International Benchmarking of Australia's Mental Health Performance – State of Play Review

Project Report

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Contents

Acronyms Used in this Report

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AIMS	Assessment Instrument for Mental Health Systems (WHO)
AMHOCN	Australian mental Health Outcome and Classification Network
CIHI	Canadian Institute of Health Information
CoAG	Council of Australian Governments
DHB	District Health Board (NZ)
HCQI	Health Care Quality Indicators Project (OECD)
GDP	Gross Domestic Product
KPI	Key Performance Indicator
KPP	Knowing the People Planning Tool (NZ)
MDG	Millenium Development Goals (United Nations)
NHGAP	Mental Health Global Action Programme (United Nations)
NHS	National Health Service (UK)
NAMI	National Alliance on Mental Illness (US)
NGOs	Non-Government Organisations
OECD	Organisation for Economic Cooperation and Development
SAMHSA	Substance Abuse and Mental Health Administration (US)
UN	United Nations
WHO	World Health Organisation

Executive Summary

There is no clear or agreed set of international benchmarks regarding the health, welfare and quality of life for people with a mental illness against which Australia can easily assess its performance against other countries.

Australia's own data limitations restrict its capacity to participate in benchmarking. Our data capacities rest largely on administrative data drawn from the health system which focuses on activity data and is not designed to deliver broader 'whole of life measures such as quality of life or social inclusion. Only two national surveys of mental health and wellbeing have been undertaken in Australia. There are other relevant surveys undertaken from time to time but these are not centrally coordinated to provide a holistic picture.

Opportunities or structures to enable international benchmarking are very much in the developmental phase. The considerable pitfalls associated with asserting international comparisons have been amply described by the Australian Institute of Health and Welfare (2012).

This does not mean it is not possible to construct some sense of Australian mental health performance. A key part of this report aims to provide this sense, drawing on data from a variety of sources. For example, the table below combines World Health Organisation data (Kessler 2007) with the findings of Australia's own Survey of Mental Health and Wellbeing (Australian Bureau of Statistics 2008) to compare the lifetime prevalence of mental illness across 18 countries.

The table below shows the reported likelihood of a person from each of these nations having a mental illness sometime in their life.

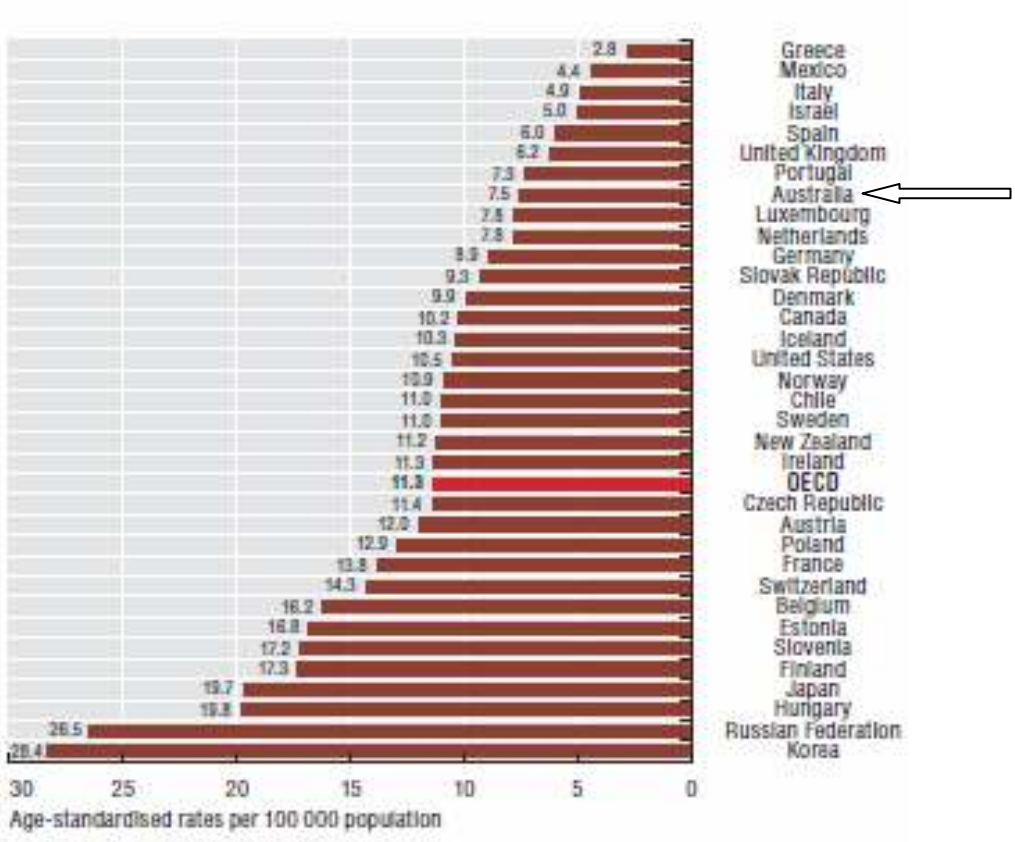
Lifetime Prevalence of Mental Illness

Country	% Lifetime Prevalence of Mental Illness
United States	47.4
Australia	45
New Zealand	39.3
Colombia	39.1
France	37.9
Ukraine	36.1
Netherlands	31.7
South Africa	30.3
Belgium	29.1
Mexico	26.1
Lebanon	25.8
Germany	25.2
Spain	19.4
Italy	18.1
Japan	18
Israel	17.6
PR China	13.2
Nigeria	12

A recurring theme in relation to comparative data such as presented in the table above is to be aware of the limitations of the data being compared.
In this case, both the international and Australian data draw on a survey instrument developed as part of the World Mental Health Survey Initiative (see here: http://www.hcp.med.harvard.edu/wmh/) but there were also modifications made. Is it really the case that an Australian is more than three times more likely than a Chinese person to have a mental illness sometime during their life, or is this a by-product of definitional differences in the way the survey is administered, the quality of the instrument used or national/cultural differences in relation to fear of disclosure?

A similar question can be asked of another key proxy measure often used to compare international mental health; suicide. Under its *Health at a Glance* publication (Organisation for Economic Development (OECD), 2011), the OECD presents data showing comparative suicide rates per 100,000 population, as shown in the table below.

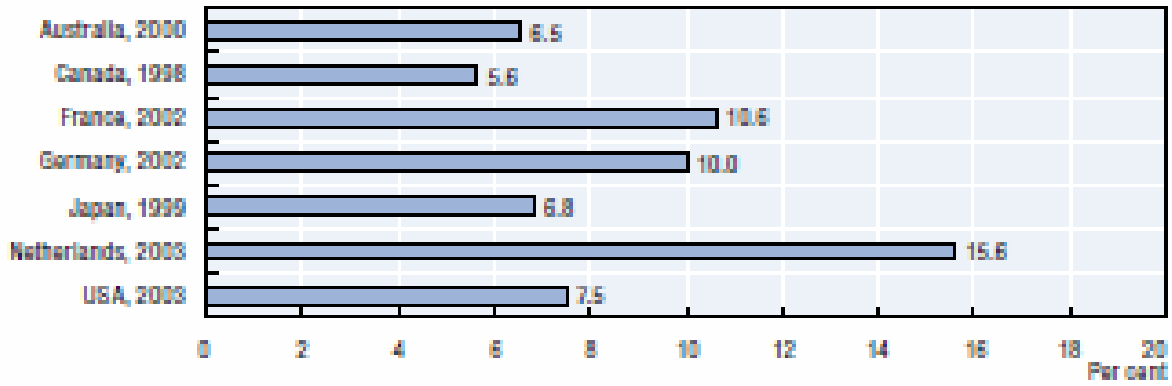
OECD Suicide Data



While suicide is clearly an issue of worldwide interest, Australian concerns about domestic data accuracy (Senate 2010) have also been noted internationally with consequent repercussions for data quality (Varnik 2012).

Spending on Mental Health

Another common proxy measure to compare mental health performance relates to its share of total health expenditure in each country. A study by Heijink (2006) indicated considerable variation in nation by nation spending on mental health, though again, differences in definitions necessitated caution in interpreting results.



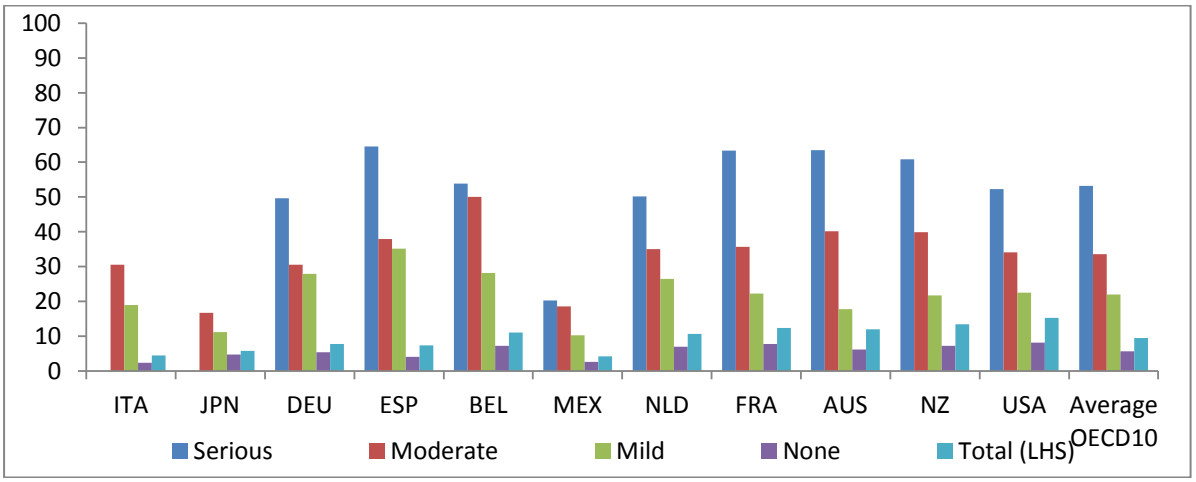
The AIHW (2003) published a document comparing Australian expenditure on mental disorders other countries however this document has not been reproduced.

Treatment Rates

Given the lack of agreed structures for international reporting, a picture of Australian mental health performance sometimes relies on joining data found in several places. For example, then Commonwealth Chief Medical Officer Jim Bishop gave a presentation to The Mental Health Services Conference held in Sydney in 2010 (see presentation here: http://www.slideshare.net/DeptHealthAgeing/deptsp20100915).

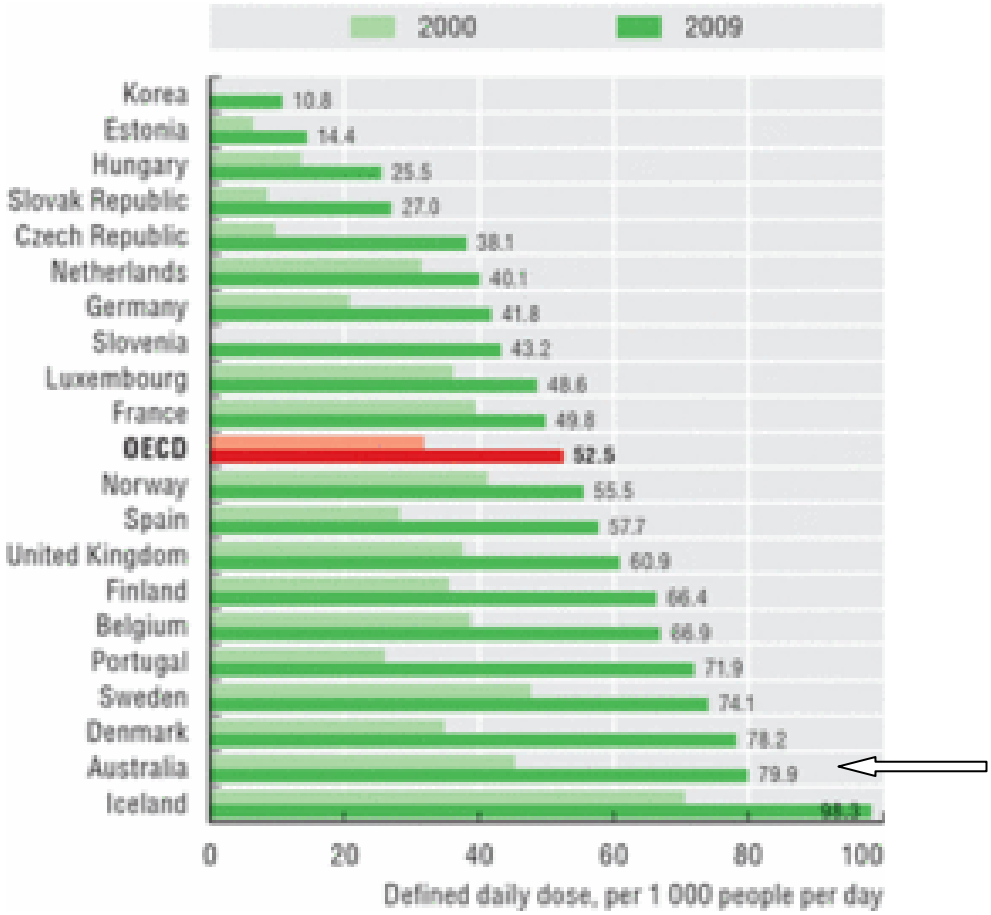
This presentation included a table comparing rates of treatment for serious, moderate and mild mental illness across ten OECD countries, using OECD data (2009). The OECD table does not include Australia but the data was added to this table, presumably drawing again on the ABS Survey so as to give an indication of Australia's performance, as shown below.

