Health Research Board

Mental health-related indicators for measuring performance and impact of mental health policy

An evidence brief

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Abbreviations

Abbreviation	Definition
CAMH	Child and Adolescent Mental Health
GP	General practitioner
HCQO	Healthcare Quality and Outcomes
HRB	Health Research Board
NGO	non-governmental organisation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Co-operation and Development
PRIMHD	Programme for the Integration of Mental Health Data
SIGN	Scottish Intercollegiate Guidelines Network
UK	United Kingdom
WHO	World Health Organization

Executive summary

Policy context

Ireland's national mental health policy, *Sharing the Vision: A Mental Health Policy for Everyone* (henceforth referred to as simply *Sharing the Vision*), was published in 2020 with the aim of enhancing the provision of mental health services and supports across a broad continuum – from mental health promotion, prevention, and early intervention to acute and specialist mental health service delivery – during the period 2020–2030. The policy is organised around 4 core outcome domains consisting of a total of 15 high-level outcomes, and it encompasses a total of 100 recommendations and associated actions which are linked to these high-level outcomes.

Aim and research questions

This evidence brief aims to describe mental health outcome indicators used internationally as part of an initial scoping exercise in order to inform the development of a set of outcome indicators for assessing the performance and impact of *Sharing the Vision*, Ireland's national mental health policy. Specifically, it addresses the following questions:

1. What indicators are used internationally to monitor and evaluate similar outcomes to those identified in *Sharing the Vision*?
2. What are the reported benefits and challenges regarding the use of these indicators for mental health policies/plans/strategies?
3. How are these indicators used to monitor and evaluate mental health policies/plans/strategies?

Methods

The methodology used to provide an overview of mental health outcome indicators, their benefits and limitations, and how they are used to monitor and evaluate mental health policies, plans, or strategies was to:

- Select a representative sample of countries and transnational organisations.
- Search the literature for national and transnational mental-health-related policies, plans, or strategies; indicator sets; outcome frameworks; performance frameworks; and national surveillance systems or frameworks.
- Extract data relevant to the research questions outlined in Section 1.3.
- Categorise the extracted data under the most relevant *Sharing the Vision* outcome domain(s) and high-level outcome(s).
- Describe the nature, including the benefits and limitations, of the indicators categorised under each high-level outcome.
- Analyse the collection of indicators deemed relevant to each high-level outcome and identify those that could be used as outcome indicators for *Sharing the Vision*, regardless of how they have been identified in their respective indicator sets.
- Summarise the outcome indicators deemed relevant to each high-level outcome within overarching indicator themes.

- Identify if/how each indicator set, framework, etc. (henceforth referred to as simply 'indicator sets') is used to monitor and evaluate the relevant mental health policy.

Indicator sets from the following five countries and one transnational organisation were selected for inclusion based on the nature and accessibility of information obtained during initial scoping:

1. Australia
2. Canada
3. England (United Kingdom (UK))
4. New Zealand
5. Scotland (UK), and
6. The Organisation for Economic Co-Operation and Development (OECD).

This evidence brief relied primarily on grey literature published by governments, statutory agencies, health systems, and independent organisations. Broad searches were undertaken using the Google and Google Scholar search engines. Search results were screened for relevance to the research questions. Websites identified by the search engine searches were searched using the websites' own search engines, and available publication lists were screened for relevant documentation. We also contacted the relevant organisations or agencies in the selected countries in order to access additional information where it was not available in the literature sourced.

Relevant information from the included sources was extracted and categorised under the most appropriate high-level outcome(s). While we prioritised the identification of outcome indicators, we did not limit our searching to indicator sets that included indicators explicitly identified as 'outcome indicators'. This is because, although different types of indicators serve distinct purposes in policy monitoring and evaluation, indicator nomenclature can vary across contexts depending on the purpose of each individual indicator set. In addition, indicators in the area of mental health are sometimes not described using terminology typically found in monitoring and evaluation literature (i.e. outcome indicator, output indicator, etc.).

Findings

We extracted and categorised indicators from a total of 18 indicator sets from the 5 selected countries and the OECD; 9 of these indicator sets included indicators explicitly described as 'outcome indicators' or that could confidently be interpreted as outcome indicators. The remaining indicator sets were described as 'performance/benchmarking indicators', 'mental health and addiction/substance use indicators', 'quality indicators', and 'chronic disease indicators'. Three of the indicator sets that included indicators explicitly described as 'outcome indicators' also included mental health determinant indicators, which were considered important in relation to outcome domains 1 and 3 as they capture the risk and/or protective factors for mental health outcomes at the individual, family, community, and societal levels.

Outcome domain 1

The majority of the indicators deemed relevant to this domain were categorised under outcome 1(a) ('Positive mental health, resilience and psychological wellbeing amongst the population as a whole'), wherein the overarching outcome indicator themes identified were: positive mental health and well-being outcome indicators (e.g. 'Psychological wellbeing'), poor mental health and well-being outcome indicators (e.g. 'Chronic stress'), life satisfaction outcome indicators (e.g. 'The proportion of people who score 7 out of 10 or higher for life satisfaction'), social well-being outcome indicators (e.g. 'A sense of

belonging'), and poor social well-being outcome indicators (e.g. 'Loneliness: percentage of adults who feel lonely often or always or some of the time'). In relation to outcome 1(b) ('Positive mental health, resilience, and psychological wellbeing amongst priority groups…through targeted promotion and preventive mechanisms'), there was a notable dearth of indicators developed specifically for priority groups, likely because in most indicator sets included in this evidence brief, data for most or all of the indicators are made available by demographic, socioeconomic, and other factors so that users can make comparisons across different groups. The overarching outcome indicator themes identified for outcome 1(c) ('Reduced stigma and discrimination arising through improved community wide understanding of mental health difficulties') distinguish between indicators of stigma and discrimination experienced by people with mental health conditions (e.g. 'Perceived discrimination') and indicators of the potential impacts of initiatives to reduce mental health stigma and discrimination in the community ('Willingness to seek help from a mental health professional – college and university students'). The overarching outcome indicator themes identified for outcome 1(d) ('Reduced prevalence of mental health difficulties and/or reduced severity of impact(s) through early intervention and prevention work') distinguish between indicators of the prevalence of mental health challenges more generally (e.g. 'Prevalence of mental illness') and indicators of the prevalence of specific mental health conditions (e.g. 'Adults with moderate or high severity symptoms of depression') in the general population.

In relation to the benefits and limitations of the indicators deemed relevant to outcome domain 1, the most commonly reported benefits and limitations pertained to the collection of indicator data using self-report measures in local and national surveys. While this approach allows decision-makers to gain a broad understanding of and measure trends in population-level mental health and well-being over time, and to make comparisons across the population and identify where inequalities might lie, self-report measures are subject to a range of response biases and require a representative sample of the target population in order to draw meaningful conclusions. In addition, responses to self-report measures have been shown to vary according to the mode of data collection (i.e. via telephone versus face-to-face interviews). The importance of understanding what indicator data can and cannot denote was emphasised in the literature sourced. For example, indicators that measure discrimination among people with a diagnosed mental health condition may not signify whether the discrimination was perceived to be due to a person's mental health condition or due to another factor.

Outcome domain 2

The majority of outcome/proxy outcome indicators deemed relevant to this domain were categorised under outcome 2(a) ('All service users have access to timely, evidence informed interventions'). Two themes of direct outcome indicators of access to timely mental health care were identified. The first includes outcome indicators that focus directly on the level of access individuals have to mental health care (e.g. 'Population access to clinical mental health care') as well as indicators of the proportion of a population that has been able to access a particular type of mental health care over a given time period (e.g. 'Early intervention for mental health and substance use among children and youth'). The second theme includes outcome indicators of the timeliness of mental health services, including wait times (e.g. 'Wait times for community mental health counselling') and time-to-treatment indicators, which measure the proportion of a population that has been able to access treatment or an assessment for a particular mental health condition within a specified period of time (e.g. 'Percentage of children and young people with eating disorders seen within 1 week (urgent)'). In addition, two themes of indirect outcome indicators of access to timely mental health care were identified. The first theme includes indicators of unmet need (e.g. 'Unmet need for mental health care among people with mental disorders'), which provide an indirect picture of service access by identifying gaps in the mental health care system's ability to meet mental health care demands. The second theme is a miscellaneous theme containing five

indicators that did not fit into any of the previously defined themes and which lacked sufficient similarity to form a new theme (e.g. 'Mental health new client index' and 'Mental health service use by selected equity groups'). The 'evidence informed' dimension of outcome 2(a) was not covered by any of the included indicators from the five selected countries and the OECD.

Only one overarching outcome indicator theme was identified for outcome 2(b) ('Service delivery is organised to enable increased numbers of people to achieve personal recovery'); this was patient recovery outcomes, and it included indicators of patient-reported and clinician-observed mental health and recovery outcomes following treatment for a mental health condition (e.g. 'Mental health outcomes of consumers of specialised public mental health services'). The service organisation dimension of this outcome was more appropriately captured by service quality indicators. A total of three overarching outcome indicator themes were identified for outcome 2(c) ('Services are coordinated through a 'stepped care' approach to provide continuity of care that will deliver the best possible outcomes for each service user'). The first is patient recovery outcomes, which predominantly includes the same indicators of patient-reported and clinician-observed mental health and recovery outcomes as outcome 2(b). The remaining two overarching outcome indicator themes identified for outcome 2(c) represent direct indicators of the outcomes that can be expected when continuity of care is optimal. The first represents outcomes of good care continuity between the different tiers of the mental health service (e.g. 'Post-discharge community mental health care'), and the second represents outcomes of good care continuity between physical and mental health services (e.g. 'Physical health outcomes for people with a mental illness'). The care continuity dimension of this outcome was also captured by service quality indicators. There were no outcome or quality indicators deemed relevant to outcome 2(d) ('Health outcomes for people with dual diagnosis are improved by ensuring greater collaboration between mental health and other relevant services'). This is likely due to the model of mental health services in Ireland, which departs from the international classification system by not including substance use disorders among the categories of mental health problems covered by Ireland's mental health system. Under this model, the responsibility of care for individuals with substance use disorders is delegated away from the mental health service to separate services that operate with their own distinct funding structure in the Irish healthcare system.

In relation to indicator benefits and limitations, we identified four common limitations of the indicators deemed relevant to outcome domain 2 (no explicit benefits of the indicators that were deemed relevant to outcome domain 2 were described in the literature sourced):

1. The importance of recognising what indicator data can and cannot denote
2. Limitations associated with indicator data collection (i.e. the use of surveys and self-report measures to collect data and the collection of data from regional or provincial (or other equivalent) systems to form national-level indicators)
3. The coverage of mental health disorders in indicator data (i.e. failure to include data for individuals diagnosed with certain mental health conditions in indicator results), and
4. Indicator results based only on State-provided mental health services (i.e. the exclusion of data from users of services other than public mental health services, which may impact on the accuracy of the findings).

The distinction between outcome indicators and quality indicators is an important one, and care should be taken when identifying whether indicators – either newly developed or co-opted for a particular purpose – represent a measure of a given outcome or a measure of service quality.

Outcome domain 3

The overarching outcome indicator themes identified for outcome 3(a) ('Service users are respected, connected, and valued in their community') were: stigma and discrimination (e.g. 'Experience of discrimination in people with mental illness'), sense of belonging (e.g. 'Connectedness and meaning in life'), and social functioning (e.g. 'Social participation in adults with mental illness'). Measures of stigma and discrimination experienced by people with mental health conditions speak to the extent to which people with such conditions do or do not feel respected and valued in their community, and measures of social functioning (social participation) provide insight into how connected people with mental health conditions are to their community. The overarching indicator themes identified for outcome 3(b) ('Increased ability of service users to manage their own lives [self-determination] via stronger social relationships and sense of purpose') speak to the pathways through which self-determined recovery can be achieved, namely through strengthened social relationships and sense of purpose. These themes, which overlap to some degree with the indicator themes identified for outcome 3(a), were: sense of belonging (e.g. 'Sense of belonging – people with mental health conditions'), social functioning (e.g. 'Percentage of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month'), and improved quality of life (e.g. 'Recovery in quality of life for patients with mental illness'). In relation to outcome 3(c) ('Improved outcomes in relation to education, housing, employment, and income for service users relative to the population as a whole (i.e. reduced disparity)'), the first overarching outcome indicator theme identified was socioeconomic functioning, which includes indicators that measure the proportion of people with mental health conditions who are in employment (or education or training), with suitable housing, and with sufficient income compared with those without mental health conditions (e.g. 'Proportion of adults in contact with secondary mental health services in paid employment'). The second outcome indicator theme was socioeconomic satisfaction, which includes indicators that assess the extent to which people with mental health conditions are satisfied with their employment, financial, and housing status (e.g. 'Employed and satisfied with job').

Limited information pertaining to the benefits and limitations of the indicators included under outcome domain 3 was provided in the literature sourced. However, as with outcome domains 1 and 2, the importance of understanding what indicator data can and cannot denote was also a recurring limitation of the indicators deemed relevant to outcome domain 3.

Outcome domain 4

There were no outcome or quality indicators deemed relevant to outcomes 4(a) ('Mental health is embedded as a national cross cutting priority that is effectively integrated into the key policies and settings in society') or 4(b) ('Dynamic performance reporting provides visibility of the performance and impact of *Sharing the Vision*'). The majority of all indicators deemed relevant to this domain were categorised under outcome 4(c) ('Services that deliver consistently high-quality person-centred supports that meet the needs and have the confidence of service users and family, carers, and supporters'). In relation to outcome/proxy outcome indicators, we identified one overarching outcome indicator theme, which was patient and carer experience (e.g. 'Patient experience of community mental health services'). Other aspects of this outcome, such as involuntary detention, restrictive practices, and patient safety, were more appropriately captured by service quality indicators. No outcome/proxy outcome indicators were considered relevant to outcome 4(d) ('Continuous improvement is future focussed and driven by adequately resourced innovation across the mental health system and related sectors'). Some aspects of this outcome, such as the provision of services that meet national standards, were more appropriately captured by service quality indicators.

The note in relation to outcome domain 2 regarding the inclusion of both outcome and quality indicators and the distinction between these types of indicators also applies to, and should therefore be considered in relation to, outcome domain 4.

Limited information pertaining to the benefits and limitations of the indicators included under outcome domain 4 was provided in the literature sourced. However, like the previous three outcome domains, the importance of understanding what indicator data can and cannot denote was also a recurring limitation of the indicators deemed relevant to outcome domain 4. The collection of data from regions or provinces (or other equivalent) was also a recurring limitation of the indicators deemed relevant to outcome domain 4 because data collection from regional or provincial (or other equivalent) systems may result in gaps in data coverage, and methodologies for data collection may vary across jurisdictions within a country, which may impact on the validity of the indicator results.

Monitoring and evaluation

Only 7 out of the 18 indicator sets described in this evidence brief were developed or co-opted to measure the priorities or actions set out in a mental health policy; this includes all 4 of the indicator sets from England, and 1 indicator set each from Australia, Canada, and New Zealand. Despite this, none of the included countries or the OECD implemented an official system or framework by which the indicator sets would be used to monitor the progress and/or evaluate the overall performance of the relevant mental health strategy. However, Australia, Canada, and England have made some progress in this regard.

In Australia, four progress reports on *The Fifth National Mental Health and Suicide Prevention Plan* (known as The Fifth Plan) have been published as of September 2023, with the first establishing a baseline for each of the 24 performance indicators against which subsequent reporting measured performance of The Fifth Plan. The indicators have a dedicated section in each of the progress reports, which provides an update on the status of the indicators and a broad overview of indicator limitations. Selected high-level analyses are provided for the available indicators, with commentary on trends over time and progress towards the desired outcomes. Additional data and information on performance trends over time are made available alongside each progress report in a downloadable Excel spreadsheet. However, implementation of The Fifth Plan was expected to finish in 2022, and at the time this evidence brief was completed in September 2023, there had not yet been a progress report published for the year 2022, or public mention of an official evaluation of the overall performance and impact of The Fifth Plan using the indicators.

A colour system was adopted for the indicator sets in Canada and England. In Canada, each of the 55 mental health indicators in *Informing the Future: Mental Health Indicators for Canada* (which was published in 2015) was assigned a colour in order to illustrate its status (green to indicate good performance; yellow to indicate no change, some concern, or uncertain results; and red to indicate significant concerns). However, the 2015 report appears to be the first and only official report on this set of mental health indicators, and it appears as though the use of the traffic light system is limited to assessing the performance of the individual indicators, rather than assessing the use of the indicators to monitor or evaluate the progress and performance of the national mental health strategy (*Changing Directions, Changing Lives: The Mental Health Strategy for Canada*) as a whole. In England, the colour system used in each quarterly publication of the National Health Service (NHS) mental health dashboard indicates whether the performance of certain indicators is better (green circle) or worse (red circle) than the national standard set for those indicators in *The Five Year Forward View for Mental Health* and subsequently in *The NHS Long Term Plan.* However, the literature sourced on the NHS mental health dashboard for this evidence brief did not provide any insight into whether action is taken in response to indicators with red circles, or the nature of any action that may be taken.

Conclusions

This evidence brief set out to describe a range of example indicators for measuring the high-level outcomes described in outcome domains 1, 2, and 3 (with the exception of outcome 2(d), which focused on health outcomes for people with dual diagnosis). In the context of outcome domain 1, capturing the risk and protective factors for mental health outcomes (i.e. mental health determinants) will be a key step in evaluating the performance and impact of the actions set out in *Sharing the Vision* regarding mental health promotion and early intervention. Certain aspects of some of the high-level outcomes, particularly those under outcome domain 2, were quality-related outcomes, and would therefore be most appropriately captured using both service quality and mental health outcome indicators. The collection of outcome indicators identified in relation to outcome domain 3 are a good foundation from which to develop a set of outcome indicators that accurately and reliably capture people's progress in mental health recovery. However, we found relatively few outcome indicators relevant to the high-level outcomes in outcome domain 4. Therefore, it may be necessary to look beyond the mental health sphere in order to gain insights for assessing accountability and continuous improvement in the mental health system.

Understanding the limitations of indicator data, specifically what indicator data can and cannot denote, is critically important when developing and applying any set of indicators; what indicators could not reflect was the most common limitation described in the literature sourced for this evidence brief, which was unsurprising given that mental health outcome measurement is still an emerging area in policy development. The infancy of mental health outcome measurement is also reflected in the observation that, while much is being measured in the mental health arena internationally, the interpretation of indicators in order to make data-driven adjustments to planned policy-led actions and assess the safety and effectiveness of mental health policy in achieving the desired outcomes is limited.

1 Introduction

According to the World Health Organization (WHO), the prevalence of mental health conditions is increasing worldwide. One in every eight people in the world – almost 1 billion people – lives with a mental health condition [1]. Mental health conditions are associated with an increased risk of death by suicide [2], comorbid physical illness [3], and poor clinical outcomes in several physical diseases, including diabetes mellitus and cancer [4]. The 2019 Global Burden of Disease study attributed nearly 15% of life years lost to mental health conditions, making mental ill health one of the top 10 leading causes of disability worldwide [5].

Data from the Organisation for Economic Co-operation and Development (OECD) indicate that the prevalence of mental health conditions in Ireland is relatively high compared with other countries in the European Union [6]. Recent survey data suggest that over 40% of adults in Ireland may meet the criteria for a mental health condition [7], with estimates ranging from one in 6 to one in 10 people in Ireland having a lifetime history of attempted suicide [7,8]. Rather than merely the absence of a mental disorder, the WHO defines mental health as a state of mental and psychological well-being [1]. Yet, the results of the Healthy Ireland Survey 2021 suggest that population well-being in Ireland is declining over time, particularly among women and people aged 45–64 years [9].

In its *Comprehensive Mental Health Action Plan 2013–2030*, the WHO underscored the importance of mental health policies in strengthening effective leadership and governance for mental health, stating, "Mental health, like other aspects of health, can be affected by a range of socioeconomic factors…that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach" [10 p2]. The overall goal of that Action Plan is "to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders" [10 p4]. Among the 10 global targets set out is Global Target 1.1, which sets the goal that by 2030, "80% of countries will have developed or updated their policy or plan for mental health in line with international and regional human rights instruments" [10 p7]. This spurred an increase in either the formulation or updating of mental health policies, plans, and strategies internationally [11]. However, the development and implementation of a national mental health policy ultimately carries with it a responsibility to critically evaluate the outcomes and impacts of said policy [12]. Accordingly, Global Target 4.1 in the WHO's *Comprehensive Mental Health Action Plan 2013–2030* sets the goal that by 2030, "80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems" [10 p14].

1.1 Definition of outcome indicators

Outcome indicators are essential tools for monitoring and evaluating the performance or desired outcomes of any policy, including health-related policy [13,14]. Indeed, they have been described as the most important type of indicator for policy evaluation because they "can be used as a tool to examine the effects of policies and they provide crucial information for policy makers to judge the effectiveness of policies and to make adjustments where required" [13 p5]. If the desired outcomes represent the underlying motivation of a policy, outcome indicators can be considered the instruments through which the effectiveness of a policy in achieving the desired outcomes can be evaluated [13]. However, outcome indicators are just one type of indicator that can be used to support the monitoring and evaluation of a policy or system;

Table 1 outlines the collection of indicators that there are most commonly collected and analysed in monitoring and evaluation processes.

Table 1 Different types of indicators identified in mental health literature

Type of indicator	Description
Input indicators	Refer to the resources required for the implementation of an action or intervention (or policy) [15].
Process indicators	Measure whether a planned action or intervention took place [15].
Output indicators	Describe the delivery of products (e.g. the provision of training, the creation of standards, the hiring of required staff); measure the 'what' [13,15].
Outcome indicators	Measure whether an action (or policy) is achieving the expected effects/changes in the short, intermediate, and long term; measure the 'why' [13,16].
Performance indicators	Demonstrate progress towards achieving a particular outcome, goal, standard, or target within a specified time frame [17]. Can be considered cross-cutting indicators as they measure the performance of an action or intervention in relation to inputs, outputs, or outcomes [18].
Quality indicators	Evidence-based, standardised tools that measure healthcare quality and provide information about the effectiveness, safety, and people-centredness of care [19,20].

Outcome indicators can be used to evaluate changes in mental health outcomes at a local and population level, as well as among particular groups (e.g. people who use mental health services), following the implementation of actions set out in a national policy. However, developing a comprehensive set of indicators aimed at monitoring and evaluating the performance or outcomes of any policy requires long-term planning and investment [21]. Outcome indicators must be valid and reliable, sensitive to change, comparable across relevant groups and settings, and capable of clearly conveying the magnitude of change achieved [22]. The supporting documentation for the Public Health Outcomes Framework in England (see Section 3.3.1.134) outlines the following essential (required for all indicators) and desirable (use wherever possible) criteria for the identification of appropriate outcome indicators [23]:

- Essential:
  - Clarity (i.e. clear in what it measures)
  - Rationale (i.e. addresses a particular policy issue or draws attention to a particular outcome)
  - Relevance (i.e. is relevant to policy and/or actions required in order to bring about change)

- Attributable (i.e. measures progress directly linked to interventions/actions)
- Interpretation (i.e. is meaningful to the intended audience(s))
- Validity (i.e. has a clear definition, is methodologically and technically sound, and is available from a reliable data source, making it meaningful and sustainable)
- Construction (i.e. there is transparency around how the indicator has been tested and justified, and in the methods used to support the stated purpose of the indicator)
- Risks (i.e. limitations, risks, or perverse incentives are identified and described with any mitigating measures)
- Availability (i.e. collected at sufficient level of geographical or organisational division), and
- Affordability and value for money (i.e. provides benefits without excessive costs, and if new challenges arise, they will be evaluated and supported by sustainable funding).

- Desirable:

- Timeliness (i.e. it is possible to update frequently (ideally can be reported quarterly) and minimise the time delay in data availability (ideally less than 1 year))
- Comparable (i.e. can be meaningfully compared with suitable domestic or international metrics)
- Disaggregates (i.e. can be broken down by equality/inequality characteristics in order to measure impacts on or outcomes for different groups), and
- Supports alignment (i.e. can be used across the health and care sector).

1.2 Policy context

Ireland's national mental health policy, *Sharing the Vision: A Mental Health Policy for Everyone* (henceforth referred to as simply *Sharing the Vision*), was published in 2020 with the aim of enhancing the provision of mental health services and supports across a broad continuum – from mental health promotion, prevention, and early intervention to acute and specialist mental health service delivery – during the period 2020–2030 [24]. The policy is organised around 4 core outcome domains consisting of a total of 15 high-level outcomes, as shown in the outcomes framework depicted in Figure 1. The policy encompasses a total of 100 recommendations and associated actions, which are linked to these high-level outcomes.

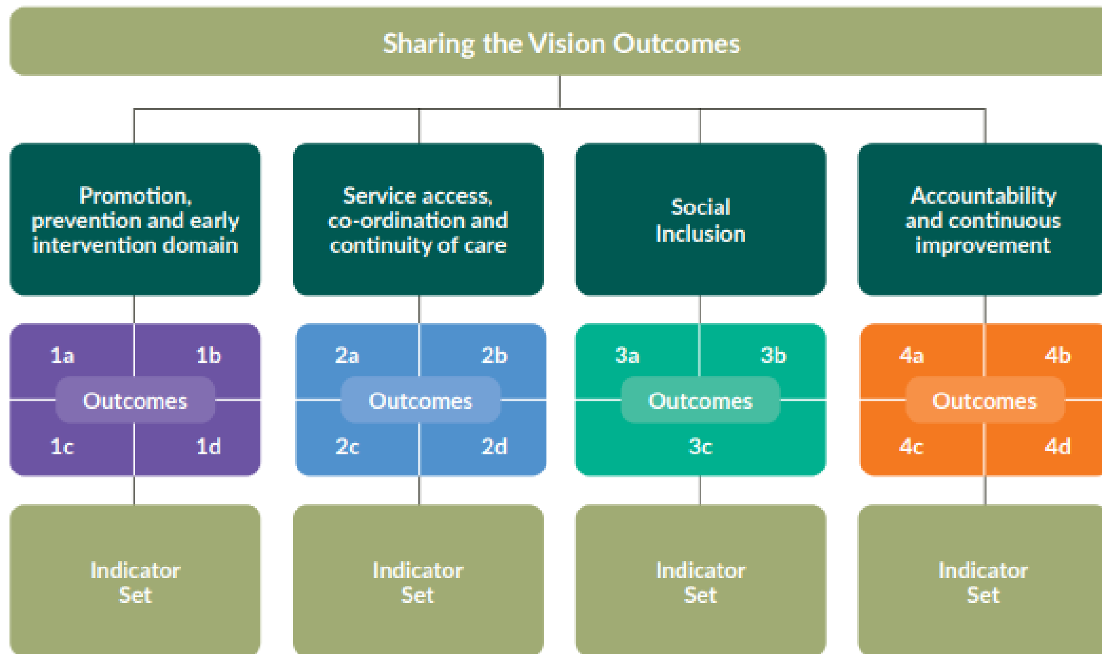

Figure 1 Outcomes framework for Sharing the Vision

Source: Government of Ireland, 2020

The high-level outcomes under each outcome domain identified in *Sharing the Vision* are as follows:

1. Domain 1: Promotion, prevention, and early intervention:
   a) Positive mental health, resilience and psychological wellbeing amongst the population as a whole
   b) Positive mental health, resilience, and psychological wellbeing amongst priority groups…through targeted promotion and preventive mechanisms
   c) Reduced stigma and discrimination arising through improved community wide understanding of mental health difficulties, and
   d) Reduced prevalence of mental health difficulties and/or reduced severity of impact(s) through early intervention and prevention work.
2. Domain 2: Service access, coordination, and continuity of care:
   a) All service users have access to timely, evidence informed interventions
   b) Service delivery is organised to enable increased numbers of people to achieve personal recovery
   c) Services are coordinated through a 'stepped care' approach to provide continuity of care that will deliver the best possible outcomes for each service user, and
   d) Health outcomes for people with dual diagnosis are improved by ensuring greater collaboration between mental health and other relevant services.
3. Domain 3: Social inclusion:
   a) Service users are respected, connected, and valued in their community
   b) Increased ability of service users to manage their own lives [self-determination] via stronger social relationships and sense of purpose, and

   c) Improved outcomes in relation to education, housing, employment, and income for service users relative to the population as a whole (i.e. reduced disparity).

4. Domain 4: Accountability and continuous improvement:
   a) Mental health is embedded as a national cross cutting priority that is effectively integrated into the key policies and settings in society
   b) Dynamic performance reporting provides visibility of the performance and impact of *Sharing the Vision*
   c) Services that deliver consistently high-quality person-centred supports that meet the needs and have the confidence of service users and family, carers, and supporters, and
   d) Continuous improvement is future focussed and driven by adequately resourced innovation across the mental health system and related sectors.

This evidence brief was requested by the Department of Health Mental Health Unit to inform the development of a set of mental health policy outcome indicators in Ireland. The scope of the project and the specific research questions were finalised following collaborative discussions between the Health Research Board (HRB) Evidence Centre and the Department of Health Mental Health Unit. It is hoped that the findings of this evidence brief will enable the Department of Health and the National Implementation and Monitoring Committee of Sharing the Vision to fully understand and analyse the outcomes of implementation and the true impact of the national policy on people who use mental health services in Ireland and on mental health promotion strategies affecting the wider community.

1.3 Aim and research questions

The aim of this evidence brief is to describe mental health outcome indicators used internationally as part of an initial scoping exercise in order to inform the development of a set of outcome indicators for assessing the impact of *Sharing the Vision*, Ireland's national mental health policy. Specifically, this evidence brief addresses the following questions:

1. What indicators are used internationally to monitor and evaluate similar outcomes to those identified in *Sharing the Vision*?
2. What are the reported benefits and challenges regarding the use of these indicators for mental health policies/plans/strategies?
3. How are these indicators used to monitor and evaluate mental health policies/plans/strategies?

2 Methods

2.1 Methodological approach

The methodology used to provide an overview of mental health outcome indicators, their benefits and limitations, and how they are used to monitor and evaluate mental health policies, plans, or strategies was to:

- Select a representative sample of countries and transnational organisations.
- Search the literature for national and transnational mental-health-related policies, plans, or strategies; indicator sets; outcomes frameworks; performance frameworks; and national surveillance systems or frameworks.
- Extract data relevant to the research questions outlined in Section 1.3.
- Categorise the extracted data under the most relevant *Sharing the Vision* outcome domain(s) and high-level outcome(s).
- Describe the nature, including the benefits and limitations, of the indicators categorised under each high-level outcome.
- Analyse the collection of indicators deemed relevant to each high-level outcome and identify those that could be used as outcome indicators for *Sharing the Vision*, regardless of how they have been identified in their respective indicator sets.
- Summarise the outcome indicators deemed relevant to each high-level outcome within overarching indicator themes.
- Identify if/how each indicator set, framework, etc. is used to monitor and evaluate the relevant mental health policy.

The literature sourced was not assessed for quality, as quality assessment is beyond the remit of an evidence brief; rather, the information is presented as is, without critical appraisal. That is, information is included as presented and described for the selected countries and organisations, with the possibility that further information may exist.

2.2 Search strategy

Given the nature of the research questions for this evidence brief, it was considered unlikely that relevant source documents would be found primarily in traditional bibliographic database sources or that a traditional approach to searching would yield relevant results. Consequently, this evidence brief relied primarily on grey literature published by governments, statutory agencies, health systems, and independent organisations.

2.2.1 Grey literature

One of the commonly used definitions of grey literature is the Prague definition:

> Grey literature stands for manifold document types produced on all levels of government, academics, business and industry in print and electronic formats that are protected by intellectual property rights, of sufficient quality to be collected and preserved by library holdings or institutional repositories, but not controlled by commercial publishers, i.e. where publishing is not the primary activity of the producing body. [25]

Broad searches were undertaken using the Google and Google Scholar search engines. Search results were screened for relevance to the research questions. Relevant documents were retained for inclusion and relevant organisations were identified for additional targeted searching. Websites identified by the search engine searches were searched using the websites' own search engines, and available publication lists were screened for relevant documentation. We also contacted the relevant organisations or agencies in the selected countries in order to access additional information where it was not available in the literature sourced.

Relevant material was imported into Zotero reference management software; when necessary, full texts were obtained for the purpose of data extraction.

2.3 Country selection and inclusion

To begin with, a representative sample of European, North American, and Oceanic countries, as well as transnational organisations, was identified in order to conduct scoping searches for existing or previously implemented mental health policies, plans, or strategies that may have published progress reports or evaluations. Specifically, we scoped the available literature in 16 English-speaking and non-English-speaking countries (Australia, Austria, Canada, Denmark, England, Finland, France, Germany, Italy, the Netherlands, New Zealand, Northern Ireland, Norway, Scotland, Spain, and Sweden) and 3 transnational organisations (the European Commission, the WHO, and the OECD). The majority of the 16 countries were profiled in a 2017 literature review conducted by Cullen and McDaid to inform the parameters of *Sharing the Vision* [26].

During the scoping phase, we paid attention to which countries/organisations had published national/transnational mental health policies, plans, or strategies (regional policies were not considered), particularly those with progress reports and/or evaluations that would likely describe the use of outcome indicators to track the progress and impact of the policy/plan/strategy. We also searched for established mental health indicator sets, outcomes frameworks, performance frameworks, and national surveillance systems or frameworks that may not necessarily be linked to a mental health strategy but may include indicators relevant to the high-level outcomes described in *Sharing the Vision*. Following scoping, a final sample of five countries and one transnational organisation was selected for inclusion in this evidence brief based on the nature and accessibility of the information we obtained during scoping. These are:

1. Australia
2. Canada
3. England (United Kingdom (UK)
4. New Zealand
5. Scotland (UK), and
6. The OECD.

The five selected countries were described by the *Sharing the Vision* Oversight Group as having "well-developed and well-resourced mental health outcome infrastructures that moved from a focus on the volume of services delivered to the value created for service users" [24 p15].

2.4 Indicator selection and inclusion

We searched for relevant mental health indicator sets, frameworks, etc. (henceforth referred to as simply 'indicator sets') to extract from each of the included countries and the OECD and categorised the information appropriately. While we prioritised the identification of outcome indicators, we did not limit

our searching only to those indicators with the specific title of ‘outcome indicators’. That is, we included any collection of mental-health-related indicators in this evidence brief if they were considered relevant to one or more of the 15 high-level outcomes described in *Sharing the Vision*. We took this decision because the nomenclature of certain indicators can vary across different indicator sets depending on the context; an output or quality indicator in one indicator set may be used as an outcome indicator in another indicator set if, for example, the first indicator set was developed to measure the performance of a health service and the second indicator set was developed to measure the impact of a health-related intervention. In addition, mental health outcome measurement, particularly as it relates to policy development and evaluation, is an emerging area [27], and it became evident during our initial scoping that many indicators in the area of mental health are not identified using terminology typically found in monitoring and evaluation literature (i.e. output indicator, outcome indicator, etc.). Therefore, excluding indicator sets or frameworks simply because they did not explicitly describe indicators as ‘outcome indicators’ would have limited the scope and subsequent utility of this evidence brief.

2.5 Data extraction

The indicators in each indicator set were extracted into a bespoke extraction sheet in Microsoft Excel and then categorised under one or more of the 15 high-level outcomes described in *Sharing the Vision*. For each indicator, we sought to extract the following pieces of information: the indicator definition, rationale (when relevant), data source, reporting frequency, disaggregation, and any indicator benefits and limitations. However, not all of these information components were reported or readily available for every indicator. This is particularly true in relation to indicator benefits and limitations, which were often not explicitly described. In addition, we intentionally did not extract and report the following information:

- Indicator limitations or caveats related to how cybersecurity attacks or COVID-19 may have affected indicator calculation or reporting; we considered these situational limitations unconnected to the nature and implementation of the indicators themselves.
- Technical information such as indicator calculation methodologies. The aim of this evidence brief is to provide an overview of mental health indicators used internationally. Once a preliminary set of indicators to monitor and evaluate the performance and impact of *Sharing the Vision* has been identified, attention can then be directed to specific considerations such as how to develop, test, calculate, and assure the quality of each indicator.

Indicators that focused on the following topics or groups were not extracted because they are not prioritised in *Sharing the Vision*:

- Drug and alcohol use
- Suicide and self-harm (except for indicators that focused on the occurrence of suicide or self-harm within acute mental health settings, which were included)
- Neurocognitive disorders (e.g. various forms of dementia)
- Mental health outcomes in carers of people with mental ill health
- The mental health workforce, and
- The costs of mental health services.

2.6 Indicator categorisation

Before categorising each indicator, we studied each outcome domain chapter in *Sharing the Vision* in order to gain a more nuanced understanding of the outcome domains and a sense of the types of

indicators that would be appropriate for measuring the high-level outcomes within each domain. We also paid attention to the recommendations and actions set out in the policy, particularly to which high-level outcome the recommendations and actions have been linked to (this information is provided in Appendix III of *Sharing the Vision* [24]).

When categorising each indicator into one or more of the 15 high-level outcomes described in *Sharing the Vision*, we were primarily guided by the indicator definitions and rationales described in the literature sourced, where possible. However, indicator definitions and rationales were occasionally quite brief or not available. In these cases, we categorised indicators according to:

1. The title of the high-level outcome in *Sharing the Vision*
2. The actions and recommendations to which the outcome has been linked in *Sharing the Vision*, and
3. The types of indicators that we had already categorised under that outcome.

Some indicators were considered relevant to more than one high-level outcome and were categorised as such.

2.7 Indicator analysis

As outlined in Section 2.4, indicators in the area of mental health are sometimes not described using terminology typically found in monitoring and evaluation literature. For example, some indicators included in this evidence brief were referred to as 'mental health indicators' rather than outcome or output indicators. In addition, other indicators were described as 'performance indicators', which, as described in

Table 1, are cross-cutting indicators that can measure the performance of an action or intervention in relation to inputs, outputs, or outcomes. It is also the case, as described in Section 2.4, that the nomenclature of certain indicators can vary across different indicator sets depending on the context. Recognising these factors, we considered it both appropriate and necessary to review all the indicators included in this evidence brief in order to determine which could be used as indicators of the high-level outcomes under which they have been categorised, regardless of how they were identified in their respective indicator sets. For this analysis stage of the evidence brief, we took the following approach for each of the 15 high-level outcomes described in *Sharing the Vision*:

1. We identified the indicators that were explicitly described as outcome indicators.
2. We reviewed the remaining indicators and identified those that represented indicators of the high-level outcome, regardless of how they were identified in their respective indicator sets, and classified these indicators as 'proxy outcome indicators'.
3. We reviewed all outcome and proxy outcome indicators under the high-level outcomes and identified overarching indicator themes for groups of indicators. For example, under outcome 1(a), all population-level indicators of positive mental health and well-being were consolidated into the overarching theme of positive mental health and well-being (see Section 3.11.1.1).

Once all outcome and proxy outcome indicators had been identified, we reviewed all remaining indicators under each high-level outcome and identified two other types of indicators that will be important to consider when measuring the performance and impact of *Sharing the Vision*. The first type is determinant indicators, which were particularly prominent in outcome domain 1 (the mental health promotion, prevention, and early intervention domain (see Section 3.7)) and, to a lesser extent, outcome domain 3 (the social inclusion domain (see Section 3.9)). Mental health determinant indicators capture the risk

and/or protective factors for mental health outcomes at the individual, family, community, and societal levels [28]. We included these indicators in the indicator analysis and summary for three reasons. First, *Sharing the Vision* is, above all, a 'whole-of-population' plan which aims to establish a mental health system that promotes prevention and early intervention and supports recovery from mental ill health [24]. Understanding and addressing the causal factors of mental ill health is perhaps the most important aspect of prevention work; in this sense, indicators of mental health determinants will be critical for measuring the impact of the population-level mental health promotion and prevention actions set out in *Sharing the Vision*. Second, we observed significant overlap between outcome and determinant indicators across the indicator sets we included under outcome domain 1, which was unsurprising given the nature of the four high-level outcomes in this domain. For example, indicators of loneliness were included as outcome indicators in some indicator sets and as determinant indicators in other indicator sets, likely because loneliness can be considered both an outcome to be measured and a determinant of mental health outcomes. Third, some aspects of outcome domains 1 and 3 were more appropriately captured as determinant indicators in the included indicator sets (for example, the resilience-related indicators in outcomes 1(a) and 1(b), and the employment gap indicators in outcome 3(c)). For these reasons, once all outcome/proxy outcome indicators in outcome domains 1 and 3 had been identified, we retained the indicators explicitly described as determinant indicators. We then reviewed the remaining indicators under these outcome domains and identified those that represent determinant indicators of mental health outcomes, and we classified these indicators as 'proxy determinant indicators' regardless of how they had been identified in their respective indicator sets.

The second type of indicator is quality indicators, which were prominent indicators in outcome domain 2 (the mental health service domain (see Section 3.8)) and outcome domain 4 (the accountability and continuous improvement domain (see Section 3.10)). Quality indicators measure the quality and safety of healthcare and are considered valuable tools by which to measure the performance of healthcare services and expose quality and safety issues in healthcare service delivery [29]. We included these indicators in the indicator analysis and summary primarily because some aspects of outcome domains 2 and 4 were more appropriately captured as quality indicators. Specifically, outcome domain 2 emphasises the importance of improved service organisation and coordination in order to ensure the best possible outcomes for people with mental ill health. Apart from patient-related outcome indicators, we found very few outcome or proxy outcome indicators that captured health service organisation and coordination, likely because these service attributes are primarily captured using service quality indicators. Outcome domain 4 emphasises the importance of ensuring positive patient experiences of mental health services, which can be appropriately captured as outcome indicators. However, this domain also emphasises patient safety and the provision of services that meet quality standards, which again are primarily captured as service quality indicators. For these reasons, once all outcome/proxy outcome indicators in outcome domains 2 and 4 had been identified, we retained the indicators that were explicitly described as quality indicators. We then reviewed the remaining indicators under these two outcome domains and identified those that represent quality indicators of mental health services, and we classified these indicators as 'proxy quality indicators' regardless of how they had been identified in their respective indicator sets.

After identifying all outcome/proxy outcome and determinant/proxy determinant indicators in outcome domains 1 and 3, and all outcome/proxy outcome and quality/proxy quality indicators in outcome domains 2 and 4, most of the few remaining indicators were classified as output indicators, which were then excluded from the indicator themes and high-level outcome summaries as they merely describe the delivery of agreed products [15] (see Section 1.1). Section 3.11 in the findings chapter of this report summarises the overarching indicator themes that we identified under each high-level outcome.

3 Findings

We extracted and categorised indicators from a total 18 indicator sets from the 5 selected countries and the OECD: 3 from Australia (Section 3.1), 4 from Canada (Section 3.2), 4 from England (UK) (Section 3.3), 3 from New Zealand (Section 3.4), 3 from Scotland (UK) (Section 3.5), and 1 from the OECD (Section 3.6). Five of these indicator sets (one in Canada, three in England, and one in Scotland) are not specific to mental health and well-being but were included in this evidence brief because they contain sub-domains or sub-dimensions that are related to mental health. These are identified throughout this findings chapter. Indicators that were not deemed relevant to any of the high-level outcomes described in *Sharing the Vision* (e.g. non-mental-health-related indicators in indicator sets that are not specific to mental health) were excluded. However, they are identifiable in tab 1 ('All_Indicators') of the supplementary Excel spreadsheet provided with this evidence brief. The collection of indicators that the HRB deemed relevant to each of the 15 high-level outcomes described in *Sharing the Vision* are outlined in tab 2 ('HRB_Selected_Indicators') of the supplementary Excel spreadsheet. The results of our analysis of the collection indicators under each high-level outcome to identify outcome/proxy outcome, determinant/proxy determinant, and quality/proxy quality indicators are outlined in tabs 3–6 ('HRB_Analysis_Summaries' for domains 1–4).

In total, 9 out of the 18 indicator sets include indicators that are explicitly described as 'outcome indicators' or could confidently be interpreted as outcome indicators, given that they are included in outcomes frameworks or developed to measure progress against agreed national outcomes or assess the progress of an outcomes-based national mental health strategy [30–38] (one of these indicator sets includes indicators referred to as 'mental health indicators' [31]). Four out of the 18 indicator sets include indicators that are explicitly described as 'performance indicators' or 'benchmarking indicators' [21,27,39,40]. Of these, one set was developed to monitor the performance of a national mental health strategy [21], two sets were developed to assess the performance of mental health services [39,40], and one set was developed to measure mental health system performance across OECD countries [27] (as noted in Section 2.4, we included any collection of mental-health-related indicators in this evidence brief if they were considered relevant to one or more of the 15 high-level outcomes described in *Sharing the Vision*). One indicator set includes indicators that are not referred to as any particular type of indicator (e.g. outcome indicator, performance indicator, quality indicator, etc.). However, the indicators in this set appear to be performance indicators are they were developed to assess the performance of a national mental health service in delivering the targets set out in two national health strategies [41]. Two indicator sets include indicators that are referred to as 'mental health and addiction/substance use indicators' [42,43]; the indicators in one of these sets appear to be outcome indicators, as they are reported against a set of national mental health outcomes [43], whereas the indicators in the other set appear to be quality indicators for mental health and substance use services [42]. One indicator set includes indicators identified as 'quality indicators' for mental health services [44]. The final indicator set includes indicators that are referred to only as 'chronic disease indicators' [45], and which estimate the burden of chronic conditions and associated determinants. Three of the indicator sets that include indicators explicitly described as outcome indicators also include determinant indicators [32,33,37], which were considered important in relation to outcome domains 1 and 3 as they capture the risk and/or protective factors for mental health outcomes at the individual, family, community, and societal levels. The types of indicators included in each indicator set are specified throughout this findings chapter and in the supplementary Excel spreadsheet.

This chapter commences by providing a concise overview of the relevant mental health policy/plan/strategy in each of the selected countries (note that the OECD does not have a transnational

mental health policy). This is accompanied by a description of the indicator sets within each country and the OECD that were selected for the purposes of this evidence brief. The main body of this chapter is structured around the four outcome domains and the high-level outcomes within each domain outlined in *Sharing the Vision* (see Section 1.2). Under each high-level outcome, we first identify and describe the indicators from each indicator set that were deemed relevant to that outcome, and then describe any documented benefits and/or limitations of those indicators. We then present the findings of our analysis of the collection of indicators categorised into each high-level outcome. The chapter concludes with an overview of how the relevant indicator sets have been or are currently being used to monitor and evaluate a national mental health policy, plan, or strategy.

3.1 Australia

3.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

In 2017, the Australian Government released *The Fifth National Mental Health and Suicide Prevention Plan* (known as 'The Fifth Plan'), which is the fifth national mental health strategy in Australia [21]. Building on the foundation of four previous national mental health strategies, as well as existing state and territory mental health and suicide prevention plans, The Fifth Plan established a national approach for collaborative government action to achieve outcomes in the following eight priority areas [21]:

1. Achieving integrated regional planning and service delivery
2. Effective suicide prevention
3. Coordinating treatment and supports for people with severe and complex mental illness
4. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
5. Improving the physical health of people living with mental illness and reducing early mortality
6. Reducing stigma and discrimination
7. Making safety and quality central to mental health service delivery, and
8. Ensuring that the enablers of effective system performance and system improvement are in place.

Included in The Fifth Plan is a set of 24 nationally agreed performance indicators, which were developed to measure the strategy's performance. Each indicator is linked to one or more of the eight priority areas outlined in the strategy. Their selection was guided by the National Mental Health Commission's 2014 report, *Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services* (the National Mental Health Commission is an independent Australian Government agency that monitors and reports on mental health services and systems and provides policy advice and evidence in order to improve mental health outcomes for Australians [46]). The indicators are categorised into the following seven domains [21]:

1. Healthy start to life
2. Better physical health and living longer
3. Good mental health and wellbeing
4. Meaningful and contributing life
5. Effective support, care and treatment
6. Less avoidable harm, and
7. Stigma and discrimination.

The indicators focus on different levels of population mental health status and mental health system performance, providing both a national view of the mental health and well-being of Australians and a more detailed picture of mental health services and of mental health in specific community groups. They range from measures of population-level mental health status (e.g. adults with very high levels of psychological distress) to measures of the process of mental health care (e.g. rates of follow-up after discharge from hospital). Under The Fifth Plan, a committee known as the Mental Health Information Strategy Standing Committee was given responsibility for identifying data sources and developing methodologies for the 24 performance indicators. As of 2021, this committee had completed work for 18 out of the 24 performance indicators: 10 monitoring the health and well-being of Australians, and 8 monitoring the performance of the mental health system against the 8 priority areas set out in The Fifth Plan [47].

The indicators allow state/territory and regional comparisons, and many also allow for outcomes to be reported separately for different age groups, gender identities, and biological sexes, and for Aboriginal and Torres Strait Islander peoples [21]. To date, four progress reports have been published (in 2018, 2019, 2020, and 2021), each of which presents updated data for the 18 performance indicators that have been fully developed and implemented [48]. The National Mental Health Commission website provides [48]:

- Annual progress report publications
- Downloadable Excel spreadsheets with supplementary data for the strategy's performance indicators, and
- A technical report providing the description, rationale, caveats, and key reporting information for each performance indicator in the 2020 progress report.

Detailed information about the calculation methodology and data sources for the indicators is provided in an online registry for Australian metadata standards for statistics and information in areas such as health, housing and homelessness, aged care, and disability, known as the Metadata Online Registry [49].

Implementation of The Fifth Plan was anticipated to be complete in 2022 [48]; however, as of completion of this evidence brief in September 2023, it is unclear whether the six remaining indicators will be reported on and if a final evaluation of The Fifth Plan is in progress or has been completed.

Of the 24 performance indicators included in The Fifth Plan, 19 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.1.2 The services for mental health performance indicator framework

The Productivity Commission is an advisory body that provides quality, independent advice and information to the Australian Government [50]. One of its core functions lies in performance monitoring and benchmarking, which results in the annual publication of the Report on Government Services to provide information on the equity, effectiveness, and efficiency of all government-provided services in Australia [51]. Each service area in the Report on Government Services has a unique performance indicator framework and a set of objectives against which the performance indicators report [52]. One such service area is mental health. Accordingly, the Productivity Commission's annual Report on Government Services includes a services for mental health report, which reports on the national, state, and territorial governments' management of mental health and mental illnesses [30].

Although not linked to The Fifth Plan (or any previous national mental health plans), the annual services for mental health report includes a mental-health-specific performance indicator framework that reports against the following objectives of the services for mental health [30]:

- To promote mental health and well-being, and, where possible, prevent the development of mental health problems, mental illness, and suicide, and
- When mental health problems and illness do occur, to reduce the impact (including the effects of stigma and discrimination), promote recovery and physical health, and encourage meaningful participation in society, by providing services that:
  - Are high quality, safe, and responsive to consumer and carer goals
  - Facilitate early detection of mental health issues and mental illness, followed by appropriate intervention
  - Are coordinated and provide continuity of care
  - Are timely, affordable, and readily available to those who need them, and
  - Are sustainable.

On the services for mental health web page of the annual Report on Government Services, the Productivity Commission presents a series of interactive tabs that provide [30]:

- The context, including a description of the overall objectives of the services for mental health in Australia
- A description of the performance indicator framework that reports against these objectives
- The indicator results, which are reported annually with downloadable Excel spreadsheets that contain annual data, calculation methodologies, and any relevant clarifications required for data interpretation
- The indicator results for Aboriginal and Torres Strait Islander people, and
- Explanatory material, including definitions of key framework terms and relevant references.

The Productivity Commission also provides a supporting document that includes indicator definitions and rationales, a description of which objective of the services for mental health each indicator is linked to, technical details defining how to measure each indicator, guidance on how each indicator should be interpreted, and a description of indicator caveats [53].

