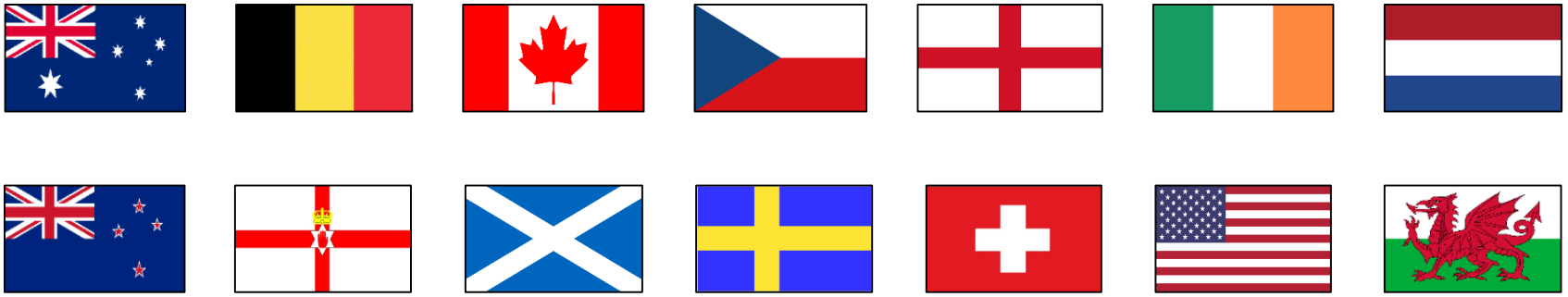
Benchmarking Network

International Mental Health Comparisons

Adult and Older Adult services

July 2018



Contents

Introduction, background & scope

This report summarises the findings from the “deep dive” project into high value indicators in mental health care.
From initial discussions and expressions of interest involving members of the International Initiative for Mental Health Leadership (IIMHL), the work has progressed in a structured manner through the following phases;

- IIMHL initiated a project in 2008 with an aim of developing a consensus framework for mental health quality and performance indicators. This work has been led by Professor Harold Pincus and team at Columbia University. The work has continued through to 2018 and published a series of papers that explore the performance schemes used and the opportunities for standardising approaches to performance and quality measurement across a range of countries.
- Following this work agreement was reached to perform a “deep-dive” into selected high value indicators to explore variation in data, indicators, provision and performance across countries. Results from the first deep-dive were published in February 2017 to participant countries.
- Following this phase of work further effort was undertaken to grow the project’s participant constituency. This included inviting additional OECD member countries to take part in the work following a presentation on the project’s work at the November 2017 OECD Health Care Quality Indicators Committee meeting. This succeeded in expanding the project’s participation group to 14 countries.
- A number of teleconference meetings of participants have taken place in order to; agree project terms of reference, participant coverage, and the data items and definitions to be used in the project.
- The development of robust definitions is central to the project’s work. Detailed work was undertaken to agree a set of definitions that are meaningful across countries and use terminology that is consistent with country specific data dictionaries. A data specification was developed which was issued to all participants to support the data collection process.
- Work was undertaken to map each country’s service model against definitional standards. The wider health and care system models used in each country have also been referred to in interpreting the data provided.
- The project launched for data collection in November 2017. The initial deadline for data submissions was April 2018. A number of data collection extensions were provided to participants to maximise the amount of data that the project could use. Final data submissions were received in June 2018.
- The NHS Benchmarking Network team undertook a structured process of data analysis and validation of first cut comparisons. All data was profiled on receipt and validated with participants to remove any outliers. Analysis was conducted in a number of ways and included the development of benchmarks to compare service provision, practice, and performance across countries.
- First draft reports were made available to participants in May 2018. The reports were discussed with participants at the IIMHL conference in Stockholm on 28th and 29th May 2018. Participants were given a further month following the IIMHL conference to supplement data prior to publication of final reports in July 2018.
- The report excludes Children’s and Young People’s mental health which is addressed in a separate document which was published in May 2018 to coincide with the IIMHL Stockholm seminar.

Interpreting project findings

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

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

Country Profiles

Australia

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

Mental health services are funded and organised as part of general health services: State governments provide acute and emergency hospital care and community mental health care, which are free at the point of service. The Commonwealth government subsidises primary care and outpatient "private" psychiatry and psychology services, with demand managed through out of pocket "gap" payments and caps on the number of subsidised sessions. Private hospitals provide around one quarter of mental health beds, but typically do not provide emergency or involuntary care. Together these arrangements mean that State/Territory governments provide the bulk of care for people living with severe and enduring conditions such as schizophrenia, while Commonwealth and Private Hospital services provide most care for common mental health conditions such as anxiety and depression. Around 61% of mental health expenditure is by State/Territory governments, 35% by Commonwealth government and 4% by private health insurers.

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

Australian data included in this report is from several sources. Australia has national data collections for hospital data, community mental health data and mental health outcomes measure, and where possible data has been provided from those collections. These collections are confined to services provided by State/Territory governments. Private hospital beds/activity, or care by Commonwealth funded GP or private psychiatry services are not included in this data, and therefore care is needed when comparing to countries with broader data coverage. For some indicators the specifications required for this project do not match Australian national specifications, or additional stratification and analysis was required: these data have been provided from one state (New South Wales), which comprises around 1/3 of the Australian population.

Canada

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

Both the public and private sectors finance Canada's health system. Public-sector funding includes payments by governments at the federal, provincial/territorial and municipal levels. Provincial and territorial government health spending accounts for about two thirds of total health expenditure in Canada. A portion of provincial and territorial health spending is funded through health transfer payments from the federal government. Services covered under the Canada Health Act, such as hospitals and physicians, are financed mainly by the public sector (Source: *National Health Expenditure Trends, 1975 to 2015,* CIHI)

Canada has been pioneering the development of mental health indicators for some years. In 2012, the Mental Health Commission of Canada (MHCC) released "Changing Directions, Changing Lives: The Mental Health Strategy for Canada". In order to build Canada's capacity to promote mental health and improve the lives of people living with mental health problems and illnesses, the Strategy identified the need for better data collection because "agreement on a comprehensive set of indicators would allow each jurisdiction to measure its progress in transforming the system and improving outcomes over time." To help accomplish this goal, the Mental Health Commission of Canada launched "Informing the Future: Mental Health Indicators for Canada" in partnership with the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University. This work aims to create a pan-Canadian set of mental health and mental illness indicators which paints a more complete picture of mental health in Canada. The indicators provide information on the mental health status of children and youth, adults, and seniors throughout their lives, as well as demonstrating how the mental health care system responds to mental illness.

In 2017, the Centre for Applied Research in Mental Health and Addiction published "Toward Quality Mental Health Services in Canada: A Comparison of Performance Indicators Across 5 Provinces." The report presented comparative results on 6 performance indicators.

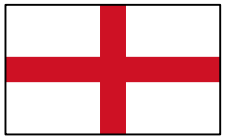
Czech Republic

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

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

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

England



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

Mental health care is commissioned by the NHS and covers England's whole population. The system is mainly supported by statutory NHS provider organisations, although the private sector also contributes and provides around 20% of the 25,000 mental health and learning disability beds available in England. The private sector tend to focus their provision on more specialist bed types including forensic care. In addition to the 25,000 beds around 700,000 adults are supported on the community caseloads of specialist mental health services in England. Almost all of these people are supported by statutory NHS provider organisations. There are 56 specialist NHS secondary care mental health provider organisations in England, each serving an average catchment population of 1 million people. Around 2% of the population are registered with secondary mental health services. The NHS also has a well developed primary care system which is also free at the point of delivery. General Practitioners provide a first line response for common mental health conditions and refer to secondary care services for access to specialist mental health care.

As a national healthcare system the NHS in England is able to develop national strategies for mental health and oversee the implementation of these strategies with providers. The "Mental Health National Service Framework" published in 1999 outlined an overall strategic objective of moving away from reliance on inpatient beds towards more integrated community services. As a result of this programme and subsequent strategies the English NHS has developed comprehensive community mental health services and significantly reduced the number of inpatient beds.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf

The latest strategy for England's mental health outlines a 5 year programme of work to further modernise services and broaden both the number of people who are able to access care, and the speed with which they access services. Within this strategy is a clear focus on service quality, outcomes and improving patient and carer experience. Specific priorities within this strategy include; first episode psychosis, crisis care, perinatal mental health, and the needs of children and young people.

https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

Republic of Ireland

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

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

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

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

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

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

Netherlands

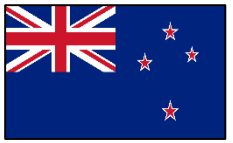
Within the Netherlands, mental health care is predominantly provided by public providers. Integrated mental health and community-based services are provided in a way which integrates mental health and addictions care. Recent years have seen a shift from clinical inpatient services to outpatient care, and from specialist to primary care provision.

Health care is provided through an insurance based system with managed competition. Within this there are three markets: the health insurance market, health care purchasing market, and health care provision market.

Specialist mental health provision is funded through the following five sources:

- Health Insurance Act (50%)
- Long-term Inpatient Care Act (7%)
- Forensic Care (9%)
- Youth Act (14%)
- Social Support Act (20%)

New Zealand



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

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

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

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

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

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

Scotland

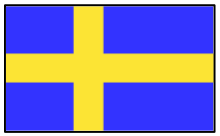
Mental health services in Scotland are almost universally provided by the National Health Service which is free at the point of delivery healthcare system. Health is devolved in Scotland from the rest of the United Kingdom so it is subject to separate legislation, targets and policy. Following the closure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

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

The Scottish Government is in the process of created a new mental health strategy. The measurement of outcomes is considered key to this and a suite of 30 measures balanced across the 6 quality dimensions of timely, equitable, effective, safe, efficient and person centred care is being developed. The proposed 5 measures of each dimension will provide information about as much of mental health service delivery as possible. Analysis of current data collection has shown an over collection of process information at the expense of outcomes.

A patient safety programme is in its 4th year and mirrors work in primary care and acute settings. This is a collaborative improvement programme with incremental testing of improvement. Data is being reported from some general psychiatric wards at present and the work is likely to expand to cover specialty wards and community transitions. An access improvement programme has started this year to improve the performance of HSCPs and overarching Health Boards in their delivery of psychological therapies and child and adolescent mental health treatment within an 18-week refer to treatment target. This programme intends to also assist with the consolidation of measurement and reporting of clinical and personal outcomes.

Sweden



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

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

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

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

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

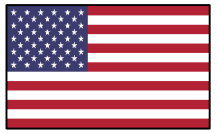
Switzerland

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

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

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

USA



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

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

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

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

USA continued

The National Quality Forum is the U.S. gold standard for evidence-based metric endorsement. The federal government, states, and private-sector organizations use NQF's endorsed measures, which must meet rigorous criteria, to evaluate performance and share information with patients and their families. NQF's multiple stakeholder workgroups offer the behavioural healthcare field an opportunity to collaborate toward common measures. Currently, NQF has endorsed approximately 55 behavioural health-related metrics and priorities for 2018 include metrics for serious mental illness and the social determinants of health.

Source: Health Insurance Coverage in the United States: 2016. Retrieved from https://www.census.gov/library/publications/2017/demo/p60-260.htmlc

Wales

NHS Wales covers just over 3 million people in a predominantly rural country covering 20,779 sq. km. It directly employs 70,000 people (making the NHS Wales' largest employer) and accounts for 40% of the total Welsh Government budget (approximately £6.5bn). It is made up of 7 Local Health Boards that plan, secure and deliver healthcare services in their geographical areas and 3 NHS Trusts delivering national services (Ambulance, Public health and cancer services). The local health boards work closely with the 22 local authorities.

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

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

National referral to treatment (RTT) times for mental health were introduced in Wales in 2012. Targets for assessment following referral was 28 days, with a further target of 56 days following assessment. 2015 saw the introduction of a 28 day target for treatment, replacing the 56 day target.

The three main recent national drivers for mental healthcare include:

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

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

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

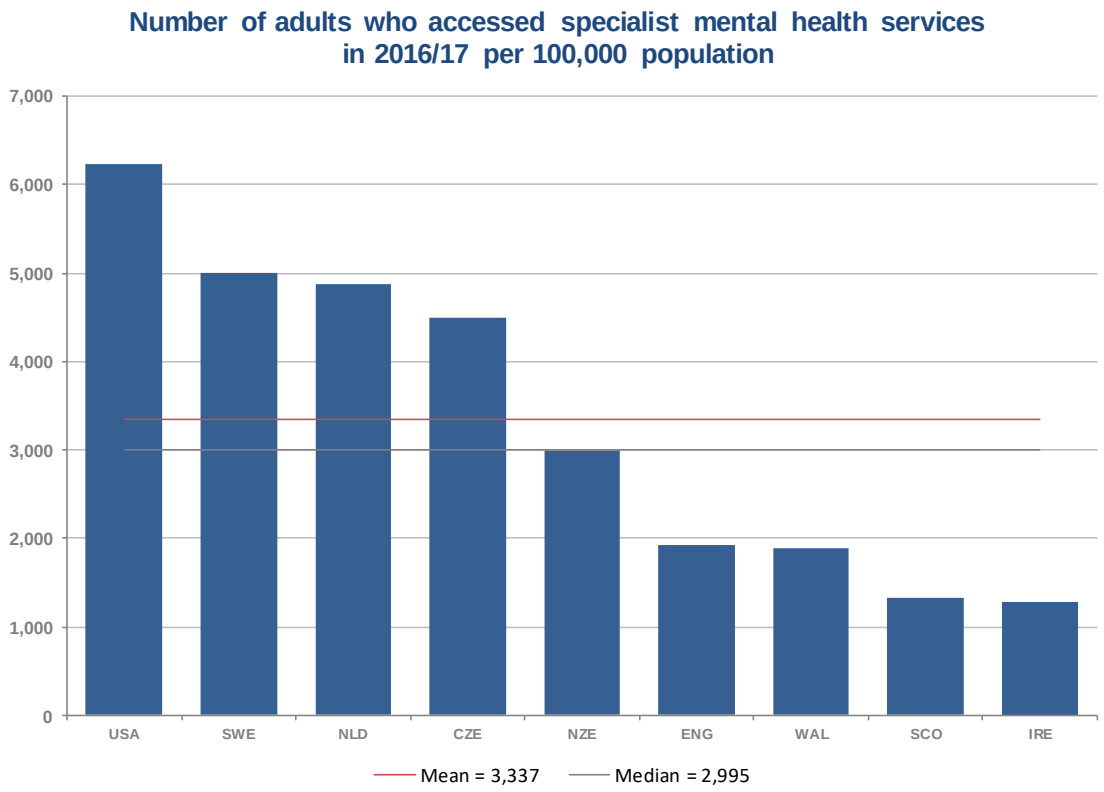
Wales has a further closely related programme of work; ***Together for Children and Young People***. A multi-agency service improvement programme reshaping, remodelling and refocusing the emotional and mental health services provided for children and young people in Wales.

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

Benchmarking Network

Access and scope of services

Access to specialist MH services

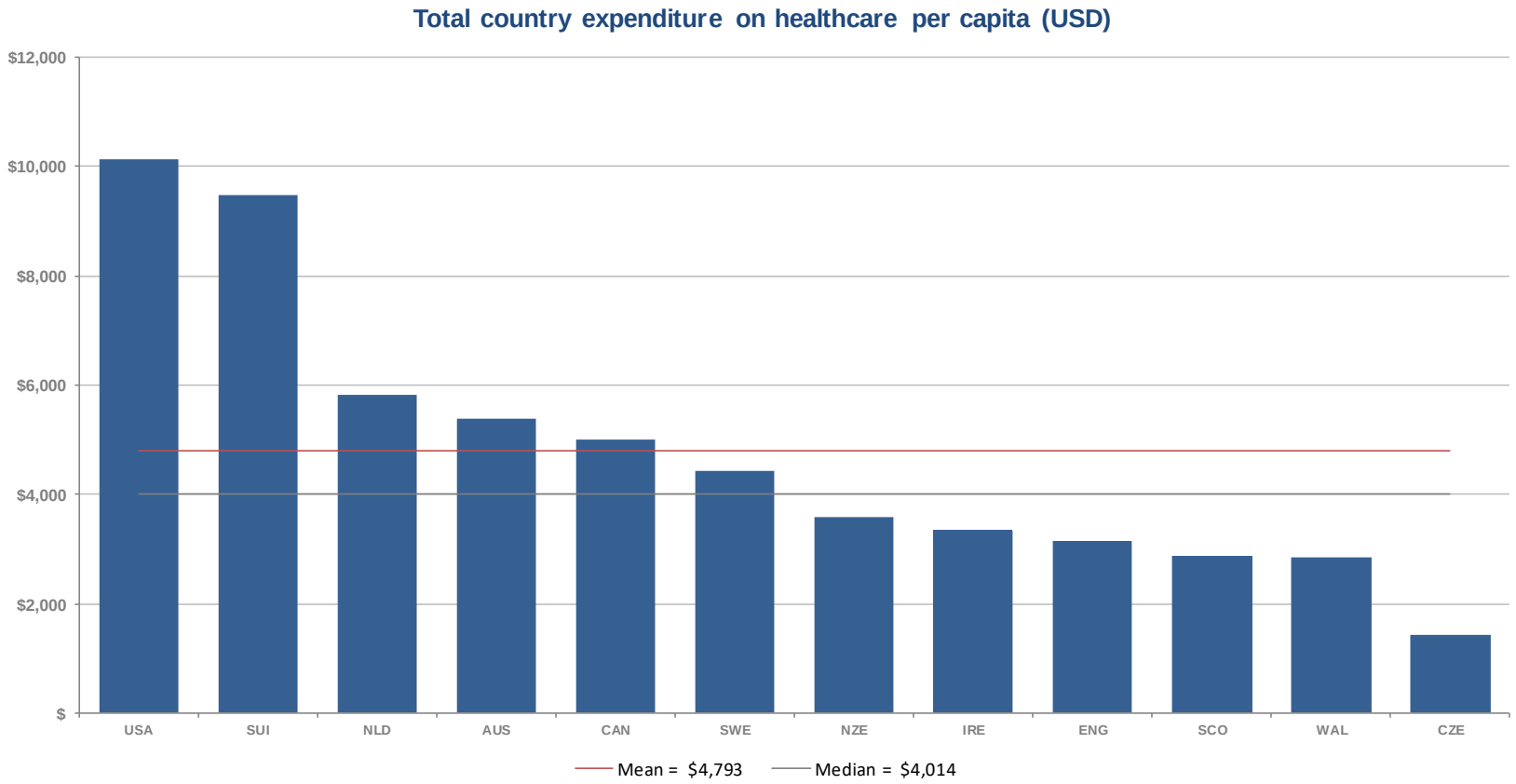


- Many countries were unable to quantify the number of people who accessed specialist mental health services in a year due to a lack of robust national data across inpatient and community care.
- This data looks at specialist secondary care services and does not include the many people who receive enhanced primary care level mental health support. In England alone, this is more than a million people per annum. The wide range of service models in play across different countries should be noted in interpreting this comparison.
- The data reveals a median average position of around 3,000 people per 100,000 population accessing specialist services. UK countries and the Republic of Ireland report the lowest access rates to specialist care. The USA report the highest levels of access followed by Sweden and the Netherlands.