Share of people receiving treatment, as a percentage of people with different forms of mental health problems, 2003 or latest available year



Use of Anti-Depressants, 2000-2009

Australia's sophisticated health administration data sets means that some information is reliable and relatively simple to procure. For example, Pharmaceutical Benefits Scheme (PBS) prescribing information permits Australia to easily compare its use of antidepressants with other countries (OECD 2011).



Psychiatric Care Beds

The same administrative data can fairly simply allow tracking of other trends or changes in the nature of international mental health service systems, such as in the number of available psychiatric beds, as shown below (Table No. 28, Health: Key Tables from OECD, 28 June 2012).

Psychiatric care beds: Per 1000 population

	2004	2005	2006	2007	2008	2009	2010
Australia	0.4	0.4	0.4	..	0.4	..	..
Canada	0.3	0.3	0.4	0.4	0.4	0.4	..
France	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Germany	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Italy	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Japan	2.8	2.8	2.8	2.8	2.7	2.7	2.7
New Zealand	..	..	..	..	..	0.1	0.2
Norway	1.1	1.0	1.0	0.9	0.9	0.9	0.8
Spain	0.5	0.5	0.5	0.4	0.4	0.4	0.4
Sweden	0.5	0.5	0.5	0.5	0.5	0.5	0.5
United Kingdom	0.8	0.7	0.7	0.7	0.6	0.6	0.5
United States	0.3	0.3	0.3	0.3	0.3	0.3	..

Another common proxy measure of mental health system performance is in relation to the rates of seclusion. A recent literature review by Janssen et al (2008) drew on data from Australia and several other countries and appeared to show enormous variations between nations in their use of seclusion as part of mental health treatment. Perhaps the more salient point was that definitional inconsistencies precluded confident comparison, particularly in relation to determining which admissions were voluntary and which were involuntary.

Educational Attainment

Often one of the confounding factors in attempting to establish meaningful comparisons is that mental health is not separated from other disabilities, meaning specific data is not apparent. Despite this, it is still possible to get a sense of Australia's performance. For example, an OECD publication on disability (OECD 2003) indicates that Australia is behind the OECD average in relation to the educational attainment of people with a disability.

Country	**% Population with a disability**	**% Lower Educational attainment**	**% Higher Educational attainment**
Australia	12.8	16.9	7.4
Canada	16.1	18.5	14.9
Germany	18.1	20.9	16/9
Norway	16.7	22.6	13.9
United Kingdom	18.2	22.8	14.9
United States	10.7	22.3	8.9
OECD	14	19.2	11.1

It is perhaps not surprising that the same OECD publication found that Australia had the lowest average personal income of disabled people, equal to 44% that of a non-disabled person.

Even with such limitations, the tables provided above do present some picture of Australia's international mental health performance. They permit comparison of the impact of different national approaches and help track progress towards policy goals. Overall, Australia's performance seems mixed with less availability of psychiatric beds than other nations and what appears to be an extremely high use of anti-depressants. In comparison to other nations, Australia appears to spend less on mental health but has had some greater success in lifting rates of access to care for some mental illnesses. This seems at odds with data from the Australian Bureau of Statistics (ABS) indicating that access to care has remained largely unchanged over the past decade (ABS 1998, 2008). The fact that Australia spends only around a quarter of the amount New Zealand allocates to non-government community mental health services has been reported elsewhere (Rosenberg and Rosen 2012).

Australia also appears to deliver a lower standard of educational attainment than OECD countries, but this is for all disabilities rather than mental health specifically. As stated, there is further evidence from the OECD indicating Australia ranks lowest in terms of the income of people with mental illnesses as a ratio of the average income of the population. AIHW data presented later in this report also indicates that Australia's suicide rate is low enough to be ranked among the top third of OECD countries.

However, problems remain. Definitional inconsistencies between nations mar accurate comparison. Also, importantly, available data tend to emphasise only aspects of the operation of the health system and largely fail to provide a 'whole of life' picture of the situation and circumstances of people with a mental illness in different countries. Data concerning rates of employment, access to stable housing and measures of quality of life are yet to emerge, either in Australia or overseas.

While existing capacities to compare between nations may be limited, things are changing. There are some emerging international processes and also several countries individually pursuing a more holistic picture of the experience of care for people with a mental illness.

Introduction

Our vision is for a Report Card that is:

- *focused on peoples lived experiences*
- *rigorous, insightful and useful*
- *a broad perspective*
- *living and dynamic*
- *a truthful mirror*

National Mental Health Commission 2012

The National Mental Health Commission has embarked on one of the most significant challenges in mental health reform ever undertaken in Australia – to try to understand if people with a mental illness are getting better.

The key element of the Commission's work in this regard is Australia's first National Report Card on Mental Health and Suicide Prevention, scheduled for release by the end of 2012.

The Commission is not merely interested in establishing useful domestic benchmarks but is also concerned with monitoring Australia's international performance in mental health.

On this basis, it commissioned this report into the state and nature of existing international mental health benchmarks. This report has been undertaken for the Commission so it can better understand:

- how Australian mental health performance currently compares with other countries;
- the extent to which comparative data is both available and robust;
- the capacity of comparative data to give a 'whole of life' picture of the experience of mental illness in different countries; and
- the extent to which there are recognised targets or proxy measures which can assist the Commission establish useful international benchmarks.

On this basis this report firstly provides a brief summary of Australia's domestic benchmarking capacity which, after all, determines the viability and breadth of our participation in broader multi-national benchmarking initiatives.

The report then outlines the extent to which there is an internationally recognised set or sets of whole of life measures by which countries can assess progress in mental health care. This review has found no such set of internationally agreed markers. There are nascent processes which are described in this paper but these have a heavy health focus rather than the more holistic perspective sought by the Commission.

This paper then sets out some of the key initiatives which are underway in individual countries as they look to put in place report card type mechanisms, including Canada, England, the United States, Scotland and New Zealand. From this work it possible to deduce some international trends in relation to the types of indicators countries deem to be important markers of reform and progress.

However, the overall picture is of a dearth of international mental health benchmarking data and few if any drivers or mechanisms impelling conjoint activity in this regard. The separateness of approaches will of course militate against international comparisons.

Particularly in relation to the whole of life indicators sought by the Commission, work internationally is at a very early or developmental stage.

Methodology

A desktop review was undertaken which collected several relevant examples and surveyed pertinent literature. The span and scope of this literature review can be seen in the reference section at the end of this paper and involved the use of international research databases such as PubMed. The literature reviewed included by academic/research publications and also national and international policy or position papers.

The review considered not only relevant datasets but also investigated the literature which underpins report card approaches and accountability, particularly as it applies to mental health.

Access to the OECD.stat database was sought and obtained with relevant datasets interrogated. In addition to these investigations into OECD data, a review was also conducted of various OECD publications.

Contact was also made with the Australian Institute of Health and Welfare to obtain information in relation to the international datasets to which Australia contributes and also to understand some of the underlying reporting processes.

Several other agencies and individuals were contacted in undertaking this review, including Professor Rachel Jenkins from the World Health Organisation (WHO) Collaborating Centre, Kings College, London; Professor Roberto Mezzina from the International Mental Health Collaborating Network (Trieste) and Gregor Henderson, independent advisor to the UK government on mental health. Additional information and advice was also provided by the OECD Library. Discussions were also held with the NZ Mental Health Commission.
The point of these inquiries was to gather evidence regarding known international mental health benchmarking processes, trends or opportunities.

Work commenced on this report in June 2012 with the final report provided to the Commission in September 2012.

Why is Benchmarking Mental Health Important?

> The impact of measuring the quality of care provided by individuals and organisations, and the reporting of results, is linked both conceptually and empirically to reductions in variations in care and increases in the delivery of effective care.
>
> *Institute of Medicine, 2006*

Successive Australian reports into mental health have demonstrated that a person's access to mental health services depends considerably on where they live and there are considerable variations in both the quality and type of services (MHCA 2005, Senate Inquiry 2006).

Calls for Australia to develop the information systems necessary to establish effective benchmarking stretch back to the first National Mental Health Strategy in 1992. These calls have echoed the concerns expressed by the Commission to ensure data collections reflect the full experience of mental illness, beyond merely reporting a person's interaction with the health system.

Developing a nationally consistent, coordinated system of collecting information on the provision of specialised mental health systems is essential. Mechanisms are also required to monitor the use of social and disability services.

Jenny Macklin, Director, National Health Strategy
Help Where Help is Needed, National Health Strategy Issue Paper No. 5, 1993

Such a view is quite consistent with the literature on report card type mechanisms which extols the virtue of this multi-dimensional approach to reporting (Rosenheck, 1998) and also fits with the holistic remit of the Commission. Any mechanism for benchmarking in mental health, local or international, needs to be flexible enough to be effective across multiple parameters because while genuine outcomes for the consumer are central, there will be continuing interest in other measures, such as cost effectiveness, equity and efficiency.

Australia's Capacity to Participate in Benchmarking

> While performance measurement has improved over time, there are still areas that require development, for example, good quality information on health system outcomes is particularly limited in the areas of primary health care services, mental health care, aged care, and private hospitals.
>
> *Australia's Health 2012*

Before considering the international scene, it is worthwhile sketching Australia's own history in relation to mental health benchmarking as this is the crucial platform from which any international comparisons can occur.

Australia has been at the forefront of activity in relation to reform and benchmarking. Of particular note was the seminal work of Eagar, Burgess and Buckingham (2000) entitled Towards National Benchmarks for Australian Mental Health Services which analysed in detail a set of potential mental health indicators, to assist federal, state and territory governments determine what types of mental health information would be most useful for benchmarking.

This paper was followed by another Commonwealth Department of Health funded report (2004) entitled Key Performance Indicators for Australian Public Mental Health Services which stated that while the use of performance indicator was well established in the acute health sector and other parts of the health system, mental health services had lagged behind these developments, due to the unavailability of suitable data and lack of consensus about how fundamental performance measurement concepts should be applied to mental health care.

Under the Second National Mental Health Plan, the Australian Government and States and Territories committed to bridge this gap by developing a specific set of mental health performance indicators and these are presented below (see next page).

Some of these indicators became data elements in the National Mental Health Report series. Others were either never collected or not reported, for example, the cost per three month community care period. Others from this list were flagged (those with a star below) for 'Phase 2 development' but are yet to be developed.

The subsequent years have seen further attention paid to the issue of mental health data and benchmarking but this process has been neither programmatic nor straightforward with multiple datasets and indicator sets emerging. It is in fact possible to identify eight different sets of national mental health indicators and 108 individual indicators.

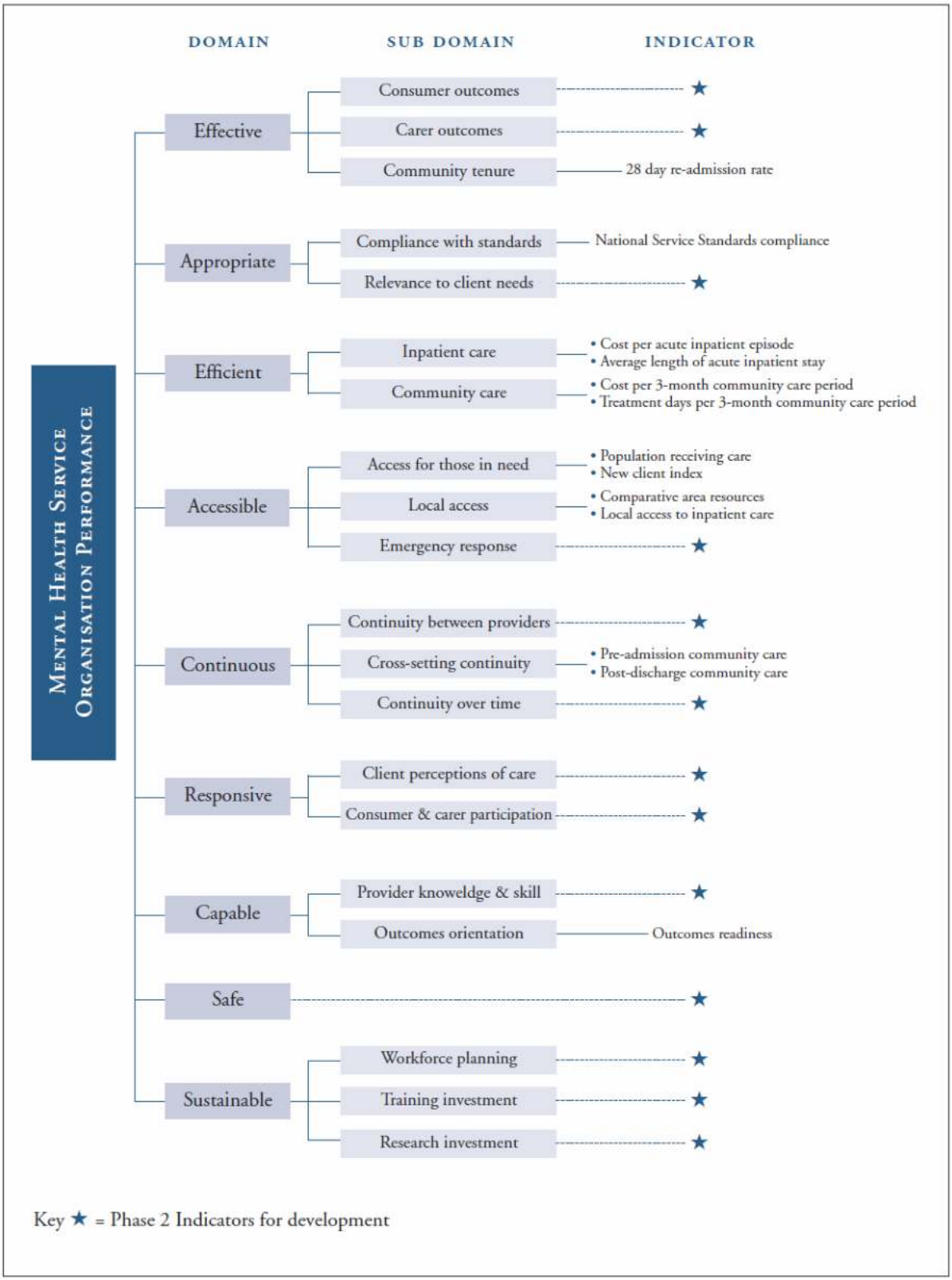
In truth, this situation is mirrored internationally with a recent review finding some 1480 individual performance indicators applied to various public mental health systems worldwide, often with little data to support validity or reliability (Lauriks 2012).