The services for mental health performance indicator framework distinguishes between outputs and outcomes: outputs are the services delivered, whereas outcomes are the impact of these services on the status of an individual or group [30]. In total, there are 6 service outcome indicators and 13 service output indicators, which are grouped under equity, effectiveness, and efficiency. The performance indicator framework is designed to reflect the process through which inputs are transformed into outputs and outcomes in order to achieve the desired objectives of the services for mental health [52].

Each annual Report on Government Services includes a description of the completeness (for the reporting period) and comparability (across time and jurisdictions) of data in each indicator [52]. In addition, the online interactive report platform allows users to view results by Indigenous status, remoteness area, and socioeconomic area [30].

Of the 19 output and outcome indicators included in the services for mental health performance indicator framework, 15 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

The *Key Performance Indicators for Australian Public Mental Health Services* was developed and first published in 2005 by the National Mental Health Performance Subcommittee in Australia with the aim of providing "a common language for describing service delivery and measuring performance and quality of care" [54]. The National Mental Health Performance Subcommittee was established to oversee the development and implementation of the National Mental Health Performance Measurement Framework in Australia, the objective of which is to improve health outcomes for Australians living with mental health conditions and ensure the sustainability of the Australian mental care health system [55]. The National Mental Health Performance Measurement Framework consists of the following three dimensions [55]:

1. Determinants of health
2. Health status, and
3. Health system.

The 'Health system' dimension in particular consists of six sub-domains, which the key performance indicators for Australian public mental health services were developed to report against. These are [55]:

1. Accessibility
2. Appropriateness
3. Continuity of care
4. Effectiveness
5. Efficiency and sustainability, and
6. Safety.

The *Key Performance Indicators for Australian Public Mental Health Services* is published by the Australian Institute of Health and Welfare, Australia's national agency for authoritative and accessible information and statistics on Australians' health and welfare [56]. Notably, the indicators are available in two subordinate indicator sets which are related but serve distinct purposes. These subordinate sets include the same indicators, but for many of the indicators, the indicator specification and calculation methodology vary depending on the level at which the indicator is being reported. One set is the 'service level' version, which is used for local benchmarking and service improvement initiatives (i.e. within jurisdictions, organisations, services, etc.), and the other set is the 'jurisdiction level' version, for which jurisdictional representatives prepare data for national submission and publication on the Australian Institute of Health and Welfare's website [54]. This evidence brief describes the jurisdiction level version of the *Key Performance Indicators for Australian Public Mental Health Services* [39].

In total, there are 16 key performance indicators for Australian public mental health services, which are collected and reported on annually [39]. Six of the indicators cannot be sourced from national data collections, so the data for these indicators are supplied annually from the Australian jurisdictions; eight indicators are calculated using existing national datasets; and two indicators are currently unavailable (these are identified in the relevant sections throughout Chapter 3 of this report) [39].

Each of the key performance indicators has a dedicated web page on the Australian Institute of Health and Welfare's website, which provides a description of the indicator, an indicator rationale, collection and usage attributes (i.e. the calculation methodology), and accountability attributes (i.e. information pertaining to reporting requirements, the organisation responsible for providing data, further data development/collection required, and indicator caveats) [39]. The Australian Institute of Health and Welfare also provides an interactive indicator results tool, which allows users to explore trends for each indicator over time, and a downloadable Excel spreadsheet, which includes annual results and data

breakdowns for each indicator (e.g. breakdowns by age, sex, target population, etc.) [57]. The most recent data available on the jurisdiction level performance indicators are from the financial year 2020–21 [39].

Of the 14 available key performance indicators for Australian public mental health services, 12 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.2 Canada

3.2.1 *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*

In 2012, the Mental Health Commission of Canada (a national non-profit organisation established by the Canadian Government in 2007 [58]) published *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, Canada's first national mental health strategy [59]. The 10-year Strategy comprised the following six strategic directions [59]:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible ('Promotion and prevention').
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights ('Recovery and rights').
3. Provide access to the right combination of services, treatments, and supports, when and where people need them ('Access to services').
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners ('Disparities and diversity').
5. Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights, and cultures ('First Nations, Inuit, and Métis').
6. Mobilise leadership, improve knowledge, and foster collaboration at all levels ('Leadership and collaboration').

The Strategy committed to strengthening Canada's capacity to track the overall mental health and well-being of the Canadian population. Specifically, under Strategic Direction 6, recommendation 6.2.1 was to "Gather and report to the public on data from the initial set of indicators for the Strategy…while developing a framework for gathering and reporting on comprehensive data on outcomes over the longer term" [59 p117]. An initial set of 15 indicators was identified by experts to allow the Mental Health Commission of Canada to track the progress of the Strategy based on data that were already being collected or that could easily be collected [59]. However, from the literature sourced for the purposes of this evidence brief, these indicators do not appear to have been formally reported on.

3.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

The Mental Health Commission of Canada published *Informing the Future: Mental Health Indicators for Canada* in 2015 [31]. The first of its kind in Canada, the report was considered an important step in the implementation of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, as it comprised a total of 63 mental health indicators that were mapped onto the 6 strategic directions outlined in the national strategy [59]. Of the 63 indicators, 8 were not included in the 2015 report, as they had not yet been developed, meaning that 55 indicators were reported on in that report. Although the 2015 report stated that the 8 omitted indicators would be released at a later date, we could not find any subsequent publications that reported on the entire set of 63 indicators; the publication *Informing the Future: Mental Health Indicators for Canada* appears to be the first and only official reporting on this particular set of mental health indicators.

The indicators – which are not described in the 2015 report as outcome indicators per se – were drawn from a wide variety of sources, including national surveys and administrative databases, and cover a broad range of topics, including access and treatment, caregiving, diversity, economic prosperity, housing and homelessness, population well-being, recovery, stigma and discrimination, and suicide. In addition, some indicators were reported specifically for selected populations, including immigrants, residents of Northern communities, and lesbian, gay, or bisexual individuals [31].

Of the 55 available indicators included in *Informing the Future: Mental Health Indicators for Canada*, 37 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.2.2 The Positive Mental Health Surveillance Indicator Framework

The Public Health Agency of Canada is a Canadian Government agency responsible for public health, emergency preparedness and response, and infectious and chronic disease control and prevention [60]. In 2016, the Agency developed a national surveillance framework to address recommendation 6.2.1 in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* related to the development of a framework for gathering and reporting on comprehensive data on mental health outcomes [59]. This surveillance framework, known as the Positive Mental Health Surveillance Indicator Framework, "provides information on positive mental health outcomes and their associated risk and protective factors" [32]. The development of the Framework was led by a research team that used systematic methods to identify a core set of indicators organised into five categories: positive mental health outcomes, and four domains of risk and protective factors (known as mental health determinants), organised at the individual, family, community, and society levels [28,32].

Within the Positive Mental Health Surveillance Indicator Framework, pan-Canadian estimates are available for adults aged 18 years and over (the Adult Framework) and for adolescents aged 12–17 years (the Youth Framework) (most estimates are available for both adults and youth), along with breakdowns by demographic, socioeconomic, and other factors. A third framework for children is currently under development [32]. The Positive Mental Health Surveillance Indicator Framework draws upon a range of survey-based data sources, such as the Canadian Community Health Survey [61], the Canadian Health Survey on Children and Youth [62], and the General Social Survey [63]. The Adult Framework contains 5 positive mental health outcome indicators and 21 mental health determinant indicators organised at the individual, family, community, and societal levels, each with one or more corresponding measures. The Youth Framework contains 5 positive mental health outcome indicators and 22 mental health determinant indicators, each with one or more corresponding measures. Almost all the indicators in the Adult Framework are included in the Youth Framework, and vice versa.

The Positive Mental Health Surveillance Indicator Framework is publicly available through an interactive data tool, which provides a definition, data breakdowns, calculation methodology, and information pertaining to the interpretation of each indicator [32]. Also provided are 'Quick Stats' summary documents for both the Adult and the Youth Frameworks, which provide indicator definitions, data sources, and the most recent data available for each indicator [32]. Thus far, there have been three publications of the Positive Mental Health Surveillance Indicator Framework; first in 2019, again in 2022, and most recently in 2023 [32]. It should be noted that the Positive Mental Health Surveillance Indicator Framework is not used to monitor the progress and impact of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*; rather, it is an outcome of the Strategy's implementation [28].

Of the 26 outcome and determinant indicators included in the Adult Framework, 11 (all 5 outcome indicators, and 6 of the determinant indicators) were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*. Of the 27 outcome and determinant indicators included in the

Youth Framework, 11 (all 5 outcome indicators, and 6 of the determinant indicators) were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.2.3 The Canadian Chronic Disease Indicators

The Canadian Chronic Disease Indicators is another resource produced by the Public Health Agency of Canada, developed with the aim of "systematizing and enhancing chronic disease surveillance in Canada by providing the basis for consistent and reliable information on chronic diseases and their determinants" [64 p1]. Each of the 36 chronic disease indicators is assessed using one or more indicator measures that provide "estimates of the burden of chronic conditions and measures of general health and associated determinants" [65 p281]. Unlike the Positive Mental Health Surveillance Indicator Framework, the chronic disease indicators are not all specific to mental health. The indicators are organised into six domains [65]:

1. Social and environmental determinants
2. Maternal and child health risk and protective factors
3. Behavioural risk and protective factors
4. Risk conditions
5. Disease prevention practices, and
6. Health outcomes/status.

Pan-Canadian statistics are available for each indicator, along with breakdowns by demographic and socioeconomic variables, as well as trends over time [45]. Data for the indicators are drawn from a range of sources, including national surveillance systems and national health surveys. The chronic disease indicators that relate to mental health fall under Domains 3 ('Behavioural risk and protective factors') and 6 ('Health outcomes/status'). The Canadian Chronic Disease Indicators is publicly available through an interactive data tool, which provides a definition, data breakdowns, the calculation methodology, and information pertaining to the interpretation of each indicator [45]. Also provided with each publication of the indicators is a 'Quick Stats' summary document which includes indicator definitions, data sources, and the most recent data available for each indicator [45,65]. The first pulibcation of the Canadian Chronic Disease Indicators was in 2018, with subsequent publications in 2019 and 2021 [45].

Of the 36 chronic disease indicators, 4 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.2.4 The mental health and substance use indicators

The Canadian Institute for Health Information is an independent, not-for-profit organisation that provides essential data and information in order to accelerate improvements in healthcare, health system performance, and population health across Canada [66]. In order to address the impact of mental ill health and substance use on individuals, families, communities, and care systems, the Canadian Institute for Health Information provides data and information "to guide decisions on clinical care, system management and policy related to mental health and substance use" [67]. Specifically, the Canadian Institute for Health Information developed and reports annually on a set of 14 mental health and substance use indicators that broadly measure mental health and substance use service access, organisation, and coordination [42].

Each of the 14 indicators is categorised under one of four interrelated quadrants in the Canadian Institute for Health Information's Health System Performance Measurement Framework, which aims to measure health system performance from a pan-Canadian perspective and support Canadian jurisdictions in their

efforts to improve overall health system performance [68]. These quadrants and their associated performance dimensions are [68]:

1. Health system outcomes:
   a) Improve the health status of Canadians
   b) Improve health system responsiveness, and
   c) Improve value for money.
2. Social determinants of health:
   a) Structural factors influencing health (e.g. socioeconomic position, education, gender, and ethnicity), and
   b) Intermediary determinants of health (e.g. biological factors, material circumstances, and psychosocial circumstances).
3. Health system outputs:
   a) Access to comprehensive, high-quality health services, and
   b) Quality attributes of health services delivered (i.e. services must be person-centred, safe, appropriate and effective, and efficiently delivered).
4. Health system inputs and characteristics:
   a) Health system leadership and governance
   b) Health system resources
   c) Efficient allocation of resources
   d) Innovation, and
   e) Adjusting to population health needs.

These performance dimensions are linked through expected causal relationships, with the end goal being better individual and population health outcomes as a result of a high-performing health system. Notably, the Health System Performance Measurement Framework views performance as "a dynamic process where it is important to analyze the expected relationships among its different components, a view particularly useful for performance improvement" [68 piii].

Each of the 14 mental health and substance use indicators has a dedicated web page on the Canadian Institute for Health Information's website, which provides identifying information (i.e. the indicator name and description), background and interpretation information (i.e. the indicator rationale and instructions on how the indicator should be interpreted), availability of results (i.e. years for which data are available, geographic coverage, and reporting disaggregation), result updates (i.e. indicator results, reporting frequency, and the most recent date the results were updated), indicator calculation information (i.e. calculation methodology), a quality statement (i.e. indicator caveats and limitations, trending issues, and additional quality commentary), and an interactive data visualisation tool [42].

Of the 14 mental health and substance use indicators, 8 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.3 England (UK)

3.3.1 *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*

In February 2011, the UK Government launched *No health without mental health: A cross-government mental health outcomes strategy for people of all ages* [69], a 10-year strategy that set "a clear and compelling vision for improving mental health and wellbeing in England" [70 p5]. The new outcomes-based strategy was considered an alternative approach to more traditional directions-based strategies, which sought to not only improve services, but also to bring about a shift in public attitudes towards mental health [69]. The Strategy encompassed six high-level mental health objectives along with several key areas for action under each objective. The six high-level objectives are as follows [69]:

1. More people will have good mental health.
2. More people with mental health problems will recover.
3. More people with mental health problems will have good physical health.
4. More people will have a positive experience of care and support.
5. Fewer people will suffer avoidable harm.
6. Fewer people will experience stigma and discrimination.

In the Strategy, these objectives were linked to indicators in the following three outcomes frameworks, all of which contain mental-health-specific indicators as well as more general health and care indicators [71]:

1. The Public Health Outcomes Framework
2. The Adult Social Care Outcomes Framework, and
3. The National Health Service (NHS) Outcomes Framework.

It is acknowledged that there is some overlap between the three frameworks [72]; however, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages* states that together, the frameworks "will provide a coherent and comprehensive approach to tracking national progress against an agreed range of critical outcomes" [69 p47].

3.3.1.1 The Public Health Outcomes Framework

The Public Health Outcomes Framework was established in 2012 by the Office for Health Improvement and Disparities, a Government unit that focuses on improving England's health and identifying and addressing health disparities [73]. The Public Health Outcomes Framework, which focuses on both physical and mental health, sets out a vision "to improve and protect the nation's health, and improve the health of the poorest fastest", and aims to achieve two high-level outcomes across the English public health system [33]:

1. Increased healthy life expectancy, and
2. Reduced differences in life expectancy and healthy life expectancy between communities.

The Public Health Outcomes Framework consists of 193 indicators, which collectively aim to cover the full spectrum of public health in the context of what can be realistically measured. The indicators are grouped into one of five domains: one domain of overarching outcome indicators, and four sets of what are referred to as 'supporting indicators' to measure progress towards achieving the two high-level outcomes [33]; the four sets of supporting indicators are:

1. Wider determinants of health

2. Health improvement
3. Health protection, and
4. Healthcare and premature mortality.

None of the overarching outcome indicators are specific to mental health, and so none were included in this evidence brief. The Public Health Outcomes Framework is refreshed every 3 years following user consultation, most recently in 2019 [23]. Notably, it is stated on the Office for Health Improvement and Disparities website that the Public Health Outcomes Framework is not a performance management tool for local authorities; rather, the data enable local authorities to benchmark and compare their outcomes with those of other local authorities. Data are published online as official statistics on the Public Health Outcomes Framework data tool, along with commentary on any data/indicator updates, as part of a quarterly update cycle which occurs every February, May, August, and November [23]. Data are presented (in graphical and tabular format) for the most recent period available, and accompanying trend data are presented where possible.

The Office for Health Improvement and Disparities provides a range of resources and information to guide users of the Public Health Outcomes Framework, including information pertaining to indicator selection, interpretation, and data sources, as well as interpretation of the information provided in the data tool (e.g. interpreting colour shading, recent trend markers, and box plots) [23]. The Office for Health Improvement and Disparities also provides a Public Health Outcomes Framework user guide, area profiles, inequalities data and data breakdowns (the majority of indicators are broken down by geographic region, deprivation deciles, sex, and age), and 'At a glance' documents, which show the most recent results available for all indicators for a particular area [23,74]. Data tables are available for all indicators, and each indicator has a dedicated 'Indicator definition and support information' web page, which outlines the indicator definition, rationale, calculation methodology, data source, caveats, and any additional notes for interpretation (see, for example, [75]).

Of the 193 outcome and supporting indicators included in the Public Health Outcomes Framework, 17 supporting indicators were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.3.1.2 The Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework was established in 2010 by the Department of Health and Social Care in England in order to measure how well social care and support services are achieving the following four outcomes-based objectives for care and support [76]:

1. Enhancing quality of life for people with care and support needs
2. Delaying and reducing the need for care and support
3. Ensuring that people have a positive experience of care and support, and
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

The Adult Social Care Outcomes Framework – which focuses on social care and is not specific to mental health care – is used at the local, regional, and national levels to measure progress against these key objectives and to strengthen transparency and accountability [77]. The current Adult Social Care Outcomes Framework consists of a total of 26 outcome indicators, the data for which are sourced predominantly from national surveys and existing datasets [78]. The indicators were first published in 2012 and are reported on annually. It is important to note that a revised version of the Adult Social Care

Outcomes Framework is due to be published in late 2023, which will include a new framework structure (e.g. the Adult Social Care Outcomes Framework will include six objectives instead of four), a handful of new indicators, and changes to a select few of the existing indicators [77]. As the new version of the Adult Social Care Outcomes Framework has yet to be formally published at the time of completing this evidence brief in September 2023, the information provided in this evidence brief was sourced from the 2021–22 edition of the Adult Social Care Outcomes Framework [78].

The 2021–22 edition of the Adult Social Care Outcomes Framework was published with a report that provides a summary of the indicators [78], which is complemented by an interactive platform which allows users to further explore the data (e.g. regions, time series data, etc.) [34]. Also provided with the publication are downloadable data files, accompanied by a guidance document for using these files [78]. A handbook of definitions is also available, which includes the following details for each indicator: a general description and formal definition, a rationale, interpretation information, information about other indicators/frameworks that the indicator aligns with, the calculation methodology (including a worked example), disaggregation information (the majority of indicators are available by geographic region, age, and sex), frequency of data collection and reporting, the data source, information pertaining to longer-term developments required, and further guidance [76].

Of the 26 outcome and supporting indicators included in the Adult Social Care Outcomes Framework, 2 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.3.1.3 The NHS Outcomes Framework

The NHS Outcomes Framework is a set of indicators established by the Department of Health and Social Care in 2010 in order to monitor the health outcomes of adults and children in England [79]. The NHS Outcomes Framework, which focuses on both physical and mental health, was designed "to provide national level accountability for the outcomes the NHS delivers, and act as a catalyst for driving transparency, quality improvement and outcome measurement throughout the NHS" [80 p3]. The NHS Outcomes Framework sets out the following five national outcome goals, or domains, that the Secretary of State uses to monitor the progress of NHS England [80]:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care, and
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

According to the NHS Outcomes Framework 2021 report, "NHS Digital develops, tests, and assures the method for each indicator" [81]. Each domain contains a set of overarching outcome indicators, and under each overarching indicator is a set of identified areas where improvements are expected to be achieved based on the available evidence (known as 'improvement areas') [82,83]. Overall, the NHS Outcomes Framework consists of 72 indicators (17 overarching outcome indicators and 55 improvement area indicators). As of March 2022, the NHS Outcomes Framework is published on an annual basis (prior to this date, it was published on a quarterly basis in February, May, August, and November of each calendar year) [35]. Not all indicators are updated in each publication of the NHS Outcomes Framework, as the timescales of the indicators vary according to the data source. However, the most recent data are used in all cases [84].

Each NHS Digital publication of the NHS Outcomes Framework includes an overall commentary on the publication and the indicator results, as well as a summary dashboard document which includes domain

summary tables and indicator summary tables [79]. The NHS Outcomes Framework is also accompanied by an interactive visualisation tool that allows users to further explore the data (e.g. by region and sociodemographic factors, by time series, etc.) [81]. In addition, a downloadable Excel data file, an indicator specification document, and an indicator quality statement are made available for each indicator (see, for example, [85]). The indicator specification document provides information pertaining to the indicator description and definition, rationale, alignment with other indicators and frameworks, data source(s), calculation methodology, and data breakdowns. The indicator quality statement provides information pertaining to, for example, the accuracy, reliability, timeliness, punctuality, accessibility, clarity, coherence, and comparability of each indicator (see, for example, [85]).

Of the 72 outcome and improvement area indicators included in the NHS Outcomes Framework, 7 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.3.2 *The Five Year Forward View for Mental Health* and *The NHS Long Term Plan*

The Five Year Forward View for Mental Health is a report that the NHS England's independent Mental Health Taskforce published in 2016, which set out a national plan for transforming mental health care in England until 2021 [86]. The plan set out the following three overarching priority actions for the NHS to undertake in order to deliver rapid improvements in outcomes by 2020–21 [86]:

1. A 7-day NHS – right care, right time, right quality
2. An integrated mental and physical health approach, and
3. Promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens.

In the report, the Mental Health Taskforce made a total of 58 recommendations, which were accepted by the British Government and NHS England. Examples of the recommendations, by area, to be delivered by 2020–21 included [87]:

- Specialist community perinatal mental health: supporting 30,000 more new and expectant mothers through maternal mental health services each year
- Children and young people's mental health: providing mental health care to 70,000 more children and young people; facilitating 95% of children and young people with eating disorders to access treatment within 1 week (urgent cases) or 4 weeks (routine cases)
- Adult common mental illness: increasing access to talking therapies to reach 25% of people in need with anxiety and depression, with a focus on integrated care for people living with long-term physical health conditions
- Adult severe mental illness: ensuring that 280,000 people with a severe mental illness have their physical health needs met; doubling the access to Individual Placement and Support in order to help adults with severe mental illness find and stay in employment
- Mental health crisis care: making a 24/7 community-based crisis response available across England; ensuring that all acute hospitals have mental health liaison services in emergency departments for people of all ages
- Mental health inpatient care: ending the practice of sending people out of their local area for acute inpatient care, and
- Suicide reduction: reducing the number of suicides by 10%.

The NHS Long Term Plan (formerly known as the 10-year plan) was published in 2019, and set out key ambitions for the entire health system to achieve over a 10-year period across three overarching areas [88]:

1. Improving services:
   - Clinical priorities
   - Primary and community services
   - Mental health and learning disabilities, and
   - Acute services.
2. Resources:
   - Finance and productivity
   - Workforce
   - Digital, and
   - Leadership and support of staff.
3. System priorities:
   - Role of patients and carers
   - Integrated care and population health, and
   - Prevention and health inequalities.

Although not specific to mental health, the emphasis on mental health funding and service improvement set out in *The NHS Long Term Plan* represented a continued commitment to mental health services [89], and in particular a continued commitment "to pursue the most ambitious transformation of mental health care England has ever known" [90 p3] as set out in *The Five Year Forward View for Mental Health* [86]. Subsequently, the NHS published the *NHS Mental Health Implementation Plan 2019/20 – 2023/24* in 2019 to outline how the key commitments to mental health services set out in *The NHS Long Term Plan* will be achieved by 2023–24 [90]. This plan both reported on progress made towards commitments set out in *The Five Year Forward View for Mental Health* and made some new commitments, including, for example [87]:

- Children and young people's mental health: By 2023–24, 345,000 additional 0–25-year-olds will access support via NHS mental health services and Mental Health Support Teams based in schools and colleges.
- Adult severe mental illness: By 2023–24, new integrated models of community care for adults with severe mental illness will ensure that 390,000 people with severe mental illness will receive a physical health check and 55,000 will receive employment support.
- Mental health crisis care: All general hospitals now have mental health liaison services; by 2023–24, there will be 100% coverage of 24/7 crisis care across all age groups.
- Problem gambling: By 2023–24, there will be 15 new clinics providing specialist NHS treatment.
- Rough sleeping mental health support: By 2023–24, there will be new specialist provision in 20 high-need areas.

3.3.2.1 The NHS mental health dashboard

The NHS mental health dashboard (formerly called the Mental Health Five Year Forward View Dashboard) was first published in October 2016 by NHS England in response to Recommendation 41 in *The Five Year Forward View for Mental Health*, which is to “identify metrics for monitoring key performance and outcomes data and that will allow us to hold national and local bodies to account for implementing this strategy” [91 p53]. A primary purpose of the NHS mental health dashboard is to monitor progress against the mental health service commitments set out in *The Five Year Forward View for Mental Health* and *The NHS Long Term Plan* [92]. Described as providing “the greatest transparency ever” in measuring mental health service performance [93], the NHS mental health dashboard, which is published on a quarterly basis, presents key data from across mental health services in England in order to assess the performance of the NHS in delivering the targets set out in both plans (*The Five Year Forward View for Mental Health* and *The NHS Long Term Plan*) [94]. In total, the NHS mental health dashboard consists of 55 indicators, which are not referred to as any particular type of indicator (e.g. performance indicator, quality indicator, etc.). The indicators are categorised into the following 11 domains [41]:

1. Children and young people mental health
2. Perinatal mental health
3. Adult mental health (NHS talking therapies for depression and anxiety)
4. Early intervention in psychosis
5. Employment support
6. Physical health checks for people with severe mental illness
7. Crisis and acute care and use of the Mental Health Act
8. Acute hospital mental health liaisons
9. Health and justice
10. Mental health service backlog, and
11. Meeting commitment to increase mental health funding.

Each quarterly issue of the NHS mental health dashboard is published in a downloadable Excel spreadsheet, which includes the following [41]:

- An overall guide tab, which describes the background and purpose of the NHS mental health dashboard, as well as information on how to use and navigate it, how to interpret the indicator results and trends, and a log of changes or updates to the NHS mental health dashboard since it was first published.
- A Metadata tab, which contains information about the data used for each indicator, a description of the indicators, the standard to be met (if applicable), information on how the indicator is calculated (where applicable), information pertaining to data quality, the indicator reporting period (quarterly or yearly), and information about and links to the data sources for the indicator.
- A Dashboard tab for each indicator, which provides the value, information about whether the standard (if applicable) has been met, trend data, information about whether a higher or lower value is considered better, and the percentage change (from 12 months prior and 24 months prior).

The NHS mental health dashboard includes data from a range of sources, including national datasets, national surveys, and the Home Office (the lead government department for immigration and passports, drugs policy, crime, fire, counter-terrorism, and police [95]). The most recent version of the NHS mental

health dashboard includes the latest data available up to and including Quarter 3 of the 2022–23 financial year [94]. The data are available by region, integrated care board, or sub-integrated care board [41]. Integrated care boards are statutory NHS organisations that are “responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area” [96]. Some indicators in the NHS mental health dashboard focus specifically on Black, Asian, or minority ethnic groups [41].

It should be noted that there is limited information available on the indicators in the quarterly issues of the NHS mental health dashboard; that is, the issues do not provide in-depth descriptions of the indicators or their limitations, nor do they provide a rationale for why indicators were selected for inclusion in the NHS mental health dashboard.

Of the 55 indicators included in the NHS mental health dashboard, 45 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.4 New Zealand

3.4.1 *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*

In 2021, the New Zealand Ministry of Health published *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* (referred to as *Kia Manawanui*), a plan aiming to transform New Zealand’s approach to mental well-being [97]. *Kia Manawanui* is underpinned by a mental well-being framework, which is applicable to national, regional, and local levels and sets out [97]:

- New Zealand’s vision of pae ora (Māori for “healthy futures”) – an equitable and thriving New Zealand population in which mental well-being is promoted and protected
- Five interconnected focus areas and associated outcomes that depict a continuum of mental well-being across the whole population of communities, whānau (Māori for the basic extended family group), and individuals
- Seven guiding principles that should underpin all actions proposed in the plan to transform New Zealand’s approach to mental well-being, and
- The system enablers required to support new ways of working.

The five focus areas of *Kia Manawanui* are [97]:

1. Build the social, cultural, environmental and economic foundations for mental wellbeing
2. Equip communities, whānau and individuals to look after their mental wellbeing
3. Foster community-led solutions
4. Expand primary mental wellbeing support in communities, and
5. Strengthen specialist services.

The first three areas focus on community-wide mental health promotion and prevention, and the remaining two areas focus on mental well-being supports and services. *Kia Manawanui* also identifies five high-level outcomes that correspond to the above focus areas, which are [97]:

1. All people in New Zealand have access to resources and live in healthy environments that support mental wellbeing
2. Communities, whānau, and individuals are strong and healthy, and take action to support positive mental wellbeing

3. Communities respond to respond to mental distress and lead solutions
4. Whānau and individuals know where to get help, and are supported to achieve mental wellbeing through accessible, equitable and high-quality services in their communities, and
5. Whānau and individuals experiencing complex mental health and addiction needs are supported to achieve mental wellbeing through accessible, equitable and high-quality services.

Kia Manawanui outlines a series of national-level actions, which are organised across the short, medium, and long term. To ensure equitable mental well-being outcomes, *Kia Manawanui* highlighted 12 population groups that require a particular focus in order to address specific needs while harnessing the strengths these groups already possess [97]:

1. Māori
2. Pacific peoples
3. Refugees and migrants
4. Lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) communities
5. Rural communities
6. Disabled people
7. Veterans
8. Prisoners
9. Young people
10. Older people
11. Children experiencing adverse childhood events, and
12. Children in state care.

Kia Manawanui states, "Knowing whether we are achieving our goals will require us to bring together information from a range of sources to understand changes across a number of areas including population outcomes, system performance, and service delivery" [97 p60]. The *He Ara Oranga wellbeing outcomes framework* (see Section 3.4.1.1) will be used in order to assess changes in population mental well-being outcomes. In relation to system performance outcomes, *Kia Manawanui* provides a set of example outcome indicators of change categorised into six domains ('Leadership', 'Policy', 'Investment', 'Information', 'Technology', and 'Workforce'). The Ministry of Health has committed to building on these example indicators in order to develop a suite of indicators of system improvement [97]. However, in the June 2023 update on progress made towards implementing *Kia Manawanui*, these indicators were not reported on, although the document does provide a narrative update on general progress made to improve mental health system performance [98]. In relation to service delivery, the He Ara Āwhina framework will be used. This is a Mental Health and Wellbeing Commission initiative which aims to monitor the performance of the mental health and addiction system at a service level. However, at the time of completing this evidence brief (September 2023), this framework was still in development and had yet to be implemented [99].

3.4.1.1 *He Ara Oranga wellbeing outcomes framework*

The Mental Health and Wellbeing Commission released the *He Ara Oranga wellbeing outcomes framework* in December 2021 [36]. This framework, which was developed alongside communities and people with lived experience of poor mental health and well-being, "describes what ideal wellbeing looks

like [and] comprises an aspirational vision, twelve wellbeing outcomes, and associated data" [36]. Two perspectives of well-being are represented in the *He Ara Oranga wellbeing outcomes framework* [36]:

1. A Māori perspective, and
2. A shared perspective (the shared perspective also applies to Māori).

The Māori perspective outcomes were developed to better understand the well-being of Māori (the Indigenous Polynesian people of mainland New Zealand), and the shared perspective outcomes were developed to understand well-being at a national level [100]. The *He Ara Oranga wellbeing outcomes framework* encompasses 12 well-being outcome domains – 6 viewed from a Māori perspective and 6 from a shared perspective – and a total of 53 outcome indicators. While recognising the importance of identifying outcome domains and reporting on outcome indicators for specific priority groups, we have decided to describe only those from the shared perspective in this evidence brief, given that it focuses on population-level well-being. The six outcome domains in the shared perspective aspect of the *He Ara Oranga wellbeing outcomes framework* are [100]:

1. Being safe and nurtured
2. Having what is needed
3. Having one's rights and dignity fully realised
4. Healing, growth, and being resilient
5. Being connected and valued, and
6. Having hope and purpose.

A total of 31 outcome indicators were developed to understand well-being across these 6 shared perspective outcome domains, each of which is underpinned by an outcome concept. The *He Ara Oranga wellbeing outcomes framework* draws upon a range of data sources to report on the indicators, including national surveys and data agencies. The Mental Health and Wellbeing Commission committed to using the *He Ara Oranga wellbeing outcomes framework* to continue to monitor and advocate for improved mental health and well-being for everyone in New Zealand [100]. As of the completion of this evidence brief in September 2023, there is limited information available pertaining to the development, nature, and reporting (e.g. data breakdowns) of the indicators included in the *He Ara Oranga wellbeing outcomes framework*. The first and only report published on the outcome indicators was in 2021 [100].

Of the 31 shared perspective outcome indicators included in the *He Ara Oranga wellbeing outcomes framework*, 11 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.4.2 The Key Performance Indicator Programme

The Key Performance Indicator Programme is an initiative owned and led by the mental health and addiction sector in New Zealand and was established in order to facilitate continuous service and performance quality improvement across district health board and non-governmental organisation (NGO) services in New Zealand. The overall goal of the Key Performance Indicator Programme is "to improve outcomes for people who use mental health and addiction services, and to support the effective use of resources across the system" [101 p11]. The programme, which was established in 2007, uses the Programme for the Integration of Mental Health Data (PRIMHD), the New Zealand Ministry of Health's national database on mental health [102], in order to generate a national picture of performance against six key performance indicators and enable the monitoring of changes to the mental health and addiction system both locally and nationally [40,101].

These six key performance indicators each measure quality in service delivery in one of three domains [103]:

1. Structure, which describes the resources and policies that enable people and whānau to access services
2. Process, which describes the evidence-informed treatment and support for people and whānau on their journey through services, and
3. Outcomes, which describes the impact of services on people.

The Key Performance Indicator Programme encompasses an adult stream, a child and youth stream, and an NGO stream [104]. The adult stream contains five indicators, the child and youth stream contains three indicators, and the NGO stream contains two indicators (some indicators are common to multiple streams). In line with the data priorities outlined in *Kia Manawanui* [97], each indicator comes with one or more dedicated data dashboards, which are interactive visualisation tools that allow users to filter and explore data relevant to a given indicator. All dashboards provide data filtered by prioritised ethnicity, gender, and age [40]. The data are updated regularly, although the frequency depends on how often organisations submit raw data to PRIMHD [103]. Access to the data and data dashboards is available only by request. In addition to the data dashboards, the Key Performance Indicator Programme website provides indicator definitions, evidence-based rationales, calculation methodologies, information pertaining to data sources and data breakdowns, and technical notes for all indicators [40].

All six of the indicators included in the Key Performance Indicator Programme were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.4.3 *National Indicators 2012*

In 2012, the Mental Health and Wellbeing Commission (formerly the Mental Health Commission) in New Zealand published *National Indicators 2012*, the second publication of a set of population-level indicators developed “to give people a better understanding of progress that is being made in improving wellbeing and mental health and addiction services” [43 p vi]. Apart from the initial *National Indicators 2011* and *National Indicators 2012*, the authors of this evidence brief were not able to find any subsequent reports. Nevertheless, the outcome domains and national indicators presented in the 2012 report were considered relevant to the aims of this evidence brief. *National Indicators 2012* encompassed three overarching aims, which were to [43]:

1. Report on indicators that give a whole-of-society picture of mental health and addiction in New Zealand.
2. Assist cross-sector government policy development and help identify key areas for action or further research.
3. Contribute to better informed public debate.

The report is based on a broad framework that includes 3 outcome domains and 15 mental health and addiction indicators. The three outcomes domains are [43]:

1. Mental health of the population
2. Health service delivery, and
3. Social inclusion.

In *National Indicators 2012*, the indicators are designated as ‘mental health and addiction indicators’, and not as outcome indicators or any other type of indicator (e.g. performance indicators, quality indicators, etc.). It should be noted that the report provides limited information on the indicators.

Of the 15 mental health and addiction indicators included in *National Indicators 2012*, 11 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.5 Scotland (UK)

3.5.1 Public Health Scotland mental health indicators

In 2022, Public Health Scotland established the Mental Health Indicators project aiming to make relevant mental health data more accessible to local and national users, and to support the use of data to improve population-level mental health through [37]:

- More effective planning
- More efficient resource allocation
- Consistent application of best practice, and
- More effective policies.

As part of the project, Public Health Scotland established two sets of mental health indicators: one for adults, and one for children and young people [105,106]. Although the mental health indicators were not developed specifically in order to support the monitoring and evaluation of the *Mental Health Strategy 2017–2027*, representatives of Public Health Scotland indicated in private correspondence with the Health Research Board (HRB) that the indicator sets align with some of the ambitions set out in the Strategy. In addition, the development paper available on Public Health Scotland’s website [107] states that the indicator sets will be used to support the monitoring of *Mental Health – Scotland’s Transition and Recovery* [108], a plan launched by the Scottish Government in 2020 aiming to respond to the mental health impacts of the COVID-19 pandemic [107]. The development of the indicator sets involved input from topic experts, community workshops, and a process of reviewing the existing literature and high-level evidence [105,106]. This work expanded on existing indicator sets developed by NHS Health Scotland for adults in 2007 [109], and for children and young people in 2011 [110,111].

The Public Health Scotland mental health indicators reflect the wide range of factors that influence mental health and underscore the importance of structural factors such as work and poverty [37]. Public Health Scotland is currently building a collection of resources around the indicator sets. The first phase of resources was published in March 2022, and it includes the indicator sets, a development paper that describes the process of developing the indicator sets, construct rationale documents that describe the constructs underpinning each indicator in both indicator sets, and community workshop reports (see [112] and [113]). The Public Health Scotland website states that headline trend data for the indicators would be published in late 2022, and then kept up to date to inform planning and decision-making [112]. However, the HRB could not source any publications in which data for the indicators are presented, nor could we find information pertaining to whether the indicators included in each indicator set will be available for specific priority groups (e.g. via data filters or disaggregated reporting).

The indicator sets focus explicitly on the importance of preventing mental health problems before they emerge [107]. According to Public Health Scotland, “Effective and cost-effective primary prevention requires us to focus on the drivers of mental health outcomes that are amenable to change by individuals themselves, the communities they live in or wider society” [107 p4]. The indicator sets focus on mental

well-being and common mental health problems, and so neither set includes indicators for less common mental health outcomes or clinical diagnoses, such as psychosis [111].

In each set, the Public Health Scotland mental health indicators are grouped by type [37]:

- Mental health outcomes – mental well-being and common mental health problems, and
- Contextual factors – the determinants (risk factors and protective factors at individual, social, community, and macroeconomic levels) of these outcomes.

The adult mental health indicator set encompasses a total of 55 indicators: 10 mental health outcome indicators (2 related to mental well-being and 8 related to mental health problems) and 45 determinant indicators of mental health outcomes (9 at the individual level, 11 at the community level, and 25 at the structural level) [105]. The children and young people mental health indicator set encompasses a total of 70 indicators: 11 mental health outcome indicators (5 related to mental well-being and 6 related to mental health problems) and 59 determinant indicators of mental health outcomes (12 at the individual level, 17 at the friend and family level, 7 at the learning environment level, 5 at the community level, and 18 at the structural level) [106].

Of the 55 outcome and determinant indicators included in the adult mental health indicator set, 12 (5 outcome indicators and 7 determinant indicators) were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*. Of the 70 outcome and determinant indicators included in the children and young people mental health indicator set, 23 (10 outcome indicators and 13 determinant indicators) were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.5.2 The National Performance Framework

The National Performance Framework is a Scottish Government initiative aiming to [114]:

1. Create a more successful country.
2. Give opportunities to all people living in Scotland.
3. Increase the well-being of people living in Scotland.
4. Create sustainable and inclusive growth.
5. Reduce inequalities and give equal importance to economic, environmental, and social progress.

To help achieve its purpose, the National Performance Framework (which is not specific to mental health or even health in general) sets out 11 national outcomes, which are that people in Scotland [114]:

1. Grow up loved, safe and respected so that they realise their full potential (‘Children and young people’ outcome)
2. Live in communities that are inclusive, empowered, resilient and safe (‘Communities’ outcome)
3. Are creative and their vibrant and diverse cultures are expressed and enjoyed widely (‘Culture’ outcome)
4. Have a globally competitive, entrepreneurial, inclusive, and sustainable economy (‘Economy’ outcome)
5. Are well educated, skilled and able to contribute to society (‘Education’ outcome)
6. Value, enjoy, protect, and enhance their environment (‘Environment’ outcome)

7. Have thriving and innovative businesses, with quality jobs and fair work for everyone ('Fair work and business' outcome)
8. Are healthy and active ('Health' outcome)
9. Respect, protect and fulfil human rights and live free from discrimination ('Human rights' outcome)
10. Are open, connected and make a positive contribution internationally ('International' outcome), and
11. Tackle poverty by sharing opportunities, wealth, and power more equally ('Poverty' outcome).

The National Performance Framework tracks Scotland's progress against these national outcomes using a total of 81 national indicators, which provide a measure of national well-being and include a range of economic, health, social, and environmental indicators [114]. To achieve the national outcomes, the National Performance Framework strives to ensure that everyone in Scotland works together, including [114]:

- National and local government
- Businesses
- Voluntary organisations, and
- People living in Scotland.

The National Performance Framework uses data from a range of sources, including national surveys and national institutes, to both understand how well Scotland is doing and help focus policies, services, and resources in order to meet challenges [114]. Due to the wide range of data sources, it is recognised that there may be issues of comparability across the indicators reported on in the National Performance Framework [115]. Some new indicators were identified following a review of the National Performance Framework in 2018, and at the time that this evidence brief was completed in September 2023, these indicators were still in development. However, they will be reported on the National Performance Framework website when complete [38]. Indicators of the following five national outcomes were deemed relevant to this evidence brief [38]:

1. Children and young people
2. Communities
3. Education
4. Health, and
5. Human rights.

Reporting frequency varies across the national indicators, as they are updated as soon as new data become available [115]. For each indicator, the National Performance Framework website presents a technical note which provides additional information about what the indicator measures, where it is sourced from, definitions used for the purposes of the indicator, and how the performance arrow for the indicator is determined (i.e. the criteria which determine in what direction the performance arrow goes). Also provided alongside each indicator is a list of the indicator breakdowns, which vary across the indicators; the performance arrow, which provides an assessment of the indicator's current performance; a graph providing headline data for the indicator; and a table providing the data from the most recent updates for the indicator [38]. The National Performance Framework website also provides a guide to understanding the information provided alongside the included indicators, as well as a link to the Equality Evidence Finder website, where breakdowns for the indicators can be viewed [115]. The data underlying

the National Performance Framework can be downloaded from the Scottish Government's open data platform [115].

Of the 81 national indicators included in the National Performance Framework, 12 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.5.3 *Mental Health Strategy 2017–2027*

In 2017, the *Mental Health Strategy 2017–2027* set out the Scottish Government's vision of "a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma" [116 p7]. The Strategy consists of a total of 20 ambitions and 40 actions for improvement across 5 primary areas [116]:

1. Prevention and early intervention
2. Access to treatment, and joined-up accessible services
3. The physical wellbeing of people with mental health problems
4. Rights, information use, and planning, and
5. Data and measurement.

To date, three progress reports have been published on the Strategy in order to provide information on the progress made on the relevant actions for improvement laid out in the Strategy [117–119]. The development of indicators to monitor the quality of mental health services was a specified action in the Strategy; specifically, Action 38 under 'Data and measurement' was to "Develop a quality indicator profile in mental health which will include measures across six quality dimensions – person-centred, safe, effective, efficient, equitable and timely" [116 p6]. To meet this commitment, the Scottish Government introduced a quality indicator profile for measuring individual care and treatment as well as service response (see Section 3.5.3.1) [120].

3.5.3.1 The Quality Indicator Profile for Mental Health

The Quality Indicator Profile for Mental Health was introduced by the Scottish Government in 2018 as a tool for monitoring and improving service quality [120]. The purpose of the indicators listed is to provide information that supports [120]:

- The development of mental health outcome measures related to the effectiveness of interventions and to service user experience
- The monitoring of the delivery of the actions listed in the *Mental Health Strategy 2017–2027*
- National tracking of service quality for people with mental health problems
- Health and social care partnership and NHS Scotland health board reporting and benchmarking of performance in relation to local mental health provision, and
- Improvement work by organisations.

The Quality Indicator Profile for Mental Health consists of 30 quality indicators categorised into 6 quality dimensions:

1. Person-centred
2. Safe
3. Effective

4. Efficient
5. Equitable, and
6. Timely.

The Scottish Government published the Quality Indicator Profile for Mental Health along with a factsheet titled *Mental Health Quality Indicators: background and secondary definitions*, which provides information about the purpose and scope of the Quality Indicator Profile for Mental Health, as well as the process of developing, feasibility testing, and implementing it, and defining the rationales for the indicators included therein [120]. Since 2020, Public Health Scotland (the national public health body for Scotland [121]) has been publishing the Quality Indicator Profile for Mental Health biannually (prior to that, it was published by Information Services Division Scotland, which merged with Public Health Scotland in 2020) [122].

To date, 19 out of the 30 indicators are available (the remaining 11 are still under development), although not all indicators are updated in each publication of the Quality Indicator Profile for Mental Health [44]. Each new publication provides an overview of and commentary on the results of the available indicators, a glossary of relevant terms for interpreting the results, metadata for the Quality Indicator Profile for Mental Health (i.e. information about data sources; time frame and timeliness; continuity of data; a revisions statement; and information about the accuracy, completeness, comparability, accessibility, and coherence and clarity of the indicators listed), and information on progress for each of the available indicators (e.g. see the most recent report from April 2023 [44]). The web page for the Quality Indicator Profile for Mental Health on Public Health Scotland's website does not indicate whether data are available or disaggregated by socioeconomic, geographic, or other factors. However, upon introducing the Quality Indicator Profile for Mental Health in 2018, the Scottish Government noted that opportunities would exist for specialist mental health services to analyse the indicators for specific populations (e.g. by gender, sexuality, and deprivation; for children and adolescents, general adults, and older people; for learning disability and autism populations, forensic populations, substance misuse populations, and perinatal populations; and for different service types, e.g. psychological therapies) [120]. The Quality Indicator Profile for Mental Health collates data from a variety of sources, including national surveys, national datasets, official national records, NHS Scotland, and existing Public Health Scotland publications [44]. Web links are provided under each indicator to the original data source, many of which are separate and independent publications (i.e. they are indicators used elsewhere, not just for the Quality Indicator Profile for Mental Health) with their own data dashboards, downloadable data files, and quality statements not provided as part of the Quality Indicator Profile for Mental Health (e.g. see [123]).

While the Quality Indicator Profile for Mental Health was developed in order to monitor the quality of mental health services as an outcome of strategy implementation, when the Scottish Government introduced the Quality Indicator Profile for Mental Health in 2018, it aligned each indicator with one or more of the 40 actions set out in the *Mental Health Strategy 2017–2027*. In this sense, the indicators can be utilised to track progress against these actions. However, the three progress reports published to date do not appear to utilise the indicators in this way; the first and third progress reports do not report on the indicators at all [117,119], and the second progress report only briefly reports on two of the indicators [118].

It is important to note that, as of its April 2023 publication by Public Health Scotland, the Quality Indicator Profile for Mental Health is still considered an experimental statistics publication. According to the 2023 report, "Experimental statistics are official statistics which are published in order to involve users and stakeholders in their development and as a means to build in quality at an early stage. It is important that users understand that limitations may apply to the interpretation of this data" [44 p2]. Once an

evaluation has been completed to ensure that statistics comply with the UK Statistics Authority's Code of Practice, the 'experimental' label will be removed. Until then, experimental statistics should be interpreted with caution. Public Health Scotland is currently seeking users' views on the presentation of the indicators in the Quality Indicator Profile for Mental Health in order to gather feedback [44].

Of the 30 quality indicators included in the Quality Indicator Profile for Mental Health, 25 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.6 The OECD

3.6.1 The OECD Mental Health System Performance Benchmark

In 2021, the Organisation for Economic Co-operation and Development (OECD) published *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, which presents the OECD Mental Health System Performance Benchmark, a framework for understanding mental health performance across the following six dimensions [27]:

1. Person-centred mental health policies and services
2. Accessible, high-quality mental health services
3. An integrated and multi-sectoral approach to mental health
4. Preventing mental illness and promoting mental well-being
5. Strong leadership and good governance, and
6. Building future-focused and innovative mental health systems.

The OECD Mental Health System Performance Benchmark, which was developed by stakeholders and experts from across OECD member countries, is a response to a call from OECD Health Ministers in 2017 for improved tools to both understand and improve mental health system performance.

A set of 23 benchmarking indicators were identified or newly collected in order to measure mental health system performance across the 6 dimensions, and the report presents an analysis of how well OECD member countries are performing on each dimension. The report ultimately concludes, "At present, OECD countries cannot measure mental health system performance in many of the domains that matter…and there are big gaps in OECD member countries' ability to measure performance in key areas such as levels of stigma, outcomes and functional improvement from treatments, service user and carer experiences, and service coverage" [27 p9]. It is important to note that there is limited information provided on the indicators in the report (e.g. in relation to indicator rationales, data sources, and indicator limitations). It is also important to note that, while the report states that the OECD Mental Health System Performance Benchmark includes a total of 23 indicators, it only appears to describe 22. Some indicators are also reported for more than one group (e.g. see Section 3.8.1.6.1.1).

Of the 22 benchmarking indicators that are described in the OECD Mental Health System Performance Benchmark, 14 were deemed relevant to one or more of the high-level outcomes identified in *Sharing the Vision*.

3.7 Outcome domain 1: Promotion, prevention, and early intervention

Outcome domain 1 focuses on the importance of population-level mental health promotion, which has three aims [24]:

1. To strengthen individuals and improve their emotional resilience
2. To strengthen communities and improve social capital through increased participation, and
3. To reduce structural barriers to good mental health through initiatives that reduce discrimination and inequalities.

The importance of adopting a life cycle approach to understanding mental health difficulties is underscored in outcome domain 1, which advocates for an approach that requires a strong emphasis on promoting mental health and building resilience at all stages of the life cycle "by embedding the principles of mental health promotion into the existing fabric of communities" [p26 24], including in schools and workplaces, as well as in healthcare and other community settings. Promoting mental health and building resilience at all stages in the life cycle also requires tailored approaches for priority groups deemed to be at an increased risk for developing mental health difficulties. This includes, but is not limited to: members of the Traveller community; lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) people; people who are homeless; refugees; migrants; and people who come into contact with the criminal justice system. This domain emphasises the importance of prevention and early intervention, particularly in schools, which are considered a key context for mental health and well-being promotion and the early detection of developmental, emotional, behavioural, or social issues. This domain also emphasises the importance of reducing the stigma and discrimination associated with mental health difficulties, as a means by which to both foster improved community-wide well-being and to improve help-seeking behaviour among people experiencing mental health difficulties [24].

Outcome domain 1 encompasses the following four high-level outcomes [24]:

a) Positive mental health, resilience and psychological wellbeing amongst the population as a whole

b) Positive mental health, resilience, and psychological wellbeing amongst priority groups…through targeted promotion and preventive mechanisms

c) Reduced stigma and discrimination arising through improved community wide understanding of mental health difficulties, and

d) Reduced prevalence of mental health difficulties and/or reduced severity of impact(s) through early intervention and prevention work.

What follows is an overview of the indicators identified in the indicator sets and frameworks from the selected countries and the OECD that were deemed relevant to each of these high-level outcomes.

3.7.1 Outcome 1(a): Positive mental health, resilience and psychological wellbeing amongst the population as a whole

3.7.1.1 Australia

3.7.1.1.1 What are the relevant mental health indicators?

3.7.1.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia includes a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better

physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21]. One of these indicators was deemed relevant to *Sharing the Vision* outcome 1(a). This indicator, which falls under domain 3 ('Good mental health and wellbeing'), is 'Adults with very high levels of psychological distress' [21], and it is measured as the percentage of adults with very high levels of psychological distress [124]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected because psychological distress can be considered a proxy measure of the overall mental health and well-being of the general population. The report states, "Very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services" [124 p9]. Data for this indicator are sourced from two surveys conducted by the Australian Bureau of Statistics [21]:

1. The National Health Survey, and
2. The National Aboriginal and Torres Strait Islander Health Survey.

The National Health Survey is conducted approximately every 3 years, with the most recent data available being from 2017–18 [125]. The survey identifies six disability groups based on the following types of disability:

1. Sensory and speech
2. Intellectual
3. Physical restriction
4. Psychosocial
5. Head injury, stroke, or acquired brain injury, and
6. Other.

