (Hazo et al., 2019[97]), a trend also identified in Australia and England (Christensen et al., 2011[98]; Department of Health, 2017[99]).

There are signs that some countries are investing more significantly in mental health research, across a range of areas from basic science to service development or service delivery. Under half of questionnaire respondents (11 countries) reported that they have a significant national or regional research agenda, including Denmark (Danish Government, 2015[100]), the United Kingdom (Department of Health, 2017[99]), Australia (Australian Government National Mental Health Commission, 2019[101]), and the United States (NIMH, 2020[102]). Non-government actors have established funds or platforms to boost innovation. The Duke and Duchess of Cambridge in the United Kingdom announced a 2 million GBP fund as part of their mental health campaign Heads Together, focused on digital tools for mental health in 2017 to develop new digital tools to help people have conversations about mental health. The first tool coming out of this fund was 'Shout', a free crisis service for people who feel they need immediate support, staffed by trained volunteers, and available 24 hours a day (Heads Together, 2019[103]). The American Psychiatric Association also launched the Psychiatry Innovation Lab in 2020, aiming to nurture early-stage ideas and ventures by investing in them with mentorship, education, funding and collaboration opportunities within our community of mental health innovators (American Psychiatric Association, 2020[104]).

In the last few years, there has indeed been considerable activity around finding innovative solutions to mental health challenges in recent years, much of which has been focused on better and broader deployment of digital tools including symptom tracking, self-help, and telemedicine (Wozney et al., 2017[105]; Gooding, 2019[106]; NHS, 2020[107]). In particular there has been an explosion in apps developed by private companies which range from tracking self-management of symptoms, for example Thrive or WorryTree for mood tracking, mindfulness apps such as Calm or Headspace, Beat Panic designed to help overcome panic attacks and anxiety or BlueIce to help young people manage their emotions (NHS, 2020[107]). Other apps, such as Ieso or Big White Wall in England or Talkspace in the United States connect people directly to licenced therapists, and in some cases access to these services are covered by employers or health insurance providers. In England, the National Institute for Health and Care Excellence (NICE) has been assessing digital therapies to be accepted under the Improving Access to Psychological Therapies Programme (IAPT) (NICE, 2020[108]).

The way that mental health services are delivered is changing, accelerated by the COVID-19 outbreak

The COVID-19 outbreak appears to have further accelerated both delivery of mental health services via telemedicine, and availability and use of internet- or app-based mental health tools. Multiple countries have lifted legislative or reimbursement limits on providing mental health services through telemedicine (OECD, 2020[66]). In Australia, the crisis rapidly accelerated use of telemedicine, and as of end-April, 50% of psychology sessions were being provided online, although it remains to be seen whether this trend continues as the health crisis subsides. In England the psychological therapies service IAPT has moved massively towards delivery via telemedicine (Royal College of Psychiatrists, 2020[109]; EuroHealthNet, 2020[110]). In general the trend for mental health service contacts, including online, appears to be down.

There are signs that other mental health tools are being accessed more. In the United States, the online therapy company Talkspace saw an increase in clients of 65% between mid-February and end-April, a federal hotline for people in emotional distress say a 1 000% increase in April 2020 compared to April 2019, and use of elf-screening questionnaires on the website of the non-profit Mental Health America increased 60-70% over the course of the outbreak (The Washington Post, 2020[111]). The COVID-19 outbreak has also pushed governments to make more online or digital mental health resources available. In mid-April 2020 the Canadian Government launched a new portal for mental health resources, Wellness Together Canada, which offers no-cost wellness self-assessment and tracking, self guided courses, apps, and other resources, group coaching and community of support, and counselling by text or phone (Wellness Together Canada, 2020[112]).

The future of mental health performance measurement

At present, OECD countries are not able to comprehensively measure mental health performance across the domains that they identify as priorities

Tracking and comparing health system data across settings and services, across time, and across countries are powerful tools for understanding performance (OECD, 2019[39]; OECD, 2019[113]). Availability of mental health data, nationally and internationally, has long lagged behind broader health data development (Hewlett and Moran, 2014[114]). Over the past six years there has been a clear increase in availability, including at an international level, of mental health data. Since their introduction in 2013-15, country coverage of the OECD's three indicators on mental health care quality has increased markedly: from 7 countries reporting excess mortality in 2013 to 12 in 2019; 14 countries reporting inpatient suicide in 2015 and 21 in 2019; and 10 countries reporting suicide after discharge in 2015, to 14 in 2019 (OECD, 2020[17]). Responses to the OECD Mental Health Benchmarking Data Questionnaire were promising (OECD, 2020[13]). However, the majority of data that was available in 10 or more countries in 2020 covered inputs (beds, spending), or processes (length of stay, admissions, contacts with specialist care). For items which gave more insights into continuity of care, quality, or outcomes – such as repeat admissions, follow up after discharge, repeat emergency department visits – far fewer countries were able to report data.

There are a number of countries, including Australia, England, Denmark, Ireland, the Netherlands, and Norway, where extensive mental health data is available. In the Netherlands, mental health indicators include prevalence, service availability and contact rates as well as staff assessment of services, workforce flows, waiting times and absenteeism due to illness (Ministry of Health Netherlands, 2020[115]). In Norway, available indicators include experiences after a 24 hour inpatient stay, rate of individual care plans, involuntary admissions rates and waiting times (Directorate of Health, 2020[116]). Some countries – Australia, Canada, Denmark, England and New Zealand – also stand out as countries where there has been notable mental health data innovation, including patient-reported data to understand outcomes and recovery, capacity to track mental health outcomes across sectors, and data frameworks to understand mental health performance in a comprehensive way.

However, available mental health measures – especially at the international level – still do not map fully onto the domains of performance that matter to OECD countries. The OECD Mental Health Performance Benchmarking project began by asking mental health stakeholders from across OECD countries, 'when it comes to mental health, what matters?', and in answer to this question the OECD Mental Health System Performance Framework was developed (Figure 1.2). Having started by indentifying the performance principles that *should* be measured, rather than what already *could* be measured using available data, the gaps in available indicators were made clear. For example, it was not possible at even a single-country level to identify measures that track the Framework Principles and Sub-Principles such as how effective the mental health system or services empower individuals to realise their own potential, or promote equity between population groups, or prioritise efficient and effective distribution of resources, or ensure that services are based on best available evidence.

More measures of quality and outcomes are warranted, even as important gaps in 'input' measures remain

In some areas of mental health system performance, with the input of experts participating in the Virtual Workshops on Mental Health Performance Benchmarking held in September 2020, indicators which would be important tools for understanding performance but are not yet available across multiple countries were identified. In particular, more robust indicators are needed on: on well-being, positive mental health and social cohesion; prevalence of mental ill-health, unmet need for care, and health care coverage; on mental health workforce and diverse care providers, and workforce training; on research; on integrated care including integration with somatic care, and physical health outcomes; and on disparities within national

population groups. The COVID-19 context, in which significant amounts of mental health care were moved to non face-to-face formats, also highlighted the importance of indicators on changing care delivery methods, for example the rate of services delivered through telemedicine formats, preferably broken down by format (e.g. video, phone, app-based or chat-based).

Recognising some of these gaps, several indicators where data is not yet available across multiple countries, but where there is a critical importance for understanding mental health performance, were included in the Mental Health System Performance Benchmark (Tables 1.1, 1.2 and 1.3). Specifically, these are: patient-reported outcomes (PROMs), population attitudes towards mental health for example mental health literacy or levels of stigma, and use of telemedicine in mental health care. These are areas where further development of internationally comparable indicators is warranted,

Additionally, there is clear scope to continue to focus on strengthening the availability of internationally measures of mental health system quality and outcomes. Across the indicators included in the data collection for this project (OECD, 2020[13]), it was by far measures of 'inputs' – service contacts, admissions – that were the most consistently reported across countries, while expert stakeholders engaged with the project consistently stressed the importance of focusing on quality and outcomes as priorities for understanding performance.

There are some newly collected indicators – follow-up after discharge, repeat readmissions to inpatient care, repeat emergency department contact for mental health reasons – that bring more insights into care quality and processes, and which several countries were able to report, and could be considered for more routine collection. Other indicators which could have been promising, for example on restrictive practices (seclusion and restraint), or involuntary admissions, showed significant variation across countries in terms of definition and practice guidelines, and do not currently appear adept for routine international comparisons.

Patient-reported measures should be at the centre of policy making and service-monitoring

The continuing gaps in availability of meaningful indicators of the dimensions of mental health performance that matter, as identified in the OECD Mental Health Performance Framework, underscore the importance of developing new measures. In particular, there is clearly space for more internationally comparable reporting on mental health service users' experiences (PREMs) and outcomes (PROMs). At present, systematic patient reporting in mental health is in its infancy, and only an estimated eight OECD countries collect PREMs and/or PROMs on a regular basis in mental health settings. Only Australia, the Netherlands and England reported that they collected and routinely reported both.

Since May 2018, the OECD has been working with patients, clinicians and policy makers in a Working Group to develop mental health PREM and PROM data collection that enable international comparisons with 17 countries involved. The main objective is to develop PREM and PROM data collection standards in mental health for international benchmarking of patient-reported outcomes. Three domains which have international coherence have been identified for PREMs (respect and dignity, communication and relationship with health care team and shared decision making), and PROMs (relief of symptom burden, restoring well-being/social function and recovery support). The Working Group is looking towards a pilot PROM data collection, beginning with hospital care, focused on the domain of well-being, drawing on the OECD Guidelines on Measuring Subjective Well-being and the WHO-5 Well-Being Index questionnaire that measures current mental well-being (time-frame of the previous two weeks). For a pilot PREM data collection, again beginning with hospital care, the items already collected through the OECD's HCQO's regular PREM data collection is underway, with an additional item on courtesy and respect adapted from the Commonwealth Fund International Health Policy Survey. It is expected that some pilot data will be available to be reported in the OECD publication *Health at a Glance 2021*.

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2 People-centred mental health policies and services

People-centred mental health systems place the individual at the centre of their own care, focusing on the individual service user's capabilities, knowledge and value-setting. People-centredness acknowledges the needs and wishes of the individual and focuses on how people can manage their own health, giving people a proactive part in care. This chapter describes how OECD countries have been accelerating their progress on creating person-centred mental health systems, but also shows that there is need for improvement. Countries should continue to prioritise person-centred mental health care, including through actions such as co-producing services and measuring experiences and outcomes of mental health care through the use of patient-reported measures.

Introduction

OECD countries increasingly recognise how important it is to equip policy makers, care providers and service users in health systems with tools to move towards a person-centred system, and improvement is being made on what it actually means to deliver person-centred mental health care. As a result, countries have already taken significant steps towards a people-centred health system, such as enhanced possibilities in choosing care providers or the provision of information about health care treatment options, helping people to make better choices in their own care path. Mental health care policies are not left behind, and significant attention has been given in recent years to how to strengthen mental health systems to make them increasingly person-centred.

Over the years, OECD countries have accelerated their progress towards person-centred mental health systems, by prioritising it on their policy agendas. Countries are reshaping their mental health systems through routine consultation with mental health service users in policy planning, through developing strategies and services for key populations with specific mental health needs, establishing service-user groups in policy design and increasingly making consultation with services users and carers systematic in care delivery, for example using personal care plans. However, although attention has increased in many mental health systems, people-centredness is at best inconsistent, and at worst tokenistic, and there is still a lot to improve.

Countries should continuously prioritise people-centredness on their policy agendas to build resilient systems and deliver appropriate care, consulting experts in the field for guidance and support in the implementation of people-centred mental health care. More systematic consultation of mental health service users should be a priority in all OECD countries – through surveys of service user experience of the mental health care system, on the system priorities of service users, family and carers, and through the use of patient-reported measures of outcome and experiences at the service level. There are also policies and practices that hold promise for making an individual-centred perspective more significant in mental health systems, including peer delivered services or co-designed services, which have been adopted in a few OECD countries but could be developed in many more.

Individual-centred mental health care puts the individual at the centre

People-centred care is a way forward to improve health care systems

In the 21st century, making health systems more people-centred is a guiding principle for OECD countries in redesigning health systems. People-centred systems move away from a supply-driven health care system, based on the idea that the patient has a passive role in their care path. Instead, a people-centred system highlights the individual patient's capabilities, knowledge and value-setting. It acknowledges the needs and wishes of the individual and focuses on how people can manage their own health, giving people a proactive part in care. Placing people at the centre in health systems also pushes health systems to become more responsive, integrated and accessible (OECD, 2019[1]; OECD, 2017[2]; Gurría and Porter, 2017[3]; OECD, 2019[4]; OECD, forthcoming[5]; van den Berg and Guanais, 2020[6]).

People-centred health care has the potential to generate significant benefits and to help overcome shortcomings in contemporary health systems, by both re-focusing attention on the needs and preferences of the health system user, and increasing service user involvement in their own care (Gurría and Porter, 2017[3]; OECD, forthcoming[5]). Taking stock of what is valuable to the service user can also improve the value of the return on investment in health care, while increasing active involvement in care through processes such as shared decision-making with professionals can lead to increased ability to self-manage and control long-term health conditions (van den Berg and Guanais, 2020[6]; OECD, 2019[1]). Efforts to re-orientate health care towards the needs and preferences of the service user, or example through shared

decision making processes, can lead to potential benefits such as increased satisfaction with care and better relationships with care providers (Aubree Shay and Lafata, 2015[7]; Hughes et al., 2018[8]).

The OECD People-Centred Health Systems Framework

Defining and implementing people-centredness in health care includes a range of different perspectives and considerations. For example, including service users' wishes and preferences in care planning, reflecting views of service users and their families in policy making, and respecting the human rights of service users. Recently, steps such as co-designed services and peer support have also been growing in importance. To identify and categorise the main components of 'people-centred care', the OECD developed the People-Centred Health Systems framework to describe and measure people-centredness in a systematic way, and enable benchmarking of people-centredness across OECD countries (OECD, forthcoming[5]). This framework can help to identify tools that help health systems to become more people centred. The framework is built on five dimensions: voice, choice, co-production, integrated care and respectful care (Box 2.1).

Box 2.1. The OECD People-Centred Health Systems Framework

The OECD Framework for People-Centred Health Systems (PCHS framework) is designed to identify key dimensions of people-centred health systems and the policies that must be put in place to achieve people-centredness. The Framework builds on existing frameworks for people-centred care, which propose different structures for thinking about this concept but share many of the same underlying principles for what key principles must be put in place to move towards a people-centred health system. The framework focuses on five dimensions of people-centred care identified in the literature – including ensuring voice, choice, co-production, respectfulness, and integration – and provides key quantitative indicators for domains and policy benchmarks that can help countries assess to what extent their systems are people-centred. By underpinning the key priorities of people-centred systems with key outcome, process and policy measures, the framework also helps to identify synergies to make health systems more people-centred.

Table 2.1. Dimensions, domains and policy benchmarks for the OECD Framework for People Centred-Health Systems

Dimensions	Domains and policy benchmarks
Voice	People having a formal role in in health policy decision-making bodies or processes
Choice	People have a choice of health care providers
Co-production	People are given accessible information during care
	People are consulted about their care
	People are engaged in their care
Respectfulness	People receive high personal attention during care
Integration	Digital technology is used for integration of care
	Electronic clinical records are used
	People experience integration and co-ordinated care

Source: OECD (forthcoming), *Supporting the Transition towards People-centred Health Systems in OECD Countries*.

OECD countries are taking important steps towards a people-centred health system

Many OECD countries have taken important steps towards increasing people-centredness in their health systems, notably when it comes to promoting the patient voice, and some choice within the health care system. Representation of patients in decision-making for health care has increased in the recent year. An OECD survey in 2019, showed the involvement of patient representatives in decision-making processes for health authorities in a number of OECD countries, including Austria, Canada, Luxembourg and Germany (OECD, forthcoming[5]). For instance, in Luxembourg, patients are included in the development of disease-specific policy plans, including cancer, rare diseases and cardiovascular diseases. Fewer countries have taken steps to more systematically include patients in decision-making around health care research or funding for research (ibid). Norway is an exception, where the majority of funded projects through both the Research Council of Norway (RCN9) and the Regional Health Hospital Authorities (RHA) – the major government funding avenues for health care research – included public involvement (Malterud and Elvbakken, 2020[9]; Norwegian Directorate of Health, 2015[10]). Additionally, health systems show patients have a substantial flexibility in choosing their health care services across multiple levels of the health system, from primary to hospital care. A survey amongst 31 reporting countries shows that patients have free choice of choosing primary care in 18 OECD countries, outpatient specialist level in 17 countries and at hospital level 16 countries offer a degree of choice (OECD, 2016[11]).

People-centred care is essential to build high-performing mental health systems

Individual-centred, or person-centred, mental health care is a high-level policy goal and is routinely included as a fundamental component of international declarations and national action plans. “Individual-centred care” is one of the six principles of a high-performing mental health system established by the OECD Mental Health Performance Framework (OECD, 2019[12]) The prioritisation of person-centredness is also reflected in other international strategies for mental health care, notably the WHO’s Comprehensive Mental Health Action Plan 2013-2020, agreed by all WHO Assembly members, puts at its centre the importance of service user-driven treatment and recovery plans and, where appropriate, with inputs of families and carers (WHO, 2013[13]). Individual-centred care, referred to more broadly as ‘people-centred’ care, is a driving policy priority across OECD health systems, and when it comes to mental health this approach is equally, if not more, critical.

There are dimensions of mental health that also make people-centredness both more critical, as well as more challenging. The stigma and discrimination that often accompanies mental illness, the lack of understanding around mental disorders, and the ability to detain and compel treatment, make people-centred mental health care all the more important but also all the more complex (Bee et al., 2015[14]).

In the OECD Mental Health Performance Framework, a high-performing mental health system focuses on the individual who is experiencing mental ill-health (OECD, 2019[12]). In this Framework, “Individual-centred care” should:

- Ensure the individual feels they have ownership of their care;
- Be respectful and inclusive of the individual, carer (where relevant), and family;
- Ensure care and treatment is tailored to individual needs and preferences;
- Be culturally, age and gender appropriate;
- Empower the individual to realise his or her own potential and contribute to society.

How effectively are OECD countries delivering individual-centred mental health care?

People-centred mental health care is a high-level policy goal shared across OECD countries. However, implementing effective and rigorous person-centred care in mental health remains challenging. While people-centredness is a strategic priority in OECD mental health policies and planning, implementing person-centred care, and ensuring that service users' views are both heard and make an impact, is less well-developed.

Do individuals have ownership of their own care?

Elevating the service users' voice in mental health care

In many respects, the mental health sector has led the way in prioritising mental health service users' voices. Mental health service users are represented in national groups or national coalitions in 21 out of 29 respondents to the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires (OECD, 2020[15]). Globally, the WHO Atlas 2017 (WHO, 2018[16]) found that globally only 52% of reporting countries, and 60% of countries in the EU region, had a formal collaboration with service users/family/caregiver advocacy groups.

In OECD at least 13 countries have national mental service-user group or coalitions of service user groups. These groups elevate the concerns of mental health service users, and often their families or carers, and are frequently the key contact point for consultation on national mental health policy or planning. Mental health service user representation is organised differently in different countries, with different degrees of national organisation in a single representative group (Table 2.2). The two groups GAMIEN-Europe (Global Alliance of Mental Illness Advocacy Networks-Europe), a non-profit patient-driven pan-European organisation, representing and advocating for the interests and rights of persons affected by mental ill-health, and EUFAMI, which represents all family members of persons affected by severe mental ill health at European level, play an important role in advocating for the rights and preferences of mental health service users, their families and carers at the European level, for example at the European Parliament.

In Australia, the National Mental Health Consumer & Carer Forum (NMHCCF) was established in 2002 to ensure mental health consumer and carer involvement at the national level of policy development and has 28 members of which 14 are mental health consumers and 14 are mental health carers. The NMHCCF is funded through state, territory and Australian Government contributions to be an independent voice for mental health consumers and carers. In Lithuania, mental health patients' community "Viltis" is an association of more than 11 000 members, which focuses on rehabilitation support for mental health care users, while the 'Lithuanian care community for mentally ill people' is an umbrella non-governmental organisation that brings together people with mental disorders, their families and communities throughout Lithuania. Similarly, in Norway 'Rådet for psykisk helse' (The Norwegian Council for Mental Health) consists of 31 member organisations within the mental health field, while in Portugal "FamiliarMente" is the Portuguese Federation of Associations of Families of People with Experience of Mental Illness. In Slovenia, patients representatives are part of interdisciplinary working groups that are a part of governance mechanism of the national mental health programme in Slovenia.

In other countries, there are multiple different mental health service user groups, for example in Belgium where there is a service user group for each national language, in Canada where there are at least three significant national groups and coalitions (Mental Health Commission of Canada, Canadian Alliance on Mental Illness and Mental Health, Canadian Mental Health Association), or in Denmark (Landsforeningen for psykisk sundhed – The National Association for Mental Well-being and Landsforeningen af Psykiatribrugere – National Association of Current and Previous Mental Health Service-users.

In some countries, non-governmental organisations take the lead in representing the views of mental health service users. In Iceland, There are several NGO organisations and forums that provide support and guidance to where to find appropriate counselling and mental health services. All but one of these NGOs work together and meet twice a year with the Ministry of Health to discuss current issues and future direct regarding mental health in Iceland. In Mexico, there is not a national group or coalition, but there are some small groups that advocate for mental health service users. One of the largest groups in the country is The Voice Mental Health Network that is a group of non-profit citizen organisations made up of family members, users and professionals dedicated to improving the quality of life of people with a mental disorder, as well as that of their family and friends.

Table 2.2. Mental health service user groups in OECD countries

Type of Mental Health Service User Representation	
National mental health service user groups or coalition	Australia, Austria, Czech Republic, Ireland, Japan, Korea, Lithuania, the Netherlands, Norway, Portugal
Multiple national mental health service user groups	Belgium, Canada, Denmark
Multiple mental health service user groups but no national umbrella or national organisation	Iceland, Latvia, Lithuania, Mexico, Slovenia, Sweden, Switzerland, Turkey
No national or coalition group, but service users systematically consulted in policy development	England

Source: OECD (2020[15]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Individual care plans are common in OECD countries, but not systematically used to their full potential

People-centred care in mental health care is not limited to service user consultation for high-level strategies or policies, but is also a principle that needs to be operationalised at the service level. Actively involving mental health services users in planning their care, and ensuring that service users' needs and preferences are heard, promotes ownership of care and is a respectful and inclusive approach to care (Luchenski et al., 2018[17]). Putting service users' rights at the centre of care has been found to contribute to stronger feelings of ownership throughout therapy, higher quality decision-making and increased treatment adherence, which all contribute to improved outcomes (Carlos Santos and Cutcliffe, 2018[18]). There is strong consensus about the importance of shared decision making, which is found to lead to increased help-seeking behaviour, compliance with treatment decisions, reduction in errors in treatment and reduced stigma (Slade, 2017[19]; de Bienassis et al., 2021[20]).

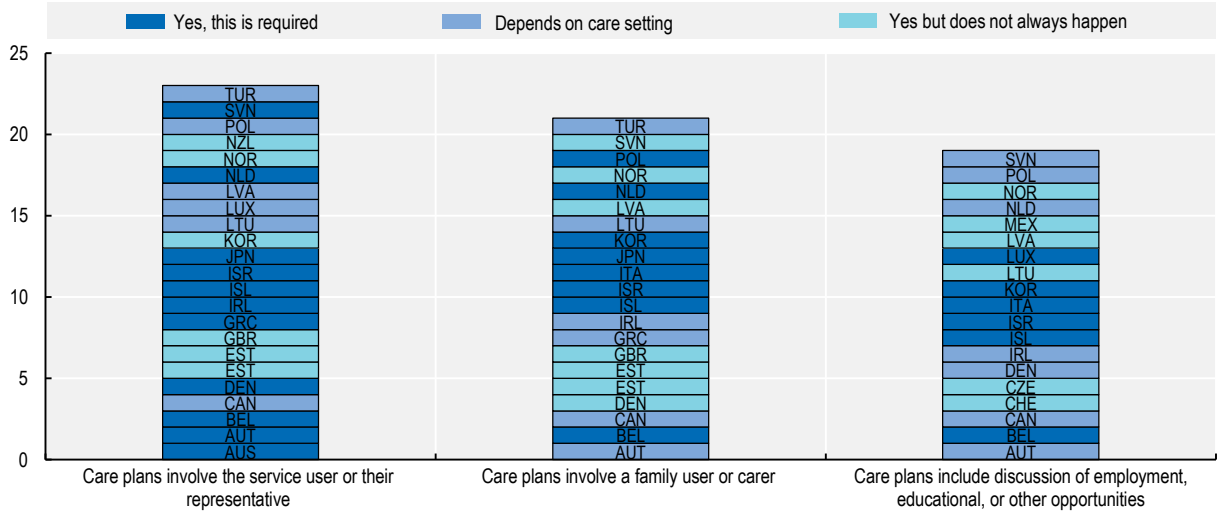
Interventions to support increased shared decision-making focus on providing information and improving communication, by using tools such as psychoeducation, discussion prompts and mobilising techniques to engage patients and carers (Comeau et al., 2019[21]; Liverpool et al., 2020[22]; Steinert, Noorthoorn and Mulder, 2014[23]). In OECD countries, service users of mental health care are increasingly involved in shared decision-making processes around their care, including through the use of personal care plans, engagement in discussion and decisions about how services are run, for instance through service user councils in inpatient settings.

Individual mental health care plans, with clinicians and service users working together to agree on care and treatment decisions, are one widely used way of incorporating service users' preferences and values into their care. Caretakers of people using mental health services have also increasingly been involved in the development of mental health care plans, especially in child and adolescent care (Liverpool et al., 2020[22]; Slade, 2017[19]).

Personal mental health care plans with clinicians and service users working together to agree care and treatment decisions, are now used in the majority of OECD countries. 27 out of 29 countries that responded

to the OECD Questionnaire require involvement of service user or a representative in their mental health care (e.g. in designing their personal care plan) in at least some settings (OECD, 2020[15]). However, the degree of service user involvement in their development appears to differ. While the majority of countries required, or strongly recommended, service users' involvement in care design of care plans, in many countries this is required in principle but does not always happen or depends on the care setting. Of the 29 countries that have responded to the OECD Questionnaire, the majority require some form of involvement of service user or a representative in their mental health care processes (Figure 2.1), but involvement differs based on care settings or other requirements.

Figure 2.1. Required involvement of services user or representative of the service user in mental health care plans



Source: OECD (2020[15]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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As an example, in Canada, where health care service provision is a provincial and territorial responsibility, involvement in care plans varies across jurisdictions and is only mandatory in certain cases, such as in some provinces (e.g. Alberta and Quebec) and teaching hospitals (OECD, 2020[15]). In other countries such as Switzerland, service user involvement is considered as guidelines but it is not a requirement. In Japan medical practitioners are obliged to draw up an inpatient-care plan and deliver it to the patient or the family with adequate explanation of care, but not necessarily involve the service user in an active role in decision-making processes. In comparison, New Zealand introduced as a target in 2014 that at least 95% of the time, services users that have used mental health and addictions services are key decision-makers regarding the services they receive; data from 2019 has shown 76% of the people felt they were involved in decisions about their care (OECD, 2020[15]).

Countries are reshaping involuntary care and putting in place frameworks to protect patient rights, including under involuntary admission

Involuntary mental health care demands extremely careful management, and should not negate a people-centred approach. 'Involuntary admission', compulsory admission, or admission under a legal act such as a Mental Health Act, is a process in which an individual experiencing symptoms of severe mental illness who refuses to receive treatment is treated against their will, often in a hospital setting (OECD,

2014[24]). Usually, a person must be presenting a danger to themselves or others in order to be detained involuntarily.

Involuntary admission is a controversial topic, as it invades in the personal liberty and the right to choose and carries the risk of abuse. It limits an individual's autonomy and freedom, which goes against the idea of enhancing people's right to, and capacity to, actively manage their own care. Nonetheless, involuntary admission is broadly accepted as having a necessary place in contemporary mental health systems, and is seen as beneficial for people who are considered to suffer from impaired reasoning because of a mental illness, while at risk of hurting themselves or others. For people who decline to seek help on their own initiative, while continuing to suffer and cause significant harm to the lives of themselves or others, involuntary treatment is seen as a last resort measure.

In order to protect the individual's safety while avoiding inappropriate use of compulsory admissions, mental health legislation determines under which conditions it is lawful to detain a person under mental health grounds. International human rights documents are available to provide context and guidance to develop legal frameworks on national level. These include the European Convention for the Protection of Human Rights and Fundamental Freedoms, and the United Nations Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care (WHO, 1996[25]; United Nations, 1991[26]). The World Health Organization has developed '10 Basic Principles for Mental Health Law' (WHO, 1996[25]) and Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (United Nations, 1991[26]) which represent international agreements on standards of good practice.

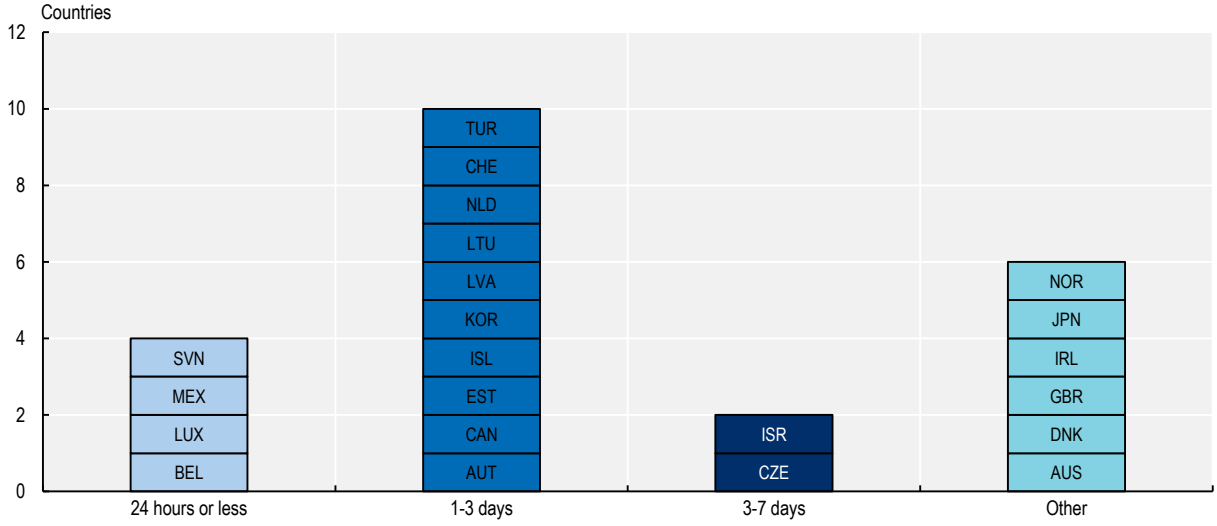
More recently, an important shift has been made in the legal frameworks for practicing involuntary admission, through the Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2007). The Convention states that all persons possess decision-making capacity, which is contradictory with the substitute decision-making used in involuntary admissions. The Convention is one of the most widely endorsed treaties in history, with the support of 180 states.

Despite the efforts to internationally standardise strategies for legal frameworks for involuntary admission, rules and regulations are diverse across countries, depending on historical and cultural factors. This concerns both the stakeholders involved in involuntary admission, and the criteria for involuntary admission. As an example, the WHO has reported that in many low-income countries with few psychiatrists, it is difficult to require that two psychiatrists certify involuntary admission (WHO, 2003[27]). While in theory all member states of the European Union (EU) require psychiatrists to provide an assessment before admission to a psychiatric facility, regulations regarding emergency assessment differ between countries. France and some Federal States of Germany consider any physician to be able to make the emergency psychiatric assessment, whereas Austria, Greece, Ireland, The Netherlands, Portugal, Spain and the United Kingdom require a certified psychiatrist undertake the assessment. 'Dangerousness' criteria also vary per country, with it being sufficient for admission in Finland, Greece, Ireland, Portugal and the United Kingdom. On the other hand, in Italy, Spain and Sweden 'dangerousness' is not considered as a criterion for admission. The presence of a mental health condition is a requirement for admission in all countries, however the type and severity differ from wide diagnostic criteria, to specific symptoms of mental illness, such as psychosis (Zhang et al., 2015[28]).

The differences in legal frameworks across OECD countries is reflected in the variety of days in which a person can be held involuntarily under the Mental Health Care Act without review of a judge, ranging from 24 hours to 7 days (Figure 2.2). Slovenia, Mexico, Luxembourg and Belgium are allowed to hold people 24 hours or less before review of a judge. In Israel and the Czech Republic, people can be held involuntarily for up to seven days before review of a judge. Even on a national level, there might be differences in legislation regarding the involuntary admission. In several countries (Australia, Denmark, Ireland, Japan, Norway, the United Kingdom) the days that a person can be held involuntarily under the Mental Health Act without review of a judge varies, for example depending on the type of detention order, or by jurisdiction,

or by assessment of an independent medical doctor (as is the case in Denmark) (see Box 2.2). In countries with federated governments such as Australia and Canada, legislation is decentralised, and states hold their own legal frameworks. However, it is difficult to draw comparisons between countries based on the number of days a person can be held involuntarily, as the duration of a hold says little about procedures that must be followed for involuntary admission to be approved, appealed, or upheld.

Figure 2.2. Days a person can be held involuntarily under the Mental Health Act without review of a judge



Source: OECD (2020[15]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Box 2.2. Managing involuntary admission – legal frameworks in England and Japan

England (United Kingdom) – Mental Health Act

In England (United Kingdom), persons held involuntarily under the Mental Health Act have the right to appeal to an independent tribunal, chaired by a judge, which has the power to discharge. For short term detentions of up to 28 days under section 2 of the Act, a patient may apply to the tribunal within the first 14 days. For longer term detentions under section 3, a patient may apply within the first six months of the detention, and again within the next six months, and annually after that. Section 68 of the Act includes requirements for the managers of hospitals to refer patients to the Tribunal in cases where the patient has not made a referral – this is required six months after the start of the detention, but for longer term patients the requirement is three years since the tribunal last considered the case (one year if the patient is aged under 18).

Ireland – Mental Health Act 2001

In Ireland the Mental Health Act 2001 provides for rules about admission to psychiatric hospitals ('Approved Centres') and rules about the rights of psychiatric patients. On arrival at an Approved Centre, the person will be examined by a consultant psychiatrist. They may be detained for a maximum of 24 hours in the centre for this examination. If the psychiatrist believes the person is suffering from a

mental disorder, they make an admission order to make them a patient of the centre. If they do not, they will be free to leave the centre. The admission order lasts for 21 days and the person can be kept in the centre for treatment for this time. A renewal order may extend this period by a further 3 months. This must be made by the consultant psychiatrist responsible and they must have examined the person in the week before making the order.

The Mental Health Commission (an independent body established under the Mental Health Act 2001) appoints mental health tribunals to automatically review all decisions to involuntarily detain patients or to extend the duration of such detentions under the provisions of the Mental Health Act 2001. Tribunals consist of three people - a consultant psychiatrist, a legal professional (practising solicitor or barrister) and a lay-person. The mental health tribunal must review the detention of the patient and make a decision within 21 days of the making of the admission order. If the tribunal is satisfied that the patient is suffering from a mental disorder and that the proper procedures have been followed, it affirms the order. If it is not satisfied, it revokes the order and directs that the patient be discharged.

Japan – Act on Mental Health and Welfare for the Persons with Mental Disorders

In Japan, the Act on Mental Health and Welfare for the Persons with Mental Disorders stipulates three types of involuntary admission. Article 29 provides that persons with mental disorders who have a high risk of self-mutilation or hurting someone else can be admitted by prefectural governor's command, provided that two Designated Physicians of Mental Health give their consent. Article 33 provides that persons with mental disorders who have no risk of self-mutilation or hurting someone but are required hospitalisation for medical care and protection can be admitted without their own consent, provided that a Designated Physician of Mental Health and a family member of the patient give their consent. In these two cases, there is no limit for the duration of involuntary hospitalisation. Those patients are discharged when they no longer need inpatient care.

In an emergency situation, Article 29-2 provides that persons with mental disorders who have a high risk of self-mutilation or hurting someone can be admitted by prefectural governor's command, provided one Designated Physician of Mental Health give his/her consent. Article 33-7 provides that persons with mental disorders who have no risk of self-mutilation or hurting someone but are required hospitalisation for medical care and protection can be admitted without their own and any of their family member's consent, provided that a Designated Physician of Mental Health gives his/her consent. In these cases, patients can be held involuntarily for up to 72 hours. In addition to those involuntary admission cases, Article 21-4 provides that patients who are voluntarily admitted can be held for up to 72 hours even though they wish to be discharged, when deemed necessary by a Designated Physician of Mental Health. Pertaining to the cases of Article 33, 33-7 and 21-4, patients can be held involuntarily for up to 12 hours without consent of Designated Physicians of Mental Health, provided that a medical doctor with specifically prescribed experiences give his/her consent.(based on Article 21-4, 33-4 and 33-7-2).

Source: OECD (2020[15]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Over recent years based on the CRPD convention, mental health frameworks around the globe have aimed to increase autonomy and choice for service users. For example, the Mental Health Act of British Columbia, Canada (2011) authorises mental health service users to give directives in advance that explicitly states their preferences and wishes in the event of mental health crisis. Northern Ireland has issued the Mental Capacity Act (2016) that is an example of fusion legislation. This legislation replaces the older Mental Health Order (1986) which utilises the presence of mental disorder and risk as criteria, and rather focuses on impairments of decision-making capacity and best interest as the only criteria to be used in involuntary admission (Lynch, Taggart and Campbell, 2017[29]; Sugiura et al., 2020[30]). The Netherlands has recently implemented policy changes concerning compulsory treatments, which came in force in the beginning of 2020 (Box 2.3), following in the footsteps of countries including England and Scotland which have adopted compulsory Community Treatment Orders (CTO) (OECD, 2014[24]).

Box 2.3. Reshaping involuntary treatment of people with mental ill-health in the Netherlands

Since January 2020, the Dutch Government has implemented a new law which allows compulsory treatment in the community (CTT) to be extended to patients' homes, called Compulsory Treatment at Home (CTH). This legislation implicates that patients can be legally compelled to undergo treatment at home (De Wet verplichte geestelijke gezondheidszorg – Wvggz).

In an attempt to move away from involuntary admission in psychiatric institutions, CCT is a less restrictive alternative to involuntary admission. CTT can be put in place when a person is discharged from involuntary admission, which is referred to as conditional charge. It allows people with psychiatric illness to receive care in their community when living at home. There is possibility to be readmitted to psychiatric hospitals if the patients' needs are not met or if the patient's condition deteriorates.

The new Dutch mental health law Compulsory Treatment at Home introduces new powers for health professionals to compel treatment, such as physical restraint and medication.

The implementation of this law raises discussions and seems to go against the efforts of reducing coercion, in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). At this point in time, there is uncertainty on how CTH will work in practice. Disadvantages of this law would be the limitation of service user's autonomy and putting a burden on the service users' social network. Moreover, there are concerns about practical implications such as the administration of force medication and the use of compulsion at home. However, this law could lead to significant increase of quality of life for service users. It could prevent compulsory admissions, which can be very traumatising. Furthermore, it could be a useful method to reduce wait times to receive treatment and early identification of relapse (Kisely, 2016[31]; Rugkåsa, 2016[32]; De Waardt et al., 2020[33]).

Additionally, from 1 January 2020, a reform is in effect which allows for increased involvement in decision-making processes of both family members or other carers and service users when it concerns involuntary assessment. Family members or carers are able to activate a process concerning involuntary admission and have a share in decision-making processes about the care plans. The service user is able to decide on care plans as well and is encouraged to develop a care plan which states their preferences and will in case of a mental health crisis.

Is mental health care respectful and inclusive of the individual, carer and family?

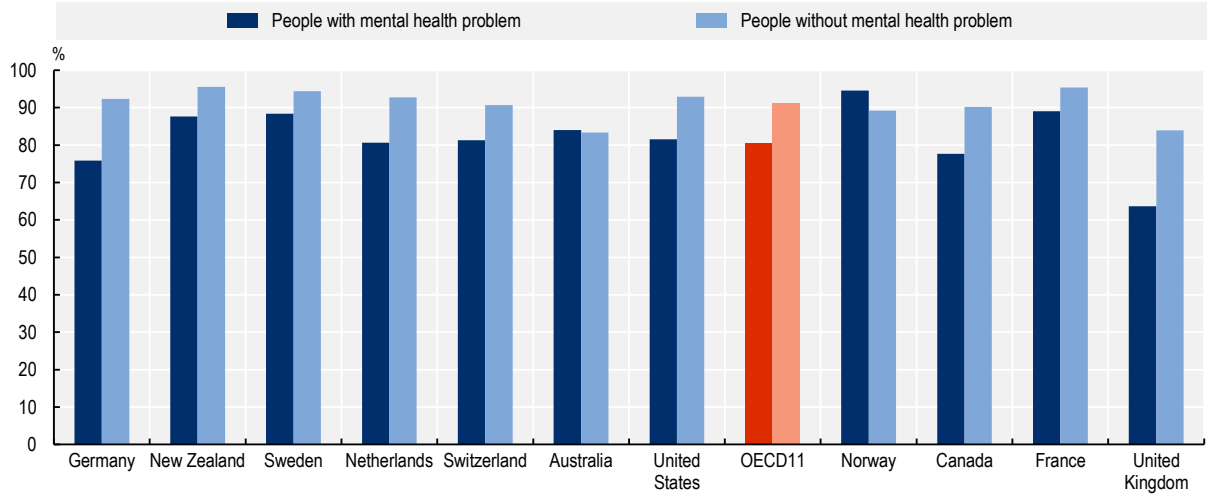
Patient-reported measures show some signs of gaps between the widely held policy principle of person-centred mental health care, and the experience of mental health service users

OECD countries put an inclusive approach at the centre of their mental health strategies and plans and included a respectful and inclusive approach as one of the sub-principles of an individual-focused approach to mental health care in the OECD Mental Health Performance Framework (OECD, 2019[12]). However, when mental health service users give feedback on the care they have received it reveals some gaps between the widely held policy principle of person-centred mental health care, and the experience of mental health service users.

In 2020, as in 2016, responses to the the Commonwealth Fund International Health Policy Survey in 11 countries showed that people who reported having a mental health problem were less likely to report being treated with courtesy and respect during a hospital stay than people without a mental health problem (includes hospital stays for any health condition, not only mental health care). On average, there was a 10 percentage point gap between people who did not report a mental health problem and reported being treated with courtesy and respect, and people with a mental health problem. In Germany, the Netherlands,

the United States, and Canada the gap exceeded 10 percentage points, and in the United Kingdom it was 20.3 percentage points (Figure 2.3). Overall, just under 20% of people who reported having a mental health problem didn't report being treated with courtesy and respect by doctors and nurses during hospitalisation. People who reported that they had depression, anxiety, or another mental health problem are also on average more than twice as likely to report receipt of conflicting information from health care professionals (OECD, 2019[34]).

Figure 2.3. Share of people who reported being treated with courtesy and respect by doctors and nurses during hospitalisation, 2020



Note: People 'with mental health problems' includes adults who responded "yes" to "Have you ever been told by a doctor that you have depression, anxiety or other mental health problems", and their responses to other survey questions. Sample sizes and survey response rates differ between countries, and results may be based on small samples. It is not possible to distinguish between individuals who were suffering from a mental health problem at the time of the survey, and those who had experienced mental ill-health in the past but have since recovered, nor whether the hospitalisation was for a mental health problem. Cultural and linguistic differences in how the question was interpreted could also influence responses. Results have not been risk-adjusted for co-morbidities and socio-economic status.
Source: OECD calculations based on the Commonwealth Fund International Health Policy Survey 2020 (forthcoming[35]), https://www.commonwealthfund.org/series/international-health-policy-surveys.

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Beyond this small international survey, it is difficult to assess in a cross-country comparable way the extent to which mental health care users – or carers or family members – judged the care they received to be respectful and inclusive. Several countries do have national or regional mental health service user surveys which give some insights into the experiences mental health service users have of their care, but cannot be compared directly across countries.

However, a number of countries have large-scale national surveys of mental health service users. New Zealand's "Ngā Poutama: consumer, family and whānau experience survey'', last administered from September to November 2019, is used monitor and improve the quality and safety of services, and complement the findings of a staff survey carried out in 2018 (Health Quality & Safety Commission, 2020[36]). The survey found that 59% of service users reported having been treated with respect, which staff mostly explained things in a way that was easy to understand (59%), and a support person was present during sessions with staff more often than not (53%). In England, the Community mental health survey in 2020 which received feedback from people between September and November 2019 (Care Quality Commission, 2020[37]). When it came to involvement in care, and communication, the survey respondents had mixed experiences; 59% of respondents said they were 'definitely' given enough time to

discuss their needs and treatment, 53% who had discussed a care plan with services were 'definitely' involved as much as they wanted to be in the planning of their care, 50% of those who had received NHS therapies in the last 12 months were 'definitely' involved as much as they wanted to be in deciding which therapies to use (ibid). In the same survey, 28% of people indicated that they had not been told who is in charge of organising their care and 41% of people who had been receiving medicines had not had the purpose of discussed with them fully (ibid).

In Australia, the Experience of Service (YES) survey has been developed for use nationwide, and is currently in place in three states or territories in Australia (New South Wales, Queensland, Victoria). The YES survey can be administered in inpatient and community care settings. In New South Wales mental health service users are offered the survey during every hospital stay or episode of community care, while in Queensland and Victoria the survey is undertaken at particular points during the year. In 2018-19, in admitted care YES survey mostly reported a positive experience of service (70.1% of respondents in NSW, 53.0% in Vic and 53.7% in Qld), with more positive responses amongst those those who had used non-admitted care (80.9% of respondents in Qld, 78.7% in NSW and 76.5% in Vic, reported a positive experience of service) (Australian Institute of Health and Welfare, 2020[38]).

The significant economic role of carers and family members in mental health care must be recognised

Over the last decades, the responsibilities for carers and family members for people with mental ill-health are generally reported to have increased, due to factors such as the shift towards community care and in general shorter hospital stays. This task, often unpaid, is often referred to as the 'carer burden'. Carers support is highly beneficial for the person with mental ill-health, which can include emotional, social and practical support for people with a mental illness (Johnson, 2016[39]).

However, carers often struggle to get the help and support that they need, both for undertaking their caring responsibilities, and for their own mental and physical health needs. Caring can leave individuals at increased risk of negative outcomes such as social isolation, lower quality of life and stress related illness; 27% of carers for people with mental health conditions reported having depression or an anxiety disorder, 26% reported back pain, and only 15% reported having some paid compensation, and only 33% reported receiving some form of additional support (EUFAMI, 2020[40]). Increasingly, countries are recognising the efforts of carers in mental illness and the burden that comes with it, but many improvements are yet to be made (Visa and Harvey, 2019[41]; Bradley and Green, 2018[42]). One of the organisations that tries to give carers a voice is the European Federation of Associations of Families of People with Mental Illness (Box 2.4).

Box 2.4. Measuring the Cost of Caring: An economic evaluation of caregiving for people with mental illness

The European Federation of Associations of Families of People with Mental Illness (EUFAMI) is a non-profit organisation with an ongoing commitment to improving care and welfare for people affected by mental ill-health. Together with the London School of Economics and Political Science/Policy and Evaluation Centre they undertook a 2-year research study, which was completed in September 2020, measuring the 'cost of caring'.

This study on the 'Cost of Caring' aimed to better understand of the economic impact of informal care and estimate the economic value of informal caring. Data was received from eight countries, respectively Canada, Denmark, Ireland, Italy, France, Malta, Spain and the United Kingdom. Dimensions of care covered were the quality of life of carers, time spent caring, value of caring, a carer's use of health services, labour participation of carers, and income.

A key finding from the research is the average length of the working week of carers. On average, informal family carers provide more than 43 hours of care every week, and 41% of carers also have to balance caring with formal employment. Also, each hour of caring time is valued by carers to be between EUR 23.62 and EUR 28.75. This indicates that the economic value of informal care is substantial – rising to an annual estimate of between EUR 61 026 and EUR 74 907. For carers who live with the person they support, who tend to spend longer hours working, the mean weakly value of the unpaid caring they provide is estimated at EUR 1 758.

It is important to stress that this study finds that the economic costs – and the unpaid labour undertaken by carers – is just one dimension of understanding the value of caring. Loneliness (carers report a mean loneliness score of 5.88, above typical scores between 2 and 4 for European populations), long term negative impacts on career progression for those with significant caring responsibilities (43% of carers reported they had reduced their work ours due to caring responsibilities, by an average 19.49 hours per week), and associated stigma can all be significant additional burdens on those caring for people with mental health conditions. The study found that overall, quality of life for carers is 40% lower than if they were not caring; 82% of carers gave up an average of 12 hours of leisure time per week, because of their caring responsibilities.

Source: EUFAMI (2020[40]), *The Cost of Caring,* http://eufami.org/resources/the-value-of-caring-resources-are-now-available/.

Are care and treatment tailored to individual needs and preferences?

Offering service users choice is key to tailoring care to individual needs and preferences, but choice is not possible in most mental health service settings

Stimulating choice and co-design of treatment can help to deliver appropriate or preferred care for the service user. Giving a choice of services or treatment options helps to go beyond the one-size-fits all approach, and is expected to create better alignment between what service users want and what kind of services are provided (Gopalkrishnan and Babacan, 2015[43]; Piat, Seida and Padgett, 2020[44]). Additionally, involving services users in choosing their treatment options has been shown to result in positive outcomes such as improved relationships with therapists, increased self-agency and motivation in one's personal recovery process (Oedegaard et al., 2020[45]). Policy agendas have increasingly promoted the involvement of service users and carers in their personal care plans, by giving them a choice about what treatment to receive and which provider to receive care from (Carlos Santos and Cutcliffe, 2018[18]).

A degree choice, for instance in the type of service or care, or the service setting, is available or sometimes available in 25 of the 29 countries which responded to the OECD Mental Health Benchmarking Policy Questionnaire, but often this depends on the care setting, region or local area, or in principle is available but this does not always happen (Table 2.3).

Table 2.3. Choice of provider or service in mental health care

Do mental health service users have any choice of provider or service?	
Yes	**Australia:** Under Better Access, patients can choose which health professional and service they access provided that they have a referral from their GP. **Belgium:** Freedom of choice of provider or health care service has to be guaranteed **Czech Republic:** Choice of a provider is guaranteed by law but sometimes limited by availability of services. **Denmark:** Citizens in need of hospital care may, within certain limits, freely choose any public and some private hospitals. **Iceland:** Choice between public or private service. They can also choose between individual health care personnel in public health care. **Lithuania, the Netherlands, Switzerland, Turkey**: except when treatment is involuntary. **Norway:** Appointments with specialists and hospitals require referral from a primary health care provider. As a patient of the specialist health service, you have a right to choose your treatment centre. Waiting lists and geographic distance limits the choice of providers for many patients. **Estonia, Israel, Korea, Latvia, Luxembourg, Poland, Slovenia**
Yes, but this does not always happen	**England:** regulations enabling people to choose their mental health provider when referred to secondary mental health services, but patients do not exercise this right in the majority of cases. **Japan:** Unless a patient is admitted involuntarily, the patient can choose any provider they prefer, but medical services are decided based on medical practitioner's advice.
Depends on care setting	**Austria:** Yes except hospital setting where responsibility is regionalised **Canada:** Mental health care standards are mandatory in certain jurisdictions and funders (e.g. provinces of Alberta and Quebec) and certain care settings (e.g. teaching hospitals in across the country) and voluntary in others In **Portugal and Turkey** service users can choose private mental health care if they wish. **Greece, Ireland**
Depends on region or local area	**Canada, Italy**
No requirement	**Mexico:** Depending on the treatment needs, the users can get services at the different mental health providers including, centres for primary care of addictions, mental health services integrated into primary health centres, mental health care services integrated into general hospitals, specialised mental health care out patients units, and psychiatric hospitals.

Source: OECD (2020[15]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

There is variation in what this means in practice, both across and within countries, and even if choice of provider or service type is offered in principle, it may well not be accessible in practice. For example, in some areas of Canada, mental health care services require that "each client's preferences and options for services are discussed as part of the assessment, in partnership with the client and family" (OECD, 2020[15]). These requirements are mandatory in certain jurisdictions and funders (e.g. provinces of Alberta and Quebec), and certain care settings (e.g. teaching hospitals in across the country), but in other settings and jurisdictions the implementation of such practices are voluntary. In Denmark, entitlement to timely hospital care means that if the Danish region cannot ensure that treatment will be initiated within 30 days, patients have the right to a so called 'extended free choice of hospital'. This means that patients may choose to go to a private hospital in Denmark. Patients also have the right to a public or private hospital treatment abroad.

In England, regulations enabling people to choose their mental health provider when referred to secondary mental health services were introduced in 2014, including legal entitlement to choice of mental health care provider, and mental health care team (NHS England, 2018[46]) However, periodic monitoring of this choice shows patients do not exercise it in the majority of cases (OECD, 2020[15]). In 2019, 50% of community mental health care users in England said that they were 'definitely' involved as much as they wanted to be in deciding which therapies to use (Care Quality Commission, 2020[37]). The National Institute for Health and Care Excellence in the United Kingdom has developed guidance and tools to promote shared decision making in mental health care plans (NICE, 2020[47]). They have developed patient decisions aids and other decision support tools to give guidance, while working together with over 40 organisations to improve shared decision making in mental health care plans. In the Netherlands, choosing a mental health care provider is supported through a website which makes it possible to find mental health care providers by mental health condition. This website additionally shows valuable information such as waiting times, religious preferences and possibilities for carer involvement (Kiezenindeggz.nl, 2020[48]).

Deinstitutionalisation expands the range of choice for people in need of mental health care

Contemporary mental health policies have made the change toward a system which promotes the autonomy of the individual by focusing on deinstitutionalisation and scaling up community care facilities for mental health care services. The Quality Kit, a policy instrument developed by the WHO based on the CRPD, recommends that countries progressively close down psychiatric long-term inpatient facilities and establish community-based services and integrate mental health into primary care services and the services offered by general hospitals. Psychiatric and other long-stay inpatient facilities have long been associated with poor-quality care and human rights violations (WHO, 2012[49]).

Deinstitutionalization is seen as essential for people-centred care systems, facilitating choice for service users by providing the highest attainable level of independence possible and increasing involved decision making in care (Thornicroft and Tansella, 2013[50]). Community care helps to improve the capacity to live and function optimally within their communities for service users, without disrupting their fulfilment of life obligations such as to family, friends, neighbours and work (Abdulmalik and Thornicroft, 2016[51]). Greater deinstitutionalisation is associated with higher quality of care in longer term psychiatric and social care facilities, and has been found to be cost-effective (Winkler et al., 2018[52]), and not associated with negative outcomes such as homelessness, imprisonment or suicides (Winkler et al., 2016[53]).

A cross-sectional study among psychiatric facilities in Bulgaria, Czech Republic, Germany, Greece, Italy, The Netherlands, Poland, Portugal, Spain and the United Kingdom showed that greater deinstitutionalisation is associated with higher ratings of self-management and autonomy, higher availability of treatments and interventions and better build therapeutic environment (Taylor Salisbury, Killaspy and King, 2017[54]).

Most mental health systems in OECD countries have shifted, or are shifting, their mental health systems towards primarily delivering services in community based settings (Knapp et al., 2011[55]). There has been a general decrease of inpatient beds among OECD countries, a trend which began in the 1960s in some countries; the rate of psychiatric beds per 1 000 population has fallen from 0.86 in 2000 to 0.69 in 2018. The magnitude of this shift varies per country, with some countries practicing the majority of care in outpatient centres and others relying more on inpatient facilities. Some countries have moved at a much slower pace, notably in central and eastern Europe, and Central Asia (Aliev et al., 2021[56]; Winkler et al., 2017[57]). As an example, in Japan, inpatient care still holds significant importance for mental health care which is reflected in the number of inpatient beds available in the population, 2.61 per 1 000 in 2018. Among OECD countries, Korea has been the only country to increase the number of inpatient beds over the recent years, from an average 0.65 per 1 000 population in 2000 to 1.26 per 1 000 in 2018, though this most recent rate does represent a decline from a peak of 1.31 in 2017 (OECD, 2021[58]).

A shift towards more community-based models of care can be a way to increase service user choice in the mental health system. In recent years, Norway has increased emphasis on municipal health care services, moving away from large psychiatric hospitals to more locally based psychiatric services. A qualitative study by Klausen and colleagues (2017[59]) shows increased involvement in decision making when receiving community mental health care. This led to positive outcomes. People felt heard and seen and were more willing to be treated. Moreover, this study highlighted barriers for shared decision-making specific to mental health care in inpatient facilities. Service users felt they were increasingly able to be involved in their own care in community mental health care centres compared to inpatient psychiatric hospitals, because of increased silence and calm in community centres compared to inpatient centres (Klausen et al., 2017[59]). A study in the United Kingdom about shared decision-making following involuntary admission to mental health hospitals found similar results, reporting as a main barrier for shared-decision making challenges in communication, noisy and busy wards which complicates one-to-one meetings (Giacco et al., 2018[60]). Slovenia is also moving mental health care more to primary health care level into newly developed structures of community mental health centres at local level, that are being developed within the 'Resolution of mental health programme 2018-2028'.

Can OECD countries deliver individual-centred mental health services which are culturally, age and gender appropriate?

Mental health services should be adapted to meet the needs of key population groups

Mental health status, and mental health system needs, are not homogenous across populations, but instead differ by age, gender, culture or ethnicity, sexual orientation as well as by a wide range of other socially important determinants. Mental health services and policies must take stock of the different needs of key population groups, especially for population groups which may be especially vulnerable to experiencing mental ill-health, or who may need particular adaptations to mental health service design in order to get the greatest benefit and best outcomes.

Several population groups are identified as being at greater risk of developing mental health problems, such as anxiety, depression and suicide ideation (Liu et al., 2019[61]; CDC, 2019[62]). These vulnerabilities vary across countries, but there are some patterns. In Australia, Canada, New Zealand and the United States and indeed worldwide, Indigenous populations have higher rates of suicide and psychological distress, suffering from symptoms of anxiety and depression at a higher rate than the non-Indigenous population (Hajizadeh, Bombay and Asada, 2019[63]; Hatcher, Crawford and Coupe, 2017[64]) Indigenous Australians shows rates of anxiety and depression between 50% and three times as high compared to the non-Indigenous population (Jorm et al., 2012[65]). Suicide rates are twice as high compared to the non-Indigenous population, and four times as high for youth (Tighe et al., 2017[66]).