It is worth remembering that generally speaking, Report Card type indicators are 'big picture' measures; therefore, they may not provide detailed explanations or analyses of the issues involved, the causes or the implications. Indicators are often presented to evoke debate at the decision-making level and in the community as well as pointing to areas that require further research.

In current approaches to data collection, what is clearly lacking is the kind of qualitative and experiential data the Commission will need in order to build a holistic picture of the quality of life enjoyed by people with a mental illness – a contributing life. It is worth noting that this issue was addressed by the Council of Australian Governments (CoAG) which established a set of 12 key indicators against which to report progress under its National Action Plan on Mental Health 2006-11 (see Attachment 1).

Overall, while the CoAG indicators suggest a desire to transcend the health system, it would difficult to suggest they can currently provide a genuine reflection of experience of mental illness in Australia or whether people are getting better.

Key Performance Indicators for Australian Public Mental Health Services - 2004



Efforts to garner data on the quality of mental health care in Australia have focused on implementation of regularised reporting of Health of the Nation Outcome Scores (HONOS) (and some other) data as part of the Australian Mental Health Outcome and Classification Network (see here: http://amhocn.org/). CoAG reports that routine measurement of consumer outcomes is now in place in an estimated 85% of public mental health services and 98% of private hospitals but also states that:

The main outcome measurement tools being used describe the condition of the consumer from the clinician's perspective and do not address the 'lived experience' from the consumer's viewpoint.

One mental health consumer has stated (personal communication) that this akin to asking the hotel manager to rate the guests!

An important exception with regards to holistic data on mental health is in relation to the material presented as part of the recent national survey into people living with psychosis (Morgan 2011) which provided a description of the profile of people with a psychotic illness including personal, social and living circumstances, their mental and physical health and cognition.

The aim of this publication was to better understand the lives of public sector mental health consumers with psychosis, their social isolation, functioning, support received and daily circumstances, to enable a comprehensive analysis of factors associated with both poorer and better outcomes.

While Australia can point to some important work, particularly developmental work in relation to mental health benchmarks, the extent to which this has translated into useful data is doubtful. By way of illustration, the National Mental Health Report 2007 (Commonwealth 2008) asked whether Australia's spending on mental health was comparable to other countries or matched international standards. Three key barriers to obtaining even this very high level data were identified:

- no reliable international benchmarks were available to assess whether the 'right' level of funding is allocated for a given population's mental health needs;

- significant differences existed between countries in how mental health is defined, how expenditure is reported and what is included as 'health expenditure', making comparisons of available data both unreliable and potentially misleading; and

- of those countries that have published potentially comparable data, differences in the costing methods used to estimate mental health spending prevented direct comparison.

The Report concluded that while international comparisons of mental health spending were desirable, they remained "elusive".

The Report further noted that substantial collaboration between countries will be required for any future international comparisons of mental health spending to be valid. This paper contends that groups such as the OECD are only now appreciating the need for specific attention on mental health as an area for comparative benchmarking and that as a result, this collaboration is in its infancy.

Overall, mental health benchmarking efforts in Australia are rudimentary and retain an unhelpful over-reliance on administrative data extracted from and about the health system. Australia's capacity to contribute to more holistic international benchmarking efforts is significantly curtailed on this basis.

International Mental Health Benchmarks

Australia's inability to establish a robust system of benchmarks in mental health is mirrored by experience overseas where the capacity to assess the performance of the sector is seen to lag behind other parts of health (Baars, 2010). One reason for this is that in mental health care, performance measurement has been seen as an expense, in contrast with business where it is seen as an investment (Adair 2003).

Opportunities and structures to build a clear picture of comparative national efforts in relation to mental health are few. Generally speaking, mental health indicators do not feature as part of international commitments on health or disability. While mental health data can sometimes be inferred, it often lacks specific reportage.

Noting this, some international benchmarking examples are listed below.

UN Convention on the Rights of Persons with Disabilities

Australia became a signatory to this Convention in 2007 and ratified the relevant Protocol in 2009 (see http://www.un.org/disabilities/convention/about.shtml). This Convention is important because it sets out an international framework and several key principles, including:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Part of ratifying this Convention is also agreeing to the provisions set out in Article 33 which explain that countries must set up a national mechanism order to monitor implementation of the Convention's precepts and must also set up some sort of independent monitoring mechanisms – which usually takes the form of an independent national human rights institution.

In addition, Australia like all UN member nations is subject to the Universal Periodic Review which assesses each country's adherence to UN conventions etc. (see here http://www.ag.gov.au/Humanrightsandantidiscrimination/Internationalhumanrights/Pages/default.aspx).

The UN Convention framework is useful in a general sense but with more specific relevance to mental health and benchmarking, it is worth noting that the issue did not receive any new momentum or attention as a result of the United Nations establishing a new set of Millennium Development Goals (MDGs) 2000 – 2015. It does not feature as one of the eight key MDG identified by the UN:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV / AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

As noted by Jenkins et al (2011) the impact of decisions such as these by the UN are profound and lead to invisibility and marginalisation of people affected by mental disorders:

> *Mental health indicators do not feature among internationally agreed indicators of health needs, progress and outcomes, such as those in the MDGs. As resource allocation and development priorities are increasingly driven to meet internationally agreed targets, areas such as mental health… do not benefit from international investment. The lack of international investment in mental health infrastructure, information systems and research hampers the ability of Ministries of Health to make an effective case to Ministries of Finance. These indicators could go beyond clinical measures of health and/or mental health, but look at other key economic and development indicators such as socioeconomic status and participation in everyday activities such as employment and education.*

Australia's limited capacity to report on the holistic aspects of mental health care is paralleled internationally.

Nevertheless, this paper has identified some relevant international processes and these are listed below.

The WHO World Mental Health Survey Initiative

See here: http://www.hcp.med.harvard.edu/wmh/

The WMH Survey Initiative is a project of the Assessment, Classification, and Epidemiology (ACE) Group at the World Health Organization (WHO) coordinating the implementation and analysis of general population epidemiologic surveys of mental, substance use, and behavioural disorders in countries in all WHO Regions. The survey had its origins in work commencing in the late 1990s.

WHO estimates that mental and addictive disorders are among the most burdensome in the world and their burden will increase over next decades. However, these estimates and projections are based largely on literature reviews and limited and isolated studies rather than on cross-national epidemiologic surveys.

In order to move forward with public health initiatives aimed at addressing the global burden of mental disorders the WMH Survey Initiative carried out general population surveys that estimate the prevalence of mental disorders, evaluate risk factors for purposes of targeting interventions, study patterns of and barriers to service use, and validate estimates of disease burden world-wide. The WMH Survey Consortium includes nationally or regionally representative surveys in 28 countries, representing all regions of the world, and with a total eventual sample size in excess of 154,000. The WHO Initiative has spawned hundreds of academic publications, listed on their website by year, covering issues arising from survey results in individual countries but also international comparative analyses in areas such as:

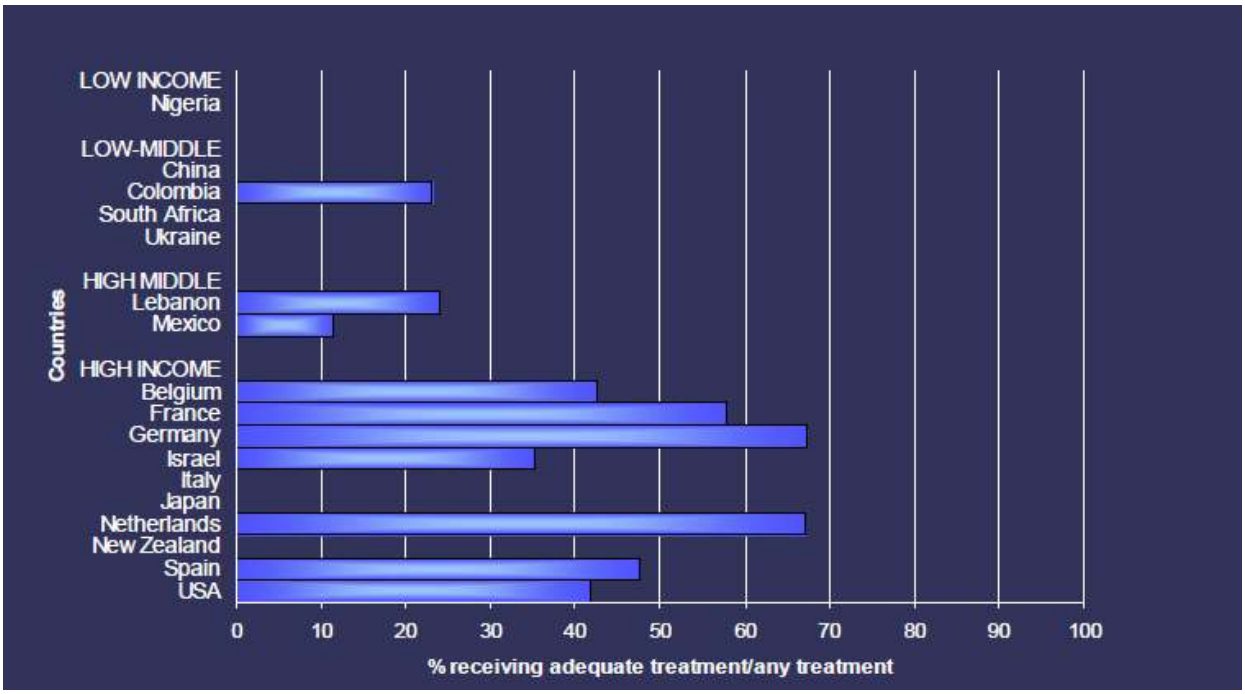
- Worldwide use of mental health services for anxiety, mood, and substance disorders
- Cross-national differences in the prevalence and correlates of burden among older family caregivers
- Common chronic pain conditions in developed and developing countries: Gender and age differences, and comorbidity with depression-anxiety disorders.
- Factors associated with use of psychiatrists and non-psychiatrist providers in six European countries

These studies appear in medical and mental health-related journals such as the British Journal of Psychiatry. There has been one edition of a summary publication (Kessler 2008) and a summary presentation of some findings has been made available on the website (see here: http://www.hcp.med.harvard.edu/wmh/IFPE_WMH.pdf)

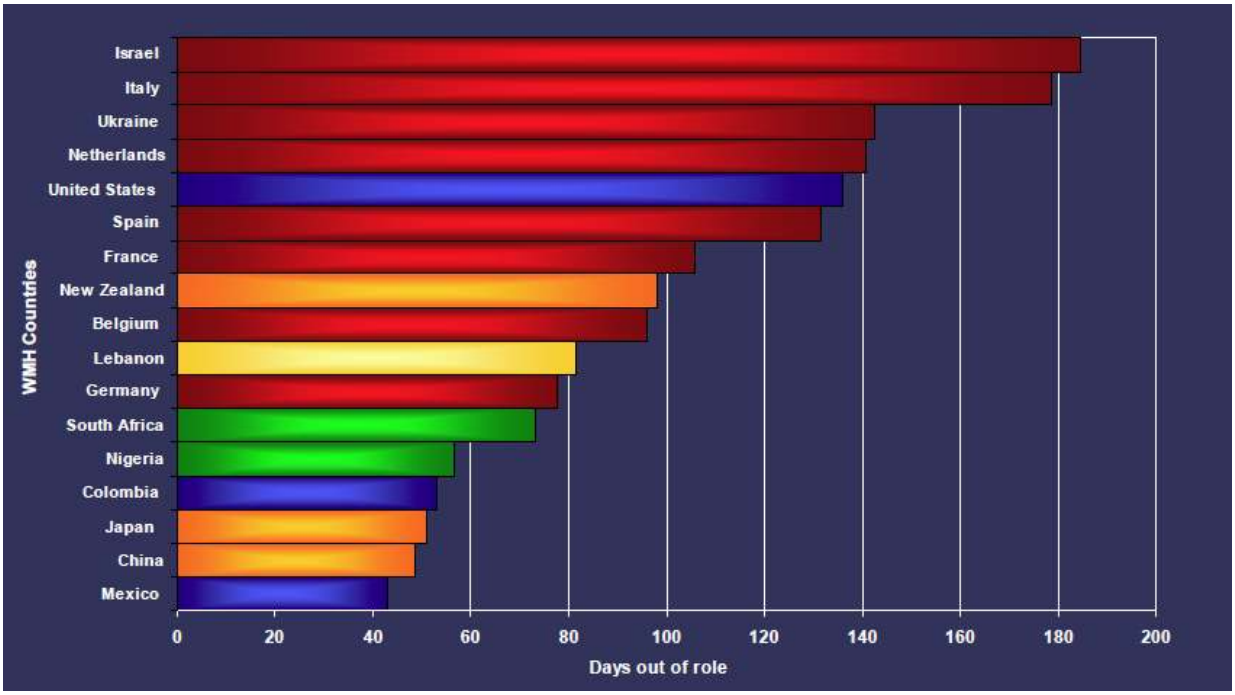
A couple of example tables from this summary presentation are shown below. Australian information was not included as data cleaning was still occurring at the time of publication however this gives some sense of the potential comparative capacity of the WHO Initiative.