The National Aboriginal and Torres Strait Islander Health Survey is conducted approximately every 6 years, with the most recent data available being from 2018–19 [126]. The survey collects information on long-term health conditions, mental well-being, and health risk factors, and identifies the presence of disability or a restrictive long-term health condition among Aboriginal and Torres Strait Islander people of all ages in both non-remote and remote areas of Australia, including discrete Indigenous communities. In both surveys, psychological distress is derived from the Kessler Psychological Distress Scale [127], a 10-item scale measuring non-specific psychological distress in the general population [124]. Higher proportions of Australians with very high levels of psychological distress indicates lower levels of well-being.

This indicator was first published in the first progress report on The Fifth Plan in 2018, and updated data for both Indigenous and non-Indigenous Australians were subsequently published in the second progress report in 2019. Psychological distress data for non-Indigenous Australians are published approximately every 3 years, and data for Indigenous Australians are published approximately every 6 years; as a result, the fourth and most recent progress report, published in 2021, does not report on more up-to-date data [124]. This indicator can be disaggregated by age, sex, remoteness, socioeconomic disadvantage categories, disability status, and by state or territory [124].

3.7.1.1.1.2 The services for mental health performance indicator framework

None of the outcome or output indicators included in the services for mental health performance indicator framework were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.1.1.3 *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.1.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan's performance indicators [21,124]. The documents do not explicitly identify the benefits associated with each indicator.

In relation to 'Adults with very high levels of psychological distress', the following limitations were described [124]:

- Data on level of psychological distress indicate non-specific (or a general level of) psychological distress based on questions about negative emotional states; the data do not provide an indication of the individual's or the community's ability to cope with psychological distress, or of the supports they may require in order to cope more effectively.
- Data only include people aged 18 years and over.

In addition to the limitations of individual performance indicators, the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* outlines general limitations with the use of performance (or outcome) indicators that apply to the above and all subsequent indicators described in *The Fifth National Mental Health and Suicide Prevention Plan* [124]. First, some data sources are annually collected administrative data, and so there are more years of data available for some performance indicators relative to others. Alternatively, other data sources are national surveys that are collected much less frequently. As a result, there are fewer years of data available for some performance indicators relative to others, making trends over time difficult or not possible to analyse. Second, where sufficient time series data are available, performance indicators can signal whether there have been improvements in mental health, well-being, and system performance. However, even with sufficient data, it is not possible to determine why an indicator of health, well-being, or system performance has or has not changed over time, or what is needed in order to achieve positive change over time [124].

3.7.1.1.2.2 The services for mental health performance indicator framework

None of the outcome or output indicators included in the services for mental health performance indicator framework were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.1.2.3 *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.2 Canada

3.7.1.2.1 What are the relevant mental health indicators?

3.7.1.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and

‘Leadership and collaboration’) [31,59]. Ten of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 1(a), all of which fall under strategic direction 1, ‘Promotion and prevention’ [59]. Some of the indicators are repeated across different population groups (e.g. see ‘Self-rated mental health’ in the list below). The 10 indicators are [31]:

1. Receipt of stress reduction resources in colleges and universities
2. Willingness to seek help from a mental health professional – college and university students
3. School-based mental health promotion
4. Self-rated mental health – adults
5. Self-rated mental health – youth
6. Self-rated mental health – general population
7. Self-rated mental health – seniors
8. Stress at work
9. Stress – general population, and
10. Sense of belonging – general population.

‘Receipt of stress reduction resources in colleges and universities’ is measured as the percentage of college and university students who report having received information about stress reduction from their post-secondary institution in a given year [31]. This indicator was selected to signal the capacity for mental health promotion (in the form of resource materials on managing stress) on Canadian post-secondary school campuses. It is also noted in *Informing the Future: Mental Health Indicators for Canada* that post-secondary institutions are a key setting in which to distribute mental health supports due to an increased likelihood of the emergence of mental health problems in adolescence and early adulthood. Data for this indicator were sourced from *American College Health Association-National College Health Assessment II: Canadian Reference Group Data Report Spring 2013* [128]. The American College Health Association-National College Health Assessment is an internationally recognised research survey that collects data related to students’ health habits, behaviours, and perceptions [129].

‘Willingness to seek help from a mental health professional – college and university students’ is measured as the percentage of college and university students who indicated that they would consider seeking help in the future from a mental health professional for a personal problem [31]. This indicator was selected because a greater willingness to seek help increases the chances of early intervention and better long-term outcomes. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from *American College Health Association-National College Health Assessment II: Canadian Reference Group Data Report Spring 2013* [128].

‘School-based mental health promotion’ is measured as the percentage of Canadian schools that have completed the Foundational Module of the Healthy School Planner over a given time period [31]. This module, which the Pan-Canadian Joint Consortium for School Health developed and launched in 2012, “includes a focus on the school’s social environment which addresses factors closely linked to mental health promotion in the school setting” [31 p21]. The indicator was selected because gaining insight into the number of schools that use a comprehensive approach to planning for a healthier school environment is an indicator of the extent to which Canadian schools are concerned with creating school communities that promote good mental health. *Informing the Future: Mental Health Indicators for Canada* notes that schools are a logical and straightforward setting in which to promote health and well-being. Data for this indicator were sourced from the Pan-Canadian Joint Consortium for School Health and the Propel Centre

for Population Health Impact between November 2012 and June 2014. The Pan-Canadian Joint Consortium for School Health was established in 2005 by the provincial, territorial, and federal governments to join together the education and health systems across Canada in order to improve health, well-being, and achievement outcomes in Canadian children and youth using a comprehensive school health approach [130]. The Propel Centre for Population Health Impact, which officially closed in 2019, was a national research programme of the Canadian Cancer Society which supported a range of public health research projects across Canada [131].

'Self-rated mental health' is measured as the percentage of Canadians of different age groups (adults, youth, general population, and seniors) who report their mental health as 'very good' or 'excellent' over a given period (2011–12 in *Informing the Future: Mental Health Indicators for Canada*) [31]. The adult indicator covers adults aged 20–64 years, the youth indicator covers children and adolescents aged 12–19 years, the general population indicator covers Canadians aged 12 years and over, and the senior indicator covers adults aged 65 years and over. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31]. The Canadian Community Health Survey is a cross-sectional survey that collects information every 2 years related to health status, healthcare utilisation, and health determinants for the Canadian population, including in relation to mental health and well-being [61].

'Stress at work' is measured as the percentage of Canadians aged 15–75 years who worked during the previous year and report that most days at work are 'quite a bit stressful' or 'extremely stressful' in a given year [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31].

'Stress – general population' is measured as the percentage of Canadians aged 15 years and over who report that most days are 'quite a bit stressful' or 'extremely stressful' in a given year [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31].

Finally, 'Sense of belonging – general population' is measured as the percentage of Canadians aged 12 years and over who describe their sense of belonging to their local community as 'somewhat strong' or 'very strong' over a given period (2011–12 in *Informing the Future: Mental Health Indicators for Canada*) [31]. Like several of the previous indicators, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31].

3.7.1.2.1.2 The Positive Mental Health Surveillance Indicator Framework

As mentioned in Section 3.2.2, the Positive Mental Health Surveillance Indicator Framework contains a core set of indicators organised into five categories: positive mental health outcome indicators, and four domains of mental health determinant indicators (i.e. risk and protective factors) organised at the individual, family, community, and society levels [32]. The Positive Mental Health Surveillance Indicator Framework is reported separately for adults (the Adult Framework) [132] and youth (the Youth Framework) [133] [32]. The Adult Framework includes a total of 26 indicators (5 positive mental health outcome indicators and 21 mental health determinant indicators), and the Youth Framework includes a total of 27 indicators (5 positive mental health outcome indicators and 22 mental health determinant indicators), each with one or more corresponding measures [32]. Almost all the indicators in the Adult Framework are included in the Youth Framework, and vice versa.

The five positive mental health outcome indicators identified in the Positive Mental Health Surveillance Indicator Framework are particularly relevant to *Sharing the Vision* outcome 1(a), as the Framework specifically aims to capture the positive dimensions of mental health [28]. The five positive mental health outcome indicators are [32]:

1. Self-rated mental health
2. Happiness
3. Life satisfaction
4. Psychological wellbeing, and
5. Social wellbeing.

'Self-rated mental health' is measured as the percentage of the Canadian population aged 18 years and over (for the Adult Framework) or aged 12–17 years (for the Youth Framework) who report that their mental health is 'very good' or 'excellent' [32]. The data source for this indicator is the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2021. Data are available by sex, age group (Adult Framework only), highest level of education (Adult Framework only), household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high percentage on this indicator denotes good mental health [32].

'Happiness' is measured as the percentage of the Canadian population aged 18 years and over (for the Adult Framework) or aged 12–17 years (for the Youth Framework) who report usually being 'happy and interested in life' [32]. The data source for this indicator is the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2020. Data are available by sex, age group (Adult Framework only), highest level of education (Adult Framework only), household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high percentage on this indicator denotes good mental health [32].

'Life satisfaction' is assessed using two indicator measures [32]:

1. The percentage of the Canadian population aged 18 years and over (for the Adult Framework) or aged 12–17 years (for the Youth Framework) who report that they are very satisfied with their life in general, and
2. The mean life satisfaction rating for the Canadian population aged 18 years and over (for the Adult Framework) or aged 12–17 years (for the Youth Framework) [32].

Like the previous two indicators, the data source for this indicator is the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2021. Data for the first measure – the percentage of the Canadian adult or youth population who report that they are very satisfied with their life in general – are available by sex, age group (Adult Framework only), highest level of education (Adult Framework only), household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high percentage on this indicator denotes high life satisfaction. Data for the second measure – the mean life satisfaction rating for the Canadian adult or youth population – are available by sex, age group (Adult Framework only), highest level of education (Adult Framework only), household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high mean score on this indicator denotes high life satisfaction [32].

'Psychological wellbeing' is measured differently between the adult and youth frameworks. For adults, this indicator is measured as the percentage of the Canadian population aged 18 years and over who have

high psychological well-being. The data source for the Adult Framework is the Canadian Community Health Survey [61], and the most recent data available for this indicator are from the year 2019. Data are available by sex, age group, highest level of education, household income quintile, province/territory, immigrant status, and ethnicity. A high percentage on this indicator denotes good mental health [32]. For youth, this indicator is assessed using two indicator measures [32]:

1. The percentage of the Canadian population aged 12–17 years who have high autonomy, and
2. The percentage of the Canadian population aged 12–17 years who have high competence.

The data source for the Youth Framework is the Canadian Health Survey on Children and Youth, a survey by Statistics Canada (Canada's national statistical office [134]) that was first conducted in 2019 and then again in 2023 that aims to examine issues that have an impact on the physical and mental health of children and youth aged 1–17 years (e.g. physical activity, the use of electronic devices, time spent in school and extracurricular activities, childhood experiences, substance use, and the impact of the COVID-19 pandemic [62]) (Statistics Canada is Canada's national statistical office). Data are available by sex, household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high percentage on this indicator denotes good mental health [32].

'Social wellbeing' is also measured differently between the adult and youth frameworks. For adults, this indicator is measured as the percentage of the Canadian population aged 18 years and over who report a 'very strong' or 'somewhat strong' sense of belonging to their local community. The data source for the Adult Framework is the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2021. Data are available by sex, age group, highest level of education, household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high percentage on this indicator denotes good social wellbeing [32]. For youth, this indicator is measured as the percentage of the Canadian population aged 12–17 years with a mean score of 3 or higher on a scale of 1 to 4 (with 4 representing 'really true for me' and 3 representing 'sort of true for me') based on the six items in the Children's Intrinsic Needs Satisfaction Scale, which measures relatedness across three life dimensions: school, family, and friends [135]. The data source for the Youth Framework is the Canadian Health Survey on Children and Youth [62], and the most recent data available for this indicator are from the year 2019. Data are available by sex, household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high mean score on this indicator denotes good social wellbeing [32].

In addition to these five positive mental health indicators, the Positive Mental Health Surveillance Indicator Framework includes a set of mental health determinant indicators (i.e. risk and protective factors) organised at the individual, family, community, and society levels, which are the focus of efforts to improve population-level mental health [28]. Although these are determinant indicators rather than outcome indicators, the following seven were deemed relevant to *Sharing the Vision* outcome 1(a) [32]:

1. Resilience (individual determinant)
2. Coping (individual determinant)
3. Community involvement (community determinant)
4. Social networks (community determinant)
5. Social support (community determinant)
6. School environment (community determinant; Youth Framework), and
7. Work environment (community determinant; Adult Framework).

As of the most recent edition of the Positive Mental Health Surveillance Indicator Framework in 2023, the 'Resilience' indicator is still in development, both in the Adult Framework and the Youth Framework [132,133].

'Coping' is measured as the percentage of the Canadian population aged 18 years and over (for the Adult Framework) or aged 12–17 years (for the Youth Framework) who, on average, answer 'excellent' or 'good' to two coping questions that assess the individual's ability to handle unexpected and difficult problems and day-to-day demands. This means that those who report a high level of coping have responded either 'excellent' or 'good' to both questions, or have responded 'excellent' on one and either 'good' or 'fair' on the other [32]. The data source for this indicator is the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2019. Data are available by sex, age group (Adult Framework only), highest level of education (Adult Framework only), household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high percentage on this indicator denotes a good ability to cope [32].

'Community involvement' is measured differently between the adult and youth frameworks. For adults, this indicator is measured as the percentage of the Canadian population aged 18 years and over who are a member of or participant in at least one recreational or professional organisation, group, association, or club. This can include a union or professional association, a political party or group, a sports or recreational organisation, or an educational or hobby organisation, among others. The data source for this indicator was the General Social Survey, a Statistics Canada programme constituting a series of independent, cross-sectional annual surveys, each covering one of seven possible themes in depth approximately every 5–7 years [63,136]. The programme, which appears to have concluded in 2019, aimed to "gather data on social trends in order to monitor changes in the living conditions and well being of Canadians, and to provide information on specific social policy issues" [63]. The 2023 edition of the Positive Mental Health Surveillance Indicator Framework uses data from the Social Identity theme in the report, *General Social Survey: An Overview, 2013* [132,137]. Data are available by sex, age group, province/territory, urban/rural residence, and immigrant status. A high percentage on this indicator denotes good community involvement [32]. For youth, this indicator is measured as the percentage of grade 6–10 students (aged 11–15 years) in Canada who are involved in at least one club or organisation. This can include a sports team, volunteer work, an arts group, or a community group (e.g. Scouts), among others. The data source is the Health Behaviour in School-aged Children study, a cross-national research study of adolescents across Europe and North America that is conducted every 4 years in collaboration with the World Health Organization (WHO) Regional Office for Europe, and which aims to gain insight into the well-being, health behaviours, and social context of 11–15-year-olds [138]. The most recent data available for this indicator are from the year 2018, and are available by sex and grade. A high percentage on this indicator denotes good community involvement [32].

'Social networks' is also measured differently depending on whether the indicator pertains to adults or youth. For adults, this indicator is assessed using three indicator measures [32]:

1. The percentage of the Canadian population aged 18 years and over who report having no close friends or family members when asked how many friends and relatives (i.e. people related by blood, marriage, or adoption residing outside of the household) they feel close to
2. The percentage of the Canadian population aged 18 years and over who report having between one and five close friends or family members when asked how many friends and relatives they feel close to, and
3. The percentage of the Canadian population aged 18 years and over who report having six or more close friends or family members when asked how many friends and relatives they feel close to.

The data source for this indicator is the General Social Survey. The 2023 edition of the Positive Mental Health Surveillance Indicator Framework uses data from the Social Identity theme in the report, *General Social Survey: An Overview, 2013* [132,137]. Data are available by sex, age group, province/territory, urban/rural residence, and immigrant status. A high percentage on this indicator denotes strong social networks [32]. For youth, this indicator is assessed using two indicator measures [32]:

1. The percentage of grade 6–10 students in Canada who report that they can count on their friends when things go wrong, based on responding above the midpoint (i.e. 5 or higher) on a scale ranging from 1 ('very strongly disagree') to 7 ('very strongly agree'), and
2. The percentage of grade 6–10 students in Canada who report that they have friends to share their happy and sad feelings with, based on responding above the midpoint (i.e. 5 or higher) on a scale ranging from 1 ('very strongly disagree') to 7 ('very strongly agree').

The data source for this indicator in the Youth Framework is the Health Behaviour in School-aged Children study [138]. The most recent data available are from the year 2018, and are available by sex and grade. A high percentage on this indicator denotes strong social networks [32].

'Social support' is measured as the percentage of the Canadian population aged 18 years and over (for the Adult Framework) or aged 12–17 years (for the Youth Framework) who report a high level of perceived social support; that is, those with a mean score of 3 ('agree') or 4 ('strongly agree') on a scale ranging from 1 to 4, based on 5 questions from the Social Provisions Scale [32]. The Social Provisions Scale measures five forms of social provision [139]:

1. Reliable alliance
2. Social integration
3. Guidance
4. Reassurance of worth, and
5. Attachment.

The data source for this indicator is the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2021. Data are available by sex, age group (Adult Framework only), highest level of education (Adult Framework only), household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. A high percentage on this indicator denotes good social support [32].

The 'School environment' indicator is only included in the Youth Framework and is measured as the percentage of grade 6–10 students who agree or strongly agree that they feel they belong at their school. The data source for this indicator is the Health Behaviour in School-aged Children study [138]. The most recent data available for this indicator are from the year 2018, and are available by sex and grade. A high percentage on this indicator denotes a high sense of belonging at school [32].

Finally, the 'work environment' indicator is only included in the Adult Framework and is measured as the percentage of the employed population in Canada aged 18–75 years who are experiencing high job strain at their main place of work, based on responses to seven items from the Job Content Questionnaire [140]. In this questionnaire, job strain is defined as having a score of 1.2 or greater, which is the ratio of psychological demands to decision latitude (skill discretion and decision authority) [32]. The data source for this indicator is the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2012. Data are available by sex, age group, household income quintile, province/territory, urban/rural residence, and immigrant status. A high percentage on this indicator

denotes a high level of job strain among the employed population in Canada, and can therefore be interpreted as a negative result [32].

3.7.1.2.1.3 The Canadian Chronic Disease Indicators

As mentioned in Section 3.2.3, the Canadian Chronic Disease Indicators consists of a total of 36 pan-Canadian chronic disease indicators, which provide information about the burden of chronic conditions and associated determinants. The indicators are categorised into six domains ('Social and environmental determinants', 'Maternal and child health risk and protective factors', 'Behavioural risk and protective factors', 'Risk conditions', 'Disease prevention practices', and 'Health outcomes/status') [45]. Each indicator is assessed using one or more indicator measures that provide "estimates of the burden of chronic conditions and measures of general health and associated determinants" [65 p281]. Of the four chronic disease indicators that are related to mental health, the following two were deemed relevant to *Sharing the Vision* outcome 1(a) [45]:

1. Chronic stress ('Behavioural risk and protective factors' domain), and
2. General health ('Health outcomes/status' domain).

'Chronic stress' is one of 10 indicators that fall under the 'Behavioural risk and protective factors' domain, and it is measured as the percentage of the Canadian population aged 12 years and over who report life to be 'quite a bit' or 'extremely' stressful most days in the last 12 months [45]. The indicator was selected because self-perceived life stress can be used as a proxy indicator for chronic stress. Data for this indicator are sourced from the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2019. Data are available by sex, age group, province (crude and age-standardised), population centre/rural area, highest level of education (by household and for respondents aged 20 years and over), household income adequacy, Indigenous status, immigrant status, and trends over time (age-standardised). A low percentage on this indicator denotes low levels of chronic stress [45].

'General health' is one of seven indicators that fall under the 'Health outcomes/status' domain, and it consists of two indicator measures, only one of which is relevant to *Sharing the Vision* outcome 1(a). This measure is the percentage of the Canadian population aged 12 years and over who report that their mental health is 'very good' or 'excellent' [45]. Data for this indicator are sourced from the Canadian Community Health Survey [61]; the most recent data available for this indicator are from the year 2019 [61]. Like the previous indicator, data are available by sex, age group, province (crude and age-standardised), population centre/rural area, highest level of education (by household and for respondents aged 20 years and over), household income adequacy, ethnicity, Indigenous status, immigrant status, and trends over time (age-standardised). A high percentage on this indicator denotes good mental health [45]. It should be noted that this indicator is also included in the Positive Mental Health Surveillance Indicator Framework (titled 'Self-rated mental health') as two distinct indicators (one for the Adult Framework and another for the Youth Framework; see Section 3.7.1.2.1.2).

3.7.1.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.1.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not explicitly identify the benefits of the indicators, but, where relevant, we highlight information provided that could be considered a benefit of a given indicator.

As noted in Section 3.7.1.2.1.1, data for ‘Receipt of stress reduction resources in colleges and universities’ were sourced from *American College Health Association-National College Health Assessment II: Canadian Reference Group Data Report Spring 2013* [128]. The sample consisted of approximately 34,000 students in 32 post-secondary institutions, with a mean response rate of 20%. As such, it was noted that the results may not be representative of the overall post-secondary student population. Importantly, *Informing the Future: Mental Health Indicators for Canada* acknowledges that students’ receipt of relevant stress reduction information does not necessarily mean that they found the information useful [31].

The limitations of the next indicator, ‘Willingness to seek help from a mental health professional – college and university students’, are the same as those described for the first indicator [31].

In relation to ‘School-based mental health promotion’, one limitation described in *Informing the Future: Mental Health Indicators for Canada* is that completion of the Foundational Module of the Healthy School Planner does not necessarily mean that the actions recommended in the Module are being implemented in schools. Equally, the completion rate may underestimate the number of schools employing comprehensive school health approaches in order to build healthier school communities [31].

In relation to ‘Self-rated mental health’, the common limitation for this indicator when used for adults, youth, the general population, and seniors is that high self-rated mental health does not necessarily mean an absence of mental health problems or a mental health condition. In addition, when this indicator is taken as a measure of the entire population (i.e. the entire adult population, the entire youth population, the entire general population, or the entire senior population of Canada), lower or higher rates of mental health among distinct groups may be masked. In relation to the benefits of using this indicator, although not explicitly described as a benefit, it is noted that by having distinct indicators for different age groups, comparisons can be made between adults, youth, the general population, and seniors [31].

In relation to ‘Stress at work’, the only limitation described in *Informing the Future: Mental Health Indicators for Canada* is that when taken as a measure of the entire working-age population, rates of perceived stress at work for distinct groups (e.g. different age groups) may be masked [31].

In relation to ‘Stress – general population’, the only limitation described is the same as that for the previous indicator: when taken as a measure of the entire population, rates of perceived stress for distinct groups may be masked [31].

As noted in Section 3.7.1.2.1.1, ‘Sense of belonging – general population’ is measured as the percentage of Canadians aged 12 years and over who describe their sense of belonging to their local community as ‘somewhat strong’ or ‘very strong’. However, it is noted that there are many different types of ‘community’ (e.g. communities of place, social or cultural identity, or practice) to which an individual may or may not feel a sense of belonging, and one or more may be important for supporting an individual’s well-being. In the Canadian Community Health Survey [61] (the data source for this indicator), respondents were asked about their local community, which implies geographic or place communities, and so the use of this indicator may not accurately represent individuals’ sense of belonging in the general population. In addition, and similar to the two previous indicators, when taken as a measure of the entire population, rates of belonging for distinct groups may be masked when using a general population indicator [31].

3.7.1.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the limitations associated with the indicators included in the Positive Mental Health Surveillance Indicator Framework were considered relevant to the purposes of this evidence brief. In addition, there was no information pertaining to indicator benefits.

3.7.1.2.2.3 The Canadian Chronic Disease Indicators

Specific information pertaining to the benefits and limitations associated with the two Canadian chronic disease indicators deemed relevant to *Sharing the Vision* outcome 1(a) was not provided in the literature sourced.

3.7.1.2.2.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.3 England (UK)

3.7.1.3.1 What are the relevant mental health indicators?

3.7.1.3.1.1 The Public Health Outcomes Framework

As mentioned in Section 3.3.1.1, the Public Health Outcomes Framework contains 193 indicators, which are categorised as either overarching outcome indicators or as supporting indicators [33]. None of the overarching outcome indicators are specific to mental health, and so none were included in this evidence brief. The supporting indicators are further categorised into one of four domains ('Wider determinants of health', 'Health improvement', 'Health protection', and 'Healthcare and premature mortality') [33]. The following nine supporting indicators were deemed relevant to *Sharing the Vision* outcome 1(a) [33]:

1. School readiness: percentage of children achieving a good level of development at the end of Reception ('Wider determinants of health' domain)
2. Loneliness: percentage of adults who feel lonely often or always or some of the time ('Wider determinants of health' domain)
3. Child development: percentage of children achieving a good level of development at 2 to 2.5 years ('Health improvement' domain)
4. Child development: percentage of children achieving the expected level in communication skills at 2 to 2.5 years ('Health improvement' domain)
5. Child development: percentage of children achieving the expected level in personal social skills at 2 to 2.5 years ('Health improvement' domain)
6. Self-reported wellbeing: people with a low satisfaction score ('Health improvement' domain)
7. Self-reported wellbeing: people with a low worthwhile score ('Health improvement' domain)
8. Self-reported wellbeing: people with a low happiness score ('Health improvement' domain), and
9. Self-reported wellbeing: people with a high anxiety score ('Health improvement' domain).

'School readiness: percentage of children achieving a good level of development at the end of Reception' represents the proportion of children defined as having reached a good level of development at the end of the early years foundation stage [75]. This indicator is considered a key measure of early years development across a range of developmental areas, including personal, social, and emotional development; physical development; and communication and language development [75]. The data source for this indicator is the results of the Department of Education's early years foundation stage profile, a statutory framework that sets the standards that schools and childcare providers must meet for the learning, development, and care of children from birth until they are aged 5 years [141]. It requires that children be assessed in the summer term of the academic year during which they turn 5 years old; children who have been held back are included in the results for the year in which they are assessed. The objective is to provide an accurate representation of each child's development at the end of the early years foundation stage in order to support their transition into year 1 of school. The early years

foundation stage profile is made up of an assessment of the child's outcomes in relation to 17 early learning goals across 7 areas of learning: 3 prime areas of learning and 4 specific areas of learning. These are [141]:

1. Communication and language (prime area of learning)
2. Personal, social, and emotional development (prime area of learning)
3. Physical development (prime area of learning)
4. Literacy (specific area of learning)
5. Mathematics (specific area of learning)
6. Understanding the world (specific area of learning), and
7. Expressive arts and design (specific area of learning).

Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in all three prime areas of learning and in two of the specific areas of learning (mathematics and literacy). This indicator is reported annually, and data are available by region, ethnic group, first language status, special educational needs status, month born, deprivation decile, and sex [75,142].

'Loneliness: percentage of adults who feel lonely often or always or some of the time' is measured as the percentage of adults aged 16 years and over who responded to the question "How often do you feel lonely?" with 'always or often' or 'some of the time' [143]. The aim of including a direct measure of loneliness in the Public Health Outcomes Framework is to "inform and focus future work on loneliness at both a national and local level, providing a focus to support strategic leadership, policy decisions and service commissioning" [143]. The data source for this indicator is the Active Lives Adult Survey, a twice-yearly survey conducted by Sport England and published by the Office for Health Improvement and Disparities in order to gain insight into how people are getting active in England [144]. This indicator is reported annually and weighted by working status, disability, socioeconomic class, and level of education in order to be representative of the population of England [143]. Data are also available by region, age, sex, deprivation decile, and ethnic group [142].

'Child development: percentage of children achieving a good level of development at 2 to 2.5 years' is measured as the percentage of children who received a 2 to 2.5 year review who were at or above the expected level in all five domains of the Ages & Stages Questionnaires, Third Edition (as part of the universal health visitor service, all children in England are eligible for a development review around their second birthday) [145]. The Ages & Stages Questionnaires, Third Edition is a developmental screening tool that indicates developmental progress in children aged 1–66 months [146]. The tool provides information about a child's development in the following five areas in order to identify the child's strengths, as well as areas where the child may need additional support [147]:

1. Communication
2. Personal-social development
3. Problem solving
4. Gross motor skills, and
5. Fine motor skills.

The Ages & Stages Questionnaires, Third Edition is one of several measures included in the Healthy Child Programme, an early intervention and prevention public health programme that involves a home health

visitation service which focuses on “providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting” [148]. The questionnaire is considered an appropriate and objective means by which to generate data for a population measure of child development outcomes [145]. The Public Health Outcomes Framework online platform states that this indicator “will help to build a picture of child development at age 2 to 2½ at national and local level…[and] support local areas in assessing the effectiveness and impact of services for 0 to 2 year olds and with planning services for children age 2 and beyond” [145]. The Office for Health Improvement and Disparities collects the data for this indicator from local authorities. This indicator is reported annually, and data are available by region and deprivation decile [142,145].

The next two indicators, ‘Child development: percentage of children achieving the expected level in communication skills at 2 to 2.5 years’ and ‘Child development: percentage of children achieving the expected level in personal social skills at 2 to 2.5 years’, are drawn from the same data source as the previous indicator: communication skills and personal social skills are two of the five domains of development assessed in the Ages & Stages Questionnaires, Third Edition. In the Public Health Outcomes Framework, these domains are reported as separate indicators to the overall assessment of development in order to provide greater insight specifically into child communication and social skills development. However, the information provided in the previous paragraph also applies to these two indicators.

The final four indicators, ‘Self-reported wellbeing: people with a low satisfaction score’, ‘Self-reported wellbeing: people with a low worthwhile score’, ‘Self-reported wellbeing: people with a low happiness score’, and ‘Self-reported wellbeing: people with a high anxiety score’, are measured as the percentage of respondents scoring 0–4 on each of the following four questions [149]:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, to what extent do you feel the things you do in your life are worthwhile?
3. Overall, how happy did you feel yesterday?
4. Overall, how anxious did you feel yesterday?

Responses are given on a scale of 0–10, where 0 is ‘not at all’ satisfied, worthwhile, happy, or anxious and 10 is ‘completely’ satisfied, worthwhile, happy, or anxious [149–152]. The Office for National Statistics (the UK’s largest independent producer of official statistics and the recognised national statistical institute of the UK [153]) is leading a programme of work to develop broader measures of population well-being because it was felt that economic measures, such as gross domestic product, are necessary (albeit insufficient) to reflect overall national progress or well-being [149]. The data source for these indicators is the Annual Population Survey published by the Office for National Statistics [149]. The Annual Population Survey is a continuous household survey in the UK covering topics such as employment and unemployment, as well as housing, ethnicity, religion, health, and education, in order to provide information on important social and socioeconomic variables at local level [154]. The scoring varies slightly between the four indicators: for the satisfaction, happiness, and worthwhile indicators, the percentage of people scoring 0–4, 5–6, 7–8, and 9–10 is calculated [149–151], whereas for the anxiety indicator, the percentage of people scoring 0–1, 2–3, 4–5, and 6–10 is calculated [152]. In the Public Health Outcomes Framework, all four of these indicators are reported annually, and data are available by region, age, sex, working status, deprivation decile, sexuality, religion, and ethnic group [142,149–152].

3.7.1.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the National Health Service (NHS) Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.1.3.2.1 The Public Health Outcomes Framework

Although the supporting information provided alongside the Public Health Outcomes Framework describes the caveats associated with each outcome indicator, the benefits of each indicator are not explicitly described.

In relation to 'School readiness: percentage of children achieving a good level of development at the end of Reception', it is noted that the indicator only includes children with a valid result for every area of learning in the early years foundation stage profile [141]; children with any exemption or missing scores in any area of their early years foundation stage profile are excluded [75]. In addition, while all providers of State-funded early years education in England (including those in the private, voluntary, and independent sector) are included in this indicator, data for children in the private, voluntary, and independent sector (which is no longer in receipt of public funding) are not in the scope of the early years foundation stage profile data collection, and are therefore not included in the results [75].

In relation to 'Loneliness: percentage of adults who feel lonely often or always or some of the time', it is noted that the first set of data on loneliness prevalence was at the local authority level, and due to small sample sizes, it was necessary to merge the 'often or always' response category with the next most severe category of loneliness, feeling lonely 'some of the time', meaning that local authorities might underestimate or overestimate the level of loneliness in their area [143]. In addition, the supporting information for this indicator cites research showing that some groups, such as men, may underreport loneliness when responding to a direct question, like that included in the Active Lives Adult Survey [144] ("How often do you feel lonely?"), which may need to be considered when interpreting the results [143].

In relation to 'Child development: percentage of children achieving a good level of development at 2 to 2.5 years', it is noted that there are concerns about the quality of the data for this indicator [145]. Specifically, data for this indicator are quality assured and then aggregated by local authorities before being submitted to the Office for Health Improvement and Disparities; however, data quality issues exist at the local level, and there is variability both within and between areas in relation to how and where the Ages & Stages Questionnaires, Third Edition are administered, and in relation to how the data are collected and processed. It is anticipated that many of these issues will be resolved in the long term with upcoming changes to data collection and processing procedures. Currently, however, it is advised that this indicator should be interpreted with caution [145]. Although the supporting information provided for the Public Health Outcomes Framework does not explicitly identify the benefits of this (or any other) indicator, it is noted that the indicator allows the Office for Health Improvement and Disparities to "measure trends and improvements in child development outcomes which will drive school readiness and longer-term outcomes in later life such as education, employment and life chances" [145]. In addition, it can help to identify where inequalities lie in terms of the number of children who achieve the expected level in their development [145]. The Public Health Outcomes Framework online platform states that this indicator "will help to build a picture of child development at age 2 to 2½ at national and local level…[and]

support local areas in assessing the effectiveness and impact of services for 0 to 2 year olds and with planning services for children age 2 and beyond" [145].

As described in Section 3.7.1.3.1.1, all information provided in relation to the 'Child development: percentage of children achieving a good level of development at 2 to 2.5 years' indicator, including the limitations associated with the use of this indicator, applies to the 'Child development: percentage of children achieving the expected level in communication skills at 2 to 2.5 years' and 'Child development: percentage of children achieving the expected level in personal social skills at 2 to 2.5 years' indicators.

In relation to the final four indicators, 'Self-reported wellbeing: people with a low satisfaction score', 'Self-reported wellbeing: people with a low worthwhile score', 'Self-reported wellbeing: people with a low happiness score', and 'Self-reported wellbeing: people with a high anxiety score', it is emphasised that the indicators are simply estimates based on a sample of the general population from each local area. For these indicators, as well as any other indicator published by the Office for National Statistics, standard errors, coefficients of variation, and confidence intervals should be used in order to fully assess the quality of the data available for each area [149]. In addition, the Annual Population Survey in the UK [154] is a mixed mode data collection survey involving both face-to-face and telephone interviews. It is reported that the method of data collection has affected responses to the survey, such that higher than average ratings for the life satisfaction question were provided by respondents interviewed via telephone compared with those who were asked during face-to-face interviews [149]. It is also emphasised that differences in levels of well-being between local areas should not be interpreted to reflect differences in people's views of their local area, as several factors can affect a person's satisfaction, happiness, anxiety, and perception that life is worthwhile, including their health, relationships, and employment situation [149].

3.7.1.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.3.2.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.3.2.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.4 New Zealand

3.7.1.4.1 What are the relevant mental health indicators?

3.7.1.4.1.1 *He Ara Oranga wellbeing outcomes framework*

As mentioned in Section 3.4.1.1, the shared perspective of well-being in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework*, published in 2021, encompasses 31 outcome indicators to measure well-being across 6 outcome domains ('Being safe and nurtured', 'Having what is needed', 'Having one's rights and dignity fully realised', 'Healing, growth, and being resilient', Being connected and valued', and 'Having hope and purpose') [36]. Each outcome indicator is underpinned by an outcome concept. However, it is important to note that there is very limited information available pertaining to the nature of the indicators in the 2021 *He Ara Oranga wellbeing outcomes framework*, which is the only publication on this framework to date. Of the 31 outcome indicators, the following 11 were deemed relevant to *Sharing the Vision* outcome 1(a) [36]:

1. The proportion of people who report feeling lonely a little or none of the time in the last four weeks (domain 1, ‘Being safe and nurtured’)
2. The proportion of adults who had face to face contact with friends who do not live with them at least some of the time (domain 1, ‘Being safe and nurtured’)
3. A sense of belonging (domain 1, ‘Being safe and nurtured’)
4. The proportion of people who score 7 out of 10 or higher for life satisfaction (domain 2, ‘Having what is needed’)
5. The proportion of people who report high positive mental wellbeing (domain 4, ‘Healing, growth, and being resilient’)
6. The proportion of people who say it would be ‘easy’ or ‘very easy’ to talk to someone if they felt down or a bit depressed (domain 4, ‘Healing, growth, and being resilient’)
7. The proportion of people who rate their family wellbeing highly (domain 4, ‘Healing, growth, and being resilient’)
8. The proportion of people who think it is easy to be themselves in New Zealand (domain 5, ‘Being connected and valued’)
9. The proportion of people who report life is worthwhile (domain 6, ‘Having hope and purpose’)
10. The proportion of people who report having high life satisfaction (domain 6, ‘Having hope and purpose’), and
11. The proportion of people who feel they have control over their lives (domain 6, ‘Having hope and purpose’).

‘The proportion of people who report feeling lonely a little or none of the time in the last four weeks’ is underpinned by the outcome concept that people should enjoy nurturing relationships [155]. The data source for this indicator is the New Zealand General Social Survey, which is conducted by Statistics New Zealand (New Zealand’s official data agency [156]) every 2 years in order to collect information about the well-being of New Zealanders aged 15 years and over. The survey covers a wide range of social and economic outcomes and provides a view of how well-being outcomes are distributed across different population groups [157].

‘The proportion of adults who had face to face contact with friends who do not live with them at least some of the time’ is underpinned by the outcome concept that people of all ages should have a sense of belonging in families and/or social groups, and that people who experience disconnection can reconnect or form positive new connections [155]. The data source for this indicator is also the New Zealand General Social Survey [157].

‘A sense of belonging’ is underpinned by the same concept as the previous indicator [155]. The data source is the Programme for International Student Assessment, an international standardised research study to assess key learning areas that began in the year 2000 and is conducted every 3 years [158], and so the indicator pertains to a sense of belonging among students in New Zealand specifically. The Programme for International Student Assessment assesses students’ achievement in three key areas (reading literacy, mathematic literacy, and scientific literacy), although a large amount of contextual background information is also collected [159]. The study asks students whether they ‘strongly disagree’, ‘disagree’, ‘agree’, or ‘strongly agree’ with the following statements about their school: “I feel like an outsider (or left out of things) at school”, “I make friends easily at school”, “I feel like I belong at school”, “I feel awkward and out of place in my school”, “Other students seem to like me”, and “I feel lonely at

school". These statements were combined to create the sense of belonging index, with an average of 0 and a standard deviation of 1 across Organisation for Economic Co-operation and Development (OECD) member countries [159].

'The proportion of people who score 7 out of 10 or higher for life satisfaction' is underpinned by the outcome concept that people, families, and communities should have the resources needed to flourish [155]. The data source for this indicator (and all remaining indicators in this section, with the exception of the final indicator, 'The proportion of people who feel they have control over their lives') is the New Zealand General Social Survey [157].

'The proportion of people who report high positive mental wellbeing' is underpinned by the outcome concept that people should enjoy emotional well-being [155].

'The proportion of people who say it would be 'easy' or 'very easy' to talk to someone if they felt down or a bit depressed' is underpinned by the outcome concept that people should have the skills, resources, and support needed in order to deal with the stresses, challenges, and transitions of life [155].

'The proportion of people who rate their family wellbeing highly' is underpinned by the outcome concept that people should be able to experience and manage a range of emotions, and families should celebrate each other's strengths [155].

'The proportion of people who think it is easy to be themselves in New Zealand' is underpinned by the outcome concept that people should be valued for who they are and free to express their unique identities [155].

'The proportion of people who report life is worthwhile' is underpinned by the outcome concept that people should have a sense of purpose and have hope about the future [155].

'The proportion of people who report having high life satisfaction' is underpinned by the same outcome concept as the previous indicator [155].

'The proportion of people who feel they have control over their lives' is underpinned by the outcome concept that people should feel as though their opinions are heard and respected, that they can make self-determined decisions about the future, and that they have the resources necessary in order to pursue their goals [155]. In the *He Ara Oranga wellbeing outcomes framework*, which is the only publication on these indicators to date, this indicator had yet to be developed [100].

3.7.1.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43]. Of these indicators, two were deemed relevant to *Sharing the Vision* outcome 1(a), both of which fall under the 'Mental health of the population' outcome domain. These indicators are [43]:

1. Life satisfaction, and
2. Psychological distress.

'Life satisfaction' was measured as the proportion of people in New Zealand aged 15 years and over who reported that they were 'very satisfied' or 'satisfied' with their life as a whole [43]. The data were

reported by age, sex, ethnicity, and neighbourhood deprivation status. The data source for this indicator was the New Zealand General Social Survey [157].

'Psychological distress' was measured as the proportion of people in New Zealand aged 15 years and over who scored 12 or higher on the 10-item Kessler Psychological Distress Scale [127]. This indicator was selected because of research indicating a strong association between scores on the Kessler Psychological Distress Scale and symptoms that meet the criteria for any mental disorder, but especially for anxiety and mood disorders [43]. The data were reported by age, sex, ethnicity, and neighbourhood deprivation status. The data source for this indicator was the New Zealand Health Survey, an annual survey that aims to provide information about the health and well-being of New Zealanders [160].

3.7.1.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.1.4.2.1 *He Ara Oranga wellbeing outcomes framework*

There was no specific information pertaining to the benefits and limitations associated with the outcome indicators included in the *He Ara Oranga wellbeing outcomes framework*.

3.7.1.4.2.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.4.2.3 *National Indicators 2012*

The *National Indicators 2012* report described the benefits and limitations associated with one of the two mental health and addiction indicators relevant to *Sharing the Vision* outcome 1(a), specifically the 'Life satisfaction' indicator (there were no benefits or limitations in relation to the 'Psychological distress' indicator described in the report) [43]. Specifically, the use of a subjective measure to assess life satisfaction in the general population was identified as a limitation of using this indicator. The report stated that subjective measures of well-being should be used alongside measures of objective conditions – such as suicide rates, service access, employment rates, and standard of living – in order to gain an accurate picture of population mental health and well-being [43]. However, it also stated that, "While subjective wellbeing measures have their shortcomings, research has established that they are sufficiently reliable and valid for wider use…. The variability between individuals in what is important for wellbeing makes a subjective life satisfaction indicator useful to gain comparability across the population" [43 p6].

3.7.1.5 Scotland (UK)

3.7.1.5.1 What are the relevant mental health indicators?

3.7.1.5.1.1 Public Health Scotland mental health indicators

As mentioned in Section 3.5.1, Public Health Scotland established two sets of mental health indicators in 2022: one for adults [105] and one for children and young people [106]. The indicators included in these indicator sets are particularly relevant to *Sharing the Vision* outcome domain 1 because they were developed with an explicit focus on primary prevention in order to emphasise the importance of preventing mental health problems before they emerge [107]. The adult mental health indicator set encompasses 10 mental health outcome indicators (2 related to mental well-being and 8 related to mental health problems) and 45 determinant indicators of mental health outcomes (9 at the individual level, 11 at the community level, and 25 at the structural level) [105].

Of the 55 outcome and determinant indicators included in the adult mental health indicator set, the following 8 were deemed relevant to *Sharing the Vision* outcome 1(a) [105]:

1. Adult mental wellbeing score (mental health outcome indicator)

2. Adult life satisfaction score (mental health outcome indicator)
3. Adult involvement in their local community (community determinant indicator)
4. Adult social support group (community determinant indicator)
5. Adult belonging to their neighbourhood (community determinant indicator)
6. Adult loneliness (community determinant indicator)
7. Adult job stress (structural determinant indicator), and
8. Adult work–life satisfaction score (structural determinant indicator).

'Adult mental wellbeing score' is a mental health outcome indicator [105], measured using the mean adult score on the Warwick-Edinburgh Mental Wellbeing Scale [161], which is a 14-item scale developed to measure mental well-being in the general population and to evaluate projects, programmes, and policies that aim to improve mental well-being [161]. The data source identified for this indicator is the Scottish Health Survey, an annual national survey commissioned by the Scottish Government Health Directorate which aims to provide "a detailed picture of the health of the Scottish population in private households [and] make a major contribution to the monitoring of health in Scotland" [162]. As noted in Section 3.5.1, data for all indicators in the Public Health Scotland mental health indicator sets have yet to be published, and so more detailed information on each of the indicators is not yet available. However, this particular indicator is also included in the National Performance Framework, and so additional information pertaining to the nature of this indicator can be found in Section 3.7.1.5.1.2.

'Adult life satisfaction score' is a mental health outcome indicator that is measured using the mean adult score of how satisfied individuals are with their life as a whole. The data source identified for this indicator is the Scottish Health Survey [162].

'Adult involvement in their local community' is a community determinant indicator of mental health outcomes that is measured as the percentage of adults who feel involved in their local community 'a great deal' or 'a fair amount'. The data source identified for this indicator is the Scottish Health Survey [162].

'Adult social support group' is a community determinant indicator of mental health outcomes that is measured as the percentage of adults who report having a primary support group of three people or more to rely on for comfort and support in a personal crisis. The data source identified for this indicator is the Scottish Health Survey [162].

'Adult belonging to their neighbourhood' is a community determinant indicator of mental health outcomes that is measured as the percentage of adults who feel that they belong 'very strongly' or 'fairly strongly' to their immediate neighbourhood [105]. The data source identified for this indicator is the Scottish Household Survey, an annual cross-sectional survey conducted by the Scottish Government since 1999 that "provides robust evidence on the composition, characteristics, attitudes and behaviour of private households and individuals as well as evidence on the physical condition of Scotland's homes" [163]. As noted in Section 3.5.1, data for all indicators in the Public Health Scotland mental health indicator sets have yet to be published, and so more detailed information on each of the indicators is not yet available. However, this indicator contributes to the 'Social capital' indicator in the National Performance Framework, and so additional information pertaining to the nature of this indicator can be found in Section 3.7.1.5.1.2.

'Adult loneliness' is a community determinant indicator of mental health outcomes that is measured as the percentage of adults who report having felt lonely 'some of the time', 'most of the time', 'almost all of

the time', or 'all of the time' in the last week. The data source identified for this indicator is the Scottish Household Survey [105]. This indicator is also included in the National Performance Framework, and so additional information on this indicator can be found in Section 3.7.1.5.1.2.

'Adult job stress' is a structural determinant indicator of mental health outcomes that is measured as the percentage of adults who find their job 'very stressful' or 'extremely stressful'. The data source identified for this indicator is the Scottish Health Survey [162].

Finally, 'Adult work–life satisfaction score' is also a structural determinant indicator of mental health outcomes that is measured as the mean score for how satisfied adults are with their work-life balance (paid work) [105]. The data source identified is also the Scottish Health Survey [162].

Of the 70 outcome and determinant indicators included in the children and young people indicator set, 17 were deemed relevant to *Sharing the Vision* outcome 1(a), one of which ('Mean mental wellbeing') is repeated across different age groups. The 17 indicators in the children and young people indicator set are [106]:

1. Mean mental wellbeing (children aged 12 years and over) (mental health outcome indicator)
2. Mean mental wellbeing (children aged 8–11 years) (mental health outcome indicator)
3. Mean mental wellbeing (children under 8 years of age) (mental health outcome indicator)
4. Pro-social behaviour (mental health outcome indicator)
5. Life satisfaction (mental health outcome indicator)
6. Communication with parents (family and friends determinant indicator)
7. Peer support (family and friends determinant indicator)
8. Loneliness (family and friends determinant indicator)
9. Peer relationship problems (family and friends determinant indicator)
10. Liking school (learning environment determinant indicator)
11. Pressure of schoolwork (learning environment determinant indicator)
12. Pressure to succeed in life (learning environment determinant indicator)
13. View of the future (learning environment determinant indicator)
14. Participation in clubs, groups, or organisations (community determinant indicator)
15. Trusted adult (community determinant indicator)
16. Sense of belonging to the community (community determinant indicator), and
17. Optimism in society's future (structural determinant indicator).

'Mean mental wellbeing' is a mental health outcome indicator [106]. For children aged 12 years and over, this indicator is measured as the mean score for pupils in secondary school years 2–6 on the 14-item Warwick-Edinburgh Mental Wellbeing Scale [161]. The data source identified for this indicator is the Health and Wellbeing Census Scotland, a Scottish Government initiative first implemented in the 2021–22 school year to provide local and national information on the health and well-being of children and young people, as well as on the behaviours that affect their well-being [164]. As of 2022 (when the most recent information in relation to the Public Health Scotland mental health indicator sets was provided), no suitable data source for the remaining two age groups (children aged 8–11 years and children aged under 8 years) had been identified.

‘Pro-social behaviour’ is a mental health outcome indicator [106] that is measured as the percentage of pupils in secondary school years 2–6 with a ‘close to average’ score on the prosocial scale of the Strengths and Difficulties Questionnaire, a 25-item behavioural screening tool that assesses 25 attributes across 5 domains [165]:

1. Emotion symptoms (5 items)
2. Conduct problems (5 items)
3. Hyperactivity/inattention (5 items)
4. Peer relations problems (5 items), and
5. Prosocial behaviour (5 items).

The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Life satisfaction’ is also a mental health outcome indicator, and is measured as the percentage of pupils in secondary school years 5–6 who ‘strongly agree’ or ‘agree’ that their life is just right [106]. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Communication with parents’ is a family and friends determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in secondary school years 5–6 who report that it is easy to speak to either their mother (or female carer) or father (or male carer) about things that really bother them [106]. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Peer support’ is a family and friends determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in secondary school years 5–6 who ‘strongly agree’ or ‘agree’ that their friends treat them well. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Loneliness’ is a family and friends determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in secondary school years 5–6 who report ‘hardly ever’ or ‘never’ feeling lonely [106]. The data source identified for the indicator is the Scottish Household Survey [105]. This indicator is also included in the National Performance Framework, and so additional information on it can be found in Section 3.7.1.5.1.2.

‘Peer relationship problems’ is a family and friends determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in secondary school years 2–6 with a ‘slightly raised’, ‘high’, or ‘very high’ score on the peer relationship problems scale of the Strengths and Difficulties Questionnaire [106,165]. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Liking school’ is a learning environment determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in primary school year 7 and secondary school years 2 and 4 who like school ‘a lot’ or ‘a bit’ [106]. The data source identified for this indicator is the Health Behaviour in School-aged Children study, a study conducted every 4 years that aims to gain insight into the well-being, health behaviours, and social context of primary school pupils in year 7 and secondary school pupils in years 2 and 4 in Scotland [166].

‘Pressure of schoolwork’ is a learning environment determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in primary year 7 up to secondary school year 6 who report a lot of pressure from schoolwork [106]. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Pressure to succeed in life’ is a learning environment determinant indicator of mental health outcomes among children and young people, which is anticipated to be measured via an assessment of whether children and young people feel pressure to succeed in life [106]. As of 2022, no suitable data source has been identified for this indicator, as additional developmental work is required.

‘View of the future’ is a learning environment determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in secondary school years 5–6 who ‘strongly agree’ or ‘agree’ that they feel positive about their future [106]. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Participation in clubs, groups, or organisations’ is a community determinant indicator of mental health outcomes among children and young people, and is measured as the percentage of pupils in secondary school years 1–6 who have participated in one or more clubs or activities in the previous year [106]. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Trusted adult’ is a community determinant indicator of mental health outcomes among children and young people that is measured as the percentage of pupils in secondary school years 5–6 who report always having an adult they trust and can talk to about any personal problems [106]. The data source identified for this indicator is the Health and Wellbeing Census Scotland [164].