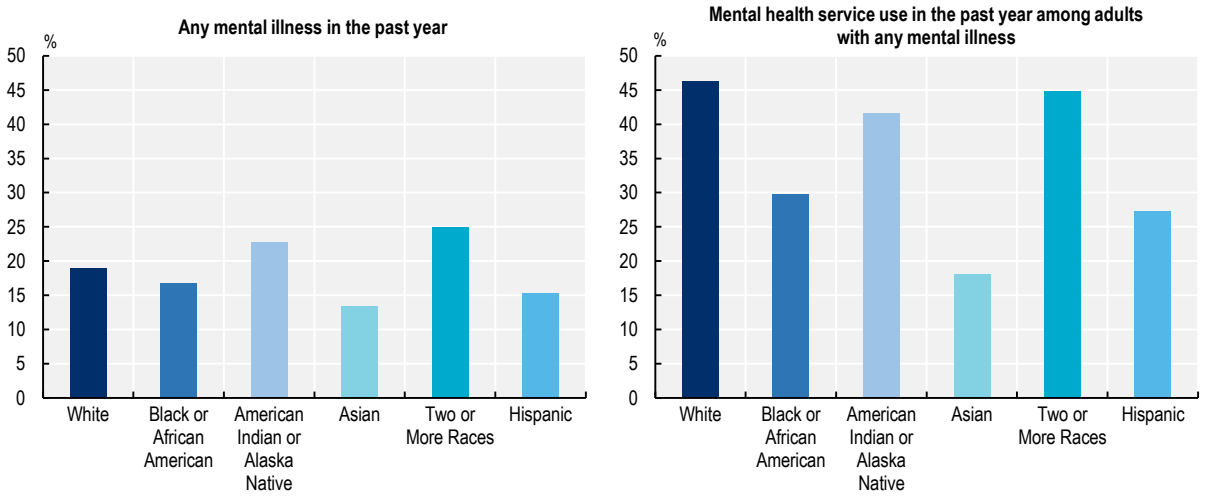
Suicide rates among the Inuit, one of the three distinct Indigenous groups in Canada, are among the highest in the world and up to ten times higher than the average suicide rate in Canada (Harder et al., 2012[67]; Kral, 2016[68]) At the same time, a 2019 paper examining suicide mortality among First Nations, Métis, and Inuit people in Canada found that there was considerable heterogeneity across communities; while suicide rates amongst some communities were high, just over 60% of First Nations bands had experienced no suicides between 2011 and 2016, and among the 50 Inuit communities, 11 communities had a suicide rate of zero between 2011 and 2016 (Kumar and Tjepkema, 2019[69]). In addition, this paper identified that socio-economic factors such as household income, labour force participation, education level and geographical factors accounted for 78% of the disparity in suicide deaths amongst First Nations people, 37% amongst Métis, and 40% amongst Inuit people (ibid). Such findings underscore the importance of first, promoting the availability of data that can be used to understand drivers of mental ill-health and suicide risks, and second, the importance of taking an intersectional approach to meeting communities' needs (see also Chapter 5).

Gender is also found to play a significant role in the prevalence of mental ill-health. In youth, boys are found to exhibit more externalizing behaviours such as ADHD, physical aggression and conduct disorders. Additionally, boys are found to have three to ten times more likely than girls to experience psychopathology during their younger developmental years. In adolescence, boys continue to outnumber physical aggression and violence. Girls, however, are twice as likely to become anxious or depressed. Adolescent boys are four times as likely than adolescent girls to complete suicide (Vander Stoep et al., 2011[70]) .

Patterns of mental health services use also differ within populations; certain population groups face greater difficulties accessing services, and poorer treatment outcomes, compared to their peers (Sanchez et al., 2016[71]; SAMHSA, 2015[72]). A study from the Substance Abuse and Mental Health Service Administration in the United States found that there were some differences in the rate of mental illness amongst different racial/ethnic groups, but bigger differences were found in patterns of service use. Certain ethnic/racial groups were less likely to use mental health services when they had a mental illness thank others (Figure 2.4). Specifically, Black and African American populations, Asian populations, and Hispanic populations were less likely to use mental health services than White, American Indian or Alaska Native populations, or people with Two or More Races.

Figure 2.4. Prevalence of mental illness and mental health service use, amongst adults in the United States by race/ethnicity, 2008-12

Annual average percentage



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-12 (2008-10 Data – Revised March 2012) reported in SAMHSA (2015[72]), *Substance Abuse and Mental Health Service Administration, Racial/Ethnic Differences in Mental Health Service Use among Adults,* https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf.

StatLink https://stat.link/cda904

There is not necessarily a consistent pattern across countries in terms of the mental health needs of key populations, and service use patterns. In Australia for instance Indigenous Australians – who have higher rates of mental distress than non-Indigenous Australians – also access public mental health services at a higher rate than non-Indigenous Australians (Australian Institute of Health and Welfare, 2020[73]). Indigenous Australians access private services, which includes GPs, at around the same rate as other Australians; given the higher level of mental distress found amongst Indigenous Australians, this likely reflects an access gap.

What is critically important is that countries take stock of the diversity of mental health needs and service preferences within their population, and take steps to respond. At present, only a few countries break down their mental health data by (nationally defined) population group. As part of OECD Mental Health Performance Benchmarking Data and Policy Questionnaires (2020[15]) countries were asked to report mental health data (for instance service use rates, admissions, death by suicide) by nationally defined key or 'vulnerable' group. Only four countries, Australia, Canada, England, and New Zealand were able to report data broken down by different population groups (other than age) (OECD, 2020[15]). Including questions on the particular needs or preferences of key population groups in mental health service user experience surveys can also be extremely valuable and informative, even if it points to shortcomings. In New Zealand's mental health service user survey, the lowest rate of positive responses was for questions about cultural and spiritual needs being met. Notably, only 14% reported staff using the reo Māori during sessions, as appropriate, 15% having access to traditional Māori healing practices, as appropriate and 18% access to kaumātua, kuia or other cultural advisors, as appropriate (Health Quality and Safety Commission New Zealand, 2018[74]).

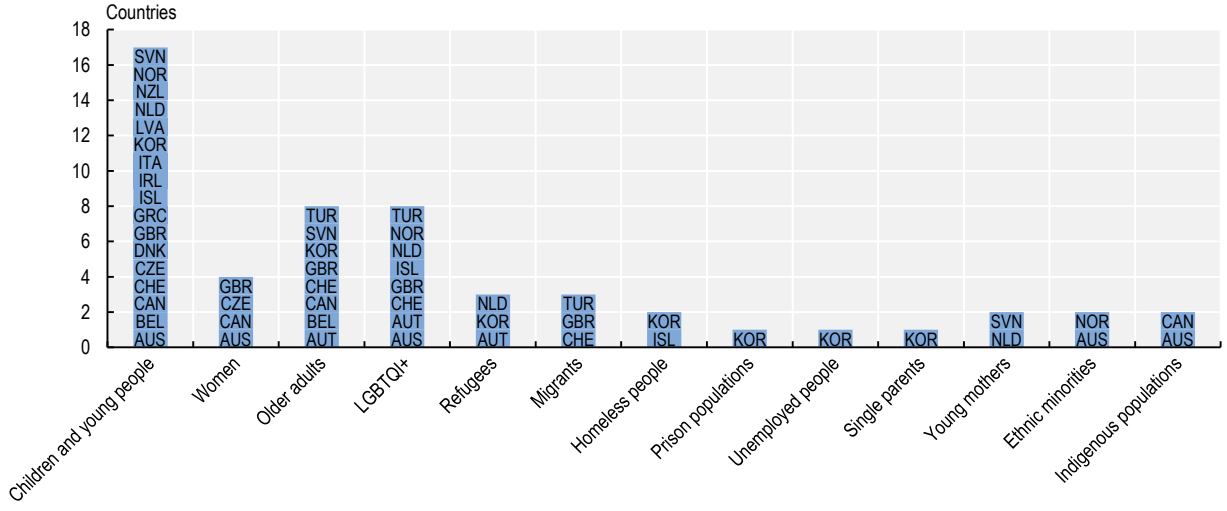
Moreover, the COVID-19 pandemic has disproportionally impacted mental health among certain population groups and has enlarged pre-exiting differences in some populations that are at risk of developing mental ill-health (OECD, 2021[75]; Winkler et al., 2020[76]). A study from the NHS in England showed that gender

interacted as a predictor of mental health deterioration, and also that Black, Asian and minority ethnic (BAME) males experienced a higher deterioration in mental health compared to British White individuals. This drop in the mental health status of BAME men was very similar to the drop in both BAME women and British White women (Proto and Quintana-Domeque, 2020[77]).

Many countries have strategies in place to support the mental health of key population groups

Many countries may have introduced mental health strategies for priority population groups (Figure 2.5). However, as detailed mental health outcomes remain disproportionately poorer for some population groups, which points to a need to further increase, or at least remain committed to, scaling-up appropriate support and services designed for and with minority and priority groups.

Figure 2.5. Mental health plans or strategies for nationally defined priority population groups



Note: Responses to the question 'Do you have a specific national or sub-national mental health strategy for different vulnerable population groups? E.g. Older adults, First nation people, ethnic minorities, LGBTQI groups'. While this term appeared to be easy to understand for questionnaire respondents, the term 'vulnerable population' can over-emphasise weakness rather than action and empowerment, and imply that all individual members of a given population are vulnerable.
Source: OECD (2020[15]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

StatLink https://stat.link/mdglqf

For example, for key population groups, the provision of accessible, co-produced services can have a significant positive impact. Fostering a supportive community with focus on local culture, such as support by social or familial network, connection to culture, development of self-identity are all related with better mental health outcomes in Indigenous populations, resulting in less suicidal ideation (Harder et al., 2012[67]; Hatcher, Crawford and Coupe, 2017[64]; Kral, 2016[68]). Canada has pursued this approach with "Culture as a Treatment"", where mental health agencies serve specific cultural practices such as talking circles, pipe ceremonies and smudging and the jointly developed the First Nations Mental Wellness Continuum Framework (Gone, 2013[78]). In Australia, Indigenous mental health policies focus on self- determination and community governance, reconnection and community life to enhance well-being and prevent suicide (Marel et al., 2016[79]).

To take one further example, OECD countries have taken some initiatives to create gender specific care, however this remains scarce and opportunities for improvement exist. In England, there have been

guidelines developed to advice on clinical management of mental health services for women who have experienced problems in antenatal or postnatal period. The guidelines cover mental ill health such as depression, anxiety disorders, eating disorders, drug- and alcohol- use disorders and severe mental illness. The guidelines are developed to promote early detection and good management of mental health problems to improve women's quality of life during pregnancy and in the year after giving birth (National Institute for Health and (NICE), 2014[80]). Finland has developed a preventative strategy to recognise that suicide was particularly high amongst young men, which led to the development of the "Time Out! Back on the track" (Aikalisä! Elämä raitelleen) initiative in 2004, which promoted social inclusion amongst vulnerable men. Two-thirds of participants reported that the participation in the programme was worth wile, while about 60% considered it had improved their life situation (Appelqvist-Schmidlechner et al., 2012[81]).

Does the mental health system empower the individual to realise his or her own potential and contribute to society?

That mental health services 'empower the individual to realise his or her own potential and contribute to society' is included as one of the dimensions of an individual-focused mental health system in the OECD Mental Health Performance Framework. This sub-principle is difficult to measure, as it demands that services adapt to support the individual in realising the contribution that best suits *their* potential.

However, if employment or educational outcomes are taken as one dimension of the individual realising his or her own potential and contributing to society, it is clear that there are some shortcomings. Fragmented information infrastructures make it difficult to assess the extent to which mental health services are integrated or connected with employment or educational settings, and/or include employment or educational outcomes, but Chapter 4 of this report clearly highlights that mental health services and employment and educational services are not systematically integrated in all countries. Nor, as Figure 2.1 in this chapter shows are employment, educational, or other opportunities systematically included as an outcome objective of mental health care planning. Only six countries (Belgium, Iceland, Israel, Italy, Korea, Luxembourg) said that discussing employment, educational, or other opportunities was a requirement in service user care plans, with a further 12 countries saying that this should be the case but didn't always happen, or depended on the care setting.

Some service user-reported data suggests challenges may remain around including educational or employment outcomes in mental health services. One service user survey in Canada found that mental health inpatient responses in the affirmative to the question, "Are staff helping you with your employment and/or education goals?" was 52.2% and outpatient responses to the questions "Are you receiving support with income-related issues" and "Are staff helping you with your housing goals?" were rated 58.2% and 59.3%, respectively (CAMH, 2014[82]). In England, a community mental health care service user survey found that 36% of people felt they had not had support with their physical health needs, 43% said they did not receive help or advice in finding support with financial advice or benefits and 43% of people did not get help or advice in finding support for keeping or finding paid or voluntary work, but would have liked this help (Care Quality Commission, 2020[37]).

Strengthening people-centred mental health care provision

OECD countries increasingly recognise how important it is to equip health systems, and mental health systems, with tools to move towards a person-centred system. However, although attention has increased in many mental health systems people-centredness is at best inconsistent, and at worst tokenistic, and there is still a lot to improve. There are numerous promising policies to promote and integrated individual-centred care in place in OECD countries, which should be adopted more widely. More systematic consultation of mental health service users should be a priority in all OECD countries – through surveys of service user experience of the mental health care system, on the system priorities of service users, family

and carers, and through the use of patient-reported measures of outcome and experiences at the service level. Peer-delivered services or co-designed services, which have been adopted in a few OECD countries but could be developed in many more, also hold great potential for putting the service user perspective at the heart of mental health service design and delivery.

Moving from consultation to co-production is key for increasing person-centredness of mental health policy and services

To secure more person-centred mental health systems, there is a need to move from light-touch consultation with service users, to leadership in the sector by mental health service users. This means working with – or having leadership from – people with lived experience of mental health service use in designing mental health services, and in delivering services. Countries including England and Ireland have begun this process, elevating the voices of mental health service users and promoting co-produced mental health services as a key way to enhance person-centredness in mental health care. This process can be adopted at a system-wide level, as well as at the individual service or even ward level. One acute mental health ward in England used a process of co-design between recent service-users and health workers on the ward to change some key aspects of the way the ward was run, including the removal of an existing triage system and improving feedback from service users to staff (Springham and Robert, 2015[83]). After this process, the number of complaints on the ward dropped significantly, and were lower than two neighbouring wards. Ireland's Health Services (HSE) recognises the value of personal lived mental health experience in developing more recovery oriented services, and has developed a structure – the office of Mental Health Engagement and Recovery – to engage service users and family members/carer's in the design delivery and evaluation of services. A key part of this is the establishment of 35 service user local engagement service improvement forums to involve service users and family carers (OECD, 2020[15]; HSE, 2019[84]).

Experiences of and outcomes from mental health services don't just vary between OECD countries, they also vary within them. Individuals' age, gender, ethnicity, socio-economic status, and sexual orientation can all intersect with their mental health needs and service preferences and can all have an impact on experiences and outcomes from mental health care. Though many countries may have strategies for priority population groups, the comparatively poor outcomes for such groups points to a need to further increase, or at least remain committed to, scaling-up appropriate support and services designed for and with minority and priority groups. Furthermore, countries need to go beyond strategies focused on priority groups and towards accessible, tailored services. Canada and Australia have focused on co-produced strategies and services with Indigenous populations as a way of improving mental health outcomes for these key populations (see Box 2.5).

Box 2.5. Co-produced strategies and services with indigenous populations in Australia and Canada

Both Australia and Canada have focused on co-produced strategies and services to improve the effectiveness of mental health care for Indigenous populations, which have been found effective. For key population groups, countries need to go beyond strategies focused on priority groups and towards accessible, co-produced services. Fostering a supportive community with focus on local culture, such as support by social or familial network, connection to culture, development of self-identity are all related with better mental health outcomes in Indigenous populations, resulting in less suicidal ideation (Harder et al., 2012[67]; Hatcher, Crawford and Coupe, 2017[64]; Tighe et al., 2017[66]). Canada has pursued this approach with "Culture as a Treatment"", where mental health agencies serve specific cultural practices such as talking circles, pipe ceremonies and smudging (Gone, 2013[78]), and the jointly developed the First Nations Mental Wellness Continuum Framework. In Australia, Indigenous mental health policies

focus on self-determination and community governance, reconnection and community life to enhance emotional well-being for Indigenous communities (Dudgeon et al., 2014[85]).

As response to the high suicide rates amongst the First Nations and Inuit communities, Canada has developed a targeted mental health strategy focusing on suicide prevention. Policy makers and researchers recognised the importance of community-based approaches in suicide prevention and mental wellness activities, given that that the First Nation and Inuit populations know what is best for their youth. Together, the Aboriginal populations and the Canadian Government established "A National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)" in 2005-10. This community-driven strategy is based on four elements of preventions; primary, secondary and tertiary prevention and knowledge-based development to help ensure individual, family and community mental health. Anticipated outcomes are improved health status of Aboriginal youth, families and communities; which it is hoped will lead to reduction in suicide rates on long term. Given that Aboriginal youth suicide is a complex issue, the government foresees it will take years to effectively assess the rates of Aboriginal youth suicide (Health Canada, 2013[86]).

The Australian Government is supporting Indigenous suicide prevention by providing AUD 4.5 million to support Gayaa Dhuwi (Proud Spirit) Australia as a national Aboriginal and Torres Strait Islander leadership body to help Australia's health system provide culturally safe and appropriate care. Further funding is included for young Indigenous leaders to participate in place-based cultural programs, a specialised centre for mental wellness of children and adolescents exposed to childhood trauma, culturally adapted compassion-focused psychological therapies, and the not-for-profit organisation Red Dust, which seeks to improve the health and well-being of disadvantaged youth in remote communities, for their work in the Northern Territory (Australian Government - Department of Health, 2019[87]).

Peer-delivered services are of value for creating appropriate people-centred care

Peer-delivered services are seen as an important driver for embedding a person-centred care approach. Peer support is as increasingly popular as a recovery-oriented service that has the potential to improve patient well-being, reduce relapse and decrease the burden on formal acute mental health services (Valenstein & Pfeiffer, 2018). Peer support was initially built on the idea of voluntary effort to contribute to practice standards, but has led to the development of professional, funded positions in mental health care. Increasingly, peer supporter workers have been delivering care informed by their own experiences. Examples of peer-delivered services in mental health care can be peer listening (active listening from a trained peer supporter); peer education; (peers educating others on specific topics, such as coping with depression), peer tutoring or mentoring (including academic or social learning, or a 'buddy' system); or peer mediation (where trained peer mediators help with formal or informal conflict resolution) (Mental Health Foundation, 2021[88]).

Some OECD countries are actively promoting the involvement of mental health service users, or former service users, in the delivery of mental health services. In England, the mental health strategy "No Health Without Mental Health" called for staff with experience and expertise to deliver individualised mental health care in resource-limited settings (Department of Health and Social Care, 2011[89]). Since then, England has been actively pursuing research into more extensive use of peer workers (people with personal experience of mental health issues) within the mental health system following evidence that peer support can bring benefits such as enhanced feeling of empowerment, better social support and increased personal recovery (Gillard, Edwards, Gibson, Owen, & Wright, 2013). In England's Mental Health Implementation Plan, the growth of peer support workers is planned for at least the period up until 2024; under this strategy peer support workers England has a national programme to develop new peer support roles, peer support workers will work across the mental health system and across different mental health conditions, and growing supervisor capacity and capability is a key objective (NHS, 2019[90]). In Ireland, an

evaluation of the impact on Peer Support Worker users found overwhelmingly positive feedback from mental health service users (Box 2.6). Peer support was recognised also in a Slovenian Delphi study as being of particular importance, and especially urgent given the COVID-19 crisis.

Box 2.6. Evaluation of Peer Support Workers in mental health in Ireland

In 2017 in Ireland, 26 Peer Support Workers were employed in Mental Health Services across 11 countries, to support service users with their recovery. Peer Support Workers were working as members of multidisciplinary teams in the community (Community Mental Health Teams, CMHT), rehab and (CMHT), rehab and recovery teams, acute wards, and early intervention psychosis services.

This programme was evaluated in 2019, and found that a feedback from service users was very positive:

- all of the service users who were surveyed stated that they liked receiving peer support (32% quite a lot; 68% very much);
- service users said that Peer Support Workers had a positive impact on their experience of mental health service (53% quite a lot; 47% very much);
- all service users found that receiving peer support was beneficial to their recovery (41% quite a lot; 59% very much);
- and felt that peer support workers empowered and supported them on their recovery journey (3% somewhat; 39% quite a lot; 58% very much);
- 76% of service users stated they are more active in their community as a result.

Mental health service providers also had a very positive view of the impact of Peer Support Workers:

- Service providers felt that Peer Support Workers are having a positive impact on service users' experience of Mental Health Services (76% yes; 23% somewhat), and were making a difference to service users (78% yes; 18% somewhat).

Source: Hunt and Byrne (2019[91]), *Peer Support Workers in Mental Health Services*, HSE Health Services, https://www.researchgate.net/publication/340716658_The_Impact_of_Peer_Support_Workers_in_Mental_Health_Services.

Peer led interventions can be of particular value for enhancing mental support for key population groups, such as Indigenous youth and LGBTQ+ communities. Peer support can help to alleviate distress and improve access to affirmative support and contribute to positive mental health outcomes. In Canada, New Zealand, Australia and the United States Governments have developed strategies to improve the health outcomes of Indigenous youth. Youth peer-led interventions have become increasingly popular to share health information with young people and has appeared to be well suited to the Indigenous community context. Within the youth communities, this included sites of interaction such as schools, sporting, and designated youth spaces. Although proof the effectiveness of peer led interventions are still in their preliminary stages, peer-led interventions have been considered particularly useful for educating young people about sensitive topics which can cause embarrassment or fear when discussed with adults, including sexual health and substance use (Vujcich et al., 2018[92]). The United States has also explored the use of peer advocates for LGBTQ communities living in rural communities, through the use of "LGBTQ peer advocate intervention" which is a programme to enhance services and social support for rural LGBTQ persons. Evaluation of this programme is still forthcoming (Willging et al., 2016[93]).

More widespread use of patient-reported measures will be critical for driving more people-centred systems

Seeking and reporting the views of individuals with lived experience of mental illness, people who use mental health services, and their families and carers, is a key method of making mental health systems increasingly people-centred. As this chapter has shown, service users' own views of their experience of care is critical to embedding a more person-centred approach, and can garner illuminating insights. However, routinely collecting patient reported outcomes and experiences remain the exception among OECD countries (OECD, 2020[15]). Mental health data availability is still dominated by inputs and resources, for example by number of beds or service contacts. While important, this information does not bring significant insights into whether care is person-centred and what it delivers to the patient.

Collecting patient-reported information of experiences of care is a way to ensure the delivery of person-centred care, giving insight in peoples experiences and outcomes of care (Santana et al., 2018[94]). Measuring a wide range of constructs related to outcomes of care such as daily functioning, mental health and disease burden and experiences of care will provide information that shows how care systems are truly delivering care that aligns with people's needs and expectations. Patient-reported measures give insights where person-centred care delivered and where there remain gaps.

Patient-reported indicators measure health status or the experience of receiving health care from the patients' perspective and are essential to ensure services are responsive to people's needs and preferences and improve the quality and outcomes of an individual's mental health. Patient- reported indicators are also particularly useful for promoting and evaluating people-centred care (OECD, 2019[34]). They are defined as:

- Patient-reported experience measures (PREMs), which are used to obtain patients' views and observations on aspects of health care services they have received (e.g. communication with nurses and doctors, staff responsiveness, discharge and care co-ordination); whereas
- Patient-reported outcome measures (PROMs), which provide the patient's perspective on their health status (e.g. symptom burden, side effects, psychological well-being and social functioning) (de Bienassis et al., 2021[20]; de Bienassis et al., 2021[95]).

The systematic use of outcomes frameworks to measure patient-reported measures is still relatively new, but could now stand to be accelerated across OECD countries (Table 2.4).

Table 2.4. Countries currently collecting patient-reported measures, 2018 or latest year for which information was available

	PROMs currently collected	PREMs currently collected	PROMs currently reported	PREMs currently reported
Australia	Yes	Yes	Yes	Yes
Canada		Yes		Yes
Costa Rica	No but plan to	No but plan to		
Chile	No	No		
Czech Republic	Yes			
Denmark	No but plan to	No but plan to	Yes	
Israel	Yes	Yes	Yes	Yes
Japan	Yes	No		
Mexico	No	No		
Netherlands	Yes	Yes	Yes	Yes
Norway		Yes		No
Korea	No	Yes		No
Sweden	Yes	Yes		Yes
United Kingdom	Yes	Yes	Yes	Yes

Source: Authors compilation of OECD survey as part of the PaRIS Working Group on Patient-Reported Measures in Mental Health.

Using information on both patient experiences and outcomes enables a broader understanding of health system performance from the service users' perspective. PREMs and PROMs are complementary and are meant to be used together to capture a more complete picture of the patient journey. The OECD has started to speed up the uptake of patient-reported measures by launching the Patient-Reported Indicators Surveys which includes the measurement of patient reported measures in mental health care (Box 2.7).

Box 2.7. The OECD Patient-Reported Indicators Surveys – PaRIS

In 2017 the OECD launched the Patient-Reported Indicators Surveys (PaRIS) to accelerate patient-reported measures to make systems more people-centred. Its aim is to systematically collect data on what matters most to patients. The PaRIS-project is focusing on standardising patient-reported indicators in fields where indicators of health care quality and outcomes are already used. This includes hip and knee replacements, breast cancer and mental health.

As part of the PaRIS initiative, the OECD launched the PaRIS Working Group on Patient-Reported Measures for Mental Health in May 2018. This Working Group, made up of experts from across OECD countries, is looking to increase mental health PREM and PROM data collection, and also facilitate international comparisons with 17 countries involved. The main objective is to develop PREM and PROM data collection standards in mental health for international benchmarking of patient-reported outcomes. Three domains which have international coherence have been identified for PREMs (respect and dignity, communication and relationship with health care team and shared decision making), and PROMs (relief of symptom burden, restoring well-being/social function and recovery support). The Working Group is looking towards a pilot PROM data collection, beginning with hospital care, focused on the domain of well-being, drawing on the OECD Guidelines on Measuring Subjective Well-being and the WHO-5 Well-Being Index questionnaire that measures current mental well-being (time-frame of the previous two weeks), with first results expected in 2021.

The PaRIS initiative also includes the development of a standardised international survey of patients with chronic conditions who are treated in primary health care or other ambulatory health care settings. At present, these is scare data on the outcomes and experiences of this significant and growing group of health care users, and even less internationally-comparable data on their experiences and outcomes of care. Mental health will be included both as a chronic condition (depression, anxiety), as a co-morbid chronic condition, and as a dimension of well-being outcome for this survey, which will begin field trials in 2021.

Source: de Bienassis et al. (2021[20]), "Measuring patient voice matters: setting the scene for patient-reported indicators", https://doi.org/10.1093/intqhc/mzab002; (2021[95]), "Patient-reported indicators in mental health care: towards international standards among members of the OECD", https://doi.org/10.1093/intqhc/mzab020, OECD (2017[96]), "PaRIS: Patient-Reported Indicator Survey. The next generation of OECD health statistics", www.oecd.org/health/PaRIS.htm; OECD (2019[1]), "Measuring what matters for people-centred health systems", https://doi.org/10.1787/4bbba455-en; OECD (2019[97]), "Measuring What Matters: The Patient-Reported Indicator Surveys, 2019 Status Report", https://www.oecd.org/health/health-systems/Measuring-what-matters-the-Patient-Reported-Indicator-Surveys.pdf.

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3 Accessible, high-quality mental health services

A system that provides accessible, high-quality mental health services includes services that are safe and evidence-based, delivered in a timely, continuous manner, while being developed close to the community and taking into account individual needs and preferences. High-quality mental health services outcomes and experiences, and support people to recover from, or better manage, mental health conditions. OECD countries have been making efforts to improve their services, including to improve accessibility and quality. However, this chapter shows room for improvement remains, as unmet need for mental health care remains high, and high rates of emergency care use, repeat admissions to inpatient care and high suicide rates after discharge points to key gaps in quality of care. This chapter identifies some policies and practices that can be implemented to improve access to and quality of mental health services, while calling for improvements in data availability to better measure how effectively mental health services are delivering improved outcomes for service users.

Introduction

In many countries, there have been significant efforts to increase availability of mental health services in recent years, more and more services are delivered in community settings (outside of hospitals) and efforts are ongoing deliver services in a timely manner. Countries have been increasing the volume of services, introducing targeted funds for priority services, and tracking time waited for services. Increasing access to talking therapies has been another way that countries have sought to better meet mental health needs, especially for common mental disorders such as depression and anxiety.

However, there is significant variation in type of mental health services available in countries: inpatient beds per population varied more than 50-fold across countries, while rate of outpatient contacts varied more than 100-fold. There are still significant limitations in available data on quality and outcomes in mental health care, but available indicators point to shortcomings. People with severe mental illness have a mortality rate markedly above the general population, there are challenges around continuity of care after inpatient discharge, with around 10% of people with acute mental health needs are regularly appearing in emergency care settings.

Countries need to keep focusing on strengthening their mental health care systems and aim for accessible, high quality service that are able to meet the needs of all people in their support and treatment for mental health. These services should range from preventative measures for maintaining mental health to high quality, more intensive treatments for people with severe mental ill-health. One way is to provide low-intensity, low threshold services as a way to promote well-being and prevent worsening for severe mental ill-health. Additionally, systems must focus on creating safe mental health services that are developed in a continuous, integrated manner.

Building high-performing mental health services

What are accessible and high-quality mental health services?

Mental health conditions affect mood, cognition, motivation and all aspects of life including employment, relationships, housing and personal care, and represent a growing burden of disease worldwide (Ride et al., 2020[1]). In 2016, mental ill-health affected more than 1 billion people globally, mental health conditions caused 7% of all global burden of disease as measured in disability-adjusted life years (DALYs) – closer to 10% if substance use disorders are included – and 19% of all years lived with disability (Institute for Health Metrics and (IHME), 2020[2]). Depression was associated with most DALYs for both sexes, with higher rates in women as all internalising disorders whereas other disorders such as substance abuse had higher rates in men (Rehm and Shield, 2019[3]).

Access to high quality mental health services can transform individuals' experience of mental health conditions. For some people, access to effective and high-quality services can contribute to a full recovery from a mental health condition. For others, effective treatment can mean improved functioning, return to work or education, and an increase capacity to participate in activities that are meaningful, even as some symptoms continue. For others still, effective mental health care helps alleviate and manage symptom burden and promote the highest quality of life and functioning possible, even if full recovery is not possible (Mind, 2017[4]; American Psychiatric Association, 2018[5]; NAMI, 2020[6]; Mental Health America, 2020[7]). Access to effective mental health services has individual and social benefits, as well as economic benefits, contributing to reducing the costs of lost productivity, higher levels of disability, and even higher costs of treating physical health conditions such as diabetes (Sporinova et al., 2019[8]; Hutter, Schnurr and Baumeister, 2010[9]; Ducat, Philipson and Anderson, 2014[10]).

That a high performing mental health system "Has accessible, high-quality mental health services" is one of the six principles of a high-performing mental health system established by the OECD Mental Health Performance Framework (OECD, 2019[11]). Accessible and high-quality mental health services are the foundation of a high performing mental health system, and mean that people experiencing mental distress can get the help and support they need. In particular, accessible and high-quality services should:

- Be evidence-based (see Chapter 7);
- Be developed close to the community;
- Be provided in a timely manner;
- Account for and respect the unique needs of vulnerable groups;
- Ensure continuity of care;
- Deliver improvement of individual's condition;
- Be safe.

How accessible and high-quality are mental health services in OECD countries?

Are services accessible and provided in a timely manner?

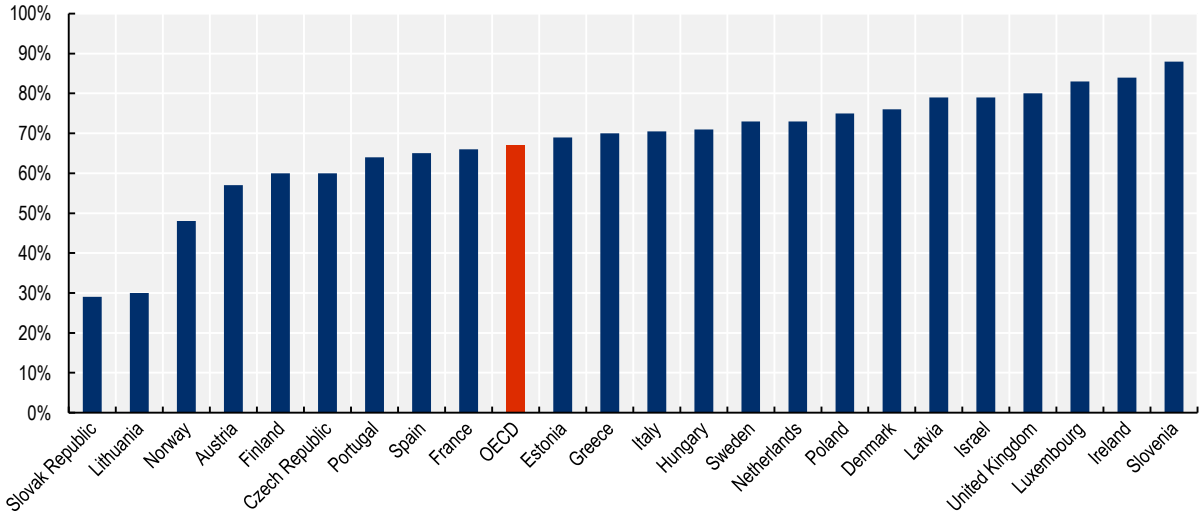
Historically, rates of unmet need for mental health care have been high

Countries have been struggling with meeting the needs of people with mental ill-health. The 'treatment gap' for mental health services has long been acknowledged and estimated to exceed 50% worldwide (Kohn et al., 2004[12]; Patel et al., 2018[13]). It is estimated that between 76% and 85% of people in low- and middle-income countries receive no treatment for their mental disorder (Wang et al., 2007[14]; WHO, 2020[15]).

In OECD countries, available indicators point to an enduring gap in need for treatment and access (Figure 3.1). There is a clear variability in accessibility: in some countries reported unmet needs for mental health care for financial reasons were far higher than for other health needs; in Iceland 8.1% of respondents reported financial barriers to accessing medical services, compared to 33.1% for mental health services. 2018 data from Canada also suggests considerable unmet needs for care; only 50% of persons who reported needing counselling or therapy had their needs fully met, and people in the lowest income were more likely to report unmet needs (Statistics Canada, 2019[16]). In addition, recent analysis from the Canadian Institute for Health Information suggests that Canadians with mental health conditions were more likely to report cost barriers to care and financial distress (CIHI, 2021[17]).

Figure 3.1. Share of people with unmet needs due to financial reasons, wait times or transport, 2016 or latest year

Unmet needs for mental health care



Note: Share of working age adults with mental distress who wanted help, but could not get it due to financial or wait times or transport. Figure presents data between 2012 and 2016.
Source: EHIS-2, GEDA in OECD (forthcoming[18]), *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation*.

StatLink https://stat.link/ti7yw9

In some countries, it appears that the COVID-19 crisis has increased unmet need for mental health care. During the COVID-19 crisis, there have been significant disruptions to the delivery of mental health services. A WHO survey in Q2 2020 found that more than 60% of countries worldwide reported disruptions in mental health services: 67% saw disruptions to counselling and psychotherapy; 65% to critical harm reduction services; and 35% to reported disruptions to emergency interventions (WHO, 2020[19]).

While many countries – 70% worldwide (ibid) – pivoted rapidly to delivering services through telemedicine formats, and maintained access to some critical in-person services, referrals into mental health services fell. For example, in the Netherlands in the first wave of the pandemic the number of referrals to mental health care fell from 25 to 80%, demand for treatment dropped between 10 and 40%; billable hours have decreased 5-20%; bed occupancy dropped 9%. The number of treatment hours for youth mental health care fell 20% in Q2 2020 (ibid). The crisis may have increased unmet need for mental health care; in a survey conducted in March-May 2020 by the Commonwealth Fund, 68% of adults in the United Kingdom and 69% of adults in the United States reported that they needed and wanted to get mental health care, but were not able to (Fund, 2020[20]). In the United States, a survey undertaken across 2020-21 found that 9.2% of surveyed adults reported that they needed counselling or therapy but did not get it in the four previous weeks in August 2020, while in 2019 4.3% of adults they could not receive needed counselling or therapy due to cost in the past 12 months (Centers for Disease Control and Prevention, 2020[21]). In the phases of the survey (Phase 3 and 3.1) in late 2020 and early 2021, the rate of adults who reported they needed counselling or therapy but did not get it in the four previous weeks ranged from lows of 9.7% to a high of 13.0% (ibid).

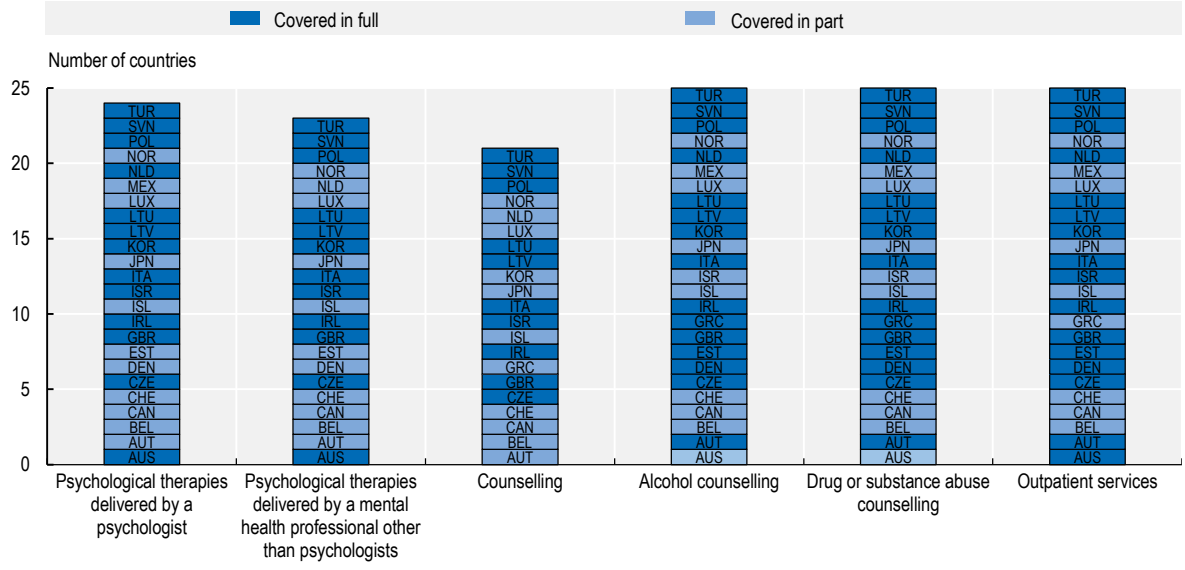
In some countries residential and long-stay mental health care were significantly disrupted, and negative impacts on quality of care were reported. A review of the impact of the COVID-19 pandemic on long-stay mental health care institutions in Europe, which included care homes, psychiatric hospitals and other forms

of residential institution, found that institutions struggled to implement the necessary protective measures in already over-stretched settings, and that "providing individualized person-centred care and support under crisis conditions is significantly more challenging to deliver in large-scale institutions than in community settings or at home" (WHO Europe, 2020[22]). In the Czech Republic, an assessment of the pandemic and the state of emergency in the Czech Republic which lasted from 12 March to 17 May 2020 on long-stay institutions found a high prevalence of poor mental health outcomes amongst both clients (46% poor well-being, 58% depression, 45% anxiety) and staff (17% poor well-being, 22% depression, 14% anxiety) (Guerrero et al., 2021[23]). Delivery of care was also disrupted, along with the admissions and discharge process, and isses including lack of clear information, lack of protective equipment, lack of activities for pateints, and an increase in use of restrictive practices were reported (ibid).

Coverage of mental health services varies across countries

The availability of services covered by basic health coverage, or the requirement to pay for services in part or full out of pocket, are important factors that influence the access to mental health services. Costs such as out-of-pocket payments for mental health care services can also be a barrier for access to care (Paris et al., 2016[24]; Auraaen et al., 2016[25]). Countries vary in the extent to which mental health services are fully or partly covered by basic health care (Figure 3.2). Alcohol, drug or substance abuse counselling, and mental health outpatient services are covered in most OECD countries (24, out of 29 respondents) while psychological therapies delivered by a psychologist are also covered in full or part in most countries. Counselling or psychological therapy services delivered by a professional other than a psychologist are covered in fewer countries and are more likely to be covered only in-part.

Figure 3.2. Mental health services covered in full or in part by basic health coverage



Note: Services covered in full or in part by basic health care coverage, e.g. basic health insurance, services covered by national health system.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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In some countries, where services are covered in part, a fixed co-payment is required which in turn can be deducted through additional health insurance coverage, such as in Norway and the Netherlands (OECD, 2020[26]). Coverage can also depend by type of services, with some countries (for instance the Netherlands) covering treatment of severe mental health in full and requiring additional out of pocket payments for less acute mental health support such as care provided by General Practitioners (OECD, 2020[26]).

Some countries have provided additional coverage for vulnerable populations. In Iceland, all services for children are free of charge and fully covered, whereas adults pay a small fee for services. Canada covers mental health services for populations at higher risk of mental ill-health such as indigenous people and veterans (OECD, 2020[26]). Countries also have a range of gatekeeping requirements regarding accessing mental health services in order to access services and/or for services to be reimbursed, for example requiring a referral from a General Practitioner such as in Australia and the United Kingdom, or requiring that services are provided by certain accredited professionals or in certain health settings such as in Canada and France (CAMH, 2021[27]; SANE Australia, 2019[28]; NHS, 2019[29]; Aide-Sociale.fr, 2019[30]).

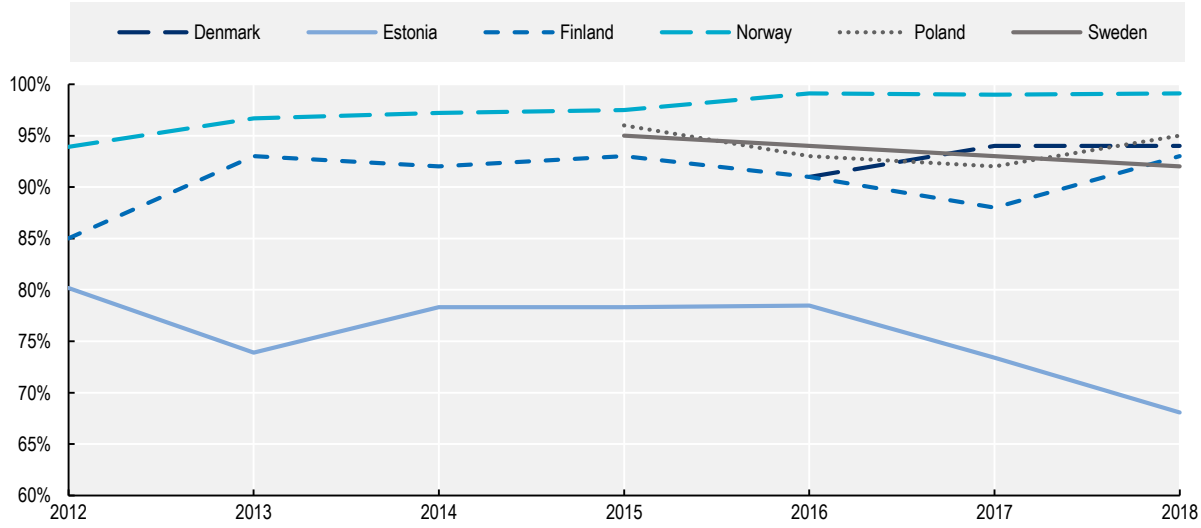
Average waiting times for mental health services decreased in countries tracking them

That services "Be provided in a timely manner" is included as one of the sub-principles in the OECD Framework, and one of the most important principles in the OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy (OECD, 2019[11]; OECD, 2015[31]). Delayed care for mental ill-health can be related to poorer outcomes, for example for people with first-episode depressive illnesses (Davey and McGorry, 2019[32]) or psychotic episodes (Fusar-Poli, McGorry and Kane, 2017[33]). Tracking waiting times can also be a way to track whether access to services is consistent across geographical areas or service type (OECD, 2020[34]).

Denmark, Finland, Ireland, Lithuania, the Netherlands, New Zealand, Norway, some regions in Spain (including Baleares, Navarra), Sweden and the United Kingdom (England, Wales, Scotland) have a waiting times target or guarantee in at least one area of mental health care, most of which aim to provide treatment or a first service contact within 1-3 months (OECD, 2020[34]; OECD, 2020[26]). Several countries (Finland, Ireland, New Zealand, Norway, Sweden, Scotland, and Wales) report separate waiting times guarantees for mental health services for children and adolescents. In Norway the wait time for children (40 days) is slightly shorter than for adults (45 days) while in Sweden the wait time target is much shorter for children and young people (30 days) than for adults (90 days).

Where data is available over time, the proportion of patients who have been assessed or treated within the maximum waiting times targets appears to have increased and average waiting times decreased for mental health (OECD, 2020[34]). In Denmark, Finland and Norway the percentage of persons seen within set mental health waiting times increased in recent years, although the percentage of people seen within the waiting times guarantee fell in Estonia (Figure 3.3). The waiting times target set in Denmark stands out in particular, where the waiting time for a first appointment and assessment is 30 days Denmark, a target met for 95% of people in 2018. Many countries continue to struggle with waiting times for people in need of mental ill health. In the Netherlands, targeting the issues behind waiting times is currently a top priority to ensure access to care, as people with severe mental ill-health have to wait over 4 months and sometimes up to 24 months to access a mental health care specialist (Box 3.1).

Figure 3.3. Percentage of persons seen within mental health waiting times target set in each country



Note: Data show the percentage of persons who meet nationally-set wait times target for mental health services. National wait times shown are as follows: Denmark (persons assessed and investigated within 30 days); Finland (patients waiting less than 90 days before receiving psychiatric care following special assessment); Estonia (percentage of patients who had a consultation with a specialist within 6 weeks); Norway (percentage of patients who have received health care within the clinically assessed deadline assigned to the patient); Sweden (percentage of patients who had first contact in specialised care within 90 days).
Source: Poland, Sweden – OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaire, all other countries OECD (2020[34]), *Waiting Times for Health Services: Next in Line*, https://dx.doi.org/10.1787/242e3c8c-en.

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Although policy discussions are not always framed in terms of reducing mental health wait times, or meeting maximum wait time targets, policies appear to be focused on better meeting demand through increased service volumes or scope, rather than managing demand. Countries also identify shorter wait times for accessing services as a way to reduce the risk of deterioration in health, and improve outcomes from treatment (Helsedirektoratets Norway, 2019[35]; NHS England, 2015[36]). For example, when England introduced maximum wait time targets for mental health services, this included an injection of funding of GBP 80 million to increase service capacity. This included GBP 40 million of recurrent funding to support increased capacity in order to meet the 2 week wait time target for early access to psychosis services. GBP 10 million was provided as implementation funding for psychological therapies services, which was to be used to confirm the accuracy of existing waiting lists, and enhance capacity to provide assessment and treatment (NHS England, 2015[36]).

Box 3.1. Addressing long wait times for mental health services for severe mental illness in the Netherlands

Long waiting lists for mental health care, especially, especially for people with severe mental ill-health, have been a major source of concern in the Netherlands in recent years. In 2020, the Court of Audit in the Netherlands estimated that 27% of people with a severe mental health condition were waiting 4 months or longer before their treatment started, compared to 8% of people considered to have mild-to-moderate mental health conditions.

The Court of Audit found main drivers for these long waiting lists:

- Financial incentives that are in place make it more attractive for care providers to concentrate on patients with less-severe disorders. Mental health care institutions have agreed on average prices with their insurers for the all mental health care they provide. The average price is above the costs to treat people with milder care needs but too-low to cover costs of more intensive treatments;
- The number of beds in the Netherlands has declined by 20% in recent years, with an ambition that this shift would be offset by increasing availability of outpatient care. However, outpatient care has not been scaled up sufficiently to meet levels of need for care for severe mental illness;
- There is a shortage of staff; psychiatrists, psychologists, clinical psychologists, specialist nurses and nurse practitioners. This is partially because working in an integrated mental health institution is not attractive to staff because of many night, weekend and evening shifts. Additionally, the Court of Audit found a heavy administrative burden in these roles, and comparatively low wages.

To overcome these challenges, the State Secretary has put in place an action plan. Because of the decentralised mental health system in the Netherlands, the Ministry of Health has implemented regional taskforces that work with local stakeholders to analyse challenges and come up with solutions. Possible solutions include enhancing visibility of people on the waiting list, imposing a temporary stop for admission at care institutions where waiting time are exceeded, increasing accessibility to care by providing care alternatives within the social domain and preventing unnecessary overtreatment. As of January 2021, these taskforces were still grappling with the challenge of finding effective ways to reduce long waits for persons with complex mental health conditions.

Source: Netherlands Court of Audit (Rekenkamer) (2020[37]), *No Place for Big Problems – Tackling specialist mental healthcare waiting lists,* https://english.rekenkamer.nl/publications/reports/2020/06/25/no-place-for-big-problems.

Are services developed close to the community?

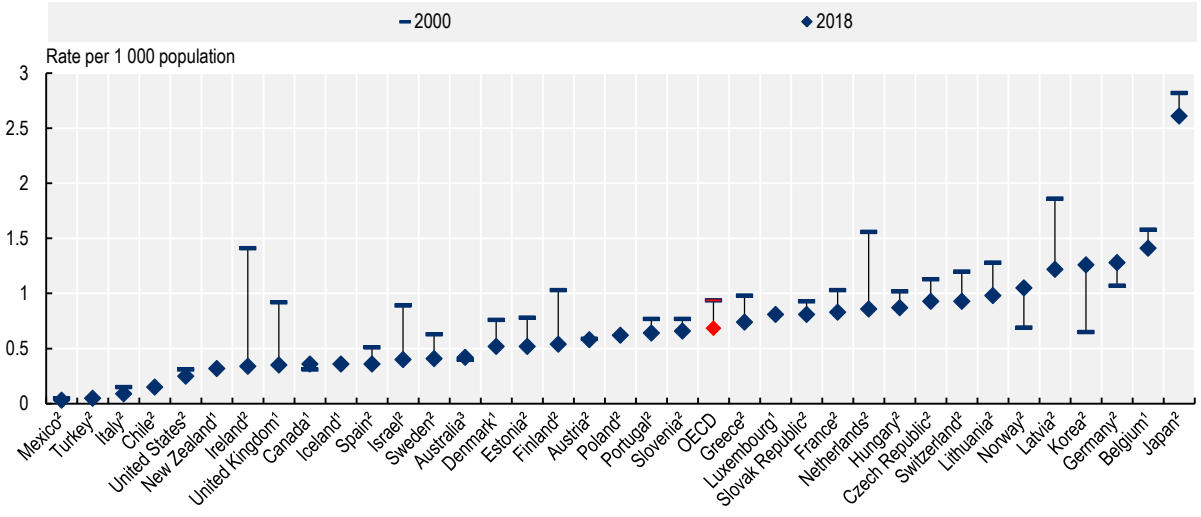
In recent decades countries have increasingly adopted a community-based approach to mental health care, shifting care away from inpatient care settings. Historically, mental health systems in OECD countries were heavily inpatient-based, and often highly restrictive, with 'patients' spending long periods in institutional settings (Hewlett and Moran, 2014[38]). From the late 1960s onwards, the 'deinstitutionalisation' movement which started in Trieste, Italy, moved more and more mental health care into community-based settings (Hewlett and Moran, 2014[38]; Forti, 2014[39]). At the same time, the organisation of mental health care within OECD countries remains highly heterogeneous - inpatient beds per population varied more than 50-fold across countries – and some countries began the shift to community-based services much later than others, or have chosen to retain a more hospital-centric system.

Community-based care is now recognised as the preferred approach for the significant majority of mental health care – with a smaller number of inpatient services focused on very acute or crisis care – and has advantages for the service users' experience, for quality and outcomes, and can have economic advantages, too (WHO, 2013[40]; OECD, 2019[11]). A strong community-based care system should result in improved quality of care, with potential benefits including reduced hospital admission rates, improved medication adherence, greater care involvement of service users in their own care, early detection of relapse, and reduced emergency department visits (Thornicroft, Deb and Henderson, 2016[41]; Clausen et al., 2016[42]; Aagaard, Tuszewski and Kølbæk, 2017[43]). Additionally, providing mental health services through community centres is considered a less costly approach to inpatient care (Winkler et al., 2018[44]).

Inpatient psychiatric beds are declining in almost all OECD countries

All OECD countries either already deliver the majority mental health services outside of inpatient settings, or have the transition to more community-based care models as a policy priority, in line with the OECD Mental Health Performance Framework (OECD, 2019[11]) and other international strategies, notably the WHO Mental Health Action Plan (WHO, 2013[40]). Between 2000 and 2018 the average number of psychiatric beds per 1 000 population fell from 0.9 to 0.68 in OECD countries, with particularly significant falls in Ireland (1.41 to 0.34), Finland (1.03 to 0.39), the Netherlands (1.56 to 0.91) and Latvia (1.86 to 1.25) (Figure 3.4). The number of beds rose only in Norway, Germany and Korea. This could indicate an overall increase in service availability, both through inpatient care and community care.

Figure 3.4. Psychiatric beds per 1 000 population, 2000 and 2018 or nearest year



1. Data from 2019; 2. Data from 2018; 3. Data from 2016.
Source: OECD (2020[45]), OECD Health Statistics 2020, https://doi.org/10.1787/health-data-en.

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The Norwegian system of mental health services is characterised by extensive decentralisation of both outpatient and inpatient care, with still-existing traditional central psychiatric hospitals alongside newer locally-organised psychiatric services in "District Psychiatric Centers" (DPCs). There is a difference in organisation in care between these centres, with some offering care in outpatient services combined with centralised regional hospitals, while others have a local institution-based model; increasingly inpatient services are offered at smaller local institutions while integrating the psychiatric beds in local DCPs with the outpatient clinics (OECD, 2014[46]). Studies in Norway comparing the use of mental health care of both centralised and local institutions models, showed that inpatients in local institution models make more use of GP and specialist outpatient care in combination with a longer inpatient stay at the local centres, compared to people receiving care through the centralised care models. Additionally, having beds available at small local institutions led to a decrease in acute admissions (Myklebust, Sørgaard and Wynn, 2017[47]; Myklebust and Lassemo, 2020[48]).

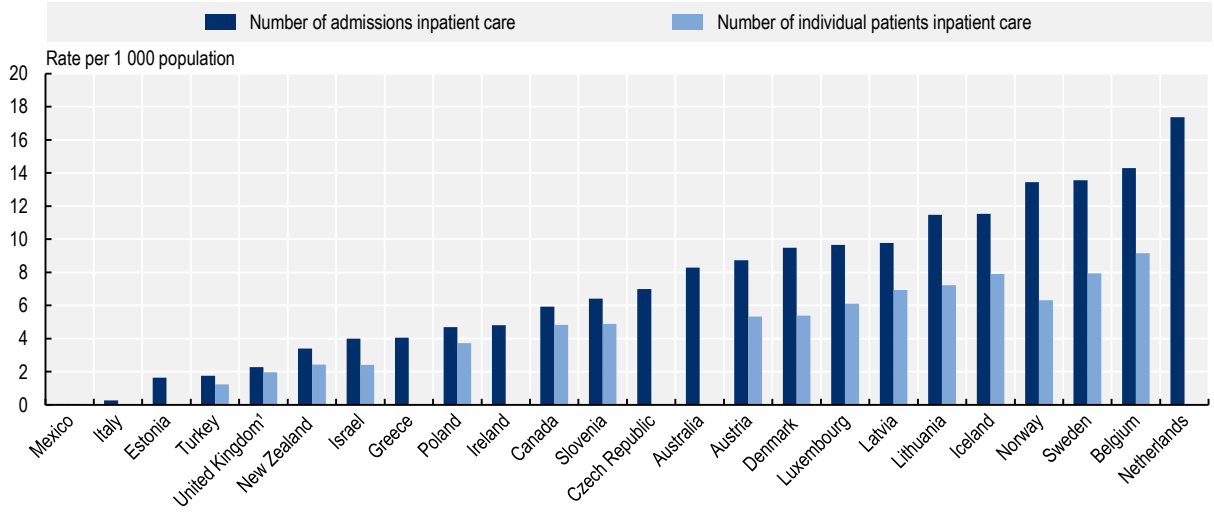
In Japan, the number of psychiatric beds is nearly four times higher than the OECD average. Japan has not reformed the system towards a deinstitutionalised system, mainly because of a lack of funding. Privately funded hospitals were not able to receive public funding to shift long-term care beds towards care in the community. The 2004 Vision for Reform of Mental Health and Welfare of the Japanese Ministry of Health, Labour and Welfare (MHLW) articulated an aim to reduce the number of long-term care beds.

Since then, the MHLW has aimed to remove 70 000 psychiatric care beds across 10 years (Okayama et al., 2020[49]). However, changes have been very slow, and in the 12 years from 2004 to 2018 bed numbers fell by only 25 000 beds, with a reduction from 356 000 to 330 000. Japan is still facing significant barriers to moving towards a community-based model including weak insurance coverage of community care, a fee schedule incentive structure that still supports inpatient care and high bed occupancy, and high levels of stigma towards mental illness (Kasai, 2017[50]; OECD, 2015[51]; Okayama et al., 2020[49]).

The use of inpatient mental health services varies across countries

Admissions to inpatient care vary across countries (Figure 3.5). Countries with very few inpatient beds (Italy, Mexico, Turkey, the United Kingdom tend to have very small numbers of admissions to inpatient care both in terms of total number of admissions, and number of individual patients admitted to inpatient care. Countries with higher numbers of inpatient beds tended to have higher rates of inpatient admission. It is unclear whether this trend is driven by a greater concentration of mental health services in the inpatient sector and fewer non-hospital alternatives, or because of a tendency to 'use available beds'.

Figure 3.5. Admissions to inpatient care across OECD countries, 2019 or latest year



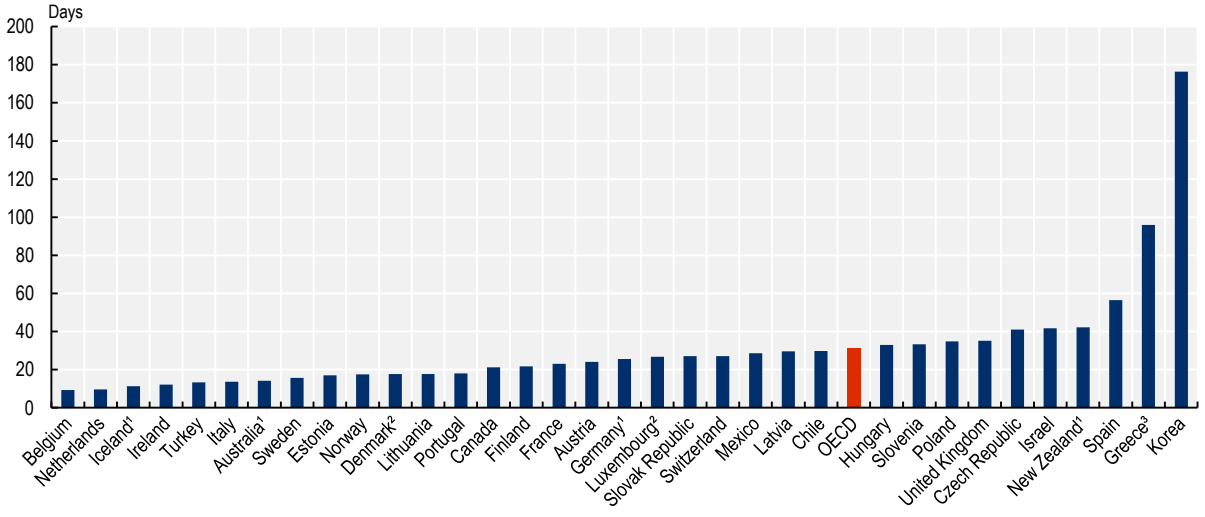
Note: Years included range from 2010 to 2019.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Data collected from 11 countries by the IIMHL/NHS Benchmarking Project – Australia, Canada, England, Ireland, New Zealand, Northern Ireland, the Netherlands, Japan, Scotland, Sweden and Wales – appears to confirm that bed availability is a key driver of inpatient admission rates. In general psychiatry average bed occupancy rates were 87% on average, and that there was relatively little variation in occupancy rates between countries despite significant difference in bed numbers, with a range of 70-90% occupancy (NHS Benchmarking Network, 2019[52]).