Of particular interest is the table referring to 'mean days out of role' as this begins to yield an international picture of the practical impact mental illness has on a person's capacity to work, study or live a 'normal' life.

Twelve Month Proportion of Treated Cases Who Received "Minimally Adequate" Treatment



Mean Days Out of Role among Respondents with 12-month severe mental disorder



The overall message arising from the Initiative was that internationally there were disturbingly high levels of unmet need, even among people with serious disorders and even in developed countries, although much more so in developing nations. The WHO Initiative intends to continue to develop its methodology to assess other areas pertinent to a more holistic understanding of mental illness, including in areas such as education completion.

Australia's capacity to participate and contribute data to this international collaboration depends on the ongoing availability of the kind of data collected as part of the ABS National Survey of Mental Health and Wellbeing, so far only conducted twice (1997 and 2007). It will be important not only that this Survey information is available regularly but also that it can be amended to keep it consistent with international data trends and definitional changes.

Life Expectancy of Indigenous People

As part of this report, data was sought to enable the comparison of the life expectancy of Australian indigenous people in comparison to their international counterparts. Numerous studies (see here: http://www.aihw.gov.au/indigenous-observatory-international-comparisons/) have indicated that the gap between indigenous and non indigenous people's life expectancy in Australia is greater than in New Zealand, Canada and the United States of America. This was confirmed by a 2007 study published by the Cooperative Research Centre for Aboriginal Health (Freemantle et al 2007), as shown in the table below.

	Australia*		New Zealand*		Canada*		USA*	
	Aboriginal and Torres Strait Islander	(All)	Maori	(All)	First Nations	(All)	American Indian/ Alaska Native	(All)
Life expectancy (years)								
Males	56	(76.6)	69.0	(76.3)	68.9	(76.3)	67.4	(74.1)
Females	63	(82.0)	73.2	(81.1)	76.6	(81.8)	74.2	(79.5)
Median age	21	(35)	22.0	(33.9)	24.7	(37.7)§	27.8	(35.8)
Infant mortality (per 1000 live births)	14 3	(4.7)	8.9	(5.7)	6.4	(5.3)	9.8	(6.8)
Low birth weight (proportion of LBW live births)	13%	(6%)	8%	(6%)	5%	(6%)	6%	(8%)

*Aboriginal compared with (all non-Aboriginal)

However, difficulties related to concepts, data and methods behind such estimates throw doubt on conclusions drawn from country comparison studies. The AIHW suggests that the uncertainty associated with indigenous life expectancy estimates could be quite large. Consequently, it is difficult to draw conclusions regarding cross-country differences. The AIHW have been able to identify the specific changes in data collection that would need to occur in each country to enable more robust comparisons to be made.

The Global Network for Research in Mental and Neurological Health

(see here: http://www.mental-neurological-health.net/)

The Network sought to establish a database on mental health policy and services in nations across the developed and developing world in order to support evidence-based decision making at government level. The objectives of the global database were:

- To provide access for policy makers, other key decision makers and leaders to information about other countries' mental health policy strategy and services;
- To facilitate use of this information to support evidence based policy development;
- To enable comparative analyses between countries, to help identify areas where urgent action is needed and to point to potential solutions;
- To provide a reference source for UN agencies, other intergovernmental agencies, NGOs, and for consultants working for such bodies;
- To provide a reference source for improving a common language for mental health policy and care. Currently, there are no internationally accepted classifications, definitions or nomenclatures for mental health services e.g. it is hard to get agreement even within countries on what is a sheltered workshop, a mental hospital, or even a psychiatric bed;
- To provide a database for compiling and publishing an annual global mental health situation report.

This network was born out of two major initiatives:

- The International Consortium for Mental Health Policy and Services
- The report on "Neurological, Psychiatric and Developmental Disorders: Meeting the Challenge in the Developing World", published in 2001 by the Institute of Medicine, Academy of Sciences, USA

The Network was designed to be consistent with the World Health Organisation's (WHO) mental health global action programme (mhGAP) and respond to the recommendations of the World Health Report 2001 (devoted to mental health, including neurological disorders). The International Consortium dealt with issues of research related to mental health policy and, in particular, to the development of methods and instruments.

After the successful achievement of its objectives, the collaborating centres decided to broaden the scope of their work in several ways: by including nervous system disorders, by addressing research issues beyond mental health policy, and by inviting further stakeholders.

The inaugural Network meeting was held in October 2001. At its pomp, 26 countries collaborated in the Network, including Australia, to build comparative profiles of mental health policies, services and approaches. The profiles of about 20 countries are still available to review though Australia is not among them.

Australia's representative in the network was Professor Harvey Whiteford.

While the website does not make it clear, given how long it has been since any meeting or publication associated with the Network (2005), it is to be assumed that this effort is now defunct.

World Health Organisation (WHO) Mental Health Atlas

(see here:
http://www.who.int/mental_health/evidence/atlas/profiles/aus_mh_profile.pdf)

The Atlas is a WHO project supervised and coordinated by Dr Shekhar Saxena. The first set of publications from this project appeared in 2001. The Mental Health Atlas-2011 represents the project's latest edition. It presents data from 184 WHO Member States, covering 98% of the world's population. Facts and figures presented in Atlas indicate that resources for mental health remain inadequate.

The Atlas is designed to collect, compile and disseminate data on mental health and neurology resources in the world, including policies, programmes, financing, services, professionals, treatment and medicines, information systems and related organizations. The primary objective of the project is to raise public and professional awareness of the inadequacies of existing resources and services and the large inequities in their distribution at national and global level. The information might also useful in planning for enhancement of resources.

The kind of data presented in the Atlas is as follows:

a) Resources to treat and prevent mental disorders remain insufficient

- Globally, spending on mental health is less than two US dollars per person, per year and less than 25 cents in low income countries.
- Almost half of the world's population lives in a country where, on average, there is one psychiatrist or less to serve 200,000 people.

b) Resources for mental health are inequitably distributed

- Only 36% of people living in low income countries are covered by mental health legislation.
- In contrast, the corresponding rate for high income countries is 92%.
- Dedicated mental health legislation can help to legally reinforce the goals of policies and plans in line with international human rights and practice standards.
- Outpatient mental health facilities are 58 times more prevalent in high income compared with low income countries.
- User / consumer organizations are present in 83% of high income countries in comparison to 49% of low income countries.

c) Resources for mental health are inefficiently utilized

- Globally, 63% of psychiatric beds are located in mental hospitals, and 67% of mental health spending is directed towards these institutions.

d) Institutional care for mental disorders may be slowly decreasing worldwide

- Though resources remain concentrated in mental hospitals, a modest decrease in mental hospital beds was found from 2005 to 2011 at the global level and in almost every income and regional group

Input to the WHO Atlas project is coordinated by the Department of Health and Ageing. Australia's 2011 entry to the Atlas (see link above) replicates some of the information provided part of the National Mental Health Report 2010 on types of services, numbers of admissions, rather than whole of life data.

World Health Organization (WHO) Assessment Instrument for Mental Health Systems (AIMS)

(see here http://www.who.int/mental_health/evidence/WHO-AIMS/en/)

Another WHO venture is WHO-AIMS – a standardised tool for collecting essential information on the mental health system of a country or region. The goal of collecting this information is to improve mental health systems and to provide a baseline for monitoring the change. For the purpose of WHO-AIMS, a mental health system is defined as all the activities whose primary purpose is to promote, restore or maintain mental health.

However, WHO-AIMS is primarily intended for assessing mental health systems in low and middle income countries, but is also suggested by WHO to be a valuable assessment tool for high resource countries. The set of data items collected by WHO is in the table below and reflects some of the broader, holistic interest of the Commission, including in the areas of housing and employment.

WHO-AIMS Mental Health Data Items

Last version of mental health policy	Psychotropic medicines included on the essential medicines list
Last version of the mental health plan	Inspecting human rights in mental hospitals
Last version of mental health legislation	Expenditures on mental hospitals
Mental health expenditures by the government health department	Existence and functions of a national or regional 'mental health authority'
Free access to essential psychotropic medicines	Availability of mental health outpatient facilities
Organization of mental health services in terms of catchment areas/service areas	Children and adolescents treated through mental health outpatient facilities
Users treated through mental health outpatient facilities	Availability of community-based psychiatric inpatient units
Users treated in day treatment facilities	Time spent in community-based psychiatric inpatient units per discharge
Beds in community-based psychiatric inpatient units	Availability of mental hospital beds
Beds/places in community residential facilities	Involuntary admissions to mental hospitals
Change in beds in mental hospitals	Physical restraint, seclusion in mental hospitals
Long-stay patients in mental hospitals	Number of beds/places in other residential facilities
Long-stay patients in forensic units	Availability of psychosocial interventions in mental health outpatient facilities
Availability of psychosocial interventions in mental hospitals	Availability of medicines in mental health outpatient facilities
Availability of medicines in mental hospitals	Refresher training programmes for primary health care doctors
Psychiatry beds located in or near the largest city	Availability of medicines to primary health care patients in physician-based primary health care
Interaction of primary health care doctors with mental health services	Refresher training programmes for primary health care nurses
Refresher training programmes for non-doctor/non-nurse primary health care workers	Mental health referrals between non-physician based primary health care to a higher level of care
Human resources in mental health facilities per capita	Interaction of mental health facilities with complementary/alternative/ traditional practitioners
Staff working in community-based psychiatric inpatient units	Staff working in or for mental health outpatient facilities
Refresher training for mental health staff on the rational use of psychotropic drugs	Staff working in mental hospitals
Family associations involvement in mental health policies, plans or legislation	Refresher training for mental health staff in psychosocial (non-biological) interventions
Other NGOs involved in community and individual assistance activities	User/consumer associations and mental health policies, plans or legislation

Primary and secondary schools with mental health professionals	Professional groups targeted by specific education and awareness campaigns on mental health
Social welfare benefits	Provision of employment for people with serious mental disorders
Report on mental health services by the government health department	Mental health care of prisoners
Proportion of health research that is on mental health	Data transmission from mental health facilities

It should be noted that WHO's role has been to develop the AIMS tool and publish findings. The actual process of data collection and reporting is done by each country and WHO does not independently verify any of the data reported.

42 countries contributed to last WHO-AIMS report in 2009, Australia was not among them.

OECD Health Care Quality Indicators (HCQI) Project - Mental Health

This is probably the most robust or vigorous benchmarking process currently underway in mental health. The initial HCQI project which began in 2002 included thirteen indicators, none of which pertained to mental health.
Initial set of HCQI

Breast Cancer Survival	Smoking rates
Mammography Screening	Asthma mortality rate
Cervical Cancer Survival	AMI 30-day case fatality rate
Cervical Cancer Screening	Stroke 30-day case fatality rate
Colorectal Cancer Survival	Waiting time for femur fracture surgery
Incidence of Vaccine Preventable Diseases	Influenza vaccination for adults over 65
Coverage for basic vaccination	

Launched in January 2011 and recognising the importance of the issue, the OECD is conducting a project specifically to develop a framework of mental health system performance indicators based around four key areas and twelve key indicators (Hermann, 2004).

OECD Health Care Quality Indicators Project - Mental Health

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

The OECD's focus is clearly to enable comparisons of health system performance. Their list of indicators has little reference to social determinants of health-type data. Outcomes data is limited to mortality.