‘Sense of belonging to the community’ is a community determinant indicator of mental health outcomes among children and young people, which is anticipated to be measured via an assessment of whether children and young people feel like they belong to a community [106]. As of 2022, no suitable data source has been identified for this indicator, as additional developmental work is required.

Finally, ‘Optimism in society’s future’ is a structural determinant indicator of mental health outcomes among children and young people, which is anticipated to be measured via an assessment of children and young people’s sense of optimism regarding the future of society, including anxieties related to climate change, politics, the power and influence of older generations, employment, and the economy [106]. As of 2022, no suitable data source has been identified for this indicator, as additional developmental work is required.

3.7.1.5.1.2 The National Performance Framework

As mentioned in Section 3.5.2, the National Performance Framework tracks Scotland’s progress against 11 national outcomes (not all of which are related to mental health, or even to health in general) using a total of 81 national indicators that provide a measure of national well-being in Scotland [114]. Twelve indicators of the following four national outcomes were deemed most relevant to *Sharing the Vision* outcome 1(a) [38]:

1. Children and young people
2. Communities
3. Education, and
4. Health.

These 12 indicators are [38]:

1. Child social and physical development (‘Children and young people’ national outcome)
2. Child wellbeing and happiness (‘Children and young people’ national outcome)
3. Children’s voices (‘Children and young people’ national outcome)
4. Children have positive relationships (‘Children and young people’ national outcome)

5. Loneliness (‘Communities’ national outcome)
6. Social capital (‘Communities’ national outcome)
7. Participation in a cultural activity (‘Communities’ national outcome)
8. Confidence of children and young people (‘Education’ national outcome)
9. Resilience of children and young people (‘Education’ national outcome)
10. Engagement in extra-curricular activities (‘Education’ national outcome)
11. Young people’s participation (‘Education’ national outcome), and
12. Mental wellbeing (‘Health’ national outcome).

‘Child social and physical development’ measures the percentage of children about whom there is a concern that their development may not be up to standard at their 27–30-month review (as a percentage of children reviewed). This 27–30-month review was introduced in Scotland in April 2013, and is conducted by personnel known as Health Visitors who assess the child’s development by [167]:

- Asking parents/carers about any concerns they have regarding their child’s development
- Asking about the child’s developmental abilities and attainment of relevant milestones
- Carefully observing the child, and
- Asking parents to complete a questionnaire about their child’s development.

Health Visitors assess the following eight domains of children’s development during each review [167]:

1. Speech, language, and communication
2. Gross motor
3. Fine motor
4. Problem solving
5. Personal/social
6. Emotional/behavioural
7. Vision, and
8. Hearing.

Public Health Scotland has published statistics from Health Visitors’ assessments of children’s development at these reviews since 2013 [167,168]. Data for this indicator are available for each financial year from 2013–14 to 2020–21, and data breakdowns are available by language spoken, ethnicity, gender, looked-after children status, and Scottish Index of Multiple Deprivation [167].

‘Child wellbeing and happiness’ measures the percentage of 4–12-year-old children who have a ‘borderline’ or ‘abnormal’ score on the Strengths and Difficulties Questionnaire [165] within the Scottish Health Survey [162]. The data for this indicator are reported annually, encompassing the previous 4 years; the earliest data available are from the 2012–15 period and the most recent data available are from the 2017–21 period [38]. Data breakdowns for this indicator are available by gender, age, limiting illness status, and Scottish Index of Multiple Deprivation, as well as by the five dimensions used in the Strength and Difficulties Questionnaire [38].

‘Children’s voices’ measures the percentage of young people who feel that adults take their views into account in decisions which affect their lives [169]. The data source for this indicator is the biennial Young People in Scotland Survey, a survey of secondary school children in 50 local authority secondary State schools across Scotland which is conducted by Ipsos, an independent market research company [170]. Data for this indicator are available for the years 2017 and 2019, and data breakdowns are available by age, gender, school year, ethnicity, religion, long-term illness or disability, urban/rural classification, and Scottish Index of Multiple Deprivation [169].

‘Children have positive relationships’ measures the percentage of pupils in secondary school years 2 and 4 who report having three or more close friends [38]. The data source for this indicator is the Health and Wellbeing Census Scotland [164]. Data for this indicator are available approximately every 3 years (data are currently available for the years 2010, 2013, 2015, and 2018), and breakdowns are available by sex, year group, Scottish Index of Multiple Deprivation, carer status, parental status, and disability [38].

‘Loneliness’ is measured as the percentage of adults who report having felt lonely ‘some of the time’, ‘most of the time’, ‘almost all of the time’, or ‘all of the time’ in the last week [38]. This indicator is considered an indirect measure of loneliness [171]. The data for this indicator are sourced from the Scottish Household Survey [163]. Thus far, data for this indicator are available only for the year 2020, and data breakdowns are available by age, disability, ethnicity, gender, Scottish Index of Multiple Deprivation, urban/rural classification, and local authority [38].

‘Social capital’ is an index measure based on four social capital themes “that collectively provide an important part of personal and social wellbeing now and in the future” [172]. These four themes are [172]:

1. Social networks
2. Community cohesion
3. Social participation, and
4. Community empowerment.

The index was developed using 18 survey questions from the Scottish Household Survey [105] in order to monitor aggregate changes in levels of social capital since 2013 [172]. In relation to tracking change over time, the National Performance Framework website states, “To account for the different magnitude of scores, each of the questions has been indexed and set to the value 100 for the base year 2013, and the percentage changes in subsequent years, relative to the base year” [172].

‘Participation in a cultural activity’ measures the percentage of adults who have participated in a cultural activity in the last 12 months [173]. For the purposes of this indicator, ‘participation in a cultural activity’ is defined as participation in at least one type of cultural activity. The National Performance Framework website provides a list of activities that are considered in scope, which includes, for example: reading books for pleasure, dance (either for fitness or not), crafts, creative writing, viewing cultural content online, playing a musical instrument or writing music, and singing in a group or choir. The data for this indicator are sourced from the Scottish Household Survey [163]. Thus far, data for this indicator are available only for the year 2020, and data breakdowns are available by gender, age, Scottish Index of Multiple Deprivation, disability, religion, ethnicity, urban/rural classification, local authority, and highest level of education [173].

‘Confidence of children and young people’ is one of the new indicators identified following the 2018 review of the National Performance Framework, and therefore it is still in development [38].

‘Resilience of children and young people’ is also one of the new indicators identified following the 2018 review of the National Performance Framework, and therefore it is still in development [38].

‘Engagement in extra-curricular activities’ is another new indicator identified following the 2018 review of the National Performance Framework, and therefore it is still in development [38].

‘Young people’s participation’ is measured as the percentage of young adults (aged 16–19 years) participating in education, training, or employment [38]. This indicator provides a measure of the status of the wider 16–19-year-old cohort, not just those who have left school. According to the National Performance Framework website, this helps to inform policy, planning, and service delivery. This indicator is based on the Annual Participation Measure, which is published by Skills Development Scotland (the national skills body supporting people and businesses in Scotland to develop and apply their skills [174]) using a shared dataset held by Skills Development Scotland on its customer support system [175]. Partners who provide input to the shared dataset are Skills Development Scotland’s corporate training system, local authorities, schools, colleges, Student Awards Agency Scotland, the Scottish Funding Council, and the Department for Work and Pensions [175]. Participation status for each individual (participating, not participating, or unconfirmed) is based on how they are classified for the highest number of days over the course of the year. The following forms of participation are in scope for this indicator [175]:

- School pupil
- Further education
- Higher education
- Modern apprenticeship
- Full-time employment
- Part-time employment
- Self-employed
- Data import – employed
- Employment fund stages 2–4
- Activity agreements (2016–19)
- Other formal training
- Personal/skills development, and
- Voluntary work.

Definitions of each form of participation are provided in the indicator technical note on the National Performance Framework website [175]. Annual data for this indicator are available from 2016 to 2022, and data breakdowns are available by age, disability, ethnicity, gender, and Scottish Index of Multiple Deprivation [38].

Finally, ‘Mental wellbeing’ is measured using the 14-item Warwick-Edinburgh Mental Wellbeing Scale [161]. Limited information is provided on the National Performance Framework website in relation to this indicator; however, annual data for this indicator are available from 2006 to 2021, and data breakdowns are available by age, gender, Scottish Index of Multiple Deprivation, limiting long-term health condition status, and urban/rural classification [38].

3.7.1.5.1.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.1.5.2.1 Public Health Scotland mental health indicators

Specific information pertaining to the benefits and limitations associated with the outcome and determinant indicators included in Public Health Scotland's mental health indicator sets for adults and for children and young people is not currently available.

3.7.1.5.2.2 The National Performance Framework

In the literature sourced, there are very few benefits or limitations described in relation to the indicators included in the National Performance Framework. Commentary of this nature was provided for only two of the indicators in the National Performance Framework.

The first indicator is 'Loneliness', for which data are gathered at the local authority level. The National Performance Framework website states, "Estimates are subject to sampling error and, particularly for small councils, will give only a broad indication of change at local authority level. Some councils may choose to gather similar data through local surveys of their residents though differences in data collection methods may make comparisons of these data difficult" [38]. There were no explicit benefits described in relation to the use of this indicator on the National Performance Framework website.

The second indicator is 'Young people's participation'. As mentioned in Section 3.7.1.5.1.2, one of the partners that contributes to Skills Development Scotland's shared dataset is the Department for Work and Pensions, which provides data for individuals aged 16–19 years who are in receipt of Universal Credit. The inclusion of these data since 2021 has led to improvements in data quality such that this indicator can now provide information on people who are out of work (unemployed, seeking employment, and economically inactive) [175]. None of the limitations described in relation to this indicator are relevant for the purposes of this evidence brief.

3.7.1.5.2.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(a).

3.7.1.6 The OECD

3.7.1.6.1 What are the relevant mental health indicators?

3.7.1.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the Organisation for Economic Co-operation and Development (OECD) Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. It should be noted that limited information pertaining to the development and nature of the indicators is provided in the OECD report. Of the 23 benchmarking indicators, 1 was deemed relevant to *Sharing the Vision* outcome 1(a). This indicator, which falls under dimension 4, 'Preventing mental illness and promoting mental well-being', is 'Life satisfaction' [27].

This indicator was selected as a population-level measure of positive mental health outcomes. In the OECD 2021 report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, this indicator was reported by 33 out of 38 OECD member countries, including Australia, Canada, New Zealand, the UK, and Ireland. The data source for this indicator was the OECD Better Life Index, which enables comparisons of population-level well-being across countries in 11 domains the OECD identified as essential to well-being, including work-life balance, health, and life satisfaction [176]. This indicator uses each country's national average score in the life satisfaction domain of the OECD Better Life Index [27].

3.7.1.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.1.6.2.1 The OECD Mental Health System Performance Benchmark

There were no explicit benefits or limitations associated with the 'Life satisfaction' indicator described in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.7.2 Outcome 1(b): Positive mental health, resilience, and psychological wellbeing amongst priority groups…through targeted promotion and preventive mechanisms

3.7.2.1 Australia

3.7.2.1.1 What are the relevant mental health indicators?

3.7.2.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

None of the performance indicators included in *The Fifth National Mental Health and Suicide Prevention Plan* were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.1.1.2 The services for mental health performance indicator framework

None of the outcome or output indicators included in the services for mental health performance indicator framework were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.2 Canada

3.7.2.2.1 What are the relevant mental health indicators?

3.7.2.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing directions, changing lives: The mental health strategy for Canada* (‘Promotion and prevention’, ‘Recovery and rights’, ‘Access to services’, ‘Disparities and diversity’, ‘First Nations, Inuit, and Métis’, and ‘Leadership and collaboration’) [31,59]. Eight of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 1(b), all of which fall under strategic direction 4, ‘Disparities and diversity’ [59]. Some of the indicators are repeated across different groups (e.g. see ‘Stress’ in the list below). The eight indicators are [31]:

1. Stress – immigrants
2. Stress – lesbian, gay, or bisexual individuals
3. Stress – residents of Northern communities
4. Self-rated mental health – immigrants
5. Self-rated mental health – lesbian, gay, or bisexual individuals
6. Self-rated mental health – residents of Northern communities
7. Self-rated mental health – people with common mental health conditions, and
8. Sense of belonging among immigrants.

‘Stress’ is measured as the percentage of individuals aged 15 years and over in the following groups who report that most days are ‘quite a bit stressful’ or ‘extremely stressful’ in a given year [31]:

- Immigrants
- Canadians who identify themselves as lesbian, gay, or bisexual, and

- Residents of Northern communities.

Data on immigrants for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31]. Data on lesbian, gay, or bisexual individuals were sourced from a special tabulations request from Statistics Canada [31,134]. Data on residents of Northern communities for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31].

'Self-rated mental health' is measured as the percentage of individuals aged 12 years and over in the following groups who report their mental health as being 'very good' or 'excellent' in a given year [31]:

- Immigrants
- Canadians who identify themselves as lesbian, gay, or bisexual
- Residents of Northern communities, and
- People with common mental health conditions.

This indicator reflects the sentiment that mental health is not equivalent to the absence of mental illness, and self-rated mental health indicates a person's capacity for enjoyment, sense of well-being, and coping abilities despite existing challenges and limitations. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator on immigrants, residents of Northern communities, and people with common mental health conditions were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time. Data on lesbian, gay, or bisexual individuals for this indicator were sourced from a special tabulations request from Statistics Canada, Canada's national statistical office [31,134].

'Sense of belonging among immigrants' is measured as the percentage of immigrants aged 12 years and over who describe their sense of belonging to their local community as 'somewhat strong' or 'very strong' over a given period (2011–12 in *Informing the Future: Mental Health Indicators for Canada*) [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31].

3.7.2.2.1.2 The Positive Mental Health Surveillance Indicator Framework

As mentioned in Section 3.2.2, the Positive Mental Health Surveillance Indicator Framework contains a core set of indicators organised into five categories: positive mental health outcome indicators, and four domains of mental health determinant indicators (i.e. risk and protective factors) organised at the individual, family, community, and society levels [32]. None of the indicators are reported for specific priority groups. However, with the exception of 'Community involvement', 'Social networks', and 'School involvement', the data for all indicators in the Positive Mental Health Surveillance Indicator Framework that are relevant to this evidence brief (under *Sharing the Vision* outcome 1(a) in Section 3.7.1.2.1.2) are available by sex, age group, highest level of education, household income quintile, province/territory, population centre/rural area of residence, immigrant status, and ethnicity. Data for 'Community involvement' and 'Social networks' in the adult cohort of the Positive Mental Health Surveillance Indicator Framework are available by sex, age group, province/territory, urban/rural residence, and immigrant status. Data for these indicators in the youth cohort of the Positive Mental Health Surveillance Indicator Framework are only available by sex and grade. For 'School environment' in the Youth Framework, data are also only available by sex and grade [32].

3.7.2.2.1.3 The Canadian Chronic Disease Indicators

As mentioned in Section 3.2.3, the Canadian Chronic Disease Indicators consists of a total of 36 pan-Canadian chronic disease indicators, which provide information about the burden of chronic conditions and associated determinants. The indicators are categorised into six domains ('Social and environmental determinants', 'Maternal and child health risk and protective factors', 'Behavioural risk and protective factors', 'Risk conditions', 'Disease prevention practices', and 'Health outcomes/status') [45]. Each indicator is assessed using one or more indicator measures that provide "estimates of the burden of chronic conditions and measures of general health and associated determinants" [65 p281].

None of the Canadian chronic disease indicators are specific to one or more priority groups in Canada. However, the two indicators relevant to *Sharing the Vision* outcome 1(a), 'Chronic stress' and 'General health', while not reported for specific priority groups in the latest data available, are available according to sex, age group, province (crude and age-standardised), population centre/rural area, highest level of education (by household and for respondents aged 20 years and over), household income adequacy, Indigenous status, immigrant status, and trends over time (age-standardised) [45] (see Section 3.7.1.2.1.3 for more information about these indicators).

3.7.2.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.2.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not explicitly identify the benefits of the indicators, but, where relevant, we highlight information provided that could be considered a benefit of a given indicator.

In relation to 'Stress', the limitations described in *Informing the Future: Mental Health Indicators for Canada* vary depending on the group being examined. For example, the group 'immigrants' is highly diverse and includes individuals who entered Canada as refugees and individuals who have been in Canada for varying lengths of time. For lesbian, gay, or bisexual individuals, it was noted that a large proportion of individuals who completed the survey did not respond to the question about sexual orientation, which limits the accuracy of this indicator. Moreover, the question being analysed only refers to lesbian, gay, or bisexual orientation, and excludes other sexual identities such as intersex, transgender, queer, and questioning. Although this was not explicitly described as a benefit of this indicator, *Informing the Future: Mental Health Indicators for Canada* stated that "monitoring this indicator provides information on vulnerability associated with sexual orientation" [31 p31]. Finally, for residents of Northern communities, the report noted that small sample sizes in these communities can affect the accuracy of results [31].

In relation to 'Self-rated mental health', a common limitation for the use of this indicator for all groups (immigrants; lesbian, gay, or bisexual individuals; residents of Northern communities; and people with common mental health conditions) was that high self-rated mental health does not necessarily denote the absence of a mental health condition. For immigrants specifically, as with the limitation associated with the indicator 'Stress' among immigrants, the report noted that this group is a highly diverse one and includes individuals who entered Canada as refugees and individuals who have been in Canada for varying lengths of time. In addition, the fact that individuals with serious mental health conditions are often denied entry to Canada could contribute to high ratings for this indicator. For both lesbian, gay, or bisexual individuals and residents of Northern communities, the limitations in relation to the 'Stress' indicator are the same as those described in the previous paragraph. For people with common mental

health conditions, the report notes that 'common mental health conditions' includes mood and anxiety disorders only, and as such, this indicator is not representative of all people with mental health conditions [31].

One limitation associated with the use of the 'Sense of belonging among immigrants' indicator is that, while one's sense of belonging is an important protective factor against mental health problems, the survey question that informs this indicator uses the phrase 'local community', which could be interpreted in a number of ways. For instance, individuals may feel a strong sense of belonging with a particular subgroup or subculture, but may not feel a sense of belonging to the broader community in which they live. Other limitations described for this indicator are the same as those described for the 'Stress' and 'Self-rated mental health' indicators [31].

3.7.2.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the limitations associated with the indicators included in the Positive Mental Health Surveillance Indicator Framework were considered relevant to the purposes of this evidence brief. In addition, there was no information pertaining to indicator benefits.

3.7.2.2.2.3 The Canadian Chronic Disease Indicators

Specific information pertaining to the benefits and limitations of the two Canadian chronic disease indicators relevant to *Sharing the Vision* outcome 1(b) was not provided in the literature sourced.

3.7.2.2.2.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.3 England (UK)

3.7.2.3.1 What are the relevant mental health indicators?

3.7.2.3.1.1 The Public Health Outcomes Framework

As mentioned in Section 3.3.1.1, the Public Health Outcomes Framework contains 193 indicators, which are categorised as either overarching outcome indicators or as supporting indicators [33]. None of the overarching outcome indicators are specific to mental health, and so none were included in this evidence brief. The supporting indicators are further categorised into one of four domains ('Wider determinants of health', 'Health improvement', 'Health protection', and 'Healthcare and premature mortality') [33]. Only one supporting indicator was deemed relevant to *Sharing the Vision* outcome 1(b). This indicator, which falls under the 'Health improvement' domain, is 'Percentage of looked after children whose emotional wellbeing is a cause for concern' [177].

This indicator measures the proportion of all looked-after children aged between 5 and 16 years (inclusive) at the date of their latest assessment who have been in care for at least 12 months and who scored 17 or over (out of a total of 40) on the Strengths and Difficulties Questionnaire (the 25-item behavioural screening measure described in Section 3.7.1.5.1.1) [165]. A higher score indicates more difficulties; a score of under 14 is considered normal, a score of 14–16 is a borderline cause for concern, and a score of 17 and over is a cause for concern [177]. The data for this indicator are collected annually by local authorities and submitted to the Department for Education through the children looked after in England return (also known as the SSDA903 data collection) [178]. Data are available by region, sex, and deprivation decile [142]

3.7.2.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the National Health Service (NHS) Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.2.3.2.1 The Public Health Outcomes Framework

The supporting information provided alongside the Public Health Outcomes Framework describes the caveats associated with each outcome indicator. The benefits of each indicator are not explicitly described in the supporting information.

In relation to 'Percentage of looked after children whose emotional wellbeing is a cause for concern', it is noted that the indicator excludes children looked after under an agreed series of short-term placements, as well as children in respite care [178].

3.7.2.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.3.2.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.3.2.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.4 New Zealand

3.7.2.4.1 What are the relevant mental health indicators?

3.7.2.4.1.1 *He Ara Oranga wellbeing outcomes framework*

As mentioned in Section 3.4.1.1, the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* represents two perspectives of well-being [36]:

1. A Māori perspective, and
2. A shared perspective (many of the outcome indicators described at the shared perspective level are also reported on for Māori).

Although Māori are identified as a significant priority group in the *He Ara Oranga wellbeing outcomes framework*, the outcome indicators are specific to Māori people and the factors that promote their well-being in the New Zealand context. Therefore, they have not been included in this evidence brief.

The shared perspective outcome indicators relevant to the outcomes in *Sharing the Vision* outcome domain 1 are all described in Section 3.7.1.4.1.1. However, none of these indicators appear to be reported for the priority groups, other than Māori, that are identified in the New Zealand Ministry of Health's *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* [97] (for example, refugees and migrants, the LGBTQ+ community, rural communities, disabled people, prisoners, young people, older people, children experiencing adverse childhood events, and children in state care [97]).

3.7.2.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43].

The two mental health and addiction indicators from the *National Indicators 2012* report deemed relevant to *Sharing the Vision* outcome 1(a), 'Life satisfaction' and 'Psychological distress', were not reported for specific priority groups [43]. However, as noted in Section 3.7.1.4.1.3, the data for both indicators were made available by sex, age, ethnicity, and neighbourhood deprivation status. No other mental health and addiction indicators in the *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.2.4.2.1 *He Ara Oranga wellbeing outcomes framework*

With the exception of those reported for Māori, none of the outcome indicators described in the *He Ara Oranga wellbeing outcomes framework* that were deemed relevant to *Sharing the Vision* outcome 1(a) appear to be reported for specific priority groups.

3.7.2.4.2.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.4.2.3 *National Indicators 2012*

Information pertaining to the limitations of one of the mental health and addiction indicators in *National Indicators 2012* that was considered relevant to *Sharing the Vision* outcome 1(b), 'Life satisfaction', is reported in Section 3.7.1.4.2.3 under outcome 1(a). The *National Indicators 2012* report did not describe any benefits or limitations in relation to the 'Psychological distress' indicator.

3.7.2.5 Scotland (UK)

3.7.2.5.1 What are the relevant mental health indicators?

3.7.2.5.1.1 Public Health Scotland mental health indicators

As mentioned in Section 3.5.1, Public Health Scotland established two sets of mental health indicators in 2022: one for adults [105] and one for children and young people [106]. The indicators included in these indicator sets are particularly relevant to *Sharing the Vision* outcome domain 1 because they were developed with an explicit focus on primary prevention in order to emphasise the importance of preventing mental health problems before they emerge [107]. The adult mental health indicator set encompasses 10 mental health outcome indicators (2 related to mental well-being and 8 related to mental health problems) and 45 determinant indicators of mental health outcomes (9 at the individual level, 11 at the community level, and 25 at the structural level) [105]. However, none of the indicators in either the adult or the children and young people mental health indicator set are specific to priority groups.

Public Health Scotland is currently building a collection of resources around both sets of mental health indicators. The first phase of resources was published in March 2022. It was planned that headline trend

data would be published in late 2022, and then kept up to date in order to inform planning and decision-making [112]. The Public Health Scotland website states that the publication of headline trend data would be followed by more in-depth analyses, including demographic breakdowns by the Scottish Index of Multiple Deprivation and equality groups [112] in order to highlight inequalities and the various challenges faced by different population groups [179], which would be particularly relevant to *Sharing the Vision* outcome 1(b). However, we could not source any publications in which data for the Public Health Scotland mental health indicator sets were presented.

3.7.2.5.1.2 The National Performance Framework

As mentioned in Section 3.5.2, the National Performance Framework tracks Scotland's progress against 11 national outcomes (not all of which are related to mental health, or even to health in general) using a total of 81 national indicators that provide a measure of national well-being in Scotland [114]. The National Performance Framework does not include indicators for specific priority groups. However, it does provide detailed breakdowns of equality data via the Equality Evidence Finder website [115] in order to show how people with protected characteristics are progressing on the same indicators, and how they compare to other groups. This helps to ensure that policies and services are designed to meet the needs of everyone in Scotland [114]. It also means that the indicators outlined in Section 3.7.1.5.1.2 for *Sharing the Vision* outcome 1(a) are relevant to *Sharing the Vision* outcome 1(b).

3.7.2.5.1.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.2.5.2.1 Public Health Scotland mental health indicators

Specific information is not currently available pertaining to the benefits and limitations associated with the outcome and determinant indicators included in Public Health Scotland's mental health indicator sets for adults and for children and young people.

3.7.2.5.2.2 The National Performance Framework

As mentioned in Section 3.7.2.5.1.2, the National Performance Framework does not include indicators for specific priority groups. However, it does provide detailed breakdowns of equality data via the Equality Evidence Finder website [115] in order to show how people with protected characteristics are progressing on the same indicators, and how they compare to other groups. Commentary on benefits or limitations was provided for only two indicators in the National Performance Framework: 'Loneliness' and 'Young people's participation' (see Section 3.7.1.5.2.2).

3.7.2.5.2.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(b).

3.7.2.6 The OECD

3.7.2.6.1 What are the relevant mental health indicators?

3.7.2.6.1.1 The OECD Mental Health System Performance Benchmark

None of the benchmarking indicators included in the OECD Mental Health System Performance Benchmark were deemed relevant to *Sharing the Vision* outcome 1(b). However, one indicator worth mentioning in relation to this outcome emphasises the importance of adapting mental health services to the needs of key population groups, including women; older adults; LGBTQI+ people; refugees; migrants;

homeless people; prison populations; and ethnic minorities [27]. This indicator – which falls under dimension 5, 'Strong leadership and good governance' – is 'National strategy for key population groups – one or more'. This was selected as a benchmarking indicator in recognition of the fact that "Mental health status, and mental health system needs, are not homogenous across populations, but instead differ by age, gender, culture or ethnicity, sexual orientation as well as by a wide range of other socially important determinants" [27 p66]. For the purposes of the OECD Mental Health System Performance Benchmark, the OECD reported which of its 38 member countries had developed and implemented a national mental health strategy for one or more key population groups; 19 out of the 38 member countries – including Australia, Canada, New Zealand, and the UK, but excluding Ireland – had done so [27].

3.7.3 Outcome 1(c): Reduced stigma and discrimination arising through improved community wide understanding of mental health difficulties

3.7.3.1 Australia

3.7.3.1.1 What are the relevant mental health indicators?

3.7.3.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21].

Only one indicator was deemed relevant to *Sharing the Vision* outcome 1(c), which is 'Experience of discrimination in people with mental illness' [21]. This indicator measures the proportion of people with a mental illness who report the experience of discrimination [21]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected because "discrimination against people with mental illness can increase feelings of isolation and create barriers to seeking help. A person's right to full inclusion and to a meaningful life of their choosing, free of stigma and discrimination, is key to recovery-oriented care" [124 p23]. There are two data sources for this indicator [180]:

1. The General Social Survey [181] (see Section 3.7.3.1.1.2), and
2. The National Aboriginal and Torres Strait Islander Social Survey [182].

The National Aboriginal and Torres Strait Islander Social Survey is a multidimensional social survey, conducted every 6 years, which collects self-reported data across key areas of social interest for Aboriginal and Torres Strait Islander people at the national level and by remoteness [182]. This indicator was first published in the first progress report on The Fifth Plan in 2018 using data from the 2014 General Social Survey and the 2014–2015 National Aboriginal and Torres Strait Islander Social Survey. The third and fourth progress reports on The Fifth Plan included selected updated data for the years 2019 and 2020 [47,124]. This indicator can be disaggregated by age, sex, state or territory, socioeconomic status, and remoteness [124]. Higher proportions of people with mental illness who have experienced discrimination in the previous 12 months suggests lower levels of well-being [180].

3.7.3.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness, and efficiency [183]. Only one of these indicators was deemed relevant to *Sharing the Vision* outcome 1(c), which is 'Stigma and discrimination experienced by people living with mental health problems or mental illness' [30].

This indicator is an outcome indicator defined as "an indicator of governments' objective to reduce the impact of mental illness (including the effects of stigma and discrimination)" [30]. For the purposes of this indicator, 'mental health problems or mental illness' refers to clinically recognised emotional and behavioural disorders, as well as perceived mental health problems such as feeling depressed, feeling anxious, feeling stressed, and sadness [184]. In addition, an individual is considered to have experienced discrimination if they respond 'yes' to the following question: "In the past 12 months, do you feel that you have experienced discrimination or have been treated unfairly by others?". The types of discrimination given as examples in the question were discrimination based on: skin colour, nationality, race or ethnic

group, language, dress or appearance, gender, age, disability or health issue, marital status, family status, sexual orientation, occupation, religious beliefs, political position, and other [184]. Although this indicator is not specific to discrimination as a result of a person's mental health condition, it is disaggregated by people who do and do not have a mental health condition [30]. The aim is to report on this indicator using two indicator measures [30]:

1. The proportion of people with a mental health condition who have experienced discrimination or been treated unfairly, and
2. The proportion of people with a mental health condition who have experienced discrimination or been treated unfairly because of their mental health condition.

Data for the second measure, however, are not yet available [30]. Data for the first measure are sourced from the General Social Survey, which is conducted every 4 years to collect information about personal and household characteristics for people resident in private dwellings across Australia (excluding very remote areas and people living in discrete Aboriginal and Torres Strait Islander communities), including demographic characteristics; subjective well-being and general life satisfaction measures; and data regarding health and disability, access to service providers, family and community involvement, discrimination, resilience and exclusion, and social networks and community participation [181]. A low or decreasing proportion of people experiencing discrimination or being treated unfairly is desirable [30].

3.7.3.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.3.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan performance indicators [21,124]. The documents do not explicitly identify the benefits associated with each indicator, but, where relevant, we highlight any information provided that could be considered a benefit of any given indicator.

In relation to 'Experience of discrimination in people with mental illness', both the original 2017 publication of The Fifth Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* note that the experience of mental illness is self-reported [21,124] [124]. In addition, the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* notes that while the indicator provides information on the proportion of people who have experienced discrimination in the previous 12 months, the data do not reflect the total number of instances of discrimination experienced, or the severity or impact of these events. Moreover, the data cannot indicate whether the experience of discrimination is directly attributable to the person's mental ill health [124].

3.7.3.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

It is noted in the 2023 Report on Government Services that while the 'Stigma and discrimination experienced by people living with mental health problems or mental illness' indicator measures discrimination among people with a diagnosed mental health condition, the data for the first measure

(the second measure is not yet available) cannot indicate whether the discrimination was perceived to be due to a person's mental illness [30]. In addition, the downloadable Excel data spreadsheet for the mental health section of the *Report on Government Services 2023* notes that for this indicator, mental illness is self-reported [184].

3.7.3.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.2 Canada

3.7.3.2.1 What are the relevant mental health indicators?

3.7.3.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and 'Leadership and collaboration') [31,59]. The following two indicators were deemed relevant to *Sharing the Vision* outcome 1(c) [31]:

1. Willingness to seek help from a mental health professional – college and university students (strategic direction 1, 'Promotion and prevention'), and
2. Discrimination among people with mental health conditions (strategic direction 4, 'Disparities and diversity').

'Willingness to seek help from a mental health professional – college and university students' is described previously under *Sharing the Vision* outcome 1(a) in Section 3.7.1.2.1.1. However, it is identified in *Informing the Future: Mental Health Indicators for Canada* as being relevant to assessing stigma and discrimination in different populations. This is because the indicator could represent a proxy measure of stigma around mental health problems among college and university students, as negative attitudes towards mental health problems are aspects of stigma that can prevent people from seeking help [31].

The information provided in relation to 'Discrimination among people with mental health conditions' in *Informing the Future: Mental Health Indicators for Canada* is limited. However, the indicator is measured as the percentage of Canadians aged 15 years and over with mental health conditions who report having experienced discrimination or being treated unfairly by others over the previous 5 years [31]. Data for this indicator were sourced from the General Social Survey [63,136].

3.7.3.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.3.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not explicitly identify the benefits of the indicators, but, where relevant, we highlight information provided that could be considered a benefit of a given indicator.

The limitations of the first indicator, 'Willingness to seek help from a mental health professional – college and university students', are described previously under *Sharing the Vision* outcome 1(a) in Section 3.7.1.2.2.1.

In relation to the 'Discrimination among people with mental health conditions' indicator, it is noted that the General Social Survey does not include a question about discrimination or unfair treatment experienced because of one's mental health. Instead, discrimination questions are asked in relation to a number of other identifiable and non-identifiable personal characteristics of people who self-report having a mental health condition [31].

3.7.3.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.2.2.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.3 England (UK)

3.7.3.3.1 What are the relevant mental health indicators?

3.7.3.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(dc).

3.7.3.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.4 New Zealand

3.7.3.4.1 What are the relevant mental health indicators?

3.7.3.4.1.1 *He Ara Oranga wellbeing outcomes framework*

As mentioned in Section 3.4.1.1, the shared perspective of well-being in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework*, published in 2021, encompasses 31 outcome indicators to measure well-being across 6 outcome domains ('Being safe and nurtured', 'Having what is needed', 'Having one's rights and dignity fully realised', 'Healing, growth, and being resilient', Being connected and valued', and 'Having hope and purpose') [36]. Each outcome indicator is underpinned by an outcome concept. However, it is important to note that there is very limited information available pertaining to the nature of the indicators in the 2021 *He Ara Oranga wellbeing outcomes framework*, which is the only publication on this framework to date. Of the 31 outcome indicators, 1 was deemed relevant to *Sharing the Vision* outcome 1(c) [36]. This indicator, which falls under domain 4, 'Healing, growth, and being resilient', is 'The proportion of people who say it would be 'easy' or 'very easy' to talk to someone if they felt down or a bit depressed'. This indicator was also deemed relevant to *Sharing the Vision* outcome 1(a), and so further information pertaining to the indicator can be found in Section 3.7.1.4.1.1.

3.7.3.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 1(c), which is 'Perceived discrimination' [43].

This indicator, which fell under the 'Social inclusion' outcome domain, was measured as the proportion of people aged 15 years and over who felt that they had been treated unfairly or had something nasty done to them in the previous year because of the group they belong to or seem to belong to [43]. The indicator was used to compare levels of perceived discrimination between people with and without symptoms of mental distress. For the purposes of the *National Indicators 2012* report, symptoms of mental distress were determined using the Short Form Health Survey, a 12-item questionnaire that assesses general self-rated health, physical and psychological symptoms, and limitations in everyday activity due to physical and mental health over the previous 4 weeks [185]. The indicator was selected because discrimination can be a barrier to social inclusion, and the perception of discrimination (more so than the extent of discrimination in reality) can have negative effects on mental health [43]. Across all levels of mental distress, data were reported and compared by age, ethnicity, and neighbourhood deprivation status. The data source for this indicator was the New Zealand General Social Survey [157].

3.7.3.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.3.4.2.1 *He Ara Oranga wellbeing outcomes framework*

There was no specific information pertaining to the benefits and limitations associated with the outcome indicators included in the *He Ara Oranga wellbeing outcomes framework*.

3.7.3.4.2.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.4.2.3 *National Indicators 2012*

There were no benefits or limitations described in relation to the 'Perceived discrimination' indicator in the Mental Health and Wellbeing Commission's *National Indicators 2012* report.

3.7.3.5 Scotland (UK)

3.7.3.5.1 What are the relevant mental health indicators?

3.7.3.5.1.1 Public Health Scotland mental health indicators

As mentioned in Section 3.5.1, Public Health Scotland established two sets of mental health indicators in 2022: one for adults [105] and one for children and young people [106]. The indicators included in these indicator sets are particularly relevant to *Sharing the Vision* outcome domain 1 because they were developed with an explicit focus on primary prevention in order to emphasise the importance of preventing mental health problems before they emerge [107]. The adult mental health indicator set encompasses 10 mental health outcome indicators (2 related to mental well-being and 8 related to mental health problems) and 45 determinant indicators of mental health outcomes (9 at the individual level, 11 at the community level, and 25 at the structural level) [105].

Of the 55 outcome and determinant indicators included in the adult mental health indicator set, 1 was deemed relevant to *Sharing the Vision* outcome 1(c), which is 'Stigma around mental health'. This is included as a structural determinant indicator of mental health. The construct underpinning this indicator is 'stigma, discrimination, and harassment', all concepts that have a well-documented impact on mental health and well-being, as well as on an individual's ability and likelihood to seek help and support around their mental health [186]. However, this indicator has yet to be developed [105].

Of the 70 outcome and determinant indicators included in the children and young people mental health indicator set, 1 was deemed relevant to *Sharing the Vision* outcome 1(c), which is 'Mental health stigma'. This indicator is included as a structural determinant indicator of mental health [106]. The construct underpinning this indicator is also 'stigma, discrimination, and harassment' [187]. It is anticipated that an estimate for this indicator will be derived from an assessment of children and young people's perception of stigma around mental health. However, as of 2022, no suitable data source has been identified for this indicator [106].

3.7.3.5.1.1 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.5.1.2 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.3.5.2.1 Public Health Scotland mental health indicators

Specific information is not currently available pertaining to the benefits and limitations associated with the outcome and determinant indicators included in Public Health Scotland's mental health indicator sets for adults and for children and young people.

3.7.3.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.5.2.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(c).

3.7.3.6 The OECD

3.7.3.6.1 What are the relevant mental health indicators?

3.7.3.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. None of the benchmarking indicators included in the OECD's *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* were deemed relevant to *Sharing the Vision* outcome 1(c). However, two indicators emphasise the importance of interrogating national approaches to measuring stigmatising attitudes towards mental ill health. These indicators, which both fall under principle 5, 'Strong leadership and good governance', are [27]:

1. Levels of stigma attitudes towards mental health – national or regional attitudes or stigma survey, and
2. Levels of stigma attitudes towards mental health – attitudes towards mental health.

'Levels of stigma attitudes towards mental health – national or regional attitudes or stigma survey' assesses whether countries have introduced anti-stigma campaigns around mental health at either a national or regional level [27]. This indicator provides insight into which countries are attempting to measure the impact of anti-stigma campaigns around mental health. In the OECD's 2021 report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, this indicator was reported by 22 out of 38 OECD member countries, including Australia, Canada, New Zealand, the UK, and Ireland [27]. As of 2021, the 'Levels of stigma attitudes towards mental health – attitudes towards mental health' indicator is not yet internationally available [27].

Notably, the OECD's 2021 report states that OECD member countries that have implemented national surveys to measure mental-health-related attitudes and/or stigma have done so using different measures, making comparison across countries very challenging [27]. The report also emphasises that the systematic repetition of such surveys is important in order to allow for the evaluation of national trends related to mental health attitudes and stigma, as is linking such surveys to the evaluation of a particular anti-stigma programme or campaign [27].

3.7.4 Outcome 1(d): Reduced prevalence of mental health difficulties and/or reduced severity of impact(s) through early intervention and prevention work

3.7.4.1 Australia

3.7.4.1.1 What are the relevant mental health indicators?

3.7.4.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia includes a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21]. The following three indicators were deemed relevant to *Sharing the Vision* outcome 1(d) [21]:

1. Children who are developmentally vulnerable (domain 1, 'Healthy start to life')
2. Prevalence of mental illness (domain 3, 'Good mental health and wellbeing'), and
3. Adults with very high levels of psychological distress (domain 3, 'Good mental health and wellbeing').

'Children who are developmentally vulnerable is measured as the proportion of children residing in Australia who are identified as vulnerable in one or more out of the five domains set out by the Australian Early Development Census [21]. The Australian Early Development Census is a "nationwide data collection of early childhood development at the time children commence their first year of full-time school" [188]. The five domains assessed in the Australian Early Development Census are [188,189]:

1. Physical health and well-being
2. Social competence
3. Emotional maturity
4. Language and cognitive skills (school-based), and
5. Communication skills and general knowledge.

According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected in order to detect poor early learning skills, such as in a child's ability to use language, solve problems, and communicate with others [124]. The Australian Early Development Census is held every 3 years (the most recent being the fifth collection in 2021) and involves teachers of children who are in their first year of full-time school completing the Australian version of the Early Development Instrument [188]. The Early Development Instrument is a 103-item questionnaire completed by kindergarten teachers that predicts poor school performance among students identified as vulnerable, which has implications for health – including mental health – and social outcomes across the lifespan. Children's scores on the Australian version of the Early Development Instrument are categorised into three groups [124]:

1. Developmentally vulnerable: scores ranked in the lowest 10%
2. Developmentally at risk: scores ranked between 10% and 25%, and
3. Developmentally on track: scores ranked between 25% and 100%.

Only children who are categorised as ‘developmentally vulnerable’ are in scope for this indicator. Higher proportions of children categorised as developmentally vulnerable indicates a greater need for support targeted at children in the early years of life [124].

For the purposes of this indicator, two groups are reported [124]:

1. The proportion of children identified as developmentally vulnerable in one domain of the Australian Early Development Census, and
2. The proportion of children identified as developmentally vulnerable in two or more domains of the Australian Early Development Census.

Data for this indicator from 2012, 2015, and 2018 were first published in the second progress report on The Fifth Plan in 2019 and updated in subsequent progress reports, including the most recent report, which was published in 2021 and included 2021 data from the Australian Early Development Census. The indicator can be disaggregated by sex, Indigenous status, state or territory, remoteness area, and socioeconomic disadvantage groupings [124].

‘Prevalence of mental illness’ is measured as the percentage of Australian residents who experienced mental illness in the previous 12 months [124]. Under this indicator, mental illness is defined as “a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities” [124 p8]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected in order to provide a high-level indication of the mental health and well-being of the Australian public [124]. Data for different components of this indicator are sourced from the National Survey of Mental Health and Wellbeing, which comprises three prevalence surveys [190]:

1. The National Study of Mental Health and Wellbeing (adults; the most recent data are from 2007)
2. The National Survey of People Living with Psychotic Illness (the most recent data are from 2010), and
3. The Australian Child and Adolescent Survey of Mental Health and Wellbeing (the most recent data are from 2013–14).

The National Study of Mental Health and Wellbeing is a comprehensive survey aiming to give an in-depth understanding of the mental health challenges that Australians are facing by capturing information on mental health conditions (such as anxiety disorders, affective disorders, and eating disorders), as well as on self-harm and mental health service use [191]. The National Survey of People Living with Psychotic Illness aims to provide a comprehensive understanding of various facets of the lives of people living with psychosis, including clinical presentation, living circumstances, social participation, and needs. The most recent survey (in 2010) covered approximately 1.5 million people aged 18–64 years, which represented approximately 10% of Australians in this age group [192]. Finally, the Australian Child and Adolescent Survey of Mental Health and Wellbeing aims to determine the number of children and adolescents with mental health problems and disorders, which disorders they have, the nature and impact of these disorders, the number of children and adolescents who have used services for mental health problems, and the role of the education sector in providing these services [193]. Lower prevalence rates of mental illness indicate higher levels of mental health and well-being in the Australian population. Data for the ‘Prevalence of mental illness’ indicator were first published in the first progress report on The Fifth Plan in 2018, with adult estimates of prevalence drawn from 2007 data, child and adolescent prevalence estimates drawn from data collected in 2013–14, and psychotic disorders estimates of prevalence drawn from data collected in 2010. This indicator can be disaggregated by age, sex, socioeconomic status, and type of mental health condition [124].

‘Adults with very high levels of psychological distress’ was also deemed relevant to *Sharing the Vision* outcome 1(a). Further information pertaining to this indicator can be found in Section 3.7.1.1.1.1.

3.7.4.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness, and efficiency [183]. The following two indicators were deemed relevant to *Sharing the Vision* outcome 1(d) [30]:

1. Primary mental health care for children and young people, and
2. Prevalence of mental illness.

‘Primary mental health care for children and young people’ is an output indicator that is categorised under service effectiveness, and more specifically, service appropriateness [30]. Defined as “an indicator of governments’ objective to facilitate early detection of mental health issues and mental illness, followed by appropriate intervention” [30], this indicator is measured as the proportion of young people aged under 25 years who received a government-subsidised mental health care service from a general practitioner (GP), psychologist, or other allied health professional. There is no official data source for this indicator; rather, data are gathered annually from the Medicare Benefits Schedule (a listing of the Medicare services subsidised by the Australian Government [194] and reported in the services for mental health performance indicator framework [184], with the most recent data available being for the financial year 2021–22). Data are available by age, sex, remoteness of area of residence, Indigenous status, and service type (GP services, clinical psychologist services, or other allied health professional services), and, for the first time, the mental health section of the *Report on Government Services 2023* includes data that are disaggregated by ‘in-person contact’ and ‘telehealth consultation’ [30]. High or increasing proportions of children and young people who have had contact with a government-subsidised primary mental health care service is desirable [30]

‘Prevalence of mental illness’ is one of six outcome indicators in the services for mental health performance indicator framework. This indicator is also included in *The Fifth National Mental Health and Suicide Prevention Plan*, and so information pertaining to this indicator can be found in Section 3.7.4.1.1.1.

3.7.4.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.4.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan’s performance indicators [21,124]. The documents do not explicitly identify the benefits associated with each indicator, but, where relevant, we highlight any information provided that could be considered a benefit of any given indicator.

In relation to the first indicator, ‘Children who are developmentally vulnerable’, it is noted that children who exhibit poor learning skills are likely to fall behind their peers, and using this indicator for early school-based detection and intervention can lead to improved longer-term outcomes for children who are identified as developmentally vulnerable [124]. In addition, scores on the Australian Early Development

Census are based on data from all children who participate, and take into account variations in age during the first year of schooling. However, the following limitations were also identified [124]:

- Data on developmental vulnerability cannot indicate the underlying cause of the vulnerability, whether the vulnerability relates to the child's mental health, or whether the child has previously received or is currently receiving additional supports for their particular vulnerability.
- Only children who are categorised as developmentally vulnerable are in scope for this indicator.
- Scores on the Australian Early Development Census are teacher-rated.

In relation to the second indicator, 'Prevalence of mental illness', it was noted that differences in the prevalence of a diagnosed mental illness across demographic groups (e.g. age, sex) can provide much needed insight for policy development as well as for tailoring service planning and delivery. However, the following limitations were identified [21,124]:

- Prevalence rates indicate the proportion of the community that is affected by mental illness but do not reflect variations in the severity or duration of mental illness, or the extent to which individuals' lives are impacted by their condition.
- While population-based surveys are the most reliable measures of prevalence, they require time and money.
- Data for this indicator are sourced from three different surveys; however, the data from each of these surveys are not comparable.
- Data obtained for people experiencing psychotic illness only include individuals who are in contact with specialised mental health services.
- The national epidemiological surveys in Australia are only conducted approximately every 10 years.

Finally, the third indicator, 'Adults with very high levels of psychological distress', was also deemed relevant to *Sharing the Vision* outcome 1(a). Further information pertaining to the limitations of this indicator can be found in Section 3.7.1.1.2.1.

3.7.4.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

It is noted in the 2023 Report on Government Services that results for the first indicator, 'Primary mental health care for children and young people', should be interpreted with caution. Variations in the use of government-subsidised primary mental health care services could be due to variations in access, or could be the result of differences in the prevalence of mental illness. In addition, the data cannot indicate whether services are appropriate for the needs of the children and young people receiving them, or whether they are correctly targeted to those in greatest need. Finally, not all primary mental health care services for children and young people are included in the data; community health centres, school and university counsellors and nurses, and some mental health care provided by state and territorial governments' specialised mental health care services are excluded [30].

There was no information that spoke to the benefits or limitations of the second indicator, 'Prevalence of mental illness' in the 2023 Report on Government Services. However, this indicator was also included in

The Fifth National Mental Health and Suicide Prevention Plan, and so information pertaining to the limitations of this indicator can be found in Section 3.7.4.1.2.1.

3.7.4.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 1 (c).

3.7.4.2 Canada

3.7.4.2.1 What are the relevant mental health indicators?

3.7.4.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and 'Leadership and collaboration') [31,59]. Eight of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 1©, some of which are repeated across different population groups (e.g. see 'Anxiety and/or mood disorders' in the list below). The eight indicators are [31]:

1. Anxiety and/or mood disorders – adults (strategic direction 1, 'Promotion and prevention')
2. Anxiety and/or mood disorders – youth (strategic direction 1, 'Promotion and prevention')
3. Anxiety and/or mood disorders – general population (strategic direction 1, 'Promotion and prevention')
4. Anxiety and/or mood disorders – seniors (strategic direction 1, 'Promotion and prevention')
5. Anxiety and/or mood disorders – immigrants (strategic direction 4, 'Disparities and diversity')
6. Anxiety and/or mood disorders – lesbian, gay, or bisexual individuals (strategic direction 4, 'Disparities and diversity')
7. Anxiety and/or mood disorders – residents of Northern communities (strategic direction 4, 'Disparities and diversity'), and
8. Vulnerable children – general population (strategic direction 1, 'Promotion and prevention').

In *Informing the Future: Mental Health Indicators for Canada*, 'Anxiety and/or mood disorders' is measured separately in adults; youth; the general population; seniors; immigrants; lesbian, gay, or bisexual individuals; and residents of Northern communities [31]. The indicators for adults, youth, the general population, and seniors are included under strategic direction 1, and the indicators for immigrants; lesbian, gay, or bisexual individuals; and residents of Northern communities are included under strategic direction 4. The indicators are measured as the percentage of individuals in the following groups who reported that they have an anxiety disorder and/or mood disorder which has been diagnosed by a healthcare professional over a given period (2011–12 in *Informing the Future: Mental Health Indicators for Canada*) [31]:

- Adults aged 20–64 years
- Youth aged 12–19 years
- Individuals aged 12 years and over (general population)
- Seniors aged 65 years and over

- Immigrants aged 12 years and over
- Individuals aged 12 years and over who identified themselves as lesbian, gay, or bisexual, and
- Individuals aged 12 years and over living in any of the three Northern territories of Canada (i.e. the Northwest Territories, Nunavut, or Yukon).

'Anxiety and/or mood disorders' was included as a separate indicator for all groups because anxiety and mood disorders are the most commonly diagnosed mental health conditions, and self-reporting provides a basis on which to assess the prevalence of these diagnosed disorders among each group, including the general population. For youth specifically, early identification and treatment can increase the likelihood of better long-term outcomes and prevent the development of more severe problems. In *Informing the Future: Mental Health Indicators for Canada*, data for these indicators (with the exception of 'Anxiety and/or mood disorders among individuals who identified themselves as lesbian, gay, or bisexual') were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time. For lesbian, gay, or bisexual individuals, data were sourced from a special tabulations request from Statistics Canada, Canada's national statistical office [31,134].

'Vulnerable children – general population' is measured as the percentage of kindergarten-aged children (i.e. children aged 4–5 years) who are identified as vulnerable on one or more of five dimensions reflecting emotional, social, and cognitive development on the Early Development Instrument (see Section 3.7.4.1.1.1) over a given period (2007–08 to 2011–12 in *Informing the Future: Mental Health Indicators for Canada*) [31]. A child is considered vulnerable in a domain when their score falls below a threshold established by the Early Development Instrument [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from a special data request to the Offord Centre for Child Studies at McMaster University for the period 2007–08 to 2011–12 [31].

