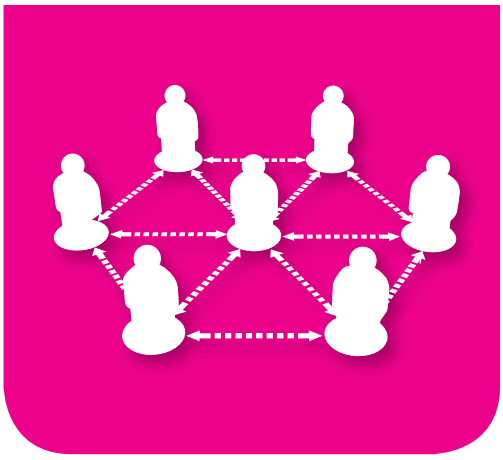
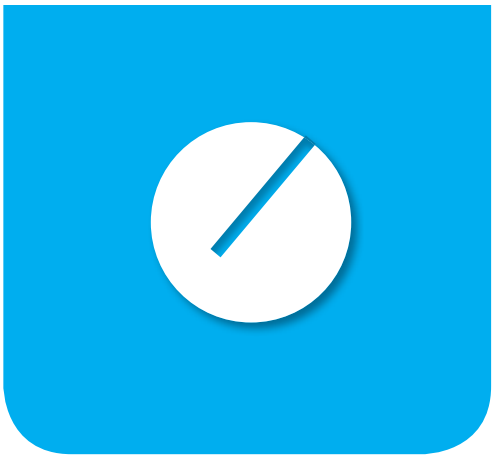
OECD Health Policy Studies

Making Mental Health Count

THE SOCIAL AND ECONOMIC COSTS OF NEGLECTING MENTAL HEALTH CARE





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THE SOCIAL AND ECONOMIC COSTS OF NEGLECTING MENTAL HEALTH CARE

Emily Hewlett and Valerie Moran

OCDE

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Foreword

Mental ill-health imposes a huge burden on individuals, their families, society, health systems and the economy. Yet mental health care remains a neglected area of health policy in far too many countries. This state of affairs should not be accepted. The social and economic costs of neglecting mental health care are too high. More must be done to make mental health count.

Making Mental Health Count *examines mental health, mental disorders, and mental health systems across OECD countries, and argues that there is still a long way to go to secure high-quality mental health care. Indicators of mental health care quality and outcomes are slowly being developed, and new payment systems are promoting care co-ordination at the primary care level. The workforce is becoming more flexible and responsive to changing patient needs and models of care. Greater attention to mild and moderate disorders – and their prevention – is proving to be good value for money. However, more must be done to improve services for people with mental health problems, for example by further improving measurement of quality in mental health, setting payment incentives that reward better integration of services, and developing appropriate workforce skills to meet mental health needs.*

This book is the result of a project conducted between 2010 and 2013 by the OECD. Using a mix of quantitative and qualitative methods, including information collected through a fact-finding and policy questionnaire covering 37 countries, this report suggests key polices and strategies that can help deliver better mental health care, and help create stronger mental health systems. It highlights examples of useful country experiences, but it also warns about the lack of data and empirical evidence, especially internationally comparable data, for many aspects of mental health. Making Mental Health Count *makes a strong argument for investing in improved data on costs, outcomes, and quality, in order to better understand the state of mental health in OECD countries. Policy makers and practitioners often know what needs to be done to improve mental health care: more information resources, more evidence-based services, more co-ordinated care, more incentives for good outcomes. What blocks them is a combination of a lack of resources and misplaced priorities. The cost to our economies and societies is too high for this to continue to be tolerated.*

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Acronyms and abbreviations

ACT	Assertive Community Treatment
ADHD	Attention Deficit and Hyperactivity Disorder
AMHP	Approved mental health professional
AMS	Aboriginal Medical Services
APPN	Advanced Practice Psychiatric Nurse
ASPEN	Anti Stigma Programme European Network
ASW	Approved social worker
ATAPS	Access to Allied Psychological Services
AUD	Australia dollar
BKZ	*Budgettair Kader Zorg* (Netherlands)
CAD	Canadian dollar
CBT	Cognitive Behaviour Therapy
CCG	Clinical commissioning groups
CCG OIS	Clinical Commissioning Group Outcomes Indicator Set
CIDI	Composite International Diagnostic Interview
CMD	Common mental disorder
CMHC	Community Mental Health Centre
CMHT	Community Mental Health Team
COAG	Council of Australian Governments
CPD	Continuing professional development
CPT	European Council for the Prevention of Torture
CPC	Care Quality Commission
CRHT	Crisis Resolution/Home Treatment Team
CRPD	UN Convention on the Rights of Persons with Disabilities
CTO	Community Treatment Order
CVD	Cardiovascular disease
CYP IAPT	Children and Young People Improving Access to Psychological Therapies
DALY	Disability adjusted life year
DBC	Diagnostic treatment combination
DRG	Diagnosis Related Group
DSM	Diagnostic and Statistical Manual of Mental Disorders
DTC	Diagnostic Treatment Combination (Netherlands)
DUP	Duration of untreated psychosis
EAP	Employee Assistance Programmes
EI	Early intervention
ESEMeD	European Study of the Epidemiology of Mental Disorders
EUFAMI	European Federation of Associations of Families of People with Mental Illness
FFS	Fee for service

FPS	Focused Psychological Strategies
FRA	European Union Agency for Fundamental Rights
FTE	Full-time equivalent
GAD	Generalised anxiety disorder
GBP	Great Britain pound
GDP	Gross domestic product
GHPU	General Hospital Psychiatric Unit
GP	General practitioner
HCQI	Health Care Quality Indicators
HoNOS	Health of the Nation Outcome Scales
IAPT	Improving Access to Psychological Therapies
IB	Individual budget
ICD	International Classification of Disease
ICM	Intensive Case Management
IEC	International Electrotechnical Commission
IIMHL	International Initiative for Mental Health Leadership
IPF PPS	Inpatient Psychiatric Facilities Prospective Payment System
IPS	Individual Placement and Support
ISHMT	International Short List of Hospital Morbidity Tabulation
ISO	International Organization for Standardization
IT	Information technology
MAOI	Monomine oxidase inhibitors
MH-CASC	Mental Health Classification and Service Cost
MHCT	Mental Health Clustering Tool
MHEEN	Mental Health Economics European Network
MHMDS	Mental Health Minimum Data Set
MHNIP	Mental Health Nurse Incentive Programme (Australia)
MHP	Mental health practitioner
NASMHPD	National Association of State Mental Health Program Directors
NCD	Non-communicable disease
NGO	Non-governmental organisations
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NOCC	National Outcomes and Casemix Collection
NOMS	National Outcomes Measures
NZD	New Zealand dollar
OCD	Obsessive compulsive disorder
PB	Personal budget
PCMHW	Primary care mental health worker
PEPP	Consolidated Payment System for Psychiatry and Psychosomatics
PICU	Psychiatric Intensive Care Unit
PYLL	Potential years of life lost
QALY	Quality adjusted life year
QOF	Quality and Outcomes Framework (United Kingdom)
SAMHSA	Substance Abuse and Mental Health Services Administration
SARN	Summary of Assessments of Risk and Need
SDQ	Strength and Difficulties Questionnaire

SE	Supported employment
SHA	System of Health Accounts
SHARE	Survey of Health Ageing and Retirement
SMI	Severe mental illness
SSRI	Selective serotonin reuptake inhibitors
STR	Support, Time and Recovery (United Kingdom)
UFM	User Focused Monitoring
UHR	Ultra-high risk
Wonca	World Organization of Family Doctors
WPA	World Psychiatric Association

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Executive summary

Despite the enormous epidemiological, social and economic burden of mental ill-health, mental health care is still not a priority in most health systems. The current weak state of mental health care is unacceptable. More must be done to make mental health count and improve the lives of those suffering from mental ill-health: policy makers must give mental health the importance it demands in terms of resources and policy prioritisation.

The over-arching policy direction for mental health systems in OECD countries in the last few decades has been "deinstitutionalisation": moving people out of mental hospitals, towards care in the community. While many countries – such as Australia, Italy, the United States, the United Kingdom, Norway and Sweden – have made significant strides in shifting care delivery from psychiatric institutions to community-based settings, in some countries inpatient care still remains dominant, for example in Korea and Japan. Despite this change, the care provided for mental disorders in most OECD countries leaves much to be desired. Policy makers continue to struggle with finding the right balance between hospital and community-based care, services for common mental disorders such depression are weak and under-provided, and the unmet need for treatment for mental disorders remains high.

A clear picture of the status of mental health systems is lacking. Few countries can reliably measure the resources they devote to mental health care, in particular to primary care and other forms of community-based services, meaning that governments cannot fully quantify the cost of mental illness. The absence of comprehensive data on quality and outcomes, in turn, inhibits a full assessment of mental health system performance. The result is poor policies – in particular, an inability to focus scarce resources on those areas of care that will lead to improved functioning and better outcomes, including under-treated mild-to-moderate disorders such as depression and anxiety.

With many countries facing cuts to public budgets and a difficult fiscal environment, a report pointing out major gaps in the provision of mental health services may seem ill-timed. Yet, difficult economic times accentuate the need to treat mental disorders. There is evidence that mental well-being has fallen in the past three years – Europeans were reporting feeling "more negative" in 2010 than in 2005-06, according to the Eurobarometer Survey – but the more convincing and important consideration is the effect of untreated mental disorder on economic productivity. Mental disorders have a huge labour market cost: OECD data suggests that one in five working age people have had a mental problem at some point in time, reducing their employment prospects, productivity and wages. The high costs of mental ill-health for society suggest a strong need for better services.

Despite this bleak picture, progress in some countries suggests what a modern, high-quality and cost-effective mental health care system would look like. Indicators of mental health care quality and outcomes are slowly being developed, for example in

Australia, Sweden and the United States. Payment systems are being reformed in England and the Netherlands to promote good care co-ordination, cost-efficiency and good outcomes. Workforce configurations are evolving to become more flexible and responsive to changing patient needs and models of care in many OECD countries. Greater attention to mild and moderate disorders – and their prevention – is proving to be good value for money. And yet, in the future, more can and must still be done.

Key findings and recommendations

The burden of mental ill-health is very high

- The direct and indirect costs of mental ill-health are very high, and can amount to over 4% of GDP.
- Mental disorders have a significant societal impact, contributing to unemployment, sickness absence, and lost productivity at work.
- Mild-to-moderate disorders affect around 20% of the working-age population in the average OECD country, and are predominantly highly treatable disorders such as anxiety and depression.
- People with severe mental illness die up to 20 years younger, have much higher unemployment, and are poorer than the general population.

Better measurement of mental health and mental health systems is needed

- Improving the mental health of the population and mental health systems depends upon good information about mental wellbeing and the prevalence of mental ill-health.
- There is a need for better internationally comparable cost data and better data on spending outside of hospitals.

Evidence-based treatments should be scaled-up

- Increased use of innovative evidence-based treatments, such as psychological therapies and eMental Health will help address the treatment gap for mild-to-moderate disorders.
- Scaling-up effective treatments can represent good value-for-money, as the economic benefits of spending on better mental health care will be seen in increasing productivity and helping people with mental illnesses go back to work.
- Countries must ensure that treatment efficacy drives decisions about which services to put in place, rather than historical or social trends in the mental health care sector.

The primary care sector can play a bigger role in securing better mental health

- Care for mild-to-moderate disorders in primary care should be strengthened through training for primary care practitioners, promoting collaboration between primary care and specialist services, putting in place primary care-appropriate clinical guidelines, and using financial incentives to promote care provision.
- A stronger co-ordinating role for primary care is a key way that OECD countries should look to deliver more integrated care for severe mental illness.

Provider incentives should be aligned with desired outcomes

- Conceptual frameworks and measurement tools are needed to define good outcomes for mental health care, and should be used to track and benchmark services.
- Data should be used as part of provider contracts and payment systems, to define policy, and to monitor targets.
- Provider payment systems that encourage desirable provider behaviour and good outcomes should be used much more widely.

Assessment and recommendations

The burden of mental ill-health is too high

The epidemiological, social and economic burden of mental ill-health in OECD countries is enormous.

Mental disorders account for a significant burden of disease worldwide, especially in middle and upper income countries such as OECD countries. The companion study to this book, *Sick on the Job? Myths and Realities about Mental Health and Work* (OECD, 2012), found that at any given moment, on average in the OECD around 20% of the working-age population is suffering from a mental disorder that reaches the clinical threshold for diagnosis.[1] Lifetime prevalence has been shown to reach levels up to 50%: one person in two will have a mental health problem at some point in their lifetime. Even more worryingly, estimates suggest that up to 60% of those who need treatment do not get it.

People with mental disorders often also have physical disorders and this can lead to increased mortality, poorer health outcomes, and higher associated health care costs. Individuals with severe mental illnesses (typically acute cases of depression, bipolar disorder and schizophrenia) experience reduced life expectancy, dying up to 20 years earlier than the general population. In England, people with severe mental illness are three times more likely to die early than the general population, while in Nordic countries, those admitted to hospital for a mental disorder have a mortality rate two to three times higher than the general population, with this gap more pronounced for men than for women. In Australia, men with psychiatric disorders die almost 16 years earlier than the general population, while the gap is 12 years for women.

Not only does mental health represent a significant disease burden, it is also very costly to OECD economies. Globally, the total costs – direct and indirect – of mental ill-health were estimated at USD 2 493 billion in 2010. In the European Union, the cost was estimated to be equivalent to a loss of 3-4% of total GDP in 2004. It has been estimated at 4.4% of GDP in Canada, 4.1% of GDP in England, and 2.3% of GDP in France. Spending on mental health can be one the highest areas of health expenditure, representing between 5% and 18% of total health expenditures for a selection of countries able to break down total spending (Germany, Hungary, Korea, the Netherlands and Slovenia). While these figures can point to high spending for mental health, it may still not be commensurate to the high prevalence and burden of disease represented by mental ill-health. The proportion of total public health expenditure allocated to mental health care is often very small. For example, mental illness is responsible for 23% of England's total burden of disease, but receives 13% of National Health Service health expenditures.

The indirect costs of mental health – the economic consequences attributable to disease, illness, or injury resulting in lost resources, but which do not involve direct payments related to the disease – are particularly high. This includes the value of

lost production due to unemployment, absences from work, presenteeism (the loss in productivity that occurs when employees come to work even when unwell and consequently function at less than full capacity) or premature mortality. *Sick on the Job? Myths and Realities about Mental Health and Work* (OECD, 2012) found that mild-to-moderate mental illnesses such as depression or anxiety disorder[2] have a strong relationship with higher unemployment, higher absenteeism, lower productivity in the workplace, and a rising burden of disability benefits claims. *Drinking Lives Away* (OECD, 2014, forthcoming) provides evidence of the employment and productivity outcomes of alcohol-use disorders, and their broader social impacts.

Indeed, across OECD countries, 88% of workers with a severe mental disorder stated that they accomplished less than they would like as a result of an emotional or physical problem, compared to 69% of those with moderate disorders, and 26% of those with no mental disorder. Unemployment is also a key issue for people with severe mental illness; they are typically six to seven times more likely to be unemployed than people with no such disorder. *Sick on the Job?* (OECD, 2012) and the accompanying reviews of mental health and employment policies in OECD countries clearly highlight the shortcomings in the way that the employment systems of OECD countries address sick leave, disability and joblessness amongst populations with mental health needs.

This report complements *Sick on the Job? to* underline how OECD health systems are not doing enough to improve mental wellbeing. OECD health systems should be doing more to help get people back to work and working productively, and reduce the economic burden of mental ill-health. OECD countries must do more to make mental health count: policy makers must give mental health the importance it demands, in terms of resources and policy prioritisation, while the care delivered for mental health must, simultaneously, add up and make good economic sense. To reduce the burden of mental ill-health, commitment to mental health should remain high, while decision making about where to direct precious resources needs to get better. Making the right prioritisations for mental health, based on good information, will be key.

There are three things that countries must do to respond better to the growing urgency of poor mental health:

- Measure mental health to better understand the scale of the problem, and what works in tackling it.
- Increase provision of evidence-based services, especially through expanding the role of the primary care sector, with appropriate system-wide support.
- Secure better outcomes for mental disorders through better use of incentives.

Measure mental health to better understand the scale of the problem, and what works in tackling it

The first crucial step that policy makers must take towards tackling the high burden of mental ill-health, while using scarce resources as effectively as possible, is to improve measurement and data availability. There is shockingly little information on almost all aspects of mental health in OECD countries, which means that policy makers cannot fully understand the scale of the challenge of mental ill-health, or what works in tackling it. There is too little evaluation of the prevalence of mental disorders, the costs of mental ill-health, treatment outcomes and service quality. This information is crucial if policy makers are to commit greater resources to mental health care, to prioritise areas of greatest need, and

make sensible decisions about effective and efficient care for mental ill-health. A better information infrastructure will be the foundation of stronger mental health systems. There are three building blocks for making this happen: understanding the prevalence of mental ill-health; measuring the high costs of mental ill-health; and tracking treatment outcomes and care quality.

Understanding the prevalence of mental ill-health

There are strong indications that the burden of mental ill-health is high, but not all countries are doing enough to measure and understand the prevalence of mental disorders across their population. In order to address the large treatment gap for mental illnesses, and the significant individual, social, and economic costs associated with mental ill-health, there is a need to systematically measure the prevalence of mental disorders and estimate unmet need. Detailed and up-to-date information on the prevalence of mental disorders can help countries make better decisions about how to best target scarce resources for tackling mental ill-health, and can serve as a starting point for understanding which mental health policies are working, and which need further attention and reflection.

Household surveys as well as national and international health surveys can be used to inform and improve mental health services, but these instruments, which exist in less than half of OECD countries, are not standardised, and vary in their ability to capture the prevalence of mental health problems in the population. Existing surveys about the prevalence of mental ill-health often cannot be broken down sufficiently so as to help better target resources; for example, it would be helpful to policy makers to know that mild-to-moderate mental disorders are particularly prevalent in urban areas rather than rural areas – or vice versa – so as to further explore the reasons behind such a trend, for example unmet need for treatment. Not all countries are able to understand the burden of mental ill-health in their population in such detail.

In addition to prevalence surveys there are other good sources of information on mental ill-health that countries should be exploiting further. Extensive OECD work on mental health and work has shown the value of looking closely at sickness and disability claims as part of understanding mental ill-health across the population and the trends and attitudes towards mental illness. *Sick on the Job?* (OECD, 2012), and the accompanying reviews of mental health and employment policies in OECD countries, have pointed out that service provider attitudes and the burden of mental disorder interact in complex ways. Sickness absences for mental health reasons may be driven by high levels of mental illness in the population; by a tendency for physicians to sign a person off on sick leave quickly due to a lack of experience in treating mental ill-health; because of a shortage of treatment options which would support recovery for individuals for mental ill-health; due to poor support offered by workplaces to employees with mental health needs; or, most likely, a complex combination of all these factors. Understanding these trends, through good collection and interpretation of information, is a first step to better tackling the problem.

Where good data on the burden of mental ill-health in the population does exist, it can be used to guide mental health policy and service design. For example, in Finland, detailed analysis of suicide rates across population groups showed that the risk of suicide was particularly high among young men aged 15 to 29. This led to the establishment of "Time Out! Aikalisä! Elämä raitelleen" ("Time Out! Back on the track!"), a programme targeting men in this age group. This initiative has shown positive results and is in place in over a hundred municipalities, reaching approximately 60% of the target group.

Measuring the high costs of mental ill-health

There are significant gaps in information on the costs of mental health. This prevents greater reflection on spending levels, and on resource allocation, which are needed to better address the unacceptably high burden of mental ill-health. Better measurement of the costs of mental illness is the second building block for a stronger, and more information-rich foundation for mental health systems.

A lack of data on the costs of mental ill-health, including direct costs, indirect costs and intangible costs, also limits the scope for meaningful cross-country analysis. The majority of data is available only at a national level, and even here data availability is uneven across countries and across cost domains. Where internationally comparable data exist, they are restricted to expenditures in hospitals. Under the OECD's System of Health Accounts, just 11 countries could break down hospital expenditures by main diagnostic group (e.g. circulatory diseases, mental and behavioural disorders), and only 6 countries could then break down spending on mental and behavioural disorders by disorder subcategory (e.g. schizophrenia, mood disorders). These shortcomings show that it is not possible to capture the full picture of the cost of mental illness in health systems that now commonly use community care, which means that policy makers are taking decisions on resource allocation based on incomplete information. These information gaps ultimately also limit the potential for countries to assess which services represent value for money and where direct spending is bringing down indirect costs – within the mental health sector, health more generally, and across the economy.

However, there are some encouraging steps in the establishment of internationally comparable data on the cost of mental illness, some of which could become still richer sources of information – and a valuable resource for prioritising mental health spending and policy setting – if a larger number of countries were to participate:

- The OECD's work on expenditure by disease as part of the System of Health Accounts gives a framework for internationally comparable reporting of mental health expenditures. Whilst some limitations remain, for example an inability to capture the costs of co-morbidities, an expansion in the number of countries able to submit expenditure by disease data for mental health would already widen the potential for meaningful analysis.
- OECD work on the impact of mental illness on employment, productivity and social benefits costs indicates the importance of indirect costs as a result of mental ill-health.
- The WHO's Global Burden of Disease created the DALYs measure to quantify the burden of disease, including mental health. DALYs combine the impact of premature death and of disability and other non-fatal health gaps, giving a good picture of the intangible costs of mental health internationally and between regions.
- OECD uses the DALY approach in estimating the health and economic impacts of prevention policies, for instance, in the area of alcohol-use disorders.

Tracking treatment outcomes and care quality

While there are some promising areas of improvement in the collection of quality and outcome indicators for mental health, overall data weaknesses continue to significantly limit understanding of the state of mental health and mental health care systems, and limit the capacity of policy makers to drive effective and efficient change.

There is an urgent need for better mental health care quality and outcome indicators. The development of mental health quality and outcome indicators is not widespread across OECD countries. While over two thirds of OECD countries (20) report using "outcome" indicators,

these may be restricted to discharge rate or suicide rate. Administrative hospital data with elements of mental health information is almost universally present in OECD countries, allowing the collection of data such as bed days and average length of stay. National registries or data collection covering severe mental disorders and suicide are also quite widely available, though not in all OECD countries, and not at all levels of care (e.g. in primary care settings).

A number of factors are responsible for the weak data infrastructure for mental health care, including the complex nature of mental health problems, high rates of co-morbidity, lack of agreement on suitable measures and weak measurement infrastructures. The absence of a unique patient identifier in many countries poses problems to building richer indicators assessing continuity of care and quality of prescription or treatment, as data sets cannot be linked across care settings. These shortcomings limit the capacity of policy makers, care commissioners, and providers to secure good care for mental health. Care commissioners, for example, cannot assess the quality of services that are in place, and care providers cannot compare outcomes for mental disorders that they are treating with those of other care providers, without improved information infrastructures tracking treatment outcomes and care quality.

The mental health subgroup of the OECD's Health Care Indicator Project recommends collection of a number of indicators of mental health care quality – for example assessing continuity of care or patient outcomes. However, many countries are still unable to report on such data.

Limited reporting of mental health data

Indicators	Number of countries able to report
Continuity of visits after mental health-related hospitalisation	6
Timely ambulatory follow-up after medical health hospitalisation	5
Visits during acute phase treatment of depression	3
Re-admission rates to the same hospital for schizophrenia and bipolar disorder	20
Excess mortality from schizophrenia or bipolar disorder	6

Source: Information compiled by the OECD based on the OECD HCQI Sub-group for Mental Health (18 countries participating).

The quality and outcomes of mental health care will continue to lag behind other disease areas until adequate information systems are put in place to track pertinent indicators and collect appropriate data. Advancing the measurement and comparison of the quality of inpatient care, primary and secondary community-based care and social outcomes first and foremost necessitates increased development and utilisation of mental health quality measurement infrastructure.

There are encouraging developments, though. A few OECD countries are already using quality and outcome indicators to drive improvements in mental health care:

- Australia, England, the Netherlands, Sweden, New Zealand and the United States have put in place more comprehensive systems to collect indicators which can encourage better treatment outcomes.
- In Sweden, the National Board of Health and Welfare developed a multi-dimensional quality framework, "Good Care", to monitor health care performance. The framework covers several dimensions of care including effectiveness, safety, patient-centeredness, timeliness, equity and efficiency, with more than 30 process and outcome indicators used to compare quality across regions or patient groups.

- In England, outcome indicators have been developed for both mild-to-moderate and severe mental illness. These outcome measures reflect patient experience, quality of life and social outcomes as well as quality of care and symptoms. The outcome measures have now been used to derive indicators for a framework to support the commissioning of mental health services. This framework, the new Clinical Commissioning Group Outcomes Indicator Set, will be used to support and enable commissioning groups to measure and benchmark outcomes of services that they commission for their patients. The framework will also provide clear, comparative information for patients and the public about the quality of health services commissioned and the associated health outcomes.
- Several international collaborations – for example, the Nordic Indicator Project and the REFINEMENT project, involving nine European research institutions – are seeking to encourage good indicator development for mental health and to support countries in gathering better data.

Increase provision of evidence-based services, especially through expanding the role of the primary care sector, with appropriate system-wide support

The high epidemiological burden, and the high economic and societal costs of mental ill-health, demand that policy makers scale-up evidence-based treatment, prioritising approaches that deliver good outcomes and which represent good value for money.

The "treatment gap" represents the gap between the true prevalence of a disorder and the proportion of affected individuals who are receiving treatment, and can also be expressed as a percentage of individuals who require care, but do not get it. Evidence shows that shortages in mental health services mean that some individuals in contact with mental health services, or receiving some treatment, are not receiving the most appropriate treatment for their disorder, or they are receiving insufficient treatment. Treatment gaps for mental disorders vary across OECD countries, but mental ill-health is undertreated, to varying extents, in all OECD countries:

- Between one-third and one-half (or more) of those with mental health disorders do not receive treatment. The "treatment gap" ranges from 32.2% for schizophrenia, to 57.5% for anxiety disorder. The gap was estimated at 56.3% for depression, 50.2% for bipolar disorder, and 57.3% for obsessive compulsive disorder.
- The ESEMeD survey of Belgium, France, Germany, Italy, the Netherlands and Spain estimated that 3% of the population have an unmet need for mental health care. Nearly one in two people with a diagnosable mental disorder reported no formal health care use for their mental disorder; in comparison, this is the case for less than one in ten of people with diabetes.

Action is needed to address this treatment gap, which contributes significantly to the high social and economic costs of mental ill-health in OECD countries. To do this, evidence-based services for mental disorders should be scaled-up. Care for mild-to-moderate disorders should be improved through better provision from primary care, and primary care providers should play a greater co-ordinating role to help deliver more integrated care for severe mental illness.

Improve provision for mild-to-moderate disorders through stronger primary care

The treatment gap for mild-to-moderate mental disorders is particularly large and as shown in *Sick on the Job?* (OECD, 2012), the impact of these disorders – which are strong drivers of presenteeism, abstenteeism, disability and unemployment – is significant.

To strengthen provision for mild-to-moderate disorders, improving and expanding the care provided at the primary care-level is a first step. In most OECD countries, primary care providers are already playing a significant role in providing care for mild-to-moderate disorders and, with a relatively small amount of additional support and resource allocation, could do more still.

Building on the good foundations in place in many OECD countries, efforts to improve primary care provision and close the treatment gap for mild-to-moderate disorders should include:

- Comprehensive training and Continuing Professional Development for diagnosing, treating and managing mild-to-moderate disorders for all primary care providers.
- Putting in place primary care-appropriate clinical guidelines for mild-to-moderate mental disorders, which are easily accessible, and up-to-date.
- Exploring the potential for primary care practitioners to deliver evidence-based treatments such as Cognitive Behavioural Therapy, with appropriate training.
- Putting in place specialist mental health services to which primary care providers can refer patients for more intensive treatment.
- Securing good support networks between primary care and specialist mental health services, in order to support primary carers with more complex cases and to help build competency and expertise at the primary care level.

Many of these elements are in place, to varying degrees, in most OECD countries. For example, training and Continuing Professional Development (CPD) for mental health in primary care is in place in two thirds of OECD countries, and appropriate – often primary care specific – clinical guidelines for mild and moderate mental disorders are used in six OECD countries. Nonetheless, there is some evidence of shortcomings in care provided in primary care. Primary carers are often being asked to perform a greater number of functions related to mental health, with few if any additional resources. Studies from Canada, Germany, the United Kingdom and the United States suggest that primary care clinicians often have considerable difficulty accurately identifying emotional distress and mild depression in primary care, with other studies suggesting that primary care physicians may not have the best and most up-to-date information available to them regarding treatment for common mental disorders. The efforts and investments needed to address these shortcomings are worthwhile for countries: not only can better primary care provision help close the treatment gap and reduce the epidemiological and economic burden of mild-to-moderate disorders, but provision in primary care has also been shown to represent good value for money.

Strengthening provision at the primary care level has also been shown to be a cost-effective way of providing care for some mental disorders. Stepped care approaches, for instance, have been supported as a cost-effective approach with good outcomes and can be delivered in part from primary care, with support from specialist services when needed. In stepped care approaches treatment starts with low intensity interventions, for example bibliographic self-help and multimedia self-help, and then rises in intensity in line with responsiveness to treatment and symptom severity, including for example one-to-one psychological therapy delivered by a specialist. The stepped care approach means that treatment intensity is scaled to need. This can reduce pressure on more specialised services by improving availability of low-intensity interventions that can be prescribed by a primary care practitioner. General practitioners (GPs) are overwhelmingly more likely

to be consulted for mental health problems than psychiatrists or psychologists and good diagnostic and referral processes for mild-to-moderate disorders from primary care can also help direct patients towards interventions that have been shown to be effective, including computerised Cognitive Behavioural Therapy (CBT) and eMental health programmes, self-help group and peer support activities.

Some OECD countries have been scaling-up treatment options through the expansion of common behavioural therapies in primary care: in 2012, 12 OECD countries reported that CBT was available in primary care. In Norway, CBT training is available for practitioners and general practitioners can deliver CBT and be reimbursed for providing it. The advantage of such a model is that it equips primary care practitioners with an additional tool with which to effectively treat patients that they are already expected to treat. This is a good way of improving the efficacy and quality of the service already being provided. It also promises to be cost-saving relative to introducing stand-alone programmes, increasing reimbursements for therapies provided by specialists or alternative medicine practitioners (especially where practitioners are in private practice), or delivering psychological therapy.

A stronger co-ordinating role for primary care in delivering more integrated care for severe mental illness

With the process of deinstitutionalisation, care for severe mental illness increasingly takes place in a large range of care settings, making care co-ordination a particular challenge. To improve mental health care for people with severe disorders, such as schizophrenia, bipolar, and severe depression, better co-ordination is needed. Poor outcomes have been associated with poor co-ordination of care, and poor co-ordination of care makes it easier for patients to fall through the gaps between inpatient and community care and for the full spectrum of a patient's care needs not to be met. Co-ordination is important not just between mental health services, but also across the care spectrum. The high level of co-morbidity of somatic disorders and severe mental disorders should be addressed through better co-ordination between the health sector and the mental health system.

A stronger co-ordinating role for primary care is a key way that OECD countries can deliver more integrated care for severe mental illness. Primary care providers have been increasingly taking on this co-ordinating role in OECD countries and this should become even more widespread and robust. Additionally, good engagement by primary care practitioners is crucial to addressing the poor physical health of individuals with severe mental illnesses, as they are more likely to consider the patient's entire physical and mental wellbeing, rather than taking a more narrow symptom-specific focus as might be expected in specialist mental health services. Primary care providers can also play a significant role in the ongoing management of stable cases of severe mental illness. While primary care practitioners rely on effective support from specialist care, and appropriate training and competence, primary care practitioners are, in many OECD countries, allowed to diagnose or adjust common medication for severe mental disorders (for example, SSRIs and antipsychotics) and as such can in some cases lead the management of stable cases of severe mental illness from the community.

Scaling-up evidence-based services

While strengthening care delivered in primary care is a good first step, OECD countries also need to scale-up services that are understood to be effective at treating both mild-to-moderate and severe mental ill-health. Given the high indirect costs associated with mild-to-moderate illness in most, if not all, OECD countries, and the large treatment gap

for these disorders, further investment in appropriate services for these disorders is likely a cost-effective approach for most countries. What is key is that resources be allocated to mental health in a way that can deliver good value-for money. Public budgets in many OECD countries are stretched and it will be a challenge to mobilise the time, resources, and expertise needed to tackle the high burden of mental health. Resources for mental health care should be directed towards evidence-based treatments which are understood to be effective.

Some existing evidence suggests that investing in care for common disorders, the majority of which have symptoms that are mild or moderate, could be cost-neutral for OECD economies. This is because when the most effective treatments are prioritised, the indirect costs of mental ill-health and sickness absences tend to drop, productivity improves, disability claims to fall, and employment and tax revenues increase as individuals return to work. Addressing the high burden of mild-to-moderate mental ill-health will demand that countries assure that the right services are in place for disorders such as anxiety and depression, and evidence suggests that innovative new interventions for mild-to-moderate disorders can also represent good value for money.

Some OECD countries have taken steps to build specialised services targeted at mild-to-moderate mental disorders through new and innovative forms of services. These include programmes that fit within the existing health system organisation as well "stand-alone" vertical programmes. Each programme has demanded significant high-level commitment and investment of resources, although there are strong arguments to suggest that such investments can be cost-effective in the medium- to long-term. Noteworthy examples include "Increasing Access to Psychological Therapies" (IAPT) in England and "Access to Allied Psychological Services" in Australia. New models of care delivery are also taking advantage of technological developments: a wide number of computer- and internet-based programmes are being used to treat and manage some forms of mental illness, for example MoodGYM, for anxiety and depression, developed in Australia but now also in use in China, Finland, the Netherlands and Norway. When based on good evidence, carefully put in place, and closely monitored, such interventions can be effective and low-cost ways of treating some mental disorders.

Evidence-based services for severe mental illness are still required of course. Assertive Community Treatment (ACT) – intensive support delivered by multidisciplinary teams available 24 hours a day, with teams often having low caseloads, and usually delivering community-based treatment and services – is a cornerstone in community-based care for people with severe mental illness, and has been associated with better engagement with services and improved quality of life and satisfaction with care. ACT is "assertive" in the sense that it is expected that mental health professionals would be assertive in seeking out and delivering treatment to patients and ensure care co-ordination. Additionally, evidence suggests that ACT is cost-effective as it is associated with improved patient outcomes, even if ACT is associated with a positive or non-negative change in costs. While ACT is far from the only treatment modality shown to be effective for severe mental illness, and while ACT has a number of shortcomings, the important point is that countries ensure that the efficacy of treatment is the primary guide for decisions about which services to put in place, rather than historical or social trends in the mental health care sector.

Further efforts to address the high disease burden of mild-to-moderate disorders should also include attention to evidence-based preventative interventions. International evidence suggests that prevention programmes targeting depression, for example in schools

and workplaces, can be effective at alleviating some of the disease burden that cannot be or is not being addressed by psychological or pharmaceutical treatments, and can represent good value for money. Extensive research carried out by the OECD suggests, similarly, that certain preventive interventions can be very worthwhile investments for reducing harmful alcohol consumption and the associated disease burden and economic costs.

Secure better outcomes for mental disorders through greater use of incentives

Policy makers should use incentives to encourage good outcomes for mental health. In mental health care, where the large treatment gap and high burden suggest that current treatment is insufficient or inadequate, there is a need to catch up with other disease areas: treatment outcomes, as well as system design and input, now need to be a primary focus. Better understanding of what good outcomes are for mental health, the need to put outcomes at the centre of care decisions, and the more effective exploitation of incentives for good outcomes, will in turn influence policy making in other areas. For example, it will help in choosing services based on which interventions deliver good outcomes, and it will render resource allocation more efficient. Furthermore, using incentive structures to drive good outcomes and to meet policy objectives is a core part of effective resource use in other areas of health care. Mental health care need be no exception.

Focusing on better outcomes for mental health

A more complete understanding is needed of what constitutes "good mental health care". Good information on the quality of mental health care, a strong desire to secure better outcomes for mental health, and a capacity to monitor mental health care in line with expected standards, are fundamental starting points. Part of the problem is due to a significant information gap in what constitutes good outcomes. The importance of measuring the quality of mental health care, which includes measuring treatment outcomes, cannot be understated. Mental health care outcomes are too rarely measured and monitored, often due to a lack of good outcomes indicators, or a framework establishing desirable and undesirable outcomes.

In other areas of health care, understanding what good care and good outcomes look like has been easier: it is possible to measure and aim for better survival rates, reduced symptom severity, more stable management of symptoms, for example. The same is true for mental health, but given the often high complexity of treating mental disorders, the very heterogeneous nature of mental disorders, and the often chronic nature of mental disorders, a definition of what a good treatment outcome is, and a push for providers to move towards it, has been difficult to achieve.

A lack of agreement over which salient measures can capture good treatment outcomes for mental health has slowed progress in the area, as to drive towards better outcomes an agreed conceptual framework is first needed. However, despite the challenge of coming up with such a framework a number of countries do focus on outcomes, using an agreed matrix, and other OECD countries should follow their lead. One noteworthy example is the Australian National Outcomes and Casemix Collection (NOCC), a set of routine outcome measures collected by all Australian states and territories. NOCC includes measures of function and consumer-rated measures of symptoms or wellbeing. NOCC also includes the Health of the Nation Outcome Scale (HoNOS), developed in England in the 1990s, which has 12 items measuring four domains of behaviour, impairment,

symptoms and social functioning, for which providers give patients a score, which can then be compared over time. Such outcome-focused measurement tools should be used widely in OECD countries.

A sufficiently broad conceptualisation of a "good outcome" is also important. For instance, OECD work on mental health and employment highlights the need to include employment and meaningful engagement with the job market as a desirable outcome. Many, if not most individuals with mental illness, can be in work, but care providers have been quick to overlook employment as an important outcome. This shortcoming is especially concerning given not only the high economic costs of unemployment and absence from work due to mental health-related disability, but also given that the right kind of employment can be highly positive for individuals with mental ill-health. A well-conceptualised focus on outcomes can turn provider attention towards such aspects, to the benefit of the individual patient and of society more widely.

Monitoring, outcome frameworks, and availability of comparative data can also help drive better outcomes. In other areas of health care, improvement has been observed as a result of providers better understanding their own outcomes, and benchmarking their outcomes and practice against that of other providers. Indeed, in Scotland the establishment of comparative indicators measuring mental health care outcomes, combined with improvement support for providers, were found to be effective in changing local practice.

Using financial incentives to secure better outcomes

The incentivisation of outcomes has an important role in closing the treatment gap for mental disorders. The introduction of outcomes frameworks, and financial incentives, are being used in different OECD countries to secure better outcomes. Such incentives could be more widespread.

At a primary care level financial incentives can encourage the provision of appropriate services for mental disorders. For instance, additional reimbursements for GPs providing psychological therapies are available in Australia and Norway. A more sophisticated outcomes-focused financial incentive scheme is the QOF, a pay-for-performance programme for GPs in the United Kingdom. The mental health component of the QOF primarily rewards the ongoing management of a serious mental illness through the primary care provider and also puts a strong emphasis on the physical health of patients with a serious mental illness. It is thus a concrete example of how to give primary care practitioners a strong incentive to manage both the physical and mental health needs of people. Under the QOF, GPs can earn points, which translate to financial rewards through establishment of a comprehensive care plan, or by regularly recording required somatic and mental health checks. In Australia, the Mental Health Nurse Incentive Programme provides payments to a range of primary care providers to engage mental health nurses to assist in the provision of co-ordinated clinical care for people with severe mental health disorders, which would include monitoring a patient's mental state, medication management and improving links to other health professionals and clinical service providers. Encouragingly, this programme had a positive effect on patient outcomes due to greater continuity of care, greater follow-up, timely access to support, and increased compliance with treatment plans. Utilisation of inpatient care was reduced and patients experienced increased levels of employment and improved community functioning.

Provider payment mechanisms for specialist care should in theory incentivise integrated care delivered in both hospital and community-based settings, yet, in practice, payment systems remain fragmented and differ according to care setting. Provider payment for mental health is predominantly either through global budgets, which give few incentives to improve quality and efficiency, and fee for service or per diem rates, which can provide incentives for the overprovision of undesirable additional "products", such as inpatient bed days driving up average length of stay.

Policy makers need to design and implement payment systems that are not tied to a particular setting and which reward the delivery of high-quality, efficient and integrated care. Many OECD countries have failed to implement such innovative payment methods due to a lack of good-quality data on costs and outcomes that span the entire care pathway and to governance challenges, among other factors. However, some promising examples do exist, notably the "Diagnostic Treatment Combination" in the Netherlands, which is an episode-based payment system that can include several hospital admissions or outpatient contacts, with the tariff paid determined by client profile, functionality, and assessed service needs.

On the whole, good cost data currently exist at a national level for hospital care in nearly all OECD countries, but high-quality data are not widely available for outpatient and community-based care, with a few notable exceptions (such as Australia, England and the Netherlands). This will likely further hinder the complicated task of developing classifications and payment methods that span care settings. The impetus is on countries to improve their collection of cost and outcome data, particularly for community-based care.

At present data limitations limit the capacity of most countries to undertake such comparative benchmarking activities. However, the understanding that availability of appropriate indicators can in and of themselves drive improvements in care, as well as guiding policy setting and resource, should be added motivation to develop better data infrastructures for mental health care.

Conclusion

Mental disorders represent a considerable disease burden and have a significant impact on the societies and economies of OECD countries, yet are still consistently under-treated or ineffectively treated. Spending on mental health care represents a significant percentage of OECD health budgets, yet the burden of mental ill-health is costing OECD economies millions every year in sickness benefits, through unemployment, and as a result of lost productivity. Policy makers cannot step away from this challenge – they must make mental health count. Governments must measure mental health, in order to better understand the scale of the problem and how to tackle it. They should increase the provision of evidence-based services, particularly through the primary care sector. And they should align financial incentives to help achieve better outcomes for those suffering from mental ill-health.

Notes

1. Psychological distress or the absence of mental well-being can affect all individuals from time to time, and would not meet the clinical threshold of a diagnosis within psychiatric classification systems. This report focuses on mental disorders which do reach the clinical threshold of a diagnosis according to international classification systems – commonly disorders such as depression, anxiety, bipolar and schizophrenia – but clearly acknowledges that "sub-threshold disorders" can account for significant suffering and hardship, and can be enduring and disabling. This report does not directly cover alcohol or substance abuse disorders, although does acknowledge the common co-morbidities of mental disorders and alcohol and substance abuse disorders.

2. *Making Mental Health Count* distinguishes between "mild-to-moderate" mental disorders and "severe" mental disorders. This distinction is based both on a clinical separation commonly made, and related to the different service needs and intensities demanded by different severities of disorder. Severity of the disorder is determined by the number of and severity of symptoms, the degree of functional impairment, and the duration of symptoms. "Mild-to-moderate" disorders usually have less severe and debilitating symptoms than other (for example, psychotic) mental disorders, and would typically include frequently occurring disorders such as depression and anxiety as well as disorders such as obsessive compulsive disorder (OCD) or somatoform disorders. There is little consistency in how severe mental illnesses (SMI) is defined in practice and no operational definitions exist, but in general, severe mental illnesses tend to refer to non-organic psychotic disorders – such as schizophrenia, schizoaffective disorder, bipolar disorder – as well as history of mental illness and treatment, and degree of disability. While the prevalence of SMI is much lower than that of mild-to-moderate mental illness, the primary focus of mental health systems has tended to be on the former. All mental disorders can significantly impede the health, daily functioning, and quality of life of affected individuals, and require appropriate diagnosis, treatment and care. While this report makes a distinction between the severities of mental disorders, it is important to note that for patients and practitioners the reality of disorders is frequently more fluid. The mental state of a patient experiencing a moderate depressive episode can worsen and become "severe", just as a severe episode can be stabilised with symptoms lessened or alleviated.

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Chapter 1

The cost of mental illness

This chapter draws on national data, OECD data, and other international data sources to explore the economic burden of mental ill-health in OECD countries. This chapter looks at direct, indirect and intangible costs, and seeks to identify some of the trends and features of the cost of mental illness in OECD countries, as well as highlighting the great need to improve data availability. This chapter explains that expenditure on mental health has, generally, been rising in OECD countries, and while a significant proportion of expenditure remains in inpatient settings, expenditure on community and outpatient services is increasing. Although there are significant data challenges, it is possible to establish that mental ill-health represents a significant cost.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

1.1. Introduction

Expenditure on mental health has, generally, been rising in OECD countries, and while a significant proportion of expenditure remains in inpatient settings, expenditure on community and outpatient services is increasing. Whilst expenditure on mental health is increasing, the high indirect costs – and the treatment gaps for mental health set out in later chapters – bear out the need for such spending, and would support the need to maintain careful investment in effective services that represent value for money. It could even be argued that spending on mental illness is too low, particularly given its large overall economic burden on society.

The nature of mental health care itself can create its own challenges. Capturing and categorising mental health expenditure across a range of diverse services and providers which can vary significantly across countries is not an easy task. As such, a more specific classification system for health care providers in the area of mental health is required to more adequately link to the types of services and care provided. This will then help to identify the drivers of costs and allow analysis to investigate whether the current level of expenditure represents good value for money.

Hospital expenditures tend to be easier to categorise than those in community settings, but it is important to note that on their own they may provide a distorted picture of mental health service provision. In most countries, following the trend towards deinstitutionalisation, there has been a decrease in the number of hospital beds allocated to mental illness. However, those beds that do remain are more often for the most severe mental illness, such as forensic and secure beds, and are therefore more resource intensive and expensive. Thus, it is important that these nuances are appropriately identified and captured when analysing expenditures, which is not always possible.

In addition, there are diverse categories of community-based services such as community mental health teams, acute outreach teams, and acute crisis services that exist in a variety of forms across OECD countries. According to the System of Health Accounts, which is usually the starting point for international comparable estimates of health spending, such expenditures should all be captured, but are not always accounted for in practice. Most countries cannot identify the relevant spending in these types of community-based service, or at least cannot in any detail, although a few countries do regularly track such spending and produce national spending reports, which is a promising step.

There remain considerable challenges in coming up with a clear estimate of the full cost of mental ill-health. Limitations in obtaining usable and informative data mean that a clear picture – one that measures the direct expenditures on mental health and social services, the indirect costs driven by employment and productivity losses and the intangible costs that take into account the reduced well-being, distress and other forms of suffering – is obscured, especially at an international level. In each of these areas, internationally comparable data are relatively scarce. At present, consistent and internationally standardised ways of collecting and reporting expenditure by disease are still very much in the development phase. The lack of such a framework can hinder a full

understanding of the level and trends in spending on mental health. This chapter sets out the data that is available on the cost of mental ill-health, and with this identifies some of the important trends that can be observed.

1.2. Getting a full picture of the costs of mental ill-health

In general, the estimation of *direct* costs of mental ill-health occurring within the health care system is one of the more developed areas, but even here there remain some shortcomings. While national data on overall mental health spending is available for a number of OECD countries, more detailed breakdowns are often limited to the hospital sector, which means that a significant and growing proportion of spending occurring in the community cannot be included and analysed in detail. At present, only a handful of OECD countries can provide such a level of detail right across all services or providers. Such detail can give a better indication of the overall trends in spending and in mental health service provision. Therefore, conclusions from the analysis may be limited and may not provide a full picture across the range of OECD countries, particularly given that the countries able to report detailed expenditure data also tend to be those at more advanced stages of the deinstitutionalisation process.

The direct *health care* costs relate to the detection, treatment, prevention, and rehabilitation of the illness and therefore include the medical care expenses such as hospitalisations, outpatient clinical care visits, care in rehabilitation and long-term care facilities, pharmaceuticals and so on (Figure 1.1). However, there are also the direct *social care* costs to be considered. These are generally related to long-term care, for example, community care services. As is the case in the health sector, there is a scarcity of data on social care costs, especially for data that is internationally comparable. In addition, the diversity of social care services across countries and the roles that social care can play heightens the need for standardised definitions to give more detailed information on mental health-related expenditure on social services.

Indirect costs refer to the economic costs attributable to disease, illness, or injury which result in lost resources, but do not involve direct payment related to the disease. This includes the value of lost production due to unemployment, absence from work, presenteeism (the loss in productivity even when at work) and premature mortality – all as a result of mental illness. Indirect costs also include the value associated with informal care – that is, care provided by family members for which there is no direct or formal reimbursement – and where there is an associated opportunity cost for activities which must be measured and valued. Generally, estimates of the indirect costs of mental health are more scarce than the direct costs. Due to the lack of standardised methods and cost components it is not often possible to directly compare the results of these studies, although they are informative, and point to the very large economic burden associated with mental illness.

Perhaps the most difficult component to accurately quantify are the *intangible* costs of mental illness – the costs that take account of reduced well-being, emotional distress, pain, and other forms of suffering (sometimes referred to as morbidity outcomes). These costs could also include the value of life itself. Although difficult to derive, for a full picture of the overall societal costs associated with disease and injury intangible costs should be considered, as they can be substantial. Excluding this component would result in an underestimation of the true disease cost. In order to be included in a cost of illness study these costs must first be measured and then valued in monetary terms, with "willingness to pay" methods being the most commonly employed methodology. Morbidity outcomes can also be valued

Figure 1.1. **Components of cost of illness**[1]

Direct	Transfer payments[2]	Indirect	Intangible
• Expenditure on health care goods and services following increased demand for health care due to the specific illness • Includes: hospital services, doctors, nurses, drugs, diagnostics, ambulances, ambulatory care, rehabilitation, long-term health care, etc. • Household production of health care is included in SHA if payment is involved	• Payments made for temporary absence from work due to illness (e.g. from employer or government or social insurance; purpose is income maintenance) • Payments made for inability to work due to illness (e.g. from government or social insurance; purpose is income maintenance) • Reduced payments (e.g. due to early death); may be netted off	• Formal labour market effects (i.e. reduced supply of labour due to illness) • Can arise through premature mortality, absence due to morbidity, and "presenteeism" due to morbidity • Expenditure on other goods and services – examples may include: fire damage (e.g. for fires caused by smoking); policing and criminal justice (e.g. when due to alcohol abuse or drug addiction) • For net resource impact, should net off change in consumption • Household production of extra health care and of extra social care and other household services (when no payment involved) • Also includes lost household production due to illness	• Pain and suffering and desire to avoid morbidity and premature mortality • Do monetary values used reflect only valuation of changes in health-related quality of life and longevity? • Or do values also reflect changes in employment, consumption, and "standard of living"? • "Caring externalities" – e.g. to others who care about sufferer?
	• Allowances paid for household production of health care (e.g. by government or social insurance) • Included in SHA if purpose is health care		
• Household production of social care	• Allowances paid for household production of social care – e.g. by government or social insurance		
• All other additional social care consumption due to the specific illness	• Allowances may be paid to people who need to buy additional social care		

1. Some grey areas may still exist, or the possibility of overlap, but by adhering to these definitions we hope that such instances will be minimised. In addition, these definitions have been employed for the purpose of increasing comparability of results while being consistent with current data collection.
2. Not included in COI from the societal perspective as these payments are transferred from one sector of the economy to another. This is included here for illustration purposes.
Source: OECD (2012), "Extension of Work on Expenditure by Disease, Age and Gender: Interim Report", OECD, Paris, available at *www.oecd.org/els/health-systems/Extensionofworkonexpenditurebydiseaseageandgender_InterimReportApr2012.pdf*.

in utility terms. Disability adjusted life years (DALYs) are, in fact, an example of a utility measure of the decrease in morbidity attributable to being ill (see Box 1.1). One DALY is the equivalent of one lost year of "healthy" life. The sum of DALYs across a population would thus measure the gap between an ideal health situation where the entire population lives to an advanced age, free of disease and disability, and years lost or lived with disease and disability. While DALYs are a measure of the burden of disease, it is difficult to combine them with the direct and indirect costs as they are not easily converted to dollar values. Another popular utility measure, often used in cost-effectiveness analysis, is quality adjusted life years (QALYs). QALYs are in fact a measure of the gain in well-being, valued in utility terms, due to a treatment or intervention, and are often used as the outcome measure in cost-utility analysis. In a cost of illness assessment they must be measured in dollar terms, which would then allow for their direct input into cost-benefit analyses.

1.3. Mental health accounts for a significant proportion of health spending in OECD countries

The most available and comparable data on mental health spending tend to be the direct health costs. The *System of Health Accounts* (SHA)[1] can provide a suitable international accounting framework for deriving estimates. The consistent "functionally defined"

boundary of health care spending proposed by SHA is seen as a necessary precondition for the production of meaningful internationally comparative estimates of expenditure on health. Almost all OECD countries and many non-OECD countries now report health spending according to SHA.

The allocation of health spending according to disease, gender and age groups is an important extension of the health accounting framework. From an international perspective, health expenditure broken down in such a way can provide important data to help understand the observed variations in overall health spending between countries and thus lead to a broader discussion of the different organisational aspects of health care systems. Specifically, expenditure by disease can be used to understand differences in where resources are being allocated across countries. When used in conjunction with outcomes data expenditure by disease can also provide information on whether, for example, certain providers are being inadequately funded, or whether resources are being used in the most effective and efficient manner. Additionally, the linking of resource-allocated health expenditures to appropriate measures of outputs (e.g. hospital discharges by disease) and outcomes (e.g. health status) can provide a useful input in the development of monitoring and evaluation indicators of health care systems.

While some countries have considerable experience in producing estimates of spending according to such characteristics, studies were not always comparable or embedded within an accounting framework such as SHA. Until now, only a minority of OECD countries have been producing disease accounts as a regular part of their health accounts exercises. However, the OECD has been actively involved in improving and expanding the availability of country data, which would improve the derivation of health care expenditures related to mental illness (OECD, 2008; OECD, 2012a).

Under a recent study (OECD, 2012a) expenditures on mental disorders were collected using the ICD-10 (International Classification of Disease).[2] While a full allocation by disease under SHA has the potential to provide detailed information about expenditures on mental health care, only a few countries are able to allocate *all* health care expenditures across disease categories. The most detailed and widely available data continues to be concentrated in the hospital/inpatient sector, reflecting the available administrative data sources. Thus, any analysis has a strong bias towards hospital care and can miss the full perspective including community-based care.

This OECD study found that expenditure on mental disorders is one the highest areas of health expenditure, representing between 5% and 18%[3] of all health expenditures for a selection of countries[4]. While these figures can point to the importance of mental health in health care spending, it is not necessarily the case that expenditure on mental health is high relative to the high prevalence and burden of disease presented by mental health. Indeed, the proportion of total *public* expenditure allocated to mental health care is often small. For example, mental illness is responsible for 23% of England's total burden of disease, but receives 13% of NHS health expenditures (Centre for Economic Performance, 2012). Economic data collected from 17 European countries under the MHEEN project (Knapp et al., 2008) further suggests low public expenditure on mental health in some countries, as well as showing the large divergence across Europe.

While such studies are indicative of the general trends in expenditure on mental health, there are limitations. For example, variations between countries in the way services are delivered, differences in the boundaries of spending (e.g. between health

and social care), and differences in included expenditures (e.g. excluding or including pharmaceutical spending) can create difficulties in interpretation. Concerning the MHEEN study it should also be borne in mind that there can be differences in accounting procedures, different boundaries around what is considered a "health service", and the fact that public expenditure can be supplemented by other funding sources in different ways across countries.

Hospitals still consume the highest proportion of mental health expenditure, although spending on services outside hospitals is increasing

While there has been growing investment in mental health services in the community, figures suggest that spending in hospitals remains a dominant sector for mental health. This trend is largely consistent with the move towards deinstitutionalisation seen in many OECD countries, but also underlines both the continued importance of hospital care, and the likely high cost of the complex functions that hospitals perform.

Table 1.1. provides a comparison of mental health spending by type of provider in the health system. Analysing this data, we can see that while Korea and the Czech Republic spend significantly less than Germany and Netherlands, across all four countries a higher proportion is concentrated in the hospital sector.[5]

Table 1.1. **Total mental health expenditures by health care provider**

	Germany		Korea		Netherlands[1]		Czech Republic[2]	
	Per capita USD	%	Per capita USD	%	Per capita USD	%	Per capita USD	%
Hospital	146.7	33.00	71.7	66.40	294.6	45.40	36	69.40
Long-term care	117.2	26.30	11.4	10.60	237.4	36.60	2.3	4.40
Ambulatory	78.1	17.50	14.7	13.60	48.4	7.50	11.7	22.60
Pharmaceuticals	55	12.40	6.9	6.40	33.7	5.20	0.1	0.20
Other providers	48.1	10.80	3.3	3.00	34.3	5.30	1.8	3.40
All expenditures	445	100.00	108.1	100.00	648.4	100.00	51.9	100.00

1. Netherlands: 89% of hospital expenditures are mental health and substance abuse hospitals.
2. Czech Republic: 75% of hospital expenditures are mental health and substance abuse hospitals.
Source: Czech Republic and Korea: unpublished data supplied to OECD; Germany and Netherlands: Slobbe, L.C.J., .J.M. Smit, J. Groen, M.J.J.C. Poos and G.J. Kommer (2011), "Kosten van ziekten in Nederland 2007. Trends in de Nederlandse zorguitgaven 1999-2010", Rijksinstituut voor Volksgezondheid en Milieu (RIVM), Bilthoven.

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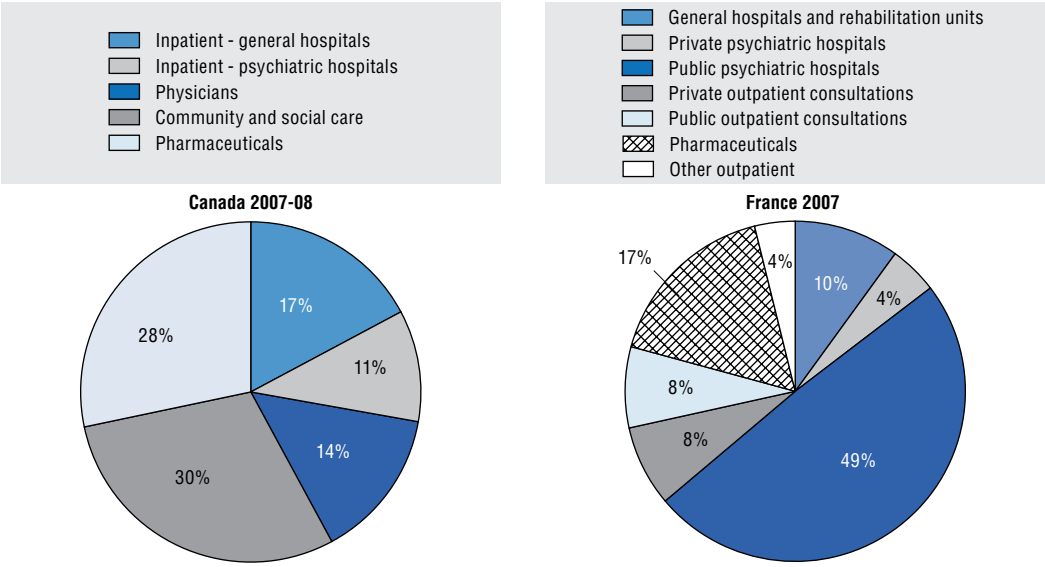
Two additional studies for Canada (Jacobs et al., 2010) and France (Chevreul et al., 2011) also show that high levels of mental health spending occurred in inpatient hospital settings (Figure 1.2).

However, in a number of countries where expenditures by provider or by service category were available over time, we can observe a trend towards falling expenditures on inpatient or hospital care alongside an increase in spending on services delivered in the community (Figures 1.3 and 1.4). Nonetheless, spending in hospitals remains high even in countries which have developed community services. It is likely that in countries where the dominance of inpatient care has fallen the threshold for admission has risen, meaning that hospitals are typically dealing with the most complex and more resource intensive care episodes.

Figure 1.2. **Mental health care expenditures, Canada, 2007-08 and France, 2007**



Note: Allowances and informal care expenditures were excluded from this chart.
Source: Jacobs, P. et al. (2010), "The Cost of Mental Health and Substance Abuse Services in Canada: A Report to the Mental Health Commission of Canada", Institute of Health Economics; Chevreul, K. et al. (2011), "Coût de la pathologie mentale en France", Unité de recherche clinique en économie de la santé (URC-Eco), Paris.

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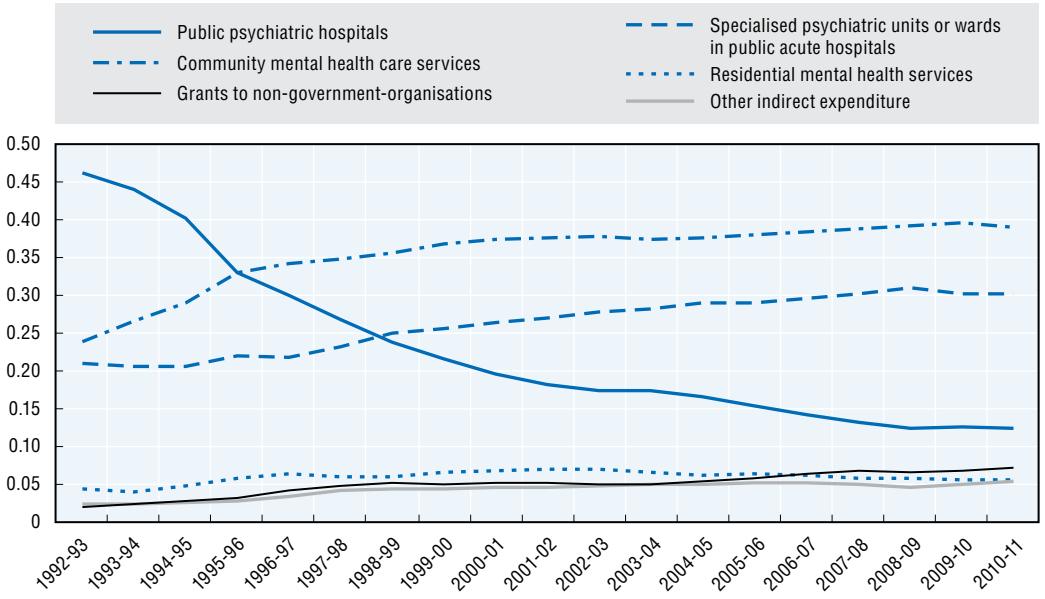
Figure 1.3. **Expenditures related to mental health care as a percentage of total mental health care expenditures, Australia, 1992/93-2010/11**



Source: AIHW – Australian Institute of Health and Welfare (2012), "Expenditure on Mental Health Services", Mental Health Services in Australia, Australian Institute of Health and Welfare, *http://mhsa.aihw.gov.au/resources/expenditure/*.

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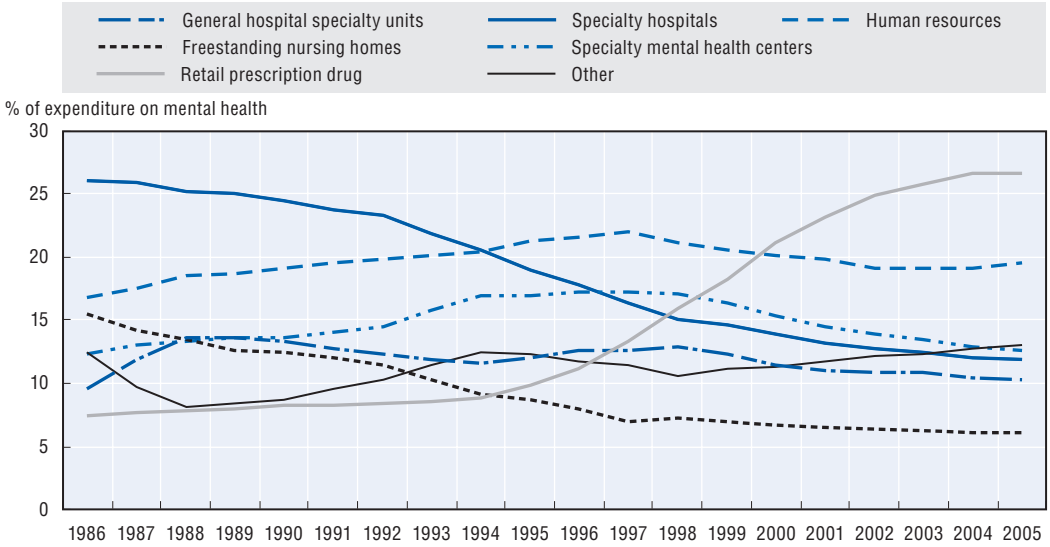
Figure 1.4. **Expenditures related to mental health care as a percentage of total mental health care expenditures, United States, 1986-2005**



Source: National Center for Health Statistics (2013), *Health, United States, 2012: With Special Feature on Emergency Care*, Hyattsville, Maryland.

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In Finland, expenditure on outpatient mental health services in primary and secondary care, and day treatment, has clearly increased over the past decade, whilst the estimated share of psychiatric specialised care in total health expenditure has decreased (Table 1.2).

Table 1.2. **Expenditure on mental health care in municipal health services in Finland, 2000-10**

Millions of euros, 2010 prices

	2000	2005	2010
Mental health outpatient treatment in primary care	52.1	79.3	131.8
Specialised psychiatric inpatient treatment	482.1	475.4	397.4
1. Long-term (>180 days)	149.3	112	82
2. Other inpatient treatment (>180 days)	332.8	363.4	315.5
Specialised psychiatric outpatient and day treatment	129.3	152.3	200.8
Other specialised psychiatric treatment	5.8	7.5	6.2
Total	669.3	714.5	736.3
Percentage of total health care expenditure	5.50%	4.80%	4.50%

Source: National Institute for Health and Welfare (2012), "Health Expenditure and Financing 2010", National Institute for Health and Welfare (THL), *Statistical Report* No. 5/2012, Finland.

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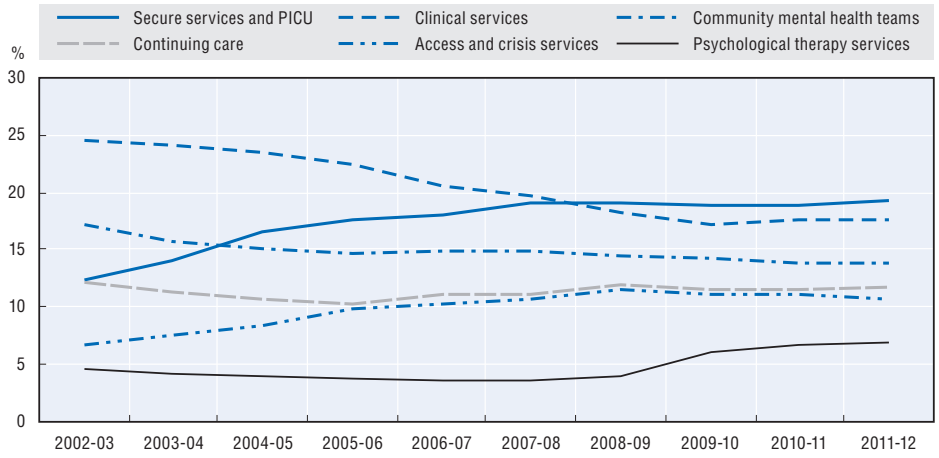
Although spending on services outside of hospitals appears to be increasing in a number of country studies, there are some exceptions and perhaps indications of "re-institutionalisation" showing up in expenditure patterns. For example, in England, the latest annual report on investment in adult mental health services (Mental Health Strategies, 2012), shows community care for severe mental illness (Community Mental Health Teams; Access & Crisis Services) receiving comparatively lower levels of expenditures, whilst expenditure on secure care appears to be rising (Figure 1.5). This suggests that in England there has been a trend for more expenditure being directed towards institutional care, albeit in institutions of a different form (re-institutionalisation).

Figure 1.5. **Distribution of direct services investment, England, 2002/03 to 2011/12**

Percentage



PICU: Psychiatric Intensive Care Unit.
Source: Mental Health Strategies (2012), *National Survey of Investment in Adult Mental Health Services 2011/12*, available at *www.gov.uk/government/publications*.