Benchmarking Network

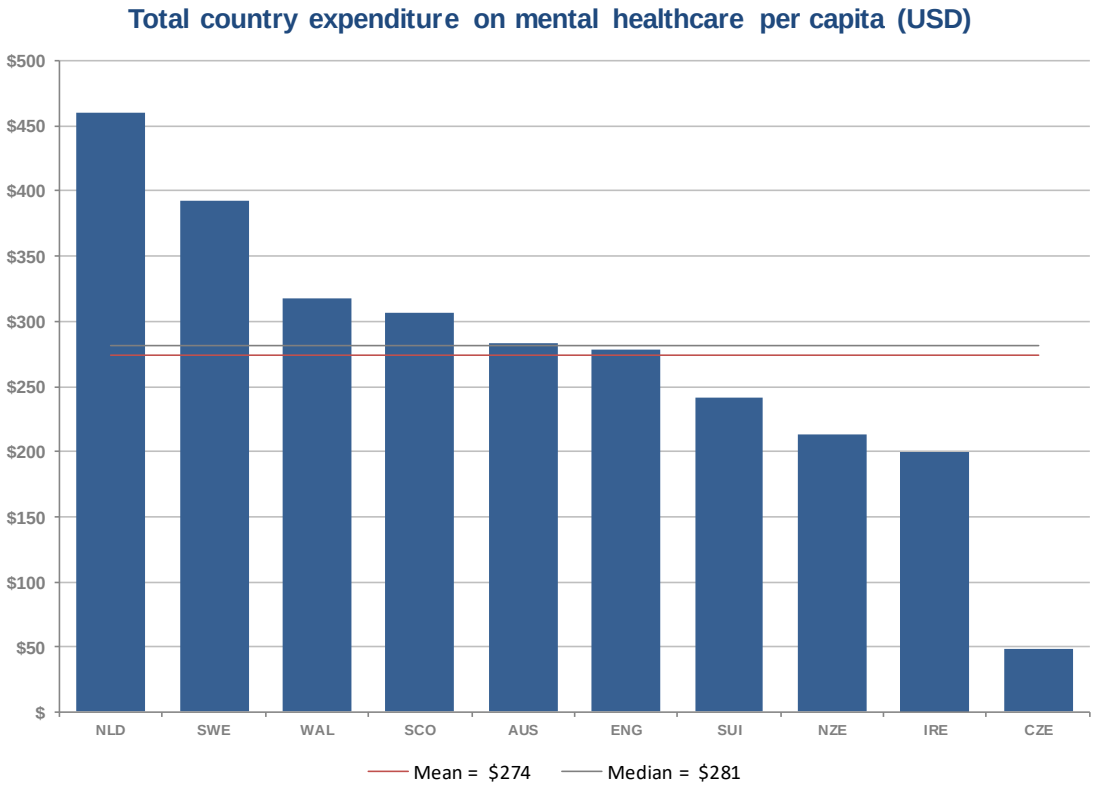
Finance

Total health expenditure



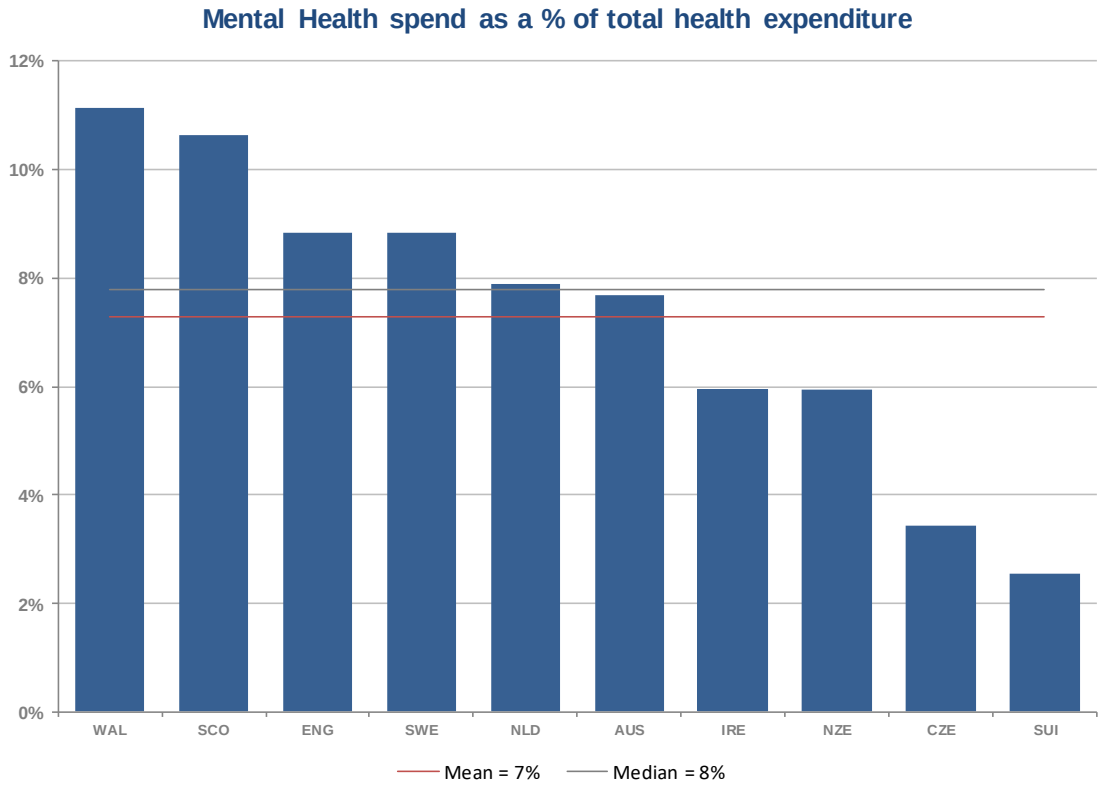
- In order to compare how much countries spend on mental health care, it is useful to include a benchmark of overall health care spending. This chart shows spend per capita on all healthcare during a year (using a standardised currency of US dollars).
- Data is standardised for year 2016/17 wherever possible and shows a median value of $4,014 healthcare expenditure per capita. Countries with the highest spend are USA and Switzerland, whilst the lowest expenditure is reported by Czech Republic.

Mental health expenditure per capita



- Further analysis was conducted to explore mental health expenditure per capita. The definition of mental health expenditure used a standard definition of mental health services that countries could reference in developing specific expenditure positions. Not all countries who were able to report total healthcare expenditure were able to identify the mental health element within this total.
- The chart shows spend per capita on all mental healthcare per annum divided by the total adult population. Data is standardised for year 2016/17 wherever possible.
- The benchmark for mental health spending has a median average of $281 per capita.
- The highest spending countries are the Netherlands ($460) and Sweden ($392) and the lowest spending country is Czech Republic at $49.

Mental health as % of total health expenditure



- Mental Health spending averages 7% of overall health spending across the participant group, where data is available.
- Wales and Scotland are the highest proportionate spenders in mental health at 11% of total healthcare expenditure, but against a lower total healthcare expenditure.
- Switzerland is lowest in percentage terms at 3% of total healthcare expenditure, but should be viewed against the backdrop of higher levels of absolute health spending which are the 2nd highest of the participant group.

Benchmarking Network

General Psychiatry Inpatient Care

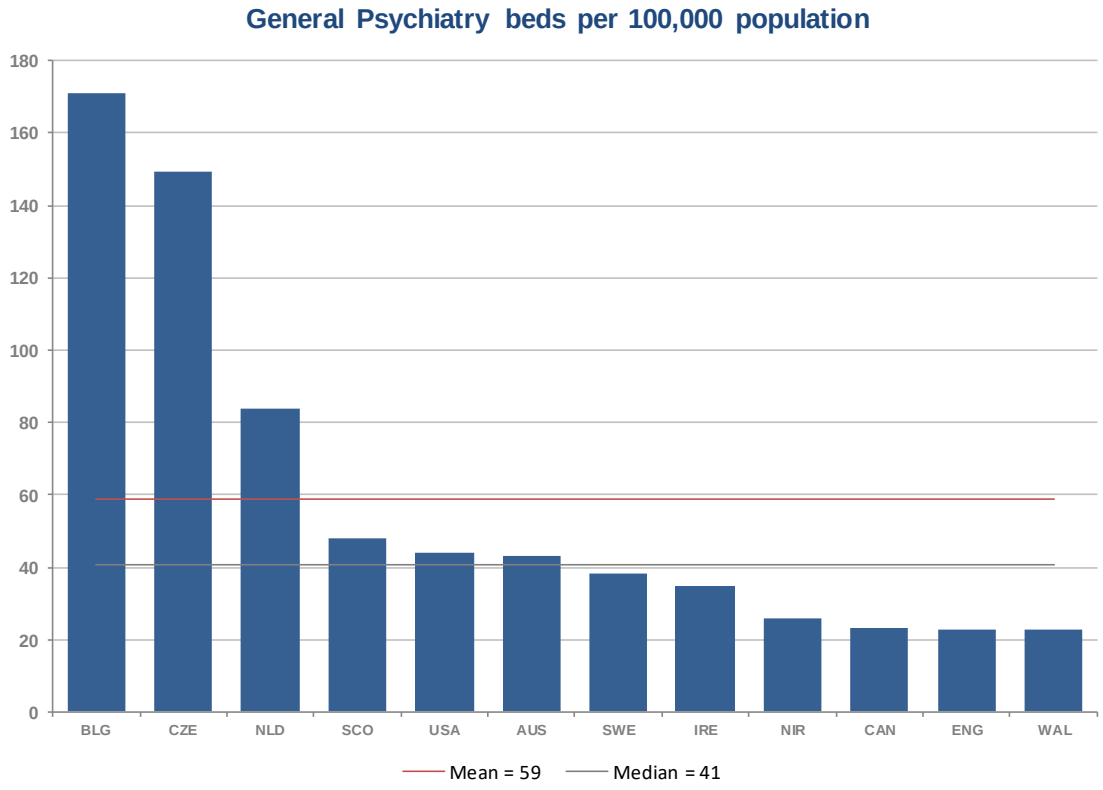
Working age adult services

Bed hierarchy

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

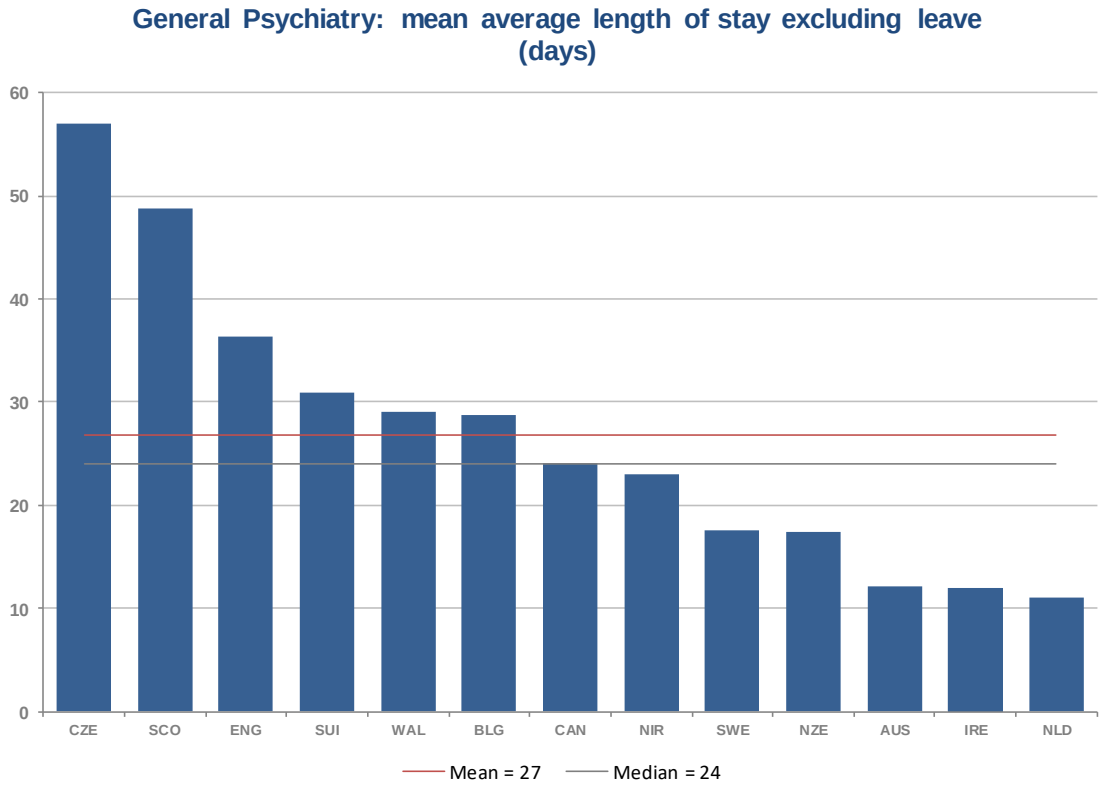
- Top hierarchy – e.g. General Psychiatry, Forensic, Rehabilitation, Other bed types
- Specialty drill-down of General Psychiatry – Adult Acute, PICU, Perinatal, Eating Disorders
- Specialty drill-down of Forensic – Low, Medium, and High Secure services
- Specialty drill-down of Rehabilitation – High Dependency Rehabilitation, Longer-Term Complex and Continuing Care
- Specialty drill-down of Other Beds – Older Adult, Child and Adolescent, Substance Misuse

Beds per 100,000 population



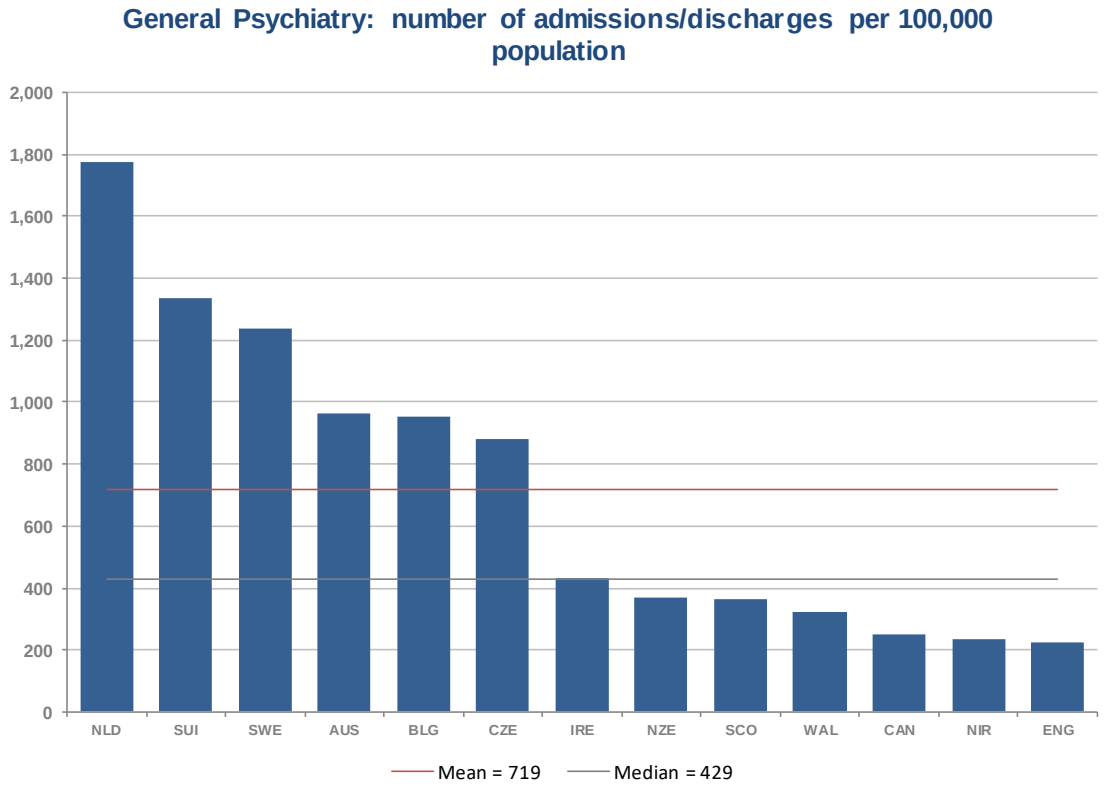
- The ability to identify and count mental health inpatient beds is a useful start point for the comparative analysis as this describes the capacity of each country's health and care system to support inpatient admission.
- The data is incomplete from some countries due to the lack of publicly available data from some private sector providers.
- The data reveals a mean average of 59 General Psychiatry beds per 100,000 population in the working age adult group aged 18-64. The highest bed numbers are reported by Belgium and Czech Republic and the lowest by England and Wales (which both reflect complete data positions for each country).
- England's and Wales' low positions within the range reflects a continued move away from institutionalised mental health care with enhanced levels of care available in the community setting.
- The median average of 41 beds per 100,000 population is perhaps more representative across the spread of data given the skewing effect on the mean average observed by the data from Belgium and Czech Republic who both report high numbers of beds.