3.7.4.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.2.1.3 The Canadian Chronic Disease Indicators

As mentioned in Section 3.2.3, the Canadian Chronic Disease Indicators consists of a total of 36 pan-Canadian chronic disease indicators, which provide information about the burden of chronic conditions and associated determinants. The indicators are categorised into six domains ('Social and environmental determinants', 'Maternal and child health risk and protective factors', 'Behavioural risk and protective factors', 'Risk conditions', 'Disease prevention practices', and 'Health outcomes/status') [45]. Each indicator is assessed using one or more indicator measures that provide "estimates of the burden of chronic conditions and measures of general health and associated determinants" [65 p281]. Of the four chronic disease indicators that are related to mental health, one was deemed relevant to *Sharing the Vision* outcome 1(d) [45]. This indicator, which is one of seven indicators that fall under the 'Health outcomes/status' domain, is called 'Morbidity – prevalence'. It consists of a total of 14 indicator measures, 2 of which were deemed relevant to *Sharing the Vision* outcome 1(d) [45]:

1. Morbidity – prevalence: prevalence of mood and/or anxiety disorders in the general population, and
2. Morbidity – prevalence: prevalence of ever having symptoms consistent with at least one of six mental or substance use disorders in the general population.

The first indicator measure, 'Morbidity – prevalence: prevalence of mood and/or anxiety disorders in the general population', is the percentage of the household population in Canada aged 12 years and over with

self-reported diagnosed mood and/or anxiety disorders in a given year [45]. Data for this indicator measure are sourced from the Canadian Community Health Survey [61]; the most recent data available for this indicator measure are from the year 2017. Data are available by sex (according to age group (aged 12 years and over, aged 12–19 years, and aged 20 years and over), and crude), age group, province (crude and age-standardised), population centre/rural area, highest level of education (by household and for respondents aged 20 years and over), household income adequacy, ethnicity, Indigenous status, immigrant status, and trends over time (according to age group (aged 12 years and over, aged 12–19 years, and aged 20 years and over) and age-standardised). A low percentage on this indicator denotes low prevalence of mood and/or anxiety disorders in the general population [45].

The second indicator measure, 'Morbidity – prevalence: prevalence of ever having symptoms consistent with at least one of six mental or substance use disorders in the general population', is the percentage of the household population in Canada aged 15 years and over living in any of the 10 provinces who met the Canadian Community Health Survey – Mental Health/World Health Organization Composite International Diagnostic Interview 3.0 criteria for at least one of the following six mental health or substance use disorders at some point in their life [195]:

1. Major depressive episode
2. Bipolar disorder
3. Generalised anxiety disorder
4. Abuse of or dependence on alcohol
5. Abuse of or dependence on cannabis, and
6. Abuse of or dependence on other drugs.

This diagnostic interview is a modified version of the World Health Organization (WHO) Composite International Diagnostic Interview [196], a standardised tool for the assessment of mental health and substance use disorders according to *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) criteria. The modified interview was designed to measure the prevalence of these disorders at the community level [195]. The most recent data for this indicator measure were presented in the 2021 edition of the Canadian Chronic Disease Indicators, but were sourced from the Canadian Community Health Survey 2012 [61,195]. Data are available by sex (crude), age group, province (crude and age-standardised), population centre/rural area, highest level of education (by household and for respondents aged 20 years and over), household income adequacy, ethnicity, Indigenous status, First Nations/Métis/Inuit status, immigrant status, and time since immigration (≥5 years and ≥10 years). A low percentage on this indicator measure denotes a low prevalence of the symptoms of at least one of the above six mental and substance use disorders in the general population [195].

3.7.4.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.4.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not explicitly identify the benefits of the indicators, but, where relevant, we highlight information provided that could be considered a benefit of a given indicator.

The common limitations associated with all seven 'Anxiety and/or mood disorders' indicators (i.e. for adults; youth; the general population; seniors; immigrants; lesbian, gay, or bisexual individuals; and residents of Northern communities) are [31]:

- Self-reports of anxiety and/or mood disorder diagnoses are based on a single survey question and so the percentage may not correspond with prevalence rates based on epidemiological studies.
- Reported receipt of a diagnosis for an anxiety and/or mood disorder does not necessarily imply receipt of treatment.

Additional limitations of this indicator specifically for immigrants; lesbian, gay, or bisexual individuals; and residents of Northern communities are also described. Immigrants are a highly diverse group which includes individuals who entered Canada as refugees and individuals who have been in Canada for varying lengths of time. In addition, the fact that individuals with serious mental health conditions are often denied entry to Canada could affect reported mental illness rates. Regarding lesbian, gay, or bisexual individuals, it was noted that a large proportion of individuals who completed the survey did not respond to the question about sexual orientation, which limits the accuracy of this indicator. Moreover, the question being analysed only refers to lesbian, gay, or bisexual orientation, and excludes other sexual identities such as intersex, transgender, queer, and questioning. Finally, for residents of Northern communities, the report noted that small sample sizes in these communities can affect the accuracy of results [31].

In relation to 'Vulnerable children – general population', the only limitation described is that the national estimate was derived from the most recent Early Development Instrument data in provinces and territories, but that data were only available for 9 out of the 13 provinces and territories [31]. In relation to benefits, although not explicitly described as a benefit, it is noted that detecting population-based vulnerability in relation to neighbourhoods, communities, regions, and other distinct factors allows decision-makers to make additional supports available, thereby mitigating the risks for vulnerable children [31].

3.7.4.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.2.2.3 The Canadian Chronic Disease Indicators

The interactive data tool for the Canadian Chronic Disease Indicators describes limitations associated with the use of the second indicator measure relevant to *Sharing the Vision* outcome 1(d), 'Morbidity – prevalence: prevalence of ever having symptoms consistent with at least one of six mental or substance use disorders in the general population', but not with the use of the first indicator relevant to the same outcome, 'Morbidity – prevalence: prevalence of mood and/or anxiety disorders in the general population'.

In relation to 'Morbidity – prevalence: prevalence of ever having symptoms consistent with at least one of six mental or substance use disorders in the general population', the Canadian Chronic Disease Indicators data tool states that the prevalence rates for mental health or substance use disorders obtained from the diagnostic interview may be an underestimate of the extent of these issues in the Canadian population. In addition, this indicator measure focuses only on major depressive episodes, bipolar disorder, generalised anxiety disorder, and abuse of or dependence on alcohol, cannabis, or other drugs. As such, other disorders are not covered in the Canadian Community Health Survey (the data source for this indicator). Finally, the following groups are excluded from the Canadian Community Health Survey and are therefore

not represented in the findings: persons living on reserves and other Indigenous settlements, full-time members of the Canadian Forces, and the institutionalised population [195].

3.7.4.2.2.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.3 England (UK)

3.7.4.3.1 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.4.3.1.1 The Public Health Outcomes Framework

As mentioned in Section 3.3.1.1, the Public Health Outcomes Framework contains 193 indicators, which are categorised as either overarching outcome indicators or as supporting indicators [33]. None of the overarching outcome indicators are specific to mental health, and so none were included in this evidence brief. The supporting indicators are further categorised into one of four domains ('Wider determinants of health', 'Health improvement', 'Health protection', and 'Healthcare and premature mortality') [33]. Only one supporting indicator was deemed relevant to *Sharing the Vision* outcome 1(b). This indicator, which falls under the 'Health improvement' domain, is 'Percentage of looked after children whose emotional wellbeing is a cause for concern' [177]. This indicator was also deemed relevant to *Sharing the Vision* outcome 1(b), and so further information pertaining to the indicator can be found in Section 3.7.2.3.1.1.

3.7.4.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.4.3.2.1 The Public Health Outcomes Framework

'Percentage of looked after children whose emotional wellbeing is a cause for concern' was also deemed relevant to *Sharing the Vision* outcome 1(b). Further information pertaining to a limitation of this indicator can be found in Section 3.7.2.3.2.1.

3.7.4.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.3.2.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.3.2.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.4 New Zealand

3.7.4.4.1 What are the relevant mental health indicators?

3.7.4.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43]. One indicator, which fell under the 'Mental health of the population' outcome domain, was deemed relevant to *Sharing the Vision* outcome 1(d). This indicator is 'Psychological distress' [43]. As it was also deemed relevant to *Sharing the Vision* outcome 1(a), further information pertaining to this indicator can be found in Section 3.7.1.4.1.3.

3.7.4.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.4.4.2.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.4.2.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.4.2.3 *National Indicators 2012*

There were no benefits or limitations in relation to the 'Psychological distress' indicator described in the *National Indicators 2012* report [43].

3.7.4.5 Scotland (UK)

3.7.4.5.1 What are the relevant mental health indicators?

3.7.4.5.1.1 Public Health Scotland mental health indicators

As mentioned in Section 3.5.1, Public Health Scotland established two sets of mental health indicators in 2022: one for adults [105] and one for children and young people [106]. The indicators included in these indicator sets are particularly relevant to *Sharing the Vision* outcome domain 1 because they were developed with an explicit focus on primary prevention in order to emphasise the importance of preventing mental health problems before they emerge [107]. The adult mental health indicator set encompasses 10 mental health outcome indicators (2 related to mental well-being and 8 related to mental health problems) and 45 determinant indicators of mental health outcomes (9 at the individual level, 11 at the community level, and 25 at the structural level) [105].

Of the 55 outcome and determinant indicators included in the adult mental health indicator set, the following 3 were deemed relevant to *Sharing the Vision* outcome 1(d) [105]:

1. Adults with a possible common mental health problem (mental health outcome indicator)

2. Adults with moderate or high severity symptoms of depression (mental health outcome indicator), and
3. Adults with moderate or high severity symptoms of anxiety (mental health outcome indicator).

'Adults with a possible common mental health problem' is a mental health outcome indicator [105] that is measured as the percentage of adults who scored 4 or higher on the 12-Item General Health Questionnaire, a scale that assesses the severity of a mental health problem over the previous few weeks [197]. A score of 4 or higher on the 12-item General Health Questionnaire indicates a possible mental health problem over the previous few weeks [105]. The data source identified for this indicator is the Scottish Health Survey, which includes the 12-item General Health Questionnaire [162].

'Adults with moderate or high severity symptoms of depression' is a mental health outcome indicator [105] that is measured as the percentage of adults who had a symptom score of 2 or higher on the depression section of the Clinical Interview Schedule – Revised, a fully structured diagnostic instrument that has been widely used to assess common mental disorders in community settings [198]. A score of 2 or higher indicates that an individual has experienced moderate- to high-severity symptoms in the previous week [105]. The data source identified for this indicator is the Scottish Health Survey, which includes the depression section of the Clinical Interview Schedule – Revised [162].

'Adults with moderate or high severity symptoms of anxiety' is also a mental health outcome indicator, and is measured in the same way as the previous indicator using data from the same data source [105].

Of the 70 outcome and determinant indicators included in the children and young people mental health indicator set, 5 were deemed relevant to *Sharing the Vision* outcome 1(d), all of which are identified as mental health outcome indicators. These five indicators are [106]:

1. Emotional symptoms
2. Conduct problems
3. Hyperactivity/inattention
4. Strengths and Difficulties Questionnaire – total difficulties, and
5. Eating disorders.

The first four indicators, 'Emotional symptoms', 'Conduct problems', 'Hyperactivity/inattention', and 'Strengths and Difficulties Questionnaire – total difficulties', are measured as the percentage of pupils in secondary school years 2–6 with a 'slightly raised', 'high', or 'very high' emotional symptoms scale score, conduct problems scale score, hyperactivity/inattention scale score, and total difficulties score on the Strengths and Difficulties Questionnaire, respectively. The data source for all four indicators is the Health and Wellbeing Census Scotland [164].

'Eating disorders' is anticipated to be measured via an assessment of the prevalence of eating disorders in children and young people aged 17 years and under. As of 2022, no suitable data source has been identified for this indicator, as additional developmental work is required.

3.7.4.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.5.1.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.7.4.5.2.1 Public Health Scotland mental health indicators

Specific information is not currently available pertaining to the benefits and limitations associated with the outcome and determinant indicators included in Public Health Scotland's mental health indicator sets for adults and for children and young people.

3.7.4.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.5.2.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 1(d).

3.7.4.6 The OECD

3.7.4.6.1 What are the relevant mental health indicators?

3.7.4.6.1.1 The OECD Mental Health System Performance Benchmark

None of the benchmarking indicators included in the OECD Mental Health System Performance Benchmark were deemed relevant to *Sharing the Vision* outcome 1(d).

3.8 Outcome domain 2: Service access, coordination, and continuity of care

Outcome domain 2 is primarily service-oriented, focusing on timely access to evidence-informed, effective, and recovery-oriented mental health services and interventions [24]. The domain emphasises the importance of adopting a 'stepped care approach', whereby services are coordinated across the following four tiers in order to ensure the best possible outcomes for every service user [24]:

1. Tier 1: community-based, non-specialist interventions
2. Tier 2: primary care
3. Tier 3: specialist community mental health services, and
4. Tier 4: specialist inpatient or residential units.

Access to specialist mental health services for people with a dual diagnosis (e.g. people with coexisting mental health difficulties and addiction) is a key aspect of this domain, as is the importance of effective service organisation and integration in order to support all service users – including people with a dual diagnosis – to achieve personal recovery. The physical health of people with mental health difficulties, and the mental health of people with physical health difficulties, is also identified as an important aspect of service integration and coordination. This domain emphasises the role of assertive outreach teams in rehabilitation and recovery, as these teams operate "to reduce hospital admissions and readmissions, prevent relapse, and improve a person's chances of returning to employment, education or training, and, more generally, to enhance their quality of life" [24 p55].

Outcome domain 2 encompasses the following four high-level outcomes, which reflect what service users (and their families and carers) can expect from mental health services [24]:

a) All service users have access to timely, evidence informed interventions

b) Service delivery is organised to enable increased numbers of people to achieve personal recovery

c) Services are coordinated through a 'stepped care' approach to provide continuity of care that will deliver the best possible outcomes for each service user, and

d) Health outcomes for people with dual diagnosis are improved by ensuring greater collaboration between mental health and other relevant services.

What follows is an overview of the indicators identified in the mental-health-related indicator sets and frameworks from the selected countries and the OECD that were deemed relevant to each of these high-level outcomes.

3.8.1 Outcome 2(a): All service users have access to timely, evidence informed interventions

3.8.1.1 Australia

3.8.1.1.1 What are the relevant mental health indicators?

3.8.1.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination' [21]. One

indicator, which falls under domain 5, ‘Effective support, care and treatment’, was deemed relevant to *Sharing the Vision* outcome 2(a). This indicator is ‘Population access to clinical mental health care’ [21].

This indicator is measured as the percentage of the Australian population receiving clinical mental health services [124]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected in order to measure population treatment rates against known rates of mental illness among the population, which provides a broad estimate of unmet need for mental health care in the community. If the prevalence of mental illness among the general population is stable, then a higher proportion of people accessing mental health services indicates less unmet need [124]. There was no official data source for this indicator; rather, data were gathered from various unpublished sources [180], including state and territory governments, the Private Psychiatric Hospitals Data Reporting and Analysis Service [199], the Department of Health Medicare Benefits Schedule [194], and the Department of Veterans’ Affairs Treatment Accounts System [200]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, the data for this indicator are collected annually [124], and, at the time of completing this evidence brief (September 2023), data were available for each financial year from 2007–08 to 2019–20 [180]. Data for this indicator were first published in the first progress report on The Fifth Plan in 2018 and updated in subsequent progress reports, including the most recent report, which was published in 2021. This indicator can be disaggregated by socioeconomic disadvantage group, remoteness, Indigenous status, and, for some data, profession type of service provider [180].

3.8.1.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness, and efficiency [183]. The following four indicators were deemed relevant to *Sharing the Vision* outcome 2(a) [30]:

1. Mental health service use by selected equity groups
2. Timely access to mental health care
3. Affordability of mental health care, and
4. Mental health service use estimates.

‘Mental health service use by selected equity groups’ is an output indicator that is categorised under service equity, and more specifically, service access [30]. It is defined as “an indicator of governments’ objective to provide services in an equitable manner” [30]. This indicator is measured as the proportion of the population in a selected equity group who are using the mental health service, compared with the proportion of the population outside the selected equity group who are using the mental health service. There is no official data source for this indicator; rather, data are collected from state and territory governments’ specialised public mental health services and government-subsidised mental health services and reported annually in the services for mental health performance indicator framework [30]. The selected equity groups are Aboriginal and Torres Strait Islander people; people from outer regional, remote, and very remote locations; and people residing in low socioeconomic areas (Socio-Economic Indexes for Areas quintiles 1 and 2). This indicator was selected in order to provide insight into whether access to mental health services is equitable for all Australians. Data are available by remoteness of area of residence, Indigenous status, socioeconomic status, and service type (state and territory governments’ specialised mental health services, private services, and government-subsidised services) [30]. The most recent data available are for the financial year 2021–22 [184].

‘Timely access to mental health care’ is an output indicator that is categorised under service effectiveness, and more specifically, service access [30]. It is defined as “an indicator of governments’ objective to provide services in a timely manner” [30]. This indicator is measured as the proportion of people who present to an emergency department with a mental-health-related care need who are seen within clinically recommended waiting times. In this context, ‘clinically recommended waiting times’ is defined according to benchmarks set by the Australasian Triage Scale, a clinical tool used to establish the maximum acceptable waiting period for the medical assessment and treatment of a patient [201]. The benchmarks, which are set according to triage category, are [30]:

- Triage category 1: need for resuscitation – patients seen immediately
- Triage category 2: emergency – patients seen within 10 minutes
- Triage category 3: urgent – patients seen within 30 minutes
- Triage category 4: semi-urgent – patients seen within 60 minutes, and
- Triage category 5: non-urgent – patients seen within 120 minutes.

Since the financial year 2016–17, annual data for this indicator have been sourced from the Australian Institute of Health and Welfare’s hospital data on mental health services in emergency departments, which are provided from state and territory governments in Australia. The most recent data reported were from the financial year 2020–21 [184]. The data can be disaggregated by people who present to emergency departments with mental-health-related or non-mental-health-related needs [184]. High or increasing proportions of patients seen within the recommended waiting times are desirable [30].

‘Affordability of mental health care’ is an output indicator that is categorised under service effectiveness, and more specifically, service access [30]. It is defined as “an indicator of governments’ objective to provide services that are affordable” [30]. The aim is to report on this indicator using three measures [30]:

1. The proportion of people who delayed seeing or did not see a GP for their mental health due to cost
2. The proportion of people who delayed seeing or did not see a psychologist, psychiatrist, or other mental health professional for their mental health due to cost, and
3. The proportion of people who delayed filling or did not fill a prescription for their mental health due to cost.

As of 2023, however, data are not available for the third measure [30]. The data source for the first two measures is the Patient Experiences Survey, held annually by the Australian Bureau of Statistics for people aged 15 years and over who are usual residents of private dwellings. This survey aims to collect national data on access and barriers to a range of healthcare services, including GP and hospital/emergency room visits [202,203]. The Patient Experiences Survey asks people about the health services they have used in the previous 12 months and the experiences they had with each service [202]. Data from the financial years 2020–21 and 2021–22 are available and can be disaggregated by people who present to health services with and without mental health conditions, as well as by the type of professional (GP, psychologist, psychiatrist, other mental health professional) they visit [184]. A low or decreasing proportion of people for each measure is desirable [30].

‘Mental health service use estimates’ is an output indicator that is categorised under service effectiveness, and more specifically, service access [30]. It is defined as “an indicator of governments’ objective to provide services that are readily available to those who need them” [30]. It is measured as the estimated proportion of the population with a mental health condition who are receiving a mental health service. A high or increasing proportion of the population with a mental health condition who are

receiving services for mental health indicates greater access to treatment. However, as of the most recent report on services in mental health in 2023, an agreed method for reporting against this indicator has not yet been determined [30].

3.8.1.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

As described in Section 3.1.3, the National Mental Health Performance Subcommittee established 16 key performance indicators for Australian public mental health services in order to address the 'Health system' dimension in the National Mental Health Performance Measurement Framework in Australia. This dimension contains six sub-domains ('Accessibility', 'Appropriateness', 'Continuity of care', 'Effectiveness', 'Efficiency and sustainability', and 'Safety') [55]. Of the 16 key performance indicators, the following 5 were deemed relevant to *Sharing the Vision* outcome 2(a) [39]:

1. Average length of acute mental health inpatient stay ('Efficiency and sustainability' sub-domain)
2. Average treatment days per 3-month community mental health care period ('Efficiency and sustainability' sub-domain)
3. Population access to specialised clinical mental health care ('Accessibility' sub-domain)
4. Mental health new client index ('Accessibility' sub-domain), and
5. Admission preceded by community mental health care ('Accessibility' sub-domain).

'Average length of acute mental health inpatient stay' is measured as the average length of stay of in-scope overnight separations from state/territory acute admitted patient mental health care service units [204]. Although this indicator is primarily used to better understand the factors which cause variations in service cost, it can also be used as a basis for service utilisation review; for example, by allowing for an assessment of services provided to a particular group against the clinical protocols developed for that group [204]. All state/territory acute admitted patient mental health care service units are in scope for this indicator, including short-stay units and emergency acute mental health admitted units. This is one of eight performance indicators that are calculated from a national dataset [39], which in this case is the Admitted patient care National Minimum Data Set. This dataset is a core set of nationally agreed data elements for mandatory collection and reporting [205,206]. State/territory health departments are responsible for providing the data. The data are disaggregated by population type (general, child and adolescent, and older people) and are available for each financial year from 2010–11, with the most recent data available being from the financial year 2020–21 [207].

'Average treatment days per 3-month community mental health care period' is measured as the average number of community mental health treatment days per 3-month period of ambulatory care provided by state/territory specialised community mental health service unit(s) [208]. Although this indicator is primarily used to better understand the factors which cause variation in service cost, it is noted in the indicator description that the indicator may also be used to demonstrate levels of accessibility of public sector community mental health services [208]. For the purposes of this indicator, the following fixed 3-month periods apply: January to March, April to June, July to September, and October to December. Only specialised mental health services provided as a public service which are managed or funded by state or territory health authorities are in scope for this indicator. Community mental health care service activities that are not associated with uniquely identifiable consumers do not qualify [208]. This is one of eight performance indicators that are calculated from a national dataset [39], which in this case is the Community mental health care National Minimum Data Set. This dataset provides data about service contact provided by specialised mental health services to service users, aside from users admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and residents in 24-hour staff specialised residential mental health services [209]. State/territory health departments are responsible

for providing the data. The data are disaggregated by state/territory and population type (general, child and adolescent, youth, older people, and forensic), and are available for each financial year from 2007–08, with the most recent data available being from the financial year 2020–21 [207].

‘Population access to specialised clinical mental health care’ is also included in *The Fifth National Mental Health and Suicide Prevention Plan* and was described in Section 3.8.1.1.1.1. However, additional information pertaining to data disaggregation for this indicator is provided in the *Key Performance Indicators for Australian Public Mental Health Services* 2021 data tables, which specify that the indicator data are available by state/territory, age group, sex, Indigenous status, and Socio-Economic Indexes for Areas quintile [207].

‘Mental health new client index’ is measured as the percentage of new clients under the care of a mental health service organisation’s mental health services [210]. This indicator was selected because access to services by people with mental health concerns is a key priority, given the concern that public mental health services in Australia are not responding adequately to new people who require care, and it is used for benchmarking and quality improvement. For the purposes of this indicator, a new consumer is defined as “a person who has not been seen in the five years preceding the first contact with the mental health service organisation in the reference period” [210]. Data for this indicator cannot be sourced from existing national data collections; instead, data are requested by the Australian Institute of Health and Welfare and supplied annually by jurisdictions in relation to services at the state/territory level. When providing data for this indicator, each jurisdiction is required to indicate whether a state-wide unique client identifier system is currently in place to allow tracking of individual consumers’ service utilisation across the public specialised mental health services in that jurisdiction. This is in order to evaluate the degree of consistency in data reported between jurisdictions. The data for this indicator are disaggregated by state/territory, service setting (inpatient, residential, or community), age group, sex, Socio-Economic Indexes for Areas quintile, remoteness, and Indigenous status [210], and are available for each financial year from 2009–10, with the most recent data available being from the financial year 2020–21 [207].

‘Admission preceded by community mental health care’ is measured as the percentage of admissions to state/territory public acute admitted patient mental health care service unit(s) where there is a record of engagement with a community mental health service involving the consumer or their carer/support person within the 7 days immediately preceding that admission [211]. This indicator is included as a proxy measure of access to community mental health care. Access to community mental health care can avert admissions to psychiatric hospitals and ensure that admission only occurs when this is the most appropriate treatment option. According to the indicator specification, it is reasonable to assume that when a consumer is known to a community mental health care team, that team has been involved in the consumer’s care prior to hospitalisation. For the purposes of this indicator, the following types of admissions are excluded [211]:

- Same-day admissions (i.e. inpatient episodes where the admission and separation dates are the same)
- Statistical and change-of-care type admissions (e.g. in-hospital transfer from another unit)
- Admissions by transfer from another acute or psychiatric inpatient hospital
- Admissions by transfer from a residential mental health care service, and
- Separations where length of stay is one night only and a procedure code for electroconvulsive therapy or transcranial magnetic stimulation is recorded.

In addition, the following community mental health service contacts are excluded:

- Service contacts on the day of admission, and
- Contacts where neither the consumer nor their carer/support person participated.

In this context, a public sector community mental health service refers to specialised mental health services provided as a public service which are managed or funded by state or territory authorities [211]. In addition, community mental health contacts are defined as "contacts with any public community mental health team within the given state or territory that occur within the week before the inpatient admission" [207]. For the purposes of this indicator, when a mental health service organisation has more than one admission unit, the units are combined for data collection and analysis. Importantly, implementation of this indicator requires the capacity to track service use across inpatient and community services, as well as the capacity to link patient identifiers [211]. Data for the indicator cannot be sourced from existing national data collections; instead, data are requested by the Australian Institute of Health and Welfare and supplied annually by jurisdictions [39]. Therefore, data for the indicator are available at state/territory level – but not at national level – for each financial year since 2005–06, and the most recent data reported were for the financial year 2020–21 [207]. When providing data for this indicator, each jurisdiction is required to indicate whether a state-wide unique client identifier system is currently in place to allow tracking of individual consumers' service utilisation across the public specialised mental health services in that jurisdiction. This is in order to evaluate the degree of consistency in data reported between jurisdictions. Data for this indicator are disaggregated by state/territory, age group, sex, Indigenous status, remoteness, Socio-Economic Indexes for Areas quintile, and population type (general, child and adolescent, youth, older people, and forensic) [211].

3.8.1.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.1.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan performance indicators [21,124]. The documents do not explicitly identify the benefits associated with each indicator.

In relation to 'Population access to clinical mental health care', the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* states that "Service access data cannot indicate whether people are accessing the right services to meet their needs. The data also cannot indicate the proportion of people who might benefit from accessing clinical mental health care who do not access care, or their reasons for not accessing care" [124 p15].

3.8.1.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

In relation to 'Mental health service use by selected equity groups', the *Report on Government Services 2023* states that this indicator should be interpreted with caution because, while variation in service use may be related to variation in service access, it may also be the result of differences in the prevalence of mental health conditions among different groups. In addition, this indicator cannot provide information as to whether the mental health services that people are accessing are appropriate for their needs, or whether the mental health services are correctly targeted to those most in need [30].

In relation to 'Timely access to mental health care', the *Report on Government Services 2023* notes that the indicator is currently only partially measured, as emergency departments are just one of many

services that provide mental health care. It is anticipated that future reporting will focus on timely access to state and territory governments' specialised public mental health services and government-subsidised services for mental health. In addition, the downloadable Excel spreadsheet for the mental health section of the *Report on Government Services 2023* notes that the limitations of mental health diagnosis coding in some emergency departments may result in an underestimation of mental-health-related presentations [184].

There were no relevant limitations described in relation to the third indicator, 'Affordability of mental health care'.

Although an agreed method for reporting against the 'Mental health service use estimates' indicator has not yet been determined, the *Report on Government Services 2023* notes that it is important to consider the fact that not all people with a mental health condition will want or require treatment, and furthermore, simply accessing a service does not guarantee that that service will be effective [30].

3.8.1.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

The indicator specification web pages and the data tables for the 2020–21 indicator set (the most recent data available as of completion of this evidence brief in September 2023) provided by the Australian Institute of Health and Welfare describe the limitations associated with each of the key performance indicators listed in the *Key Performance Indicators for Australian Public Mental Health Services*. The benefits associated with the indicators are not explicitly described.

In relation to 'Average length of acute mental health inpatient stay', it is noted on the indicator specification web page that the data source for this indicator (the Admitted patient care National Minimum Data Set [205]) allows length of stay to be calculated for individual hospitals but does not allow sub-units of individual hospitals (e.g. specialised psychiatric units) to be identified separately [204]. As a result, the data source does not provide the necessary data to determine the average length of stay specifically for specialised psychiatric units within those hospitals on a national scale [204]. The 'psychiatric care days' flag in the Admitted patient care National Minimum Data Set enables identification of which patients received treatment in a specialised psychiatric unit within a hospital, which enables construction of the indicator at a national level. However, this flag does not distinguish between acute and non-acute units. A data-trimming method can be applied to approximate the number of separations attributable to acute units. Nevertheless, while the use of the 'psychiatric care days' flag and the trimming process can help identify separations in specialised psychiatric units and approximate acute units, the data source does not currently provide the ability to disaggregate acute psychiatric units by the target population (i.e. by the types of patients or specific conditions being treated in the acute psychiatric units) [204].

In relation to 'Average treatment days per 3-month community mental health care period', it is noted on the indicator specification that further development of national funding models (e.g. adopting episode-based or case mix funding models) will "enable more meaningful measurement than the arbitrary three-month period used in this indicator" [208].

In relation to 'Mental health new client index', it is noted on the indicator specification that this indicator poses complexities at the data analysis stage. Specifically, there are different approaches to defining what constitutes a 'new client', and the definition used depends on resolving the following issues [210]:

- The level of the mental health system at which 'newness' is defined: The determination of 'newness' can be based on different levels within the mental health system. For example, a consumer might be new to a particular organisation but already have a history of receiving mental

health services from another organisation. Counting new consumers at the state/territory level would yield lower estimates compared to counting them at the organisation level.

- The diagnostic criteria for defining 'newness': A consumer may present with a new condition, even if they have received previous treatment for a different condition, which raises the question of how to define 'newness' in terms of mental health diagnoses.

Thus far, an initial measure has been implemented with a view to further refinement following work to address the complexities associated with defining new clients and the potential implementation of unique state-wide patient identifiers within all jurisdictions [210].

In relation to 'Population access to specialised clinical mental health care', this indicator is also included in *The Fifth National Mental Health and Suicide Prevention Plan*. Therefore, its limitations are described in Section 3.8.1.1.2.1.

In relation to 'Admission preceded by community mental health care', several limitations are described. First, data for this indicator cannot be sourced from existing national data collections; instead, they are requested by the Australian Institute of Health and Welfare and supplied annually by jurisdictions [39]. There are two national datasets that this indicator could be constructed from: the Admitted patient care National Minimum Data Set [205], and the Community mental health care National Minimum Data Set, which includes data about mental health service contacts provided by specialised mental health services for patients/clients in the community [212]. However, this is currently not possible because these datasets do not share a common unique identifier that would allow people who were admitted to hospital to be tracked in the community services data. In addition, states and territories in Australia vary in the extent to which they have implemented state-wide unique patient identifiers that would allow accurate tracking of consumers who are seen by multiple organisations. The solution to these challenges requires the development of a system of state-wide unique patient identifiers within and across all mental health minimum datasets [211]. Second, the collection of the carer/support person contacts component of this indicator was added in 2020. However, not all jurisdictions are able to supply these data, and they are not currently available in any of the national datasets. As such, developmental work is required in order to enable the consistent capture of information about carers in state/territory data systems [211]. Third, this indicator does not capture variations in the frequency of contacts prior to hospital admissions. Finally, this indicator does not distinguish between different modes of community contacts (i.e. face to face or via telephone) [211].

3.8.1.2 Canada

3.8.1.2.1 What are the relevant mental health indicators?

3.8.1.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and 'Leadership and collaboration') [31,59]. The following four indicators were deemed relevant to *Sharing the Vision* outcome 2(a) [31]:

1. Individuals hospitalised for more than 30 days in a year (strategic direction 3, 'Access to services')
2. Unmet need for mental health care among people with mental disorders (strategic direction 3, 'Access to services')

3. Unmet need for general health care among people with common conditions (strategic direction 4, 'Disparities and diversity'), and
4. Recovery-focused program accreditation (strategic direction 2, 'Recovery and rights').

'Individuals hospitalised for more than 30 days in a year' is measured as the proportion of individuals hospitalised for a mental illness who spent a total of 30 days or more in hospital in a given year [31]. This indicator was selected because access to appropriate community supports and good coordination between community- and hospital-based services should reduce the time that individuals with mental health conditions spend in hospital. That is, if adequate community care is available, the proportion of people hospitalised for more than 30 days in a year should be low [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced via a special tabulation request from the Canadian Institute for Health Information [66] for the financial year 2012–13 [31].

'Unmet need for mental health care among people with mental disorders' is measured as the percentage of Canadians aged 15 years and over with mental health disorders who reported that in a given year there was a time when they needed mental health care but did not receive it [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] (see Section 3.7.1.2.1.1) for the year 2012.

'Unmet need for general health care among people with common conditions' is measured as the percentage of Canadians aged 12 years and over with a common mental health condition who report not receiving general healthcare in a given year [31]. This indicator was selected because it is necessary to estimate unmet need for general medical care among people with common mental health conditions in order to improve access to healthcare and diminish elevated rates of morbidity and mortality in this population [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, and 2010 in order to analyse trends over time [31].

'Recovery-focused program accreditation' is measured as the number of Canadian programmes which meet the accreditation standards for mental health programmes developed by Accreditation Canada as of 2013. Accreditation Canada is an independent, non-government, not-for-profit organisation that works with health, social, and community service organisations in order to improve the quality and safety of healthcare services in Canada and internationally, providing accreditation programmes and services to healthcare organisations, including hospitals, clinics, long-term care facilities, and other healthcare providers [213]. This indicator was selected because an increase in mental health programme accreditation suggests that there is an increasing availability of accredited recovery-based services for people with mental disorders across a range of care settings [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator for the years 2011, 2012, and 2013 were sourced via a special request to Accreditation Canada [31].

3.8.1.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.2.1.4 The mental health and substance use indicators

As mentioned previously in Section 3.2.4, the Canadian Institute for Health Information established a set of 14 mental health and substance use indicators that broadly measure mental health and substance use

services, access, and organisation [42]. The following five indicators were deemed relevant to *Sharing the Vision* outcome 2(a) [42]:

1. Early intervention for mental health and substance use among children and youth
2. Frequent emergency room visits for help with mental health and substance use
3. Wait times for community mental health counselling
4. Mental health and substance use disorder discharges, and
5. Total days stayed for mental health and substance use disorder hospitalisations.

'Early intervention for mental health and substance use among children and youth' is measured as the proportion of individuals aged 12–24 years with early mental health and/or substance use needs who accessed community-based mental health and substance use services in the last 6 months [214]. This indicator is categorised under the 'Health system outputs' quadrant in the Canadian Institute for Health Information's Health System Performance Measurement Framework as a person-centred service quality attribute [68]. For the purposes of this indicator, early mental health and substance use needs are defined as "new or pre-existing self-reported functional impairment (working or doing school work, taking care of things at home or getting along with other people) or a perceived need for care in the last 6 months" [214]. Children and youth who report severe impairment as a result of mental health and/or substance use issues, with an onset prior to the previous 6 months, are excluded. This indicator focuses on the age of onset for a range of major mental health disorders, and it was selected because it provides an indirect measure of whether children and youth in Canada can access early intervention services when they begin to experience mild to moderate mental health and/or substance use issues [214]. This indicator also focuses on access to formal services only (i.e. those with a mandate to provide mental health and substance use services to children and youth); other intervention initiatives in community settings are excluded. For this indicator, individuals who report accessing at least one of the following services in the last 6 months are included [214]:

- Counselling or therapy
- Trained peer support services
- Indigenous-focused services
- Cultural-based services
- Case management
- Youth worker or essential needs services, or
- School-based services or crisis support services.

Services provided in an acute care setting (e.g. emergency department visits and inpatient facilities) are excluded from the scope of this indicator. In addition, the service must be provided by someone trained in supporting children and young people with their mental health and/or substance use. The data source for this indicator is the Early Intervention for Mental Health and Substance Use Among Children and Youth Survey, which was implemented by the Canadian Institute for Health Information for the first time in 2022 [215]. As such, only 1 year of data has been collected as of completion of this evidence brief in September 2023. Data are disaggregated by province/territory [214].

'Frequent emergency room visits for help with mental health and substance use' is measured as the percentage of individuals who had four or more emergency room or urgent care centre visits for help with mental health and substance use in a 365-day period among individuals who had at least one emergency

room or urgent care centre visit for mental health and substance use in a given year [216]. This indicator is categorised under the ‘Health system outputs’ quadrant in the Canadian Institute for Health Information’s Health System Performance Measurement Framework as an indicator of access to comprehensive, high-quality health services [68]. This indicator was selected because frequent visits to emergency departments or urgent care centres is an indication that people are not able to access the services or supports they need for their mental health and/or substance use within their communities. A higher rate of emergency room visits may suggest that people had conditions that were inadequately managed in their communities, or that people were unaware of available services in their communities, had difficulty accessing them, or had negative experiences or outcomes with community care [216]. Scheduled emergency department visits and transfers from another emergency department are not in the scope of this indicator. This indicator does not include dementia or problems related to brain injuries, such as concussion or stroke. The data source for this indicator is Canada’s National Ambulatory Care Reporting System, which is a system managed by the Canadian Institute for Health Information that contains data for hospital-based and community-based ambulatory care, including day surgery, outpatient and community-based clinics, and emergency departments [217]. Data are collected annually and are available for the years 2017–2021. Data are disaggregated by province/territory, region, age group, recorded sex or gender, mental illness category (substance-related and addictive disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, selected disorders of personality and behaviour, or other disorders), neighbourhood income quintile, urban versus rural/remote, and ambulatory care type [216].

‘Wait times for community mental health counselling’ is measured as the median number of calendar days that clients waited for ongoing community mental health counselling services, calculated from the date that they received the initial referral to the date of the first scheduled counselling session [218]. This indicator is categorised under the ‘Health system outputs’ quadrant in the Canadian Institute for Health Information’s Health System Performance Measurement Framework as an indicator of access to comprehensive, high-quality health services [68]. According to the Canadian Institute for Health Information, this indicator is a starting point for measuring access to community-based supports. For the purposes of this indicator, the first scheduled counselling session refers to the first appointment offered and accepted by the client, regardless of whether or not the client attends the appointment. Counselling is defined as “therapy grounded in a psychological theory or evidence-based practice that uses a set of recognized communication skills, and which is planned to be provided over 1 or more scheduled sessions by trained mental health professionals to promote positive growth, wellbeing, and mental health. Counselling may be individual-, group- or family-based” [218]. Examples include dialectical behavioural therapy, cognitive behavioural therapy, brief low-intensity counselling, psychodynamic therapy, and mindfulness-based interventions. The following types of counselling are excluded: crisis services, assertive community treatment and flexible assertive community treatment, drop-in/walk-in, self-help, coach-guided programmes, peer-led, clubhouses, residential care, intensive outpatient treatment (e.g. day/evening treatment, day hospital, or intensive day treatment programmes), educational counselling, information sharing, forensic services, single-session counselling programmes, standalone substance use services (e.g. withdrawal management services), specialised consultations, and general support/supportive listening. Only publicly funded services that are scheduled in advance are in scope for this indicator; in this context, ‘publicly funded’ refers to services that are provided, coordinated, or overseen by the Canadian Government. This indicator was selected because wait times reflect the responsiveness of the healthcare system and indicate whether individuals have timely access to mental health services in the community. Only new referrals (i.e. referrals for new clients or clients who are being referred for a new episode of care), regardless of source (i.e. walk-in, family physician, emergency department, crisis services, or self-referral), are in scope. The Canadian Institute for Health Information

collects and reports annual data for this indicator from provincial and territorial data collection systems; coverage is considered full if referrals reported constitute 95% or more of those in the jurisdiction, partial if between 50% and 95%, and incomplete if below 50% (results are not reported when coverage is incomplete) [218]. Data for the years 2020 and 2021 are currently available, and are disaggregated by province/territory, age group, and gender [218].

'Mental health and substance use disorder discharges' is measured as the number, percentage, and crude and age-standardised rate of discharges for mental health and substance use disorder hospitalisations [219]. It is categorised under the 'Health system inputs and characteristics' quadrant in the Canadian Institute for Health Information's Health System Performance Measurement Framework as an indicator of health system resources [68]. This indicator was selected in order to provide information about hospital utilisation, and because it "may reflect differences in the health of the population and mental health service delivery models as well as variations in the availability and accessibility of specialized, residential and/or ambulatory and community-based health services" [219]. For the purposes of this indicator, discharges by year are based on the date of discharge rather than on the date of admission, and each discharge represents a single episode of care. In addition, the data are event-based, rather than person-based, so an individual may be represented multiple times in the data. If an individual was hospitalised prior to the beginning of a fiscal year, the days they stayed prior to the year of discharge are included in the total number of days stayed for that event. Only individuals with a primary diagnosis of a mental health or substance use condition on discharge are included in the analyses, and discharges are assigned to diagnosis groups based on the primary diagnosis or the diagnosis that contributed most to an individual's length of stay during the hospitalisation period. Neurocognitive disorders (e.g. various forms of dementia) are in scope for this indicator, and may be included or excluded by selecting or deselecting the neurocognitive disorders filter in the data visualisation tool for this indicator [219]. Data for this indicator are collected and reported annually by the Canadian Institute for Health Information from the following five sources [219]:

1. The Discharge Abstract Database, a Canadian Institute for Health Information database that captures administrative, clinical, and demographic information on hospital discharges (including deaths, sign-outs, and transfers) [220]
2. The Human Metabolome Database, a freely available electronic database containing detailed information about small molecule metabolites found in the human body, which is designed to link three kinds of data: chemical data, clinical data, and molecular biology/biochemistry data [221]
3. The Ontario Mental Health Reporting System, a Canadian Institute for Health Information system that includes information about the physical and mental health, social supports, service use, care planning, and outcome measurement of all individuals receiving adult mental health services in Ontario [222]
4. The Hospital Mental Health Survey, which collects separated records from selected psychiatric hospitals that do not report to the Discharge Abstract Database [223], and
5. Statistics Canada, Canada's national statistical office [134].

Data for this indicator are available for the years 2017–2021 and are disaggregated by province/territory, age group, recorded sex or gender, hospital type, and diagnosis category/subcategory [219].

'Total days stayed for mental health and substance use disorder hospitalisations' is measured as the total number of days stayed; percentage of days stayed; average number of days stayed; 0.5% trimmed average, median, and 25th and 75th percentiles; and crude and age-standardised rate of days stayed for mental health and substance use disorder hospitalisations [224]. This indicator is categorised under the 'Health system inputs and characteristics' quadrant in the Canadian Institute for Health Information's

Health System Performance Measurement Framework as an indicator of health system resources [68]. This indicator was selected to “provide information about hospital utilization and [to] reflect differences in the health of the population and mental health service delivery models as well as variations in the availability and accessibility of specialized, residential and/or ambulatory and community-based health services” [224].

For this indicator, length of stay is calculated as the discharge date minus the admission date. If service interruptions and alternate level of care days (i.e. hospital beds that are occupied by patients who would more appropriately be cared for in another setting [225]) occurred during the stay, they are included in the calculation of length of stay. For the purposes of this indicator, the discharge date includes cases where the individual was transferred to another hospital or care setting, cases where the individual left against medical advice, and cases where the individual died in hospital [224]. In addition, the data are event-based rather than person-based, so an individual may be represented multiple times in the data. If an individual was admitted prior to the beginning of the fiscal year, the number of days they stayed prior to the beginning of the year are included in the total number of days stayed for that event [224]. Data for this indicator are collected and reported annually by the Canadian Institute for Health Information from the same five sources as the previous indicator, ‘Mental health and substance use disorder discharges’. Data for this indicator are available for the years 2017–2021 and are disaggregated by province/territory, age group (not provided for age-standardised rates), recorded sex or gender, hospital type, and diagnosis category/subcategory [224].

3.8.1.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.1.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not explicitly identify the benefits of the indicators.

Informing the Future: Mental Health Indicators for Canada noted that data for the ‘Individuals hospitalised for more than 30 days in a year’ indicator are based on hospitalisations for substance-related disorders; schizophrenia, delusional, and non-organic psychotic disorders; mood/affective disorders; anxiety disorders; and selected disorders of personality and behaviour among adults. As such, some of the most uncommon mental health diagnoses may not be included in the scope of this indicator [31].

In relation to ‘Unmet need for mental health care among people with mental disorders’, *Informing the Future: Mental Health Indicators for Canada* noted that the findings of the Canadian Community Health Survey are limited to a subsample of individuals with certain diagnosed mental health conditions (i.e. mood, anxiety, and substance use disorders) and therefore may not reflect the level of unmet need among people with other mental health conditions [31].

In relation to ‘Unmet need for general health care among people with common conditions’, *Informing the Future: Mental Health Indicators for Canada* noted that self-reports of anxiety and mood disorders are based on single survey items in the Canadian Community Health Survey and therefore may not correspond to prevalence rates in epidemiological studies [31].

In relation to ‘Recovery-focused program accreditation’, *Informing the Future: Mental Health Indicators for Canada* noted that because Accreditation Canada is not the only accrediting body for mental health programmes in Canada, this indicator may not provide an accurate picture of national programme accreditation. In addition, in *Informing the Future: Mental Health Indicators for Canada,* it was noted that there is no overall count of the total number of mental health programmes in Canada, which precludes a determination of the percentage of programmes that have been accredited [31]. This limitation was,

however, noted in 2015, and an overall count of the total number of mental health programmes in Canada may have been introduced since then.

3.8.1.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.2.2.4 The mental health and substance use indicators

The Canadian Institute for Health Information mental health and substance use indicator web pages describe the limitations associated with each indicator. They do not explicitly describe any benefits associated with the indicators.

As previously mentioned, the data source for 'Early intervention for mental health and substance use among children and youth' is the Early Intervention for Mental Health and Substance Use Among Children and Youth Survey [215], and survey results are only representative of the surveyed population [215]. Moreover, information pertaining to both respondents' service access and their mental health and substance use issues in the previous 6 months is self-reported, which is subject to respondents' ability to remember their experience. Notably, the Early Intervention for Mental Health and Substance Use Among Children and Youth Survey did not involve probability sampling, so not everyone in the target population had an equal chance to participate, and some groups (e.g. age groups or genders) may be under- or overrepresented. In addition, the survey was only available in French and English, so people who do not speak either of these languages would have been unable to complete the survey, as would those without Internet access or with low computer literacy. Finally, informal supports are not in scope for this indicator, despite recognition of the fact that early intervention can occur in a variety of settings, including informal settings [215].

In relation to 'Frequent emergency room visits for help with mental health and substance use', the Canadian Institute for Health Information notes that the diagnosis of mental health conditions in emergency rooms is not always possible, which may mean that mental health conditions have been under-captured by this indicator [216]. In addition, the capture of diagnoses is dependent on the level of detail submitted to the National Ambulatory Care Reporting System, the data source for this indicator [217]. It is also noted that visits related to substance use may be underestimated because poisonings are not included in the indicator [216].

The Canadian Institute for Health Information notes that caution should be used when interpreting the indicator 'Wait times for community mental health counselling' because it does not include all community-based mental health counselling services available across Canada. As previously mentioned, the data for this indicator are sourced from independent provincial and territorial systems, which have known variations in definitions [of indicators] and gaps in data coverage (particularly coverage in relation to the health regions and data from publicly funded services that are contracted out to third-party organisations). According to the Canadian Institute for Health Information, "There is a commitment among jurisdictions to work toward harmonizing definitions and improving comparability of results" [218]. In addition, there is no standard classification across Canada of what constitutes urgency, nor is there a common benchmark wait time, and so differences in the mix of acuity levels across jurisdictions may result in differences in wait times [218].

The Canadian Institute for Health Information states that, when comparing results for the indicators 'Mental health and substance use disorder discharges' and 'Total days stayed for mental health and substance use disorder hospitalisations' between provinces/territories, it is important to consider factors that might contribute to variation at the province/territory level. This includes, for example [224]:

- Provincial/territorial or regional health policies, practices, and resources
- Geography and urban/rural population distribution
- Environmental and socioeconomic characteristics
- Types of patients served and acuity of their illness
- The range of health services available beyond general and specialty psychiatric hospitals (such as community mental health services), and
- Accessibility and awareness of alternative points of entry to the health system.

3.8.1.3 England (UK)

3.8.1.3.1 What are the relevant mental health indicators?

3.8.1.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.3.1.4 The NHS mental health dashboard

As mentioned in Section 3.3.2.1, the NHS mental health dashboard includes a total of 55 indicators organised into 11 domains ('Children and young people mental health', 'Perinatal mental health', 'Adult mental health (NHS talking therapies for depression and anxiety)', 'Early intervention in psychosis', 'Employment support', 'Physical health checks for people with severe mental illness', 'Crisis and acute care and use of the Mental Health Act', 'Acute hospital mental health liaisons', 'Health and justice', 'Mental health service backlog', and 'Meeting commitment to increase mental health funding'). The data reported on the NHS mental health dashboard are available by region, integrated care board, or sub-integrated care board [41]. However, it should be noted that the NHS mental health dashboard publications provide limited information about the indicators. The following 26 out of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 2(a) [92]:

1. Number of children and young people accessing support by NHS funded community services
2. Percentage of children and young people with eating disorders seen within 1 week (urgent)
3. Percentage of children and young people with eating disorders seen within 4 weeks (routine)
4. Number of bed days for children and young people under 18 in child and adolescent mental health services tier 4 wards
5. Number of admissions for children and young people under 18 in child and adolescent mental health services tier 4 wards

6. Bed days of children and young people under 18 in adult inpatient wards
7. Number of children and young people under 18 in adult inpatient wards
8. Children and young people Crisis Long Term Care Plan ambition
9. Number of people aged 18 to 24 supported through NHS funded mental health
10. Number of women accessing specialist community perinatal mental health services
11. NHS talking therapies access
12. NHS talking therapies percentage of all referrals that are for older people 65+
13. NHS talking therapies percentage of people receiving first treatment appointment within 6 weeks of referral
14. NHS talking therapies percentage of people receiving first treatment appointment within 18 weeks of referral
15. NHS talking therapies percentage of in-treatment pathway waits over 90 days
16. Percentage of people who started treatment within 2 weeks of referral (all ages)
17. Percentage crisis services which are open access, including for self-referral
18. Percentage adult crisis services operating 24/7 including face to face response
19. Percentage adult crisis services that respond to older adults
20. Total number of inappropriate out of area bed days
21. Number of inappropriate mental health out of area placements started in the period
22. Percentage of acute hospitals that are open/available 24/7
23. Number of patient assessments in the adult prison estate, for mental health issues, during the reporting period
24. Number of patient treatments in the adult prison estate, for mental health issues, during the reporting period
25. Number of referrals to community-based mental health and learning disability services, yet to receive their second contact, and
26. Number of people with a severe mental illness eligible but waiting for all six components of a physical health check in the last 12 months.