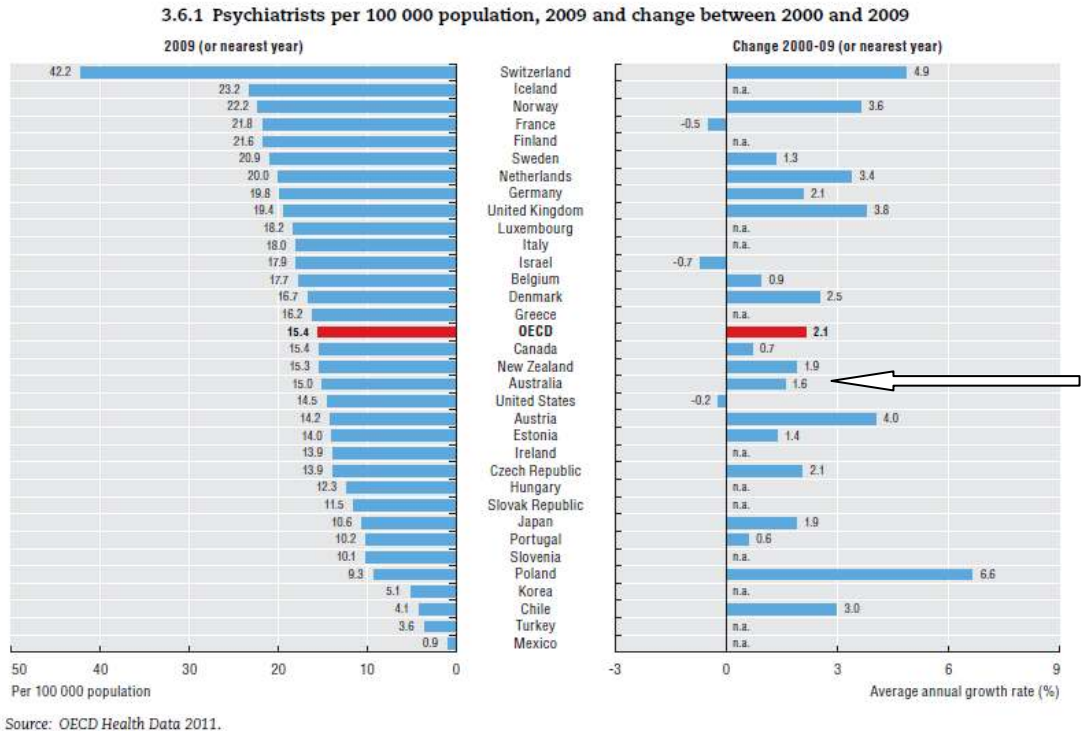
Professor Jane Pirkis from the University of Melbourne has participated in the OECD's detailed process for developing the HCQI set (Hermann, 2006). The OECD has noted the wide variation in the capacity of member countries to provide necessary data and no data is yet available from the HCQI mental health project.

For the moment, international OECD mental health system performance comparisons are very limited. The OECD.stat database includes 17 pages of indicators which can be found here: http://www.oecd.org/els/healthpoliciesanddata/List%20of%20variables_OECD%20Health%20Data%202012_ENGLISH.pdf

However, the section entitled Care for Mental Disorders only includes the following as indicators; dementia; alcohol use disorders; drug use disorders; Parkinsons and Alzheimers Disease (listed under Diseases of the nervous system), intentional self-harm, and social employment and some drug-related prescribing information.

Under its *Health at a Glance* publication (OECD 2011), while there are 62 indicators listed only three relate specifically to mental health: suicide (see table provided in the Executive Summary earlier in this report), psychiatric workforce and unplanned readmissions.

Psychiatrist Workforce Changes 2000-09



The OECD iLibrary website lists 53 'key tables' under its Health section but apart from suicide only one of these relates to mental health: Psychiatric Care Beds per 1000 population.

Unplanned Hospital Readmissions for Mental Disorder

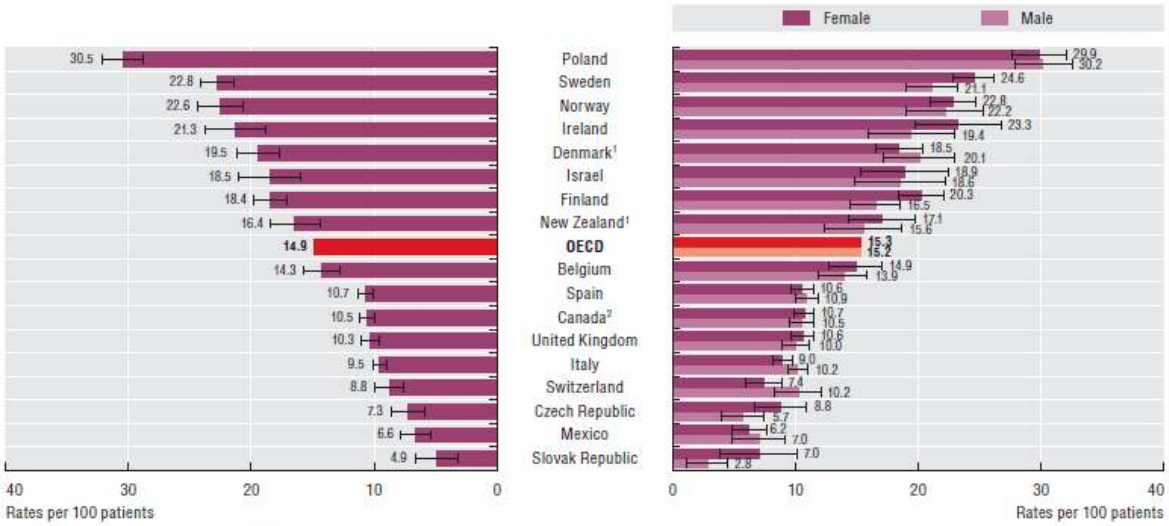
This indicator (again from Health at a Glance) offers two tables: schizophrenia re-admissions to the same hospital; and bipolar disorder re-admissions to the same hospital. Australian data does not feature (see below).

5.7.1 Schizophrenia re-admissions to the same hospital, 2009 (or nearest year)

Note: Rates age-sex standardised to 2005 OECD population. 95% confidence intervals represented by ⊢⊣.
1. Data do not include patients with secondary diagnosis of schizophrenia and bipolar disorder.
2. Only re-admissions within 30 days of the initial hospitalisation were counted as re-admissions.

Source: OECD Health Data 2011.

5.7.2 Bipolar disorder re-admissions to the same hospital, 2009 (or nearest year)



Note: Rates age-sex standardised to 2005 OECD population. 95% confidence intervals represented by ⊢⊣.
1. Data do not include patients with secondary diagnosis of schizophrenia and bipolar disorder.
2. Only readmissions within 30 days of the initial hospitalisation were counted as readmissions.

Source: OECD Health Data 2011.

The OECD publishes several other mental health-related tables, for example comparative lifetime prevalence rates between nations but Australian data does not always feature.

More recently, and building on the work of its HCQI Project, the OECD has published a technical paper giving an overview of the present mental health care information systems in 18 OECD countries, their capacity for measuring the quality of mental health care and to identify potential indicators for the HCQI set (Armesto 2008). Some of the key findings of the survey, to which Australia contributed, were as follows:

1. The availability of data across countries is generally very good for some types of data (structure and activity) and problematic for other, particularly data on processes, outcomes, treatment and procedures.

2. The data sources currently most widely available across countries are hospital administrative databases, national surveys and national registries.

3. The expansion of the availability of the unique patient identifier expected in the next two years would mean a real step forward in terms of ability to track patients across settings and levels of care. However the introduction of a unique patient identifier does not seem to be evolving in parallel with the degree of development of administrative data sources at the primary care and community care levels. This can pose problems to build indicators assessing continuity of care and quality of prescription or treatment at this level. That is especially important because most of mental health care is provided out of the hospital across OECD countries.

4. The integration of information systems across different levels of care provision is low.

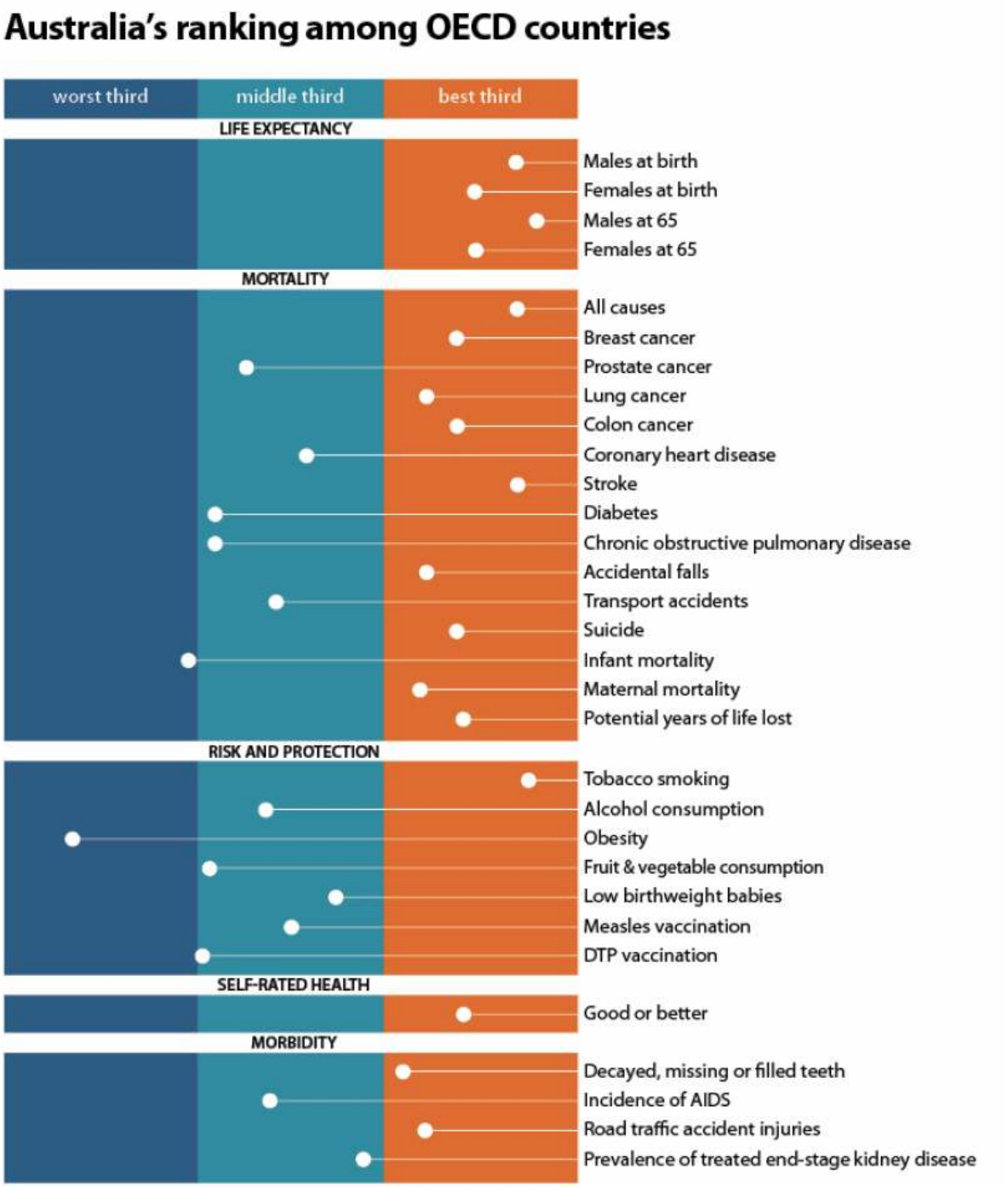
5. The use of this type of information for consumer's information or public accountability is infrequent across countries.

6. The capacity of countries to measure more of the HCQI set is increasing.

The report noted Australia strength in reporting aspects of care but also areas for further development, such as primary and community settings.

AIHW OECD Benchmark Summary

In relation to the OECD but beyond mental health, from time to time, the Australian Institute of Health and Welfare will publish relevant material, highlighting Australia's benchmark performance against OECD nations. An example is shown below. However the only mental health-related indicator used is suicide.



The AIHW has published a paper (AIHW 2012), so that Australians can better understand the strengths and weaknesses of international comparisons, in areas including mental health including a checklist to help researchers make comparisons (see Attachment 2).

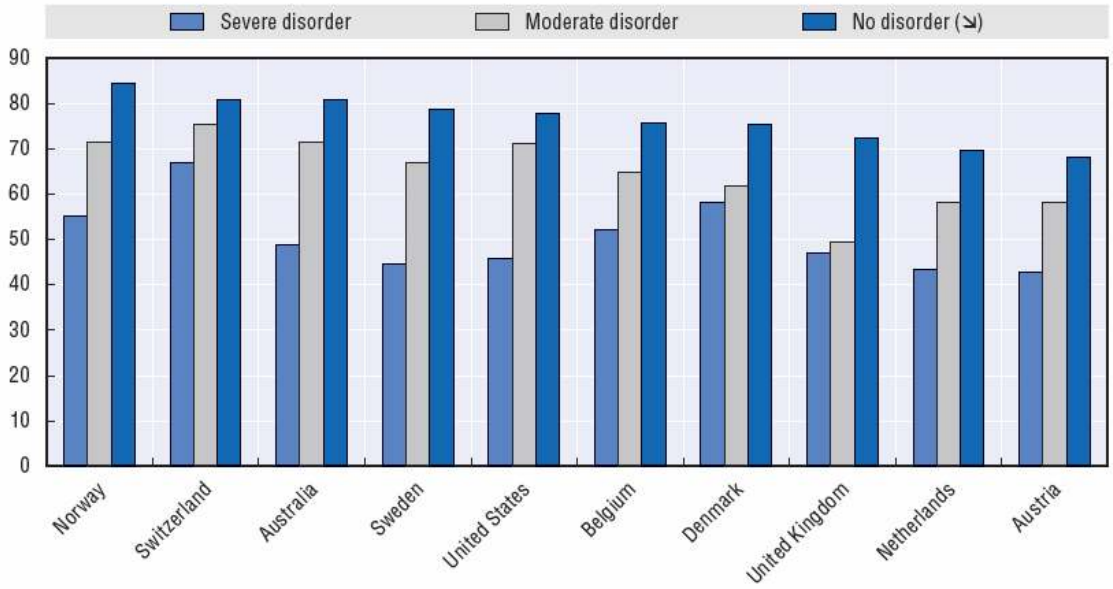
Other OECD Initiatives

The OECD carries out surveys or special reports into a wide range of areas, including some which traverse ground of keen interest to the Commission. For example, in its *Sick on the Job* Report (OECD, 2012) the OECD compiled and presented a range of information pertaining to mental illness and employment, such as can be seen in the graph below. Australian data for this report was provided by the Department of Education, Employment and Workplace Relations (DEEWR) as well as Health and other agencies.