Average length of stay



- A number of factors can influence length of stay, including bed availability, patient acuity, rates of involuntary detention and models of community care to facilitate a prompt discharge.
- An almost five-fold variation is demonstrated, with Australia, New Zealand and the Netherlands reporting the shortest lengths of stay, and Czech Republic reporting the longest length of stay.
- Canada's figure is based on cases meeting diagnosis criteria in all hospital beds (not limited to general psychiatry).
- *Canada's figure includes leave days which could not be segregated in local information systems. Switzerland's figure also includes leave days.*

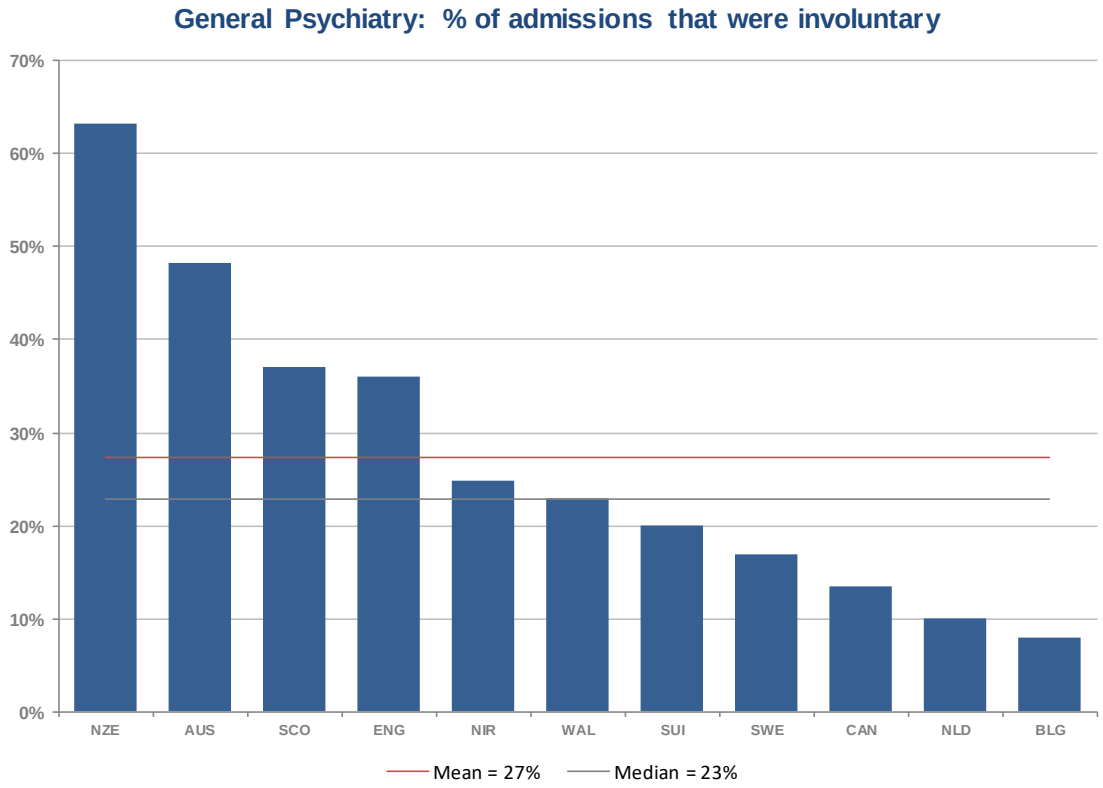
Discharges per 100,000 population



- Rates of discharge from inpatient care, show throughput in the system, and may directly reflect both available bed numbers and length of stay. This comparison offers countries an opportunity to report on either admissions or discharge as a measure of flow based on local data availability.
- A mean average of 719 discharges per 100,000 population per annum was reported. The median average was 429 discharges per 100,000 population per annum. The Netherlands and Switzerland report the highest admission rates
- England's position with the lowest number of discharges per 100,000 population relates to England's low number of beds and longer average length of stay than some countries. The other UK countries also report low levels of admissions / discharges per 100,000 population which also links to higher length of stay across the UK.

Involuntary admissions

Detentions as a percentage of admissions

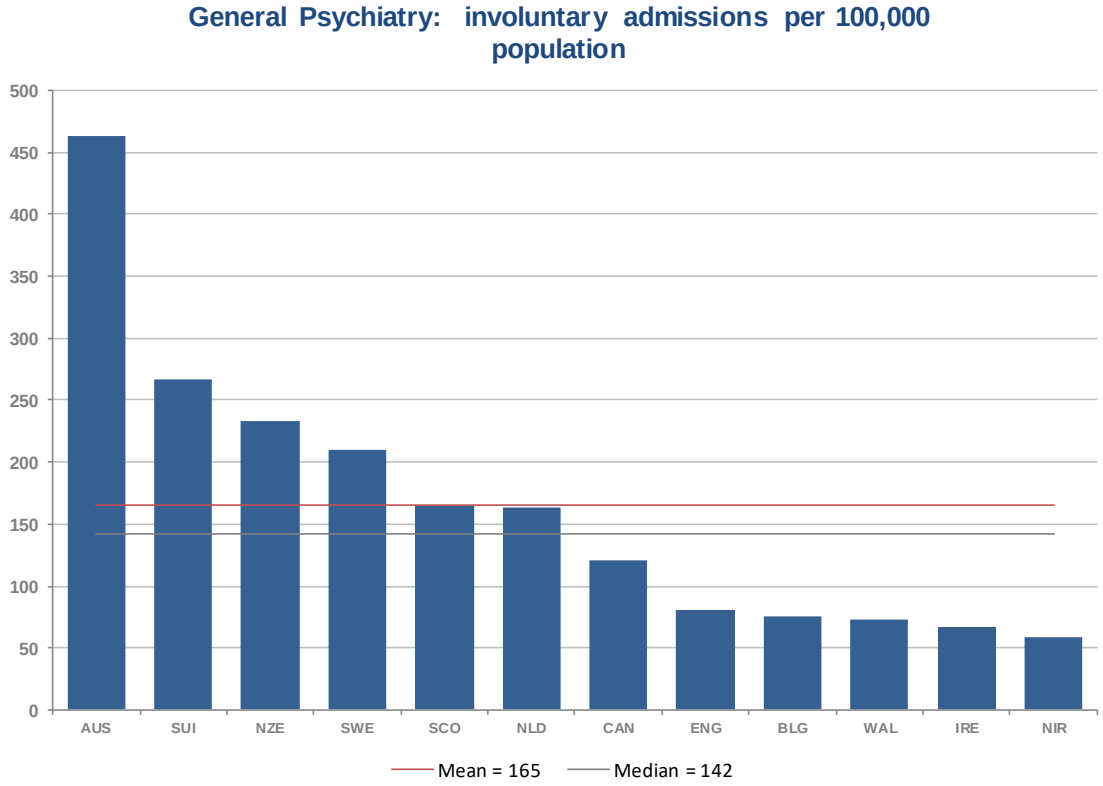


- Involuntary admissions are compulsory admissions made using legal arrangements to detain a person in an inpatient mental health facility.
- Where bed numbers are smaller, it is likely that the percentage of admissions that are involuntary will be higher, as thresholds for admission rise, and patients detained under local Mental Health Act legislation make up a larger proportion of the inpatient cohort.
- New Zealand's figure of 63% is the highest amongst all participants, but should be considered against its small bed base.
- Belgium reports the highest number of beds per 100,000 population alongside the smallest percentage of detentions.

Canada's figure is based on all hospital beds (not limited to general psychiatry) and is limited to data from 5 out of 13 provinces/territories

Involuntary admissions

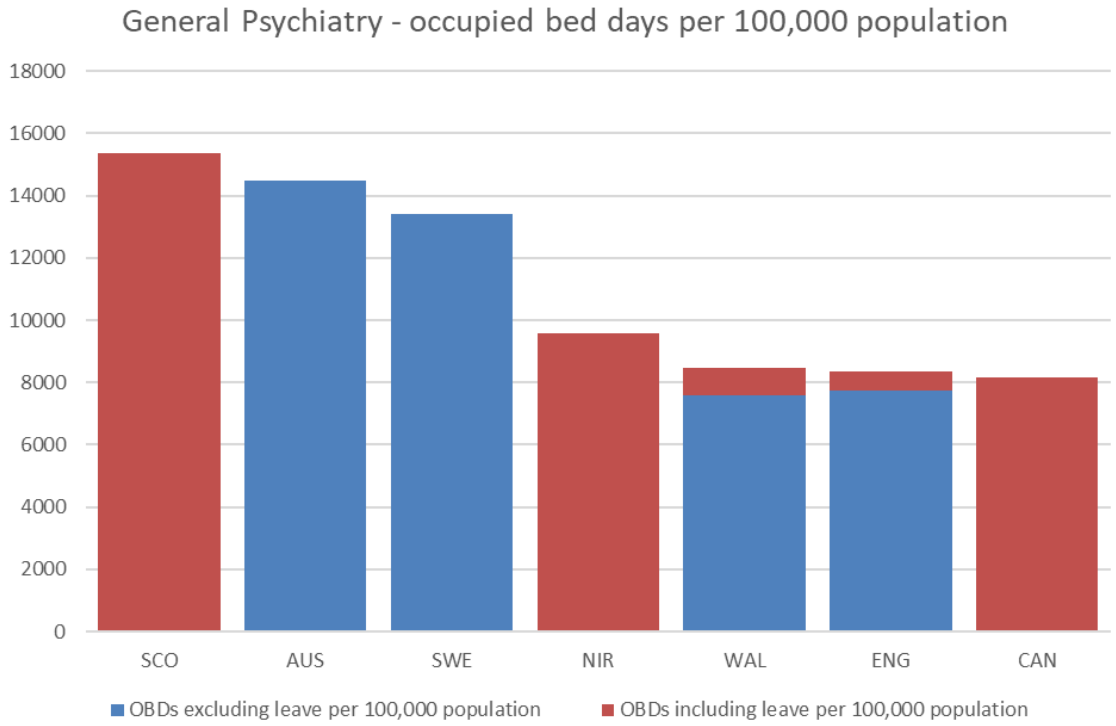
Detentions per capita



- A further way to compare detention rates is on a per capita basis. Although this may to some extent still be influenced by bed availability to facilitate admissions, it has the advantage of showing a whole population view of overall detention rates.
- Based on this data, people in Northern Ireland are least likely to experience involuntary detention under mental health act legislation, and people in Australia are most likely.
- This data confirms wider links with beds and average length of stay positions for each country.
- Mental health act legislation varies between participants and can comprise short-term hold and assessment, or longer term detention (typically 1 month) with abilities within legislation to extend the length of detention orders as required.
- Australia's higher detention rate should be viewed in the context of State based mental health laws which typically allow for short-term flexible detention arrangements.

Canada figure is based on all hospital beds (not limited to general psychiatry) and is data from 5 of 13 provinces / territories

Occupied bed days



- Occupied bed days per 100,000 population is a good measure of service provision and utilisation. Differences between countries measuring definitions including or excluding time spent away from the hospital on a period of authorised leave are accounted for here, with the chart showing measures excluding leave in blue and including leave in red. Where only one colour is shown, countries provided the figure for one of the measures only.
- Factors which impact on occupied bed days include bed numbers, bed occupancy rates, and local mental health act legislation.

Bed occupancy

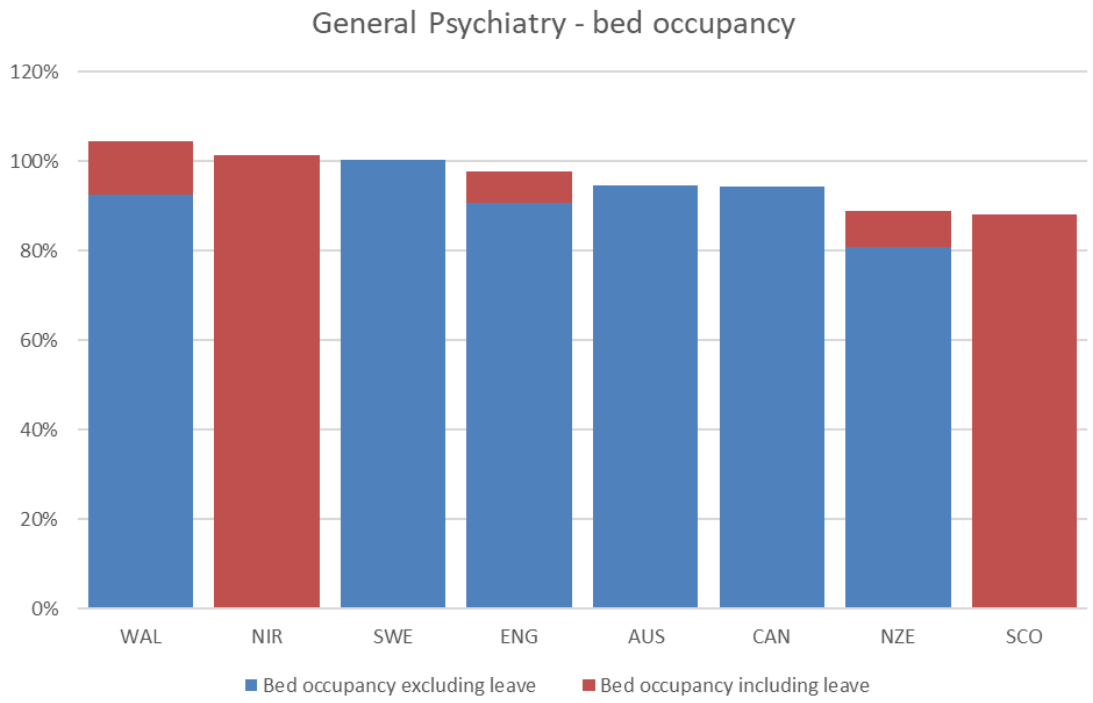
- Bed occupancy is a measure of how occupied a ward or unit was over a period. Typically calculated over a 12 month period, this compares the number of possible bed days that could have been occupied against the number of bed days that were occupied. A bed that was available for a full year would have 365 available bed days. On occasion, a bed may close for a period of time and not be available for a patient to occupy, for example during an outbreak of sickness on the ward or due to staffing shortages or ward reconfigurations.

- Most health systems will report high levels of bed occupancy as inpatient facilities tend to be accessed whenever available for use. Comparative occupancy is therefore not an indicator of patient acuity but of wider demand for healthcare services. Bed occupancy data needs to be seen in the context of wider data on bed numbers and the extent to which community based alternatives are available.