'Number of children and young people accessing support by NHS funded community services' is categorised under 'Children and young people mental health' in the NHS mental health dashboard. This indicator is a measure of the number of children and young people (aged 0–17 years) accessing support by NHS-funded community services and school- or college-based mental health support teams (i.e. they have received at least one contact) [41]. This indicator is described as the headline metric for measuring mental health among children and young people, and it uses as a data source the NHS Mental Health Services Data Set, a patient-level, output-based secondary uses dataset aiming "to deliver robust, comprehensive, nationally consistent and comparable person-based information for patients who are in contact with Mental Health Services" [226]. The NHS Mental Health Services Data Set is the basis for the Mental Health Services Monthly Statistics, a monthly publication that provides "the timeliest picture available of people using NHS funded secondary mental health, learning disabilities and autism services in England at Provider level" [227]. All providers of specialist secondary mental health, learning disabilities,

and autism spectrum disorder services in England are required to submit data to the Mental Health Services Data Set, including providers and organisations in the voluntary and independent sectors [226]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a rolling 12-month basis [41].

'Percentage of children and young people with eating disorders seen within 1 week (urgent)' is categorised under 'Children and young people mental health' in the NHS mental health dashboard. This indicator is a measure of the proportion of children and young people with eating disorders who are considered urgent cases who wait 1 week or less from referral to commencement of treatment approved by the National Institute for Health and Care Excellence (NICE) [228]. NICE is an executive, non-departmental public body sponsored by the Department of Health and Social Care that provides evidence-based guidance and recommendations for improving health and social care in England [153]. From 2016–17 to the end of 2022, the data source for this indicator was the Strategic Data Collection Service collection for children and young people with eating disorders, a bespoke data collection that focused on waiting times for children and young people with eating disorders who were referred to treatment [229]. However, this collection has been retired, and since the beginning of 2021, access to and waiting times for services for this population have been monitored and reported on using the NHS Mental Health Services Data Set [226]. The most recent version of the NHS mental health dashboard states that regional and national data for this indicator are reported on a quarterly basis, whereas at the level of clinical commissioning groups and Sustainability and Transformation Partnerships, data for this indicator are reported on a rolling 12-month basis [41] (clinical commissioning groups, which were dissolved in 2022 and replaced with integrated care boards, were clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local areas [230], and Sustainability and Transformation Partnerships are 5-year plans covering all aspects of NHS spending in England, which also focus on the integration of health, social care, and other local authority services [231]). This indicator tracks progress against a national standard, which was 95% in 2021–22 [41].

'Percentage of children and young people with eating disorders seen within 4 weeks (routine)' is categorised under 'Children and young people mental health' in the NHS mental health dashboard. This indicator is a measure of the proportion of children and young people with eating disorders who are considered routine cases who wait 4 weeks or less from referral to the commencement of NICE-approved treatment. The data source, reporting periods, and standard for this indicator are identical to those described for the 'Percentage of children and young people with eating disorders seen within 1 week (urgent)' indicator [41].

'Number of bed days for children and young people under 18 in child and adolescent mental health services tier 4 wards' is categorised under 'Children and young people mental health' in the NHS mental health dashboard. Tier 4 of Child and Adolescent Mental Health Services covers facilities for children and young people with mental health problems who require hospital admission [232]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator includes children in medium secure wards and deaf inpatient children [41]. The data source for this indicator is the NHS Mental Health Services Data Set [226], and the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that it is reported on a quarterly basis [41].

'Number of admissions for children and young people under 18 in child and adolescent mental health services tier 4 wards' is categorised under 'Children and young people mental health' in the NHS mental health dashboard. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) noted that all information provided in relation to the 'Number of bed days for children and young people under 18 in child and adolescent mental health services tier 4 wards' indicator (see previous paragraph) also pertains to this indicator [41].

‘Bed days of children and young people under 18 in adult inpatient wards’ is categorised under ‘Children and young people mental health’ in the NHS mental health dashboard. This indicator is a count of bed days for people aged 0–17 years who were placed in an adult ward each month. The data source for this indicator is the NHS Mental Health Services Data Set [226]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis; data are submitted on a monthly basis by providers, and then 3 months’ worth of data are aggregated to produce quarterly figures [41].

‘Number of children and young people under 18 in adult inpatient wards’ is categorised under ‘Children and young people mental health’ in the NHS mental health dashboard. This indicator is a count of the number of children and young people aged 0–17 years who were admitted to an adult inpatient ward at any time during the reporting period. The data source for this indicator is the NHS Mental Health Services Data Set [226]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis. To avoid counting individuals more than once, individuals are allocated to a clinical commissioning group (now an integrated care board) and are counted based on data submitted for the latest month in the quarter that person spent time in an adult inpatient ward [41].

‘Children and young people Crisis Long Term Care Plan ambition’ is categorised under ‘Children and young people mental health’ in the NHS mental health dashboard. This indicator is a measure of the proportion of full or partial coverage of crisis provision for children and young people, which combines crisis assessment, brief response, and intensive home treatment functions. This indicator was selected in order to monitor progress against the commitment set out in *The NHS Long Term Plan* to ensure that all children and young people experiencing a mental health crisis will have access to crisis care 24 hours per day, 7 days per week, by the end of the 2023–24 reporting period [41]. The aim is for crisis services developed in line with *The NHS Long Term Plan* ambition to be comprehensive and, at a minimum, offer the following functions of operation to all children and young people aged 0–17 years (up to 17 years and 364 days) [41]:

- Single point of access, including through calling 111, crisis support, advice, and triage
- Crisis assessment within the emergency department and in community settings
- Crisis assessment and brief response within the emergency department and in community settings, with children and young people offered brief interventions, and
- Intensive Home Treatment Service for children and young people who might otherwise require inpatient care or intensive support that exceeds the normal capability of a generic children and young people’s mental health community team.

In relation to hours of operation, the aim of this indicator is to monitor progress towards achieving the following aims:

- Single point of access, crisis assessment, and brief response must operate 24/7, and
- Intensive Home Treatment Service should be available 7 days per week across locally determined extended hours (i.e. hours outside of the standard hours of operation: Monday to Friday, 9.00 am to 5.00 pm).

The data source for the ‘Children and young people Crisis Long Term Care Plan’ indicator is not made clear in the information provided in the NHS mental health dashboard. However, it does state in the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) that this indicator is

reported on annually, with the most recent data available (as of completion of this evidence brief in September 2023) being for the 2021–22 reporting period [41].

'Number of people aged 18 to 24 supported through NHS funded mental health' is categorised under 'Children and young people mental health' in the NHS mental health dashboard. This indicator is a count of people aged 18–24 years who have had at least one contact (either direct or indirect) with an NHS-funded mental health service in the previous 12 months. The data source for this indicator is the NHS Mental Health Services Data Set [226]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a rolling 12-month basis [41].

'Number of women accessing specialist community perinatal mental health services' is categorised under 'Perinatal mental health' in the NHS mental health dashboard. This indicator is a measure of the number of women who have had at least one attended contact (whether face-to-face or video contact) with a specialist community perinatal mental health service or maternal mental health service. This indicator was selected in order to monitor progress against the commitment set out in *The NHS Long Term Plan* (see Section 3.3.2) to ensure that "at least 66,000 women with moderate to severe or complex perinatal mental health needs will have access to specialist community care, from pre-conception to 24 months after birth, with increased availability of evidence-based psychological therapies" [41]. Consultation mediums other than face to face or video (e.g. telephone, SMS text messaging, or email) are excluded from the dataset for this indicator. In addition, women are only counted once nationally in the reporting period, even if they receive multiple episodes of care. This indicator tracks progress against the national standard, which is 66,000 women per year by the end of the 2023–24 reporting period. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a rolling 12-month basis [41].

'NHS talking therapies access' is categorised under 'Adult mental health (NHS talking therapies for depression and anxiety)' in the NHS mental health dashboard. This indicator is a measure of the number of people entering NHS-funded talking therapy during the reported period. The data source for this indicator is the NHS Talking Therapies Data Set (formerly the Improving Access to Psychological Therapies Data Set), which was developed "as a patient level, output based, secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable information for patients accessing NHS-funded [talking therapy] services in England" [233]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a rolling quarterly basis in order to measure progress against national quarterly targets set for NHS talking therapies [41].

'NHS talking therapies percentage of all referrals that are for older people 65+' is categorised under 'Adult mental health (NHS talking therapies for depression and anxiety)' in the NHS mental health dashboard. This indicator is a measure of the proportion of all referrals that are for individuals aged 65 years and over. The data source for this indicator is the NHS Talking Therapies Data Set (formerly the Improving Access to Psychological Therapies Data Set) [233]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis [41].

The next two indicators, 'NHS talking therapies percentage of people receiving first treatment appointment within 6 weeks of referral' and 'NHS talking therapies percentage of people receiving first treatment appointment within 18 weeks of referral' are categorised under 'Adult mental health (NHS talking therapies for depression and anxiety)' in the NHS mental health dashboard. These two indicators are measures of the proportion of people who finished treatment during the reporting period who had their first treatment appointment within 6 or 18 weeks of referral, respectively. These indicators track progress against the national standards of 75% (for receiving a first treatment appointment within 6 weeks) and 95% (for receiving a first treatment appointment within 18 weeks). The most recent version of

the NHS mental health dashboard states (for quarter 3 of 2022–23) that both indicators are reported on a quarterly basis [41].

‘NHS talking therapies percentage of in-treatment pathway waits over 90 days’ is categorised under ‘Adult mental health (NHS talking therapies for depression and anxiety)’ in the NHS mental health dashboard. This indicator is a measure of the proportion of people who waited more than 90 days between their first and second treatment appointment for NHS talking therapies during the reporting period. The purpose of this indicator is to measure the number of people who have waited more than 90 days between their first and second appointments for NHS talking therapies so that appropriate measures can be taken to reduce the number of people placed on an internal waiting list before a full course of treatment can commence. The data source for this indicator is the NHS Talking Therapies Data Set (formerly the Improving Access to Psychological Therapies Data Set) [233]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis [41].

‘Percentage of people who started treatment within 2 weeks of referral (all ages)’ is categorised under ‘Early intervention in psychosis’ in the NHS mental health dashboard. This indicator is a measure of the proportion of individuals with suspected first episode psychosis who were referred to a service and who received their first treatment appointment within 2 weeks of referral during the reporting period. For the purposes of this indicator, referrals entering treatment are individuals who have had a first contact with an early intervention for psychosis team and have been assigned to a care coordinator. This indicator is disaggregated into two categories [41]:

1. Individuals who waited 2 weeks or less to enter treatment, and
2. Individuals who waited more than 2 weeks to enter treatment.

This indicator tracks progress against the national standard of 60%. The data source for this indicator is the NHS Mental Health Services Data Set [226]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis [41]. This indicator is calculated by NHS England at the regional and Sustainability and Transformation Partnership levels, and data are then published in the NHS mental health dashboard. To date, national-level data have been calculated and published by NHS Digital (the national information and technology partner to the health and social care system [234]) but not for the purposes of this indicator. However, in February 2023, NHS Digital merged with NHS England, and so henceforth, this indicator may be calculated and published at both the regional and national levels [41].

‘Percentage crisis services which are open access, including for self-referral’ is categorised under ‘Crisis and acute care and use of the Mental Health Act’ in the NHS mental health dashboard. This indicator is a measure of the percentage of crisis teams serving the clinical commissioning groups (now known as integrated care boards) in England which are open access. In this context, open access means that patients can self-refer, either directly to crisis resolution or home treatment teams, or via an alternative single point of access. Referrals are also accepted from families and friends, members of the public, and any member of a system partner, including police, ambulance services, NHS 111, GP practices, emergency departments, and the voluntary sector. Information pertaining to the data source for this indicator is lacking; the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) only states that the data are collected using a national survey, but the title or nature of the survey are not provided. It is noted, however, that this indicator is reported annually [41].

‘Percentage adult crisis services operating 24/7 including face to face response’ is categorised under ‘Crisis and acute care and use of the Mental Health Act’ in the NHS mental health dashboard. Like the previous indicator, information pertaining to the data source for this indicator is lacking; the most recent

version of the NHS mental health dashboard only states that the data are collected using a national survey, but the title or nature of the survey are not provided. It is noted, however, that this indicator is reported annually [41].

'Percentage adult crisis services that respond to older adults' is categorised under 'Crisis and acute care and use of the Mental Health Act' in the NHS mental health dashboard. Like the previous two indicators, information pertaining to the data source for this indicator is lacking; the most recent version of the NHS mental health dashboard only states that the data are collected using a national survey, but the title or nature of the survey are not provided. It is noted, however, that this indicator is reported annually [41].

'Total number of inappropriate out of area bed days' is categorised under 'Crisis and acute care and use of the Mental Health Act' in the NHS mental health dashboard. This indicator is a measure of the total number of days in which patients have been placed out of area due to there being no available beds in their usual network of services. For the purposes of this indicator, an 'out of area placement' occurs when:

> A person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that does not form part of their usual local network of services. By this we mean an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service, and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning. An 'Inappropriate' out of area placement is one that is solely or primarily necessitated because of the unavailability of a local acute bed. [41]

This indicator tracks progress against the national standard of zero. The current data source for this indicator is the Out of Area Placements in Mental Health Services collection, a monthly report on the number of patients in England who are admitted to an acute mental health inpatient unit that does not form part of their usual care [235]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that the Out of Area Placements in Mental Health Services collection will be the data source for this indicator until the data become aligned with the NHS Mental Health Services Data Set [226]. For the purposes of the NHS mental health dashboard, this indicator is reported on a quarterly basis [41].

'Number of inappropriate mental health out of area placements started in the period' is categorised under 'Crisis and acute care and use of the Mental Health Act' in the NHS mental health dashboard. This indicator is a measure of the total number of patients who have started a placement out of area due to there being no available beds in their usual network. The data source, reporting period, and national target for this indicator are identical to those described for the previous indicator [41].

'Percentage of acute hospitals that are open/available 24/7' is categorised under 'Acute hospital mental health liaisons' in the NHS mental health dashboard. The data source for this indicator is the Survey of Liaison Psychiatry in England, a national survey now on its sixth cycle that assesses progress towards providing adequate liaison psychiatry in all acute hospitals with emergency departments in England [236], a goal set out in *The Five Year Forward View for Mental Health* (see Section 3.3.2) [41].

'Number of patient assessments in the adult prison estate, for mental health issues, during the reporting period' is categorised under 'Health and justice' in the NHS mental health dashboard. This indicator is a measure of the number of mental health assessments completed in the adult prison estate during the reporting period. Almost no information is provided in relation to this indicator in the NHS mental health dashboard publications. The data source is the NHS England Health and Justice Indicators of Performance, a dataset which enables commissioners to assess whether the health needs of prisoners are being met in

prison healthcare delivery [237]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis [41].

'Number of patient treatments in the adult prison estate, for mental health issues, during the reporting period' is categorised under 'Health and justice' in the NHS mental health dashboard. This indicator is a measure of the number of episodes of structured treatment activity delivered (excluding initial assessments) in the adult prison estate during the reporting period. Like the previous indicator, almost no information is provided in relation to this indicator in the NHS mental health dashboard publications. The data source and reporting period for this indicator are the same as those outlined in the previous paragraph [41].

'Number of referrals to community-based mental health and learning disability services, yet to receive their second contact' is categorised under 'Mental health service backlog' in the NHS mental health dashboard. This indicator measures the number of individuals who have been referred to access NHS-funded community-based mental health and learning disability and/or autism services, including NHS talking therapy services, who are waiting to receive a second contact with a service as of the end of the reporting period. This indicator was selected in order to provide insight into pressures on services, and it is used to monitor and improve waiting times at provider and system level. All ages and multiple referrals for the same person (a person can have more than one referral) are in scope for this indicator; inpatient services are out of scope [41]. This indicator is calculated using two data sources [41]:

1. The NHS Talking Therapies Data Set (formerly the Improving Access to Psychological Therapies Data Set) [233], and
2. The NHS Mental Health Services Data Set [226].
3. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis [41].

'Number of people with a severe mental illness eligible but waiting for all six components of a physical health check in the last 12 months' is categorised under 'Mental health service backlog' in the NHS mental health dashboard. This indicator measures the number of people on the General Practice Severe Mental Illness register who are eligible for a physical health check, but who did not receive all six components of the health check in the last 12 months in any setting. Like the previous indicator, this indicator was selected in order to provide insight into pressures on mental health services and ensure that eligible patients can access and receive physical health checks. The data for this indicator are sourced from NHS England's data collection for people with severe mental illness who are receiving a full physical health check, which contains information gathered by clinical commissioning groups (now known as integrated care boards) from GP practices and other primary care services in their area on the number of people on the General Practice Severe Mental Illness register at the end of each quarter and how many of them received a comprehensive physical health check during the 12 months prior to the end of the reporting period [238]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis [41].

3.8.1.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.1.3.2.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.3.2.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.3.2.4 The NHS mental health dashboard

The NHS mental health dashboard publications do not explicitly describe the benefits and limitations associated with the 55 included indicators. However, the following three indicators which were deemed relevant to *Sharing the Vision* outcome 2(a) were classified as experimental in the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) [41]:

1. Bed days of children and young people under 18 in adult inpatient wards
2. Number of children and young people under 18 in adult inpatient wards, and
3. Number of referrals to community-based mental health and learning disability services, yet to receive their second contact.

Experimental statistics are a subset of newly developed official statistics which are undergoing evaluation in line with the UK Statistics Authority's Code of Practice [239] and therefore may be subject to change [240]. Experimental statistics are published "in order to involve users and stakeholders in their development, and as a means to build quality at an early stage" [240]. It is suggested in the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) that indicators that rely on experimental statistics be interpreted with caution [41].

3.8.1.4 New Zealand

3.8.1.4.1 What are the relevant mental health indicators?

3.8.1.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.4.1.2 The Key Performance Indicator Programme

As mentioned in Section 3.4.2, the Key Performance Indicator Programme consists of six key performance indicators distributed across three streams: an adult stream, a child and youth stream, and a non-governmental organisation (NGO) stream [104]. The adult stream contains five indicators, the child and youth stream contains three indicators, and the NGO stream contains two indicators (some indicators are common multiple streams). Of the six key performance indicators, one was deemed relevant to *Sharing the Vision* outcome 2(a). This indicator, which is only included in the child and youth stream of the Key Performance Indicator Programme, is 'Wait times' [241].

'Wait times' measures the length of time between the day a person seeking help is referred to a mental health or addiction service and the first day that they are seen by the service [242]. Information is also included on the length of time between the day a person is referred to a mental health or addiction service and the third day that they are seen by the service as a proxy 'time to treatment' marker, which is considered the most probable point for therapeutic intervention to occur [242]. For the purposes of this indicator, wait time is calculated using calendar days, not 24-hour periods. Referrals where contact is not necessarily expected are considered out of scope [241]. As mentioned in Section 3.4.2, the data source for all indicators in the Key Performance Indicator Programme is the Programme for the Integration of

Mental Health Data (PRIMHD), the New Zealand Ministry of Health's national database on mental health [102]. There are four data dashboards available for this indicator [242]:

1. A national summary dashboard
2. A health division dashboard
3. An indicator exploration dashboard, and
4. A forensic inpatient national summary dashboard.

These data dashboards were developed using criteria specific to children and young people aged 0–19 years. However, they also contain some information for adults (aged 20–64 years) and older people (aged 65 years and over), where services have reported the data to PRIMHD. Results of the 'Wait times' indicator are available for each financial quarter and can be filtered by age, gender, ethnicity, and health division. The data dashboards also provide data on the percentage of individuals seen within 3–8 weeks of referral [242].

3.8.1.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 2(a). This indicator, which falls under the 'Health service delivery' outcome domain, is 'Access to services' [43].

This indicator was measured as the proportion of people who had accessed mental health and addiction services in the last 12 months [43]. The data were reported by age group (adults aged 20–64 years, youth aged 1–19 years, and older people aged 65 years and over), and also reported separately for Māori and non-Māori populations. The data source for this indicator was the New Zealand Ministry of Health, which provided annual data from 2002–03 until 2009–10 for trend analysis [43].

3.8.1.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.1.4.2.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.4.2.2 The Key Performance Indicator Programme

The Key Performance Indicator Programme website provides supporting information for each of the six key performance indicators [40].

The Key Performance Indicator Programme website does not explicitly describe any benefits and limitations for the 'Wait times' indicator. However, it notes that there is no mechanism for categorising a service episode as urgent in the calculation methodology used for the indicator. The website also notes that there is no correction for duplicates, and that activities that occur on the same day are all considered individually, which is how a single referral can have 0 days to both first and third contact with the service (i.e. when three separate activities occur on the day of the referral) [241].

3.8.1.4.2.3 *National Indicators 2012*

There were no benefits or limitations described in relation to 'Access to services' in the Mental Health and Wellbeing Commission's *National Indicators 2012* report.

3.8.1.5 Scotland (UK)

3.8.1.5.1 What are the relevant mental health indicators?

3.8.1.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.5.1.3 Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health includes a total of 30 quality indicators categorised into 6 quality dimensions ('Timely', 'Safe', 'Person-centred', 'Effective', 'Efficient', and 'Equitable') [120]. Of these indicators, the following seven were deemed relevant to *Sharing the Vision* outcome 2(a) [120]:

1. Percentage of people who commence psychological therapy-based treatment within 18 weeks of referral ('Timely' dimension of service quality)
2. Percentage of young people who commence treatment by specialist Child and Adolescent Mental Health services within 18 weeks of referral ('Timely' dimension of service quality)
3. Percentage of unscheduled presentations referred to specialist mental health services, who have had direct assessment by mental health specialists within 4 hours ('Timely' dimension of service quality)
4. Percentage of first presentation psychosis patients that start Scottish Intercollegiate Guidelines Network (SIGN) or NICE guideline evidence-based treatment within 14 calendar days of referral to specialist mental health services ('Timely' dimension of service quality)
5. Number of days people spend in hospital when they are ready to be discharged per 1,000 population ('Effective' dimension of service quality)
6. Percentage of did not attend appointments for community-based services of people with mental health problems ('Efficient' dimension of service quality), and
7. Percentage of under 18 psychiatric admissions admitted out with NHS specialist Child and Adolescent Mental Health (CAMH) ward ('Equitable' dimension of service quality).

'Percentage of people who commence psychological therapy-based treatment within 18 weeks of referral' is a measure of the proportion of people who commence psychological therapy-based treatment for a mental disorder or illness within 18 weeks of referral, which is the standard set by the NHS in Scotland in relation to psychological therapy services [243]. This indicator was selected because waiting times are a key measure of how well the NHS is responding to demand for services. Regular reporting on waiting times provides insight into where there are delays in the system, and it enables monitoring of system performance and effectiveness [243]. This indicator can be adjusted according to how long a person waited for treatment, taking into account any periods that the person was unavailable and any appointments that they missed or had rearranged. If a person has no periods of unavailability and attends their appointment on the first date that they accept, then no adjustments to the indicator are made [243]. Although psychological therapies refer to a range of interventions designed to assist people in understanding and modifying their thinking, behaviour, and relationships in order to alleviate distress and to improve overall functioning, this indicator applies specifically to psychological therapies for the treatment of a mental disorder or illness [123]. The data source for this indicator is the Psychological

Therapies Waiting Times publication, which is published on a quarterly basis by Public Health Scotland based on data received from each NHS Board in Scotland [123,243]. The Psychological Therapies Waiting Times publication is available with downloadable data files, a data quality statement, and an interactive data dashboard which provides data visualisations and information about trends in the indicator results over time [123,244].

'Percentage of young people who commence treatment by specialist Child and Adolescent Mental Health services within 18 weeks of referral' is a measure of the proportion of young people who commence treatment for a mental disorder or illness by specialist CAMH services within 18 weeks of referral, which is the standard set by the NHS in Scotland in relation to CAMH services [245]. The rationale underlying this indicator is identical to that described for the previous indicator [245]. This indicator can also be adjusted according to how long a person waited for treatment, after taking into account any periods they were unavailable and any appointments that they missed or had to rearrange [245]. The data source for this indicator is the Child and Adolescent Mental Health Services Waiting Times publication, which is published on a quarterly basis by Public Health Scotland based on data received from each NHS Board in Scotland [245,246]. Like the data source for the previous indicator, the Child and Adolescent Mental Health Services Waiting Times publication is available with downloadable data files, a data quality statement, and an interactive data dashboard which provides data visualisations and information about trends in the indicator results over time [246,247].

'Percentage of unscheduled presentations referred to specialist mental health services, who have had direct assessment by mental health specialists within 4 hours' is currently still under development [44]. However, it was selected for inclusion in the Quality Indicator Profile for Mental Health in order to gain insight into how many unscheduled presentations to frontline emergency services are mental health related, and, of those, how many are referred to mental health specialists and how timely the response is [120]. In the introductory publication of the Quality Indicator Profile for Mental Health*,* the Scottish Government defined 'unscheduled presentations' as "emergency presentations from any source to all first line statutory emergency services, including emergency services provided by mental health and by acute services" [120 p10]. 'Direct assessment' is defined as a one-to-one verbal assessment – either face to face, over the phone, or using digital technology – and 'mental health specialists' includes any clinical member of a specialist mental health team of any discipline or grade [120]. Although this indicator is still under development, the introductory publication of the Quality Indicator Profile for Mental Health notes that, in order to appropriately capture this indicator, it will be necessary to measure the time between unscheduled presentations being referred to mental health services and the commencement of direct assessment. It is also recommended that work should commence with data from emergency departments [120].

'Percentage of first presentation psychosis patients that start SIGN or NICE guideline evidence-based treatment within 14 calendar days of referral to specialist mental health services' is also currently still under development [44]. However, it was selected for inclusion in the Quality Indicator Profile for Mental Health because people who experience psychosis are subject to receiving different quality of care, particularly in relation to access to assessment and treatment, and because improvement in first episode psychosis services will promote service development [120]. In addition, early intervention in psychosis is highlighted as a priority in the Scottish Government's *Mental Health Strategy 2017–2027* [116]. SIGN produces evidence-based guidelines in order to help health and social care professionals and patients understand and apply medical evidence to healthcare decision-making, reduce unnecessary variations in practice, and improve healthcare across Scotland [248] (see Section 3.8.1.3.1.4 for information about NICE). In the introductory publication of the Quality Indicator Profile for Mental Health*,* the Scottish Government defined 'first presentation psychosis' as "any psychosis regardless of diagnosis presenting to

first line services, both inpatient and community" [120 p11]. In addition, 'treatment' is defined as guidelines- and evidence-based therapeutic involvement of mental health specialists that goes beyond mental health assessment [120]. It is also noted that this indicator, when developed, will apply to people of all ages, and that specialist mental health services will be responsible for tracking and reporting the time between referral of an individual who presents with first episode psychosis and the commencement of their physical, psychological, and/or social treatment as defined by SIGN or NICE [120].

'Number of days people spend in hospital when they are ready to be discharged per 1,000 population' is a measure of the total number of days' delay that patients spend in hospital when they are clinically ready to be discharged [44]. This indicator was selected because delayed discharge from hospital may reflect problems with enacting discharge planning due to social support deficits or lack of availability of community care [120]. All NHS psychiatric hospital inpatients aged 18 years and over are included in the scope of this indicator. For the purposes of this indicator, the decision that a patient is ready for discharge must be made by the consultant responsible for the patient's inpatient care [120]. The data source for this indicator is the Delayed discharges in NHSScotland monthly publication, as well as the Delayed discharges in NHSScotland annual summary, both of which present information about delayed discharges across NHS Scotland hospitals and are available on the Public Health Scotland website with downloadable data files [249].

'Percentage of did not attend appointments for community-based services of people with mental health problems' is a measure of the percentage of people who did not attend their appointment for mental health problems at community-based services [44]. This indicator was selected because 'did not attends' may be a sign of difficulty in accessing community-based services, wasted resources, and/or that services are not being used to full capacity [120]. This indicator includes all ages and care groups. Limited information is provided about this indicator, but data for the indicator are collected by Public Health Scotland from NHS Scotland health boards [44]. This indicator is available with downloadable data files and a data issues and completeness statement [44].

'Percentage of under 18 psychiatric admissions admitted out with NHS specialist CAMH ward' is a measure of the proportion of children and young people admitted to hospitals other than specialist CAMH wards [120]. This indicator was selected because, while admissions out with CAMH wards may be due to factors such as rural location, these may also signal an absence of available beds in wards [120]. The data source for this indicator is the Scottish Morbidity Records, which are a series of datasets published monthly on Discovery, an online information management system and collaboration between NHS Boards, the Scottish Government, and Public Health Scotland [250]. Discovery is not open to members of the public, the press, academia, or researchers; rather, it provides approved users (e.g. representatives from the Scottish Government, territorial and special health boards, local authorities, and health and social care partnerships) with access to a range of comparative healthcare information [250]. This indicator is sourced from the Scottish Morbidity Records dataset 04, 'Mental Health Inpatient and Day Case', which "collects episode level data on patients who are receiving care at psychiatric hospitals at the point of both admission and discharge" [251]. This dataset comprises a variety of information, including patient characteristics, their mental health diagnosis, length of stay, destination upon discharge, whether they were admitted under mental health legislation, and any previous psychiatric care they have received [251]. A Scottish Morbidity Record 04 should be generated for every episode of inpatient or day care received in a mental health specialty in a psychiatric hospital or unit in NHS Scotland [44]. This dataset allows patients to be allocated to the following specialties [44]:

- General psychiatry
- Child and adolescent psychiatry

- Forensic psychiatry
- Psychiatry for old age
- Learning disability, and
- Psychotherapy.

Scottish Morbidity Record 04 data are received by Public Health Scotland from NHS Boards and healthcare providers every 6 weeks and uploaded to Discovery. Although the dataset is not available to the public, Scottish Morbidity Record completeness estimates are, and are published monthly [252].

3.8.1.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.1.5.2.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 2(a).

3.8.1.5.2.3 Quality Indicator Profile for Mental Health

The benefits and limitations associated with the quality indicators included in the Quality Indicator Profile for Mental Health were not described in the literature we sourced. However, as noted in Section 3.5.3.1, at the time that Public Health Scotland published the most recent Quality Indicator Profile for Mental Health in April 2023, it was still considered an experimental statistics publication [44].

3.8.1.6 The OECD

3.8.1.6.1 What are the relevant mental health indicators?

3.8.1.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the Organisation for Economic Co-operation and Development (OECD) Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions (‘Person-centred mental health policies and services’, ‘Accessible, high-quality mental health services’, ‘An integrated and multi-sectoral approach to mental health’, ‘Preventing mental illness and promoting mental well-being’, ‘Strong leadership and good governance’, and ‘Building future-focused and innovative mental health systems’) [27]. Of these indicators, three were deemed relevant to *Sharing the Vision* outcome 2(a), one of which is repeated across different categories (see ‘Services that can be accessed without referral’ in the list below). It should be noted that limited information pertaining to the development and nature of the indicators is provided in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*. The three indicators are [27]:

1. Unmet needs for mental health care due to financial, wait times, or transport (dimension 2, ‘Accessible, high-quality mental health services’)
2. Number of people who accessed specialist mental health services per 1,000 population (dimension 2, ‘Accessible, high-quality mental health services’), and
3. Services that can be accessed without referral (dimension 4, ‘Preventing mental illness and promoting mental well-being’); separate indicator for:
   - Self-referral directly to services

– National telephone hotline

– Web-based information, and

– Emergency department.

'Unmet needs for mental health care due to financial, wait times, or transport ' is measured as the proportion of the population in each country with unmet needs for mental health care due to financial reasons, service wait times, or a lack of transport options. In *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, this indicator was reported by 22 out of 38 OECD member countries, including the UK and Ireland (it was not reported in Australia, Canada, or New Zealand) [27]. The data source is the Commonwealth Fund International Health Policy surveys (2016 and 2020), which collect annual data on patients' experiences and opinions of their countries' health system performance in selected OECD member countries [253].

'Number of people who accessed specialist mental health services per 1,000 population' was reported by 13 out of 38 OECD member countries, including Canada, New Zealand, the UK, and Ireland (it was not reported by Australia) [27]. Data for the indicator were sourced from the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires [27]. *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* provides limited information pertaining to the development and nature of these questionnaires, but, for the purposes of this indicator, it does define people with a mental health problem as adults who responded 'yes' to the question "Have you ever been told by a doctor that you have depression, anxiety or other mental health problems?" [27].

The 'Services that can be accessed without referral' indicator provides information about which countries permit self-referral to public mental health services and which countries provide access to the following mental health supports without a referral from a GP, emergency department, or a psychiatrist [27]:

- National telephone hotline
- Web-based information, and
- Emergency department.

Some or all of the indicators were reported by 24 out of 38 OECD member countries, including Australia, Canada, New Zealand, the UK, and Ireland [27]. Like the previous indicator, data for these indicators were sourced from the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires. However, limited information pertaining to the development and nature of these questionnaires is provided in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.8.1.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.1.6.2.1 The OECD Mental Health System Performance Benchmark

There were no explicit benefits or limitations associated with the benchmarking indicators deemed relevant to *Sharing the Vision* outcome 2(a) described in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.8.2 Outcome 2(b): Service delivery is organised to enable increased numbers of people to achieve personal recovery

3.8.2.1 Australia

3.8.2.1.1 What are the relevant mental health indicators?

3.8.2.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination' [21]. The following two performance indicators, both of which fall under domain 5 ('Effective support, care and treatment'), were deemed relevant to *Sharing the Vision* outcome 2(b) [21]:

1. Change in mental health consumers' clinical outcomes, and
2. Mental health readmissions to hospital.

'Change in mental health consumers' clinical outcomes' measures the proportion of mental-health-related episodes of care where either significant improvement, significant deterioration, or no significant change was identified between baseline and follow-up of completed outcome measures [124]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected in order to evaluate the effectiveness of mental health services across jurisdictions using routinely collected outcome measures. The report states, "If services are highly effective, a high proportion of consumers will experience significant improvement, and few or no consumers will experience significant deterioration or no significant change" [124 p14]. Data for this indicator are collected annually from the National Outcomes and Casemix Collection, an Australian Mental Health Outcomes and Classification Network collection of clinician- and consumer-rated measures of consumer symptoms and functioning at key points of care within public clinical mental health services [254]. Data are collected annually and are available for each year from 2007–08 to 2019–20. Data for this indicator were first published in the first progress report on The Fifth Plan in 2018 and have been updated in subsequent progress reports, including the most recent report, which was published in 2021. This indicator can be disaggregated by service setting (inpatient services, community services), territory, and age group [124]. This indicator is also included in the services for mental health performance indicator framework (see Section 3.8.2.1.1.2). Moreover, it is also one of the key performance indicators for Australian public mental health services (see Section 3.8.2.1.1.3).

'Mental health readmissions to hospital' measures the percentage of in-scope overnight separations from state or territory acute admitted patient mental health care service units that are followed by readmission to the same or to another public sector acute admitted patient mental health care service unit within 28 days of separation (also known as rapid readmission) [124]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected because rapid readmissions may reflect deficiencies in the functioning or organisation of the overall mental health care system; for example, incomplete or ineffective inpatient treatment or inadequate follow-up care to maintain the consumer's treatment post discharge. There is no official data source for this indicator; rather, data are gathered annually from state and territory governments by the Australian Institute of Health and Welfare [180]. This indicator was first published in the first progress report on The Fifth Plan in 2018, and it was updated in the three subsequent progress reports in 2019, 2020, and 2021. [47,124]. Annual data are available since the financial year 2005–06. This indicator can be disaggregated by age group, sex, socioeconomic group, remoteness, and Indigenous status. Additional information pertaining to this indicator can be found in Section 3.8.2.1.1.2.

3.8.2.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness,

and efficiency [183]. The following two indicators were deemed relevant to *Sharing the Vision* outcome 2(b) [30]:

1. Mental health outcomes of consumers of specialised public mental health services, and
2. Readmissions to hospital within 28 days of discharge.

'Mental health outcomes of consumers of specialised public mental health services' is one of six outcome indicators included in the services for mental health performance indicator framework, under which this indicator is defined as "an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society" [30]. This indicator is also included in *The Fifth National Mental Health and Suicide Prevention Plan* and as such was described previously in Section 3.8.2.1.1.1.

'Readmissions to hospital within 28 days of discharge' is an output indicator that is categorised under service effectiveness, and more specifically, service continuity. It is defined in the services for mental health performance indicator framework as "an indicator of governments' objective to provide services that are coordinated and provide continuity of care" [30]. This indicator is also included in *The Fifth National Mental Health and Suicide Prevention Plan* and as such was described previously in Section 3.8.2.1.1.1. However, the downloadable Excel data spreadsheet for the mental health section of the *Report on Government Services 2023* provides additional information pertaining to the nature of this indicator, noting that "A readmission for any of the separations identified as ''in-scope' is defined as an admission to any other public psychiatric acute unit within the jurisdiction that occurs within 28 days of the date of the original separation. For this to occur a system of unique client identifiers needs to be in place that allows individuals to be tracked across units" [184]. In addition, for the purposes of this indicator, the following separations are considered out of scope [184]:

- Same-day separations
- Overnight separations that occur through discharge/transfer to another hospital
- Statistical discharge – change in type of care provided in an inpatient setting, and
- Patient left against medical advice/discharge at own risk and death.

3.8.2.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

As described in Section 3.1.3, the National Mental Health Performance Subcommittee established 16 key performance indicators for Australian public mental health services in order to address the 'Health system' dimension in the National Mental Health Performance Measurement Framework in Australia. This dimension contains six sub-domains ('Accessibility', 'Appropriateness', 'Continuity of care', 'Effectiveness', 'Efficiency and sustainability', and 'Safety') [55]. Of the 16 key performance indicators, the following 2, which both fall under the 'Effectiveness' sub-domain, were deemed relevant to *Sharing the Vision* outcome 2(b) [39]:

1. Change in mental health 'consumers' clinical outcomes, and
2. Mental health readmissions to hospital.

Both of these key performance indicators, however, were also included in *The Fifth National Mental Health and Suicide Prevention Plan*. As such, they have been previously described in Section 3.8.2.1.1.1.

3.8.2.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.2.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan performance indicators [21,124]. The documents do not explicitly identify the benefits associated with each indicator.

In relation to 'Change in mental health consumers' clinical outcomes', the first limitation to this indicator described in the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* is that it cannot reflect why consumers' clinical symptoms improved, deteriorated, or did not significantly change. In addition, it is noted in the original 2017 publication of The Fifth Plan that data for this indicator are only available for mental health services run by Australian states and territories, and that it would require considerable work to collect routine outcome measures from other service providers, such as private psychiatrists and NGOs [21].

The *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describes two limitations to the indicator 'Mental health readmissions to hospital' [124]. First, while rapid readmission may reflect deficiencies in the functioning of the mental health system, readmission data cannot indicate where the deficiency exists. Second, due to data limitations, it is not possible to make a distinction between planned and unplanned readmissions [124]. In addition, the original 2017 publication of The Fifth Plan notes that readmissions data are only available from public hospitals [21].

3.8.2.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

As mentioned in Section 3.8.2.1.1.2, 'Mental health outcomes of consumers of specialised public mental health services' was also included in The Fifth Plan, and the limitations associated with this indicator as described in the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* are outlined in Section 3.8.2.1.2.1. However, the mental health section of the *Report on Government Services 2023* describes the following additional limitations [30]. First, the use of a single average outcomes score does not reflect the complexity of a mental health services system "in which services are delivered across multiple settings and provided as both discrete, short-term episodes of care and prolonged care over indefinite periods" [30]. As the data are disaggregated by service setting (inpatient care and community care), an individual consumer's overall outcome is not tracked across treatment settings. Second, this indicator reflects consumers' outcomes from a clinician's perspective rather than from the consumers' perspective [30].

In relation to 'Readmissions to hospital within 28 days of discharge', the *Report on Government Services 2023* noted, "While readmissions can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate, they can also reflect the cyclic and episodic nature of some illnesses" [30]. In addition, the downloadable Excel data spreadsheet provided alongside the *Report on Government Services 2023* notes that because data collection systems in most Australian mental health services do not include a reliable and consistent method for distinguishing planned admissions to hospital from unplanned admissions, this indicator cannot distinguish between planned and unplanned readmissions [184].

3.8.2.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

The limitations of the two key performance indicators for Australian public mental health services deemed relevant to *Sharing the Vision* outcome 2(b) were described previously under *The Fifth National Mental Health and Suicide Prevention Plan* (see Section 3.8.2.1.2.1). Additional limitations of these

indicators are described in Section 3.8.2.1.2.2 as both indicators are also included in the annual Report on Government Services.

3.8.2.2 Canada

3.8.2.2.1 What are the relevant mental health indicators?

3.8.2.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and 'Leadership and collaboration') [31,59]. Two of these indicators were deemed relevant to *Sharing the Vision* outcome 2(b), both of which fall under strategic direction 3, 'Access to services' [59]. The two indicators are [31]:

1. Mental illness hospital readmissions within 30 days, and
2. One-year rate of repeat hospitalisations for persons with a mental illness.

'Mental illness hospital readmissions within 30 days' is measured as the percentage of people aged 15 years and over who are readmitted to hospital within 30 days of hospital discharge for a stay related to a mental illness in a given year [31]. This indicator was selected because, while rapid readmissions may indicate relapse or other complications, they may also reflect service inadequacies/disorganisation, such as a lack of stabilisation during the patient's previous hospitalisation, poor discharge planning, or inadequate post-hospitalisation community support. Data reported in *Informing the Future: Mental Health Indicators for Canada* were sourced from the Canadian Institute for Health Information portal for the financial year 2012–13 [31]. This portal is a comprehensive, web-based analytical platform that enables the viewing, sharing, and reporting of Canadian Institute for Health Information data [255]. The Canadian Institute for Health Information has collected 30-day readmissions data annually since 2013, with the most recent data available (as of completion of this evidence brief in September 2023) being from the year 2021 [256]. Data can be disaggregated by province/territory, region, age group, recorded sex or gender, neighbourhood income quintile, urban versus rural/remote location, and mental health category [256].

'One-year rate of repeat hospitalisations for persons with a mental illness' is measured as the percentage of people aged 15 years and over with at least three mental-illness-related hospitalisations among the population who had at least one hospital stay for a mental illness over a 1-year period. This indicator was selected for the same reason as the previous indicator; while more than one hospitalisation in the same year may be appropriate for some people with severe mental health conditions, it may also reflect service inadequacies/disorganisation in the mental health system. Repeat hospitalisations are routinely tracked by the Canadian Institute for Health Information as a key indicator of mental health system performance [31,66].

3.8.2.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.2.1.4 The mental health and substance use indicators

As mentioned previously in Section 3.2.4, the Canadian Institute for Health Information established a set of 14 mental health and substance use indicators that broadly measure mental health and substance use services, access, and organisation [42]. The following three indicators were deemed relevant to *Sharing the Vision* outcome 2(b) [216]:

1. 30-day readmission for mental health and substance use
2. Navigation of mental health and substance use services, and
3. Repeat hospital stays for mental health and substance use.

'30-day readmission for mental health and substance use' is categorised under the 'Health system outputs' quadrant in the Canadian Institute for Health Information's Health System Performance Measurement Framework as a person-centred service quality attribute [68]. Further information pertaining to this indicator can be found in Section 3.8.2.2.1.1, as it is one of the 55 mental health indicators identified by the Mental Health Commission of Canada in *Informing the Future: Mental Health Indicators for Canada* [31].

'Navigation of mental health and substance use services' is a recent addition to the list of mental health and substance use indicators, and it is measured as the proportion of individuals aged 15 years and over who said they 'always' or 'usually' (not 'sometimes', 'rarely', or 'never') had the support necessary to move within and between mental health and/or substance use services once they accessed services in the past year [257]. This indicator is categorised under the 'Health system outputs' quadrant in the Canadian Institute for Health Information's Health System Performance Measurement Framework as a person-centred service quality attribute [68]. For the purposes of this indicator, 'support' refers to "the receipt of guidance, assistance or resources from a professional, related to navigating mental health and substance use services" [257]. This indicator was selected in order to determine whether service users efficiently and effectively receive the mental health and/or substance use services they need in order to improve their health and promote recovery. In addition, this indicator may help to identify [257]:

- Areas for improved health system integration and timely access to care, and
- Populations that experience differences in navigating mental health and/or substance use services.

People who were not able to access services or who did not require an additional service after their first one are excluded from analyses. The following services for mental health and/or substance use are in scope for this indicator [257]:

- Family doctor, nurse practitioner, or specialist visit services
- Counselling or therapy services
- Trained support group services
- Emergency department or urgent care services
- Overnight stay in a hospital or health centre
- Crisis support services
- Withdrawal management services, drug-replacement therapies, or detoxification services
- Case management, youth worker, or essential services
- Indigenous-focused services

- Culturally based services for immigrant, refugee, ethno-cultural, and/or racialised groups
- Harm reduction approach services, and
- School-based services.

The data source for this indicator is the Navigation of Mental Health and Substance Use Services Survey, a national survey of mental health and substance use service users conducted by the Canadian Institute for Health Information in 2022 [258]. Data for this indicator will be collected annually but, as of completion of this evidence brief in September 2023, are only available for the year 2022, and are disaggregated by province/territory [257].

'Repeat hospital stays for mental health and substance use' is measured as the risk-adjusted percentage of individuals who had three or more episodes of care for mental health and substance use disorders among all those who had at least one episode of care for mental health and substance use disorders in general or psychiatric hospitals within a given year [259]. This indicator is categorised under the 'Health system outputs' quadrant in the Canadian Institute for Health Information's Health System Performance Measurement Framework as a person-centred service quality attribute [68]. This indicator was selected as an indirect measure of the appropriateness of care, as the need for repeat admissions depends on the person and the type of mental health disorder. This indicator is included under *Sharing the Vision* outcomes 2(b) and 2(c) because challenges in receiving appropriate care may reflect deficiencies in the organisation of mental health services and/or a lack of continuity of care between inpatient and community services. For the purposes of this indicator, 'repeat hospital stays' is defined as at least three episodes of care in a 1-year period. In addition, an episode of care refers to all contiguous inpatient hospitalisations in general and psychiatric hospitals, as well as all day surgery visits regardless of diagnosis. Data for this indicator are collected and reported annually by the Canadian Institute for Health Information from four data sources [259]:

1. The Discharge Abstract Database [220]
2. The Human Metabolome Database [221]
3. The National Ambulatory Care Reporting System, a Canadian Institute for Health Information system that contains data for hospital- and community-based ambulatory care (day surgery, outpatient and community-based clinics, and emergency departments) [217], and
4. The Ontario Mental Health Reporting System [222].

Annual data for this indicator are available from 2013, with the most recent data available as of completion of this evidence brief in September 2023 being from the year 2021. Data are disaggregated by province/territory, region, age group, recorded sex or gender, mental illness category (substance-related and addictive disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, selected disorders of personality and behaviour, or other disorders), neighbourhood income quintile, and urban versus rural/remote location [259].

3.8.2.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.2.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not identify any explicit benefits associated with each indicator.

In relation to ‘Mental illness hospital readmissions within 30 days’, *Informing the Future: Mental Health Indicators for Canada* noted that data for this indicator are based on hospitalisations for substance-related disorders; schizophrenia, delusional, and non-organic psychotic disorders; mood/affective disorders; anxiety disorders; and selected disorders of personality and behaviour among adults. As such, some of the most uncommon mental health diagnoses may not be included. In addition, patients admitted to freestanding (i.e. privately owned) psychiatric facilities are not in scope for this indicator [31].

The limitations described above for the ‘Mental illness hospital readmissions within 30 days’ indicator also apply to ‘One-year rate of repeat hospitalisations for persons with a mental illness’ [31].

3.8.2.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.2.2.4 The mental health and substance use indicators

The Canadian Institute for Health Information’s mental health and substance use indicator web pages describe the limitations associated with each indicator. They do not describe any explicit benefits associated with the indicators.

The limitations associated with ‘30-day readmission for mental health and substance use’ are described in Section 3.8.2.2.2.1, as this indicator is also included in *Informing the Future: Mental Health Indicators for Canada* [31].

As previously mentioned in Section 3.8.2.2.1.4, the data source for the ‘Navigation of mental health and substance use services’ indicator is the Navigation of Mental Health and Substance Use Services Survey [258], and survey results are only representative of the surveyed population [257]. Moreover, respondents’ ability to assess the support they received with navigating services in the previous 12 months is subject to their ability to remember their experience. Notably, the Navigation of Mental Health and Substance Use Services Survey did not involve probability sampling, so not everyone in the target population had an equal chance to participate, and some groups (e.g. age groups or genders) may be under- or overrepresented. In addition, the survey was only available in French and English, and so people who do not speak either of these languages would have been unable to complete the survey, as would those without Internet access or with low computer literacy [257].

The Canadian Institute for Health Information did not outline any limitations or benefits associated with the use of the third indicator, ‘Repeat hospital stays for mental health and substance use’.

3.8.2.3 England (UK)

3.8.2.3.1 What are the relevant mental health indicators?

3.8.2.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.3.1.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, the NHS Outcomes Framework contains 17 overarching outcome indicators and 55 improvement area indicators categorised into 5 outcome domains ('Preventing people from dying prematurely', 'Enhancing quality of life for people with long-term conditions', 'Helping people to recover from episodes of ill health or following injury', 'Ensuring that people have a positive experience of care', and 'Treating and caring for people in a safe environment and protecting them from avoidable harm') [35]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 2(b). This indicator, which is included in the NHS Outcomes Framework as an improvement area indicator under domain 3, 'Helping people to recover from episodes of ill health or following injury', is 'Total health gain as assessed by patients for elective procedures – psychological therapies' [79]. However, as of the March 2022 publication of the NHS Outcomes Framework, this indicator has yet to be developed, and so information pertaining to its nature and data source is not yet available [83].

3.8.2.3.1.4 The NHS mental health dashboard

As mentioned in Section 3.3.2.1, the NHS mental health dashboard includes a total of 55 indicators organised into 11 categories ('Children and young people mental health', 'Perinatal mental health', 'Adult mental health (NHS talking therapies for depression and anxiety)', 'Early intervention in psychosis', 'Employment support', 'Physical health checks for people with severe mental illness', 'Crisis and acute care and use of the Mental Health Act', 'Acute hospital mental health liaisons', 'Health and justice', 'Mental health service backlog', and 'Meeting commitment to increase mental health funding'). The data reported on the NHS mental health dashboard are available by region, integrated care board, or sub-integrated care board [41]. However, it should be noted that the NHS mental health dashboard publications provide limited information about the indicators. The following 4 out of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 2(b) [92]:

1. NHS talking therapies recovery rate
2. NHS talking therapies recovery rate for Black, Asian or minority ethnic groups
3. Adults in adult mental health beds length of stay rate (over 60 days), and
4. Older adults in acute mental health beds length of stay rate (over 90 days).

'NHS talking therapies recovery rate' is categorised under 'Adult mental health (NHS talking therapies for depression and anxiety)' in the NHS mental health dashboard. This indicator is a measure of the proportion of people who have attended at least two treatment contacts and are moving to recovery in the reporting period. In this context, 'recovery' refers to those who were assigned 'caseness' at initial assessment but were not at their final session. 'Caseness' is the term used to describe a referral that scores high enough on measures of depression and anxiety to be classed as a clinical case [260]. This indicator tracks progress against the national standard of 50%. The data source for this indicator is the NHS Talking Therapies Data Set (formerly the Improving Access to Psychological Therapies Data Set) [233]. This indicator is reported on a quarterly basis [41].

'NHS talking therapies recovery rate for Black, Asian or minority ethnic groups' is categorised under 'Adult mental health (NHS talking therapies for depression and anxiety)' in the NHS mental health dashboard. This indicator is a measure of the proportion of people who are Black, Asian, or of a minority ethnicity who have attended at least two treatment contacts and are moving to recovery in the reporting period. The same definitions of 'recovery' and 'caseness' described in the previous paragraph are also applicable to this indicator. This indicator also has the same data source and reporting frequency as those described for the previous indicator [41], and it tracks progress against the national standard of 50%.