Employment of People with a Mental Illness

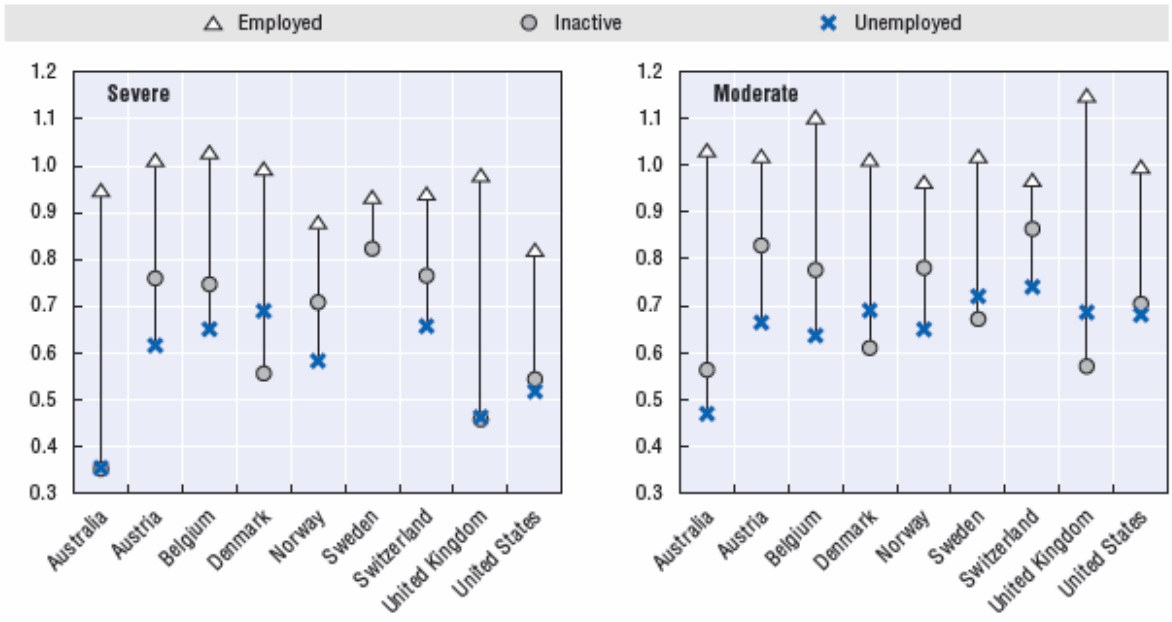
Figure 1.3. **People with a mental disorder face a considerable employment disadvantage**

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



This same OECD report however also ranks Australia lowest in terms of the income of people with mental illnesses as a ratio of the average income of the population.

OECD Incomes of People with Severe and Moderate Mental Illnesses



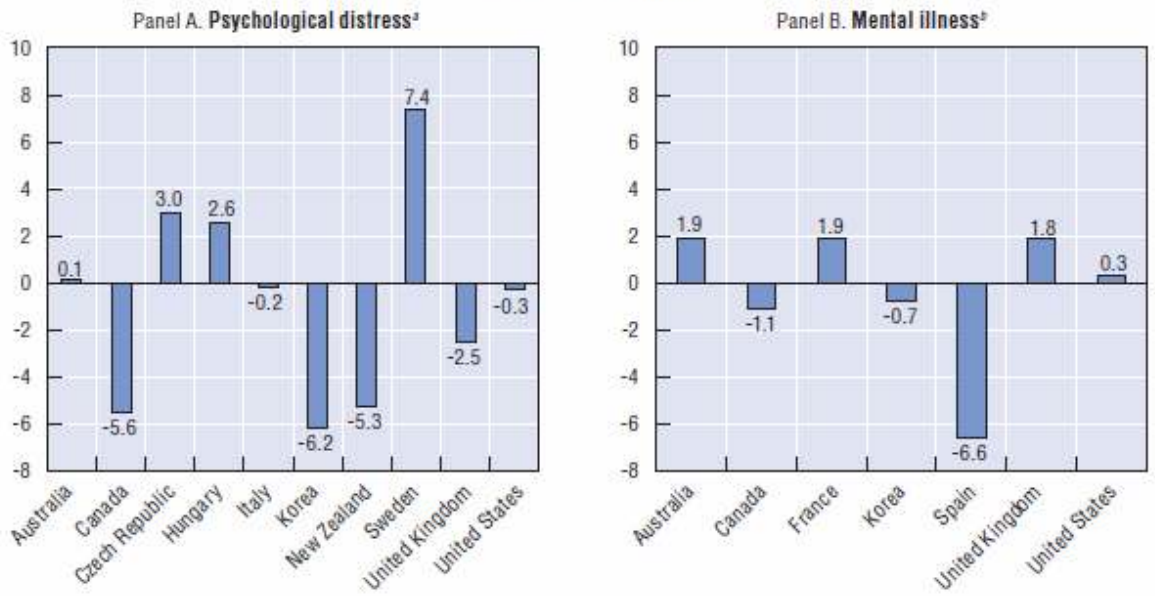
The Commission may need to think laterally about how to effectively build up the holistic picture it seeks, drawing on sources beyond strictly defined 'mental health reports'.

Another example is the OECD's Employment Outlook Publication (2008) which provided several comparative tables on the interaction between mental health and employment status.

Psychological Distress and Mental Illness

Figure 4.3. **Change in the prevalence of psychological distress and mental illness in selected OECD countries**

Percentage-point change



Homelessness

No recognised international benchmark of homelessness has been found in the course of this report. Some organisations have collated international data on numbers and other salient data (see here for example: http://www.homelessworldcup.org/content/homelessness-statistics) but definitional barriers to comparison remain.

Individual Country Approaches

While opportunities for international collaborations have been rare, there are few individual countries that have been working to develop a mechanism similar to a national report card of mental health. However, most focus on the health system, few of these are capable of addressing the holistic aspects sought by the Commission.

Scotland

Scotland has a dashboard set of nineteen health-focused indicators but access to the data is available only to authorised employees of the Scottish government.

Scottish Mental Health Dashboard Indicators
See here: http://www.isdscotland.org/Health-Topics/Finance/Publications/2012-03-27/2012-03-27-MH-Toolkit-Report.pdf

Total spend for mental health	Percentage readmissions within 133 days
Total mental health spend in the community	Percentage delayed discharges
Percentage community spend	Percentage of community-based Compulsory Treatment Order (CTO) of Total CTOs.
Drugs Costs	Percentage of voluntary inpatients and compulsory inpatients by Board
Total occupied care home beds per 100,000 population	Number of practising mental health officers
Total mental health staff numbers	Suicide rates per 100,000 (crude and standardised rates)
Total psychiatric beds per 100,000	Training and supervision index
Average length of stay	Persons on incapacity benefit/severe disablement allowance
Information quality and capture	Relative risk of death for persons with severe and enduring mental illness
Percentage readmissions within 28 days	

The Scottish Health Dashboard focuses quite clearly on health and health services, rather than seek to report on the experience of mental illness, social determinants and quality of life. In other words, as with the OECD approach, replicating the Scottish dashboard would not permit Australia's National Mental Health Commission to fulfil its mandate for a more holistic report card.

However, there are several other Scottish innovations that are noteworthy. To support these indicators and as one of its key 'HEAT' targets for health performance, Scotland has committed to a target of reducing the suicide rate by 20% between 2002-13. This is now a regular feature of reporting.

More generally, *Scotland Performs* lists the Government's key areas and targets for progress. One of the five key areas listed is 'Healthier Lives' which then measures national adult mental wellbeing against the Warwick Edinburgh Mental Wellbeing Scale (see here: http://www.scotland.gov.uk/About/Performance/scotPerforms/outcomes/healthierlives).

The Scottish Public Health Observatory produce regular summaries of mental health against these indicators (see here: http://www.scotpho.org.uk/health-wellbeing-and-disease/mental-health/key-points).

The Observatory and the Scottish NHS have now developed a framework of adult mental health indicators that is broader than the health system, as shown below. A set of indicators for children has also been produced.

Framework of adult mental health indicators (number of indicators in brackets)

HIGH LEVEL	
Positive mental health (2)	Mental health problems (7)

CONTEXTUAL		
Individual	**Community**	**Structural**
Learning and development (1)	Participation (3)	Equality (1)
Healthy living (4)	Social networks (1)	Social inclusion (2)
General health (3)	Social support (2)	Discrimination (3)
Spirituality (1)	Trust (2)	Financial security/debt (2)
Emotional intelligence (1)	Safety (4)	Physical environment (6)
		Working life (6)
		Violence (3)
Socio-demographic analysis across all indicators, where possible, by gender, age and area deprivation or socio-economic status.		

A 'traffic-light' dashboard is then produced to highlight progress against each of the indicators, as shown below (see here: http://www.scotpho.org.uk/downloads/scotphoreports/scotpho090227_mhadults2009_briefing.pdf).

Scottish Adult Mental Health Indicator Dashboard

			Indicator	Time Trend
High Level		Positive Mental Health	Positive Mental Health	No trend data
		Positive Mental Health	Life Satisfaction	No significant change
		Mental Health Problems	Common Mental Health Problems	Improved
		Mental Health Problems	Depression	No significant change
		Mental Health Problems	Anxiety	No significant change
		Mental Health Problems	Alcohol Dependence	Worsened
		Mental Health Problems	Psychoactive Substance-related deaths	Worsened
		Mental Health Problems	Suicide	Improved
		Mental Health Problems	Deliberate self-harm	No trend data
Contextual	Individual	Learning and Development	Adult learning	Improved
		Healthy Living	Physical activity	Improved
		Healthy Living	Healthy eating	Improved
		Healthy Living	Alcohol consumption	No significant change
		Healthy Living	Drug Use	No trend data
		General Health	Self-reported health	No significant change
		General Health	Long standing physical condition or disab	No significant change
		General Health	Limiting l-standing physical cond or disab	No significant change
		Spirituality	Indicator to be identified	Undefined
		Emotional Intelligence	Indicator to be identified	Undefined
	Community	Participation	Volunteering	No trend data
		Participation	Involvement in local community	Improved
		Participation	Influencing local decisions	No trend data
		Social Networks	Social contact	No significant change
		Social Support	Social support	No significant change
		Social Support	Caring	No trend data
		Trust	General trust	No trend data
		Trust	Neighbourhood trust	No trend data
		Safety	Neighbourhood safety	No significant change
		Safety	Home safety	Improved
		Safety	Non-violent neighbourhood crime	No data
		Safety	Perception of local crime	No trend data
	Structural	Equity	Income inequality	No significant change
		Social Inclusion	Worklessness	Improved
		Social Inclusion	Education	Improved
		Discrimination	Discrimination	No data
		Discrimination	Racial discrimination	No trend data
		Discrimination	Harassment	No data
		Financial Security/Debt	Financial management	Improved
		Financial Security/Debt	Financial inclusion	Improved
		Physical Environment	Neighbourhood satisfaction	Improved
		Physical Environment	Noise	No significant change
		Physical Environment	Escape facility – indicator to be identified	Undefined
		Physical Environment	Greenspace	No data
		Physical Environment	House condition	Worsened
		Physical Environment	Overcrowding	Worsened
		Working Life	Stress	No significant change
		Working Life	Work-life balance	No trend data
		Working Life	Demand	No significant change
		Working Life	Control	No significant change
		Working Life	Manager Support	Worsened
		Working Life	Colleague Support	No significant change
		Violence	Partner abuse	No trend data
		Violence	Neighbourhood violence	No data
		Violence	Attitude to violence – indicator to be identified	Undefined

England

In addition to an ABS-style survey of mental health and wellbeing, the English NHS is also producing a range of outcome frameworks that include indicators on mental illness.

The NHS Outcomes Framework 2012/13 includes indicators with regards to reducing premature death in people with serious mental illness (excess mortality in adults <75yrs with serious mental illness); employment of people with mental illness; and improving the experience of healthcare for people with mental illness (see here: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf).

England also has a Public Health Outcomes Framework which for 2013-16 will be used to drive local services and agencies to achieve better outcomes in public health. In relation to mental health, these outcomes include improving the numbers of people with mental illness in settled accommodation, improving employment, reducing numbers of people in prisons who have a mental illness. Also includes suicide prevention and self reported wellbeing (like Scotland, using the Warwick Edinburgh Mental Wellbeing Scale), see here (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf).

More generally and across the entire United Kingdom, it is worth noting that the Office of National Statistics has embarked on a project to develop new measures of national well-being, beyond traditional GDP-type approaches. The Health domain includes mental health. This link provides more information: http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/index.html.

New Zealand

The Key Performance Indicator (KPI) Framework for New Zealand Mental Health and Addiction Services is a whole-of-sector initiative designed to promote national quality and performance improvement efforts (see here: http://www.hdc.org.nz/media/199062/national%20indicators%202011.%20measuring%20mental%20health%20and%20addiction%20-%20summary.pdf).