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Comparing hospital care to the other main categories of illness, it is apparent that for a group of OECD countries spending on mental illness accounts for between 5% and 19% of total inpatient expenditures, typically behind circulatory diseases and cancer (Figure 1.6). Again it should be reiterated that differences in the level of inpatient spending can reflect the organisation of a country's health care system and specific policies related to the treatment of mental health care.

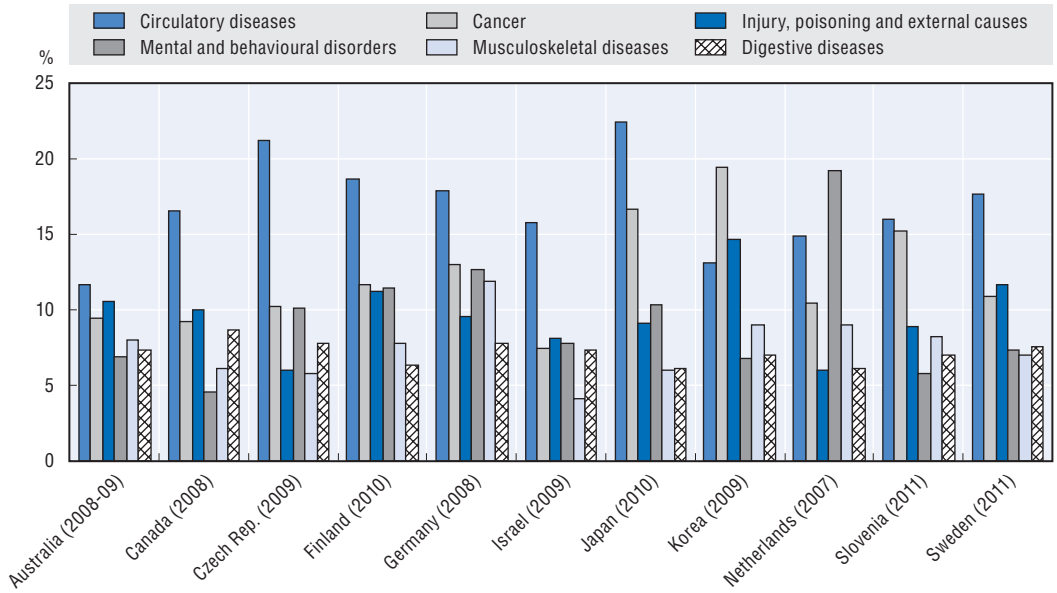
Severe and enduring mental disorders represent a small burden of disease, but a significant proportion of expenditure

Comparing expenditures only at the aggregate level of *all* mental illnesses is rather restrictive. "Mental and behavioural disorders" as a grouping encompasses a wide range of conditions, from substance abuse to mood and depression to schizophrenia, as well as dementia. For further insight into the differences in expenditures by type of mental illness, a few countries are able to provide a more detailed breakdown of spending into these categories of mental illness.[6]

Figure 1.7 reveals that severe mental illnesses (SMIs) such as schizophrenia tend to account for a dominant proportion of acute mental health expenditure. Given the higher symptom severity and chronic nature of SMIs it is perhaps not surprising that inpatient expenditure is higher for these disorders. The dominance of expenditure on mental health in hospitals, and on highly specialised services, might suggest that these acute patients and severe mental illnesses account for the bulk of overall mental health spending.

However, the lack of non-hospital data, i.e. on community and primary care-level services, and the inability to break down the data that is available by disorder category, mean that for countries with more deinstitutionalised mental health systems the picture is very incomplete, and there is a particular lack of expenditure information on mild-to-moderate mental disorders. In order to allocate primary care spending it is necessary to have detailed data on diagnoses in primary care settings. While in Korea all primary care data includes a diagnosis in its coding, this is often not the case in other countries. This

Figure 1.6. **Share of hospital inpatient expenditures by main diagnostic category, 2011 (or nearest year available)**



Note: Data sources are as follows Australia: AIHW (2012); Canada, Czech Republic, Finland, Israel, Korea, Slovenia and Sweden: unpublished data; Germany: Federal Statistical Office (2013); Japan, Netherlands: OECD calculations using published data.

Source: OECD (2013), *Health at a Glance 2013 – OECD Indicators,* OECD Publishing, Paris, *http://dx.doi.org/10.1787/health_glance-2013-en.*

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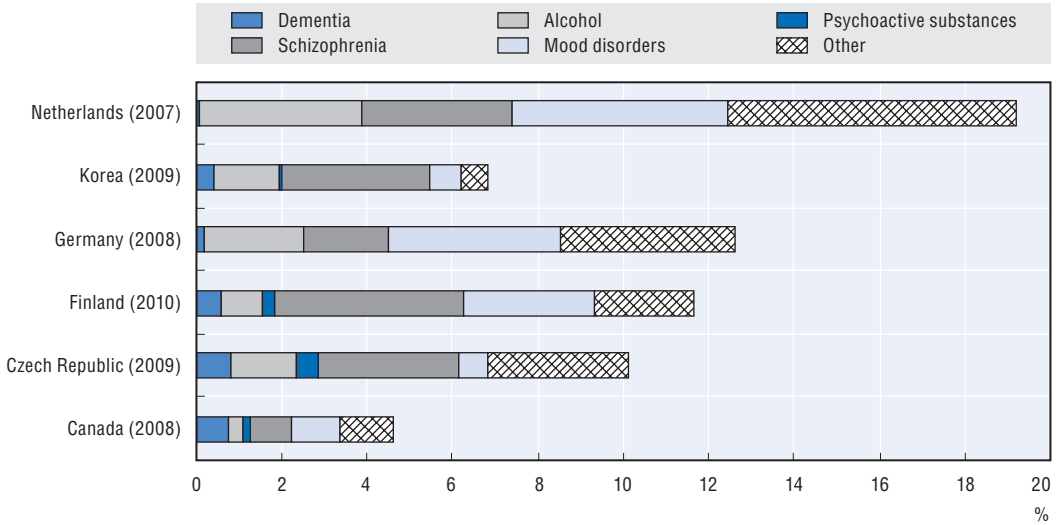
Figure 1.7. **Share of acute inpatient expenditures by sub-category of mental illness**



Source: OECD calculations using published data.

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data gap represents a significant problem: for example, it is understood that there is a high prevalence of mild-to-moderate disorders and a high treatment gap, as well as high associated indirect costs, but it is not possible to appraise the extent to which direct costs are or are not offsetting indirect costs, or get a picture of spending on improving treatment for mild-to-moderate disorders.

Mental health spending tends to be increasing over time

A few countries have developed time series on expenditures by disease to provide us with an idea of whether spending on mental health is increasing both in level and in comparison to other illnesses. Table 1.3 shows that for a group of OECD countries there has been a general trend of increasing expenditures on mental health as a share of overall health spending. For example, taking a WHO (Garg and Evans, 2011) summary of spending on main non-communicable disease categories shows that in all countries, except for the United States, mental health accounts for an increasing proportion of total health spending. In France, Germany and the Netherlands the share allocated to mental health has more than doubled.

Table 1.3. **Share of major NCDs in total health expenditures, selected countries**

Percentages

	Australia		France		Germany		Netherlands		United States	
	2000	2004/05	1998	2002	2002	2006	2003	2005	2000	2005
Cardiovascular disease	8.2	5.6	8.2	12	9.7	16.2	7.7	11.1	18.5	17
Neoplasm (cancers)	4.6	4.7	4.3	7.1	5.2	7.9	3.8	5.5	6.7	7.2
Endocrine and metabolic diseases	3.9	4.4	2.6	3.9	3.9	4	1.8	2.7	4.3	4.4
Respiratory diseases	5.5	4.8	4.3	7.3	3.8	5.4	3.5	4.9	8.1	6.6
Mental health and neurological disorders	4.5	9.6	6.6	13.5	4.8	17.4	8.2	20.3	10.6	9.5

NCD: Non-communicable disease.

Source: Garg, C. and D. Evans (2011), "What Is the Impact of Non-communicable Diseases on National Health Expenditures: A Synthesis of Available Data", *Discussion Paper* No. 3, Department of Health Systems Financing, WHO, Geneva.

StatLink http://dx.doi.org/10.1787/888933030781

Additional studies also provide further evidence of general increases in mental health spending. In the Netherlands, the Gross Healthcare Budgetary Framework (Budgettair Kader Zorg – BKZ) allocated to mental health care – which is the total of expenditures financed by revenues from premium taxes – has almost doubled from 2000 to 2010, from EUR 2.78 billion to EUR 5.09 billion, with costs rising at almost exactly the same rate as all health care costs across the period (Folkertsma et al., 2013; Van Dijk et al., 2011; Hilderink and van't Land, 2008; Heijnen, 2013). In Australia overall spending on mental health services increased by 5.7% in real terms between 2006-07 and 2010-11. In Korea spending on mental health (as a percentage of total health spending) almost doubled between 2006 and 2009, rising from 3.5% to 6% of total health spending. However, it is important to note that most of the increase was for dementia, which accounted for half of mental health spending in Korea in 2009. On the other hand, in Finland, while mental health spending increased in nominal terms between 2000 and 2010, the share of total health expenditures actually fell from 5.5% to 4.5% (National Institute for Health and Welfare, 2012).

More recently there have also been drops in mental health expenditure in some countries, perhaps as a result of the global financial crisis and pressures to contain health spending overall. In England, although investment in mental health has risen significantly – an increase of almost 60% in real terms between 2001/02 and 2011/12 – it actually fell for the first time by 1% in 2011 in line with measures taken right across the NHS (Mental Health Strategies, 2012). In the Netherlands, mental health care expenditure also decreased in 2012, in contrast to the current general trend in health care spending, where costs are continuing to rise (Van Dijk et al., 2011; Hilderink and van't Land, 2008; Heijnen, 2013). However, it is worth nothing that the costs of certain pharmaceuticals frequently used in the treatment of mental ill-health have been falling, meaning that some elements of mental health treatment simply cost less.

Indirect costs can be as important as direct costs for mental health

Indirect costs refer to economic consequences attributable to disease, illness, or injury resulting in lost resources due to situations brought on by mental illness such as reduced activity in the labour market and premature mortality. In the area of mental health premature mortality is more likely to be affected due to co-morbid conditions exacerbated by mental illness.

A number of national and international studies give some indication of the level of indirect costs. The OECD project on mental health and employment (OECD, 2012b) deals in part with the indirect costs of mental health with relation to unemployment, sickness absence and presenteeism. Several countries have also attempted to estimate the indirect costs associated with mental illness. All of the studies included an estimate of the value of lost production, with some made more comprehensive than others by the inclusion of additional components, such as presenteeism. Other indirect costs such as care giving have also been estimated at times. Due to the lack of standardised methods and cost components it is not usually possible to directly compare the results of these studies, although they are informative and point to the large economic burden associated with mental illness. Indeed, the indirect costs rival the direct costs associated with mental illness (Table 1.4).

Table 1.4. **Direct and indirect costs of mental illness: Results from selected studies**

Country, year	Direct costs[1] (billions)	Indirect costs[1] (billions)	Total costs (billions)	% of GDP
Canada, 2011	CAD 42.3	CAD 6.3	CAD 48.6	4.40
England, 2009/10	GBP 21.3	GBP 30.3	GBP 51.6	4.10
France, 2007	EUR 22.8	EUR 21.3	EUR 44.1	2.30
Global, 2010	USD 823	USD 1 670	USD 2 493	

1. All values are in the national currency valued in national current units. Global costs in USD.

Source: Smetanin, P., D. Stiff, C. Briante, C.E. Adair, S. Ahmad and M. Khan (2011), *The Life and Economic Impact of Major Mental Illnesses in Canada: 2011 to 2041"*, RiskAnalytica, on behalf of the Mental Health Commission of Canada 2011; Centre for Mental Health (2010), *The Economic and Social Costs of Mental Health Problems in 2009/10*, Centre for Mental Health, London; Chevreul, K. et al. (2009), "Le coût de la pathologie mentale en France en 2007", available at: *www.urc-eco.fr/Le-cout-de-la-pathologie-mentale*; Bloom, D.E. et al. (2011), *The Global Economic Burden of Noncommunicable Diseases*, World Economic Forum, Geneva.

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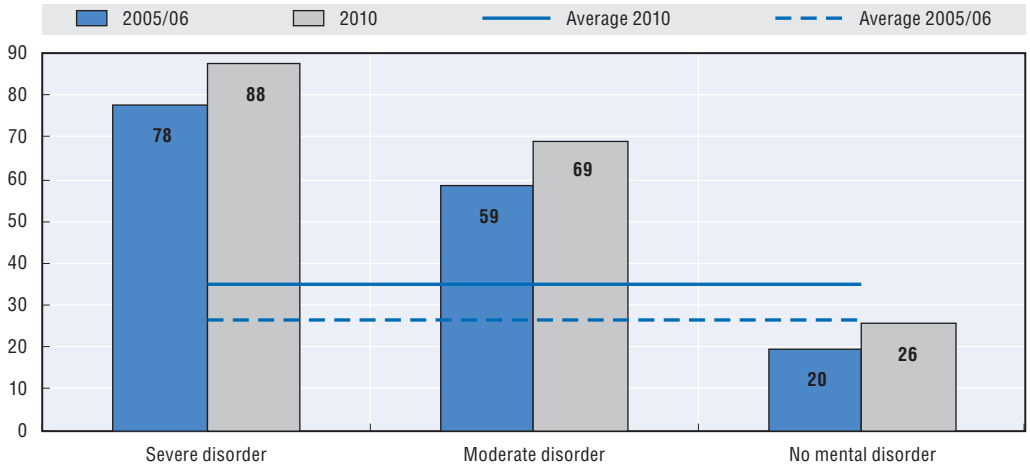
The impact of mental ill-health on productivity is costly

The impact of mental ill-health on economic productivity can be significant, as the effects of mental illness fall mainly on people during their working lives, as opposed to the burden of most other diseases which commonly affect older individuals. There are high indirect costs of mental ill-health as a result of reduced productivity in the workplace (presenteeism), increased sickness leave from work (absenteeism), and increased unemployment. There is also the indirect effect of increased presenteeism, absenteeism and unemployment amongst the carers of individuals with mental disorders. In addition, premature mortality has a cost in terms of lost potential productivity.

Poor mental health can decrease workers' marginal productivity when they are at work as they are likely to get less done due to emotional or physical health problems brought on or exacerbated by mental illness. This is referred to as presenteeism. 88% of workers with a severe mental disorder stated that they accomplished less than they would like as a result of an emotional or physical problem, compared to 69% of those with moderate disorders, and 26% for those with no mental disorder. In fact presenteeism has been on the rise in recent years (see Figure 1.8).

Figure 1.8. **Presenteeism has increased among all groups of the population**

Percentage of workers who were not absent in the past four weeks but who accomplished less than they would like as a result of either an emotional or a physical health problem, average of 21 European OECD countries, 2005 and 2010



Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

StatLink http://dx.doi.org/10.1787/888933030249

Individuals suffering from mental illness who are able to work are more likely to have temporary absences than those without any mental disorders. Forty-two percent of all workers suffering from severe mental disorders were absent from work in the previous week, compared with 28% for those with a moderate disorder, and 19% for those with no mental disorder (OECD, 2012b). In England it was found that among people in work, mental illness accounts for nearly a half of all absenteeism (Centre for Mental Health, 2012).

Unfortunately the costs in lost production attributable to absenteeism, and especially presenteeism, are difficult to estimate and they are often not included in cost-of-illness studies, although when estimated their associated costs have been substantial. In Australia, the cost of reduced productivity due to mental illness among those in the workforce has

been estimated at AUD 5.9 billion per year due both to absenteeism and presenteeism (Department of Health and Aging, 2010).

Mental illness and employment share a complex relationship, with unemployment leading to mental illness, and those who are mentally ill, often, being unable to work. Individuals with mental disorders are less likely to be employed and the employment gap increases significantly with the severity of the mental illness: people with severe mental disorders are 6-7 times more likely to be unemployed than people with no disorder, and people with mild to moderate mental disorders are 2-3 times more likely to be unemployed (OECD, 2012b). Australia's Productivity Commission has stated that of mental disorder, cancer, cardiovascular problems, major injury, diabetes and arthritis, mental illness is most likely to be associated with unemployment. Not only might mental health issues lead to unemployment, but the reverse is also likely to be true. Recent OECD findings show that moving from employment to unemployment or inactivity has a large negative effect on mental health (OECD, 2012b), and the longer individuals are unemployed, the more damaging the consequences for their mental health. The costs of unemployment due to mental illness are high.

A number of countries have worked to quantify the indirect costs of mental ill-health as a result of presenteeism, absenteeism and unemployment. Whilst estimates are not comparable due to different methodologies in arriving at estimates, they do give an indication of the high costs of mental illness (see Table 1.5).

Table 1.5. **The cost of mental health: Absenteeism, presenteeism and unemployment**

	Estimated indirect costs associated with lost workplace productivity
Australia	The cost of reduced productivity due to mental illness among those in the workforce has been estimated at AUD 5.9 billion per year due both to absenteeism and presenteeism.
England	It was estimated that mental illnesses were responsible for increasing the unemployment rate by 4% due to those unable to work and a further 1% if absenteeism (sick days) is taken into account. Including presenteeism, the annual costs associated with lost production as a result of mental illness was GBP 30.3 billion.
France	It was estimated that the cost of lost output was EUR 20 billion (EUR 9.33 billion due to unemployment and EUR 10.67 billion due to sickness leave). Furthermore, reduction in carers' working capacity led to an estimated cost of EUR 45 million. It is important to note, however, that this study does not take presenteeism into account. Informal care was valued at approximately EUR 1.3 billion (usually provided without actual compensation by family members).
Japan	The economic burden of depression in Japan is about USD 11 billion; of which an estimated USD 6.91 billion in workplace costs. Workplace costs were broken down into absenteeism costs (USD 5.60 billion), presenteeism (USD 1.31 billion).

Source: Department of Health and Aging (2010), "National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services Under the National Mental Health Strategy 1993-2008", Commonwealth of Australia, Canberra; Centre for Mental Health (2010), "The Economic and Social Costs of Mental Health Problems in 2009/10", Centre for Mental Health, London; Chevreul, K. et al. (2009), "Le coût de la pathologie mentale en France en 2007", available at: *www.urc-eco.fr/Le-cout-de-la-pathologie-mentale*; Okumura, Y. and T. Higuchi (2011), "Cost of Depression Among Adults in Japan", *Primary Care Companion for CNS Disorders*, Vol. 30, No. 3, pp. e1-e9.

In addition, estimates of indirect costs suggest that it is important that a proper focus be placed on the identification and treatment of mental illness at an early age. About 50% of adults with mental illness developed a mental illness before age 15, and 5% of serious mental health conditions have their onset before the age of 25. Thus, addressing mental health problems early has the potential to significantly reduce costs over the long term (Centre for Economic Performance, 2012; Degney et al., 2012). This is particularly important as individuals may get stuck out of work and reliant on disability payments if they get trapped in the cycle of unemployment and mental health issues at an early age (OECD, 2012b). It has also been found that young people with mental disorders are often granted disability payments quite early, and easily which may steer them away from the labour market on a permanent basis, thus increasing the likelihood of receiving disability benefits (OECD, 2012b).

Premature mortality as a result of mental ill-health can result in high costs in and of itself; in Canada the value of lost production in 2000 due to premature mortality was estimated to be around CAD 2 billion (Jacobs et al., 2010), and in Japan estimates suggest an annual USD 2.54 billion in depression-related suicide costs (Okumura and Higuchi, 2011). Premature mortality caused by mental ill-health can be accounted for by increased somatic disorders and high rates of co-morbidity, which are discussed further in Chapter 3, but also by the economic cost of suicide. For example, in the United States the economic cost of suicide is estimated to be USD 34 billion annually, with the burden of suicide falling most heavily on adults of working age, the cost to the economy results almost entirely from lost wages and work productivity (AFSP, 2010). In New Zealand, one study suggests that the annual cost of suicides and attempted suicides was over NZD 23 million (in 2004 values) in direct police, coroners, victim support and health care costs. However, if the loss of people's productive lives was considered, then the total was over NZD 200 million; if non-economic costs such as quality of life were included the total was NZD 1.4 billion (Phillips, 2012). A modelling exercise using data on suicide rates and non-fatal suicide attempts, life expectancy and economic activity in Germany, Hungary, Ireland and Portugal suggested that the average lifetime costs of each completed suicide are around 2 million in EU countries (McDaid et al., 2010).

The high cost of co-morbidities for health systems

The presence of a mental disorder can exacerbate somatic conditions, or even cause additional physical illnesses. In fact, mental disorders are a risk factor for poor diagnosis in many prevalent physical illnesses. Evidence shows that among 50-64 year-olds with either a moderate or severe mental disorder, around 80% also suffer from a physical condition; a finding that appears consistent across countries[7] (OECD, 2012b). It has been estimated in England that co-morbid mental health problems raise the total health care costs by at least 45% for each person with a long-term mental health condition and co-morbid mental health problem. It has also been estimated that extra physical health care necessitated by mental illness co-morbidity costs the NHS GBP 10 billion per year (Centre for Economic Performance, 2012). Hence, when estimating the full economic costs associated with mental illness it is important to consider these indirect costs as well as the costs associated with co-morbid conditions.

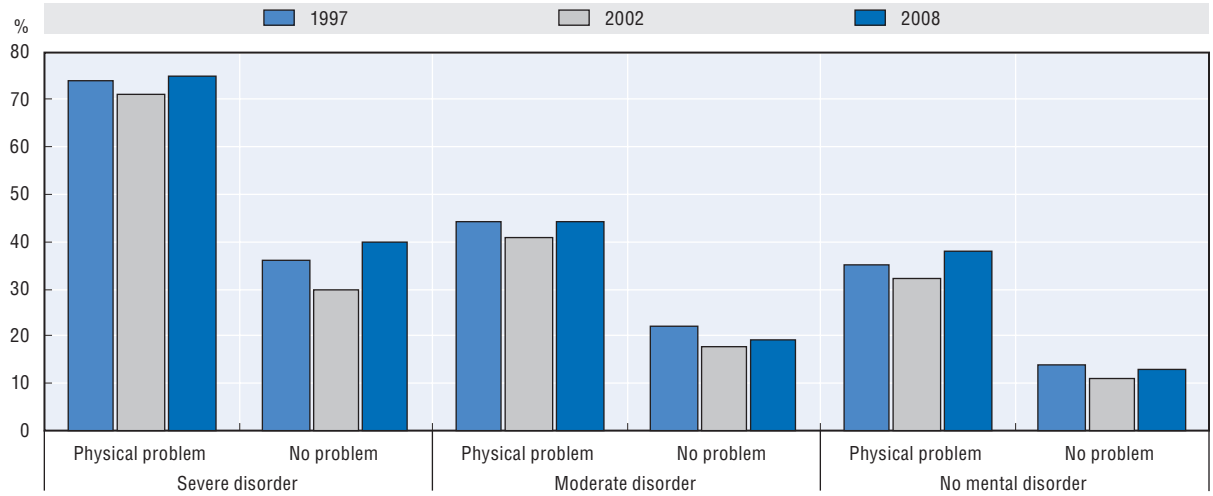
The presence of co-morbidities is also responsible for higher rates of income replacements and disability benefits (see Figure 1.9).

Social security payments for mental ill-health represent a significant cost

As previously discussed, people with mental disorders are more likely to be unemployed than those without any disorder and thus, they often rely on unemployment or disability payments. In addition, people with severe mental illness are not only more likely to be unemployed than those with mild-to-moderate disorders, but they are also more likely to be unemployed for longer periods of time, with long-term unemployment more likely to lead to disability payments. Examining disability benefit claims caused by mental illness, there has been a large increase in virtually all OECD countries over the past two decades (Figure 1.10). Presently, about one-third of new disability benefit claims are attributable to mental disorders with the figure as high as 50% in some countries (OECD, 2012b).

Figure 1.9. **Benefit recipiency rates are much higher with co-morbidity**

Proportion of individuals receiving any income-replacement benefit,[1] by severity of the mental disorder and the prevalence of physical health problems, United States, 1997, 2002 and 2008



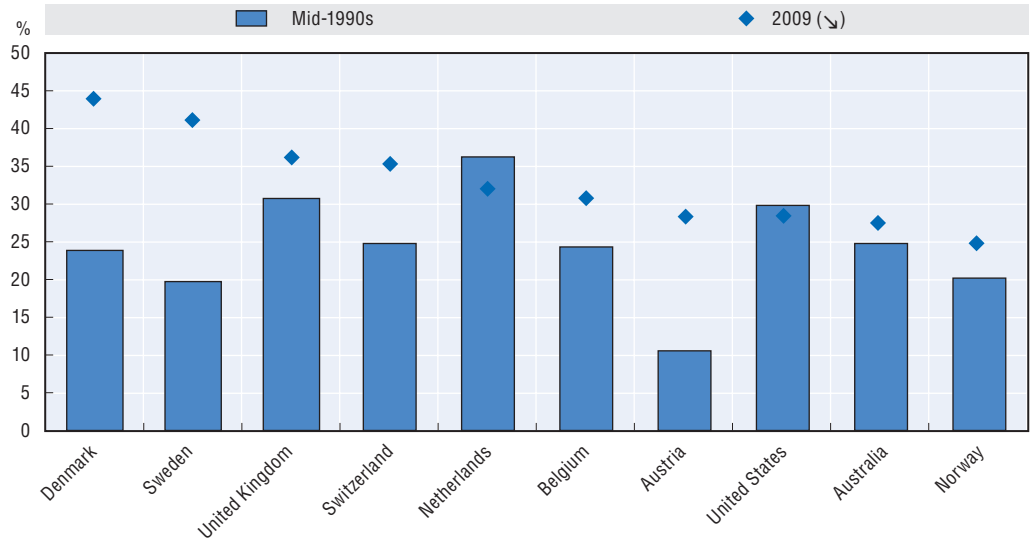
1. Income-replacement benefits include disability, unemployment, welfare and other income-replacement benefits.

Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

StatLink http://dx.doi.org/10.1787/888933030268

Figure 1.10. **Significant increases in disability benefit claims are being driven by claims for mental ill-health**

Newly granted disability benefits for people with a mental health condition[1] as a proportion of all disability benefit grants, selected OECD countries, mid-1990s and latest available year



1. Data include mental retardation/intellectual disability, organic mental disorders and unspecified mental disorders for: Austria, Belgium, Sweden and the United States (of which mental retardation/intellectual disability, accounts for 4.6% of the total inflow in 2006). Data for Australia include organic disorders and Switzerland mental retardation.

Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

StatLink http://dx.doi.org/10.1787/888933030287

High disability payments result in high costs to countries. In Canada in 2007 total income support expenditures were CAD 3.7 billion, broken down into the Canada Pension Plan, Worker's Compensation, Provincial income support, and disability payments. Long-term disability expenditures came to CAD 1.35 billion (30% of total long-term disability payments of CAD 4.5 billion), and short-term disability expenditures to CAD 180 to 300 million (18% to 30% of the total short-term disability payments of 1 billion). Provincial income support (also only reported in six provinces) accounted for CAD 1.2 billion (Jacobs et al., 2010). In England, amongst those out of work, mental illness is the direct cause for 44% of people on incapacity benefits (GBP 8 billion). In France, approximately EUR 4.4 billion in paid benefits was provided for those unable to work. Under sickness leave, daily allowances attributable to mental illness came to EUR 1.41 billion. Unemployment payments attributable to mental illness were distributed under unemployment benefits (EUR 353.2 million), invalid allowances (EUR 2.26 billion) and minimum guaranteed income (EUR 254 million) (Chevreul et al., 2009).

1.4. Measuring intangible costs, and estimating the human cost of mental ill-health

Disability adjusted life years (DALYs) and quality adjusted life years (QALYs) are used as indicators of intangible costs. One DALY is the equivalent of one lost year of "healthy" life, and across a population measures the gap between an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

The *WHO Burden of Disease 2004 Update* study identified unipolar depressive disorders as making up the greatest burden of disability adjusted life years (DALYs) in middle- and upper-income countries. Unipolar depressive disorders are set to become the leading cause of DALYs, globally, by 2030 (WHO, 2008). The Global Burden of Disease 2010 estimated that, worldwide, major depressive disorders accounted for 2.55% of all DALYs, anxiety disorders accounted for 1.08%, schizophrenia 0.55% and bipolar affective disorder 0.52% of total DALYs (Institute for Health Metrics and Evaluation, 2013). Using data from the same study, Whiteford et al. (2013) found that mental and substance use disorders accounted for between 6·2% and 8.6% of all DALYs worldwide (Whiteford et al., 2013).

A QALY measures both quality of life and life expectancy, and can be used to assess the effectiveness and efficiency of specific health care interventions (Box 1.1), or to determine the state of a population's health in a more comprehensive measure than morbidity might give. A number of factors are considered when measuring someone's quality of life, in terms of their health. They include, for example, the level of pain the person is in, their mobility and their general mood. The quality of life rating can range from negative values below 0 (worst possible health) to 1 (the best possible health).

Although only a few studies have derived the monetary costs of intangible costs, the available estimates show that they are potentially substantial. In France, the estimated costs associated with a decline in quality of life attributable to mental health come to EUR 65.1 billion. This stems from a quality of life that is an average of 30% lower than the French average as well as an estimated 2.19 million QALYs lost to mental illness (at an estimated EUR 29 765 per QALY) (Chevreul et al., 2009). In England, the human costs of mental health (costs associated with decreased quality of life) were estimated to be GBP 41.8 billion in 2009-10, while in Scotland, for the same time period, the human costs were estimated to total GBP 5.6 billion.

Box 1.1. **Using QALYs to assess the effectiveness of a specific health intervention**

Patient X has a serious, life-threatening condition.

- If he continues receiving standard treatment he will live for one year and his quality of life will be 0.4 (0 or below = worst possible health, 1 = best possible health)
- If he receives the new drug he will live for one year and three months (1.25 years), with a quality of life of 0.6.

The new treatment is compared with standard care in terms of the QALYs gained:

- Standard treatment: 1 (year's extra life) × 0.4 = 0.4 QALY
- New treatment: 1.25 (one year, three months extra life) × 0.6 = 0.75 QALY

Therefore, the new treatment leads to 0.35 additional QALYs (that is: 0.75 – 0.4 QALY = 0.35 QALYs).

- The cost of the new drug is assumed to be GBP 10 000, standard treatment costs GBP 3 000.
- The difference in treatment costs (GBP 7 000) is divided by the QALYs gained (0.35) to calculate the cost per QALY. So the new treatment would cost GBP 20 000 per QALY.

Source: NICE – National Institute for Clinical Excellence (2010), "Measuring Effectiveness and Cost-effectiveness: The QALY", available at *www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectivenesstheqaly.jsp*.

1.5. Conclusion

Expenditure on mental health has, generally, been rising in OECD countries, and while a significant proportion of expenditure remains in inpatient settings, expenditure on community and outpatient services is increasing. Whilst expenditure on mental health is rising, the high indirect costs – and the treatment gaps for mental health set out in later chapters – bear-out the need for such spending, and would support the need to maintain careful investment in effective services that represent value for money. It could even be argued that spending on mental illness is too low, particularly given its large overall economic burden on society. However, data limitations somewhat limit deeper analysis and cannot answer the question as to whether spending is flowing to the right places.

Given the significant potential benefits in increased employment and thus production, and the better quality of life that can be achieved by effective mental health treatment, particularly for those who suffer from mild-to-moderate disorders, it is likely that investment in mental health care can bring cost-savings elsewhere. Increase spending on mental health should emphasise the importance of ensuring that mental health services deliver good value for money. A study in the Netherlands noted that the return value of indirect costs for investment in mental health care was estimated to be EUR 2.59 for every euro spent on primary health care. In England the Depression Report, which primarily addressed the cost of mild-to-moderate depression, established that further expenditure on psychological therapies for depression would generate enough cost-savings in productivity gains, and reduced health costs, that overall the programme would pay for itself. It has also been strongly suggested that workplace health promotion programmes have the potential to be very effective in reducing the costs associated with absenteeism and presenteeism.

Expenditure data, broken down to give indications of the comparative cost of services, could be used with improved outcomes indicators to give an impression of the value for money presented by services. A preliminary analysis was performed by the OECD in order

to assess mental health system performance, looking at how inputs in the mental health system were translated into outputs and outcomes, using input and output variables that are routinely available in OECD data such as suicide rate, re-admissions for severe mental illness, psychiatric discharges, number of psychiatrists, mental health spending, antidepressant consumption, etc. This analysis found that there was wide variation across OECD countries both in terms of inputs and outputs, and revealed significant differences across OECD countries in terms of the efficiency with which inputs are translated into outputs. However, this study was beset with a number of limitations relating to data availability and coverage; in particular, the majority of available data related to inpatient care, and there was a lack of data for primary and community-based care. Thus, the analysis was biased towards care for severe mental illness and did not adequately consider mild-to-moderate disorders. Moreover, there was limited country coverage for some variables including those on expenditures and re-admission rates and there was a lack of consistency in the measurement of indicators across countries. Nevertheless, while it remains difficult to draw definitive conclusions based on available data, this very preliminary study did suggest there is scope to improve efficiency in OECD mental health systems.

That said, there is a pressing need to improve the data on the costs of mental illness. To gain a deeper understanding of the resources consumed by mental health care, standardised data on costs are needed, as well as better estimates of spending on primary and community care, and for highly specialist services such as secure and forensic services. These measures are particularly important as mental health care in OECD countries shifts away from hospitals. Data at a more disaggregated disease level would also allow the distinction between mild, moderate, and severe disorders, providing valuable information to inform mental health policy setting and service design. More comparable and regular results related to the indirect costs of mental health, including the value of informal care, are needed given the particularly high indirect costs that mental ill-health drives.

Nonetheless, the data that does exist strongly suggest that the overall cost of mental illness is high, and demand effective, high-quality, value-for-money services – both in the health sector, and in employment and social services and beyond – to try to reduce some of the significant burden that mental ill-health is placing on individuals, communities, and economies.

Notes

1. *A System of Health Accounts* first published by the OECD in 2000 and revised in 2011 by OECD, European Union and WHO describes the national health care system from an expenditure perspective related to the consumption of health care goods and services (OECD, 2011).
2. ICD-10 Chapter V ("Mental and behavioural disorders") is comprised of ICD-10 codes F00-F99 and therefore excludes Alzheimer's disease, G30.
3. Note that due to methodological issues this figure is more accurate for some countries than others. For example, in the Czech Republic a large proportion of pharmaceutical expenditures were not properly allocated; hence most of the pharmaceutical spending for mental health care would not have been included.
4. The following countries participated in the pilot project: Czech Republic, Hungary, Korea, Netherlands, and Slovenia. Germany provided data for the original project but more recent data was downloaded from the German Health Reporting web site. Australia provided data for the pilot project, however according to Global Burden of Disease categories; hence the mental health expenditures were not directly comparable as the GBD categories use different grouping of ICD categories.

5. It should be noted that some of the differences may not be true differences in the patterns of provision in countries but may be attributable to data quality and the level to which data could be attributed across provider categories. For example, the Czech Republic was not able to allocate the majority of pharmaceutical expenditures, resulting in an under-estimation of the percentage of mental health expenditures attributable to pharmaceuticals, while Canada was unable to allocate long-term care expenditures according to disease. Work is ongoing to increase the comparability of the results.
6. The International Short List of Hospital Morbidity Tabulation (ISHMT) provides a useful categorisation of ICD groupings that many countries can employ and which can be used for comparisons.
7. These results are from the Survey of Health Ageing and Retirement (SHARE), a survey that covers a large range of OECD and non-OECD countries, mostly in Europe.

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Chapter 2

Securing better care for mild-to-moderate disorders

This chapter explains that mild-to-moderate disorders are highly prevalent in OECD countries, and widely undertreated. The costs of untreated mild-to-moderate disorders are high, and countries need to strengthen and scale-up treatment for common conditions, such as depression and anxiety. The experiences of some OECD countries suggest that cost-effective treatments are available, but their adoption is not widespread. This chapter looks at ways that existing care delivery, particularly at the primary care level, can be improved. Examples of successful ways of ensuring that organisational and financial incentives align with desired outcomes of care provision for mild-to-moderate disorders are given. The growing range of cost-effective initiatives, particularly initiatives that promote access to psychological therapies, which are highly promising for delivery of better care for mild-to-moderate disorders, are explored.

2.1. Introduction

The focus of mental health systems has traditionally been on severe mental illness, rather than mild-to-moderate mental illness. As the following chapter highlights, specialist care for mental disorders has undergone significant changes in most OECD countries, in particular with the shifting of care to community settings, and the subsequent effect on care delivery and payment systems. Whilst there remain significant advances to be made to improve specialist care for mental disorders, momentum for change and improvement has been quite significant. However, investment of energy and resources in care for less severe mental illnesses has been less forthcoming. This chapter seeks principally to address care provision for common mental disorders that have symptoms that are "mild-to-moderate", although it is clear that distinctions and diagnoses are rarely so clear-cut.

Mild-to-moderate mental illnesses often fall outside of the remit of specialist mental health care in the community and in inpatient settings. In countries where hospital care for mental ill-health is still dominant, mild-to-moderate mental illnesses risk being neglected, as most hospitalisation of patients with mild-to-moderate depression or anxiety, for example, is infrequent. Where care in the community is more dominant, much of the focus has been on providing community care to replace institutional care, which means that whilst the majority of specialist care is delivered in the community with hospitals providing high intensity support when necessary, the focus remains on the most severe cases. Meanwhile, the burden of these mental illnesses is high, and while symptoms tend to be less severe, untreated disorders can cause significant harm to individuals, and have a detrimental impact on wider society. Mild-to-moderate mental illness has been shown to have a strong relationship with higher unemployment, higher absenteeism, lower productivity in the workplace, and a rising burden of disability benefits claims.

Some OECD countries have seen that there is significant potential to improve care for mild-to-moderate mental illnesses by building the capacity of existing care systems to treat mild-to-moderate cases of disorders such as anxiety and depression. Notably, there is potential for strengthening the role that primary care physicians play in the management of mild-to-moderate mental illness in community settings. There are often cost incentives to improving existing systems rather than building new ways of delivering treatment, and evidence suggest that mild-to-moderate disorders can be cost-effectively treated from primary care. However, in order for treatments to be effective and of high quality, the right capacity and knowledge, incentives, and information systems must be in place. In addition, some OECD countries have had some success in building additional tailored services to address unmet need for treatment of mild-to-moderate mental illnesses. A number of examples have suggested that new treatment modalities are cost-effective. This chapter explores some of the approaches being taken by OECD countries in responding to the pressing need for better treatment for mild-to-moderate disorders, highlighting examples of practice that represents good value for money, and can secure high-quality care, as

well as drawing attention to the need for many countries to significantly scale-up their treatment provision for this oft-neglected group of disorders.

2.2. The burden of mild-to-moderate mental disorders in OECD countries

What are mild-to-moderate disorders?

This chapter uses the term "mild-to-moderate" to describe a set of mental disorders which have high prevalence in OECD populations – notably depression and a range of anxiety disorders, panic disorders, phobias, somatoform disorders, eating disorders and ADHDs (Attention Deficit and Hyperactivity Disorders). These disorders usually have less severe and debilitating symptoms than other (for example, psychotic) mental disorders, and this chapter deliberately excludes more severe cases of mental disorders, including the more severe cases of common disorders such as depression and anxiety. Severity of the disorder is determined by the number of and severity of symptoms, the degree of functional impairment, and the duration of symptoms. Mild-to-moderate disorders impede the health, daily functioning, and quality of life of affected individuals, and require appropriate diagnosis, treatment and care.

Because of the high prevalence of these disorders, they are often referred to as "common" disorders. This chapter uses the term "common" when discussing highly prevalent disorders such as depression and anxiety, where a distinction between symptom severity has not been made. Of all common disorders, a significant percentage have symptoms that are mild-to-moderate. While estimates vary, for the purposes of this chapter 75-80% of common disorders will be assumed to have mild-to-moderate symptoms (Kessler et al., 2005a and 2005b; Australian Bureau of Statistics, 2007; OECD, 2012).

To take an example, following the ICD-10 classification system, a mild depressive episode (ICD-10 F32.0) would consist of two or three of the specified symptoms being present (for example, lowering of mood, reduction of energy, reduced capacity for enjoyment and concentration, disturbed sleep, marked tiredness, diminished appetite, reduced self-confidence and self-esteem), and the patient would usually be distressed but able to continue with most activities (WHO, 2010). Moderate depression (ICD-10 F32.1) would usually include four or more symptoms, and the patient would have great difficulty in continuing with ordinary activities. Severe depression (ICD-10 F32.2) or severe depression with psychotic symptoms (ICD-10 F32.3) are not directly addressed by this chapter, but would typically include a large number of marked and highly distressing symptoms, with suicidal thoughts and acts common, and in the case of F32.3 the presence of hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible. Severe depression and severe depression with psychotic symptoms would more typically require specialised, high-intensity treatment.

While this publication makes a distinction between the severities of mental disorders, it is important to note that for patients and practitioners the reality of disorders is frequently more fluid. The mental state of a patient experiencing a moderate depressive episode can worsen and become "severe", just as a severe episode can be stabilised with symptoms lessened or alleviated. Good co-ordination between services and sensitivity to the need for different intensities of treatment are very important. In addition, it is increasingly recognised that sub-threshold mental disorders (where the symptoms fall below the diagnostic criteria for the disorder) can be distressing and disabling, particularly if persistent, and low-intensity treatment for such cases is often appropriate.

Mild-to-moderate mental illnesses account for a significant burden of disease in OECD countries…

Mental disorders represent a significant disease burden, and have a significant impact on the lives of OECD populations. Those mental disorders with the most severe symptoms are relatively rare, affecting only small proportions of the population (see Chapter 3). Across the OECD each year, millions of people are affected by mild-to-moderate mental disorders. Furthermore, mild-to-moderate mental disorders are often highly treatable.

Although there are significant challenges around estimating prevalence of mental disorders, especially in generating internationally comparable estimates (see, for example, Wittchen and Jacobi, 2005), existing studies suggest that the prevalence of disorders such as anxiety and depression is high across countries. In a comprehensive review of all available European epidemiological surveys, the 12-month prevalence of anxiety disorders was estimated at 14% of the EU27 population, and major depressive disorder had an estimated 12-month prevalence rate of 6.9% (Wittchen et al., 2011). This study found no substantial country or cultural variations. The ESEMeD survey of Belgium, France, Germany, Italy, the Netherlands and Spain conducted between 2001 and 2003 highlighted the magnitude of mood disorders, anxiety disorders, and alcohol disorders in Europe (Alonso et al., 2004). This study found a lifetime prevalence of any mental disorder (mood, anxiety, and/or alcohol disorder) of 25%; lifetime prevalence of any mood disorder (major depression and dysthymia) was estimated at 13.6%, and lifetime prevalence of anxiety disorders (generalised anxiety disorder, social phobia, specific phobia, post-traumatic stress, agoraphobia, agoraphobia with panic disorder and panic disorder) was estimated at 13.6%. Some variations in prevalence of mental disorders have been found, for example, according to the WHO World Mental Health Surveys, self-reported prevalence of depression in France was about twice that in Germany in the mid-2000s (Kessler and Üstün, 2008). An estimated 75-80% of these common mental disorders are mild-to-moderate (OECD, 2012).

In the wake of the economic crisis, there have been indications that rates of anxiety and depression have been rising, for example in rising prescriptions of anti-depressants. Gili et al. (2012) state that in Spain "recession has significantly increased the frequency of mental health disorders and alcohol abuse among primary care attendees in Spain, particularly among families experiencing unemployment and mortgage payment difficulties". Europeans were reporting feeling "more negative" in 2010, than in 2005-06, according to the Eurobarometer Survey (European Commission, 2010).

… and have a significant impact upon individuals and society

The majority of mild-to-moderate mental disorders are not disabling in an absolute sense. Rather, the majority of people with a common mental disorder – 65-70% (OECD, 2012) – are in employment. However, the impact of mild-to-moderate disorders on individuals and on society is significant. It is probable that given the greater prevalence of mild-to-moderate disorders, their detrimental effects outweigh those of the most severe disorders in terms of the overall disability burden for society (OECD, 2012; Kessler et al., 2005a and 2005b). Mild-to-moderate disorders also contribute to premature mortality, higher morbidity, and poorer outcomes for chronic diseases.

The WHO Burden of Disease 2004 Update study identified unipolar depressive disorders as making up the greatest burden of disability adjusted life years (DALYs) in middle- and upper-income countries, measuring the gap between current health status and a year of full health. Unipolar depressive disorders were predicted to become the leading cause of

DALYs, globally, by 2030 (WHO, 2008). The growing burden of DALYs caused by unipolar depressive disorders also supports this report's conclusion that there are significant gaps in the treatment of mental disorders, particularly in relation to mild-to-moderate mental disorders which make up the majority of episodes of depressive disorder.

The co-morbidity of somatic and mental disorders leads to poorer health outcomes, and higher health care costs. Depression is more common amongst individuals with a range of cardiovascular diseases, diabetes, and chronic musculoskeletal disorders (Naylor et al., 2012). Anxiety disorders are particularly prevalent among people with chronic obstructive pulmonary disease (ibid.). Co-morbid mental health problems may reduce an individual's ability to effectively manage chronic disorders (DiMatteo et al., 2000). The high rate of co-morbidity of diabetes and depression is associated with significant morbidity, mortality, and increased health care cost (Egede and Ellis, 2010; Gonzalez et al., 2008; Schram et al., 2009). The Kings Fund (Naylor et al., 2012) found that in England individuals with co-morbid mental and somatic health problems had 45% higher total health care costs. Depression has also been shown to increase risky and unhealthy behaviours, including smoking (Naylor et al., 2012). Work in Scotland by Barnett et al. (2012) underlines how common mental health conditions impact upon chronic somatic conditions, particularly for the 45-60 year age group; this study showed that the presence of a mental health disorder increased as the number of physical morbidities increased.

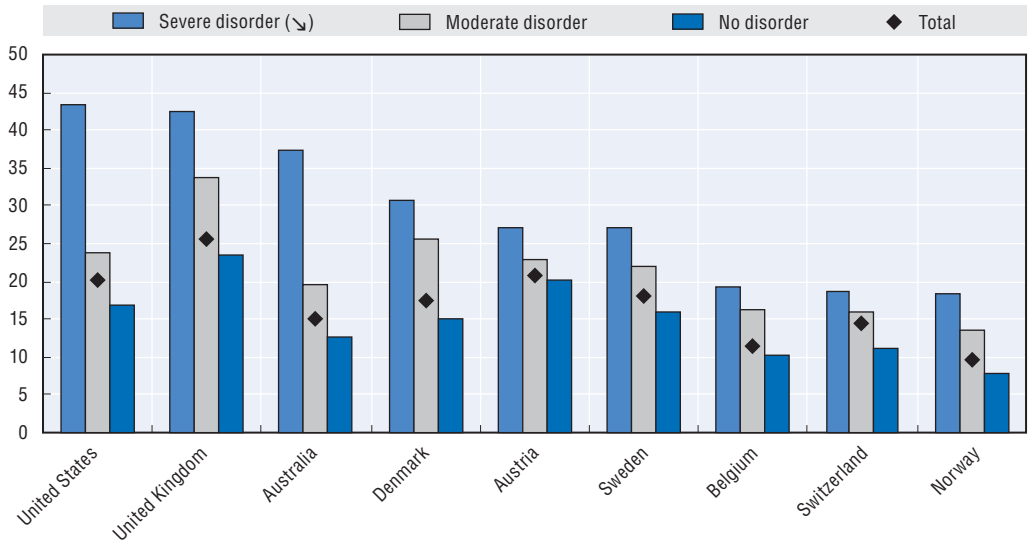
For individuals, the impact of mild-to-moderate mental disorders can be profound. People with mental disorders, especially with anxiety disorders, have been found to be more likely to divorce, and to be married for a shorter period of time than populations without a mental disorder (Kessler et al., 1998; Breslau et al., 2011). Mild-to-moderate mental illnesses have been shown to have a strong relationship with higher unemployment, higher absenteeism, lower productivity in the workplace, and a rising burden of disability benefits claims (Alonso et al., 2004; European Commission, 2010; OECD, 2011). Whilst most people with common mental disorders are in employment, the rate of employment for those with a common mental disorder (CMD) is 10 to 15 percentage points lower than the population without a CMD (OECD, 2012). Depression has been found to be highly correlated with poverty (Brown, 2012) (Figure 2.1).

Mild-to-moderate forms of mental disorders are responsible for a high degree of losses of potential output, productivity and work days. A wide number of publications underline the financial losses as a result of reduced output related to mental disorders, including Chapter 1 in this publication (Centre for Mental Health, 2010; OECD, 2012). Lost earnings as a result of all depression in England were estimated at GBP 5.82 billion in 2007, rising to a projected GBP 6.31 billion (2007 prices) by 2026 (McCrone et al., 2008). Lost earnings as a result of anxiety disorders were estimated at GBP 7.7 billion in 2007 rising to 8.34 billion in 2026.

As well as the financial burden upon national economies in lost earnings and the cost to the health system, the burden upon social care systems and the criminal justice system is significant. Over the past two decades, most OECD countries have seen a sharp increase in the number and share of people claiming disability benefit on the grounds of mental ill-health (OECD, 2012). The share in the total disability beneficiary caseload of people who were granted a benefit on the grounds of a mental health condition has been increasing in many OECD countries over the past decades: from around 15-25% in the mid-1990s to some 30-50% in 2009/10 (OECD, 2012). A high proportion of those in touch with criminal justice systems suffer from mental disorders; the WHO estimates that 40-70% of prisoners have at least one mental disorder (WHO Europe, 2013), and a large number of prisoners

Figure 2.1. **People with a mental disorder face a large poverty risk**

Percentage of individuals with severe, moderate or no disorder with a household income below the low-income threshold[1]



1. The low-income threshold determining poverty risk is 60% of median income.

Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

StatLink http://dx.doi.org/10.1787/888933030306

suffer from mild-to-moderate disorders or (often multiple) sub-threshold disorder(s), that in many cases could be effectively treated, and that are often undiagnosed (Rickford, 2003; Naidoo and Mkize, 2012; Værøy, 2011; Cunnife et al., 2012).

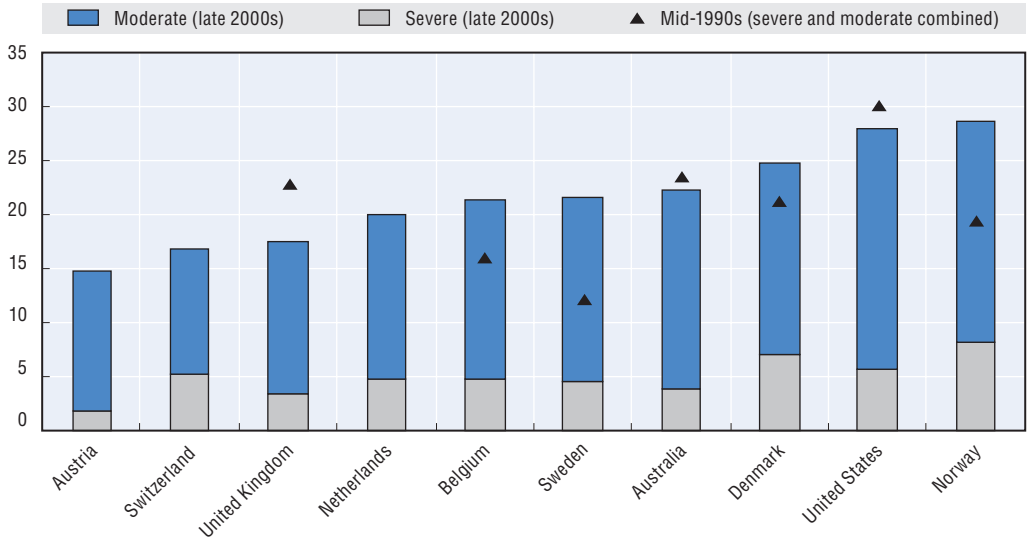
Mild-to-moderate mental illnesses affect children, adolescents and young adults as well as adults, and can have a damaging effect on young people's experience of education, and their future employment prospects. Research suggests that a very young age of onset of for a range of mental disorders and especially for anxiety disorders (median age of onset 11 years) (Kessler et al., 2005b). There is a high prevalence of mental disorders, including mild and moderate disorders, amongst young people, in many cases a prevalence higher than across the general population (Figure 2.2). Young people with mental disorders, emotional or behavioural problem are at a higher risk of dropping out of school, and have poorer chances of finding stable employment (OECD, 2012).

Where data are available, they indicate large treatment gaps

Services for common, mild-to-moderate mental illness have often been neglected, even when community services for severe disorders are strong. Globally, the median treatment gap for all mental illness appears to be high, although sources of data are limited (Kohn et al., 2004). The "treatment gap" represents the gap between the true prevalence of a disorder – the population that with symptoms that would meet the symptom threshold for a clinical diagnosis – and the proportion of affected individuals who are receiving treatment. The treatment gap can also be expressed as a percentage of individuals who require care, but do not get it. As a percentage the treatment gap for mild-to-moderate disorders is likely to be higher, as these estimates include severe episodes, for which treatment is more likely. Internationally and regionally, estimates differ due to variations in data availability and in definition of "need". Nonetheless, the treatment gap for all depression and anxiety globally

Figure 2.2. **Around one in four young people have a mental disorder**

People aged 15-24 with a mental disorder as a percentage of the total youth population, late 2000s and mid-1990s



Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

StatLink http://dx.doi.org/10.1787/888933030325

has been estimated at a median 56.3% for depression, and 57.5% for generalised anxiety disorder (Kohn et al., 2004). In a the countries included in the ESEMeD study it was estimated that 3.1% of the population have an unmet need for mental health care; 48% of those with a diagnosable mental disorder reported no formal health care use for their mental disorder. In comparison, only 8% of people with diabetes reported no use of services for their condition (Alonso et al., 2007). In the United States and Ontario it was found that most adults with a probable depressive or anxiety disorder do not receive appropriate care for their disorder (Young et al., 2001; Kessler et al., 2003). The OECD (2012) found high treatment gaps for moderate disorders across a selection of countries (Figure 2.3).

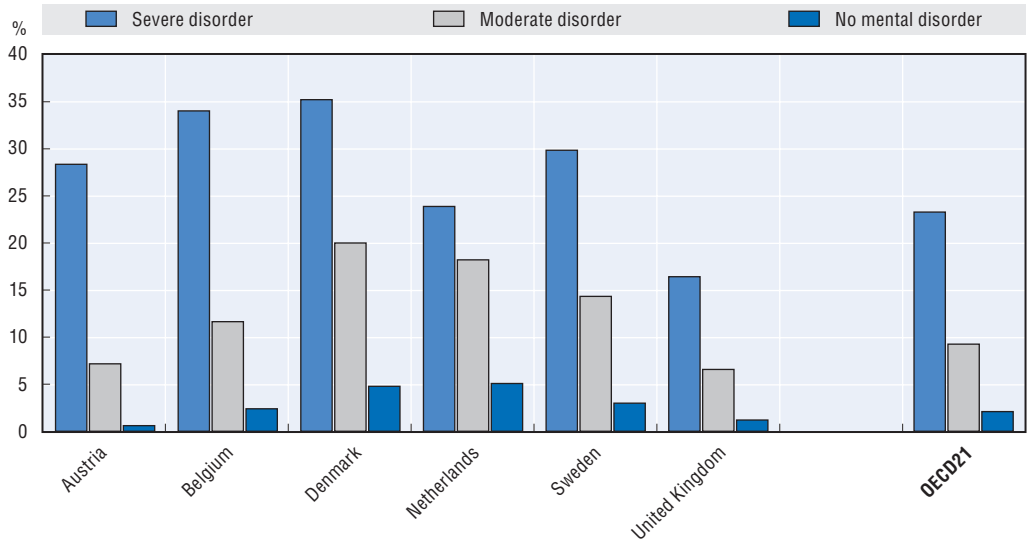
Part of the excess disability due to mental disorders is a result of their early age of onset, combined with a frequent delay in initial treatment (Kohn et al., 2004). In many cases treatment is unavailable – or, often, available treatment is inappropriate or insufficient – and in other cases individuals do not seek help, often because of a perception that treatment is ineffective or that the problem will go away without help, or a lack of knowledge about where to seek help. Stigma, from others and self-stigmatisation, remains a significant barrier to seeking treatment (Andrews et al., 2001; Barney et al., 2006; Schomerus et al., 2009). Financial barriers, accessibility and availability may remain an obstacle for some people.

Reducing the treatment gap for mild-to-moderate disorders represents good value for money

There is a strong economic argument for closing the treatment gap for mild-to-moderate disorders. Common mental illnesses have been shown to have a strong relationship with higher unemployment, higher absenteeism, lower productivity in the workplace, and a rising burden of disability benefits claims, and despite being highly treatable, treatment gaps are significant. Despite the high burden of mild-to-moderate disorders, investment in treating them is low. In the Netherlands, for example, depression has the highest burden of disease

Figure 2.3. **The opportunity to seek specialist treatment varies considerably across countries**

Share of people in specialist treatment[1,2] by severity of the mental disorder, 2010



1. "Specialist" includes psychiatrist, psychologist, psychotherapist or psychoanalyst. "No specialist" includes general practitioner, pharmacist nurse, social worker or "someone else".
2. Treatment for a psychological or emotional problem in the last 12 months.
Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

StatLink http://dx.doi.org/10.1787/888933030344

across all disorders (8.2%) – more significant than cardiovascular diseases or cancer – yet public spending on treating depression for the whole population is comparatively low, at approximately 1% of the national health care budget (Van Geldrop, 2013). As many OECD countries look to curb, and in many cases cut, health spending, the necessary investment of time, money, expertise and human resources is, in many health systems, difficult to come by. However, investments in care for common disorders have the potential to be cost-neutral or even cost-saving (McCrone et al., 2004).

An increase in the number of people in treatment, receiving evidence-based interventions, would increase service costs but could bring savings elsewhere – if the most effective treatments are prioritised –, in indirect costs elsewhere in the health sector, and in reduced sickness absences, improved productivity, falling disability claims, and increased employment and tax revenue as individuals return to work (McCrone et al., 2004; OECD, 2011). The cost-benefits of increasing effective treatment for mild-to-moderate disorders will largely accrue outside of the health sector, through increased employment and tax revenue, and reduced benefits payments, and therefore appropriate strategic investments would be made with this in mind (McKrone et al., 2004; OECD, 2012).

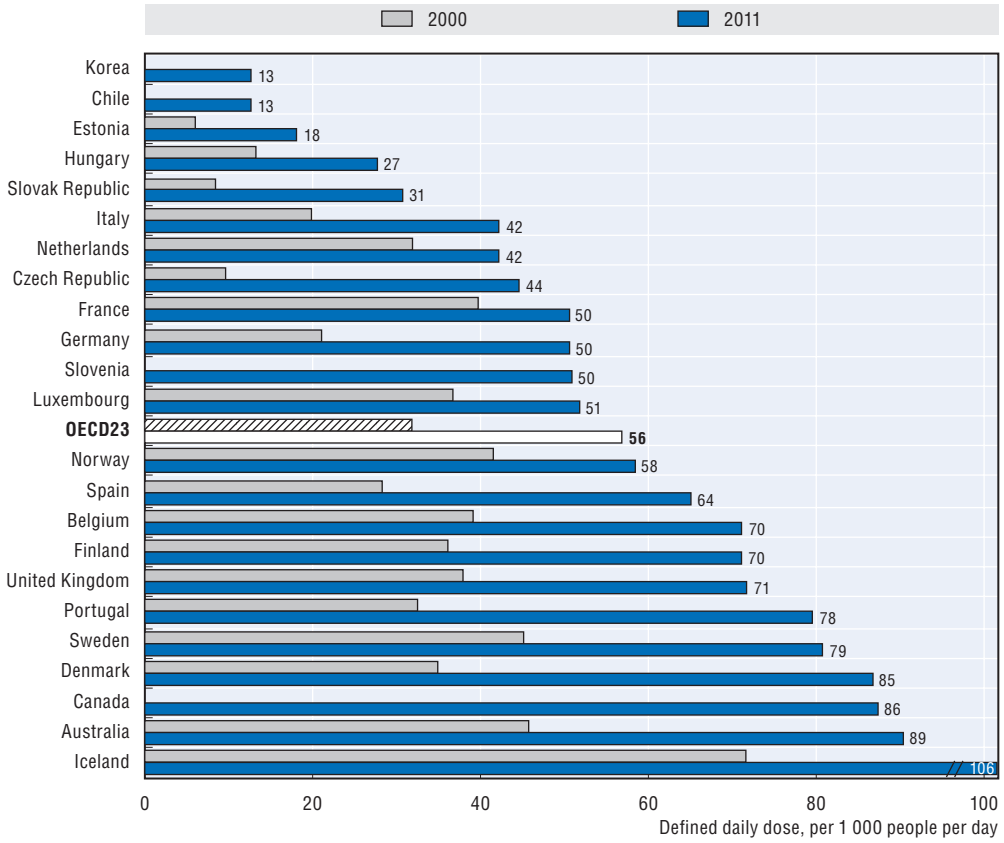
2.3. How are OECD countries treating mild-to-moderate disorders?

Prescribing patterns reflecting a scaling-up of treatment?

Increased consumption of antidepressants, the more widespread use of antidepressants with fewer side effects (SSRIs – Selective serotonin reuptake inhibitors), and increased prescribing of anxiolytics have been suggested to have reduced the treatment gap for mild-to-moderate mental illness in some countries. The consumption of antidepressants and

anxiolytics has increased significantly in most OECD countries since 2000, and although wide variations in consumption levels have remained, it is hopeful that this increase represents some narrowing of the treatment gap for depression (OECD, 2011; OECD, 2013), as a result of better availability of more appropriate antidepressants, increased diagnosis, or a change in prescribing behaviours among general practitioners and psychiatrists. Increases in antidepressant consumption could also indicate an increasing prevalence of depression. The drivers are likely to vary across countries (Figure 2.4).

Figure 2.4. **Antidepressants consumption, 2000 and 2011 (or nearest year available)**



Source: OECD (2013), *Health at a Glance 2013 – OECD Indicators*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/health_glance-2013-en*.

StatLink http://dx.doi.org/10.1787/888933030363

The level of antidepressant consumption depends on the prevalence of depression in each country, but also upon the prevalence of diagnosed depressions and the frequency of drug treatments within the context of other treatments, especially psychotherapy (Grandfils and Sermet, 2009). Variations in consumption across countries may indicate differences in the prevalence of depression, but will also reflect the organisation and reach of the mental health system and available services. Guidelines for the pharmaceutical treatment of depression vary across countries, and there is also great variation in prescribing behaviours among practitioners across OECD countries. Greater intensity and duration of treatments are some of the factors explaining the general increase in antidepressant consumption in a number of countries. In England and in France, for example, the increase in antidepressant consumption has been associated with a longer duration of drug treatment (Grandfils and

Sermet, 2009; Moore et al., 2009). Rising consumption levels can also be explained by the extension of the set of indications of some antidepressants to milder forms of depression, generalised anxiety disorders or social phobia (Hollingworth et al., 2010; Mercier et al., 2011). These extensions in the prescription of some antidepressants have raised concerns about appropriateness in some countries. Changes in the social acceptability and willingness to seek treatment during episodes of depression may also contribute to increased consumption.

Some authors have argued that increases in the use of antidepressants may be linked to the insecurity created by the economic crisis affecting many countries (Gili et al., 2012). In Spain, the consumption of antidepressants per capita has increased by 23% between 2007 and 2011, while in Portugal it went up by 20%. However, the consumption of antidepressants rose even more quickly in countries such as Germany (a rise of 46% between 2007 and 2011) that were less affected by the economic crisis and have experienced a more rapid economic recovery.

The increase in prescription of antidepressants in most countries may indicate rising prevalence and need, rising diagnosis, or over-diagnosis, to varying extents. Rising consumption in the United Kingdom was found to be related to longer-term prescribing of antidepressants, rather than new diagnoses, which raises concerns both about a remaining treatment gap and over-prescription for a small group of patients (Moore et al., 2009). In all cases, this underlines the need for attention to be paid to appropriate treatment for depression, and the very large scope of the problem.

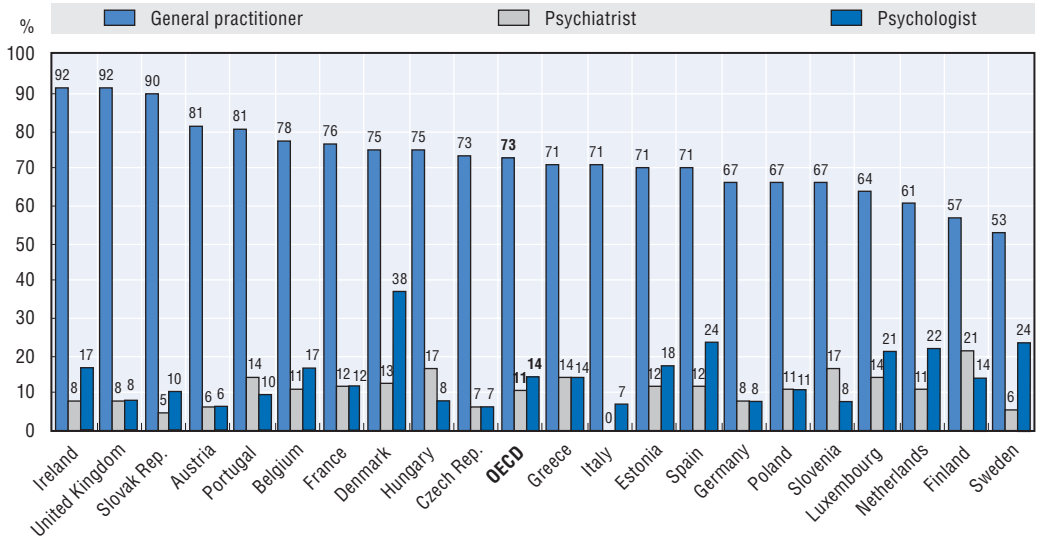
The treatment gaps for mental disorders vary across OECD countries, but all OECD countries have at least some treatment gap, especially for common mental disorders, notably depression and anxiety. What is underlined is a need to address both the unmet need for treatment and the unmet need for appropriate treatment, and how difficult it is to establish *need* for treatment. Increased consumption of antidepressants may, for example, indicate a closing treatment gap in some countries. Should this be the case then there is a strong need to stress the highly significant treatment gap in other countries. However, increased consumption rates driven by longer duration of treatment would not suggest increased treatment across the population. Nor does increased consumption necessarily indicate an increase in appropriate treatment, or in treatment leading to meaningful recovery.

For some OECD countries, where antidepressant consumption is very low – Korea, Chile, Estonia – there is likely a strong case for better addressing unmet need, and examining possible reasons that antidepressant consumption is low. For other countries – those with particularly high antidepressant consumption (Moore et al., 2009), and those who have seen particularly significant increases in consumption – assessment of the appropriateness of prescribing patterns may be called for, and set against availability other appropriate treatments for depression.

Primary carers are at the forefront of diagnosing and treating common mental disorders

In most OECD countries, primary care practitioners are already expected to diagnose, treat and manage mild-to-moderate mental illness. *Health at a Glance – OECD Indicators* (2011) reported that for selected EU countries, the General Practitioner was overwhelmingly more likely to be consulted for mental health problems than psychiatrists or psychologists (Figure 2.5).

Figure 2.5. **Type of provider(s) consulted for mental health problems, selected EU countries, 2010**



Note: The question asked during the interview was: "In the last 12 months, did you seek help from a professional because of a psychological or emotional problem? If yes, indicate who in the provided list (multiple answers possible)".
Source: OECD (2011), *Health at a Glance 2011 – OESD Indicators*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/health_glance-2011-en*.

StatLink http://dx.doi.org/10.1787/888933030382

Although some clients have been reported as being reluctant to seek help from GPs due to a perceived lack of specialist training in mental health as well as a more limited available consultation time (Happell et al., 2010), GPs are regularly consulted by patients with a psychological or emotional problem. Interestingly, although in Ireland and the United Kingdom, where GP consultations are the most dominant, GPs play a gatekeeping function, in many other countries where GP consultation for mental health problems is high GPs do not play a gatekeeping function, and patients can access specialist care directly, for example in Italy. This suggests that factors beyond compulsory gatekeeping or financial incentives influence GP consultation rates, for example GP competency, a good GP-patient relationship, or patient confidence in mental health care provided by primary care practitioners.