The majority of countries report hospital stays between 10 and 40 days for people with 'mental and behavioural disorders'. Spain, Greece and Korea are outliers, with respectively an average of 56, 96 and 176 days stay in inpatient settings.

Figure 3.6. Average length of inpatient stay, mental and behavioural disorders, 2018 or latest year



Note: Years range from 2014 to 2018.
1. Data from 2017; 2. Data from 2016; 3. Data from 2014.
Source: OECD (2020[45]), OECD Health Statistics 2020, https://doi.org/10.1787/health-data-en.

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In Korea, hospital treatment remains the foremost option in mental health care, and inpatient care is far more prevalent than outpatient or community care. This is reflected as well in the increase of psychiatric beds of the last decades, which has showed an increase over 200% (Figure 3.4). In Korea, the payment system is one of the main factors driving high rates of admission are of psychiatric patients, with reimbursements for inpatient higher and more attractive to providers (Kim, 2017[53]).

About 80% of all psychiatric admissions are involuntary in Korea, with admissions completed under the Mental Health Act, often submitted by family members (Kim, 2017[54]). There are some signs that involuntary admissions that are medically unjustifiable have been frequently reported in Korea. In 2008, only 4.8% of patients who requested to be discharged only obtained the permission to discharge and more than half of the patients were admitted again, with half of those readmitted within a day after discharge (Kim, 2017[53]). In 2016, Korea began revising the Mental Health Act, which aims to promote human dignity, human rights and recovery-based practice environment (Chung and Yang, 2020[55]). Over the last decade, Korea has also increasingly made a shift towards community mental health care, for example under the Third 5-Year National Mental Health Plan 2016-2020 prioritises the development of community-based mental health facilities. In 2017 the existence of more than 300 mental health rehabilitation centres were reported, and number of mental health welfare reached over 200 nationwide (Ministry of Health and Welfare, 2017[56]).

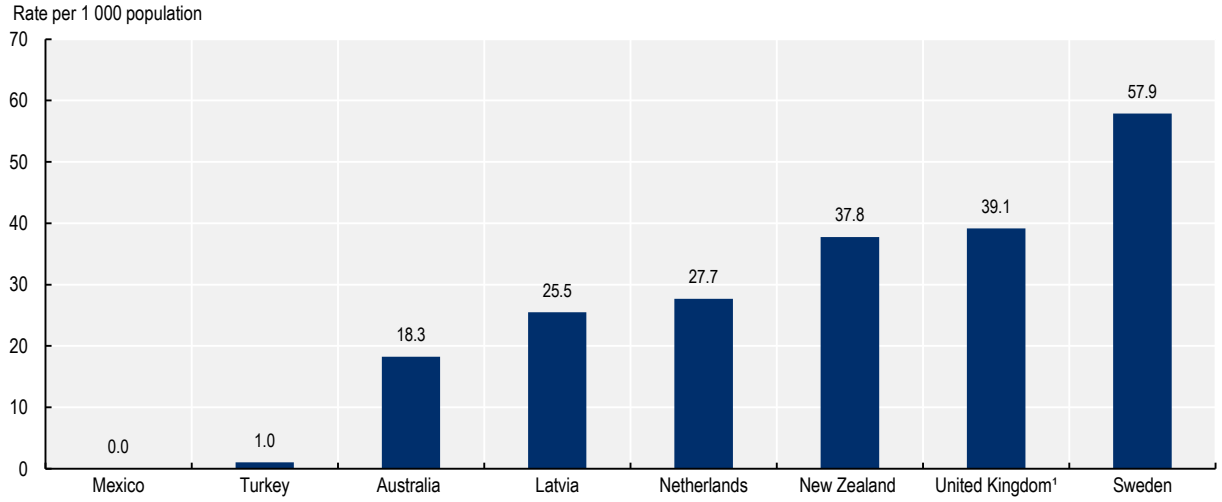
Community-care capacity for mental health varies more than 30-fold between OECD countries

It is difficult to understand the extent to which countries have replaced hospital-based services with care in the community, and how available and evidence-based the care provided in community settings is; only 7 countries were able to report the number of individuals under the care of community teams, and 15 the number of individuals attending outpatient clinics (Figures 3.7 and 3.8). There are also longstanding challenges around comparability of mental health services across countries, as outpatient and community services can play quite different roles from one country to another; for example, in some countries

outpatient clinics may include services for intellectual disabilities or dementia, or substance mis-use including or excluding alcoholism, while others may not.

A limited amount of data does point, again, towards significant variation in available resources (Figures 3.7 and 3.8). In Mexico (0.04 individuals per 1 000 population under mental health care in community teams in 2017, 0.2 per 1 000 population attending outpatient clinics) and Greece (0.5 individuals per 1 000 population attending outpatient clinics), for example, it appears that community care through outpatient clinics or community teams are very limited.

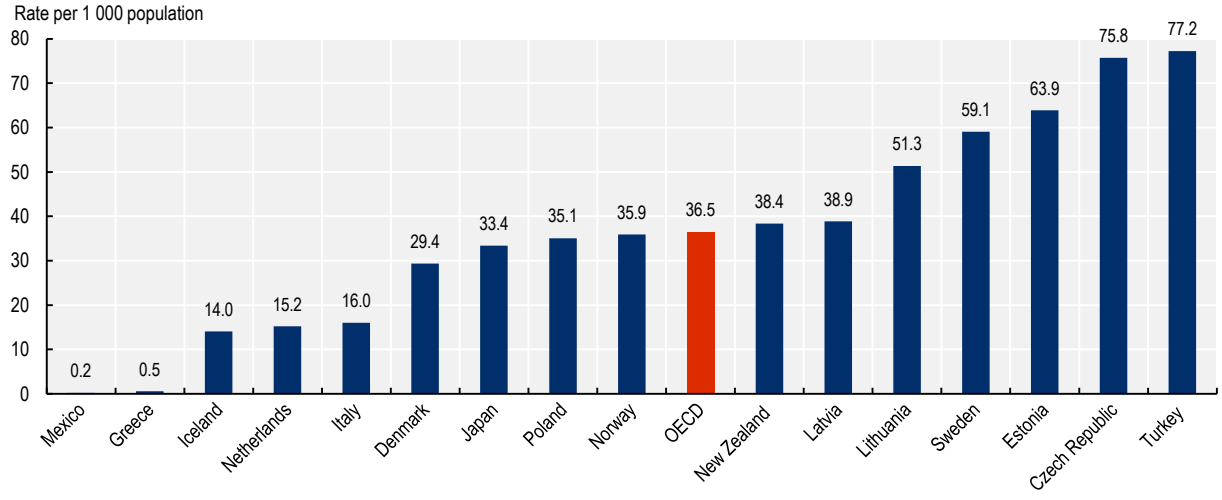
Figure 3.7. Individuals under mental health care in community teams, 2018 or latest year



1. England.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Figure 3.8. Individuals attending mental health outpatient clinics, 2018 or latest year



Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Is continuity of care assured?

Community-based mental health care demands good care co-ordination

While evidence suggest that moving away from inpatient settings and increasing community-based services will improve quality and accessibility of care, the shift in the mental health systems leads to additional challenges, with countries struggling to provide strong community-based services, and to co-ordinate care across multiple settings (Abdulmalik and Thornicroft, 2016[57]). Mental health problems are complex and often require multiple interventions and approaches, involving different care institutions and sectors (Doran and Kinchin, 2019[58]). Poor co-ordination of care is associated with poor outcomes, such as increased risk of suicide, homelessness and criminal justice involvement (Beadles et al., 2015[59]; Ilgen et al., 2008[60]; Van Dorn et al., 2013[61]). Especially people with severe mental illnesses are at risk to fall into gaps between inpatient and community care (MacDonald et al., 2019[62]). Not only continuity of care between care settings but also longitudinal continuity of care is important, which refers to the capacity of professionals and services to provide care across longer periods of time, while maintaining a good quality of patient-provider relationship (MacDonald et al., 2019[62]).

Assessing the provision of continuity care delivery is a challenge given the complexity of mental health care systems and above all due to shortcomings in data availability. Data on 'continuity of care' across countries is limited, but available evidence points to ongoing challenge of providing high quality, consistent care.

In 2020, six OECD countries (Australia, Israel, Italy, Lithuania, New Zealand, Norway, Turkey, the United Kingdom [England]) were able to report on the percentage of service users who received a follow up within the nationally mandated or nationally recommended period following discharge from inpatient care (e.g. within 7 days, within 14 days, depending on national guidelines). The percentage of service users who were received a follow-up ranged from 37.4% in Italy within 14 days in 2018, to 98.80% within 7 days in England in 2018, although this only covers the proportion of patients on 'Care Programme Approach (CPA)' (OECD, 2020[26]) Table 3.1. The Care Programme Approach delivers community mental health services for those diagnosed with mental illness and with complex needs, with the individual's health and social services needs assessed and addressed in a written care plan, patients are allocated a care co-ordinator, and their care plan is regularly reviewed.

Table 3.1. Follow up after discharge from inpatient care within nationally mandated or recommended period, 2018 or latest year

	Percentage of patients who received a follow up within the mandated or recommended period following discharge from inpatient care	Nationally mandated or recommended period following discharge from inpatient care
Australia	75.2%	7 days
Israel	85%	Percentages where outpatient appointment was set (no time limit specified).
Italy	37.4%	Within 14 days
Lithuania	56.9%	Unspecified
Norway	70%	Within 30 days
New Zealand	66.50%	Within 7 days
Sweden[1]	22%	7 days or 8 days, depending on county
Turkey	79.2%	Rate reported for within 14 days, but ideal time for follow up is set at 7 days.
United Kingdom (England)	95.80%	Patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge

Notes: [1]Data only reported by 1/3 of the Swedish counties.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Emergency care visits and repeat admissions to inpatient care point to gaps in care co-ordination between inpatient and community care

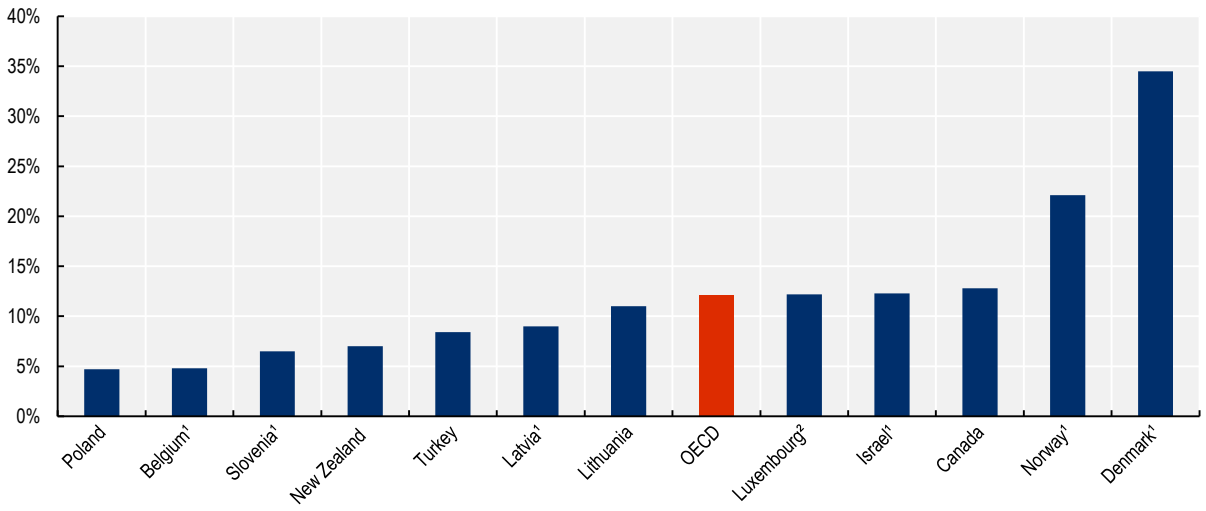
Repeat visits to emergency care for mental health conditions, and repeat inpatient admissions, can be signs of poor care co-ordination for people with mental health conditions (Lay, Nordt and Rössler, 2011[63]; Brännström, Strand and Sand, 2018[64]; Kalseth et al., 2016[65]; Hewlett and Moran, 2014[38]; Berchet, 2015[66]). Reporting in the Netherlands suggested that 15% of the involuntary admissions were repeated admissions, and 80% of the people that are being admitted are already receiving care within psychiatric care settings (De Volkskrant, 2020[67]). Monitoring repeat emergency care contacts for psychiatric illness can point to individuals in need of mental health support, as well as gaps in access to care (CIHI, 2020[68]; Sirotich, Durbin and Durbin, 2016[69]; Slankamenac, Heidelberger and Keller, 2020[70]). Although evidence is mixed, there are studies that indicate timely follow up after discharge (for example within 30 days) result in less frequent visit emergency department and re-hospitalisations (Beadles et al., 2015[59]; Durbin et al., 2019[71]).

In countries reporting data, an average of 10% of patients were repeatedly admitted to inpatient care for mental health in a year; repeat admissions can be part of a care plan, but can also point to poor community-based follow-up care, or repeated crisis events (Figure 3.10). Twelve OECD countries were able to report data, which showed a range of 5 to 35% in repeated admission between countries, with Denmark reporting the highest number of people admitted to inpatient care at least three times in a year.

Repeated emergency department visits for mental health reasons can be another signal of gaps in community care coverage (Figure 3.9). In Denmark and Israel approximately 10% of people who attended the emergency department for mental health reasons, attended at least 4 times in 2018. In New Zealand this number was even higher and has increased over the years with currently 16% of the people visiting emergency departments visiting at least four times in 2018. In New Zealand, emergency department use is used as a quality measure across the health service; like for mental health emergency department visits, the overall volume of emergency department visits has seen an upward trend in recent years (Ministry of Health New Zealand, 2016[72]; Tenbensel et al., 2017[73]). The Māori population in New Zealand have high emergency department use (Curtis et al., 2019[74]); in 2018 17% of the Māori population attended emergency departments at least four times for a mental health reason, higher than the 16% population average (OECD, 2020[26]).

Figure 3.9. Repeat admissions to inpatient care, 2019 or latest year

Percentage of people admitted to inpatient care at least three times in a year

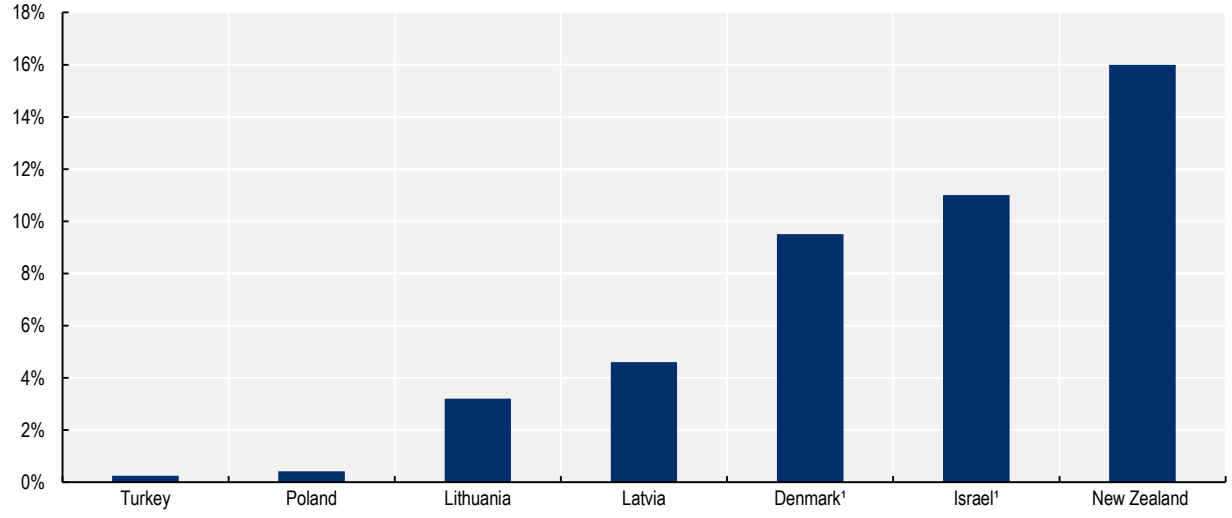


Note: It is not possible to distinguish between 'planned' and 'unplanned' repeat admissions. Some countries may include transfers across inpatient services as admissions, while other countries exclude transfers.
1. Data from 2018; 2. Data from 2016.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Figure 3.10. Repeat emergency department visits, 2019 or latest year

Percentage of people who attend the emergency department for mental health reasons, who attended at least four times in a year



1. Data from to 2018.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

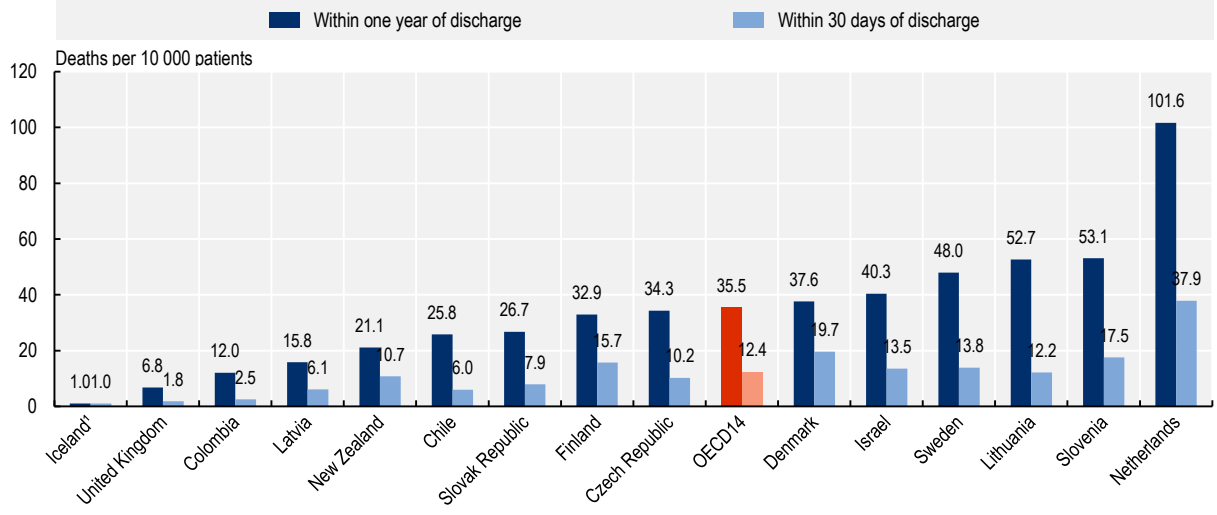
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Services after discharge – suicide following discharge inpatient admissions

With the shift to deinstitutionalised care settings, community settings are given the priority for psychiatric care delivery and in OECD countries inpatient hospital settings focus more on acute care needs (Hewlett and Moran, 2014[38]). Continuity of care has become one of the key issues in mental health care provision, with challenges remaining in continuing care for people with severe mental illnesses. There are some key points in mental health care delivery where continuity of care is critically important, one of which is immediately following discharge from inpatient care. Managing the transition from inpatient care to community-based support for ongoing mental health management, to support the service user at a clinically vulnerable moment, to improve long-term outcomes, and to ensure that service users are connected with services to meet their ongoing mental health needs (Tyler, Wright and Waring, 2019[75]; Lynch et al., 2020[76]).

Looking at outcome indicators such as suicide rates after hospital discharge can indicate the quality of care in the community, as well as co-ordination between inpatient and community settings (OECD, 2019[77]). The first week, and the first month, after discharge from inpatient care are periods of acute suicide risk for psychiatric patients (Chung et al., 2019[78]); patients with less contact with mental health services after discharge have been found to be more likely to die by suicide (Large et al., 2011[79]). Across OECD countries, suicide rates among patients who had been hospitalised in the previous year was as low as 1 per 10 000 patients in Iceland and the United Kingdom but higher than 50 per 10 000 in the Netherlands, Slovenia and Lithuania (Figure 3.11). In England, which has one of the lowest rates of suicide following hospitalisation for a psychiatric disorder, post-discharge period has nonetheless been found to be a period of peak suicide risk; in the period 2002-2012 deaths by suicide in the first three months after discharge represented 18% of all patient suicides (University of Manchester, 2014[80]). Recognition of the high risk of suicide immediately after discharge in England has led to a clinical guideline for follow-up within 7 days of discharge from psychiatric inpatient care, and within 48 hours if suicide risk has been identified (Bojanić et al., 2020[81]; NICE, 2016[82]).

Figure 3.11. Suicide following hospitalisation for a psychiatric disorder, within 30 days and one year of discharge, 2017 or nearest year



Note: Age-sex standardised rate per 10 000 patients. Suicide following hospitalisation for a psychiatric disorder, within 30 days and one year of discharge, 2017 or nearest year.
1. Three year average.
Source: OECD (2020[45]), OECD Health Statistics 2020, https://doi.org/10.1787/health-data-en.

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Do services deliver improvement of individual's condition?

OECD countries are focusing on on delivering care that provide meaningful improvements of an individual's condition. To deliver care that helps to maintain and improve health and well-being of populations, measures to evaluate health system delivery need to bring insights into outcomes of care, and go beyondindicators such as volume of service or rate of resources which have been more commonly available. Better data on inputs and processes is still sorely lacking in mental health systems, but, this information does not always provide sufficient information whether health systems are also improving an individual's condition, which can result in patients receiving health care that is not necessarily tailored to achieve the outcomes they prioritise.

The OECD publishes international benchmarking data on a number of mental health indicators, including on excess mortality, which measures the difference between the mortality rate for the general population, and those who have had a diagnosis of schizophrenia or bipolar disorder. An "excess mortality" value that is greater than one implies that people with mental disorders face a higher risk of death than the rest of the population. In 2015-17, excess mortality ranged from 1.3 in Lithuania to 6.1 in Norway for people who had lived with schizophrenia (OECD, 2020[45]).

On a national level, OECD countries are increasingly focusing on quality and outcome indicators of mental health. According to the OECD Policy Questionnaire 17 out of 29 countries reported the use of some sort of outcomes framework (OECD, 2020[26]). In 2016, Denmark set national goals to ensure better health care quality by focusing on monitoring quality by looking at outcomes of care by adopting the Danish Healthcare Quality Programme. This national programme aims for better continuity of care, stronger management of chronically ill and elderly patients, higher survival rate and improved patient safety, high quality treatment, quick assessment and treatment, greater patient involvement, additional healthy life years and more efficient health care systems. To better understand the outcomes of an individual's condition, Denmark uses a framework of indicators, which includesindicators that measure the outcomes of people suffering from mental ill-health, such as "acute somatic/psychiatric readmissions within 30 days", "mental illness and excess mortality" and "patients satisfaction with somatic and psychiatric care". A measure used frequently on in international level to assess health and social function of people who use mental health services, is the Health of the Nation Outcome Scales (HoNOS). It covers symptoms, functioning, social relationships and environmental issues. The scale has been adopted in a number of countries as a quality and outcome measure, notably in Australia, New Zealand and the United Kingdom.

While countries are struggling to implement measures that give valuable information on outcomes of care, the use of patient-reported measures of health care provides an opportunity to shed light on how health care systems impact an individual's condition. As of 2018, a survey from the OECD showed that only five of the 12 countries surveyed (Australia, Israel, the Netherlands, Sweden, the United Kingdom) regularly use patient-reported measures in mental health care.

In 2017 the OECD launched the Patient-Reported Indicators Surveys (PaRIS) to accelerate patient-reported measures to make systems more people-centred (see also Chapter 2, Chapter 7). Its aim is to systematically collect data on what matters most to patients. As part of the PaRIS initiative, the OECD launched the PaRIS Working Group on Patient-Reported Measures for Mental Health in May 2018. The main objective is to develop PREM and PROM data collection standards in mental health for international benchmarking of patient-reported outcomes, with first results expected in 2021.

Are services safe?

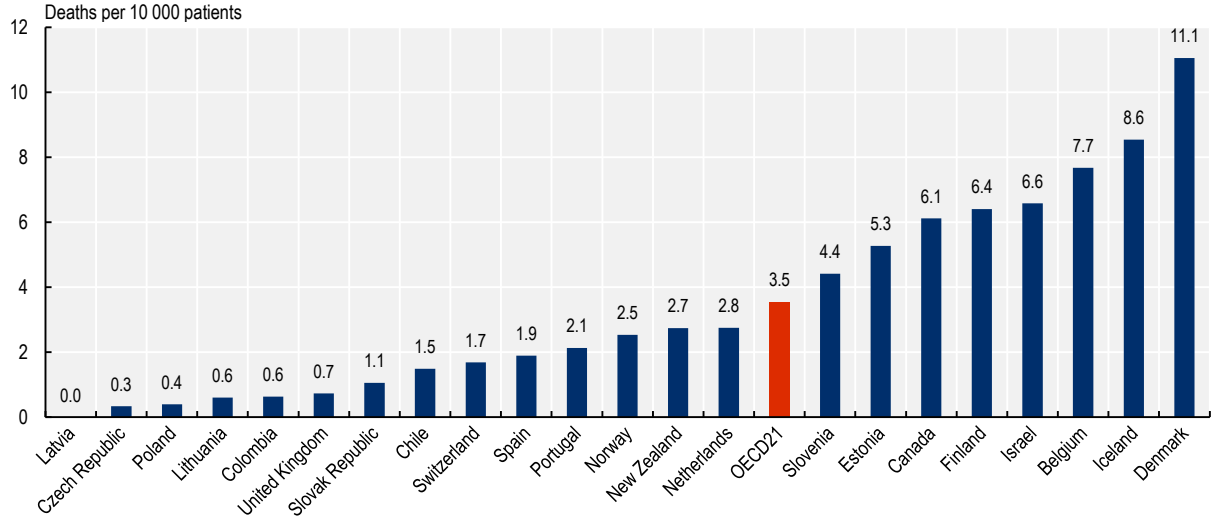
Alongside the patient safety risks seen across the health system, such as medication error or failures in communication (Slawomirski, Auraaen and Klazinga, 2017[83]; Auraaen, Saar and Klazinga, 2020[84]; de Bienassis, Llena-Nozal and Klazinga, 2020[85]; de Bienassis et al., 2020[86]), there are some safety risks that are specific to mental health settings, including higher rates of suicide and self-harm, and stigma

around mental illness. Some forms of mental health care delivery can also be high-risk to patients' safety, such as the use of restraint and seclusion. In addition, issues such as stigmatisation of people suffering from ill-health or the lack of listening to the patient's voice in mental health services can jeopardise the safety of a patient (Brickell and McLean, 2011[87]; Berzins et al., 2018[88]).

Inpatient suicides point to shortcoming in OECD countries

Looking at the incidences of adverse advents can help us understand a patient's safety when using mental health services. The OECD indicators on inpatient suicide and suicide after discharge point to shortcomings in many countries when it comes to safety in hospital settings, and continuity of care. Inpatient suicide is a "never event", which should be closely monitored as an indication of how well inpatient settings are able to keep patients safe from harm. Most countries report inpatient suicide rates below 10 per 10 000 patients, but Denmark is an exception, with rates of over 10 (Figure 3.12).

Figure 3.12. Inpatient suicide among patients with a psychiatric disorder



Note: Three year average except for New Zealand. Age-sex standardised. Data from 2015-2017.
Source: OECD (2020[45]), OECD Health Statistics 2020, https://doi.org/10.1787/health-data-en.

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Countries have tried to identify factors related with inpatient suicide and come up with strategies to lower inpatient suicide, however evidence and effectiveness has been inconclusive. For example, Australia's Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) agreed by all Australian Governments has identified 'Making safety and quality central to mental health service delivery' as a priority area for attention, while 'Safety' is also a domain in Australia's National Mental Health Performance Reporting Framework and the broader Australian Health Performance Framework, and has repeatedly been identified as a key area of concern for consumers and carers.

Denmark, too, has been focused on lowering the suicide rate. Inpatient suicide in Denmark increased since 2009, following a decling trend up until 2009, and then an annual 7.5% increase of inpatient suicides. Inpatient suicides and post-discharge suicide constitute a substantial part of the total number of suicides in Denmark (Madsen, Erlangsen and Nordentoft, 2017[89]; Madsen et al., 2020[90]). Initiatives taken by Denmark have included removing harmful objects such as plastic bags and sharp objects as well as a systematic risk assessment by time of admission and discharge (ibid).

Seeing to reduce inpatient suicides in the United States, the Department of Veteran Affairs has developed a checklist to check the safety of acute psychiatric units which has shown to be effective at decreasing inpatient suicides (Watts et al., 2017[91]). The checklist consists of 134 questions that focus on structural and special changes. Clinicians at the mental health centres can use this checklist to signal environmental hazard points and look to remove or decrease the hazards to improve safety wards. The checklist has been used since 2007 and has led to a decrease of 5 inpatient suicides per 100 000 admissions to 1 inpatient suicide per 100 000 admissions (Watts et al., 2017[91]).

Coercion in contemporary mental health care

Coercive measures, such as seclusion or restraint of a person in patient care, are used psychiatric settings to prevent harm towards the service user or others. Use of coercive measures might occur in response to or to prevent aggression or violence, or when a service user is not able, or refuses, to accept treatment. Restrictive interventions should be seen as a last resort, and any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need; coercive measures should never be a form of routine care, or used as a 'punishment'.

Four main methods of coercion are used in contemporary mental health care: physical restraint; mechanical restraint; chemical restraint; and seclusion. Coercive measures may occur in different settings and concerning different population groups, such as psychiatry wards targeting adults and children with psychiatric illness (NICE, 2017[92]; Gooding, 2019[93]; Völlm and Nedopil, 2016[94]; Völlm and Nedopil, 2016[94]). Seclusion and restraint are controversial techniques in contemporary mental health systems, highlighting risk for physical and psychological trauma, while adding to the organisational costs of mental health facilities. Use of coercive measures can result in lasting psychological harm to service users, and in some cases physical harm, especially if appropriate safety steps are not taken (NICE, 2017[92]; Care Quality Commission, 2020[95]).

The United Nations' 2007 Convention on the Rights of Persons with Disabilities (CRPD) pushed towards alteration change in the use of coercive measures in mental health systems, underlining the rights and need for equality in all aspects of life for people with disabilities, while respecting dignity, autonomy and independence, although there is clear evidence that a gap between the principles of the CRPD and its implementation in practice (Winkler et al., 2020[96]; Mahomed, Stein and Patel, 2018[97]; Steinert et al., 2016[98]) Evidence of efficacy of coercion is fragmented and there is little research in this area that focus on interventions and outcomes (Barbui et al., 2020[99]; Madsen, Erlangsen and Nordentoft, 2017[89]).

Coercive practices are increasingly regulated or restricted by a variety of standards and facility policies, and recommendations and guidelines from professional and trade organisations are progressively being developed (Völlm and Nedopil, 2016[94]). Across OECD countries, while there is an overall commitment to the safe and reduced use of coercive measures, there is also significant diversity in the 'preferred' forms of coercion. In some countries certain types of coercion are prohibited while these measures are very common in other countries (Table 3.2). This difference appears to be mainly based on cultural preferences around which methods present least harm to the service user; for example, seclusion is usually not allowed in Denmark for ethical reasons, while it is the preferred technique in the Netherlands. Secondly, mechanical restraint is prohibited in the United Kingdom, with a (relative) preference for the use of physical restraint and chemical (pharmaceutical) restraint. Germany considers chemical restraint as a last resort treatment and is perceived as very invasive. Up until 2013 chemical restraint was prohibited in Germany, and is now currently allowed again only under very strict conditions and as a last resort (Gooding, 2019[93]; Martin et al., 2007[100]; Steinert, Noorthoorn and Mulder, 2014[101]; Völlm and Nedopil, 2016[94]).

Both data collected by the OECD and literature on the use of coercive measures shows a wide variation in incidence and duration between countries, which in addition to significant differences between countries in regulation and clinical guidelines over coercive measures, makes it difficult to compare the use of coercive measures across countries. Additionally, there are considerable difference between countries

with regards how they report coercive measures. In most countries there is currently no centralised agency collecting, analysing and publishing data on use of coercive measures. Countries differ in how they report their coercive practices, which care settings are included and which institutions are in charge of reporting which makes it difficult to compare to what extent coercive practices are used (Lepping et al., 2016[102]).

Table 3.2. Use of coercive measures in OECD countries

Country	Techniques used in order of preference	Comments
Belgium	1. Mechanical restraint 2. Seclusion	Physical restraint is not used.
Denmark	1. Medical restraint 2. Physical restraint	Seclusion not allowed in Denmark.
Finland	1. Mechanical restraint 2. Seclusion 3. Physical Restraint	Physical restraint is rarely used, only used in child psychiatry when parents agreed.
France	1. Physical restraint 2. Seclusion 3. Mechanical restraint	
Germany	1. Mechanical restraint 2. Seclusion 3. Medication	Until 2011, the use of mechanical restraint was widely accepted, since then considerable change in opinion, for example coercive medication is approvable again only under strict conditions
Iceland	1. Seclusion 2. Physical restraint	Mechanical restraint has not been used as a routine measure for decades.
The Netherlands	1. Seclusion 2. physical restraint	Mechanical restraint is rarely used. Since 2005, the Dutch Government has launched a programme to reduce use of seclusion, since a 2004 international study showed increased use of seclusion compared to other European countries.
Norway	1. Physical restraint 2. Seclusion 3. Mechanical restraint.	
Sweden	1. Physical restraint 2. Seclusion 3. Mechanical restraint.	
United Kingdom	1. Physical restraint and medication 2. Seclusion	Mechanical restraint is not allowed. Staff is highly is trained in the use of physical restraint techniques, seclusion is rarely used.
United States	1. Mechanical restraint 2. Seclusion 3. Medication	The use of involuntary medication is restricted.

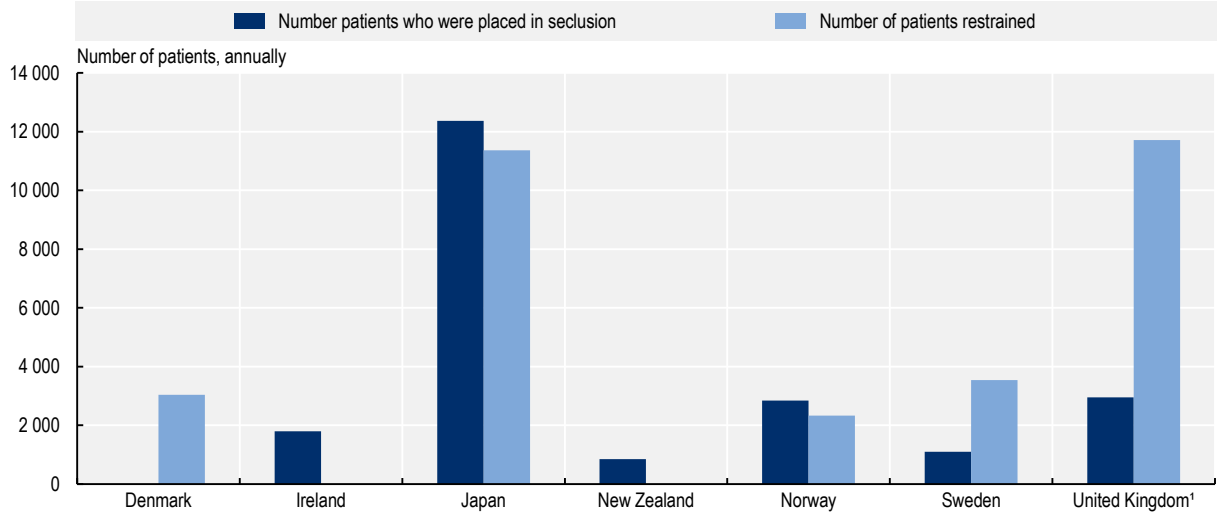
Source: Bak and Aggernæs (2012[103]), "Coercion within Danish psychiatry compared with 10 other European countries", https://doi.org/10.3109/08039488.2011.632645; Kaltiala-Heino et al. (2003[104]), "Reasons for using seclusion and restraint in psychiatric inpatient care", https://doi.org/10.1016/s0160-2527(02)00210-8; Raboch et al. (2010[105]), "Use of coercive measures during involuntary hospitalization: Findings from ten European countries", https://doi.org/10.1176/ps.2010.61.10.1012; Steinert, Noorthoorn and Mulder (2014[101]), "The Use of Coercive Interventions in Mental Health Care in Germany and the Netherlands. A Comparison of the Developments in Two Neighboring Countries", https://doi.org/10.3389/fpubh.2014.00141; Völlm and Nedopil (2016[94]), "The use of coercive measures in forensic psychiatric care: Legal, ethical and practical challenges", https://doi.org/10.1007/978-3-319-26748-7.

OECD-collected data shows countries have reported little data on the use of coercive practices, and available data shows international difference in seclusion and restraint practices (Figure 3.13). Although it is difficult to infer conclusion based on these numbers, it implies that countries make different use of coercive measures, with is reflected in the number reported. Japan shows high rates of seclusion and restraint. Compared to other countries, Japan has fewer psychologists and higher bed number (WHO, 2018[106]). One of the possible barriers mentioned for reducing seclusion and restraint is staffing ratios,

however, data remains inconclusive. The United Kingdom shows high rates of restrain, and much less use of seclusion, which is in line with their national policy on the use of coercive measures (Table 3.2).

Variations in the use of coercive measures are supported by findings in literature. The mean duration of restraint in German psychiatric hospitals was found to be 10 hours compared to 49 hours in Switzerland (Martin et al., 2007[100]). In Finland, one study found a mean total time of 19 hours (Kaltiala-Heino et al., 2003[104]). The longest duration was reported in a Japanese study which found durations of being restrained could vary from under 24 hours to over 30 days (Odawara et al., 2005[107]). A comparative study in Germany, Bulgaria, Czech Republic, Greece, Italy, Lithuania, Poland, Spain, the United Kingdom and Sweden shows on average 38% of the patients in inpatient settings were exposed to some sort of coercive measures, with a variability between countries, from 21% in Greece to 59% in Poland (Kalisova et al., 2014[108]).

Figure 3.13. Countries reporting different annual rates of seclusion and restraint, 2019 or latest year



Note: Absolute numbers of patients placed in seclusion or restraint, data from 2019 or nearest year; data is not weighted to population or to number of inpatient admissions or patients. Chemical and physical restraint were not distinguished.
1. England.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Do mental health services account for and respect the needs of vulnerable groups?

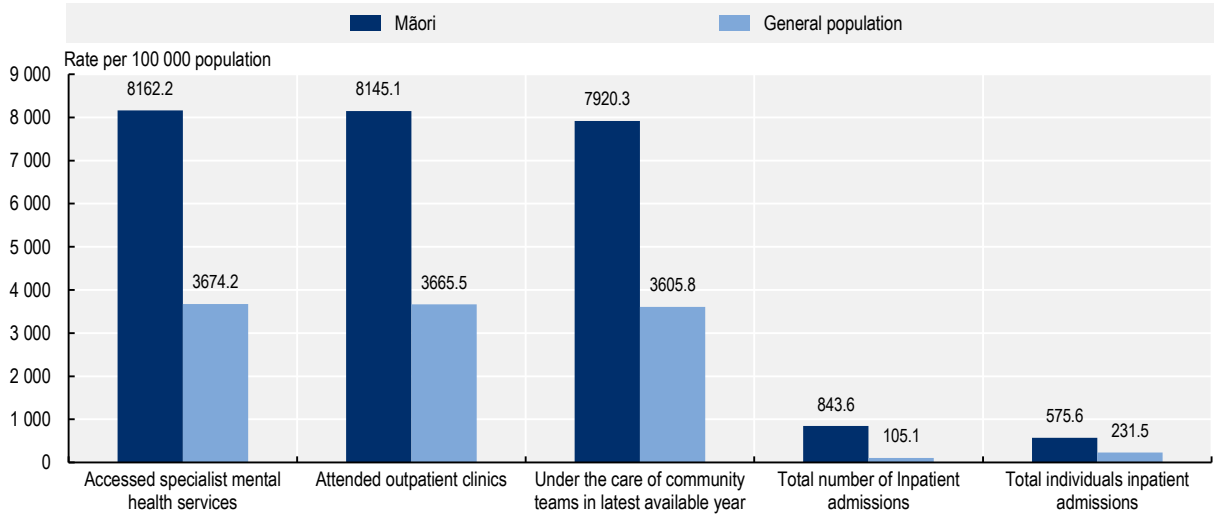
Certain population groups can have both higher risk of mental ill-health, such as the LGBTQ+ community, Indigenous populations, refugees, and children and youth (Kuyper and Fokkema, 2011[109]; Mitrou et al., 2014[110]; Sijbrandij et al., 2017[111]). For example, in New Zealand in 2016-17, Māori adults were 1.1 times as likely to have mild or greater anxiety, depression or somatic symptoms, and Māori children were 1.5 times as likely to have emotional or behavioural problems, than non-Māori adults and children (Ministry of Health New Zealand, 2020[112]). In Australia, Aboriginal and Torres Strait Islander people die by suicide at a rate double that of non-Indigenous Australians; in the period 2014-18 there was an increase in the age standardised rate of suicide deaths amongst Aboriginal and Torres Strait Islander populations from 20.2 per 100 000 person between 2009 and 2013 to 23.7 per 100 000 persons between 2014 and 2018,

compared to 12.3 suicide deaths amongst non-Indigenous Australians (Australian Institute of Health and Welfare, 2020[113]).

The population groups at particular risk of mental ill-health vary across countries, and population groups not necessarily inherently 'vulnerable' to mental health condition; population group characteristics such as ethnicity, race, gender identity or sexual orientation intersect with social, historical, and economic trends such as discrimination, poverty, inequality or unemployment (Mental Health Foundation, 2019[114]).

Just as the key population groups with particular mental health risks differ across countries, the service needs of these groups differ across and within countries. Key population groups may need more, or different, mental health services (see also Chapter 2, for discussion of adapting and co-creating services for different key population groups). Across OECD countries, relatively few countries were able to report mental health service use patterns by population group; in 2020 five countries were able to provide some broken-down data on mental health service use and/or outcomes such as death by suicide, Australia (indigenous Australians receiving specialist or community care, suicide), Canada (six key groups receiving specialist services, and suicide), Turkey (over 65s, under 18s, contact with specialist services, outpatient services, repeat emergency department contacts), and the United Kingdom (England) (five population groups by ethnicity, contact with specialist services) (OECD, 2020[26]). New Zealand was able to break down a significant amount of its mental health data to show contact rates for the Māori population, including rate of receiving specialist, outpatient, community care, repeat emergency contacts, rate of inpatient admissions, repeat admissions, rate of seclusions and involuntary admissions, and deaths by suicide. The data shows service use is higher for the Māori population compared to the general population use (OECD, 2020[26]) (Figure 3.14).

Figure 3.14. Service use in New Zealand of Māori and general population, 2019



Note: Service use is not weighted by need, or rate of mental distress.
Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

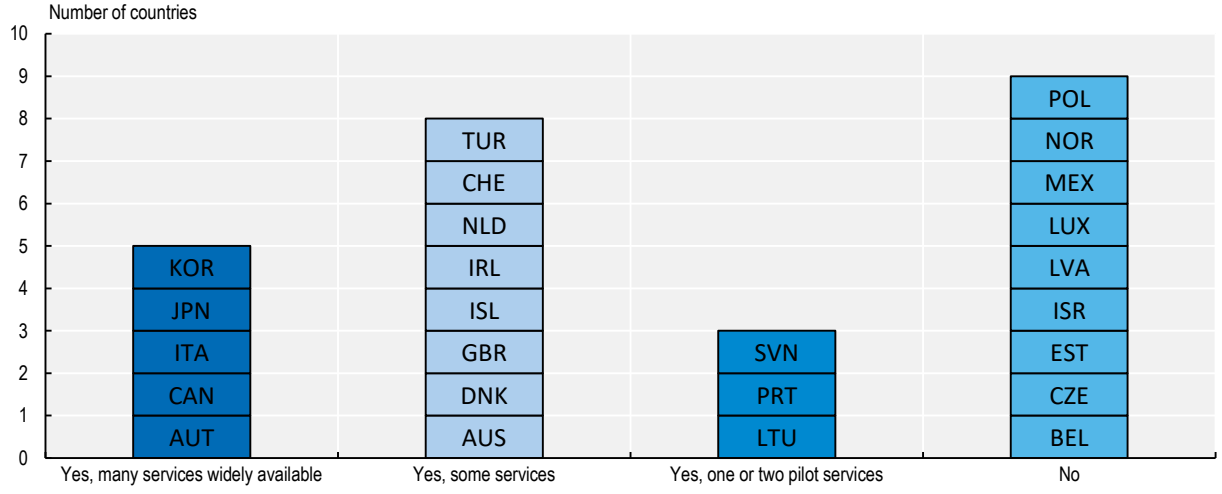
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The service use patterns for key population groups are not consistently predictable. Some key groups may have a higher rate of mental health service use than the general population, or be disproportionately represented in some service settings such as inpatient care. Some groups may have higher mental health service use, but when adjusted to the burden of mental health conditions, mental health service use is in

line with or even below expected needs. Monitoring different service use patterns by population group can help to identify where access to services is not being ensured – for instance high rates of or repeat inpatient care or emergency department contacts in a group may point to problems with access to community services – or where the service model is not reflecting different needs or preferences of that group – for instance higher rates of coercive practices, or involuntary admissions, may point to a failure of services to adapt to a group's specific needs. For example, the Black Caribbean population in England who are estimated to have a risk of psychosis nearly seven times higher than in the White population, and the Black Caribbean population has a higher rate of mental health service contact than the White population (Mental Health Foundation, 2019[114]). Detention rates under the Mental Health Act was four times higher for Black or Black British populations than for White populations in 2017-18, and from 2006 to 2010 Black population groups had higher than average inpatient admission and detention rates (Quality Commission, 2011[115]; Mental Health Foundation, 2019[114]). These patterns could point to difficulties in delivering appropriate and high quality services in community settings for Black populations in England.

In recognition of the different mental health service needs of key population groups, most OECD countries aim to make mental health services more accessible or appropriate for key groups who may have particular mental health risks. Thirteen countries have implemented services specifically designed for these key populations in at least some settings, and a further three countries have at least a number of pilots for specific groups (Figure 3.15). Five countries – Austria, Canada, Italy, Japan, and Korea – report that there are many widely available services for key population groups in place. For example, Canada fully covers mental health services for Indigenous populations and has developed additional strategies and services to meet the needs of these populations and ensure quality of care. Other countries have more specific services developed for vulnerable populations such as mental health initiatives for the Traveller community in Ireland, where mental health initiatives that focus on promoting mental health and reducing death by suicide by travellers, through training and educational programs (OECD, 2020[26]).

Figure 3.15. Services specifically designed for key populations



Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Improving the accessibility and quality of mental health services

Providing high quality and accessible mental health services remains a challenge among OECD countries, and available data points out the need for improvement. High rates of emergency care use, repeated admissions to inpatient care and high suicide rates after discharge point out there is a need to strengthen continuity of care. OECD countries should focus on providing strong integrated care systems, with a primary focus on enhancing care systems in the community.

Community care has been proven beneficial for the service user outcomes and less costly compared to inpatient care. However, available data shows OECD countries practice various levels of community care, which is reflected by the number of inpatient beds, admissions of inpatient care and people under care of community teams. Mental health systems continue to struggle with delivering safe services. People using mental health services are exposed to specific risks, and data on inpatient suicides points to shortcomings in OECD countries.

Additionally, there is still a lot that remains unclear about the state of health systems among OECD countries, because relatively little data is available.Contemporary mental health systems have tried to prioritise delivering services that provide improvements rather than focusing solely on the volume of services in place, and even if key gaps in understanding quality and outcomes of services remain, there is clearly scope for further. There is still more that remains to be done, and data systems should focus on integrating measures that shed light on how care is delivered for the individual. Patient-reported measures are a way forward and will help to provide the insights that are needed to delivered effective care; patient-reported indicators can also point to gaps between what matters to service users in service delivery and design, and what matters to policy makers or practitioners.

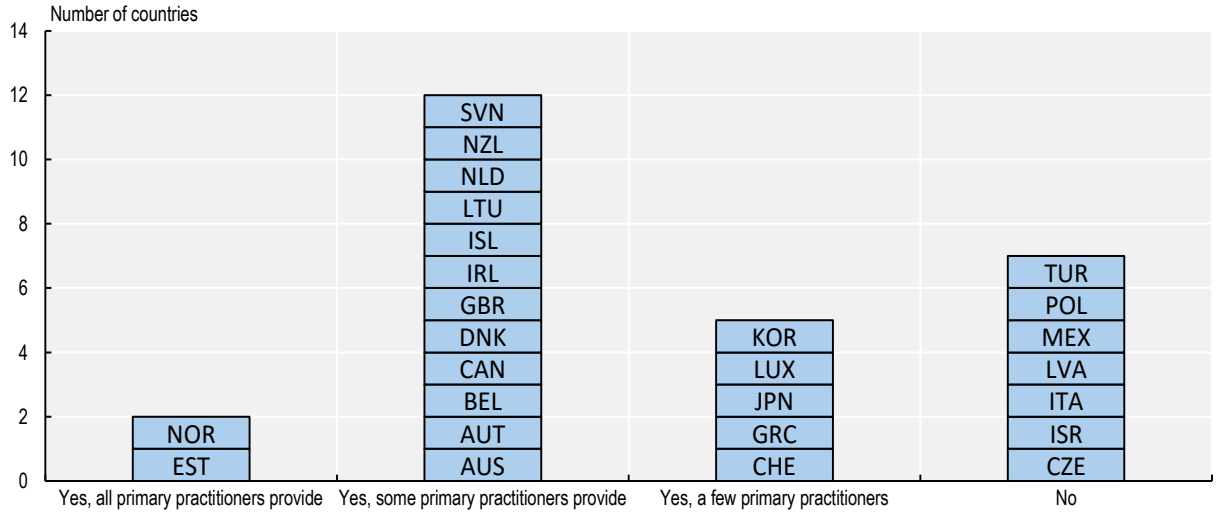
Strengthening community services by developing early intervention approaches and accessible services such as talking therapies

The prevalence of mild-to-moderate mental health conditions, and in particular mild-to-moderate cases of anxiety and depression, is significant. The mental health burden is high, and in Europe alone tens of millions of people suffer from a mental illness during a certain point in their life, and tens of thousands of people dying each year because of suicide or death related to mental illness. Although countries are taking actions to prevent and treat mental illnesses, as discussed across the chapters of this report, unmet need for care including for mild-to-moderate mental health conditions, remains high. For people with mild-to-moderate ill health, low-intensity, low threshold services are a way to promote well-being and prevent worsening for severe mental ill-health. Psychological therapies are a treatment of choice for these disorders (Thornicroft, 2018[116]).

Countries have been focusing on increasing access to talking therapies, especially for mild-to-moderate disorders. In particular, there has been significant activity around increasing services including psychological therapies, counselling, group therapy, and general advice for example provided by General Practitioners or available online. All respondents to the OECD Policy Questionnaire (OECD, 2020[26]) indicated that psychological therapies delivered by a psychologist were covered in full or part, and in most countries a range of other services were also covered in full or part. In addition in 12 countries primary care practitioners are providing some form of talking therapy, for example brief psychological therapy. 62 Norwegian municipalities have established '*Rask psykisk helsehjelp* – Prompt mental health care' to improve access to psychological therapy by offering low threshold services without referral, cost or long waiting times, supported by the government with a grant scheme since 2013. As an example, Lithuania now has more than 100 mental health centres that work alongside with general practitioners and are the first point of contact for people with mental health disorders. These centres consist out of a psychiatrist, psychologist and social workers (OECD, 2020[26]). In Slovenia, community mental health centres are being established (currently there are 10 for adult populations and 11 for child and adolescent populations), at a

primary care level, where interdisciplinary work with multiple professionals (psychiatrists, psychologists, social workers, speech therapists, occupational therapists, nurses) are working together.

Figure 3.16. Talking therapy provided by primary care providers, 2020



Source: OECD (2020[26]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

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Talking therapies can be an evidence-based intervention for a range of mental health conditions, from high prevalence disorders such as depression and anxiety, to conditions such as eating disorders, obsessive compulsive disorder, bipolar disorder and schizophrenia.

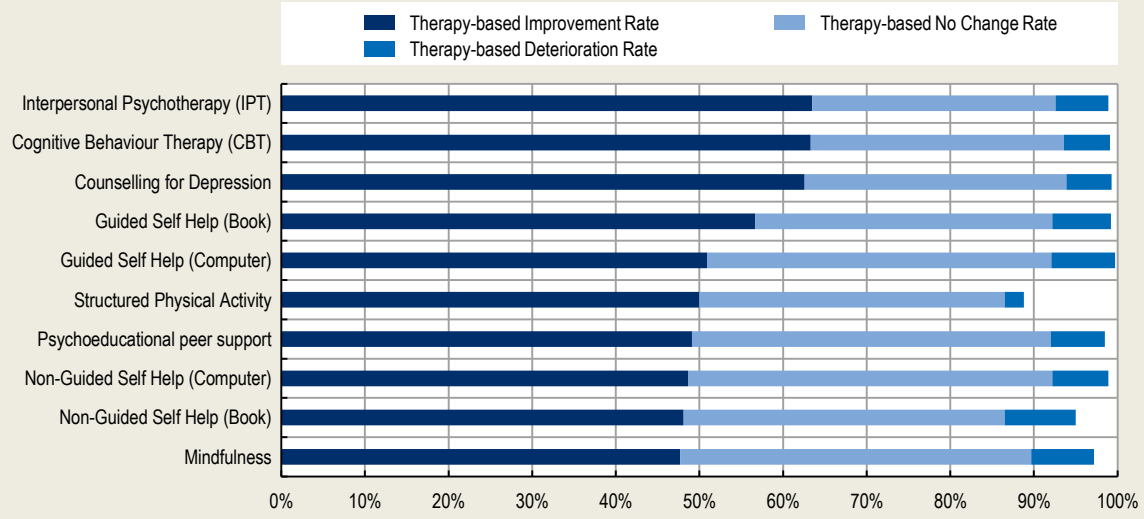
In Denmark, the health care system includes an opportunity for psychological treatment. According to Section 69 of the Health Care Act, specific vulnerable groups of patients have the opportunity of being referred by the local GP to psychological treatment and partly reimbursed for the costs; up to 12 consultations may be granted. In some cases a person may be referred to treatment twice and thereby be offered another 12 consultations with partly reimbursement of the costs. The subsidy covers 60% of the cost and is granted by the regional council whereas the remaining 40% is paid by the patient. Additionally patients who are between 18-21 years old can receive psychological treatment due to depression or anxiety disorders for free. From the second half of 2021, this entitlement was expanded to include all patients between 18 and 24 years. Efforts to scale-up access to talking therapies include stand-along schemes such as the IAPT programme in England, as well as trials to reimburse talking therapies in France (Box 3.2).

Box 3.2. Scaling-up access to talking therapies in England and France

The Increasing Access to Psychological Therapies (IAPT) programme in England has significantly transformed access to talking therapies, and continues to stand out internationally as a game-changing programme. IAPT began in 2008 to provide talking therapies for adult anxiety and depression, and has steadily increased the number of people who access services year-on-year, with more than a million people using IAPT services in 2018 alone. The programme originally began with a significant focus on cognitive behavioural therapies, and has since expanded to include a wider range of therapies found to be clinically effective by NICE (e.g. counselling, brief psychodynamic therapy, interpersonal psychotherapy), and a wider range of health conditions (phobias, OCD, PTSD, body dysmorphic disorder, irritable bowel syndrome, chronic fatigue syndrome).

IAPT stands out for its significant reach in terms of the number of people who are accessing services, but also for at least three other reasons: systematically including only therapies assessed as effective by NICE; the use of a stepped-care model with lower intensity services delivered by a specifically trained non-psychologist workforce, notably by 'psychological well-being practitioners'; and the integration of outcomes measures for all services. All IAPT services collect outcome measures at least at the start, middle, and end of treatment, including symptom measures (mostly using PHQ-9 or GAD-7), measures of disability (using WSAS). The measure of disability includes the extent to which a person's mental health problem interferes with their functioning at work, at home, at leisure, socially and with their family. At the beginning of the IAPT programme a target of 50% recovery was set for the services, which was reached in 2017-18 with a recovery rate of 50.8% (NHS Digital, 2019[117]; NHS Digital, 2019[118]).

Figure 3.17. IAPT recovery rates (select therapies), 2018-19



Source: NHS Digital (2019[117]), *Psychological Therapies, Annual Reports on the Use of IAPT Services, 2018-19*, https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2018-19.

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In France, mild-to-moderate mental disorders are typically managed by GPs, with antidepressants the main treatment available to them; psychological therapies provided by psychologists have not been reimbursed under basic health insurance. In 2018, the French health insurance began a pilot project in three regions to reimburse psychologist-provided psychological therapies (Gandré et al., 2019[119]; L'Assurance Maladie, 2018[120]). Unlike the approach taken by IAPT, these pilots did not create a new system or protocol for the type of psychological therapies to be delivered. Rather, the pilots introduced standardised protocol for referral and reimbursement of a range of psychologist-provided therapies. To benefit from reimbursed therapies recipients must be referred by their GP after following common referral guidelines and tools, after which an assessment is undertaken by a psychologist, and if appropriate the person is referred for ten sessions of supportive psychotherapy. After ten sessions the GP is able to refer for a further ten sessions if necessary. Psychologists delivering services are reimbursed directly, based on fixed tariffs. An evaluation of the pilots was due to begin in early 2020; initial findings suggest that the pilots have been extremely popular, with high demand for services from the population.

Early intervention techniques can effectively target adolescents or young adults

A system that wants to focus on proactive and accessible mental health services should also strengthen services for young people. The majority of mental health disorders often occurs in adolescence or young adulthood with 50% of mental disorders emerging by the age of 14 years, and 75% by the age of 24 years. When left untreated, there is a high rate of recurrence and increased chances of negative outcomes for the individual possible resulting in severe mental illness (Hetrick et al., 2017[121]). This makes it crucial for mental health systems to intervene during early stages of mental distress.

However, the process of early intervention, early diagnosis and timely access can still be a challenge. Many services are fragmented, while providing care that is strictly age based and with low levels of integration by being focused on specific diagnosis or comorbidities. This has led to lack of early intervention for people in need of mental health care (Hetrick et al., 2017[121]; Parabiaghi et al., 2019[122]; Malla et al., 2018[123]).