It consists of a series of KPIs (specific indicators of performance) mapped to domains and sub-domains (categories of performance).

Domain 1 Mental health of the population	Domain 2 Health service delivery	Domain 3 Social inclusion
Life satisfaction	Access to services	Isolation
Psychological distress	Unmet need for help	Perceived discrimination
Potentially hazardous drinking	Seclusion	Employed and satisfied with job
Harmful effects of alcohol and drug use	Input into treatment	Standard of living
Suicide	Family participation	Housing satisfaction

The KPI data is reported and compared against other service providers enabling providers to learn from each other about the practices that lead to good outcomes for service users.

All 20 District Health Boards (DHBs) in New Zealand participate in this benchmarking. Each Board also partners with an NGO, both to better understand their local system of care and also to permit the NGO to shadow requisite data collection processes. The intention is that NGOs will be submitting their data shortly and this is part of building requisite capacity.

According to the NZ reports, all DHBs had areas of good performance and areas in which they wanted to see improvement. This project deliberately avoided a naming and shaming approach to the data as the intention is to encourage open comparison and discussion about each organisation's data.

While the NZ approach appears sound, there remains considerable emphasis in reality on inpatient service benchmarking, particularly because this was where benchmark data was most easily obtained. Data on functional outcomes for consumers still requires considerable further development in NZ.

Importantly, there is a consumer advisor on the national benchmarking steering group and each DHB has been encouraged to engage a consumer advisor.

Another NZ initiative is the Knowing the People Planning (KPP) program which was introduced in 2002 (see here: http://www.tepou.co.nz/improving-services/knowing-the-people-planning).

The KPP is a tool, used voluntarily by mental health organisations, that is designed to help services assess how well they provide the key elements of good service provision, as identified by consumers, their families and clinicians.

The 10 key features of KPP are: Prompt access to services when needed; Treatment leading to discharge and self-management; Personal assessment and treatment plans; Relapse prevention plans; Continuity of care; Health treatment and advice; Social support; Service accountability; Coordination of services; and Service evaluation.

Some of the data derived from KPP includes:

- Being able to track a decrease in the number of service clients using the service for longer than two years;
- The number of clients without a GP decreased from 19% in 2007 to 12% in 2009;
- The number of clients in employment increased from 22% to 28% over the same period.

There have also been important developments in the United States, the European Union and several other nations (Lauriks 2012).

Canadian Institute for Health Information (CIHI)

https://secure.cihi.ca/free_products/health_indicators_2011_en.pdf

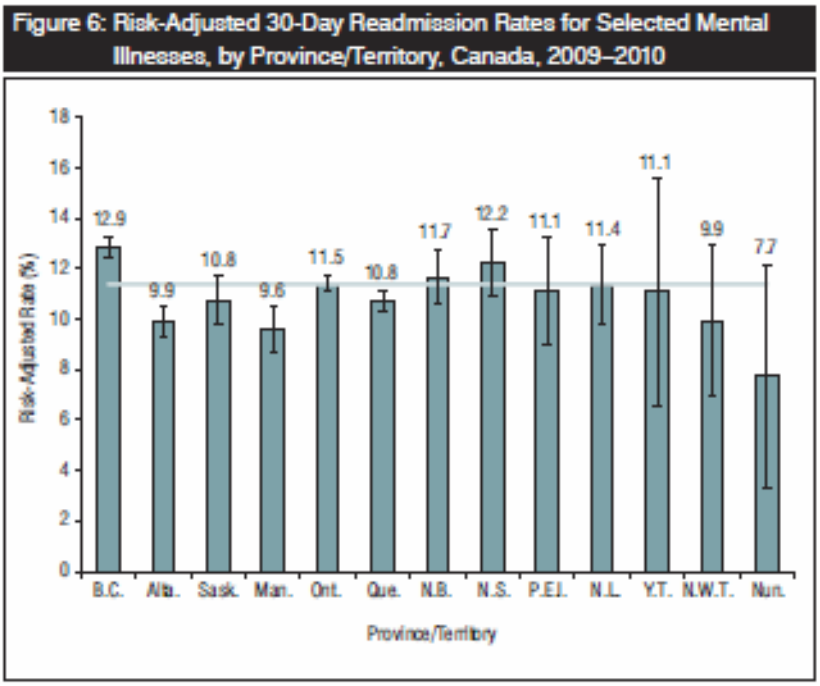
In response to calls for better accountability for mental health, CIHI developed three specific performance indicators related to mental health services in Canada.

Although the indicators are based on data from general hospitals, they are interpreted as being more closely related to outcomes associated with effective community-based care and supports in both treating persons age 15 and older who are living with mental illnesses and in reducing unnecessary or avoidable hospitalizations. These indicators chosen were:

- Self-injury hospitalization rates, a partial measure of the extent to which community-based services are accessible and effective in minimizing self-injury;
- 30-day mental illness readmission rates, a proxy measure of coordination and continuity of services; and
- Repeat hospitalizations for mental illness, a proxy measure for aspects of appropriateness of services.

CIHI recognise that these indicators do not provide a complete picture of the performance of the mental health system in Canada; they are intended to provide an initial glimpse of the patterns of mental health service use and of the performance of the mental health system. CIHI then publish data comparing the performance of each province and territory, as shown below.

Canadian Benchmark Example



It should be noted that while the Canadian Mental Health Commission has recently released the first ever national strategy for mental health (see here: *http://www.mentalhealthcommission.ca/English/Pages/Strategy.aspx*), this paper does not propose or define any agreed set of indicators against which to assess progress.

United States

The National Alliance on Mental Illness' *Grading the States Report* (NAMI 2009) produced by the US National Alliance on Mental Illness attempts to grapple with indicators beyond health, looking at housing and jail diversion. They present a simple school report style A-F grading of each state in the US, assessed against multiple criteria in four main categories:

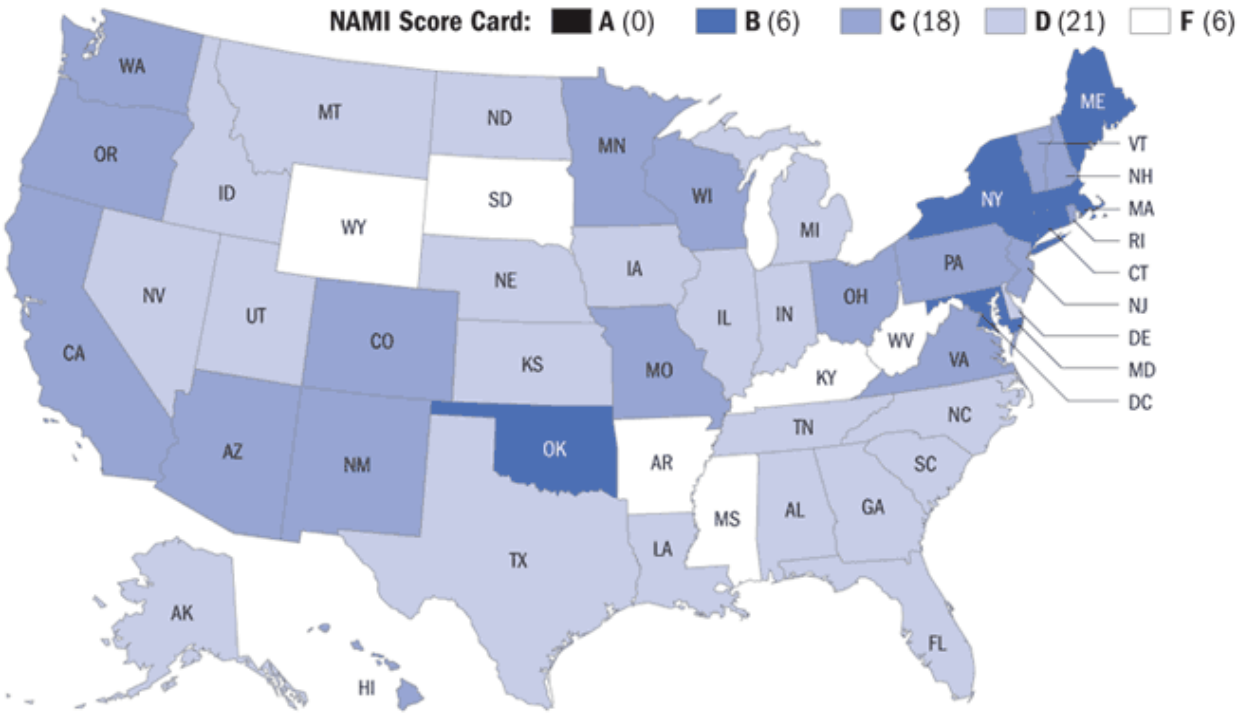
1. Health Promotion and Measurement
2. Financing & Core Treatment/Recovery Services
3. Consumer & Family Empowerment
4. Community Integration and Social Inclusion

The detailed descriptions of the measures collected and reported by NAMI are listed in the table below.

Category I: Health Promotion & Measurement	
Workforce Development Plan	Quality of Race/Ethnicity Data
State Mental Health Insurance Parity Law	Have Data on Psychiatric Beds by Setting
Mental Health Coverage in Programs for Uninsured	Integrate Mental and Primary Health Care
Quality of Evidence-Based Practices Data	Joint Commission Hospital Accreditation
Public Reporting of Seclusion & Restraint Data	Have Data on ER Wait-times for Admission
Wellness Promotion/Mortality Reduction Plan	Reductions in Use of Seclusion & Restraint
Performance Measure for Suicide Prevention	State Studies Cause of Death
Workforce Development Plan - Diversity Components	Smoking Cessation Programs
Category II: Financing & Core Treatment/Recovery Services	
Workforce Availability	Targeted Case Management (Medicaid pays)
Inpatient Psychiatric Bed Capacity	Medicaid Outpatient Co-pays
Cultural Competence - Overall Score	Mobile Crisis Services (Medicaid pays)
Share of Adults with Serious Mental Illness Served	Transportation (Medicaid pays)
Assertive Community Treatment (ACT) - per capita	Peer Specialist (Medicaid pays)
ACT (Medicaid pays part/all)	State Pays for Benzodiazepines
Family Psychoeducation (Medicaid pays)	No Cap on Monthly Medicaid Prescriptions
Supported Housing (Medicaid pays part)	Assertive Community Treatment (availability)
Supported Employment (Medicaid pays part)	Certified Clubhouse (availability)
Supported Education (Medicaid pays part)	State Supports Co-occurring Disorders Treatment
Language Interpretation/Translation (Medicaid pays)	Illness Self Management & Recovery (Medicaid pays)
Telemedicine (Medicaid pays)	Access to Antipsychotic Medications
Access to Antipsychotic Medications	Clinically-Informed Prescriber Feedback System
Clinically-Informed Prescriber Feedback System	Same-Day Billing for Mental Health & Primary Care
Same-Day Billing for Mental Health & Primary Care	Supported Employment (availability)

Family Psychoeducation (availability)	Integrated Dual Diagnosis Treatment (availability)
Services for National Guard Members/Families	Permanent Supported Housing (availability)
Illness Self Management & Recovery (availability)	Housing First (availability)
Category III: Consumer & Family Empowerment	
Consumer & Family Test Drive (CFTD)	Promote Peer-Run Services
Consumer & Family Monitoring Teams	State Supports Family Education Programs
Consumer/Family on State Pharmacy (P&T) Committee	State Supports Peer Education Programs
Consumer-Run Programs (availability)	State Supports Provider Education Programs
Category IV: Community Integration & Social Inclusion	
Housing - Overall Score	Mental Illness Public Education Efforts
Suspend/Restore Medicaid Post-Incarceration	State Supports Police Crisis Intervention Teams (CIT)
Jail Diversion Programs (availability)	Mental Health Courts - Overall Score
Reentry Programs (availability)	Mental Health Courts - per capita

NAMI then offers a clickable map of the United States which permits readers to assess each state's performance and call up individual, detailed report cards with the final marks for each jurisdiction, as shown below.