Of those OECD countries that have responded to the "Mental Health Systems in OECD Countries: Policy and Data Availability Questionnaire", almost all state that primary care physicians are expected to provide care for mild-to-moderate mental disorders, or provide "first care" prior to referral (see Table 2.1). Almost all OECD countries reported that primary care practitioners could initiate and/or adjust prescription of at least some antidepressants, and often psycho stimulants for ADHD also (Table 2.2).

Primary care physicians have reported feeling ill-equipped to respond to mental disorder

Primary care providers may not have the necessary resources to diagnose, treat and manage mild-to-moderate mental illness, even if they are systematically expected to do so. Good primary care for mild-to-moderate mental disorders depends in part on organisational and financial incentive structures. Primary carers are often being asked to perform a greater number of functions related to mental health, with few if any additional resources (Clarke et al., 2006); primary-care providers can then be frustrated with a lack of

Table 2.1. **How are mental health problems dealt with in primary care?**

	Which mental health problems, and of what severity, would primary care practitioners typically manage themselves?
Australia	Patients with mild-to-moderate disorders, or refer them to specialist services including the ATAPS (Access to Allied Psychological Services) programme and the Better Access programme.
Austria	Patients with mild depression, anxiety disorders, other mild disorders.
Belgium	In principle, primary health care physicians can treat all patients, and the physician also has the freedom to refer patients or not.
Canada	Mild-to-moderate depression, stress and anxiety related disorders.
Chile	PHC provide care (detection, diagnosis, treatment, follow up and referral to secondary level of care) for mild and moderate mental disorders, including depression, alcohol and drug use disorders, family violence, hyperkinetic disorder, schizophrenia (detection and referral).
Czech Republic	Anxiety disorders, depressive disorders, dementia.
Estonia	Mild-to-moderate anxiety and mood disorders.
Finland	Treatment of mild and moderate disorders (depression, anxiety disorders, insomnia, alcohol dependence).
France	Patients can address themselves directly to a psychiatrist (unless under 25, in which case there are financial incentives for obtaining a referral from primary treating physician).
Germany	Principally general practitioners (GPs) are able to carry out the first care of mental illnesses. As soon as possible patients get referral to specialists or hospital care, depending on severity.
Hungary	Primary care manages mild mental health disease i.e. anxiety, and manages interdisciplinary problems such as insomnia and dementia.
Ireland	90% of mental health presentations occur in a primary care context and account for over 5 million occasions of care each year.
Israel	Common mental disorders.
Italy	General Practitioners usually act as gatekeepers to the secondary level of care, often treating themselves symptoms of depression and anxiety, and referring patients suffering from more severe disorders to mental health services.
Japan	Primary care physicians have varying degrees of mental health expertise and provide mental health services according to this varying expertise.
Korea	Patients meet psychiatric specialists easily, and there is no settled family doctor system. For patients with mild mental disorders treatment can be at a primary care level.
Luxembourg	Referrals and treatment depend on the professional judgment and the conscience of the providers.
Mexico	Primary care services only treat people with mild mental disorders. If the person has a moderate or severe mental disorder, they are referred to specialised care.
Netherlands	The GP deals with mental health problems which are not severe, or where patients are stable, and plays a gatekeeping role.
New Zealand	Screening, assessment, prescription of medication and primary mental health services that include packages of care, GP consultation and psychological interventions.
Norway	Mild-to-moderate disorders, including anxiety and depression.
Portugal	Family doctors provide care to people with common mental health disorders (i.e. depression, anxiety). Several local mental health services in general hospitals deliver outpatient care in the Primary Health Care Centres (PHCCs).
Slovak Republic	Prescription regulations authorise primary health care doctors to prescribe and/or to continue prescription of psychotherapeutic medicines but with restrictions.
Slovenia	In primary care setting stress disorders, depression and anxiety disorders are treated, and patients with more severe symptoms are referred to specialists.
Spain	Common mental disorders, and follow-up for severe mental disorders.
Sweden	Organisation and delivery are managed regionally and locally and based on agreements and contracts between the regional government and the providers of local primary health care.
Switzerland	Depending on the severity they can decide on their own to treat or to refer the patient to a specialist or to an inpatient clinic.
Turkey	Mild-to-moderate mood disorders, anxiety disorders, and mild drug dependences (nicotine and alcohol).
United Kingdom (England)	Depression and anxiety disorders especially, but also other mental illnesses such as eating disorders, are frequently treated by General Practitioners at a primary care level, although treatment is very variable across the country.
United States	Primary care physicians provide care for a variety of mental health conditions, most typically conditions where there is less risk of self-harm or when prescribed medications have less serious side effects. Primary care physicians are more likely to provide care for some mood disorders, anxiety disorders, and attention deficit/hyperactivity disorder.

Source: OECD Mental Health Questionnaire 2012.

Table 2.2. **Medications which primary care providers would typically adjust or prescribe**

	Benzodiazepines	Antidepressants		
		Tri-cyclics	Selective serotonin re-uptake inhibitors (SSRI)	Monoamine oxidase inhibitors (MAOI)
Australia	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Austria	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Belgium	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Canada	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Chile	Initiate/Adjust	Initiate	Initiate	Initiate
Czech Republic	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Estonia	Initiate/Adjust		Initiate/Adjust	
Finland	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	
France	GPs are entitled to prescribe and adjust any prescription. But typically they would not initiate 2nd and 3rd generation or atypical antipsychotics.			
Germany	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	
Hungary	Adjust	Initiate	Initiate	
Iceland	Initiate			
Ireland	Initiate			
Israel	Initiate	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Japan	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Korea	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	
Luxembourg	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Mexico	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Adjust
New Zealand	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Portugal	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	
Slovak Republic	Initiate/Adjust			
Slovenia	Initiate/Adjust		Initiate/Adjust	
Spain	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Sweden	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
Switzerland	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust	
Turkey	Initiate	Initiate/Adjust	Initiate/Adjust	Initiate/Adjust
United Kingdom (England)	Initiate/Adjust			
United States	Initiate/Adjust			

Source: OECD Mental Health Questionnaire 2012.

appropriate treatments to address detected problems in primary care (Clarke et al., 2006). Organisational expectations, and payment mechanisms such as capitation, may limit the time that GPs are able to spend on diagnosis and care provision; GPs can feel limited by the time that they have allocated for consultations, which may not be sufficient to diagnose and treat mental illnesses (Mitchell et al., 2010; Mykletun et al., 2010).

Competency of practitioners also impacts upon quality of care. Primary care clinicians have been found to have considerable difficulty accurately identifying emotional distress and mild depression in primary care, with a study in the UK finding that only one in three people were correctly diagnosed (Mitchell et al., 2010). In the United States, Saver et al. (2007) found frequent missed diagnoses of depression in primary care and significant information gaps and lack of understanding amongst both patients and providers. Large studies in Germany (Wittchen, 2002) and the United States (Katzelnick et al., 2001; Weisberg, 2007) found that generalised anxiety disorder (GAD) was poorly recognised and poorly treated in primary care.

Primary care physicians may not have the best and most up-to-date information available to them regarding treatment for common mental disorders; some GPs appear to need more evidence-based knowledge about the disorders they are treating (Andersson et al., 2005). This information gap will lead to poorer treatment options for patients, and a lack of understanding for patients. As primary care practitioners in a number of countries are being asked to do more and deliver a wider range of services for mild-to-moderate mental illness – many GPs are being asked to delivery cognitive behavioural therapy, for example (see Table 2.5) – levels of confidence in the ability to effectively care for patients – will make the difference between poor, average and excellent quality of care.

2.4. Strengthening primary care provision

Mild-to-moderate mental disorders can be cost-effectively treated from primary care

Primary care-based interventions have been found to be effective at treating and managing some mild-to-moderate disorders (Chisholm et al., 2004; Ford et al., 2002). Effective care at a primary care level includes appropriate diagnosis of disorders, initiation and management of treatment, referral and case management, and the long-term management of some cases of mild-to-moderate disorders using the principles of chronic disease management (Ford et al., 2002). There is considerable diversity in strategies for primary care–based treatment of mild-to-moderate disorders between OECD countries, and strategic approaches differ based on the organisation of the mental health system and primary care provision, as well as in many instances following the idiosyncrasies of individual primary care practices (Glied et al., 2010).

Expanding and improving the quality of care for mild-to-moderate disorders in primary care can be a cost-effective way to strengthen mental health care provision, improving accessibility and population coverage, and closing the treatment gap for mild-to-moderate disorders. Treating mild-to-moderate mental disorders in primary care is less costly for health systems than treatment by specialists, or by most specialist services (WHO and Wonca, 2008). With sufficient increase in coverage, depression treatments in primary care were found to be an effective use of health resources, even in resource-poor settings (Chisholm et al., 2004). As well as bringing economic benefits through helping return to work and improved productivity (OECD, 2012), more effective treatment of mental disorders in primary care can contribute to fewer inappropriate referrals to more expensive specialist care services (NICE, 2011).

Organisational and financial incentives must be aligned to promote good outcomes and cost-effective treatment approaches

The treatment approach taken by primary care practitioners will influence the outcome of the care, and different interventions have been found to have different levels of efficacy. Appropriate evidence-based interventions likely lead to better outcomes at a primary care level. To ensure that primary care provision for mild-to-moderate disorders is cost-effective and leads to good outcomes, appropriate treatments must be available to primary care practitioners, and organisational and financial incentives must be well aligned to encourage their use.

Stepped care approaches promote a balance between appropriate care and good outcomes, and cost-effective care. Stepped care sees interventions range from less costly low intensity interventions, for example self-help or guided self-help, to higher intensity

interventions such as psychological therapy combined with pharmacological therapy, in line with symptom severity. Research suggests that some forms of psychological therapy and counselling are at least as effective as antidepressants (NICE, 2009; Badi et al., 2000), and that individuals prefer talking therapies to medication when they are offered the choice. Intensity of interventions can then be increased in patients who fail to respond to lower-intensity interventions within a certain time period. Such care management approaches have been found to be clinically effective and cost-effective at a primary care level (Bachman et al., 2005). For more enduring cases combination therapy of medication and talking therapies has been shown to be effective (NICE, 2009).

Primary care practitioners are limited by the services that are available to them. Workload pressures, lack of skills and knowledge, poor support from specialist care, economic factors or organisational structures can inhibit or disincentivise the provision of high-quality mental health care by primary care practitioners (Telford et al., 2002; Katz, 1998). Across OECD countries the range of treatments that the practitioner can employ varies. For example, in treating depression, most primary care practitioners in OECD countries can initiate and adjust prescription of antidepressants, and in most countries this includes both tri-cyclics and SSRIs. In some countries, for example Korea, primary care practitioners are not allowed to prescribe SSRIs. Some primary care practitioners can easily refer patients to psychological therapies, whilst in other counties such services are not available at a primary care level.

However, there are indications that some practitioners do not provide appropriate care even in mind of those treatment options available to them, for example prescribing antidepressants at too low a dose, or at too short a treatment duration, which leads to poorer patient outcomes. Shoenbaum et al. (2002) found that in primary care practices, where appropriate care was provided (44% of patients were deemed to have received appropriate care at follow up), patients were found to have had lower rates of depressive disorder (24% versus 70%), higher rates of employment (72% versus 53%) and better quality of life at a six-month follow up. Diagnosis of antidepressants has been found to be inappropriate in a number of studies (Harman et al., 2004), and antidepressant prescription can be rendered less effective by non-adherence to treatment or non-persistence (Olfson et al., 2006; Tournier et al., 2011). Professional or cultural bias can influence practitioners, and lead them away from treatments that may be more appropriate and lead to better outcomes. Practitioners do not always follow guidelines, even when they are available (Mercier et al., 2011; Smith et al., 2004). In the United States and Ontario it was found that most adults with a probable depressive or anxiety disorder do not receive appropriate care for their disorder (Young et al., 2001).

Where it appears that practitioners are not providing appropriate care even in mind of those treatment options available to them, realignment of organisational and financial incentives may be needed. Some countries have been including preferential reimbursement, or adapted reimbursement structures, to GPs who are responding to mental health needs. In Australia and Norway GPs can be reimbursed for providing longer consultations, and following certain types of care management protocol, such as putting in place care plans. In Australia the GP Mental Health Care Programme (GP MHC) was introduced under the Better Access to Mental Health Care Programme in November 2006. The GP MHC items were included in the portfolio of services for which GPs were reimbursed. The items are designed to encourage early intervention, assessment and

management of patients with mental disorders by GPs, in conjunction with psychiatrists, psychologists and other allied health professionals. A specific mental health consultation item has been added for GPs to provide patients diagnosed with mental disorders with extended consultations (at least 20 minutes). Notably, the use of the GP MHC consultation item can be used for the ongoing management of any patient where the primary treatment problem is in relation to a mental disorder; it is not restricted to patients with a GP MHC Plan nor are there any restrictions on how often the consultation item can be used. GPs were also given increased referral options through the expanded reimbursment of a range of allied health items.

Amongst the challenges of incentivising primary care provision for mental health is a lack of good information on care quality and outcomes. In England, the Quality and Outcomes Framework (QOF) looked – amongst other targets – to incentivise screening for depression in primary care as well as to improve information availability, but has been met with a number of challenges. The QOF combines a financial incentive with comprehensive data collection, but some other countries – Scotland, for example – have found that improving comparative data and increasing support to GPs has been effective in changing local practice (Box 2.1).

Box 2.1. **Primary care-level incentives: The QOF**

Prior to the introduction of the Quality Outcomes Framework, GPs were paid by capitation for basic services, a payment mechanism that the government felt did not reward those who took on extra work, made their services more responsive and accessible or who successfully relieved pressures on hospitals. The Quality and Outcomes Framework (QOF) was introduced in 2004 to address these problems (Cashin et al., 2014), and takes the form of an annual contract, giving bonuses to GPs and practices that meet certain outcome and quality targets.

The QOF is an annual contract, providing financial bonuses to GPs who meet certain outcome and quality targets. In 2011/12 there were a maximum of 1 000 points available to practices for meeting set targets, their attribution weighted for different indicators, with practices paid an average of GBP 130.51 per point. Although uptake of the QOF contracts is voluntary for general practices, virtually all practices in England are represented by QOF contracts. There are 142 indicators (on which the targets are measured), ten of which relate to mental health care, whilst a separate set of three indicators is devoted to depression. Mental health indicators include the ability to register people with schizophrenia, bipolar and other psychoses, and then the achievement of certain functions (such as the recording of alcohol consumption, BMI, blood pressure etc.) in a certain proportion of these patients. There is also an indicator for the proportion of patients given a "care programme approach" (CPA).

From 2008 NICE, in association with several other bodies including the British Medical Association, the Department of Health and the General Practitioners Committee, has been responsible for managing the process to develop the clinical and health improvement indicators for the QOF. A potential path should be able to be traced from government policy setting, for example from "No Health Without Mental Health", which influences NICE Quality Standards, which in turn and in time can help to define QOF indicators. Mental health policy should, additionally, influence the NHS Outcome Framework indicators and outcome indicators, and outcomes targets and indicators set at a local level between commissioning groups and secondary and other care providers.

Box 2.1. **Primary care-level incentives: The QOF** *(cont.)*

Given that a comprehensive time series was not established, nor a control group evaluation of the QOF carried out, it is hard to tell conclusively what effect this scheme has had on GP activity (Cashin et al., 2014). One observation that can be drawn from reports on the QOF is the fact that, of the cases that GPs are allowed to exclude from their performance results data under certain conditions, effective exception rates indicate that GPs are excluding a higher proportion of mental health patients than other major health groups (the effective exception rate for patients with mental health needs was 13.51 in 2007/8, compared to rates of 3.61, 5.36 and 6 for cancer, asthma and diabetes patients). This could suggest that the high level of points attributed to GPs for mental health services successfully rendered encourages patient selection and the deliberate exclusion of more difficult cases from the data. Concerns have also been expressed that GPs are directing attention away from activity not rewarded by the QOF, and as such care delivery quality is declining in some areas (Cashin et al., 2014).

In June 2011 the QOF Independent Advisory Committee raised concerns about the three QOF depression indicators (2011/12 indicators DEP1, DEP4 and DEP5, which all addressed diagnosis and assessment of severity of depression) and concluded that these indicators were not shown to be effective in improving process of care or health outcomes for people with depression (NICE, 2011). The recommendation by the Primary Care QOF Indicator Advisory Committee on behalf of NICE was that these indicators be withdrawn, and that a consideration process for new indicators was considered. At present these indicators remained in the QOF framework for 2011/12, although the points value of all of the indicators was reduced. Furthermore, there were concerns raised about the depression indicators and their incentive to improve diagnoses of depression: the QOF indicators include incentives to follow up assessments and depression checks following diagnoses, and to perform depression screening for patients on the diabetes register, but offer no incentives for increasing or improving depression screening across patients. It could be argued, therefore, that the QOF indicators as they stand present GPs with a perverse incentive to not increase screening or depression diagnoses, as this would increase the follow-up and the severity assessments and screening required to meet the QOF targets. In Scotland, where the QOF was also introduced, the depression indicators also presented challenges. Among the whole indicators set, the depression indicator group scored the lowest achievement level, although achievement increases were seen across 2009-11.

Source: For a full list of QOF mental health indicators for 2013/14 please see: NHS Employers (2013), *2013/14 General Medical Services (GMS) Contract Quality and Outcomes Framework (QOF): Guidance for GMS Contract 2013/14,* available at: *www.nhsemployers.org/Aboutus/Publications/Documents/qof-2013-14.pdf*; ISD Scotland (2012), "Quality & Outcomes Framework (QOF) of the New GMS Contract", available at *www.isdscotland.org/Health-Topics/General-Practice/Publications/2012-09-25/2012-09-25-QOF-Report.pdf?48537844420*; Cashin, C. et al. (2014), *Paying for Performance in Health Care*, Open University Press, Maldenhead.

In Australia the Mental Health Nurse Incentive Programme provides incentive payments to community-based general practices, private psychiatrist practices and other appropriate organisations who engage mental health nurses to assist in the provision of co-ordinated clinical care for people with severe mental disorders. Mental health nurses must work with psychiatrists and GPs to provide services like monitoring a patient's mental state, managing their medication and improving links to other health professionals and clinical service providers. Payments are made on a sessional basis with each session being 3.5 hours. A minimum of two patients must be seen per session, and evaluations seem to suggest that the programme has been quite succesful.

Improving mental health competency for primary care physicians: Training and clinical guidelines

Primary care physicians have reported feeling ill-equipped to respond to mental disorders; their skills and competencies may not be sufficient to effectively treat mild-to-moderate disorders, and they may not have the best and most up-to-date information. Increased and/or improved training and continuing professional development (CPD) and use of evidence-based guidelines in primary care have the potential to be a cost-effective way to narrow some of the treatment gap for common disorders, and improve quality of care.

In many, but not all, OECD countries mental health training is a component of primary care physician training (undergraduate or medical degree training). In some OECD countries mental health training is included as part of their continuing professional development training. A joint report of the WHO and World Organization of Family Doctors (WHO and Wonca, 2008) stresses the importance of pre-service and/or in-service training of primary care workers on mental health as an essential prerequisite for mental health integration, and reducing the treatment gap for mental health. Improved physician knowledge of mental health is as effective in improving appropriateness of care as changes to financing structures for mental health (Sturm and Wells, 1995; Wells et al., 1999). The inclusion of mental health training in the curriculum for primary care physicians, and for nurses, is a critical step in improving quality of mental health in primary care.

Furthermore, on-going opportunities for professional development which prioritise mental health will help practitioners stay up to date with the latest evidence base for common mental disorders, and can promote learning that is relevant to their experience in primary care work. Of the 32 countries that responded to the OECD Mental Health Questionnaire (2012), just four (Austria, Korea, Poland and Switzerland) reported that mental health was *not* a component of primary care physician training. By contrast, just ten countries (Austria, Canada, Germany, Hungary, Ireland, Israel, the Slovak Republic, Spain, Sweden and Turkey) stated that primary care physicians *were* compelled to do mental health training as part of their continuing professional development (CPD).

Efforts should be made to track take-up of CPD opportunities, where they are voluntary, and to take steps to address systematic failure to engage with mental health-related CPD. In order to maximise on the potential for CPD to improve practitioners' skills and confidence in treating common mental disorders, CPD programmes should be well-followed, and should include appropriate material and be well-designed. Practitioner buy-in – through programmes that are user friendly, time flexible, interactive, and respond to practitioner needs – will maximise the impact of CPD programmes.

Continuing professional development for mental health could also be encouraged either through incentives or through penalties for primary care physicians without certificates of CPD for mental health. In a number of OECD countries, incentives for CPD are in place. In Austria, core mental health training for primary care practitioners is quite limited, but some primary care physicians have undertaken additional psychotherapeutic medicine training at different intensities. Training results in the accreditation of psy-1, psy-2 and psy-3 diplomas which also allow primary care physicians to deliver certain treatments (in total, some 5 000 general practitioners in Austria hold one of these diplomas). In Australia, under the Better Access initiative to strengthen treatment of common mental disorders, there has been some specification of mental health training requirements for GPs, including a differentiation of Medicare rebate sums, with higher

rebates for GPs who have complete Mental Health Skills Training (a total training time of six hours) (DoHW, 2011). The General Practitioners Mental Health Standards Collaboration (GPMHC) recommends that all GPs with Medical Health Skills Training accreditation undertake ongoing Mental Health Continuing Professional Development (MH CPD) (six hours of training time) each triennium. GPs can also register as providers of Focused Psychological Strategies (FPS) upon the completion of 20 hours of training, and then continue to receive regular training updates. Penalties are another way to encourage take-up of CPD opportunities; in Germany, in cases of non-compliance with continuing medical education (non-specific to mental health), the physician's fee is cut.

Evidence-based clinical guidelines for mental disorders which establish the most appropriate treatment are another way of empowering to primary care physicians, and can improve the quality of care delivered to patients. Many OECD countries – 21 out of 32 countries (OECD Mental Health Questionnaire 2012) – already have clinical guidelines for the diagnosis, treatment and management of patients with mental disorders in primary care. Fewer countries reported disorder-specific guidelines for common mental illnesses. Seven countries (Australia, Canada, Czech Republic, Mexico, Spain, Turkey and United Kingdom (England)) reported that they had guidelines for common mental disorders (OECD Mental Health Questionnaire 2012). Eleven countries [Australia, Canada, Czech Republic, Germany, Iceland, Mexico, Portugal, Spain, Turkey, United Kingdom (England) and the United States] reported that they had clinical guidelines for anxiety; sixteen countries [Australia, Canada, Chile, Czech Republic, Finland, France, Germany, Hungary, Iceland, Japan, Korea, Portugal, Spain, Turkey, United Kingdom (England) and the United States] reported having guidelines for depression; fourteen countries reported having guidelines for ADHD, five countries had guidelines for depression with a chronic physical health problem; ten for eating disorders; seven for obsessive compulsive disorder (OCD); eight for generalised anxiety disorder (GAD); and six for specific phobias (OECD, 2012).

Sharing of guidelines, or guideline-production knowledge, between countries has the potential to be a cost-effective way of improving available information resources for mental health in primary care. There are opportunities for OECD countries to share experiences of best practice for treating depression in primary care, and use these to make sure that clinical guidelines are up-to-date and reflect the most recent evidence-base. Chile and Estonia, for example, both report drawing on guidelines from other OECD countries to establish their own clinical guidelines. Australia, the Czech Republic, Iceland, Israel, Italy, Korea, New Zealand, Portugal, Slovenia and United Kingdom (England) also report that they have national guidelines adapted from guidelines developed in other countries (OECD, 2012). Systematic ways of sharing guidelines, and guideline-production knowledge could be further developed by OECD countries. NICE International (*www.nice.org.uk/aboutnice/niceinternational/niceinternational.jsp*) works with countries on a not-for-profit basis to help them develop system-specific appropriate guidelines for identified areas of need, and has worked with a number of other OECD countries including Brazil, Estonia, Japan, Mexico and Turkey (NICE, 2012).

Guidelines should steward practitioners and patients through the mental health system, reflecting the most appropriate evidence-based approaches. In an area such as mental health, where knowledge gaps and stigma – even amongst the medical community (Sartorious, 2002; Sartorius, 2007; Magliano et al., 2004; Magliano et al., 2011) – can be significant, and practitioners' knowledge may not keep pace with developments in diagnosis, treatment and management. To be most effective, guidelines will likely reflect

the treatment options available, and the referral pathways that are open to practitioners. In the UK guidelines and pathways, including an expected pathway for depression treatment, are produced by NICE (*http://pathways.nice.org.uk/pathways/depression*). The internationally recognised NICE Depression guideline (for adults and for children) covers identification, assessment, and initial management of depression, diagnosis and appropriate steps for persistent sub-threshold depression, persistent sub-threshold depression with inadequate response to initial interventions, moderate and severe depression, and complex and severe depression. The guideline lays out appropriate treatment options, as well as appropriate courses of action if the patient responds well or poorly to treatment. These pathways are set out interactively via the NHS Pathways website, which is also easily accessible to patients and tends to use non-medicalised language, accompanied by linkage to source guidance. The NICE depression guideline, which reviewed the evidence base for the treatment of depression, also had a significant impact upon treatment approaches in England and has backed up a push for the greater use of psychological therapies.

Adherence to clinical guidelines in primary care can be poor, and most countries are not using incentives or sanctions to promote guideline use in primary care. Non-adherence to guidelines can be for a range of reasons, including a need for guidelines to be better adjusted to clinical practice, a lack of confidence in guidelines, a lack of appropriate resources to implement guideline advice, overloading with multiple guidelines, organisational constraints, lack of knowledge regarding the guideline recommendations, or unclear or ambiguous guideline recommendations (Nielsen et al., 2013; Cabana et al., 1999; Mazza and Russell, 2001; Lugtenberg et al., 2009; Swennen et al., 2013).

Good networks between professionals can strengthen primary care delivery

Informal and formal linkages are a further way of improving knowledge and skills held in primary care. The WHO and Wonca have stated that "collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, are an especially promising way of providing on-going training and support" (WHO and Wonca, 2008, p. 6). Many OECD countries report that there are already expectations that there will be some collaboration between primary care physicians and mental health specialists, although in other countries collaboration is more limited. In countries where health care is organised regionally, efforts towards collaboration frequently vary across region, for example in Italy, Luxembourg and Sweden.

In many countries referral is a key link between primary and specialist care. In Japan, there is no formal system encouraging links between primary and specialist care, except for a reimbursement fee for primary care physician upon referral of patients with mental disorders such as depression to a psychiatrist (OECD Mental Health Questionnaire 2012). In Australia the referral process is often more interactive: the GP refers the patient for a specific number of sessions to an allied mental health professional, and if the allied mental health professional thinks the patient requires more services, the patient will be sent back to the GP for review. The outpatient model, where specialists see a selection of cases pre-selected by the primary care physician, is quite widely used in OECD countries. In such instances mental health specialists visit primary health clinics to review, with primary health clinic staff, a small selection of cases, sometimes including a clinical meeting with the patient. The whole mental health network would usually meet together on a regular basis for co-ordination, training or other purposes.

Table 2.3. **Are primary care physicians required or incentivised to comply with treatment guidelines or practice protocols established?**

	Yes, there are incentives and monitoring with sanctions for poor compliance	Yes there are incentives but no sanction or monitoring	No, there are no incentives and no sanctions
Australia			X
Austria			X
Belgium			X
Canada	X		
Chile			X
Czech Republic		X	
Estonia		X	
Finland			X
France		X	
Germany			X
Hungary			X
Iceland			X
Ireland	X		
Israel			X
Italy			X
Japan			X
Korea			X
Luxembourg			X
Mexico		X	
Netherlands			X
New Zealand			X
Norway			X
Poland			X
Portugal			X
Slovak Republic	X		
Slovenia	X		
Spain			X
Switzerland			X
Turkey	X		
United Kingdom (England)			X
United States			X

Source: OECD Mental Health Questionnaire 2012.

A consultation-liaison model, where specialists provide informal advice to primary care practitioners when they need advice on a particular patient is used in a large number of OECD countries. In Italy, in the Emilia Romagna region, the consultation-liaison model has been encouraged as part of improving co-ordination between GPs and mental health services. Most recent reporting suggests that this programme has been successful in improving communication between GPs and community mental health services. In Finland consultation via video link has been used to support primary care physicians in remote areas (OECD, 2012). Collaboration such as this is a way of increasing physician knowledge in a way that can bring benefits across their patient portfolio (Box 2.2).

A facilitation model, where specialists provide short training or courses to primary care professionals, is reported to already be in place in a large number of OECD countries. Multi-disciplinary review meetings – regularly scheduled meetings between primary providers,

Box 2.2. **Consultation-liaison model between GPs and community mental health services in Italy**

The "G. Leggieri" consultant-liaison programme was first implemented in a Community Mental Health Centre (CMHC) in Bologna (Emilia Romagna) in 1999, and in 2002 the service was implemented in the metropolitan area. The model aims primarily at building co-operation between GPs and a dedicated team of consultant psychiatrists, resident psychiatrists, psychologists and nurses; improving the quality of treatment of all mental health problems; and modifying the pathways of care, by treating mild to moderate mental health problems in primary care and severe mental health problems in secondary care.

The consultation-liaison system was designed as a "go-between" for general practitioners and mental health services and often takes place in CMHCs. According to the "stepped care" model adopted by the Leggieri programme, three different approaches could be implemented, depending on the severity of the case. Individuals with mild mental health problems are directly treated by GPs. People with moderate mental health problems are treated by GPs in conjunction with the support of CMHCs, which provide either a simple consultation or suggest a treatment. People with severe mental illness are treated by CMHCs, and there is a follow-up consultation with patients by GPs after the treatment is finished (Menchetti et al., 2006).

specialist mental health services and/or additional health and social services – are less widely in place. However, similar approaches may be in place on an individual level for patients with care plans, where all stakeholders in the patient's care gather – typically with the patient, or their legal representative – to discuss appropriate care. Care plans tend to be more common for individuals with severe and enduring mental illnesses, and/or complex health and social care needs.

Given that in some OECD countries there is a shortage of mental health specialists, and not all primary care systems are arranged in such a way that greater care provision for mental health is easily achievable, building the primary care workforce in other ways ought to be investigated further. Many OECD countries report that psychiatrists, psychologists, mental health nurses and mental health social workers are working in primary care practices. A small study of integrating psychologists into primary care practices in Ontario, Canada, suggested positive outcomes for primary care physicians and patients (Chomienne et al., 2010). In Finland several health stations or centres have started to use a depression nurse model. A survey conducted in 2008 in all Finnish health centres indicated that 78% of all health centres had a depression or psychiatric nurse and 61% of centres had adopted a uniform practice for the screening of depression (Partanen et al., 2010). Mental health nurses are playing an increasing role in the delivery of mental health primary care services and some countries such as Australia have introduced financial incentives to support and develop this role (Happell et al., 2010).

Collaborative care models can improve outcomes and represent good value for money

There are numerous clinical trials in mental health showing that care co-ordination improves outcomes. A comprehensive meta-analysis of effectiveness of the collaborative care model in mental health showed that it significantly improved health outcomes. It

Table 2.4. **Links between primary care and specialist care for mental disorders**

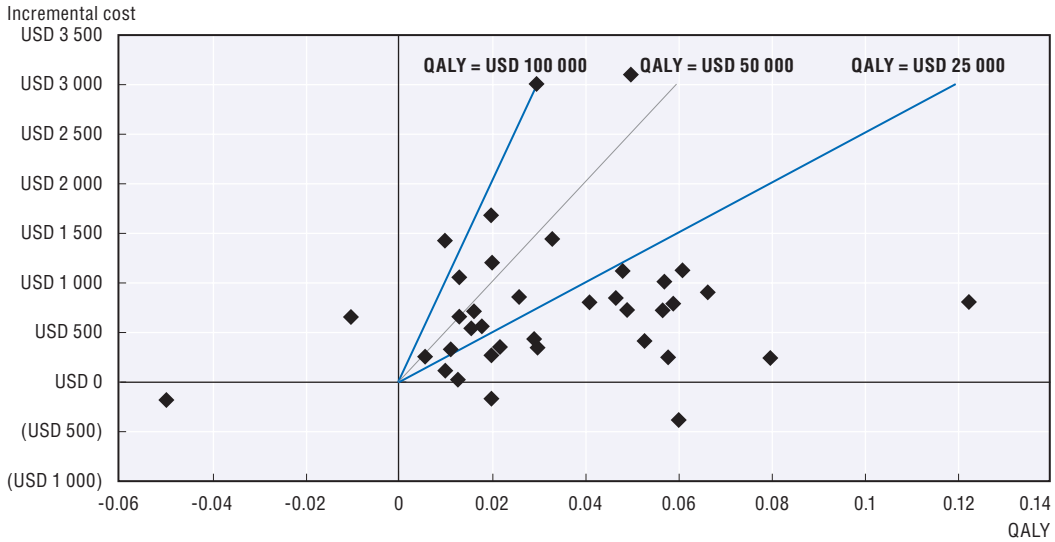
	Outpatient model	Consultation liaison model	Facilitation model	Multi-disciplinary review meeting
Australia				✓
Austria	✓			
Belgium		✓		
Canada	✓	✓	✓	
Chile	✓	✓	✓	✓
Czech Republic	✓	✓		
Estonia		✓	✓	
Finland	✓	✓		✓
France	✓			
Iceland		✓	✓	
Ireland	✓			
Israel		✓	✓	
Italy		✓		
Korea		✓		
Luxembourg		✓	✓	✓
Mexico		✓	✓	
Netherlands	✓	✓		
New Zealand	✓	✓	✓	✓
Norway	✓	✓	✓	✓
Portugal	✓	✓	✓	✓
Slovak Republic	✓	✓	✓	
Slovenia	✓	✓	✓	
Spain	✓	✓	✓	
Switzerland		✓		
Turkey			✓	
United Kingdom (England)	✓	✓	✓	✓
Unites States	✓	✓	✓	✓

Source: OECD Mental Health Questionnaire 2012.

showed 25% improved quality of life at six months and 15% at five years. UK studies show even higher effectiveness. These are very substantial gains compared to common medical treatments. To take an example, the costs of the collaborative care model in treatment of depression include physician time, care manager services, specialty consultation, and registry-decision support. Figure 2.6 presents eight studies of the cost-effectiveness of the collaborative care model. Each of the points shows the relative effectiveness of collaborative care model for the treatment of moderate depression. The chart shows that there are a vast number of studies demonstrating the effectiveness of collaborative intervention; all of the studies show that collaborative intervention improves clinical outcomes. The vast majority of the studies show that the improvement in outcomes is at a relatively low cost, and it is below the traditional threshold used by UK NICE for evaluating new drugs (approximately USD 50 000 per QALY). Even if one is fairly conservative in making assumptions about effectiveness, these collaborative care models still appear to be good value for money.

It is important to emphasize that collaborative care programmes for depression do not necessarily save money. However, they can be highly cost-effective and more cost-effective than collaborative treatment approaches in other disease areas (OECD, 2010).

Figure 2.6. **Eight studies of the cost-effectiveness of the collaborative care model for depression**



QALY: Quality adjusted life years.
Note: Data points represent randomised controlled trials.
Source: OECD (2010), *Value for Money in Health Spending*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264088818-en*.
StatLink http://dx.doi.org/10.1787/888933030401

Furthermore, the cost-effectiveness would be enhanced if it included a wider definition of costs, e.g. the costs of lost productivity. The collaborative care models that use stepped care are even more cost-effective. This is when the intensity is stepped up only when proven necessary. Patients are first offered an intervention that while likely to be effective is relatively easy to implement and carries relatively low cost or side effects. If the effect turns out to be insufficient, treatment is stepped up to a more complex, costly or taxing level. The aim is to ensure that all eligible patients have access to appropriate care, while reserving the most intensive treatments for those that have not to benefitted from lower intensity treatments.

Scaling-up treatment options through the expansion of common behavioural therapies in primary care

To make robust improvements to mental health care for mild to moderate disorders it is likely that most OECD countries will have to invest in building additional appropriate services. There is evidence to suggest that psychological treatments, especially cognitive behavioural therapy (CBT), are effective treatments for mild-to-moderate depression and anxiety (Otte, 2011; Driessen and Hollon, 2010; NICE, 2009). In many OECD countries primary care practitioners are able to refer patients to psychological therapies, although these therapies often are not reimbursed (Table 2.5). Countries also report that where fully reimbursed, or psychological therapies are provided free at the point of care, there are often severe limitations in service availability. When patients have to pay for psychological therapies themselves, or when there are high co-payments, this represents a barrier to access. Increasing access to psychological therapies for mild-to-moderate mental illness would likely help close the large treatment gap for such disorders.

Table 2.5. **Availability and reimbursement of psychological therapies and cognitive behavioural therapy (CBT)**

	Is cognitive behavioural therapy available in primary care?	Are psychological therapies reimbursed?	
		Fully	Partially[1]
Australia	✓	✓	✓
Austria	✓		✓
Belgium	✓		✓
Canada		✓	✓
Chile		✓	✓
Czech Republic		✓	
Finland			✓
Germany		✓	
Iceland	✓		✓
Ireland			✓
Israel			✓
Italy		✓	✓
Japan			✓
Korea	✓		✓
Luxembourg	✓		✓
Mexico	✓		✓
Netherlands			✓
New Zealand	✓		
Norway	✓	✓	✓
Poland		✓	
Portugal			✓
Slovak Republic			✓
Slovenia		✓	
Sweden	✓		✓
Switzerland			✓
Turkey		✓	
United Kingdom (England)	✓	✓	
United States	✓	✓	✓/deductible

1. In some countries where therapies are only partially reimbursed this may include a deductible and/or there may be exemptions to cost-sharing for psychological therapies and CBT.
Source: OECD Mental Health Questionnaire 2012.

A number of countries have established primary care-based programmes of CBT, delivered by primary care practitioners. In Norway, for example, CBT training is available for practitioners, and GPs can deliver and be reimbursed for providing CBT. The advantage of such a model is that it equips primary care practitioners with an additional tool with which to effectively treat the patients that they are already expected to treat. In this sense, it is an effective way of improving the efficacy and quality of the service that primary care practitioners are already providing. Furthermore, given this, introducing primary care-based CBT or talking-therapy equivalents is likely to be cost-saving relative to introducing stand-alone programmes, increasing reimbursements of non-primary care practitioner provided therapies (especially where alternative practitioners are private), or investing in capacity building for the delivery of psychological therapies. The potential for the delivery of CBT or CBT equivalents in primary care will depend on the organisation of the primary care system; some OECD countries have a weak tradition of primary care physicians, which would undermine the efficacy of establishing

CBT in the existing primary care system. In particular, in countries with weak primary care systems and where there are high levels of stigma around mental illness, introducing CBT to primary care is not likely to be the most efficient use of resources.

Expanding referral options from primary care through extending coverage for more specialist services can also contribute to scaling-up treatment. Under the Australian Better Access initiative, following the preparation of a Mental Health Treatment Plan, GPs are able to refer patients to clinical psychologists, allied mental health professionals, or appropriately trained GPs providing focused psychological strategy (FPS) services. Whilst the "Better Access" initiative has met some challenges this is a good example of building greater capacity for effective treatment from a primary care level, promoting co-ordination between primary carers and specialists to provide good treatment, and promoting psychological therapies as an appropriate treatment for primary care practitioners to refer to.

2.5. New interventions for mild-to-moderate disorders can represent good value for money

Scaled interventions for appropriate and cost-effective care

Stepped care for mild-to-moderate mental illness have been supported as a cost-effective approach with good outcomes by a wide range of clinical guidelines. In many cases, services at different intensities are likely provided slightly outside of primary care settings, with or without co-ordination or management by a primary care practitioner, and require some investments in new interventions, especially at the lower intensity end.

Low-intensity interventions for low threshold symptoms have been supported by a range of literature, and clinical guidelines (NICE, 2011). Bibliographic self-help and multimedia self-help interventions for depression and marital issues have been found to have modest but clinically successful effects (Clarke et al., 2006). Self-help and guided self-help approaches are advantageous in their low cost, flexible nature. It has also been suggested that there is a significant proportion of persons who decline – at least initially – to seek traditional medical assistance, preferring to address problems themselves (Clarke et al., 2006), which is borne out by the low numbers of people who seek help for mental disorders relative to the prevalence rate. A range of studies report a significant benefit from use of self-help materials based on CBT approaches for treatment of depression, anxiety, bulimia and binge eating disorder (Lewis and Anderson, 2003). Guided self-help – self-help interventions with minimal sessions with a trained professional – has been seen to be particularly effective as a low-intensity intervention (Fairburn and Carter, 1997; Lewis and Anderson, 2003, Clarke et al., 2006).

A range of appropriate bibliographic references that are clinically effective for low-intensity interventions can be made available to individuals seeking advice; for example, the NHS website NHS Choices suggests a range of literature appropriate for mild depression, anxiety, coping with grief, and obsessive compulsive disorder (OCD) (*www.nhs.uk/Conditions/stress-anxiety-depression/Pages/self-help-therapies.aspx*). In England GPs have also been prescribing NICE-approved self-help books to patients who may benefit from low intensity interventions. The "Books on Prescription" scheme (*www.booksonprescription.org.uk/*) allows books off a set list to be prescribed by GPs and then borrowed free of charge from local libraries, and has been supported by the Royal Colleges of GPs, Nursing and Psychiatrists, the British Association for Behavioural and Cognitive Psychotherapies and the Department of Health through the Improving Access to Psychological Therapies

Programme. Countries without extensive bibliographic resources for self-help in their native language may find it advantageous to invest in production of such resources, or explore the appropriateness of translating existing clinically validated resources.

A growing number of programmes are also being delivered via the internet or computers. Internet or computer-based programmes are usually more interactive than bibliographic resources, and can also be programmed to maximise therapeutic efficacy, for example in setting sessions that must be followed in a certain order, following a timescale (for example weekly, bi-weekly), which cannot be overridden by the user. As part of the Improving Access to Psychological Therapies (IAPT) and following a small trial and series of cohort studies that assessed the programme efficacy, a computer-based CBT programme, "Beating the Blues" has been progressively rolled-out across primary care practices in the United Kingdom. Prescribed by a GP, the patient then completes eight weeks of Beating the Blues sessions at home, while the GP who enrolled the patient receives progress updates and risk alerts. The programme has been found to bring reliable and clinically significant treatment effects when used in routine care, and benefits are similar to the routine delivery of face-to-face CBT care, and was recommended by NICE (Cavanagh, 2006; NICE, 2008) as a useful low-intensity tool as part of a stepped-care framework. Beating the Blues and other evidence-based computerised programmes, prescribed by GPs, have the significant benefit of being easily and quickly accessible as a first-line intervention. In settings where capacity for face-to-face CBT is limited, computerised CBT can be a good alternative for some, and a first alternative for others. "Beating the Blues" was also found to have a high probability of being cost-effective, when assessed in a randomised control trial, yielding substantial clinical benefit, good outcomes and employment benefits which lower employment-related costs with patients more likely to remain in paid employment and reporting fewer missed days from work owing to illness (McCrone et al., 2004). Beating the Blues and FearFighter, a computerised CBT programme for panic and phobias, were both recommended as clinically and cost-effective by NICE in 2006 (three other programmes, two for depression and one for OCD were deemed to have insufficient evidence showing them as clinically and cost-effective).

Some computerised CBT programmes have shown to be adaptable across countries, and there is potential for international collaboration in developing and expanding effective computerised interventions. For example, the freely available MoodGYM, for anxiety and depression, was developed in Australia by the Centre for Mental Health Research at the Australian National University (moodgym.anu.edu.au). MoodGYM has since been suggested for use in the United Kingdom, translated into Norwegian by the University of Tromso, Norway, translated into Chinese by the Beijing Suicide Research and Prevention Centre and then put into production with the help of further funding from the national depression initiative, and translated into Dutch by MoleMann Mental Health. Beating the Blues has also been introduced to primary care settings in New Zealand following a trial in 2008. A trial of 100 patients in four primary health organisations in New Zealand found that patients, who had been referred to the trial by their GP, had improved well-being, reduced symptoms, and improved functioning at the end of the eight week programme (*www.beatingtheblues.co.nz*). Beating the Blues is now available across New Zealand as part of treatment through GP prescribing (Box 2.3).

Self-help groups, support groups and information made available by user and carer groups are valuable resources. In some cases individuals may find such resources themselves, but they can also be included in "informational prescriptions" given by primary

Box 2.3. **Developments in eMental health for mild-to-moderate disorders**

Computerised counselling for common mental disorders in the United Kingdom

A range of computerised counselling courses are available on prescription from GPs in the United Kingdom, two of which – Beating the Blues and FearFighter – have been approved by NICE as effective evidence-based treatments. Beating the Blues is a computerised CBT course for mild depression, whilst FearFighter is a computerised CBT course specifically for panic and phobias.

Living Life to the Full Interactive is a computerised CBT course for mild-to-moderate depression and anxiety, and is supervised by a GP or qualified therapist. In Scotland, Living Life to the Full Interactive is accessible through an online platform, through self-referral to the service hosted by NHS 24 (the national telephone and internet health system), or through local health boards. Entitlement to the treatment course – free of charge – is for all Scottish citizens who score a set "mood score" on a standardised test. Initial contact can be through the internet, via e-mail, and individuals can download a self-assessment mood scale, after which they are contacted for further discussion and decisions over next treatment steps.

NHS Choices, the NHS's central information portal, also suggests Overcoming Bulimia, an online CBT-based course to help people with bulimia and other eating disorders; Overcoming Anorexia, an online course, based on CBT, for carers of people with anorexia nervosa; and the free self-help CBT programme for depression and anxiety, MoodGYM.

Evidence-based eMental health in the Netherlands

The first online treatments and supervisory processes for mental ill-health started in the Netherlands in the late 1990s with the first fully online alternatives to regular treatment. A small group of mental health care organisations and the Trimbos Institute, the national institute for mental health and addiction, initiated this development. Since then, a large series of treatment modules for a range of conditions (depression, anxiety, alcohol, eating disorders, dementia, diabetes and co-morbid depression, stress at work and others) have been developed and evaluated for their effectiveness and cost-effectiveness, leading to positive recommendations from the government for large-scale roll-out. In order to provide users with transparent information about quality, a "self accreditation" tool has been developed that will help organisations assess the quality of their programme and provide it with a "quality label". Since then, more attention has been given to evidence-based and blended treatment. Currently a trend of mobile eMental health apps is emerging, through which patients can be treated anytime, anywhere.

According to the Network Online Help, between 2007 and 2010, the number of persons receiving online treatment for depression or eating disorders had tripled to 181 000 (Trimbos, 2013). In 2010, almost 1.8 million individuals had accessed an online site for help. Although a world leader in the eMental health field, implementation throughout the Netherlands is currently stagnating. There are a number of factors that are presently being considered. First, there is a lack of information on the costs and benefits of eMental health in general. The general consensus is that eMental health will be cost-effective. However, so far scientific studies do not entirely confirm this expectation. As a result, the willingness to invest on a large scale is scarce (Riper et al, 2013). Second, eMental health requires a culture change. Care professionals will have to deal with changing circumstances in which their control and supervision over patients will adapt.

Box 2.3. **Developments in eMental health for mild-to-moderate disorders** *(cont.)*

If care professionals use eMental health merely in addition to regular care then efficiency will not improve. It has to be applied as a substitute for (part of) the regular care meaning that a paradigm shift is necessary (Putters et al., 2012).

Source: NHS Choices, Self-help Terapies, www.nhs.uk/Conditions/stress-anxiety-depression/Pages/self-help-therapies.aspx, accessed 2 September 2013; Putters, K., M. Janssen, T. van der Wel and M. Kelder (2012), "E-health: Face-to-Facebook. Over E-health en zelfredzaamheid van patiënten in de ggz" [E-health: Face-to-Facebook. About e-health and self-reliance of patients in mental health care], Erasmus University, Rotterdam; Trimbos (2013), [Online], available at *www.trimbos.nl/*, accessed 8 July 2013; Riper, H., L. Kooistra, J. de Wit, W. van Ballegooijen en T. Donker (2013), "Preventie & eMental- Health kennissythese 2012" [Prevention eMental Health knowledge synthesis], ZonMW. Den Haag.

care practitioners, which might include addresses, telephone numbers and website addresses that people may find useful. Almost all OECD countries reported that they had a national mental health user group (see Chapter 6), and in many instances user groups have local branches that organise meetings to offer peer support, discussion, and information. Often, support groups are disorder specific, for example in Germany more than 5 000 self-help support groups were identified, covering a broad range of psychiatric disorders, particularly groups for families and partners, bereavement, anxiety disorders, depression, and eating disorders. Support groups appear to be popular with individuals with mental disorders, and with their carers; Meyer et al. (2004) found an 84% rate of return amongst surveyed German self-help groups. Approaches that blend peer support and therapeutic approaches from eMental health are also beginning to emerge. Although individuals with mild-to-moderate disorders are much less likely to self-identify as mental health service users, and therefore less likely to seek help from such groups, the support offered by such groups – for example informally, or through an online forum – can be valuable (Box 2.4).

An expanded and diverse workforce is needed to meet demands for treatment

A number of OECD countries have found that, in order to close the treatment gap for mild-to-moderate disorders, it was necessary to increase the workforce capacity to enhance treatment provision across the health system. Many OECD countries have sought to expand treatments for mild-to-moderate disorders using psychological behavioural therapies. Psychological therapies have come to be well-recognised as an important tool for increasing treatment availability, improving recovery rates, offering choice and quality of treatment, and closing the treatment gap for common mental disorders. In many cases psychological therapy provision has come to focus as a step in between primary care – where GPs often still provide first diagnoses, treatments including pharmacotherapy and some psychological therapies, and often play a gatekeeping role – and specialist services, which tend to address the most severe and enduring cases of common mental illness. This intermediary type of service is an important tool for attempts to effectively treat mental illness. The continued involvement of GPs in patient care is usually important, especially as a partner with psychologists and psychological services, given that psychologists would not typically be able to prescribe medication, and may have reduced referral capacity.

In many cases increasing treatment possibilities for mental health outside of the primary care system has meant investment in the increased training of psychologists, and the funding of psychological therapies. There is quite considerable variation in

Box 2.4. **Blended therapies: stepped care though guided peer support, group therapies, and individual evidence-based therapies, delivered online**

Big White Wall, founded in 2007, is an independent online early intervention service for people in psychological distress in the United Kingdom and New Zealand, which blends internet-provided therapies, a peer support environment, and evidence-based therapies provided in groups or one-to-one. Provided in partnership with the London-based Tavistock and Portman NHS Foundation Trust for mental health, Big White Wall (BWW) combines social networking principles with a choice of clinically informed interventions to improve mental well-being. BWW includes a chat room orientated towards peer support and individual self-expression and mood-monitoring, talk therapy in community, groups and on a one-to-one basis, Guided Groups informed by recognised therapies such as cognitive behaviour and interpersonal therapies, and information resources. The site can be accessed 24/7 and has staff (Wall Guides) who monitor discussion and self-expression in the chat room, and can for example encourage users to participate further in group chats, or to seek help in the case of alerts to risky behaviour (for example discussion of self-harm or suicidal thoughts). BWW is open to individuals who can pay a monthly subscription to join, and access can also be prescribed by BWW clients who have bought access entitlements. An access entitlement may include access to the chat room only, or a certain number of group or individual therapy sessions, delivered via the site. At present, BWW clients (in addition to individuals) include the Ministry of Defence, which has provided access to the BWW chat room for all serving military personnel and their families, some NHS Primary Care Trusts and NHS Foundation Trusts, a number of Universities in the United Kingdom, and the Auckland District Health Board in New Zealand.

The monitoring of site usage can give rich information about mental health needs, and statistical analyses of the site are done monthly, with surveys finding that two thirds of BWW users use the site mostly to relieve stress and loneliness, half saying they used the site to relieve anxiety, and a third to deal with depression. An independent review found that 75% of members talked about an issue for the first time on BWW, that 80% of users self-managed their psychological distress through the site, and that 95% reported one or more improvements in well-being. Jane Chapman, independent risk adviser to the Tavistock and Portman NHS Trust, conducted a comprehensive governance and risk assessment of Big White Wall. The assessment showed BWW carries an overall low risk for users given the safeguards in place.

Source: Big White Wall, "Big White Wall-About Us", *www.bigwhitewall.com,* accessed 1.10.2013.

the number of psychologists per 100 000 population in OECD countries, and in the rate of change in numbers of psychologists (see Chapter 5). This could indicate different directions that countries are taking in the development, and prioritisations, in their mental health systems. In Norway, where there is a perceived shortage of psychologists, and in particular nurses and psychologists in schools, the Ministry of Health and Care Services has been directly funding an increase in psychologists to work in municipalities, and this direct funding is due to be allocated to psychologists in schools also. Under Norway's mental health plan, that ran from 1998-2008, treatment provision was to be strengthened with the addition to the mental health workforce of 184 psychologists, and a further 260 additional full-time-equivalent staff to strengthen psychosocial services, personal support offerings, cultural and recreational programmes for children and adolescents, and a further 800 full-time staff to strengthen health clinics and school

health services (Norwegian Ministry of Health and Care Services, 1998). Figures suggest that progress towards these workforce targets is on-going, and direct funding for the training and appointment of psychologists continues.

In resource-tight settings, the training of a large additional workforce may not be a realistic prospect, and countries such as Australia, New Zealand and Scotland have been exploring the viability of training front-line care staff to deliver psychological therapies. There is some evidence that suggests that CBT delivered by trained non-clinical staff, in an informal or structured way, can lead to improvements for patients with mild-to-moderate mental disorders, or improve mental well-being (Armstrong et al., 2010; Shah et al., 2013). The concern with more informal delivery models for CBT and other evidence-based therapies is that efficacy is lost with a loss of fidelity to the evidence-based model. Research on promoting fidelity to CBT models and other psychological therapies suggest positive results, although these could be harder to put in place where therapy delivery is more ad hoc or informally delivered (British Psychological Society and Royal College of Psychiatrists, 2010; Hepner., 2011).

Specialist vertical programmes targeted at mild-to-moderate disorders

Having taken account of the high burden of mild-to-moderate mental disorders and the large treatment gap, a very small number of OECD countries have taken steps to build specialised services targeted at mild-to-moderate mental disorders. New forms of services to specifically address mild-to-moderate disorders have included programmes that fit within existing health system organisation and financing mechanisms, and vertical programmes that are somewhat "stand alone" in their scope, designed to be dedicated treatment points for mild and moderate disorders. Each programme has demanded significant high-level commitment and investment of resources, although there are strong arguments to suggest that such investments are cost-efficient in the medium to long term.

One noteworthy example of a national programme of psychological therapies is the Improving Access to Psychological Therapies (IAPT) which was established in several test sites in England, and then rolled out across the country, from 2009. The indirect economic costs of mild-to-moderate mental disorders, in terms of lost productivity, unemployment, and sickness benefits claims have been estimated to be extremely high. Taking these costs into account, and offsetting them against the projected economic benefits of improved treatment for mild-to-moderate mental illness, has been used to drive investment in psychological therapies. In England in particular, this economic reasoning was used to make the case for the introduction of the Improved Access to Psychological Therapies (IAPT) programme. It was argued, in particular by the economist Lord Layard, that the economic benefits that IAPT would bring in terms of cost-saving on benefits, and improved economic productivity, meant that even set against the costs of establishing such a programme, of training and staffing a national rollout of cognitive behavioural therapies, IAPT would eventually pay for itself (London School of Economics, 2006) (Box 2.5).

For many countries, in the context of falling health spending (see OECD, 2013), significant investments such as the one demanded by IAPT are not a feasible possibility. For countries with good primary care systems it may be more realistic to extend care from this base, even if cost-effectiveness arguments for investment in wide-scale psychological therapies programmes are persuasive. Australia significantly increased funding for psychological therapies through the Access to Allied Psychological Services programme,

Box 2.5. **Extensive roll-out of psychological therapies: The English IAPT experience**

In England the IAPT programme of evidence-based psychological therapies is in the process of being rolled out across the country, dramatically increasing availability of talking therapies for mild-to-moderate depression and anxiety. Improving Access to Psychological Therapies (IAPT) was established in England, and then rolled out across the country as part of an initiative led with the express support of the then Prime Minister, Tony Blair, from 2009, following a campaign supporting the economic efficiency of psychological therapies driven by Labour peer and economist Lord Richard Layard.

The economic argument backed by high-level support

Depression and anxiety had been costing England GBP 7 billion per year, with large numbers of people taking absences from work or out of work because of depression. Depression was identified as a major risk factor for suicide and premature mortality. Evidence from depression and anxiety guidelines suggested that CBT was a cost-effective way of treating depression. Backed by the evidence presented in the NICE guideline, GBP 177 million was invested to train and employ 6 000 CBT therapists. In two regional trials cognitive behavioural therapy was found to be cost-saving as an intervention for depression, with outcomes as good as those in clinical trials.

Recovery rates of patients who have passed through the IAPT programme have been found to be consistently in excess of 45% and approaching those expected from the randomised controlled trials that generated the initial NICE recommendations (Department of Health, 2012). Significant effects were seen for patients with higher depression scores, even though a lower proportion moved to recovery, suggesting IAPT services are effective across a range of symptom severity. Self-referred patients in IAPT recovered more quickly, with a fewer number of CBT sessions than GP-referred patients.

- *The IAPT Model*: the IAPT model of "stepped care" is central to its design and implementation. Interventions – from guided self-help to one-to-one cognitive behavioural therapy – are tailored to symptom severity. Patients are assessed on an on-going basis, and the intensity of their intervention can be increased where needed. "Low intensity" IAPT services for those with less acute service needs are delivered by IAPT trained therapists, whilst "High intensity" services, for more complex needs (e.g. one-to-one IAPT-model CBT) are delivered by certified psychologists with IAPT training. Funding for IAPT is provided by the National Health Service, and individuals can access IAPT services with a referral or through self-referral. It is estimated that 50% of the adult population has access to an IAPT service.
- *Training*: one of the priorities for the implementation of the IAPT programme was to establish, quickly, a well-trained, highly skilled professional workforce able to deliver the IAPT model of CBT. This was done through a standardised training programme for already qualified psychologists, and a second standardised training programme for individuals who were not certified psychologists but who had some appropriate experience or training. The IAPT training programme is a standardised model which trains individuals across one year, where time is split between one or two days per week in formal training, and three or four days per week in supervised service delivery, following an intensive introductory course. Trainees are paid throughout their training. Using this training model 1 500 new IAPT therapists have been trained since IAPT's establishment.

Box 2.5. **Extensive roll-out of psychological therapies: The English IAPT experience** *(cont.)*

- *Oversight*: Oversight and monitoring are crucial to the IAPT delivery model, and to ensuring quality of care. At the end of each session with an IAPT client, the therapist fills out a specially designed outcomes questionnaire, which is reviewed each week by a supervisor. Supervisors are experienced IAPT therapists with specialist training. Supervision sessions are weekly, and ensure that patients being seen by therapists are showing appropriate improvements, and that the therapist is keeping to the IAPT protocol and model. The skill of the supervisor to support therapists who are struggling, to highlight successes and difficulties, and to identify variety and divergence from the IAPT model in the therapy that is being delivered is very important in ensuring the success of IAPT services. This monitoring also provides a wealth of data on patient outcomes from IAPT.

Source: Layard, R. et al. (2007), "Cost-Benefit Analysis of Psychological Therapy", *CEP Discussion Paper* No. 829, Centre for Economic Performance, London, available at *http://eprints.lse.ac.uk/19673/1/Cost-Benefit_Analysis_of_Psychological_Therapy.pdf*; Department of Health (2012), "IAPT Three-year Report: The First Million Patients", available at *www.iapt.nhs.uk/silo/files/iapt-3-year-report.pdf*.

building upon the existing primary care system. The system model for ATAPS is more tractable than the IAPT model, with sessions delivered by a range of health professionals with more diverse qualifications (Box 2.6). The suggestion that evidence-based psychological therapies are cost-effective is an important message. Given the high indirect costs associated with mild-to-moderate illness in most if not all OECD countries (see chapter on expenditures in OECD, 2012), the message that investment in evidence-based therapies is not just important from the perspective of a moral imperative of closing the treatment gap, but can also save health systems, and national economies, money in the medium- to long-term is an important one.

For countries with significant treatment gaps, or with less developed models of primary care, vertical programmes like the IAPT may be a highly appropriate investment. For countries such as Korea or Japan, where primary care systems are weaker, the strength of the IAPT model would be the way that it stands slightly apart from primary care practitioners, with services organised into IAPT centres to which patients can be referred, or can self-refer. Facilitating technology-based referral or self-referral would also be advantageous given the high levels of stigma towards mental disorders which can stop individuals seeking help. This can facilitate links with GPs, as is the case in England, but does not rely on a good primary care structure to function effectively. For countries which tend to have single-practitioner organisations of primary care less able to provide allied services within their practice might benefit from IAPT-type systems.

Investment in better care for children and youth will likely deliver value for money in the medium- to long-term

Efforts are being made, but should be scaled-up, to address mild-to-moderate mental disorders amongst the school-age population, and for young adults. As demonstrated at the beginning of this chapter, prevalence of moderate mental disorders amongst young people in OECD countries is high. Despite this, specialist services are still disproportionately focused on adults with mental disorders, and in (often small) child and adolescent mental

Box 2.6. **The Access to Allied Psychological Services (ATAPS) in Australia**

The **Access to Allied Psychological Services (ATAPS)** programme, established in 2003, is designed primarily to treat common mental disorders of mild to moderate severity in the primary care setting by providing short-term psychology services. People with more complex or severe mental disorders are not excluded if their GP believes the individual will benefit from the short-term psychological interventions that are available through this programme. The most common diagnoses across all ATAPS programmes were depression (54%) and anxiety disorders (41%), whilst more severe disorders were reported relatively infrequently across all ATAPS programmes. ATAPS is a component of Better Outcomes in Mental Health Care (BOiMHC), established in 2001 to produce better outcomes for patients with common mental health problems in primary care settings through psychological therapies; offer referral pathways for GPs; offer non-pharmacological approaches to the treatment of common mental disorders; and promote a team approach to the management of mental disorders. Approximately AUD 27 million per year is allocated by the Australian Government to the ATAPS programme, with a total of AUD 80.7 million allocated from 2003 to 2010.

Patients are referred to ATAPS by GPs, but sessions are provided by a relatively mixed workforce of mental health professionals, which includes psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.

Through ATAPS, patients are eligible for six time-limited sessions, with an option for further sessions following a mental health review by the referring GP and up to a maximum of 18 individual services per patient per calendar year. On the top of these individual sessions, patients are also eligible for group therapies. The average number of sessions provided per referral overall is 5.2, although this is a conservative estimate. The most common interventions provided have been CBT-based cognitive (47% of sessions) and behavioural interventions (35% of sessions).

Overall, between July 2003 and December 2011, 273 639 referrals were made to the ATAPS programme. Of these referrals, 213 045 (78%) received services, with a total of 1 102 485 sessions delivered in the same period, suggesting a relatively high up-take rate. ATAPS also provides a high number of services to low-income earners, who represent one third of all those receiving ATAPS services. Further, 41% of services are provided in rural Australia. Given these findings, the potential for ATAPS to reach marginal groups seems high. Nationally, the majority (63%) of sessions did not incur a co-payment. For the 175 772 sessions where a co-payment was incurred, the mean co-payment amount was approximately AUD 16, with slight differences across different programmes and between rural and urban areas. Where available, outcome data show that all ATAPS services are producing significant clinical improvement for consumers.

Source: Fletcher, J., K. King, B. Bassilios, L. Reifels, G. Blashki, P. Burgess, J. Pirkis (2012), "Evaluating the Access to Allied Psychological Services (ATAPS) Program. Nineteenth Interim Evaluation Report. Update on the achievements of Tier 1 and Tier 2 ATAPS", Centre for Health Policy, Programs and Economics, available at *www.ataps-mds.com*, accessed 4 September 2013.

health services most resources are dedicated to treating individuals with the most severe disorders and the most acute needs.

A growing body of evidence suggests that a considerable proportion of mental disorders develop before individuals reach adulthood, developing in childhood or adolescence, with risk factors present even in early childhood or infancy. The OECD-wide median age of onset for mental disorders is 14 years, with anxiety and personality disorders sometimes

beginning around age 11 (OECD, 2012). Evidence from Australia, for example, suggests that 64% of people experience their first episode of mental illness before turning 21, and 25% before the age of 12. Nonetheless, only 25% of under 25-year-old Australians with mental disorder access mental health services. In Italy, similarly, only 20% of young people suffering from mental ill-health seek professional help (Forti, 2014).

The failure to address mild-to-moderate mental disorders amongst children and adolescents at their onset can have harmful consequences, and high costs, across the life course. Addressing mental health is important for good educational outcomes – mental disorders are found to have a large negative influence on educational achievements and are correlated to higher dropout from school (OECD, 2012). Likewise, evidence shows that poor education increases the risk of poor mental health (Chevalier and Feinstein, 2006; Bjelland et al., 2008). A failure to effectively treat mild-to-moderate mental disorders in children, adolescents and young people can lead to a worsening of the disorder, long-term mental health problems, poorer physical health, and lasting demands on the health system. In health systems which have focused the majority of efforts on adults, there has been a gradual realisation that each year a new and more complex group of consumers were arriving at the door of adult services, moving up from inadequate child and adolescent services.

A focus on child and youth mental health needs has the potential to be cost-saving to the health system, lowering demand on adult services in the long-term, by preventing consumers coming into the system. Effective early intervention and treatment can help reduce very costly complex cases, for example multiple-morbidity disorders, and mental disorders with co-morbid alcohol and substance abuse. An expansion in the services offered to children and adolescents has been made a priority in a number of OECD countries, including Australia, New Zealand and the United Kingdom. A number of countries are trying to adapt and direct some of the most successful new interventions in place for adults towards children and young people. In England, the IAPT service that delivers psychological therapies for working-age adults is being expanded to children and young people. The Children and Young People Improving Access to Psychological Therapies (CYP IAPT) programme will be distinct from the adult IAPT programme, and more closely integrated with specialist Child and Adolescent Mental Health Services, but will draw on many of the successes of the adult IAPT approach (*www.iapt.nhs.uk/cyp-iapt*). Specifically, CYP IAPT will be using treatments based on best evidence with an outcomes focus and attention to building a client-informed and participatory service. Initially, CYP IAPT will focus on disorders such as anxiety and depression, OCD and PTSD, as well as behavioural problems in 3-10 year-olds. The CPY IAPT approach will also include parenting courses, and links with the national curriculum in schools.

Addressing mental health needs for children and youth can also help reduce later disability, sick leave, and long-term unemployment, and thus bring cost-savings across society. There is the potential for improved identification of mental disorders in children and adolescents through school-based interventions (Weare and Nind, 2011). School-based mental health programmes include a large variety of initiatives, which span from whole-school programmes aiming to promote mental well-being, to more selective interventions aiming to increase mental health literacy across students and teachers, and early intervention programmes targeted at at-risk students in tandem with health services. A range of school-based programmes are discussed in more detail in Chapter 6 of this publication. Reducing school drop-out due to mental disorders improves employment

prospects in later life (OECD, 2012). Social services should also be supported, by governments and by the mental health system, in being attentive to the often acute mental health needs of vulnerable and cared-for children. Spending on improved children and young people's mental health services, and good co-ordination with schools and also employment centres, will feed into improving outcomes for children and young people affected by mental disorders, and will represent good value for money in the short- to medium-term.

A focus on prevention makes good economic sense

There is reason to believe that preventative interventions for mental disorders could help to decrease the disease burden that is not alleviated by effective treatments currently available, or that could be made available. Furthermore, evidence suggests that preventative interventions for some mental disorders can be cost-effective. A comprehensive review of available evidence around depression by Smit et al. (forthcoming) was carried out for a forthcoming volume on health promotion and disease prevention, produced through a collaboration between the OECD, the European Observatory and WHO-Europe (McDaid et al., forthcoming). This review (Smit et al., forthcoming) suggests that certain school-based programmes, and some workplace interventions, can be effective ways of tackling the high burden of depression.