Internationally there has been a response to these challenges that includes reforming youth mental health into more integrated care models. Among others, Australia, Canada, France, Ireland, Israel, Italy, the United Kingdom and the United States have all taken certain steps to move towards to integrated youth mental health care by implementing initiatives based on integrated care models (Cocchi et al., 2018[124]; Hetrick et al., 2017[121]), with significant leadership in this area coming from Australia. Initially, these early intervention models developed in Australia focused on young individuals at risk for developing psychosis because of the prevalence of behaviour identified as possible prodromal phase in the development of psychotic disorders (McGorry, Killackey and Yung, 2008[125]). However, transdiagnostic perspectives have been presented later on, expanding towards a general understanding of "at-risk" mental states and other signs of psychological distress as cues, with youth potentially at risk for developing multidimensional psychopathologies. Australia's commitment to providing comprehensive mental health support for young people has led to the development of 'headspace' centres which provide a 'one-stop shop' for mental health, physical health (including sexual health), alcohol and other drugs or work and study support, and are in place in more than 130 communities across Australia. The Australian Government also funds the Early Psychosis Youth Services (EPYS) Program, which leverages off the headspace platform to provide early intervention treatment and support to young people aged 12 to 25 years who are at ultra-high risk of, or actively experiencing, their first episode of psychosis. The EPYS Program aims to reduce the incidence and severity of psychosis within the community through prevention, early detection, and co-ordinated care delivery, and currently operates in 14 headspace centres in six locations across Australia.

In Ireland, too, integrated mental health support for young people has been prioritised, with the 'Jigsaw' programme now reaching hundreds of thousands of young people, while in Canada programmes such as the 'ACCESS Open Minds' have sought to transform mental health services for young people aged 11 to 25 years (Box 3.3). Canada's ACCESS Open Minds programme aligns with the 'Common Statement of Principles on Shared Health Priorities (CSOP)', a statement of intent in which Health Ministers agreed on the importance of promoting mental wellness, and of addressing gaps in mental health and addiction services and recovery, including for children and youth. From 2017, and for at least the ten following years, this CSOP constituted a commitment from Health Ministers to improve access to evidence-supported mental health and addiction services and supports for Canadians and their families. Specifically, actions identified that should be pursued included expanding access to community-based mental health and addiction services for children and youth (age 10-25), recognising the effectiveness of early interventions to treat mild to moderate mental health disorders.

Box 3.3. Ireland's 'Jigsaw' mental health early intervention programme for young people and 'ACCESS Open Minds' in Canada

Jigsaw in Ireland

To improve early intervention in mental health care in 2014, Ireland has responded to transform youth mental health services through the development of Jigsaw. This project aims to transform mental health services for young people aged 12 to 25 years and support young people across Ireland in close collaboration with statutory, voluntary and community mental health and related services.

Jigsaw is now established in ten communities with a reach of 150 000 to 250 000 people. The centres are staffed by a multi-disciplinary teams or health professionals, who work in a brief and solution, while basing their treatments on CBT principles.

The core objectives identified to transform services are:

1. To ensure young people have access to youth-friendly, integrated mental health support in their community.
2. Build capacity in front-line workers and volunteers to support young people's mental health
3. Promote community awareness around mental health.

A review of the effectiveness of the services in 2015 highlighted more than 8 000 young people have received a service from Jigsaw. The study showed that there was a gender balance between the youth receiving support, which was seen as a strength, considering males do not seek help as frequently as females. The most common presenting issue was anxiety. People reported high levels of psychological distress pre-intervention and significantly lower levels post intervention (O'Keeffe et al., 2015[126]).

'ACCESS Open Minds' in Canada

To improve early intervention in mental health care, in 2018, Canada has responded to transform youth mental health services through ACCESS (Adolescents/young adult Connections to Community-driven, Early, Strengths-based and Stigma-free services) Open Minds.

This pan-Canadian project aims to transform mental health services for young people aged 11 to 25 years and to evaluate the impact of this transformation on individual and system outcomes. The programme focuses on reducing unmet needs, through early identification of at-risk individuals, providing rapid access (within 72 hours) to an assessment, facilitating referral to an appropriate care service within 30 days (Malla et al., 2018[123]).

Integrated continuous community care to improve mental health for people with severe mental health conditions

Data shows mental health systems are not yet able to deliver the care that people with severe mental illness need, while showing high numbers of readmissions, repeated emergency visits and suicide after discharge. Severe mental ill health is a complex condition, and people with severe mental ill health are often dependent on receiving long term care, while being highly vulnerable to future episodes and experiencing persisting symptoms (Rodgers et al., 2018[127]; Austin et al., 2013[128]).

Outpatient care models have been developed for people with severe mental ill health to serve their complex care needs. These models been associated with reduced hospital admissions, including involuntary admissions (Aagaard, Tuszewski and Kølbæk, 2017[43]; Burns, Tomita and Kapadia, 2014[129]). Assertive Community Treatment (ACT) and Case Management (CM), and Intensive Case Management (ICM) are all models that have been used or are currently used in care settings. These approaches are delivered by a multidisciplinary team of professionals, who offer services in community settings, by helping with a broad range of services which can include medication management, housing, finances and everyday problems in life. Intensive Case Management evolved from ACT and CM, where ICM emphasises the importance of a small caseload (fewer than 20) and high intensity input (Bond et al., 2001[130]; Dieterich et al., 2017[131]).

Continuous, open ended, integrated care treatments could provide people with severe mental ill-health the care they need to improve in illness severity and overall functioning, while preventing worsening of their condition. In 2006, Germany has developed the ACCESS-model which is an integrated care treatment based on ACT for patients with schizophrenia-spectrum disorder (SSD), while providing continuous and open-ended treatment. The ACCESS-model was incorporated into clinical routine as a time-unlimited care model and delivered to a sample of severely ill patients, primarily for people with multiple-episode schizophrenia-spectrum disorder and people with bipolar disorder with psychotic features, thus very complex treatment needs. Between May 2007 and December 2013, 115 patients were treated within the ACCESS care model over a continuous 48 months. Patients in the ACCESS received high frequent face-to-face contacts, with a mean of 2.0-2.4 contacts per week. Care was provided by a multidisciplinary team of psychiatrists, psychologists, nurses and social workers. This rate remained stable of the 4 years. Moments of contact focused on assertive engagement and shared decision making, while frequently involving family or significant others. The ACCESS treatment had positive outcomes, leading to improvement in patients' psychopathology, illness severity, functioning and quality of life. Service disengagement rate of 48 months remained low at 8.7% overall, a very low hospitalisation rate and a much lower rate of involuntary admissions compared to 2 years before involvement in ACCESS-care, respectively 7.8% in 4 years to 34.8% in the 2 years before. It is assumed that the continuously high rate of outpatient contact in ACT was a key component in stabilising patients' psychopathology (Schöttle et al., 2018[132]; Schöttle et al., 2019[133]). Given the success of this model, it has since been modified and extended to severely ill early psychotic adolescents and young adults between 12 to 29 years (Lambert, 2016[134]).

Ongoing efforts must also focus on improving services and therapeutics for people with serious mental illness, and this should include accelerating innovation and research in this area (see also Chapter 7). Innovation in service delivery for serious mental illness could include interventions which deliver better outcomes (e.g. symptom reduction, improved physical health outcomes), which have a higher rate of adherence, or which offer a better experience to service users for instance because of fewer side effects, or because the care model is more compatible with other social or professional objectives. In Norway, and in some other countries, efforts to explore drug-free treatments are one example of an alternative treatment model for severe mental health conditions (Box 3.4). While such an approach may not be the right one for all settings or all service users, it is critical that efforts to develop a diversity of different approaches to management of severe mental health conditions continue.

Box 3.4. Alternative treatment models for serious mental illness – exploring drug-free treatment in Norway

Treatment of severe mental illness with psychiatric medications remains the treatment of choice. However, there are ongoing challenges around the use of psychiatric medication, including adherence, and significant side effects. Side effects of anti-psychotic treatment can include mental and physical side effects such as concentration problems, emotional deregulation, weight gain, constipation and sexual dysfunction, all of which undermine adherence (Kasper and Resinger, 2003[135]; Iversen et al., 2018[136]). While newer, second generation psychiatric medication are found to have fewer side effects, the effects can still be significant. In particular, people were found to be a risk for weight gain and developing diabetes (Sernyak et al., 2002[137]).

Innovations to improve outcomes and experience in treatment of severe mental illness should be prioritised. There is an increased desire to explore medication free treatment of psychotic disorders. Studies have shown promising results, with successful outcomes in drug-free treatment. As an example, a study by Francey et al. (2020[138]), found young people with early-stage psychosis have experience reduced symptoms and improved functioning without antipsychotic medication, when they were provided with psychological interventions and comprehensive case management. Another study by Morrison et al. (2018[139]) examined outcomes between cognitive behavioural therapy and antipsychotic drugs, and a combined therapy of both cognitive behavioural therapy and antipsychotic drugs, which resulted in similar outcomes in people with psychosis.

Countries are increasingly exploring other ways to provide the treatment for people with severe mental illness and looking at possibilities for drug-free treatments. In a response to service users, Norway does now offer drug free treatment for people with psychosis. Demand for it rose due to an increase of negative experiences with psychiatric medication and led to Norway to adopt drug free treatment in 2016. While it is an option to receive drug-free treatment in some other countries, Norway is the first to embed it in their national mental health system. The University Hospital in Tromso has most of their patients to abate anti-psychotic drugs and the first signs point to positive outcomes. However, drug-free treatment remains controversial and data on outcomes remain scarce, and reassessment is needed to shed light of the use of drug-free treatments (BBC News, 2021[140]).

Creating safe inpatient settings while reducing coercive measures

Although countries are continuously working towards a model where care is provided in community settings, inpatient psychiatric care remains an integral part – albeit to differing extents – of OECD mental health systems. Countries have been focusing on creating safe inpatient settings, which concerns both patients and staff and is crucial in the process towards recovery from mental illness. However, inpatient suicides remain high, and countries are trying to identify the factors that contribute to unsafe inpatient facilities. Incidences such as assault, aggressive behaviour towards staff and patients, and the use coercion are among factors that could influence patient safety on inpatient wards. Lack of patient engagement, insufficient ward activities and lack of staff involvement have been pointed out as factors that aggravate aggression and violence (Janner and Delaney, 2012[141]; Polacek et al., 2015[142]).

From an international perspectives there have been attempts to reduce the use of coercive measures, and research has tried to identify the factors that influence the use of coercive measures. These factors concern both the causes for the destructive and aggressive behaviours from the patients, and secondly the frequency of the use of coercive measures by staff. Governments and mental health organisations are making attempts to reduce the use of coercive measures to a minimum required. To do so, several initiatives have been implemented. In some cases, strategies have been proven effective and are

promising in reducing the use of coercive measures. These strategies often relate to open door policies, ward culture and staff/patient ratios and models that have been developed combining several strategies (Bak & Aggernæs, 2012b; Gooding, 2018; Janssen et al., 2011; Cibis et al., 2016; Fan et al., 1994; Steinert et al., 2008; Sullivan et al., 2004). A frequently used model is the Six Core Strategies for Reduction of Seclusion and Restraint (6CS) (Box 3.5).

Box 3.5. The Six Core Strategies for Reduction of Seclusion and Restraint (6CS) – a model to reduce coercive practices

The Six Core Strategies for Reduction of Seclusion and Restraint (6CS) is a strategy model developed by the NASMHPD National Technical Assistance Centred in the United States. This is a synthesis of strategies, shown to be effective in reducing the use of seclusion and restraint (Gooding, McSherry and Roper, 2020[143]; NASMHPD, 2006[144]). The strategies in this model include;

1. 'Leadership towards organisational change' – promoting a climate of care which focused on reduction of coercive measures
2. 'Using data to inform practice' – Using empirical data to examine patterns of seclusion and constraint
3. 'Workforce development' – developing procedures and training, based on mental health recovery
4. 'Use seclusion and restraint reduction tools' – training programme for staff for de-escalation tools and techniques
5. 'Consumer roles in inpatient settings' – including patients and clients to manage their own behaviour
6. 'Debriefing techniques' – conducting an analysis of why the coercive measure occurred and evaluating its impact on individuals with the lived experience.

These strategies have been used in the United States, Canada, Australia and New Zealand. Several studies examined the use of the Six Core Strategies approach and all reported a significant decrease in the use of seclusion and restraint. In a study by Wieman et al. (2014[145]), out of the 28 facilities that had a stable implementation of the model, nine achieved reductions in overall population secluded, with an average reduction of 17%. Fifteen facilities reduced the amount of seclusion with 19%, respectively 1 000 hours. Nine facilities achieved reductions in the percentage of patients who were restrained, with an average reduction of 30%.

When coercive measures are inevitable, care facilities should strive for using the least intrusive measures possible

In cases when containment measures seem inevitable, it is important to apply the measures which are least harmful and safest for the patients and staff. Many organisations such as the World Health Organization, have passed statements that only the least restrictive measure should be applied (WHO, 2019[146]). What is considered as the least restrictive measure is difficult to define, given the cultural and historical geographical differences. Qualitative approaches consider human rights and medical ethics to determine what approach is most preferable. According to medical ethics, a procedure should lead to benefits, while physicians avoid harm and respect the patient's autonomy and act under aspect of fairness. This is line with the human rights perspective based on the CRPD, which states that individuals should maintain the highest level of autonomy and independence. These rights are difficult to respect as in cases of coercion, patients' autonomy is severely restricted. Some studies consider the restriction in autonomy

is less when staying in a seclusion room, than being immobilised by the use of bed belts. However, there is no unified opinion about which measure is least restrictive (Völlm and Nedopil, 2016[94]).

Another perspective is to consider the amount of distress a coercive measure evokes, by using a technique which minimises the harm done to an individual. An instrument has been developed to measure subjective distress and impairments of human dignity during coercive measures; the Coercion Experience Scale (CES) (Bergk, Flammer and Steinert, 2010[147]). A study by Bergk et al. (2011[148]) compared the use of seclusion and mechanical restraint, which showed patients who experienced mechanical restraint experienced more distress in retrospect. The same instrument was used in a study comparing the use of involuntary medication to seclusion. The study showed that people who were exposed to seclusion experienced more distress, and the people who receive both involuntary medication and seclusion experienced highest levels of distress (Georgieva et al., 2019[149]).

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4 An integrated and multi-sectoral approach to mental health

A multi-sectoral, integrated approach to mental health means making mental health a priority in sectors beyond the mental health system – good performance in mental health is not only the responsibility mental health specialists, but rather must include a wide range of actors and sectors including teachers and schools, line managers and workplaces, as well as other community actors. Such an approach also means making sure that an integrated perspective is included within the mental health system, for example prioritising employment and education outcomes, and making meaningful links across sectors. This chapter find that more could still be done to strengthen the multi-sectoral policies, and above all working practices, when it comes to mental health. Action in this area is even more critical in light of the mental health impacts of COVID-19, which are weighing most heavily on populations with a lower socio-economic status, people experiencing unemployment, and young people, and where an integrated and whole-of-society response is needed.

Introduction

A multi-sectoral, integrated approach to mental health care means making mental health a priority in sectors beyond the mental health system – including the physical health system, and in education, employment, and societal settings and policies. Such an approach also means making sure that an integrated perspective is included within the mental health system, for example prioritising employment and education outcomes, and making meaningful links across sectors. As of 2019-20, five years after the introduction of the *OECD Recommendation on Integrated Mental Health, Skills and Work Policy*, the importance of a multi-sectoral, integrated approach to mental health performance is well-accepted amongst OECD countries. Cross-government approaches to mental health are growing increasingly common, in particular in mental health strategies which regularly set out the importance of engaging actors beyond the specialist mental health system in efforts to promote good mental health, and reduce the burden of mental ill-health. This approach is also an economic necessity; the majority of the economic costs of mental ill-health are not driven by spending on care or treatment, and fall outside of the health system in spending on social security programmes, including paid sick leave benefits, disability benefits and unemployment insurance benefits.

However, this chapter – and the OECD Report *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation* (OECD, forthcoming[1]) – find that more could still be done to strengthen the multi-sectoral policies, and above all working practices, when it comes to mental health. The employment and education outcomes of people with mental health conditions remain significantly poorer than the general population, and both the inclusion of employment and education outcomes as a goal of mental health services, and the integration of mental health support into social protection services, are ad-hoc at best. More systematic cross-sectoral mental health policy, and an integrated approach at the service-delivery level, is now even more critical in light of the COVID-19 crisis. Since the start of the COVID-19 crisis, the growing burden of mental ill-health has weighed disproportionately on populations with a lower socio-economic status, people experiencing unemployment, and young people. In responding to the crisis, an integrated response that includes mental health support, should be prioritised.

Why do mental health systems need to be integrated and multi-sectoral?

Good performance in mental health is not only the responsibility of medical staff in hospitals and clinics, but rather must include a wide range of actors and sectors including teachers and schools, line managers and workplaces, as well as other community actors. Additionally, 'high performance' of mental health systems must extend beyond symptom treatment.

Principle 3 of the OECD Mental Health Performance Framework sets out that a high performing mental health system 'Takes an integrated, multi-sectoral approach to mental health', and that an integrated, multi-sectoral approach should:

- Pursue a 'mental health in all policies' approach;
- Ensure physical health needs are met;
- Involve social protection systems that promote recovery and encourage return to work or education;
- Enable front line actors to connect individuals to appropriate services.

Cross-sectoral mental health policies can support good mental health

Across the past decade, OECD work has highlighted the importance of cross-sectoral, integrated mental health policy for delivering good outcomes for people with mental health conditions, and for supporting good mental health for all.

Mental ill-health affects people of all ages, socio-economic groups, ethnicities, and identities, and intersects with peoples' ability to lead the lives they want – in work, in schools, at home. OECD work has highlighted, first, the significant burden of mental ill-health amongst working-age and youth populations (OECD, 2012[2]; OECD, 2015[3]). Young people with a mental health condition are 35% more likely to have repeated a grade at school, and to leave school early, and working-age adults are 20% less likely to be in employment if they have a mental health condition (OECD, 2015[3]).

At the same time, most people with a mental health condition are in-work. And, being in-work (or in school) has a positive impact on mental health status. Indeed, for young people measures to address mental health problems are more effective if they are put in place while students are still in school, while mental health support is more effective at helping people stay in employment than it is at helping people return to work after unemployment or sickness absence (OECD, 2015[3]; OECD, forthcoming[1]). Integrated policies across sectors – health, youth, labour, and social policy – help meet people where they are – in work, in school, in their communities – to provide mental health support, and help people experiencing mental ill-health to return to or stay in work or education, which helps improve and secure mental health outcomes. Integrated support also goes both ways, including both the integration of mental health awareness and/or practices in work places, schools, or social support services, as well as an employment- or education-focus in mental health services.

Integrated mental health policies could also go beyond the health, employment, education and social affairs or social benefits sectors. For example, good quality housing or environmental planning that promotes access to green spaces can have significant positive impacts on population mental health, just as poor or insecure housing or lived environments can have a negative impact on mental health, or make mental health conditions harder to manage (Mind, 2017[4]; European Parliament, 2020[5]).

OECD member countries have, since 2015, committed to recognising the importance of integrated mental health policy and taking steps to strengthen it, in their adherence to the *Recommendation of the OECD Council on Integrated Mental Health, Skills and Work Policy (2015)* (OECD, 2015[6]) (see Box 4.1). In 2019, a process to follow-up on the progress made by countries in implementing this Recommendation began, some of the findings for which are discussed later in this chapter.

Box 4.1. OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy

Recognising that mental ill-health demands interventions that are cross-sectoral in scope and complementary in nature, in 2015 the OECD Council published the *OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy*.

This recommendation is a sign that governments in OECD countries understand that good policies can make a significant difference when it comes to preventing mental illness at all ages, including in youth and adolescence, in supporting those experiencing mental illness to stay in the workplace and supporting those who have left employment to return to the labour market. The OECD Recommendation gives a series of guidelines to address the impact of mental ill-health on employment, education, health and social outcomes. These guidelines, which all OECD signatories are expected to follow, encourage countries to seek to "promote mental well-being, prevent mental health conditions, and provide appropriate and timely services which recognise the benefits of meaningful work for people living with mental health conditions".

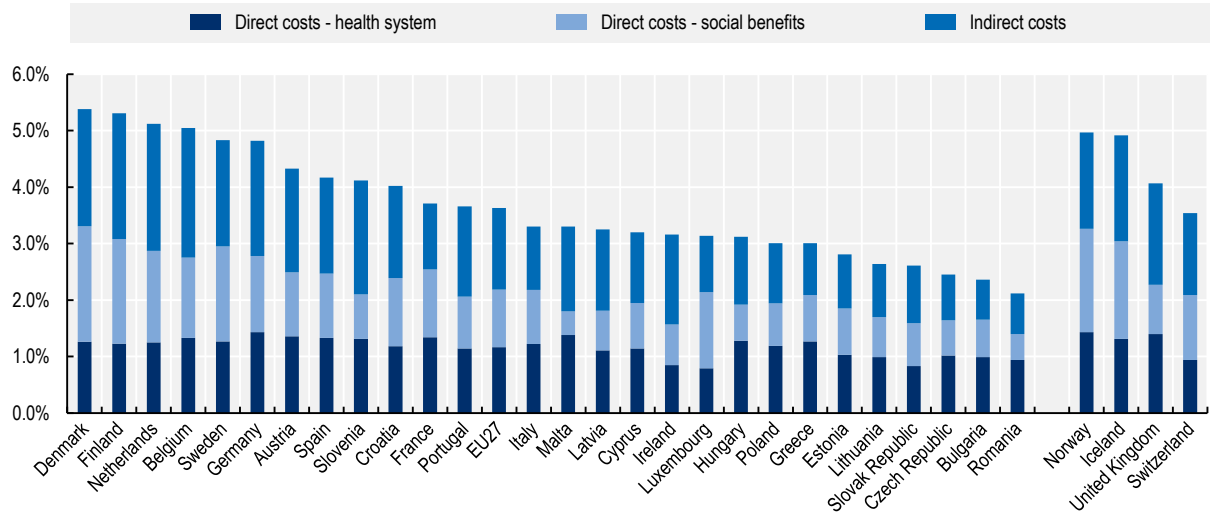
The economic costs of mental ill-health are distributed across multiple sectors

The economic costs of mental ill-health are distributed across multiple sectors, which is further motivation for an integrated, multi-sectoral approach to mental health policy and practices.

The economic costs of mental ill-health can exceed 4% of GDP in European countries (OECD, 2012[2]; OECD/European Union, 2018[7]). However, the majority of the economic costs of mental ill-health are not driven by spending on care or treatment. Direct costs outside of the health system – spending in many social security programmes, including paid sick leave benefits, disability benefits and unemployment insurance benefits – and indirect costs related to reduced labour market participation and productivity are significant. In European countries in 2015 the costs of mental ill-health outside the health sector accounted for more than half of the total economic costs – EUR 194 billion – of mental ill-health: disability benefits accounted for EUR 112 billion (or 0.76% of GDP); paid sick leave benefits related to mental health problems accounted for EUR 28 billion (or 0.19% of GDP); unemployment insurance benefits accounted for EUR 29 billion (or 0.20% of GDP) (OECD/European Union, 2018[7]). Indirect costs due to lower employment rates for people with mental health problems and reduced productivity due to higher absenteeism and lower productivity at work account for over EUR 240 billion (or 1.6% of GDP) (ibid) (Figure 4.1).

Figure 4.1. Estimated direct and indirect costs related to mental health problems across European countries

As a percentage of GDP, 2015



Note: OECD estimates based on Eurostat Database and other data sources. Following the departure of the United Kingdom from the European Union, the EU average was updated in 2021.
Source: OECD/European Union (2018[7]), *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, https://doi.org/10.1787/health_glance_eur-2018-en.

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A significant proportion of short and long term sickness absence or disability claimants have mental health conditions, especially long term disability recipients. For example, mental health conditions have accounted for 29% of all sickness compensation in Sweden, according to Swedish Social Insurance Agency data, from 2015 to 2019 (OECD, 2020[8]). In Iceland, 32.1% of recipients of invalidity pension and 38.8% of recipients of rehabilitation pension had a mental health condition in 2019, and in the Netherlands 32.7% of long term absenteeism is for a mental health condition in 2017. In Norway, 16.9% of sickness absences, 42.9% of recipients of Work Assessment Allowance, and 35.8% of disability benefit recipients had a mental health condition as the major cause in 2019. In England, 59.5% of Employment Support Allowance claimants, 50% of ESA Support Group, and 35.77% of Personal Independence Payment

claimants had a mental and behavioural disorder, based on 2019 data. In other countries, the percentage of sickness absences or disability payments for mental health conditions is far lower, for example in Luxembourg where mental health conditions accounted for 5.1% of sickness benefit claims in 2018, or Slovenia where 6/7% of compensated sick leave days were for a mental health condition, and 2.1% of total sick leave compensation in 2018 (ibid).

A range of national estimates already suggest that the economic costs of mental ill-health are as high across all OECD countries as they are in the European countries. For example, in Japan, the total costs of depression have been estimated at USD 11 billion, schizophrenia at USD 23.8 billion, and anxiety disorders at USD 20.5 billion (Sado et al., 2013[9]; Sado et al., 2013[10]), while estimates for the costs of mental ill-health in Canada have ranged from CAN 48-50 billion (Mental Health Commission of Canada, 2016[11]), to up to CAN 65.3 billion (Jacobs, Knoops and Lesage, 2017[12]).

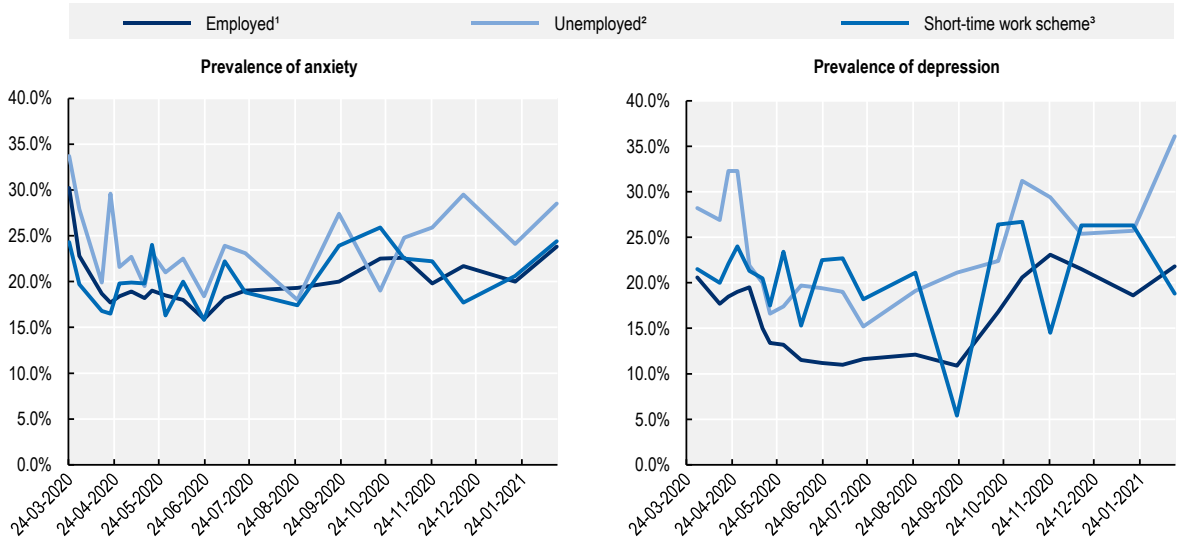
Estimates from Australia suggest that the total costs of mental ill-health amount to 4% of GDP, 45% of which is indirect costs (OECD, 2015[13]; Australian Government - National Mental Health Commission, 2016[14]). Since these estimates were made, a report by the Australian Productivity Commission Inquiry on mental health has pointed to the quality of life and economic benefits that reforms to the mental health system can bring – including focusing on promotion and prevention, improving access to care and integration of services, and promoting recovery (Australian Government Productivity Commission, 2020[15]). This report suggested that such reforms could bring quality of life improvements valued at AUD 18 billion annually, and increased economic participation valued at AUD 1.3 billion; the report also found that about 90% of the reforms, equivalent to AUD 17 billion, could be delivered through a number priority reforms which would require spending of AUD 2.4 billion but also generate savings of up to AUD 1.2 billion per year (ibid).

The COVID-19 crisis calls for a re-doubling of efforts to integrate mental health, work, and education policy

Cross-sectoral mental health policy, and especially integrated mental health, employment, education and skills policy, is even more critical in light of the COVID-19 crisis. Across most OECD countries, people with mental health problems struggle more with education, and are less likely to be in employment, than the general population (OECD, 2015[3]; OECD, 2012[2]).

Across all countries that are tracking population well-being across 2020 during the COVID-19 crisis, mental health status amongst people who are experiencing unemployment, facing economic difficulties, and young people, has been markedly worse than the general population. Longitudinal evidence from France (Figure 4.2) shows that individuals in employment have been less likely to report symptoms of depression and anxiety than unemployed people. Across the OECD, job retention or short-time work schemes were introduced or adapted to protect jobs, as these scheme allow employees to keep their contracts with the employer even if their work is suspended (OECD, 2021[16]). It is not always clear whether the mental health of these population groups has worsened faster than the general population – and general population mental health has declined in 2020 compared to previous years – or if these gaps mostly reflect differences in mental health status that pre-date the pandemic. At the same time as mental health status declined, there were significant disruptions to mental health support and services delivered in schools, workplaces, unemployment centres and other settings outside of specialist mental health care. Worldwide, 78% of countries reported at least partial disruptions to school programmes, and 75% to workplace mental health services (WHO, 2020[17]).

Figure 4.2. Anxiety and depression are more prevalent among the unemployed in France



Note: Results are based on a survey with a small sample size (2 000 total respondents by survey wave) which may drive sharp drops and falls in some survey waves.
1. 'Travail'; 2. 'Chomage'; 3. 'Chomage partiel'.
Source: Santé Publique France, Enquête CoviPrev, https://www.santepubliquefrance.fr/etudes-et-enquetes/coviprev-une-enquete-pour-suivre-l-evolution-des-comportements-et-de-la-sante-mentale-pendant-l-epidemie-de-COVID-19 in OECD (2021[18]), "Tackling the mental health impact of the COVID-19 crisis: An integrated, whole-of-society response", https://doi.org/10.1787/0ccafa0b-en.

The COVID-19 crisis underlines the importance of integrated mental health and somatic health care: all signs point to both possible lasting psychological impacts for COVID-19 patients, especially those who experienced long hospitalisations or those living with 'long COVID', as well as increased risks of contracting COVID-19 and experiencing complications for individuals living with severe mental illnesses. It was already clear that the health outcomes of people living with severe mental illness are significantly worse than the general population, in part due to increased risk of death by suicide, but also due to increased risk of cardiovascular disease, diabetes, and cancer (see Figure 4.2), and COVID-19 comes as an additional health risk that must be managed.

Are OECD mental health systems integrated and multi-sectoral?

Do OECD countries take a 'mental health in all policies' approach?

International mental health strategies recognise the importance of sectors beyond the health system for mental health policy

Many of the protective factors for good mental health go beyond the scope of mental health systems or programmes designed specifically to strengthen or protect mental health. Social, economic and cultural factors, such as employment status, income, physical health, experiences during childhood and adolescence, all have a significant impact upon mental health across the life course (Patel et al., 2018[19]; OECD, 2012[2]; OECD, 2015[3]).The COVID-19 pandemic has further underlined how inter-sectoral mental health status is: the COVID-19 crisis has been acknowledged as an international mental health crisis, with risk factors for short- and long-term mental health being common during the COVID-19 pandemic, specifically driven by social restrictions, unemployment, financial instability and school closures are

amongst the several factors contributing to a worsened mental health outcome (WHO, 2021[20]; OECD, 2021[18]). This crisis has highlighted that our mental health is impacted by much more than factors related to the mental health system and emphasises the need for a cross-governmental approach of promoting and caring for mental health.

Already before the COVID-19 pandemic, a cross-governmental approach in mental health has been receiving increased attention. OECD Countries endorsed the OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy in 2015, and committed to pursuing mental health policies and interventions that are cross-sectoral in scope and complementary in nature (Box 4.1). The Sustainable Development Goals defined by the United Nations, which recognises mental health as a fundamental human right, apply a multi-sectoral approach to promoting and protecting mental well-being and require a broad interdisciplinary perspective on mental health systems (Patel et al., 2018[21]). In a response, in 2019 the WHO has called for a multi-sectoral action on treating mental ill health. In this action, they defined mental health as physical and mental health and well-being. The action approached social progress by objective indicators of physical and mental health, health equity and well-being, including the conditions in which people are born, live and work, and called for the whole of government work together to achieve these goals in health and well-being (WHO Europe, 2019[22]).

A need for more cross-governmental working is not only a priority for mental health systems, but also other fields of policy making such as public health in general (Jenkins, 2005[23]). Countries have been trying to break down silos and working together between ministries to develop intersectional policies. In Austria, there are 10 ‘Health Targets’ which were developed and approved in 2012, with the aim to prolong the healthy life years of all people living in Austria within 20 years (until 2032). Health target #9 is “To promote psychosocial health in all population”, which has three impact goals: Health promotion/prevention/early detection; Care/rehabilitation/training; and Society/de-stigmatisation (OECD, 2020[8]). The Targets are backed by more than 40 concrete measures have been started all over Austria by various initiatives, which include measures that target mental health in the workplace, such as a programme to boost mental health competencies at the work place for management and employees (“Gesundheitskompetenz für psychische Gesundheid fur Akteure im Betrieb”), and a trial project on patient-centred medical communication for medical doctors

Finland is widely recognised as having been a leader in the field of the “Health in All Policies” approach, which stresses that policies that are made outside traditional health policy making have a significant impact on health, such as transport, agriculture, education and employment. The Finnish Health in All Policies approach requires all government sectors to keep health problems at the forefront, to be held accountable for policies affecting health and health care, to prioritise inter-sectoral pro-health intervention, and to educate policy makers, lawmakers and the public in all sectors about how health and health services will be affected by their decisions. In Finland, this cross-sectoral focus originally started with a desire to enhance public health, focusing on improving nutrition, reducing smoking and reducing injuries. During the Finnish EU Presidency in 2006 when ‘Health in All Policies’ was adopted as the theme for health work. At the Finnish level, the work has evolved from tackling a single health issue to a wider scope such as programmes, policies and governmental inter-sectoral programs (OECD, 2019[24]).

OECD countries have made cross-sectoral mental health policy a priority in strategies, but implementation in practice is inconsistent

To develop a high performing mental health system, it is important that governments approach mental health from a cross-governmental approach, with a co-ordination on mental strategies and implementing policies while working with multiple ministries to address mental health. Nineteen OECD countries have reported they have mental health strategies that are being addressed by other ministries than the health ministry (Table 4.1). Fewer countries (Austria, Belgium, Iceland, Italy, Japan, the Netherlands, Norway, Slovenia, Switzerland, Turkey) reported that ministries other than the Ministry of Health had a

dedicated mental health budget that they were able to identify. In countries with federated health systems or where regions and municipalities have particular responsibility for health care or education, for instance, efforts to work cross-sectorally are also undertaken at the sub-national level.

For example, Norway has developed the National Mental Health Strategy with seven ministries, respectively their Ministry of Health, Culture, Children and Equality, Labour and Social Affairs, Education, Local Government and Modernisation, and Justice. Norway has also applied a cross government approach while developing additional mental health strategies. Eight ministries have been involved in developing an escalation plan on children and young people, respectively the Ministry of Education, Employment, Social Affairs, Families, Justice, Local Government and Modernisation, Culture and Agriculture and Food. Additionally, the Norwegian Ministry of Employment and Social Affairs has a programme which aims for more inclusive labour markets including people with mental health and substance abuse problems. Similarly, in 2019, Denmark has as agreed on a political statement for an improved working environment with initiatives to support and improve mental health at work. This agreement focuses on gathering information on regulations of psychosocial risks as work, following up with increased inspections and actions to improve working environments by providing additional training for managers and employees to foster inclusive working environments that promote mental well-being (OECD, 2020[8]). In Costa Rica, work on mental health is carried out in an inter-institutional and inter-sectoral manner: the Ministry of Health, the Costa Rican Social Security Fund, the Ministry of Public Education, the Ministry of Youth, the National Children's Trust, the Institute of Alcoholism and Drug Addiction, local governments, are involved in developing approaches, among others.

Table 4.1. Cross-sectoral policy making for mental health

Programmes, strategies, and budgets for mental health in Ministries outside of the Health Ministry

	Any national programmes/strategies for developing integrated cross-government approaches to mental health governance	Ministries that have a dedicated mental health strategy, plan or work programme	Ministries that have a dedicated mental health budget
Australia	Yes	Education, Employment, Social affairs, Families, Other Ministries	Cannot answer
Austria	Yes		Social Affairs
Belgium	Yes		Employment, Social affairs, Other Ministry
Canada	No	Correctional Service Canada; Veterans Affairs Canada; and Indigenous Services Canada, other Federal Departments.	Cannot answer
Czech Republic	Yes	Education, Social Affairs, Justice, other Ministry	Cannot answer
Denmark	Yes	Education, Social Affairs, Health	Cannot answer
England	Yes	Economy, Education, Employment, Justice, other	Cannot answer
Estonia	Cannot answer	Cannot answer	Cannot answer
Greece	Cannot answer	Other; Ministry of Health	Other
Iceland	Yes	Social Affairs, Health	Social Affairs, other
Ireland	Yes		Other
Israel	No	Cannot answer	Cannot answer
Italy	Yes	Economy, Education, Employment, Social Affairs, Families, Justice	Economy
Japan	Yes	Employment, Social Affairs, Families, Other	Employment, Social Affairs, Families, Other
Korea	Yes	Ministry of Health and Welfare, Other	Other
Latvia	Yes	Other	Other
Lithuania	Yes	Council of Ministers	
Mexico	No		Other Ministry
Netherlands	Cannot answer	Social Affairs, Justice, Other Ministries	Social Affairs
Norway	Yes	Education, Employment, Social Affairs, Families, Justice, Other; Ministry of Local Government and Modernisation, Ministry of Culture, Ministry of Agriculture and Food	Education, Employment, Social Affairs, Families
Poland	Yes	Council of Ministers	Other
Portugal	Yes	Social Affairs, Justice	Cannot answer
Slovenia	Yes	Finance, Economic Development and Technology, Public Administration, Environment and Spatial Planning, Interior, Justice, Education, Social Affairs, Families	Education, Social Affairs, Families
Sweden	Yes		
Switzerland	No	Economy, Employment, Social Affairs, Families	Economy, Employment, Social Affairs, Families
Turkey	Yes	Education, Employment, Social Affairs, Families	Employment, Social Affairs, Families, Other Ministries

Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Integration of mental health, skills, and work policy is uneven

As of 2019-20, five years after the introduction of the *OECD Recommendation on Integrated Mental Health, Skills and Work Policy* (OECD, 2015[6]) the importance of a multi-sectoral, integrated approach to mental health performance is well-accepted amongst OECD countries (henceforth, 'the Recommendation'). The Monitoring Report on the Implementation of the Recommendation has found that in recent years, a number of respondents have introduced mental health plans with a focus on mental health policies that are integrated with education, employment, social and health policy (OECD, forthcoming[1]). In the follow-up on the implementation of the Recommendation, five years after its establishment, a significant number of Adherents to the Recommendation ('Adherents') had included educational, employment and social protection dimensions of mental health in their national strategies or plans for the first time. The most recent mental health plans in OECD countries appear to demonstrate a clear commitment to a cross-governmental approach, even if clear targets or outcome objectives can be absent (OECD, forthcoming[1]).

Nineteen of twenty-nine respondents to the OECD Mental Health Benchmarking Policy Questionnaire have national programmes/strategies for developing integrated cross-government approaches to mental health governance, and in at least 14 countries Ministries other than the Ministry of Health have a dedicated mental health strategy, plan or work programme (OECD, 2020[8]). In Denmark, the Ministry of Employment developed a broad political agreement from April 2019 on a new and improved working environment effort including initiatives to support improvement of mental health at work, from regulation on psychosocial risks at the work place, to a focus on education of managers and employees in how to take care of the psychosocial working environment. In England, the government has established an Inter-Ministerial Group for Mental Health which includes representatives from other Government Departments, and at least six Government departments – from education to digital affairs to environment, food and rural affairs – have established strategies or actions covering mental health.

The follow-up to the implementation of the Recommendation found that the extent to which countries had integrated mental health, skills and work policy was uneven – both across areas of policy, and across countries (OECD, forthcoming[1]). Policy development is highly uneven across the four thematic areas covered by the Recommendation (health systems, youth support systems, workplace policies, and social protection systems). Most OECD countries place growing importance on integrating mental health care with schools, workplaces and skills, but this emphasis has tended to be at the strategy level, and examples of working-level implementation are far fewer. OECD countries reported significant recognition in youth support systems of the need for an integrated approach includes responds to mental health and its impact on education and employment. There were some examples of integrated workplace and health policies that could be found. And there were relatively few examples where social protection systems – employment services and social benefits – are implemented systematically, and this sector seems to be lagging behind, despite the high prevalence of mental health conditions amongst benefit recipients and employment service users.

Do mental health systems ensure physical health needs are met?

People with severe mental health conditions have a lower life expectancy than the general population

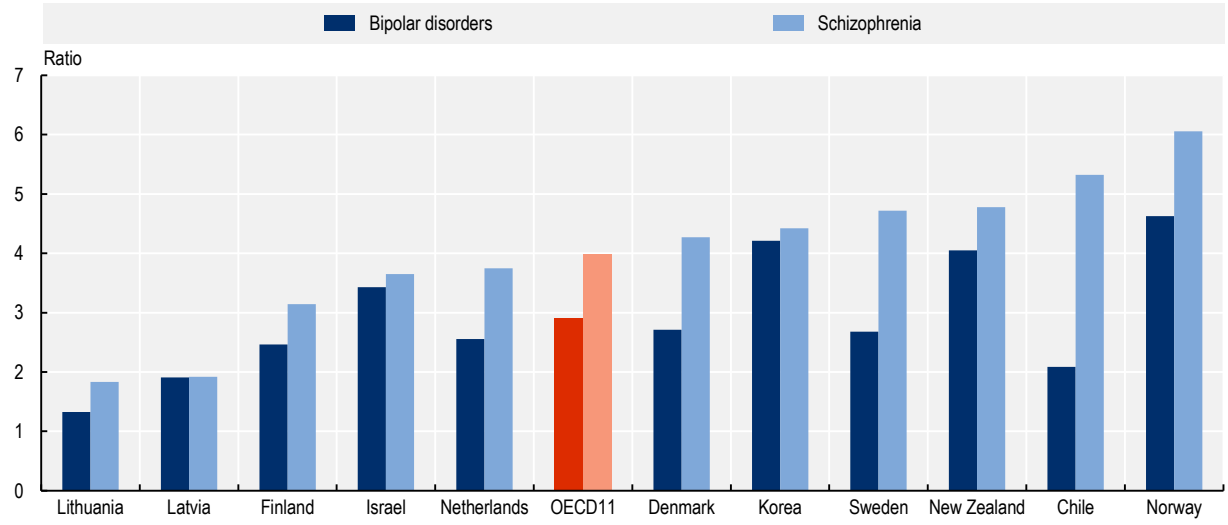
People with mental health conditions have long experienced poorer physical health care than the general population, driven by both a higher rate of physical health risks, and a poorer access to health care (Firth et al., 2018[25]; Teasdale et al., 2019[26]; Thornicroft, 2013[27]). People with mental health conditions have been found to be at a 1.4 to 2 times higher risk of obesity, diabetes and cardiovascular disease compared to the general population (Firth et al., 2019[28]). Additionally, studies have identified people with mental ill health to display behaviours that are risk factors for physical diseases at a higher rate, such as smoking, excessive alcohol consumption, dietary risks, physical inactivity and sleep disturbance (Teasdale et al.,

2019[26]; Stubbs et al., 2018[29]; Firth et al., 2018[25]; Firth et al., 2019[28]). People with mental health conditions can also be at increased risk of physical ill-health because of the use of certain psychiatric medications; in particular, the use of antipsychotics has been consistently linked to cardiovascular and metabolic side effects (Ali, Jalal and Paudyal, 2020[30]; Westman et al., 2018[31]; Ösby et al., 2016[32]; Wahlbeck et al., 2011[33]; Pringsheim et al., 2017[34]; Solmi et al., 2017[35]).

Co-morbidity between mental health conditions and somatic conditions, especially non-communicable diseases, is extremely common. Mental ill-health is a risk factor for physical health conditions, just as some physical health conditions increase the risk of mental ill-health. A 2017 WHO report found that depression is two to three times more common in those with diabetes than those without, that depression is associated with a 60% increase in the disk for diabetes and type 2 diabetes is associated with a 15% increased risk for depression (WHO Regional Office for Europe, 2017[36]). The same report found that depression increases the risk of coronary heart disease by 1.6 to 1.9 times, and the risk of chronic obstructive pulmonary disorder (COPD) by 2.5 times, while people with COPD are more likely to have symptoms of anxiety disorder (10-19% for people with stable COPD, and 58% of those recovering from acute episodes) (Ibid). The same report found that about 25% of people with cancer also have anxiety and/or depression. Co-morbid mental health and physical health conditions are also more difficult to manage, and can make it harder for people to adhere to treatments or engage in care for either their physical or mental health condition; co-morbid depression has been found to be associated with poorer glycaemic control for people with diabetes (type 1 or 2); depression has been found to worsen outcomes from cardiovascular disease by 2.4 times, and increase rates of re-hospitalisation rates (ibid).

Mental health conditions, especially severe mental health conditions, are associated with high rates of premature mortality. The OECD indicator on excess mortality for measures the difference between the mortality rate for the general population, and those who have had a diagnosis of schizophrenia or bipolar disorder (Figure 4.3). An “excess mortality” value that is greater than one implies that people with mental disorders face a higher risk of death than the rest of the population. In 2015-17, excess mortality ranged from 1.3 in Lithuania to 6.1 in Norway for people who had lived with schizophrenia (OECD, 2019[37]). Similar trends are found in other countries; in the Czech Republic a study comparing deaths in people with mental and behavioural disorders discharged from psychiatric hospitals with deaths in the general population found a mortality risk more than two times higher amongst people with mental disorders than in the general population (Krupchanka et al., 2018[38]). Inversely, people living with chronic diseases, such as cardiovascular disease or diabetes, are at increased risk of mental disorders such as depression (Glassman, 2007[39]; Holt, de Groot and Golden, 2014[40]).

Figure 4.3. Excess mortality for persons with bipolar disorder or schizophrenia, 2015-17



Note: Data represent a three-year average except for the Netherlands (two-year average 2016-17).
Source: OECD (2020[41]), OECD Health Statistics, https://doi.org/10.1787/health-data-en.

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A small number of OECD countries have specific initiatives relating to physical health care support or liaison for mental health service users

Given the high rate of co-morbidity between mental health conditions and physical health conditions, integrated service deliver is key. This integration should include effective physical health care – including health promotion and prevention – for people with mental health conditions, as well as screening for physical health conditions and increased health risks for persons with mental health conditions, and for mental health conditions for persons with physical health conditions that present an increased risk for mental ill-health (see also Chapter 5, on promotion and prevention).

To improve the integration of mental health and physical health care, and to improve health outcomes for people with mental health conditions, countries are increasingly trying to take a multidisciplinary approach (Table 4.2). For example, Israel has undertaken periodic studies on physical health for people with mental ill-health, while looking at mortality numbers in psychiatric patients, and is currently in the process of linking both data from patients with a psychiatric hospitalisation with data on general hospitalisations, which should result in a more integrated approach (OECD, 2020[8]). In Denmark, one example of an initiative to support better physical health outcomes has been through the Steno Diabetes Center, under the supervision of the Danish Health Authority, which has developed a tool meant to be used by supported housing facilities for people with mental illness in order to prevent somatic illness. The tool can also be used as a guide for the staff in terms of speaking with residents about physical symptoms, general physical health and habits such as smoking, exercise, substance abuse and other risky behaviours (OECD, 2020[8]). In Norway in 2019, the government introduced patient pathways for mental health and substance abuse when patients are referred to specialised health care. One of the goals of introducing the pathways is to better maintain the somatic health of these patients, and the pathways include recommendations about somatic health care and checks (ibid).

However, room for improvement clearly remains. Only two OECD countries, Korea and the United Kingdom report routinely collecting information on access to physical health are for persons with mental ill-health, such as cholesterol checks, BMI measurements, smoking status or general physical health screenings.

Table 4.2. Initiatives to support good physical health for people with mental health conditions

Countries which have initiatives relating to physical health care support/liaison for mental health service users, e.g. a standard check around physical health care checks on an annual basis, or at the point of admission to inpatient care

	Countries and policy examples
Yes, specific targeted initiative exists	Specific commitment to physical health checks for people with mental health conditions: England, Ireland Patient pathways for somatic care for patients with mental health or substance abuse conditions: Norway
Yes or Yes, but this does not always happen	GPs are responsible for supporting physical health care: Australia, Portugal Community or Public Health Nurses co-ordinate physical heath support: Australia Included in clinical guidelines: Czech Republic, Korea, the Netherlands (for psychosis an annual physical check is required), Turkey (applied as a clinical necessity, prevention, early diagnosis and treatment processes are prioritised) Other/not specified: Israel, Latvia
Depends on care settings	Support/liaison services in inpatient settings: Austria, Japan, Portugal (full medical observation at inpatient admission) Physical health care planning include in individual care plans: Canada Specific guide for somatic illness prevention in mental health care: Denmark (in supported housing) Routine pre/post-natal screening: Iceland Other/not specified: Belgium, Estonia, Greece, Iceland, Italy, Norway, Slovenia
Cannot answer or No requirement	Lithuania, Mexico, Switzerland

Note: Authors' elaboration based on submissions to the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires 2020.
Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

In England and in Ireland, health checks have been being used to routinely monitor the physical health of people with mental health conditions. In Ireland, the Irish Mental Health Services have introduced a new physical health assessment proforma for all service users in acute adult approved centres on admission, and at six months. This proforma includes questions on lifestyle behaviours and was developed by practitioners and service users. The Irish Mental Health Services have also developed referral pathways to assist staff carrying out a brief intervention with making changes to lifestyle behaviours, as well as publishing guidelines on how mental health services can support services users to be more physically active (OECD, 2020[8]). In England, the short and long term mental health plans have set the ambition of 280 000 people with severe mental illness receiving a full annual physical health check by 2020/21, up to 390 000 people with an annual check-up 2023/24, carried out either by a General Practitioner or in secondary care (ibid). A comprehensive physical health check includes a weight or BMI, diet, nutritional and physical activity check, a cardiovascular status check (pulse and blood pressure), metabolic status, liver function, renal and thyroid check (NICE, 2018[42]).

Just as co-morbid mental health conditions and somatic conditions are common, so too are multiple or 'co-occurring' mental health conditions. Co-occurring mental health conditions demand particular attention to integration in services and policy models, in particular across often-fragmented 'mental health' services and substance use or addiction services (Box 4.2).

Box 4.2. Managing co-occurring mental health conditions

Co-morbidity of multiple mental health conditions, or 'co-occurring disorders', has been found to be very common; for example in Australia one in four adults who had experienced a mental disorder in the previous year had experienced more than one class of disorder (Department of Health, 2009[43]). In Australia, the most commonly co-occurring disorders were affective and anxiety disorders, followed by substance use disorders in combination with anxiety disorders; over half (54.0%) of Australians with more than one class of mental disorder experienced severe impairment, compared to 7.5% of Australians with only one class of disorder (ibid). Co-occurrence of a primary mental disorder, with a secondary addictive disorder, is common (Grant et al., 2004[44]; Kessler et al., 1996[45]; Merikangas et al., 1998[46]). In the United States in 2019 an estimated 9.5 million adults (3.8% of the population) experienced a mental health condition and a co-occurring substance use disorder (Lipari and Park-Lee, 2020[47]). Persons with co-occurring mental health conditions often have poorer outcomes than persons with a single disorder category, including higher probability of homelessness, and relapse and readmission to inpatient care (Rush et al., 2008[48]). Persons with co-occurring mental health conditions tend to use services at a higher rate than persons with one mental health condition (Kessler et al., 1996[45]; Rush et al., 2008[48]).

Integrated interventions for co-occurring mental disorders, including co-occurrence with a substance use disorder, is seen as an effective way to treat co-occurring conditions (NAMI, 2020[49]; Marel et al., 2016[50]). 'Sequential' (the psychiatric and substance disorders are treated consecutively and there is little communication between services) or 'parallel' (treatment of the two different disorders is undertaken at the same time, with drug and mental health services liaising to provide services concurrently) are other approaches, that can come with risks of both duplications and gaps in service provision but have been more common in European countries at least (European Monitoring Centre for Drugs and Drug Addiction, 2016[51]). In the United Kingdom, the NICE Guideline on 'Coexisting severe mental illness and substance misuse' recommends a multi-agency approach, in particular using a care co-ordinated and a care plan established with the service user, and taking a collaborative approach with other organisations (NICE, 2016[52]).

Nonetheless, persons with co-occurring mental health conditions and especially co-occurring conditions that include a substance use disorder can face additional challenges to accessing appropriate services, including high levels of stigma, difficulties accessing 'mental health' services without first undergoing a detoxification programme, and the functional separation of mental health and substance use service that exists in many countries. For example in many countries, drug addiction was historically treated through social interventions, although a more medicalised approach (for example the use of methadone replacement) has developed in more recent years (OECD, 2019[53]; OECD, 2014[54]). Where mental health and substance and addiction governance and services have not been developed as a single integrated system, particular efforts are required to ensure that services are well-co-ordinated, and that individuals are not excluded from a set of services because of another co-occurring disorder (OECD, 2014[54]).

Managing the risks of COVID-19 to people with severe mental health conditions

The evidence on the impact of the COVID-19 crisis on the mental health, and physical health, of people with existing mental health conditions is mixed. Some studies, and patterns of service user, seem to suggest that people with pre-existing mental conditions are at higher risk not only of COVID infection and of developing poorer mental health during the pandemic (Moreno et al., 2020[55]). Other evidence, for example a study in the Netherlands, found that people without a mental health condition (depression, anxiety, obsessive compulsive disorder) prior to the pandemic saw a more negative impact on their mental

health, while individuals with pre-existing conditions did not experience increased symptom severity compared to pre-pandemic levels (Pan et al., 2021[56])

A self-reported questionnaire in Australia in April with 5 070 adult participants, showed participants with self-reported history with a mental health diagnoses had significantly higher distress, health anxiety, and COVID-19 fears than those with a prior mental health diagnosis (Newby et al., 2020[57]). A similar study with the purpose to assess psychological well-being in adolescents, while including 760 Australians between 12 and 18 years old, the study not only showed higher levels of sleep disturbance, psychological distress and health anxiety compared to normative examples, but effects on mental health were worse among those who reported a previous diagnosis in mental health (Li et al., 2020[58]). In Slovenia, monitoring telephone calls to a COVID-19 helpline for psychosocial support showed that almost a third (31.3%) of callers reported having a pre-existing mental illness, and 65.3% of them were taking antidepressants and/or benzodiazepines (EuroHealthNet, 2020[59]). Meanwhile, in Italy, 14% of community mental health centre was closed and one-quarter of hours reduced for care. (Carpiniello et al., 2020[60]). In Norway, there are several phone and online mental support services and during the COVID-19 pandemic these phone and online services received additional funding (approx. NOK 15-20 million extra in 2020, through the budgets of the Ministry of Health and Care and the Ministry of Children and Families) to increase their capacity. The Norwegian Directorate of Health has also published information and made available free online tools in helsenorge.no to support mental well-being and resilience.

In the Netherlands, a case control study was conducted to assess perceived psychological impact related to COVID-19 the few weeks after the national lockdown between April and May 2020. This shows that people with severe and chronic mental health issues, including anxiety disorders, depression, and obsessive-compulsive disorders perceived greater psychological impact, stronger fear of COVID-19, and more difficulty in coping with the pandemic, comparted to those without psychological issues. However, symptom severity amongst these populations did not increase, and in some cases people with the most severe or chronic mental health disorders even showed an average significant decrease in symptom severity. In this study, people with lifetime psychological issues are younger, women and lower educated, compared to people without a lifetime problem (Pan et al., 2021[56]). In France, the CoviPrev study that ran throughout 2020 found that amongst people with existing mental health problems levels of anxiety and depression were both higher than the general population across the year, but also levels of depression in particular amongst this population increased during the first (March-April) and second (November) lockdown periods (Santé Publique France, 2020[61]).

People living with severe mental illness are at a higher risk of severe cases of COVID-19 (Wang, Xu and Volkow, 2021[62]; Siva, 2021[63]; Jeon et al., 2021[64]; Lee et al., 2021[65]). Persons with psychotic disorder, bipolar disorder, or severe depression are at increased risk of being hospitalised, and dying, from COVID-19, with severity of outcomes for persons with severe mental illness are about double those without severe mental illness with outcomes comparable to persons with cardiac, pulmonary or autoimmune issues (Siva, 2021[63]). Some studies also found that persons with serious mental illness were at increased risk of contracting COVID-19 (Taquet et al., 2021[66]). At the time of writing (early March 2021), amongst European countries, only four countries had included persons severe mental illness amongst priority populations for vaccinations (Denmark, Germany, the Netherlands, the United Kingdom) (De Picker et al., 2021[67]; Siva, 2021[63]).

Are social protection systems tailored to promote recovery, return to education, or to work for people with mental health conditions?

Living with mental health problems has an impact on people's daily lives, including on ability to work. Mental health problems often impede an individual's ability to participate in the labour market which can lead to a "vicious circle" whereby the longer people are out of work, the more damaging the consequences are for their mental health. The OECD Mental Health Performance Benchmarking Framework includes

'social protection systems tailored to promote recovery, return to education, or to work for people with mental health conditions' as a key sub-principle. Equally, the *OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy* recommends that 'Adherents seek to improve the responsiveness of social protection systems and employment services to the needs of people living with mental health conditions' (Box 4.2).

Box 4.3. OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy – extracts of the Recommendation on social benefits and employment services

IV.RECOMMENDS that Adherents seek to improve the responsiveness of social protection systems and employment services to the needs of people living with mental health conditions. To this effect, Adherents should, as appropriate:

a) reduce preventable disability benefit claims for mental health conditions through recognition of the (possibly reduced or partial) work capacity of those potentially claiming a benefit, using appropriate tools and methods to identify work capacity, and through a focus on early identification and early provision of medical and/or vocational support as necessary;

b) help jobseekers living with mental health conditions into work through appropriate outreach tools to identify an adequate support process that facilitates access to employment services and training as well as services that address the labour market barriers associated with a jobseeker's mental health condition;

c) invest in mental health competences for those administering the social protection system by providing training for caseworkers, social workers and vocational counsellors to improve their understanding of mental health issues and the health benefits of work and by ensuring adequate co-operation of benefits, social services and employment services offices with psychological coaches;

d) encourage the integration of mental health treatment into employment service delivery by stimulating co-operation of employment services with the health sector, especially primary and community-based mental health professionals, and by encouraging the development of evidence-based vocational interventions for jobseekers with mild-to-moderate mental health conditions which combine psychological counselling with pre- and post-placement services or work experience programmes.