'Adults in adult mental health beds length of stay rate (over 60 days)' is categorised under 'Crisis and acute care and use of the Mental Health Act' in the NHS mental health dashboard. This indicator is a

measure of the rate per 100,000 population of people aged 18–64 years in adult acute mental health beds with a length of stay over 60 days. For the purposes of this indicator, the length of stay is calculated from the date of admission to the date of discharge [41]. This indicator tracks progress against the national standard, which is a rate of 8.0 (additional information pertaining to the nature or determination of this standard is not provided) [41]. The data source for this indicator is the NHS Mental Health Services Data Set [226]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a rolling quarterly basis [41].

'Older adults in acute mental health beds length of stay rate (over 90 days)' is categorised under 'Crisis and acute care and use of the Mental Health Act' in the NHS mental health dashboard. This indicator is a measure of the rate per 100,000 population of people aged 65 years and over in adult acute mental health beds with a length of stay over 90 days. Like the previous indicator, this indicator tracks progress against the national standard of 8.0, and the data source and reporting period for both indicators are also the same (additional information pertaining to the nature or determination of this standard is not provided) [41].

3.8.2.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.2.3.2.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.3.2.3 The NHS Outcomes Framework

There were no benefits or limitations described in relation to 'Total health gain as assessed by patients for elective procedures – psychological therapies', as this indicator is still in development.

3.8.2.3.2.4 The NHS mental health dashboard

The NHS mental health dashboard publications do not explicitly describe the benefits and limitations associated with the 55 indicators.

3.8.2.4 New Zealand

3.8.2.4.1 What are the relevant mental health indicators?

3.8.2.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.4.1.2 The Key Performance Indicator Programme

As mentioned in Section 3.4.2, the Key Performance Indicator Programme consists of six key performance indicators distributed across three streams: an adult stream, a child and youth stream, and an NGO stream [104]. The adult stream contains five indicators, the child and youth stream contains three indicators, and the NGO stream contains two indicators (some indicators are common to multiplr streams). Of the six key performance indicators, one was deemed relevant to *Sharing the Vision* outcome 2(b). This indicator, which is only included in the adult stream of the Key Performance Indicator Programme, is '28-day readmission' [241].

‘28-day readmission’ measures the percentage of overnight discharges from a mental health and addiction service organisation’s acute inpatient unit(s) that result in readmission within 28 days of discharge [261]. For the purposes of this indicator, the percentage is calculated from all acute inpatient discharges that were readmitted, regardless of where that readmission occurred (whether in the same health division or a different one). This indicator was selected because “unplanned admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital” [261]. As mentioned in Section 3.4.2, the data source for all indicators in the Key Performance Indicator Programme is PRIMHD [102]. There are five data dashboards available for this indicator [262]:

1. A national summary dashboard
2. A health division dashboard
3. A ‘Readmission details’ dashboard, which explores the details of readmissions (i.e. when, where, etc.)
4. An indicator exploration dashboard, and
5. An ‘Ask me anything’ dashboard (a natural language processor whereby the user can type in a question or something they want to see, and the data will answer).

These data dashboards were developed for the indicator using criteria specific to adults aged 20–64 years. However, they also provide age filters for children and young people (aged 0–19 years) as well as older people (aged 65 years and over), where services have reported these data to PRIMHD. Results of this indicator are available for each financial quarter or year and can be filtered by age, gender, ethnicity, target population, discharge date, and health division [261].

3.8.2.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission’s *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.4.1 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.2.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission’s *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.4.1.2 The Key Performance Indicator Programme

There were no benefits or limitations described in relation to ‘28-day readmission’ in the supporting information provided on the Key Performance Indicator Programme website.

3.8.2.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission’s *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.5 Scotland (UK)

3.8.2.5.1 What are the relevant mental health indicators?

3.8.2.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.5.1.3 Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health includes a total of 30 quality indicators categorised into 6 quality dimensions ('Timely', 'Safe', 'Person-centred', 'Effective', 'Efficient', and 'Equitable') [120]. Of these indicators, the following four were deemed relevant to *Sharing the Vision* outcome 2(b) [120]:

1. Percentage of people in mental health services seen for at least 1 month that show improvement in any personal outcome measurement over the previous month ('Person-centred' dimension of service quality)
2. Percentage of people seen for at least 1 month that show improvement in symptom severity using any clinical outcome measurement over the previous month ('Effective' dimension of service quality)
3. Rate of emergency bed days for adults ('Efficient' dimension of service quality), and
4. Percentage of did not attend appointments for community-based services of people with mental health problems ('Efficient' dimension of service quality).

'Percentage of people in mental health services seen for at least 1 month that show improvement in any personal outcome measurement over the previous month' is currently still under development [44]. However, in its introductory publication of the Quality Indicator Profile for Mental Health, the Scottish Government noted that any personal outcome evidence-based tool or measure can be used for the purposes of this indicator, and the indicator will apply to all ages, settings, and care groups. In relation to the data source (which is still undetermined), the Scottish Government noted that patients receiving follow-up care will require application of a personal outcome tool or measure at assessment, at discharge, and at 3-monthly intervals [120].

'Percentage of people seen for at least 1 month that show improvement in symptom severity using any clinical outcome measurement over the previous month' is also currently still under development [44]. As with the previous indicator, however, the Scottish Government noted in its introductory publication of the Quality Indicator Profile for Mental Health that any personal outcome evidence-based tool or measure can be used for the purposes of this indicator, and the indicator will apply to all ages, settings, and care groups. In relation to the data source (which is still undetermined), the Scottish Government noted that patients receiving follow-up care will require application of a clinical outcome tool or measure at assessment, at discharge, and at 3-monthly intervals [120].

'Rate of emergency bed days for adults' is a measure of the rate of emergency bed days for adults in psychiatric hospital beds following emergency admission per 100,000 population [44]. This indicator was selected for several reasons [120]. For instance, the number of hospital admissions and the duration of bed stays can have contrasting trends (i.e. one can increase while the other decreases), and the use of this indicator can ensure a balanced view. In addition, it provides insight into how effectively hospitals are streamlining their processes and sharing best practice in order to ensure that people can leave hospital as soon as they are well enough to do so. Finally, this indicator provides insight into the timeliness of provision of appropriate community-based care in order to enable people to leave hospital as soon as they are well enough to do so [120]. The data source for this indicator is the Scottish Morbidity Records, specifically the Scottish Morbidity Records dataset 04, 'Mental Health Inpatient and Day Case' (see Section 3.8.1.5.1.3).

‘Percentage of did not attend appointments for community-based services of people with mental health problems’ was also deemed relevant to *Sharing the Vision* outcome 2(a), and as such, further information pertaining to this indicator can be found in Section 3.8.1.5.1.3.

3.8.2.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.2.5.2.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.2.5.2.3 Quality Indicator Profile for Mental Health

The benefits and limitations associated with the quality indicators included in the Quality Indicator Profile for Mental Health were not described in the literature we sourced. However, as noted in Section 3.5.3.1, at the time that Public Health Scotland published the most recent Quality Indicator Profile for Mental Health in April 2023, it was still considered an experimental statistics publication [44].

3.8.2.6 The OECD

3.8.2.6.1 What are the relevant mental health indicators?

3.8.2.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions (‘Person-centred mental health policies and services’, ‘Accessible, high-quality mental health services’, ‘An integrated and multi-sectoral approach to mental health’, ‘Preventing mental illness and promoting mental well-being’, ‘Strong leadership and good governance’, and ‘Building future-focused and innovative mental health systems’) [27]. Of these indicators, the following two were deemed relevant to *Sharing the Vision* outcome 2(b) (it should be noted that limited information pertaining to the development and nature of the indicators is provided in the OECD report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*) [27]:

1. Patient-reported outcomes (dimension 1, ‘Person-centred mental health policies and services’), and
2. Repeat admissions to inpatient care (dimension 2, ‘Accessible, high-quality mental health services’).

‘Patient-reported outcomes’ are measurement tools completed by patients in order to collect information about aspects of their health status that are relevant to their quality of life, such as symptoms and functionality, as well as physical, mental, and social health [263]. The 2021 OECD report *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* notes that ‘Patient-reported outcomes’ is one of several indicators where data are not yet available across multiple countries, as “systematic patient reporting in mental health is in its infancy” [27 p40]. The report goes on to state, “The continuing gaps in availability of meaningful indicators of the dimensions of mental health performance that matter…underscore the importance of developing new measures. There is clearly space for more internationally comparable reporting on mental health service users’ experiences…and outcomes” [27 p40]. To address this, the OECD has conducted a pilot project in collaboration with a working group of patients, clinicians, and policy-makers in order to develop mental health patient-reported outcomes data collection that enables international comparisons with 17 OECD member countries [27]. The main objective of this initiative is to develop data collection standards in

mental health in order to facilitate international benchmarking of patient-reported outcomes. As of 2021, three domains that have international coherence have been identified [27]:

1. Relief of symptom burden
2. Restoring well-being/social function, and
3. Recovery support.

The working group began with a pilot programme for patient-reported outcomes data collection, which began with hospital care, focused on the well-being domain, and drew on the 2013 *OECD Guidelines on Measuring Subjective Well-being* [264] and the 1998 World Health Organization Five Well-Being Index (WHO-5) questionnaire [265]. The results of the pilot are not described in the OECD report; however, some pilot data were reported in the OECD's *Health at a Glance 2021* publication [266].

'Repeat admissions to inpatient care' measures the proportion of people with three or more admissions to inpatient psychiatric units within a single year [27]. According to *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, while repeat admissions may be part of an individual's personal care plan, this indicator can provide insight into a potential lack of continuity and quality of care which may reflect gaps in community care. This indicator was reported by 12 out of 38 OECD member countries, including Canada and Ireland (it was not reported by Australia, the UK, or New Zealand) [27]. Data for this indicator were sourced from the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires. However, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* provided limited information pertaining to the development and nature of these questionnaires [27].

3.8.2.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.2.6.2.1 The OECD Mental Health System Performance Benchmark

A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health does not describe any explicit benefits of the benchmarking indicators identified in the OECD Mental Health System Performance Benchmark. A limitation it describes in relation to one of the indicators deemed relevant to *Sharing the Vision* outcome 2(b), 'Repeat admissions to inpatient care', is that the indicator cannot distinguish between planned and unplanned repeat admissions [27].

As the 'Patient-reported outcomes' indicator had not yet been adequately developed and implemented at the time of publication of the OECD's report, there were no explicit benefits or limitations described.

3.8.3 Outcome 2(c): Services are coordinated through a 'stepped care' approach to provide continuity of care that will deliver the best possible outcomes for each service user

3.8.3.1 Australia

3.8.3.1.1 What are the relevant mental health indicators?

3.8.3.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life',

'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21]. The following six indicators were deemed relevant to *Sharing the Vision* outcome 2(c) [21]:

1. Long-term health conditions in people with mental illness (domain 2, 'Better physical health and living longer')
2. Avoidable hospitalisations for physical illness in people with mental illness (domain 2, 'Better physical health and living longer')
3. Mortality gap for people with mental illness (domain 2, 'Better physical health and living longer')
4. Change in mental health consumers' clinical outcomes (domain 5, 'Effective support, care and treatment')
5. Post-discharge community mental health care (domain 5, 'Effective support, care and treatment'), and
6. Mental health readmissions to hospital (domain 5, 'Effective support, care and treatment').

'Long-term health conditions in people with mental illness' measures the percentage of people with mental illness who have another long-term health condition. In this context, 'another long-term health condition' is defined as any of the following conditions, which has either lasted 6 months or more or is expected to last 6 months or more [124]:

- Asthma
- Arthritis
- Cancer
- Diseases of the circulatory system
- Diabetes mellitus
- Back problems, and
- Chronic obstructive pulmonary disease (i.e. bronchitis, emphysema)).

According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected in order to monitor progress on efforts to improve the physical health of Australians with mental health conditions. Higher incidence of long-term physical health conditions in people with mental health conditions indicates poorer overall physical health for the population as a whole. There are two data sources for this indicator [180]:

1. The National Health Survey [125] (see Section 3.7.4.1.1.1), and
2. The National Aboriginal and Torres Strait Islander Health Survey [126] (see Section 3.7.4.1.1.1).

This indicator was first published in the first progress report on The Fifth Plan in 2018, and it was updated in subsequent reports [124]. As the National Health Survey is conducted approximately every 3 years and the National Aboriginal and Torres Strait Islander Health Survey is conducted every 6 years, the most recent data available for this indicator (as of completion of this evidence brief in September 2023) are from the 2017–2018 National Health Survey and the 2018–2019 National Aboriginal and Torres Strait Islander Health Survey. This indicator can be disaggregated by age (all ages are in scope), sex, socioeconomic status, remoteness, and state/territory [124].

'Avoidable hospitalisations for physical illness in people with mental illness' is a measure of the number and proportion of people with a mental health condition who have been hospitalised for an avoidable

physical illness in the previous 12 months [21]. When this indicator was identified and included in the set of 24 performance indicators for The Fifth Plan, its anticipated data source was the Australian state and territory clinical mental health and patient administration systems [21]. However, as of the publication of the 2021 progress report on The Fifth Plan, this indicator is not available for reporting, as it requires further development [47].

'Mortality gap for people with mental illness' is a measure of the average life expectancy for a person with mental illness compared with the life expectancy of all Australians [21]. When this indicator was identified and included in the set of 24 performance indicators for The Fifth Plan, its anticipated data source was the Australian state and territory clinical mental health and patient administration systems [21]. However, as with the previous indicator, the 2021 progress report on The Fifth Plan states that this indicator is not available for reporting, as it requires further development [47].

'Change in mental health consumers' clinical outcomes' was also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, further information pertaining to this indicator can be found in Section 3.8.2.1.1.1.

'Post-discharge community mental health care' measures the percentage of discharges from state or territory public acute admitted patient mental health care service units for which a community mental health service contact was recorded in the 7 days following that separation [124]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected because "A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability, and to minimise the need for hospital readmission" [124 p16]. There is no official data source for this indicator; rather, data are gathered annually from state and territory governments [180]. This indicator was first published in the first progress report on The Fifth plan in 2018, with annual data available since 2005–06 and updated data published in the three subsequent progress reports in 2019, 2020, and 2021 [47,124]. This indicator can be disaggregated by age group, sex, socioeconomic disadvantage group, remoteness, and Indigenous status, as well as by whether the consumer and/or carer participated in the community mental health contact. Higher proportions of people who access community mental health care following their discharge from hospital suggest a more effective mental health system [124].

Finally, 'Mental health readmissions to hospital' was also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, further information pertaining to this indicator can be found in Section 3.8.2.1.1.1.

3.8.3.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness, and efficiency [183]. The following four indicators were deemed relevant to *Sharing the Vision* outcome 2(c) [30]:

1. Community follow-up after psychiatric admission/hospitalisation
2. Readmissions to hospital within 28 days of discharge
3. Physical health outcomes for people with a mental illness, and
4. Mental health outcomes of consumers of specialised public mental health services.

'Community follow-up after psychiatric admission/hospitalisation' is an output indicator that is categorised under service effectiveness, and more specifically, service continuity [30]. It is defined as "an indicator of governments' objective to provide services that are coordinated and provide continuity of care" [30]. This indicator is measured as the proportion of state and territory governments' overnight

acute separations of specialised public-admitted patients from psychiatric units for which a community-based ambulatory contact was recorded in the 7 days following separation. Since the financial year 2011–12, annual data for this indicator have been collected from the Australian Institute of Health and Welfare hospital data on admitted patient and community mental health care, with the most recent data reported (as of completion of this evidence brief in September 2023) being from the financial year 2020–21 [184]. A high or increasing rate of community follow-up within the first 7 days of discharge from hospital is desirable [30].

'Readmissions to hospital within 28 days of discharge' was also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, further information pertaining to this indicator can be found in Section 3.8.2.1.1.2.

'Physical health outcomes for people with a mental illness' is one of six outcome indicators included in the services for mental health performance indicator framework. The indicator is defined as "an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society" [30]. This indicator is measured as the proportion of adults with a mental health condition (compared with those without a mental health condition) who have experienced any of the following long-term physical health conditions [30]:

- Cancer
- Diabetes
- Arthritis
- Cardiovascular disease, and
- Asthma.

For the purposes of this indicator, people with a mental or behavioural condition are defined as "having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more", including organic mental conditions (e.g. Alzheimer's dementia), alcohol and drug conditions, mood conditions, and other mental and behavioural conditions [184]. The data source for this indicator is the National Health Survey, which is conducted every 3 years [125] (see Section 3.7.4.1.1.1). Data have been reported since financial year 2011–12, with the most recent data available being from 2017–18 [184]. For all the physical health conditions described in the bulleted list above, the data are disaggregated by people with and without a diagnosed mental health condition. Low or decreasing proportions of people with a mental illness who experience a long-term physical health condition are desirable [30].

Finally, 'Mental health outcomes of consumers of specialised public mental health services' is the same indicator reported in The Fifth Plan in relation to *Sharing the Vision* outcome 2(b), and it is described in Section 3.8.2.1.1.1.

3.8.3.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

As described in Section 3.1.3, the National Mental Health Performance Subcommittee established 16 key performance indicators for Australian public mental health services in order to address the 'Health system' dimension in the National Mental Health Performance Measurement Framework in Australia. This dimension contains six sub-domains ('Accessibility', 'Appropriateness', 'Continuity of care', 'Effectiveness', 'Efficiency and sustainability', and 'Safety') [55]. Of the 16 key performance indicators, the following 3 were deemed relevant to *Sharing the Vision* outcome 2(c) [39]:

1. Change in mental health consumers' clinical outcomes ('Effectiveness' sub-domain)

2. Mental health readmissions to hospital (‘Effectiveness’ sub-domain), and
3. Post-discharge community mental health care (‘Continuity of care’ sub-domain).

The first two indicators, ‘Change in mental health consumers’ clinical outcomes’ and ‘Mental health readmissions to hospital’, were also deemed relevant to *Sharing the Vision* outcome 2(b) and were included in The Fifth Plan. As such, information pertaining to both of these indicators can be found in Section 3.8.2.1.1.1.

‘Post-discharge community mental health care’ is also included in *The Fifth National Mental Health and Suicide Prevention Plan* (see Section 3.8.3.1.1.1). However, additional relevant information about this indicator is provided in its description as a key performance indicator for Australian public mental health services [267]. For instance, the following separations are considered out of scope for this indicator [267]:

- Same-day separations (i.e. inpatient episodes where the admission and separation dates are the same)
- Statistical and change of care type separations (e.g. in-hospital transfer to another unit)
- Separations that end by transfer to another acute or psychiatric hospital
- Separations that end in death
- Separations where length of stay is one night only and procedure code for electroconvulsive therapy or transcranial magnetic stimulation is recorded, and
- Separations that end by transfer to community residential mental health services.

In addition, the following community mental health service contacts are excluded [267]:

- Mental health service contacts on the day of separation, and
- Contacts where neither a consumer nor their carer/support person participated.

Community mental health service contacts in which a consumer and/or their carer/support person participated are in scope for this indicator [267]. In this context, a public sector community mental health service refers to specialised mental health services provided as a public service which are managed or funded by state or territory authorities [210]. Moreover, community mental health contacts are defined as “contacts with any public community mental health team within the given state or territory” [207]. For the purposes of this indicator, when a mental health service organisation has more than one admission unit, the units are combined for data collection and analysis. Importantly, implementation of this indicator requires the capacity to track service use across inpatient and community services, as well as the capacity to link patient identifiers [267]. Data for this indicator cannot be sourced from existing national data collections, but rather are requested by the Australian Institute of Health and Welfare and supplied annually from jurisdictions [267]. Therefore, data for this indicator are available at state/territory level (i.e. specialist mental health services provided by states and territories) – but not at national level – for each financial year since 2005–06, with the most recent data (as of completion of this evidence brief in September 2023) being from the financial year 2020–21 [207]. When providing data for this indicator, each jurisdiction is required to indicate whether a state-wide unique client identifier system is currently in place in order to allow tracking of individual consumers’ service utilisation across the public specialised mental health services in that jurisdiction. This is to evaluate the degree of consistency in data reported between jurisdictions. Data for this indicator are disaggregated by state/territory, age group, sex, Indigenous status, remoteness, Socio-Economic Indexes for Areas quintile, and population type (general, child and adolescent, youth, older people, and forensic) [267].

3.8.3.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.3.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan performance indicators [21,124]. The documents do not explicitly identify any benefits associated with each indicator.

In relation to 'Long-term health conditions in people with mental illness', the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describes two main limitations. First, the data do not support analysis of differences in the physical health of people with different types of mental health conditions. Second, data about the experience of both physical and mental health conditions are collected via self-reports [124].

In relation to 'Avoidable hospitalisations for physical illness in people with mental illness' and 'Mortality gap for people with mental illness', no limitations were described in either The Fifth Plan or the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*; according to the 2021 progress report on The Fifth Plan, these indicators are not available for reporting [47].

'Change in mental health consumers' clinical outcomes' was also deemed relevant to *Sharing the Vision* outcome 2(b). Further information pertaining to the limitations of this indicator can be found in Section 3.8.2.1.2.1.

In relation to 'Post-discharge community mental health care', several limitations are described in The Fifth Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* [21,124]. First, only direct contact with the consumer constitutes a 'post-discharge follow-up' for this indicator. However, there is evidence suggesting that for some groups of consumers, such as children, it is best practice to follow up with the consumer's carer. Second, data on post-discharge community mental health care do not reflect why some consumers do not access community mental health care following discharge from an acute hospital, nor do they reflect whether consumers have accessed other forms of support outside community mental health services. Third, the indicator does not consider variations in intensity or frequency of mental health service contacts following discharge from hospital [124]. Finally, data are only available for community mental health services run by Australian states and territories. The original 2017 publication of The Fifth Plan notes, "Considerable work would be required to develop data linkages to other forms of care in the community, such as GPs and private office-based care providers" [21 p60].

'Mental health readmissions to hospital' was also deemed relevant to *Sharing the Vision* outcome 2(b). Further information pertaining to the limitations of this indicator can be found in Section 3.8.2.1.2.1.

3.8.3.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

In relation to 'Community follow-up after psychiatric admission/hospitalisation', it is noted in the *Report on Government Services 2023* that the indicator does not reflect the frequency of contacts reported in the 7 days following separation, nor does it distinguish between the mode of contact. In addition, this indicator only includes follow-up contacts made by state and territory governments' specialised public mental health services [30].

The limitations associated with 'Readmissions to hospital within 28 days of discharge' are described in Section 3.8.2.1.2.1, as this indicator was also deemed relevant to *Sharing the Vision* outcome 2(b) under The Fifth Plan.

There were no relevant limitations described in relation to the third indicator, 'Physical health outcomes for people with a mental illness'.

Finally, the limitations associated with 'Mental health outcomes of consumers of specialised public mental health services' are described in Section 3.8.2.1.2.1, as this indicator was also deemed relevant to *Sharing the Vision* outcome 2(b) under The Fifth Plan.

3.8.3.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

The limitations described in relation to 'Change in mental health consumers' clinical outcomes' and 'Mental health readmissions to hospital' were described previously in Section 3.8.2.1.2.1 under The Fifth Plan, and in Section 3.8.2.1.2.2 under the services for mental health performance indicator framework, as these indicators were also deemed relevant to *Sharing the Vision* outcome 2(b).

The limitations described in relation to 'Post-discharge community mental health care' are identical to those described in Section 3.8.1.1.2.3 under *Sharing the Vision* outcome 2(a) in relation to the key performance indicator 'Admission preceded by community mental health care' [267]. Additional information pertaining to the limitations of this indicator can be found in Section 3.8.3.1.2.1 as it was also selected as a performance indicator in *The Fifth National Mental Health and Suicide Prevention Plan*.

3.8.3.2 Canada

3.8.3.2.1 What are the relevant mental health indicators?

3.8.3.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and 'Leadership and collaboration') [31,59]. The following four indicators were deemed relevant to *Sharing the Vision* outcome 2(c) [31]:

1. Individuals hospitalised for more than 30 days in a year (strategic direction 3, 'Access to services')
2. Mental illness hospital readmissions within 30 days (strategic direction 3, 'Access to services')
3. One-year rate of repeat hospitalisations for persons with a mental illness (strategic direction 3, 'Access to services'), and
4. Unmet need for general health care among people with common conditions (strategic direction 4, 'Disparities and diversity').

The first indicator, 'Individuals hospitalised for more than 30 days in a year', and the fourth indicator, 'Unmet need for general health care among people with common conditions', were also deemed relevant to *Sharing the Vision* outcome 2(a), and as such, information pertaining to these indicators can be found in Section 3.8.1.2.1.1

'Mental illness hospital readmissions within 30 days' and 'One-year rate of repeat hospitalisations for persons with a mental illness' were also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, information pertaining to these indicators can be found in Section 3.8.2.2.1.1.

3.8.3.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.2.1.4 The mental health and substance use indicators

As mentioned previously in Section 3.2.4, the Canadian Institute for Health Information established a set of 14 mental health and substance use indicators that broadly measure mental health and substance use services, access, and organisation [42]. The following four indicators were deemed relevant to *Sharing the Vision* outcome 2(c) [216]:

1. 30-day readmission for mental health and substance use
2. Frequent emergency room visits for help with mental health and substance use
3. Navigation of mental health and substance use services, and
4. Repeat hospital stays for mental health and substance use.

'30-day readmission for mental health and substance use' [216] was also deemed relevant to *Sharing the Vision* outcome 2(b) and has also already been described in Section 3.8.2.2.1.1 as one of the indicators included in *Informing the Future: Mental Health Indicators for Canada* [31].

'Frequent emergency room visits for help with mental health and substance use' was also deemed relevant to *Sharing the Vision* outcome 2(a) and is therefore described previously in Section 3.8.1.2.1.4.

'Navigation of mental health and substance use services' and 'Repeat hospital stays for mental health and substance use' were also deemed relevant to *Sharing the Vision* outcome 2(b) and are therefore described previously in Section 3.8.2.2.1.4.

3.8.3.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.3.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not explicitly identify any benefits associated with each indicator.

'Individuals hospitalised for more than 30 days in a year' and 'Unmet need for general health care among people with common conditions' were also deemed relevant to *Sharing the Vision* outcome 2(a), and as such, information pertaining to the limitations associated with these indicators can be found in Section 3.8.1.2.2.1.

'Mental illness hospital readmissions within 30 days' and 'One-year rate of repeat hospitalisations for persons with a mental illness' were also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, information pertaining to the limitations associated with these indicators can be found in Section 3.8.2.2.2.1.

3.8.3.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.2.2.4 The mental health and substance use indicators

The Canadian Institute for Health Information's mental health and substance use indicator web pages describe the limitations associated with each indicator. They do not describe any explicit benefits associated with the indicators.

The limitations associated with '30-day readmission for mental health and substance use' are described in Section 3.8.2.2.2.1, as this indicator was also deemed relevant to *Sharing the Vision* outcome 2(b), and it was included in *Informing the Future: Mental Health Indicators for Canada* [31].

The limitations associated with 'Frequent emergency room visits for help with mental health and substance use' are described in Section 3.8.1.2.2.4, as this indicator was also deemed relevant to *Sharing the Vision* outcome 2(a).

The limitations associated with 'Navigation of mental health and substance use services' are described in Section 3.8.2.2.2.4, as this indicator was also deemed relevant to *Sharing the Vision* outcome 2(b).

The Canadian Institute for Health Information did not outline any limitations associated with the use of the final indicator, 'Repeat hospital stays for mental health and substance use'.

3.8.3.3 England (UK)

3.8.3.3.1 What are the relevant mental health indicators?

3.8.3.3.1.1 The Public Health Outcomes Framework

As mentioned in Section 3.3.1.1, the Public Health Outcomes Framework contains 193 indicators, which are categorised as either overarching outcome indicators or as supporting indicators [33]. None of the overarching outcome indicators are specific to mental health, and so none were included in this evidence brief. The supporting indicators are further categorised into one of four domains ('Wider determinants of health', 'Health improvement', 'Health protection', and 'Healthcare and premature mortality') [33]. Two supporting indicators were deemed relevant to *Sharing the Vision* outcome 2(c), both of which fall under the 'Healthcare and premature mortality' domain [33]:

1. Premature mortality in adults with severe mental illness, and
2. Excess under 75 mortality rate in adults with severe mental illness.

'Premature mortality in adults with severe mental illness' is measured as the directly age-standardised rate of deaths of adults aged 18–74 years with severe mental illness per 100,000 population [268]. This indicator was selected because it is considered one part of measuring the inequality of quality of healthcare experienced by people with severe mental health problems. It also supports the delivery of the commitments to reduce such inequalities set out in *The Five Year Forward View for Mental Health* and *The NHS Long Term Plan* (see Section 3.3.2). This indicator is calculated using data from the following three sources [268]:

1. The NHS Mental Health Services Data Set [226]
2. The Office for National Statistics Civil Registration of Deaths [269], and
3. The Office for National Statistics mid-year population estimates [270].

Values are not calculated for areas where the number of deaths was fewer than 10 [268]. This indicator is reported annually, and data are available by region and sex [142,268].

‘Excess under 75 mortality rate in adults with severe mental illness’ is included in the Public Health Outcomes Framework but is sourced from the NHS Outcomes Framework. Therefore, information pertaining to this indicator can be found in Section 3.8.3.3.1.3.

3.8.3.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.3.1.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, the NHS Outcomes Framework contains 17 overarching outcome indicators and 55 improvement area indicators categorised into 5 outcome domains (‘Preventing people from dying prematurely’, ‘Enhancing quality of life for people with long-term conditions’, ‘Helping people to recover from episodes of ill health or following injury’, ‘Ensuring that people have a positive experience of care’, and ‘Treating and caring for people in a safe environment and protecting them from avoidable harm’) [35]. The following three indicators were deemed relevant to *Sharing the Vision* outcome 2(c) [79]:

1. Excess under 75 mortality rate in adults with serious mental illness (improvement area indicator under domain 1, ‘Preventing people from dying prematurely’)
2. Excess under 75 mortality rate in adults with common mental illness (improvement area indicator under domain 1, ‘Preventing people from dying prematurely’), and
3. Total health gain as assessed by patients for elective procedures – psychological therapies (improvement area indicator under domain 3, ‘Helping people to recover from episodes of ill health or following injury’).

‘Excess under 75 mortality rate in adults with serious mental illness’ is a measure of the extent to which adults with a serious mental illness die younger than adults without a serious mental illness [271]. In August 2021, this indicator was decoupled from the NHS Outcomes Framework and made available as a series in its own right, although it was still included in the list of indicators in the March 2022 publication of the NHS Outcomes Framework [83]. This indicator was selected as a means by which to address inequality of outcome for a vulnerable group by monitoring the rate of premature deaths for this group over time and comparing this with the rate of premature deaths in the general population [272]. Data from the following three sources are used to calculate this indicator [271]:

1. The NHS Mental Health Services Data Set [226]
2. The Office for National Statistics Civil Registration of Deaths [269], and
3. The Office for National Statistics mid-year population estimates [270].

This indicator covers those aged 18–74 years. This is because the age profile of people with serious mental health problems is different to that of the general population aged 75 years and over [272]. The data do not capture people with mental health problems who have not been in contact with specialist mental health services [272]. For the purposes of calculating this indicator, the general population used for comparison is altered to remove people with serious mental illness [272]. This indicator is reported annually, with data relating to deaths that occurred over a 3-calendar-year period. The May 2022 publication of this indicator includes data for the calendar years 2018–2020 [273]. Data are available by provider, region, local authority, age group, Index of Multiple Deprivation quintile, gender, and underlying cause of death (i.e. cancer, cardiovascular disease, liver disease, respiratory disease, or all) [271,273]. The higher the value of this indicator, the greater the difference between the mortality rate in the adult population without serious mental illness than that in the adult population with serious mental illness. If a value decreases over time, this indicates that the disparity is reducing [272].

As of the most recent publication of NHS Outcomes Framework in March 2022, 'Excess under 75 mortality rate in adults with common mental illness' and 'Total health gain as assessed by patients for elective procedures – psychological therapies' have yet to be developed. Therefore, information pertaining to the nature and data sources of these indicators is not yet available [83].

3.8.3.3.1.4 The NHS mental health dashboard

As mentioned in Section 3.3.2.1, the NHS mental health dashboard includes a total of 55 indicators organised into 11 categories ('Children and young people mental health', 'Perinatal mental health', 'Adult mental health (NHS talking therapies for depression and anxiety)', 'Early intervention in psychosis', 'Employment support', 'Physical health checks for people with severe mental illness', 'Crisis and acute care and use of the Mental Health Act', 'Acute hospital mental health liaisons', 'Health and justice', 'Mental health service backlog', and 'Meeting commitment to increase mental health funding'). The data reported on the NHS mental health dashboard are available by region, integrated care board, or sub-integrated care board [41]. However, it should be noted that the NHS mental health dashboard publications provide limited information about the indicators. The following 6 out of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 2(c) [92]:

1. Number of people on the GP severe mental illness register receiving full physical health check in any setting
2. Adults in adult mental health beds length of stay rate (over 60 days)
3. Older adults in acute mental health beds length of stay rate (over 90 days)
4. Proportion of discharges from hospital followed up within 72 hours
5. Number of referrals to community-based mental health and learning disability services, yet to receive their second contact, and
6. Number of people with a severe mental illness eligible but waiting for all six components of a physical health check in the last 12 months.

'Number of people on the GP severe mental illness register receiving full physical health check in any setting' is categorised under 'Physical health checks for people with severe mental illness' in the NHS mental health dashboard. This indicator is a measure of the number of people on the GP severe mental illness register who have received a full physical health check in any setting in the preceding 12 months. A full physical health check includes the following six components [41]:

1. A measurement of weight
2. A blood pressure and pulse check
3. A blood lipid (including cholesterol) test
4. A blood glucose test
5. An assessment of alcohol consumption, and
6. An assessment of smoking status.

The data source for this indicator is NHS England, which collates data provided by sub-integrated care boards, which in turn gather information from GP practices and other providers of primary care services in their areas. This indicator is reported on a quarterly basis [41].

'Adults in adult mental health beds length of stay rate (over 60 days)' and 'Older adults in acute mental health beds length of stay rate (over 90 days)' were also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, further information pertaining to these indicators can be found in Section 3.8.2.3.1.4.

‘Proportion of discharges from hospital followed up within 72 hours’ is categorised under ‘Crisis and acute care and use of the Mental Health Act’ in the NHS mental health dashboard. This indicator is a measure of the number of patients who were discharged from adult acute beds and who were eligible for 72-hour follow-up in the reporting period as a proportion of all adult acute bed discharges on a rolling 3-month basis. This indicator tracks progress against the national standard of 80%. The data source for this indicator is the NHS Mental Health Services Data Set [226]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that regional and national data for this indicator are reported on a quarterly basis [41].

The remaining two indicators, ‘Number of referrals to community-based mental health and learning disability services, yet to receive their second contact’ and ‘Number of people with a severe mental illness eligible but waiting for all six components of a physical health check in the last 12 months’, were also deemed relevant to *Sharing the Vision* outcome 2(a), and as such, further information pertaining to these indicators can be found in Section 3.8.1.3.1.4.

3.8.3.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.3.3.2.1 The Public Health Outcomes Framework

The supporting information provided alongside the Public Health Outcomes Framework describes the caveats associated with each outcome indicator. The benefits of each indicator are not explicitly described.

In relation to ‘Premature mortality in adults with severe mental illness’, the Public Health Outcomes Framework notes that variations in access to secondary mental health services and in referral practices across local authorities will affect indicator results. This is because areas where fewer adults have access to mental health services will have lower rates of premature mortality in adults with severe mental illness because fewer adults will be diagnosed as having severe mental illness. The opposite is true for areas with good service access, wherein rates of premature mortality in adults with severe mental illness will be higher because more adults will be diagnosed as having severe mental illness. As such, the Public Health Outcomes Framework suggests that “Analysis of this indicator should be combined with local knowledge and consideration of other indicators in the Severe Mental Illness profile” [268]. Another limitation is that, for the purposes of this indicator, adults with referrals to secondary mental health services are used as a proxy for adults with a diagnosis of severe mental illness. This means that the indicator excludes patients with severe mental illness who are being cared for in primary care alone and includes patients with referrals to secondary mental health services for common (i.e. not severe) mental health conditions, although the difference between common and severe conditions is not made explicit. It has not yet been possible to identify a suitable data source that includes patients with severe mental illness who are receiving care in primary services only (and not in secondary services), nor has it been possible to restrict the count of patients with referrals to secondary services to just those with a diagnosis of severe mental illness due to the incomplete rates of diagnosis in the mental health data [268].

Information pertaining to the limitations of the second indicator, ‘Excess under 75 mortality rate in adults with severe mental illness’ can be found in Section 3.8.3.3.2.3, as this indicator is sourced from the NHS Outcomes Framework.

3.8.3.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.3.2.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, an indicator quality statement is published alongside each indicator in the NHS Outcomes Framework, with the exception of those still in development. These documents do not explicitly identify the benefits and limitations associated with each indicator. However, they do provide some noteworthy information in relation to the use and interpretation of the indicators.

In relation to 'Excess under 75 mortality rate in adults with serious mental illness', it is noted that there is no established definition of 'serious mental illness'. This indicator takes a pragmatic approach by focusing on people who have been in contact with specialist mental health services over the past 5 years. However, there are a range of mental health conditions which vary in severity [272]. The indicator quality statement states that proxies to mental health conditions, such as whether the patient has spent time in an inpatient unit for a mental health diagnosis, may be used; however, proxies are not true measures of mental health condition severity. Another limitation to this indicator is that it does not take into account whether the patients with the serious mental illnesses included are more ill than the general population, or that it is possible that being chronically physically ill has brought on the mental health problems the patients are experiencing [272]. Moreover, this indicator is standardised by age only, and not by any other factors that could potentially influence the mortality rate (e.g. differences in case mix beyond that accounted for by standardisations, comorbidities, level of deprivation, etc. may also contribute to variations in the data). Finally, it is important to note that this indicator is classified as experimental in the March 2022 publication of the indicator quality statement [274] (see Section 3.8.1.3.2.4 for information on experimental statistics).

As of the March 2022 publication of the NHS Outcomes Framework, 'Excess under 75 mortality rate in adults with common mental illness' has yet to be developed, and as such, information pertaining to the nature of or data source for this indicator is not yet available [83].

There were no benefits or limitations described in relation to 'Total health gain as assessed by patients for elective procedures – psychological therapies', as this indicator is still in development.

3.8.3.3.2.4 The NHS mental health dashboard

The NHS mental health dashboard publications do not explicitly describe the benefits and limitations associated with the 55 indicators included in the dashboard. However, 'Number of referrals to community-based mental health and learning disability services, yet to receive their second contact' is classified as experimental in the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) [41] (see Section 3.8.1.3.2.4).

3.8.3.4 New Zealand

3.8.3.4.1 What are the relevant mental health indicators?

3.8.3.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.4.1.2 The Key Performance Indicator Programme

As mentioned in Section 3.4.2, the Key Performance Indicator Programme consists of six key performance indicators distributed across three streams: an adult stream, a child and youth stream, and a non-governmental organisation (NGO) stream [104]. The adult stream contains five indicators, the child and youth stream contains three indicators, and the NGO stream contains two indicators (some indicators are common to multiple streams). Of the six key performance indicators, the following three were deemed relevant to *Sharing the Vision* outcome 2(c) [241]:

1. 7-day follow-up

2. 28-day readmission, and
3. Continuity of care.

'7-day follow-up' (also known as 'acute inpatient post-discharge community care') is only included in the adult stream of the Key Performance Indicator Programme and is measured as the percentage of acute inpatient discharges that are followed up in the community setting within the 7 days immediately following discharge from an acute inpatient stay [275]. For the purposes of this indicator, the percentage of all acute inpatient discharges that were followed up is calculated, regardless of where that follow-up occurred (whether in a New Zealand health division, an NGO, or both). This indicator was selected because responsive community services and supports reduce the risk of rapid readmission. As mentioned in Section 3.4.2, the data source for all indicators in the Key Performance Indicator Programme is PRIMHD [102]. There are five data dashboards available for this indicator [275]:

1. A national summary dashboard
2. A health division dashboard
3. A heat map comparison matrices dashboard
4. An indicator exploration dashboard, and
5. An 'Ask me anything' dashboard (a natural language processor whereby the user can type in a question or something they want to see, and the data will answer).

These dashboards were developed for this indicator using criteria specific to adults aged 20–64 years. However, they also provide age filters for children and young people (aged 0–19 years) as well as older people (aged 65 years and over), where services have reported these data to PRIMHD. Results of this indicator are available for each financial quarter and can be filtered by age, gender, ethnicity, and health division [261].

The '28-day readmission' indicator was also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, information pertaining to this indicator can be found in Section 3.8.2.4.1.2.

'Continuity of care' is included in two out of the three streams of the Key Performance Indicator Programme: the adult and NGO streams [40]. The indicator description is the same in both streams. This indicator is designed to support services to understand the quality of continuity of care between health divisions (previously known as district health boards) and NGO mental health services, providing insight into inconsistencies in the continuity of care and where improvement is needed in order to achieve better outcomes for individuals who access acute inpatient services [276]. As previously mentioned, the data source for all indicators in the Key Performance Indicator Programme is PRIMHD [102]. There are two data dashboards for this indicator [276]:

1. The NGO national quarterly summary, which analyses NGO activity by health division as indicated through NGO engagement before, during, and after an individual's admission to an acute inpatient unit. This dashboard includes all service consumers regardless of whether there was an NGO activity recorded in the 28 days before an acute inpatient admission.
2. The national quarterly continuity of care dashboard, which analyses NGO activity by health division in relation to when NGO engagement occurred, unique referrals, and a visualisation of what effect NGO pre-admission care has on divisional average length of stay and 28-day readmission rates.

Although this indicator is only listed under the adult and NGO streams in the Key Performance Indicator Programme, the data dashboards were developed using criteria for all populations, where services have

reported these data to PRIMHD. Results of this indicator are available for each financial quarter and can be filtered by age, gender, ethnicity, and health division [261].

3.8.3.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission's *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.3.4.2.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.4.2.2 The Key Performance Indicator Programme

There were no benefits or limitations described in relation to '7-day follow-up', '28-day readmission', or 'Continuity of care' in the supporting information provided on the Key Performance Indicator Programme website.

3.8.3.4.2.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission's *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.5 Scotland (UK)

3.8.3.5.1 What are the relevant mental health indicators?

3.8.3.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.5.1.3 Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health includes a total of 30 quality indicators categorised into 6 quality dimensions ('Timely', 'Safe', 'Person-centred', 'Effective', 'Efficient', and 'Equitable') [120]. Of these indicators, the following 12 were deemed relevant to *Sharing the Vision* outcome 2(c) [120]:

1. Percentage of all discharged psychiatric inpatients followed-up by community mental health services within 7 calendar days ('Safe' dimension of service quality)
2. Percentage of people in mental health services seen for at least 1 month that show improvement in any personal outcome measurement over the previous month ('Person-centred' dimension of service quality)
3. Number of days people spend in hospital when they are ready to be discharged per 1,000 population ('Effective' dimension of service quality)
4. Percentage of people with severe and enduring mental illness and/or learning disability who have had their body mass index measured and recorded in the last 12 months ('Effective' dimension of service quality)

5. Percentage of people seen for at least 1 month that show improvement in symptom severity using any clinical outcome measurement over the previous month (‘Effective’ dimension of service quality)
6. Rate of emergency bed days for adults (‘Efficient’ dimension of service quality)
7. Percentage readmissions to hospital within 28 days of discharge (‘Efficient’ dimension of service quality)
8. Total psychiatric inpatient beds per 100,000 population (‘Efficient’ dimension of service quality)
9. Percentage of did not attend appointments for community-based services of people with mental health problems (‘Efficient’ dimension of service quality)
10. Premature mortality rate (‘Equitable’ dimension of service quality)
11. Percentage of people with severe and enduring mental illness and/or learning disability who have had an annual health check within the previous 12 months (‘Equitable’ dimension of service quality), and
12. Percentage of caseload with an active anticipatory care plan (‘Equitable’ dimension of service quality).

‘Percentage of all discharged psychiatric inpatients followed-up by community mental health services within 7 calendar days’ was selected as an indicator because the first 7 days post-discharge have been identified as a critical period for suicide prevention [120]. All hospital psychiatric wards and all community mental health services of all care groups and all ages are included in the scope of this indicator. For the purposes of this indicator, ‘followed-up’ is defined as a one-to-one verbal assessment by a mental health practitioner, which can be conducted face to face, via digital technology, or over the phone [120]. Limited information is provided in relation to this indicator, only that Public Health Scotland collects data for the indicator from NHS Scotland health boards [44].

‘Percentage of people in mental health services seen for at least 1 month that show improvement in any personal outcome measurement over the previous month’ was also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, further information pertaining to this indicator can be found in Section 3.8.2.5.1.3.

‘Number of days people spend in hospital when they are ready to be discharged per 1,000 population’ was also deemed relevant to *Sharing the Vision* outcome 2(a), and as such, further information pertaining to this indicator can be found in Section 3.8.1.5.1.3.

‘Percentage of people with severe and enduring mental illness and/or learning disability who have had their body mass index measured and recorded in the last 12 months’ is currently still under development [44]. However, in the introductory publication of the Quality Indicator Profile for Mental Health, the Scottish Government noted that this indicator would apply to people in secondary care [120]. This indicator was selected for inclusion in the Quality Indicator Profile for Mental Health in order to provide a proxy measure for the effectiveness of systems established to monitor the physical health of people with severe and enduring mental illness and/or learning disabilities [120].

‘Percentage of people seen for at least 1 month that show improvement in symptom severity using any clinical outcome measurement over the previous month’ and ‘Rate of emergency bed days for adults’ were also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, further information pertaining to these indicators can be found in Section 3.8.2.5.1.3.

‘Percentage readmissions to hospital within 28 days of discharge’ is the number of emergency readmissions for spells of inpatient treatment for mental health within 28 days of a patient’s discharge from a previous spell of treatment (any length of stay), measured as a percentage of total admissions [44,120]. This indicator was selected because it reflects several aspects of integrated care, including

discharge arrangements and coordination of care between inpatient and community-based services, which is underpinned by good communication between care providers. The 28-day follow-up period was selected because “this is the time that the initial support on leaving hospital, including medicines safety, could have a negative impact and result in readmission. A longer period of follow up would be more likely to include admissions that are unrelated to the initial one, whereas a shorter period (e.g. 7 days) is more likely to only pick up immediate issues linked to the hospital care” [120 p22]. All psychiatric hospital patients, regardless of age and care group, are included in the scope of this indicator [120]. The data source for this indicator is the Scottish Morbidity Records, specifically the Scottish Morbidity Records dataset 04, ‘Mental Health Inpatient and Day Case’ (see Section 3.8.1.5.1.3).

‘Total psychiatric inpatient beds per 100,000 population’ is a measure of the number of beds for mental health specialties per 100,000 population, adjusted for cross-boundary flow between specialties [44,120]. This indicator is also adjusted using the National Resource Allocation Formula, which adjusts the population of each NHS Board area for the following three factors, which are known to influence healthcare utilisation [277]:

1. The age-sex profile of the population
2. The additional needs of the population due to morbidity and life circumstances, and
3. The unavoidable excess costs of supplying services in different geographical areas.

This indicator was selected because the number of available beds is a marker of alternative provision by the community, in that reducing the need for psychiatric beds is dependent on the provision of effective community-based supports [120]. The data source for this indicator is the Acute Hospital Activity and NHS Beds Information for Scotland publication, an annual Public Health Scotland publication that provides statistical information on different aspects of hospital care, sourced from hospital administration systems across Scotland [278]. This includes information on trends on outpatient, inpatient, and day patient activity; numbers of diagnoses, operations, and emergency admissions; and bed statistics [278].

‘Percentage of did not attend appointments for community-based services of people with mental health problems’ was also deemed relevant to *Sharing the Vision* outcome 2(a), and as such, further information pertaining to this indicator can be found in Section 3.8.1.5.1.3.

‘Premature mortality rate’ is measured as the age-sex standardised mortality rate of the population with mental health conditions (i.e. people in contact with the mental health service in Scotland) compared with the general population [44]. There is limited information in relation to this indicator, although it is calculated using data from the following two sources [44]:

1. The Scottish Morbidity Records, specifically the Scottish Morbidity Records dataset 04, ‘Mental Health Inpatient and Day Case’ (see Section 3.8.1.5.1.3), and
2. The National Records of Scotland statistics of deaths [279].

‘Percentage of people with severe and enduring mental illness and/or learning disability who have had an annual health check within the previous 12 months’ is currently under additional development, having been published in a 2021 publication of the Quality Indicator Profile for Mental Health but subsequently excluded due to its imprecise definition [44]. Nevertheless, for the purposes of this indicator, an ‘annual health check’ is defined as an assessment of health needs, a guided physical examination, and a review of medication performed by a health professional [120].

‘Percentage of caseload with an active anticipatory care plan’ is currently still under development [44]. However, in its introductory publication of the Quality Indicator Profile for Mental Health, the Scottish Government defined an ‘active anticipatory care plan’ as “any care plan, made and shared with a patient,

that lists identified problems and approaches to help these" [120 p27]. In addition, it is noted that anticipatory care plans are created in primary care for people with complex comorbidity who are regular users of health services, and, as such, this indicator will serve as a gauge for achieving a balance between mental and physical health care, emphasising equal importance [120]. In relation to the data source (which is still undetermined), it was noted that in order to implement this indicator, services will need to identify how many people on their caseload have an active anticipatory care plan [120].

3.8.3.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.3.5.2.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 2(c).

3.8.3.5.2.3 Quality Indicator Profile for Mental Health

The benefits and limitations associated with the quality indicators included in the Quality Indicator Profile for Mental Health were not described in the literature we sourced. However, as noted in Section 3.5.3.1, at the time that Public Health Scotland published the most recent Quality Indicator Profile for Mental Health in April 2023, it was still considered an experimental statistics publication [44].

3.8.3.6 The OECD

3.8.3.6.1 What are the relevant mental health indicators?

3.8.3.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. Of these indicators, two were deemed relevant to *Sharing the Vision* outcome 2(c). It should be noted that limited information pertaining to the development and nature of these indicators is provided in the OECD report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*. The two indicators are [27]:

1. Patient-reported outcomes (dimension 1, 'Person-centred mental health policies and services'), and
2. Repeat admissions to inpatient care (dimension 2, 'Accessible, high-quality mental health services').

Both indicators were also deemed relevant to *Sharing the Vision* outcome 2(b), and as such, information pertaining to each one can be found in Section 3.8.2.6.1.1.

3.8.3.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.3.6.2.1 The OECD Mental Health System Performance Benchmark

Information pertaining to a limitation associated with 'Repeat admissions to inpatient care' can be found in Section 3.8.2.6.2.1. There were no explicit benefits of the benchmarking indicators described in the OECD's 2021 report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*.

3.8.4 Outcome 2(d): Health outcomes for people with dual diagnosis are improved by ensuring greater collaboration between mental health and other relevant services

3.8.4.1 Australia

3.8.4.1.1 What are the relevant mental health indicators?

3.8.4.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

None of the performance indicators included in Australia's *Fifth National Mental Health and Suicide Prevention Plan* were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.1.1.2 The services for mental health performance indicator framework

None of the outcome or output indicators included in the services for mental health performance indicator framework were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.2 Canada

3.8.4.2.1 What are the relevant mental health indicators?

3.8.4.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

None of the mental health indicators included in *Informing the Future: Mental Health Indicators for Canada* were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.2.1.4 The mental health and substance use indicators

As mentioned previously in Section 3.2.4, the Canadian Institute for Health Information established a set of 14 mental health and substance use indicators that broadly measure mental health and substance use services, access, and organisation [42]. One of these indicators was deemed relevant to *Sharing the Vision* outcome 2(d) – 'Navigation of mental health and substance use services' [216]. This indicator was also deemed relevant to *Sharing the Vision* outcome 2(b) and is therefore described previously in Section 3.8.2.2.1.4.