- The UK Royal College of Psychiatrists advises *"A bed occupancy rate of 85% is seen as optimal. This enables individuals to be admitted in a timely fashion to a local bed, thereby retaining links with their social support network, and allows them to take leave without the risk of losing a place in the same ward should that be needed. Delays in admission, which result from higher rates of bed occupancy, may cause a person's illness to worsen and may be detrimental to their long-term health."*[1]

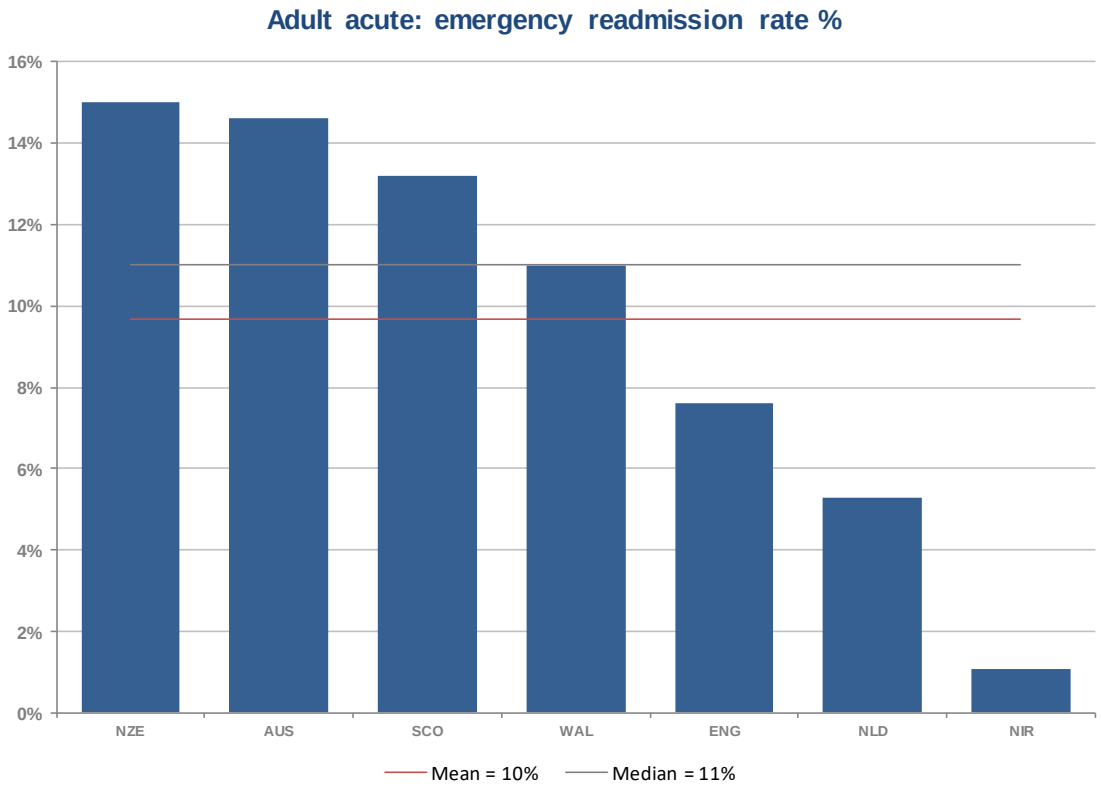
[1] RCPsych "*Do the right thing: how to judge a good ward*", June 2011

Bed occupancy



- Bed occupancy rates show the extent to which beds are occupied during the year. Although not every country was able to supply data, there is relatively little variation between the eight nations on the chart.
- General Psychiatry beds have high occupancy rates, typically in the 90% to 100% range.
- Three countries report bed occupancy in excess of 100% when leave days are accounted for. This confirms that demand management and bed management are issues for all countries.

Emergency readmissions

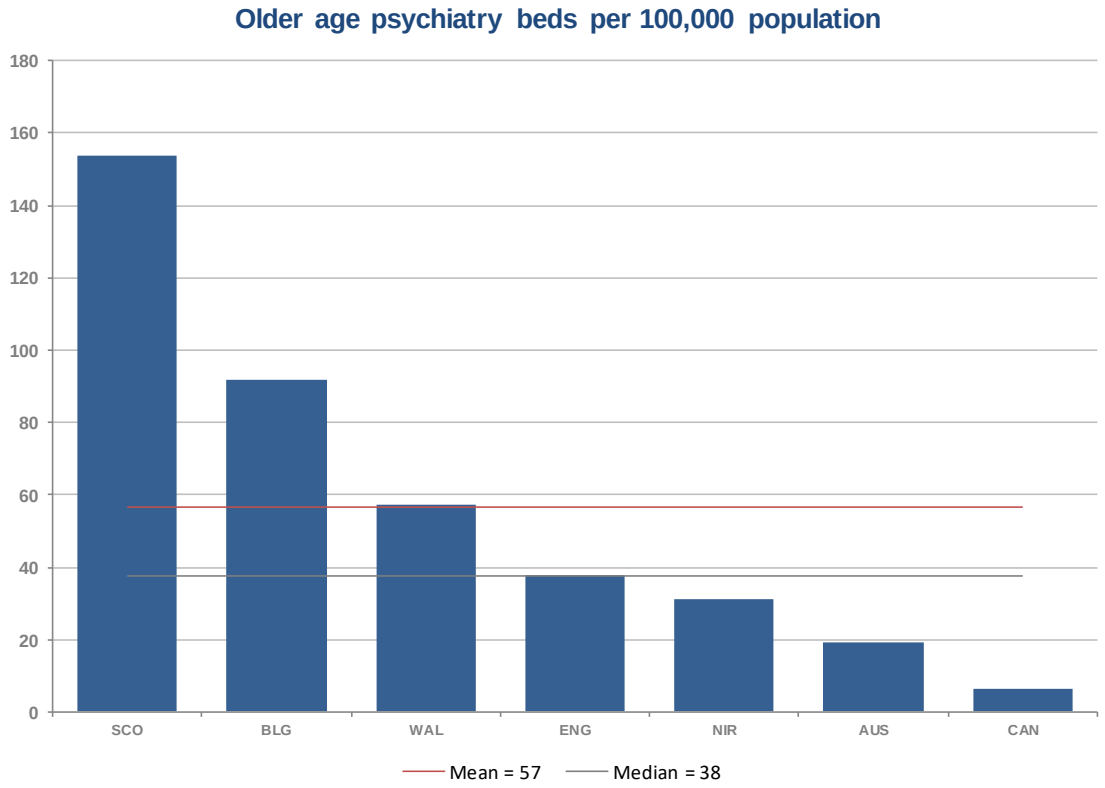


- Emergency readmissions are defined as an unplanned / unexpected readmission to a ward within a defined period (e.g. 28 or 30 days) of time following discharge from an inpatient unit, for a problem that is the same or similar to the original complaint for which the patient was treated.
- Emergency readmissions may occur if a patient was discharged too early or if their support in the community following discharge was inadequate. For example, a package of care may not have been intensive enough to support a patient in a community setting. There may also be a correlation between higher rates of bed occupancy and lower readmissions, regardless of perceived need for these, as it may be difficult to access a bed when availability is tight.
- Emergency admissions are not always avoidable and can reflect a relapse in clinical symptoms and illness triggered by other events. The data suggests a median average readmission rate of 11%.

Benchmarking Network

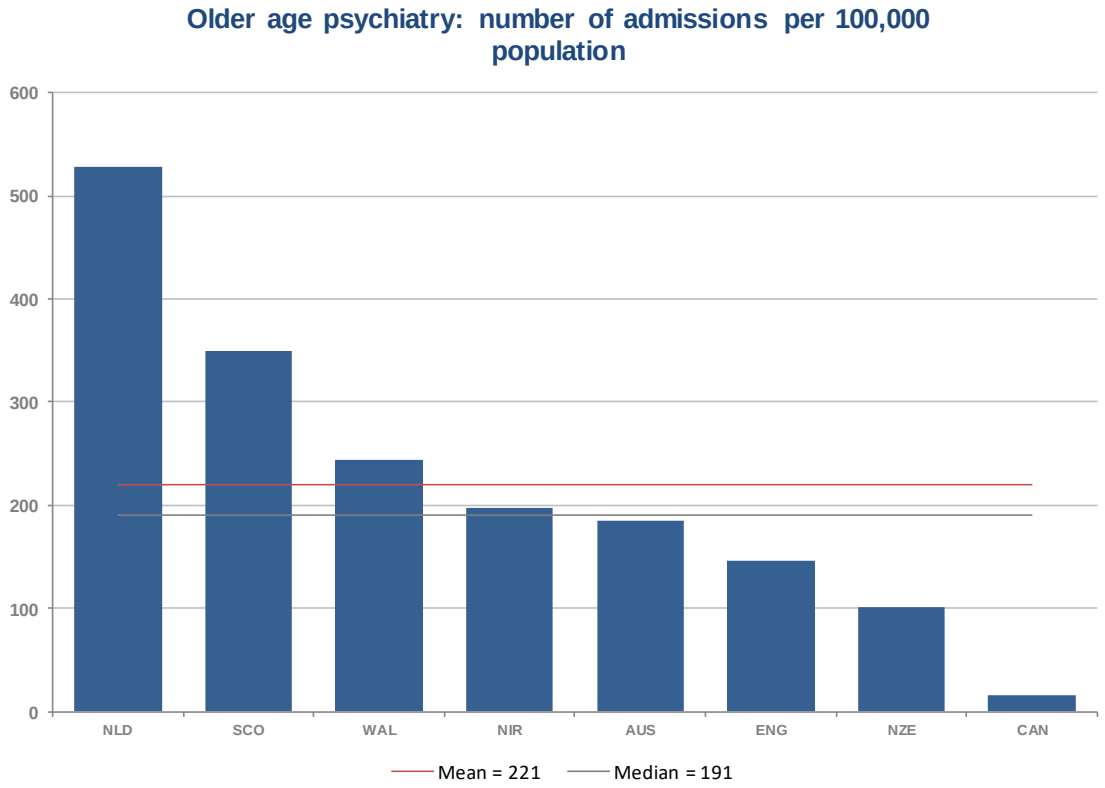
Older People's Inpatient Care

Beds per 100,000 population



- Older age psychiatry beds are acute admission beds for a cohort that is typically aged 65 or older. These admissions may be due to organic or functional disorders. Bed numbers are shown here per 100,000 population (age 65+) and therefore local demographics effect the rate, as may the availability of other beds for this cohort such as longer term rehabilitation units or continuing care.
- Scotland reports the highest number of old age beds and Canada the fewest. The median position is 38 beds per 100,000 people aged 65 and older.
- Time series trends from the UK suggest an ongoing decline in Old Age Psychiatry beds in recent years with a transition to more community based care including the provision of community memory services.

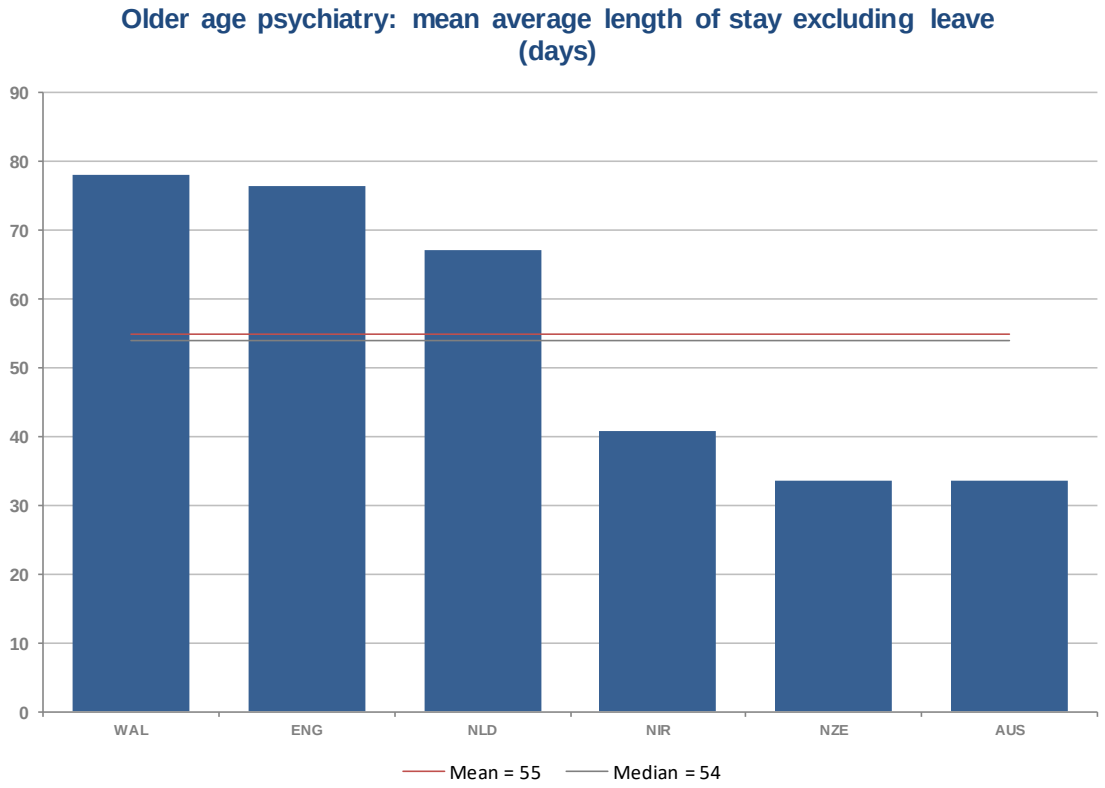
Admissions per 100,000 population



- Rates of admission to older adult beds largely reflect the number of older adult beds in the system, with countries who have a larger bed stock also reporting higher numbers of admissions.
- The Netherlands and Scotland report the highest admission rates and Canada the lowest. This is consistent with the bed positions reported on the previous pages.

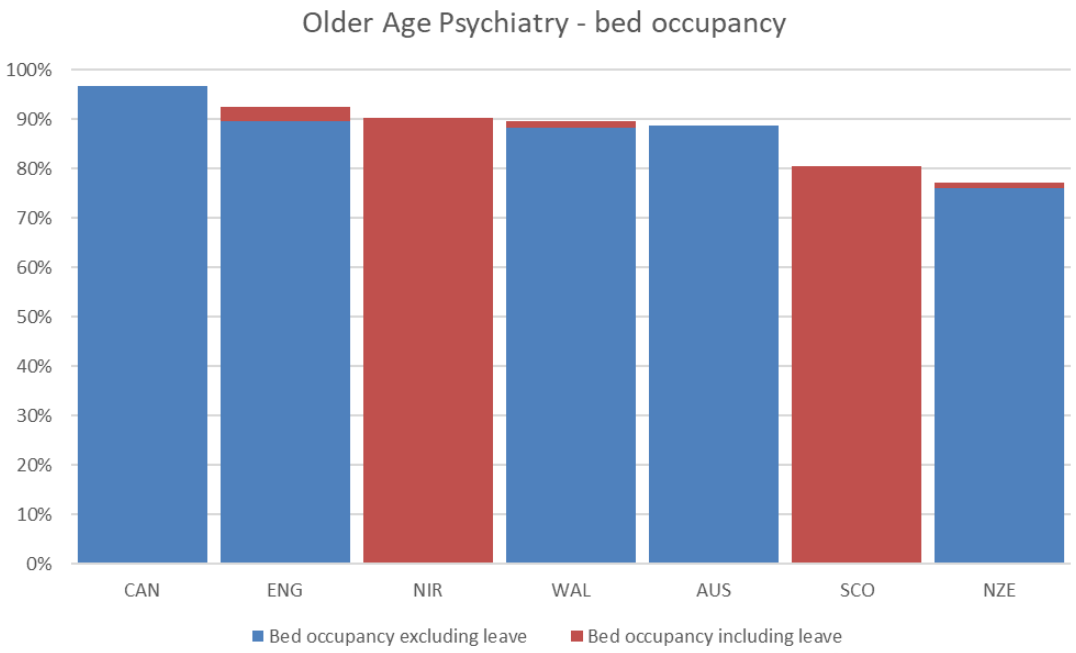
Average length of stay

Old Age Psychiatry



- Length of stay for older adults can be several months longer than for patients of working age. This is linked to the complexity of organic mental health conditions and also the presence of functional illness and co-morbid frailty.
- Variation is also evident within this measure, with average length of stay in Australia and New Zealand (33 days) typically being less than half that of comparative admissions in England (76 days) and Wales (78 days).

Bed occupancy

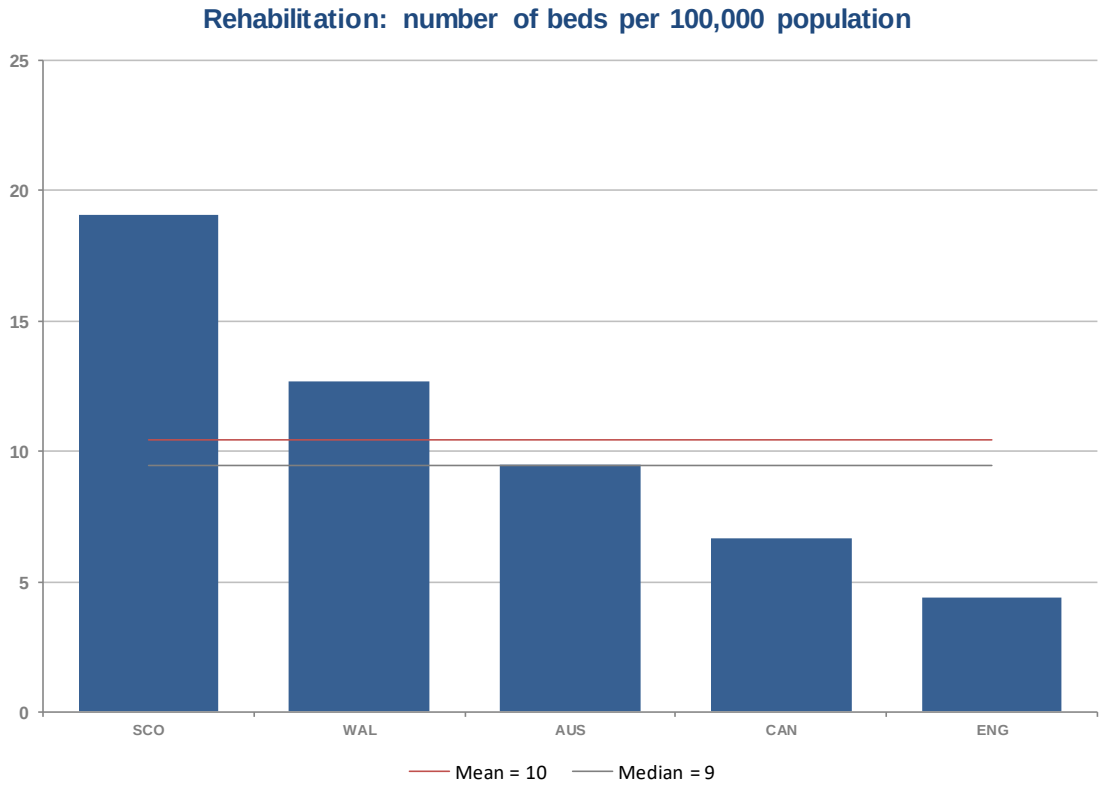


- Bed occupancy in Old Age Psychiatry services averages 90% including leave. This is marginally lower than in working age adult services and broadly consistent with the 85% good practice standard identified by the UK Royal College of Psychiatrists.