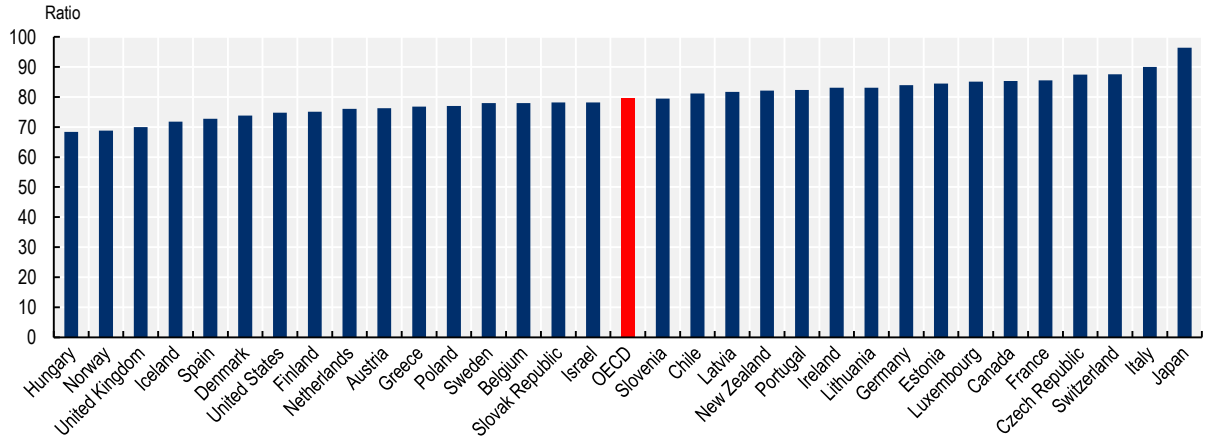
Source: OECD (2015[6]), *Recommendation of the Council on Integrated Mental Health, Skills and Work Policy*, http://legalinstruments.oecd.org.

People living with mental ill-health have consistently worse education and employment outcomes

Five years on from the introduction of the *OECD Council Recommendation of the Council on Integrated Mental Health, Skills and Work Polic*y, and in a context where more and more countries are recognising – in strategies at least – the impact of mental health on good employment and education outcomes, people living with mental health conditions have consistently less good education and employment outcomes.

On average, the employment rate for persons with a mental health condition was 20% less than for those without, rising to 30% in Hungary, Norway, and the United Kingdom (OECD, forthcoming[1]) (Figure 4.4). In European countries, people living with chronic depression were significantly less likely to be in work; based on 2014 data, only about half of the population aged 25-64 reporting chronic depression were in employment, compared with over three-quarter (77%) among those who do not report chronic depression on average across EU countries (OECD/European Union, 2018[7]).

Figure 4.4. The employment gap between persons with and without a mental health condition is large



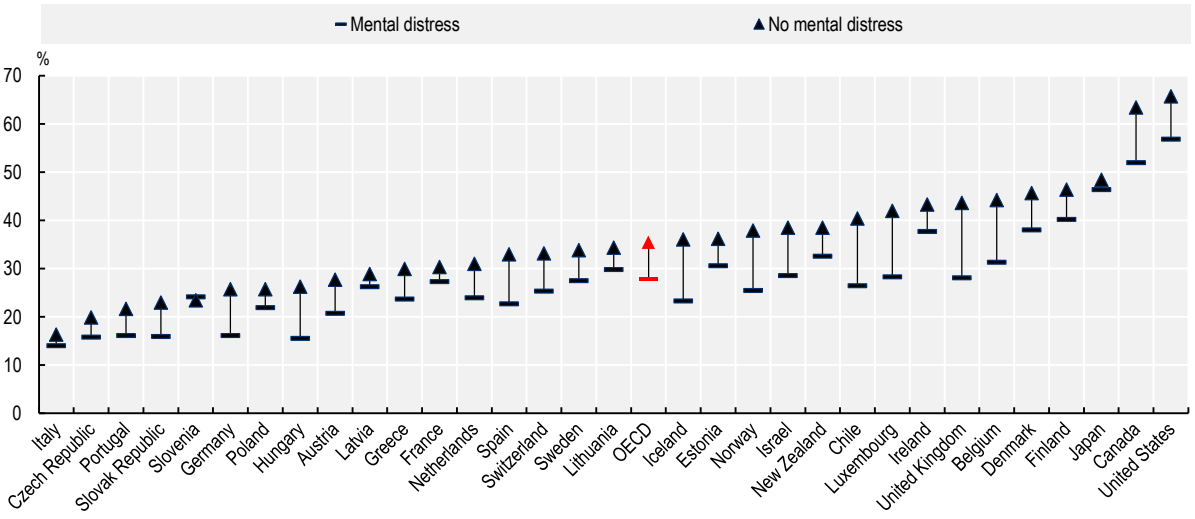
Note: The figure presents data between 2012 and 2016. OECD average is the unweighted average of the depicted countries. A value of 100 indicates that people with mental health conditions are equally likely to be working as persons without mental health conditions. Individuals with a mental health condition have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. A value of 0 means that people with any form of mental distress are not working at all.
Source: EHIS-2 and national sources, in OECD (forthcoming[1]), *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation*.

StatLink https://stat.link/ht0uym

On average across the OECD, students with mental health conditions are 35% more likely to have repeated a grade (OECD, forthcoming[1]). This is not the case for all countries. In Slovenia, Portugal, Poland, and Colombia, this group of students is slightly less likely to have repeated a grade, while in the United Kingdom there is no difference between the two groups. On the other side of the spectrum, students with mental health conditions in Greece, Estonia, Denmark and Iceland are all at least 75% more likely to have repeated a grade. In all countries, persons with mental health conditions are less likely to complete higher education, with particularly significant gaps in Canada, the United States, the United Kingdom, Belgium, Chile, Luxembourg, and Iceland (Figure 4.4).

Figure 4.5. Persons with mental health conditions are less likely to complete a high-level education

Share of working age individuals with an education at ISCED 5 or higher, by mental health status, mid-2010s



Note: The figure presents data between 2012 and 2016. OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
Source: EHIS-2 and national sources, in OECD (forthcoming[1]), *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation*.

StatLink https://stat.link/8gvjwh

People with lower income are significantly more likely to report having chronic depression, while people with the lowest level of education are more likely to report having chronic depression than people with secondary education, who in turn are more likely to report depression than people with the highest level of education (Eurostat, 2014[68]). Some more limited but similar relationships between poverty and higher prevalence are also seen for severe mental illnesses such as bipolar disorder and schizophrenia, as well as for alcohol and substance use disorders (Hastings et al., 2019[69]; Burns, Tomita and Kapadia, 2014[70]; Werner, Malaspina and Rabinowitz, 2007[71]).

A few countries have dedicated efforts to support young people with mental health during critical moments in their education or transition to work

While mental health services for children and adolescents often have a link – which can vary between well integrated and quite fragmented – with schools and educational settings, a few OECD countries have dedicated initiatives to support young people with mental health conditions to stay in education or work.

A few initiatives exist that focus on young people transitioning to work or further education. In the United Kingdom, a taskforce in the Department of Education was set up in 2019 and focuses on supporting good mental health amongst university students (OECD, forthcoming[1]). Notably this taskforce has promoted good practices such as 'Know Before You Go', run by the charity Student Minds that focuses on young people's mental health, which is an online guide for school leavers going to university that provides practical life advice and tips, with ideas about how to maintaining good mental health and seek help if needed embedded throughout the guide (Student Minds, 2018[72]).

Other initiatives link other services for young people across different sectors. Among these initiatives in Canada is the Youth Mental Health Count Program in Ontario (OECD, 2020[8]). The programme diverts youth from the justice system by providing comprehensive health and social rehabilitation supports. The

Youth Mental Health Count Program provides support to 12 to 17-year-olds with identified mental health needs, and works as a bridge between the criminal justice system and mental health services, creating a plan based on the young person's needs.

Good examples of initiatives to integrate services to promote return to the labour market can be found across OECD countries, but are far from systematic

Good examples of initiatives to integrate services across sectors can be found across OECD countries, and across sectors. Some reforms are being introduced to ensure that social protection systems, and mental health services, promote recovery and encourage return to work, or return to school (OECD, forthcoming[1]). Initiatives range from preventing absence from work, promoting rapid return to work, providing concurrent or integrated mental health and employment support for job seekers or long-term unemployed, and developing appropriate work placements for people with serious mental health needs who require adapted working environments and/or tasks (OECD, 2012[2]; OECD, 2015[3]; OECD, forthcoming[1]). At the same time, when it comes to promoting good employment and education outcomes, taking a proactive approach to promoting good mental health and preventing mental ill-health and supporting people to stay in school or work should be a priority strategy, as also discussed in Chapter 5 of this report.

Some good examples of support for return-to-work, and reducing preventable sickness absences for mental health reasons can be found in OECD countries. For many workers, a flexible approach is key when returning to the labour market after a sickness absence. In Austria, a new model to promote part-time return to work (WIETZ) was introduced in 2017 which promotes a more flexible return-to-work model, with workers entitled to shorter working hours and financial protection during the reintegration period. Though the programme was not intended for mental health conditions alone, amongst applicants to the programme – of whom there have been more than 73 000 since 2017 – mental ill-health is the most common reason for prolonged absence (OECD, forthcoming[1]). In Denmark, a 2015 project led to the development of the 'IBBIS' (Integrated Mental Health Care and Vocational Rehabilitation to Individuals on Sick Leave Due to Anxiety and Depression) model, which connects people out of work who are identified through job centres, with integrated mental health and vocational rehabilitation services, including stepped mental health care intervention (Region Hovedstadens psykiatriske hospital, 2020[73]; Poulsen et al., 2017[74]). In a few countries, there are examples of incentives or requirements for employers to support return-to-work for employees after sickness absences, including the Netherlands, Norway, and Sweden where employers and their employees have to agree return-to-work action plans after around eight weeks of sickness absence (OECD, 2012[2]).

In some countries, reforms to rules and legislation in social benefits and employment services are helping encourage and incentivise job seekers with mental health conditions to return to employment (OECD, forthcoming[1]). In response to the Questionnaire on the Implementation of the *OECD Recommendation on Integrated Mental Health, Skills and Work* countries included Canada, Finland and Estonia indicated that they had made changes to their jobseekers programmes. Canada has made amendments to its Employment Insurance rules to extend maternity and sickness benefits, allowing claimants to work while claiming benefits, and gradually reducing benefits for each dollar earned. In Finland, a recently launched work ability programme will also adjust rules on partial working capacity, again allowing people with partial work capacity – including those on sickness absence for mental health conditions – to return to work gradually or part time while keeping part of their unemployment benefits. In Estonia, introduction of a of 'partial work capacity' to access unemployment benefits, and has helped identify pathways for specific employment roles, or training options.

However, systematic inclusion of work or employment outcomes in mental health service delivery, or mental health outcomes in employment support services, is not the norm. Most countries did not include employment or labour market outcomes in mental health service outcomes frameworks, or only included them for some care settings. The lack of integration is most apparent in social protection systems despite the well-known high prevalence of mental ill-health among social benefit recipients and employment service users (Table 4.1).

Table 4.3. Integration of mental health and employment services

	Mental health service outcomes frameworks include employment or labour market outcomes	Initiatives relating to employment support/liaison for mental health service users	Mental health support available to persons using unemployment services[1]
Australia		Yes	
Austria	Depends on care settings/region/local area	Yes	Yes, systematically available
Belgium		Yes	
Canada	Depends on care setting	Depends on the region/local area	
Czech Republic	Depends on care setting	Yes	Yes, a few pilot projects
Denmark	Yes	Yes	Yes, systematically available
Greece	Depends on care setting	Yes, but this doesn't always happen	
Iceland	Yes	Depends on care setting	Yes, support sometimes available
Ireland	Depends on care setting	Yes	
Israel	Depends on care setting	Yes	
Japan		Yes	Yes, support sometimes available
Korea	Yes	Yes	Yes, systematically available
Latvia			Yes, systematically available
Lithuania		Yes	Yes, systematically available
Netherlands			Yes, support sometimes available
Norway	Depends on care setting	Yes	
Poland			
Slovenia	Depends on the region/local area	Yes	Yes, support sometimes available
Switzerland			Yes, support sometimes available
United Kingdom[2]	Yes	Depends on the region/local area	Yes, systematically available

Note: Countries which responded to the questionnaire but did not respond to these questions (Luxembourg), or where no services were available (Estonia, Mexico) were not included.
1. Excludes services that are de-facto available to the whole population; 2. England.
Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Initiatives related to liaison services between services, and mental health support for people using unemployment services are more common (Table 4.1). In England, the 'job coaches' working in the national unemployment services 'Jobcentre Plus' will, from 2021, all have received training on supporting claimants with health conditions, to build their expertise and provide the most effective support (OECD, 2020[8]). If the work coach knows the claimant has complex mental health issues then further safeguards are put into place for failure to attend interviews: two attempts at a home visit are made which, if not successful, is then referred for a management decision on next action to be taken. As of September 2019 over 10 000 job coaches had been given this training (ibid). Or, in an initiative which facilitates referrals from the health sector into the employment or vocational rehabilitation sector, in Iceland health care personnel can refer individuals to 'Virk – Vocational Rehabilitation Fund' which is a private foundation of which all the major unions and employers in the labour market in Iceland are member (OECD, 2020[8]). England is has also taken significant steps to integrate an employment-forward approach into its nationwide programme of Improving Access to Psychological Therapies (IAPT) services. IAPT services in 40% health regions in England now have employment advisers (OECD, 2020[8]).

In Lithuania, changes to the way that people with mental health are given labour market support is seen as a key part of the transition to a more community-based model of mental health care (Box 4.4). At the service user-level Australia and England collect information on employment through their service outcomes framework, the National Outcomes and Casemix Collection (NOCC) in Australia, and the NHS Outcomes Framework in England.

Box 4.4. Employment support as a key part of the transition to community-based mental health care in Lithuania

In Lithuania, where efforts to transition to a more community-based model of mental health care are ongoing, increasing support for people with mental health needs to participate in the labour force has been part of this broader strategy. Since January 2020, to promote the employment of people with intellectual and mental disabilities a law on social enterprises allows for state aid providing wage subsidies and social insurance contributions, subsidies for the creation of workplaces or their adaptation to better meet the needs of employees with intellectual or mental disabilities, and subsidies for training. From January 2020, disabled people using Employment Services are handled by the assigned case managers, and new employment with assistance services are provided to give individual assistance in finding a job suited to the individuals' abilities and needs, and give support to the individual in establishing themselves in the workplace.

These legal changes follow an institutional reform process that began in 2014, which supports people with intellectual or mental disabilities to access individual services and live in the community. To achieve this, various alternative services to institutional care are being tested in Lithuania. One of them is to help with recruitment, which aims to help a person find a job, teach working skills, communicate with the employer and the broader company. The service will be tested in 6 regions of Lithuania from 2020-21 onwards, and about 200 service users are expected to be involved.

Source: Information submitted to OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Denmark stands out as a country with strong integration of mental health and employment services, and outcomes, with a range of initiatives to bridge mental health and employment services, and the inclusion of "access to the workforce (for somatic and psychiatric patients)" as one of the eight national health care quality goals. The Danish Ministry of Health has established a partnership of 48 members ranging from employee and employer organisations from the private and public sector to participants from patient organisations. The partnership, 'Sammen om mental sundhed' (which roughly translates to 'Together on Mental Health'), commenced in 2015 as a cross-sectoral effort, bridging the health and employment sectors, in order to pool knowledge and experience, and to create an overview of existing knowledge and tools within the field of mental health in the workplace.

Box 4.5. 'Sammen om mental sundhed' – Denmark

The Danish Ministry of Health has established a partnership of 48 members ranging from employee and employer organisations from the private and public sector to participants from patient organisations. The partnership, 'Sammen om mental sundhed' (which roughly translates to 'Together on Mental Health'), commenced in 2015 as a cross-sectoral effort, bridging the health and employment sectors, in order to pool knowledge and experience, and to create an overview of existing knowledge and tools within the field of mental health in the workplace. The partnership is co-ordinated by a secretary of three organisations with research and communication backgrounds to ensure that the content is qualified and is easy to use.

The partnership has launched a shared digital toolbox at https://mentalsundhed.dk/, bridging partners' professional knowledge, opinions and values in a science-based Q&A that lends support to various roles in different workplaces. More than 400 relevant tools provided by partners were tagged, sorted and linked to the science-based Q&A to provide inspiration for possible future actions. The toolbox presents knowledge and tools to:

- Prevent that employees develop mental health problems
- Provide support to employees to help them stay at work during times of challenges
- Help employees getting back to work after a long-term sick leave.

Source: Mental Sundhed (2020[75]), *Mental Sundhed – Sammen om mental sundhed*, https://mentalsundhed.dk/, accessed 3 February 2020; OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Can front line actors recognise and respond to mental distress, to connect individuals to appropriate services?

This sub-principle is directly linked to the sub-principle 'Enable front line actors to recognise and respond to mental distress' included in Chapter 5 on preventing mental illness and promoting mental well-being. Equipping front line actors with the information and skills to identify and respond to mental distress are intrinsically linked, and important as part of both an integrated and multi-sectoral approach to mental health, and to good promotion and prevention practices. To maintain this link, the discussion of mental health knowledge, skills and ability to connect individuals to appropriate services has been brought together in this chapter.

Front line actors can help people find access to mental health care system and improve the stigmatisation around mental health problems in a community

Given the high prevalence of mental health problems across the OECD countries, there is an increasing demand for people who can identify mental health issues and have knowledge and skills to deal with them regardless of their professions. It often takes time even for individuals themselves to understand that they need mental health care, while the stigma around mental health conditions which can discourage people from seeking professional support.

There are certain key workers who are more likely to come into contact with people experiencing mental distress, or for whom having the capacity to identify mental distress could bring significant social benefits, including school teachers, line managers, co-workers, General Practitioners, emergency doctors, occupational doctors, pharmacists, and nurses. These front-line actors can play a critical role in raising awareness of mental health problems and improving the stigma around mental health problems. Line managers, for instance, would notice that co-workers have mental health problems when they show less

productivity or they take frequent sick leave because those with mental ill-health often show presentees and absentees at work (OECD/European Union, 2018[7]). In another case, a pharmacist at a drug store could understand that a customer presenting with sleeplessness and appetite loss might be experiencing mental distress, and could be usefully directed towards appropriate support. Training programmes offer mental health knowledge, skills to deal with people with mental health problems depending on their professional and mental health training backgrounds.

Some impressive efforts to improve mental health knowledge of key front-line actors exist, but implementation is inconsistent

Broad and significant efforts to improve the mental health knowledge of key front-line actors, and to support connections between front line services such as police, emergency departments, and teachers, with mental health services, and in some countries mental health training is provide for a significant number of front line actors (Table 4.4).

Training for front line actors can reduce stigma around mental health conditions, help actors spot signs of mental distress and react with sensitivity, and direct people in need towards appropriate mental health services. Many countries provide at least some mental health training for front line actors, in particular for teachers, GPs, and police, but less often for paramedics, the fire department, and unemployment counsellors or staff. Teachers, in particular, receive significant training in England, Canada, Latvia and Lithuania.

In Mexico, mental health training has been given to front line workers through the National Addiction Prevention Strategy '*Together for Peace*, which has as one of its objectives "to reduce the mental health care gap" through "improving the care of people with mental health problems and addictions in health services". Among the actions contemplated for this point is "the training of first and second level health care providers through the WHO Mental Health Gap Action Program (mhGAP) and the Intervention Guide for Mental, Neurological and Substance Use Disorders of the World Health Organization (WHO)" so that first and second level health care personnel can identify and provide care for priority mental disorders in the population. To date, 3 683 first-level health care personnel have been trained. In Mexico the Ministry of Health, through the National Council of Mental Health and Psychiatric Care Services, is also looking to increase the availability of mental health services by promoting the National Program of Telementoring in Mental Health and Addictions. This programme brings together a group of specialists from various mental health institutions who establish virtual advisory groups to train and guide first and second level health personnel to provide timely and quality mental health care.

However, in response to the OECD Policy Questionnaire most countries indicated that only 'some training' was provided to these front line actors, and coverage tended to be through relatively ad-hoc courses, or depend on local or regional initiatives. For example in Australia some programmes are specific to States, such as a programme for teachers in Victoria or for Fire and Rescue workers in New South Wales. In England in 2016-17 90% of schools and colleges offered training to at least some of their staff around how to support pupils' mental health and well-being while 47% offered training to all staff (Marshall et al., 2017[76]; OECD, 2020[8]).

In Canada, Yukon health professionals, including physicians, will receive education and training to provide compassionate and culturally sensitive transgender care, and the Mental Health Commission of Canada (MHCC) launched new mental health literacy training specific to police through a new agreement with the Ontario Provincial Police (OPP). In Costa Rica, training for frontline actors who are not mental health specialists is due to begin, to raise awareness of mental health needs and improve person-centred approaches for people with mental health problems. There are also differences between the substance of the training that is provided to front line actors. For example in Latvia front line actors were mostly covered in general awareness raising campaigns, even if there were some targeted educational seminars for example on bullying and emotional welfare for teachers.

Table 4.4. Mental health training provided to front line actors

Countries who responded 'a lot of training' or 'some training' for each category of front line actor based on responses from 27 countries

	Teachers	Emergency department staff	Paramedics	General Practitioners / family physicians	Fire department staff	Police	Unemployment service counsellors/staff	Total (a lot or some training) [1 – 7]
	✓ – A lot of training for these professionals ⦸ – Some training for these professionals							
Australia	⦸				⦸	⦸	⦸	**4**
Austria	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Belgium	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Canada	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Czech Republic		⦸		⦸		⦸	⦸	**4**
Denmark		⦸		⦸	⦸	⦸	⦸	**5**
Estonia	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Greece	⦸	⦸		⦸				**3**
Iceland	⦸	✓	⦸	✓	⦸	⦸		**6**
Ireland	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Israel		⦸	⦸	⦸	⦸			**4**
Italy		⦸						**1**
Japan	⦸			⦸	⦸	✓	✓	**5**
Korea	✓	✓	✓	✓	✓	✓	✓	**7**
Latvia	⦸			⦸				**2**
Lithuania	✓	⦸	⦸	⦸	⦸	⦸		**6**
Luxembourg								
Mexico	⦸			⦸		⦸		**3**
Netherlands	⦸	✓	⦸	✓	⦸	⦸	⦸	**7**
New Zealand	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Norway		⦸	⦸	⦸				**3**
Poland	⦸	⦸	⦸	⦸				**4**
Slovenia	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Sweden								
Switzerland	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Turkey		⦸		⦸	⦸	⦸	⦸	**5**
United Kingdom[1]	⦸	⦸	⦸	⦸	⦸	⦸	⦸	**7**
Total (a lot or some training)	**19**	**21**	**16**	**23**	**18**	**19**	**16**	

1. England.
Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

If front line actors are better able to identify mental distress, this needs to be backed up by good referral pathways

If front line actors are coming in regular contact with people with mental health needs, and are also being given the training and skills to identify mental distress, then this also gives front line actors an important gatekeeping role to identify when people are in need of further mental health service provision. However, studies report frontline workers might feel powerless when unable to access mental health services or being able to refer people in need of mental health care to necessary services (European Journal of Homelessness, 2016[77]), and without specialist support may struggle to identify the best course of action for someone showing signs of mental distress (Splett et al., 2019[78]). Increased training is necessary to stimulate collaboration between front line actors and further mental health services, while giving them the

confidence to signal symptoms of mental ill-health and inform them about therapeutic interventions and possibilities to refer (European Journal of Homelessness, 2016[77]). It is important for front line actors, if they identify a case of mental distress, to be able to direct this person towards appropriate support. For example, police services having easy and direct contact for a psychiatric consultation, health services – including outside of emergency departments – having access to mental health for patients assessments as necessary, or teachers and schools being able to easily refer students to child and adolescent mental health service assessment.

Some front line services have been focusing on integrating and strengthening referral pathways within their services, by training front line actors and providing them with tools such as screening questionnaires to identify whether an individual is in need of additional care. As an example, in the United States, Massachusetts, the Gloucester police department has developed a police-led addiction referral programme, with the aim to improve access to treatment systems for people with an opioid use disorder. Police officers were provided a brief set of questions for assessing any acute medical or psychiatric needs, asking about current drug use and time of last use, followed by calls to treatment programs. The programme was a success with a 94.5% direct referral rate, which exceeds hospital-based initiatives designed for detoxification and treatment. During the first year of the programme, from June 2015 through May 2016, 376 different persons presented for assistance, with a total of 429 times. The model has been adopted by 153 other police departments in 28 states (Schiff et al., 2017[79]).

Improving performance: Policies to promote multi-sectoral integration

Strengthening integration between the 'mental health' and 'physical health' sectors through multidisciplinary teams, and cross-sectoral training

Multi-morbidities require a multi-disciplinary approach, and an increase in efforts to integrate 'physical' and 'mental' health care. Given the significantly worse physical health outcomes for people with severe mental illness, as well as the high rate of comorbidity between mental health conditions and a range of physical health conditions, notably non-communicable diseases, efforts to increase co-ordination are needed. There is clear scope, in almost all countries, for more initiatives that focus on different types of care to address the needs of the population, ranging from preventative measures for maintaining mental and physical health, to more intensified co-ordination efforts for people with more acute or complex health needs who are in need of continuous care.

In Switzerland, the Federal Office of Public Health commissioned a review to identify models of good practice in the co-ordination of acute psychiatry, and acute somatic medicine. The commission found a range of different initiatives that could be effective at increasing care co-ordination and integration, including using systematic screening, transfer of patients from psychiatric to acute hospitals following a defined schema, training on integrated care for students, training for family doctors from psychiatrists or other relevant specialists, and the appointment of key liaison contact to respond to psychiatric questions within the acute hospital setting (Spiess and Ruflin, 2018[80]). The commission found that this range of models were effective, could be applied in heterogeneous settings, and improved service user outcomes directly or indirectly.

Evidence-based lifestyle interventions have been found to result in positive outcome for people with mental ill-health and should be made available and implemented as a standard component of mental health care (Happell, Davies and Scott, 2012[81]). Introducing adapted lifestyle interventions for people with mental ill-health, that include exercise, diet and broader lifestyle interventions have been proven effective for people with mental illness while resulting in improved physical health and mental health (Richardson et al., 2005[82]; Czosnek et al., 2019[83]). Additionally, the use of lifestyle interventions can act as a low-threshold treatment, resulting in increased treatment adherence, especially for disengaged service users in more

traditional mental health treatments (Firth et al., 2018[25]; Firth et al., 2019[28]). It is important to consider how these trainings programs are adapted to different settings and conditions, to make sure these interventions are delivered in an appropriate manner. Adapting these interventions to the population is crucial, as people with mental ill-health can face additional challenges to make and sustain lifestyle changes. Effects of psychiatric symptoms and consequences of these symptoms like social isolation are all potential barriers for the uptake of a healthy lifestyle (Yarborough et al., 2016[84]). As an example, an urban community health centre in southern New Hampshire has set up a 24-week peer-group lifestyle intervention which consisted out of regular weight management sessions with two lifestyle coaches, exercise sessions with a fitness training, and mobile health technology and social media to increase motivation and facilitate self-monitoring and peer support. The training led to weight loss in 72% of the participants (Aschbrenner et al., 2016[85]).

Over the last decade, health professionals are increasingly working in multidisciplinary teams in integrated care settings, including disciplines such as physical activity, nutrition and behaviour change. Receiving training is important for both physical and mental health professionals to provide appropriate care and to learn how to work in an integrated manner. Mental health clinicians should receive training to enable them not to overlook somatic symptoms and to pay attention to physical complaints and lifestyle behaviours (Saxena and Maj, 2017[86]). Similarly, health practitioners should receive training on psychopathology and education on how to work with people with mental illness. From 2008, the WHO has developed the mental health Gap Action Programme Intervention Guide (mhGAP-IG) which provides evidence-based guidance and tools on for the assessment of mental, neurological and substance use disorders in non-specialised health settings, which will help to strengthening the workforce for an integrated approach of health. The mhGAP-IG has been successfully used in different regions of the world and in various academic institutions, for example in the National Autonomous University in Mexico, where an evaluation showed young doctors have more knowledge in mental health and mental health disorders (Chaulagain et al., 2020[87]; WHO, 2020[88]; Mills and Lacroix, 2019[89]).

A mix of targeted employment support programmes could be backed by a more proactive employment- or education-focus in mental health outcome tracking

Good examples of initiatives to integrate services across sectors can be found across OECD countries, and across sectors. It is clear from the report *Integrated Mental Health, Skills and Work Policy: Implementation of the Council Recommendation* that reforms are being introduced to ensure that social protection systems, and mental health services, promote recovery and encourage return to work or education (OECD, forthcoming[1]).

Australia, Denmark, England, Ireland, Italy, the Netherlands, Norway and New Zealand have been implementing or testing Individual Placement and Support (IPS), a proven evidence-based practice in which multidisciplinary mental health teams including an employment specialist provide co-ordinated health and employment support for jobseekers (OECD, 2020[8]; Modini et al., 2016[90]). IPS have become widespread in OECD countries, and have demonstrated transferability between different systems and settings. However, IPS – which have been found to have a positive impact in helping individuals find and stay in employment or work (OECD, forthcoming[1]) – are nonetheless quite resource intensive, given the individualised level of support that they provide, and tend to focus on individuals with severe mental ill-health. IPS do show some promise in being able to be broadened to also be directed at individuals with mild-to-moderate mental illness. In England, IPS are being tested for people with a broader cohort of conditions beyond severe mental illness, in Australia a trial of IPS for young people run through the headspace programme found improvements to the employment and educational outcomes of young people. The programme was also found to be more cost effective than other employment programmes. In Australia this programme was due to be rolled out in a further 26 sites (in addition to the existing 24) (Department of Social Services, 2020[91]; Department of Social Services - KPMG, 2019[92]). Norway started implementing Individual placement and support (IPS) from 2013, supported by a grant scheme; IPS is

specifically aimed at persons with severe mental health problems also in need for unemployment services and are now available in all counties of Norway.

Specific programmes supporting better employment or educational outcomes for people with mental health conditions are clearly a critical part of a high performing and integrated mental health system. Alongside these programmes, efforts to embed employment support in mental health services – for example IPS counsellors in mental health community teams in Ireland, or employment counsellors in psychological services in England – are a significant step towards integration. To make integration even more systematic, and to make good employment or educational outcomes a key expectation for mental health services, some health system outcome or monitoring frameworks now include employment outcomes for people with mental health (Box 4.6), but this approach could certainly stand to be used more widely.

Box 4.6. Health outcomes frameworks or health system monitoring frameworks including employment or educational status

In Denmark, the National Goals of the Danish Healthcare System now include an indicator on access to the workforce for somatic and psychiatric patients (Ministry of Health Denmark, 2019[93]). The goals set the overall direction of the health care system and are be used in measuring the overall quality of the health care sector. Each year a status report is published where the regions and municipalities can see their development from year to year and benchmark how they compare with national average and other regions/municipalities using a traffic light system. The indicator on 'retention of (somatic or psychiatric) patients in the workforce' is broken down between somatic and psychiatric patients, and reported in a national average and regional rates. Latest available data, for 2016, suggest that rate of retention of psychiatric patients in the workforce was 47.4% nationwide, compared to 80.9 for somatic patients (ibid). The Goals also include a target on 'Access to educational services for young people with mental illness', but an indicator for this goal is still under development.

In England, the NHS Outcomes Framework Indicators Framework is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England (NHS Digital, 2021[94]). The framework provides an overview of how the NHS is performing, and includes an indicator on the 'Employment of people with mental illness'. This indicator shows the percentage point difference between the rate of employment in the general population of working age (16-64) and the rate of employment amongst adults of working age with a mental illness. As of February 2021, there was a 26.0% gap between the employment rate of the general population, and adults with a mental illness. Over the five years that the indicator had been tracked, the size of the gap had fallen by 8.7 percentage points (NHS Digital, 2021[95]). In England the Public Health Outcomes Framework also includes indicators for the gap in employment for people with mental health problems and learning disabilities and the general employment rate, as well as an indicator on stable employment rate for people in secondary mental health services (Public Health England, 2021[96]).

More mental health training should be provided to a bigger range of front line actors

A significant number of countries indicate that mental health training is provided to key front line actors. However, this training is inconsistent both across categories of front line actor – teachers are far more likely to receive training than unemployment counsellors, for example – and across countries (see Table 4.4). In addition, in many countries, whether front line actors receive mental health training depends on regional or local initiatives, or ad-hoc programmes, and is far from systematic or routine.

Mental health training for front line actors can help with both reducing stigma around mental health conditions and towards people living with mental health conditions and with directing people towards

appropriate support. Programmes to increase mental health awareness and skills have shown good transferability across different settings, perhaps most notably the Mental Health First Aid programme which has been implemented in at least 20 countries worldwide (Box 4.7). Mental health training for front line actors can also stand to benefit the front line actors themselves, giving them the skills and knowledge to seek mental health help if they need it, and/or support their peers during periods of mental ill-health.

Box 4.7. Mental Health First Aid

At least 20 countries worldwide have implemented mental health first aid training as a way for the general population to provide mental health support and awareness to their peers. Mental Health First Aid is a programme, developed in Australia by Betty Kitchener and Anthony Jorm in 2001, which teaches members of the public to recognise mental health problems in their peers, respond appropriately, and guide the person to appropriate professional support. The MHFA model involves training instructors, who then teach the course to others, who should then be equipped with the skills to offer mental health first aid support to their peers, for instance in their workplace or community. The course covers topics such as symptoms and risk factors for depression, anxiety, and substance use disorders, mental health crisis situations, and appropriate ways to respond which are practiced throughout the course (Richardson et al., 2018[97]).

Mental Health First Aid has been adapted to a range languages and population groups, for example Aboriginal and Torres Strait Islander people in Australia. The Mental Health Commission of Canada provides a Mental Health First Aid training programme, with modified versions of the programme developed with support from government departments or community organisations, for specific sub-populations such as Canadian Armed Forces Veterans, Police, and those who work with youth. In January 2017, the British Prime Minister committed to having Mental Health First Aid training available to all secondary schools by 2020. As of March 2020, training had been provided in over 2 500 schools.

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5 Preventing mental illness and promoting mental well-being

Policies to promote mental well-being and prevent mental ill-health have also been shown to make a meaningful impact on population health, and represent good value-for-money. Effective interventions to promote mental health, build mental resilience, and prevent mental ill-health can be found across the life course and in multiple settings. This chapter sets out some of the compelling reasons that promotion and prevention activities are a critical part of a high-performing mental health system, summarises the extent to which OECD countries have mental health promotion and prevention policies and interventions in place, and gives some recommendations of promising policies that could be used across OECD countries.

Introduction

Many of the protective factors for good mental health go beyond the scope of mental health systems or programmes designed specifically to strengthen or protect mental health. Social, economic and cultural factors, such as employment status, income, physical health, experiences during childhood and adolescence, all have a significant impact upon mental health across the life course. However, programmes or interventions designed to promote mental well-being and prevent mental ill-health have also been shown to make a meaningful impact and represent good value-for-money.

Interventions to promote mental health, build mental resilience, and prevent mental ill-health can be found across the life course and in multiple settings. Interventions to promote good mental-health and prevent mental ill-health are particularly in infancy, childhood, and adolescence, and most OECD countries are taking steps to promote mental well-being for children in schools. Workplaces, too, are common sites where OECD countries are taking steps to protect against risks to mental health, and some are introducing mental health promotion programmes as well. Increasingly, mental health promotion and prevention is seen as a cross-government, multi-sectoral effort, which includes efforts such as promoting good mental health literacy, a focus on positive mental health, training for front line actors, as well as comprehensive approaches to preventing suicide.

This chapter starts by setting out some of the compelling reasons that promotion and prevention activities are a critical part of a high-performing mental health system, summarises the extent to which OECD countries have mental health promotion and prevention policies and interventions in place, and gives some recommendations of promising policies that could be used across OECD countries. There are strong links between the discussion in this chapter and many of the other chapters in this report, and in particular with Chapter 4 on multi-sectoral and integrated policies, and Chapter 6 on good governance and leadership, which includes efforts to reduce stigma around mental health conditions.

Why do mental health systems need to prevent mental illness, and promote mental well-being?

In the OECD Mental Health Performance Framework, a high-performing mental health system should prevent mental illness and promote mental well-being. Good prevention and promotion policies should:

- Reduce the rate of suicide;
- Ensure mental health literacy;
- Make schools mental health-friendly environments that build resilience;
- Ensure that workplaces foster good mental health;
- Enable front line actors to recognise and respond to mental distress;
- Make it easy for individuals to seek help.

Mental health exists on a spectrum – and includes both positive mental health and poor mental health

One in every two people in OECD suffer from mental health problems in their lives and the direct and indirect cost of mental illness are estimated to exceed 4% of GDP (OECD/European Union, 2020[1]). It is essential to support those with mental health issues by providing medical care, social support and financial aid. At the same time, preventing mental ill-health and promoting good mental well-being are critical parts of a high performing mental health system.

Mental health can be understood to exist on a spectrum, from positive mental health to poor mental health, and can also be conceptualised using the 'dual continuum model' for mental health, which sets out that mental illness and mental health are on related but different axes. Someone with a mental illness can have good mental health (i.e. be managing it well and experiencing good mental well-being), just as someone with no mental illness can experience poor mental health.

The purpose of health promotion and disease prevention programs is keeping people healthy, and improving people's health. While disease prevention is a measure for reducing a risk of diseases and a severe condition of diseases. Both approaches are intended to result in increasing the quality of life and reducing the mortality of diseases.

Health promotion was discussed in the first International Conference on Health Promotion held in Ottawa in 1986 with a growing expectation for better public health. After 30 years of this conference, United Nations General Assembly adopted in 2015 "The 2030 Agenda for Sustainable Development", aiming that all human being can fulfil their potential in dignity and equality in a healthy environment. One of the 17 goals of Sustainable Development Goals (SDGs) focus on ensuring healthy lives and promoting well-being for all people at all ages (WHO, 2017[2]).

Mental health promotion in this chapter includes 'aiming to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments' (Saxena, Jané-Llopis and Hosman, 2006[3]). Mental ill-health prevention is includes 'having as its target the reduction of symptoms and ultimately of mental disorders. It uses mental health promotion strategies as one of the means to achieve these goals' (McDaid, Hewlett and Park, 2017[4]; Saxena, Jané-Llopis and Hosman, 2006[3]).Mental health promotion encourages positive mental health by increasing psychological well-being and creating supporting living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders (Saxena, Jané-Llopis and Hosman, 2006[3]).

Preventing mental ill-health and promoting mental well-being has taken on a new importance – and new complexity – in light of the COVID-19 crisis

Up until 2020, adult mental health status was largely stable but children and young people were showing signs of increased mental distress

Even prior to the COVID-19 pandemic, reviews of available evidence have suggested some rising rates of self-reported mental distress, especially amongst adolescents (Choi, 2018[5]; Collishaw, 2015[6]; Blomqvist et al., 2019[7]). Studies have pointed towards higher rates of internalised mental health symptoms especially amongst girls, higher rates of teenagers reporting 'feeling low' in the international HBSC survey or reporting feelings of anxiety about school work in the OECD's PISA study, and some instances of rising rates of self-harm and suicidal ideation (Choi, 2018[5]; OECD, 2018[8]; OECD., 2017[9]; McManus et al., 2019[10]). More time spent online, and stresses and pressures arising from significant social media use, have also been pointed to as areas of new concern for children and adolescents' mental health, even if academic evidence for these trends remains partial (OECD, 2018[8]; Kowalski et al., 2014[11]). Other literature suggests that an apparent increase in prevalence might be due to growing awareness and help-seeking behaviours children and young people and their parents, a broader classification of disorders, or more assiduous recording practices (Choi, 2018[5]; Comeau et al., 2019[12]).

During the COVID-19 pandemic, young people's mental health appears to have worsened faster than the general population. For example, young people in Belgium and France were more likely to be experiencing depression or anxiety than the all-age population average in 2020, while in a survey of young people in the United Kingdom 80% of respondents stated that the pandemic had made their mental health worse, with 41% stating it had made their mental health 'much worse' (Santé Publique France, 2020[13]; Sciensano, 2020[14]; Young Minds UK, 2020[15]). Young Minds UK undertook two mental health surveys, in

September 2020 and June-July 2020: in September, just after schools had reopened, there was a slight rise in indicators such as the percentage of respondents feeling lonely or isolated, feeling anxiety (Young Minds UK, 2020[15]).

During 2020, population mental health status worsened across OECD countries

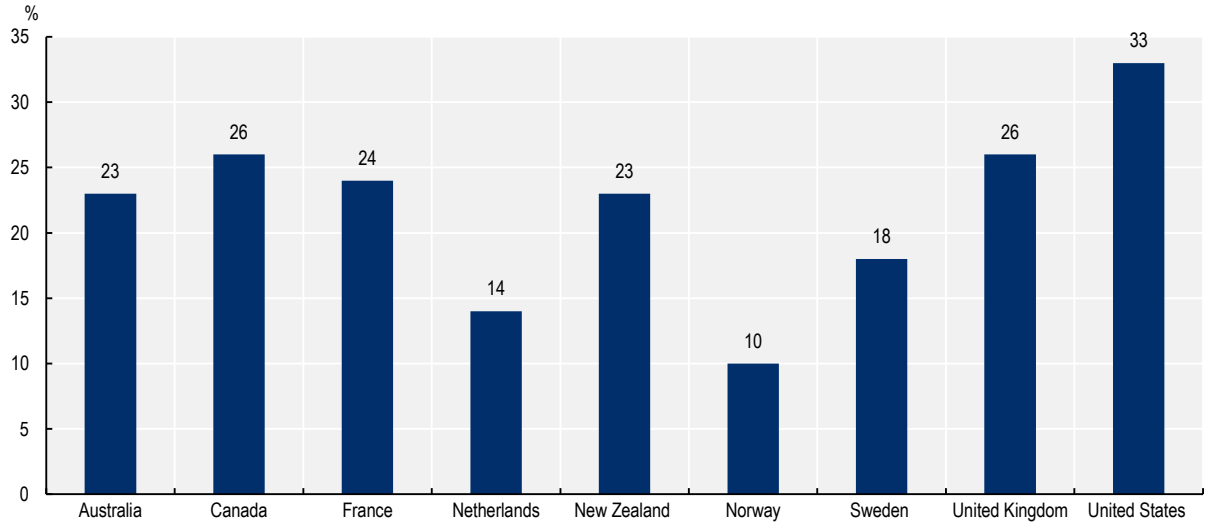
Overall levels of mental distress have not changed significantly across the past two decades. IHME data and other sources suggest that prevalence is fairly consistent, and the OECD average has been around 18% since 2002 (IHME, 2018[16]; OECD, 2015[17]). The COVID-19 crisis across the course of 2020 has changed this trend. Overwhelmingly, surveys of OECD populations showed that mental health had worsened: in Australia 78% of respondents reported their mental health had worsened (Newby et al., 2020[18]); in Austria 43.5% of respondents reported the psychological impacts of the COVID-19 outbreak as moderate or severe (Traunmüller et al., 2020[19]); 50% of Canadians reported worsened mental health since the start of the pandemic, and 6 in 10 said their mental health had worsened 'a lot' (CAMH, 2020[20]); in Luxembourg 37% reported their mental health had declined (Luxembourg Chronicle, 2020[21]); in the United States 40.9% of 5 470 survey respondents in June 2020 reported an adverse mental or behavioural health condition (Czeisler et al., 2020[22]).

For example, regarding the prevalence of people who experienced anxiety, national surveys showed that anxiety increased in all countries in 2020 compared to previous years. New Zealand conducted the research between 15 and 18 April 2020 and showed 15.6% of anxiety prevalence, which is much higher than in 2017 (Cabarkapa et al., 2020[23]; Ministry of Health NZ, 2020[24]). In Belgium, survey results point to significant increases in both self-reported anxiety (from 11% to 23%) and depression (from 10% to 20%) between 2018 and 2020 (Sciensano, 2020[14]). In Czech Republic, the prevalence of anxiety disorders significantly increased between 2017 and 2020 (Winkler et al., 2020[25]). Surveys in the United Kingdom and Denmark have also suggested that more people are feeling anxious and are having more difficulties staying upbeat (ONS, 2020[26]; Sønderskov et al., 2020[27]). In the United Kingdom, where anxiety levels increased significantly from 21% in 2019 to 50% in 2020, this could show particularly high levels of anxiety amongst the population, but may also be influenced by reporting factors such as a population more open to discussing their mental state or a more sensitive survey instrument. In Canada, a national poll by Mental Health Research Canada, found that as of December 2020, levels of high anxiety and high depression among Canadians were elevated. The proportion of Canadians reporting high levels of anxiety was four times pre-COVID levels, with a quarter (23%) reporting that they had high anxiety, up from 6% before the outbreak. The proportion of Canadians reporting high depression (15%) was more than double pre-COVID estimates (6%) (Mental Health Research Canada, 2020[28]).

While it is difficult to compare prevalence of mental distress, and changes in mental distress, between countries given the differences in survey instruments, self-reported stress, worry and anxiety were higher in some countries than others in mid-2020. A survey by the Commonwealth Fund in August 2020 found that at least 10% of adults reported experiencing stress, anxiety, or great sadness that was difficult to cope with alone since the outbreak started, with a particularly high percentage of adults experiencing this mental distress in Canada (26%), the United Kingdom (26%) and the United States (33%) (Figure 5.1).

Figure 5.1. Levels of mental distress were higher in some countries than others in August 2020

Percent of adults who reported experiencing stress, anxiety, or great sadness that was difficult to cope with alone since the outbreak started



Note: Percentage of adults who reported experiencing stress, anxiety, or great sadness that was difficult to cope with alone since the outbreak started. Differences between the United States and all other surveyed countries were statistically significant at the P<0.05 level.
Source: Reginald D. Williams II et al. (2020[29]), *Do Americans Face Greater Mental Health and Economic Consequences from COVID-19? Comparing the U.S. with Other High-Income Countries,* Commonwealth Fund 2020, available at: https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/americans-mental-health-and-economic-consequences-COVID-19.

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Investing in promotion and prevention in mental health makes good economic sense

The economic costs of mental ill-health are significant, and some of these costs could be offset by investment in more interventions to promote mental resiliency and well-being, prevent mental ill-health, and intervene early when mental health conditions occur.

A series of different reviews of the cost-effectiveness of promotion and prevention in mental health have found positive findings in terms of return on investment, and some programmes seem to hold potential to bring savings in health care costs, and/or improvements in productivity. In Australia, the National Mental Health Commission undertook a modelling exercise looking at ten promotion or prevention interventions in a range of different areas, including in schools, for women post-birth, for older age groups, and in workplaces (National Mental Health Commission, 2019[30]). All but one intervention demonstrated at least a modest positive return on investment. Some interventions – notably e-health interventions, and parenting interventions for preventing anxiety disorders in young people; e-health and educational interventions for reducing loneliness for older adults; and exercise programmes to prevent post-natal depression – showed a return on investment of more than 2.0.

In England, Public Health England also undertook a cost-effectiveness evaluation looking at effective mental health promotion and prevention programmes, and identified eight initiatives that demonstrated a positive return on investment (Public Health England, 2017[31]; Public Health England, 2017[32]). Initiatives that had potential to generate savings included social and emotional learning for children which was estimated to result in savings of GBP 5.08 for every GBP 1 invested over three years, a whole of school anti bullying programme, which was estimated to result in savings of GBP 1.58 for every GBP 1 invested across four years, a well-being programme in the workplace (savings of GBP 2.37 for every GBP 1

invested, over 1 year) and a debt and welfare service (GBP 1 invested leading to savings of GBP 2.60 over five years) (Public Health England, 2017[31]).

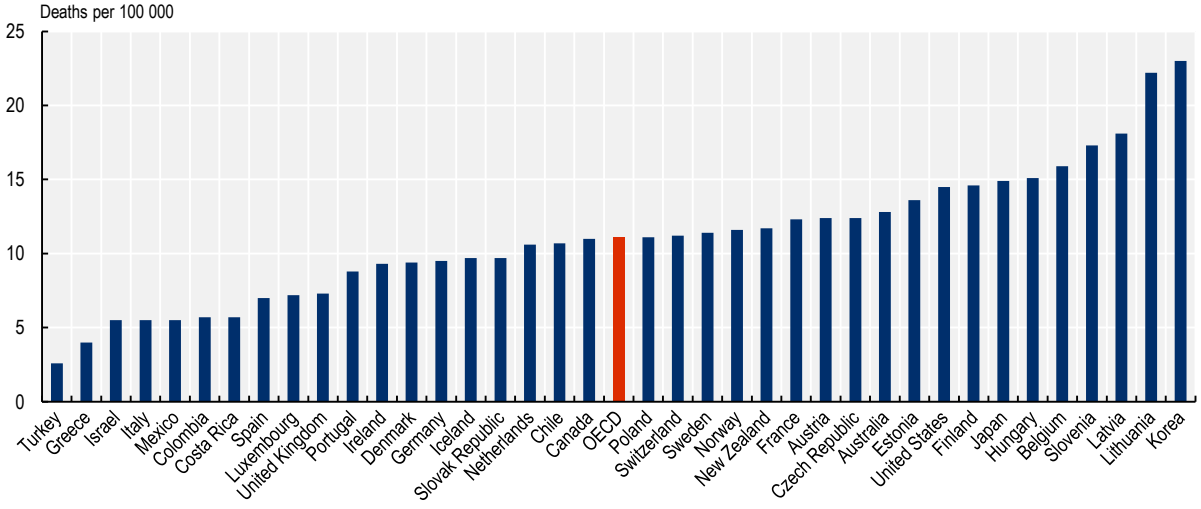
Are OECD mental health systems effectively preventing mental illness and promotion mental well-being?

Are countries reducing the rate of suicide?

Suicide rates are falling in OECD countries but still cause significant numbers of deaths every year

The rate of deaths by suicide varies nearly 10-fold across the OECD countries, with the lowest rates found in Turkey (2.6 per 100 000) and Greece (4 per 100 000), and the highest rates found in Lithuania (22.2 per 100 000) and Korea (23.0 per 100 000) (Figure 5.2).

Figure 5.2. Deaths by suicide 2018, or latest year

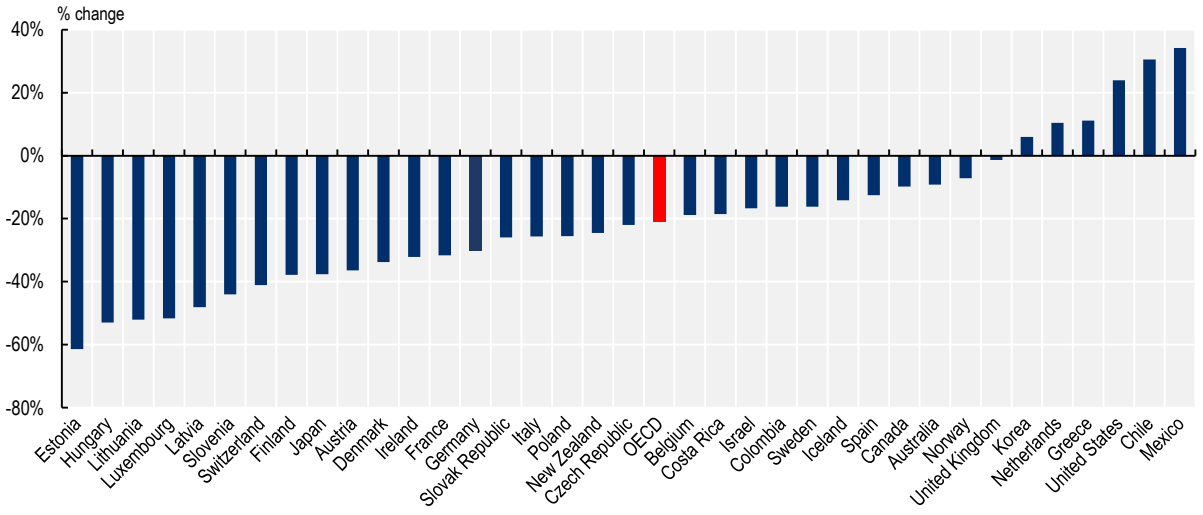


Source: OECD (2020[33]), OECD Health Statistics, https://doi.org/10.1787/health-data-en.

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Deaths by suicide in OECD countries have been falling across recent decades; between 1997 and 2017 rate of death by suicide per 100 000 population fell or remained stable in all but six OECD countries (Korea, the Netherlands, Greece, the United States, Chile, Mexico) (Figure 5.3).

Figure 5.3. Change in rate of suicide 1998-2018, or latest year



Source: OECD (2020[33]), OECD Health Statistics, https://doi.org/10.1787/health-data-en.

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In some countries – Estonia, Hungary, Lithuania, Luxembourg – the rate of suicide has fallen by more than half, albeit in some countries from an initially high rate. In Estonia, where the rate of death by suicide fell from 32.5 in 1997 to 13.6 in 2018, with the majority of this decline happening up to 2006, socio-political change across the period as well as changes to regulation around alcohol sales have been pointed to as significant drivers (Värnik et al., 2007[34]). Indeed, other countries in the region which underwent similar socio-political transformations after the end of the Soviet Union also saw significant declines in the rate of suicide, even if Estonia's close neighbours Latvia and Lithuania have higher rates of suicide for most recently reported years.

In a few countries, suicide rates have remained fairly low for two decades or more, including Israel, Italy and Spain. In Greece, where the suicide rate is low compared to the OECD average (4 deaths per 100 000, compared to 11.1 OECD-wide), the rate of suicide saw an increase from 2011 onwards, possibly in part due to the prolonged economic crisis that Greece was facing (van Gool and Pearson, 2014[35]).

Korea is, and has been for some time, an outlier amongst OECD when it comes to deaths by suicide. Not only has suicide risen in Korea between 1997 and 2017 – from a rate of 8.8 to a rate of 23 – which runs against the overall average trend in OECD countries, but Korea also has the highest rate of deaths by suicide amongst all OECD countries, well above the OECD average of 11.1 deaths per 100 000 population in 2018. Korea has been seeking to reduce its suicide rate for many years – including introducing national suicide prevention campaigns, media guidelines on reporting on suicides, suicide prevention hotlines, reduction of access to lethal means and seeking to increase access to mental health care (Park et al., 2020[36]; Kim and Yoon, 2013[37]; Kim et al., 2015[38]; Paik et al., 2014[39]; Kim et al., 2019[40]). Korea's current Master Plan for Prevention of Suicide includes 13 measures, including development of a counselling manual on suicide, tailored suicide prevention measures for each age group, promotion of mental health through management of depression and drug addiction, and follow-up management of people at risk of suicide or following a suicide attempt (OECD, 2020[41]).

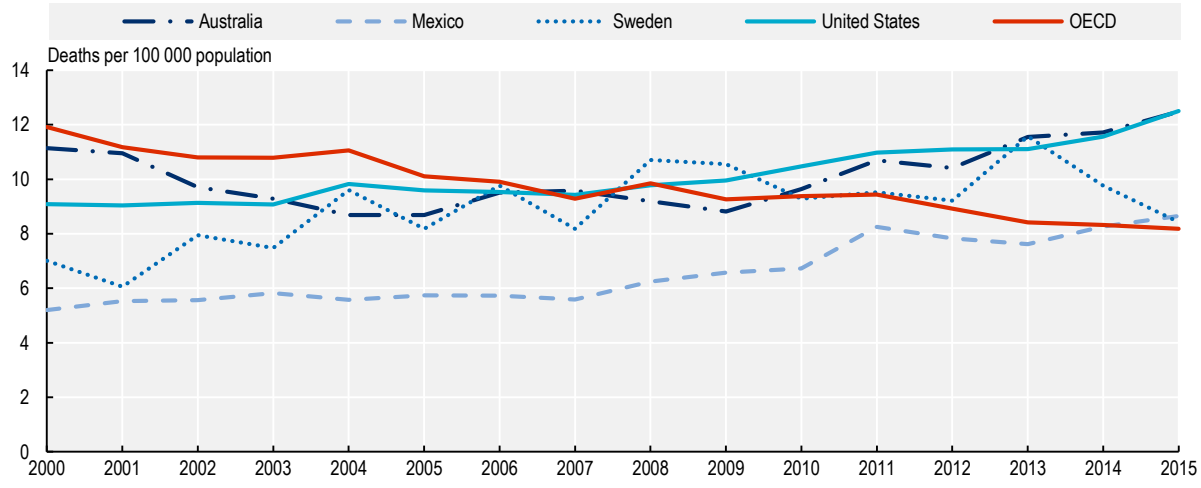
Suicide had also been declining in Korea from 2012, where suicide rates reached a high of over 33 deaths per 100 000 in the period 2009-11. However in 2020, most recently available data points to worrying trends in Korea when it comes to suicide rates, and signs that the COVID-19 crisis may have contributed to an increase in deaths by suicide amongst young women in Korea. Korean data suggests that there was a 43% increase in deaths by suicides by women in their 20s in the first half of 2020 compared with the same period last year (The Washington Post, 2020[42]; The Economist, 2020[43]).

There are signs that the COVID-19 crisis is also having an impact on rates of death by suicide in Japan. A Japanese study recently found by using difference-in-difference estimate that overall suicide rate decreased by 14% during the 'first wave' (from February to June 2020) of the COVID pandemic, a time during which schools were closed, working hours were reduced for many people, and broad household financial support was provided by the governments. Analysis by the 'Japan Suicide Countermeasures Promotion Center' (JSCP), a research institute designated by the Minister of Health, Labour and Welfare, suggested that growing public anxiety may have stimulated people's instinct to protect themselves, contributing to a decline in deaths by suicide (JSCP, 2020[44]). During the 'second wave' (July to October 2020), the suicide rate amongst Japanese women, children and adolescents increased by 37% and 49% respectively (Tanaka and Okamoto, 2021[45]). Suicide can be triggered by multiple factors, including psychiatric disorders, chronic medical conditions, alcohol or drug abuse, stressful life events, or social isolation (Mayo Clinic, 2021[46]), but the correlation of the significant rise in the suicide rate and psychological issues possibly related to the COVID-19 crisis is highly alarming.

Every year a small but concerning number of children and young people die by suicide

Every year, a small number of children and some young people die by suicide (Figure 5.4). Based on data submitted to the OECD, and available in the WHO Mortality Database, there does not appear to have been an overall rise in deaths by suicide amongst children and young people. Between 2000 and 2015, the average number of deaths by suicide amongst young people aged 15 to 25 fell by 31%, but rose by 10% or more in a small number of countries (Australia, Luxembourg, Mexico, the Netherlands, New Zealand, Sweden, the United States). In Australia, death by suicide are particularly high amongst young Aboriginal and Torres Strait Islander populations, for those with serious and complex mental ill-health. Rates of suicide are highest for those who have experienced child abuse and neglect (Stefanac et al., 2019[47]; Orygen, 2016[48]; Australian Institute of Health and Welfare, 2019[49]). Canada has also observed increases in the suicide rate in recent decades among females aged 10-24 and 45-64 years old (Varin et al., 2021[50]).