Based on available evidence, Smit et al. (forthcoming) found that certain interventions in schools, when applied completely and with fidelity to the intended model, had a positive effect on children, families, and communities across a range of mental health, social, emotional and educational outcomes. A small literature looking at the economic impact of interventions for school-age children in Australia, the United Kingdom (Wales) and the United States – for example giving training to the child, parents and teachers – suggested that such programmes could be cost-effective, especially when targeted at children most likely to benefit (i.e. children with behavioural problems, or in at-risk groups). Depression-specific interventions in schools were also found to have some positive impact even when delivered universally to all children. There is also limited evidence that some school-based depression-specific interventions can be cost-effective, notably a psychological intervention for teenagers manifesting elevated depressive symptom levels at school covered in an Australian study.

The scope for workplace-based intervention in reducing the impact of mental ill health is explored in some depth in the OECD publication *Sick on the Job?* (2012) and the series country-specific reviews of employment and mental health policies that followed. This work has strongly advocated for the better integration of employment policies and mental health policies, and promotes certain workplace-based interventions. Smit et al. (forthcoming) found a range of evidence that suggested that workplace-based interventions aiming to prevent depression could be effective, and have potential economic benefits, notably by reducing economic losses associated with absenteeism and presenteeism.

The findings of this work are consistent with some of the findings of extensive work done by the OECD on prevention of harmful alcohol consumption (OECD, 2014, forthcoming). Through micro-simulation modelling including a number of OECD countries, this work highlighted approaches such as brief interventions in primary care as having the potential to reduce harmful alcohol consumption, and represent good value for money, when the associated disease burden and economic consequences of harmful alcohol use are considered.

2.6. Conclusion

With a high prevalence of mild-to-moderate disorders, and a large treatment gap across OECD countries, there is a need to strengthen existing approaches to treating mild-to-moderate disorders, and a strong case for investing in new interventions. An increase in the number of people in treatment, and receiving evidence-based interventions, would increase service costs but could bring savings in other areas – if the most effective treatments are prioritised.

Primary care providers are delivering the majority of care for mild-to-moderate disorders. In most countries, primary carers will likely continue to be the first port-of-call for individuals affected by mild and moderate mental disorders, and will continue to lead a great deal of the treatment for such disorders, especially in mild and sub-threshold cases. Where primary care practitioners are not effectively engaging with mental disorders, there is a need to ensure that incentive systems for providing often complex and time consuming care are in place. To assure high-quality treatment, in particular treatment that is timely, appropriate, and effective, primary care practitioners would benefit from greater support in developing mental health competency, and stronger professional support systems. Sufficient mental health training and continuing professional development, and primary-care specific best practice guidelines, can improve practitioners' competence in treating disorders, and ensure that they are up-to-date on best evidence-based practice.

Professional support networks, and an expansion of referral options from primary care, are key to improving the treatment of mild-to-moderate mental disorders. Good networks between professionals, formal or informal, can strengthen primary care delivery. The establishment of such networks, which can follow a range of different models, may need facilitation and encouragement from health system leaders, including making time and resources available for meaningful collaboration. Such investments may pay dividends, with evidence suggesting that collaborative care models for mental disorders can improve outcomes and represent good value for money. Strengthening the care delivered by primary care practitioners is an important first step, but will likely need to be accompanied by a scaling-up of treatment options in primary care to make meaningful improvements. A number of countries have recognised this need, and have expanded the use of common behavioural therapies in primary care.

Whilst traditional primary care systems have an important role in improving care for mild-to-moderate disorders, there will likely be a limit to their capacity to provide appropriate treatment, especially in countries with weak primary care systems. New interventions for mild-to-moderate disorders can represent good value for money. Stepped care for mild-to-moderate mental illness has been supported as a cost-effective approach with good outcomes by a wide range of clinical guidelines, and low-intensity interventions such as bibliographic and guided self-help, peer support groups, and a range of new internet-based interventions can be effectively implemented with low costs, especially when backed with support from primary carers. For cases which need higher intensity interventions, an expanded and more diverse workforce is needed, along with a wider range of available treatments. Specialist vertical programmes targeted at significantly expanding available treatment for mild-to-moderate disorders have been put in place in a small number of cases with considerable success.

Alongside a need to scale-up treatment for adults with mild-to-moderate mental disorders, efforts should also be made to address mild-to-moderate mental disorders amongst the school-age population, and for young adults. Investment in better care for children and youth will likely deliver value for money in the medium- to long-term, through reducing complex mental and co-morbid disorders later in life, and helping secure good educational outcomes and good transitions into the workforce. A strengthening of services for children and young people within the mental health system, for example an expansion of available psychological services, should be backed up through attention to mental disorders in schools and other services for children and young people.

Whilst better treatment of mild-to-moderate mental disorders in the mental health system can represent good value for money, for example through improving outcomes for other chronic conditions, the cost-benefits are more likely to be felt elsewhere in the economy, in terms of increased employment and tax revenue, and reduced benefits payments (McCrone et al., 2008; OECD, 2012).

It will be important for governments to recognise that the cost-benefits of increasing effective treatment for mild-to-moderate disorders will largely accrue outside of the health sector, and therefore to make the appropriate strategic investments with this in mind. As this chapter demonstrates, effective treatments and excellent care do exist for mild-to-moderate disorders, and can significantly improve the lives of individuals affected by mental illnesses, but rely on strong commitment from governments and health systems to increase their availability. Even in a time of shrinking health budgets and cuts to services, there is a very strong case to be made for maintaining – and in many cases increasing – efforts to secure excellent care for mild-to-moderate mental disorder.

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Chapter 3

Advancing the organisation, payment and integration of care for people with severe mental illness

While the prevalence of severe mental illness is small relative to mild-to-moderate mental illness, severe mental illness tends to dominate the organisation of mental health systems in OECD countries and consume the majority of resources. This chapter describes policies that have been put in place to improve care for such illnesses, and highlights areas where attention is still needed. Co-morbidities of severe mental illness and somatic illnesses are a cause for concern, and some efforts have been made to counteract the negative consequences that arise from co-morbidities. In particular, GPs can play an important role in co-ordinating the physical and mental health care of people with severe mental illness but require effective co-operation with specialist care. While specialist care is increasingly delivered by multi-disciplinary teams in a multitude of community-care settings, inpatient care still has a role to play especially in times of crisis. This chapter examines how reliance on inpatient beds varies considerably across OECD countries. Finally, this chapter explores the potential for innovative payment systems for specialist mental health care to evolve beyond a primary focus on inpatient settings to reflect the multiplicity of care settings available and promote an integrated and cross-sectoral approach to providing care.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

3.1. Introduction

While Chapter 2 discussed how to secure better care for mild-to-moderate mental illnesses, this chapter is concerned with the main policy issues surrounding severe mental illness (SMI). Ruggeri et al. (2000) note that there is little consistency in how SMI is defined in practice and no operational definitions. In general, definitions of SMI tend to focus on a diagnosis of a non-organic psychotic disorder as well as history of mental illness and treatment, and disability (Ruggeri et al., 2000). While the prevalence of SMI is much lower than that of mild-to-moderate mental illness, the primary focus of mental health systems has nevertheless tended to be on the former. SMI in the form of psychosis manifests itself in adolescence and early adulthood. The early age of onset of psychosis implies a potentially large economic cost in terms of lost productivity due to lower educational and employment outcomes, disability and premature mortality (McGorry, 2008).

3.2. The high burden of severe mental illness and co-morbidities with physical ill-health

While the prevalence of SMI is lower than that of most mild-to-moderate illnesses, it nonetheless represents a significant burden. An OECD study (OECD, 2012) found that around 5% of the working-age population have a severe mental disorder, such as schizophrenia, bipolar disorder, or severe depression. The WHO Burden of Disease Estimates 2011 (WHO, 2013) identified schizophrenia as making up the 17th greatest burden of disability adjusted life years (DALYs), with bipolar disorder at 18th; schizophrenia accounted for an estimated 13.1 million DALYs lost in 2011, with bipolar disorder accounting for 13 million. Additionally, there is a high treatment gap for mental disorders. In a study comparing a number of countries, the median treatment gap was found to be 32.2% for schizophrenia and 50.2% for bipolar disorder (Kohn et al., 2004).

In addition, people with SMI experience increased co-morbidities with physical ill-health, and reduced life expectancy. While this can in part be attributed to mortality from accidental and intentional injuries, it is largely due to an increased prevalence of nutritional and metabolic, cardiovascular and viral diseases among people with SMI. Increased physical ill-health is a result of a complex interplay of various risk factors such as lifestyle and health behaviours, socio-economic conditions and the negative side effects of psychiatric medications as well as professional attitudes and a lack of fully integrated systems of physical and mental health care. Reducing disparities in life expectancy for people with SMI necessitates a multifaceted approach encompassing integration of physical and mental health care, behavioural interventions, and changing professional attitudes and roles. Such actions are necessary in order to reduce the large economic costs the burden of co-morbidity of SMI and physical illness places not only on the health sector but also on employment and social protection.

A complex interaction of multiple factors account for increased risk of physical ill-health among people with SMI

A complex web of several factors related to mental diagnosis and psychopathology, adverse side effects of psychotropic medication, lifestyle and health behaviours, professional attitudes and roles, and health system organisation and funding contribute to the increased risk of physical ill-health among people with SMI.

The diagnosis, psychopathology and symptoms of SMI itself can reduce the likelihood of individuals seeking out and receiving the care they need for somatic conditions. People with SMI may be less likely to seek out and use health care services, leading to an increased risk of physical ill-health, and deterioration as conditions are untreaded or poorly managed (De Hert et al., 2011a; Crompton et al., 2010). Illness-related cognitive impairment can reduce awareness of physical problems, reduce capacity to take action to address identified health concerns, and can lead to reduced compliance with care due to difficulty comprehending health care advice and/or following through on necessary changes in lifestyle (Berren et al., 1999; Crompton et al., 2010; De Hert et al., 2011a; Drapalski et al., 2008; Happell et al., 2012; Kaufman et al., 2012). SMI can also contribute to communication difficulties resulting in a reduced ability to explain any physical symptoms to the doctor (Borba et al., 2012; Kaufmann et al., 2012; Berren et al., 1999; Drapalski et al., 2008; De Hert, 2011a). Fear of negative attitudes of staff towards SMI or a fear of the outcome of a medical visit in terms of a recommended medical treatment procedure may also discourage people with SMI seeking help for a physical health problem (Borba et al., 2012; Happell et al., 2012). Negative, disorganised and depressive symptoms may reduce motivation to exercise and contribute to physical ill-health and weight problems (De Hert et al., 2011a).

Adverse side effects of psychotropic medication can lead to weight gain and obesity which in turn contribute to an increased risk of diabetes and cardiovascular disease (CVD). Weight gain during acute and maintenance treatment of patients with schizophrenia is a well-established side effect of antipsychotics, affecting between 15 and 72% of patients. Antidepressants and mood stabilisers have also been associated with weight gain (De Hert et al., 2011b). Evidence suggests that antipsychotics can increase the risk of diabetes mellitus. Atypical antipsychotics appear to have a stronger diabetogenic risk than conventional antipsychotics with the risk being 1.3 fold higher in people with schizophrenia taking atypical antipsychotics compared with those receiving conventional antipsychotics (De Hert et al., 2011b). In addition to weight gain and obesity related mechanisms, there appears to be an independent effect of antipsychotics that contributes to an elevated risk of CVD. Patients with schizophrenia have been reported to be three times as likely to experience sudden cardiac death compared to the general population.

Risky health behaviours and poor lifestyle choices such as unhealthy diet and lack of exercise, smoking, substance abuse, and unsafe sexual practices can also contribute to increased prevalence of certain physical diseases in patients with severe mental illness (De Hert et al., 2011a). Lifestyle factors such as a lack of exercise and an unhealthy diet contribute to overweight and obesity which are important risk factors for diabetes mellitus type 2 and CVD (De Hert et al., 2011b). For some patients, smoking may help to reduce symptoms such as depression and anxiety and this may be why people with mental disorders who smoke are more likely than members of the general population to anticipate trouble quitting, and are less likely to succeed in an attempt to quit (*The Lancet*, 2013). Difficulty quitting smoking might also be due to the negative cognitions and motivational problems associated with both mood and psychotic disorders. Furthermore, agitation

resulting from the absence of cigarettes might be misattributed to mental illness, not nicotine withdrawal (*The Lancet*, 2013).

Institutional characteristics of health and mental health systems contribute to the co-morbidity of mental and somatic disorders. Professional attitudes and roles pose impediments to the effective treatment of physical disorders in people with SMI. There is often a lack of clarity and consensus among mental health professionals regarding whose role it is to monitor and manage the physical health of patients with SMI (De Hert et al., 2011a). Many psychiatrists still consider their primary or, even, sole function to be providing clinical care in terms of psychiatric symptom control, and are reluctant to monitor physical health (De Hert et al., 2011a). General practitioners are often limited by the time constraints of appointments and a heavy workload and therefore focus primarily on the treatment of the mental diagnosis presented by patients (Happell et al., 2012). The complexity and time intensity of co-ordinating both medical and psychiatric conditions/treatment can pose a significant barrier for many professionals (De Hert et al., 2011a). There may also be a tendency for health professionals to downplay any concerns about physical health problems expressed by the patient due to "diagnostic overshadowing" or an inclination for the provider to view the consumer entirely in terms of a diagnosis of mental illness. This in turn may lead to future reticence on the part of the patient to report symptoms or disclose their mental illness (Happell et al., 2012). Health care professionals may harbor erroneous beliefs that physical symptoms do not really exist but are imagined by patient or physical complaints may be viewed as psychosomatic symptoms (Happell et al., 2012; De Hert et al., 2011a). Other misleading views held by health professionals may include the belief that patients with SMI are unable or unwilling to adopt healthy lifestyles and that weight gain is mainly an adverse effect of medications (De Hert et al., 2011a).

Barriers to adequate treatment of the physical health of people with SMI are also rooted in the organisation and financing of the overall health system. Poor quality physical health care arises from insufficient assessment, monitoring and treatment of the physical health needs of people with SMI (De Hert et al., 2011a). For example, SMI patients have very high rates of CVD mortality yet there is often a significant deficit in the monitoring of cholesterol values and the prescription of statins as well as low rates of surgical interventions, such as stenting and coronary artery bypass grafting (De Hert et al., 2011b). Such quality deficits may arise due to the separation of physical and mental health care's organisational and financing structures (Berren et al., 1999; De Hert, 2011a).

People with SMI may face particular difficulties accessing health care services due to financial or geographical access barriers, and adverse consequences related to mental illness such as low educational attainment, reduced family and social support, unemployment, poverty and poor housing (Happell et al., 2012; De Hert et al., 2011a). There is a need for greater integration and co-ordination of physical and mental health care – particularly in primary care settings. Clear communication and co-ordination between primary care and specialist mental health care are vital to adequate follow-up once physical health problems have been identified (Happell et al., 2012). Poor access to care including long waiting times can lead to higher rates of attendance at emergency departments and consequently to higher health care costs (Kaufman et al., 2012). At the same time, under-resourcing of mental health care provides little opportunity for specialists to focus on issues outside their core specialty while limited budgets for GPs also inhibit them from undertaking care co-ordination activities.

A failure to address differentials in physical health between people with and without SMI has profound economic and population health consequences

Disparities in the physical health of people with and without SMI have profound economic and population health consequences. A recent OECD report (OECD, 2012) established that the much larger unemployment disadvantage for people with a severe mental disorder compared to those with a moderate disorder is partly a reflection of the much higher likelihood of this group of having co-occurring physical (or other mental) health problems. As a consequence, people with SMI and co-morbid physical ill-health are more likely to be dependent on income-replacement benefits such as disability, unemployment, welfare or other income-replacement benefits. In the United States, for example, persons with a severe mental disorder, in combination with a physical health problem, have a benefit recipiency rate of over 70% – twice the recipiency rate of people with severe mental disorders who do not suffer from a physical problem (OECD, 2012).

Increased physical morbidity among people with SMI can also result in greater health care resource use in terms of longer inpatient length of stay and increased use of hospital emergency departments (Minsky et al., 2011; Berren et al., 1999; Happell et al., 2012). Finally, as highlighted in Chapter 4, the greater burden of physical ill-health among people with SMI leads to substantial excess mortality and points to a substandard quality of physical and mental health care. Data from England show a premature mortality rate among people with SMI that is three-fold higher compared with the general population; research from the Nordic countries revealed that people admitted to hospital for a mental disorder had a two-to-threefold higher mortality than the general population; in Australia a life expectancy gap of almost 16 years for males and 12 years for females has been observed. Parks et al. (2006) report that people with serious mental illness die on average 25 years earlier than the general population.

A range of policy approaches can be adopted to reduce excess mortality for people with SMI

Disparities in life expectancy between people with and without SMI are not inevitable. However, concerted action on the part of governments and health policy makers is needed in order to properly address these disparities. Such action should focus on the design and implementation of behavioural interventions for people with SMI, a change in the attitudes and roles of mental health professionals in treating the physical health problems of people with SMI, and improved integration of physical and mental health care.

Behavioural interventions to support improved physical health should be made easily available to individuals with SMI, for example counselling for weight loss or weight management, effective physical activity programmes, as well as smoking cessation support. Notably, there is emerging evidence that treatment of tobacco dependence is effective in patients with SMI and treatments that work in the general population appear to be approximately equally effective in SMI patients. Moreover, treating tobacco dependence in SMI patients whose psychiatric conditions are stable does not lead to deterioration in mental state (De Hert et al., 2011a).

GPs and mental health professionals play a key role in fostering improved physical health in people with SMI but require additional support and training in order to adopt attitudes and roles that will help to achieve this goal. In addition to the better availability of appropriate targeted programmes (for weight loss, smoking cessation, etc.), Morden et al. (2009) identify key strategies that primary care physicians can undertake to reduce physical health disparities. Such strategies include increased collaboration with

psychiatrists, establishing SMI registries and monitoring protocols, facilitating access to appropriate behavioural change programmes, tracking missed visits, practicing outreach, optimising continuity of care, and facilitating treatment adherence. In multidisciplinary team environments, psychiatrists, physicians, nurses and other members of the multidisciplinary team can help educate and motivate people with SMI and their families to undertake lifestyle improvements, addressing smoking, diet and exercise (De Hert et al., 2011a). However, for such professional advice to be successful, it is also necessary to educate and train health care professionals in the assessment and treatment of physical health risks in persons with SMI, and to encourage awareness of the disparities in physical health between the population with and without SMI (De Hert, 2011a). Increased awareness among multi-disciplinary teams of the importance of physical health monitoring of people with SMI and liaison with primary care health services can lead to improved outcomes (Vasudev and Martindale, 2010).

The potential for mental health nurses to help improve the physical health of people with SMI has been widely promoted (Robson and Gray, 2007; Bradshaw and Pedley, 2012; Happell et al., 2012). Mental health nurses can play an important role in the assessment and monitoring of a patient's physical health alongside their psychiatric needs. Mental health nurses can and should be encouraged to systematically and proactively enquire about the quality of people's dietary intake, level of physical activity, smoking behaviour and sexual health, and actively collaborate with other health professionals to design or promote specialist health promotion programmes for people with SMI (Robson and Gray, 2007; Bradshaw and Pedley, 2012). Despite the potentially positive contribution of mental health nurses to the physical health of people with SMI, evidence suggests that they are often ambivalent about this role, and might perceive themselves as being inadequately trained and lacking in confidence (Bradshaw and Pedley, 2012). In order to address concerns about knowledge or training deficits, a number of physical health assessment tools have been developed to aid mental health nurses in profiling the physical health of SMI patients and direct them towards available interventions to address any identified health problems (Bradshaw and Pedley, 2012).

Integration of physical and mental health care is associated with positive benefits in terms of access, utilisation and quality of services which in turn translate into improved physical health outcomes. Integration of physical and mental health care can be achieved in a number of ways. Examples include the co-location of services such as locating a primary health care team close to mental health services, with good links between the staff of both services; regular visits and contacts between staff working in physical and mental health care settings; appointing case managers to liaise between services and co-ordinate the overall care for the patient; and the forging of stronger collaborations between medical and mental health specialists and other health care professionals (De Hert et al., 2011a). Such collaborations should seek to develop comprehensive educational efforts, aimed at improving the knowledge of primary care physicians and psychiatrists to better monitor and manage physical illness in SMI patients as well as to reduce stigmatisation (De Hert et al., 2011a). Communication between mental health and primary care providers is an important factor in enhancing integrated somatic and psychiatric care for persons with SMI, as barriers to communication can arise due to stigma and lack of clarity regarding accountability for medical services (Kilbourne et al., 2012). Good communication can be facilitated by regular meetings of primary care and specialist providers and a clear delineation of the roles and responsibilities of the respective providers.

3.3. Organisation and delivery of mental health care for people with SMI

In most OECD countries the delivery of mental health care for people with SMI encompasses a multitude of settings that range from primary care to specialist care in various community-based settings, to acute inpatient care and longer-term residential care. New trends of treatment approaches that target specific stages of illness, or aim to improve the organisation and delivery of on-going care are also emerging.

Community care for SMI: The role of primary care

This chapter has already emphasised that primary care practitioners and other mental health professionals in primary care settings play a key role in managing the physical health needs of people with SMI. These professionals have a crucial role to play in helping address the poor physical health outcomes of people with SMI. However, in addition, responsibilities for management of pharmacological treatment and wider treatment management can be devolved to primary care practitioners. Given the chronic nature of most SMI, on-going case management is needed, and this is increasingly seen as an appropriate role for primary care practitioners. In order for such an approach to be effective, co-ordination with specialist care, in particular for out-of-hours care is essential, and the primary care practitioner must have the skills and support required to respond to the complex and often heterogeneous needs of patients with SMI.

Most OECD countries allow primary care practitioners to initiate and adjust medication for SMI

A key role for primary care practitioners in the management and treatment of SMI is to initiate, but especially to manage, psychotropic medication. Tricyclic and Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants are the most common medication for SMI that primary care providers are permitted to initiate, followed by monomine oxidase inhibitors (MAOI) (Table 3.1). Typical or first generation antipsychotics are more commonly permitted to be initiated by primary care providers than the new atypical antipsychotics. Unsurprisingly, it is less common for primary care providers to initiate the atypical antipsychotic clozapine which is generally prescribed for treatment-resistant schizophrenia. In Canada, Portugal and Spain, primary care providers are allowed to initiate a wide range of medications. Primary care providers have much wider scope to adjust medication for SMI compared to initiation, strongly suggesting that GPs typically play a role in the ongoing management of SMI, while establishing appropriate treatment for SMI is usually done by a psychiatrist (Table 3.2).

It is important to stress that although GPs may be allowed to initiate or adjust a wide range of medications appropriate for the treatment of SMI, the effective treatment of SMI from primary care will depend on their appropriate usage. For example the fact that primary care practitioners are allowed to initiate treatment of monomine oxidase inhibitors (MAOIs) – usually prescribed for the treatment of atypical depression – does not mean that they necessarily would, or should, in the vast majority of cases. In England, where GPs are allowed to initiate use of MAOIs, GPs would also follow clinical guidelines, which would not suggest that a GP take such a step. Rather, because of high risk of associated complications and drug interactions, MAOIs are usually reserved as a last line of treatment, which would in almost all cases be overseen by a psychiatrist. This example underlines the importance of primary care practitioners having appropriate skills when initiating and managing pharmacological treatment for SMI, and also the importance of clinical guidelines in guiding treatment approaches. Clinical guidelines for primary care practitioners are further discussed in Chapter 2.

Table 3.1. **Initiation of SMI pharmaceuticals by primary care practitioners in selected OECD countries**

	Initiate								
	Typical antipsychotics	Atypical antipsychotics	Depot antipsychotics	Clozapine	Carbarmazepine or valproate for bipolar/manic states	Lithium	Tricyclics	SSRI	MAOI
Australia			X		X	X	X	X	X
Austria							X	X	X
Belgium	X	X	X	X	X	X	X	X	X
Canada	X	X	X	X	X	X	X	X	X
Chile	X				X			X	X
Czech Republic							X	X	X
Estonia	X	X						X	
Finland	X	X					X	X	
France	X		X	X	X	X	X	X	X
Hungary							X	X	
Iceland	X	X	X	X	X	X	X	X	
Israel	X	X					X	X	X
Japan							X	X	X
Korea							X	X	X
Luxembourg	X	X	X	X	X	X	X	X	X
Mexico	X	X			X		X	X	
New Zealand	X				X	X	X	X	X
Portugal	X	X	X	X	X	X	X	X	
Slovenia	X	X						X	
Spain	X	X	X	X	X	X	X	X	
Sweden	X	X					X	X	X
Switzerland	X	X	X				X	X	
Turkey	X		X			X	X	X	X
United Kingdom (England)	X	X			X	X	X	X	X

MAOI: Monomine oxidase inhibitor. SSRI: Selective serotonin reuptake inhibitor.
Source: OECD Mental Health Questionnaire 2012.

It is, however, noteworthy that in some OECD countries the capacity of primary care practitioners to initiate or manage pharmaceuticals is particularly limited, for instance in the Czech Republic, Estonia, Japan, Korea, and Turkey. This may well be related to relatively weak primary care systems in these countries, for example in Japan and Korea, but may also be associated with SMI having been historically outside of primary care practitioner competences, as is likely the case in the Czech Republic. Primary care providers without the competence or experience of treating SMI should not be expected to rapidly take on such new responsibilities. However, with falling reliance on institutional and inpatient care for SMI, and an encouraging trend towards management of SMI in the community by multi-professional teams, such countries may well need to explore ways of managing SMI from a primary care-equivalent care level. What is more, as already discussed, good engagement by primary care practitioners is likely crucial to address the poor physical health of individuals with SMI, a key priority for the better treatment of SMI.

In addition to a role in initiating/adjusting pharmacological therapies for SMI, in a small number of countries a range of cognitive behavioural therapies are being delivered in primary care. Chapter 2 highlighted a range of psychological therapies, notably cognitive behavioural therapy (CBT), as effective treatments for mild-to-moderate mental disorders. It appears that

Table 3.2. **Adjustment of SMI medication by primary care practitioners**

	Typical antipsychotics	Atypical antipsychotics	Depot antipsychotics	Clozapine	Carbarmazepine or valproate for bipolar/ manic states	Lithium	Tricyclics	SSRI	MAOI
Australia	X	X	X	X	X	X	X	X	X
Austria	X	X	X	X	X	X	X	X	X
Belgium	X	X	X	X	X	X	X	X	X
Canada	X	X	X	X	X	X	X	X	X
Czech Republic							X	X	X
Estonia								X	
Finland	X	X	X	X	X	X	X	X	
France	X		X	X	X	X	X	X	X
Germany	X	X					X	X	
Israel	X	X	X	X	X	X	X	X	X
Japan		X					X	X	X
Korea							X	X	X
Luxembourg	X	X	X	X	X	X	X	X	X
Mexico	X	X	X	X	X	X	X	X	X
New Zealand	X				X	X	X	X	X
Portugal	X	X		X	X	X	X	X	
Slovenia	X	X							X
Spain	X	X	X	X	X	X	X	X	X
Sweden	X	X	X	X	X	X	X	X	X
Switzerland	X	X	X				X	X	
Turkey							X	X	X
United Kingdom (England)	X	X			X	X	X	X	X

MAOI: Monomine oxidase inhibitor. SSRI: Selective serotonin reuptake inhibitor.
Source: OECD Mental Health Questionnaire 2012.

there is also scope for CBT and other therapies to be used in the treatment of SMI. CBT can be used as a complement to more conventional pharmacological treatment approaches to treat psychotic symptoms among patients with schizophrenia (Clark and Samnaliev, 2005; Rathod and Turkington, 2005). It has been asserted that CBT improves the prognosis of patients with schizophrenia through improved adherence and symptom management leading to reduced relapse (Rathod and Turkington, 2005). Evidence does remain mixed: the recent Cochrane Review of CBT for schizophrenia concluded that trial-based evidence suggests no clear and convincing advantage for CBT over other therapies for people with schizophrenia (Jones et al., 2012). Nevertheless, the National Institute for Health and Clinical Excellence (NICE) in England recommends that all people with schizophrenia be offered CBT beginning either during the acute phase of their illness or later, including in inpatient settings (NICE, 2009). In terms of cost-effectiveness, Clark and Samnaliev (2005) report that an experimental intervention consisting of CBT and a motivational intervention for people with schizophrenia and co-occurring substance misuse was equally costly, but more effective than routine care alone in improving functioning, and in reducing symptoms and days in relapse.

Additionally, there is some evidence to suggest that CBT for bipolar disorder can reduce relapse and improve psychiatric symptoms, social functioning and illness management (Turkington and McKenna, 2003; Rathod and Turkington, 2005). In Australia, people with SMI can benefit from short-term psychological interventions that are available through the Access to Allied Psychological Services (ATAPS), while in England, there are current plans

to extend the Improving Access to Psychological Therapies (IAPT) programme to severe mental illness (SMI) in England (see Chapter 2 for more details on the ATAPS and IAPT programmes).

Primary care practitioners rely upon effective co-ordination with specialist care

Effective co-operation with specialist care is necessary for primary care practitioners to successfully manage and treat people with SMI (see also Chapter 2 for a discussion of co-ordination between primary and specialist care for mild-to-moderate mental illness). The degree to which primary care and specialist care for SMI are co-ordinated varies greatly across OECD countries with some having formal structures and guidelines for how such co-operation should unfold, while in other countries co-operation is informal and consists of little more than basic communication between primary care practitioners and specialists (Table 3.3). Weak links between primary care and specialist care may undermine the ability of primary care practitioners to effectively treat and manage SMI, and may contribute to poorly co-ordinated care.

Table 3.3. **Formal or informal co-ordination between primary and specialist mental health care**

	Formal	Informal
Australia	The *Better Access* initiative aims to improve treatment and management of mental illness within the community and encourage general practitioners to work more closely and collaboratively with specialist mental health professionals.	
Austria		X
Canada	"Shared care" approach whereby specialists and primary care share information and treatment strategies.	
Chile	"Mental health consultation" model is implemented whereby specialists regularly visit the primary health care service to review, with the PHC staff, one to six cases, sometimes through a clinical meeting with the patient.	
Czech Republic		X
Estonia		X
Finland	Uniform criteria for access to non-emergency psychiatric care that physicians use when deciding on the treatment of patients.	
France		X
Germany	Co-operation between outpatient and inpatient, primary care (GP) and specialists respectively, is regulated by law. Providers of therapeutic services of the same region can build up networks which are functioning as one whole medical care structure and thereby the treatment of a specific illness is organised.	
Ireland	A guidance document entitled "Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services" has been recently published in order to encourage mental health professionals to increase collaboration.	
Israel		X
Italy	"Consultation-liaison" system which aims primarily at building co-operation between GPs and a dedicated team of consultant psychiatrists, resident psychiatrists, psychologists and nurses. Psychiatrists offer a diagnosis and evaluation of patient's symptoms and provide guidelines to GPs, whose consent is necessary for psychiatrists to refer serious cases to the Community Mental Health Centre instead of treatment in primary care.	
Korea		X
Luxembourg	Regional platforms allow primary care providers to exchange and co-ordinate psychosocial interventions, assertive outreach, case management and individual care plans with the providers of out and inpatient facilities, community mental health services and residential facilities.	
Mexico		X
New Zealand	A consultation-liaison model is offered to primary care while co-ordination also occurs via case management through community mental health teams.	
Netherlands		X
Poland		X
Portugal	Mental health services work directly with the primary care centres from the same catchment area.	
Spain		X
Switzerland		X
United States	Individual states have an option to establish "health homes" to improve care co-ordination for low-income individuals enrolled in their Medicaid programmes. This opportunity will allow states to direct joint state and federal funding towards better co-ordinated care for individuals with multiple chronic conditions including serious mental illness.	

Source: OECD Mental Health Questionnaire 2012.

Community care for SMI: The role of specialist services

Whilst primary care practitioners in OECD countries do appear to be taking on a growing share of the responsibility for treating SMI, the majority of treatment for SMI is still led and delivered by specialised services. Specialist community-based services play a central role in providing care for people with SMI away from inpatient settings. Such services are often team-based and designed to respond to both urgent and ongoing care needs. The availability of various community-based specialist services varies considerably across OECD countries.

Community mental health teams are an integral part of community-based mental health care

Community mental health teams (CMHTs) have been described as the basic building block for community mental health services (Thornicroft and Tansella, 2004). Such teams comprise a range of mental health professionals including psychiatrists, community psychiatric nurses, social workers, psychologists and occupational therapists who deliver a range of interventions for people with severe mental illness within a defined geographical catchment area (Thornicroft and Tansella, 2004).

Malone et al. (2007) evaluated the effects of CMHT treatment for people with serious mental illness compared with standard non-team management. The review revealed that treatment by a CMHT may reduce suicide and be more acceptable to those with mental illness than a non-team standard care approach. CMHTs are also associated with reduced inpatient admission but do not have an advantage over standard care in terms of attendance at emergency departments. Moreover, CMHTs do not increase primary care contact or dramatically improve loss to services. There is also no conclusive evidence regarding the use of CMHT management with respect to mental state or social functioning (Malone et al., 2007).

While CMHTs in various forms are widely used across OECD mental health systems, their exact composition and function varies. A common method of delivering care within CMHTs is case management. As opposed to the targeted scope of practice accorded to CMHTs working on crisis resolution or early intervention, case management services are aimed at meeting a wide range of patient needs (Dieterich et al., 2010). More generally, case management involves the co-ordination, integration and allocation of individualised care using limited resources (Thornicroft and Tansella, 2004). Telephone case management can play a useful role in re-integrating services users into the community. In some OECD countries the use of telephone case management is experimental or is not implemented on a nationwide basis. Telephone case management can also play an important role in increasing access to rural and geographically remote areas, as is the case in Canada and New Zealand. In some countries, such as Hungary and Israel, telephone case management is provided by non-governmental organisations (NGOs).

Assertive Community Treatment is a cornerstone in community-based care for people with SMI. Assertive Community Treatment (ACT) was established in the United States in the early 1970s in response to the deinstitutionalisation of mental health care (Clark and Samnaliev, 2005). In contrast to hospital-based care, the shift of mental health services to the community resulted in a more complex and fragmented system of care delivery which posed challenges for people with SMI to successfully navigate. Thus, ACT was developed in order to assist people with SMI live more successful lives in the community, seeking to maintain contact with mental health services, reduce hospital admissions and improve

social functioning and quality of life (Clark and Samnaliev, 2005; Kent and Burns, 2005). ACT offered intensive support delivered by multidisciplinary teams available 24 hours a day with other distinguishing characteristics being low caseloads and community-based treatment and services (Rosen et al., 2007; Clark and Samnaliev, 2005; Kent and Burns, 2005). Moreover, ACT was "assertive" in the sense that it was expected that mental health professionals would be assertive in seeking out and delivering treatment to patients and ensuring care co-ordination (Kent and Burns, 2005).

Evidence on the impact of ACT on inpatient use is mixed but ACT appears more acceptable to patients than standard community care. Studies from the United States have shown that ACT is associated with a range of positive outcomes including reduced symptoms, hospitalisation and length of stay, gains in quality of life and functional status including employment and social skills, higher patient and carer satisfaction and improved housing stability (Rosen et al., 2007; Clark and Samnaliev, 2005). Conversely, in the United Kingdom there is little evidence to suggest ACT has an advantage over standard community mental health team care in terms of reduced inpatient days or clinical or social functioning (Kent and Burns, 2005; Killaspy et al., 2006, Holloway and Carson, 1998, Burns et al., 1999; Killaspy et al., 2009). However, ACT has been associated with better engagement with services and improved quality of life and satisfaction with care (Holloway and Carson, 1998; Killaspy et al., 2006). Evidence suggests that ACT is cost-effective as it is associated with improved patient outcomes, even if ACT is associated with a positive or non-negative change in costs (Essock et al., 1998; McCrone et al., 2009; Karow et al., 2012).

The availability of community mental health services for people with SMI varies across OECD countries

The availability of community mental health services for people with SMI varies across OECD countries. While a number of OECD countries offer a wide range of crisis, early intervention, outreach, recovery and day services, these are limited in some countries (Table 3.4). The Czech Republic, Estonia and France report that comprehensive community-based services are not routinely available.

Out-of-hours treatment is a vital part of care in the community for SMI

Access to specialist care is crucial for primary care practitioners and community mental health care teams to be able to successfully manage the care of people with SMI, in particular during acute episodes of SMI. Out-of-hours access to specialist care is primarily via emergency departments or on-call psychiatric specialists but some countries have more specialised crisis care (Table 3.5).

Where crisis and home treatment services exist – and they are relatively widespread in OECD countries (Table 3.4) – they can form a central role in out-of-hours access to care. A recent Cochrane Review of crisis intervention for people with severe mental illness (Murphy et al., 2012) found that crisis intervention – in the form of home care with elements of crisis intervention; mobile crisis teams; or crisis homes – compared favourably to standard care in terms of reduced re-admissions and family burden, improved mental states and higher satisfaction with care by both patients and families but there were no differences in death outcomes. Poor quality data on the cost-effectiveness of crisis intervention hindered definitive conclusions in this regard while there was no available data on relevant outcomes such as staff satisfaction, carer input, complications with medication or number of relapses (Murphy et al., 2012). In the United Kingdom (England) a key function of Crisis

Table 3.4. **Services that are routinely available as part of community mental health services, selected OECD countries**

	Crisis and home treatment services	Early intervention services	Assertive outreach services	Community based recovery services	Day services	Other (please specify)
Australia	X	X	X	X	X	Many and varied, including home-based support and respite services
Chile	X	X				
Czech Republic						Community services are scarce and not routinely available
Estonia					X	
Finland	X			X	X	
France	X					
Iceland		X		X	X	
Israel		X	X	X	X	
Korea	X	X	X	X	X	
Luxembourg	X	X	X	X	X	
New Zealand	X	X	X	X	X	
Poland		X			X	
Portugal	X			X	X	
Slovak Republic				X	X	
Slovenia	X		X		X	
Spain				X	X	
Switzerland	X	X		X	X	
Turkey	X	X			X	
United States[1]	X		X	X	X	

1. These services are not universally covered and their use differs across states and jurisdictions.
Source: OECD Mental Health Questionnaire 2012.

Resolution/Home Treatment Teams (CRHTs) is a 24 hour a day service 365 days a year. Research specifically on CRHTs in England have provided some evidence supporting cost-effectiveness (McCrone et al., 2009) but not that CRHTs per se make any difference to admissions (Jacobs and Barrenho, 2011). CRHTs are a specialised form of community mental health teams.

Recent trends in community-based specialist mental health care

Recent trends in the delivery of team-based specialist community mental health care include the development of early intervention, and Intensive Case Management approaches. While the former is targeted at people potentially in the early stages of psychosis, the latter is concerned with providing a comprehensive range of services to long-term users of specialist mental health care.

Early intervention aims to provide appropriate treatment at early onset of psychosis

The aim of early intervention (EI) is to recognise and treat the early stages of psychosis. The onset of psychosis has been characterised by three distinct stages: 1) the onset of persistent symptoms and impairment that justifies a need for care – the prodromal, sub-threshold or ultra-high risk (UHR) stage; 2) the duration of untreated psychosis (DUP) stage; and 3) the onset of a first episode of psychosis and the subsequent "critical period"

Table 3.5. **Availability of out-of-hours access to specialist care, selected OECD countries**

	Emergency departments in public general or psychiatric hospitals	Psychiatric specialists on-call	Private sector	Other
Australia	X	X		
Austria				Outpatient clinics in public hospitals.
Belgium		X		
Canada				Varies between jurisdictions, but beyond inpatient care, it is probably limited.
Chile	X			
Czech Republic				Acute inpatient care in the regional psychiatric facility.
Denmark	X	X		Acute psychiatric teams with outpatient function.
Estonia	X			
Finland	X			
France	X			
Germany		X		
Hungary	X			
Iceland		X		
Ireland	X			
Israel	X			
Italy	X		X	
Korea	X			
Luxembourg	X		X	
Mexico	X			
New Zealand	X			
Netherlands				Primary care providers and others such as family or police can contact the psychiatric crisis facility in their region.
Poland	X			
Portugal	X			
Switzerland	X			
Turkey	X			
United States	X			

Source: OECD Mental Health Questionnaire 2012.

of the following 2-5 year period (McGorry, 2012). EI is concerned with early detection and phase-specific psychological, social or physical treatment – the so-called "clinical staging model" (Marshall and Rathbone, 2011; McGorry, 2011). The aim of the clinical staging model is to reduce the risk of progression from one stage to the next by delivering treatments with risk/benefit ratios appropriate to that particular phase of illness such as cognitive behavioural therapy (CBT) which has been shown to be effective in the UHR stage but less so in later stages, and low dose antipsychotic medications and vocational interventions in first-episode psychosis. Stronger medications such as clozapine are reserved for a later stage reflecting a more acceptable benefit/risk ratio (McGorry, 2011). Thus, early intervention has been described as pre-emptive rather than preventative or curative (McGorry, 2011).

EI needs to be balanced against the risks of over-intervention. Concerns have been raised about EI approaches, primarily due to the uncertainty surrounding early diagnosis and the consequences in terms of unnecessary treatment and its resultant costs. While schizophrenia and related illnesses are rare, symptoms that may indicate their imminent onset are quite common (Pelosi, 2008). This implies that in the prodromal phase, high rates of false-positives are likely especially in the low-risk population (Singh and Fisher, 2005). These false positive rates may exceed 50-60% (McGorry, 2008). The resulting unnecessary treatment has economic costs in terms of diverting scarce resources from patients who have been diagnosed and for whom effective treatments exist (Castle, 2012; Bosanac et al., 2010). There may also be adverse side effects in terms of stigma arising from engagement with clinical services (Singh and Fisher, 2005; Bosanac et al., 2010). For those who receive antipsychotic medication there are additional negative effects in terms of increased risk of adverse health outcomes (Castle, 2012; Bosanac et al., 2010).

While available evidence on the impact of EI is inconclusive, there are some suggestions that it has a beneficial impact on outcomes and costs. A Cochrane Review (Marshall and Rathbone, 2011) evaluated the effects of: 1) early detection; 2) phase-specific treatments; and 3) specialised early intervention teams in the treatment of people with prodromal symptoms or first-episode psychosis. The review found emerging, but inconclusive, evidence that people in the prodrome of psychosis can be helped by some interventions while there is also some support for phase-specific treatment focused on employment and family therapy, and for specialised EI services, but the long-term sustainability of benefits is unclear. Similarly, evidence on cost-effectiveness suggests the potential for EI to be cost-saving, in particular with regard to lost production costs and, in the longer-term, in reduced rates of homicide and suicide (McCrone et al., 2010; Valmaggia et al., 2009) and have favourable cost-effectiveness, particularly for quality of life and vocational outcomes (McCrone et al., 2010).

Case management and ACT have evolved into Intensive Case Management (ICM)

More recently, case management and ACT have tended to converge into a community-based model of care known as Intensive Case Management (ICM), which is characterised by a small caseload and high intensity of care (Dieterich et al., 2010), and has been used in a number of OECD countries. ICM aims to provide long-term care and a comprehensive range of treatment, rehabilitation and support services to people with SMI who are not in need of immediate admission to inpatient care in order to improve outcomes, reduce hospitalisation and prevent loss of contact with services (Dieterich et al., 2010). In a recent Cochrane Review Dieterich et al. (2010) assessed the effects of ICM (where the caseload is less than 20 people) in comparison with non-ICM (comprised of the same package of services but with a caseload of more than 20 people) and with standard community care (where people are seen as outpatients but their support needs are less clearly defined) in people with SMI. The review drew on data covering Australia, Canada, Europe and the United States. Compared to standard care, ICM was shown to reduce hospitalisation, improve engagement with services and also improve social functioning. The effect of ICM on mental state and quality of life was unclear. ICM was found to be of particular value to people with SMI who are frequent users of inpatient care. Compared to non-ICM, ICM performed better in terms of maintaining patient contact with services.

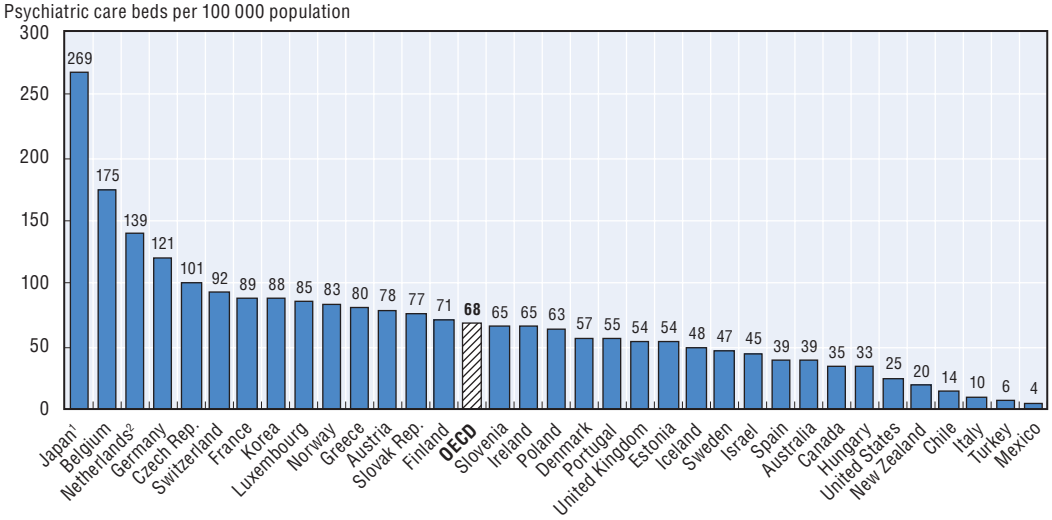
Inpatient care

With the closure of large psychiatric hospitals in most OECD countries, much of the care for severe mental disorders is now delivered in community-based settings. Yet, inpatient care maintains an important role, particularly in urgent and crisis situations, although the function varies between countries. Delivery of inpatient care has evolved to encompass acute psychiatric units in general hospitals, acute day hospitals and long-stay community residential care. While rates of psychiatric care beds have fallen in most OECD countries in recent years, there remain large variations between countries in the reliance on such beds. While countries with fewer beds tend to reserve the use of inpatient care for emergency situations, as a "last resort", or for a brief stay to stabilise a patient in an acute phase of their disorder, countries where bed rates are much higher rely more on inpatient services for the day-to-day management of SMI.

Community-based mental health care does not preclude a role for inpatient care

While mental health care is entrenched in the community in most OECD countries, this does not suggest that inpatient care has no role to play. High-intensity support in acute inpatient settings remains an important part of treatment for people who need urgent medical assessment, those with severe and co-morbid medical and psychiatric conditions, those experiencing severe psychiatric relapse and behavioural disturbance and those with high levels of suicidality or assaultativeness even in highly de-institutionalised systems (Thornicroft and Tansella, 2004). Acute inpatient services should work complementarily with community services and the number of beds required will be dependent upon the overall organisation and availability of mental health services as well as the specific social and cultural context of care. Funding and provider payment incentives also shape the balance between inpatient and community-based care, as does the availability of different services. There is a wide variation in rates of psychiatric care beds across OECD countries as evident in Figure 3.1.

Figure 3.1. **Psychiatric care beds per 100 000 population, 2011**



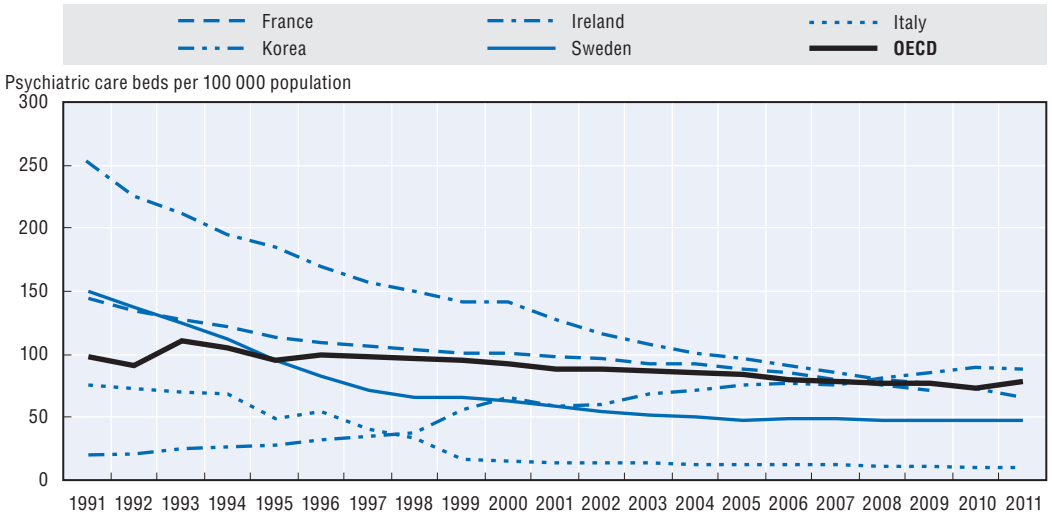
1. In Japan, a high number of psychiatric care beds are utilised by long-stay chronic patients.
2. In the Netherlands, psychiatric bed numbers include social care sector beds that may not be included as psychiatric beds in other countries.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030420

In general, over the past 20 years there has been a general trend of decreasing psychiatric care beds among OECD countries as mental health care has shifted to community-based settings. There are cross-country variations in decreases in psychiatric bed rates with countries with higher initial rates of beds experiencing steeper reductions. However, rates of psychiatric care beds have risen in Korea (Figure 3.2).

Figure 3.2. **Psychiatric care beds per 100 000 population, selected OECD countries, 1991-2011**



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030439

The majority of mental health care in Korea is delivered in an inpatient setting, in general hospitals or psychiatric hospitals. The Mental Health Promotion Comprehensive Plan notes that inpatient care is far more prevalent in Korea than community care or outpatient hospital care, and this is in part because of a shortage of community services combined with a relatively high number of psychiatric inpatient beds (see Figure 3.2). The Mental Health Promotion Comprehensive Plan outlines an intention of improving the efficacy of hospital treatment, promoting early discharge and expanding community and rehabilitative facilities (Hewlett et al., forthcoming). However, it is also evident that inpatient care is used in Korea to treat disorders that would almost always be managed or treated in a community setting in other countries, for example alcohol addiction disorder or acute learning disabilities. This trend may be gradually changing, but is likely still reflected in the makeup of inpatient settings.

A high proportion of inpatient mental health care in Korea is involuntary, with admissions completed under the Mental Health Act, and submitted by family members. The types of service provided in hospitals vary, with most focusing on medication regimes, sometimes supplemented by occupational therapy, educational courses, cognitive behavioural therapy and other psychological therapies, although this varies between hospital and according to a patient's insurance coverage and ability to pay (Hewlett et al., forthcoming). Low reimbursement rates for inpatient care act as a structural factor limiting therapeutic treatment provision for inpatients, and per diem payment costs do little to disincentivise long rates of inpatient stay. Indeed, Korea has an extremely long rate of stay for psychiatric inpatients compared to all other OECD countries (OECD, 2013).

Low reimbursement rates for outpatient care, especially for Medicaid, also incentivise inpatient care (Hewlett et al., forthcoming).

Some OECD countries appear to have a higher reliance on inpatient care than others; Japan, Belgium and the Netherlands have rates of psychiatric care beds well above the OECD average (Figure 3.1). These trends reflect a variety of social and historical trends, policy decisions around mental health care, organisational and financial incentives, and data collection methods.

In Japan, a high number of psychiatric care beds are utilised by long stay chronic patients (Ng et al., 2010). The institutional nature of the Japanese mental health care system is rooted in the Mental Hygiene Law of 1950 which required people with mental illness to receive treatment in hospital as opposed to home confinement which had been the common practice previously (Ng et al., 2010). Since 2002, there has been a policy focus on shifting mental health care from hospitals to the community. A 2004 policy document entitled "The Reform Vision for Mental Health and Welfare Services" outlined a goal of reducing the number of psychiatric beds by 70 000 by 2014 but it looks unlikely that this will be achieved. The community-based infrastructure remains underdeveloped with relatively low numbers of staff working in the community, and low numbers of supportive housing facilities, coupled with a strong emphasis on physical treatments rather than psychosocial treatments (Ng et al., 2010). While community-based services are provided by both the public and private sector, there is limited input from general practitioners, allied health staff, and NGOs in providing support and care in the community for individuals with SMI (Ng et al., 2010). Nevertheless, greater funding incentives have been created for private hospitals[1] to encourage treatment and discharge of acute patients within 90 days. Nursing outreach visits and community oriented services in private hospitals and clinics have been established in order to support early discharge. The numbers of psychiatric day care centres, private psychiatric outpatients' clinics and social rehabilitation facilities have also increased. Mental health hospitals have been renovated to improve physical amenities and greater functional differentiation of these hospitals has been implemented in order to provide a comprehensive range of services to meet patients' needs. However, the broad perception that mentally ill patients could be discharged out of hospital and could live independently in the community is far from widespread, and more positive attitudes of both staff and community need to be fostered (Ng et al., 2010).

In the Netherlands, clinical psychiatric beds include beds in psychiatric departments of general and university hospitals, beds in mental health and substance abuse hospitals and beds in sheltered housing facilities of the Regional Mental Health Organisations for Assisted Independent Living and Sheltered Housing (*Regionale Instellingen voor Begeleid en Beschermd Wonen*). These sheltered housing facilities provide low intensity care for long-term patients with mental health problems. Such facilities might be included in the social care sector in most other countries which means that comparisons of rates of psychiatric beds between the Netherlands and other countries must be interpreted with care (Forti et al., 2014). Nevertheless, a fragmented funding base has contributed towards the concentration of mental health care delivery in specialised mental health institutions with fewer services being delivered through general acute care hospitals. Data from the WHO (2011) show that in the Netherlands a large share (82%) of mental health beds are in specialised clinics, suggesting that general acute care hospitals (which also treat other diseases) have a comparatively small role in mental health treatment. Moreover, the number of psychiatric departments in acute care hospitals declined by 56% between 1998

and 2006. Health care insurers and providers aim to reduce the current total bed capacity so that by 2020 psychiatric beds will be a third less of the number of beds available in 2008. As a consequence, outpatient care will play a more important role in mental health service provision (Forti et al., 2014).

Relatively low rates of psychiatric care beds usually reflect a strong policy emphasis on community-based mental health care. Italy has a rate of ten psychiatric care beds per 100 000 population – approximately seven times less than the OECD average (Figure 3.1) – and has historically demonstrated significant leadership in moving mental health care for people with SMI from institutions to the community. In 1978, the approval of Law 180 (Law Basaglia) prohibited new admissions to mental health institutes and the construction of new mental hospitals. Law 180 aimed to progressively close existing mental hospitals and replace them with community-based mental health facilities. Therefore, Law 180 marked an important transition from a system of mental health care delivered in segregated mental health facilities to that of fully integrated psychiatric services. Prevention, care and rehabilitation represented important new features of the 1978 law, with the new mental health facilities taking charge of the full array of mental health care, i.e. providing appropriate care to patients through community-based services, outpatient interventions and/or exceptional and temporary compulsory admissions (Forti, 2014). This transition from old-style mental hospitals to new community-based facilities was, however, a slow process, with the 1978 law failing to design a precise framework and timeline for this transition and with all mental health hospitals being eventually closed only in 1999 (WHO, 2011). There are currently no stand-alone mental hospitals in Italy, as all of them have progressively been replaced by the Departments of Mental Health (DMHs) (*Dipartimento di Salute Mentale* – DSM) and a set of mental health services and facilities including Community Mental Health Centres (CMHCs), the General Hospital Psychiatric Units (GHPU), semi-residential facilities and residential facilities (Forti, 2014).

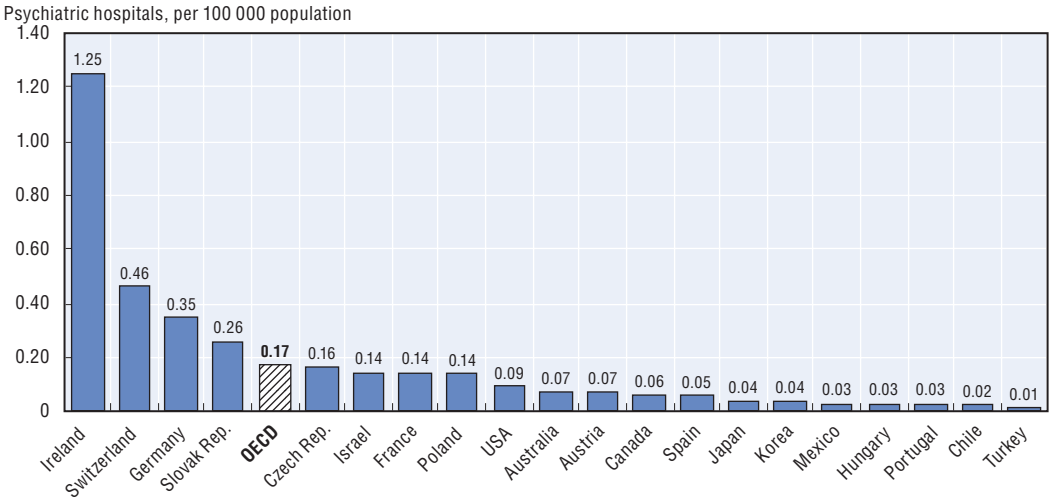
Inpatient care has shifted from stand-alone psychiatric hospitals towards other forms of inpatient care

With the closure of large psychiatric hospitals, inpatient care has shifted to acute psychiatric units in general hospitals, day hospitals and long-stay community residential care. Full definitions of these types of care are included in Annex 3.A1 at the end of this chapter.

The progressive inclusion of acute psychiatric units in general hospital settings is a practice that has been intentionally pushed forward in many OECD countries (Tansella, 2010). Shifting acute inpatient mental health care from specialised to general hospitals can contribute to decreasing stigma around mental ill-health, and encourages collaboration, closer relationships and better links between mental health and other medical and surgical disciplines. Figure 3.3 shows that for those countries that could provide this data, there is less than one public psychiatric hospital per 100 000 population. The exception is Ireland which has just over one psychiatric hospital per 100 000 population.

In mental health systems where there is a strong focus on provision of care in the community, admission to an inpatient setting is less common. Psychiatric care in general hospitals has shifted to have an acute care function, with the patient discharged to community care services when stabilised. Criteria for admission to an acute inpatient psychiatric care unit may include: dangerousness to self or to others; the need for intensive observation and diagnosis; medical treatment or medication stabilisation; positive psychotic symptoms; self-care deficits; respite for carers, especially when they

Figure 3.3. **Public psychiatric hospitals per 100 000 population in selected OECD countries, 2010**



Note: OECD compilation based on responses to the OECD Mental Health Questionnaire 2012 and the WHO Mental Health Atlas 2011. Data is non-standardised and has not been independently validated.
Source: OECD Mental Health Questionnaire 2012; *WHO Mental Health Atlas 2011*.

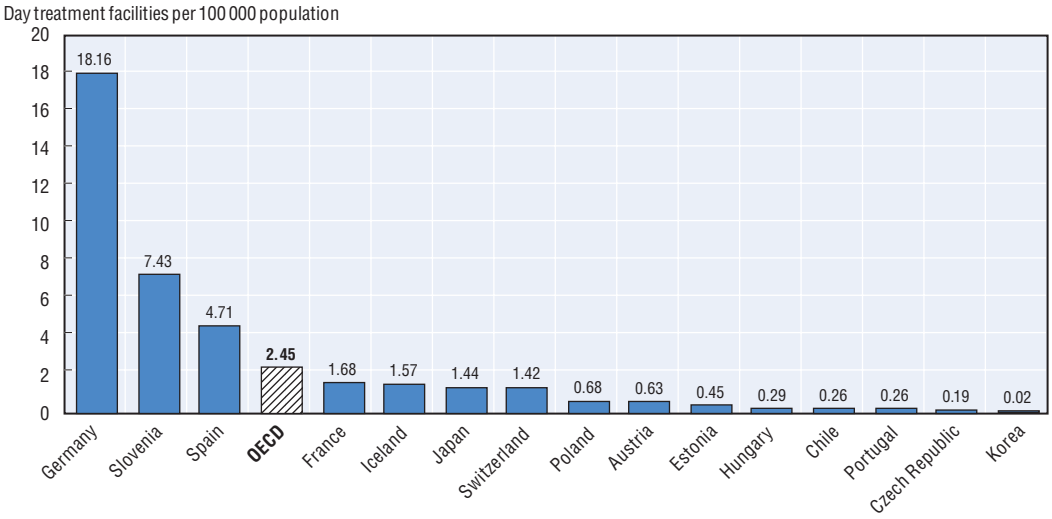
StatLink http://dx.doi.org/10.1787/888933030458

have been impacted negatively by other events; and refuge for the patient by leaving an environment that threatens their coping abilities (Horsfall et al., 2010). Admissions to acute inpatient psychiatric are associated with assessment in out-of-hours units and emergency departments, socio-economic deprivation, unemployment, patient harm to self or others and a patient history of involuntary admissions (Horsfall et al., 2010).

Day hospitals are a less restrictive alternative to inpatient admission for people who are acutely and severely mentally ill (Marshall et al., 2011). A recent review by Marshall et al. (2011) compared acute day hospital care to inpatient care and found that provision of acute psychiatric care is as effective in acute day hospitals in terms of loss to follow-up by one year and re-admissions. There is some evidence that the duration of care (adjusted days/month) is longer for patients in day hospital care than inpatient care. Patients treated in the day hospital had the same levels of treatment satisfaction and quality of life as those cared for as inpatients. The day hospital patients were also no more likely to be unemployed at the end of their care. However, further data are still needed on the cost effectiveness of day hospitals. The availability of public day treatment facilities varies across the OECD countries for which this data was available, with Germany reporting a relatively high number – approximately six times the OECD average – while a number of countries report less than one day treatment facility per 100 000 population (Figure 3.4).

Long-stay community residential care provides an alternative to long-stay wards in psychiatric institutions and cater for people with SMI who require additional support to manage self-care and other aspects of day-to-day living in the community (Thornicroft and Tansella, 2004; MacPherson et al., 2009). Long-stay community residential care includes 1) 24-hour staffed residential care such as high-staffed hostels, residential care homes or nursing homes; 2) day-staffed residential places: hostels or residential homes which are staffed during the day; and 3) lower supported accommodation such as minimally supported hostels or residential homes with visiting staff (see also Annex 3.A1 at the end of

Figure 3.4. **Public day treatment facilities per 100 000 population, selected OECD countries**

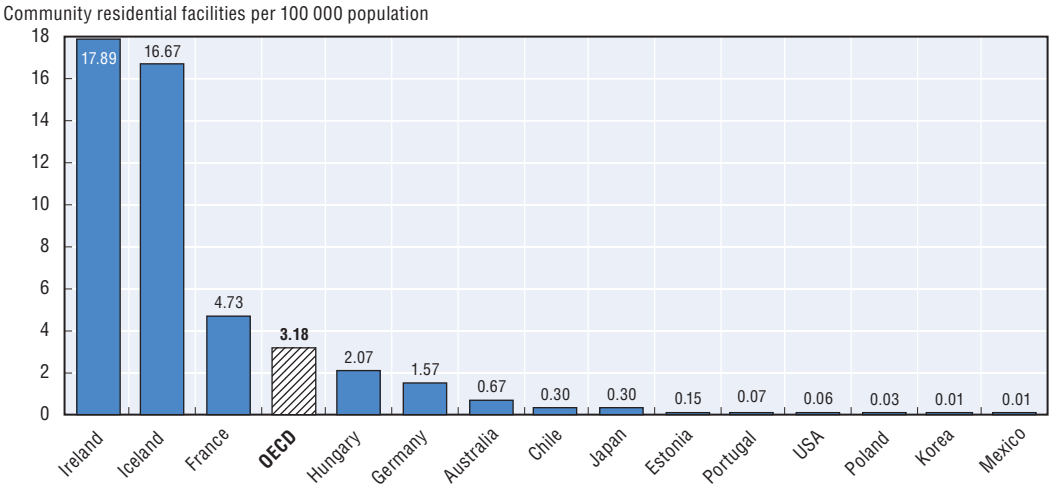


Note: OECD compilation based on responses to the OECD Mental Health Questionnaire 2012 and the WHO Mental Health Atlas 2011. Data is non-standardised and has not been independently validated.
Source: OECD Mental Health Questionnaire 2012; *WHO Mental Health Atlas 2011*.

StatLink http://dx.doi.org/10.1787/888933030477

this chapter). Figure 3.5 shows rates of public community residential facilities for selected OECD countries that can provide this data. There are large variations across countries with many OECD countries reporting few public community residential facilities. However, Ireland and Iceland report relatively high rates of such facilities. There is, again, limited evidence regarding the effectiveness and cost-effectiveness of these types of residential care (Thornicroft and Tansella, 2004; MacPherson et al., 2009).

Figure 3.5. **Public community residential facilities per 100 000 population, selected OECD countries**



Note: OECD compilation based on responses to the OECD Mental Health Questionnaire 2012 and the WHO Mental Health Atlas 2011. Data is non-standardised and has not been independently validated.
Source: OECD Mental Health Questionnaire 2012; *WHO Mental Health Atlas 2011*.

StatLink http://dx.doi.org/10.1787/888933030496

3.4. Provider payment for treatment of SMI

Provider payment systems face unique challenges when applied to mental health and this section highlights some innovative practices in both primary and specialist care settings. Financial incentives can be an important tool in securing better care for mental disorders, for example to promote increased co-ordination of care, or reward better health outcomes. While the delivery of mental health care is increasingly more integrated across different care settings, provider payment systems are more fragmented and differ according to care setting, adding to problems with co-ordination and further disrupting the patient's care pathway. Thus, the challenge for OECD countries is to design and implement payment systems which incentivise the delivery of high-quality, efficient and integrated care, and which reflect the diversity of treatment settings for mental disorders.

Primary care incentives can promote co-ordinated care and improve health outcomes

Primary care presents the ideal opportunity to improve care co-ordination for people with SMI leading to improved physical and mental health outcomes. England and Australia have introduced incentive schemes focused on SMI in primary care.

Chapter 2 describes England's pay-for-performance scheme for GPs, the Quality and Outcomes Framework (QOF) (see Box 2.1). The mental health component of England's QOF primarily incentivises the ongoing management of SMI in primary care. There is a strong emphasis on monitoring the physical health needs of people with SMI with indicators relating to annual checks of blood pressure; hdl cholesterol; blood glucose or HbA1c; body mass index (BMI); alcohol consumption and cervical screening for women aged less than 65. Thus the QOF provides a concrete example of how to incentivise primary care practitioners to manage both the physical and mental health needs of people with SMI. To date, there is no published evaluation of the impact of the QOF on mental health care so it is difficult to assess the extent to which these incentives translate into better health outcomes.

The Mental Health Nurse Incentive Programme (MHNIP) was introduced in Australia in 2007 and provides payments to community-based general practices, private psychiatric practices and Aboriginal Medical Services (AMS) to engage mental health nurses to assist in the provision of co-ordinated clinical care for people with severe mental health disorders. Mental health nurses provide a range of services including monitoring a patient's mental state, medication management and improving links to other health professionals and clinical service providers. The mental health nurse works in a variety of settings such as clinics or patient's homes. As well as improving levels of care and reducing unnecessary hospital (re-)admissions for people with severe and persistent mental illness, the aim of the MHNIP is to relieve workload pressure for GPs and psychiatrists in order that they can devote more time to complex cases (Healthcare Management Advisors, 2012). A recent evaluation of the programme found that it is strongly supported by patients, carers and medical practitioners. Moreover, the programme had a positive effect on patient outcomes due to greater continuity of care, greater follow-up, timely access to support, and increased compliance with treatment plans. Utilisation of inpatient care was reduced and patients experienced increased levels of employment and improved community functioning. The MHNIP also had a positive impact on medical practitioner workloads. The MHNIP proved to be an efficient use of resources with reduction in hospital admissions and length of stay generating savings equivalent to the cost of providing the programme (Health Management Advisors, 2012). Despite the initial success of the MHNIP there remain some

areas for improvement including geographical disparities in MHNIP services, the lack of control over programme expenditure, and the need to strengthen operational guidelines and improve data collection. While, the programme is currently being redesigned in order to address these limitations, it continues to attract additional funding from the Australian Government for 2013-14.

OECD countries use a range of payment systems to reimburse inpatient mental health care

OECD countries use a range of provider payment methods such as global budget, payment per case, retrospective reimbursement of costs, per diem payments, fee for service (Table 3.6) each of which provide specific incentives for the quantity, quality and productive efficiency of hospital services (Paris et al., 2010).