Benchmarking Network

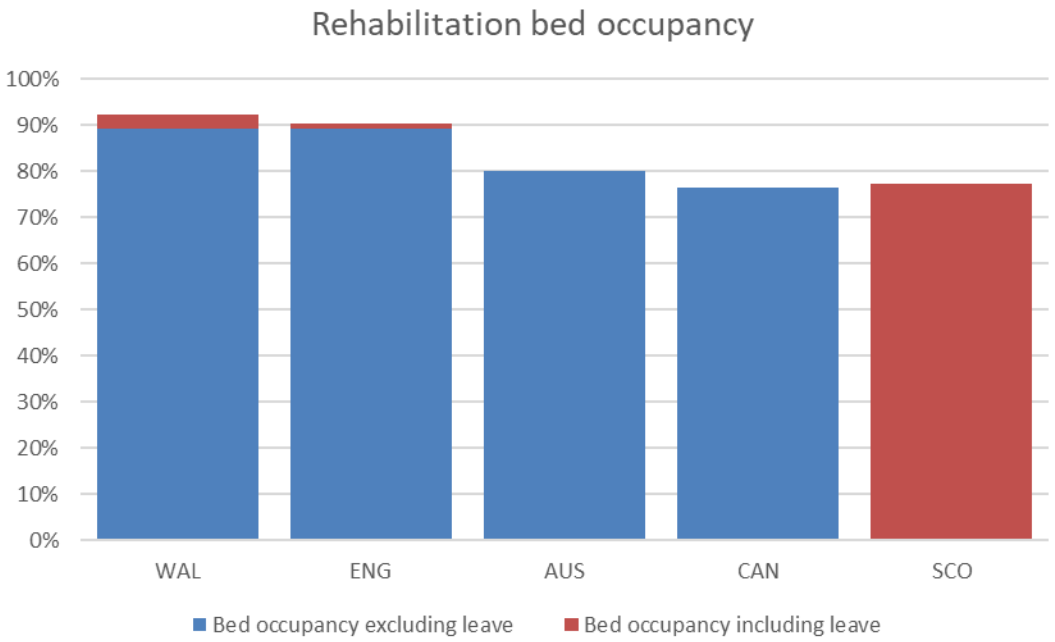
Rehabilitation Inpatient Care

Beds per 100,000 population



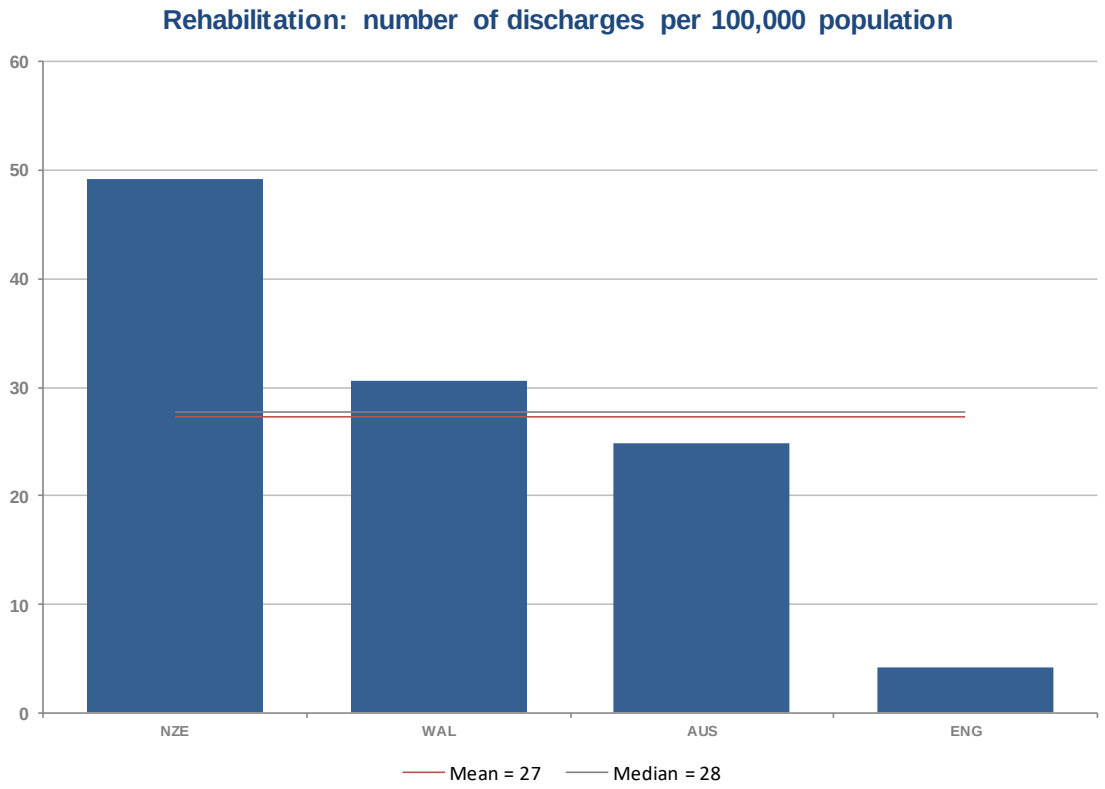
- Dedicated rehabilitation beds typically have a long length of stay and provide in depth, focused care with a view to enabling patients to live independently.
- Only five countries were able to identify dedicated beds for this specialty, with a mean average of 9 beds per 100,000 population. England (4) reports the fewest beds and Scotland the highest at 18 beds per 100,000 population.

Bed occupancy



- Bed occupancy for rehabilitation services reports a median average level of 80%. This is marginally below the levels reported in Adult and Older Adult services and may reflect the specialised nature of these services.
- The long-term nature of rehabilitation services will often involve an extended assessment and admission process which mitigates against rapid admission and discharge arrangements and reduces bed utilisation.

Discharges per 100,000 population

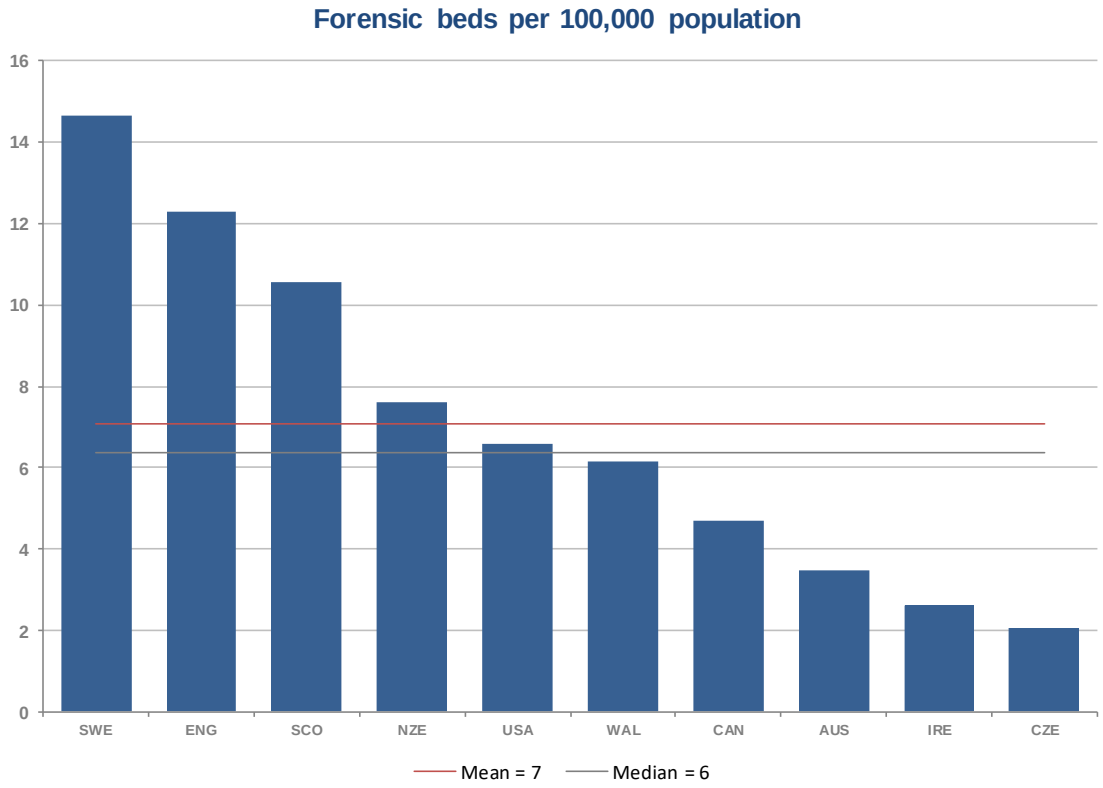


- Discharge rates from inpatient rehabilitation services are typically low due to both the small bed base and long average lengths of stay. Discharge rates have a mean average of 27 per 100,000 population. New Zealand has the highest rates at 49 per 100,000 population and England the lowest at 4 discharges per 100,000 population. The range in these data positions may reflect differences in service models and clinical cohort between countries.

Benchmarking Network

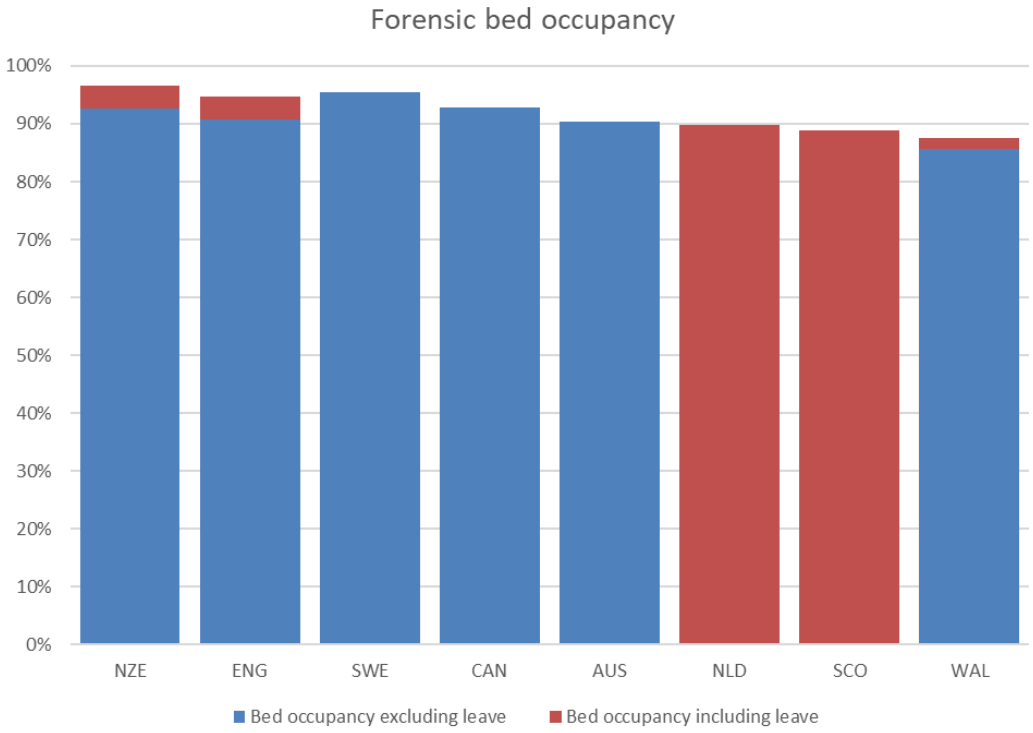
Forensic Inpatient Care

Beds per 100,000 population



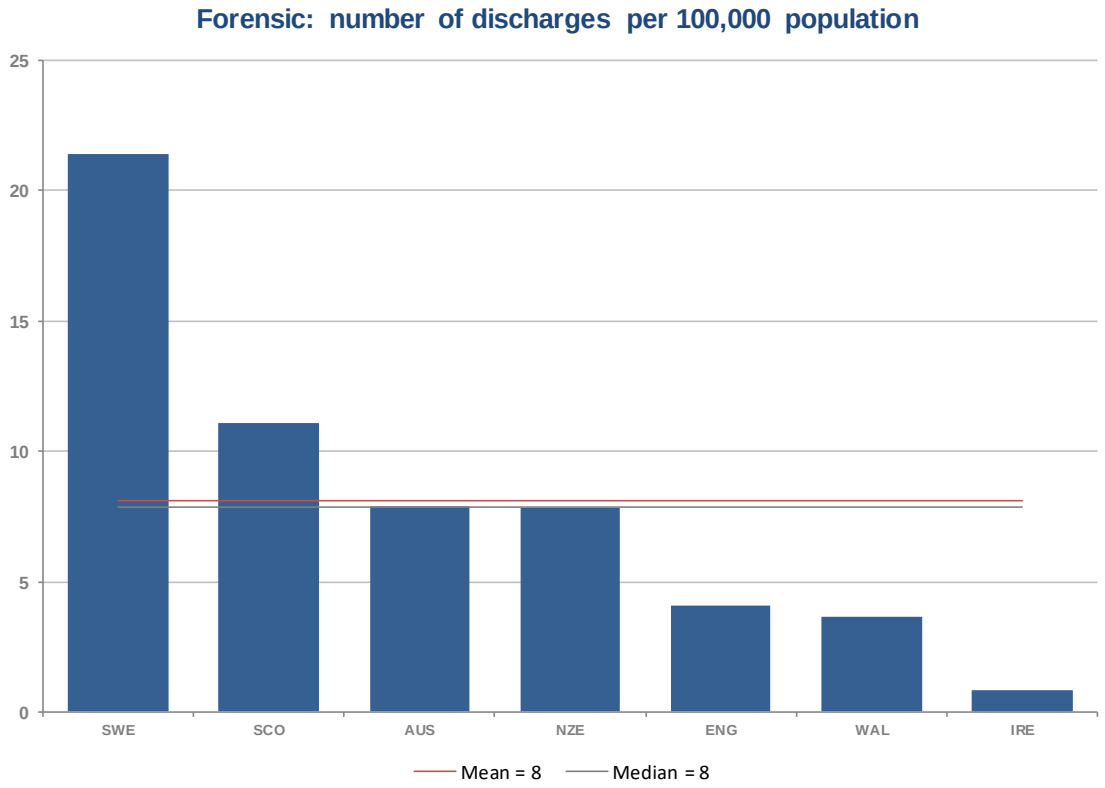
- Ten of the fourteen country participant group were able to identify dedicated forensic bed capacity within mental health systems. Commentary from countries suggests that these facilities typically provide support to service users who have; a history of serious offending, have been referred by the criminal justice system, or present high risks to themselves or society.
- The mean average rate of provision is 7 beds per 100,000 population, with the highest number of beds provided by Sweden, England and Scotland. This is interesting given the different positions occupied by these countries in terms of parallel number of places in the prison system. Sweden has one of the lowest number of prison places in Europe, whereas England and Scotland have above average positions.
- The Czech Republic and Republic of Ireland report the lowest number of forensic beds per 100,000 population.