Figure 5.4. Death by suicide amongst young people age 15-25 in select countries, 2000-15 or nearest year



Note: Mortality data from WHO Mortality Database; population data from UN Population Database.
Source: OECD calculations, based on WHO Mortality Database and UN Population Database.

StatLink https://stat.link/rshw37

Data submitted to the OECD for the years 2009-18 suggest that death by suicide amongst Australian adolescents (age 15-19) rose across this time period, including in the most recent years (OECD, 2020[41]). Death by suicide amongst children and young people appears, as for adults, correlated with mental ill-health, access to lethal means, and previous suicide attempts, which point to a need for overall strengthening of access robust mental health care (McKean et al., 2018[51]; McKean et al., 2018[51]; Pettit, Buitron and Green, 2018[52]; Im, Oh and Suk, 2017[53]; McGillivray et al., 2020[54]). Some evidence also supports school-based interventions for suicide prevention; in ten European countries the Youth Aware of Mental Health (YAM) programme has been associated with a 55% reduction in incident suicide attempts and 50% fewer cases of severe suicidal ideation after 12 months, and is now being evaluated in Australia (McGillivray et al., 2020[54]).

Are countries ensuring mental health literacy?

Good mental health literacy can reduce stigma, support self-management of mental distress, and encourage help-seeking

'Health literacy' includes an individual's health knowledge, their capacity to understand and process information about health and health care, and their capacity to make decisions about their own health and their use of health services ((Institute of Medicine, 2004[55]; Moreira, 2018[56]). Health literacy can support more people-centred care, supporting increased shared decision making, and a more egalitarian relationship between the care provider and consumer. Increased health literacy can also improve the care user's capacity to manage their own health, for example managing a chronic disease, or seeking help in the event of ill-health (Paasche-Orlow and Wolf, 2007[57]). Some studies have found that health literacy contributes to improved self-reported health status, decrease in the frequency of health care service, and shorter the hospitalisations (Sørensen et al., 2012[58]).

Mental health literacy includes knowledge and skills related to mental health – both understanding of good mental health, and mental health problems and conditions –, improved attitudes and reduced stigma towards mental health conditions, and understanding of how to seek help in the event of mental ill-health (Wei et al., 2015[59]). At present, mental health literacy is not widely or consistently measured, and a range of different measurement tools exist. The most widely used approach to measuring mental health literacy is through questionnaires, which tend to measure either mental health knowledge, or stigma and attitudes (including self-stigma). Widely used measures of mental health knowledge include the Mental Health Literacy Questionnaire (MHLQ), the Mental Health Knowledge Schedule (MAKS), the World Psychiatric Association 'Open the Doors" survey (WPA-OD), or condition-specific measures such as the Depression Literacy Scale (DLS), Knowledge about Schizophrenia Questionnaire (KASQ), or Schizophrenia Knowledge Questionnaire (SKQ) (Wei et al., 2015[59]).

Stigma, and efforts to reduce stigma, are also closely linked to mental health literacy, and are discussed in Chapter 4 of this report.

Efforts to improve mental health literacy are in place in many countries

The OECD questionnaire found that 16 out of 29 respondents countries have national and/or regional or local programmes that focuses on improving general population understanding or knowledge of mental health/mental illness (Table 5.1). These include programmes in Japan and Latvia, which have focused on increasing the level of information that the population has on mental health (OECD, 2020[41]). In Japan the Ministry of Health, Labor and Welfare (MHLW) has been operating a portal site called "Minnano Mental health" (Mental Health for Everyone), which provides useful information, including contact details of specialised medical institutions, support systems and national policies, as well as materials aimed to promote proper understanding of mental health conditions and reduce stigma. Municipal governments in Japan also organise seminars and other events to promote mental health understanding in a way that is

tailored to local population needs, and Public Health Centers and Mental Health and Welfare Centers organise campaign events including an annual national conference on mental health care, during Mental Health Awareness Week in Japan. In Latvia, there is also a national platform, www.nenoversies.lv, which provides information and educational lectures about mental health conditions, and each year the ministry leads a particular push around mental health awareness in October, coinciding with World Mental Health Day on 10 October.

Table 5.1. National programme that focuses on improving general population understanding or knowledge of mental health/mental illness

At least one national programme that focuses on improving general population understanding or knowledge of mental health/mental illness	
National campaign on mental health literacy	Australia, Canada, Czech Republic, England, Iceland, Ireland, Italy, New Zealand, the Netherlands, Poland, Slovenia, Switzerland
Regional or local campaign on mental health literacy	Belgium, Japan, Korea, Lithuania, Switzerland

Source: OECD (2020[41]), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires*.

Indeed, events and activities around World Mental Health Day appear to be a key part of countries' efforts to increase mental health literacy, and to tackle stigma around mental health (see also Chapter 6). For example in Norway NGOs organise information and awareness campaigns on World Mental Health Day each year, while in Turkey key days such as 10 September which is Suicide Prevention Day and World Mental Health, public awareness seminars, panels, and conferences are organised on combating stigmatisation, including activities in primary care services, as well as the distribution of information brochures (OECD, 2020[41]).

During the COVID-19 crisis countries have increased public communication about mental health and staying mentally well

During the COVID-19 crisis, countries have prioritised communication with the public about mental health during COVID-19, including the increased risks to mental health during the pandemic, how to stay mentally healthy, and how to seek help for mental health problems if needed. Governments have also been regularly communicating about mental health issues in 'COVID-19 briefings', which have become regular and common place in OECD countries, for example sharing phone support numbers, or referring to latest data on mental health impacts of the crisis. Internet search activity has also shown increases in information-seeking related to mental health and emotional well-being during the COVID-19 crisis (Brodeur et al., 2021[60]).

Over the course of 2020, most OECD countries, and multiple international agencies such as the World Health Organization, the Inter-Agency Standing Committee (IASC), and the European Commission, have produced guidance on coping and staying in good mental health during the COVID-19 crisis. This mental health information, commonly shared online, has included advice for the general public, for health care workers, parents, children and young people, and mental health professionals. Materials include advice on steps to protect mental well-being, such as trying to limit news consumption, maintain social contact by phone or internet, undertaking physical activity at home, getting enough rest, eating healthily, and avoiding tobacco, alcohol or other drugs. Some materials produced by international agencies have been translated and used across hundreds of countries. For example the IASC developed an informational illustrated book, 'My Hero is You' for children coping during COVID, which has since been published in 137 languages (IASC, 2020[61]). In OECD countries, Ministries of Health, professional associations, and mental health associations have shared a diverse range of information on coping online. In Portugal, for example, the COVID-19 pandemic has meant that mental health has received more media coverage, and the

government website on COVID-19 and mental health (https://saudemental.min-saude.pt/category/covid-19-e-saude-mental/) has been regularly consulted (OECD, 2020[41]). In Finland, the Institute for Health and Welfare has made information on strengthening coping through everyday routines, reducing risk and stress, supporting others and getting help for psychiatric symptoms via its website (THL, 2021[62]). In Turkey, the Psychiatric Association of Turkey has published a wide range of Turkish language resources, including guidelines for adults with existing mental health conditions, recommendations on sleep hygiene during the coronavirus pandemic, guidelines against burnout for health professionals, and the psychological effects of quarantine and means of prevention (European Psychiatric Association, 2020[63]). In Slovenia, the National Institute of Public Health (NIJZ) has published guidelines on promoting mental well-being during COVID-19, mental health first aid guidelines for general population, recommendations on how to talk about COVID-19 with children, how to talk about death and grieving during the COVID-19 pandemic.

Most OECD countries have also introduced mental health support phone lines during the COVID-19 crisis. For instance in Germany, a phone line staffed by volunteers from the Professional Association of German Psychologists (BDP eV) was opened from the end of March until the beginning of July 2020, and received over 12 000 calls (Berufsverband Deutscher Psychologinnen und Psychologen, 2020[64]). In Portugal, a free phone line with 24 hour psychological support from 63 mental health specialists (psychologists) has been created in partnership with the Ministry of Health, the philanthropic foundation Fundação Calouste Gulbenkian (donating EUR 300 million) and the charter of psychologists Ordem dos Psicólogos Portugueses (Servico Nacional de Saude, 2020[65]). In Costa Rica, an 'Office of Psychological Support' and more recently the Primary Psychological Support Center (CAPP) have been created by the College of Professionals in Psychology of Costa Rica, while the 'Here I Am' (*Aquí estoy*) phone line was established by the Ministry of Education. In France, a phone hotline where people can get psychological support is widely promoted, including in each COVID-19 press briefing held by the government.

Are schools mental health-friendly environments that build resilience?

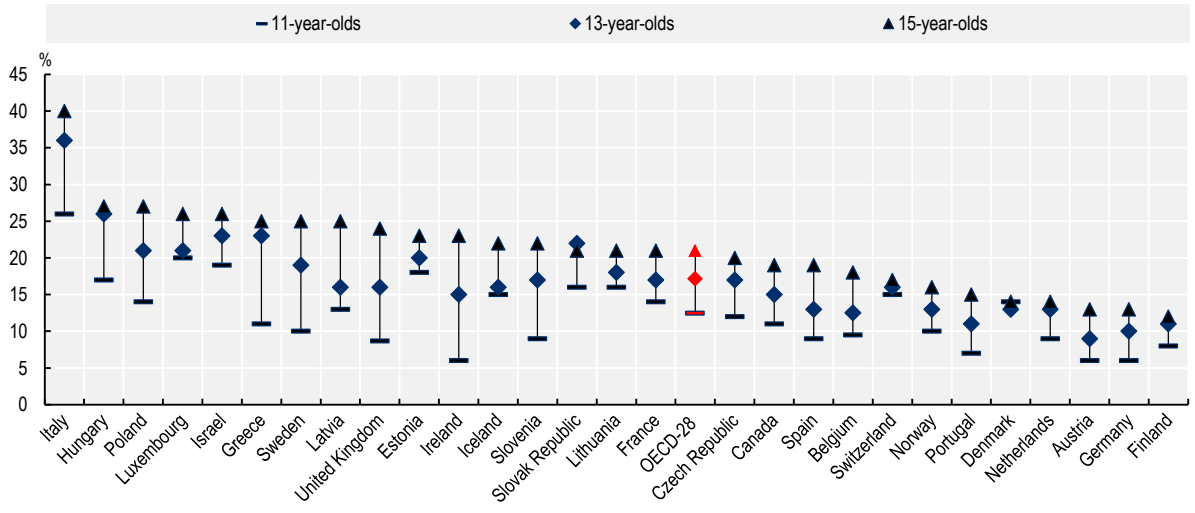
Promoting good mental health in early life is critical

A considerable number of children experience mental health problems which, unless they receive appropriate care and support, may have a lasting effect throughout their lives. Evidence suggests that many mental disorders begin at adolescence or even younger; roughly half of all lifetime mental disorders start by the mid-teens, and as many as three-quarters of lifetime mental disorders have their first incidence by age 24 (Kessler et al., 2007[66]; Kessler et al., 2007[67]). Children and adolescents with mental disorders, emotional, or behavioural problems are at higher risk of dropping school and struggling with finding stable jobs after leaving school (Hewlett and Moran, 2014[68]), and living with a mental health condition can also affect a child or adolescent's interpersonal and family functioning (Wei et al., 2015[59]).

As many as 10% of boys and 14% of girls aged 11 reported 'feeling low' more than once a week in the last six months on average across 28 European countries which are members of the OECD. The share of children reporting feeling low increases quite sharply with age, and gender differences become even starker – as 11-year-olds, 14% of girls compared to 10% of boys felt low, but as 15-year-olds, this gap widened with 29% of girls feeling low compared with only 13% of boys (Figure 5.5).

Figure 5.5. Share of children reporting feeling low more than once a week, by age, 2016

Children and adolescents who reported 'feeling low' more than once a week, HBSC survey 2016



Note: Figures for the United Kingdom and Belgium have been averaged, unweighted.
Source: World Health Organization (2016), Growing up unequal: gender and socio-economic differences in young people's health and well-being, in OECD/European Union (2020[1]), *Health at a Glance: Europe 2020: State of Health in the EU Cycle*, https://dx.doi.org/10.1787/82129230-en.

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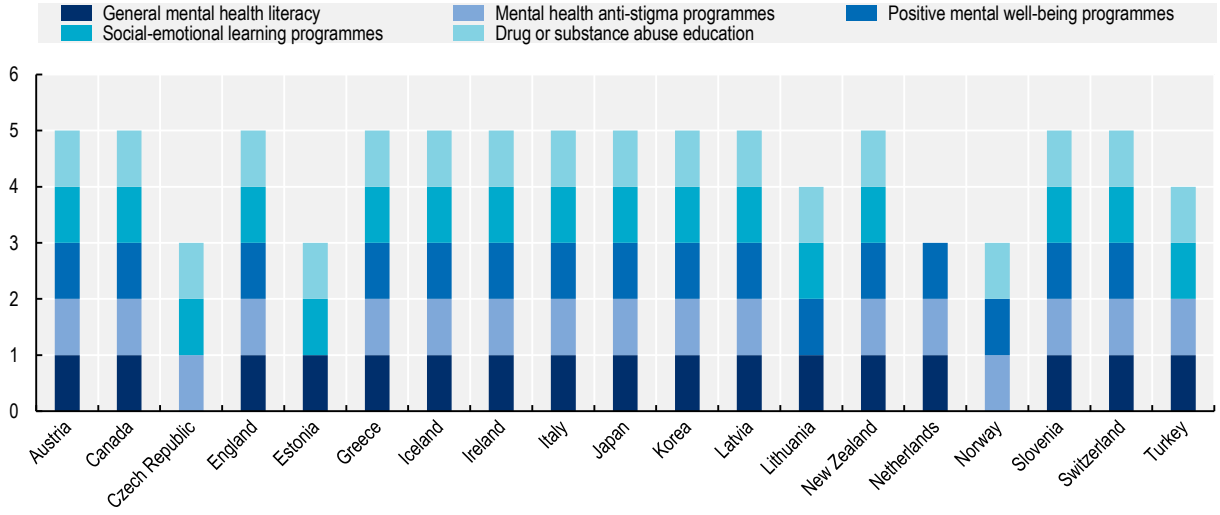
Schools are a very good place to do mental health promotion and prevention

Schools are a very effective setting for mental health promotion and prevention activities. First, because almost all children and adolescents in OECD countries spend much of their week in educational settings, and second, because mental health promotion and prevention activities have found to be particularly effective when targeted at children and young people (McDaid, Hewlett and Park, 2017[4]; Union, 2018[69]; OECD, 2015[17]). Interventions delivered in school settings targeting mental health, social and emotional outcomes have been found to have benefits to mental health in the medium-to-long term, as well as having benefits such as a better school attachments, less risky behaviour, improved academic performance, and better resilience and cognitive skills (Durlak et al., 2011[70]; Weare and Nind, 2011[71]; McDaid, Hewlett and Park, 2017[4]).

In 2020 most OECD countries reported that programmes to build mental health literacy and well-being, reduce stigma, and advance social-emotional learning were in place in some or all schools (Figure 5.6), and 20 out of 29 respondents to the OECD Mental Health Performance Benchmarking Policy Questionnaire reported that teachers received some or a lot of mental health training (OECD, 2020[41]). Most countries (19) that were able to report whether they had a mental health education or awareness programmes in school in fact had multiple different programmes, either running at different points in the school year, for different age groups, or in different regions. Some of those countries which were unable to report whether they had specific mental health programmes in schools signalled that some mental health or socio-emotional education was nonetheless included in the school curriculum, for example in Denmark where primary school students all receive physical and mental well-being teaching as a compulsory subject Health, Sexual and Family education curriculum. Several countries – England, Ireland, and Norway – have made recent national commitments to embed mental health teaching in the school curriculum for students across age groups, while other countries – Denmark, Iceland, Finland – have taken such an approach for some time already (OECD, 2020[41]).

When asked what percentage of schools had some programme in place, or by age 15 what percentage of children had received at least two hours of mental health education, most countries were unable to answer but responses ranged from 100% of children in 100% of schools (in Iceland), to 60-70% of schools (in England and Estonia) (OECD, 2020[41]).

Figure 5.6. Mental health education or awareness programmes in schools



Source: OECD (2020[41]), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.*

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In some countries (notably Lithuania and Switzerland, and Denmark) a mental health focus in schools is expected, but teachers and schools are left to set their own teaching curriculum and approach and tailor it to student needs. In many countries, though, national programmes for mental health promotion in schools have been rolled out, either as part of the school curriculum delivered by teachers or as a specific initiative in schools.

Implementing mental health promotion programmes in schools typically requires close collaboration between the Ministry of Health and the Ministry of Education, and/or leadership by the Ministry of Education. In England, in July 2019, the Department of Education also announced a major new GBP 9.3 million 'School Link Programme, joining up schools and the NHS by offering two whole-day workshops on mental health to all schools, colleges and alternative provision settings (OECD, 2020[41]). The Programme is designed to improve partnerships with professional NHS mental health services, raise awareness of mental health concerns and improve referrals to specialist help when needed. Schools Link Training began roll out to schools and colleges in October 2019 and will be delivered in phases over four years, being offered to up to 22 000 schools and colleges, including alternative provision settings. All the elementary and the secondary school have counselling offices with psychological professionals specialising in mental health prevention at school in Slovenia, which offer counselling to children, adolescents, and their parents. In addition, 'This is Me' is an online counselling web portal established by the Institute of Public Health Slovenia in 2001 to strengthen mental health among adolescents. The programme has offered adolescents online counselling service by professionals such as medical specialists, psychologists, social workers, and teachers, and helps adolescents with problem-solving efforts focusing on self-esteem, social and life skills.

England was also planning to introduce compulsory health education in all state-funded schools in England from September 2020 (OECD, 2020[41]). This change included statutory requirements and guidance

passed by Parliament, and includes specific mental health content for all 5-16 year-olds. The aim is that this will improve quality and consistency of education on mental health, and provide a preventative benefit helping to stop problems developing and escalating, which including a support package for schools, with GPB 6 million earmarked this 2019/20 to help schools prepare for introduction of mental health education. This dual focus on including mental health in the school curriculum, and strengthening the link between schools and mental health support services is also found in Iceland. In Iceland the health services in primary school place an emphasis on mental health promotion and psychoeducation, and the Ministry of Health and the Ministry of Education and Culture are collaborating on promoting mental health of upper secondary school students via access to supportive services, education about mental health and access to psychological services. As part of England's 'Transforming Children and Young People's Mental Health' approach, the country is also looking to expand the support system around children, and around schools. This includes three key proposals: incentivising every school or college to identify and train a Senior Lead for Mental Health; creating new Mental Health Support Teams in and near schools and colleges; piloting a four-week waiting time for specialist NHS, so that there is swifter access to specialist NHS services for those children and young people who need it. The aim is that it will deliver early interventions for mental health issues, encourage a whole-school approach to positive mental health, and reduce waiting times for moderate-severe mental health needs services.

Norway, like England, has also recently introduced national commitments to ensure that students of all ages are getting mental health education in schools, and from August 2020 every school in Norway has to implement the subject 'public health and life mastery'. Norway already has "Mental health in school", a grant scheme to promote knowledge about mental health in schools, which offers support to many external programmes, and sits alongside a grant scheme about student's mental health and substance use, aimed at universities and welfare organisations for students (OECD, 2020[41]).

In Ireland, a new national approach is also being pursued for schools, with the ambition that the promotion of well-being will be at the core of the ethos of every school and education setting. The Well-being Policy Statement and Framework for Practice 2018-2023 was launched by the Minister for Education and Skills in July 2018, and policy requires that a Well-being Promotion Process is developed and implemented, through the use of the School Self-Evaluation (SSE) process, in all schools by 2023 (OECD, 2020[41]).

In many countries, the regional or state governments are responsible for education and schools, including mental health programmes in schools. Despite this decentralised responsibility the national government, including the Department of Health, are still taking particular steps to support mental health programmes in schools in some countries. In New Zealand, schools are self-governing and choose the tools, resources and programmes that suit their needs. There are however a number of mental well-being programmes available for schools to uptake if they choose to do so, such as Sparklers, a well-being toolkit especially designed for classroom use with nearly 100 activities designed by child behavioural experts to support students with learning about their mental health and well-being (OECD, 2020[41]).

In Australia, the Australian Government also funds the Mental Health in Education Initiative, known as BeYou. BeYou is a national initiative supporting mental health promotion and prevention activities across education settings, ranging from early childhood learning through to secondary schools. BeYou seeks to ensure educators develop valuable mental health skills and knowledge, while also providing a model for implementing a whole-learning community approach to mental health and well-being. In addition, while states and territories are responsible under the Australian Constitution for school education, the Australian Government plays an important role in providing national leadership across important policy areas. The Australian Government's Student Well-being Hub at www.studentwellbeing.edu.au provides a range of freely available information and resources for educators, students and parents to assist them to create and maintain a safe and supportive school environment (OECD, 2020[41]).

In Canada, where again mental health education and awareness programmes in schools are region specific, a range of different mental health programmes located in schools have been developed in different

regions. Many of these efforts go beyond well-being education, and focus on providing mental health support directly to students. For example, Prince Edward Island has established Student Well-being Teams to cover all public schools in both official languages, giving students access to a team of mental health care professionals that are also able to provide social services supports, while British Columbia has established 24/7 mental health support for post-secondary students throughout the province. These services will include counselling and referral services to ensure students receive immediate, on-demand services or are able to be referred as appropriate (OECD, 2020[41]).

In Mexico, the Ministry of Public Education will create content in the curriculum that encourages and promotes healthy lifestyles, as well as health education, in the 2020-21 school cycle. A new school subject, 'Healthy Life' has been developed for preschool, elementary, middle, and high school students, and will also engage teachers and parents, and will include the promotion of mental health. This approach also promotes the implementation of a system of counselling and support for distance learning, to promote communication between teachers and students, in addition to the development of online seminars on socioemotional skills, as well as socioemotional resources using digital platforms.

Finland stands out as an OECD country that has not only implemented a significant evidence-based programme to support students' socioemotional well-being in school across age groups (see Box 5.2), but has also made mental health a key part of the educational system's objectives. Finland has a strong legal framework around school health and welfare, which has included embedding teams of health and welfare professionals in schools since 1966 (Coburn, 2019[72]). Further legislative changes were introduced in the early 2010s, strengthening efforts to identify children with social or emotional difficulties, and referring them to assessment and support either within or outside the school (ibid).

Do OECD workplaces foster good mental health?

Workplaces can be good, or bad, for mental health

Being in work has been shown to be good for mental health; non-employment generally is worse for mental health than working (OECD, 2008[73]; OECD, 2015[17]). A 2008 review of five countries found that mental health suffers when individuals move from employment to unemployment or inactivity, and non-employment is detrimental for mental health, and that individuals' mental health tends to improve when they move from unemployment into having a job (OECD, 2008[73]); a 2016 systematic meta-review found that available evidence points to employment being good for employees' well-being (Modini et al., 2016[74]).

At the same time, poor workplace environments can constitute a risk to mental health, and low-quality jobs or 'non-standard' jobs seem to have a weaker association with positive mental health for employees (OECD, 2008[73]). Previous OECD work (OECD, 2012[75]) has set out the multidirectional relationship between the work environment, and mental ill- health; job-related strain and a poor psychosocial work environment can cause mental ill-health; workers with mental health problems tend to work in lower-quality jobs and poorer work environments; and workers with mental health problems perceive their work situation more negatively because of their condition.

To support individuals to be in employment, and stay in employment, efforts are needed to ensure that workplaces don't constitute a threat to employees' well-being, and also contribute to improving mental health. The importance of implementing appropriate policies for workplace mental health promotion are underscored in the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, which specifically requires that OECD countries – who are all Adherents to the Recommendation – "promote and enforce psychosocial risk assessment and risk prevention in the workplace", "develop a strategy for addressing the stigma, discrimination and misconceptions faced by many workers living with mental health conditions at their workplace", and "…[develop] guidelines for line managers, human resource professionals and worker representatives to stimulate a better response to workers' mental health conditions" (OECD, 2015[76]).

Some countries have been focusing on reducing mental health risks in workplaces

OECD countries have been using workplace safety legislation to include provisions to protect employees' mental health. Multiple countries, including Austria, Belgium, Finland, France, Norway, and the Netherlands, use labour legislation to require employees to reduce psychosocial workplace risks (OECD/European Union, 2020[1]).

In the follow-up to the implementation of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, several countries including Canada and Japan were found to have made recent amendments to labour regulations to add or strengthen provisions making it clear that employers had a responsibility for their employees' mental health, as well as their physical safety, in the workplace (OECD, forthcoming[77]). In the EU-Compass for Action on Mental Health and Well-being, the 2017 focus was on mental health in school and work. As part of this activity, 70% of EU members states reported that addressing mental health in the workplace was a priority in policy or strategy documents, and more than half of countries had introduced programmes or policies to address mental health in the workplace (EU Compass for Action on Mental Health and Well-Being, 2017[78]).

Psychosocial risk assessment is a tool in place in a few countries, including Japan which has a mandatory 'stress check' for employees. In order to prevent mental health illnesses and reduce their burden in the Japanese labour force, and to encourage improved working conditions, employers with more than 50 employees are obliged to evaluate the stress level of workers (stress check) once a year (OECD, 2019[79]). This initiative was first introduced by the National Federation of Industrial Health Organization in Japan to its affiliated employers, and the central government then implemented this initiative nationwide in 2015. This stress test measures employees' mental health through an online questionnaire which was developed based on the questionnaire designed by the National Institute of Occupational Safety and Health in the United States. It aims to make employees aware of their stress level so that they can try to prevent developing mental health problems, and also aims to promote changing the work environment based on stress check results.

In 2020, OECD (forthcoming[77]) pointed to Canada and the United Kingdom as taking a broader approach to workplace mental health than most countries, focusing on both reducing psychosocial risks, and promoting good mental health in workplaces. In the United Kingdom, the government along with other key actors such as employers' associations, introduced a set of 'Core Standards', or 'Management Standards, for employers. The Health and Safety Executive has developed a set of guidelines including risk identification, evaluation, monitoring and review, and actions, to reduce work-related stress. These standards cover a range of dimensions of workplace stress, including demand (workload, patterns, the working environment), how much control over their work an employee has and how much support they're given, workplace relationships, and managing change. Canada also introduced a National Standard for Psychological Health and Safety in 2013, giving guidelines for employees on creating a healthy and safe working environment.

Workplace programmes can build mental health literacy, reduce stigma, build mental resilience, and direct people towards appropriate support

Promotion and prevention activities in workplaces do not just need to focus on reducing psychological risks and stress in the workplace. Workplace programmes can also proactively build mental health literacy, reduce stigma, build mental resilience, and direct people towards appropriate support.

Several workplace-based programmes have been found to be effective at improving mental health literacy, and reducing stigma, including the Mental Health First Aid programme (see Chapter 4), and some workplace programmes have been specifically tailored for certain professional groups. For example, 'Beyond Silence' in Ontario, Canada, is a two day course led by trained peer educators to support the mental health of health care workers (Beyond Silence, 2021[80]). The programme has also been expanded

to a smartphone app, which gives information and support for managing mental health at work, and gives the option of a direct link to a peer support worker. An evaluation of the Beyond Silence programme found that while this programme – like many mental health literacy programmes – did not directly lead to an increase in help-seeking behaviours, it did improve increase mental health literacy, improve attitudes towards seeking mental health treatment, and was linked to sustained decreases in stigmatised beliefs (Moll et al., 2018[81]).

Some countries have programmes to reduce mental health stigma, and/or improve mental health literacy in workplaces, some of which are based on general awareness campaigns, and others on training for employees or employers. In Lithuania, legislation prohibiting certain jobs due to mental illness is currently under review, and in 2019 the Minister of Health established an order by which public health bureaus should organise trainings (40 hours in-length) in companies for employees and employers focusing on strengthening their mental health competences. During the trainings participants also acquire knowledge and practical skills on reducing psychosocial risks and work-related stress (OECD, 2020[41]).

Australia has taken steps to promote mentally healthy workplaces through the Mentally Healthy Workplace Alliance, which was established by the National Mental Health Commission; members include key representatives from business, union, government, workplace health and mental health sectors (The Mentally Healthy Workplace Alliance, 2018[82]; National Mental Health Commission, 2021[83]). The Mentally Healthy Workplace Alliance supports businesses through information and resources to encourage practical steps to strengthen mental health support in the workplace. The Australian Federal Government has supported the work of the Mentally Healthy Workplace Alliance with USD 11.5 million over four years provided in the 2019-20 Federal Budget for the National Workplace Initiative. This project will lead a nationally consistent approach to mentally healthy work and workplaces (Mentally Healthy Workplace Alliance, 2020[84]).

There is also clear scope for businesses and companies to take proactive steps to promote mental health in their workplaces, going beyond national guidelines or regulations. The American Psychiatric Association (American Psychiatric Association, 2017[85]) has pointed to the positive experience of several large employers, specifically the companies Garmin, HealthPartners and Unilever, which implemented company-wide mental health resilience programmes with positive effectives. These companies various used health behavioural assessments, emotional resilience coaching, health promotion programmes and brochures, training to managers and executives, and communication and education campaigns tailored to the specific workforce.

Can front line actors recognise and respond to mental distress, to connect individuals to appropriate services?

This sub-principle is directly linked to the sub-principle ‘Enable front line actors to connect individuals to appropriate services’ included in Chapter 4. An integrated and multi-sectoral approach to mental health. Equipping front line actors with the information and skills to identify and respond to mental distress are intrinsically linked, and important as part of both an integrated and multi-sectoral approach to mental health, and to good promotion and prevention practices. To maintain this link, the discussion of mental health knowledge, skills and ability to connect individuals to appropriate services has been brought together in Chapter 4 of this report.

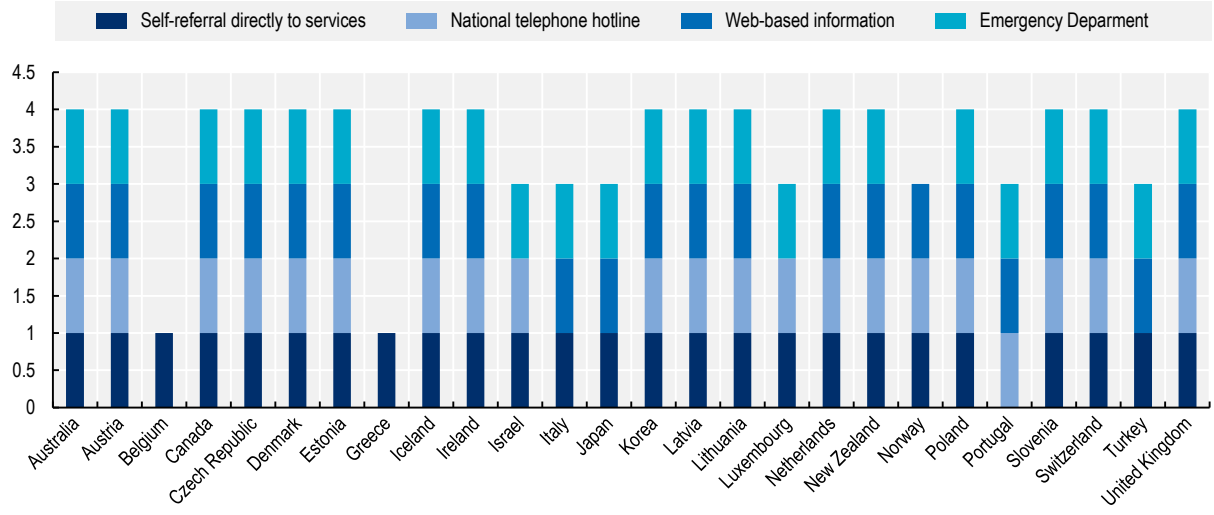
Do OECD countries make it easy for individuals to seek help?

Improving mental health literacy, and reducing stigma around mental ill-health, are expected to contribute towards increase help-seeking behaviour if individuals are experiencing mental distress (Bonabi et al., 2016[86]; Henderson, Evans-Lacko and Thornicroft, 2013[87]; Schnyder et al., 2017[88]). If more people know where to go to seek help – be that low-threshold support such as mental health information, guidance, or

self-help, or more intensive support from a trained professional – it should eventually mean that more people get help recovering from, or managing, mental health conditions when they occur. Along with stigma (including self-stigma), barriers to accessing mental health care can be financial or due to long wait times for services (see Chapter 3), and can also be related to lack of knowledge on where to seek help, or a shortage of available mental health support. For example, a 2017 study in the United Kingdom found that 35% of young adults experiencing emotional or mental health difficulties did not seek any formal or informal help, with stigma, or mental health literacy and a preference for self-reliance significant barriers to seeking help (Mitchell, McMillan and Hagan, 2017[89]).

Making services easily accessible can be one way of encouraging help-seeking for mental health needs. Amongst OECD countries, 26 reported that at least some services were accessible without previous referral (Figure 5.7).

Figure 5.7. Mental health that can be accessed directly, without referral



Note: Mental health that can be accessed directly, without referral, i.e. excluding services which need referral from a General Practitioner, from the emergency department, or from a psychiatrist. Some services may be private services, or require out-of-pocket payments from service users.
Source: OECD (2020[41]), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.*

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Many countries have online information, or phone lines, which can be accessed directly without referral, including Ireland, Lithuania, Slovenia, Portugal, Norway, Canada and New Zealand. In Ireland this includes the website 'yourmentalhealth.ie' and a signposting mental health telephone number, and Lithuania has a 'hope line', a women's support line, and various other telephone support lines, and New Zealand has a range of web-based information and resources can be accessed directly. In addition, mental health and well-being telehealth services are available free of charge to all New Zealanders, including specific lines for youth, Māori, depression, alcohol and other drugs, gambling, and more. Portugal has both national and regional phone hotlines, as well as several websites giving information about how to access to services.

In England, a range of mental health advice and information is available online, including the NHS Apps library which includes apps for mental health which gives guidance on app-based mental health support tools that have been assessed to be effective for a range of different conditions or concerns (see also Chapter 7). In Canada, the Wellness Together Canada (WTC) online portal provides short-term mental health and substance use supports and services to Canadians, including access to immediate crisis support by phone. The WTC also includes a link to the Kids Help Phone web page, which provides

resources for youth, including immediate access to counselling by phone/text/live chat. Another resource available to Canadians living in Ontario is a library hosted by the Centre for Addiction and Mental Health (CAMH). It provides access to a wide range of hard-copy and digital books, journals, research reports, government documents and videos relating to mental health and addictions. The broader CAMH website includes information on mental health and addictions that is accessible to all Canadians.

Amongst services that can be accessed without referral, all but one country (Portugal) reported that some self-referral directly into services was possible. However, self-referral tends not to be possible across all services. Several countries make self-referral possible for telephone services and/or online services. In Australia services that can be accessed directly include a wide range of telephone and online mental health services run by non-government organisations, funded by the Australian Government, which can be accessed directly or via the Government's gateway to digital mental health services, Head to Health. This includes MindSpot, the Australian Government's virtual clinic, a free service for Australian adults who are experiencing difficulties with anxiety, stress, depression and low mood, which provides assessment and treatment courses, and also helps clients find local services that can help. In Norway, many municipalities also offer digital courses and self-help programmes. The government has initiated a project to develop a digital tool treating milder forms of anxiety, depression and sleep issues – all municipalities should be able to use this tool when the project is finished.

In England, people may self-refer to some mental health services such as talking therapies through the 'Increasing Access to Psychological Therapies' (IAPT) programme. In Ireland, a number of voluntary agencies to provide services that are accessible without referral, including 'Jigsaw' and 'Turn2Meonline' counselling which are both for 12-25 year-olds. In Iceland, too, there are different NGOs that provide mental health support/counselling which can be accessed directly.

When it comes to accessing specialist mental health care, gatekeeping and referral pathways differ between countries. In Lithuania and Turkey, some specialist mental health care can be accessed without referral, including primary-level mental health centres in Lithuania, and primary, secondary and tertiary level services in Turkey. Additionally, in most countries some mental health services, notably psychological services such as psychological therapies delivered by a counsellor or a psychologist, can be accessed directly with out-of-pocket payment.

Strengthening prevention and promotion in mental health

An comprehensive approach to suicide prevention and harm reduction can reduce can reduce deaths by suicide

Most OECD countries have long had suicide prevention plans, either as stand-alone strategies, or as a key part of their mental health plans and policies (Hewlett and Moran, 2014[68]). A comprehensive approach to suicide prevention – which takes stock of the drivers of deaths by suicide, and their different distribution across population groups – is needed. A range of measures are recognised as effective in reducing suicide, including restricting access to lethal means, raising awareness of suicide and suicide risk, signposting to sources of help and protective measures in suicide "hotspots" (Zalsman et al., 2016[90]), as well as improving access to mental health treatment, and tailored efforts to reduce suicide following hospitalisation, for example psychosocial assessment and good follow-up care (Hawton et al., 2016[91]).

While suicide should not be considered a proxy for mental illness, and mental ill-health is not the sole driver of suicide rates, many of the steps that can be taken to strengthen population mental well-being, capacity to seek appropriate help, and receive care when needed can also contribute towards broader suicide reduction. A comprehensive strategy to reduce suicide should be tailored to the national context – and start by identifying risk and protective factors – and then built out to include interventions that will work to respond to the specific problems identified (Figure 5.8).

Figure 5.8. A comprehensive approach to preventing suicide

Effective interventions at targetting different settings, and different population risks

Population-level
- Awareness building campaigns in schools can reduce suicide attempts and suicidal ideation[1]
- Reducing access to lethal means , for instance fire arms or pesticides – banning highly hazardous pesticides could result in fewer suicide, and has been found to be cost-effective[2]
- Policies to reduce harmful alcohol consumption can reduce deaths by suicide[3]

Building capacity to prevent suicide
- Training for key workforce, such as General Practitioners, emergency department staff, teachers, counsellors, or criminal justice staff can help with identifying persons at risk of suicide, and help these stakeholders take the lead in suicide prevention efforts – the WHO has developed a toolkit on suicide prevention for key workforce categories[4]

Supporting at-risk populations
- Access to mental health care is a key part of suicide reduction, given the strong association of suicide and mental health conditions such as depression[5]
- Interventions to reduce the risk of key populations (e.g. alcohol or substance mis-use reduction, increasing access to mental health care for depression)[6]

Risk-reduction and surveillance in mental health settings
- Identification of individuals at increased suicide risk and appropriate follow-up, for example following a suicide attempt[7]

Source: [1]Zalsman et al. (2016[90]),"Suicide prevention strategies revisited: 10-year systematic review, http://dx.doi.org/10.1016/S2215-0366(16)30030-X, WHO (2019[92]), *Suicide prevention: toolkit for engaging communities*, https://www.who.int/publications/i/item/suicide-prevention-toolkit-for-engaging-communities (accessed on 8 March 2021); [2]Lee et al. (2020[93]), "The cost-effectiveness of banning highly hazardous pesticides to prevent suicides due to pesticide self-ingestion across 14 countries: an economic modelling study", http://dx.doi.org/10.1016/s2214-109x(20)30493-9, du Roscoät and Beck (2013[94]), *Efficient interventions on suicide prevention: A literature review*, http://dx.doi.org/10.1016/j.respe.2013.01.099; [3]Xuan et al. (2016[95]), *Alcohol Policies and Suicide: A Review of the Literature*, http://dx.doi.org/10.1111/acer.13203, Pridemore and Snowden (2009[96]), "Reduction in suicide mortality following a new national alcohol policy in Slovenia: An interrupted time-series analysis", http://dx.doi.org/10.2105/AJPH.2008.146183; [4]WHO (2019[97]), *Preventing Suicide: a resource series*, https://www.who.int/publications/i/item/preventing-suicide-a-resource-series (accessed on 8 March 2021), Isaac et al. (2009[98]), *Gatekeeper Training as a Preventative Intervention for Suicide: A Systematic Review*; http://dx.doi.org/10.1177/070674370905400407; [5]du Roscoät and Beck (2013[94]), *Efficient interventions on suicide prevention: A literature review*, http://dx.doi.org/10.1016/j.respe.2013.01.099, Yeh et al. (2019[99]),, *Diagnosed mental health conditions and risk of suicide mortality*, http://dx.doi.org/10.1176/appi.ps.201800346; Bilsen (2018[100]), "Suicide and Youth: Risk Factors", http://dx.doi.org/10.3389/fpsyt.2018.00540; [6]Zalsman et al. (2016[90]), "Suicide prevention strategies revisited: 10-year systematic review", http://dx.doi.org/10.1016/S2215-0366(16)30030-X, MH Innovation (2015[101]), *How to build a comprehensive Suicide Prevention Strategy: Dr. Alexandra Fleischmann | Mental Health Innovation Network*, https://www.mhinnovation.net/how-build-comprehensive-suicide-prevention-strategy-dr-alexandra-fleischmann (accessed on 8 March 2021), Bilsen (2018[100]), "Suicide and Youth: Risk Factors", http://dx.doi.org/10.3389/fpsyt.2018.00540; Bachmann (2018[102]), "Epidemiology of Suicide and the Psychiatric Perspective", http://dx.doi.org/10.3390/ijerph15071425; [7]du Roscoät and Beck (2013[94]), *Efficient interventions on suicide prevention: A literature review*, http://dx.doi.org/10.1016/j.respe.2013.01.099, Brådvik (2018[103]), *Suicide risk and mental disorders*, http://dx.doi.org/10.3390/ijerph15092028, Heinz et al. (2020[104]), "Suicide prevention: Using the number of health complaints as an indirect alternative for screening suicidal adolescents", http://dx.doi.org/10.1016/j.jad.2019.08.025, Ghanbari et al. (2015[105]), *Suicide Prevention and Follow-Up Services: A Narrative Review*, http://dx.doi.org/10.5539/gjhs.v8n5p145, Inagaki et al. (2019[106]), "Active contact and follow-up interventions to prevent repeat suicide attempts during high-risk periods among patients admitted to emergency departments for suicidal behavior: A systematic review and meta-analysis", http://dx.doi.org/10.1186/s12888-019-2017-7, National Action Alliance for Suicide Prevention (2019[107]), *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient care to outpatient care*.

Many OECD countries have either suicide prevention plans, or a suicide-prevention focus in their strategic mental health plans. These plans can also be a way to focus on the particular risks of suicide, and policy needs, of key vulnerable groups, as has been the case in Finland and New Zealand (Box 5.1).

Box 5.1. Taking account of key populations' suicide risks in suicide prevention strategies – Finland and New Zealand

Finland

In Finland, the rate of suicide has fallen by over 50% over the past 30 years, in particular amongst young men aged 20-29. Suicide prevention campaigns in Finland began in the 1980s, and led to a series of national suicide prevention programmes that ran during the 1990s. Finland's strategy identified depression, access to mental health care, substance and alcohol abuse, and access to lethal means as central features. Recognition that suicide was particularly high amongst young men led to the development of the "Time Out! Back on the track" (Aikalisä! Elämä raitelleen) initiative in 2004, which promoted social inclusion amongst vulnerable men. Two-thirds of participants reported that the participation in the programme was worthwhile, while about 60% considered it had improved their life situation.

In more recent years, Finland has moved towards integrating suicide prevention as part of its broader mental health policy planning, rather than having a stand-alone strategy. At the end of 2017, the Finnish Parliament allocated EUR 300 000 in 2018 to develop a new national strategy to prevent suicide, which will be included in Finland's National Mental Health Strategy. This work will establish a network for co-ordinating suicide prevention, and improve the planning, implementation, monitoring and evaluation of suicide prevention measures.

New Zealand

In New Zealand, the 'Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019-2029', and the 'Suicide Prevention Action Plan 2019-24 for Aotearoa New Zealand' was published in 2019, which give a framework and targets for suicide prevention over the following ten years. The framework consists of:

- a vision, setting the long-term aspiration for the strategy and suicide prevention in Aotearoa New Zealand
- outcomes sought through the strategy to support the vision
- focus areas, which describe actions needed to support the vision
- collective ownership and shared ways of working that must underpin delivery of the vision.

A national Suicide Prevention Office was also established in New Zealand from November 2019. The Suicide Prevention Office is part of wider work to improve all aspects of mental health and well-being for people in New Zealand, in line with the direction set out in He Tapu te Oranga. To support He Tapu te Oranga and efforts to prevent suicide in New Zealand, the government allocated NZD 40 million over four years to a package of suicide prevention initiatives through Budget 2019.

In New Zealand, ensuring that Māori populations benefit fully from mental health policies and practices is a priority, and the same is true when it comes to suicide prevention. Lived experience and Māori advisory functions have also been established to support the work of the Suicide Prevention Office. The funding package for suicide prevention includes a NZD 12 million Māori and Pacific suicide prevention community fund, which will be used to support Māori and Pacific providers to design and deliver culturally responsive suicide prevention initiatives.

Source: OECD (2020[41]), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires*, OECD/European Union (2020[1]), *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, https://doi.org/10.1787/health_glance_eur-2018-en.

Building good mental health for children and young people represents good value-for-money

Many of the protective factors for good mental health go beyond the scope of mental health systems or programmes designed specifically to strengthen or protect mental health. Social, economic and cultural factors, such as employment status, income, physical health, experiences during childhood and adolescence, all have a significant impact upon mental health across the life course (Patel et al., 2018[108]). Interventions to improve socio-economic status, security, and reduce inequality, especially in childhood, can well be seen through a lens of building positive mental health.

At the same time, programmes or interventions designed to promote mental well-being and prevent mental ill-health have also been shown to make a meaningful impact and represent good value-for-money (McDaid, Hewlett and Park, 2017[4]). Interventions to promote good mental-health and prevent mental ill-health are most effective in infancy, childhood, and adolescence (McDaid, Hewlett and Park, 2017[4]; Patel et al., 2018[108]; Knapp, McDaid and Parsonage, 2011[109]). Interventions targeting children and young people, including universal programmes for example in schools, have also been found to demonstrate good return-on-investment in cost-effectiveness evaluations

Online programmes such as MoodGYM in Australia and Norway, the Netherland's Master Your Mood Online, online stress prevention and coping skills training in Germany and In One Voice in Canada have been various associated with improvements in symptoms of depression and anxiety, improved mental health literacy and knowledge about stress and coping (Clarke, Kuosmanen and Barry, 2014[110]). France, meanwhile, has included the development of mindfulness in schools as part of its National Strategy for mental health and psychiatry. A number of programmes have shown transferability across multiple countries, and/or have had a longstanding positive impact in school settings (Box 5.2).

Box 5.2. Evidence-based mental health promotion and prevention programmes in schools

Zippy's Friends

Zippy's Friends is a social and emotional learning programme for children around age 5-12 which is in place in around 30 countries, including Chile, the Czech Republic, Denmark, Ireland, Lithuania, the Netherlands, Norway, Poland, the Slovak Republic and the United Kingdom. Zippy's Friends is a universal school-based programme, aiming to teach coping and emotional skills to children of all ages. The programme consists of a series of stories across 24 sessions, with modules covering feelings, communication, friendship, conflict, change and loss, and moving forwards. The programme helps children develop positive strategies to deal with problems, using learning approaches such as story telling, discussion, games, role-play and drawing (Partnership for Children, 2021[111]; European Commission - Employment, 2019[112]).

Multiple evaluations have found that Zippy's Friends has a positive impact on children's mental well-being. An evaluation in Norway found that the programme helped to improve the classroom atmosphere, reduce bullying, and improve academic scores (Holen et al., 2013[113]). An evaluation in Ireland also found that the programme had a positive impact on children's coping skills, and that teachers reported that the programme had a positive effect in terms of raising their awareness about children's emotional well-being (Clarke, Bunting and Barry, 2014[114]; Clarke and Barry, 2010[115])

KiVa anti-bullying programme

The KiVa anti-bullying programme began in Finland and uses online and in-person lessons for all students mainly focusing on bullying, as well as targetted actions for children and adolescents who have been involved in bullying as either perpetrators or victims. KiVa is a whole-school programme, with

actions accessible for children age 7 to 15 years. KiVa has also been piloted in other OECD countries, including a pilot study in 3 schools in England and 14 schools in Wales, and pilots in Estonia and Italy, that have demonstrated the feasibility of implementation across countries (McDaid, Hewlett and Park, 2017[4]). In Finland, evaluations of both a randomised control trial (2007-09) and nationwide rollout (since 2009) have found positive impacts on children, including reduced bullying, increased empathy and self-efficacy to support victimised peers, and more positive feelings towards school (Salmivalli and Poskiparta, 2013[116]). The rollout in Finland has been across all schools – as of 2013 90% of Finnish comprehensive schools were using the programme – but the biggest impacts have been found for primary school age children (ibid). A range of evaluations, including in Finland and the United States, have also suggested positive changes in levels of anxiety and depression following the introduction of the programme (Williford et al., 2012[117])

KiVa was also recently introduced in 7 schools in New Zealand, and a year after implementation significant positive impacts across the 1 175 students surveyed were reported; positive impacts included reductions in self-reported rates of bulling and victimisation, and an increase in the number of children feeling safer at school (Green et al., 2020[118]).

Mental health policies should focus on promoting positive mental health

Some countries are also focusing on positive mental health, and building well-being, across the life course. In Canada, there are two frameworks for *positive* mental health – for adults and for adolescents – developed by the Public Health Agency of Canada (PHAC). The 'Positive Mental Health Surveillance Indicator Framework' framework addresses mental health from a strengths-based perspective, covering positive mental health outcomes, risks, and protective factors, furnished by data from ongoing Canadian surveys. For example, the framework uses indicators such as population rating of their own mental health and life satisfaction to measure positive mental health outcomes, as well as items on discrimination and stigma, on political participation, on school and neighbourhood environment, health status and physical activity (Government of Canada, 2020[119]; Orpana et al., 2016[120]; Public Health Agency of Canada, 2017[121]). Canada also has further mental health indicators that are collected nationally and/or at state level, tracking indicators including service use, quality and safety, emergency room visits, wait times and referrals (CIHI, 2019[122]).

In 2019 New Zealand announced the world's first 'well-being budget', which focused on 'taking mental health seriously', improving child well-being, supporting Māori and Pacific populations, and building a productive nation. This ambition is backed with NZD 445 million for mental health services, NZD 40 million for suicide prevention, and commitments to put more nurses in secondary schools, tackle homelessness, and spend NZD 320 million addressing family and sexual violence.

Steps to promote mental resilience in the face of the COVID-19 pandemic should be maintained

Across the course of 2020, it became increasingly clear that the COVID-19 crisis was having a significant impact on population mental well-being. The rapidity and scope of the response by OECD countries, and the steps taken to protect mental well-being, were striking. There is every reason to support the maintenance of some if not most of these new mental health resources well beyond the end of 2020 and the COVID-19 pandemic. OECD countries took rapid, concrete steps to make mental health support more available in 2020, especially through low-threshold resources such as internet and phone-based information and support (see also Chapter 3, Chapter 7).

Phone and online mental support service are available for the general population in at least 20 OECD countries, including Australia, Austria, Canada, Chile, Costa Rica, the Czech Republic, France, Greece, Japan, Luxembourg, New Zealand, Portugal, Slovenia, the United States and the United Kingdom

which have issued specific mental health guidance, set up support phone lines, or online platforms (OECD, 2020[123]). In Australia, the government has announced more than AUD 500 million in funding direct supports to respond to the mental health impacts of the COVID-19 pandemic.

In France, a phone hotline where people can get psychological support is widely promoted, including in each COVID-19 press briefing held by the government. France has also strengthened its National Strategy for Mental Health and Psychiatry with a number of key structural changes, including reimbursement of psychological therapies for children, students and adults, strengthening of emergency psychological support systems and offering treatment for psycho-trauma, the creation of a a national suicide prevention number and a range of targeted support for key vulnerable populations. In New Zealand, three online mental health tools including a health journal app and an e-therapy programme are available for free, while the government launched two additional mental health support programmes – Getting Through Together and Sparklers at Home – and a set of well-being activities and resources for parents to use with children at home (Government of New Zealand, 2020[124]).

From the first weeks of the pandemic, Canada has prioritised mental health support, launching the online portal 'Wellness Together Canada' on 15 April 2020 to connect Canadians to peer support workers, social workers, and psychologists for confidential online or phone chats. Canada also allocated surge funding to the Canada Suicide Prevention Service and the Kids Help Phone distress lines, as well as including self-care advice in the Canada COVID-19 app used to record potential COVID-19 symptoms. As of 12 April 2021, over 1.1 million individuals across all Canadian provinces and territories had accessed the Wellness Together Canada (WTC) portal with 45% of registered users are under age 30. To date, the Government of Canada has invested USD 68 million in the WTC portal. Overall, through the 2021 Budget, the Government of Canada allocated an additional CAN 62 million for the portal so it can continue to support Canadians through 2021-22.

In April 2020, the Canadian Institutes of Health Research (CIHR) also launched the COVID-19 and Mental Health Initiative, in close collaboration with Health Canada, the Public Health Agency of Canada and others, to provide evidence to decision makers and practitioners on mental health and substance use responses in the context of COVID-19. To date, CIHR has launched three funding opportunities under this initiative, supporting a total of 101 projects for a total investment of CAN 13.5M from CIHR and partners.

Promoting strategies for mental health self-care – exercise, mindfulness, social connection

Not all mental health promotion, or illness prevention, has to be delivered by governments or specialist service providers. There are many steps that individuals can take to maintain or improve their own mental health, and OECD countries can take steps to point people towards effective self-care strategies for mental health. Indeed, not all mental distress requires specialist intervention, and some mental distress or mild mental health conditions can be managed by people on their own – often with support from their families or peers – if they have some key knowledge and tools. During the COVID-19 crisis, when mental distress increased across the population, individuals may not all need formal mental health support, but can still benefit from conscious steps to stay in good mental health.

There are some evidence-based ways to strengthen mental well-being which are highly accessible. Chief amongst them are exercise, and mindfulness, and social connection (Box 5.3). Guided self-help can also be a way for individuals to manage their own mental health, including both self-help books, as well as – increasingly – self-help apps. Apps, websites and books can include both tips and tools for managing moments of mental distress, symptoms of mental health conditions, or behaviours that might support mental well-being such as good sleep habits or eating habits (for more on mental health apps, see Chapter 7). For example, the Czech Republic has developed and launched a website (in Czech, English and Russian) through which people can: screen themselves for mental health problems; find evidence-based information on how to obtain and maintain a good mental health; and seek help if they need it (samopomo.ch, 2021[125]; Duševní zdraví, 2021[126]; My Mental Health Guide, 2021[127]).

Box 5.3. Social connection, exercise, and mindfulness – strategies for staying mentally healthy

Social connection

Strong social relationships, and social connectedness, have a positive impact on mental health; inversely, social disconnectedness and loneliness have a negative impact on mental health, and can increase the risk and/or severity of mental health conditions such as depression and anxiety (Newman and Zainal, 2020[128]; Saeri et al., 2018[129]). A longitudinal study using the New Zealand Attitudes and Values Survey looking at the bidirectional relationship between social connectedness and mental health concluded that "psychological resources conferred by social connectedness can act as a 'social cure' for psychological ill-health" (Saeri et al., 2018[129]). During the COVID-19 crisis, social distancing requirements made social connection more difficult across OECD populations; during this period, governments, international agencies such as the WHO, and non-government mental health agencies across OECD countries provided tips for staying mentally healthy and consistently included 'connection with others' as one key tip. People were encouraged to find ways of connecting, for example talking on the phone, connecting online, or spending time together outside, in a way that was safe and consistent with local COVID-19 guidelines (OECD Brief on Mental Health and COVID-19, forthcoming).

Exercise

Exercise has been established to have a significant positive effect on mental health, both boosting positive mental health and helping improve the symptoms of mental health conditions such as depression. Exercise can contribute to improved mood, improved self-esteem, lower stress levels, and lower levels of anxiety (Mikkelsen et al., 2017[130]; NHS, 2018[131]). In the United Kingdom, the NICE clinical guideline on mild-to-moderate depression includes a physical activity programme as one of three initial treatments (along with a self-help programme, and computerised cognitive behavioural therapy) based on best available evidence of effective interventions (NICE, 2009[132])

Mindfulness and mindfulness meditation

Mindfulness, or mindfulness meditation, is a type of meditation which tends to encourage focus on the present moment, and practicing being aware of thoughts, feelings and sensations without judgement. Mindfulness can be practiced in different ways, but might include focus on the breath, step-by-step awareness of the physical body, or a walking mediation paying particular attention to physical sensations and surroundings. Mindfulness exercises can be self-led, or followed guided tools such as audio supports. Other practices, such as yoga, tai chi, and qigong, can also bring some of the benefits of mindful meditation. Practicing mindfulness has been found to have benefits including reduced stress, less ruminative thoughts, improved focus, less emotional reactivity; mindfulness has been found in some studies to have benefits for persons living with mental health conditions including anxiety and depression (American Psychological Association, 2012[133]; Gu et al., 2015[134]; Goldberg et al., 2018[135]; Hofmann and Gómez, 2017[136]). App-based mindfulness support has been growing in population, and a number of studies suggest that for healthy adults regular app-based mindful meditation can improve psychosocial well-being (Bostock et al., 2019[137]; Economides et al., 2018[138]; Champion, Economides and Chandler, 2018[139]; Headspace, 2021[140]). Mindfulness can also be practiced in school or work settings; for example, in Estonia mindfulness-based programme 'Minutes of Silence' has been introduced in 100 schools as basic training, individual teachers have knowledge and skills of the technique in a further 300 schools (OECD, 2020[41]).

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6 Strong leadership and good governance

Strong leadership and good governance can make mental health a priority, set an ambitious direction of travel for the overall mental health system, and marshal often-scarce resources. This chapter looks at the steps OECD countries are taking to make mental health a high level policy priority, invest in delivering a high-performing mental health system, and effectively distributing resources for mental health.

Introduction

Strong leadership and good governance can make mental health a priority, set an ambitious direction of travel for the overall mental health system, and marshal often-scarce resources. Following the OECD Mental Health Performance Framework, strong leadership and good governance are a key part of a high performing mental health system, underpinned by making mental health a high-level national priority. Investing in delivering a high-performing mental health system, and prioritising efficient and effective distribution of resources, are also priorities. Finally, taking steps at the national level to promote equity geographically, between population groups, and between mental disorders is a primary function of good mental health governance.

Across OECD countries, governments and leaders have been paying more attention to the importance of mental health, in line with many of the principles of the OECD Framework. Such prioritisation, and public leadership by high-profile national figures, can make a big difference to awareness and stigma around mental health, especially when accompanied by targeted messaging. Most OECD countries also have anti-stigma campaigns in place, which though difficult to measure, have in some instances reduced negative attitudes around mental illness, and increased mental health literacy. High-level strategies to transform the mental health landscape, in some cases backed by new funding commitments, have been made in a handful of countries. Nonetheless, on average increasing attention does not appear to have been matched with increasing overall resources for mental health; mental health spending has risen over time, but no faster than overall health spending. At the same time, the mental health sector has been slow to adopt efficiency measures and payment innovation that have become relatively commonplace elsewhere in health systems, and understanding and assessing effective distribution of mental health resources is extremely challenging. While improving the efficiency of resource use can be challenging, many countries are taking steps to try and improve the equity of available resources, especially between key population groups.