Table 3.6. **How are specialist mental health services reimbursed for services provided?**

	Global budget		Payment per case		Retrospective reimbursement of costs		Per diem		Payment per procedure/service	
	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private
Australia	X					X		X		X
Belgium									X	X
Austria	X		X	X					X	X
Canada	X		X						X	
Chile				X		X			X	X
Czech Republic					X				X	
Estonia									X	X
Finland							X		X	
France	X	X								
Germany										X
Hungary			X							X
Iceland										X
Ireland	X									
Israel	X			X						
Korea							X	X	X	X
Luxembourg	X	X								
Mexico	X	X		X						
New Zealand	X									
Norway	X									
Poland									X	X
Portugal	X		X				X	X	X	X
Slovak Republic							X	X	X	X
Slovenia			X						X	
Spain	X									
Switzerland	X					X	X			
Turkey	X		X	X					X	
United Kingdom (England)	X	X	X	X	X	X	X	X		
United States	X		X	X	X		X (in some cases these are level of care adjusted)	X (in some cases these are level of care adjusted)	X	X

Source: OECD Mental Health Questionnaire 2012.

Global budgets allow hospitals more flexibility in resource allocation between cost categories. Ireland, New Zealand and Norway fund inpatient mental health care exclusively through global budgets. Global budgets do not give incentives to produce more services, at least in the short run, while in some situations, i.e. when the budget constraint is tight, hospital supply of services can even be insufficient to satisfy the demand for care, generating waiting lists (Paris et al., 2010).

A retrospective payment of costs covers all hospital incurred costs and is used by the Czech Republic, the United Kingdom and the United States, but it is never used in isolation but combined with another payment system(s).

Payments per case, which would include diagnosis related groups (DRG), fee for service (FFS) (payment per procedure or service) and per diem all directly relate to actual levels of activity. They correspond to fees established prospectively for a single "product" delivered by the hospital. However, they differ in the definition of the "product". Payments per procedure usually cover only the provision of clinical services. Per diem payments are widely defined for part or all services provided during one hospital "day" and do not directly depend on the quantity of clinical services delivered. Payments per case typically cover all clinical and non-clinical services provided in hospitals (accommodation, nursing). Those three modes of payment provide incentives to produce additional "products" (days, stays or procedures) as long as the prospective fee/price equals or exceeds the actual production cost (Paris et al., 2010).

The use of DRGs as a form of payment per case in provider payment systems is particularly widespread in acute inpatient medical care due to the perceived benefits of cost control, quality improvements and promotion of an efficient use of services. However, the use of DRGs to reimburse acute psychiatric services is not as common for a number of reasons. In order to see why this is the case it is useful to start by exploring the relationship between classification and payment systems.

The weakness of the DRG classification system for mental health gives rise to undesirable incentives

DRG-based payment systems are usually not successful for reimbursing inpatient psychiatry as classification systems are weak in relation to mental health care due to the difficulty of classifying mental health patients into groups that are clinically meaningful and economically homogeneous.

Ideally, DRG systems consider the most important determinants of resource use as classification variables. Otherwise, payments to hospitals may be inappropriate if a considerable number of patients and hospitals face financial risk. The risk facing providers can be divided into *systematic risk* and *unsystematic risk* (Horgan and Jencks, 1987). Systematic risk occurs if there are systematic differences between providers in the costs of care provided that are not measured or sufficiently captured by the DRG system, such as differences in the severity of patients treated, differences in treatment philosophy or physician practice style, or differences in the efficiency with which care is provided. Nonsystematic risk results from random variation around the average value in case cost within a DRG, which is often the case with psychiatric DRGs (Horgan and Jencks, 1987). Payment systems can incorporate various mechanisms that serve to mitigate the potential risks faced by providers due to the inadequacies of the classification system (Dada et al., 1992; Cots et al., 2011). From a policy perspective the primary concern is whether a payment system can be devised that creates appropriate incentives to control costs while

at the same time preventing providers from facing unacceptable levels of financial risk or engaging in undesired behavioural responses (Dada et al., 1992).

Diagnosis is not a good predictor of the costs of inpatient mental health care as the same psychiatric diagnosis can be associated with differing severities of illness and lengths of stay and subsequently costs of care. Thus, the provider is exposed to financial instability as they are liable to absorb the full difference between costs incurred retrospectively and payment received prospectively. Subsequently, the use of DRGs to reimburse inpatient mental health care can result in unintended negative consequences. These include "cream skimming" and "adverse selection" whereby providers avoid treating more severe and hence more costly patients; "skimping" whereby providers reduce quality of care in order to reduce costs; and "dumping" or inappropriately referring patients to other care settings (Mason and Goddard, 2009). Such practices can result in higher costs and lower quality and patient outcomes as well as an inefficient level of care provision. More narrowly defined DRGs can better account for differences in patient costs and reduce provider risk but negative incentives for "up-coding" (where providers allocate patients to a more costly DRG group than is clinically warranted) or "DRG creep" (classifying patients into a DRG with higher costs) and overtreatment are heightened (Cots et al., 2011). Moreover, DRGs are more amenable to acute rather than chronic illnesses such as mental disorders. The use of DRGs in some European countries has resulted in mental health being underfunded, as reimbursement rates have not always fully taken into account all of the costs associated with chronic mental health problems (Knapp and McDaid, 2007).

Per diem systems should take account of length of stay to avoid over-utilisation

Per diem systems of provider payment can incentivise over-utilisation and unnecessarily long lengths of stay if they do not take account of length of stay along with serious patient and provider characteristics that drive costs.

In the United States, the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) was introduced in 2005 and allows Medicare to pay for the per diem routine, ancillary, and capital costs associated with covered inpatient psychiatric services. Each per diem payment is patient-specific. Payments are calculated using the federal average cost of an inpatient day of psychiatric care. This base rate is then adjusted to account for patient (age, diagnosis, co-morbidities, length of stay) and facility (wage index, teaching status, rural location, cost of living, emergency department) characteristics that are associated with significant cost differences (Centers for Medicare & Medicaid Services 2011; Medpac 2011). Importantly, the system incorporates variable per diem adjustments that reflect the higher cost occurred in the initial stay and are subsequently reduced over a 21-day period. The payment system also incorporates an "interrupted stay policy" to discourage inappropriate premature discharges undertaken for financial gain. Re-admissions within three days are treated as if they were a continuation of the original stay. This means that the first days of these "re-admissions" are not paid the higher initial per diem rate, but the lower rate that would have been paid had the patient not been discharged (Medpac, 2011). There are also three "budget neutrality adjustments", funded by top slicing around 20% from the per diem base rate (Medpac, 2011). These adjustments comprise outlier payments, a minimum income guarantee[2] and a "behavioral offset" adjustment to account for higher payments resulting from improved coding practices. Estimates suggest that the per diem approach and adjustment factors explain a high percentage of cost variation (85%). Moreover, payments are updated annually and adjustment factors recalculated

when sufficient data are available. Since January 2009, all eligible psychiatric providers are fully funded for Medicare patients under IPS PPS.

Germany is undertaking a reorganisation of its per diem payment system for providers of inpatient psychiatric care in order to take account of severity of illness and complexity of treatment (Hübener, 2013). A performance-orientated and fixed rate reimbursement system on the basis of day-related charges will be introduced – the PEPP (Consolidated Payment System for Psychiatry and Psychosomatics).

OECD countries need to develop and implement payment systems that are independent of care setting

In order to incentivise integrated care for SMI, it is necessary to move towards provider payment systems that are independent of care setting. The use of DRGs, per diem and other hospital-based payment systems can potentially tip the balance of care from the community back to institutions, contrary to policy objectives in most OECD countries as well as distort care pathways and discourage integrated care. For example, following the introduction of the DRG system in Austria a shift from outpatient to inpatient care was observed partly because of the lack of interfaces between inpatient and outpatient care but also because the outpatient financing system differed considerably from the financing system used for inpatient services delivered in hospitals (Kobel and Pfeiffer, 2009).

Implementing a payment system that spans care settings requires 1) designing a classification that goes beyond diagnosis in order to fully account for cost differences; 2) defining a product or unit for which payment is paid; 3) attaching a tariff to the product; and 4) implementing additional payment mechanisms that reduce negative incentives for providers. Examples from Australia, England and the Netherlands are outlined in the following paragraphs to demonstrate how OECD countries can potentially pursue a similar strategy.

Australia launched a Mental Health Classification and Service Cost (MH-CASC) Project in 1995 with the aim of developing a national case mix classification, with associated weights, for specialist mental health services (Buckingham et al., 1998). The project sought to explore the potential relationship between patient attributes, or needs, and service costs and if such a relationship could be utilised for funding purposes. In England, the recently developed "Care Pathways and Packages Approach" utilises individualised care packages that encompass different care settings in order to reduce incentives for "re-institutionalisation" or neglect of community-based care. In the Netherlands, two separate systems fund mental health care. Since 2008, the first year of inpatient medical psychiatric care and all medical psychiatric care in other settings is covered by the 2006 Health Insurance Act and is reimbursed by a DRG-based system known as "Diagnose Behandeling Combinatie" or diagnostic treatment combination (DBC). Longer-term mental health care for patients diagnosed with a DSM psychiatric disorder is funded under the Exceptional Medical Expenses Act (AWBZ) – the mandatory national long-term care insurance scheme (Mason and Goddard, 2009).

Under Australia's MH-CASC Project classification variables focused on patient characteristics including psychiatric diagnosis (ICD-10 codes); severity and level of functioning (HoNOS and other assessment tools); focus of care (acute or maintenance); legal status; and factors influencing health status and contact with health services (Child and Adolescent services only). Severity and need underpin the classification system developed in England. The Health of the Nations Outcome Scales (HoNOS) (Wing et al.,

1999) and the Summary of Assessments of Risk and Need (SARN) (Self et al., 2008) have been used to develop a Mental Health Clustering Tool (MHCT) which is used to allocate individuals to 21 Care Clusters or classification groups (Department of Health, 2011). The care clusters are based primarily on the characteristics of a service user, rather than their diagnosis alone and the same diagnosis can be associated with several clusters, depending on level of need. Classification of patients to a DBC is contingent not just on diagnosis but also on medical specialty, type of care, demand for care and treatment axis (Swan Tan et al., 2011). Furthermore, the Netherlands plans to further refine the episode-based payment system in order to take account of both care intensity and care outcomes for secondary mental health care.

The product under the MH-CASC was an episode of care defined in terms of fixed periods of care (e.g. one month, three months, etc.) for both community and longer term inpatient episodes. Three separate episode types were defined consisting of: completed inpatient episodes; ongoing inpatient episodes; and community episodes. The preliminary classification system resulted in 42 groups: 23 for in-patient episodes, and 19 for community episodes. In England, the 21 Care Clusters define the product for which payment is made. The clusters are mutually exclusive and a service user can only be allocated to one cluster at a time – if they transfer to a new cluster, the previous cluster episode ends. The clusters are also designed to be setting independent, on the premise that people should be treated in the least restrictive care setting possible. The care package or pathway that follows the assessment and clustering process for each service user is not being nationally defined thus allowing for autonomy at the local level regarding the development of the care options available to individuals. It also allows the tailoring of care packages to individual's requirements as part of the service design and care planning process thus the care packages are centered around individuals, rather than organisations.

The "product" defined under the Dutch DBC system is one diagnosis-treatment combination which can include several hospital admissions or outpatient contacts. Hence, the system has the advantage of defining groups on the basis of the treatment that is necessary for a specific condition, independent of the setting. The payment units used in the National Act on Exceptional Medical Expenses (AWBZ) are named "Zorgzwaartepakketten" (ZZP, care packages) and incorporate three components: client profile; functioning and weekly client hours (with and without day care); and care setting characteristics. In each ZZP, the client profile gives a detailed description of the typical client group, their average scores on a range of "limitation" assessments, the proportion with active or passive psychiatric problems, and the key aims of treatment/support. Average care times are estimated on the basis of contact and non-contact time and include time spent assisting client functioning, and providing nursing and personal care. Day care use and therapist use are also specified for each ZZP and the tariffs are then informed by these estimates. There are 13 Mental Health Care Packages divided into two categories: Category B for inpatients (seven care packages) and Category C for patients requiring support in sheltered accommodation (six care packages).

Results of the MH-CASC Project found that while the overall explanation of variance of MH-CASC proved to be higher than that achieved by using the mental health classes in the Australian inpatient DRG system, it required on-going clinical refinement and further research in order to be used for reimbursement (Whiteford et al., 2000). This decision not to use MH-CASC for reimbursement may have been based on the fact that the casemix methodology, based on average resource use, could cause financial

instability, particularly if cost variations affect factors outside of provider's control. In England, the payment for each care cluster will inevitably be an average payment. It is likely that additional top-up payments or alternative funding arrangements in addition to the core cluster payment will be established to cover the cost of more specialised services. Tariffs in the Dutch DBC system differ by treatment duration, therapy received and length of stay and are based on actual labour, material and capital costs that were first collected in 2005. Providers are paid a fixed price both for the type of intervention and for the length of stay. Under the AWBZ each ZZP is assigned a maximum tariff with tariffs informed by estimates of average care times day care use and therapist use (Mason and Goddard, 2009).

Central to the design of classification and payment systems is good quality data on costs and outcomes. On the whole, good cost data currently exists for hospital care (see Chapter 1) but high-quality data is not widely available in all OECD countries for outpatient and community-based care. This will likely hinder the development of classification and payment methods that span care settings. Similarly, data on variables that predict costs will be available from routine administrative data for inpatient care (e.g. discharge records) but will be scarcer for community-based care. Good outcome data is also necessary in order to predict costs accurately and adjust case mix for severity. For example, in England the "Care Pathways and Packages" approach uses items from the Health of the Nation Outcome Scales (HoNOS) to capture severity of illness and allocate service users to care clusters. In order to design an adequate classification system that can accurately predict costs it is necessary to take account of all relevant variables.

Personal budgets offer enhanced choice, autonomy and individualised care but can contribute to unsustainable expenditure growth

Personal budgets (PBs) comprise a payment made directly to an individual with which they can purchase their unique set of care services. PBs have the potential to increase user satisfaction and introduce flexibility and choice into service utilisation. In order for PBs to be successful it is necessary that service users have adequate information and support in accessing and utilising the payment and mechanisms are put in place to control costs and prevent incentives for fraud.

In England, personal health care budget pilots in mental health have been quite successful, both in terms of the care they delivered and in reducing the overall level of spend. An early evaluation of the system of individual budgets (IBs) found that mental health service users partaking in the budgets reported significantly higher quality of life than those in the comparison group. A number of these service users had not found the services available under conventional arrangements to their liking, and saw an IB as an opportunity to access more appropriate support. Although not significant statistically, the data also suggest some tendency for psychological well-being to be better for the IB group. Moreover, IBs appeared to be more cost-effective than standard arrangements on both the social care and psychological well-being outcome measures (Glendinning et al., 2008). Later experiences following wider roll out in social care, however, appear to show more mixed results. Many users, carers and professionals have found that IBs are highly bureaucratic, and have raised anxieties that the use of IBs is a disguised way of cutting services and funding. These concerns underline the need for ongoing refinement of any newly or recently introduced financing mechanism, and supporting users, carers, and providers through the adjustment process, remaining open to their complaints and demands.

Since 1997, patients in the Netherlands have been able to use PBs to purchase care from professional organisations, or from non-professionals, such as neighbours, friends, and family. The average budget amounted to EUR 43 000 for those assessed for residential care and EUR 12 000 for other patients, with spending in excess of these amounts covered by the patient. Demand for PBs proved high and between 2002 and 2010 the number of PB holders increased ten-fold, while spending increased on average by 23% a year during the same period. A lack of strict eligibility criteria combined with lenient accountability and control mechanisms led to instances of fraud. Moreover, the complex administration accompanying personal budgets encouraged the unregulated growth of specialised agencies to broker arrangements between care providers and budget holders. Due to these unforeseen consequences, a series of measures have been introduced to restrict eligibility for PBs. By January 2014, only those who can benefit by purchasing services to enable them to continue living at home and prevent a move to nursing or residential care will be eligible to hold or apply for a PB. This corresponds to approximately 10% of current budget holders. In order to prevent fraud, budget holders will have to make payments from a separate account opened for the purpose of the PB and cannot employ specialised agencies to purchase care on their behalf. In addition, they will need to outline a care plan corresponding to the use of PB funds (van Ginneken et al., 2012).

In recent years, the Mental Health Department in Trieste, Italy has invested large sums of money to support particularly difficult patients using personalised health care budgets. These personal budgets have been developed with the support of NGOs. 160 clients per year receive a personal budget in order to fulfil the aims of a joint and shared plan of recovery in the areas of housing, work and social relationships. This represented about 18% of the overall budget of the Department of Mental Health in 2011 (Forti, 2014).

3.5. Employment and vocational rehabilitation for people with SMI

A recent OECD publication (2012) has highlighted the fact that unemployment is a key issue for people with SMI, who are typically 6-7 times more likely to be unemployed than people with no such disorder. Two broad approaches have been taken to support people with SMI in obtaining and maintaining employment: "first-train-then-place" versus "first-place-then-train". While both have been associated with positive employment outcomes, the latter – more commonly known as supported employment (SE) – is the preferred approach promoted in OECD countries. A key feature of SE that is instrumental in improving outcomes is the integration of employment and mental health services. The success of SE is dependent on cross-sectoral co-operation and favourable economic conditions. SE policies must also take account of various socio-demographic, work-related, illness-related and person related factors that are intrinsic to successful employment outcomes for people with SMI.

Two contrasting principles dominate the vocational training of people with SMI

Two contrasting principles dominate the vocational training of people with SMI. The traditional approach to vocational rehabilitation of people with SMI has been based on a "first-train-then-place" principle whereby clients undertake a stepwise approach to employment, beginning with training in a safe environment (OECD, 2012). Most countries have offered *sheltered workshops* where individuals can work in a protected, non-competitive environment while other countries have also established "club houses" offering prevocational training and transitional employment programmes as well as other psychosocial interventions (OECD, 2012). A drawback of such prevocational training programmes – which normally yield substantial positive effects in a supported

environment – is that these positive effects are difficult to replicate in non-sheltered environments. The problem of transitional employment is, evidently, that it is transitional, offering supervised and typically low-level jobs on a temporary basis (OECD, 2012). The *first-train-then-place* principle is of particular benefit to clients who may profit from some specific prevocational training, while others profit from enhanced self-confidence experienced in transitional employment interventions, reducing their fear of failure and allowing them to make further steps towards employment. In the past two decades, a new *first-place-then-train* paradigm has evolved which is generally referred to as "supported employment" (OECD, 2012; Clark and Samnaliev, 2005). Supported employment (SE) helps people with SMI find competitive jobs in their communities. Evidence-based SE is characterised by seven core principles as summarised in Box 3.1.

Box 3.1. **Principles of supported employment (SE)**

- *Zero exclusion policy*. All persons with a disability can work at competitive jobs in the community without prior training. The only precondition for participation in SE is that the client wants to work. No one is excluded regardless of diagnosis, symptoms, work history, substance abuse, cognitive impairment or other problems.
- *Integration of vocational rehabilitation and mental health services*. Close co-ordination and collaboration of SE with treatment and other rehabilitation services is necessary to pursue the vocational goals of the client. This can be achieved when employment specialists work closely with other professionals, with regular meetings of all those involved. These meetings provide a vehicle for discussing clinical and rehabilitation issues relevant to work, such as medication side effects, persistent symptoms, cognitive difficulties, or other rehabilitation needs.
- *Client preferences are important*. Vocational goals, support and timing should respond to the client's preferences regarding the type of work, work setting, work hours, other job features, and disclosure of mental illness.
- *Rapid job search*. Assessment is minimised in favour of rapidly helping the client to pursue the job that he or she chooses. To help direct the job search, the employment specialist draws up a vocational profile that includes a review of the clients' preferences. SE does not require lengthy pre-employment assessment and training.
- *Conventional paid employment is the goal*. The SE specialist is committed to help each client find a regular part-time or full-time job in the community that pays a minimum wage or more. A regular job is a paid job that anyone in the community can apply for. The SE model endorses regular jobs for several reasons: Clients prefer paid jobs; and such jobs reduce stigma, inspire self-esteem and enable life in the mainstream.
- *Time-unlimited support*. The goal of the employment specialist is to help clients become as independent as possible in their vocational role, while remaining available to provide support and assistance when needed. Some clients need support over long periods of time, even though for many the extent of support gradually decreases over time. Therefore, clients are never terminated from SE services, unless they request it.
- *Benefits counselling*. Benefit counsellors help clients calculate exactly how much money they could make at their jobs without disrupting benefit entitlements. They also advise clients and caregivers about benefit eligibility rules, income ceilings, work incentives and other issues and regulations related to employment benefits.

Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

While supported employment has been very effective in terms of placing clients in normal work settings, it is not without some limitations (OECD, 2012). SE programmes usually find entry-level jobs in the service industry, around half of the clients leave their jobs within six months, and clients do not normally work full-time in order not to jeopardise their social security benefits. In addition, supported employment programmes are not as widespread as one would expect, due to implementation barriers including fragmented funding, leading to fragmented service provision. Another important barrier is the beliefs of clinicians, who underestimate their patients' needs for vocational services (OECD, 2012).

Policies promoting employment of people with SMI need to be integrated into mental health systems

Policies and services that promote and support the employment of people with SMI need to be integrated into mental health systems in order to produce positive outcomes in this regard. SE has been associated with superior employment outcomes – around 50% of supported employment clients achieve paid employment at some time over a 12-18-month period compared with around 15-20% for other vocational interventions and is innovative in a number of aspects (OECD, 2012). SE assumes that people with severe mental illnesses are able to work in normal competitive settings and has actively promoted the integration of mental health care and employment services (OECD, 2012). Research has found that this improved integration is fundamental to improved client outcomes. Henry et al. (2004) examined inpatient hospitalisations and emergency service visits among clients in a SE programme based on the Individual Placement and Support (IPS) model in comparison to a propensity score matched group of clients who did not participate in IPS. Superior clinical outcomes in terms of fewer hospitalisations and emergency service visits were only achieved by SE clients who also received more regular mental health service hours. The interaction effect was diminished somewhat, but continued to be moderate, when client functioning was controlled for. The interaction between SE participation and mental health services may be a measure of service integration leading the authors to suggest that their findings lend further support to the assumption that the integration of mental health and employment services leads to enhanced client outcomes.

SE policies must adopt a cross-sectoral approach that takes account of the national economic context

In order to maximise employment outcomes for people with SMI, SE policies must be integrated across employment, health and social welfare sectors and take account of the country-specific context of these sectors.

Cross-country comparison of SE programmes provides useful insights into their dependence on the national context and favourable economic circumstances. Burns and Catty (2008) report on a randomised controlled trial (EQOLISE) of IPS versus high-quality train-and-place vocational rehabilitation in six European countries (Netherlands, United Kingdom, Italy, Bulgaria, Germany and Switzerland) with very different labour market and health and social care conditions. A sample of 312 individuals with psychotic illness were included in the study conditional on a minimum of two years illness duration, with at least one year of continuous unemployment and six months contact with their current mental health services. The study found that after a follow-up of 18 months almost half (54.5%) of the IPS participants worked for at least one day compared to just over one-quarter (27.6%) of the vocational service patients. IPS participants were also significantly less likely to have been re-hospitalised. However, the success of the IPS intervention was

not independent of external economic factors with a significant amount of the variation in IPS effectiveness explained by local unemployment rates and both national economic growth and welfare systems influencing overall employment rates in both services. Knapp et al. (2013) investigated the cost-effectiveness of the EQOLISE trial using two primary outcomes: additional days worked in competitive settings and additional percentage of individuals who worked at least one day. The analysis found that IPS produced better outcomes than alternative train-and-place vocational services at lower cost overall to the health and social care systems. This pattern also held in disaggregated analyses for five of the six European sites (the exception was the Netherlands). The authors conclude that compared to standard vocational rehabilitation services, IPS is, therefore, probably cost-saving and almost certainly more cost-effective as a way to help people with severe mental health problems into competitive employment (Knapp et al., 2013).

Employment policies must recognise important factors that lead to significantly better work outcomes

Improved work outcomes are related to a range of socio-demographic, work-related, illness-related and person related variables. In order to improve employment outcomes of people with SMI it is necessary that employment policies take account of these factors and adopt a multifaceted approach. In terms of socio-demographic factors educational status plays an important role; the higher the education, the better is the employment prognosis for vocational rehabilitation. As noted earlier, SMI is characterised by early onset which can impact on educational achievement. Thus, early intervention and preventative efforts are often concentrated in schools (see Chapter 6). The findings on age are mixed and may depend on the specific mental disorder, but often a young age is found to lead to better employment outcomes while the role of gender is unclear (OECD, 2012). Employment history appears to play an important role with higher pre-illness employment and social functioning associated with better work outcomes while social skills are another crucial element of successful employment uptake and retention (OECD, 2012). Finally, illness-related factors impact heavily on employment outcomes. A later onset and shorter illness duration is associated with a better outcome. In terms of diagnosis, schizophrenic disorders have an especially poor prognosis and affective disorders a better prognosis – though a weakness of the research is its concentration on schizophrenia, which has a very low prevalence in the population. Illness symptoms are also predictive with sudden excessive symptoms positively associated with work outcomes compared with a steadily increasing loss of cognitive capacities for example. Cognitive deficits, more generally, are a negative predictive factor in vocational rehabilitation, especially deficits in the working memory, but also in general intelligence and social cognition abilities. However, this is probably a result of the schizophrenia bias in rehabilitation research. The vast impact of illness-related factors on employment outcomes provides a strong impetus for the integration of vocational rehabilitation into specialised mental health treatment (OECD, 2012). Improved integration will also benefit from a range of non-vocational outcomes for people with SMI that are positively associated with employment and paid work such as reduced re-admissions and improved symptom improvement, self-esteem and cognitive performance.

3.6. Conclusion

High rates of physical co-morbidity in people with SMI are the culmination of multiple factors which necessitate a concerted change in attitudes and behaviours on the behalf of both patients and mental health professionals, as well as enhanced integration of physical

and mental health care. All OECD countries should take further steps, such as those outlined, to address the unacceptably high rate of physical ill-health amongst populations with SMI. There is scope for GPs to undertake some tasks relating to the ongoing care and treatment of people with SMI and good co-ordination between primary and specialist care is essential to ensuring that care is effective, efficient and of high quality.

In many OECD countries, the majority of specialist mental health care is delivered in community-based settings by multi-disciplinary teams with inpatient care mainly reserved for people in need of high-intensity support. Nevertheless, there are wide variations in psychiatric care beds between OECD countries, and inpatient care plays a greater role in care delivery in some countries than others. Despite enhanced integration in the delivery of mental health care between outpatient (including primary care) and inpatient settings, provider payment still remains highly fragmented with different systems in different settings. There is a particular need for countries to move towards payment systems that are independent of care setting for specialised care in order to provide appropriate incentives to maintain a balanced system of care. Good data on costs and outcomes is essential to the successful design and implementation of such systems. Payment systems for primary care providers can incentivise the ongoing management of mental disorders, promote continuity and co-ordination of care and support better treatment of physical illness in people with SMI. Improving the physical health of people with SMI will also lead to increased employability and productivity and enhance the effectiveness of vocational rehabilitation and training programmes for this group.

Notes

1. The Japanese mental health system is also characterised by the large private sector share in provision – more than 80% of the psychiatric services are provided by the private psychiatric sector in Japan (Ng et al., 2010).
2. During the three-year transitional period (2005-08) a minimum income guarantee was paid to existing providers to ensure that their total PPS payments were no less than 70% of the payment received under the previous "reasonable cost" scheme.

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ANNEX 3.A1

Definitions of mental health care facilites and community teams

For the purposes of cross-country comparisons in this chapter the following definitions are employed (adapted from OECD Mental Health Questionnaire 2012):

Mental health outpatient facility: A facility that specifically focuses on the management of mental disorders and related clinical problems on an outpatient basis. These facilities are staffed with health care providers specifically trained in mental health (WHO, 2011).

Mental health day treatment facility: A facility that provides care for users during the day. The facilities are generally available to groups of users at the same time and expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff and/or participate in therapy activities. Attendance typically ranges from a half to one full day (4-8 hours), for one or more days of the week (WHO, 2011).

Psychiatric ward in a general hospital: A ward within a general hospital that is reserved for the care of persons with mental disorders (WHO, 2011).

Community residential facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions (WHO, 2011).

Mental hospital (psychiatric hospital): A specialised hospital-based facility that provides inpatient care and long-stay residential services for people with severe mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialisation varies considerably; in some cases only long stay custodial services are offered, in others specialised and short-term services are also available (WHO, 2011).

Community-based psychiatric inpatient unit: a psychiatric unit that provides inpatient care for the management of mental disorders within a community-based facility. These units are usually located within general hospitals, but sometimes some beds are provided as part of a community centre. Community-based beds mostly provide care to users with acute problems, and the period of stay is usually short (weeks to months) (WHO, 2008).

Forensic units: forensic units care for people with mental disorders who have come into contact with the criminal justice system. They may also be called secure units or special hospitals (WHO, 2008).

Community Mental Health service/Community Mental Health Team (CMHT): secondary or specialist care (care that cannot be provided by a primary care physician). At its most basic, it may be office-based private care or, more often, outpatient clinic (polyclinic) provision for assessing and treating mental illness by a trained mental health professional (such as a psychiatrist or psychologist). It can also be provided by a multidisciplinary team (community mental health team) comprising psychiatrists, mental health nurses and often psychologists and social workers. They usually provide care for the inhabitants of a clearly defined catchment area (such as a borough or town). Care is provided in a variety of settings (such as clinics, people's homes and day centres). An alternative structure is the community mental health centre, where several teams run a range of services, one of which is assessment and care outside the hospital (WHO, 2008).

Assertive outreach treatment (AOT): community-based services that work intensively over time with people with complex mental health needs addressing mental health, physical health and social needs (WHO, 2008).

Secure psychiatric beds "Secure mental health services provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public. Sometimes known as "forensic" mental health services, secure services work predominantly with people who have been imprisoned or admitted" directly to hospital through the 1983 Mental Health Act following a criminal offence (Centre for Mental Health, 2011).

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Chapter 4

Improving quality measurement and data collection for mental health

Mental disorders account for a large burden of disease and addressing unmet need by delivering high-quality targeted interventions will greatly improve the outcomes and efficiency of mental health services. Mortality indicators such as suicide and premature mortality provide important information on mental health status and the interplay of mental and physical health, but more specific indicators are necessary to reflect the quality of mental health care. Measuring and improving the quality of mental health care is a key challenge not least given the need to capture complex care pathways and encompass a range of outcomes. Numerous ongoing and completed projects seek to measure and benchmark the quality and outcomes of mental health care at an international level in spite of the many challenges faced by such endeavors. Moreover, considerable progress in developing quality and outcomes indicators as well as mental health targets and standards has occurred at a national level. Better quality and outcome indicators are crucial for measuring and improving the quality and efficiency of mental health care yet progress in developing such data has fallen far behind other disease areas.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

4.1. Introduction

Information on the quality and outcomes of mental health care services is inadequate. This chapter assesses the development of collection of information on mental health prevalence, and the development and use of indicators of the quality and outcomes of mental health services. As outlined in Chapters 2 and 3 mental disorders comprise a large burden of disease, yet a large treatment gap exists, and a first step in reducing this treatment gap is to systematically measure the prevalence of mental disorders using tools such as surveys, as well as data on mortality from suicide, a loose proxy measure for population mental health. Increased information on the burden of mental ill-health, for example using population surveys, can inform potential need for services, as well as contribute to improving service design and delivery. However, the identification of mental ill-health is futile without adequate high-quality treatment. Indicators of mental health care quality and outcomes are already used by some OECD countries, but remain largely limited to hospital-based care. Further development of the data infrastructure for mental health systems is needed; indicators should reflect whole treatment pathways, as well as life domains such as accommodation and social integration as well as societal and economic benefits such as physical health, education, employment and public safety.

The importance of measuring the quality of mental health care cannot be understated. Overwhelming international evidence suggests that health care is often not delivered in accordance with evidence-based and commonly agreed professional standards, resulting in poor quality and unsafe care that harms tens of thousands of people every year, and the squandering of scarce health care resources (OECD, 2010a). Unfortunately mental health care is not exempt from this problem, with far-reaching and considerable consequences for individuals, families and society. Deficiencies in the quality of (mental) health care can result at all levels of care and cross sectors. There may be problems in the organisation of care, access, capacity, poor co-ordination and poor decision support for clinicians (for example due to a lack of clinical guidelines). Poor care may also be due to factors outside the immediate care delivery environment, such as policy, payment and regulation. The grave consequences of poor quality and ineffective care create an impetus to improve measurement and ultimately performance (IOM, 2006). Good information on the quality of mental health care is essential to prevent poor quality of care occurring and improve the quality of care when deficiencies become apparent.

4.2. The epidemiological burden of mental ill-health: Using surveys and mortality indicators to collect information on prevalence and need

Mental disorders represent a considerable disease burden, and have a significant impact on the lives of the OECD population. There is a need to systematically measure the prevalence of mental disorders in order to address the significant unmet need for treatment. Driven by frequent under-supply of mental health services, especially for mild-to-moderate mental disorders, combined with stigma and a lack of awareness and understanding of mental illness, a substantial proportion of mental disorders in OECD countries go undiagnosed and

un- or under-treated. However, the burden of mental ill-health is challenging to measure, especially across countries, and efforts to measure the prevalence of mental disorders, and the burden of mental disorders, vary across OECD countries.

Surveys are a useful tool to inform and improve mental health services

Population surveys are an underutilised tool for informing policy makers on the state of mental health of the population, and to inform improvements in mental health services. Countries have not been successful at addressing unmet need partly because it is so difficult to identify and quantify. A starting point to identifying unmet need is household surveys that use a variety of screening instruments to identify individuals at risk of or suffering from mental health problems. These instruments are not standardised, however, and estimates of the prevalence of mental health problems can vary widely within the same population.

National and international health surveys can be used to estimate the burden of mental ill-health in OECD countries. Such surveys suggest that around 5% of the working-age population have a severe mental disorder and a further 15% have a common mental disorder (OECD, 2012). Some, but not all, OECD countries report having a national survey to measure the prevalence of mental disorders (Table 4.1).

In Australia the National Survey of Mental Health and Wellbeing is used to measure prevalence of mental ill-health. The Survey includes three main components – a population-based survey of adults, a service-based survey of people with low-prevalence psychotic disorders, and a population survey of children. The 2007 National Survey of Mental Health and Wellbeing was conducted by the Australian Bureau of Statistics from August to December 2007. The survey collected information from approximately 8 800 Australians aged 16-85 years. The survey provides information on the prevalence of selected lifetime and 12-month mental disorders by three major disorder groups: anxiety disorders (e.g. social phobia), affective disorders (e.g. depression) and substance use disorders (e.g. alcohol harmful use). The survey also provides information on the level of impairment, the health services used for mental health problems, physical conditions, social networks and caregiving, as well as demographic and socio-economic characteristics.

The Canadian Community Health Survey contains a mental health component on an annual basis with questions related to positive mental health, depression and suicidal thoughts and attempts. In 2012, the Canadian Community Health Survey (Area Specific Version) focused on mental health. The focus on mental health resulted from a number of criteria such as data gaps identified by stakeholders, the significant number of people affected by mental health and the significant impact on family, community and health care costs. Moreover, mental health has been identified as a priority in terms of policy, research and surveillance requirements.

The Canadian Community Health Survey (CCHS) – Mental Health has a number of objectives including:

1. assessment of the mental health status of Canadians on both illness and positive mental health continuums through selected mental and substance disorders, mental health problems, and well-being;
2. assessment of timely, adequate, and appropriate access to and utilisation of formal and informal mental health services and supports as well as perceived needs;
3. assessment of functioning, ability and disability in relation to mental health and illness;

Table 4.1. **Instruments used to measure prevalence of mental disorders in OECD countries**

	Instruments to measure prevalence of mental disorders
Australia	The National Survey of Mental Health and Wellbeing includes three main components – a population-based survey of adults, a service-based survey of people with low-prevalence psychotic disorders, and a population survey of children.
Belgium	Minimal Psychiatric Data (only for residential care).
Canada	The Canadian Community Health Survey (Annual Cycle) has a mental health component; Canadian Community Health Survey – Mental Health (2012).
Chile	There is no national official survey for measuring mental disorders prevalence. However, university staff (Universidad de Concepción, Programa de Epidemiología Psiquiátrica) have developed various studies since 1990, using the WHO Composite International Diagnostic Interview (CIDI), and CIDI II instruments, which provide a rather good national representation, and have been used as a reliable source.
Czech Republic	Health care statistics, surveys.
Finland	Some population studies made by Institute for Health and Welfare (THL) provide information about mental health prevalence. The survey-based population studies draw on information reported by the research subjects themselves. Some of the population studies include also information from health examinations. These studies use both questionnaires and measurements performed by nurses on the research subjects.
Germany	National prevalence of mental disorders is measured by surveys under the resposibility of the Robert Koch Institute.
Hungary	Hungarian Epidemiological Panel (2002-06); Hungarian Central Statistical Office (annual); 2086 Report of the psychiatric outpatient network; 2105 Report on the care of drug users; 2088 Report on the care of patients with addiction.
Ireland	The prevalence of mental disorder in the general population is not obtainable. However the Health Research Board (HRB) conducted a survey in 2009 of mental health and associated health services on the island of Ireland. This was based on a telephone survey.
Israel	True prevalence: national surveys on the young and adults. Treated prevalence: inpatient services.
Italy	The Cnesps and the ISS have recently (October 2012) published the outcomes of a national survey conducted across a pool of ASLs across regions. The survey aimed at measuring the percentage of people (adults and old people) suffering from depression and being socially excluded.
Japan	National surveys such as patient surveys.
Korea	WHO CIDI (Korean version).
Mexico	1) National Survey on Psychiatric Epidemiology; 2) National Comorbidity Survey-Adolescents Supplements; 3) Information System Report on Drugs; 4) National Addictions Survey.
Netherlands	A periodic prevalence survey carried out by the Trimbos Institute.
New Zealand	Te Rau Hinengaro: The New Zealand Mental Health Survey.
Poland	Measurement of prevalence is based on number of admissions to in and outpatient care facilities.
Slovak Republic	Persons with mental disorders treated in primary health care, interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders, persons treated in mental health outpatient facilities, admissions in general hospitals with psychiatric beds, admissions in mental hospitals.
Switzerland	The Federal Ministry of Statistics collects and processes data from different sources (surveys and clinical ratings).
Turkey	Surveys and reports on suicide.
United Kingdom (England)	Most data comes from Health and Social Care Information Centre, the organisation commissioned by DH to collect national statistics. Current routine information collected are: National Mental Health Minimum Dataset (NMHMDS); Improving Access to Psychological Therapy Performance Indicators; Hospital Episode Statistics; Community Mental Health Teams Activity Collection (data is currently obtained from two sources, DH Unify2 and H&SC IC Omnibus collections. From April 2013 IC will collect data via MHMDS). Surveys managed and published by NHS IC: Health Survey for England (GHQ12- Assessment of Psychological health) (National level); Adult Psychiatric Morbidity Household Survey (conducted once every seven years) (National and Regional level data).
United States	National Co-Morbidity Survey; National Survey of Children's Health; National Survey of Child and Adolescent Well-Being; National Institute on Drug Abuse (NIDA) Monitoring the Future Survey.

Source: OECD Mental Health Questionnaire 2012.

4. examination of the links between mental health and social, demographic, geographic, and economic variables or characteristics (covariates); and
5. evaluation of changes in patterns of mental health, service use, and functioning from the 2002 CCHS on Mental Health and Well-being.

The survey covers the population 15 years of age and over living in the ten provinces with a sample size of approximately 27 000 respondents.

In Finland, a number of population studies made by Institute for Health and Welfare (THL) provide information about mental health prevalence. The survey-based population studies draw on information reported by the research subjects themselves. Some of the population studies also include information from health examinations. These studies use both questionnaires and measurements performed by nurses on the research subjects.

In Germany, the Robert Koch Institute undertakes surveys that measure national prevalence of mental disorders. Data for the population aged 18 to 65 years is available from the "Bundesgesundheitssurvey 1998", the German Health Update (GDA) and the German Health Interview and Examination Survey for Adults (DEGS). Data for the agegroup 0 to 17 years is gained since 2003 via the German Health Interview and ExaminationSurvey for Children and Adolescents (KiGGS).

In Switzerland, the Federal Ministery of Statistics collects and processes data from different sources such as surveys and clinical ratings. The United States collects data on national prevalence of mental disorders in numerous surveys including: National Co-Mordibity Survey; National Survey of Children's Health; National Survey of Child and Adolescent Well-Being; and the National Institute on Drug Abuse (NIDA) Monitoring the Future Survey.

There is some variation in survey methods and coverage across OECD countries, making cross-country comparison very difficult. For example, in Korea the survey samples households but excludes psychiatric inpatients. Australia, on the other hand, developed a survey to cover populations in touch with specialist mental health services – the *People Living with Psychotic Illness* survey. In the absence of relevant surveys, some countries measure prevalence using utilisation of services as a proxy. In Poland, for example, prevalence is calculated based on the number of admissions to in and outpatient facilities. The Slovak Republic also proxies prevalence based on treatment in primary and secondary care. However, measuring prevalence of mental disorders by quantifying service use is unreliable, and often underestimates the total burden of mental disorders in a given health system. Therefore some countries complement treated prevalence with information from national survey. The Trimbos Institute in the Netherlands conducted a large survey twice in order to measure the national mental health prevalence among adults with the most recent carried out in 2010. Prevalence is also estimated by the use of mental health services, which results in a lower rate, as many people with mental health problems do not seek or get appropriate care. Similarly in Israel, true prevalence is measured using national surveys on the young and adults while treated prevalence is estimated from use of inpatient services.

International estimates of the international cross-country prevalence of mental disorders do exist, but rely on projects such as the WHO World Mental Health Survey Initiative, which uses a standardised survey instrument. In 1998, the World Mental Health Survey Initiative undertook a cross-national survey using the WHO CIDI. They estimated prevalence rates for any disorder of between 12.2% (Turkey) and 48.6% (United States) (WHO International Consortium in Psychiatric Epidemiology, 2000). A 2008 update of this

survey, covering 28 countries, found an estimated lifetime prevalence of mental disorders between 18.1% and 36.1% (Kessler et al., 2009).

Surveys can play an important role in service design and planning

Surveys can also be used to inform planning around services, and highlight areas of particular prevalence and gaps in services. For example, in Australia the Early Psychosis Prevention and Intervention Centres (EPPIC) scheme was extended to young people to improve their access to mental health care. The motivation for doing this came from survey findings that 25% of people reporting mental disorders in Australia have their first mental ill-health episode before the age of 12, and 64% before the age of 21, and that a large treatment gap existed for this group. To take an example from Finland, when survey information highlighted groups with a particularly high suicide rate, suicide prevention was appropriately tailored towards these groups and successfully contributed to a reduced suicide rate.

Whilst surveys can be extremely useful tools for understanding the mental health burden in a country, the identification of the problem is insufficient if there is ineffective follow-through and referral to treatment. Investments in population-targeted surveys are most fruitful if such surveys are used to promote access to appropriate treatment, which necessitates investment and reflection around good referral and treatment pathways.

Mortality indicators can shed light on mental health status

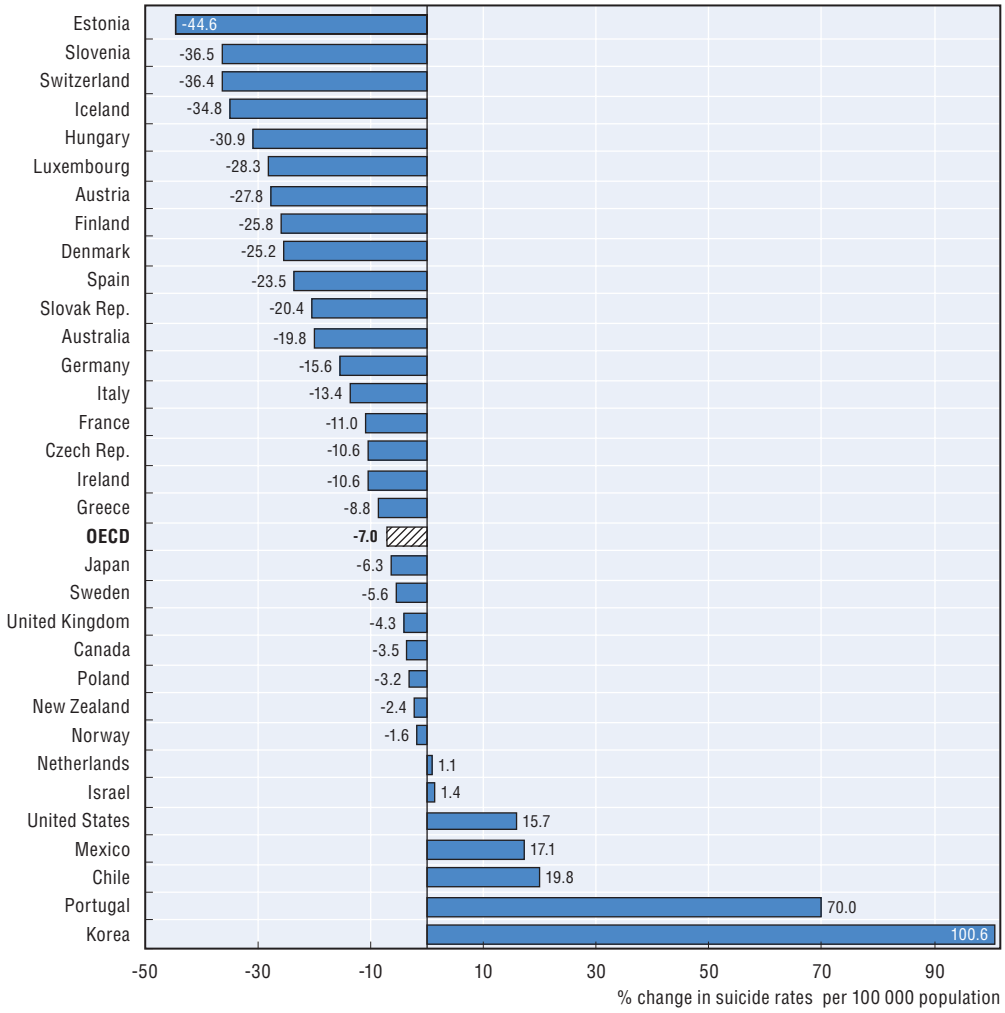
Mortality indicators, such as suicide and premature mortality, provide important information on mental health status and the interplay of mental and physical health. Mortality from suicide varies considerably across OECD countries and provides valuable insight into the mental health status of these populations. While indicators on premature mortality also offer further information on the mental health of populations covered, they are often used as an indicator of health care quality and treatment outcomes, and discussed later in this chapter.

Suicide is often used as a proxy indicator of the mental health status of a population. Suicide is the end-point of a number of different contributing factors. Suicide is evidence not only of personal breakdown, but also of a deterioration of the social context in which an individual lives. Suicide is more likely to occur during crisis periods associated with upheavals in personal relationships, through alcohol and drug abuse, unemployment, as well as with clinical depression or other forms of mental illness. Although used as a measure of mental health, many people who commit suicide have not been in touch with (mental) health services. Therefore suicide prevalence can play an important role in better understanding of the weaknesses of the mental health system, in particular surrounding access to services and combating stigma. However, care should be taken when comparing data between countries – as several factors, both cultural and religious, systematically influence how suicides are reported (OECD, 2013a).

Suicide rates vary widely across OECD countries, with the highest rates in Asian countries such as Korea and Japan, and European countries such as Hungary and Finland, and the lowest rates in Southern European countries such as Greece, Italy and Spain (OECD, 2013b).

Whilst most OECD countries have seen decreasing suicide rates since 1995, with pronounced declines observable in Estonia, Austria, Slovenia and Finland, deaths from suicide have increased significantly in Korea – by just over 100% (Figure 4.1). Moreover, other disease areas such as cardiovascular disease have experienced more impressive improvements over a similar time frame, which suggests a relatively poor trajectory for mental health outcomes, and also great disparities in the mental well-being of the population in different OECD countries.

Figure 4.1. **Change in suicide rates, 2000 and 2011 (or nearest year available)**



Source: OECD (2013), *OECD Health Statistics 2013*, OECD Publishing, Paris, *www.oecd.org/health/healthdata*.

StatLink http://dx.doi.org/10.1787/888933030515

4.3. Filling gaps in the information to help drive improvements in the quality of mental health care

Improving the quality of mental health care is a key challenge that must be acknowledged and met by policy makers in OECD countries. Instrumental to any improvements is good information on the quality of mental health care, and on patient outcomes.

Appropriate quality measures for mental health care

Defining and agreeing what high quality of care is and determining which salient measures can capture this concept is not a simple task. Mental health problems can be complex and multi-factorial in nature and thus can require multifaceted interventions and approaches involving different agencies and sectors. For example, health services may well work with other sectors such as social welfare services, employment, education and housing. Additionally, mental health service users may find it more difficult to participate in shared decision making as a result of the problems they are experiencing, and importantly as a result of staff attitudes and behaviours. This may lead to under reporting of adverse

effects. Involuntary treatment not only has implications for patient decision making and control over care, but also makes measuring performance and quality of care vital and more complex (Pincus et al., 2011). Critically, defining high-quality care involves having an agreed conceptual framework with users and carers as well as professionals.

Co-morbidity between mental disorders and substance abuse and physical ill-health are common. The frequently found separation between physical and mental health care systems can lead to discontinuities and a lack of co-ordination of care. It can also make defining and measuring quality more difficult.

Developing and measuring salient quality outcomes within this complexity is difficult, but not impossible, and some promising steps towards establishing appropriate indicators of mental health care quality have been made. However, there remains an urgent need for further development of quality indicators for mental health care, which should be used to drive improvements in care.

Re-admission rates are a commonly used indictor of the quality of inpatient care

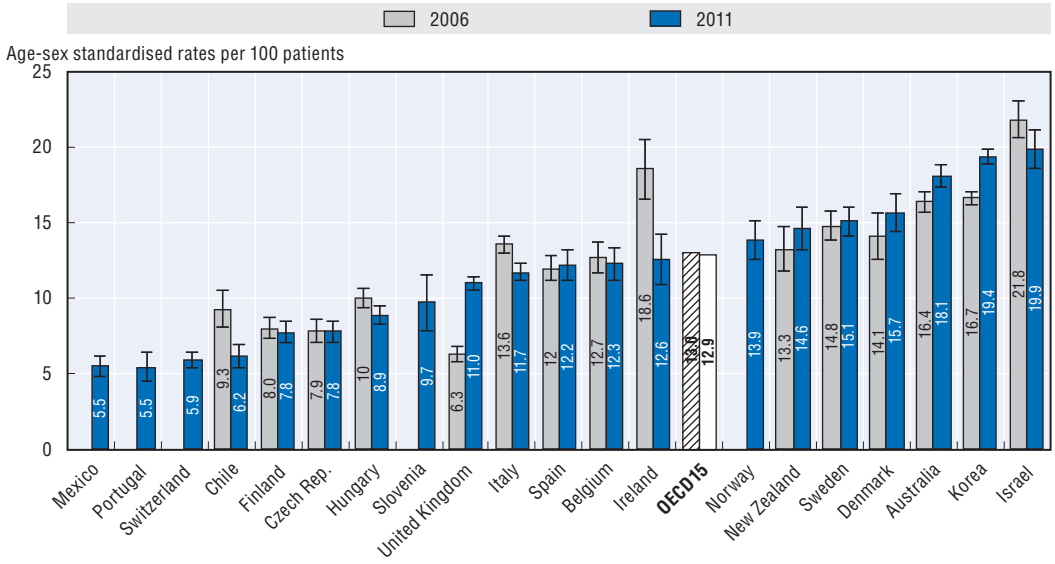
Patients with severe mental disorders still receive specialised care at hospitals, but in de-institutionalised settings good care should also be provided in the community. If appropriate and co-ordinated follow-up is provided after discharges, patients are not usually re-admitted to hospital within 30 days. A high rate of unplanned re-admissions is therefore an indicator of the quality of several dimensions of the mental health system. In order to monitor quality of mental health care and mental health system performance, unplanned 30 day hospital re-admission rates are used by organisations in various OECD countries such as the Canadian Institute for Health Information, the Care Quality Commission in the United Kingdom and the National Mental Health Performance Monitoring System in the United States.

Schizophrenia re-admission rates to the same hospital varied substantially across countries in 2011 (Figure 4.2). In Israel and Korea around 19 per 100 patients with schizophrenia were re-admitted to the same hospital within 30 days. In Korea, this relatively high rate is likely due to poor transition planning and a lack of access to effective outpatient care or a low admission threshold. In contrast, the percentage of patients with schizophrenia re-admitted to the same hospital within 30 days is relatively low in Mexico, Portugal and Switzerland at less than six per 100 patients.

The pattern of re-admissions within 30 days is similar for patients with bipolar disorder, with Israel again reporting the highest rates in both 2006 and 2011 (Figure 4.3). However, the bipolar disorder re-admission rate is lower than that recorded for schizophrenia disorder. Similarly, Portugal reports the lowest re-admission rate for bipolar disorder at 4.5 per 100 patients which is again lower than that reported for bipolar disorder. There is no clear trend across countries regarding the change in re-admission rates between 2006 and 2011 for either bipolar or schizophrenia disorders.

Re-admission rates need to be interpreted with care, taking into account the prevalence of these disorders and the characteristics of mental health systems. While the international comparability of data on re-admission rates is somewhat limited, it is nevertheless highly desirable that countries can produce these indicators on a national basis to gain insights into the quality of mental health care. A high or rising unplanned re-admission rate may represent an inadequate provision of mental health support in the community. It may also represent inadequate inpatient care during the index admission, in particular in relation to adequate discharge preparedness (Durbin et al., 2007). However, it can also be interpreted

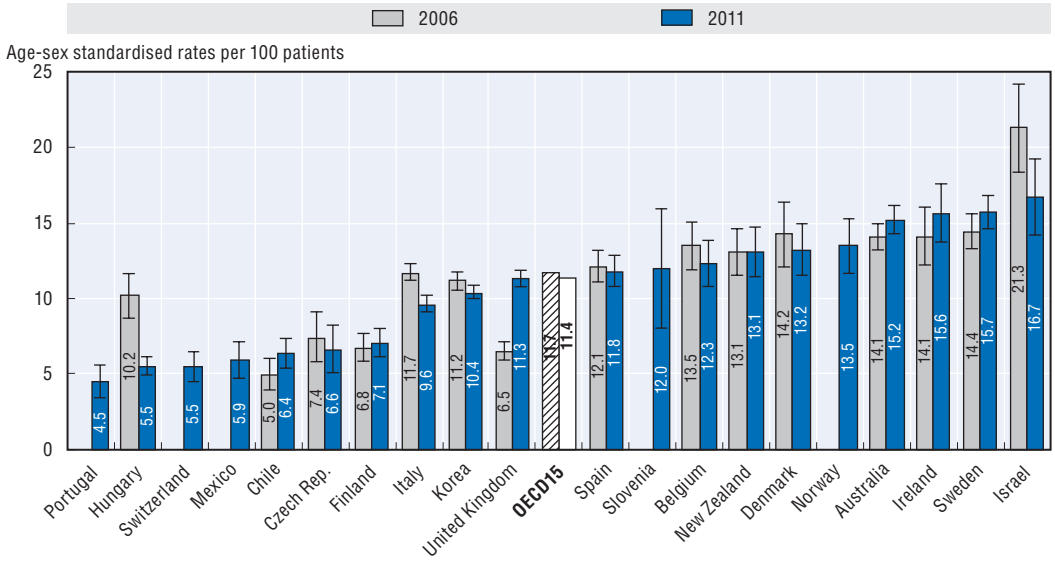
Figure 4.2. **Schizophrenia re-admissions to the same hospital, 2006 and 2011 (or nearest year available)**



Note: 95% confidence intervals represented by H.
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030534

Figure 4.3. **Bipolar disorder re-admissions to the same hospital, 2006 and 2011 (or nearest year available)**



Note: 95% confidence intervals represented by H.
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030553

as representing good quality of care in that timely access to an appropriate and safe mental health place or hospital bed is provided in a crisis situation (Healthcare Commission, 2005).

It is very difficult to interpret re-admission indicators without data on length of inpatient stay and utilisation of community services. Previous research does not provide conclusive evidence on the relationship between length of stay and re-admission rates.

Shorter initial hospital stays have been shown to be related to higher rates of re-admission (Capdevielle et al., 2009, CIHI, 2008; Lin et al., 2006). Similarly, Systema et al. (2002) report that a longer length of stay is associated with a lower risk of re-admission while the risk of re-admission increases with more previous admissions. A higher re-admission risk was also associated with a higher use of outpatient care and use of day-patient care suggesting that high users of inpatient facilities tended also to be high users of community services and a high risk of re-admission was not necessarily associated with a low uptake of community resources. Conversely, Korkeila et al. (1998) report that an increased risk of multiple re-admissions is associated with a long length of stay as well as previous admissions and diagnosis of psychosis or personality disorder.

Inpatient suicide or suicide after discharge has been used as an indicator of treatment outcomes

Psychiatric illness is a major risk factor for suicide and it has been estimated that 90% of suicide attempters and completers suffer from at least one, mostly unrecognised, untreated, or inadequately treated mental illness, most frequently major depressive episode (56-87%), substance use disorder (26-55%) or schizophrenia (6-13%) at the time of their act (Gonda et al., 2012). It can, however, be argued that suicide rates are not always a good measure of the quality of mental health care *per se* because some people who commit suicide have never been in contact with mental health services. Hence, it is necessary to also consider other indicators related to suicide such as inpatient suicide or suicide following discharge.

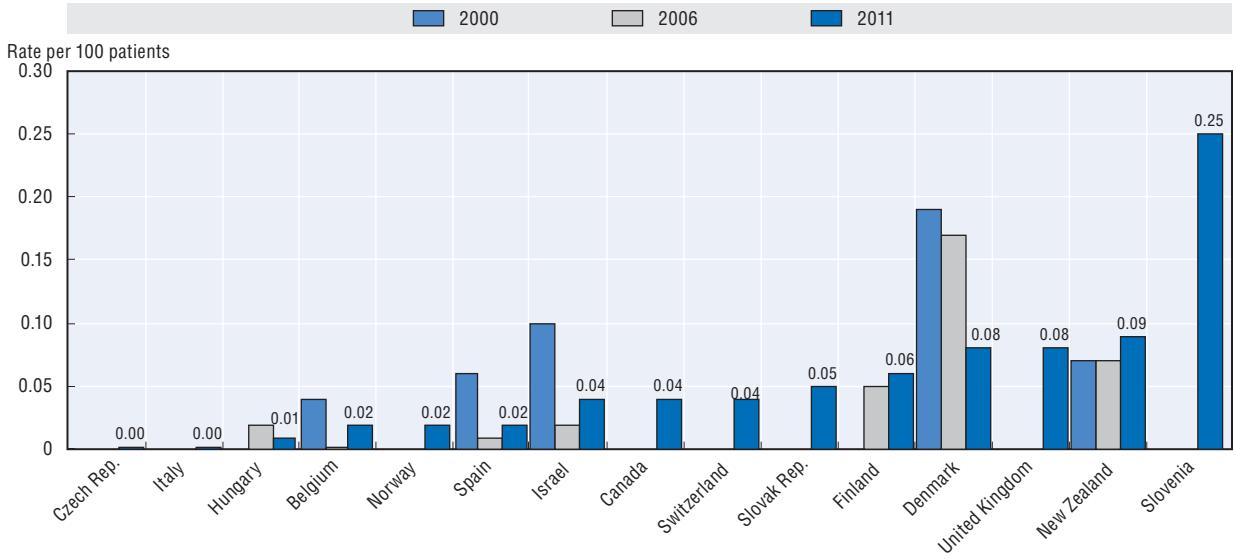
A psychiatric illness that necessitates hospitalisation is one of the strongest risk factors for suicide. Patients admitted to psychiatric hospitals have increased rates of suicide in comparison with the rate in the general population (Pirkola et al., 2005; Sharma et al., 1998; Hunt et al., 2012). This increased risk of suicide among patients with mental disorders that require inpatient care has been estimated as being ten-fold higher than in the general population.

Figure 4.4 compares data on rates of inpatient suicides among patients diagnosed with schizophrenia or bipolar disorders among selected OECD countries for the years 2000, 2006 and 2011. Overall, rates are low with countries reporting less than one death per 100 patients indicating that inpatient suicide among patients with schizophrenia and bipolar disorders is a rare event. In 2011, Slovenia had by far the highest rates at 0.25 per 100 patients which Italy and the Czech Republic record rates of 0.00 per 100 patients (Figure 4.4.). For countries that could provide time-series data, in general, rates of inpatient suicide have generally fallen between 2000 and 2011 with Denmark experiencing the most dramatic decreases. In contrast, rates have increased between 2006 and 2011 in Finland and New Zealand (Figure 4.4).

However, inpatient suicide alone does not present a full picture. For example English data show that over half the suicides among people in contact with specialist mental health services occur outside hospital, reflecting the shift in mental health care towards the community. Indicators related to suicide such as inpatient suicide or suicide following discharge can give a clearer impression of medium-term outcomes following inpatient care, but in most cases cannot be used to assess community care experiences, which are becoming increasingly dominant in OECD countries.

Evidence suggests that the risk of suicide in the first year after discharge from psychiatric inpatient care is much greater than that for the general population (Goldacre et al., 1993; Hoyer et al., 2009). The initial part of this time period deserves particular

Figure 4.4. **Inpatient suicides among patients diagnosed with schizophrenia or bipolar disorder, age(-sex) standardised rate per 100 patients, 2000, 2006 and 2011 (or nearest year available)**



Note: Data for Israel refers to 2009. Data for Belgium, New Zealand and Switzerland refer to 2010.
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030572

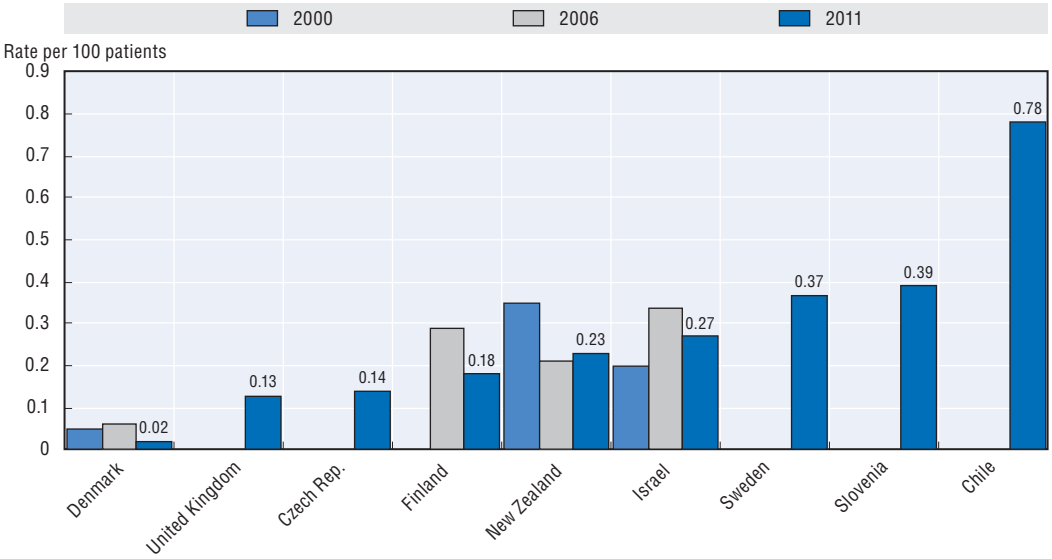
attention as the first month and especially the first week of discharge is exceptionally high-risk (Goldacre et al., 1993; Pirkola et al., 2005). Suicide after discharge from inpatient care reflects the degree of follow-up and co-ordination between inpatient and community-based care settings. Again, this underlines the need for linked data in order to fully measure and understand mental health care quality.

Figure 4.5 displays data on deaths after discharge from suicide among patients diagnosed with schizophrenia or bipolar disorder among selected OECD countries for the years 2000, 2006 and 2011. As with inpatient deaths from suicide, deaths after discharge from suicide are generally low – less than one in 100 patients – for the countries that could provide this data. In 2011, Chile had the highest rate while Denmark had the lowest rate. Among countries with time-series data, rates tended to be lower in 2011 compared to previous years.

Premature mortality of serious mental illness (SMI) has been used as a treatment outcome indicator

Premature mortality is another important population mental health outcome. Individuals with schizophrenia and other severe mental illnesses have higher age and sex-adjusted mortality rates than members of the general population. Data from England show a premature mortality rate among people with SMI that is three-fold higher compared with the general population. Similarly, research from the Nordic countries revealed that people admitted to hospital for a mental disorder had a two-to-three fold higher mortality than the general population with this gap in life expectancy more pronounced for men than for women (Wahlbeck et al., 2011). Evidence from Australia has revealed a life expectancy gap of almost 16 years for males and 12 years for females with psychiatric disorders and these gaps have increased over time (Lawrence et al., 2013). A large proportion of excess

Figure 4.5. **Deaths after discharge from suicide among patients diagnosed with schizophrenia or bipolar disorder, age(-sex) standardised rate per 100 patients, 2000, 2006 and 2011 (or nearest year available)**



Note: Data for Israel refers to 2009. Data for Chile and New Zealand refer to 2010.
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

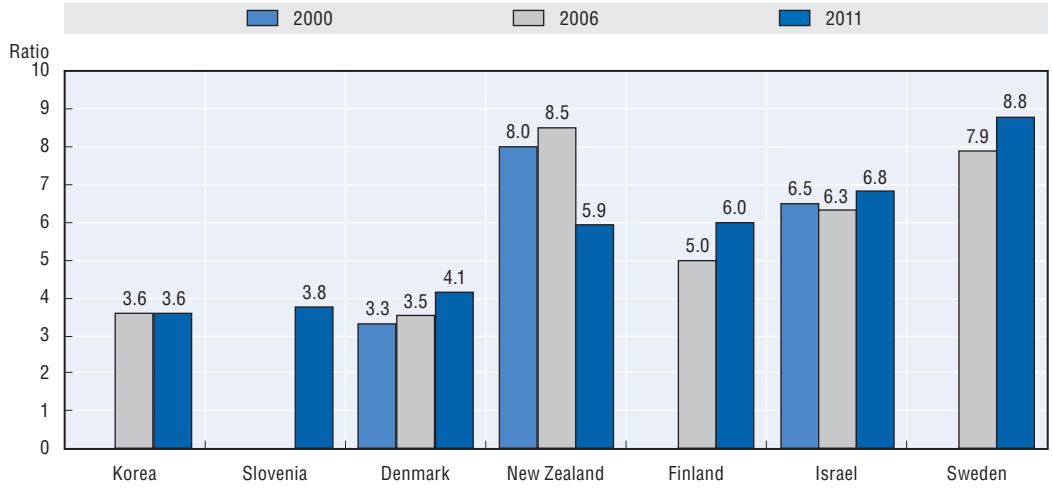
StatLink http://dx.doi.org/10.1787/888933030591

deaths were attributed to physical health conditions including cardiovascular disease (29.9%) and cancer (13.5%) while suicide accounted for 13.9% of access deaths. A similar finding is reported by Parks et al. (2006) who report that people with serious mental illness die on average 25 years earlier than the general population with physical conditions are responsible for the majority of excess mortality. An Israeli study investigated the overall mortality and selected natural and external causes of death by age, gender and mental health-related variables among persons who were ever admitted to psychiatric inpatient services (Haklai, 2011). Results revealed that the age-adjusted mortality rate of hospitalised psychiatric persons was double that of the non-hospitalised. The highest mortality rate ratios were found for external causes of death, in particular suicide but natural causes also showed higher risk with the exception of malignancies. One-third of all deaths and 62% of suicides occurred before discharge or within a year from discharge underlying the increased risk of suicide faced by individuals who have been hospitalised or recently discharged from inpatient care.