Bed occupancy



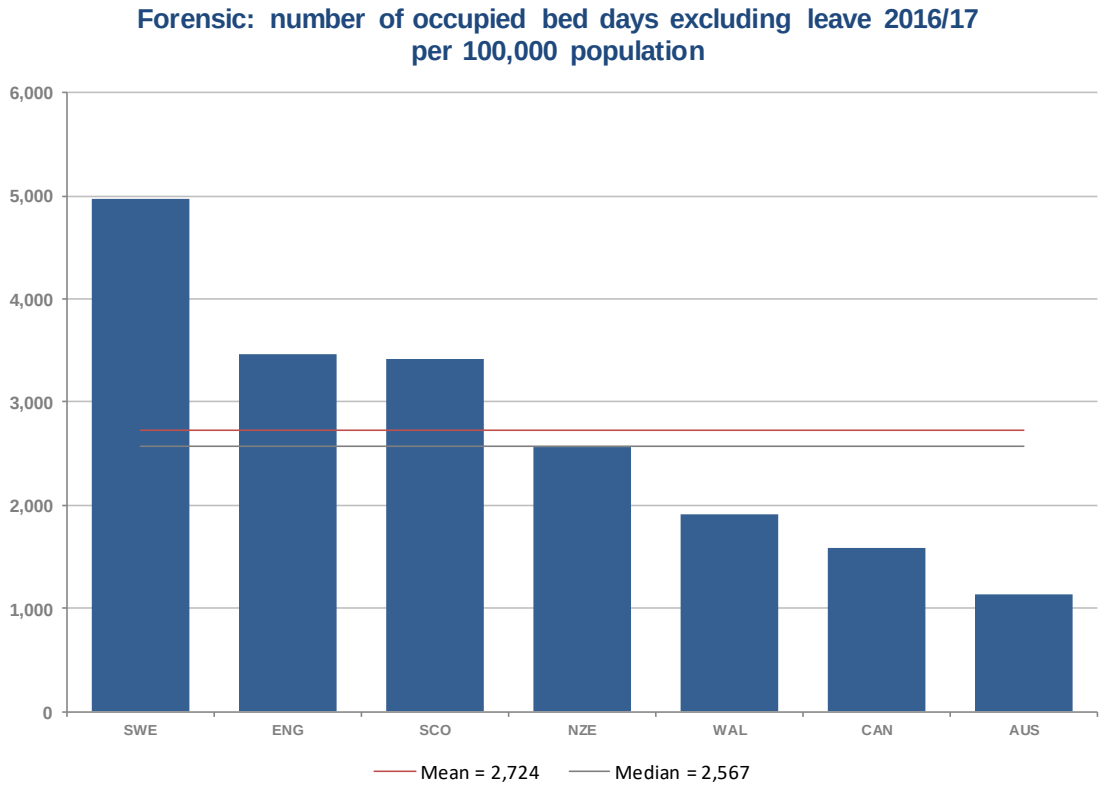
- Bed occupancy in forensic services averages 91% (median).
- Leave is less used to manage bed capacity and typically accounts for 2% - 3% of bed days.
- There is a broad consistency of reported occupancy levels at around 90%, which relates to the long average length of stay expected in forensic inpatient care.

Discharges per 100,000 population



- The long-term nature of forensic care generates a low discharge rate which has a median position of 8 discharges per 100,000 population. When compared to the average bed position at 7 beds per 100,000 population, this indicates an average length of stay of around one year.

Occupied bed days

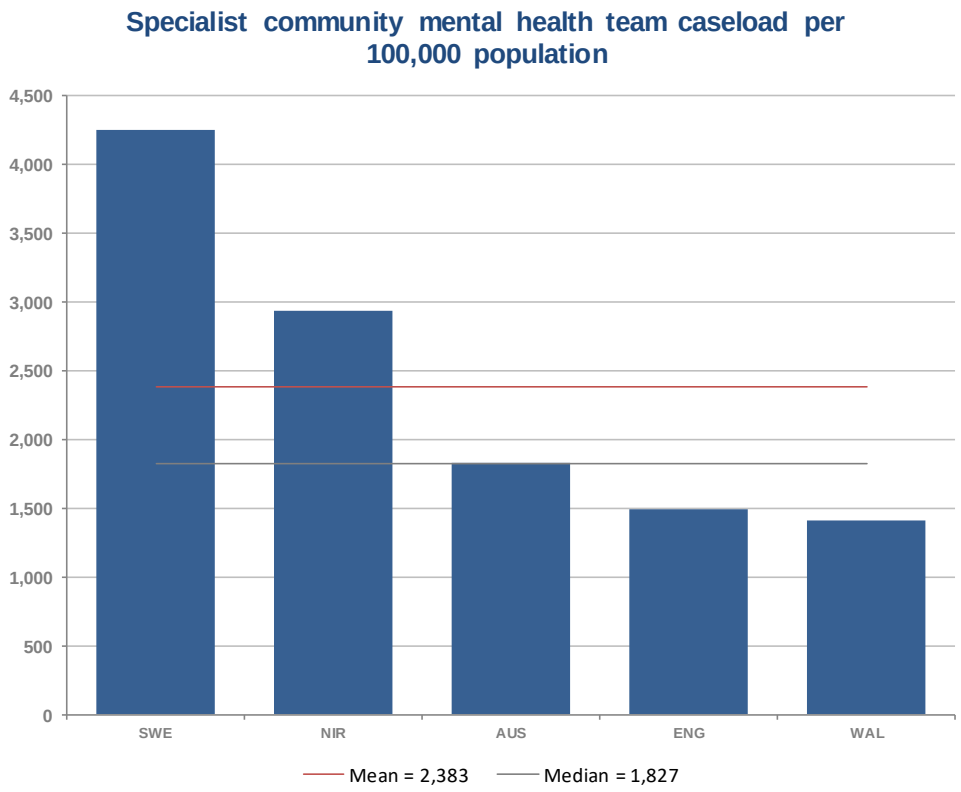


- The number of occupied bed days reported per 100,000 population closely maps the extent of bed provision with Sweden reporting the highest value at just under 5,000 bed days per 100,000 population.

Benchmarking Network

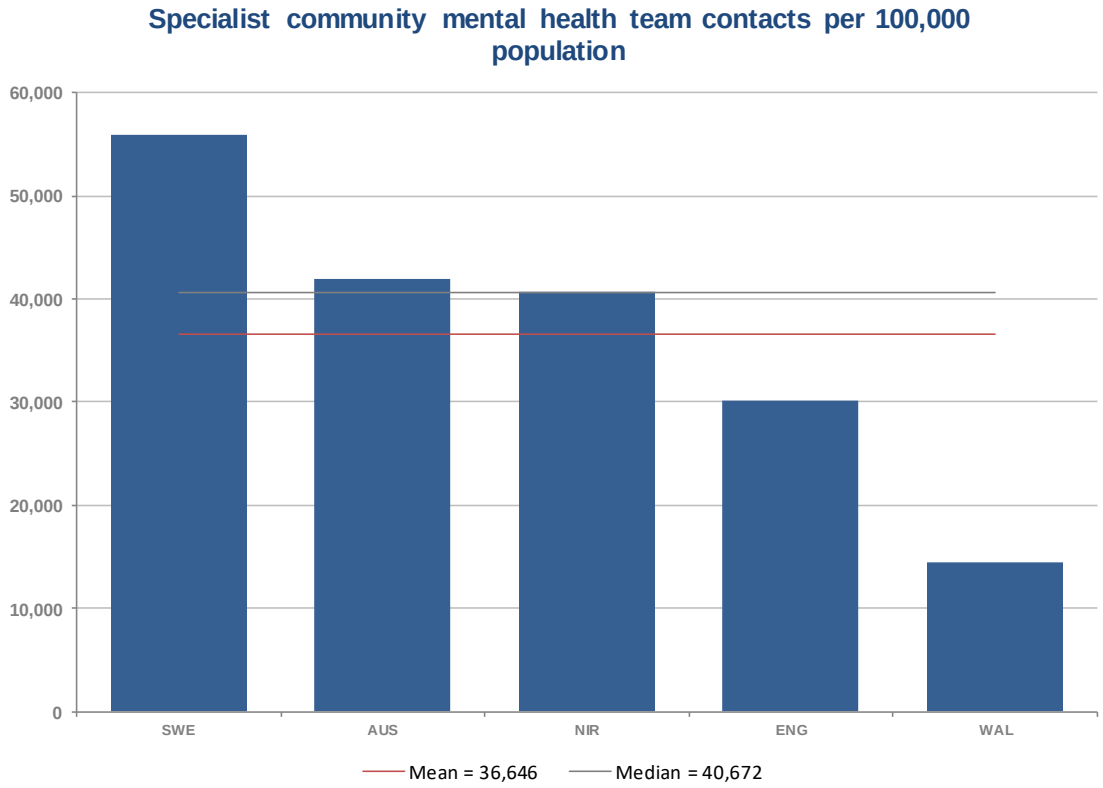
Community based care

Community team caseloads



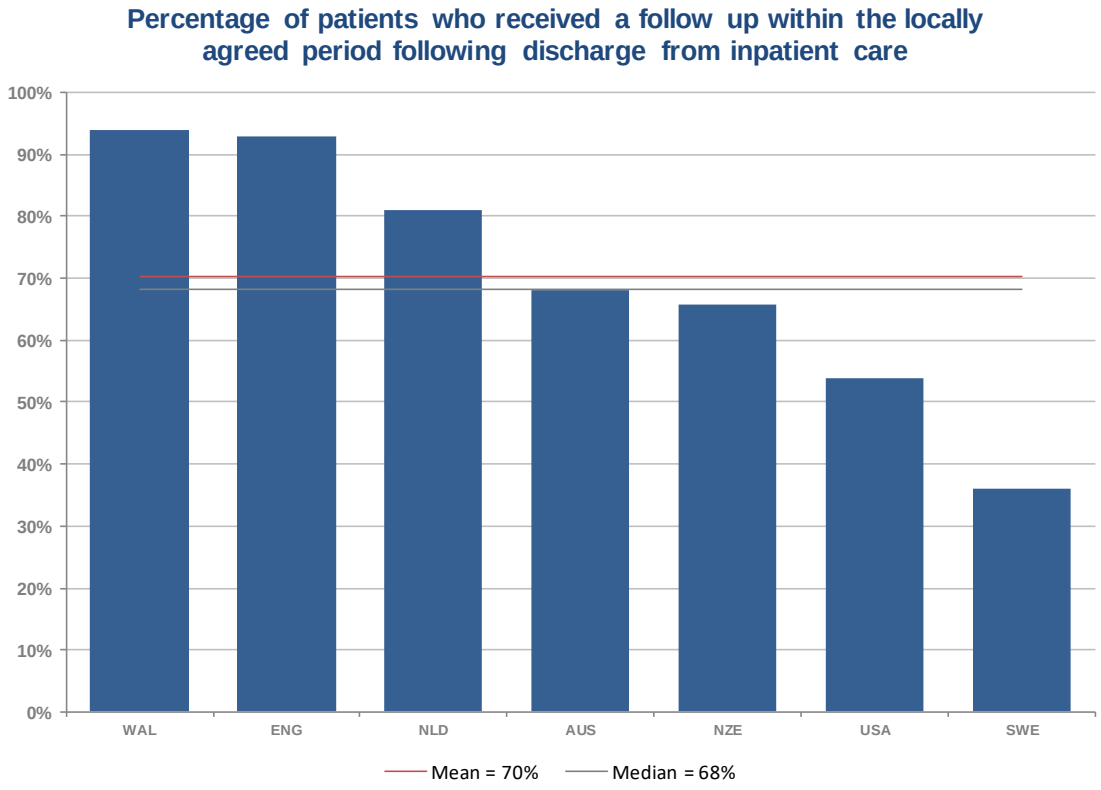
- Community mental health services are essential for a developed mental health system in providing wide and speedy access to mental health services. Community mental health services provide most mental health interventions in developed countries and also support the process of minimising hospital admissions. In the UK around 97% of mental health service users at any time are supported by specialist mental health services in community teams, rather than occupying inpatient beds.
- The number of people supported by specialist mental health teams in the community varies. Caseloads in England and Wales are less than half those of Sweden when benchmarked per 100,000 population. Data provided by participants suggests that Sweden supports the highest number of people in the community setting at 4,245 people per 100,000 population. Australia occupies the median position at 1,827 per 100,000 population, and Wales the lowest position at 1,415 people per 100,000 population.
- In addition to the specialist community services described above, England also has a large intermediate tier of services providing access to psychological therapies in primary care. Around 1m people are supported by these services each year in England, a higher figure than the 700,000 reported on the chart opposite. This also highlights the possibility for different service models to be evident in participant countries.
- It should also be noted that only 5 of the 14 participant countries were able to quantify and report the extent of community based care. This confirms that data from community services is less frequently systemised and collected than in parallel inpatient services.

Community team contacts



- The data set for community team contact levels is smaller than for community contact levels due to issues with the completeness of national datasets on community care.
- The number of contacts provided in specialist community mental health teams largely reflects the number of people held on community caseloads. Sweden reports the largest number of contacts delivered during a 12 month period, at 55,827 contacts per 100,000 population.
- Australia and Northern Ireland provide the second and third highest rates of community contacts.

Follow up post-discharge

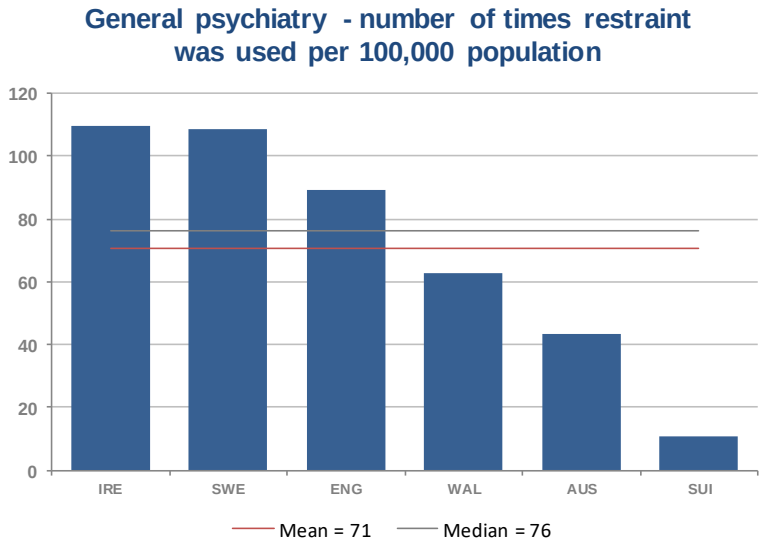


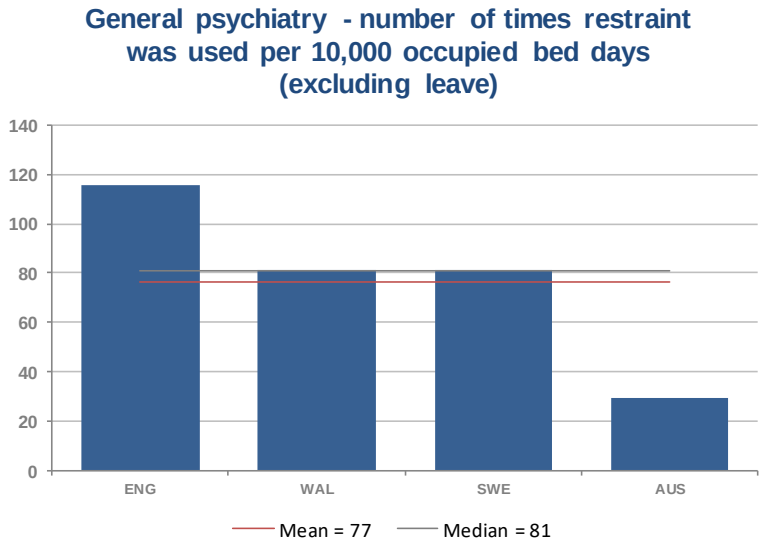
- Countries were asked for the period during which they aim to offer a first follow up appointment for patients discharged from inpatient care. This was typically reported as within 7 days or within 14 days of discharge. Countries are shown here for their attainment against their local measure. Not all countries have explicit targets relating to speed of community follow-up after discharge and this may impact on both the completeness and quality of data, and also on the behaviour of each country's mental health system.
- In some cases this data includes patients who received a follow up only by specialist mental health community services and excludes patients whose follow up within 7 or 14 days took place with their GP.
- Wales (94%) and England (93%) report the highest rate of community based follow up care with patients followed up by a specialist mental health practitioner within 7 days of discharge. England and Wales also follow the best standard evident in the participant country group with patients needing to be followed up by a mental health specialist rather than a general physician or care worker.