Why are good governance and strong leadership important for mental health system performance?

“Strong leadership and good governance” is one of the six principles of a high-performing mental health system established by the OECD Mental Health Performance Framework (OECD, 2019[1]). Strong leadership and good governance involve clearly prioritising mental health, setting an ambitious direction of travel for mental health, and marshalling available resources to best deliver a high performing mental health system. Specifically, “strong leadership and good governance” includes five sub-principles:

- Make mental health a high-level national priority;
- Reduce stigma around mental illness;
- Invest in delivering a high-performing mental health system;
- Prioritise effective distribution of resources;
- Promote equity geographically between population groups and between mental disorders.

Making mental health a high-level priority is critical to changing attitudes and awareness

Good governance and leadership in OECD countries is crucial to drive changes in structures and planning for mental health, to prioritise mental health in national policy agendas, and to commit to funding to drive mental health improvements. Strong leadership when it comes to mental health is crucial, too, as part of increasing awareness of the importance of mental health and reducing stigma around mental ill-health.

Attention to mental health from governments, society, news and media, has clearly increased over the past decade. Momentum has been building across OECD countries, and indeed globally, when it comes to mental health:

- In 2013, mental health was included in Goal 3 of the Sustainable Development Goals (SDGs), a recognition that the promotion of mental health and well-being are priorities within the global development agenda (United Nations, 2015[2]);
- In 2015, OECD countries all signed up to the *Recommendation of the OECD Council on Integrated Mental Health, Skills and Work Policy*;
- In September 2018, at the Third UN High-level Meeting on Non-communicable Diseases, mental disorders were recognised by the WHO as one of the major drivers of death and disability (WHO, 2018[3])
- In October 2018, at the first Global Ministerial Mental Health Summit on 10 October 2018, the Declaration on Achieving Equality for Mental Health in the 21st Century concluded that Ministers: "*welcome the vision and leadership already shown by some countries in building political sponsorship and momentum at the highest levels of government to address mental health challenges at the global and local level. We commit to harnessing this momentum to further the improvement of mental health promotion, prevention and service provision around the world*." (The Global Ministerial Mental Health Summit, 2018[4]).

This high-level, public-facing prioritisation can make a big difference when it comes to mental health. Mental health has been historically under-prioritised in OECD countries – for example as measured by percentage of health spend relative to burden of disease – and has been, and continues to be, surrounded by significant degrees of stigma (Hewlett and Morgan, 2014[5]; WHO, 2013[6]; WHO Europe, 2015[7]). Changing the place given to mental health in government and international strategies, and in public discourse, are leadership functions that can make a big difference symbolically, and – when backed with appropriate policies and resources – contribute to improving mental health performance.

How effective are OECD countries at delivering strong leadership and good governance for mental health?

Are OECD countries making mental health a high-level national priority?

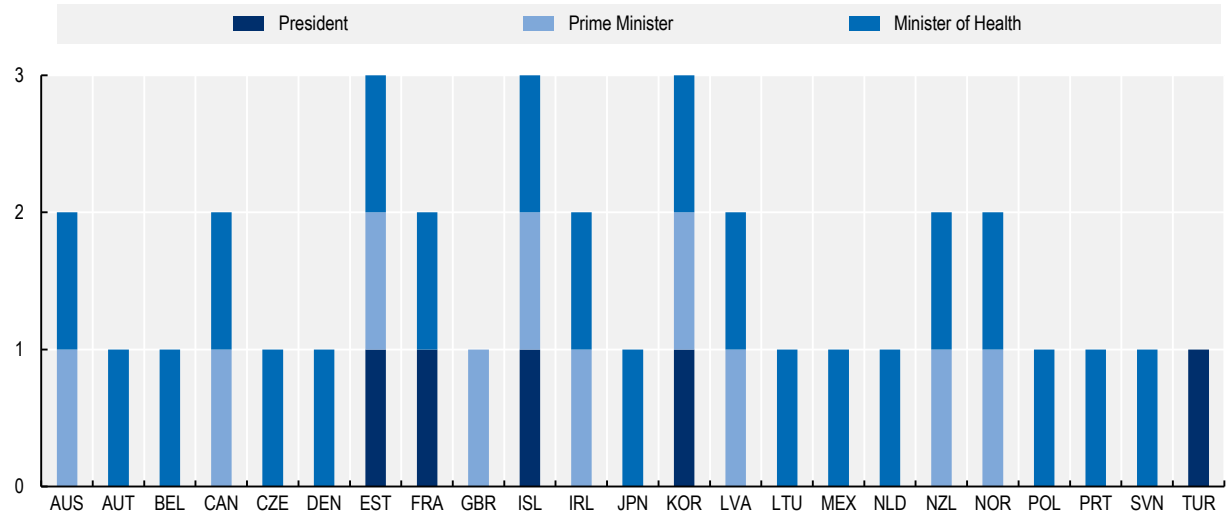
OECD governments have been leading the discourse on improving mental health

Across the world, public figures and celebrities have increasingly been speaking out about their experiences of mental ill-health. The former Prime Minister of Norway Kjell Magne Bondevik became the highest ranking political leader to speak publicly about his own mental illness while in office; Lady Gaga's 'Born This Way Foundation' is committed to supporting the well-being of young people; while the Dukes and Duchesses of Cambridge and of Sussex lead the 'Heads Together' campaign to change views on mental health in the United Kingdom and beyond.

At the national level, some OECD Governments have been putting mental health at the centre of not just their health portfolio, but their government and leaders' portfolios. Speeches focused on mental health from government leadership are one way of signalling importance, and have particular weight given the longstanding stigma associated with mental health (Figure 6.1). Some government administrations have made a focus on mental health a central priority for their mandate. In 23 countries out of 29 OECD countries who responded to the OECD Mental Health Policy Questionnaire, the Prime Minister, President or Minister of Health made a major speech on mental health in the previous year, and in a

number of countries the President or Prime Minister had made a major speech on mental health (OECD, 2020[8]).

Figure 6.1. President, Prime Minister, or Minister of Health given at least one speech specifically on mental health in the last year, 2020



Note: Based on responses from 29 countries.
Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

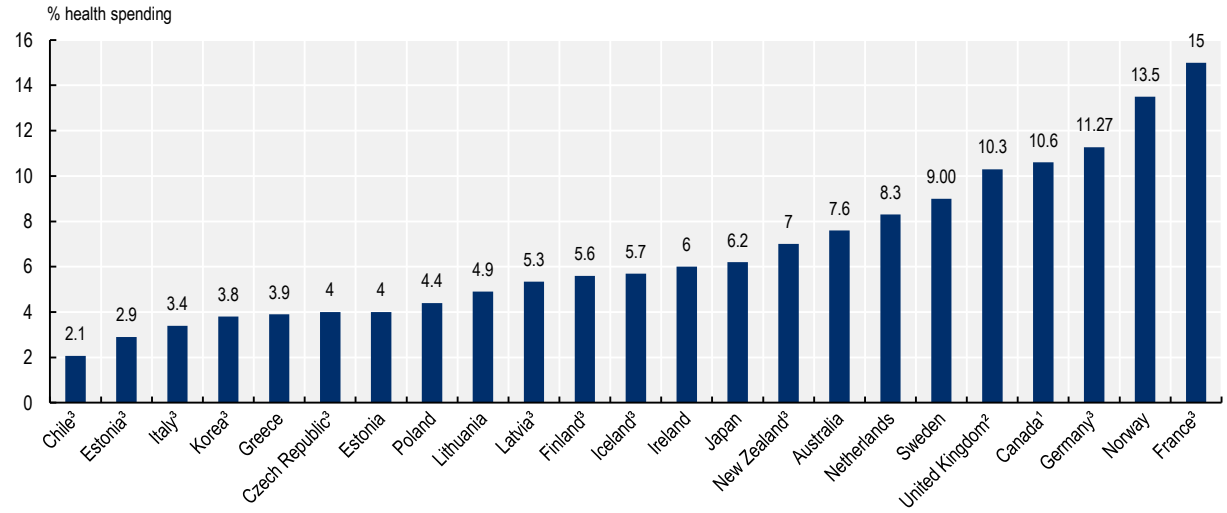
For example, in 2019, the Prime Ministers of Australia and Canada gave major speeches on mental health announcing new policies and stressing the importance of talking about mental health issues. In Australia, in 2019 Prime Minister Scott Morrison gave a significant speech focusing on student mental health. The speech pointed out that although more than 20% of student have mental health issues, only few would seek help, and more than 50% of students felt embarrassed to talk about mental health issues. The Prime Minister's speech focused on highlight the mental health support structures that are available to students, and how important it was for students to ask for help if they need it (SBS NEWS, 2019[9]). In Canada, for mental health week in May 2019, the Prime Minister encouraged people to talk more about mental health, stressed that mental health problems can happen to anyone, and that talking about mental health problems more is a critical part of reducing stigma (Prime Minister of Canada, 2019[10]). Canada's Minister of Health also co-launched the Alliance of Champions for Mental Health and Well-being (the Alliance) with Ministers of Health from Australia and the United Kingdom in May 2018. The Alliance is a coalition of Ministers who collectively amplify the importance of mental health globally and commit to advancing the global mental health agenda through both domestic and international actions. In France, a national roadmap has been started to develop a global strategy for mental health, the French President Emmanuel Macron announced that the 'Assises de la santé mentale et de la psychiatrie', a broad national consultation about the future of mental health, mental health care and psychiatry in France, would be held in the summer of 2021.

On average, the share of mental health spending remains low

There remain significant methodological challenges in collecting and comparing mental health spending, in particular scope of what services are included, whether all age groups are included, whether dementia is included, and whether government expenditure or all expenditure is included. Despite these methodological challenges the range in levels of mental health spending is clear; in 2018, mental health spending ranged from around 4% of total health spending (in Estonia, Greece and Poland) to 13.5% in Norway and 15% in France (Figure 6.2). Governments also spend only a small percentage of their health

budget on mental health in many countries; in 10 countries less than 5% of spending on health went towards mental health spending. Only five countries (United Kingdom, Canada, Germany, Norway, France) reported spending more than 10% of health spending on mental health.

Figure 6.2. Estimated mental health spending as percentage of total government health spending, 2018 or latest year



Note: Reporting methods differ by country, including the range of services covered and whether spending can be disaggregated by age. Therefore, caution should be taken in comparing spending across countries.
1. Includes dementia; 2. Data for England; 3. WHO Atlas 2017 – Percentage of total government health expenditure.
Source: OECD (2020[8]), "Total expenditure on mental health care as a percentage of total health spending ", OECD Mental Health Performance Benchmarking Questionnaires; WHO (2018[11]), "Government's total expenditure on mental health as percentage of total government health expenditure", WHO Mental Health Atlas 2017.

Are countries ensuring mental health literacy, and reducing stigma around mental illness?

Stigma is a major barrier to help-seeking, and an additional burden for persons living with a mental health condition

Stigma – labelling, stereotyping thoughts, prejudice, and discrimination (Link and Phelan, 2001[12]) – includes stigmatising attitudes or behaviours in society towards those with mental health issues, as 'self-stigmatisation' or 'internalised stigma' whereby people may have a negative view of mental health conditions that reduces help-seeking and leads people to 'hide' their mental health condition. Indeed, stigma attached to mental health issues is one of the most significant barriers to help-seeking (Clement et al., 2015[13]; Thornicroft, 2008[14]).

High levels of internalised stigma have also been found to reduce adherence to treatment and reduce openness to therapeutic interventions, and even reduce the efficacy of some treatments (Shrivastava, Johnston and Bureau, 2012[15]; Kamaradova et al., 2016[16]; Ansari et al., 2020[17]; Rüsch et al., 2009[18]). In Slovenia, for example, it is reported that only 41.5% of those with psychological problems had sought professional help, a treatment gap that may well be exacerbated by stigma around to mental health issues (Roskar et al., 2017[19]). Common stigma measures include the Social Distance scale (SD), Opinions about Mental Health Illness (OMI), Community Attitudes towards Mental Illness (CAMI, a modified version of OMI), Devaluation-Discrimination (DD), and Depression Stigma scale (DSS, also called Personal and Perceived Stigma of Mental Illness) amongst others (Wei et al., 2015[20]).

Stigma around mental ill-health also contributes to discriminatory attitudes in society, in workplaces, and even in the health system (Thornicroft, 2008[14]; OECD, 2015[21]; OECD, 2015[22]). Lack of understanding around mental health condition can lead to negative stereotypes of mental illness in the media, to reluctance by employers to talk about mental health in the workplace or hire someone with a mental health condition, or even to rejection of someone living with mental illness by their family or friends. Stigma around mental illness can contribute to resistance from communities to having mental health services in their local area. Stigma towards mental ill-health by health care providers also contributes to lower quality of care worse physical health outcomes for people living with a mental health condition (Knaak, Mantler and Szeto, 2017[23]; Henderson et al., 2014[24]).

Stigma, and efforts to reduce stigma, are also closely linked to mental health literacy, which is discussed in Chapter 5 of this report.

Reducing mental health stigma is a priority in OECD countries

Many OECD countries have introduced anti-stigma campaigns around mental health, either at a national or regional level (Table 6.1).

Table 6.1. Countries with at least one national programme that focuses on reducing stigma around mental health and mental ill-health

National anti-stigma campaign	Australia, Canada, Czech Republic, Denmark, England, Estonia, Italy, the Netherlands, New Zealand, Korea, Latvia, Switzerland, Turkey
Regional or local anti-stigma campaign	Austria, Korea, Norway, Portugal, Slovenia, Switzerland

Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

In Australia, to improve the knowledge and attitude on depression, the public awareness activities were organised by the National Depression Initiative, Beyond Blue. This included distributed posters and pamphlet, and a website with information, and TV advertisement.

In Canada, the Mental Health Commission of Canada has a number of programs related to reducing stigma and increasing mental health literacy, including 'Opening Minds' and 'Mental Health Champions', as well as 'Mental Health First Aid' which is a mental health awareness and response training programme. In addition, Bell Let's Talk is a national level private sector programme aimed at reducing stigma and increasing awareness of mental health issues.

Several countries have anti-stigma campaigns which are implemented locally by municipal or local governments, for example Denmark with the 'En af Os' (One of Us) campaign that has been running since 2010. This campaign is organised nationally and regional Psychiatric Information Centres (PsykInfos) works closely with the One of Us staff. The One of Us project focuses on several populations including young people, working-aged people, health care workers, and media. They have provided learning opportunities and materials to educational institutions, workplaces, and journalists to raise awareness of mental health issue because lack of knowledge is one of the important causes of stigmatisation. For example, mass media has a huge impact on stereotypes by providing negative images on those with mental health problems. To improve mental health literacy among journalists, One of Us provides educational materials and information to them. Media in Denmark are also monitored, following the 'StigmaWatch' guidelines, following which anyone can report a media item which is considered inappropriate or stigmatising towards mental health conditions.

Lithuania has strengthened the role of public health bureaus in improving mental health knowledge, allocating EUR 2.5 million to municipalities in 2019 (WHO Europe, 2020[25]). The Ministry of Health established a law in 2019 by which public health bureaus should organise training courses for workers on

mental health issues. This course aims at improving the employees' competencies by acquiring skills and knowledge to cope with mental health risks and related problems as an educational intervention. Through this legislation, companies should provide the training course that runs to 40 hours in total. Detailed contents of the course are provided by the Ministry of Health.

As with efforts to improve mental health literacy (see Chapter 5), many efforts to reduce mental health stigma focus on World Mental Health Day on 10 October, where high-profile campaigns are held in multiple countries, and internationally. In Ireland, the Green Ribbon Campaign which is inspired by the green ribbon that is the international symbol for mental health, is a month long roll-out focusing on distributing green ribbons across the population to inspire people to improve their mental health awareness. The campaign has been running for 7 years, and over this period the number of people aware of the campaign increased quite steadily; between 2018 and 2019, the number of people strongly agreeing that it was important to have open conversations about mental health with friends/family/colleagues increased from 20% to 54% (See Change, 2019[26]).

The impact of anti-stigma campaigns is inconsistently, but where stigma has been measured over time attitudes towards mental health have improved

While many countries have been running anti-stigma campaigns around mental health for years or even decades, it is often difficult to establish whether attitudes and stigma around mental health has been changing over time. To track levels of stigma over time, some OECD countries have used national attitude surveys. A wide range of different stigma measurement tools have been developed across the world, of which the most widely used measurement is the Internalised Stigma of Mental Illness Inventory (ISMI) scale, which measures stereotypes about mental health issues in a society (Fox et al., 2018[27]). Other tools include Depression Stigma Scale (DSS), and the Community Attitudes Toward the Mentally Ill Scale (CAMI). Another type of stigma hold among general people is measured by people's attitude towards those with psychiatric issues and recognition on mental health diseases. At least 11 OECD countries have a national survey to measure attitudes or level of stigma around mental health issues (Table 6.2). However, as the table shows, each country has measured national stigmatising attitudes with different indicators, making comparison of levels of stigmatising attitudes across countries very challenging.

Table 6.2. Surveys used to measure stigma and attitudes towards mental health problems

Country (Year)	Measurement	Instrument
Australia (1995, 2003/4, 2011)	1. Mental health literacy 2. Stigmatising attitudes	1. Kessler 6-item (K6) psychological distress questionnaire (to see anything wrong with a person) 3. 5-item scale developed by Link et al. (to see desire for social distance) 4. Computer-assisted telephone interviews (CATI)
Austria (1998-2018)	Stigmatising attitudes towards people with mental health condition	"Mopustia" Monitoring Public Stigma in Austria 1998-2018
Canada (2012, 2013)	Healthcare providers' 1. Attitudes towards people with a mental illness 2. Attitudes towards people with mental illness 3. Preferred social distance and includes the following statements Canadian Community Health Survey – Mental Health 2012: percentage of population with a mental health problem who report having been affected by negative opinions or unfair treatment, due to their mental health problem	20-item Opening Minds Scale for Health Care Providers (OMS-HC) questions
Czech Republic (2015)	Level of willingness to accept a person with mental health problems	8-item Reported and Intended Behaviour Scale (RIBS) Questionnaire: Community Attitudes towards the Mentally Ill (CAMI)

Country (Year)	Measurement	Instrument
Denmark (2010)	1. Experiences of stigma 2. Population attitudes towards mental illness 3. Knowledge of people with mental illness and willingness to deal with them 4. Knowledge about people with mental illness	1. Questionnaire: Community Attitudes towards the Mentally Ill (CAMI) 2. Reported and Intended Behaviour Scale (RIBS) 3. Mental Health Knowledge Schedule (MASKS)
England (2008-17, 2019)	Change in 1. Mental health-related knowledge, 2. Attitudes to mental illness 3. Desire for social distance from people with mental illness among the general public	1. Interview: Computer Assisted Personal Interviewing (CAPI) 2. Questionnaire: 2 items based on the 40-item Community Attitudes toward the Mentally Ill (CAMI) scale 3. Stigma-related knowledge was measured by the Mental Health Knowledge Schedule (MAKS),
Ireland (2019)	Stigma and attitudes	Green Ribbon Impact Report 2019 which focuses on the impact Green Ribbon campaign had nationally on changing stigma and attitudes
Lithuania (2019)	Stigma and attitudes	The first national representative survey in Lithuania was conducted in September 2019 on attitudes related to mental health and stigma. It includes a translated version of Attribution questionnaire AQ-9 and a compilation of other questions related to trends and priorities related to mental health stigma in Lithuania.
New Zealand (2015 -18)	Experiences of stigma and discrimination	The Health Promotion Agency's Health and Lifestyles Survey measures the experience of stigma related to mental health and illness
Poland (since 1990)	Public Attitudes	CBOS Public Attitudes Survey
Slovenia (2017)	1. Public attitudes towards help seeking behaviour (2. Sociodemographic data and participants' experience with mental distress)	24-item Inventory of Attitudes towards Seeking Mental Health Services (IASMHS)

Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Second, national surveys are not systematically repeated and this makes it difficult to evaluate national trends of literacy or attitudes to mental health issues in a country, nor are they always linked to the evaluation of an anti-stigma programme or campaign. A few countries, including Australia, England and Ireland, have either repeated national attitudes surveys in different years, or evaluated the impact of anti-stigma campaigns. For example, in England, the attitude survey has conducted every year since 2008, in the following year 'Time to Change' campaign aiming at reducing stigmatising attitude to mental health issues started. The survey has measured mental health related knowledge and it reported that there was improvement in knowledge, attitude, and desire for social distance (Henderson, Potts and Robinson, 2020[28]). From these surveys, literacy and attitude towards mental health issues, including a desire for social distance have generally improved, although these positive effects are being observed slowly. In addition, a survey in Australia found that stereotype concepts, such as 'psychiatric disease are dangerous", still remain (Reavley, Too and Zhao, 2015[29]) and long-term effect need to be improved.

On the other hand, the Czech Republic conducted a national survey on stigmatising attitude in 2015, using the 8-item Reported and Intended Behaviour Scale (RIBS) and compared the result with the attitudes in the population in England. This analysis found that in Czech Republic population readiness to accept a person with psychological issues is lower than that the population average in England (Winkler et al., 2015[30]). Negative attitudes were confirmed by a subsequent national survey using CAMI. This survey found high level of negative attitudes in both the general population and amongst medical doctors (Winkler et al., 2016[31]). However, recent research does show improvement of population attitudes which is being associated with both mental health care reform and a national anti-stigma programme (Winkler et al., Forthcoming 2021[32]). In Canada, change in stigmatising attitude before and after the intervention which shared mental health knowledge assessed by 20-item Opening Minds Scale for Health Care Providers (OMS-HC). This survey concluded that approximately 25% of participants have improved their attitude towards mental health issues and participants perceived that listening to lived experience was the most

effective intervention, compared to the other methods (Kopp, Knaak and Patten, 2013[33]). Also in Canada, the Canadian Community Health Survey (CCHS) – Mental Health 2012 included an item on 'percentage of population with a mental health problem who report having been affected by negative opinions or unfair treatment, due to their mental health problem', with a rate of 21% of adults reporting in the affirmative in 2012 (Health Canada, 2020[34]).

Australia has carried out an attitude survey three times since 1995 and observed the change of stigmatising attitude related to mental health issues in the country (Box 6.1).

Box 6.1. National surveys of mental health literacy, stigma and discrimination in Australia

Australia implemented the National Mental Strategy in 1992 to improve the mental health literacy, and since then Australia has conducted a national survey three times, in 1995, in 2003-04, and in 2011. The surveys focused on mental health literacy, stigma, and perceived discrimination, to assess whether there have been changes in recognition, treatment beliefs, stigmatising attitudes and other aspect of mental health literacy in the population. The survey results showed that over time mental health literacy improved, and there were some falls in stigmatising attitude over the years.

Mental health literacy

As a measure of mental health literacy, the rate of people who recognise depression correctly and who understand antidepressant was measured. In 2011, 75% of respondents recognised depression correctly and this rate had increased compared to the previous survey in 1995. Likewise, more respondents in 2011 understood that a GP can provide professional support for depression, and that antidepressants are effective, than in in 1995.

Stigmatising attitudes

2011 survey data showed stigmatising attitudes are found more frequently towards men with mental health illness rather than women with mental ill-health. Additionally, the data showed the desire for social distance people was most common when concerning colleagues and in-laws with a mental illness. Comparing data of 2003/4 and 2011, stigmatisation slightly decreased over time, with data showing some reduction in the desire for social distance from people with mental disorders, together with a decrease in negative beliefs about dangerousness and unpredictability of people with mental illness.

Perceived discrimination

In 2011, 34.7% of respondents reported being treated as less competent once others learned they had psychological illness, while more than 60% of respondents with mental health problems had experienced a negative or offensive attitude from others.

Source: Reavley, Too and Zhao (2015[29]) National Surveys of Mental Health Literacy and Stigma and National Survey of Discrimination and Positive Treatment, Mental Health Commission of New South Wales.

Are countries investing in delivering a high-performing mental health system?

Spending on mental health has increased, but the total share of health spending going towards mental health has stayed stable or even fallen

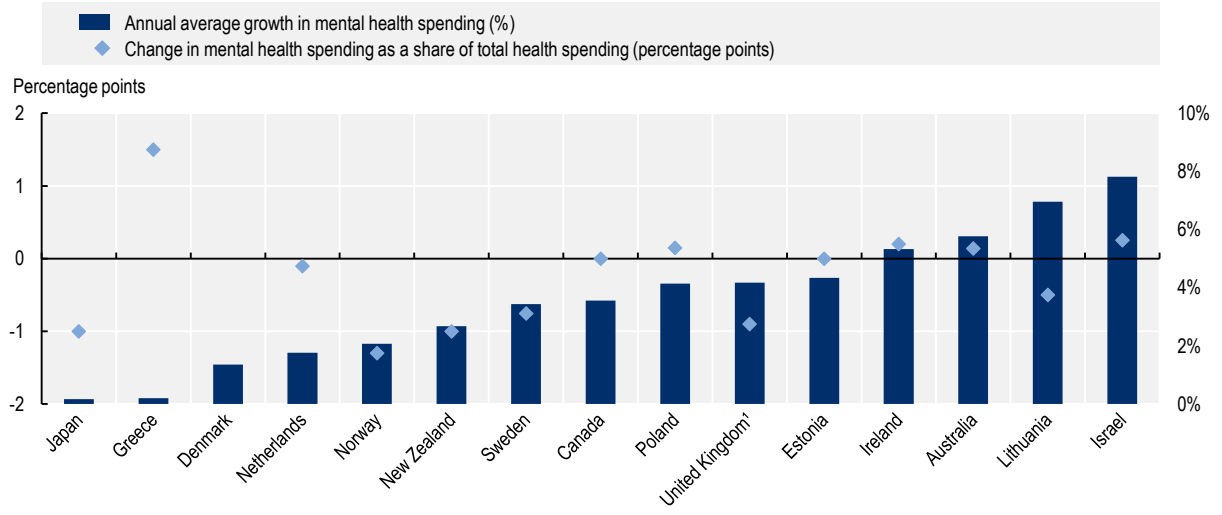
Mental health has been a long-neglected area, but this is beginning to change; significant attention from some governments and leaders – in Australia, in Canada, in New Zealand, in Norway, in the

United Kingdom – is testament to global momentum around mental health. In some cases this has been accompanied by new high-level strategies or funding, in all instances such signals can be an important way to raise awareness and reduce stigma.

National expenditure, reported in national currency, increased in all countries in the last decade, by with an average annual growth in mental health spending of more than 6% in Lithuania and Israel. However, overall government spending on health has also been increasing, and as a percentage of this total health spending the increases in resources for mental health have not been particularly significant. Generally spending on mental health as a percentage of total health spending has not increased significantly, and in some countries – Japan, Norway, New Zealand, the United Kingdom, Lithuania – has declined (Figure 6.3).

Figure 6.3. Total expenditure on mental health care, percentage change 2009-19 or nearest year

Change in mental health spending over time (%) and change in mental health spending as a share of total health spending (percentage points)



Note: Australia (2009-18), Canada (2011-19), Denmark (2011-18), Estonia (2015-17), Greece (2009-18), Ireland (2014-19), Israel (2009-17), Japan (2009-17), Lithuania (2016-19), Netherland (2015, 2017), New Zealand (2009-19), Norway (2013-17), Poland (2009-19), the United Kingdom (England) (2017-18).
Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

A number of countries, including New Zealand, England (increase of GBP 1.4 billion between 2015/16 and 2017/18) and Australia (AUD 1.6 billion between 2015-16 and 2018-19), have pointed towards significant increases in mental health funding in recent years (NHS England, 2017[35]; Australian Institute of Health and Welfare, 2021[36]).

However, some reviews of spending have also pointed to real-term falls in mental health spending even when governments are publicly committing to increasing investments. A 2018 review in England, where parity of esteem for mental health has been a guiding principle, funding gaps for NHS mental health providers and NHS acute providers appear to continue, and some mental health providers have seen funding fall (The King's Fund, 2018[37]).

Mental health has been prioritised in COVID-19 responses

During the COVID-19 crisis, OECD governments have prioritised mental health as part of their COVID-19 response plans, and taken steps to increase mental health support. In particular, countries have introduced new forms of mental health support including informational materials (mostly online), new mental health

support phone lines, shifting mental health services to telemedicine formats and in some cases increasing service capacity or entitlement, and in some countries increasing investment in mental health (OECD, 2021[38]). For instance, in April 2020, Health Canada launched the Wellness Together Canada (WTC) portal to provide short-term mental health and substance use supports and services to Canadians during COVID-19. Key objectives were to help address the anticipated increase in mental health and substance use service needs faced by Canadians, and to address disruptions to normal service delivery resulting from the pandemic.

In addition, a few countries have committed to new or increased funding for mental health care in light of the toll that the COVID-19 crisis is taking on mental health. In Australia, the government announced AUD 5.7 billion funding for mental health and aged care under the country's COVID-19 pandemic plan (Department of Health, 2020[39]). Funding was to be committed to the mental health programs and services under the COVID-19 Mental Health Support Package, to support increased demand for services, and additional funding was provided to the state of Victoria where COVID-19 restrictions were more significant than elsewhere in the country. In Canada, the government invested CAD 11.5 million in community-based programmes to promote the mental health of particularly vulnerable Canadians during the COVID-19 crisis (Government of Canada, 2020[40]).

In Ireland, too, additional funding was provided under the 2021 budget (EUR 38 million) for new mental health services in response to the crisis, along with an additional EUR 12 million for existing needs, a total of a EUR 50 million increase compared to the 2020 budget (Government of Ireland, 2020[41]). The Latvian Government has diverted an additional EUR 7.12 million to mental health services in 2021 in response to the COVID-19 crisis, including funding for mental health specialists, for family doctors providing mental health support, and for psycho-emotional support for medical staff (Baltic News Network, 2021[42]). In February 2021, Chile announced that the budget for mental health would increase by 310% compared to the previous budget (Ministerio de Salud, 2021[43]). This increased funding will be distributed across a range of mental health services, and comes in the context of both an increase in mental health consultations in Chile in recent months and the 'Programa Saludablemente' (Health Mind Programme) which was developed in the COVID-19 context to share mental health information and guidance and connect people with mental health services (Gobierno de Chile, 2020[44]).

Prioritising efficient and effective distribution of resources

All health care systems are seeking to deliver a maximum amount of effective care, with limited resources. In the mental health sector where resources are particularly tight, maximising the impact of scarce resources is even more critical. However, assessing how 'efficient' mental health care systems are has been a long-standing challenge, limited by loose conceptualisation of efficiency in mental health systems (Lagomasino, Zatzick and Chambers, 2010[45]), heterogeneity in service design even within countries (Gutiérrez-Colosía et al., 2019[46]; Monzani et al., 2008[47]), and above all by a lack of relevant data (Moran and Jacobs, 2013[48]; García-Alonso et al., 2019[49]). This topic is also discussed in Chapter 7, including looking at whether mental health care is delivered in line with best available evidence.

Despite the complexities, it is clear that OECD countries are taking steps to reflect on how limited resources can be used most effectively to deliver mental health care. As even the scope of the OECD Mental Health Performance Framework underscores, the range of policies and interventions that mental health systems include is very diverse – from prevention and promotion activities, to low-threshold services for mild-to-moderate disorders, to community-based care, and acute inpatient services – and setting the right balance is an ongoing challenge for countries. In most OECD countries, national or regional strategies address issues around overall service models, design and balance (Table 6.3).

Table 6.3. National or regional strategies address issues around overall service models, design and balance

E.g. strategies that determine the role of primary mental health care, and the balance between community based care and inpatient services.

Yes, a national strategy, regional or local covers service design	Australia, Austria, Belgium, Czech Republic, England, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Norway, Poland, Portugal, Slovenia, Switzerland, Turkey
Yes, some regional or local strategies cover service design	Canada, New Zealand, the Netherlands
No, but this is a priority policy issue	Mexico
No, no specific strategy or discuss of this issue	Luxembourg

Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Although they weren't seen consistently across all strategies, plans and policy documents, the use of incentives, information collecting and sharing, and a need-focused approach were included in some national and international approaches. The recommendations in the 2017 annual report of the EU Compass for Action on Mental Health and Well-being emphasised financial resources, as well as services organisation, development and quality (EU Compass for Action on Mental Health and Wellbeing, 2017[50]), while the Five Year Forward View on Mental Health (NHS England, 2018[51]) in England placed emphasis on incentives, levers and payment.

In other OECD countries, strategies cover the goals for the mental health system, such as increase integration across sectors (Australia, Canada, England, Ireland, Slovenia), and balancing service provision between primary and specialist care and/or stepped care approaches (Czech Republic, Denmark, Ireland, Japan, Norway, Slovenia, Switzerland, Turkey). In Iceland, a significant part of the recent mental health strategy has been focused on redistributing mental health resources, and the move toward deinstitutionalisation and implement more extensive mental health service provided by the primary health care centres around the country by establishing mental health teams and the increased availability of service provided by psychologist, co-ordination and quality control overseen by Primary Health care Services, development centre. Iceland's Health Policy running up until 2030 also places strong emphasis on co-ordination of care and providing the correct services at the appropriate time and service level. Japan, Korea and the Czech Republic have also been focusing on redistributing mental health resources outside of inpatient settings, and shifting the focus of care towards community settings as a priority part of mental health reform (Box 6.2).

Box 6.2. Managing deinstitutionalisation in the Czech Republic, Japan and Korea

Pushing for reform from the government, NGOs, and the psychiatric association in the Czech Republic

Similarly to other Central and Eastern European countries, in the Czech Republic, mental health care has historically been highly hospital-focused (Winkler et al., 2017[52]). Since 1989, outpatient care has been expanded, and recently, more community based care was expanded (Höschl, Winkler and Peěč, 2012[53]). However, the hospital-centric approach has continued, with long hospital stays (41.2 days on average in 2017) even as the number of psychiatric beds has fallen (from 1.05 per 1 000 in 2008 to 0.94 in 2017) (OECD, 2019[54]). In the early 2000s, NGOs and the Czech Psychiatric Association were the main actors involved in pushing for mental health reform (Pec, 2019[55]). The Czech Government began to play a more active role in driving for mental health reform from around 2013; the Ministry of Health, assisted by teams of mental health professionals, experts and patients, created the Strategy for the Reform of Psychiatric Care, which was issued in October 2013, and from 2016-17, the government began using EU structural funds for psychiatric care. Recent reforms have included the development of Mental Health Centres (MHC) to offer community mental health care services, which often include integrated professional teams with psychiatric nurses, social workers and psychiatrists. MHCs can also include bed places for emergency cases, and staff undertake out-patients visit (Pec, 2019[55]). However, expenditure on mental health is low, and has between 2006 and 2015; spending on mental health as a percentage of health spending was at 4.14% of health spending in 2006 and had fallen to 4.08% in 2015 (Broulikova et al., 2020[56]). The bulk of 2015 expenditures were also being spent on inpatient care, and as of 2020, despite the considerably reduced long-term hospitalisations and increased community care, the Czech mental health system could still be considered to be highly hospital based (Broulikova et al., 2020[56]).

Japan slowly shifts mental health care from hospital to community

In Japan, mental health care is highly hospital-based. Average hospital stay was 281 days in 2014, which is much longer than that the OECD average in 2014 (OECD, 2020[57]) and 85.9% of the psychiatric beds are occupied according to Ministry of Health, Labour and Welfare data. Ministry of Health Labour and Welfare (MHLW) reported in 2017 that more than 60% of inpatients stay in a hospital more than one year (MHLW, 2017[58]). The vision of reforming mental health service, “from hospital care to community-based care”, was announced in 2004 to reduce the length of hospital stay and strengthen mental health services in communities. The government set the goal in 2004 to reduce the number of psychiatric beds by 20%, and inpatients by 10%. The municipal governments are encouraged to support those with psychological problems to live in a community and focus on building community-based integrated care system. For example, the government supports municipals to ensure communication between medical and community care staff, as well as family care, and peer support. However, the changes have been very slow, due to the strong stigmatisation, besides the systematic barriers, such as insufficient insurance coverage of community care by non-medical professionals (Kasai, 2017[59]). The number of psychiatric beds has reduced by 7.5% from 2004 to 2018, according to the 2004 and 2018 Surveys of Medical Institutions undertaken by the Ministry of Health, Labour and Welfare.

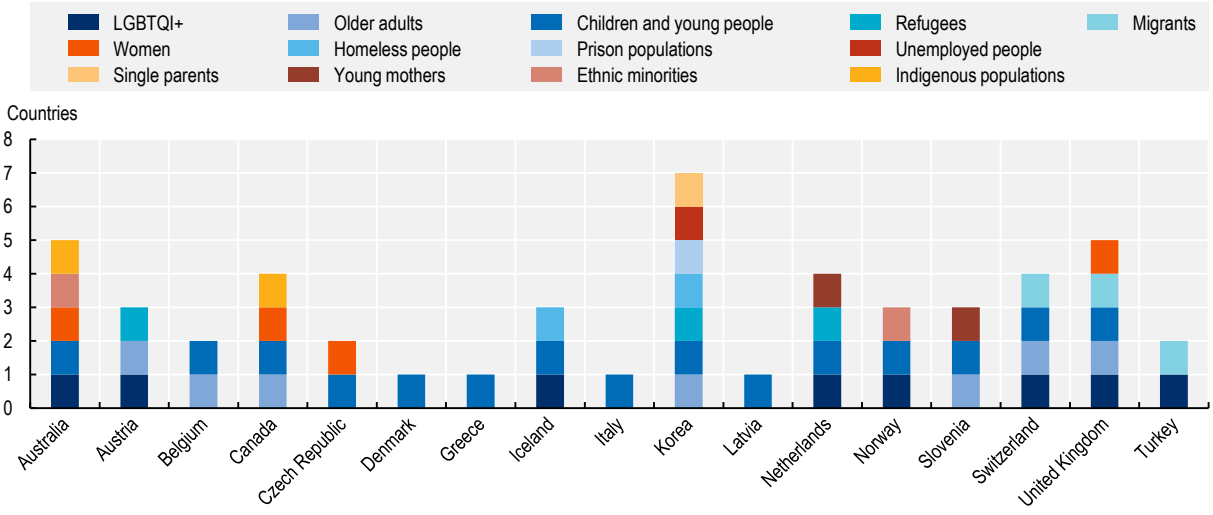
Strengthening community mental health care in Korea

Korea largely relies on psychological care on inpatient service despite that the number of mental health patients is increasing. The length of hospital stay has increased from 114.5 days in 2008 to 168 days in 2017. The number of hospital beds per 1 000 population has increased from 0.81 in 2008 to 1.31 in 2017 (OECD, 2018[60]). Since the Mental Health Act was introduced in Korea in 1995, the number of rehabilitation facilities increased by 5 times from 66 in 2001 to 333 in 2015, however, the number of private mental hospital is still 10 times as that of rehabilitation facilities (Heo, Kahng and Kim, 2019[61]). The number of Mental health Welfare Centres (MHWCs) was increased to lead mental health service in community, however, they are not distributed across the country and better co-ordination is still needed.

Promoting equity geographically, between population groups, and between mental disorders

Multiple population groups have been identified as being particularly vulnerable to mental ill-health, and many have poorer experiences and outcomes of, and less access to, mental health care. Such population groups vary across countries, and include but are not limited to the LGBTQI+ community, indigenous populations, certain ethnic groups including ethnic minorities, older adults, and refugees (Mitrou et al., 2014[62]; Zehetmair et al., 2018[63]; Catalan-Matamoros et al., 2016[64]; Soysal et al., 2017[65]; McCann and Brown, 2017[66]; Meyer, 2003[67]; WHO, 2020[68]). Seventeen OECD countries reported having mental health strategies or plans in place addressing the specific needs of nationally defined population groups (Figure 6.4). Strategies addressing children and young people are most common (15 countries), followed by older adults (7 countries) and LGBTQI+ communities (8 countries). The OECD Mental Health Performance Benchmarking Data Questionnaire included a data sheet requesting data broken down by population group, for example rate of service contacts for nationally defined population groups (OECD, 2020[8]). As of May 2020, 4 countries (Australia, Canada, Japan, and the United Kingdom) were able to provide partial data covering a range of groups, including aboriginal populations, data by ethnic group, foreign-born population, which is being further explored by the Secretariat.

Figure 6.4. Mental health plans or strategies for nationally defined priority population groups



Note: Responses to the question 'Do you have a specific national or sub-national mental health strategy for different vulnerable population groups? E.g. Older adults, First nation people, ethnic minorities, LGBTQI groups'. While this term appeared to be easy to understand for questionnaire respondents, the term 'vulnerable population' can over-emphasise weakness rather than action and empowerment, and imply that all individual members of a given population are vulnerable.
Source: OECD (2020[8]), OECD Mental Health Performance Benchmarking Data and Policy Questionnaires.

Though many countries may have strategies for priority population groups, the comparatively poor outcomes for such groups points to a need to further increase, or at least remain committed to, scaling-up appropriate support and services designed for and with minority and priority groups. To take one pertinent example, in Australia, Canada, New Zealand and the United States and indeed worldwide indigenous populations have higher rates of suicide and psychological distress, suffering from symptoms of anxiety and depression (Hajizadeh, Bombay and Asada, 2019[69]; Hatcher, Crawford and Coupe, 2017[70]). Indigenous Australians shows rates of anxiety and depression between 50% and three times as high compared to the non-Indigenous population (Anthony F Jorm Sarah J Bourchier, 2012[71]). Suicide rates are twice as high compared to the non-Indigenous population, and four times as high for youth (Tighe et al., 2017[72]). Suicide rates among the Inuit, one of the three distinct Indigenous groups in Canada, are

among the highest in the world and up to ten times higher than the average suicide rate in Canada (Harder et al., 2012[73]; Kral, 2016[74]). Furthermore, countries need to go beyond strategies focused on priority groups and towards accessible, co-produced services. Fostering a supportive community with focus on local culture, such as support by social or familial network, connection to culture, development of self-identity are all related with better mental health outcomes in Indigenous populations, resulting in less suicidal ideation (Harder et al., 2012[73]; Hatcher, Crawford and Coupe, 2017[70]; Tighe et al., 2017[72]). Canada has pursued this approach with "Culture as a Treatment"", where mental health agencies serve specific cultural practices such as talking circles, pipe ceremonies and smudging (Gone, 2013[75]). In Australia, Indigenous mental health policies focus on self-determination and community governance, reconnection and community life to enhance emotional well-being for Indigenous communities (Dudgeon et al., 2014[76]).

OECD countries have taken some initiatives to create gender specific care, however this remains scarce and opportunities for improvement exist. In England, there have been guidelines developed to advice on clinical management of mental health services for women who have experienced problems in antenatal or postnatal period. The guidelines cover mental ill health such as depression, anxiety disorders, eating disorders, drug- and alcohol- use disorders and severe mental illness. The guidelines are developed to promote early detection and good management of mental health problems to improve women's quality of life during pregnancy and in the year after giving birth (NICE, 2014[77]). Finland has developed a preventative strategy to recognise that suicide was particularly high amongst young men, which led to the development of the "Time Out! Back on the track" (Aikalisä! Elämä raitelleen) initiative in 2004, which promoted social inclusion amongst vulnerable men. Two-thirds of participants reported that the participation in the programme was worth wile, while about 60% considered it had improved their life situation (Appelqvist-Schmidlechner et al., 2012[78]).

Strengthening mental health leadership and governance to improve performance

Policy attention needs to be backed with smart and significant investment in mental health services

Mental health is indeed a significant and growing priority for OECD policy makers. At their Ministerial meeting at the OECD in 2017, which led to the development of this report, Ministers highlighted the significant burden of mental ill-health, and that interventions to prevent, treat, and manage mental health are insufficient. Ministers pointed to gaps in effective policies, but also in applying policies that are well-established as effective. Furthermore, at their 5-6 November 2017 meeting in Milan, G7 Ministers of Health highlighted the burden of mental health issues on adolescence, and concerns over the impact of social media on mental health, and asked OECD to "benchmark mental health performance focusing specifically on adolescents" (http://www.salute.gov.it/imgs/C_17_pubblicazioni_2656_allegato.pdf). During the COVID-19 crisis, governments have prioritised mental health as part of their COVID-19 response plans, with countries including Australia, Denmark, Canada and Norway rapidly committing new resources to scaling-up mental health support, often with a focus on particularly vulnerable population groups.

Based on the findings of this report, no mental health system in OECD countries is a top performer across the board. In some areas, for example 'unmet need for mental health care', even 'top performers' see 50% or more reported unmet need for care (see Chapters 2 and 3). There is room for improvement for all countries. Mental health has been a long-neglected area, but this is beginning to change; significant attention from some governments and leaders is testament to global momentum around mental health. In some cases this has been accompanied by new high-level strategies or funding, in all instances such signals can be an important way to raise awareness and reduce stigma. However, despite growing attention to mental health, and in some cases increases in funding and service provision, OECD countries have not significantly increased funding for mental health.

If OECD countries are going to deliver the kinds of high performing mental health systems that were set out in OECD Mental Health Performance Framework, which was developed by stakeholders from across OECD countries, further investment in mental health is surely needed in most, if not all, OECD countries.

If countries wish to invest additional resources in mental health care, there are a range of different approaches that can be taken. Some OECD countries have committed new funding to mental health services in response to the COVID-19 crisis. As discussed earlier in this chapter these countries include Australia which has committed funding for specific additional mental health services, Canada where the government has committed resources with a particular focus on particularly vulnerable population groups, and Ireland which has committed new funding for both new additional mental health services, and for existing mental health needs. Prior to the COVID-19 crisis, countries had also been introducing targeted mental health resources for example for specific services which were over-stretched, or which were judged to be particularly important for meeting demand for care. This includes countries such as England, which introduced GBP 80 million to address mental health waiting times for psychological therapies and psychosis services in 2015, and Australia which directed AUD 152 million towards headspace services (for young people) which were experiencing high levels of demand in 2019 (OECD, 2020[79]).

Targeted resources for specific mental health services is by no means the only way that countries have gone about increasing mental health funding. Several countries have committed new resources to their mental health systems through comprehensive reform approaches, or new mental health strategies. Amongst these countries, New Zealand's 'Well-being Budget' stands out as a very comprehensive approach to increasing investment in mental health, that not only includes new commitments to services but also commitments to addressing some of the key risk and resilience factors around mental health (Box 6.3).

Box 6.3. New Zealand's well-being budget

In 2019 New Zealand announced the world's first 'well-being budget', which focused on 'taking mental health seriously', improving child well-being, supporting Māori and Pacific populations, and building a productive nation. The Budget intended to focus policy attention, and resources, an diverse dimensions of well-being including mental health, childhood development, reducing domestic violence, protecting the environment, and reducing inequality. They budget intention state: "Well-being is when people are able to lead fulfilling lives with purpose, balance and meaning to them. Giving more New Zealanders capabilities to enjoy good well-being requires tackling the long-term challenges we face as a country, like the mental health crisis, child poverty and domestic violence. It means improving the state of our environment, the strength of our communities and the performance of our economy" (Government of New Zealand, 2019[80]).

The Budget focused on improving well-being in three ways: breaking down cross-government silos and improving integration; focusing on long-term impacts and policies; tracking progress with broader measures of success.

This ambition was backed with NZD 445 million for mental health services, NZD 40 million for suicide prevention, and commitments to put more nurses in secondary schools, tackle homelessness, and spend NZD 320 million addressing family and sexual violence. Services are being rolled out nationally over five years and will be offered in a range of settings including general practices, kaupapa Māori, Pacific, community and youth settings. Responses will be designed collaboratively with communities to ensure local services meet local need. These services will utilise a diverse workforce, including mental health and addiction workers (including staff with peer and cultural expertise) co-locating with primary health services. It is also expected that services will provide pathways to access cultural and social supports, including those which provide employment and income assistance.

In 2020, in light of the COVID-19 crisis, the Well-being Budget was slightly reoriented, with more significant focus on funding for existing public services, and a pause on new initiatives. The 2020 Budget nonetheless included almost NZD 5.6 billion for the health sector, and NZD 3.9 billion in operating funding for New Zealand's District Health Boards which represents the largest ever investment in such operating costs (New Zealand Government Budget 2020, 2020[81]).

Investing in programmes to reduce mental health stigma and improve mental health literacy can transform population attitudes

Reducing mental health stigma is a priority in OECD countries, and national or regional campaigns are in place in multiple countries. Though attitudes and stigma are inconsistently measured over time, and anti-stigma campaigns rarely fully evaluated, but where they are evaluations point to important improvements in attitudes. More positive attitudes towards mental health can reduce stigma towards others – helping decrease discrimination towards people with mental health conditions – and also reduce self-stigma, making it more likely for people to seek support if they experience mental distress. England has a particularly long-running mental health campaign, Time to Change, which unlike campaigns in some countries which are focused on one day or one period of the year (e.g. World Mental Health Day) runs diverse activities through the year. The campaign has also been evaluated multiple times, and has found progressive improvement in attitudes towards mental health (Box 6.4).

Box 6.4. Reducing stigma and improving mental health literacy

Time to Change campaign to change attitudes towards mental health in England

'Time to Change' in England began in 2007 funded by the Department of Health and Social Care, Comic Relief, and The National Lottery Community Fund. The campaign focused on ending stigma and discrimination related to mental health issues and change people's attitudes at a national level, recognising that stigma was preventing people from setting support they need. The main focus of the campaign was on creating opportunities to talk about mental health problems in workplaces, at schools, and in the local community. Five years after the campaign was introduced in 2007 it appears to have contributed towards significant improvements in positive attitudes towards mental health (Evans-Lacko et al., 2014[82]). More than ten years after the campaign's introduction, 2018-19 data shows a 3.1% improvement in attitudes amongst the adult population compared to baseline data from 2016/17, and a 12.7% improvement since 2008 when the programme first started collecting data (Time to Change, 2021[83]).

Since the campaign began, in the general population there were significant increases in positive attitudes related to prejudice and exclusion, and an increase in tolerance for community care (Evans-Lacko et al., 2014[82]). While it is difficult to attribute these changes to the Time to Change campaign alone, some of the attitude changes were most significant after the launch of the campaign, and there was also some positive relationship between campaign awareness and improvement in mental health knowledge and attitudes (ibid). The evaluation found that the campaign represented a potentially cost-effective and low-cost intervention.

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7 Building future-focused and innovative mental health systems

Building higher quality and more efficient mental health care demands a focus on building the innovative and high-performing mental health systems of the future. A future-focused approach to mental health includes developing a strong mental health workforce for future generations, investments in research, a strong data infrastructure, and a commitment to innovation and integrating new ideas into mental health practice. At the same time, there is more to do to ensure that more people get access to what is already understood to be the best practice care available, and that this care is delivered in the most effective and efficient way possible. This chapter explores the approaches that OECD countries are already taking to build efficient and sustainable mental health systems, opportunities to maximise uptake of effective and innovative treatment and services, and areas where more investment of attention and resources are needed.

Introduction

Just as in other areas of health care, building higher quality and more efficient mental health care, requires a focus on building the innovative and high-performing mental health systems of the future. A future-focused approach to mental health demands that steps are taken to ensure that a mental health workforce for future generations is being trained now, and that investments are made in research that will benefit populations in the years or decades to come. Innovative solutions, too, must be identified: leaps forward in health care, from the use of new technology and digital solutions, to personalised medicine and pharmaceutical advances, should be harnessed for mental health. At the same time, there is more to do to ensure that more people get access to what is already understood to be the best practice care available, and that this care is delivered in the most effective and efficient way possible. Both to maximise access to effective and efficient mental health care today, and to build innovative and sustainable systems for the future, robust information systems must be available to track progress and identify what works.

This chapter explores the approaches that OECD countries are already taking to build efficient and sustainable mental health systems, opportunities to maximise uptake of effective and innovative treatment and services, and areas where more investment of attention and resources are needed.

Why do mental health systems need to be future-focused and innovative?

"A future-focused and innovative approach" is one of the six principles of a high-performing mental health system established by the OECD Mental Health Performance Framework (OECD, 2019[1]). A future-focused and innovative approach to mental health policies and care is essential for building a dynamic system today, for capitalising on the most promising new developments in health care and beyond, and looking forward to secure ever-improving mental health policies and services in the years to come. Specifically, "a future-focused and innovative approach" includes six sub-principles:

- Ensure all services are based on best available evidence;
- Deliver care and services in the most effective and efficient way;
- Invest in mental health research;
- Promote innovative solutions to mental health challenges;
- Build mental health workforce capacity for future generations;
- Build strong information systems for mental health.

How future-focused and innovative are OECD mental health systems?

Are OECD countries investing in mental health research?

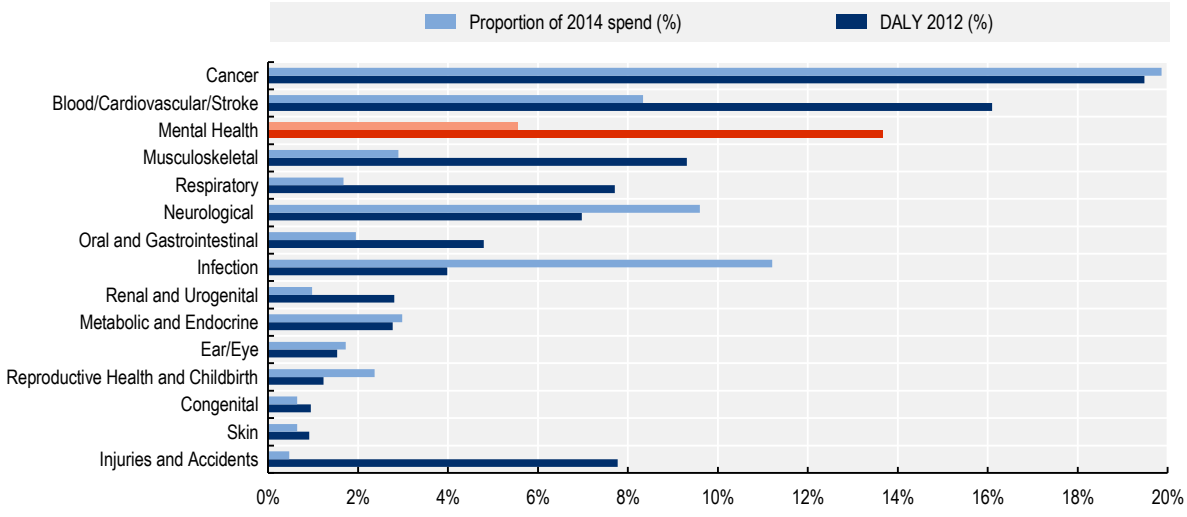
In recent decades mental health research has had low levels of attention and investment

Despite the significant and long-standing epidemiological and economic burden of mental disorders, mental health research has lagged behind many other areas, in terms of prioritisation, funding, and breakthroughs. Investment in research focused on mental and behavioural disorders has historically been low compared to overall burden of disease, and compared to other areas of health research.

In Europe, the three year ROAMER project ran from 2015 to 2018 to create a roadmap for mental health, and found that mental health and well-being were under-represented both relative to the burden of disease, and to other health-related fields (Hazo et al., 2019[2]). As part of the ROAMER project the national research budget for mental health in 2011 in four countries, Finland, France, Spain and the

United Kingdom, was identified and again a significant gap between research investment and DALY attributable to mental disorders was found (Hazo et al., 2017[3]). At the European level between 2007 and 2013 the EU spent EUR 373.3 million on mental health research, compared to EUR 802 million on neurological and neurodegenerative research, despite the epidemiological and economic burden of mental disorders being twice that of neurological and neurodegenerative diseases (Hazo et al., 2016[4]). Research in Australia also pointed to low levels of funding for mental health research (Christensen et al., 2011[5]). In the United Kingdom, a mapping of funding across areas of health research from 64 funders found that spending on mental health research as a percentage of total research spending was significantly lower than the relative DALY burden of mental health conditions in the United Kingdom, but had grown slightly from 2002 to 2014 (Figure 7.1).

Figure 7.1. DALY rates and proportion of total research spending by health category in the United Kingdom, 2014



Note: Comparison of Disability Adjusted Life Years (DALY) rates for the United Kingdom in 2012, and proportion of the United Kingdom total funding distribution by health categories in (64 funders) 2014.
Source: UK Clinical Research Collaboration (2015[6]), UK Health Research Analysis 2014, Available at: http://www.hrcsonline.net/pages/uk-health-research-analysis-2014.

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While looking to establish the extent of investment in mental health, especially at an international level, it is difficult to take stock of different funders, from the governments to research institutes as well as charitable or foundation-based investors, and the pharmaceutical industry. Some national analysis from the United Kingdom in 2017 suggested that in fact mental health research investments across all actors was below the relative burden of disease (Department of Health, 2017[7]). The same analysis notes that a number of major pharmaceutical companies have withdrawn from brain research in the past decade (Cressey, 2011[8]; Nutt and Goodwin, 2011[9]).

In 2014 in the United Kingdom charity spend on mental health research (GBP 25.1 million) was about 12% of the total spend on cancer (GBP 299.2 million), and less than half the spending on cardiovascular (GBP 85.2 million), neurological (GBP 63.4 million) or infection (GBP 78.4 million) research. Government spending on mental health research (GBP 42.8 million), however, was more closely matched with other areas of health research including cancer (GBP 45.7 million) (UK Clinical Research Collaboration, 2015[6]).

There are some exceptions, notably Norway. In Norway, a 2019 report reviewing research and development efforts in mental health found significant investment in research and development in psychiatry – NOK 1.4 billion in 2017, or 4% of total research investments in Norway and more than 15% of the NOK 9 billion spent on research and development for medicine and health sciences in 2017 (NIFU, 2019[10]). The same report found that in the period 2011-17 there was an overall increase in total research in Norway including in medicine and health, and that research on mental health has kept pace with this increase, both in terms of the number of scientific publications and in terms of resources. Nonetheless, research efforts did not necessarily match the distribution of the burden of mental ill-health in Norwegian society; for example, depression and anxiety had a lower share of resource input despite being a significant driver of ill-health in Norway.

Governments are leading the push for more mental health research

In recent years, there are signs that some countries are investing more significantly in mental health research, across a range of areas from basic science to service development or service delivery. Just under half of OECD countries (11 of 29 responses) reported that they have a significant national or regional research agenda, for example focused on mental health service improvement, pharmaceutical development, or biomedical research, for mental health (OECD, 2020[11]). Many of these national research agenda have been defined by government-defined multi-year research strategies, often backed by significant national funding, though the scope of the research agenda does differ.

Several OECD countries have developed, or are in the process of developing, national mental health research strategies. These countries include the United Kingdom (Department of Health, 2017[7]), Australia (Australian Government National Mental Health Commission, n.d.[12]), and the United States (The National Institute of Mental Health, 2015[13]). Denmark is currently working on a 10-year plan for mental health which will set the long-term direction for mental health treatment in Denmark, and which will also focus on research. Across these strategies, there are some significant similarities. Notably, the strategies point to the need for further basic research to accelerate understanding of the causes and potential treatment for mental disorders, but also the significant interaction with life course, socio-economic, and cultural factors, an emphasis also made in the findings of the EU Roamer project which set six European mental health research priorities (Wykes et al., 2015[14]).