Co-morbidity is a key contributor to premature mortality as studies in some countries have found medical conditions to be under-detected and under-treated among individuals with psychiatric conditions (see Section 3.2 in Chapter 3). Again, this reflects the failure of current policies to adequately promote co-ordination with the general health system. There is also a clear need for evidence-based interventions that can reduce excess mortality which may include smoking reduction or cessation in people with mental illness, or specific lifestyle programmes that seek to modify risk factors for cardiovascular, respiratory, and malignant diseases (Thornicroft, 2013). Improved access to health care and prevention of suicides and violence are also necessary to further reduce the life expectancy gap (Wahlbeck et al., 2011).

The construction of indicators on premature and excess mortality among people with mental illness usually requires the linkage of datasets such as mortality data, psychiatric case registries, and hospital inpatient or other mental health service utilisation data. At present, few countries regularly undertake these types of data linkage so there is limited cross-country evidence on excess mortality. However, a small number of OECD countries succeeded in submitting such data to the OECD HCQI project. Figure 4.6 shows excess mortality from schizophrenia disorder for selected OECD countries in 2006 and 2011 while Figure 4.7 shows excess mortality for bipolar disorder in 2006 and 2011. Excess mortality is measured as a ratio of the mortality rate of patients with a mental disorder to that of general population and is aimed to account for the excess mortality by all

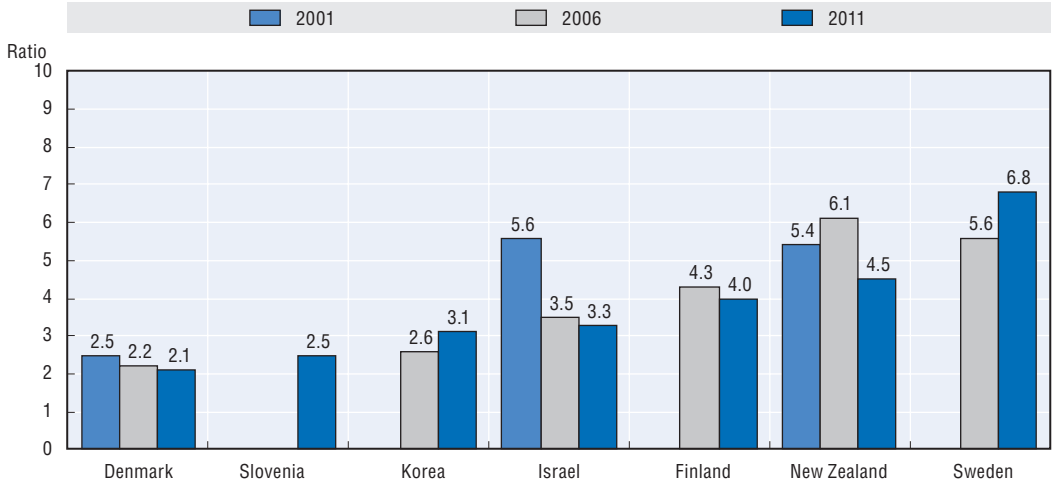
Figure 4.6. **Excess mortality from schizophrenia, 2006 and 2011 (or nearest year available)**



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030610

Figure 4.7. **Excess mortality from bipolar disorder, 2006 and 2011 (or nearest year available)**



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030629

causes attributable to a diagnosis of schizophrenia or bipolar disorder. A comparison of Figures 4.6 and 4.7 shows that the excess mortality ratio is greater for schizophrenia disorder compared to bipolar disorder. For example, in Denmark and Israel the excess mortality ratio for schizophrenia disorder is around twice that of the excess mortality ratio for bipolar disorder in 2011.

Excess mortality from schizophrenia increased from 2006 to 2011 in Denmark, Finland, Israel and Sweden while it decreased in New Zealand for the same years. In contrast to schizophrenia, excess mortality for bipolar disorder decreased from 2006 to 2011 in Denmark, Israel and Finland. Similar to schizophrenia, the excess mortality for bipolar disorder increased in Sweden from 2006 to 2011 but to a larger extent (21% increase for bipolar disorder versus 11% increase for schizophrenia disorder). Excess mortality for bipolar disorder also increased in Korea from 2006 to 2011. Similar to schizophrenia disorder, excess mortality for bipolar disorder decreased in New Zealand from 2006 to 2011 but to a lower extent (31% decrease for schizophrenia as opposed to 26% decrease for bipolar disorder).

Suicide and premature mortality are population mental health outcomes that are more relevant to severe mental illness. Hence there is a need to develop indicators of population mental health that also reflect mild-to-moderate mental illness.

4.4. Quality and outcome measures for mental health care must improve in order to catch up with other disease areas

Better quality and outcome indicators are crucial for measuring and improving the quality and efficiency of mental health care yet progress in developing such data has fallen far behind other disease areas. A number of factors are responsible for this lag including the complex nature of mental health problems, high rates of co-morbidity and lack of agreement on suitable measures. Stakeholder – in particular clinicians, patients and families – involvement and the integration of quality and outcome measurement into key processes of care are integral to ensuring mental health is at the forefront of high-quality services that are efficient and deliver value for money.

Improved measurement of the quality and outcomes of mental health care plays a crucial role in developing and implementing services that provide value for money. To understand mental health system performance at an international level, better measures of the quality and outcomes of mental health care are needed. Defining and agreeing what is a high quality of care and determining which pertinent measures can capture this concept is not a simple task and requires strong governance and leadership. Critically defining high-quality care involves having an agreed conceptual framework with users and carers such as that outlined in IOM (2006) as well as professionals. High rates of co-morbidities with substance abuse and physical illnesses, as already pointed out, can also make defining and measuring quality more difficult. Ideally, quality and outcome measures should encompass the entire patient experience, from first access in primary care (prescribing indicators) to secondary care (both inpatient and community-based) to follow-up measures to recovery measures. Information from population surveys to establish prevalence of mental disorders would then form an important backdrop to improved quality and outcome measures, giving an indication of the coverage of services.

Mental health care suffers from a less developed quality measurement infrastructure than general health care (IOM, 2006). Information technology (IT) tends to be under-developed and less widely adopted and used for clinical care support. There remains a need

to build information systems into psychiatric practice (Harding et al., 2011) and address weaknesses in current data systems that hinder the reporting and monitoring of quality of care measures (Herbstman and Pincus, 2009).

In 2008, the OECD assessed the availability of information to measure and compare quality of mental health care across OECD countries (Garcia-Armesto et al., 2008). The study found that the data sources most widely available across countries at the time were hospital administrative databases, national surveys and national registries. The absence of a Unique Patient Identifier (UPI) in many countries posed problems for constructing certain quality of care indicators, in particular those assessing continuity of care and quality of prescription or treatment in primary and community care. These are the settings where an increasing proportion of mental health care is provided in many OECD countries. Moreover, the study revealed the low level of integration of information systems across different levels of care provision which again has implications for assessing continuity of care.

More recent OECD work in this area reviewed the extent to which 20 countries participating in the OECD HCQI project have national mental health inpatient data and the infrastructure in place to support data linkages (OECD, 2013a). Seventeen countries reported mental hospital inpatient data is available at a national level while 14 of these countries reported using mental hospital inpatient data to regularly report on health care quality. Twelve countries reported that national mental hospital inpatient data contains a UPI number that could be used for record linkage. Five countries reported that national record linkage projects were used for regular mental health care quality monitoring. These results illustrate that considerable progress is needed in terms of having a comprehensive and well-designed infrastructure in place to measure the quality of mental health care across OECD countries. It is also worth emphasizing that inpatient data is generally better developed than data for community and other mental health care.

Quality indicators are more likely to focus on inpatient mental health care, and need to be expanded to reflect a greater diversity of care settings

A key challenge in mental health care is measuring quality across the entire care pathway, which requires integrated information systems. As a result, existing measures tend to be limited to inpatient care. Renewed attention must be given to the quality of community-based care including primary care and social outcomes. This may require additional investments in quality measurement infrastructure and consideration of issues pertinent to the construction of quality indicators. Such an endeavour is likely to result in numerous benefits given the multiple uses of quality indicators.

Mental health quality indicators are more likely to focus on inpatient mental health care because of better data availability. Despite a diversity of mental health care delivery settings and models, indicators reflecting care that spans inpatient and community-based care are in most cases under-developed. In order to accurately assess quality of care in the context of changing modes of delivery, a broader set of measures are needed to measure quality across the entire care pathway. Shifts in mental health care from institutions to the community have made it harder to track mental health care at the population level, as few countries have a health information infrastructure suitable for following patients across a variety of delivery settings. This has made it difficult for countries to track the quality of the entire mental health care pathway. The majority of OECD countries have detailed information on inpatient mental health care but lack the data and information

necessary to measure the quality of community-based care. People with mild-to-moderate disorders often go unrecognised and untreated, and so more attention is needed to improve identification of mild-to-moderate disorders, which are predominantly treated in community or outpatient settings, as well as tracking progress of quality of care. Quality of mental health care services needs to include not just the quality of specialist services, but also quality of primary care services, and quality of services supplied by other sectors, for example housing or employment services. However, there is often an inability to avoid choosing indicators for quality benchmarking that reflect the data source that is available rather than optimal measures of quality of care, which has perpetuated reliance on inpatient orientated indicators, rather than reflecting the shift in the care delivery patterns. It is crucial that once optimal quality measures have been agreed upon, there is a commitment to work towards collecting these data.

Quality and outcome indicators for primary care

There are several domains that can be used for measuring the quality of primary mental health care including access, comprehensiveness, continuity, co-ordination, effectiveness, efficiency and equity (Gask et al., 2009, Druss et al., 2008). Gask et al. (2009) outline key interventions to improve the quality of primary health care.

As Chapter 3 highlights, GPs and other primary care professionals can play a key role in the management and treatment of both the physical and mental health needs of people with SMI, and thereby improve the comprehensiveness, continuity and co-ordination of care. The establishment of registers and regular assessment of people with SMI in primary care can help to reduce the burden of physical illness and improve the quality of care (Holt et al., 2009; Gask et al., 2009). Yet it is exceedingly rare in OECD countries that primary care providers are required to keep a register of people with mental disorders (Table 4.2).

Financial interventions can promote the efficiency and equity with which mental health care is delivered in primary care settings and hence improve quality. In Australia, the Mental Health Nurse Incentive Programme (MHNIP) provides payments to community-based general practices to engage mental health nurses to assist in the provision of co-ordinated clinical care for people with severe mental health disorders and has been shown as successful in improving patient outcomes (see Chapter 3). In the United Kingdom, the Quality and Outcomes Framework (QOF) has incentivised GPs to increase care provision for depression and SMI on a range of indicators (see also Chapters 2 and 3) but there is currently a lack of evidence regarding whether changes in the process of care has led to better patient outcomes (Gask et al., 2009).

Developing primary care-level indicators is an essential step towards capturing the quality of care. A number of OECD countries measure the quality of mental health care in primary care settings using a range of indicators. Sweden monitors the use of inpatient somatic care for patients with a mental disorder diagnosis that could have been avoided if primary care and/or primary or secondary prevention was sufficient. Finland tracks total mental health visits to primary care which sometimes include visits to specialists (psychiatric nurse, psychiatrist) who work within primary care as well as mental health related visits to a primary care physician. The Netherlands are developing an outcome measurement system for primary mental health care. Other countries utilise data relating to prescribing and consumption of anti-depressants for which there are relatively wide variations between OECD countries (see Chapter 2).

Table 4.2. **Primary care providers are required to keep a register of people with mental disorders**

	Yes	No
Australia		X
Austria		X
Belgium		X
Canada		X
Chile		X
Czech Republic		X
Estonia		X
Finland		X
France		X
Germany		X
Hungary		X
Iceland		X
Ireland		X
Israel		X
Italy		X
Japan		X
Korea		X
Luxembourg		X
Mexico		X
Netherlands		X
New Zealand		X
Norway		X
Poland		X
Portugal		X
Slovak Republic		X
Slovenia		X
Spain		X
Sweden		X
Switzerland		X
United Kingdom (England)		X
United States		

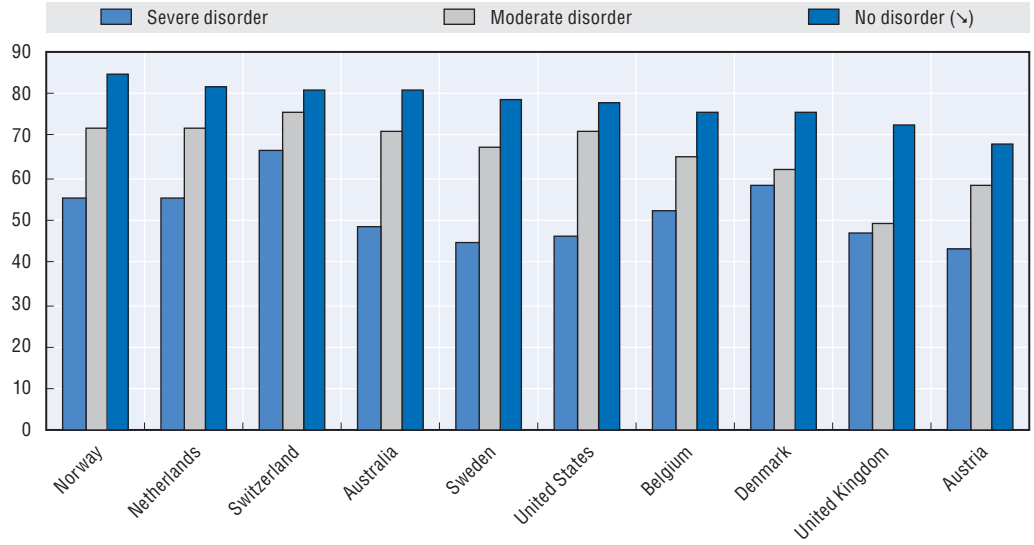
Source: OECD Mental Health Questionnaire 2012.

Quality measures must encompass social outcomes

Measurement of the quality of mental health care must move beyond traditional indicators to encompass social outcomes. There is a growing trend in OECD countries to orient the objectives and outcomes of mental health systems and services to include impacts on life domains affected by mental illness, including education, employment, housing, and social integration. While evidence shows that effective treatment leads to symptoms reduction it does not automatically lead to improved social outcomes such as improved labour or educational participation. This is evident from a recent OECD study which reveals that people with a mental disorder face a considerable employment disadvantage (Figure 4.8). Hence there is a need to also consider a broader range of outcome measures in addition to clinical "process" outcome measures.

Figure 4.8. **People with a mental disorder face a considerable employment disadvantage**

Employment/population ratio (employed people[1] as a proportion of the working-age population), by severity of mental disorder, ten OECD countries, latest available year



Note: Data for the United Kingdom shown in this chart refer to England only.
1. Employment is generally defined as paid or self-employed work of at least one hour per week (ILO definition).
Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.

StatLink http://dx.doi.org/10.1787/888933030648

The use of employment related measures such as sickness absence and uptake of sickness and disability benefits will also better reflect the outcomes of people with mild-to-moderate mental illnesses.

Delivering high-quality cross-sectoral care is potentially dependent on several agencies and professionals working together, especially in community care settings. For example health services working with other sectors such as social welfare services, employment, education and housing. Developing and measuring relevant quality outcomes for specific mental health care services within this complexity is difficult. There are inter-dependencies between these different sectors in terms of their impact on mental health outcomes and quality of care which can make it more difficult to establish accountability when shortcomings arise. Consequently, strong system governance and leadership plays a key role.

4.5. OECD HCQI work on measuring the quality of mental health care

The OECD Health Care Quality Indicators project (HCQI), initiated in 2002, aims to measure and compare the quality of health service provision in the different countries. A set of quality indicators have been developed to compare OECD countries in a number of areas including health promotion, prevention and primary care, cancer care, patient safety and responsiveness and patient experiences. Acknowledging the dearth of appropriate international quality indicators for mental health, the HCQI project has also developed indicators for mental health care and the evolution of this process is described in the following section.

History of the OECD HCQI mental health quality indicators

Under the auspices of the HCQI project an international expert panel on indicators for mental health care was convened to provide consensus recommendations on mental health care quality indicators to be routinely collected by the HCQI Project (Hermann et al., 2004). This panel decided that the final indicator set ought to cover the following four key aspects of mental health care:

1. treatment;
2. continuity of care;
3. co-ordination of care;
4. patient outcomes.

These domains are also reflected in the dimensions of health care performance addressed by the HCQI project:

- effectiveness;
- safety;
- responsiveness/patient-centredness;
- access.

A total of 134 indicators from 24 different sources were initially identified by the HCQI Secretariat. Given resource constraints, this work was limited to reviewing existing indicators in member countries rather than developing new indicators. To reduce this list to a number of indicators that could be reasonably evaluated by the Mental Health Panel, the Chair of the expert panel in collaboration with the HCQI Secretariat identified a short list of 24 indicators, which met the following screening criteria:

- the indicator can likely be constructed from administrative data using uniform coding systems (e.g., ICD 9 or DSM codes), rather than requiring dedicated data collection or non-standardised data elements;
- the indicator measures the technical quality with which care is provided, not interpersonal or consumer perspectives;
- the indicator is focused on quality of care, not on cost or utilisation;
- the indicator is built on a single item, not on a multi-item scale;
- the indicator is likely to be useful in quality assessment at the health care system level, rather than the provider level.

Five of those 24 indicators met the initial selection criteria, whereas four indicators were rejected using those criteria. The Mental Health Panel evaluated the remaining 15 indicators through a series of conference calls and e-mail discussions and converged on a final list of 12 indicators to cover the four key areas of treatment, continuity of care, co-ordination of care, and patient outcomes. These 12 indicators are listed in Table 4.3.

Some gaps remained, in particular in areas such as psychotherapeutic treatments. In addition, the recommended indicators gave very limited insight in to disparities in care among racial and ethnic minorities, or other issues related to equity. They also omitted consideration of accessibility of care, safety issues, or integration of social services along with mental health care for those with severe psychiatric disabilities.

Table 4.3. **Mental health quality indicators recommended by the HCQI Mental Health Panel**

Area	Indicator name
Patient outcomes	Mortality for persons with severe psychiatric disorders
Treatment	Hospital re-admissions for psychiatric patients Use of anti-cholinergic anti-depressant drugs among elderly patients Length of treatment for substance-related disorders Visits during acute phase treatment of depression Continuous anti-depressant medication treatment in acute phase Continuous anti-depressant medication treatment in continuation phase
Co-ordination of care	Case management for severe psychiatric disorders
Continuity of care	Timely ambulatory follow-up after mental health hospitalisation Continuity of visits after hospitalisation for dual psychiatric/substance related conditions Racial/ethnic disparities in mental health follow-up rates Continuity of visits after mental health-related hospitalisation

Source: Information compiled by the OECD based on the OECD HCQI Sub-group for Mental Health.

Data availability for the selected indicators was found to be limited in many countries

Selecting a set of indicators for international use is constrained by the limited range of data potentially available on a comparable basis in many countries. Administrative data systems commonly focus most extensively on numbers and locations of hospitalisations and outpatient visits. Diagnostic information is typically only collected when required for billing. Administrative data lack information on the severity of patient symptoms and functional impairment, as well as the content of many clinical treatments.

Subsequent work by the HCQI sub-group on mental health assessed the availability of data to collect the 12 indicators (in Table 4.1) by examining the data sources available at national level in 18 countries[1] as well as the institutional arrangements framing ownership and use of the information system. The data sources most widely available across countries were hospital administrative databases, national surveys and national registries and this may determine the indicators selected. The availability of data across countries was revealed to be generally very good for some types of data (structure and activity) and problematic for others. In order to measure the process and outcome of mental health care, data on treatment and procedures, together with mental morbidity individual data and specific mortality data would be required. A clear need to improve information systems across OECD countries in this respect was revealed. However, many of the countries where this type of information was not available were undergoing some kind of reform along these lines, so the availability of these data was expected to improve significantly in the short term.

Administrative hospital data with elements of mental health information was found to be almost universally present, followed by national surveys on morbidity, health care utilisation, and pharmaceutical consumption. National registries or statistics about severe mental disorders and suicide were also widely present across countries. However, specific mental health data information systems and patient safety/adverse events linked information systems were a rarer occurrence. The lack of availability of administrative sources outside hospitals was noteworthy due to limited primary care administrative data and community centres administrative data sources. Since a significant proportion of mental health care is provided in these settings this represents a major challenge for mental health services monitoring in general and quality assessment in particular.

Administrative databases were predominantly used for accounting purposes in whatever setting (hospital, primary care or community centres). In many cases they were also used for output measurement, but quality monitoring use appeared to be more predominant in the hospital environment and remarkably low in primary care settings, where reimbursement took precedence (Garcia-Armesto et al., 2008).

National surveys on morbidity, health care utilisation and pharmaceutical consumption incorporating mental health related components were another relatively widespread source of data but surveys on continuity of care were much rarer. The range of uses attributed to data coming from national survey sources varied widely across countries. Outcome measurement was the main purpose for which compiled data were used; quality/clinical guidelines monitoring and benchmarking also featured high in the ranking.

In addition to the general sources of health information containing some components of mental health or mental health services data, many countries worked with specialised data sources such as national registries for severe mental diseases or for suicide. The principal use of these data sources was for outcome measurement, followed by quality assessment and benchmarking activities.

However, the absence of a unique patient identifier in many countries posed problems to building indicators assessing continuity of care and quality of prescription or treatment. Another problem was the low level of integrated information systems across different levels of care provision. However, the integration between mental health care information and physical health information was revealed to be reasonably good at hospital level indicating that outcome indicators linking somatic and mental health could be feasible.

Table 4.4 shows the list of 12 indicators (in Table 4.3) ranked by data availability.

Table 4.4. **Recommended indicators ranked by availability**

Indicator	Number of countries readily available	Not available (number of countries)
Hospital re-admissions for psychiatric patients	13	5
Length of treatment for substance-related disorders	12	6
Mortality for persons with severe psychiatric disorders	12	6
Use of anti-cholinergic anti-depressant drugs among elderly patients	9	9
Continuity of visits after hospitalisation for dual psychiatric/substance related conditions	6	12
Continuity of visits after mental health-related hospitalisation	6	12
Timely ambulatory follow-up after medical health hospitalisation	5	13
Case management for severe psychiatric disorders	5	13
Continuous anti-depressant medication treatment in acute phase	4	14
Continuous anti-depressant medication treatment in continuation phase	4	14
Visits during acute phase treatment of depression	3	15
Racial/ethnic disparities in mental health follow-up rates	3	15

Source: Information compiled by the OECD based on feedback from countries as part of the OECD HCQI Sub-group for Mental Health.

Following the exercise in data availability summarised above, the HCQI project started to collect two mental health indicators – re-admission rates for bipolar and schizophrenia disorders – as part of their regular data collection. In 2013, two additional indicators – excess mortality for bipolar and schizophrenia disorders were added to the data collection. These data are presented and discussed earlier in this chapter (Figures 4.6 and 4.7).

4.6. International initiatives to measure and benchmark quality and outcomes of mental health care

Numerous ongoing and completed projects seek to measure and benchmark the quality and outcomes of mental health care at an international level in spite of the many challenges faced by such endeavors. It has been argued that quality improvement is and should be an international endeavor to facilitate learning and mental health care should not be an exception (Mainz et al., 2009). Benefits of international collaboration include the sharing of frameworks, terminologies and definitions as well as philosophies and methods, designs and principles which can result in considerable time and cost-savings.

IIMHL Clinical Leaders Group project on quality of mental health care

In 2008, clinical experts from 12 countries (Australia, Canada, England, Germany, Ireland, Japan, the Netherlands, New Zealand, Norway, Scotland, Taiwan, and the United States), meeting as part of the Clinical Leads group of the International Initiative for Mental Health Leadership (IIMHL), initiated this project in order to develop a consensus framework for reporting on mental health care quality. The ultimate aim of this project was to develop and implement a balanced, inclusive, and common framework of measures that allows for international comparisons and benchmarking of system performance, with a long-term goal of informing initiatives to improve mental health services in these countries.

The work for the IIMHL Clinical Leaders Group project has involved the following steps:

1. Phase I:
   - A systematic review of peer-reviewed journal articles, government reports, white papers, and other grey literature on population-based performance measurement in mental health in the 12 countries. Representatives from each of the 12 participating countries were asked to identify peer-reviewed journal articles, government reports, white papers, and other "grey literature" on population-based quality or performance measurement initiatives in mental health using three main criteria for inclusion in this review:
     - The initiative must describe indicators related to mental health and/or substance use.
     - The indicators should a) be precisely defined at the numerator and denominator level, b) contain information about data sources, and c) measure quality (as defined by the six US Institute of Medicine domains of effectiveness, efficiency, equitability, safety, timeliness, and patient- and/or community-centered).
     - The indicators should have a national- or regional-level focus, or otherwise be used to assess performance among organisations or providers.
   - The compilation of indicators collected through the literature review:
     - 29 programmes from ten countries and two cross-national programmes yielded 650+ total measures which were organised into 17 domains and 80 sub-domains.
   - A survey to collect information on current state of collection of indicators in countries under review. The survey aimed to on-going or soon-to-be-established national-level mental health quality measurement programmes in the 12 participating countries with a special focus on gaining a deeper understanding of the qualifying programmes and responsible organisations, the derivation of quality indicators, the entities assessed, the sources and means of data collection (including the level of reporting) and how the data are used.

2. Phase II:
   - The development of a survey instrument based on "measurement concepts" to identify a core set of indicators collectable across countries. Following the collection and grouping of the performance indicators, researchers at Columbia University developed a survey instrument, with a goal of a consensus list of mental health quality indicators organised by modules. Indicators were grouped into "measurement concepts" – for example medication monitoring, follow-up after hospitalisation, symptom or diagnostic assessment with validated tool. These "measurement concepts" then provided the basis for developing the survey questions built around a "base indicator" and variants of that base indicator that might offer a better alternative approach to a measure.
   - Rating results for all measurement concepts – domain/base indicator/validity/ importance – revealed that the three most highly ranked base indicators for *importance* include seclusion [8.3 (0.6)],[2] patient involvement [8.2 (0.9)], and seven-day follow-up after inpatient discharge as well as symptom reduction with the latter two both displaying a rating of 8.2 (0.4). On the lower end of the rating spectrum for all indicators, indicators measuring polypharmacy [6.1(2.1)], school absence [5.9(2.4)] and criminal justice encounter [4.3(2.1)] showed the lowest ratings. For *validity*, the ratings for the three most highly ranked base indicators span from 7.9 (0.5) for seven-day follow-up after inpatient discharge to 7.5 (1.4) for involuntary/ compulsory hospitalisation and 7.4 (1) for seclusion. Measures with the lowest ratings for validity include patient education [5(1.5)], criminal justice encounters [4.6(1.7)], and school absence [4.2(2.3)]). The survey's proposed variants to the base indicators failed to achieve a high level of support from the survey participants highlighting the stability of the base indicators.
3. Phase III:
   - In collaboration with participating countries, Phase III of the project will focus on piloting implementation of the IIMHL Clinical Leaders Framework and collection of data on a selected number of indicators based on the rating results of the Delphi process. In addition, the project would incorporate collaboration with the OECD mental health quality measurement initiative.
   - Convene an international group of mental health experts on quality with a multi-disciplinary approach to develop a phased strategy for enhancing the development of recovery oriented measures for quality improvement and accountability. This effort will be augmented by the perspective from consumer advocates and policy experts who will join the group as full members and share their expertise, providing crucial input to shape the group's discussions about challenges, obstacles and strategies for measuring recovery, strengths and limitations of instruments/ measures currently in use, and ideas for further instrument/measure development and testing, and promotion of a recovery agenda in general.

Nordic Indicator Project

The Nordic Council of Ministers initiated the Nordic Project on Measuring the Quality of Health Services in 2007. The project group was asked to prepare proposals for indicators that could comprise the basis for registering and monitoring the quality of mental health services in the Nordic countries (NORDEN, 2011).

The project group decided to include all indicators of quality that are used to indicate the quality of mental health services in the Nordic countries in relation to hospital (inpatient and outpatient) treatment and potential indicators that are expected to be implemented in the Nordic countries in the near future within the following areas:

- generic indicators of the quality of mental health services;
- compulsory measures;
- electroconvulsive therapy;
- schizophrenia among adults and among children and adolescents;
- moderate and severe depression being treated in hospitals;
- bipolar disorder;
- attention deficit hyperactivity disorder;
- quality as rated by patients and their family members.

The Nordic countries are thus among the countries that have achieved the most in national measurement of the quality of mental health services. The Nordic countries have unique opportunities to measure the quality of mental health services because of well-established health-related registries and because data can be collected that are linked to individual patients. Thus, the Nordic countries can contribute substantially to inspiring and collaborating on the international measurement of the quality of mental health services based on quality indicators.

The REFINEMENT Project

The REFINEMENT (Research on Financing Systems' Effect on the Quality of Mental Health Care) project comprised a collaboration between nine research institutions in Italy, Austria, United Kingdom, Finland, Spain, Norway, Estonia, France and Romania funded by the European Commission during 2011-13. The overall aim of the project was to examine the relationship between different models of health care financing and the extent to which mental health care services meet the goals of high quality, equity, efficiency and better long-term health outcomes. Thus the various work packages covered: analysis of the financing of health and social care systems; functional and dysfunctional financial incentives; mapping services for mental health care; pathways of care; quality of mental health care and met/unmet needs; and building best practice models of mental health care financing as well as project management; evaluation and dissemination. The objectives of the work package on quality of care and met/unmet needs are to:

1. Identify indicators of performances and outcomes of mental health care.
2. Identify at which levels (national/regional, local or individual) data are available in the nine European countries.
3. Develop a strategy for the collection of information about performance and outcome indicators of quality of mental health care.
4. Train the investigators in the data collection tasks.
5. Perform the statistical analyses of the data collected.
6. Provide a public-access information base to engage all stakeholders, including national policy makers and health systems planners, in planning and decision-making processes about mental health care.

Mental health indicators for a comprehensive health monitoring system

An earlier European Commission funded project was led by STAKES (National Centre for Research and Development in Welfare and Health in Finland) during 1999-2001 to collate the mental health indicators necessary for a comprehensive health monitoring system. The project collected information on existing mental health and well-being indicators and information systems and on this basis selected a set of mental health indicators for integration into a comprehensive health monitoring system in Europe. These indicators are listed in Table 4.5.

Table 4.5. **List of mental health indicators for inclusion in a comprehensive European health monitoring system**

Domain of the indicator (number refers to ECHI subgroup)	Individual indicators (number refers to individual rank number of the indicator)
2. HEALTH STATUS	
2.1.3. Cause specific mortality	1. Suicide 2. Harmful events, intention unclear 3. Drug related deaths 4. PYLL fraction: suicide
2.2. Morbidity, disease specific	5. Generalised anxiety disorder (incidence & prevalence) 6. Major depression (incidence & prevalence) 7. Alcohol dependency 8. Suicide attempts (12-month prevalence)
2.3. Morbidity, generic	9. Psychological distress 10. Psychological well-being a) Energy, vitality (in SF-36) b) Andrews single item question (happiness) 11. Role limitations due to emotional problems
3. DETERMINANTS OF HEALTH	
3.2.1. Personal conditions	12. Mastery 13. Optimism
3.3.3. Social and cultural environment	14. Social support 15. Social isolation 16. Social networks 17. Life events
4. HEALTH SYSTEMS	
4.1. Prevention, health protection and promotion	18. Suicide prevention projects 19. Projects to support parenting skills
4.2. Health resources	20. Psychiatric beds 21. Psychiatrists 22. Child psychiatrists 23. Other professionals in the field of mental health
4.3. Health care utilisation: psychiatric beds & outpatient care; social services	24. Number of inpatient episodes for mental health conditions 25. Number of inpatient episodes for mental health conditions for minors 26. Number of long stay patients 27. Use of outpatient services 28. Self-reported use of mental health services 29. Consumption of psychotropic drugs 30. Number of disability pensions due to mental disorders 31. Money spent on disability due to mental disorders 32. Sickness compensation periods due to mental disorder
4.4. Expenditure	33. Total national expenditure on psychiatric services 34. Proportionate national expenditure on psychiatric services 35. Proportionate national expenditure on psychiatric services for minors
4.5. Health care quality indicators	36. Availability of national quality accreditation

Source: Establishment of a set of mental health indicators for European Union Final Report, National Research and Development Centre for Welfare and Health STAKES, Helsinki.

International benchmarking poses considerable challenges

The undertaking of such projects as those outlined above is not without the challenges inherent in international benchmarking as outlined by Mainz et al. (2009). These challenges include: the difficulty of collecting data for even relatively simple indicators; the reported indicator data may be related to different years for different countries; the differential ability of countries to track patients after hospital admissions which is related to the presence or absence of UPIs; the lack of risk adjustment; deficiencies in relation to validity testing and exhaustive and exclusive data specifications; and the inability to avoid choosing indicators for quality benchmarking that reflect the data source that is available rather than optimal measures of quality of care.

4.7. Using data to drive improvements: Developing mental health quality and outcome indicators, targets and standards

There are many potential uses of quality indicators, including: benchmarking, performance management and quality improvement; consumer information; and provider payment. Quality indicators can be used for benchmarking purposes at both national and international levels. Public reporting of quality metrics engages providers and organisations to improve performance and enhance their reputation. It is also crucial for holding health care organisations to account for improving care (Kilbourne et al., 2010). Considerable progress in developing quality and outcomes indicators as well as mental health targets and standards has occurred at a national level. Specific examples drawing on experiences in Australia, England, Netherlands, Sweden and the United States are explored further in the following sections. Other promising examples, for which there is not space to describe in full here, are developing in a number of other OECD countries and progress should be followed attentively, for example the MARS project in Switzerland and the Scottish Recovery Indicator 2 approach.

Extensive development of mental health quality and outcome indicators, targets and standards has occurred across OECD countries

As evident from Table 4.6, the development of mental health quality and outcome indicators, targets and standards is widespread across OECD countries. Countries have adopted different approaches to the development of indicators, standards and targets. Differences exist between countries in the extent to which such measures are mandatory or not, which in turn may be related to their purpose. In some countries these data are used as part of a purchasing or payment system. In others, they are used to monitor and benchmark providers. The following section outlines in more detail the experience of selected OECD countries in the development of outcome and quality indicators.

Australia mandated collection of a routine set of outcome measures and prioritised key performance indicators

Australia routinely collects a suite of clinician- and consumer-rated outcome measures and has prioritised complementary measures resulting in a comprehensive suite of performance indicators.

The National Outcomes and Casemix Collection (NOCC) is the set of routine outcome measures collected by all Australian state and territory mental health services. NOCC includes HoNOS as well as measures of function such as the Life Skills Profile (LSP), Strength and Difficulties Questionnaire (SDQ) and consumer-rated measures of symptoms

Table 4.6. **Development of mental health outcome indicators, targets and standards at a national or regional level, selected OECD countries**

	Outcome indicators	Targets	Standards
Australia	X	X	X
Austria		X	X
Belgium		X	X
Canada	X		X
Chile		X	X
Czech Republic	X		X
Finland	X	X	X
France	X	X	X
Germany	X		X
Hungary	X	X	X
Iceland	X	X	X
Ireland	X	X	X
Israel	X	X	X
Korea	X	X	X
Mexico	X	X	X
Netherlands	X		X
New Zealand	X	X	X
Norway	X	X	X
Poland	X	X	
Portugal	X	X	X
Slovak Republic	X		X
Spain		X	
Sweden	X		
Turkey	X	X	X
United States			X

Source: OECD Mental Health Questionnaire 2012.

or well-being such as the Kessler 10 (K10) and BASIS-32. While there has been a steady increase in the collection of the HoNOS family of outcome measures, collection of consumer rated measures and the SDQ remains low. Gaps in the information collected have been identified. These include education, employment, housing, therapeutic alliance, trauma related issues, consumer and carer experiences of care, family functioning, security and risk and measures for 0-4 years. However, there is a trade-off between expanding the areas for which information is collected and minimising the burden of collecting this data.

The Fourth National Mental Health Plan Measurement Strategy (Commonwealth of Australia, 2011) summarises five priority areas for mental health performance indicators. The priority areas are 1) social inclusion and recovery; 2) prevention and early intervention; 3) service access, co-ordination and continuity of care; 4) quality improvement and innovation; and 5) accountability – measuring and reporting progress. Indicators included under the first domain relate to education, employment, housing and community participation of people with mental illness as well as rates of stigmatising attitudes within the community. The second domain seeks to track the prevalence of mental illness, suicide rates, rates of understanding of mental health problems and illness in the community, mental illness and use of mental health services among young

people and mental health literacy in schools. The third domain monitors people receiving mental health care including their pre-admission and post-discharge care, re-admission rates, primary care, emergency department waiting times and prevalence of mental illness among homeless and prison populations. The fourth domain covers standards and quality of care, service user outcomes and patient and carer experiences. The fifth domain is measured using the proportion of services publicly reporting performance data.

The key performance indicators for Australian Public Mental Health Services (NMHWG Information Strategy Committee Performance Indicator Drafting Group, 2005) outlines nine domains under which indicators are grouped: effectiveness as measured by the 28 day re-admission rate; appropriateness in terms of compliance with National Service Standards; efficiency measured by the costs and duration of inpatient and community care stays; and accessibility as measured by the population receiving care, a new client index, comparative area resources and local access to inpatient care. Continuity of care is measured in terms of pre-admission and post-discharge community care and capability of care is reflected in outcomes readiness. Other domains include responsiveness, safety and sustainability of care.

Outcome indicators reflect the spectrum of mental disorders in England and are integral to purchasing and payment mechanisms

In England, outcome indicators have been developed for both mild-to-moderate and severe mental illness. Outcome measures play a key role in purchasing mental health services and paying providers. Outcome measures reflect patient experience, quality of life and social outcomes as well as quality of care and symptomatology.

NHS Outcomes Framework

The NHS Outcomes Framework reflects the coalition government's desire to move away from measuring process targets to health outcomes. Indicators in the Outcomes Framework are grouped into five domains of which three include indicators relating to mental health. The NHS Outcomes Framework 2013-14 gives a stronger emphasis to mental health. A new measure relating to psychological therapies has been added which ensures that the framework reflects recovery from common mental health problems such as depression and anxiety. This new indicator measures the response to depression and anxiety disorders through the delivery of the Improving Access to Psychological Therapies (IAPT) programme (see also Chapter 2). Inclusion of this new indicator reflects the government's aim of "parity of esteem for mental and physical health". The indicators related to mental health in the NHS Outcomes Framework are presented in Table 4.7.

Clinical Commissioning Group Outcomes Indicator Set

The NHS Outcomes Framework has been used to derive indicators for the new Clinical Commissioning Group Outcomes Indicator Set (CCG OIS) (formerly known as the "Commissioning Outcomes Framework" or "COF"). The CCG OIS will be used to support and enable the new clinical commissioning groups (CCGs) to measure and benchmark outcomes of services commissioned by CCGs. The CCG OIS will also provide clear, comparative information for patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes. The CCG OIS indicators related to mental health are displayed in Table 4.8.

Table 4.7. **Mental health indicators in NHS Outcomes Framework**

1. **Preventing people from dying prematurely**
Reducing premature death in people with serious mental illness
1.5 Excess under75 mortality rate in adults with serious mental illness
2. **Enhancing quality of life for people with long-term conditions**
Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness
3. **Helping people to recover from episodes of ill-health or following injury**
Improving Outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
v. Psychological Therapies
4. **Ensuring that people have a positive experience of care**
Improving experience of health care for people with mental illness
4.7 Patient experience of community mental health services

Source: NHS England (2013), "CCG Outcomes Indicator Set 2014-15-At a Glance", NHS England, available at: *www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-at-a-glance.pdf*.

Table 4.8. **Mental health indicators in the CCG OIS**

Domain 1	**Preventing people from dying prematurely**
	Reducing premature death in people with severe mental illness
	People with severe mental illness who have received a list of physical checks
	Severe mental illness: smoking rates
Domain 2	**Enhancing quality of life for people with long-term conditions**
	Enhancing quality of life for people with mental illness
	Access to community mental health services by people from BME groups
	Access to psychological therapy services by people from BME groups
	Recovery following talking therapies (all ages and older than 65)
	Health-related quality of life for people with a long-term mental health condition
Domain 3	**Helping people to recover from episodes of ill-health or following injury**
	Improving recovery from mental illness
	Alcohol admissions and re-admissions
	Mental health re-admissions within 30 days of discharge
	Proportion of adults in contact with secondary mental health services in paid employment
Domain 4	**Ensuring that people have a positive experience of care**
	Improving experience of health care for people with mental illness
	Patient experience of community mental health services (NHS OF 4.7)

Source: NHS England (2013), "CCG Outcomes Indicator Set 2014-15-At a Glance", NHS England, available at: *www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-at-a-glance.pdf*.

Quality and Outcomes Framework

The mental health indicators included in the Quality and Outcomes Framework (QOF) (Table 4.9) focus both on mild-to-moderate disorders such as depression and SMI such as schizophrenia, bipolar affective disorder and other psychoses. For depression, the indicators relate to severity and bio-psychological assessment at the time of diagnosis. The indicators for severe mental illness concern physical health checks reflecting the high rates of physical co-morbidities for people with severe mental illness that contribute to premature mortality. There are also indicators to monitor and record the use of lithium therapy.

In England, a new payment system for providers of specialist mental health care – the Care Pathways and Packages Approach has been developed whereby patients will be allocated to a care cluster which will comprise the unit of activity for which providers are paid (see Chapter 3, Section 3.4 for more details). Quality indicators for each care cluster must be agreed between providers and purchasers of specialist mental health care and monitored on a quarterly basis (NHS England, 2013). For this purpose, ten indicators have

Table 4.9. **Depression and mental health indicators included in the Quality and Outcomes Framework 2013-14**

Depression (DEP)	
DEP001	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded
DEP002	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than ten days after and not later than 35 days after the date of diagnosis
Mental health (MH)	
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy
MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate
MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months
MH004	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months
MH005	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months
MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months
MH008	England: The percentage of women aged 25 or over and under who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding five years(In other countries ages are : aged 25 or over and under the age of 65 in Northern Ireland, aged 20 or over and under the age of 61 in Scotland and aged 20 or over and under the age of 65 in Wales)
MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding nine months
MH0010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding four months

Source: NHS Commissioning Board, BMA and NHS Employers (2013), "Quality and Outcomes Framework guidance for GMS contract 2013/14", available at: *file:///E:/_OECD%20Mental%20Health%202013/Comments_Revisions/gpqof guidance20132014.pdf.*

been recommended for national and local use and a number of additional indicators on which further work will be undertaken. These are outlined in Table 4.10. The data for these indicators will be collected using the Mental Health Minimum Data Set (MHMDS) – a mandatory data collection for all mental health provider organisations in the English NHS since April 2003. The MHMDS includes information on care received by service users during a spell, as well as details of clinical problems, treatments given, and aspects of social care and outcomes (HoNOS scores).

Health of the Nation Outcome Scales (HoNOS)

HoNOS was developed in 1993 by the Royal College of Psychiatrists Research Unit (CRU) in England. The work was commissioned by the Department of Health in order to measure progress towards achieving the Health of the Nation target "to improve significantly the health and social functioning of mentally ill people" (Wing et al., 1994). The instrument has 12 items measuring four domains of behaviour, impairment, symptoms and social functioning (Wing et al., 1996). Each item is scored from 0 (no problem) to 4 (severe problem) yielding a total score in the range of 0 (best) to 48 (worst) (Table 4.11). HoNOS is a provider-rated instrument with ratings carried out by an individual psychiatrist, nurse, psychologist, or social worker, or by using input from the clinical team (a consensus rating based on a team discussion). The individual patient's outcome is measured by comparing a patient's

Table 4.10. **Recommended and Additional Quality Indicators for use with mental health currencies in England**

Recommended indicators		Additional indicators	
R1	The proportion of users in each cluster who are on Care Programme Approach (CPA)	C4	Distribution of actual cluster review periods
R2	The proportion of users on CPA who have had a review within the last 12 months	C5	Distribution of actual cluster episode period duration
R3	The completeness of ethnicity recording	C6	Distribution of actual MH cluster review period duration
R4	The accommodation status of all users (as measured by an indicator of settled status)	C7	Re-referral rate (to any in scope services)
R5	The intensity of care (bed days as a proportion of care days)	C8	Proportion of reviews (CPA) with a corresponding clustering review
R6	The proportion of users with a crisis plan in place, limited to those on Care Programme Approach (CPA)	C10	Indicator of accommodation problems
R7	The proportion of users who have a valid ICD10 diagnosis recorded	C11	Cluster Profile
C1	Proportion of in scope patients assigned to a cluster	C12	Step Up/Step Down/Little change/Discharges
C2	Proportion of initial cluster allocations adhering to red rules		
C3	Proportion of patients within cluster review periods		

Source: NHS England (2013) "Draft Guidance on Mental Health Currencies and Payment", available at *www.monitor.gov.uk/sites/default/files/publications/Draft%20guidance%20on%20mental%20health%20currencies%20and%20payment.pdf*.

Table 4.11. **Items, structure and scoring of the HoNOS**

Item	Subscale/sections	Scoring
1. Overactive, aggressive, disruptive or agitated behaviour 2. Non-accidental self-injury 3. Problem-drinking or drug-taking	Behaviour (1-3)	Each item rated on a five-point scale: 0. no problem 1. minor problem requiring no action 2. mild problem but definitely present 3. moderately severe problem 4. severe to very severe problem Scoring yields individual item scores, subscale scores and a total score.
4. Cognitive problems 5. Physical illness or disability problems	Function/impairment (4-5)	
6. Problems associated with hallucinations or delusions 7. Problems with depressed mood 8. Other mental and behavioural problems	Symptoms (6-8)	
9. Problems with relationships 10. Problems with activities of daily living 11. Problems with living conditions 12. Problems with occupation and activities	Social (9-12)	

Source: Jacobs, R. (2009), "Investigating Patient Outcome Measures in Mental Health", *CHE Research Paper,* No. 48.

scores at two points in time. Scores at the second point in time can be more challenging to obtain if there are issues of staff changes or patient access (Jacobs, 2009).

HoNOS has been modified to include versions specific to older adults (HoNOS65+), children and adolescents (HoNOSCA), forensic services (HoNOS-Secure), learning disabilities (HoNOS-LD), and acquired brain injury (HoNOS-ABI).

In England, the use of HoNOS is recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health on outcome indicators for severe mental illnesses. HoNOS forms part of the MHMDS and also underpins the Mental Health Clustering Tool (MHCT). The MHCT has been developed by a partnership of the Department of Health, the Royal College of Psychiatrists Centre for Advanced Learning

and Conferences and the Care Pathways and Packages Project (CPPP) in order to allocate service users to Care Clusters under the Care Pathways and Packages Approach.

HoNOS is also widely used in Australia and New Zealand. In Australia, HoNOS is mandated as a standard outcome measure for all patients using in or outpatient mental health care. It is expected that all patients should have the HoNOS completed at least twice (Jacobs, 2009). HoNOSCA and HoNOS65+ are also mandated for use in child and adolescent mental health services (CAMHS) and older people's mental health services respectively.

The Netherlands developed a comprehensive suite of performance indicators on outcome, safety and client satisfaction

In the Netherlands, market-based health reforms have driven the development of a comprehensive set of performance indicators on outcome, safety and client satisfaction. In 2006, the Dutch Government introduced a competing insurance market for health care including mental health. Mental health providers have to reach an agreement with insurance funds on the price and quality of mental health services. From 2006 onwards, service providers have collected the relevant data and submitted these to a national database. The results of every service provider are published on the internet. In 2010, an evaluation of this system criticised the reliability of the data, validity of the indicators and the value of the indicators for decision making processes at national and provider level. After some debate, the number of performance indicators in mental health care was reduced from 28 to 10 indicators covering the three domains of effectiveness and support, safety and client satisfaction. This exercise is one of the most far-reaching efforts to measure outcomes in mental health care. The goal is for the majority of all mental health care episodes to be measured. Each year, the percentage of patients measured is to increase to eventually cover the whole population. This approach is very promising and offers a radical departure from the lack of measurement in mental health care. The ten indicators are presented in Table 4.12.

Table 4.12. **Dutch indicators on outcome, safety and client satisfaction**

Domain: Effectiveness of treatment and support
1. Reduction in the severity of symptoms
a. As reported from the perspective of the client (CQ Index)
b. Measured change in severity of problems (Routine Outcome Monitoring)
2. Change in daily functioning of life (Routine Outcome Monitoring)
3. Change in perceived quality of life (Routine Outcome Monitoring)
4. Drop out of treatment against the advice of the professional
5. Availability of a screening procedure for somatic disorders by patients with schizophrenia
6. Timely contact following discharge from a clinic
Domain: Safety
7. Medication safety
a. Availability of an up-to-date medication list during prescribing of medication
b. Information on side effects of medication (CQ Index)
8. Coercion, encompassing restraint, seclusion and forced medication
9. Perceived safety of client (CQ Index)
Domain: Client satisfaction
10. Client opinion (as measured by the CQ Index with 69 questions)
a. on informed consent
b. on freedom of choice between professionals and/or treatments
c. on fulfilment of wishes in care delivered
d. on the evaluation/adjustment of treatment or support
e. on the co-ordination of care
f. on housing and living conditions in a clinical setting or sheltered housing
g. on approach of clients by professionals

Source: Compiled by the author based on Forti, A. et al. (2014), "Mental Health Analysis Profile: The Netherlands", *OECD Health Working Papers,* OECD Publishing, Paris, *http://dx.doi.org/10.1787/18152015*.

Sweden successfully adapted a multi-dimensional quality framework to monitor mental health care performance

In Sweden, the National Board of Health and Welfare developed a multi-dimensional quality framework – *Good Care* – in order to monitor health care performance. The framework covers several dimensions of care including effectiveness, safety, patient-centredness, timeliness, equity and efficiency. This framework has been applied to psychiatric care with the development of more than 30 process and outcome indicators which were then compared between regions or patient groups (Bjorkenstam et al., 2011). In terms of *effectiveness*, the study revealed low compliance to anti-depression treatment with small regional variations. In contrast, large regional variations were evident for *timeliness* of care. Suicide rates were used as a measure of *safety* and these were found to have decreased during 1997-2007. The *equity* dimension showed large disparities in the results of somatic care between patients with and without co-morbid psychiatric disease. For *efficiency* the study compared costs and outcomes for a group of psychiatric patients but no clear relationship between costs and outcomes was found. In summary, while large regional disparities in the quality of mental health care did not appear to exist, there were large disparities in somatic care outcome between patients with and without a co-morbid mental disorder. There was a lack of data to measure *patient-centredness* at a national level and the development of new data sources related to health outcomes would lead to a more comprehensive and satisfactory assessment of the overall quality and performance of mental health care.

The United States has developed outcome and performance indicators at both federal and state levels

The United States has developed a comprehensive set of performance and outcome indicators. While no indicators have been developed that address the entire US population, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed National Outcomes Measures (NOMS). The NOMS focus on substance abuse treatment and prevention and mental health services and are used by state and federally funded mental health and substance abuse promotion, early intervention and treatment services. In addition, the Medicare Health Outcomes survey also measures mental health outcomes on a national level for Medicare beneficiaries.

The National Quality Forum reviews, endorses, and recommends use of standardised health care performance measures. NQF-endorsed measures have undergone careful review by expert committees made up of doctors, hospitals and other providers, employers, health plans, public agencies, community coalitions, and patients –most of who use measures on a daily basis to ensure better care. NQF endorsed measures for mental health care include:

- adherence to antipsychotic medications for individuals with schizophrenia;
- diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications;
- cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications;
- cardiovascular health monitoring for people with cardiovascular disease and schizophrenia;
- diabetes monitoring for people with diabetes and schizophrenia;
- follow-up after hospitalisation for Schizophrenia (7- and 30-day);
- follow-up after hospitalisation for mental illness.

An independent evaluation of the performance of the Veteran's Health Administration was carried out between 2006 and 2010 (Watkins et al., 2010). The evaluation focused on five mental health diagnoses – schizophrenia, bipolar disorder, post-traumatic stress disorder, major depressive disorder and substance use disorder. The study drew on the Donabedian framework to measure quality of care using a facility survey and administrative data to measure structure of care in terms of services available to veterans; administrative data and medical record review to assess process of care in terms of services received by veterans; and a client survey and medical record review to measure outcomes of care.

At a state level, the National Association of State Mental Health Program Directors (NASMHPD) developed a framework of mental health performance indicators in order to provide states, counties, provider networks and other organisations with a standardised set of mental health performance indicators in order to assess the impact of services on the public mental health system.

Healthy People 2020 sets ten year targets for the health of the population of the United States. Healthy People 2020 includes 12 mental health goals ranging from reducing the suicide rate to increasing the number of people with serious mental illness who are employed. These targets are not tied to financial or management incentives.

There is no one overall set of mental health treatment standards in the United States. However, SAMHSA as well as some of the major trade associations for mental health care providers such as the American Psychiatric Association and the National Association of Social Workers issue standards and guides for best practices for specific providers and populations. In addition, there are multiple accreditation, licensing and credentialing organisations that provide monitoring services for states, hospitals, nursing homes, mental health centres/clinics and providers. These organisations monitor public and private delivery systems that provide mental health treatment. The Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission, formally JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) are two examples of independent, not-for-profit organisations that issue standards and accredit health care systems and managed care organisations.

Other OECD countries utilise a range of process and outcome indicators

Other OECD countries collect various mental health process indicators as well as indicators focusing on population and social outcomes, access to services and risk factors.

In terms of process indicators, the Czech Republic monitors length of hospitalisation while Finland publishes data on the number of periods of care, care days, and visits in outpatient and inpatient care in psychiatry pharmacotherapy as well as the use of coercive measures. In Portugal the reduction in psychiatric beds and closure of psychiatric hospitals are key indicators tracked.

In the Czech Republic, the Quality Indicator for Rehabilitative Care (QuIRC) was translated and partially included into clinical practice. Israel collects indicators regarding psychosocial rehabilitation while Germany monitors days of incapacity to work and early retirement.

A number of countries, including Finland and Germany monitor suicide rates, while Korea measures experience of depression symptoms and suicidal ideation.

In Norway there are about 30 mental health indicators covering:

- Health situation (self-assessment, mental health consultations by GP, suicide rates);
- Risk factors (living alone, disoccupation, drug dependence, school drop-out, divorces, social support, low income, physical activity, number of young disabled persons, education);
- Prevention (openness on mental health), service delivery (re-admissions, detentions, waiting times);
- User involvement (economic support);
- Co-ordination and continuity (contentment of GPs, rates of individual plans);
- Access (accommodation, waiting times, rate of coverage for children and adolescents);
- Capacity of specialist services.

Mental health targets place a strong emphasis on suicide prevention

The scope and range of mental health targets also varies across OECD countries but there is a strong emphasis on suicide prevention and reduction.

In Scotland, the HEAT targets are NHS Scotland's performance targets in the areas of health improvement, efficiency, access and treatment. A HEAT target related to mental health is to reduce the suicide rate by 20% between 2002 and 2013. A wide range of suicide prevention activity has been implemented at both local and national levels in order to achieve this target. Suicide rates (which are calculated on a three-year rolling average in order to smooth out annual fluctuations) steadily decreased from 2000-02 to 2005-07, increased from 2005-07 to 2006-08 but decreased again in the period up to 2009-11.

Switzerland has no national or local mental health targets but some NGOs state targets concerning suicide prevention.

The current aims of Finland's social and health policy are set out in the document "Socially Sustainable Finland 2020 – Strategy for Social and Health Policy" as well as in the government programme. The indicators used for monitoring strategic goals include two mental health indicators of which one is potential years of life lost (PYLL) for mortality from suicide. The other mental health indicator is "Access to services in psychiatric specialised health care for young people". A similar target is in place in Norway regarding access to and coverage of mental health services for children and adolescents. Other Norwegian targets concern the response within ten days from specialist services and individual assessments of maximum waiting times to treatment.

Turkey has adopted a target to establish Mental Health Centers in order to carry out the Community Based Mental Health Care Strategy as defined in the National Mental Health Action Plan.

Responsibility for standard setting is usually under the auspices of purchasers of mental health care

Purchasers of health care play a key role in standard setting. In the majority of OECD countries, the government – in the form of Ministries of Health – are primarily responsible for standard-setting for mental health care. In the Czech Republic standards are issued by the Ministry of Health but are controlled by insurance companies.

In New Zealand, the Ministry of Health works alongside Standards New Zealand which is the operating arm of the Standards Council, an autonomous Crown entity operating under the Standards Act 1988. The Standards Council, an appointed body with representatives

from a wide range of community sectors, is the governing body for Standards New Zealand. The majority of the Standards are developed in partnership with Standards Australia. As New Zealand's representative for the International Organization for Standardization (ISO) and the International Electrotechnical Commission (IEC), Standards New Zealand ensures that New Zealand has a voice in the international Standards community. New Zealand Standards are used by a diverse range of organisations to enhance their products and services, improve safety and quality, meet industry best practice, and support trade into existing and new markets.

In Portugal, recent government standard-setting activities include the issuance of guidelines on the use of antipsychotic drugs, the use of anxiolytic and hypnotic drugs and the use of antidepressant drugs. In the Netherlands, the national associations of mental health care professionals have developed national (multidisciplinary) guidelines for the treatment of several mental illnesses.

In Turkey, Quality Commissions in hospitals meet twice a year, and the Quality Inspection Team of the Ministry of Health visits hospitals on an annual basis. Evaluation is carried out according to positive or negative performance rating according to aspects of services.

4.8. Conclusion

This chapter has provided an overview of the current state of play across OECD countries regarding information on the prevalence of mental disorders as well as the quality and outcomes of mental health care. While mental disorders comprise a large burden of disease they are generally undertreated, partly because people with mental disorders are not adequately identified resulting in a large treatment gap. National surveys provide a useful tool to estimate prevalence of mental illness and are preferable to estimates based on utilisation of services. However, the design and content of such surveys tends to vary across countries and standardised cross-country measurement tools are limited. National surveys can also provide information on the quality of mental health services.

In general, better outcome measures are needed for mental health care. Suicide and premature mortality can give an indication of mental health outcomes at a population level but these are biased towards severe mental illness. Quality and outcome measures tend to be biased towards inpatient care due to data infrastructure and information availability. The lack of UPIs also inhibits measurement of quality across the entire care pathway including in primary care where the majority of mild-to-moderate mental disorders are treated. There is also a need to measure social outcomes such as employment and housing. While a number of international initiatives have made considerable progress in benchmarking the quality and outcomes of mental health systems across countries, these efforts are often impeded by the substantial challenges posed by cross-country comparisons. Therefore, it is often possible to develop and collect a more comprehensive set of indicators at a national level. This is because such indicators usually form a core part of purchasing and provider payment systems so in cases where collection is not mandated, implicit incentives encourage data reporting. Clinicians and patients play a crucial role in the development and uptake of measures and this should be reflected in clinician training and payment systems. The quality and outcomes of mental health care will continue to lag behind other disease areas until adequate information systems are put in place to track pertinent indicators and purchasers and providers are given appropriate incentives to improve performance in this area.

Potential strategies to improve mental health quality and outcomes and the accompanying indictors are numerous. At the clinical level, introducing and applying standardised longitudinal measurement-based care for clinical evaluation and treatment is a key strategy to improve the quality and outcomes of mental health care. However, it is also necessary to link quality measurement with activities at the centre of care and the day-to-day operations of providers in order to fully effect change. Communication, training, stakeholder involvement, and use of mechanisms for measurement, feedback and redesign are all essential to successful implementation of new and changing work practices to improve quality of care. Clinicians at the front line need to be actively engaged in the process of improving quality at multiple levels (for example, payment, licensure, and organisational change), and payment systems should reward high quality of care. The adoption and use of measurement-based care practices should also be an integral part of clinicians training and education. Standardised measures that allow results to be monitored and tracked uniformly over time are the foundation of performance improvement. Finally, measures should be used by multiple stakeholders at multiple levels to actually improve care.

Notes

1. Australia, Canada, Denmark, Finland, France, Iceland, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Korea, Spain, Sweden, Switzerland, United States.
2. Mean (standard deviation).

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Chapter 5

Developing skilled workforces for high-performing mental health systems

The composition of the mental health workforce in OECD countries is diverse, and this chapter examines how OECD countries differ in terms of the numbers and mix of mental health professionals, which can in turn impact on the access, quality and cost of care provided. Cross-country comparisons of the human resources available to respond to mental health care needs are, however, hampered by the non-standardisation of data, the overlapping roles and tasks of different providers, and the challenge in properly measuring the input of primary care providers (notably general practitioners) in diagnosing and treating different mental health problems. The training, accreditation and continuing professional education of the mental health workforce plays a critical role in the supply, remuneration and mobility of mental health professions as well as the quality of care provided. Changing models of human resources and mental health care delivery have increased the potential for the provision of more efficient and effective services that promote better quality and service integration. As mental health care has become more integrated into community settings, service users and family caregivers play an increasing and critical role in supporting people with mental health problems.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

5.1. Introduction

A workforce of skilled mental health professionals is essential to the delivery of high-quality mental health care. Delivery of mental health care is a staff-intensive process that relies less on technologies than other medical specialities, meaning that human resources account for a relatively high proportion of mental health expenditure and resource use. This means that the organisation and payment of mental health professionals brings huge scope for producing better value for money for mental health systems. In contrast to some other disease areas, the provision of mental health care draws on a range of health professionals beyond doctors (including psychiatrists) and nurses, such as psychologists and occupational therapists, as well as professionals involved in the delivery of social care. Primary care practitioners also play a key role, in particular as the point of first contact with mental health services and in the provision of mental health care to people with mild-to-moderate mental illness (see Chapter 2). Mental health care is also rather unique in that existing and former service users often play an active role in the design and delivery of services in some OECD countries, a recent and quite innovative development for the mental health workforce.

5.2. Composition of the mental health workforce in OECD countries

The mental health workforce in OECD countries comprises a diverse range of service providers. These providers include psychiatrists; psychologists; mental health nurses; social workers and occupational therapists. A comparison of rates of mental health professionals across OECD countries and changes in these rates is appealing in order to obtain a sense of how workforce configurations differ across countries. Different mental health workforce configurations will have diverse impacts on the quality, efficiency and integration of mental health services. Considerable limitations in comparing the mental health workforce across countries still remain and are acknowledged. In particular, while recognising the important contribution of social workers and occupational therapists to the mental health workforce, we do not present cross-country comparisons of these professions due to inadequate data availability. A description of the definitions of mental health professional categories employed in this chapter can be found in Annex 5.A1.

Cross-country comparisons of mental health professionals

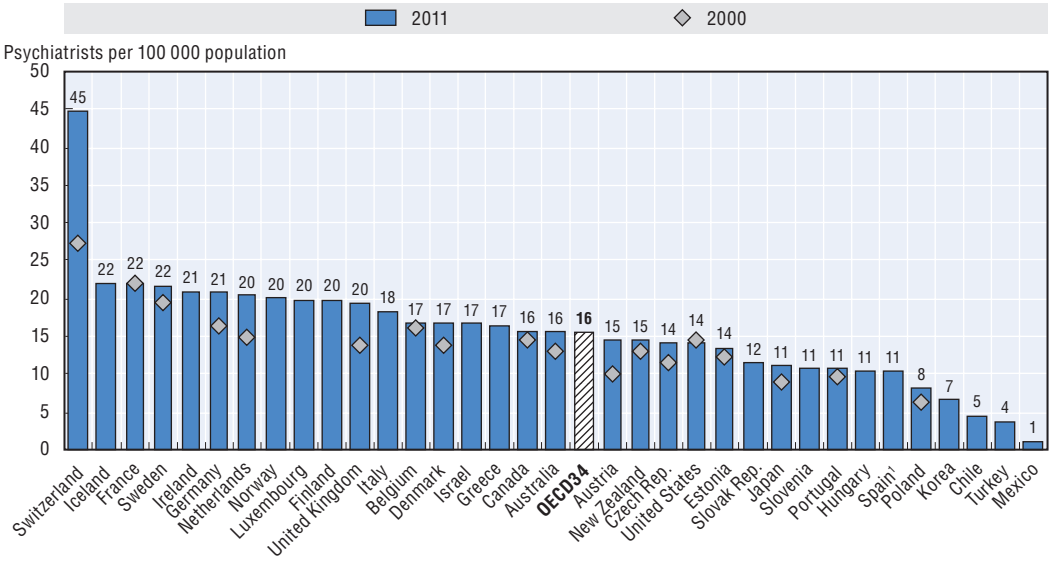
Cross-country comparisons of mental health professionals provide a useful starting point to shed light on differences in mental health service provision and the potential costs and efficiency of this provision. Differences in rates of mental health professionals across countries reflect different models of care, but they are also indicative of differences in the supply of and demand for these professionals which in turn are related to price and quality differentials. Changes in the number of mental health professionals also provide insight into the evolution of these groups and the potential direction of different modes of mental health care provision.

Psychiatrists have been the traditional mainstay of mental health care provision, particularly for people with severe mental illness. While many people with mental health problems – in particular those with mild-to-moderate mental illness – do not encounter psychiatrists, they can have a wide influence in mental health services and, not surprisingly, they are the higher paid and therefore more costly than other mental health professionals.

Figure 5.1 shows the variations in the number of psychiatrists across OECD countries. On average, there were 16 psychiatrists per 100 000 population in 2011. Switzerland had by far the highest number, with 45 psychiatrists per 100 000 population, almost three times more than the OECD average and twice the rate of Iceland, France and Sweden which had the next highest rate. It is unclear if this high rate is due to any oversupply of psychiatrists or a high demand for their services and if, in the latter case, these services could be provided by a lower cost professional without sacrificing service quality. In contrast, Turkey and Mexico report less than five psychiatrists per 100 000 population.

The rate of psychiatrists per 100 000 population has increased in a number of OECD countries between 2000 and 2011, most notably in Switzerland, Germany, the Netherlands and the United Kingdom. There was a slight decrease in the rate of psychiatrists per 100 000 population in the United States (as the increase in the number of psychiatrists did not fully keep up with the increase in the population), while the rate remained stable in France (Figure 5.1).

Figure 5.1. **Psychiatrists per 100 000 population, 2000 and 2011 (or nearest year available)**

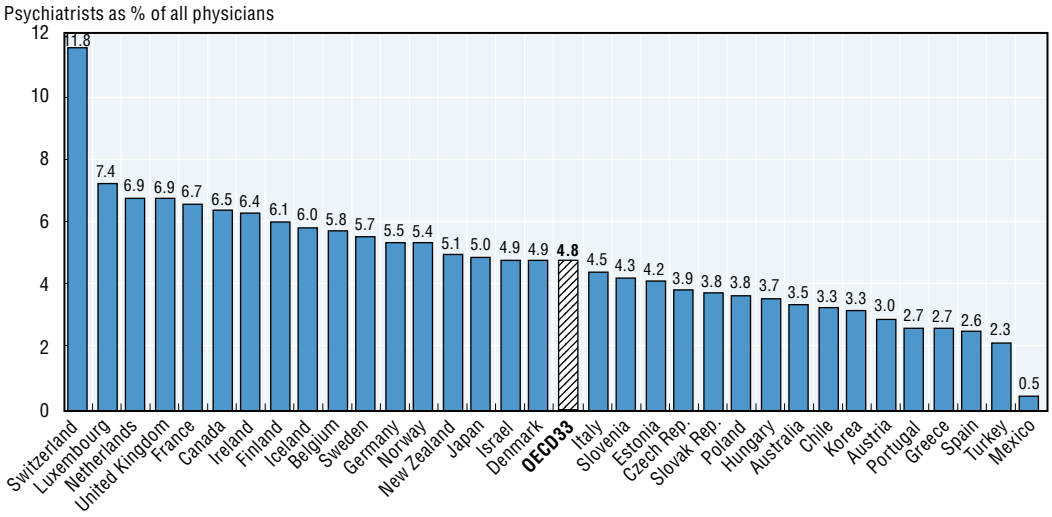


1. In Spain, the number of psychiatrists only includes those working in hospital (resulting in an under-estimation).
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030667

The proportion of physicians who are psychiatrists can provide an indication of the relative attractiveness of psychiatry compared with other medical specialisations. In 2011, on average 5% of physicians were psychiatrists across OECD countries, but with significant variation (Figure 5.2). In Switzerland, 12% of all doctors were psychiatrists, compared with 1% to 2% only in Mexico and Turkey. In most countries, between 3% and 6% of all doctors are psychiatrists.