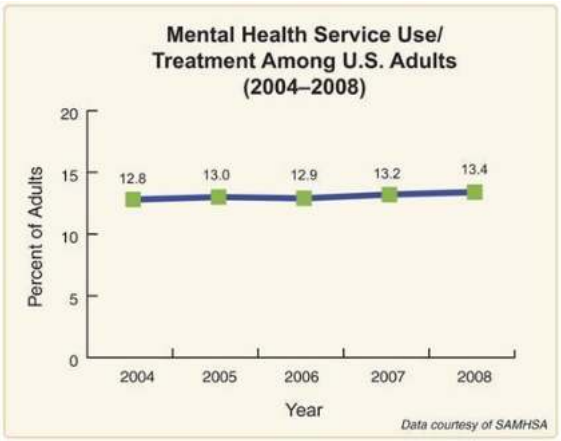


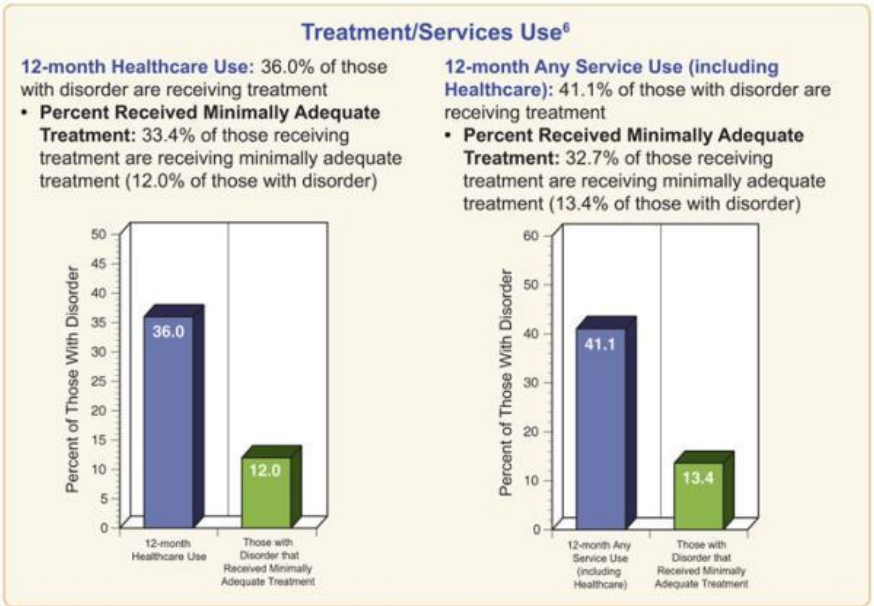
In 2009 NAMI's *Grading the States* report made the following comment in relation its national report card:

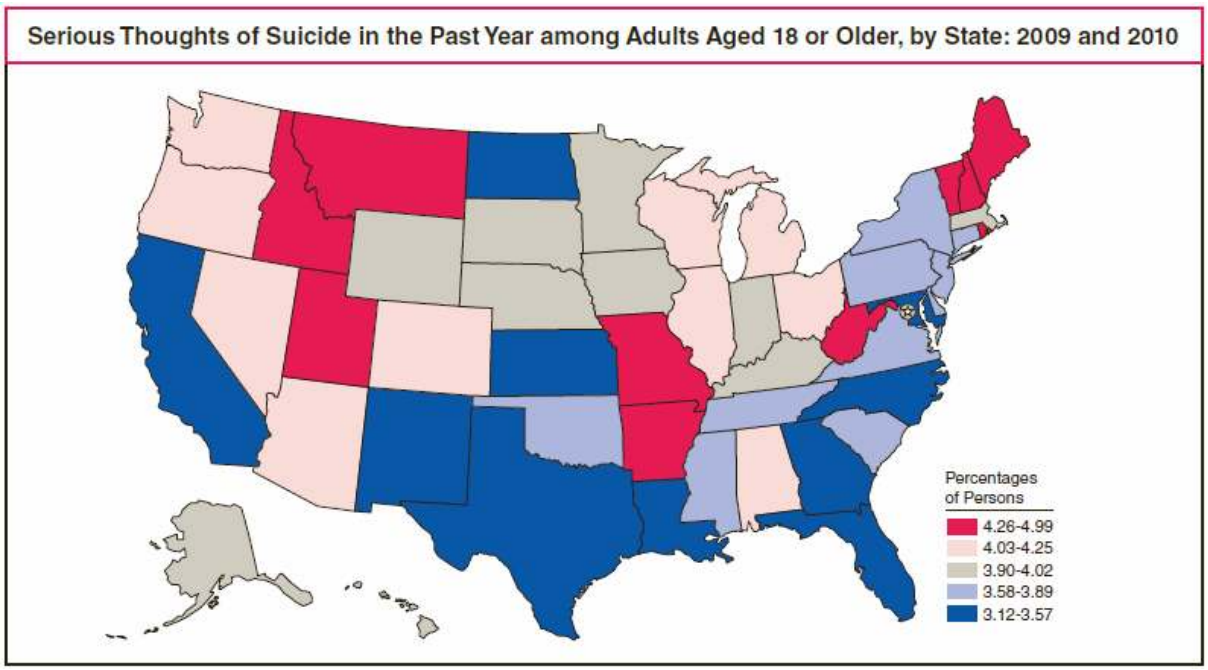
> *Mental health care in America is in crisis. The nation's mental health care system gets a dismal D. As the nation confronts a severe economic crisis, demand for mental health services is increasing -- but state budget cuts are creating a vicious cycle that is leaving some of our most vulnerable citizens behind.*

America's Substance Abuse and Mental Health Administration (SAMHSA) also regularly publish data comparing the national and state performance so as to track the mental health of Americans, such as the data presented below.

Examples of SAMHSA Data (US)







Other Initiatives

Noteworthy too is the recent work of the (Sarkozy) Commission on the Measurement of Economic Performance and Social Progress (http://www.stiglitz-sen-fitoussi.fr/en/index.htm) and even our own Australian Treasury's Wellbeing Framework (Australian Government 2004) which demonstrates the significance placed by the central government agencies both in Australia and overseas on moving beyond merely accounting for gross domestic product and towards a broader understanding of markers of social inclusion and participation.

In February 2008, the President of the French Republic, Nicholas Sarkozy, unsatisfied with the state of statistical information about the economy and the society created a Commission to identify the limits of GDP as an indicator of economic performance and social progress, including the problems with its measurement; to consider what additional information might be required for the production of more relevant indicators of social progress; to assess the feasibility of alternative measurement tools, and to discuss how to present the statistical information in an appropriate way. The Sarkozy Commission's final report was delivered in 2009. In describing the poor level of mental health data available to assist the Sarkozy Commission in its work, its report stated:

> *Variations in the measures and underlying data are inevitable given the many manifestations of poor health, but this also poses a real obstacle to comparing countries and monitoring changes in people's morbidity over time. Measures are even sparser when moving from physical to mental disorders, despite evidence that these affect (at least in mild forms) a large share of people, that most of these disorders go untreated, and that their incidence has been increasing in some countries.*

The challenges facing international health benchmarking have also been noted by the Rand Corporation (Nolte 2010) in a report recently conducted for England's National Health Service. This report also refers to health performance indicator developments in Sweden, Holland, Taiwan and elsewhere. The Dutch model had some interesting elements, for example being able to report that seven out of ten clients in mental health care were of the opinion that their treatment or support plan was carried out in accordance with their wishes.

The key issue is that these national developments do not join up in any collaborative benchmarking effort nor do they adequately focus on the health and welfare of people with a mental illness.

Conclusion

The paucity of international mental health benchmarks is striking. Efforts are very limited, even within the specific confines of data on mental health care. Broadening this definition to include the more 'whole of life' perspective desired by the Commission means there is limited data from which to draw.

It is possible to find singleton elements that could populate a Report Card but these are often generated in the course of one-off surveys or reports, such as *Sick on the Job* (OECD, 2012) rather than forming part of a regularised process of data collection and reporting. Mental health data is often not included or poorly included in existing data collections. It is often the case that the only marker deemed worthy of inclusion is suicide.

This means it is not really possible to draw a detailed picture of Australia's mental health performance against other countries. This report has highlighted some areas where international data has been published but this has mostly focused on individual aspects of health care rather than a comparative, whole of life assessment of the wellbeing of people with a mental illness in different countries.

There are two clear challenges facing any Australian report card on mental health. The first is to break out of the cycle of merely reporting mental health service administrative data and instead initiate data collections which can more fully reflect the experience of having a mental illness in 21st century Australia.

The second is for Australia to find and invest in suitable mental health benchmarking processes that permit international comparisons to be fairly established.

Given the desire to avoid the trap of administrative data, perhaps the establishment of an agreed international process for gathering the validated experience of care of mental health consumers and carers would be a good place to begin. Such processes already exist both overseas (Jenkinson, 2002) and domestically (Ning, 2010).

The voice of consumers and carers is the key performance measure absent from our reporting system. Such a measure would permit service users to not only contribute to mental health service quality improvement but also to provide holistic feedback on their experience of housing, employment, education, transport and the other issues which impact daily on quality of life.

The National Mental Health Commission is not alone in its desire to make progress in relation to benchmarking. There are similar commissions with similar remits operating not only across different state and territory jurisdictions of Australia but also in other countries, such as New Zealand and Canada. There are also peak bodies in other countries trying to provide this new accountability for mental health, such as NAMI in the USA, as well as relevant activity in Scotland and England. Together with the WHO and the OECD, these groups obviously represent a potentially rich network of common interest in benchmarking to drive future activity.

These groups are beginning to lay down markers or proxy measures, some of which have been described in this report. Most are keen to pursue data beyond the health system, along the lines of interest to the Commission. All are grappling with definitions and issues around consistency.

Work and resources should be invested in this network as a priority so that Australia can both contribute to and benefit from common approaches as soon as possible. This way we can confirm the merit of Australian approaches, identify areas for improvement and make a genuine contribution to worldwide quality in mental health care in the broadest sense.

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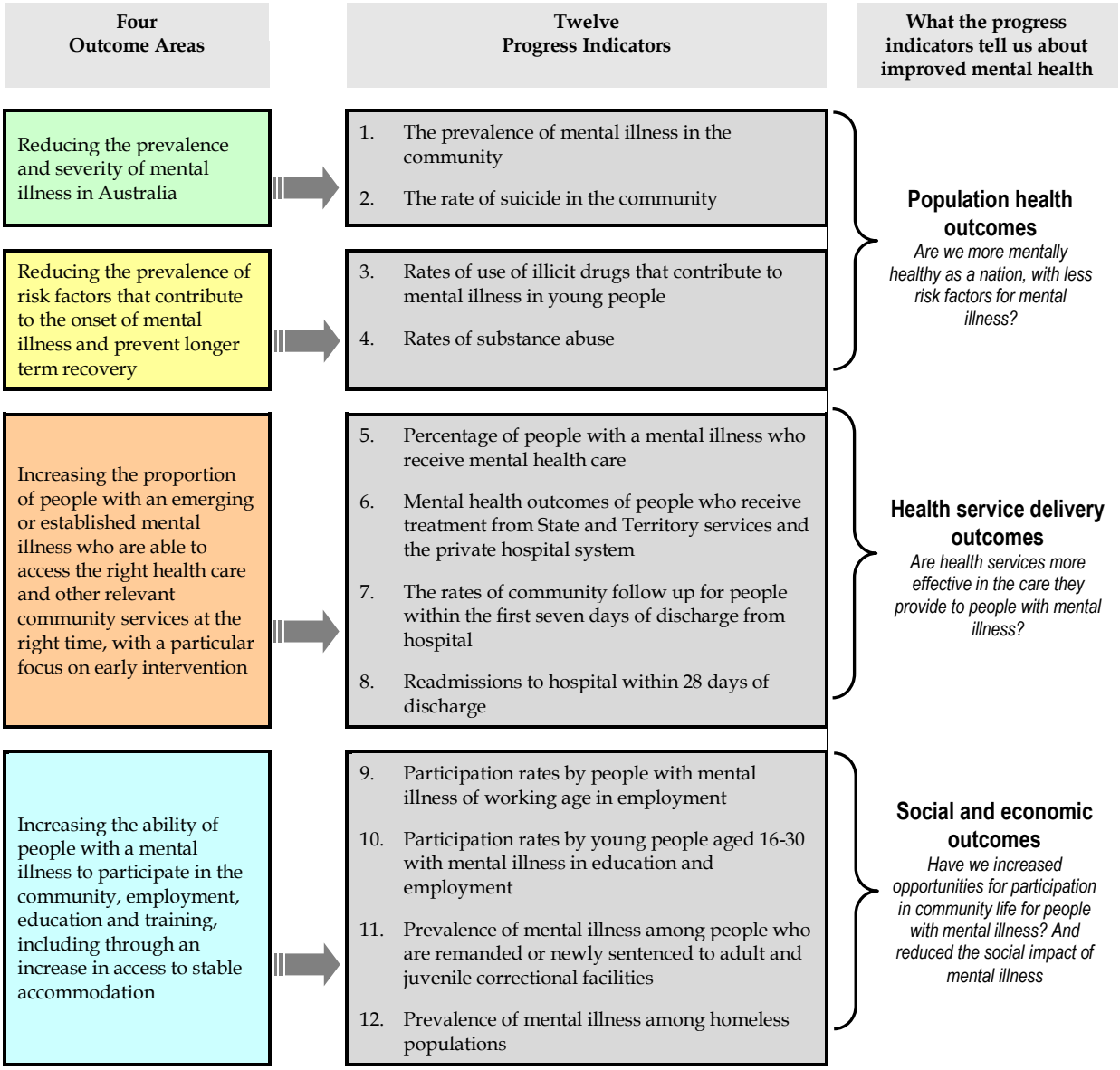
Attachment 1 – CoAG National Action Plan on Mental Health Outcome Measures



Attachment 2 - AIHW Benchmarking Checklist

Checklist for international comparisons of health-related data

Consider these questions when presenting or interpreting an international comparison of health-related data. Additional questions specific to the subject area may also be required.

Data quality

- ☐ Consistency—are the data defined consistently across countries?
- ☐ Methodology—do all countries use the same method to collect the data?
- ☐ Coverage—do the data cover similar parts of the population?
- ☐ Time period—do the data refer to the same time period?

Choice of countries

- ☐ Comparability—are countries sufficiently similar to support comparison?

Presentation and interpretation

- ☐ Presentation—are the data presented appropriately?
- ☐ Explanation—is the variation between countries adequately explained?
- ☐ Underlying differentials—are differences within countries considered?
- ☐ Context—can the data be used outside of an international comparison?