Benchmarking Network

Restrictive interventions

Use of restraint



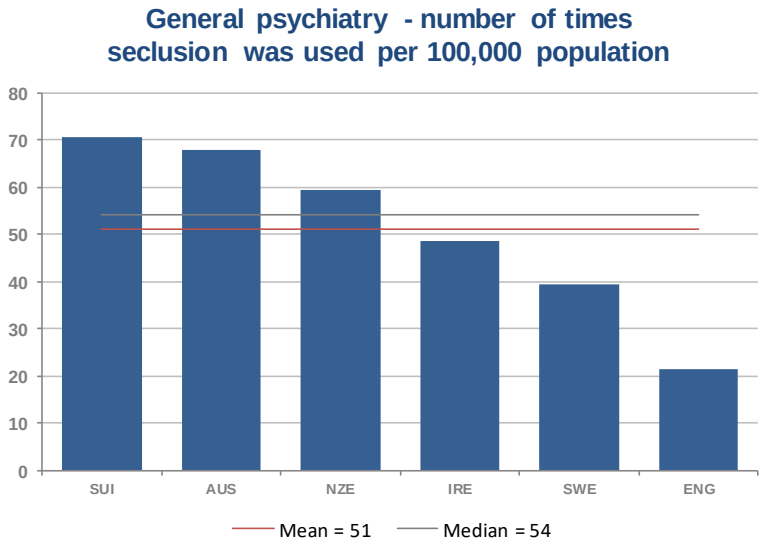


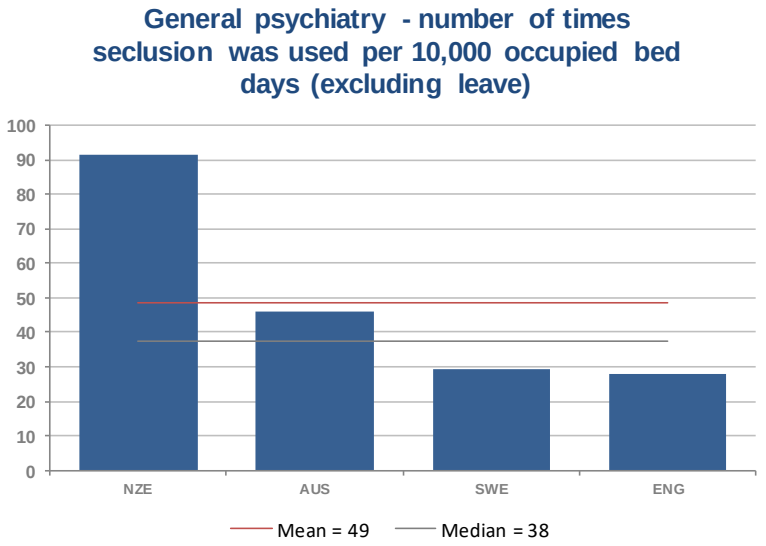
The use of restraint to manage challenging behaviour and de-escalate a dangerous situation on a ward remains a subject of much debate. Restraint should be used only when there is immediate or imminent risk of harm to self or others (including staff and other patients). Many countries also demonstrate a clear commitment to minimising the use of prone restraint.

Only 6 countries were reliably able to report on restraint volumes and when benchmarked these equated to a median position of 76 incidents of restraint per 10,000 occupied bed days, a position occupied by both Wales and Sweden. Switzerland reported the lowest use of restraint and England the highest when measured against a denominator of occupied bed days.

When assessed against a wider denominator of restraint per 100,000 population, Australia again report the lowest rates, with Sweden and Republic of Ireland reporting the highest rates.

Use of seclusion





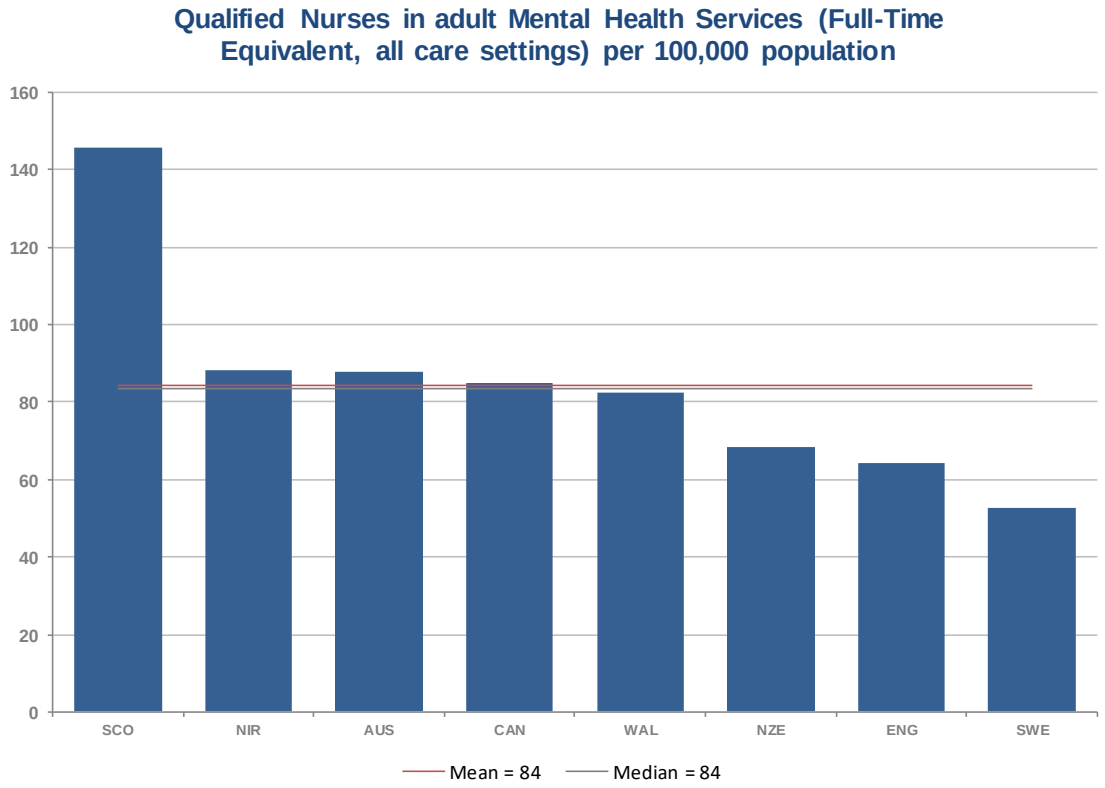
Seclusion is another restrictive intervention that is actively monitored as a service quality standard in inpatient mental health care. Only 6 countries reported data on this issue, perhaps indicating the difficulty in capturing reliable national data. Seclusion rates often link with restraint rates and should be viewed as part of a wider restrictive practices agenda.

Switzerland and Australia report the highest national rates of seclusion, and England and Sweden the lowest.

Benchmarking Network

Workforce

Mental Health Nursing



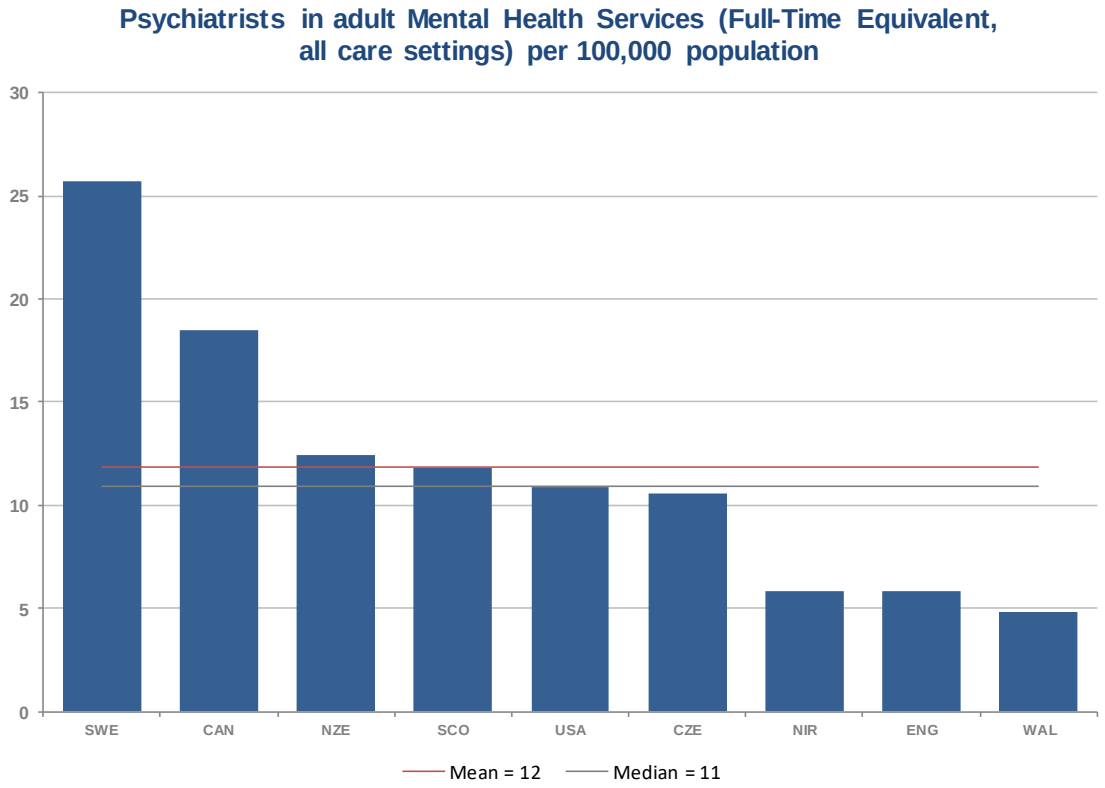
- Participants in the project were keen to collect data on comparative workforce size and composition. The charts on the following pages outline the profile of the specialist mental health workforce in each country and focuses on 2 main professions;

    1. Mental Health Nursing
    2. Consultant Psychiatrists

- The chart opposite explores comparative workforce data on qualified nurses working in adult mental health services (both inpatient and community based)

- Scotland reports the highest number of mental health nurses, and Sweden the fewest. The median and mean positions are both 84 nurses per 100,000 adult population.

Psychiatrists



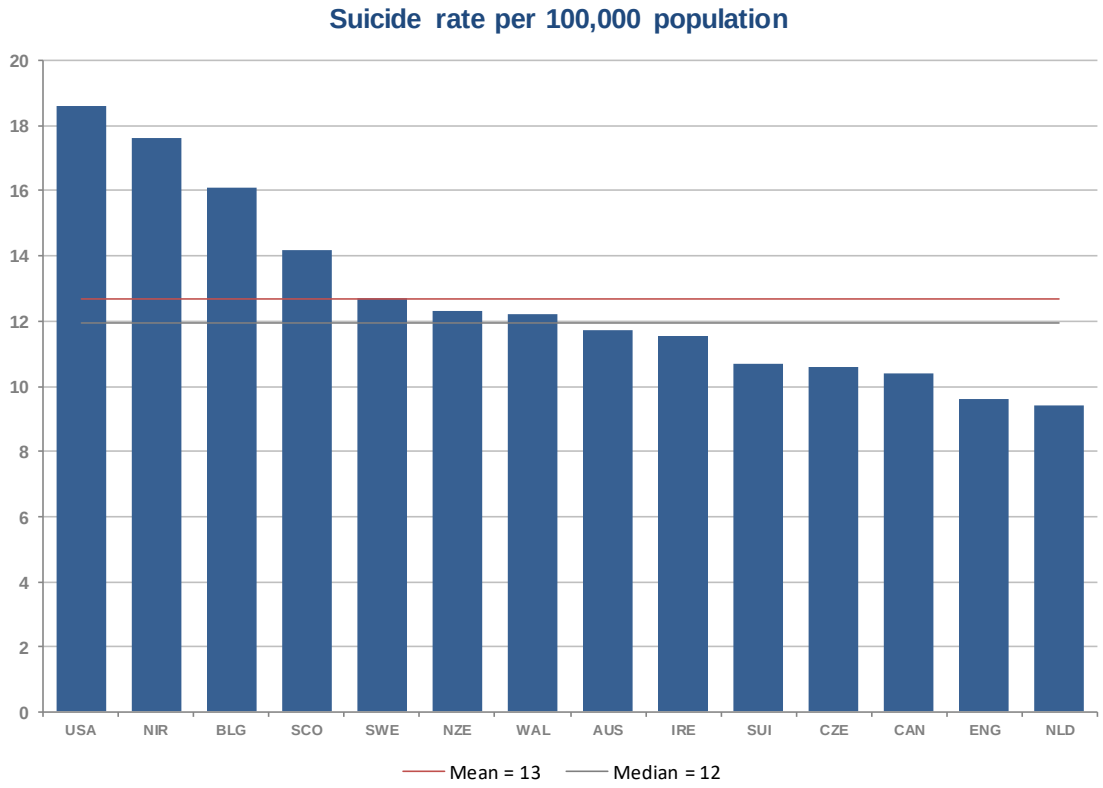
- Consultant Psychiatrists working in adult mental health services (both inpatient and community based) are shown in the chart on the left.
- Although Sweden reported the fewest nurses of the countries who could provide this data, they report the largest number of Consultant Psychiatrists.
- Northern Ireland, England and Wales report the lowest rates per capita.

Benchmarking Network

Outcomes

Suicide rates

Suicide rates



- This data considers whole population suicide rates and is not exclusive to those in contact with mental health services. Data from the UK suggests that approximately 26% of suicides annually are from those in contact with specialist mental health services.
- There is observable variation on this metric between the countries surveyed with the Netherlands reporting the lowest suicide rates at 9 per 100,000 population, and the USA the highest at just over 18 deaths per 100,000 people. The median average is 12 deaths per 100,000.

Conclusions

- We would like to express our thanks to participant countries for their involvement in the latest cycle of international mental health benchmarking. The work confirms the opportunity for international collaboration and the momentum that exists for the use of evidence in developing strategies for mental health care both across and within countries.
- The project's work has been interesting on a number of levels and has engaged countries in the debate about mental health data, definitions, interpretation, and analysis. The process of working with the countries represented on the project group has also confirmed the support for international collaboration of this type and for forums that provide leadership and support for the collection and interpretation of country level data on mental health.
- The growth of the project's participant group to 14 countries is particularly welcomed and has provided further impetus to the work as well as the additional critical mass on which all healthcare comparisons project depend.
- The aspiration of undertaking international mental health service comparisons has been met and interesting variations have emerged in the comparative data. The reasons for this variation are numerous and include issues around; data completeness, data quality, ability to produce data in line with the project's definitions, the contextual position of each country's health system, resource levels, and performance variations that exist both within and between countries. Participants in the project have had an opportunity to discuss the findings from the work in a number of teleconference discussions and at the International Initiative for Mental Health Leadership (IIMHL) seminar held in Stockholm in May 2018. Further observations on the project's findings are welcomed from both participants and commentators.
- The project's findings show coherence on a number of areas. Perhaps the strongest elements of the analysis relate to the data on usage of inpatient services. Within inpatient services, data on; admissions, readmissions, average length of stay, and bed utilisation by diagnosis category perhaps offer the most robust comparisons. The data supports interesting descriptions of variation that exists between countries, often due to differences in service models and local mental health strategies. The data also supports stories of coherence, perhaps best illustrated with the consistency in the data on comparative bed occupancy.
- Data on community based services perhaps remains the greatest challenge with less than half of countries able to confidently describe and collect data in this area. This is a particular issue in countries where market based systems rely on health insurers to provide data, often fragmented at community level.
- New additions to the project's dataset this year confirm the value of exploring data in other specialties including Forensic care and Rehabilitation. The inclusion of strategic measures around relative health system spend are also valuable and highlight variation in national baseline investment levels between countries.
- Future areas of interest for the project may include collection of health outcomes data for mental health systems. This work may take place with reference to the OECD's plans to develop international standards for Patient Reported Outcome Measures (PROM) and Patient Reported Experience Measures (PREM) in mental health.
- The project's findings will be shared with all participant countries and we welcome comments on the potential future direction for the work. Comments should be forwarded to Stephen Watkins s.watkins@nhs.net or Zoe Morris zoe.morris@nhs.net for sharing with participants and stakeholders.

NHS Benchmarking Network

Benchmarking Network

Appendix A

Project data specification

Agreed data specification – National context

Core data specification with supporting data definitions

INTERNATIONAL MENTAL HEALTH BENCHMARKING 2017

COUNTRY

Completed Data collection templates should be returned to Zoe Morris at zoe.morris@nhs.net

Reporting period

Please provide data for your most recent financial year, and indicate here which 12 month time period this is e.g. *January - December 2016* or *April 2016 to March 2017*

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

National Policy	Children	Adults	Older Adults (if separate to adults)	*Any Additional Comments by Country*
Do you have a national (or state-wide) mental health policy for this age group? If yes, please provide a link to where it is published online				
Do you have any national (or state-wide) targets relating to access e.g. maximum waiting times for treatment? If yes, please describe (including waiting times)				
Do you have a national published indicator set for mental health services? (please provide hyperlink if available)				
Do you have national published clinical pathways for mental health conditions? (please provide hyperlinks if available)				
Please summarise how patient user voice (or child and/or parents and guardians) is routinely incorporated into planning and evaluation				
Please describe the outome measures routinely used in your services e.g. sessional or pre- and post-treatment scores				
Do you have a process of national or regional quality ratings for providers? If yes, please describe.				
What is your main clinical nomenclature for recording care needs? E.g. ICD, DSM etc				

Mental Health Service Access				
Number of people who accessed specialist mental health services in 2016/17				
Number of people who accessed primary care based mental health services in 2016/17				

Supplementary data specification - Finance

Supplementary data specification with supporting data definitions

Focusing on analysis of length of stay and community support by major condition type

Finance Summary

Please detail the currency you are using for these questions

	Children	Adults	Total
Total country expenditure on healthcare 2016/17 (currency listed above)			
Total country expenditure on mental health services 2016/17 (currency listed above) - **including** addiction services			
Total country expenditure on mental health services 2016/17 (currency listed above) - **excluding** addiction services			
Percentage of Total healthcare expenditure on mental healthcare in 2016/17 (currency listed above) - **including** addiction services			
Percentage of Total healthcare expenditure on mental healthcare in 2016/17 - (currency listed above) - **excluding** addiction services			
Expenditure per capita on mental health services 2016/17 (currency listed above) - **including** addiction services			
Expenditure per capita on mental health services 2016/17 (currency listed above) - **excluding** addiction services			

Finance Detail

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

Scope of **Specialist Mental Health Services**, including inpatient care, community care, and secondary care prescribing	Please answer "yes" if they are within scope in your country
Day Care Services	
Crisis Resolution Team / Home Treatment	
Community Mental Health Teams	
Assertive Outreach Team	
Rehabilitation & Recovery Services	
General Psychiatry	
Psychiatric Liaison	
Psychotherapy Service	
Young Onset Dementia	
Personality Disorder Service	
Early Intervention in Psychosis Team	
Assessment and Brief Intervention	
Memory Services / Dementia Services	
Forensic Services	
Autistic Spectrum Disorder Service	
Peri-Natal Mental Illness / Mother and baby	
Eating Disorders	
Criminal Justice Liaison and Diversion Service	
Prison Psychiatric Inreach Service	
Asylum Seekers Service	
Psychiatric Intensive Care	
Continuing Care / Longer Term Complex Care	
Employment Services for mental health service users	
Accommodation Services for mental health service users	
Neurodevelopmental services	
Other mental health services	

Substance Misuse Services Could Include

Substance Misuse - Drug Services	
Substance Misuse - Alcohol Services	

please exclude wider behavioural concerns from the above definitions if possible i.e. services for people with gambling addictions

Data specification – excess mortality

Comprehensive data definitions support data collection.