Figure 5.2. **Share of psychiatrists among all physicians, 2011 (or nearest year available)**



1. In Spain, the number of psychiatrists only includes those working in hospital (resulting in an under-estimation)
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933030686

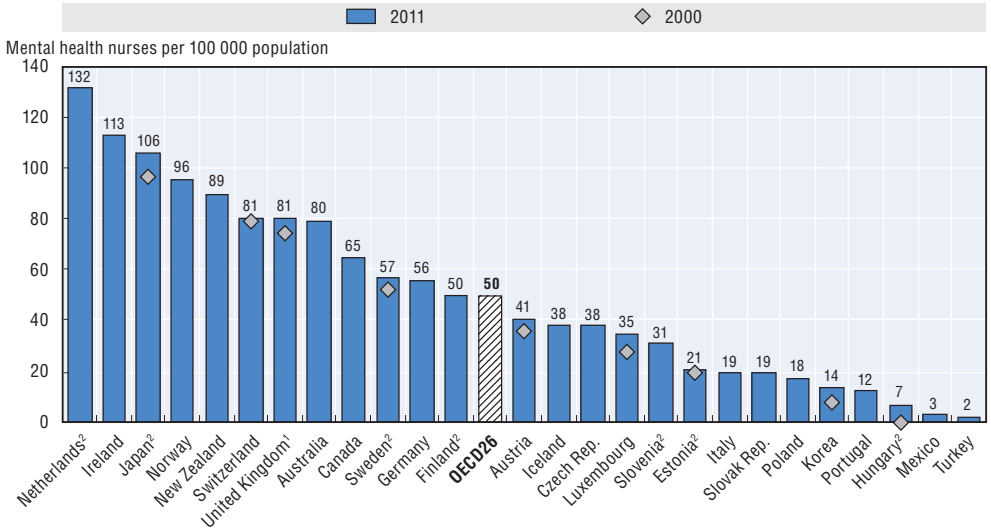
The availability and comparability of the data on nurses working in mental health care is more limited than for psychiatrists. Figure 5.3 shows variations in mental health nurses across OECD countries. The Netherlands, Ireland and Japan have the highest rates with over 100 mental health nurses per 100 000 population. As with psychiatrists, Mexico and Turkey have relatively low rates – 3 or less per 100 000 population – while Hungary also had less than ten mental health nurses per 100 000 population. The OECD average was 50 mental health nurses per 100 000 population (Figure 5.3). There have been some slight increases in the number of mental health nurses per 100 000 population over the past decade, notably in Japan, the United Kingdom, Luxembourg, Korea and Hungary.

The availability and comparability of data on psychologists is also more limited than those on psychiatrists. Figure 5.4 shows the variation in the number of psychologists among selected OECD countries. Almost half of the countries that could provide this data have five or less psychologists per 100 000 population. Israel has approximately 132 psychologists per 100 000 population – more than five times the OECD average and the highest rate among the OECD countries that could provide this data. This may suggest a shift in mental health provision towards psychological strategies in primary care or an increased representation of psychologists in multi-disciplinary teams in secondary care. Austria also exhibits relatively large numbers of psychologists– almost 80 per 100 000 population.

In the United States, the number of psychologists per 100 000 population decreased slightly between 2000 and 2011 (Figure 5.4), as is the case for the number of psychiatrists (Figure 5.1). In contrast, Sweden and Finland have experienced considerable increases in the number of psychologists per 100 000 population.

This analysis has shown that there is considerable variability across OECD countries in terms of rates of mental health professionals, although the availability and comparability of the data tends to be more limited beyond psychiatrists.

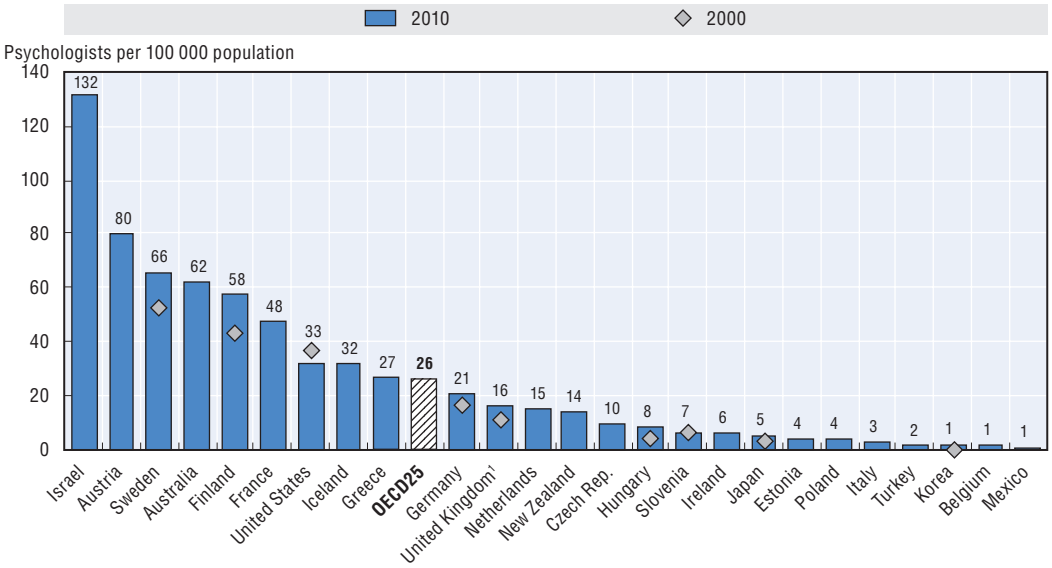
Figure 5.3. **Mental health nurses per 100 000 population, 2000 and 2011 (or nearest year available)**



1. Data for the United Kingdom refers to England only.
2. Data for Estonia refers to 2011 and 2004, Finland 2007, Hungary 2010 and 2000 and Slovenia refers to 2010, Japan 2010 and 2003, Netherlands 2007 and 2000, Sweden 2009 and 2000.
Source: OECD Mental Health Questionnaire 2012 and *WHO Mental Health Atlas 2011*.

StatLink http://dx.doi.org/10.1787/888933030705

Figure 5.4. **Psychologists per 100 000 population, 2000 and 2011 (or nearest year available)**



1. Data for the United Kingdom refers to England only.
Source: OECD Mental Health Questionnaire 2012 and *WHO Mental Health Atlas 2011*.

StatLink http://dx.doi.org/10.1787/888933030724

Unclear delineations of roles and lack of standardisation poses a problem for mental health workforce policy

The lack of standardised roles and scopes of practice(s) between different types of mental health workers contributes to a number of problems. First, data comparability is limited, second, overlapping roles can lead to inefficiency and instability in service provision, third, definitions of roles and scopes of practice are difficult to develop at the international level, and fourth, it is difficult to measure the contribution primary health care professionals make to the provision of mental health services.

Data on the mental and behavioural workforce lacks standardisation which in turn limits comparability

Data on the mental and behavioural workforce is often not standardised and can come from diverse sources resulting in an incomplete picture of the mental health workforce. In the United States, for example, the various professional associations have not collected information on the mental health workforce using a standardised dataset nor a common survey schedule. This makes it difficult to present a unified picture of the mental health workforce or to compare the various disciplines (SAMHSA, 2007). The heterogeneity of data sources can also result in data that is imprecise, conflicting and lacks comprehensiveness for the full workforce. Other issues relate to the co-ordination of professionals and other types of providers. There is often little or no consensus about which disciplines to include or exclude in an assessment of the mental health workforce or how to integrate data across professions. Moreover, information on emerging or allied professionals may be especially difficult to document (Robiner, 2006).

Mental health professionals experience overlapping roles and duties

Mental health professionals may perform similar duties at certain times and experience overlapping roles which can lead to inefficiency and instability in service provision. This overlap of roles and duties can also blur the boundaries of the various professional groups as scopes of practice of some groups expand (e.g. prescriptive authority of advanced practice nurses) into professional duties that were previously the sole domain of others (e.g. psychiatrists). This presents a challenge of how to assess and reimburse the relative value of each discipline's contribution (Robiner, 2006). Moreover, lower-cost providers may erode the market share of higher-cost providers when service purchasers and consumers perceive that similar services are offered at different prices (Ivey et al., 1998). Overlap of roles and scopes of practice as well as substitutability of skills also makes it difficult to measure each profession's workforce relative to need or demand for services. Hence, the ability of each profession to define the areas where its particular skills can add value to the skills of other groups will prove critical to their continued success as a professional entity (Ivey et al., 1998). This also highlights the need for the development and co-ordination of an interdisciplinary workforce (Robiner, 2006).

Definitions of roles and scopes of practice are difficult to develop at the international level

A key challenge is the problem of defining what the various categories of professionals mean in each country. Mental health professional categories in one country may not be defined in the same way in another country. Second, and more interestingly, even if membership in a particular professional category is identical, the role performed functionally by a particular professional in one country might be very different compared

to another country. The scope of practice may vary from country to country and even with identical scope of practice laws and regulations the emphasis in practice may vary. Understanding these contextual and inter-country differences is essential to conducting a meaningful and illuminating analysis of this set of issues. Third, even if the professionals were to be identically defined and have an identical scope of practice and distribution or emphasis in practice, there is likely to be variability over time because of specific policies governing the allocation of these professional resources in various sectors of mental health service delivery. There are policies that relate to the division of labour among these professionals affecting the production functions and the costs. And there are policies that relate to the allocation of these scarce resources across countries that would vary from country to country – or decisions about who to train and for what purposes.

It is challenging to measure the input of providers of mental health services in primary care settings

While it is acknowledged that a sizeable proportion of mental health services are delivered in a primary care setting, it is difficult to get precise estimates or data for such services. Primary care practitioners are increasingly playing an important role in the provision of mental health care, in particular as a point of first contact (see Chapter 2).

Moreover, mental health professionals that traditionally provided services primarily in specialist settings are increasingly incorporated into primary care settings on a full- or part-time basis. While psychologists and mental health nurses are the most common type of mental health professional found in primary care practices working alongside general practitioners, psychiatrists are also an integral part of this care delivery setting in many countries (Table 5.1).

Table 5.1. **Availability of mental health professionals in primary care settings**

	Psychiatrist		Psychologist		Mental health nurse	
	Full time	Part time	Full time	Part time	Full time	Part time
Australia	X	X	X	X	X	X
Austria	X	X	X	X		
Chile			X			X
Czech Republic	X		X		X	
Finland			X	X	X	X
France	X	X			X	X
Germany						X
Iceland			X		X	
Israel		X		X		X
Japan	X	X	X	X	X	X
Korea	X	X	X	X	X	X
Luxembourg	X	X	X		X	
Mexico	X	X	X			
Netherlands						X
Norway			X		X	
Portugal	X	X	X	X	X	
Slovak Republic	X		X		X	
Slovenia	X		X			
Turkey		X	X		X	
United States	X	X	X	X	X	X

Source: OECD Mental Health Questionnaire 2012.

5.3. Education and accreditation of mental health professionals

The training, accreditation and continuing professional education of the mental health workforce plays a critical role in the quality of care produced. When addressing specialised areas of mental health (such as infant and early childhood mental health) training, accreditation and continuing professional education become even more significant for quality service. Training and accreditation also determine the supply of mental health professionals at any given point in time. Placing restrictions on supply in turn influence price in terms of workforce remuneration. Training and accreditation standards also determine workforce mobility and the extent to which countries can address national workforce shortages by recruiting from other countries as well as the opportunities for professionals to emigrate in response to relatively higher salaries or better working conditions compared to their country of origin.

The mix of mental health professionals trained in OECD countries

Table 5.2 shows the mix of selected mental health professionals graduated from training (most recent year available) for selected OECD countries. In most countries mental health nurses account for the largest proportion of recent graduates but in the United States psychologists comprise the majority.

Table 5.2. **Mix of new graduates mental health professionals per 100 000 population, 2011 (or most recent year available)**

	Psychiatrists	Psychologists	Mental health nurses
Australia	0.57		
Austria	1.04	6.2	80.63
Canada	0.44		
Denmark	0.6		41.01
Estonia	0.52		
Finland	0.84	3.62	
France	0.32	3.86	34.3
Germany	0.99	10.09	
Hungary	0.4	0.85	0.07
Iceland	0.65	5.84	33.41
Ireland			31.07
Israel	0.52	6.73	
Italy	0.31	16.46	19.35
Israel	0.52	6.62	
Japan	1.3	3.79	1.35
Korea	0.29	0.65	0.92
Luxembourg			14.44
Mexico	0.03	7.05	3.66
Netherland		13.62	13.74
Poland	0.45		
Slovakia	0.48		8.57
Switzerland	1.99	6.75	
Sweden	1.32	3.63	1.94
Turkey	0.23	1.98	
United States	0.67	3.09	0.46

Source: OECD Mental Health Questionnaire 2012.

StatLink http://dx.doi.org/10.1787/888933030819

Specialist accreditation of mental health professionals in OECD countries

In OECD countries professional accreditation is granted by professional associations and national authorities or boards (Table 5.3).

Accreditation with professional bodies may necessitate additional training to that outlined in Table 5.3. For example, in Australia, mental health nurses can be nationally credentialed by the Australian College of Mental Health Nurses (ACMHN), which requires applicants to have undertaken one FTE year of postgraduate study of clinical nursing practice in a mental health setting. Applicants must also have at least 12 months' experience following their postgraduate qualification or have three years' experience as a registered nurse working in mental health. In addition, applicants must have been practising within the last three years. The ACMHN Mental Health Nurse Credential recognises the skills, expertise and experience of nurses who are practicing as specialist mental health nurses.

Accreditation bodies are usually specific to a particular profession but they can also be responsible for a range of professional categories. Accreditation is essential for ensuring high professional standards and quality of care (see also Chapter 6). Australia has enshrined accreditation boards into law on a national basis as described in Box 5.1.

Table 5.3. **Professional accreditation bodies in selected OECD countries**

	Professional associations	National authorities/Boards
Australia	X	X
Canada	X	
Finland		X
Iceland	X	
Ireland	X	
Mexico		X
New Zealand	X	
Norway		X
Portugal	X	
Slovenia		X
Spain		X
Sweden		X
Turkey	X	
United Kingdom	X	
United States	X	

Source: OECD Mental Health Questionnaire 2012.

Training requirements of mental health professionals in OECD countries

The requirements for training and accreditation of these mental health professionals differ from country to country (Table 5.4).

Generally in OECD countries, training in a psychiatric speciality takes 4-6 years following completion of a general medical degree. This postgraduate training usually combines elements of both theory and practice.

Box 5.1. **Specialist accreditation in Australia**

In Australia, the National Registration and Accreditation Scheme (the Scheme) is a national scheme in which health practitioners are registered under the laws of their respective state and territory jurisdictions, and operates independently of the Commonwealth. The Health Practitioner Regulation National Law Act 2009 (known as the National Law) has been enacted in all states and territories, and provides for the full operation of the Scheme. Under the National Law there is a national registration board for each participating health profession. There are 14 professions covered by the Scheme, including medicine (which covers psychiatry), nursing and psychology.

Each national board is responsible for regulating the practice of its own profession by registering practitioners, developing professional practice standards, approving standards for the accreditation of training programmes, assessment of the skills of overseas trained practitioners, and managing notifications and complaints against practitioners. For practitioners working in the area of mental health, these boards include the Medical Board of Australia (MBA), the Nursing and Midwifery Board of Australia (NMBA) and the Psychology Board of Australia (PsyBA).

For each profession regulated under the Scheme, there is an accreditation authority, which develops accreditation standards and accredits and monitors programmes of study. For the medical profession, the accreditation authority is the Australian Medical Council (AMC). The accreditation authority for the nursing and midwifery professions is the Australian Nursing and Midwifery Accreditation Council (ANMAC). The accreditation authority for the psychology profession is the Australian psychology Accreditation Council (APAC). While the National Law makes provision for specialist registration in any profession, it currently only applies to certain specified professions, including medicine. Medical practitioners can apply for specialist registration in the field of psychiatry, which requires that the practitioner meets advanced training and other requirements as set by the MBA. Specialist registration does not currently apply to the nursing or psychology professions. In psychology, practitioners that meet advanced training and other requirements as set by the PsyBA can apply for "area of practice endorsement", which recognises expertise in particular areas of psychology practice. The PsyBA currently recognises nine areas of practice, which include (amongst others) clinical psychology, clinical neuropsychology, community psychology, counselling psychology, and educational and developmental psychology.

Source: OECD Mental Health Questionnaire 2012.

Mental health nurses generally undertake some specialised training in psychiatric care following an undergraduate degree in general nursing, sometime leading to a master's degree. In some countries, however, nurses working in psychiatric care do not need to have taken any specialised training in this field (e.g., in Australia).

In order to practice as a psychologist, it is necessary to undertake postgraduate training upon completion of undergraduate degrees in psychology.

While the training of primary care physicians is not outlined in detail here (see Chapter 2 for further information), mental health training is a component of primary care physician training (undergraduate or medical degree training) in most, but not in all OECD countries.

Table 5.4. **Training requirements of mental health professionals in selected OECD countries**

	Psychiatrist	Psychologist	Mental Health Nurse
Australia	Five- or six year undergraduate or four-year postgraduate entry-level medical training followed by a medical internship. Qualification as a psychiatric specialist takes an additional five years full-time equivalent (FTE).	Three-year undergraduate and one-year postgraduate degree in psychiatry followed by a further two years of supervised professional training or a postgraduate professional degree at the Masters/PhD level.	A Registered (Division 1) Nurse qualification is required to commence work as a nurse in a mental health setting. Mental health nurses can be nationally credentialed by the Australian College of Mental Health Nurses (ACMHN), which requires applicants to have undertaken one FTE year of postgraduate study of clinical nursing practice in a mental health setting.
Chile	Three years of specialist training following seven years of general medical studies.		Mental health nurse training entails an additional one year of study following an initial training in general nursing.
Czech Republic	Postgraduate training entails 5.5 years of practising psychiatry at accredited departments with rotation in various types of wards and outpatient facilities.	The basic education of psychologists lasts five years. Full qualification requires a board exam.	Nurses working in a mental health setting can take a higher qualification covering psychiatry, psychology and psychotherapeutic training.
Estonia	Four years of specialist training following completion of a medical degree.		
Finland	Following a medical degree, six years of training in psychiatry.		
Germany	Medical doctors complete a five-year postgraduate training in "psychiatry and psychotherapy".	Psychologists can complete a three-year (fulltime) or five-year (extra occupational) postgraduate training in "psychotherapy".	
Hungary	Five years of post-graduate psychiatric specialty training.		Entry-level nursing training results in a BSc after four years or an MSc after 5.5 years. Psychiatric training consists of an additional year.
Iceland			A total of five years of training (one additional year to registered nurse training).
Ireland	Five years of specialist training following completion of a medical degree.		
Italy	Following a medical degree, a four-year postgraduate training.	A three-year bachelor's degree programme followed by a two-year master's degree programme followed by an additional four-year postgraduate training.	A three-year bachelor degree in nursing followed by a master's degree in mental health nursing.
Japan	Five years of specialist training following completion of a medical degree.		A total of five years of training.
Korea	Four years of specialist training following completion of a medical degree.	Licensed clinical psychologists must train in a registered centre for at least one year to qualify as a mental health clinical psychologist.	Licensed nurses undertake training in registered mental health centres for at least one year.
Mexico	A specialisation in psychiatry has a duration of four years.	Four year bachelor's degree courses followed by a master's or doctoral for specialisation in a clinical area.	A one-year specialty training in mental health nursing following completion of a basic nursing degree.
Portugal			A total of 6.5 years of training.
Sweden	Physicians licensed to practise medicine undertake specialist training (ST) under supervision for at least five years.		
Switzerland	Six years of specialist training following completion of a medical degree.	An undergraduate qualification in psychology followed by postgraduate training in psychotherapy of 4-5 years.	Post-graduate training following basic training as a general nurse.
United States	Generally, a medical degree (four years of graduate training) with additional training.	In general, a doctoral degree entailing at least five years of graduate training.	

Source: OECD Mental Health Questionnaire 2012.

5.4. Continuous professional education and development

Continuous professional education and development is essential to promoting and maintaining high-quality care and also contributes to employee satisfaction and retention. However, OECD countries vary widely in the extent to which mental health professionals are obliged to undertake continuing professional education and development. Requirements for continuing professional development (CPD) can also vary within a country by professional category.

Continuous professional development is mandatory in some OECD countries and voluntary in others

The expectation that mental health professionals undertake CPD varies across OECD countries. In some countries such as Australia, Czech Republic, Germany and New Zealand CPD is compulsory for mental health professionals including psychiatrists, psychologists and mental health nurses. In others such as Chile and Estonia, CPD is undertaken on a voluntary basis.

In Germany, continuing medical education is enshrined in the "Act on Modernisation of the Statutory Health Insurance" from 2004. After undertaking continuing medical education, doctors receive a certificate from the medical association of the respective Land (state). In cases of non-compliance the doctor's fee will be reduced. Although there is no "must/have to" rule established in the legislation, the continuing medical education should be conducted in a balanced manner over all medical specialties. Continuing medical education can be organised for example as lecture and discussion, participation in congress and workshop and scientific publications. The amount of activities on continuing medical education is constructed as a point system. For each of the stated activities doctors and psychotherapists get a specific number of points, and they have to reach 250 points in five years.

There is no formal requirement for doctors to undergo continuous training in Sweden. This gap has been recognised and there is now general agreement about the need for CPD for all doctors, including psychiatrists, and the establishment of a uniform structure for physician training that should include systems for quality improvement, quality assurance and quality control. According to a joint policy document from the Swedish Society of Medicine and the Swedish Medical Association, such training should be systematic and based on an analysis of needs based on current and upcoming tasks. All specialists must therefore have an individual training plan which should be documented and followed up in annual performance reviews.

In some OECD countries mental health training is included as part of the CPD training of primary care practitioners (see Chapter 2 for more details).

Requirements for continuous professional development varies by professional categories

The amount of CPD that is required also varies across professions and accreditation bodies. For example, in Australia, the Royal Australian and New Zealand College of Psychiatry (RANZCP) requires psychiatrists to undertake mandatory CPD of 50 hours per year. For the purposes of being recognised as a specialist mental health nurse, the ACMNH requires CPD of 200 hours per three years, including both education and development sub-categories. The Psychology Board of Australia requires psychologists to complete 30 hours of CPD each year. This includes a minimum of ten hours of peer consultation a year. To maintain Accredited Mental Health Social Worker status, the Australian Association of Social Workers requires completion of 75 points per year. This requires completion of

30 points a year directly relevant to Mental Health practice, including ten hours of Focused Psychological Strategies related CPD, within the 75 points per year.

In the United States, continuing education requirements differ across states and jurisdictions. For psychiatrists to be recertified by the American Board of Psychiatry and Neurology (ABPN), a requirement for practising in many settings, psychiatrists must complete an average of 30 hours of CPD training per year every ten years. States also have requirements for practising as a physician, which typically vary from 20 to 50 hours of CPD per year, depending on the state. CPD hours completed for the ABPN can typically count towards state CPD requirements and vice versa. Not all states require continuing education for psychologists, but most require between 20 and 60 hours of continuing education every two years, with the modal requirement being 40 hours every two years. Social workers are also required to complete a certain number of hours of continuing education in most states, typically around 10 to 20 hours per year evaluated over multi-year periods.

5.5. Shortages in mental health professions

The issue of the adequacy of the mental health workforce has been raised in several OECD countries in light of the challenges to recruitment and retention of professionals, in particular in remote or rural areas as well as increased demand due to growing populations and increased service provision. An insufficient mental health workforce will have repercussions for access to services. On the other hand, any shortages in mental health professionals can also provide a stimulus to improve the delivery of mental health care in terms of efficiency and effectiveness. Shortages may be related to restrictions in supply due to staff training quotas or they can arise in response to a negative perception of working in mental health services. This suggests that solutions to mental health workforce shortages must be varied and often require innovative approaches.

Shortages in mental health workforce is an issue in several OECD countries

A number of OECD countries report shortages in their mental health workforce in one or more professional categories. In Australia, workforce shortages for psychiatry are focused in the public sector, with acute psychiatry and adolescent psychiatry particular areas of concern. There are also issues with the geographical distribution of the psychiatry workforce. For example, in 2009, the number of psychiatrists per capita was two times greater in certain states and territories compared with others (AIHW, 2012). Workforce projections to 2025 have also forecasted shortfalls in mental health registered nurses in Australia, in the context of a broader projected shortage of registered nurses in general (Health Workforce Australia, 2012). Portugal, where there are relatively few psychiatrists and mental health nurses per capita, reports that there is a general shortage in these mental health professional categories. Chile also reports workforce shortages in all categories of mental health professionals. In Estonia, shortages for all mental health professionals are reported due to "brain drain" to other EU countries. In other countries, shortages are concentrated in particular professional specialities. In Finland, the largest shortages relate to child psychiatrists while Belgium also reports shortages for child psychiatrists. Poland suffers from a shortage of child and adolescent psychiatrists which is attenuated by the reduction of the share of the population in this group. Israel reports shortages for workers in child/adolescent and older people's mental health services. Despite having the highest rates of psychiatrists among OECD countries, Switzerland reports a shortage of this professional group due to the poor image of psychiatry compared to other medical specialties. Moreover, it has been suggested that future shortages will be most acute for older people's mental health services.

Mental health workforce shortages have a geographical dimension in several OECD countries such as Australia, Canada, Finland, France, Japan, Korea, New Zealand, Slovak Republic and Slovenia. Canada reports shortages of psychiatrists and other mental health professionals in certain regions of the country, in particular rural, northern and sparsely populated areas, because of a low supply in these regions. In the United States, the Health Resources and Services Administration estimates that an additional 5 791 mental health professionals including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists, are needed to meet the current needs of the United States population (US Department of Health and Human Services Health Resources and Services Administration). Mental health workforce shortages are a particular problem for rural areas in the United States and primary care providers often play a large role in mental health care as a result. However, even in urban areas there is a shortage of mental health care providers who are culturally competent or linguistically diverse and this could intensify the disproportionate burden of mental illnesses on racial and ethnic minorities (Sundararaman, 2009).

In Germany the professional group of psychiatrists has had a relatively constant net increase of 4.5% over the last few years making it the fastest growing medical speciality. A similar development is observed for psychological psychotherapists. The demand for treatment of mental illnesses increased mainly due to successful initiatives and political efforts focused on mitigating the stigmatisation of mental illness.

Despite the large growth in psychiatrists as a percentage of all physicians (see Figure 5.2), Ireland also perceives shortages in psychiatrists and other mental health professionals. However, 414 posts have been approved to implement an additional EUR 35 million package of specific measures for mental health. A further EUR 35 million was allocated in 2013 for the recruitment of further additional staff.

There is also perceived poor recruitment in psychiatry in England. The Royal College of Psychiatrists' Census (2011) suggests that approximately 10% of consultant posts are filled by locums (temporary positions) and about 5% of posts are vacant or unfilled at any time. The Royal College of Psychiatrists has established a Taskforce to make recommendations to improve recruitment. The Taskforce is investigating the factors before medical school, during medical school, during foundation training, in core and higher psychiatric training, in other aspects of postgraduate training and in the profession as a whole that could boost recruitment, progression and retention of psychiatrists. The College is supporting a number of initiatives to promote a career in psychiatry. A strategy is being developed to ensure successful initiatives are rolled out across the United Kingdom through the College's Divisions.

Shortages in the mental health workforce can have an adverse impact on quality of care and patient outcomes. Moreover, in the context of the current economic crisis when demand for mental health services can be expected to increase, workforce shortages can contribute to unmet need.

Shortages in mental health workforce may be associated with staff stress and "burnout"

Psychiatry is often viewed as an unattractive career choice due to the stigma surrounding mental illness and the stressful nature of mental health practice, including risks to personal safety (Holmes, 2006; Kenny et al., 2009).

Concern has been raised that mental health workforce shortages may be related to high staff turnover due to "burnout" and stress (Paris and Hoge, 2009). Burnout is a syndrome comprised of a set of symptoms related to emotional exhaustion, depersonalisation (or

cynicism), and reduced personal accomplishment (inefficacy). Burnout is a significant problem within the mental health workforce regardless of country, work setting or type of personnel examined, particularly in relation to emotional exhaustion.

Evans et al. (2006) examined the prevalence of stress and burnout, and job satisfaction among mental health social workers in England and Wales. Mental health social workers reported high levels of stress and emotional exhaustion and low levels of job satisfaction. Feeling undervalued at work, excessive job demands, limited latitude in decision making, and unhappiness about the place of the mental health social worker in modern services contributed to the poor job satisfaction and most aspects of burnout. The authors warn that the high levels of stress and burnout among mental health social workers may exacerbate recruitment and retention problems. However, a causal link between burnout and staff turnover has not yet been established (Paris and Hoge, 2009).

Johnson et al. (2012) undertook a large-scale survey of English inpatient mental health staff to ascertain levels of staff morale. Staff morale was assessed in terms of 1) burnout relating to emotional exhaustion, cynicism and personal accomplishment, 2) well-being, 3) job satisfaction, 4) overall psychological health, and 5) motivation. While staff well-being and job satisfaction were found to be fairly good, emotional exhaustion was high among acute general ward and Community Mental Health Team (CMHT) staff and among social workers. Multilevel regression analyses revealed that factors associated with greater emotional strain included working in a CMHT or psychiatric intensive care unit (PICU), high job demands, low autonomy, limited support from managers and colleagues, age under 45 years and junior grade. Greater positive engagement was associated with high job demands, autonomy and support from managers and colleagues, Black or Asian ethnic group, being a psychiatrist or service manager and shorter length of service. The study may be limited by systematic differences between respondents and non-respondents as the overall representativeness of the workforce could not be tested.

Research on retention of mental health nurses in England has found that the main sources of job satisfaction were caregiving opportunities and supportive working relationships. The main sources of dissatisfaction were pay and paperwork, opportunities for professional development, and some aspects of work/life balance (Robinson et al., 2005). A study of occupational therapists working in mental health settings in Australia revealed that key elements that kept study respondents in positions included the nature of the work, being in a supportive team and the opportunity to use occupational therapy skills. Elements that prompted people to consider leaving positions were the desire for new and different types of work, a desire to work closer to home, insufficient time or high workloads, feeling "bored" or "stale", organisational change or juggling multiple demands, working in unsupportive or dysfunctional teams and family or other personal factors (Scanlan et al., 2009).

Staff shortages may be aggravated in rural areas due to a number of factors such as professional and personal isolation, small organisations, heavy workload, inadequate infrastructure, issues of access and excessive distances to deliver and refer services, and difficulties of access to professional development and training (Moore et al., 2010; Thomas et al., 2012; Perkins et al., 2007).

Workforce shortages can drive more effective and efficient service delivery

Shortages in mental health workforce can provide an increased impetus to co-ordinated care and innovations in payment and delivery systems. In Australia service redesign has been highlighted as potentially affecting future demand for the mental health specialist

workforce including the development of shared care models (for example the development of a diploma qualification for GPs to support shared care models); changed emergency department models of care, with earlier psychiatric (or registrar or mental health nurse) consultant involvement; and improved access to psychiatric services through further development of telehealth models (Health Workforce Australia, 2012).

Telehealth models have particular appeal as a solution to workforce shortages in rural areas and offer the potential for professionals in distant areas to use video conferencing to communicate with patients (Thomas et al., 2012). The use of e-screening could also prove an efficient way to increase the availability of mental health care in rural areas. Screening is an important preventative intervention and can be effective in reducing overall expenditures. Thomas et al. (2012) report on a pilot study investigating the use of electronic screening for mental health in a rural primary care setting that used a computer with touch-screen and audio-assisted technology. A printout of the e-screening results was provided to both the patient and the health care provider which increased the power of intervention to inform clinical practice. The majority of the study subjects found this system easy to use and the e-screening tool proved to be an acceptable and effective means of screening for depression in a rural population (Thomas et al., 2012).

In Australia, the Expanded Specialist Training Programme (ESTP) was established by the Federal Government in 2007 in order to achieve better professional and community outcomes and to make psychiatry an attractive career option by correcting gaps in training by broadening exposure to non-traditional psychiatric settings. These expanded settings encompass private psychiatric hospitals, clinics and consulting rooms, primary mental health services, indigenous and transcultural services, regional and rural services and leadership and research posts. The treatment of high frequency mental disorders (anxiety, depression and substance abuse) by means of psychological therapies in private practice settings emerged as the largest identified gap in current teaching practice. The ESTP was established in response to the perception that trainees had limited experience in managing the more typical anxiety, affective and substance use disorders and the belief that psychiatrists, as the leaders of clinical teams or as solo practitioners, should be properly equipped to manage these so-called high-prevalence conditions using psychological treatments, with or without psychotropic medications, irrespective of their final career choice. Additional benefits of the ESTP are to produce better-rounded specialists, and to improve access to specialists in regional and rural areas of Australia (O'Connor et al., 2009; Schweitzer et al., 2009; O'Connor and Spratt, 2010).

Mental health workforce shortages have also provided an impetus for the introduction of new professional roles such as mental health nurse practitioners in Australia and Advanced Practice Psychiatric Nurses (APPNs) in the United States. These new professional entities have enhanced roles in relation to prescribing and referral tasks which were historically the domain of psychiatrists and GPs. In the United States, increasing the numbers of APPNs who have specialised education in various types of psychotherapy, psychopharmacology, and complementary treatments as well as authorisation to prescribe psychotropic medication is seen as another potential solution to address rural mental health workforce shortages in particular (Hanrahan and Hartley, 2008). In England, a new professional role – a mental health practitioner (MHP) – was introduced to health services in southern England in 2003 partly in response to workforce shortages. The role combines practices of nursing, psychology, medicine and occupational therapy. Graduates are employed in mental health services and undertake a two-year multidisciplinary postgraduate training programme (Zeeman and Simons, 2011).

Migration of mental health professionals may mitigate workforce shortages in receiving countries

Mental health workforce shortages may also be alleviated by recruitment from other countries. This approach has been adopted by Australia which issued 185 subclass 457 visas (related to a stay of up to four years for business purposes) to psychiatrists and mental health registered nurses during 2011-12. The Czech Republic have recruited mental health graduates from Slovak Republic and Ukraine while Slovenia has also recruited mental health professionals from neighbouring countries. In Germany, the federal government undertook several measures to address the shortage of skilled personnel in some professions in general including mental health professionals. A new website was set up (*www.anerkennung-in-deutschland.de*) to provide professionals from abroad with information and assistance on how to gain recognition of their foreign medical degree in Germany. Recruitment from abroad has also been helped by the abrogation of the so-called "Vorrangsprüfung" (which ensured a check that a job could not be filled by a German skilled worker before being occupied by a foreign skilled employee) for doctors and engineers since June 2011. In the United States, individuals from foreign countries have been recruited by provider organisations to meet workforce needs in a variety of health professions including mental health. In New Zealand mental health professionals, psychiatrists in particular, are recruited mainly from Australia and the United Kingdom because they meet New Zealand's training and qualification requirements and do not require further training. In Switzerland about half of the non-Swiss psychiatric doctors come from Germany and Austria. The remainder come from Balkan countries and Turkey as well as Italy and Francophone African countries.

However, recruitment from other countries is not a viable option for some countries, for example Estonia which reports low salary levels as a barrier to attracting overseas staff. Furthermore, language barriers may impede recruitment from abroad as in the case of Belgium where immigrant psychiatrists would have to be able to communicate in both French and Dutch.

While migration of mental health professionals can help to alleviate workforce shortages in receiving countries, they may contribute to shortages in the sending countries including OECD member countries. As discussed earlier Estonia is one such country that suffers from workforce shortages due to emigration of professionals.

5.6. Changing models of human resources in mental health care

Changing models of human resources and mental health care delivery have increased the potential for the provision of more efficient and effective services that promote better quality and service integration. As illustrated earlier in this chapter, the range of mental health professionals has expanded widely providing scope for a shift away from costly specialists towards lower cost nurses and allied health professionals. This is evident in the extensive use of multi-disciplinary team working, the expansion of roles and the formation of new job functions and responsibilities. Central to the evolution of human resources models in mental health care has been the adoption of new roles and settings and enhanced teamwork, resulting from a changing context of care.

New roles and settings

In many countries, psychiatrists are moving from hospital-based settings to community-based multidisciplinary team settings where, in addition to diagnostic and treatment roles, they are increasingly taking on roles involving team leadership and oversight and

management of other professional groups. Table 5.5 presents an overview of the various models of collaboration between psychiatric specialists and general practitioners in OECD countries. It is relatively rare for psychiatrists to merely see a selection of cases that are pre-selected by the primary care physician – the so-called "Outpatient model". Instead, psychiatrists also commonly provide informal advice to primary care physicians when the latter requires advice on a particular patient with mental illness – the "Consultation liaison model" – or indeed provide training in primary care settings and advise primary care providers about how to manage patients with specific conditions – the "Facilitation model". Psychiatrists also frequently participate in regular scheduled meetings – "Multi-disciplinary review meetings" – between primary care providers and other mental health professionals to discuss individual patients and/or service delivery (Table 5.5). Regularly scheduled specialist consultation to multi-disciplinary groups of professionals can contribute to building capacity to respond to the needs for mental health care from infancy and early childhood through to the adult life cycle. Chapter 2 provides more detail on these care models.

Table 5.5. **Models of collaboration between psychiatric specialists and general practitioners (GPs)**

	Outpatient model	Consultation liaison model	Facilitation model	Multi-disciplinary review meeting
Australia				X
Austria	X			
Belgium		X		
Canada	X	X	X	
Chile	X	X	X	X
Czech Republic	X	X		
Estonia		X	X	
Finland	X	X		X
France	X			
Iceland		X	X	
Ireland	X			
Israel		X	X	
Italy		X		
Korea		X		
Luxembourg		X	X	X
Mexico		X	X	
Netherlands	X	X		
New Zealand	X	X	X	X
Norway	X	X	X	X
Portugal	X	X	X	X
Slovak Republic	X	X		
Slovenia	X	X	X	
Spain	X	X	X	
Switzerland		X		
Turkey			X	
United Kingdom (England)	X	X	X	
United States[1]	X	X	X	X

1. There is not one uniform model across the country, but each of these strategies is sometimes used.
Source: OECD Mental Health Questionnaire 2012.

In England, suitably qualified mental health nurses and pharmacist prescribers have moved from being largely limited to prescribing from within the constraints of a treatment plan agreed by a doctor ("supplementary prescribing") to one where they can potentially

prescribe independently any medication (with the exception of controlled drugs) within their area of competence (CSIP/NIMHE, 2007). Potential benefits of this expansion in non-medical prescribing include more timely and effective access to medication for service users, reduced cost of prescriptions and the exploitation of the full range of skills and knowledge of nurses and pharmacists (CSIP/NIMHE, 2007). However, the introduction of non-medical prescribing also requires several factors to increase its success. These include clarity of purpose regarding why non-medical prescribing is being introduced and to meet what needs; a clear plan for implementation; and initial engagement with stakeholders in order to ensure professionals, managers, service users and carer representatives understand the rationale of non-medical prescribing; and the implementation of suitable clinical governance mechanisms such as supervision, access to learning materials and auditing of safe practice (CSIP/NIMHE, 2007).

In England, clinical psychologists have created an autonomous space away from medical dominance by taking direct referrals of "common mental disorders" from primary care and aspire to treat more serious mental illness such as psychosis using psychological therapies (Scheffler and Kirby, 2003; Mueser et al., 2013). The emphasis in England on improving access to psychological therapies for a range of mental health problems provides a new opportunity for more power and status for psychologists and nonmedical psychological therapists (Pilgrim and Rogers, 2009).

England and Wales have introduced a new role of "responsible clinician" under the 2007 Mental Health Act which replaced the former role of "responsible medical officer". While the latter role was only open to doctors, the new responsible clinician role is open to a wider range of mental health professionals with the appropriate training and competences, including chartered psychologists, nurses, social workers and occupational therapists, in addition to doctors. The responsible clinician has overall responsibility for a service user's care and treatment plan in the context of the multidisciplinary team (CSIP/NIMHE, 2007). The potential benefits of the change in roles include the potential to reduce reliance on locum doctors and increase numbers of staff in the responsible clinician role; improved skill mix at senior clinical/practice levels meeting service user needs; more cost-effective service delivery and improved career pathways for non-medical staff as well as retention of non-medical senior expertise in frontline practice (CSIP/NIMHE, 2007).

The 2007 Mental Health Act in England and Wales also introduced the role of "approved mental health professional" (AMHP) to replace the role of approved social worker (ASW). As a consequence the ASW role was opened up to a wider group of trained and qualified mental health professionals, including nurses, occupational therapists and chartered psychologists, in addition to social workers (CSIP/NIMHE, 2007). The AMHP is responsible for organising, co-ordinating and contributing to Mental Health Act assessments. Perceived benefits of the introduction of the AMHP role include increased flexibility and a more appropriate and affordable skill mix, potential to reduce pressure on the social work workforce by increasing the numbers of AMHPs, increased access to AMHPs in rural settings, a wider range of career opportunities for non-social-work professionals and potential for AMHPs to take on the responsible clinician role after the accumulation of extensive experience, and solutions to workforce problems regarding recruitment, retention and age profiles of social work professionals (CSIP/NIMHE, 2007).

England also introduced another new role specific to primary care – primary care mental health workers (PCMHWs) – whose purpose is to support the delivery of brief, evidence-based effective interventions such as interpersonal counseling, anxiety management, problem solving, and other brief structured treatments and self-help for

people with common mental disorders of all ages (Shepherd and Rosairo, 2008). PCMHWs can also undertake wider community work such as the development of databases of local mental health services and liaising with charitable and voluntary sector services, including service user groups to promote better links and promote access and better support for people with mental health problems. Hence, PCMHWs have the potential to strengthen the information available for patients; support the development of practice-based information systems, audit and outcome measurement; improve service users' satisfaction with care; and improve knowledge within the practice about the network of community resources for people with mental health problems (Shepherd and Rosairo, 2008). PCMHWs must be educated to degree level but this degree need not be mental health related. They complete a part-time post-graduate certificate in primary care mental health in their first year of employment (Shepherd and Rosairo, 2008). However, despite the perceived benefits of new professional roles, the lack of precedent may bring unintended problems. Shepherd and Rosairo (2008) note that the training offered to PCMHWs may not equip them to assess clients, to manage cases of the complexity often presented, or to work at the level of autonomy expected of them in their work settings. This has sometimes resulted in clients being seen by PCMHWs unqualified to help them, caused PCMHWs to suffer high levels of stress and isolation, and created confusion about how to make the best use of the valuable services PCMHWs can offer. This underlines the importance of adequate training, supervision, role clarity and team integration and support when introducing new roles in mental health care.

Additional challenges that can arise when introducing new roles or new ways of working are that new roles are actively resisted and career structures do not support retention. Furthermore, many newer roles are not specifically linked to a single existing profession, making assimilation into services more complex. Therefore it may be necessary for organisations to actively challenge existing assumptions about traditionally professionally qualified staff always being the "best" providers for care, communicate new innovations/roles to existing staff early in the transition process as well as ensure new roles have defined career frameworks and processes for review (CSIP/NIMHE, 2007).

Several principles underlie the adoption of new roles and ways of working by mental health professionals. These include matching the knowledge and skills of practitioners to the needs of individual service users (the more complex the needs, the more experienced and skilled the worker); a reorientation in mindset towards competence of worker rather than profession; a sharing of knowledge, skills and competences across professional and practitioner boundaries; dispersed leadership and the adoption of a team approach, rather than an individual practice or practitioner focus, with the aim of making more effective use of existing resources (CSIP/NIMHE, 2007).

A consequence of the shift in emphasis towards competences and capabilities is that mental health workforce planning will become more complex. Workforce planning has often traditionally concentrated on numbers (supply and demand) based on the existing staff groups based on the assumption that a new member of a certain professional group e.g. a mental health nurse, will replace a vacancy left by a former member. In light of a competences and capabilities approach an adequate workforce supply may mean that existing staff extend their practice or the introduction of a new role (CSIP/NIMHE, 2007). The ways that different professions define their own roles in mental health care provision will similarly affect future workforce needs (Scheffler and Kirby, 2003).

More teamwork

Mental health professionals in many OECD countries have adopted a flexible team-based approach in the form of community mental health teams (CMHTs) or more specialised alternatives (assertive outreach teams or early intervention teams). The formation of multi-disciplinary mental health teams has been motivated by the need to meet new needs of service users as mental health care shifts from institutional to community-based settings. As mental health services move into community settings, professionals will find themselves working in multi-disciplinary teams with many more professional groups involved and a much wider range of shared, as opposed to specific, skills (Winton and Robinson, 2005). Responsibility is distributed amongst team members rather than delegated by a single professional, traditionally the psychiatrist. Perceived benefits to service users and carers are that a team approach is more responsive to individual needs and strengths, rather than just clinical symptoms and can offer enhanced access, continuity of care and communication. The CMHT approach also brings potential benefits to professionals in terms of more manageable workloads with team support as well as increased opportunities for personal development (CSIP/NIMHE, 2007).

Evaluating the effect of new roles on access, quality and cost

There is no doubt that changing roles and scopes of practice has an impact on access, quality and cost of mental health services but it is difficult to evaluate to what extent this has occurred without good cost data and quality indicators. The impact of expanding the roles of non-medical practitioners on cost will depend partly on the remuneration gaps between different categories of providers, yet without adequate remuneration data it is difficult to say to what extent new workforce configurations might result in lower costs. Similarly, a lack of quality and outcome data prohibits an assessment of the cost-effectiveness of these new ways of working.

Also of importance is whether quality differentials arise from different professionals performing similar tasks. Patient satisfaction surveys have been used as a measure of quality to examine whether patients treated under a team-based approach using a nurse practitioner (ACT-NP) for medication management report lower levels of satisfaction than those whose medications are managed by a psychiatrist (ACT-MD). Results from these surveys indicate that the latter group of patients (those managed by psychiatrists) reported significantly higher satisfaction with medication management than patients managed by nurse practitioners, mainly because patients reported that psychiatrists took more time and were more thorough during each medication visit (Williams et al., 2009). The authors suggested that patients may have been more satisfied seeing a psychiatrist because of their perceived greater authority and expertise.

Duplication of services delivered by different professional groups should be avoided in order to ensure efficient delivery of good quality services. Robiner (2006) recommends that better communication and co-ordination of services among disciplines has the potential to enhance services for patients and enrich each discipline. Efforts by professional organisations to develop effective interdisciplinary collaborations may potentially improve care to patients, working relationships among practitioners, and reduce divisiveness and professional rivalries.

5.7. Integration of service users and carers into the mental health workforce

As mental health care has become more integrated into community settings, service users and family caregivers play an increasing and critical role in supporting people with mental health problems (see also Chapter 6). There is emerging evidence that

these elements of the "workforce" (and indeed many of them will benefit from paid and professional support to achieve maximum utility) play important parts in reducing risks at primary, secondary and tertiary levels. However, the full contribution of this informal workforce is difficult to quantify and assess, in particular their impact on the overall costs and quality of mental health care and patient outcomes.

Benefits and barriers to participation of service users and carers

Service user and carer involvement in mental health services has the potential to produce benefits for the service user and a wider group of stakeholders but faces numerous barriers to successful implementation. According to Tait and Lester (2005) user involvement encapsulates a range of different ideas ranging from active participation at the micro-level of individual decision making, to more macro-level involvement in service planning and evaluation and, increasingly, in the training and research arenas. Effective involvement leads to service users and carers feeling empowered, confident and valued, thereby making them feel more in control and better able to make choices, and so enhancing the quality of their lives and advancing the potential for a more effective and positive workforce (CSIP/NIMHE, 2007). Evidence suggests that employment of former service users in service delivery is feasible and can be beneficial to the clients receiving their services (Simpson and House, 2003). Service user involvement can bring a range of benefits including bringing the perspective of the user to the design and delivery of mental health care; increasing understanding of mental distress and reducing stigma; greater social inclusion and providing therapeutic benefits to the user (Tait and Lester, 2005).

Barriers to user involvement in mental health services include a relative lack of information for service users on the nature of mental health problems, the side effects of medication, alternative forms of treatment and mental health law; financial and time costs; and concerns over representativeness in that those service users who can participate may not be representative of service users more generally in that they are "too well", or "too vocal and articulate". Another not insignificant barrier is professional resistance to the idea of users as experts (Tait and Lester, 2005). The attitudes of mental health professionals to user and carer participation in mental health service delivery can also pose a significant impediment to this participation (Cleary et al., 2006). Goodwin and Happell (2007a, 2008) ascertained the attitudes of mental health nurses (which in general comprise the largest proportion of the mental health workforce) to consumer and carer participation. Although the study was limited to a sample of 30 nurses in two specific settings in rural Victoria, Australia, the study revealed some notable insights. Respondents generally recognised the importance of consumer and carer participation in the delivery of care and treatment, in particular citing carer involvement as an essential element in the provision of high-quality care. However, not all participants considered it the role of the nurse to actively encourage consumer and carer participation. With regard to the main barriers to consumer and carer participation in care, the study participants felt these most strongly related to 1) time and working conditions, 2) the impact of mental illness, and 3) geographical isolation. Working conditions were considered a major obstacle as nurses perceived that insufficient time and high caseloads inhibited effective engagement with consumers and carers in order to facilitate participation. Issues arising from the consumer's mental illness included difficulties engaging the consumer as well as limitations on the ability of consumers to participate. Finally, social and geographical isolation was a particular problem in rural areas.

Integrating current and former service users into the mental health workforce

Employment practices and new roles may be used to integrate current and former service users into the mental health workforce. Recognition and implementation of key employment practices and the creation of new roles contribute to a positive employment experience for existing and former service users. Wolf et al. (2010) identified three categories of key practices in employment of former service users and individuals in recovery in the mental health workforce. These practices include 1) pre-employment and training practices, 2) human resources practices and 3) organisational practices.

- Pre-employment and training practices play an important role in preparing individuals in recovery to enter the workforce as this group may have had little prior work experience or spent an extended time out of the workforce. Relevant practices that can prepare persons in recovery for mental health workforce employment include volunteer experience, supported education, supported employment, and preservice education and training. Volunteering can aid introduction to a work environment, help build the skills and confidence of the volunteer and provide an impetus towards paid employment. Supported education offers assistance and support to individuals pursuing educational endeavours that can lead to employment. Similarly, pre-service education and training aid individuals in recovery to acquire the educational credentials and competencies necessary to perform potential work roles.
- Human resources policies contribute to the successful employment of individuals in recovery by implementing practices to promote role clarity, adequate support, effective supervision and career development opportunities. Adequate and flexible employment benefits, including sick leave, are particularly important for retention of persons in recovery in employment.
- Organisational practices include the involvement and participation of persons in recovery at different levels of decision making and governing structures. In addition, continuous feedback mechanisms are important in order to increase overall staff communication and satisfaction, encourage a positive work environment, and promote both staff and client empowerment and satisfaction.

A new role introduced recently in England – the Support, Time and Recovery (STR) worker – is potentially one avenue to employment in mental health services for existing and former service users (Department of Health, 2003). The role of STR workers is to be flexible in providing the Support service users want by giving them Time and thus promote their Recovery (CSIP/NIMHE, 2007). The role was created in response to the concern expressed by service users that staff working in mental health services have little time to discuss with service users their individual needs and expectations from services and offer them advice and support. An STR worker participates in a team that provides mental health services and focuses directly on the needs of service users. STR workers carry out their role in a range of community settings as well as in acute and secure care settings. They undergo a single nationally agreed induction programme and also undertake ongoing training. An evaluation of the introduction of STR workers revealed that the role generates positive and desired outcomes for service users – particularly through the provision of time, and continuity of support (Huxley et al., 2006).

In Scotland, peer support is still developing, but there are around 60 peer support workers across Scotland with a commitment to increase this further. An accredited training programme is in place providing supervision and support for peer support workers.

Carers value collaboration with mental health professionals but barriers impede extensive participation

Carers value collaboration with mental health professionals – in particular mental health nurses – but differing viewpoints and nurses' attitudes are among the barriers to effective participation of carers. Cleary et al. (2006) note that carers' viewpoints are frequently different to those held by health professionals and can also differ from the views expressed by the individual being cared for. These differing views can pose challenges to collaboration, in particular in the development of care plans. Cleary et al. (2006) posit that there is also a need to be cognisant of the physical, mental and social challenges faced by the carer. The availability of respite care and adequate supports (including education and information) for carers can have a positive impact on carer's levels of personal satisfaction and help to reduce feelings of frustration associated with their role. Clear and coherent channels of communication between health professionals and carers also make a positive contribution to this relationship. Most importantly, it is necessary that the role of carers is clearly delineated to minimise duplication, maximise the use of resources, and maintain positive relationships between service providers, consumers, and carers. Moreover, in the absence of good support networks the indirect cost of caring will be high if it leads to reduced labour market participation or impacts negatively on the physical and/or mental health of the carer.

In a study that elicited carers' perspectives of participation in mental health care, Goodwin and Hapell (2007b) revealed that the role and attitude of nurses was considered as significant by carers. In particular, carers appreciated instances when nurses expressed consideration and respect for them and the person they cared for and also listened to them and provided them with information. In some instances, carers did not perceive that nurses actively encouraged their involvement, perhaps due to a lack of awareness on the part of the nurse or because nurses believed that the carers did not need active encouragement in their role.

With regard to carers' perceptions of barriers to participation of carers and consumers in mental health care, the major themes that emerged included 1) changes to service delivery, 2) issues of access, 3) the role of the nurse, and 4) the impact of geography. Changes in service delivery, including reductions in length of inpatient stay and increased care in the community, meant that carers felt that there was insufficient time to establish a relationship with nurses that would facilitate opportunities for participation. Issues around access related particularly to information regarding the care and treatment of the consumer. With respect to the role of the nurse, participants identified the pressures nurses worked under, due to insufficient numbers of nurses, which made it difficult or impossible to adequately fulfil the responsibilities of their work. Geographical issues related to those of access to adequate services (Goodwin and Hapell, 2007c).

Training and education of mental health professionals provides an innovative new role for service users and carers

Repper and Breeze (2007) conducted a review of the literature on user and carer involvement in the training and education of health professionals. With regard to mental health care, they found that benefits to service users stemming from inclusion in professional education included the acquisition of new skills, increased self-confidence and a genuine feeling of empowerment. There were also potential benefits for students in terms of their interpersonal skills and increased empathy with service users (ibid.). However, teachers/academics were more reserved about the potential benefits of including service users in

professional education. They voiced concern over the ability of individuals with mental illness to teach large groups of students and that individuals who were capable of this may not have been representative of the core group of users. There was also a fear of an erosion of their professional duties and responsibilities and a threat to their professional identity as educators. Cleary et al. (2006) feel that there is also a developing role for carers in mental health professional education programmes and acknowledge that carers should be involved in curriculum development and delivery.

5.8. Conclusion

As mental health care provision has moved away from inpatient care in hospitals to community-based settings workforce configurations have evolved from an organisation based primarily on hospital-based psychiatrists towards more community-based workers. Allied health professionals such as psychologists, social workers and occupational therapists have taken on enhanced roles. In order to sufficiently plan, monitor and evaluate an evolving mental health workforce it is necessary to have adequate data and evidence. While data coverage is quite good for psychiatrists, psychiatric nurses, and psychologists it is sparser for other professions such as psychiatric social workers and occupational therapists. Hence information on the mental health workforce has not evolved in tandem with models of service delivery. There is also a paucity of data on remuneration of mental health professionals. As a consequence, it is difficult to assess what impact the changing workforce configurations will have on the overall costs of mental health care and whether new ways of working are efficient and cost-effective.

Mental health professionals are increasingly working in multi-disciplinary teams in community settings. However, unequal team roles resulting in the dominance of one or more professional groups and the marginalisation of others may impede effective team functioning. In mental health care, medical professions – in particular psychiatrists – may emerge as dominant players. Consequently, workers outside the health sector such as social workers feel marginalised and experience difficulties in team working resulting from a clash of values and beliefs between the "medical" and "social" models of mental health care and also working in a medically dominated hierarchy (Carpenter et al., 2003). Hence, it is important to enhance role clarity and reduce role conflict in order to ensure positive outcomes for community mental health staff. Other potential barriers can arise from professional rivalry and mistrust, lack of support for team working from key professionals and mental health managers/administrators and a lack of knowledge of what other mental health professionals do and what unique skills they have to offer. Interprofessional education (IPE) is regarded as a key solution to enhancing the collaborative and team efforts of health and social care staff. It is imperative that the participation of all relevant professional staff in both the development and delivery of IPE is supported.

Despite the perceived difficulties that multi-disciplinary team working can encounter, such teams are associated with positive benefits for both the professionals themselves and also for the clients. Positive professional outcomes include higher job satisfaction, increased autonomy and decision making, improved retention, and decreased burnout as well mutual support and education (Mental Health Commission, 2006; Swartz et al., 2011). Care delivery by a multi-disciplinary team ensures the skill range to meet the increasingly complex needs of service users who require the different skills of different professionals and enables the provision of a wide range of services and resources for service users (Mental Health Commission, 2006). Moreover, through better use of existing resources, collaboration

through multi-disciplinary teams has the potential to enhance clinical quality and value for money (Reeves et al., 2006) and have been shown to be cost-effective (Knapp et al., 1994).

Workforce shortages exist in many OECD countries which can be addressed to some extent by recruitment from other countries. Unfortunately, a lack of adequate data on migration of mental health workers inhibits a comprehensive assessment of its patterns and consequences. Workforce shortages have also given rise to more innovative and efficient models of mental health care delivery which do not compromise quality. Caregivers and service users also serve to fill some workforce "gaps" but again insufficient data hinders a full assessment of the benefits and costs associated with this "informal" workforce.

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ANNEX 5.A1

Definitions of mental health professional categories

For the purposes of cross-country comparisons in this chapter the following definitions are employed:

Mental health nurses: A health professional having completed a formal training in nursing at a recognised, university level school for a diploma or degree in nursing. Data presented and discussed in this chapter concern only nurses working in mental health care (WHO, 2011).

Occupational therapists: A health professional having completed a formal training in occupational therapy at a recognised, university-level school for a diploma or degree in occupational therapy. Data presented and discussed in this chapter concern only occupational therapists working in mental health care (WHO, 2011).

Psychiatrists: Psychiatrists are defined according to the OECD definition and thereby include medical doctors who specialise in the prevention, diagnosis and treatment of mental illness. They have post-graduate training in psychiatry and may also have additional training in a psychiatric specialty. They include doctors specialised in the following: psychiatry; neuropsychiatry; adult and geronto-psychiatry; child psychiatry; psychiatry – addictive disorders/diseases; social psychiatry; psychiatric rehabilitation; and resident medical officers training in these psychiatric specialties. This definition explicitly excludes psychologists (OECD, 2012).

Psychologists: A professional having completed a formal training in psychology at a recognised, university-level school for a diploma or degree in psychology. Data presented and discussed in this chapter concern only psychologists working in mental health care (WHO, 2011).

Social workers: A professional having completed a formal training in social work at a recognised, university-level school for a diploma or degree in social work. Data presented and discussed in this chapter concern only social workers working in mental health care (WHO, 2011).

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Chapter 6

Good governance for better mental health

Good governance and leadership in OECD countries is crucial to drive changes in structures and planning for mental health, and to make mental health count. Mental health has been traditionally neglected and underfunded, especially when the significant burden of disease accountable to mental disorders is considered, and there is a need for governments to keep mental health high on the health agenda. A number of key stakeholders are involved, including governments at various administrative levels, user and carers organisations, and professional organisations, and this chapter considers their various roles. Mental health policy makers are using a variety of tools to improve mental health systems and lead system-wide improvements, including legislative frameworks, mental health strategies, and vertical initiatives to deliver mental health services to target population groups.

6.1. Introduction

Considerable challenges, and gaps in care provision and quality, remain in all OECD mental health systems. To address these shortcomings, and to secure change in some of the areas where change is much needed – many of which are outlined in the other chapters of this book – strong leadership and significant commitment are needed. This chapter identifies some of the key leadership challenges of mental health systems in OECD countries, and explores the tools which high-level policy makers can use to address them. Policy makers face three important challenges: firstly, there is a need to make mental health a priority, when it has frequently been a marginalised area within health systems; secondly, managing the significant changes to the organisation of mental health systems that have already happened and continue to be called for, as care provision shifts away from inpatient settings and towards care in the community; and thirdly, a need to promote better co-ordination both across and beyond mental health services.

High-level commitment is needed to drive meaningful change in mental health, but a range of stakeholders must be involved in this movement, including from outside of the health sector and across society. Governments and policy makers, leaders in mental health and health, leaders in education and employment, legislators and human rights groups, mental health service users and their carers and representatives, mental health care professionals and professional associations, and international leaders and networks, all have important roles to play. This chapter identifies the key mental health stakeholders and the roles they are playing in OECD countries.

In delivering good governance for mental health a number of tools are available to policy makers, which have been successful in influencing positive change. This chapter looks at the use of mental health legal frameworks and mental health strategies, and their potential to be used to address key mental health challenges. This chapter also explores the role of targeted, vertical programmes to fill gaps in mental health services, reach vulnerable population groups, and promote good mental health in different settings, such as schools or in the workplace.

Whilst considerable weaknesses remain, in this chapter an overview of the state of mental health governance and leadership is complemented by a wide range of positive examples that can serve as starting points for efforts to secure better mental health.

6.2. What are the key leadership challenges for mental health systems?

In a context where mental health has been traditionally marginalised, neglected and underfunded compared to its burden of disease, and where the treatment gap for mental disorders is still high, strong leadership is needed to make mental health a priority, channel resources toward mental health systems, and commit to providing excellent and innovative services. Strong leadership is also needed to address the key challenges arising from the shift towards community services; all OECD countries – to varying degrees – are concerned with the move away from hospital care. Whilst in some OECD countries – for example

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Italy, the United Kingdom, the United States – the "deinstitutionalisation" process started over 50 years ago and is currently at an advanced stage, and a large number of countries – Australia, Finland, the Netherlands, Norway, and Sweden – have shifted away from stand-alone hospital care in more recent decades, and in many instances are at the forefront of innovative approaches to care in the community. Other OECD countries – the Czech Republic, Japan, Korea – are today taking their first steps towards care in the community. High-level commitment is needed for countries to be able to plan and implement the shift towards community services, which requires a gradual reduction of inpatient services but most importantly the parallel building of well-functioning community services. In countries where the deinstitutionalisation of mental health is at more advanced stages, there is the need to improve co-ordination across and beyond mental health services, and governments should be looking to strengthen cross-sectoral co-ordination and promote collaboration across key stakeholders.

Mental health is often marginalised in societies and health systems, and needs strong leadership to be made a priority

In a period where the burden of disease associated with mental disorders is high and likely to increase in the near future with increasing life expectancy, and where health expenditures are falling (OECD, 2013), the quality and availability of services relies upon a national commitment to mental health care. The treatment gap for mental disorders remains high in most OECD countries, and mental health spending is low relative to the burden of disease, suggesting that there is the need for governments to make mental health a priority and invest in excellent mental health care.

In the context of the economic crisis, where a number of countries have made significant cuts to their health and welfare systems, there is a need to prioritise mental health within the health system and across society. The economic crisis currently affecting many OECD countries is likely to have an impact on the population's mental health, for example increasing insecurity and anxiety. As well as adversely affecting individuals and their families, poor mental health can bring negative social consequences, for example higher expenditures on disability benefits, increased absenteeism and reduced productivity in the workplace (presenteeism) (OECD, 2012), as well as increased homelessness and crime.

Mental health care delivery is shifting towards community services, and good stewardship is required to implement such a shift

OECD countries' experiences suggest that implementing the shift towards community-based services requires a strong national commitment and the involvement of policy makers at the highest level of government. Careful stewardship of this process of change, or of the consolidation of many decades of change, is called for.

The shift towards community-based services is a time-consuming process, and requires adequate planning and careful national policy commitment in order to avoid gaps in the provision of mental health care and fragmentation of services. For example, whilst the closure of mental hospitals in Italy was mandated in 1978 through the Law 180, the actual closure of the last mental hospital took place in 1999, over 20 years after the approval of Law 180 (WHO, 2011).

The success of deinstitutionalisation depends not only of closing psychiatric hospitals and reducing inpatient beds, but also of developing alternative mental health services in the community (Lamb and Bachrach, 2001). Experiences from OECD countries where

the shift towards communities started over 40 years ago suggest that there have been, in some cases, unintended consequences of deinstitutionalisation. The common trend was to first close asylums through tailored mental health legislation, and then gradually develop community-based services, with gaps in the provision of mental health services arising as a result (Munk-Jørgensen, 1999). Although many individuals with mental health needs have benefited from the process of deinstitutionalisation and the development of a new models of care, when mental hospitals have not been replaced by comprehensive and easily accessible community services, people with mental illness have in some cases suffered from homelessness, inappropriate incarceration and frequent admissions to hospitals (Lamb and Bachrach, 2001). In Denmark, for example, the process of deinstitutionalisation was paralleled by a series of negative indicators such as increased rates of suicides, a rise in the number of criminals suffering from some type of mental disorder, increased coercive activities in inpatient settings, increased bed occupancy rates and stable re-admission rates for patient suffering from schizophrenia (Munk-Jørgensen, 1999). This challenge is one that Denmark is certainly aware of, and its experiences in responding to these unintended consequences could be usefully shared with countries at earlier stages in the deinstitutionalisation process.

Furthermore, with the move towards community care come new organisational complexities, posing new challenges and opportunities for governance (Sugarman and Kakabadse, 2008). Psychiatric hospitals can function as self-contained treatment worlds, but with the growth of community care, mental health has moved away from the organisational and financial simplicity of a single setting for care delivery. Administrative responsibility for different areas of health and social care is often separate, with different governance and financial structures inhibiting meaningful integration of policies and approaches across fields. National and local service providers often struggle with co-ordinating service delivery across jurisdictions, and administrative separation in responsibilities and funding streams contribute to silo-thinking. Integrated working can offer the opportunity for mental health and other sectors to operate equally, breaking down traditional barriers and creating seamless services, but there is often a need for associated integration mechanisms and/or incentives.

There is a need for governments to promote better co-ordination both across and beyond mental health services to better service individuals with complex needs

Good co-ordination across mental health services is needed to steward individuals with mental ill-health towards the most appropriate services for their – often diverse and multiple – needs. In the course of their illness a single individual, for example with severe depression, may have medication prescribed or adjusted by their GP, be in touch with a local specialised community support service, visit the mental health department of a local general hospital as an outpatient, and have some short stays as an inpatient in a specialist psychiatric hospital. Many mental illnesses are chronic disorders, and system-level planning to promote co-ordination is needed, especially where clinical care pathways span a range of providers, provider jurisdictions and payment systems. A high-level perspective on mental health service provision is needed to help reduce duplication of services, identify service gaps, maximise effectiveness and promote value for money. Co-ordination of mental health services is crucial in order to guarantee the continuity of care for people with mental disorders who are often lost to follow up (Preston et al., 1999). Furthermore, co-ordinated services can be beneficial for both users and providers, for example by improving adherence to medication whilst facilitating the transfer of expertise across professionals

(Blount, 2003). Continuity of care across mental health services is considered by patients as an essential feature of good quality mental health care, and is strongly related to patient satisfaction (Adair et al., 2004; Jones et al., 2009).

Cross-sectoral co-ordination should also be promoted in OECD countries to address the complex needs of people suffering from a mental disorder. The way in which mental disorders intersect with wider social needs is well established. People suffering from some type of mental health problem are frequently subject to inter-related problems of unemployment, discrimination, poor education achievements, poor health, diminished social roles, lack of social networks as well as increased somatic health problems (Royal College of Psychiatrists, 2009). Co-ordination is needed across health services: people suffering from mental disorders are more likely to suffer from other co-morbid health conditions, such as cancer, diabetes, and cardiovascular diseases, than the general population (Sartorius, 2007; Leucht et al., 2007; WFMH, 2010). An individual suffering from some type of mental health problem may also have particular employment needs: individuals with mental disorders are more likely to struggle at work, to have difficulties finding and retaining employment (OECD, 2012). Sickness benefits and housing needs add another layer of administrative/governmental complexity to the journey of an individual with mental health problems, and adds complexity to the roles of those health care professionals delivering services. Systems that facilitate integrated care delivery for patients with multiple complex needs have been developed in some countries, and demand further attention and commitment, given their potential to bring positive results in terms of improved co-ordination and improved outcomes.