These national strategies have approaches in common including stressing the importance of research focusing on prevention, recognising different risks and needs across the life course, and the particular vulnerability of some age groups, notably children and adolescents, research developing and development and linking of data, research into new technologies and telemedicine, and interaction between risk and experience of mental disorders and socio-economic and cultural factors. The United Kingdom's strategy also notes some of the potential for studying the genetics of mental health problems, especially at a population level. The United Kingdom is one of more than 40 countries contributing to the Psychiatric Genomics Consortium at the UNC School of Medicine in North Caroline, the United States, which has already identified over 128 genetic risk factors for mental health problems (Department of Health, 2017[7]; Psychiatric Genomics Consortium, 2020[15]).

In other countries, for example Canada, the Czech Republic, the Netherlands, Norway or Poland, there is not necessarily a single national research strategy for mental health but there is nonetheless a significant and broad mental health research agenda, often being led by dedicated institutes or academic departments, or a national research programme with significant backing from the government, as in the Netherlands.

In Canada, there are widely recognised knowledge gaps related to mental health prior to COVID-19; however the underlying systematic challenges to measuring mental health, mental disorders and the impact of care became more obvious when trying to determine the impacts of the pandemic. Canada is working to address these gaps by exploring initiatives that better capture of the state of mental illness in

Canada (including changes over time) using valid and practical measures, and better integrate data from multiple sources to effectively assess the impact of health services, investments, and policies on mental health outcomes. For example, a longitudinal survey across 2020 by Mental Health Research Canada has tracked how the COVID-19 crisis has been impacting the mental health of Canadians, aiming to generate data that helps policy help policy makers, governments and service delivery agents tailor programmes to the need of Canadians in this crisis (Mental Health Research Canada, 2020[16]; OECD, 2021[17]). The Canadian Institutes of Health Research – Institute of Neurosciences, Mental Health and Addiction (INMHA) covers biomedical and clinical brain health research, alongside health system and services research, and research on the social, psychosocial, cultural and environmental factors that affect the health of populations (OECD, 2020[11]; Canadian Institutes of Health Research, 2020[18]).

In the Czech Republic the National Institute of Mental Health has a research programme which spans areas including brain science, public health and social psychiatry, and international collaboration, as well as epidemiological research, economic evaluation of services, development of interventions and mental health programmes, and studies on stigma and discrimination (National Institute of Mental Health, 2020[19]).

A number of OECD countries are backing their national mental health research agenda with new and significant funding. For example in the Netherlands, the Ministry of Health, Welfare and Sport has funded the Dutch Association of Mental Health and Addiction Care (GZZ Netherlands) mental health research including a long-term cohort study and a range of clinically applied research (ZonMw, 2020[20]). Funding totalled EUR 10 million across 2016-17, a further EUR 5 million in 2018, and EUR 35 million for the period 2019-25 (ZonMw, 2020[20]; ZonMw, 2020[21]) (Table 7.1).

Table 7.1. National spending on mental health research, annually or latest year

National investment in mental health research as part of national programmes, total national spending and research spending as a percentage of GDP

	Australia	Canada	Denmark	Japan	Korea	Netherlands	Norway
Estimated spending on mental health research (annually, or latest year)	AUD 71.7 million in mental health research in 2018.[1]	CAD 72 million for 2018-19.[2]	2018 public sector investment DKK 572 million 2018 public sector investment.	JYN 318 million in 2019.	KWON 75 421 million in 2020.	An average of EUR 5 million annually.	NOK 253 million in 2018.[3]
Investment as a percentage of GDP	0.002972%	0.002755%	0.025219%	0.000056%	0.002852%	0.000549%	0.006795%

1. From 2009-18 the National Health and Medical Research Council (NHMRC) funded an average of AUD 71.7 million in mental health research, and the Australian Government is providing AUD 125 million over 10 years from 2018-19.
2. Estimated investment for projects affiliated with the Canadian Institutes of Health Research (CIHR) were CAD 305 from 2014-15 to 2018-19, and 2018-19 investment CAD 72 million.
3. Research and development within mental health was 17% of the total research and development resources in health and care in 2017, which in would 2018 amount to NOK 253 million.
Source: Investment estimates taken from OECD (2020[11]), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires*; data on national GDP taken from OECD.Stat.

Are OECD countries promoting innovative solutions to mental health challenges?

While research investment and pharmaceutical innovation may have been sluggish in recent decades, digital tools and technology-based approaches to supporting mental well-being, and managing and treating mental ill-health, have been booming. In many cases innovation is led by private actors, for example app developers or non-governmental organisations, and disseminated or validated by governments to a greater

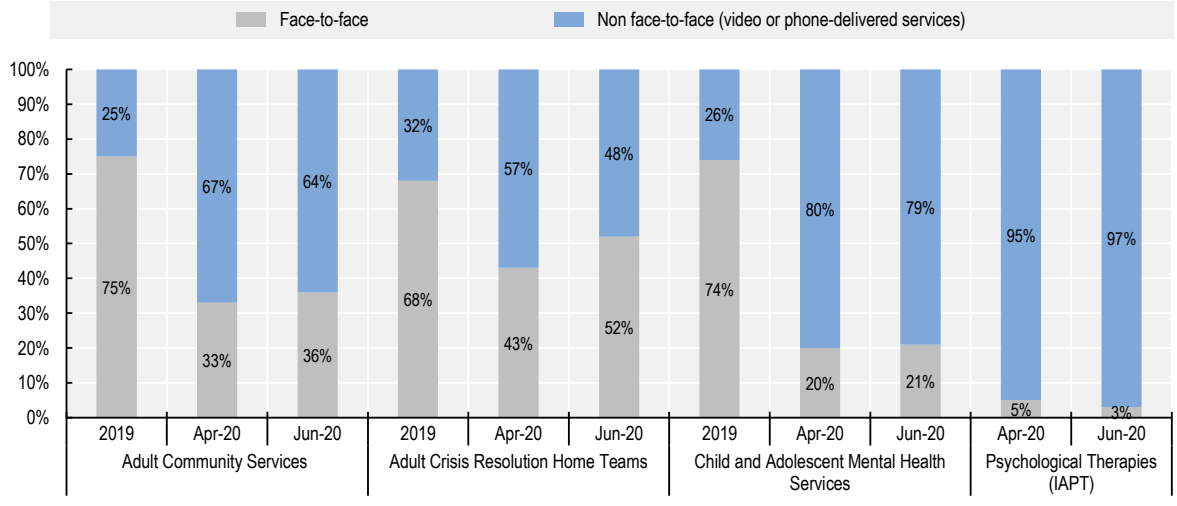
or lesser extent. The COVID-19 crisis, and its impact on population mental health, use of digital and online platforms, and disruptions to traditional service delivery models, has accelerated the use of technology in the mental health space.

The COVID-19 outbreak has rapidly accelerated the use of digital tools in the mental health space

Online cognitive behaviour therapy has shown comparable levels of efficacy with that of face-to-face treatment, but the uptake of telemedicine in mental health has been slow (Feijt et al., 2020[22]). The COVID-19 outbreak appears to have further accelerated both delivery of mental health services via telemedicine, and availability and use of internet- or app-based mental health tools (Moreno et al., 2020[23]). Multiple countries have lifted legislative or reimbursement limits on providing mental health services through telemedicine. In mid-2020 80% of high-income countries reported to the WHO that they had used telemedicine/teletherapy to replace in-person mental health consultations, or the use of helplines (WHO, 2020[24]).

In Australia, the COVID-19 crisis rapidly accelerated the use of telemedicine, though these measures may be reviewed and service-delivery modes adapted as the COVID-19 crisis abates. As of end-April 2020, half (49.9%) of mental health services under the Medicare Benefits Schedule were being provided remotely; by the end of 2020 even as rates of face-to-face services increased again, the weekly rate of telehealth services was 76 000 in December and 60 000 in early January, compared to approximately 30 000 in late March 2020 (Australian Institute of Health and Welfare, 2020[25]). In England (United Kingdom) mental health services moved significantly to non-face-to-face formats (phone and video) in 2020 (Figure 7.2); all mental health services had lower rates of face-to-face service delivery in April 2020 than the 2019 rate. Some services, for example Adult Crisis Resolution Home Team services, maintained at least some face-to-face services even during the peak of the 'first wave' of the outbreak in April 2020, and ratios of face-to-face: non-face-to-face started shifting back to levels more similar to 2019 patterns even from June. Other services, though – notably child and adolescent mental health services and psychological therapies (IAPT) – massively moved to non-face-to-face formats. In June 2020 only 3% of IAPT services were being delivered in-person in England.

Figure 7.2. Face-to-face and non face-to-face (video or phone-delivered services) in England (United Kingdom), 2019 and 2020



Note: Data for service delivery method Psychological Therapies (IAPT) in 2020 is not available.
Source: NHS Benchmarking Network – COVID-19 Monthly Tracker Mental Health, Learning Disability & Autism Services June 2020.

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Kaiser Permanente, the largest managed care organisation in the United States with 12 million plan members, was delivering 90% of its psychiatric care virtually as of 2020 (Gratzer et al., 2020[26]; Torous and Keshavan, 2020[27]). The Centre for Addition and Mental Health (CAMH), the largest psychiatric hospital in Canada, increased virtual care visits by 750% in March and April 2020 compared to the pre-pandemic period (Cisco Canada, 2020[28]). A study from the Netherlands showed an increase from less than half of practitioners using digital tools before the pandemic, resulting in the large majority using digital tools for therapy on a daily basis (Feijt et al., 2020[22]).

There are also signs that other mental health tools are being accessed more. In the United States, the online therapy company Talkspace saw an increase in clients of 65% between mid-February and end-April, a federal hotline for people in emotional distress say a 1 000% increase in April 2020 compared to April 2019, and use of self-screening questionnaires on the website of the non-profit Mental Health America increased 60-70% over the course of the outbreak (National Council for Behavioral Health, 2020[29]; Mental Health America, 2020[30]). The COVID-19 outbreak has also pushed governments to make more online or digital mental health resources available. In April 2020 the Canadian Government (Health Canada) launched the Wellness Together Canada (WTC) portal to provide short-term mental health and substance use supports and services to Canadians during COVID-19. Key objectives are to help address the anticipated increase in mental health and substance use service needs faced by Canadians, and to address disruptions to normal service delivery resulting from the pandemic (Government of Canada, 2020[31]). To date, the Government of Canada has invested CAN 68 million in the WTC portal, and will continue to fund the portal into 2021-22 with an additional CAN 62 million.

Countries are at different stages in taking advantage of the growing number of mental health apps and digital tools

Over the past decades, technological tools for remote psychological treatment have been developed, enhancing accessibility and flexibility of mental health care for people with mental health conditions, in particular for people living in rural areas. Internet-delivered cognitive behaviour therapy has existed for more that 20 years (Andersson et al., 2019[32]). In recent years mobile technology has led to the development of multiple mobile phone apps to deliver effective mental health care, including many apps applicable for severe mental illness such as CBT2GO, PRIME, Intellicare, CBT-coach, T2 mood Tracker, PeerTech, Stop Breath and Think, mind LAMP, Mindfulness Coach and Virtual Hopebox are among many other apps for delivering mental health care for people with severe mental illness (Torous and Keshavan, 2020[27]; Firth and Torous, 2015[33]; Depp et al., 2019[34]). Indeed, in the last few years, there has indeed been considerable activity around finding innovative solutions to mental health challenges in recent years, much of which has been focused on better and broader deployment of digital tools including symptom tracking, self-help, and telemedicine. In particular there has been an explosion in apps developed by private companies, sometimes in partnership with governments or health service providers (Box 7.1).

Box 7.1. App-based mental-health care

There has been an explosion of apps and digital tools to promote mental well-being and manage mental health in OECD countries in recent years. The function of these apps ranges from tracking self-management of symptoms, for example Thrive or WorryTree for mood tracking, mindfulness apps such as Calm or Headspace, Beat Panic designed to help overcome panic attacks and anxiety or BlueIce to help young people manage their emotions (NHS, 2020[35]). Other apps, such as Ieso or Big White Wall in England (United Kingdom) or Talkspace in the United States connect people directly to licenced therapists, and in some cases access to these services are covered by employers or health insurance providers. Apps such as SAM Screener, for PTSD symptoms or MIRROR for screening for PTSD can be used as self-screening tools for mental health conditions.

A range of apps have been found to be effective in delivering mental health care. A meta-analysis covering 22 mobile apps to treat depression found positive impacts on alleviating symptoms and improving self-management, with the greatest benefits for persons with mild-to-moderate depression, while a meta-analysis of nine randomised control trials of mobile apps for anxiety contributed to improved symptoms, especially in combination with in-person or internet-based therapy (Firth et al., 2017[36]; Firth et al., 2017[37]). A systematic review of mobile apps for schizophrenia also showed positive impacts, with a high rate of app retention by users (92%) and regular daily use by users, and a range of clinical benefits (Firth and Torous, 2015[33]; Chandrashekar, 2018[38]).

In OECD countries, a range of non-government actors have established funds or platforms to boost innovation in the mental health space. The Duke and Duchess of Cambridge in the United Kingdom announced a GBP 2 million fund as part of their mental health campaign Heads Together, focused on digital tools for mental health in 2017 to develop new digital tools to help people have conversations about mental health. The first tool coming out of this fund was 'Shout', a free crisis service for people who feel they need immediate support, staffed by trained volunteers, and available 24 hours a day (Heads Together, 2019[39]). The American Psychiatric Association also launched the Psychiatry Innovation Lab in 2020, aiming to nurture early-stage ideas and ventures by investing in them with mentorship, education, funding and collaboration opportunities within our community of mental health innovators (American Psychiatric Association, 2020[40]).

Integration of apps and digital tools – e-mental health – in broader health services is at different stages in different OECD countries, but at present appears to be ad-hoc or experimental rather than systematic. For instance in Ireland, the health service has been involved in developing an online cognitive behavioural therapy platform eWell (Health Service Executive Ireland, 2018[41]), and several Irish universities have contributed to the development mental health digital tools (for example Pesky gNATS (Pesky gNATs, 2021[42]), but the 2013 National eHealth Strategy did not make particular mention of mental health (Vlijter, 2020[43]). In Belgium, though there are some regional e-mental health initiatives and e-mental health is high on the national agenda and included in the 2019-21 eHealth Action Plan, no large-scale or national e-mental health projects are in place (Vlijter, 2020[43]). In France and Germany there is interest in e-mental health at different levels, for example a 'health innovation hub' to fast track innovative digital health care ideas in Germany and a e-mental health is included in a number of strategies in France – Mental Health and Psychiatry in 2018, and Accelerate the Digital Shift in 2019 (Ministère des Solidarités et de la Santé, 2018[44]; Agence du Numèrique en Santé, 2019[45]) – but neither country systematically include e-mental health use in service delivery.

The Netherlands and England stand out as two countries where e-mental health has been adopted widely. The Netherlands had its first e-mental health provider in 1997, and the use of e-mental health has increased rapidly in recent years with most GPs and mental health providers now offering e-mental health

tools, and e-mental health widely reimbursed by insurance companies (Vlijter, 2020[43]). In England, over 50% of GPs use e-mental health tools – primarily self-management tools – and the NHS apps library guides service users towards apps found to be effective, which they can often access without referral (Vlijter, 2020[43]; NHS, 2020[35]).

Interest in the use of artificial intelligence in the mental health field is growing

In the academic community, and in some business sectors, and in some countries, interest in the use of artificial intelligence (AI) in the mental health field is growing. A range of studies have found that machine learning methods can be applied to data gathered from online platforms, internet use, computer games, wearables such as smart watches, or specifically-designed apps, and that this data can be used to detect mental health conditions such as depression, anxiety or bipolar disorder (Garcia-Ceja et al., 2018[46]). In Australia, for example, the data and digital specialist unit of the Australian national science research agency CSIRO has developed a computer game and AI technology which, combined, is able to identify specific behavioural patterns linked to depression and bipolar disorder (CSIRO, 2019[47]; Dezfouli et al., 2019[48]). With further development, such technology could be used by or with mental health practitioners, and help improve diagnosis rates and accuracy of diagnoses of mental health conditioners.

Some discussion has been focused on whether analysis of patterns of internet or social media use can point to population-level mental health trends, identify persons at risk of mental ill-health or even suicide, or even direct at-risk persons towards appropriate support (Chancellor and De Choudhury, 2020[49]; Garcia-Ceja et al., 2018[46]). A 2020 study looked at Facebook messages and images of 223 participants, some of whom had schizophrenia spectrum disorders or mood disorders, and analysed content uploaded or shared in the 18 months before a hospitalisation event (Birnbaum et al., 2020[50]). This study found that using machine learning algorithms, different patterns of content shared could be distinguished between persons with a mental health condition, and healthy volunteers, using Facebook activity alone. Facebook itself has been looking to use machine learning technology applied to Facebook content to create a suicide and self-harm alert tool, using a pattern-recognition system to scan users posts and videos for key terminology (WIRED UK, 2017[51]; New Scientist, 2017[52]). The application of AI to identifying mental health risks or mental ill-health is not unique to Facebook; in the United States the Department of Veterans Affairs has applied AI technology to scanning medical records to identify suicide risks (The New York Times, 2020[53]), while a study at the KU Leuven University in Belgium found that a risk-screening algorithm could be a promising approach to identify students at the time of university entrance who may be at high risk for suicidal thoughts and behaviours (Mortier et al., 2017[54]).

The use of AI in the mental health field may have promise, but it is not without challenges. The use of individuals' data to identify or signal mental health risks raises important questions about privacy and consent for data usage (Business Insider France, 2019[55]; Barnett and Torous, 2019[56]).

In addition, it is not always clear how AI-led alert systems for example, can be integrated with appropriate services to support those identified as at-risk; such undertakings could also raise important questions about duty of care for persons identified as at risk – or who are not identified as at-risk – by such algorithms, including that of private companies (The New York Times, 2020[53]; Barnett and Torous, 2019[56]; The New York Times, 2018[57]).

Are care and services delivered in the most effective and efficient way, based on best available evidence?

It is extremely difficult to assess how 'efficient' and 'evidence-based' mental health systems are

All health care systems are seeking to deliver a maximum amount of effective care, with limited resources. In the mental health sector where resources are particularly tight (Chapter 6), maximising the impact of scarce resources is even more critical. However, assessing how 'efficient' mental health care systems are has been a long-standing challenge, limited by loose conceptualisation of efficiency in mental health systems (Lagomasino, Zatzick and Chambers, 2010[58]), heterogeneity in service design even within countries (Gutiérrez-Colosía et al., 2019[59]; Monzani et al., 2008[60]), and above all by a lack of relevant data (Moran and Jacobs, 2013[61]; García-Alonso et al., 2019[62]).

Nonetheless, promoting effective use of resources and reducing waste should remain a priority in mental health systems, and many of the key ways of improving efficiency in health care – such as reducing administrative costs, improving care co-ordination, and reducing emergency care visits (OECD, 2017[63]) – should also be considered in mental health care. In addition, some mental health services can represent opportunities for efficiency gains, for example greater investment in community-based services which can offer good value-for-money compared to inpatient services (see Box 7.2). Equally, investment in effective promotion and prevention (see Chapter 5) and integrated care (see Chapter 4) has potential to pay-off in terms of reducing mental health needs, responding to more mental health needs through lower-threshold care options, and reducing broad economic costs including disability, sickness absences, and lost productivity (OECD/European Union, 2018[64]).

Box 7.2. Community-based services for mental health care can represent good value-for-money

Across OECD countries reform efforts have been moving mental health services, including services for severe and enduring mental health conditions, away from inpatient settings and towards community-based care delivery. That services 'be developed close to the community' is one of the key sub-principles in the principle 'High Quality and Accessible Services' in the OECD Mental Health System Performance Framework, as discussed in Chapter 3 of this report (OECD, 2019[1]). Community-based services for mental health care can also represent better-value-for money as compared to inpatient services (Knapp et al., 2010[65]; Winkler et al., 2018[66]). While most OECD countries see a key role for inpatient mental health services even in strongly community-orientated systems (Thornicroft and Tansella, 2002[67]; Thornicroft, Deb and Henderson, 2016[68]), prioritising investment in community-based services can represent good value-for-money.

The cost of care for an individual in a community setting, compared to an inpatient setting, can be significantly lower. In Australia in 2018-19, the average cost per acute mental health admitted patient day was AUD 1 328, compared to the average cost per community mental health treatment day of AUD 353 (Australian Institute of Health and Welfare, 2021[69]). In Australia, there is a comparatively low rate of mental health beds and inpatient care and community-based services are well-developed, and Australia's mental health spending has reflected the growing importance of community-based care services over the past three decades. In 1992-3 spending on psychiatric care in hospitals represented (AUD 82.01 per capita) more than twice the spending on community mental health services (AUD 29.93 per capita), but by 2018-19 spending on community services (AUD 97.2 per capita) was close to the same as spending on hospital services (AUD 112.42 per capita) (Australian Institute of Health and Welfare, 2021[69]).

In countries where inpatient care still represents a significant proportion of mental health care, increasing investment in community-based services can represent a cost-effective way to shift care away from hospital settings, and/or increase the availability of mental health services. For example, in the Czech Republic, where the rate of psychiatric beds (0.93 per 1 000 population) is above the OECD average (0.68 per 1 000 population) and well above the bed rate in countries with a long history of community-based services such as Australia (0.42), Ireland (0.36), the United Kingdom (0.35) or Italy (0.09) (OECD, 2020[70]), a cost-effectiveness analysis of care of people with psychosis has found good economic evidence for deinstitutionalisation (Winkler et al., 2018[66]). In the Czech Republic, the total societal cost of discharge into community services was EUR 8 503, nearly twice the cost of no discharge and continued inpatient care which was EUR 16 425, while the annual QALY was 0.77 for patients receiving community care at baseline compared with 0.80 in patients in hospital at baseline.

To deliver good outcomes for people using mental health services, it is critical that mental health services are based on best available evidence, and are not shaped only by historical practices or determined by existing service infrastructure. 'Evidence-based practice' or 'evidence-based medicine' are "… the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996[71]; Guyatt et al., 1992[72]) and have become the standard expectation for health care in OECD countries. When it comes to mental health care, uptake of evidence-based practices (EBPs) in mental health seemed to lag behind the rest of the health care sector. For example in the early 2000s, as EBPs increased throughout the health care sector in the United States, relatively few accounts of the implementation of EBPs were found in mental health care (Magnabosco, 2006[73]). Concerns have also been raised about how 'evidence' for mental health interventions is developed and whether this approach overlooks the importance of the skill and experience of the practitioner to adapt to the individual service users' needs, and whether an EBP-approach overlooks interventions, for example in psychology, that may be less well-adapted to testing through randomised control trails (Psychiatric Times, 2008[74]; Tanenbaum, 2005[75]).

However, even when mental health services are available – and in most OECD countries 50% or more of the population have reported at least some unmet need for mental health care (see Chapter 3 of this report) – it is very difficult to assess the extent to which services are well-aligned with best available evidence. To ensure quality of care and deliver evidence-based practices, countries have increasingly developed clinical guidelines to stimulate the uptake of dissemination and implementation of evidence-based practices. For example, the Netherlands has developed protocols to deliver evidence-based practices, and to strengthen compliance with these protocols and guidelines, care providers and health care insurances have agreed to only cover psychological practices in basic health insurance that are seen as evidence-based and effective (Kwaliteitsontwikkeling GGZ, 2017[76]). An international comparison of the use of evidence based clinical guidelines for eating disorders in Australia, New Zealand, Germany, the Netherlands, Spain, the United Kingdom and the United States shows that although clinical guidelines are increasingly disseminated amongst care providers and main treatment approaches have strong commonalities across countries, there still remains large differences amongst additional recommendations on evidence-based treatments (Hilbert, Hoek and Schmidt, 2017[77]). Even where tools to move services towards evidence-based practice are well in place, such as clinical guidelines being widely available, it is challenging to assess how well services adhere to guidelines or best available evidence (Nguyen et al., 2020[78]; Van Fenema et al., 2012[79]; Joosen et al., 2019[80]; Van Dijk et al., 2013[81]).

Do countries have strong mental health information systems?

With a few exceptions, countries are unable to comprehensively measure the dimensions of mental health performance that they defined as most important

The OECD Mental Health Performance Framework (OECD, 2019[1]) was defined by stakeholders from across OECD countries, including government policy makers, experts-by-experience, academic experts, and workforce representatives. This Framework defined the ultimate goals of a high-performing mental health system – that the system be person-centred, deliver accessible and high quality care, promote good mental health and prevent mental ill-health, be cross-sectoral and integrated, have good governance and leadership, and be future-focused and innovative. At this point, few if any countries are able to comprehensively measure performance at the national level across all of these high-priority areas of performance.

Tracking and comparing health system data across settings and services, across time, and across countries are powerful tools for understanding performance (OECD, 2019[82]; OECD, 2019[83]). Availability of mental health data, in countries and internationally, has long lagged behind broader health data development (Hewlett and Moran, 2014[84]). Over the past six years there has been a clear increase in availability, including at an international level, of mental health data. Since their introduction in 2013-15 country coverage of the OECD's three indicators on mental health care quality has increased markedly: from 7 countries reporting excess mortality in 2013 to 12 in 2019; 14 countries reporting inpatient suicide in 2015 and 21 in 2019; and 10 countries reporting suicide after discharge in 2015, to 14 in 2019 (OECD, 2020[70]).

Responses to the OECD Mental Health Benchmarking Data Questionnaire were promising (Table 7.2). However, the majority of data that was available or broadly available to be reported to the OECD in 2020 covered inputs (beds, spending), or processes (length of stay, admissions, contacts with specialist care). For items which gave more insights into continuity of care, quality, or outcomes – such as repeat admissions, follow up after discharge, repeat emergency department visits – far fewer countries were able to report data. This means that even when appropriate quantitative indicators to measure performance for some of the performance subprinciples identified in the OECD Mental Health Performance Framework – continuity of care measured by follow-up, timeliness measured through waiting times for services, involvement of social protection systems or improvement of individual's condition measured through employment status or unemployment claims for mental health conditions – few countries are able to report them. Under the Data Questionnaire all data were requested with deliberately broad definitions; for those items where there are sufficient countries reporting data, a further phase of review by the Secretariat is being undertaken to assess the similarity of the sources and methods for the items, and their potential for comparability.

Table 7.2. Mental health data availability for national and international reporting

Country	Items answered in OECD 2020 Data Questionnaire (General Adult)	Reporting on OECD HCQO Indicators (max 4)	National/regional published indicator data set for mental health services
Australia	9		1
Austria	3		1
Belgium	4	1	1
Canada	7	1	1
Chile	-	4	
Czech Rep.	-	3	1
Denmark	11	4	1
Estonia	8		
Finland	-	5	
France	-		
Germany	-		
Greece	5		1
Hungary	-		
Iceland	-	3	1
Ireland	6		1
Israel	8	6	
Italy	9		
Japan	8		1
Korea	-	2	1
Latvia	7	4	1
Lithuania	10	4	1
Luxembourg	4		
Mexico	6		1
Netherland	12	4	1
New Zealand	-	4	
Norway	17	2	1
Poland	9	1	1
Portugal	-	1	
Slovak Rep.	-	3	
Slovenia	6	3	
Spain	-	1	
Sweden	13	4	
Switzerland	-	1	1
Turkey	-		
United Kingdom	18	4	1
United States	-		

Source: OECD (2020[11]), OECD Mental Health Benchmarking Data and Policy Questionnaires; OECD (2020[70]), OECD Health Statistics 2020, https://doi.org/10.1787/health-data-en.

There are a number of countries, including Australia, England, Denmark, Ireland, the Netherlands, New Zealand, and Norway, where extensive mental health data is available. In the Netherlands, mental health indicators include prevalence, service availability and contact rates as well as staff assessment of services, workforce flows, waiting times and absenteeism due to illness (Ministry of Health Netherlands, 2020[85]). In Norway, available indicators include experiences after a 24 hour inpatient stay, rate of individual care plans, involuntary admissions rates and waiting times (Directorate of Health, 2020[86]). Some countries – Australia, Canada and New Zealand – also stand out as countries where there has been notable mental health data innovation, including patient-reported, data to understand outcomes and recovery, tracking mental health outcomes across sectors, and data frameworks to understand mental health performance in a comprehensive way.

Box 7.3. Mental health performance frameworks in New Zealand

The New Zealand Mental Health and Addictions KPI Programme (KPI Programme) is a provider-led initiative, designed to bring about quality and performance improvement across the Mental Health and Addiction sector.

The KPI Framework was developed as a quality and performance improvement tool, to improve outcomes for people who use mental health and addiction services. The indicators are designed to be used as tools to promote greater understanding about the differences between services in different regions and to prompt discussion about the activities that lead to improved outcomes.

The specific goals of the KPI Programme are to implement the New Zealand KPI Benchmarking Framework into all district health boards (DHBs) and partnering non-governmental organisations (NGOs) to ensure sustainable benchmarking across the sector, in order to:

- maintain and strengthen clinical ownership and responsibility for provider performance.
- enable continued learning and innovation through the availability of comparative performance data and opportunities to actively challenge, question and share information between providers to achieve performance improvements.
- develop NGO capacity and capability to contribute to performance improvement in the broader system of care as well as the NGO sector.

There are also requirements for DHBs to report against a range of performance measures. These are reviewed every year; however, they often include one or more mental health service-related measures.

Source: OECD (2020[11]), OECD Mental Health Benchmarking Data and Policy Questionnaires.

However, available mental health measures – especially at the international level – still do not map fully onto the domains of performance that matter to OECD countries. The OECD Mental Health Performance Benchmarking project began by asking mental health stakeholders from across OECD countries, 'when it comes to mental health, what matters?', and in answer to this question the OECD Mental Health System Performance Framework was developed. Having started by identifying the performance principles that *should* be measured, rather than what already *could* be measured using available data, the gaps in available indicators were made clear. For example, it was not possible at even a single-country level to identify measures that track the Framework Principles and Sub-Principles such as how effective the mental health system or services empower individuals to realise their own potential, or prioritise efficient and effective distribution of resources, or ensure that services are based on best available evidence.

Do countries have mental health workforce capacity for future generations?

There is significant variation in mental health workforce capacity, between and within countries

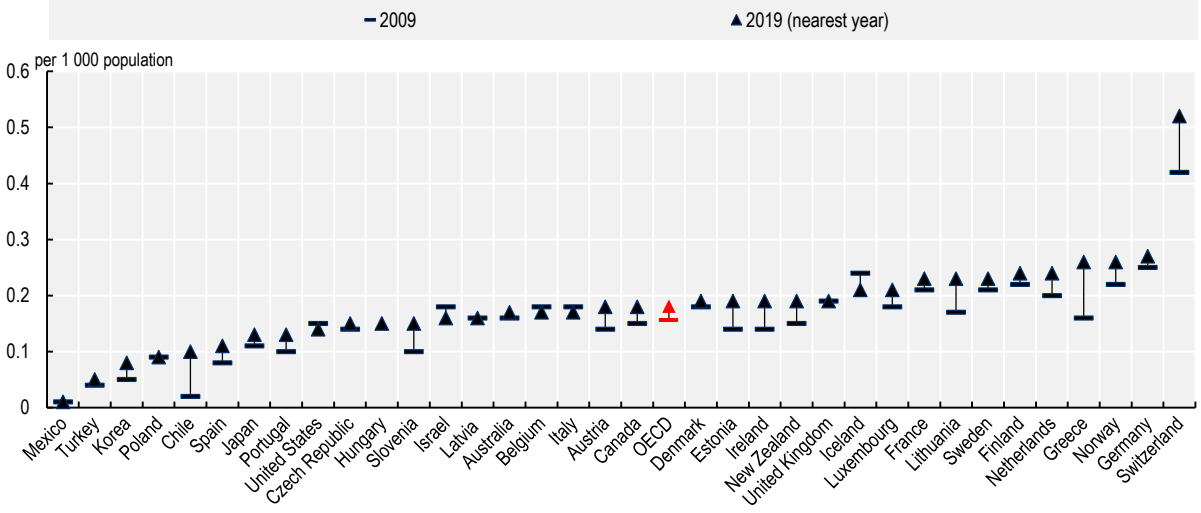
There is significant variation in the mental health workforce across OECD countries. For workforce categories for which data is most easily available, specifically psychiatrists, there is wide variation across countries. The number of psychiatrists per 1 000 population in 2019 ranged from 0.01 in Mexico, 0.05 in Turkey, 0.08 in Korea or 0.09 in Chile, to 0.25 or more in Greece, Norway and Germany, and 0.52 in Switzerland (OECD, 2020[70]), (Figure 7.3).

On average, the rate of psychiatrists increased between 2009 and 2019, from 0.16 per 1 000 population to 0.18; in some countries the increase was even more significant, more than 30% in Korea, Chile,

Portugal, Estonia, Ireland, Lithuania and Greece. In a few countries – the Czech Republic, Iceland, Israel, the United States – the rate of psychiatrists fell. In Israel the overall number of doctors has fallen over recent decades, but in other countries falls in the rate of psychiatrists do not reflect overall workforce trends (OECD, 2019[82]; OECD, 2020[70]). In the United States, the overall number of physicians per 1 000 population increased from 2.44 in 2009 to 2.61 in 2018, with other categories of physician such as primary care physicians and neurologists also increasing, while the rate of psychiatrists fell by 7% (OECD, 2020[70]; Bishop et al., 2016[87]). Challenges around recruitment of medical students into psychiatry which contribute to overall shortages have also been reported in Australia (although the overall rate of psychiatrists increased by 5.6% between 2014 and 2018 (Australian Institute of Health and Welfare, 2018[88]; Stampfer, 2011[89]), Canada (Lau et al., 2015[90]), and the United Kingdom (Goldacre et al., 2013[91]).

Within countries, psychiatrists (and other mental health specialists) are not necessarily well-distributed across the population. In 2013, analysis of the rate of physicians per population in the United States suggested that psychiatrists were particularly unequally geographically distributed (Bishop et al., 2016[87]). 2018 analysis found that rural countries had a significantly lower proportion of psychiatric residents in training, with likely long term workforce implications as psychiatrists are found to be likely to practice in the state they completed their residency (Beck et al., 2018[92]). In Australia, access to mental health care in rural and remote areas is a longstanding challenge, and workforce shortages in these areas contribute to the difficulties. In 2018 86.4% of psychiatrists in Australia were employed in major cities (where 72.0% of the population live), with 16.0 psychiatrists per 100 000 population in major cities, compared to 6.7 in remote areas and 3.1 in very remote areas (Australian Institute of Health and Welfare, 2018[88]). Though there was a higher rate of psychiatrists in major cities, the location of psychiatrists was more skewed towards less remote locations than all medical practitioners, for who there is almost double the workforce in major cities compared to remote areas.

Figure 7.3. Psychiatrists per 1 000 population, 2009 and 2019 or nearest year



Source: OECD (2020[70]), OECD Health Statistics 2020, https://doi.org/10.1787/health-data-en.

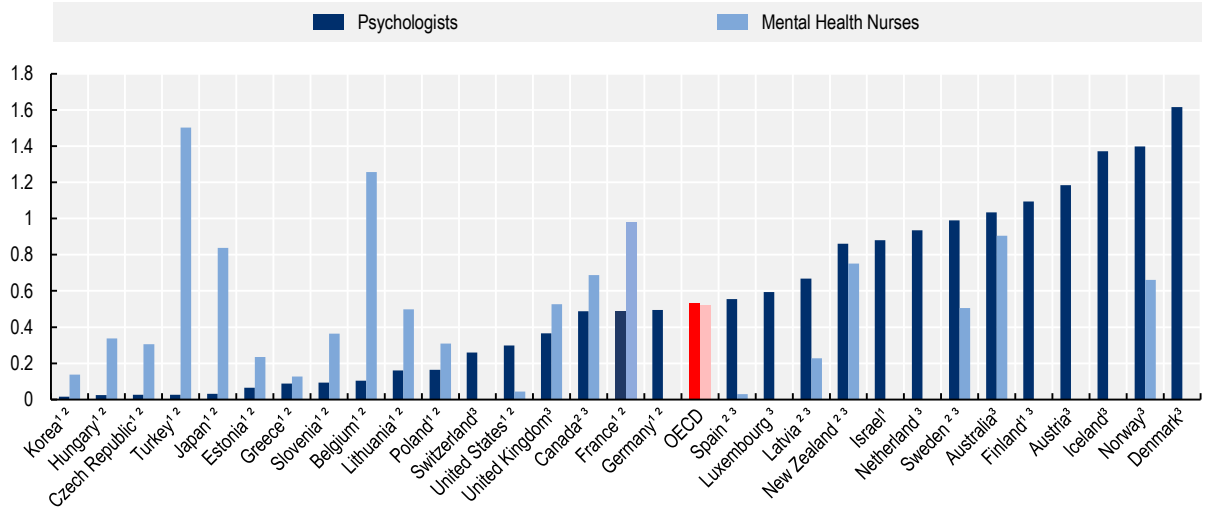
StatLink https://stat.link/yv2hbf

Other categories of mental health workforce play a critical role in delivering mental health services, including mental health nurses and psychologists, but also social workers, counsellors, General Practitioners or family doctors, occupational therapists, paramedics, and more. In many countries diverse teams of mental health professionals work together to deliver care. However, it is extremely difficult to collect workforce data for these diverse categories of mental health workforce; at the national level, this data is not routinely reported in all countries, and internationally there are significant comparability challenges. There are differences between countries in terms of how workforce data is reported (for example, full-time equivalent, all registered professionals, including or excluding private sector or non-hospital workers), as well as in terms of how mental health professionals are classified. For example, when it comes to psychologists there is significant variation in how psychologists are accredited, with some countries having single national accreditation systems for psychologists, and other countries having multiple accreditations or no nationally endorsed accreditation.

These comparability issues are a significant challenge for understanding the capacity and sustainability of the mental health workforce in OECD countries. However, given the diversity of different workforce categories involved in delivering mental health care, it is clear that reporting the rate of psychiatrists alone does not give a sufficiently good picture of the mental health workforce.

Keeping in mind the comparability challenges, a scan of available workforce data, drawn from national sources and the WHO 2017 Mental Health Atlas, suggests wide variations. Based on national sources, the number of psychologists per 1 000 population ranged from 0.095 in Estonia, to 1.4 in Norway and more than 1.6 in Denmark (Association of Estonian Psychologists, 2019[93]; Statistics Norway, 2020[94]; The Ministry of Health, 2017[95]).

Figure 7.4. Psychologists and mental health nurses per 1 000 population, 2018 or latest year



Note: Workforce reporting practices vary across countries, including but not limited to differences in recording full time or part time workers, inclusion of all qualified medical workforce or only active workforce, different classification systems especially for psychologists, and differences in inclusion or exclusion of workforce categories such as occupational therapists or social workers in mental health workforce estiamtes.
1. Data on number of psychologists taken from WHO Mental Health Atlas 2017; 2. Data on mental health nurses taken from WHO Mental Health Atlas 2017; 3. National sources used.
Source: Australia (https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce), Austria (http://gesundheitspsychologie.ehealth.gv.at/), Canada (https://www.statista.com/statistics/806108/psychologist-number-in-canada/), Denmark (https://www.sum.dk/English/~/media/Filer%20-%20Publikationer_i_pdf/2016/Healthcare-in-dk-16-dec/Healthcare-english-V16-dec.ashx), Iceland (http://sal.is/felagsmenn/starfsleyfi-salfraedinga/), Ireland (https://www.psychologicalsociety.ie/), Latvia (https://viis.lv/Pages/Psychologist/Public/PsychologistPublicSearch.aspx), Luxembourg (http://www.collegemedical.lu/Fr/Professionnels/default.asp?Type=145), Netherlands (https://www.bigregister.nl/over-het-big-register/cijfers), New Zealand (https://www.psychology.org.nz/), Norway (http://www.ssb.no/hesospers_en/, https://www.ssb.no/en/statbank/table/09551), Spain (http://www.infocoponline.es/pdf/epsc_2017.pdf), Sweden (https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/statistik/2019-9-6312.pdf), Switzerland (https://www.psychologie.ch/die-fsp/mitgliedschaft), United Kingdom (https://www.hcpc-uk.org/resources/freedom-of-information-requests/2019/number-of-psychologists-by-location-and-age---march-2019/; https://www.healthcareers.nhs.uk/explore-roles/nursing/roles-nursing/mental-health-nurse). All other data, WHO (2018[96]), Mental Health ATLAS 2017, http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/.

StatLink https://stat.link/dtehz9

Workforce projections show that action is needed to increase the numbers of mental health professionals

Mental health workforce shortages are reported in numerous OECD countries. However, due to weak workforce data and many countries not preparing workforce projections for the mental health sector, it is difficult to estimate the scale of the shortage, or the gap in workforce that would need to be filled. When workforce projections are prepared, they often focus on just a few categories of staff – notably psychiatrists, sometimes mental health nurses – and do not account for the diversity of workforce roles in mental health such as psychologists, social workers, occupational therapists, and General Practitioners.

Workforce projections take stock of the range of factors influencing workforce capacity in a sector, such as average age of the professionals, rate of training, recruitment of foreign workers, capacity for ongoing training or workforce retention rates. Making workforce projections means that steps can be taken to anticipate eventual workforce shortages. Given the time it takes to train and recruit new health professionals, workforce projections need to look at a multi-year or even multi-decade time horizon (Ono, Lafortune and Schoenstein, 2013[97]). Only 16 out of 29 countries that responded to the OECD Mental Health Performance Benchmarking Policy Questionnaire indicated that they prepare mental health

workforce projections, or include mental health workforce in overall workforce projections (OECD, 2020[11]). In some countries, such as Canada, workforce planning is de-centralised responsibility, and workforce projections are not undertaken nationally but by professional associations.

Where countries have undertaken workforce projections for the mental health sector, they tend to highlight both existing and escalating workforce shortages. The Association of American Medical Colleges has identified an escalating shortage of psychiatrists, driven by factors including lower reimbursement rates for mental health providers, and the fact that more than 60% of psychiatrists are over the age of 55, one of the highest proportions of older physicians across all specialties (AAMC, 2018[98]). A 2016 report from the Australian Government Department of Health identified that workforce shortages for psychiatry are focused in the public sector, with acute psychiatry and adolescent psychiatry particular areas of concern (Department of Health, 2016[99]). The same report projects a future undersupply of 125 psychiatrists by 2030 based an anticipated 2% increase per year in Australia (Department of Health, 2016[99]); between 2014 and 2018 the mental health workforce trend was already towards an increase in Australia, with an increase in psychiatrists (+ 5.6%), mental health nurses (+ 4.0%) and psychologists (+ 5.5%) (Australian Institute of Health and Welfare, 2018[88]).

Some workforce plans also target increases in the mental health workforce, and in some cases a diversification of staff roles in mental health. In England, *'Stepping forward to 2020/21: the mental health workforce plan for England'* set the target of establishing a total of 21 000 new mental health workforce posts between 2017 and 2021 (Health Education England, 2017[100]). This same strategy also takes stock of a greater diversity of staff roles. For example, in England the 2020/21 workforce plan included establishing a significant number of new posts, including 11 000 'traditional' posts such as nurses, occupational therapists or doctors, and 8 000 posts in diverse roles such as peer support workers, personal well-being practitioners, or call handlers (ibid).

Improving performance: future-focused and innovative policies and practices

Prioritising mental health workforce growth, new workforce categories and models

As this chapter has identified, there are significant variations in the availability of mental health workforce across OECD countries, and many countries are confronted with – or will be confronted with – workforce shortages in key professions. There is a clear need for countries to undertake their own workforce projections for the mental health system, and at the same time international understanding of mental health workforce levels and distribution would be greatly helped by more consistency in workforce data reporting, which is a real challenge currently.

At the same time, there are ways that workforce capacity in the mental health field could be increased alongside 'traditional' workforce categories such as psychiatrists, psychiatric nurses, and psychologists. Some countries are looking to integrate a wider range of different workforce categories in their mental health workforce planning. In England's *'Stepping forward to 2020/21: the mental health workforce plan for England'* which set the target of increasing the mental health workforce, the strategy also takes stock of a greater diversity of staff roles. For example, in England the 2020/21 workforce plan included establishing a significant number of new posts, including 11 000 'traditional' posts such as nurses, occupational therapists or doctors, and 8 000 posts in diverse roles such as peer support workers, personal well-being practitioners, or call handlers (Health Education England, 2017[100]). Many countries are also increasingly offering mental health training to key front line actors, such as police, emergency departments, and teachers, as well as for the general population; while such training does not replace specialised mental health care, it can provide crucial low-threshold support to people experiencing mental distress, or in need of directing towards appropriate services (see also Chapter 4).

Some OECD countries are actively promoting the involvement of mental health service users, or former service users, in the delivery of mental health services. In England, the mental health strategy "No Health Without Mental Health" called for staff with experience and expertise to deliver individualised mental health care in resource-limited settings (Department of Health and Social Care, 2011[101]). Since then, England has been actively pursuing research into more extensive use of peer workers (people with personal experience of mental health issues) within the mental health system following evidence that peer support can bring benefits such as enhanced feeling of empowerment, better social support and increased personal recovery (Gillard, Edwards, Gibson, Owen, & Wright, 2013). In both Ireland and Australia evaluations of the impact on Peer Support Worker (in Ireland), and peer workers (in Australia) users found overwhelmingly positive feedback from mental health service users (see also Chapter 2). In Australia, peer support workers also reported that their work had positive impacts on their own mental health (Health Workforce Australia, 2014).

Digital apps and tools offer the possibility of massively increasing access to mental health support, but need to be integrated into the mental health system

The COVID-19 crisis has rapidly accelerated the use of digital mental health care, most notably telemedicine-delivered services, openly accessible phone and online support services, and app-based or online tools for self-screening, self-management, or treatment, and blended treatment integrating self-help and practitioner-led therapies. These services have the potential to respond to some of the significant unmet need for mental health care, have scope to support better outcomes, and in the case of app-based technologies could help massively scale-up access at a relatively low cost (Moreno et al., 2020[23]; Naslund et al., 2017[102]). Preliminary results have also shown that clinicians and clients have been positive about the uptake of digital services for the delivery of mental health during COVID-19, with service users reporting high levels of satisfaction with video-delivered services, good levels of adherence to treatment and some practitioners reporting more frequent check ins with clients (Torous et al., 2020[103]; Feijt et al., 2020[22]; Ramaswamy et al., 2020[104]).

Sustaining the positive growth of digital tools in mental health care will require efforts to integrate digital tools and technologies into the broader mental health system. Increasing access to telemedicine services for mental health has, for example, demanded changes to privacy regulations around use of online technologies, or reimbursement schedules. For example, the United States made changes around telehealth with federal regulations temporarily permitting unprecedented access across state lines and non-secure platforms (Gratzer et al., 2020[26]).

When it comes to the use of more diverse digital tools such as apps developed by private companies, the issues of ensuring integration with the mental health system, maintaining user privacy, and assuring quality are key issues. For example adherence to digital tools for health tracking is supported by support from an in-person practitioner (Moreno et al., 2020[23]; Simblett et al., 2018[105]), but privacy concerns or legislative structures can limit practitioners' access to the self-monitoring data generated by the app user.

The European-level 'eMEN' project looks at how digital health solutions and specifically e-mental health can be used to improve quality and access to mental health services, and scaling-up safe and effective implementation of e-mental health technologies in European Union member states. Currently, eMEN is running e-mental health pilots in the Netherlands, Belgium, Germany, the United Kingdom, France and Ireland, and the challenge of health system integration is a recurring theme (eMEN, 2020[106]).

There are also ways that countries can take a more proactive role in quality checks for freely available mental health support tools. In England, NICE has been assessing digital therapies to be accepted under the Improving Access to Psychological Therapies Programme (IAPT) (NICE, 2020[107]), while England's NHS apps library guides service users towards apps found to be effective, which they can often access without referral (Vlijter, 2020[43]; NHS, 2020[35]). In Australia, too, the government has developed a digital mental health gateway which aims to guide people towards trusted information and digital tools (Box 7.4).

Box 7.4. Head to Health – the Australian Government's digital mental health gateway

Head to Health is the Australian Government's digital mental health gateway and lists quality digital mental health resources delivered by trusted Australian service providers. Head to Health aims to help people more easily access information, advice and free or low cost mental health services and supports, that most suit their needs. Currently, as part of a quality assurance mechanism, only digital resources funded by the Commonwealth or state/territory governments are listed on Head to Health.

In early 2018, an internal assessment was undertaken to evaluate the implementation of Head to Health post launch. This assessment has informed future considerations around ongoing operations of the site, and has also been of value in informing the development of new IT-enabled products the Department of Health (the Department) has undertaken. It also provided a comparison against the predecessor to Head to Health, mindhealthconnect.

While funding has not been available to support an independent review of the effectiveness and performance of Head to Health, the Department routinely collects data and analytics on how the site is performing and resonating with end users, including through a monthly Digital Activity Report. Visits to the site increased significantly as the COVID pandemic emerged. Current statistics (from launch in October 2017 to March 2021) indicate:

- 2 742 753 sessions (averaging approximately 2 100 per day);
- a low bounce rate of 25.47% (a bounce is where a user views only one page and then leaves the site);
- 4 404 959 page views;
- Average session time of 2 minutes 16 seconds;
- Average pages viewed per session of 1.61;
- A total of 247 166 conversions including search completions, decision support tool completions (Sam the Chatbot), email resources, and print resources requests;
- An average of 6 500+ outbound referrals per month to the resources listed on Head to Health.

The Department conducted a general survey of Head to Health users in the second half of 2019. This survey aimed to measure people's satisfaction with Head to Health, gather feedback to inform future enhancements and improve the user experience. Responses to the survey indicated that the:

- Majority of users (62%) found it easy or very easy to find what they were looking for on Head to Health;
- Majority of users (88%) trust the information and resources on Head to Health a moderate amount, a lot, or a great deal;
- Majority of users (81%) find the resources on Head to Health somewhat relevant, relevant or extremely relevant;
- Majority of users (88%) rate their experience on Head to Health as okay, good or great;
- Majority of users (81%) are likely to recommend Head to Health to someone else.

Source: Department of Health (2021[108]), *Head to Health*, https://headtohealth.gov.au/, accessed 15 May 2021.

Evidence shows that a significant number of mental health treatments are efficient and effective, and should be prioritised in mental health systems

While it is extremely difficult to assess the overall efficiency and effectiveness of mental health systems, there is both good and growing evidence of which mental health interventions are effective and efficient, and countries have been taking steps to ensure that these interventions are prioritised. The evidence-base for effective mental health services is significant even if significant scope for further research remains (see Chapter 3 of this report, as well as the WHO guidelines on mental health and substance abuse (WHO, 2020[109]), and the forthcoming WHO menu of mental health 'best buys' (WHO, 2019[110])).

Clinical guidelines are one way that evidence-based practices can be disseminated and widely used in OECD in countries. Clinical guidelines for the diagnosis, treatment and management of mental health conditions were used in 21 OECD countries in 2012, and since then the availability of clinical guidelines for mental health conditions – covering more conditions, covering more specific patient groups – has grown (Hewlett and Moran, 2014[84]). For example, the National Institute for Clinical Excellence (NICE) in the United Kingdom now has at least one set of clinical guidance – often accompanied by a care pathway, quality standard, or less formal 'NICE advice' – across 15 broad categories of mental health and behavioural conditions (NICE, 2020[111]).

Some countries are also taking steps to ensure that investments in mental health are directed towards evidence-based services, and that mental health system reforms make evidence-based services a priority. In the Czech Republic, a mental health system reform that began in 2013 which included the aim of supporting evidence-based mental health care development. Together with the WHO, the Czech Government has assessed the quality of care in Czech psychiatric hospitals to improve care, and developed a system for evidence-based decision making and monitoring of the quality and performance of the Czech mental health care system. The system to support evidence based mental health care development in the Czech Republic consists of both macro and micro level indicators: macro level indicators look at mental health care structure and performance (such as structure of care, or mortality), and micro-level indicators are based on outcome measurement in psychiatry with the Global Assessment of Functioning, Health of the Nation Outcome Scale, and Assessment of Quality of Life in order to evaluate existing services as well as new innovative programs. As part of this ongoing reform work, a comparison of cost-effectiveness of different types of care for people with chronic psychotic disorders, comparing discharged into community services, with inpatient psychiatric care for at least three months, was undertaken (Winkler et al., 2018[66]). This study found that discharge into community services for people with psychosis represented similar outcomes in terms of Quality Adjusted Life Years (QUALYs), but that the costs of discharge to the community were around half the cost of ongoing inpatient care, and underscored how discharge to community care is cost-effective compared with care in psychiatric hospitals in the Czech Republic.

Further data development is needed to make international mental health benchmarking more effective

In some areas of mental health system performance, with the input of experts participating in the Virtual Workshops on Mental Health Performance Benchmarking held in September 2020, indicators which would be important tools for understanding performance but are not yet available across multiple countries were identified. In particular, more robust indicators are needed on: on well-being, positive mental health and social cohesion; prevalence of mental ill-health, unmet need for care, and health care coverage; on mental health workforce and diverse care providers, and workforce training; on research; on integrated care including integration with somatic care, and physical health outcomes; and on disparities within national population groups. The COVID-19 context, in which significant amounts of mental health care were moved to non-face-to-face formats, also highlighted the importance of indicators on changing care delivery

methods, for example the rate of services delivered through telemedicine formats, preferably broken down by format (e.g. video, phone, app-based or chat-based).

Recognising some of these gaps, several indicators where data is not yet available across multiple countries, but where there is a critical importance for understanding mental health performance, were included in the Mental Health System Performance Benchmark. Specifically, these are: patient-reported outcomes (PROMs), population attitudes towards mental health for example mental health literacy or levels of stigma, and use of telemedicine in mental health care. These are areas where further development of internationally comparable indicators is warranted,

Additionally, there is clear scope to continue to focus on strengthening the availability of internationally measures of mental health system quality and outcomes. Across the indicators included in the data collection for this report (OECD, 2020[11]), it was by far measures of 'inputs' – service contacts, admissions – that were the most consistently reported across countries, while expert stakeholders engaged with the project consistently stressed the importance of focusing on quality and outcomes as priorities for understanding performance.

There are some newly collected indicators – follow-up after discharge, repeat readmissions to inpatient care, repeat emergency department contact for mental health reasons – that bring more insights into care quality and processes, and which several countries were able to report (Chapter 3). Other indicators which could have been promising, for example on restrictive practices (seclusion and restraint), or involuntary admissions, showed significant variation across countries in terms of definition and practice guidelines, and do not currently appear adept for routine international comparisons.

More measures of quality and outcomes are warranted, even as important gaps in 'input' measures remain

In some areas of mental health system performance, with the input of experts participating in the Virtual Workshops on Mental Health Performance Benchmarking held in September 2020, indicators which would be important tools for understanding performance but are not yet available across multiple countries were identified. In particular, more robust indicators are needed on: on well-being, positive mental health and social cohesion; prevalence of mental ill-health, unmet need for care, and health care coverage; on mental health workforce and diverse care providers, and workforce training; on research; on integrated care including integration with somatic care, and physical health outcomes; and on disparities within national population groups. The COVID-19 context, in which significant amounts of mental health care were moved to non face-to-face formats, also highlighted the importance of indicators on changing care delivery methods, for example the rate of services delivered through telemedicine formats, preferably broken down by format (e.g. video, phone, app-based or chat-based).

Recognising some of these gaps, several indicators where data is not yet available across multiple countries, but where there is a critical importance for understanding mental health performance, were included in the Mental Health System Performance Benchmark (OECD, 2020[11]) (see 'Key Findings' chapter in this report). Specifically, as a minimum these are: patient-reported outcomes (PROMs), population attitudes towards mental health for example mental health literacy or levels of stigma, and use of telemedicine in mental health care. These are areas where further development of internationally comparable indicators is warranted.

Additionally, there is clear scope to continue to focus on strengthening the availability of internationally measures of mental health system quality and outcomes. Across the indicators included in the data collection for this project (OECD, 2020[11]), it was by far measures of 'inputs' – service contacts, admissions – that were the most consistently reported across countries, while expert stakeholders engaged with the project consistently stressed the importance of focusing on quality and outcomes as priorities for understanding performance.

There are some newly collected indicators – follow-up after discharge, repeat readmissions to inpatient care, repeat emergency department contact for mental health reasons – that bring more insights into care quality and processes, and which several countries were able to report. It is suggested that these indicators are further discussed in the context of the HCQO Expert Group, and considered for more routine collection. Other indicators which could have been promising, for example on restrictive practices (seclusion and restraint), or involuntary admissions, showed significant variation across countries in terms of definition and practice guidelines, and do not currently appear adept for routine international comparisons.

Patient-reported measures should be at the centre of policy making and service-monitoring

The continuing gaps in availability of meaningful indicators of the dimensions of mental health performance that matter, as identified in the OECD Mental Health Performance Framework, underscore the importance of developing new measures. In particular, there is clearly space for more internationally comparable reporting on mental health service users' experiences (PREMs) and outcomes (PROMs). At present, systematic patient reporting in mental health is in its infancy. As of 2018, a survey from the OECD showed that only five of the 12 countries surveyed (Australia, Israel, the Netherlands, Sweden, the United Kingdom) reported PROMs and PREMs collection on a regular basis in mental health settings. Only Australia, the Netherlands and England reported that they collected and routinely reported both. Furthermore, patient-reported data in mental health covers a wide and diverse range of conditions, settings, interventions and patient populations.

Since May 2018, the OECD has been working with patients, clinicians and policy makers in a Working Group to develop mental health PREM and PROM data collection that enable international comparisons with 17 countries involved. The main objective is to develop PREM and PROM data collection standards in mental health for international benchmarking of patient-reported outcomes. Three domains which have international coherence have been identified for PREMs (respect and dignity, communication and relationship with health care team and shared decision making), and PROMs (relief of symptom burden, restoring well-being/social function and recovery support). The Working Group is looking towards a pilot PROM data collection, beginning with hospital care, focused on the domain of well-being, drawing on the OECD Guidelines on Measuring Subjective Well-being and the WHO-5 Well-Being Index questionnaire that measures current mental well-being (time-frame of the previous two weeks). For a pilot PREM data collection, again beginning with hospital care, the items already collected through the OECD's HCQO's regular PREM data collection is underway, with an additional item on courtesy and respect adapted from the Commonwealth Fund Questionnaire. It is expected that some pilot data will be available to be reported in *Health at a Glance 2021*.

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OECD Health Policy Studies

A New Benchmark for Mental Health Systems

TACKLING THE SOCIAL AND ECONOMIC COSTS OF MENTAL ILL-HEALTH

Mental ill-health affects millions of people, and drives economic costs of more than 4% of GDP. A good mental health system helps people stay in good mental health, and connects those in need to appropriate support to manage their mental health condition or even fully recover from it. However, mental health care has long been neglected and under-funded, and unmet need for care is still high. The long-lasting COVID-19 crisis and the toll it is taking on mental health has made mental health systems more important than ever. This timely report provides an in-depth analysis of how well countries are delivering the policies and services that matter for mental health system performance. The report highlights recent reforms countries have taken to strengthen mental health performance, including by increasing access to mental health care, ensuring that service users take the lead in planning and even delivering services, and prioritising integration and mental health promotion. The report also identifies promising approaches countries should pursue to better meet their populations' mental health needs. This report sets up a framework for understanding mental health performance through internationally comparable indicators, an approach set to grow stronger still in the coming years as more data become available.

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