Telephone and e-mail support line in place for query resolution.

Excess Mortality

Excess mortality; Age-Sex Standardised Ratio (ages 15-74)		OECD Indicator Value (see definition below)
Estimated national position on average years of life lost for people suffering from severe mental illness (from local data sources)		Average value in years of life lost for service users with severe mental illness (e.g. 5 years, 10 years etc)
Service user population to whom this refers e.g. primary care or secondary care service users		
If you have additional information on excess mortality by different ethnic groups and/or by disease, please provide details		

Extract of Definition for OECD HCQI Measure of Excess Mortality

Excess mortality from severe mental illnesses [EXCESMIL]
This indicator is a ratio of two mortality rates and aims to account for the excess mortality from all causes in people who have a diagnosis of severe mental illnesses (SMI). Only the countries with a pre-existing registry which records the whole population of severe mental illnesses need to report this indicator. You are requested to provide details on which mental illnesses are recorded in this registry in S&M worksheet in the Excel questionnaire.
Rate 1: Directly age- and sex-standardised "all cause" mortality rate in the reference year (eg 2013) for all persons aged between 15 and 74 years old in the prevalent population with SMI.
Numerator: All deaths among the denominator population in the reference year.
Denominator: All people aged 15-74 ever diagnosed with SMI as obtained from a register or equivalent data source in the reference year.
Rate 2: Directly age- and sex-standardised "all cause" mortality rate in the same reference year for all persons aged between 15 and 74 years old in the total population.
Numerator: All deaths among the denominator population in the reference year.
Denominator: All people aged 15-74 in the reference year.
The indicator will be the ratio of Rate 1: Rate 2

Data specification Adults

Comprehensive data definitions support data collection.

Telephone and e-mail support line in place for query resolution.

CORE DATA SPECIFICATION (repeated from 2016 project)

Definition key		Acute inpatient	Psychiatric intensive care unit (PICU)	Perinatal Mental Health	Eating Disorders	Sub Total General Psychiatry (Adults)	Old Age Psychiatry Services	Longer Term Care / Rehabilitation services
	Activity							
1	Number of inpatient beds							
2a	Number of available bed days 2016/17							
2b	Number of occupied bed days 2016/17 excluding leave							
2c	Number of occupied bed days 2016/17 including leave							
3	Number of admissions to inpatient mental health care 2016/17							
3a	Emergency readmission rate %							
3b	Number of discharges from inpatient mental health care 2016/17							
4	Detention rate % (percentage of admissions that were involuntary, i.e. admissions that were mandated under local mental health act legislation)							
5a	Mean average length of stay including leave							
5b	Mean average length of stay excluding leave							
5c	Median average length of stay including leave							
5d	Median average length of stay excluding leave							
	Quality							
6a	Number of times seclusion was used 2016/17							
6b	Number of patients who were placed in seclusion 2016/17							
6c	Number of times involuntary seditive medication was used without consent i.e. rapid tranqulisation							
7a	Number of times restraint was used 2016/17							
7b	Number of patients who were restrained 2016/17							
7c	Number of times prone restraint was used 2016/17							
7d	Number of patients who were restrained in a prone position 2016/17							

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

Outpatient Clinics for Mental Health	
Number of individual patients who attend outpatient clinics in 2016/17	
Number of face to face contacts delivered 2016/17	

	Specialist Community Mental Health Services (all Team Types)	
8	Number of individual patients under the care of community teams 2016/17	
9a	Number of face to face contacts delivered 2016/17	
9b	Number of non face to face contacts delivered 2016/17	
9c	Total number of contacts delivered 2016/17	
9d	Additional services for number of people with common mental health problems - total number of patients receiving care in year	
9e	Additional services for number of people with common mental health problems - total number of contacts delivered in year	

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

Additional Community Teams data - please provide if of interest and data is available *This section is discretionary supplements the analysis in sections 8 and 9 above*

Assertive Outeach Teams - number of patients receiving care in most recent year	
Assertive Outreach Teams - number of patient contacts delivered in most recent year	
Intensive Home Treatment Teams - number of patients receiving care in most recent year	
Intensive Home Treatment Teams - number of patient contacts delivered in most recent year	
Crisis Resolution Teams - number of patients receiving care in most recent	
Crisis Resolution Teams - number of patient contacts delivered in most recent year	
Early Intervention in Psychosis Teams - number of patients receiving care in most recent year	
Early Intervention in Psychosis Teams - number of patient contacts delivered in most recent year	

Data specification - Forensic

Comprehensive data definitions support data collection.

Telephone and e-mail support line in place for query resolution.

CORE DATA SPECIFICATION - FORENSIC CARE

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

Please describe the scope of your Forensic inpatient mental health care i.e. Is it for service users who are part of a criminal justice pathway? Do you have different levels of security e.g. medium secure / high secure? Is it provided by public or private providers or both?	
Number of Prison places in country at 31st March 2017 (or most recently available data)	

Definition key		Forensic Inpatient Care
	Activity	
1	Number of inpatient beds	
2a	Number of available bed days 2016/17	
2b	Number of occupied bed days 2016/17 excluding leave	
2c	Number of occupied bed days 2016/17 including leave	
3	Number of admissions to inpatient mental health care 2016/17	
3a	Emergency readmission rate %	
3b	Number of discharges from inpatient mental health care 2016/17	
4	Detention rate % (percentage of admissions that were involuntary, i.e. admissions that were mandated under local mental health act legislation)	
5a	Mean average length of stay including leave	
5b	Mean average length of stay excluding leave	
5c	Median average length of stay including leave	
5d	Median average length of stay excluding leave	
	Quality	
6a	Number of times seclusion was used 2016/17	
6b	Number of patients who were placed in seclusion 2016/17	
7a	Number of times restraint was used 2016/17	
7b	Number of patients who were restrained 2016/17	
7c	Number of times prone restraint was used 2016/17	
7d	Number of patients who were restrained in a prone position 2016/17	
	Forensic Outpatient Services and Community Teams	
8a	Number of patients on caseload in latest year	
8b	Number of patient contacts in latest year	
	Forensic Patient Sheltered Housing Places	
	Number of Forensic sheltered housing places available in latest year	

Data definitions

Comprehensive data definitions support data collection.

Telephone and e-mail support line in place for query resolution.

DATA DEFINITIONS

2016/17 refers to 1st April 2016 to 31st March 2017
You can substitue 1st January 2016 to 31st December 2016 if this is more convenient

	Item	Definition
1	Number of inpatient beds	Number of beds that were available as of 31st March 2017 OR the average number of beds of that type available over a rolling 12 month period (this data may not be available to countries operating insurance based models of care)
2a	Number of available bed days 2016/17	The number of bed days that were available over the 12 month period. If 10 beds were each available every day, this would be 10 x 365 = 3650 bed days.
2b	Number of occupied bed days 2016/17 excluding leave	The number of bed days that were occupied over the 12 month period, counted on patients in the bed at midnight. This number can be equal to or less than the number of available bed days. Exclude days where a patient was on leave but a bed was kept for them. Only count when the patient was occupying the bed overnight.
2c	Number of occupied bed days 2016/17 including leave	The number of bed days that were occupied over the 12 month period, counted on patients in the bed at midnight and patients under the care of the ward who were on approved leave and thus sleeping elsewhere. This number may be greater than the number of available bed days is beds are not kept empty for patients on leave and are instead given to other patients to occupy in the meantime.
3	Admissions to inpatient mental health care in 2016/17	Admissions that occurred in the 12 month period covered by the data collection (2016/17)
3a	Emergency readmission rate %	Of all the admissions that occurred in the 12 month period, what % were emergency (unplanned) readmissions for patients who had been discharged from inpatient psychiatric care within the last 28 days.
4	Detention rate %	Of all the admissions that occurred in the 12 month period, what % were involuntary, i.e. admissions that were mandated under local mental health act legislation
5a	Mean average length of stay including leave	Average length of stay from admission to discharge or transfer; include time spent on permitted leave
5b	Mean average length of stay excluding leave	Average length of stay from admission to discharge or transfer; exclude time spent on permitted leave
5c	Median average length of stay including leave	Median length of stay from admission to discharge or transfer; include time spent on permitted leave
5d	Median average length of stay excluding leave	Median length of stay from admission to discharge or transfer; exclude time spent on permitted leave
6a	Number of times seclusion was used 2016/17	The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. Number of times seclusion was used during the 12 month period.
6b	Number of patients who were placed in seclusion 2016/17	Of all the times seclusion was used (above), number of unique patients who were place in seclusion over the 12 month period.
7a	Number of times restraint was used 2016/17	Restraint defined as planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: - take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and - end or reduce significantly the danger to the person or others; and - contain or limit the person's freedom' Number of times restraint was used, as per this definition, over a 12 month period.
7b	Number of patients who were restrained 2016/17	Of all the times restraint was used (above), number of unique patients who were restrained over the 12 month period
7c	Number of times prone restraint was used 2016/17	The use of restraint (defined above) in a face down or chest down position. Incidents of restraint that involve a service user being placed face down or chest down for any period (even if briefly prior to being turned over), should be defined as prone restraint. Similarly if a service user falls or places themselves in a face down or chest down position during a restrictive intervention, this should be defined as prone restraint. Number of times prone restraint was used, as per this definition, over a 12 month period.
7d	Number of patients who were restrained in a prone position 2016/17	Of all the times prone restraint was used (above), number of unique patients who were restrained in a prone position over the 12 month period
8	Number of patients under the care of community teams 2016/17	Unique patients who were on a community caseload at any point during the 12 month period. Including specialist secondary care mental health services, but excluding generic GP services.
9a	Number of face to face contacts delivered 2016/17	The number of face to face contacts delivered in a community setting by specialist secondary care mental health services. A Group Therapy session counts as one contact, regardless of how many patients it involved.
9b	Number of non face to face contacts delivered 2016/17	The number of non face to face contacts delivered in a community setting by specialist secondary care mental health services e.g. phone calls as part of a treatment plan. Exclude purely administrative tasks e.g. sending a text message with confirmation of an appointment date/time.
9c	Total number of contacts delivered 2016/17	The total of the above
10	Percentage of patients who received a follow up within the locally mandated or locally recommended period following discharge from inpatient care (e.g. follow up within 7 days or 14 days of discharge)	Of all patients discharged within the 12 month period, the percentage who received a follow up within the stated time period

Data submissions should be returned by 2nd Feburary 2018 to Zoe Morris

Questions about any aspect of data collection or data definitions? Please mail: s.watkins@nhs.net
zoe.morris@nhs.net

NHS Benchmarking

ICD10 Mapping

Category	Category Code	Description	Category
Organic, including symptomatic, mental disorders (F00-F09)	F00	Dementia in Alzheimer disease	Organic mental illness
	F01	Vascular dementia	Organic mental illness
	F02	Dementia in other diseases classified elsewhere	Organic mental illness
	F03	Unspecified dementia	Organic mental illness
	F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances	Organic mental illness
	F05	Delirium, not induced by alcohol and other psychoactive substances	Organic mental illness
	F06	Other mental disorders due to brain damage and dysfunction and to physical disease	Organic mental illness
	F07	Personality and behavioural disorders due to brain disease, damage and dysfunction	Organic mental illness
	F09	Unspecified organic or symptomatic mental disorder	Organic mental illness
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	F10	Mental and behavioural disorders due to use of alcohol	Substance Misuse / Addictions
	F11	Mental and behavioural disorders due to use of opioids	Substance Misuse / Addictions
	F12	Mental and behavioural disorders due to use of cannabinoids	Substance Misuse / Addictions
	F13	Mental and behavioural disorders due to use of sedatives or hypnotics	575
	F14	Mental and behavioural disorders due to use of cocaine	Substance Misuse / Addictions
	F15	Mental and behavioural disorders due to use of other stimulants, including caffeine	Substance Misuse / Addictions
	F16	Mental and behavioural disorders due to use of hallucinogens	Substance Misuse / Addictions
	F17	Mental and behavioural disorders due to use of tobacco	Substance Misuse / Addictions
	F18	Mental and behavioural disorders due to use of volatile solvents	Substance Misuse / Addictions
	F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	Substance Misuse / Addictions
Schizophrenia, schizotypal and delusional disorders (F20-F29)	F20	Schizophrenia	Psychotic disorders
	F21	Schizotypal disorder	Psychotic disorders
	F22	Persistent delusional disorders	Psychotic disorders
	F23	Acute and transient psychotic disorders	Psychotic disorders
	F24	Induced delusional disorder	Psychotic disorders
	F25	Schizoaffective disorders	Psychotic disorders
	F28	Other nonorganic psychotic disorders	Psychotic disorders
	F29	Unspecified nonorganic psychosis	Psychotic disorders

ICD10 Mapping

Mood [affective] disorders (F30 - F39)	**F30**	Manic episode	Affective disorders
	F31	Bipolar affective disorder	Affective disorders
	F32	Depressive episode	Affective disorders
	F33	Recurrent depressive disorder	Affective disorders
	F34	Persistent mood [affective] disorders	Affective disorders
	F38	Other mood [affective] disorders	Affective disorders
	F39	Unspecified mood [affective] disorder	Affective disorders
Neurotic, stress-related and somatoform disorders (F40-F48)	**F40**	Phobic anxiety disorders	Other diagnosis
	F41	Other anxiety disorders	Other diagnosis
	F42	Obsessive-compulsive disorder	Other diagnosis
	F43	Reaction to severe stress, and adjustment disorders	Other diagnosis
	F44	Dissociative [conversion] disorders	Other diagnosis
	F45	Somatoform disorders	Other diagnosis
	F48	Other neurotic disorders	Other diagnosis
Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	**F50**	Eating disorders	Other diagnosis
	F51	Nonorganic sleep disorders	Other diagnosis
	F52	Sexual dysfunction, not caused by organic disorder or disease	Other diagnosis
	F53	Mental and behavioural disorders associated with the puerperium, not elsewhere classified	Other diagnosis
	F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere	Other diagnosis
	F55	Abuse of non-dependence-producing substances	Other diagnosis
	F59	Unspecified behavioural syndromes associated with physiological disturbances and physical factors	Other diagnosis
Disorders of adult personality and behaviour (F60-F69)	**F60**	Specific personality disorders	Other diagnosis
	F61	Mixed and other personality disorders	Other diagnosis
	F62	Enduring personality changes, not attributable to brain damage and disease	Other diagnosis
	F63	Habit and impulse disorders	Other diagnosis
	F64	Gender identity disorders	Other diagnosis
	F65	Disorders of sexual preference	Other diagnosis
	F66	Psychological and behavioural disorders associated with sexual development and orientation	Other diagnosis
	F68	Other disorders of adult personality and behaviour	Other diagnosis
	F69	Unspecified disorder of adult personality and behaviour	Other diagnosis

ICD10 Mapping

Mental retardation (F70-F79)	**F70**	Mild mental retardation	Other diagnosis
	F71	Moderate mental retardation	Other diagnosis
	F72	Severe mental retardation	Other diagnosis
	F73	Profound mental retardation	Other diagnosis
	F78	Other mental retardation	Other diagnosis
	F79	Unspecified mental retardation	Other diagnosis
Disorders of psychological development (F80-F89)	**F80**	Specific developmental disorders of speech and language	Other diagnosis
	F81	Specific developmental disorders of scholastic skills	Other diagnosis
	F82	Specific developmental disorder of motor function	Other diagnosis
	F83	Mixed specific developmental disorders	Other diagnosis
	F84	Pervasive developmental disorders	Other diagnosis
	F88	Other disorders of psychological development	Other diagnosis
	F89	Unspecified disorder of psychological development	Other diagnosis
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	**F90**	Hyperkinetic disorders	Childhood behavioural disorders
	F91	Conduct disorders	Childhood behavioural disorders
	F92	Mixed disorders of conduct and emotions	Childhood behavioural disorders
	F93	Emotional disorders with onset specific to childhood	Childhood behavioural disorders
	F94	Disorders of social functioning with onset specific to childhood and adolescence	Childhood behavioural disorders
	F95	Tic disorders	Childhood behavioural disorders
	F98	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Childhood behavioural disorders
Unspecified mental disorder (F99-F99)	**F99**	Mental disorder, not otherwise specified	Other diagnosis