6.3. Who will lead efforts to address these challenges? Key stakeholders in mental health governance

The organisation, the financing and delivery of mental health services is a complex process which involves multiple stakeholders and different administrative levels. Governments, service users and carers and professional associations are key stakeholders that can work together to address the challenges related to mental health systems and improve mental health services. International leadership can also play an important role in promoting the sharing of knowledge and best practice examples.

Setting policy and delivering services: national, regional and local administrations

In all OECD countries the Ministry of Health has some responsibilities over mental health governance, whilst in a significant number of countries major responsibilities have also been devolved to regional and local governments.

At the national level, the Ministry of Health is typically responsible for setting mental health strategies, establishing minimum quality standards of mental health care, and developing mental health legislation. Given the multi-sectoral nature of mental health, other ministries such as the Ministry of Justice and the Ministry of Education, may be involved in governance for mental health, for example by participating in the development of national strategies and targeted programmes.

The vast majority of OECD countries devolve some responsibilities for mental health to regional and local administrations, although the depth and breadth of these responsibilities varies significantly across countries. In federal states, such as Australia, Germany and the United States, regional governments have major responsibilities and powers over mental health policies and planning. In other countries, such as Italy and Spain, the Ministry of

Health is still in charge of settling national strategies, developing new legislation, and settling standards of care whilst the planning of mental health services, financial and human resources are administered at the regional level.

User and carer groups are playing a key role in driving change and improvement

Although almost all OECD countries have national level mental health service user group, the strength and influence of mental health service users varies across the OECD. In a large number of OECD countries, especially those with a relatively long history of deinstitutionalisation, service user groups have a powerful voice in representing the views of patients. Their involvement can include: the development of mental health strategies and legislation; participation in the education of health professionals; planning of the delivery of mental health services; setting of research priorities; participation in the monitoring of mental health services; and participation in work to help ensure that the human rights of patients are respected. In other countries, user involvement in mental health services remains in some instances limited to consultation rather than meaningful partnership. In these countries, despite the formal government commitment to involving user groups in high-level policy making decisions, there is a concern that governments demanding agencies to involve mental health user groups might be tokenistic in that user activities become a formal procedure to be ticked off rather than an actual organisational practice that empowers user groups (NCCSDO, 2004).

However, in many OECD countries, service users are increasingly engaged in the running of the mental health system, and different forms of exchange with policy makers. Service users have a unique perspective on the experience of having a mental disorder, and the experience of using mental health services. The personal experiences of patients can be an important resource that can help to identify gaps in the mental health system, including access to care, connections between primary and secondary care and across different specialised services, aftercare arrangements and processes of discharge. In a number of OECD countries, user and carer groups receive support from governments and are actively encouraged to take part of high-level decision making processes for the development of national strategies, legal frameworks and targeted programmes for mental health. In Italy, for example, the Italian National Union of Associations for Mental Health (*Unione Nazionale delle Associazioni per la Salute Mentale* – UNASAM) aims to promote and defend the rights of mentally ill people by getting involved in policy making and the legislative/regulatory process on local, regional and national levels. UNASAM was actively involved in developing the two National Plans for Mental Health and contributed to the organisation of the first government conference on mental health in 2001 (Forti, 2014). In the Netherlands, over the last years the National Platform Mental Healthcare (Landelijk Platform GGz, hereafter "the Platform") – a not-for-profit association with 16 employees that unifies 20 mental health consumer and carer organisations – has been actively involved in a range of policy initiatives. Notably, the Platform has been co-operating with the government in the development and modification of laws and legislation which affect the mental health system, and around youth mental health and compulsory treatment protocols. The Platform played a key role in the development of the first national quality standard for depression, mental health guidelines and performance indicators (Forti et al., 2014).

As in the Netherlands, umbrella organisations are used in some OECD countries to increase the influence of service users and carers. In Australia, a country which already had a strong user community, the Commonwealth Minister for Mental Health and Ageing

announced the establishment of a new National Mental Health Consumer Organisation in July 2011, an umbrella group for user organisations. This body, once established in the autumn of 2014, will bring a strong and consolidated consumer voice and ensure the views of mental health consumers are integral to mental health reforms, such as having a role informing the work of Australia's first National Mental Health Commission. In some OECD countries, umbrella organisations participate in initiatives aiming to fix concerns around mental health high on governments' agendas, for example by promoting mental health in specific settings. In Germany, the Federal Ministry of Labour and Social Affairs and the umbrella organisations of employers and trade unions made a joint statement on the importance of maintaining and improving mental health during working life. In particular, the statement outlines a common basic understanding regarding the growing importance of maintaining good mental health in the workplace. The statement points to specific aspects of stress and strain, which can affect the mental health of employees positively as well as negatively, the principles and methods of successful work design and prevention in order to avoid mental stress, and the potential for successful reintegration of employees with mental health problems back into the workplace, underlining both the negative impacts of mental ill-health for employment and the potential for positive change (German Ministry of Labour and Social Affairs, 2013).

A number of countries have been encouraging the involvement of consumers in the education of health professionals. In England, initiatives have been undertaken for the involvement of service user trainers in the development and delivery of training courses in physical restraint for mental health professionals (Obi-Udeaja et al., 2010). In other countries, including France, Germany, Poland, the United Kingdom and the United States, other less formal systems of exchange have been supported, such as "trialogues", which are encounters on equal footing between people with mental health problems, family members and carers, and mental health professionals (Amering, 2010).

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. Given this, England is 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 (see Chapter 5).

Consumer involvement has been influencing research priorities and methods in a variety of areas, and has been encouraged by researchers in universities, non-governmental organisations and research institutes. For example, people with mental health problems have advocated for governments to invest in more research for better psychotropic medicines (Saks, 2012). Psychiatric patients are in a unique position to highlight that psychotropic medicines can have significant side effects which can be extremely distressing for patients and can have long-term health impacts (Fakhoury, 1999), that might discourage people with mental disorders to start or adhere with treatment (Mitchell and Selmes, 2007). In some cases, this has entailed shift around "what counts" in terms of scientific evidence as well as transforming existing professional hierarchies and structures in mental health settings (WHO Regional Office for Europe, 2010a).

Several OECD countries have developed methods – such as consultations, surveys, participation in service inspection teams and service-user-led evaluation and monitoring – to engage service users in quality assurance and monitoring of services, either at a

national or local level. Patient satisfaction and the collection of indicators of patient experience are key components of high-quality care (see Norwegian Knowledge Centre for the Health Services, 2008). In Germany, in Norway and in the United Kingdom, through User Focused Monitoring (UFM) service users are trained to conduct interviews focus groups and/or surveys with other service users about their experience in mental health services. In the Netherlands and in the United States, existing service users and carers are recruited to give regular feedback on their contact with services. Anonymous feedback is given to staff to help them improve the quality of services they provide (Sweeney and Wallcraft, 2010). Other countries use complaint systems to better address service users' needs. In Italy, Local Health Authorities have established a complaint system for citizens to make complaints and suggestions and thus participate in improving the health, including mental health, system (Forti, 2014).

User groups can also play an important role in safeguarding the human rights of psychiatric patients. No other arena in health care has such a history of enforced treatment as psychiatry, where individuals can still be detained and treated against their will. In Italy, there is currently no public body, national or regional, in charge of monitoring and assessing the human rights protection of patients in mental health services on a regular basis. This task has been progressively devolved to patient and family associations, such as the UNASAM, which have always collaborated with the Italian Ministry of Health (Forti, 2014).

The families and carers of mental health service users play an important role in providing support to people with a mental disorder. Besides emotional support, carers and families often also provide more practical support in daily living arrangements, assisting with keeping medical appointments, encouraging adherence to care plans and medication, or through financial support (WHO Regional Office for Europe, 2010b; WHO Regional Office for Europe, 2010c). International networks, such as the EUFAMI, can be a valuable source of support, resources and knowledge for carer organisations (see Box 6.1).

Professional groups play a pivotal role in influencing key organisations and decision makers

Mental health professional organisations lead, represent and support mental health professionals; set standards and promote excellence in mental health care; and work in collaboration with patients, service users, carers organisations, and mental health professional associations. In many OECD countries, professional groups function as specialist accreditation bodies which are responsible for regulating the practice of their own profession by registering practitioners, developing professional practice standards, approving standards for the accreditation of training programmes, assessment of the skills of overseas trained practitioners, and managing notifications and complaints against practitioners (see Chapter 4).

Professional groups can play a pivotal role in driving the changes for mental health in OECD countries and influencing key organisations and decision makers. In most OECD countries, mental health professional groups are involved in the development of national mental health strategies, and together with government departments, patients and carers associations, and other agencies have a voice in determining priorities within the mental health agenda. Mental health professional associations typically promote knowledge and the sharing of information on mental health through education, training and research, and can lead the way in developing excellence and promoting best practice in mental

Box 6.1. **European Federation of Associations of Families of People with Mental Illness (EUFAMI)**

Founded in 1992, the European Federation of Associations of Families of People with Mental Illness (EUFAMI) is the representative body for family-run voluntary organisations across Europe. EUFAMI encompasses 48 member associations from 28 European countries and promotes the interests of all people affected by severe mental health problems across European and international organisations such as the European Union Commission, the European Parliament, the WHO and the World Psychiatric Association. EUFAMI has a clear commitment towards person-centered care, a model of care that takes into account patient's preferences and needs, ensures continuity of care, develops partnerships with families and patients, and treats the patient as a person and not only the symptoms. EUFAMI embarked in a number of projects thus far for empowering families of people with mental health problems. For example, the Trialogue programme aims at addressing issues of communication. Traditionally communication occurs dually either between the patient and the professional, or between the patient and the family, resulting in communication gaps between family members/carers and professionals. The Trialogue seeks to bridging this gap through the encouragement of a three-way discussion between patients, professionals and families. Families have direct experience with mental disorders and, according to the EUFAMI, have much to teach health professionals. EUFAMI advocates for the recognition of families' expertise with mental health problems and the involvement of family training as part of the official training curriculum. In the long-run both patients, families and professionals would gain from such training programmes, as professionals will learn about different aspects of mental disorders, and patients and families will feel more involved and valued as well as less isolated (Steffen, 2010).

Source: Steffen, S. (2010), "European Federation of Associations of Families of People with Mental Illness Initiatives on Person-centred Care", *Journal of Evaluation* in *Clinical Practice,* Vol. 17, No. 2, pp. 344-346.

health services. In a number of OECD countries, mental health professional associations have played an important role in promoting the development of an overarching body to commission guideline development. In the Netherlands, the *Landelijk Samenwerkingsverband Kwaliteitsstandaarden GGZ* (LSKS-GGz) the national collaboration for quality of care standards in mental health care, was initiated by the professional organisations of psychiatrists and psychologists and the national consumers platform in mental health. The goal of the LSKS-GGz is to continuously improve the practice of professionals working in mental health care.

International leadership and information sharing are influencing the direction of mental health systems

A number of OECD countries are participating in international initiatives to bring leaders and policy makers in mental health together and promote effective communication, information sharing and exchange of knowledge. The WHO mental health policy and service guidance package and the International Initiative for Mental Health Leadership (IIMHL) are two good examples.

WHO is advising countries in a number of areas around mental health. For example, WHO has developed a tool to guide governments to develop or improve mental health policies and plans, as well as to assist governments in policy development and service planning in a number of areas in mental health. WHO mental health policy and service guidance package consists of WHO mental health policy and plan checklists, and

14 interrelated modules (WHO, 2013). WHO has developed a checklist for mental health policies, and a plan in order to assist with the evaluation of the development and implementation of mental health policies and plans. The guidance package includes a series of interrelated user-friendly modules designed to address a number of needs and priorities in policy development and service planning. The purpose of the guidance package is to assist policy makers and planners in developing better mental health systems. There are 14 modules, covering topics that include mental health policy, plans and programmes, mental health financing and budgeting, legislation and human rights, quality improvement and monitoring and evaluation guidance.

The IIMHL is an interesting example of how countries can easily exchange leadership expertise through constant consultations and activities and create a network for sharing best practices. The International Initiative for Mental Health Leadership is an international collaborative that works on improving mental health as well as addiction services; at the time of writing, seven OECD countries were participating as part of the IIMHL. The IIMHL promotes the exchange of information about effective leadership, management and operational practices for the delivery of mental health services. Furthermore, the IIMHL encourages the exchange of best practices within mental health services and supports exchange across leaders in the mental health sector. In particular, the IIMHL organises the leadership exchange, a week-long learning event which is held every 16 months; knowledge transfer, workshops, training, education and support of learning collaboration and information dissemination; the IIMHL update, which is a twice-monthly e-mail that includes the latest mental health and disability news, research and policy documents; webinars, to promote a continuous exchange of knowledge; and newsletters for key leaders, on specific topics of interest. In addition, with the purpose of building relationships and networks that are mutually helpful for leaders, organisations and countries, the IIMHL engages in peer consultation activities, research, joint programme and service development (IIMHL, 2012).

Numerous other international networks and initiatives are facilitating the exchange of ideas and good practice for mental health, either on a formal or informal basis. Bi-lateral exchanges between countries are another valuable way through which new ideas are spread.

6.4. Influencing the functioning of the mental health system through mental health legislation

Mental health legislation is being used by OECD governments in a number of areas, some of which are common to the health care system – such as setting minimum standards or to promote high-quality care – whilst others are mostly specific to mental health care. For example, legislation is being used for regulating involuntary placements and treatments, protecting patients' rights in critical areas such as education, employment and housing, as well as in inpatient services. Changes to legislation can drive significant changes in the mental health system and to the lives and rights of individuals with mental health needs.

OECD countries have adopted both "stand-alone" mental health legislation, or/and have integrated mental health provisions into other laws (e.g. laws governing the health system, employment law, disability legislation) (Table 6.1). Consolidated legislation on mental health combines all the issues of relevance to mental health in a single, separate legislation, and has the advantage of raising public awareness of mental health issues and

enhancing public visibility. On the other hand, consolidated mental health legislation has been argued to risk increasing stigma around mental illness (FRA, 2012), and to reinforce the traditional separation of the mental health system, as mental health is treated as a legally separate concern (WHO, 2003b). The integration of mental health provisions in a range of legislation can have the advantage of promoting co-ordination and integration, as mental health provisions have to be dealt with in other sectors, for example mental health concerns considered in employment law (WHO, 2003b). Nonetheless, it can be more difficult to ensure coverage of all legislative aspects relevant to people with mental health problems with multiple mental health provisions included in a range of legislation. Although there is little evidence that one approach is better than the other (WHO, 2003b), it is possible that a combined approach is most likely to address the complex needs of individuals with mental ill-health. Some OECD countries combine specific mental health law and general legislation (Table 6.1). The vast majority of OECD countries have included mental health provisions in any existing legislation on disability, equality and/or discrimination, in some cases in addition to stand-alone mental health legislation.

Table 6.1. **Mental health legal frameworks in OECD countries**

There is a separate mental health law	Mental health provisions are included in different legislations	There is a separate mental health law and legal provisions included in different legislations also exist
Canada, Estonia, Finland, France, Iceland, Ireland, Israel, Italy, Japan, Korea, Luxembourg, New Zealand, Norway, Poland, Portugal, Slovenia, Sweden, United Kingdom (England)	Australia, Austria, Belgium, Canada, Germany, Hungary, Israel, Italy, Luxembourg, Mexico, the Netherlands, Norway, Slovak Republic, Spain, Switzerland, Turkey, United States	Canada, Israel, Italy, Luxembourg, Norway

Source: OECD Mental Health Questionnaire 2012.

Legislation regulating involuntary treatment orders affects care delivery patterns

Involuntary treatment orders, also often referred to as compulsory admissions, or involuntary admissions, are a legal process through which an individual with symptoms of severe mental illness who refuses to be treated is detained in a hospital against their will. In order to protect the patient's safety whilst avoiding improper use of compulsory admissions, mental health legislation is necessary to establish under which conditions it is lawful to detain a person with mental health problems, and to determine the terms (e.g. venue, length of stay, treatment) of the detention. While some OECD countries have stand-alone acts regulating involuntary orders for persons with mental health problems, other countries, such as the Czech Republic and Greece (FRA, 2012) regulate these issues through general health care acts.

Concerns about the rights of involuntarily admitted patients have arisen internationally. The European Commission Green Paper on mental health (European Commission, 2005) acknowledged that involuntary placements and treatments severely affect patients' rights – especially the right to liberty – and as a consequence should be applied only as a last resort when less restrictive measures have failed, and should be of limited duration. The adoption of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the principle that involuntary orders are increasingly becoming an issue of public concern for national governments. Within this context, some OECD governments have recently adopted new acts or amendments in line with the CRPD. In Austria in 2010 the Compulsory Admission Act was amended, and made explicit reference to the CRPD.[1]

In 2011, the Ministry of Justice of the Czech Republic established a working group to start reforming the law in the area of involuntary orders for mental disorders, in order to enhance the protection of fundamental rights of people with mental health problems, in line with CRPD directions (FRA, 2012).

The variation in legal frameworks regulating involuntary placement and treatment may be reflected in differences in involuntary admission rates and quotas across OECD countries. Involuntary admission rates and quotas differ substantially across the OECD, spanning from 4% of total psychiatric admissions in Iceland to almost 80% in Korea (OECD Mental Health Questionnaire 2012). Comparisons between countries are very difficult, as data are not standardised, data recording methods differ significantly – for instance, some countries might register a patient's change from a voluntary to an involuntary treatment regimen during the same admission, whereas other countries might not (Salize and Dressing , 2004) – and legal frameworks differ substantially across the OECD. Rather, figures should be taken as indicative of the trend within a country, and more rigorous interpretation should only be in a country-specific context.

Legislation on compulsory admissions significantly varies across the OECD, resulting in significant differences in the definitions and standards of practice. Some common criteria for involuntary admissions tend to apply: that the patient should suffer from some type of mental disorder; that the patient refuses to undertake treatment voluntarily. However, other requirements for involuntary admissions differ across OECD countries (Table 6.2). Some OECD countries give more importance than others to issues of public safety and aim to protect the patient and the society from harm (FRA, 2012). In these countries, the patient should represent a danger to him/herself or others in order to be involuntarily placed. Legal frameworks for the assessment of risk and the level of danger, however, are not standardised across countries, in that the danger criterion is in some cases inexistent or vague (FRA, 2012). Other OECD countries, such as Italy, Scotland and Spain, focus on the importance of the patient being treated. In these countries, the criteria of presenting a danger to oneself or others is not a condition for involuntary placement, and the legislation is based on the assumption that individuals suffering from some type of mental disorders might not recognise the need for mental health care because of the symptoms of their mental disorder. In other OECD countries, both the treatment and safety requirements have to be met in order for the compulsory order to take place.

Table 6.2. **Criteria for involuntary treatment orders in selected OECD countries**

Safety: Patient should represent a danger to him/herself or others	Treatment: There is the urgent need for the patient to receive treatment	Both safety and treatment requirements
Austria, Belgium, the Czech Republic, Germany, Estonia, Luxembourg and the Netherlands	Italy, Scotland and Spain	Denmark, Greece, Finland, France, Ireland, Poland, Portugal, Slovenia, Sweden and in the United Kingdom (England)

Source: FRA (2012), "Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems", FRA European Union Agency for Fundamental Rights.

Not only do criteria for compulsory admissions differ across OECD countries, but they also require different standards for validation and approval. Compulsory detention usually requires objective evidence from a competent authority, which in most OECD countries includes a psychiatrist. In a smaller number of OECD countries, for example in Belgium, any medical personnel (not necessarily a psychiatrist or neurologist), is authorised to perform

the medical evaluation. In other countries, such as in the United Kingdom (England), the approval of two medical professionals, generally a GP and a psychiatrist, is required. The addition of a second expert witness is generally seen as an important safeguard against arbitrary decisions and ensures the impartiality of the medical opinion (FRA, 2012). In other OECD countries, such as in Germany and in the Netherlands a non-medical authority – generally a court – has the responsibility to make the final decision; in some countries authorisation from administrative bodies (e.g. the Mayor of the city) is required – on the top of the approval from the mental health medical personnel –, as it is the case in Italy. In Scotland, any detention of over 48 hours is subject to control by an independent tribunal, and any detention of more than 28 days can only be ordered by a tribunal. In countries where administrative or court authorisation is required for a formal involuntary admission, there is usually a clause allowing for a brief period of involuntary admission in the case of an emergency, the criteria for which are also set out. In the Netherlands, for example, the Acute Involuntary Admission (AIA) is used in case of imminent danger, as opposed to a Court Order (CO), which is used when there is no emergency. Anyone can request an AIA, but a psychiatrist has to examine the individual according to a number of criteria. If it is decided that an AIA is necessary, a medical report is submitted to the mayor, who then decides whether or not an AIA is issued. Within 24 hours of issuing an AIA an individual is put into detainment (Nuijen, 2010; Mental Health Europe, 2012; Forti et al., 2014).

Legislation on compulsory orders also sets the maximum length of stay for a compulsory hospitalisation, and this significantly varies across OECD countries. For instance, whilst in Italy the length of stay of compulsory hospitalisation cannot exceed seven days (although this is extendable) and in France the recent Law 2013-869 of 27 September 2013 highlighted the temporary nature of compulsory hospitalisations and required further legal consultation for hospitalisations extending over 12 days, in Korea and in Czech Republic involuntary hospitalisations should be terminated after three months, but can be extended upon further re-evaluation.

The number of psychiatric beds, along with (voluntary and involuntary) length of stay, should be considered when explaining variations in compulsory orders across countries. For instance, both Italy and England saw their psychiatric beds declining significantly since the 1970s, but whilst the proportion of compulsory admissions declined sharply in Italy, they increased significantly in England. This might be explained by differences in length of hospital stays (for both voluntary and involuntary admissions). Whilst in Italy the strong ideological commitment to community care has resulted in keeping length of stays as short as possible, in England length of stays are on average much longer. This could have possibly caused delays in admission and treatment for acute patients in England, who subsequently become more ill and require compulsory orders (Guaiana and Barbui, 2004).

Involuntary admission rates are likely influenced also by systems of incentives. In Korea in 2011, for example, 68.1% of psychiatric admissions were made involuntarily by family members; 9.1% of psychiatric admissions were involuntary and made by the government; and only 21.4% of psychiatric admissions were voluntary (Hewlett et al., forthcoming). Involuntary "family" admissions are made with the assent of two family members and a psychiatrist, but it is unclear whether such admissions are always in the best interest of the patient. It was communicated to the OECD that some psychiatrists were validating involuntary admissions because of pressure from family members (Hewlett et al., forthcoming). The lack of community services and poor social services might push families to demand involuntary hospitalisations for their relatives. On the mental health

care side, psychiatrists are also incentivised to support involuntary hospitalisations, as the per diem payment system combined with a relatively high number of psychiatric beds create the negative incentive to fill up psychiatric beds.

Other forces might also be at play in determining the number of compulsory orders in a country, such as variations in patients and professionals' attitudes towards involuntary admissions (Zinkler and Priebe, 2002) and/or service characteristics (Wierdsma and Mulder, 2009). Different compulsory admission rates also reflect differences of service characteristics; Hansson et al. (1999) suggested that poor formal referral procedure to psychiatric services is associated with higher rates of compulsory care. Other studies suggest that higher compulsory admission rates are correlated with high social deprivation and poorly organised emergency services. Bindman et al. (2002) found that in England compulsory admissions are associated with indicators of service quality, such as waiting times, with higher quality of services being correlated with lower compulsory admission rates. Involuntary admission rates are also related to patient characteristics, such as the severity of disorder and/or ethnicity. For example, in England minority ethnic groups are more likely to be involuntary committed than the general population (CQC, 2011).

Developing involuntary treatment orders in community settings

A growing number of OECD countries allow people suffering from a mental illness to be placed under a Community Treatment Order (CTO). CTOs legally compel individuals suffering from mental health problems to comply with treatment, without being detained in the hospital. Considered to be a less restrictive alternative to traditional inpatient involuntary treatment orders, CTOs allow patients to live in the community whilst ensuring that they comply with treatment, which should also result in reduced hospital admission rates.

Like involuntary treatment orders in inpatient settings, legal provisions regulating CTOs vary in their design, intent and application across the OECD. The overall objectives of most CTOs is to increase compliance with treatment in the least restrictive environment; to reduce the "revolving door syndrome" which sees patients have many hospital re-admissions; to encourage safe early discharges and post-discharge compliance to treatment; and to prevent violence and reduce criminal incarceration (O'Brian et al., 2009). In some countries, for example in Scotland, CTOs are limited to "revolving door" patients, where individuals are admitted to hospital, recover and are then discharged, but fail to engage appropriately with community mental health services and comply with treatment when not under a compulsory order, resulting in further hospital admissions (Lawton-Smith, 2006).

Some authors (Lawton-Smith et al., 2008) raised concerns about whether CTOs might distract services from promoting voluntary mental health services, as well as increase the number of people being placed under compulsory orders. In England, the Care Quality Commission (2010) report on the use of the Mental Health Act 2009-10 found trends of over prescription of medications associated with CTOs, and that CTOs were being given to patients (almost one-third) who had no reported history of non-compliance or disengagement with treatment. The CQC (2011) report suggests that CTOs were being used as preventative measures for a significant minority of patients, rather than being used in response to previous difficulties. Given that, in England, a CTO should only be given if the patient meets the criteria set out under the Mental Health Act, such trends may have worrying consequences for patient rights. However, in Scotland, evidence suggests that the use of CTOs has reduced the use of compulsory inpatient admission by slightly less than

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the number of community orders; there has been a slight overall increase in the use of compulsory orders, but a noticeable decrease in compulsory hospital admissions.

Moreover, even though reducing hospital admissions is often an explicit target of CTOs, there is no conclusive evidence suggesting that compulsory community care reduces hospital admission rates (Kisely et al., 2004), or is cost-effective (Kisely et al., 2005). Patients' and professionals' views have often been in support of the use of CTOs (Gibbs et al., 2005; Romans et al., 2004), although there is little available evidence that strongly supports their use in terms of traditional treatment outcomes (Woolley, 2010). Evidence from New Zealand shows that patients prefer outpatient to inpatient treatment as the former allows them to have greater freedom and control over their lives, whilst community support gives them a greater sense of security (Gibbs et al., 2005). Furthermore, some evidence from New Zealand (Romans et al., 2004) shows that according to medical professionals the use of CTOs facilitates and improves the organisation of community-based services. In fact, according to surveyed mental health professionals, CTOs can help in maintaining regular contacts between community services and patients, improve medication adherence, allow greater involvement of patients and make detection of relapse easier. Although patients and professionals appear at present to view CTOs positively, there is a need to undertake further research to better establish the impact of CTOs on patient outcomes such as recovery, treatment adherence and satisfaction. In this respect, the Oxford Community Treatment Order Evaluation Trial (OCTET) – currently conducting research to remedy current evidence gaps – has the potential to bring informative new insights to discussions around CTOs (Burns et al., 2008).

Mental health legislation is used to protect the rights of people with mental disorders, both in inpatient and community settings

OECD countries have used legislation to protect the rights of people with mental disorders both in the community and in inpatient settings, although legal frameworks in some OECD countries still fail to do so sufficiently. People with mental disorders face discrimination, stigma, and marginalisation from society, which in turn increases the risk of violation of their rights. Although improvements have been made over the past decades to promote the rights of people with mental illness in the community, continuous action is needed, as in some OECD countries individuals with mental disorders still face disproportionate barriers in education, and are often excluded from employment opportunities (OECD, 2012). In Korea, for example, the Mental Health Act theoretically excludes individuals classed as mentally ill from a number of professions, and even from a number of national parks.

Mental health legislation is widely used across the OECD to protect the rights of people with mental disorders in inpatient settings. Historically, psychiatric patients have been institutionalised in stand-alone and often geographically isolated psychiatric hospitals, commonly victims of degrading conditions. In some countries, such as in Italy previous to the introduction of Law 180, being admitted to a psychiatric facility meant the loss of all civil and political rights. Some psychiatrists such as Enrico Morselli in Italy during the 1880s highlighted the multifaceted nature of the mental health asylum institution, which stems from its dual purpose of healing mentally disordered people whilst protecting society from potential harm. Other thinkers, such as Michel Foucault in France during the 1970s, have highlighted the traditional punitive role of psychiatric institutions. Where it was once used to strip individuals of their rights, mental health legislation has in the past half century proved a powerful tool for the protection of the rights of individuals with mental health

needs who are undergoing treatment for mental disorders. Often, changes in legislation have come following protest from service user groups (see, for example, Mind, 2012). Government actions in this respect have resulted in the development of legal frameworks aiming to limit or at least regulate the use of coercive measures in inpatient settings. In England, for example, the Mental Health Act and the Care Quality Commission respectively define and monitor criteria for the utilisation of coercive measures in inpatient settings and acknowledge the use of mechanical restraint as a last resort (Carr, 2012). Progress has been made in this respect over the past decades to protect the rights of people with mental health problems in inpatient settings, but room for improvements remains.

There are ways to better enforce quality expectations in mental health care

Mental health legislation represents a good tool for governments to use to define minimum mental health care standards and ensure the quality of care. However, monitoring of mental health systems is an important part of ensuring that legislation is respected, that standards are maintained, and that there is transparency in service delivery. In order to develop a high-performing mental health system, there is the need to deliver quality services that are based on best available evidence, evaluated and monitored on a regular basis.

In some countries, mental health legislation has been used to set minimum quality standards. Such legislation is especially useful in decentralised mental health systems, as it allows central government to set a minimum standard of service availability across jurisdictions. Most OECD countries have put in place monitoring bodies that are responsible for monitoring basic standards of care, such as beds per population/wards, number of medical professionals per patients, and seek to ensure that minimum standards of care are in line with legal frameworks on mental health. In Italy, since 2001 the Government has used Essential Levels of Assistance (*Livelli Essenziali di Assistenza* – LEA), defining health, including mental health, services and facilities that the NHS is responsible for ensuring, free or with users' co-payments, to all Italian citizens across the independent health regions. Besides their standard-setting functions, LEAs are also a monitoring tool that is used both to measure the performance of the health services and to efficiently allocate resources across regions. The LEA Committee verifies whether the regions are complying with their obligations to deliver the LEAs to their inhabitants through a set of indicators monitoring regional adherence to standards (Italian Ministry of Health, 2012).

In some OECD countries, mental health legislation is used to impose quality standards for mental health care providers, and where such legislation exists, monitoring bodies are in place to monitor the quality of care provided. In the Netherlands, for example, some of the legislation defining the mental health care process itself is concerned with the quality of care, and imposes quality standards on health care organisations or on the relationship between the health care provider and the patient. The KZi (*Kwaliteitswet zorginstellingen* – Quality of Health Facilities Act) demands that mental health providers assess, control and improve the quality of the service delivery. One of the demands concerns the publication of a yearly public quality report, to account for the quality of care on a range of quality indicators. Another important piece of legislation regulates quality of the individual practitioner. The BIG (*Wet op de beroepen in de Individuele gezondheidszorg* – Act on Professions Inpersonalised Health Care Delivery), for instance, states that psychotherapists and health care psychologists can only perform specific treatments (with a certain risk for patients) if

they are competent and authorised to do so. If they are, they need to be registered in the BIG register and participate in continuous professional education (Forti et al., 2014). The Health Care Inspectorate (IGZ) monitors in the Netherlands whether the quality of health care provided is in line with national standards. The IGZ enforces statutory regulations on public health; investigates complaints and irregularities in health care; and takes measures if deemed necessary and appropriate. Quality indicators, reported by providers and institutions, are powerful tools for the IGZ. Values on the indicators may give rise to a practice visit or an investigation to check whether guidelines and procedures are observed (Groenewegen et al., 2007; Forti et al., 2014).

Most OECD countries have adverse event monitoring for inpatient care, which monitors and records incidents such as suicide, self-harm, or assault. In Italy the work of the Parliamentary Commission of Inquiry into the efficacy and the efficiency of the National Health Service (*Commissione Parlamentare di Inchiesta sull'efficacia e l'efficienza del Servizio Sanitario Nazionale*) (hereafter the "Commission"), set up in 2008 to monitor the quality of both public and private health services, was established in line with particular needs and priorities identified by mental health policy makers. Part of the work of the Commission was devoted to the investigation of the operation of Italy's Judicial Psychiatric Hospitals (OPGs), following recommendations from the European Council for the Prevention of Torture (CPT) (Council of Europe, 2010). The Commission organised regular unannounced on-the-spot inspections during the years 2008-11 into each of the six OPGs and carried out interviews with OPG directors and with consumer associations. The outcome of the investigation revealed the inadequacy of primary and secondary health care provision in almost all OPGs and was summarised in a report (Italian Parliament, 2011). Legislation was approved by the Italian Government, dictating that all OPGs should be closed and replaced by new secure mental health facilities of smaller size (20 places). The planning of these new security mental health facilities is currently ongoing (see Forti, 2014 for further information).

Some OECD countries have established monitoring bodies to monitor patient rights and safety. The Care Quality Commission (CQC), the independent regulator for all health and social care services in England, ensures that care, including mental health care, provided by hospitals, ambulance services, care homes and community services meet government standards for quality and safety. Monitoring is conducted through inspections and feedback, or following information from "whistleblowers", to ensure that care complies with standards. There are currently 16 "essential standards of quality and safety", including respect for service users, consent to care and treatment, care and welfare, cleanliness, medicine management, safety and staffing.[2] The Care Quality Commission is also responsible for monitoring detentions under the Mental Health Act. As part of this role the CQC publishes an annual report on the Mental Health Act, including information about involuntary admissions and detentions under the Act, community treatment, patient involvement in treatment, and use of control and constraint on mental health wards.

6.5. A high-level perspective for system-wide improvements: Setting strategic directions to plan and execute change in mental health

Mental health strategies and plans (henceforth "strategies") have proved a valuable tool for OECD policy makers at the highest level of government to drive the direction of the mental health system, and identify common priorities and views to push forward at a national level. Typically, such strategies constitute a key part of governments' official statement of intent

regarding mental health, conveying an organised set of values, principles, objectives and areas for action to improve the mental health of the population. Mental health strategies have, in some countries, concrete impacts on the planning and delivery of mental health services, have had strong influence on the prioritisation of mental health, and have helped make the case for more funding for services. Setting high-level strategic directions can also be a tool to improve cross-governmental and cross-societal co-operation around mental health, drawing in many stakeholders in setting priorities and goals.

Mental health strategies have ranged from a broad-brush establishment of key principles for the mental health system – for example, a need to move towards deinstitutionalisation – to strategies that articulate future steps for the mental health system in much greater detail. The experience of OECD countries suggests that mental health strategies have been useful tools to plan and execute change in mental health at a national level. For example, the process of deinstitutionalisation is significantly aided by both high-level political commitment, and careful strategic planning. Mental health strategies can provide governments with a useful tool to help establish a realistic time frame for a gradual shift from hospitals to community services, consider new ways of allocating resources, assist with the adjustment of the mental health workforce for new needs (for example, to train primary care practitioners), and to promote inter-sectoral co-ordination (WHO, 2003a). Well-constructed national policies should have a meaningful impact on regional or local decision making. In England, for example, the national strategy No Health Without Mental Health (Department of Health, 2011) was cited by 33% of Clinical Commissioning Groups (CCGs) (responsible for commissioning health services for a set population) as having an impact on commissioning plans (see Rethink Mental Illness, 2013). Most CCGs reported to have set mental health priorities in line with national priorities and frameworks.

Shifting the centre of care from hospitals to the community demands commitment at the highest policy level, and the experience of some OECD countries show that mental health strategies or plans are an effective way to guide the implementation of such a shift. In countries where deinstitutionalisation is at a more advanced stage, such as in Italy, the United Kingdom and the United States, the shift from hospital to community services was in part the result of a strong national commitment and national policy intervention. In England, the 1962 hospital plan for England and Wales stated that large psychiatric hospitals should close and that local authorities should start to develop community services, and this was followed in later decades by a number of mental health policies and plans aimed at implementing the vision of community care; in Italy, Law 180 mandated the closure of all mental hospitals in 1978, and national mental health strategies were later designed and implemented to build mental health community services to replace mental hospitals (see Forti, 2014 for further information).

Developing good mental health strategies demands accurate information and the involvement of multiple stakeholders

The development of good mental health strategies or plans relies upon the availability of information about the mental health status of the population, the organisation of the mental health system and mental health services offered. A comprehensive understanding of the prevalence of mental disorders as well as of the weaknesses of the mental health services – through population-wide epidemiological surveys, surveys targeting specific population groups, and surveys of mental health service users and mental health workers for example –, can inform policy makers and enable governments to define appropriate priorities for the mental health agenda, and design well-tailored interventions.

When establishing mental health strategies the vast majority of OECD countries have involved a range of stakeholders, who have been consulted on, or actively participated in, the development and implementation of the strategy. In the Netherlands, for example, policy makers alongside representatives of health care providers and professional organisations – including the professional association of the mental health and addiction sector, the platform for mental health institutions, the associations of psychologists, psychiatrists and psychotherapists, primary care organisations, health care insurers, organisations representing clients and their families and the government – jointly set out the mental health strategy for the years 2013-2014/17 (Forti et al., 2014).

National mental health strategies and plans can promote better co-ordination, especially across government departments

Mental health strategies in most OECD countries reflect governments' commitment to enhance cross-sectoral co-operation. In addition to widespread focus on public mental health,[3] well-being[4] and prevention,[5] most mental health strategies in OECD countries have addressed mental health care in relation to employment/disability, education, early detection, learning disabilities, as well as alcohol and substance abuse in their mental health strategies (Table 6.3).

England's most recent mental health strategy "No health without mental health" (Department of Health, 2011) deliberately highlights the links between mental ill-health and specific population groups for example prisoners, homeless people, and between mental health problems and outcomes in education and employment. Moreover, this strategy points out that mental ill-health is not only a concern for the health care sector but rather "everyone's business", requiring a cross-governmental approach. The New Zealand government recognises that in order to provide continuity of care it is essential that different parts of the mental health system work together. The Second New Zealand Mental Health and Addiction Plan 2005-15 (New Zealand Ministry of Health, 2005) explicitly draws attention to strengthening cross-agency working both vertically between regions and the central government, and horizontally across different sectors, such as mental health care and government-funded social services, as well as primary health care, housing, employment, education and welfare services.

Some mental health strategies are explicitly addressing the mechanisms through which cross-sectoral co-ordination can be better promoted. National-level high-profile strategic planning around a national strategy can provide the impetus and authority needed to bring government departments together, assign new systemic responsibilities (e.g. to a certain clinical provider), or to introduce country-wide policies in a federal system, with more or less autonomy left to states or regions to then implement such policies. In Australia the COAG National Action Plan on Mental Health 2006-11 (COAG, 2006) introduced a new system of linking care, whereby patients with severe mental illness and complex needs who are most at risk of falling through the gaps in the system are followed by both a clinical provider (e.g. a GP or a mental health nurse) and a community co-ordinator. Whilst the clinical provider is responsible for the clinical management of the patient, the community co-ordinator is in charge of connecting the patient to the non-clinical services they need, for example accommodation, employment, education, and both are encouraged to work in tandem. This new model of care aims at giving patients information about who is providing their care, how to access emergency care, and who can help link them into the variety of services they need (COAG, 2006). In addition to this new system of linking care,

Table 6.3. **Areas covered by mental health strategy or plan in selected OECD countries**

	Public mental health	Well-being	Prevention	Employment/ Disability	Education	Early detection	Learning disabilities	Dementia	Alcohol abuse	Substance abuse
Australia	x	x	x	x	x	x	x	x	x	x
Austria	x	x	x	x	x	x	x	x		x
Belgium	x		x			x			x	x
Canada	x	x	x	x	x	x		x	x	x
Chile	x	x	x					x	x	x
Finland	x	x	x	x	x	x	x		x	x
France	x		x	x		x			x	x
Hungary	x	x	x	x	x	x	x	x	x	x
Ireland	x	x	x						x	x
Israel				x		x			x	x
Italy	x	x	x	x	x	x	x	x	x	x
Japan	x	x	x	x	x	x	x	x	x	x
Korea	x	x	x	x	x	x	x	x	x	x
Luxembourg	x	x	x	x	x	x	x	x	x	x
Mexico	x	x	x	x	x	x	x	x	x	x
New Zealand	x	x	x	x		x			x	x
Norway	x	x	x							
Poland			x	x		x		x	x	x
Portugal	x	x	x	x				x		
Slovak Republic	x	x	x	x	x	x	x	x	x	x
Spain	x	x	x	x	x	x				
Sweden	x		x	x						
Switzerland								x	x	x
Turkey	x	x	x	x	x	x	x	x	x	x
United Kingdom (England)	x	x	x	x	x	x				
United States	x	x	x	x	x	x	x	x	x	x
Total	22	20	24	21	15	20	12	14	20	21

Source: OECD Mental Health Questionnaire 2012.

different governments in Australia are undertaking a variety of different actions to promote integration of mental health services, including implementing new Medical Benefits Schedule items for psychology and other allied health providers, psychiatry and GPs, providing more services in rural and remote areas and more flexible approach to service delivery in these areas, providing additional care co-ordination services through the public, private and non-government sector, improving services for people with mental illness in the criminal justice system, including community-based forensic mental health services and integrating mental health and drug and alcohol services, including in Indigenous communities (COAG, 2006).

However, the inclusion of cross-sectoral approaches in strategies is not without challenges. In France, for example, one of several evaluations conducted of the 2005-08/10 Mental Health Plan focused specifically on the links between health and social care (Maresca et al., 2011). The evaluation (Maresca et al., 2011) of the Plan highlighted that housing was seen as the "Achilles Heel" of social care in France. The evaluation interestingly observed that there is a significant tension between the philosophies found among

practitioners of health and social care, noting that the medical model and the social model do not co-exist harmoniously in this context.

Using target indicators to strengthen mental health strategies

Mental health strategies can be a starting point for building action, but the existence of a mental health strategy does not guarantee that it is successfully implemented. The absence of funding, skilled leaders, effective infrastructures or a competent labour force can all be significant obstacles to the implementation of a strategy (WHO Regional Office for Europe, 2008). In addition, the experiences of some OECD countries show that developing indicators aligned to mental health policies is a way to increase leverage and policy delivery, as well as measuring improvements. Although mental health strategies are widely used amongst OECD countries, far fewer countries are including clear targets or outcome measures in their strategies.

Mental health indicators are generally quantitative indicators and usually include physical resources (e.g. number of beds and facilities), outcome indicators (e.g. suicide rates and prevalence), and activity data (e.g. admission/discharge rates and average length of stay). In some OECD countries policy makers have committed to shifting the focus of care away from hospitals towards community settings, and have developed mental health strategies and national indicators to respectively implement and monitor such a shift. In Israel, The Maurice Falk Institute for Economic Research in Israel is in charge of monitoring the process of downsizing the mental hospitals according to policies established by the ministry. Among the mental health indicators gathered at the national level are *the number of psychiatric beds*, and *length of hospitalisation* – which are being used to measure whether the goals of the mental health strategy are being met. Other OECD countries have committed to improve access to mental health services. In New Zealand, the monitoring of the mental health strategy includes mental health performance indicators such as the access to mental health services and waiting times (New Zealand Ministry of Health, 2010) in line with the overall strategy's aim of improving access to mental health services (New Zealand Ministry of Health, 2005).

As many OECD countries have now moved towards care in the community and are trying to improve the quality of care delivered, the development of quality indicators linked to the mental health strategy would be most appropriate and could improve the quality of mental health care (see Chapter 4).

6.6. Identifying and addressing gaps in mental health systems using vertical programmes

Vertical programmes are a key tool with which OECD governments can fill gaps in mental health services, reach vulnerable population groups who may struggle to access care, as well as promote good mental health in different settings, such as in schools or in the workplace. Stand-alone mental health programmes are usually short-term initiatives that sit slightly outside of the standard range of mental health services offered. Although sometimes representing a short- to medium-term solution to more enduring problems, stand-alone programmes have been a tool for governments – and increasingly non-governmental organisations – to direct responses to address urgent unmet needs.

As part of filling systemic gaps in mental health, vertical programmes are being used by OECD governments to make services more accessible to population groups that are facing greater barriers in accessing services. Mental health problems are unequally distributed

across societies, and are more prevalent in some of the most vulnerable groups, including the unemployed, the elderly, as well as refugees, migrants, ethnic minorities, persons in criminal justice system and homeless people (Fazel et al., 2008; Halliwell et al., 2007). Even if these groups have the same rights to access health services as the general population, they might nonetheless not benefit as fully from available services, a phenomenon known as the "implementation deficit" (Civenti et al., 2012). This is mainly due to the characteristics of the services (community services, as opposed to hospitals), the stigma related to the utilisation of mental health facilities and, in the particular case of immigrants, the absence of multicultural specialists able to decode mental health symptoms while taking into account cultural differences (Civenti et al., 2012).

Almost all OECD countries have implemented some type of targeted mental health programme. In particular, school or educational institution-based prevention activities are common, with 27 countries having at least one such a programme in place in 2012. Mental health initiatives in the workplace, and anti-stigma campaigns, are also very common (see Table 6.4).

School-based mental health programmes are used to address mental health problems early in life, promote mental well-being and prevent mental disorders

Children's and adolescents' mental health are in most countries an issue of particular national concern and policy commitment. The prevalence and incidence of mental disorders are high amongst children, and risk factors associated with mental health problems are present from a very young age (see also Chapter 2). In the European Union, for example, prevalence of mental disorders across children and adolescents spans from 9.5% in the United Kingdom to 22% in Denmark (Jané-Llopis and Braddick, 2008). The incidence of mental disorders is also higher across children and adolescents than across adults. A significant portion of mental disorders originate at early stages of life i.e. half of all lifetime cases start by age 14 and three-fourths by age 24 (Kessler et al., 2005). Risk factors associated with mental disorders, such as poorer child physical health, maternal emotional distress, harsh discipline, and overinvolved/protective parenting are situated in the family context and present from a very young age (Bayer et al., 2011), and it is argued that early exposure to risk factors might lead to mental health problems in later ages (Jané-Llopis and Braddick, 2008).

As developed countries have moved toward universal education, the role of the school has expanded to provide care and services to address issues beyond traditional schooling (Hendren et al., 1994). In tandem with appropriate child and adolescent mental health services, schools can represent an appropriate setting to tackle mental disorders in children and adolescents. Mental disorders are found to have a significant negative influence on educational achievements (Johnston et al., 2011), and are correlated to higher dropout from school (Kessler and Foster, 1995). Likewise, evidence shows that poor education increases the risk of poor mental health (Chevalier and Feinstein, 2006; Bjelland et al., 2008), as education can improve a person's ability to process information, or increase the likelihood of compliance with treatment.

Recognising the potential of schools to tackle mental health problems across children and adolescents, most OECD countries are promoting school-based mental health programmes to address mental health problems early in life, promote mental well-being and prevent mental disorders. School-based mental health programmes include a large variety of initiatives,

Table 6.4. **Mental health programmes in OECD countries**

	Anti-stigma campaign	School or educational institution-based prevention	Mental health in the workplace
Australia	x	x	x
Austria		x	x
Belgium	x	x	x
Canada	x	x	x
Chile		x	
Czech Republic	x	x	x
Finland		x	x
France	x		
Germany	x	x	x
Hungary	x	x	x
Iceland		x	x
Ireland	x	x	x
Israel	x	x	x
Italy	x	x	x
Japan	x		x
Korea	x	x	x
Luxembourg	x	x	x
Mexico	x	x	x
Netherlands		x	x
New Zealand	x	x	x
Norway	x	x	x
Portugal	x	x	
Slovak Republic	x	x	
Slovenia	x	x	x
Spain	x	x	x
Sweden	x	x	x
Switzerland	x		x
Turkey		x	x
United Kingdom (England)	x	x	x
United States	x	x	x

Source: OECD Mental Health Questionnaire 2012.

which span from whole-school programmes aiming to promote mental well-being (Hendren et al., 1994), to more selective interventions aiming to increase mental health literacy across students and teachers, and early intervention programmes targeted to at-risk students. Such programmes have been shown to have positive effects in increasing knowledge acquisition and reducing stigma towards mental illness (Pinfold et al., 2003; Pinto-Foltz et al., 2011), as well as enhancing help-seeking behaviours (Anderson and Doyle, 2005).

Governments are investing in school-based mental health prevention programmes. For example, students who are victims of bullying at school are significantly more likely to have some type of mental health problem, such as depression (Rothon et al., 2011). Furthermore, evidence shows that observing the victimisation of other peers can have significant negative effects on the mental health of the students (Rives et al., 2009). In Finland, a large-scale programme on bullying, funded by the Finnish Ministry of Education, has been developed

in the University of Turku. This Kiva-school programme aims to prevent and decrease bullying in schools and since its launch in 2006, the programme has been increasingly implemented in schools. The programme consists of general measures where information is disseminated through proactive material (assessment of school environment, classes, online games, booklets for parents), and targeted measures (discussion with the teacher and the school team), which are applied should bullying be detected. Initial evaluations of the KivaKoulu programme have shown that the programme has reduced self and peer-reported bullying and victimisation (Kärnä et al., 2011).

OECD countries are increasingly investing resources in the development of early intervention programmes aiming to detect first symptoms of mental disorders amongst students and refer them to appropriate mental health services. Existing evidence shows that increased school engagement in early identification is significantly associated with higher mental health service utilisation for adolescents with common mental and behaviour disorders (Green et al., 2013), possibly suggesting reduced treatment gaps for mental health problems. By addressing mental health problems experienced by children and adolescents early, governments can reduce the number of complex consumers of specialist adult mental health services in the years to follow. Australia, for example, has developed targeted interventions for at-risk children and adolescents. The Access to Allied Psychological Services (ATAPS) Child Mental Health Service (CMHS) initiative provides psychological interventions to children who have, or are at risk of developing, a mental, childhood behavioural or emotional disorder. ATAPS CMHS is designed to provide short-term psychological service strategies by a range of ATAPS mental health professionals. The ATAPS CMHS is also available to parents and family members or to other persons with custodial responsibility to assist them to better support the child. Infants and children can be referred to the ATAPS CMHS by their GP, paediatrician or psychiatrist. Clients can receive up to 12 sessions per calendar year, with a further six sessions in some circumstances. Establishing and maintaining linkages with schools and early childhood services are a key objective of the programme to assist in the early identification and intervention of children with, or at significant risk of developing a mental, childhood behaviour or emotional disorder.

There are some examples of school-based programmes across the OECD which aim to train teachers to pick up symptoms of mental disorders amongst students. In the Netherlands, for example, the "Rivierduinen" is an institute for the mental health of children and adolescents that trains teachers in both primary and secondary education to pick up signals of mental health problems and to act adequately. Rivierduinen also offers individual consultation for schools that have children with mental disorders in their classes, or hosts classes for students who have parents with mental disorders. Furthermore, Special Care and Advice Teams (ZATs) provide care and education professionals and help detect a variety of problems, including mental health problems. ZATs are largely used by both primary and secondary schools. In 2011 over 98% of secondary schools and 67% of primary schools had access to ZATs (Van der Steenhoven and Van Veen, 2011).

Some OECD countries have developed programmes which combine the promotion of mental health, and the prevention and early intervention of mental health problems. The Australian Government funds two school-based mental health promotion, prevention and early intervention initiatives, KidsMatter (2013) and MindMatters (2013). KidsMatter is a suite of activities funded by the Australian Government. It provides mental health promotion, prevention and early intervention initiatives for primary schools and early

childhood education and care services focusing on the mental health needs of children. KidsMatter aims to contribute to improving the mental health and well-being of children, reducing mental health problems amongst children, and achieving greater support for children experiencing mental health difficulties, and their families. The MindMatters initiative supports mental health promotion, prevention and early intervention for Australian secondary schools. The aim of the MindMatters initiative is to increase a school's capacity to implement a whole-school approach to mental health promotion, prevention and early intervention by providing hardcopy resource materials, a website, and professional development and implementation support for teachers and school personnel.

Investment in mental health programmes in workplaces is a priority for OECD countries

Mental disorders are significantly linked to poor employment outcomes and vice versa, which has led a number of OECD governments to invest in workplace interventions. Studies confirm that the workplace environment can have a significant impact on a person's mental health, and in particular that work is beneficial to health, including mental health, and conversely unemployment is not (Waddell and Burton, 2006). The OECD publication *Sick on the Job?* (2012) highlighted the fact that employment rates for people suffering from common mental disorders (CMD) are around 60-70%, around 2-3 times lower than the general population (OECD, 2012). Furthermore, job dissatisfaction has shown to be correlated with psychological distress (Lee et al., 2009). People suffering from some kind of mental disorder are more likely to work in low-skilled jobs and/or in jobs that do not match well with their skills, leading to unhealthy work-related stress (OECD, 2012). Discriminatory behaviours from managers and colleagues such as lack of opportunities of advancement might be a reason for distress within the workplace (Brohan and Thornicroft, 2010).

Mental health programmes in the workplace are very common across the OECD. Approaches include: assistance programmes aiming to support workers with both common and severe mental health problems, such as Employee Assistance Programmes (EAPs) (ODEP, 2009); training programmes aiming to increase the knowledge and skills of employers and employees to address mental health issues in the workplace, such as the National Workplace Training Programme (*http://nwt.edu.au/*) in Australia and the Mental Health Works (*www.mentalhealthworks.ca/*) in Canada; and programmes for the prevention, early identification, treatment, rehabilitation and return to work for workers with depression, such as the Masto project in Finland (Finnish Government, 2012; see Patana, forthcoming for further information). The OECD has an ongoing series that assesses the range of workplace interventions for mental well-being in select countries, and offers pertinent recommendations for strengthening interventions, as part of the "Sick on the Job" OECD project.

Anti-stigma campaigns are needed to reduce stigma, which is a major obstacle to improving the lives of people with mental disorders

Anti-stigma campaigns can be a sound policy instrument for policy makers to reduce the treatment gap and further intervention for mental disorders. People suffering from mental ill-health have to cope not only with symptoms associated with mental disorders, but also with stigma and prejudice – a "second illness" that frequently inhibits recovery from the first. Not only does mental health-related stigma result in social isolation, low self-esteem, and more limited chances in areas such as employment, education and housing,

but it also delays help-seeking behaviours reducing early interventions and increasing the treatment gap for mental illness (Quinn et al., 2013). Stigma has been found to make decision makers see people with mental health problems with low regard, resulting in reluctance to invest resources in mental health care (Sartorious, 2007); discrimination is at play also among medical professionals, with negative consequences on the quality of mental health services delivered (Sartorious, 2002; Sartorius, 2007; Magliano et al., 2004; Magliano et al., 2011).

Anti-stigma campaigns for mental health aim to change perceptions and prejudices of mental disorders and can target either the entire population or a subsample, such as employers, health care providers, educators, young people or landlords. Whilst some OECD countries have promoted and implemented anti-stigma campaigns targeting the whole population (see Box 6.2), a number of countries have also implemented anti-stigma programmes targeted to specific population groups or settings (see Box 6.3), such as in the workplace or in schools, to complement existing public campaigns and contribute to the overall effectiveness of the anti-stigma message.

While there are some persuasive arguments that support universal campaigns targeting the general population (Gaebel et al., 2008; Crisp et al., 2005; Myers et al., 2009), the understanding that large scale public campaigns have low rates of audience awareness

Box 6.2. ***See Me* – a whole population stigma change campaign in Scotland**

The Scottish anti-stigma campaign, *See Me,* used a variety of different approaches in pursuing a population-wide impact, and has involved a variety of different sectors, especially the media, but also educational and sporting institutions. *See Me* has used cinema and TV advertisements, press releases and outdoor posters to reach the general public, and a *See Me* website (*www.seemescotland.org*) was developed to share information on the campaign and related activities. The "Stigma Stop Watch" programme gives the public the opportunity to complain about offensive representations of people suffering from mental illness in the media and advertising. For instance, in 2003 *The Sun* newspaper ran the headline, "Bonkers Bruno Locked Up", referring to the boxer Frank Bruno's detention under mental health legislation. In response to this, *See Me* sent an e-mail alert to those who had signed up to Stigma Stop Watch and generated a public reaction. With the same objective of changing media attitudes towards mental disorders, *See Me* developed the media guidelines "Mind Your Language", which aim at supporting the use of non-stigmatising language by preventing the use of denigratory terms around mental illness in the media. Additionally, through the "Media volunteer programme" people who are suffering from some kind of mental illness can have access to a programme offering training for communications with the media. *See Me* has also undertaken anti-stigma initiatives with education and sporting institutions, such as the Bell College and the Motherwell Football Club, which agreed to publicly sign the *See Me* anti-stigma pledge. This Pledge is a visible commitment by organisations to work with *See Me*. For instance, the football players of the Motherwell Football Club wore *See Me* t-shirts during their football matches. *See Me* has recently been re-launched with an increased focus on discrimination, and greater orientation towards service user involvement, drawing on lessons from the Anti Stigma Programme European Network (ASPEN).

Source: Myers, F., A. Woodhouse, I. Whitehead, A. McCollam, L. McBryde, V. Pinfold, G. Thornicroft, R. McBrierty and L. Wilson (2009), "Evaluation of 'See Me' – The National Scottish Campaign Against the Stigma and Discrimination Associated with Mental Ill-Health", Scottish Government Social Research, Edinburgh.

Box 6.3. **This is me – an innovative technology campaign targeting young people in Slovenia**

Some programmes targeting young people have been exploring new technologies, for example *This is Me*, the largest youth counselling web portal in Slovenia, which provides teens with a friendly, simple, fast, free, and anonymous public access to expert information and problem-solving assistance. *This is Me* supports adolescents in their problem-solving efforts. Most users are between the ages of 13 and 18. The programme focuses on development of positive mental health, with emphasis on self-image, social and life skills. The programme was created by the Institute of Public Health Celje, and today the network of web counsellors includes 38 experts (medical specialists, psychologists, social pedagogues, social workers, and teachers), who are volunteers from 12 different institutions. Over the course of ten years, experts have answered almost 21 000 questions about dilemmas and problems faced by teens (ASPEN, 2013; Lekic et al., 2011). Although the main aim of these targeted initiatives was not to reduce stigma towards people with mental health problems, reduced stigma remains one of the expected outcomes of the programmes.

Source: ASPEN (2013), "The ASPEN Project, The Anti-stigma: European Network", Anti Stigma Programme European Network (ASPEN), [Online], available at *www.antistigma.eu/*, accessed 12 June 2013; Lekic, K., J.N. Konec, P. Tratnjek and B. Jereb (2011), "Slovenian Practice Story: 10 Years of e-Counselling Service for Teenagers", Institute of Public Health, Celje, Slovenia, available at *www.ncbi.nlm.nih.gov/pubmed/21685594*, accessed 12 June 2013.

and recognition (Szeto and Dobson, 2011), coupled with the consideration that awareness does not necessarily entail comprehension and understanding (Corrigan and Shapiro, 2010), makes it difficult to appreciate the benefits associated with running such large scale, population-based anti-stigma campaigns. It is difficult to evaluate the effectiveness and the efficiency of large scale anti-stigma campaigns, and to therefore justify public expenditures on such programmes (Corrigan and Shapiro, 2010). Nonetheless, drawing from the example of the Scottish national anti-stigma campaign "See Me" (see Box 6.2), McCrone et al. (2007) suggested that – when taking into account the potential economic and social costs associated to mental health-related stigma, which include increased treatment gaps, reduced productivity and employment opportunities for mentally disordered individuals, and the undermining of academic achievements in school, with consequences on earnings and career – even if only 10% of a positive change in attitudes was due to the campaign, the benefit of reduced stigma in the population would still outweigh the cost of running the campaign.

OECD countries such as Australia, Canada, New Zealand and the United Kingdom, are leading the way in developing population-based anti-stigma programmes at the national level. Other OECD countries, such as Belgium, Mexico and Hungary have also developed population-based stigma change initiatives on a local level.

Although some OECD countries have developed population-wide anti-stigma campaigns, in recent years there has been a shift towards more targeted stigma change initiatives. Tailored anti-stigma campaigns have the advantage of targeting specific population groups or individuals – such as employers, landlords, and educators – likely to have significant influence over decisions that will affect the lives of people with mental disorders. For example, stigmatising attitudes towards mental disorders amongst employers and landlords can undermine employment and housing opportunities for people with mental disorders (Corrigan and Shapiro, 2010). The evidence that knowledge gained through a public initiative – such as a public anti-stigma campaign – is likely to be

tied to the context in which it was learned in (Gawronski et al., 2010) suggests that counter-attitudinal information given as part of an anti-stigma campaign needs to be given in multiple contexts in order to eliminate the context-dependency of the information.

In this respect, anti-stigma programmes targeting specific population groups are seen to lead to more potent, and measurable, outcomes, and can be used by OECD policy makers to complement existing public campaigns and contribute to the overall effectiveness of the anti-stigma message. Most of these targeted initiatives, however, have a variety of objectives, including reducing stigma but also increasing employment and educational achievements. For example, campaigns directly targeting stigma around mental health amongst young people have been used in a number of OECD countries, including Finland, Norway and Sweden, who have put in place school-based educational programmes, seeing these as more effective at generating lasting change than population-level interventions.

In addition to local and national anti-stigma programmes, stigma change initiatives have been undertaken at an international level (see Box 6.4). In 1996 the World Psychiatric Association (WPA) embarked on a Global Anti-stigma programme named "Open the Doors", a good example of cross-country collaboration and international dialogue, in which countries regularly share knowledge and experiences. The aim of "Open the Doors" is to increase awareness and knowledge of the nature of schizophrenia and treatment options, improving public attitudes about those who have or have had schizophrenia and their families, and generating action to eliminate discrimination and prejudice (WPA, 2005). At the time of writing, over 20 countries are participating in Open the Doors, including some OECD countries such as Australia, Austria, Canada, Chile, Germany, Greece, Italy, Japan, Spain, Slovakia, the United Kingdom, the United States, and Turkey. Open the Doors also promotes leadership networking through the organisation of regular seminars where leaders share country experiences and best practice examples, showing that international

Box 6.4. **The Anti Stigma Programme European Network (ASPEN)**

The Anti Stigma Programme European Network (ASPEN), which ran over three years (2009-11) and received funding from the European Commission, aimed at addressing stigma related to depression in the 27 EU member states. The website (*www.antistigma.eu/*) collects best practice examples of depression-related anti-stigma initiatives, with the aim of spreading knowledge across all the relevant stakeholders. ASPEN gathered experiences from 18 EU countries, as well as universities, governmental agencies, public health bodies, human rights groups, NGOs, charities and mental health service user groups across Europe (ASPEN, 2013).

A recent evaluation of the project (Quinn et al., 2013) identified 26 depression-specific programmes across the 18 EU countries participating in the project. The existence and the number of programmes in a country was found to depend on a variety of issues. For example, it was apparent from the evaluation that countries where there was a stronger policy commitment to tackling stigma were also countries where the enthusiasm of professionals sit along-side national or local programmes. Conversely, in countries lacking a strong national commitment, there were fewer programmes promoted and run by grassroots groups, probably due to lack of an identifiable supported service user movement. The evaluation also pointed out that in non-European countries, especially in Australia and the United States, depression anti-stigma programmes are much more frequent than in Europe, possibly due to the availability of funding from pharmaceutical companies in non-European countries (Quinn et al., 2013).

Box 6.4. **The Anti Stigma Programme European Network (ASPEN)** *(cont.)*

Whilst most programmes (58% of all programmes) were targeting the whole population, the remaining programmes (42% of all programmes) targeted specific groups, such as health professionals (39%), young people (39%) and service users (35%). The most common aim of the programmes identified were improving literacy, reducing stigmatising attitudes and discriminatory behaviour, promoting help-seeking, empowerment of people with mental health problems, and suicide prevention. The evaluation interestingly found that 46% of programmes had no type of evaluation, 46% had report-level evaluations, whilst only two programmes had peer review evaluations. As the evaluation pointed out, this could be driven by a variety of reasons, including lack of resources; small scale programmes; and a focus on action rather than evaluation. Most importantly, the impact of the anti-stigma campaign has proven particularly difficult to quantify, due to the significant number of determinants at play in reducing/increasing stigma towards mental disorders. The lack of systematic evaluations of anti-stigma campaigns related to depression makes it difficult to identify the most effective and efficient programmes.

These findings suggest that the commitment and engagement of national governments with anti-stigma programmes is valuable not only for the development and implementation of national stigma change campaigns, but also for the promotion and support of more local, independent groups to undertake independent initiatives, as stigma towards mental disorders is looked at as a national concern. ASPEN represents a valuable initiative to promote cross-government co-operation, further commitment of national governments, enhance the sharing of knowledge, experiences and best practice examples of anti-stigma campaigns for depression. These findings, however, also suggest that stigma change programmes need more systematic commitments towards measurement and quantification.

Source: ASPEN (2013), "The *ASPEN Project, The Anti-stigma: European Network*", Anti Stigma Programme European Network (ASPEN), [Online], available at *www.antistigma.eu/*, accessed 12 June 2013; Quinn, N., L. Knifton, I. Goldie, T. Van Bortel, J. Dowds, A. Lasalvia, G. Scheerder, J. Boumans, V. Svab, M. Lanfredi, K. Wahlbeck and G. Thornicroft (2013), "Nature and Impact of European Anti-stigma Depression Programmes", Oxford University Press 2013.

collaboration can be long-lasting and lead to long-lasting relationships across leaders. The peculiarity of the Open the Doors programme is that it represents a long-lasting commitment to stigma reduction, rather than a short-lived campaign, in virtue of the idea that in order to address the stigma of mental health, programmes should become a routine part of everyday services (Sartorious, 2009).

6.7. Conclusion

Good governance and leadership in OECD countries are crucial to making mental health count. Mental health has been traditionally neglected and underfunded compared to the burden of disease related to mental disorders, and in the context of economic crisis and stagnating health expenditures in many OECD countries, mental health risks being further neglected. Governments today must keep mental health high on the policy agenda.

Good governance is needed to lead changes at the national level. In countries where the move away from reliance on inpatient psychiatric care and towards community services is still on-going, this shift has to be carefully planned and implemented. The experience of OECD countries shows that the move towards community services requires a high level commitment from policy makers and other stakeholders, for example through the establishment of mental health plans at the national level, and making appropriate

revisions to legal frameworks. Mental health leadership is also needed to define the next wave of agenda in countries where the process of deinstitutionalisation is at a more advanced stage. Moving away from the organisational and financial simplicity of a single setting for care delivery (the psychiatric hospital), there is the need to improve co-ordination of services both between and beyond mental health services. In a context where mental health services today are often highly fragmented, and can be isolated from the rest of the health, employment, education and housing systems, good governance is important in order to improve the co-ordination of care and promote cross-government co-operation.

Governments and mental health policy makers do have at their disposal a wide variety of tools that can be used to improve mental health care and lead system-wide improvements. Mental health legislation is being used by OECD governments to regulate involuntary placements, promote and protect the rights of people with mental disorders in inpatient settings as well as in society, and set standards of mental health care. National strategies and plans have proved effective tools to drive and share changes at a national level, highlight priorities, promote gross-government co-operation, and ultimately impact upon regional and local service planning and delivery. Where there are significant gaps in care or coverage in mental health systems, or limits to the scope of traditional mental health systems, governments have been using targeted initiatives, such as school-based mental health programmes, anti-stigma campaigns and workplace interventions. With enough political commitment, and the inclusion of all relevant stakeholders, these tools can help deliver meaningful change in the lives of individuals with mental disorders.

Notes

1. Austria, BGBI. I Nr. 18/2010, 17 March 2010.
2. For all CQC-enforced government standards, see *www.cqc.org.uk/public/what-are-standards/government-standards*.
3. **Public mental health:** The art and science of promoting well-being and equality and preventing mental ill-health through population-based interventions to: reduce risk and promote protective, evidence-based interventions to improve physical and mental well-being; and create flourishing, connected individuals, families and communities (Department of Health, 2011).
4. **Well-being:** (Sometimes referred to as mental well-being or emotional well-being). A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment (Department of Health, 2011).
5. **Prevention:** Mental disorder prevention focuses on reducing risk factors and enhancing protective factors associated with mental ill-health with the aim of reducing the risk, incidence, prevalence and recurrence of mental disorders (WHO Regional Office for Europe, 2008).

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