3.8.4.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.8.4.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

None of the mental health indicators included in *Informing the Future: Mental Health Indicators for Canada* were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.2.2.4 The mental health and substance use indicators

The limitations associated with 'Navigation of mental health and substance use services' are described in Section 3.8.2.2.2.4, as this indicator was also deemed relevant to *Sharing the Vision* outcome 2(b).

3.8.4.3 England (UK)

3.8.4.3.1 What are the relevant mental health indicators?

3.8.4.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.4 New Zealand

3.8.4.4.1 What are the relevant mental health indicators?

3.8.4.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission's *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.5 Scotland (UK)

3.8.4.5.1 What are the relevant mental health indicators?

3.8.4.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.5.1.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 2(d).

3.8.4.6 The OECD

3.8.4.6.1 What are the relevant mental health indicators?

3.8.4.6.1.1 The OECD Mental Health System Performance Benchmark

None of the benchmarking indicators included in the OECD Mental Health System Performance Benchmark were deemed relevant to evaluating *Sharing the Vision* outcome 2(d).

3.9 Outcome domain 3: Social inclusion

Outcome domain 3 is a recovery-oriented domain that focuses on individuals with complex mental health challenges who are at higher risk of social exclusion compared with those without complex mental health challenges. People with complex mental health challenges are more likely to experience stigma and discrimination; a lack of appropriate support and accommodation in the workplace; limited access to income, employment, and training or education; and barriers to social inclusion in their communities [24]. Overall, the recommendations and actions set out in outcome domain 3 of *Sharing the Vision* aim to "empower service users by supporting them to achieve full and effective participation in society" [24 p66] by empowering people with complex mental health challenges to thrive in their communities, cultivate a sense of purpose, and build strong and meaningful social connections, as well as by strengthening access to supports that guarantee improved outcomes for these individuals in relation to housing, employment, income, and training and education.

Outcome domain 3 encompasses the following three high-level outcomes [24]:

a) Service users are respected, connected, and valued in their community

b) Increased ability of service users to manage their own lives [self-determination] via stronger social relationships and sense of purpose, and

c) Improved outcomes in relation to education, housing, employment, and income for service users relative to the population as a whole (i.e. reduced disparity).

What follows is an overview of the indicators identified in the mental-health-related indicator sets and frameworks from the selected countries and the OECD that were deemed relevant to each of these high-level outcomes.

3.9.1 Outcome 3(a): Service users are respected, connected, and valued in their community

3.9.1.1 Australia

3.9.1.1.1 What are the relevant mental health indicators?

3.9.1.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21]. The following three indicators were deemed relevant to *Sharing the Vision* outcome 3(a) [21]:

1. Connectedness and meaning in life (domain 3, 'Good mental health and wellbeing')
2. Social participation in adults with mental illness (domain 4, 'Meaningful and contributing life'), and
3. Experience of discrimination in people with mental illness (domain 7, 'Stigma and discrimination').

'Connectedness and meaning in life' measures the proportion of mental health care consumers who report a sense of connectedness and meaning in life, and is considered an indirect indicator of reduced stigma and discrimination against people with mental illness [21]. However, as of the most recent progress report on The Fifth Plan, which was published in 2021, this indicator has not yet been implemented and requires developmental work in order to confirm feasibility and methodology [21,47]. In the 2017 publication of The Fifth Plan, it was anticipated that data for this indicator would be collected

by having people using mental health care services complete the Living in the Community Questionnaire, and that data breakdowns would likely be available by state/territory, sex, age group, and Indigenous status [21].

'Social participation in adults with mental illness' is measured as the percentage of adults aged 15 years and over with mental illness who report social participation over the previous 12 months [21]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected because participation in community activities and contribution to one's community are important factors for recovery from mental illness, particularly because people who experience mental health problems experience high levels of social exclusion, including reduced participation in day-to-day social/community activities [124]. There are two data sources for this indicator [180]:

1. The General Social Survey [181] (see Section 3.7.3.1.1.2), and
2. The National Aboriginal and Torres Strait Islander Social Survey [182] (see Section 3.9.1.1.1.1).

This indicator was first published in 2019 in the second progress report on The Fifth Plan using data from the 2014 General Social Survey and the 2014–2015 National Aboriginal and Torres Strait Islander Social Survey. As data for these surveys are collected approximately every 4–6 years, and as the most recent progress report was published in 2021, subsequent progress reports on The Fifth Plan do not include more up-to-date data [47,124]. This indicator can be disaggregated by age group, sex, remoteness area, and Indigenous status. The data are also reported by type of activity (i.e. participation in one or more social events, participation in community groups, participation in social groups, participation in civic or political groups, attendance at a sport event as a spectator, and attendance at a cultural venue or event). Data are also available for people without a diagnosed mental illness so that responses among those who do and do not have a mental illness can be compared [180]. Higher proportions of adults with a mental illness who report social participation suggest that more people with mental illness have a meaningful and contributing life [124]

'Experience of discrimination in people with mental illness' was also considered relevant to *Sharing the Vision* outcome 1(c). Further information pertaining to this indicator can be found in Section 3.7.3.1.1.1.

3.9.1.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness, and efficiency [183]. The following two indicators were deemed relevant to *Sharing the Vision* outcome 3(a) [30]:

1. Stigma and discrimination experienced by people living with mental health problems or mental illness, and
2. Social and economic inclusion of people with a mental illness.

The first indicator was also deemed relevant to *Sharing the Vision* outcome 1(c). Further information pertaining to this indicator can be found in Section 3.7.3.1.1.2.

'Social and economic inclusion of people with a mental illness' is one of six outcome indicators in the services for mental health performance indicator framework and is defined as "an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society" [183]. The indicator is reported using two indicator measures [183]:

3. The proportion of people aged 16–64 years with a mental illness who are employed, and

4. The proportion of people aged 15 years and over with a mental illness who had face-to-face contact with family or friends living outside the household in the past week.

The most recent data available for the first indicator measure were sourced from the 2017–2018 National Health Survey [125] (see Section 3.7.4.1.1.1), are comparable for people with and without a mental health condition, and are available across jurisdictions and over time. For the purposes of this measure, people with a mental health or behavioural condition are defined as having a current, self-reported mental health and/or behavioural problem that has lasted for at least 6 months, or which the respondent expects to last for 6 months or more [183]. The most recent data available for the second indicator measure were sourced from the 2014, 2019, and 2020 General Social Survey, a national survey conducted every 4 years in order to collect information about personal and household characteristics for people resident in private dwellings across Australia (excluding people living in very remote areas or in discrete Aboriginal and Torres Strait Islander communities), including demographic characteristics, subjective well-being and general life satisfaction measures, and details regarding health and disability, access to service providers, family and community involvement, discrimination, resilience and exclusion, and social networks and community participation [181]. Data are comparable for people with and without a mental health condition and are available across jurisdictions and over time [183]. For the purposes of this measure, people with a mental illness refers to people with clinically recognised emotional and behavioural disorders, as well as perceived mental health problems such as feeling depressed, feeling anxious, feeling stressed, and sadness. Overall, high or increasing proportions of people with a mental illness who are employed, or who had face-to-face contact with family or friends in the previous week, are desirable for this indicator [183].

3.9.1.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.1.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan performance indicators [21,124]. The documents do not explicitly identify the benefits associated with each indicator.

In relation to ‘Connectedness and meaning in life’, the major caveat described is that it is unclear whether sufficient data will be available to support reporting of a national indicator; it is likely that implementation of the Living in the Community Questionnaire will occur within state and territory mental health care services [21].

In relation to ‘Social participation in adults with mental illness’, the similarities between people with and without mental illness reported for this indicator do not align with other reports that people with mental illness experience higher levels of social exclusion compared with those without mental illness. However, the data cannot be disaggregated by type or severity of mental health condition, and therefore cannot provide a nuanced indication of the variation in experiences that may exist between subgroups of people with different types of mental health conditions [21,124]. In addition, this indicator cannot indicate whether social participation among people with mental illness reflects the level of social participation they want or their satisfaction with their social participation; it is simply a measure of self-reported social participation [21,124]. Finally, mental illness is self-reported in the General Social Survey [181], which is the data source for this indicator [124].

Information pertaining to limitations of 'Experience of discrimination in people with mental illness', can be found in Section 3.7.3.1.2.1 of this report, as this indicator was also deemed relevant to *Sharing the Vision* outcome 1(c).

3.9.1.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

Information pertaining to limitations of the first indicator, 'Stigma and discrimination experienced by people living with mental health problems or mental illness', can be found in Section 3.7.3.1.2.2 of this report, as this indicator was also deemed relevant to *Sharing the Vision* outcome 1(c).

In relation to 'Social and economic inclusion of people with a mental illness', it is noted in the 2023 Report on Government Services that this indicator does not provide information about whether the employment or social activities people reported on were appropriate or meaningful, nor does it provide information on why people who were not employed may not be looking for work [183].

3.9.1.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.2 Canada

3.9.1.2.1 What are the relevant mental health indicators?

3.9.1.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and 'Leadership and collaboration') [31,59]. The following two of these indicators were deemed relevant to *Sharing the Vision* outcome 3(a) [31]:

1. Sense of belonging – people with mental health conditions (strategic direction 2, 'Recovery and rights'), and
2. Discrimination among people with mental health conditions (strategic direction 4, 'Disparities and diversity').

'Sense of belonging – people with mental health conditions' was measured as the percentage of people aged 12 years and over with common mental health conditions who describe their sense of belonging to their local community as 'somewhat strong' or 'very strong' in a given year [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31].

'Discrimination among people with mental health conditions' was also deemed relevant to *Sharing the Vision* outcome 1(c). Further information pertaining to this indicator can be found in Section 3.7.3.2.1.1.

3.9.1.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.1.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not identify any explicit benefits associated with each indicator.

In relation to 'Sense of belonging – people with mental health conditions', one limitation described is that while a sense of belonging is an important protective factor against mental health problems, the survey item that informs this indicator uses the phrase 'local community', which could be interpreted in many ways. For instance, individuals may feel a strong sense of belonging with a subgroup or subculture but may not feel a sense of belonging to the broader community in which they live [31]. The other limitations associated with this indicator are the same as those described in Section 3.7.1.2.2.1 for the various stress indicators and for the 'Self-rated mental health' indicator.

Information pertaining to limitations of 'Discrimination among people with mental health conditions', can be found in Section 3.7.3.2.2.1 of this report, as this indicator was also deemed relevant to *Sharing the Vision* outcome 1(c).

3.9.1.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.2.2.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.3 England (UK)

3.9.1.3.1 What are the relevant mental health indicators?

3.9.1.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.4 New Zealand

3.9.1.4.1 What are the relevant mental health indicators?

3.9.1.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43]. Of these indicators, two were deemed relevant to *Sharing the Vision* outcome 3(a), both of which fall under the 'Social inclusion' outcome domain. These indicators are [43]:

1. Isolation, and
2. Perceived discrimination.

'Isolation' was measured as the proportion of people in New Zealand aged 15 years and over who felt isolated from others in the previous 4 weeks, and it was selected because perceived isolation is a subjective indicator of people's satisfaction with the number and quality of their relationships [43]. This indicator was used to compare levels of perceived isolation between people with and without symptoms of mental distress. For the purposes of the *National Indicators 2012* report, symptoms of mental distress were determined using the Short Form Health Survey, a 12-item questionnaire that assesses general self-rated health, physical and psychological symptoms, and limitations in everyday activity due to physical and mental health over the previous 4 weeks [185]. Across all levels of mental distress, data were reported and compared by age, ethnicity, and neighbourhood deprivation status. The data source for this indicator was the New Zealand General Social Survey [157].

'Perceived discrimination' was also deemed relevant to *Sharing the Vision* outcome 1(c), and so information pertaining to this indicator can be found in Section 3.7.3.4.1.3.

3.9.1.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.1.4.2.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.4.2.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.4.2.3 *National Indicators 2012*

There were no benefits or limitations described in relation to the 'Isolation' or 'Perceived discrimination' indicators in the Mental Health and Wellbeing Commission's *National Indicators 2012* report.

3.9.1.5 Scotland (UK)

3.9.1.5.1 What are the relevant mental health indicators?

3.9.1.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.5.1.3 Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health includes a total of 30 quality indicators categorised into 6 quality dimensions ('Timely', 'Safe', 'Person-centred', 'Effective', 'Efficient', and 'Equitable') [120]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 3(a). This indicator, which is categorised under the 'Effective' dimension of service quality, is 'Percentage of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month' [120].

Although this indicator is currently still under development [44], the Scottish Government noted in its introductory publication of the Quality Indicator Profile for Mental Health that it would apply to people of all ages, in all settings and care groups, and that any evidence-based functioning outcome measurement tool would be appropriate [120]. In addition, 'functioning' was defined as social functioning, including employment, education, and participation in social activities. In relation to the data source (which is still undetermined), patients in follow-up will require application of a personal outcome tool or measure at assessment, at discharge, and at 3-month intervals [120].

3.9.1.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.1.5.2.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.1.5.2.3 Quality Indicator Profile for Mental Health

The benefits and limitations associated with the quality indicators included in the Quality Indicator Profile for Mental Health were not described in the literature we sourced. However, as noted in Section 3.5.3.1, at the time that Public Health Scotland published the most recent Quality Indicator Profile for Mental Health in April 2023, it was still considered an experimental statistics publication [44].

3.9.1.6 The OECD

3.9.1.6.1 What are the relevant mental health indicators?

3.9.1.6.1.1 The OECD Mental Health System Performance Benchmark

None of the benchmarking indicators included in the OECD Mental Health System Performance Benchmark were deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.2 Outcome 3(b): Increased ability of service users to manage their own lives [self-determination] via stronger social relationships and sense of purpose

3.9.2.1 Australia

3.9.2.1.1 What are the relevant mental health indicators?

3.9.2.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21]. The following two performance indicators were deemed relevant to *Sharing the Vision* outcome 3(b) [21]:

1. Connectedness and meaning in life (domain 3, 'Good mental health and wellbeing'), and
2. Social participation in adults with mental illness (domain 4, 'Meaningful and contributing life').

However, both indicators were also deemed relevant to *Sharing the Vision* outcome 3(a), and so further information pertaining to these indicators can be found in Section 3.9.1.1.1.1.

3.9.2.1.1.2 The services for mental health performance indicator framework

The only indicator in the services for mental health performance indicator framework that was deemed relevant to *Sharing the Vision* outcome 3(b) was also deemed relevant to outcome 3(a). This indicator, which is one of six outcome indicators in the services for mental health performance indicator framework, is 'Social and economic inclusion of people with a mental illness'. Further information can be found in Section 3.9.1.1.1.2.

3.9.2.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.2.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

Information pertaining to the limitations of the two indicators from *The Fifth National Mental Health and Suicide Prevention Plan* deemed relevant to *Sharing the Vision* outcome 3(b) can be found in Section 3.9.1.1.2.1, as both indicators were also deemed relevant to *Sharing the Vision* outcome 3(a).

3.9.2.1.2.2 The services for mental health performance indicator framework

As 'Social and economic inclusion of people with a mental illness' was deemed relevant to *Sharing the Vision* outcome 3(a), information pertaining to the limitations of this indicator can be found in Section 3.9.1.1.2.2.

3.9.2.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the indicators included in the *Key Performance Indicators for Australian Public Mental Health Services* were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.2 Canada

3.9.2.2.1 What are the relevant mental health indicators?

3.9.2.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and 'Leadership and collaboration') [31,59]. One these indicators was deemed relevant to *Sharing the Vision* outcome 3(b) – 'Sense belonging – people with mental health conditions' [31]. This indicator was also deemed relevant to *Sharing the Vision* outcome 3(a). Therefore, further information pertaining to this indicator can be found in Section 3.9.1.2.1.1.

3.9.2.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.2.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

The only indicator from *Informing the Future: Mental Health Indicators for Canada* considered relevant to *Sharing the Vision* outcome 3(b) – 'Sense belonging – people with mental health conditions' – was also deemed relevant to *Sharing the Vision* outcome 3(a) [31]. Further information pertaining to the limitations of this indicator can be found in Section 3.9.1.2.2.1.

3.9.2.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.2.2.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.3 England (UK)

3.9.2.3.1 What are the relevant mental health indicators?

3.9.2.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.3.1.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, the NHS Outcomes Framework contains 17 overarching outcome indicators and 55 improvement area indicators categorised into 5 outcome domains ('Preventing people from dying prematurely', 'Enhancing quality of life for people with long-term conditions', 'Helping people to recover from episodes of ill health or following injury', 'Ensuring that people have a positive experience of care', and 'Treating and caring for people in a safe environment and protecting them from avoidable harm') [35]. Of these indicators, two were deemed relevant to *Sharing the Vision* outcome 3(b), both of which are included in the NHS Outcomes Framework as improvement area indicators under domain 2, 'Enhancing quality of life for people with long-term conditions'. These are [79]:

1. Health related quality of life for people with mental illness, and
2. Recovery in quality of life for patients with mental illness.

However, the most recent summary dashboard for the NHS Outcomes Framework, which was published in March 2022, states that both of these indicators have yet to be developed. Therefore, information pertaining to the nature and data sources of these indicators is not yet available [83].

3.9.2.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.2.3.2.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.3.2.3 The NHS Outcomes Framework

The two indicators in the NHS mental health dashboard considered relevant to *Sharing the Vision* outcome 3(b) have yet to be developed, and so information pertaining to any limitations associated with these indicators is not yet available [83].

3.9.2.3.2.4 The NHS mental health dashboard

3.9.2.4 New Zealand

3.9.2.4.1 What are the relevant mental health indicators?

3.9.2.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission's *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.5 Scotland (UK)

3.9.2.5.1 What are the relevant mental health indicators?

3.9.2.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.5.1.3 Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health includes a total of 30 quality indicators categorised into 6 quality dimensions ('Timely', 'Safe', 'Person-centred', 'Effective', 'Efficient', and 'Equitable') [120]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 3(b). This indicator, which is categorised under the 'Effective' dimension of service quality, is 'Percentage of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month' [120]. As this indicator was also deemed relevant to *Sharing the Vision* outcome 3(a), further information can be found in Section 3.9.3.5.1.3.

3.9.2.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.2.5.2.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.2.5.2.3 Quality Indicator Profile for Mental Health

The benefits and limitations associated with the quality indicators included in the Quality Indicator Profile for Mental Health were not described in the literature we sourced. However, as noted in Section 3.5.3.1, at the time that Public Health Scotland published the most recent Quality Indicator Profile for Mental Health in April 2023, it was still considered an experimental statistics publication [44].

3.9.2.6 The OECD

3.9.2.6.1 What are the relevant mental health indicators?

3.9.2.6.1.1 The OECD Mental Health System Performance Benchmark

None of the benchmarking indicators included in the OECD Mental Health System Performance Benchmark were deemed relevant to *Sharing the Vision* outcome 3(b).

3.9.3 Outcome 3(c): Improved outcomes in relation to education, housing, employment, and income for service users relative to the population as a whole (i.e. reduced disparity)

3.9.3.1 Australia

3.9.3.1.1 What are the relevant mental health indicators?

3.9.3.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21]. The following two indicators – both of which fall under domain 4, 'Meaningful and contributing life' – were deemed relevant to *Sharing the Vision* outcome 3(c) [21]:

1. Adults with mental illness in employment, education or training, and
2. Proportion of mental health consumers in suitable housing.

'Adults with mental illness in employment, education or training' is measured as the proportion of adults in Australia with a mental illness who are in employment, education, or training. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected because research shows that people with mental health problems are overrepresented in national underemployment statistics in Australia, and that increasing employment rates among this population can lead to better health outcomes [124]. In this context, 'in employment' includes people who are employed to work full time (typically 35 hours per week) or part-time (from 1 to less than 35 hours per week), and 'in education and training' includes people who indicated that they are currently studying for a qualification and people aged 15–19 years who indicated that they are attending secondary school.

There are two data sources for this indicator [180]:

1. The National Health Survey [125] (see Section 3.7.4.1.1.1), and
2. The National Aboriginal and Torres Strait Islander Health Survey [126] (see Section 3.7.4.1.1.1).

This indicator was first published in the first progress report on The Fifth Plan in 2018 using data from the 2014–2015 National Health Survey and from the 2014–2015 National Aboriginal and Torres Strait Islander Health Survey. The second progress report on The Fifth Plan (published in 2019) included selected updated data from the 2018–2019 National Aboriginal and Torres Strait Islander Health Survey [124]. As data for these surveys are collected approximately every 3–6 years, subsequent progress reports on The Fifth Plan did not include more up-to-date data [47,124]. This indicator can be disaggregated by age, sex, state or territory, socioeconomic status, and remoteness, and specific data for Aboriginal and Torres Strait Islander peoples are also available. Higher proportions of people with mental illness who are in employment, education, or training suggest that more people with mental illness are being supported to live a contributing life [124].

As per the fourth and most recent progress report for *The Fifth National Mental Health and Suicide Prevention Plan*, which was published in 2021, the 'Proportion of mental health consumers in suitable housing' indicator has yet to be implemented, as it requires additional developmental work in order to confirm methodology and feasibility. It is anticipated that data will be available by age, sex, state/territory, and Indigenous status [280].

3.9.3.1.1.2 The services for mental health performance indicator framework

The only indicator in the services for mental health performance indicator framework that was deemed relevant to *Sharing the Vision* outcome 3(c) was also deemed relevant to outcome 3(a). This indicator, which is one of six outcome indicators in the services for mental health performance indicator framework, is 'Social and economic inclusion of people with a mental illness'. Further information can be found in Section 3.9.1.1.1.2.

3.9.3.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.3.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan performance indicators [21,124]. The documents do not explicitly identify the benefits associated with using each indicator.

As noted in Section 3.9.3.1.1.1, the 'Proportion of mental health consumers in suitable housing' indicator has yet to be implemented, and so no information that reflected the benefits or limitations of this indicator was available.

In relation to 'Adults with mental illness in employment, education or training', it is noted that the indicator cannot indicate whether people with mental illness who are in employment, education, or training have adequate support to maintain their employment, education, or training long term; it is simply an estimate of proportion [21,124]. Another limitation described was that individuals' experience of mental illness is collected by self-report. In addition, 'in education' only captures people who are both enrolled and currently participating in a course, and so people who have enrolled but not commenced their education and people undertaking hobby or recreational courses are not included in this indicator. Finally, given the difference in data sources, data for Aboriginal and Torres Strait Islander peoples and non-Indigenous people are not directly comparable [124].

3.9.3.1.2.2 The services for mental health performance indicator framework

As the 'Social and economic inclusion of people with a mental illness' indicator was also deemed relevant to *Sharing the Vision* outcome 3(a), information pertaining to the limitations of this indicator can be found in Section 3.9.1.1.2.2.

3.9.3.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the indicators included in the *Key Performance Indicators for Australian Public Mental Health Services* were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.2 Canada

3.9.3.2.1 What are the relevant mental health indicators?

3.9.3.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

As described in Section 3.2.1.1, *Informing the Future: Mental Health Indicators for Canada* was published in 2015 by the Mental Health Commission of Canada and reported on 55 mental health indicators spanning the 6 strategic directions outlined in the 2012 national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* ('Promotion and prevention', 'Recovery and rights', 'Access to services', 'Disparities and diversity', 'First Nations, Inuit, and Métis', and

‘Leadership and collaboration’) [31,59]. The following three indicators were deemed relevant to *Sharing the Vision* outcome 3(c) [31]:

1. Mental illness-related disability claims (strategic direction 1, ‘Promotion and prevention’)
2. Employment among people with common mental health conditions (strategic direction 2, ‘Recovery and rights’), and
3. Number of individuals living in shelters (strategic direction 3, ‘Access to services’).

The first indicator, ‘Mental illness-related disability claims’, is measured as the percentage of Canada Pension Plan disability beneficiaries whose claims were related to mental disorders in a given year [31]. This indicator was selected because mental health problems can interfere with people’s ability to work and function in other areas of life. Given the economic and social implications of mental-health-related disability, this indicator can signpost the need for measures to address and support workers’ mental health. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canada Pension Plan Disability Benefits by Class of Diagnosis dataset for the 2012–13 period. This is an annually updated table representing disability beneficiaries in pay as of December of each year [281]. Previous data for the years 2004–2011 were obtained from Statistics Canada, Canada’s national statistical office [134]. Although not a direct indicator of improved outcomes for service users in relation to education, housing, or employment, a variation of this indicator could be developed in order to assess *Sharing the Vision* outcome 3(c).

The second indicator, ‘Employment among people with common mental health conditions’, is measured as the percentage of Canadians aged 12 years and over with common mental health conditions who report that they have worked at a job or business in the previous 12 months [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the Canadian Community Health Survey [61] for the years 2003, 2005, 2007–08, 2009–10, and 2011–12 in order to analyse trends over time [31].

‘Number of individuals living in shelters’ pertains to the number of people in Canada living in homeless shelters. Although the indicator is not specific to people with mental health conditions, it is noted in *Informing the Future: Mental Health Indicators for Canada* that many homeless individuals suffer from mental health conditions and addictions. If adapted to be specific to the number of people with mental health conditions, this indicator could provide a gauge on whether social inclusion initiatives in relation to housing for people with mental health conditions are achieving the desired outcomes. This indicator, as described in *Informing the Future: Mental Health Indicators for Canada*, is measured as the number of individuals identified through census data as living in a shelter in a given year [31]. In *Informing the Future: Mental Health Indicators for Canada*, data for this indicator were sourced from the collective dwelling reports of the Census of Canada for the years 2001, 2006, and 2011 in order to analyse trends over time [31].

3.9.3.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.2.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.3.2.2.1 *Informing the Future: Mental Health Indicators for Canada*

Informing the Future: Mental Health Indicators for Canada describes the limitations associated with each mental health indicator [31]. The document does not identify any explicit benefits associated with each indicator.

In relation to 'Mental illness-related disability claims', it is noted that the indicator does not capture short-term work-related disability associated with mental disorders and only reflects individuals who have made sufficient Canada Pension Plan contributions and who have mental disorders that prevent regular work. As a result, the indicator likely underestimates work disability claims related to mental disorders in Canada [31].

In relation to 'Employment among people with common mental health conditions', it is stated that for the purposes of this indicator, common mental health conditions only include diagnosed anxiety disorders and/or mood disorders. As such, the validity of the indicator is compromised by only including people with anxiety and/or mood disorders because employment for people with other mental illnesses, such as schizophrenia, is known to be very low. Therefore, the rate of employment among people with common mental health conditions reported in *Informing the Future: Mental Health Indicators for Canada* was higher than it would have been if data from people with other serious mental illnesses were included [31].

Finally, in relation to 'Number of individuals living in shelters', it is noted that census data "potentially underestimate the number of individuals in shelters because of the transient nature of this population as well as the challenges associated with tracking homeless individuals" [31 p41].

3.9.3.2.2.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.2.2.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.2.2.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.3 England (UK)

3.9.3.3.1 What are the relevant mental health indicators?

3.9.3.3.1.1 The Public Health Outcomes Framework

As mentioned in Section 3.3.1.1, the Public Health Outcomes Framework contains 193 indicators, which are categorised as either overarching outcome indicators or as supporting indicators [33]. None of the overarching outcome indicators are specific to mental health, and so none were included in this evidence brief. The supporting indicators are further categorised into one of four domains ('Wider determinants of health', 'Health improvement', 'Health protection', and 'Healthcare and premature mortality') [33]. Five supporting indicators were deemed relevant to *Sharing the Vision* outcome 3(c), all of which fall under the 'Wider determinants of health' domain. Two of these five indicators, however, are sourced from the Adult

Social Care Outcomes Framework, and they are therefore described in Section 3.9.3.3.1.2; these indicators are 'Percentage of the population who are in contact with secondary mental health services and on the care plan approach, that are in paid employment (18–69 years)' (titled 'Proportion of adults in contact with secondary mental health services in paid employment' in the Adult Social Care Outcomes Framework) and 'Adults in contact with secondary mental health services who live in stable and appropriate accommodation' (titled 'Proportion of adults in contact with secondary mental health services living independently, with or without support' in the Adult Social Care Outcomes Framework). The remaining three supporting indicators are [33]:

1. Gap in the employment rate between those with a long-term physical or mental health condition (16–64 years) and the overall employment rate
2. Percentage of the population with a long-term physical or mental health condition in employment (16–64 years), and
3. Gap in the employment rate for adults who are in contact with the secondary mental health services (18–69 years) and on the Care Programme Approach, and the overall employment rate.

'Gap in the employment rate between those with a long-term physical or mental health condition (16–64 years) and the overall employment rate' is measured as the percentage point gap between the percentage of respondents in the Labour Force Survey aged 16–64 years who have a long-term physical or mental health condition who are classified as employed and the percentage of all respondents in the Labour Force Survey aged 16–64 years who are classified as employed [282]. The Labour Force Survey, which is published quarterly by the Office for National Statistics, is the largest household study providing the official measures of employment and unemployment across the UK [283]. This indicator was selected because it provides a good indication of the limiting impact of long-term illness (physical or mental) on employment [282]. In addition, this indicator is intended to monitor progress on the Government's goal to see 1 million more people with disabilities in work by 2027 [284] by tracking the number of working-age people with disabilities who are in employment [282]. For the purposes of this indicator, a 'long-term health condition' is defined as a physical or mental health condition or illness that has lasted or is expected to last more than 1 year [282]. The data source for this indicator is the Annual Population Survey, a continuous household survey in the UK covering topics such as employment and unemployment, as well as housing, ethnicity, religion, health, and education, in order to provide information on important social and socioeconomic variables at local level [154]. The Annual Population Survey combines samples of the Labour Force Survey in England to form the English local Labour Force Survey dataset [282]. The indicator is reported annually, and data are available by deprivation decile [142]. Although the indicator, as it is currently used, compares employment rates among people with a long-term physical or mental health condition with rates among the general population, it could be adapted to be a more mental-health-specific outcome indicator for other purposes.

'Percentage of the population with a long-term physical or mental health condition in employment (16–64 years)' is measured as the percentage of respondents to the Annual Population Survey [154] who have a long-term physical or mental health condition who are classified as employed (as either an employee, self-employed, in government employment and training programmes, or an unpaid family worker (as per the International Labour Organization's definition of basic economic activity) aged 16–64 years) [285]. Like the previous indicator, this indicator was selected because it provides a good indication of the limiting impact of long-term illness (physical or mental) on employment, and is intended to monitor progress on the Government's goal to see 1 million more people with disabilities in work by 2027 [284] by tracking the number of working-age people with disabilities who are in employment [282]. Similarly, for the purposes of this indicator, a 'long-term health condition' is defined as a physical or mental health

condition or illness that has lasted or is expected to last more than 1 year [285]. The data source for this indicator is the same as that for the previous indicator, and data are available by deprivation decile [142]. Like the previous indicator, this indicator could be adapted to be a more mental-health-specific outcome indicator for other purposes.

'Gap in the employment rate for adults who are in contact with the secondary mental health services (18–69 years) and on the Care Programme Approach, and the overall employment rate' is measured as the percentage point gap between the percentage of working-age adults (aged 18–69 years) who are receiving secondary mental health services and who are on the Care Programme Approach who are recorded as being in paid employment at the time of their most recent assessment, formal review, or other multidisciplinary care planning meeting, and the percentage of all respondents in the Labour Force Survey [283] aged 16–64 years who are classified as employed [286]. The Care Programme Approach is a package of care that is used by secondary mental health services whereby mental health service consumers who have a wide range of needs from different services or are thought to be at high risk receive a care plan and someone to coordinate their care in order to support their recovery [287]. This indicator aligns with a particular objective of the *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (see Section 3.3.2), which is to improve access to mental health support for people in work and support people with severe mental health conditions to seek and retain employment [286]. As suggested by its title, this indicator relates to a subgroup of people who have been in contact with mental health services, rather than to all people with mental health conditions [286]. For the purposes of this indicator, 'adults who are in contact with the secondary mental health services' is defined as those aged between 18 and 69 years who are receiving secondary mental health services and who are on the Care Programme Approach. This can include adults who [286]:

- Have a severe mental health problem
- Have learning disabilities
- Are at risk of suicide, self-harm, or harming other people
- Tend to neglect themselves and do not take treatment regularly
- Are vulnerable (for example, because of financial difficulties)
- Have misused drugs or alcohol
- Rely on a carer, or are a carer themselves
- Have recently been sectioned
- Are affected by difficult parenting responsibilities, or
- Have a history of violence or self-harm.

This indicator is focused on 'paid' employment (excluding voluntary work), which is measured using the following two categories of employment:

1. Working as a paid employee or self-employed (16 or more hours per week), or
2. Working as a paid employee or self-employed (up to 16 hours per week).

This indicator is aligned with an associated indicator from the Adult Social Care Outcomes Framework [288], 'Proportion of adults in contact with secondary mental health services in paid employment'. As such, data for the indicator numerator (employment rate for adults who are in contact with the secondary mental health services) are sourced from the Adult Social Care Outcomes Framework (specifically from the Mental Health Services Data Set; see Section 3.9.3.3.1.2), and data for the indicator denominator

(employment rate for the general population) are sourced from the Annual Population Survey [154]. This indicator is reported annually, and data are available by sex and deprivation decile [142].

3.9.3.3.1.2 The Adult Social Care Outcomes Framework

As described in Section 3.3.1.2, the Adult Social Care Outcomes Framework includes a total of 26 outcome indicators, which are not all specific to mental health [78]. The outcome indicators are categorised into four outcomes-based objectives (‘Enhancing quality of life for people with care and support needs’, ‘Delaying and reducing the need for care and support’, ‘Ensuring that people have a positive experience of care and support’, and ‘Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm’) [78]. Two of the indicators were deemed relevant to *Sharing the Vision* outcome 3(c), both of which fall under outcome objective 1, ‘Enhancing quality of life for people with care and support needs’; these are [76]:

1. Proportion of adults in contact with secondary mental health services in paid employment, and
2. Proportion of adults in contact with secondary mental health services living independently, with or without support.

‘Proportion of adults in contact with secondary mental health services in paid employment’ measures the percentage of adults receiving secondary mental health services who are in paid employment at the time of their most recent assessment, formal review, or other multidisciplinary care planning meeting [76]. This indicator is also included in the Public Health Outcomes Framework, and aligns with the *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (see Section 3.3.2) objective to improve access to mental health support for people in work and to support people with severe mental health conditions to seek and retain employment [286]. This indicator was selected because improved employment outcomes for adults with mental health problems reduces the risk of social exclusion and discrimination, and supporting individuals to seek and maintain employment is a key part of the recovery process [76]. For the purposes of this indicator, ‘adults in contact with secondary mental health services’ is defined as those aged 18–69 years who are receiving secondary mental health services and who are on the Care Programme Approach [287]. In addition, the measure focuses only on paid employment, thus excluding voluntary work. Employment status is recorded using the following categories [76]:

- Employed
- Unemployed and seeking work
- Students who are undertaking full-time (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work
- Long-term sick or disabled individuals; those who are receiving Incapacity Benefit, Income Support, or both; or Employment and Support Allowance
- Homemakers looking after the family or home and who are not working or actively seeking work
- Those who are not receiving benefits and who are not working or actively seeking work
- Unpaid voluntary workers who are not working or actively seeking work
- Those who are retired, and
- Not stated (the person was asked but declined to provide a response).

As suggested by its title, this indicator relates to a subgroup of people who have been in contact with mental health services, rather than to all people with mental health conditions [286]. The data source for this indicator is the Mental Health Services Data Set, a “patient-level, output-based secondary uses data

set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for patients who are in contact with Mental Health Services" [289]. The dataset covers the characteristics and scope of treatment of patients of mental health services located in England, as well as patients located outside of England who are receiving treatment commissioned by an English integrated care board, an NHS England specialised commissioner, or an NHS-Led Provider Collaborative. A range of mental health care providers and organisations that provide mental health services submit monthly data to the dataset (e.g. NHS mental health trusts, NHS Care Trusts, and any qualified provider offering mental health services) [289]. The data for this indicator are collected monthly, and then aggregated and reported annually. The data are available by region and sex [76].

'Proportion of adults in contact with secondary mental health services living independently, with or without support' measures the percentage of adults receiving secondary mental health services who are living independently at the time of their most recent assessment, formal review, or other multidisciplinary care planning meeting [76]. This indicator was selected because improved housing-related outcomes for adults with mental health problems improves their safety and reduces their risk of social exclusion [76]. It also prevents the need to readmit people into hospital or more costly residential care [290]. 'Adults in contact with secondary mental health services' is defined in the same way as for the previous indicator. 'Living independently, with or without support' is defined as "accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their usual accommodation in the medium to long term, or is part of a household whose head holds such security of tenure/residence" [76 p35] (recorded as settled accommodation). This definition excludes accommodation arrangements that are precarious, or where the person has no or low security of residence in their usual accommodation and so may be required to leave at very short notice (recorded as non-settled accommodation) [76]. The data source for this indicator is the Mental Health Services Data Set [289]. The data for this indicator are collected monthly, and then aggregated and reported annually. The data are available by region and gender [76].

3.9.3.3.1.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, the NHS Outcomes Framework contains 17 overarching outcome indicators and 55 improvement area indicators categorised into 5 outcome domains ('Preventing people from dying prematurely', 'Enhancing quality of life for people with long-term conditions', 'Helping people to recover from episodes of ill health or following injury', 'Ensuring that people have a positive experience of care', and 'Treating and caring for people in a safe environment and protecting them from avoidable harm') [35]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 3(c). This indicator, which is included in the NHS Outcomes Framework under domain 2, 'Enhancing quality of life for people with long-term conditions', is 'Employment of people with mental illness' [79].

This indicator, which is considered complementary to the employment indicators included in the Public Health Outcomes Framework (see Section 3.9.3.3.1.1) and the Adult Social Care Outcomes Framework (see Section 3.9.3.3.1.2) [76], measures the difference between the percentage of people in the general working-age population who are in employment and the percentage of people of working age with a mental illness who are in employment [291]. As such, three key figures are reported in order to allow for the impact of the wider economic situation to be taken into account [85]:

1. The employment rate for all people in England
2. The employment rate for people with mental illness, and
3. The gap in employment rates between those with mental illness and the total population.

The data source for this indicator is the Labour Force Survey [283] (see Section 3.9.3.3.1.1). Data are published quarterly, approximately 3 months after the end of the relevant quarter, and are available by age, sex, ethnicity, geographic region or local area, religion, and condition – learning disability or mental illness (either 'depression, bad nerves or anxiety' or 'mental illness or suffer from phobia, panics or other nervous disorders') [291].

3.9.3.3.1.4 The NHS mental health dashboard

As mentioned in Section 3.3.2.1, the NHS mental health dashboard includes a total of 55 indicators organised into 11 categories ('Children and young people mental health', 'Perinatal mental health', 'Adult mental health (NHS talking therapies for depression and anxiety)', 'Early intervention in psychosis', 'Employment support', 'Physical health checks for people with severe mental illness', 'Crisis and acute care and use of the Mental Health Act', 'Acute hospital mental health liaisons', 'Health and justice', 'Mental health service backlog', and 'Meeting commitment to increase mental health funding'). The data reported on the NHS mental health dashboard are available by region, integrated care board, or sub-integrated care board [41]. However, it should be noted that the NHS mental health dashboard publications provide limited information about the indicators. Of the 55 indicators, only 1 was deemed relevant to *Sharing the Vision* outcome 3(c). This indicator, which is categorised under 'Employment support' in the NHS mental health dashboard, is 'Number of people accessing Individual Placement and Support services' [92].

This indicator is a measure of the number of people with severe mental illness or complex mental health needs who accessed an Individual Placement and Support service during a given financial year for the purposes of receiving employment support. The Individual Placement and Support service is an evidence-based support service integrated within community mental health teams for people with severe mental health conditions which aims to support them in finding and retaining employment [292]. This indicator tracks progress against the national target of 33,000 people by quarter 3 in the 2022–23 reporting period. The data source for this indicator is the NHS Mental Health Services Data Set [226]. However, it is noted in the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) that the data are not complete, and work is under way to ensure that all activity is captured by this dataset. The indicator is reported for the cumulative financial year to date by quarter [41].

3.9.3.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.3.3.2.1 The Public Health Outcomes Framework

Although the supporting information provided alongside the Public Health Outcomes Framework describes the caveats associated with each outcome indicator, the benefits of each indicator are not explicitly described.

In relation to 'Gap in the employment rate between those with a long-term physical or mental health condition (16–64 years) and the overall employment rate', it is noted that the indicator provides information on the employment of people surveyed who disclosed that they had a long-term physical or mental health condition that they expected to last 12 months or more, and as such, it does not necessarily represent all people in England with a long-term health condition [282].

In relation to 'Percentage of the population with a long-term physical or mental health condition in employment (16–64 years)', the same limitation as identified for the previous indicator applies. In addition, it is noted that this indicator merely provides additional contextual information on the previous indicator ('Gap in the employment rate between those with a long-term physical or mental health condition (16–64 years) and the overall employment rate') [285].

In relation to 'Gap in the employment rate for adults who are in contact with the secondary mental health services (18–69 years) and on the Care Programme Approach, and the overall employment rate', the limitations described predominantly relate to the differences in data sources for this indicator. Specifically, the age group captured by the Mental Health Services Data Set in the Adult Social Care Outcomes Framework for the employment rate for adults who are in contact with the secondary mental health services is 18–69 years, whereas the age group captured by the Annual Population Survey for the employment rate for the whole population is 16–64 years. In addition, the Adult Social Care Outcomes Framework Mental Health Services Data Set measure only includes people in paid employment, whereas the Annual Population Survey includes people who are in employment as either an employee, self-employed, in government employment and training programmes, or an unpaid family worker, which is the International Labour Organization's definition of basic economic activity [293]. These differences may result in an artificial increase in the employment gap value, and therefore values for this indicator should be interpreted with caution [286]

3.9.3.3.2.2 The Adult Social Care Outcomes Framework

The *Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions* (as of September 2023, the 2023–24 handbook for the revised edition of the Adult Social Care Outcomes Framework is still in draft form [77]) does not explicitly describe the benefits and limitations associated with each indicator. However, in relation to 'Proportion of adults in contact with secondary mental health services in paid employment', it is noted that interpretation of the measure should take into account the likelihood that some people in contact with secondary mental health services are being supported in paid employment by their local council but are not captured under the definition of 'paid employment' (see Section 3.9.3.3.1.2) [76].

In relation to 'Proportion of adults in contact with secondary mental health services living independently, with or without support', it is noted that interpretation of this measure should take into account the likelihood that some people in contact with mental health services are being supported in accommodation by their local council but are not captured under the indicator because they are not on the Care Programme Approach [76]. However, upcoming changes to the Mental Health Services Data Set are likely to see the decommissioning of measures around the Care Programme Approach and amendment of employment status measures so that they apply to all working-age adults under the care of community mental health services, whether they are under the Care Programme Approach or any other framework [286].

3.9.3.3.2.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, an indicator quality statement is published alongside each indicator in the NHS Outcomes Framework, with the exception of those still in development. Although these documents do not explicitly identify the benefits and limitations associated with each indicator, some provide noteworthy information in relation to the use and interpretation of the indicators included in the NHS Outcomes Framework. However, none of the information provided in the 'Employment of people with mental illness' quality statement reflects the limitations or benefits of this indictor [80].

3.9.3.3.2.4 The NHS mental health dashboard

The NHS mental health dashboard publications do not explicitly describe the benefits and limitations associated with the 55 indicators included in the dashboard.

3.9.3.4 New Zealand

3.9.3.4.1 What are the relevant mental health indicators?

3.9.3.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43]. Of these indicators, three were deemed relevant to *Sharing the Vision* outcome 3(c), all of which fall under the 'Social inclusion' outcome domain. These indicators are [43]:

1. Employed and satisfied with job
2. Standard of living, and
3. Housing satisfaction.

'Employed and satisfied with job' was measured as the proportion of people aged 15–64 years who are employed and have been satisfied with their job in the last 4 weeks [43]. This indicator was used to compare rate of employment and level of job satisfaction between people with and without symptoms of mental distress. For the purposes of the *National Indicators 2012* report, symptoms of mental distress (none, mild, moderate, or severe) were determined using the Short Form Health Survey, a 12-item questionnaire that assesses respondents' general self-rated health, physical and psychological symptoms, and limitations in everyday activity due to physical and mental health over the previous 4 weeks [185]. This indicator was selected because participation in employment is important for social contact and one's sense of self-worth, and income from participation in employment contributes to people's economic standard of living. In addition, because poor working conditions contribute to the erosion of well-being, satisfaction with employment was an important component to this indicator. As such, this indicator combined the objective measurement of people being employed and the subjective measurement of job satisfaction to provide an indicator of good working conditions for people who experience different levels of mental distress [43]. Across all levels of mental distress, data were reported and compared by age, ethnicity, and neighbourhood deprivation status. The data source for this indicator was the New Zealand General Social Survey [157].

'Standard of living' was measured as the proportion of people aged 15 years and over who scored 17 or more (out of a possible score of 31) on the Economic Living Standard Index Short Form [43]. The Economic Living Standard Index Short Form is a survey tool for measuring people's economic standard of living, which refers to the material aspect of well-being that is reflected in a person's consumption of goods and personal possessions (e.g. their household durables, clothing, recreations, access to medical services, etc.) [294]. An aggregate score that is less than 17 is an indication of some hardship. This indicator was used to compare standard of living scores between people with and without symptoms of mental distress using the same approach as the previous indicator. Data were also reported by age, sex, ethnicity, and neighbourhood deprivation status. The data source for this indicator was the New Zealand General Social Survey [157].

'Housing satisfaction' was measured as the proportion of people aged 15 years and over who reported being 'satisfied' or 'very satisfied' with the housing they were currently living in [43]. This indicator was used to compare housing satisfaction between people with and without symptoms of mental distress

using the same approach as the first indicator, ‘Employed and satisfied with job’. Data were also reported by age, sex, ethnicity, and neighbourhood deprivation status. The data source for this indicator was the New Zealand General Social Survey [157].

3.9.3.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.3.4.2.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission’s *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.4.2.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.4.2.3 *National Indicators 2012*

There were no benefits or limitations described in relation to any of the three mental health and addiction indicators deemed relevant to *Sharing the Vision* outcome 3(c) in the Mental Health and Wellbeing Commission’s *National Indicators 2012* report.

3.9.3.5 Scotland (UK)

3.9.3.5.1 What are the relevant mental health indicators?

3.9.3.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.5.1.3 Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health includes a total of 30 quality indicators categorised into 6 quality dimensions (‘Timely’, ‘Safe’, ‘Person-centred’, ‘Effective’, ‘Efficient’, and ‘Equitable’) [120]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 3(c). This indicator, which is categorised under the ‘Effective’ dimension of service quality, is ‘Percentage of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month’ [120]. As this indicator was also deemed relevant to *Sharing the Vision* outcome 3(a), further information can be found in Section 3.9.3.5.1.3.

3.9.3.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.3.5.2.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 3(c).

3.9.3.5.2.3 Quality Indicator Profile for Mental Health

The benefits and limitations associated with the quality indicators included in the Quality Indicator Profile for Mental Health were not described in the literature we sourced. However, as noted in Section 3.5.3.1, at the time that Public Health Scotland published the most recent Quality Indicator Profile for Mental Health in April 2023, it was still considered an experimental statistics publication [44].

3.9.3.6 The OECD

3.9.3.6.1 What are the relevant mental health indicators?

3.9.3.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. Of these indicators, two were deemed relevant to *Sharing the Vision* outcome 3(c), both of which fall under dimension 3, 'An integrated and multi-sectoral approach to mental health'. It should be noted that limited information pertaining to the development and nature of the indicators is provided in the OECD report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*. The two indicators are [27]:

1. Rate of higher education of those with mental distress to those without other disabilities or mental distress, and
2. Employment rate of those with mental distress to those without other disabilities or mental distress.

'Rate of higher education of those with mental distress to those without other disabilities or mental distress' assesses mental health system performance across countries in relation to the rate of higher education completion between people with and without a mental health condition [27]. *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* presents data from between 2012 and 2016 for this indicator, which was reported by 31 out of 38 OECD member countries, including Canada, New Zealand, the UK, and Ireland. Data for this indicator were sourced from the European Health Interview Survey (wave 2), which was conducted between 2013 and 2015, as well as from national sources [27]. The European Health Interview Survey is a general population survey which collects data on health status, healthcare use, and health determinants [295]. Submitting data for collection is mandatory for all 28 European Union (EU) member states [296]. For the purposes of this indicator, the rate of higher education in each country was determined according to the three groups specified by the International Standard Classification of Education [297]:

1. Basic
   - Primary education, or
   - Lower secondary education.
2. Intermediate
   - Upper secondary education, or
   - Post-secondary non-tertiary education.
3. Advanced
   - Short-cycle tertiary education
   - Bachelor's degree or equivalent level

- Master’s degree or equivalent level, or
- Doctoral degree or equivalent level.

Each of the 31 OECD member countries for which data were available for this indicator was awarded a score to allow for international comparison. A value of 100 indicated that people with mental distress were equally likely to have higher education as those without mental distress [27].

‘Employment rate of those with mental distress to those without other disabilities or mental distress’ assesses mental health system performance across countries in relation to the employment gap between persons with and without a mental health condition [27]. In *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, this indicator was reported by the same 31 OECD member countries as the previous indicator, which included Canada, New Zealand, the UK, and Ireland (the report identifies the indicator data source for each member state). As with the previous indicator, data were sourced from the European Health Interview Survey (wave 2), as well as from national sources [27]. Likewise, in relation to scoring, each member state for which data were available was given a score to allow for international comparison. A value of 100 indicated that people with mental distress were equally likely to have higher education as those without mental distress [27].

3.9.3.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.9.3.6.2.1 The OECD Mental Health System Performance Benchmark

There were no explicit benefits or limitations associated with the benchmarking indicators deemed relevant to *Sharing the Vision* outcome 3(c) described in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.10 Outcome domain 4: Accountability and continuous improvement

Outcome domain 4 focuses on the overall mental health system, placing a strong emphasis on innovation and continuous improvement. The domain highlights the importance of recognising mental health as a national priority to be "integrated into all key and relevant policies and settings in society" [24 p72] through, for example, prioritising mental health research funding, increased utilisation of digital technologies in service delivery, improved information and communication technology infrastructure, and legislative reform. Outcome domain 4 prioritises measuring the performance of mental health services and the mental health system, and it emphasises tracking the experiences of service users – and those of their families, carers, and supporters – as a key aspect of performance assessment. Outcome domain 4 also prioritises patient safety, recognising the importance of safeguarding vulnerable people against abuse and inappropriate use (i.e. disproportionate to the assessed risk) of restrictive interventions that compromise an individual's freedom and integrity. Additionally, this outcome domain emphasises leadership in relation to service quality and organisational oversight in order to ensure that services meet the relevant quality standards and clinical effectiveness/best practice guidelines, which "play an important role in continuous improvement and measurement/monitoring of desired standards and practices in mental healthcare in Ireland" [24 p76].

Outcome domain 4 encompasses the following four high-level outcomes [24]:

a) Mental health is embedded as a national cross cutting priority that is effectively integrated into the key policies and settings in society

b) Dynamic performance reporting provides visibility of the performance and impact of *Sharing the Vision*

c) Services that deliver consistently high-quality person-centred supports that meet the needs and have the confidence of service users and family, carers, and supporters, and

d) Continuous improvement is future focussed and driven by adequately resourced innovation across the mental health system and related sectors.

What follows is an overview of the indicators identified in mental-health-related indicator sets and frameworks from the selected countries and the OECD that were deemed relevant to each of these outcomes.

3.10.1 Outcome 4(a): Mental health is embedded as a national cross cutting priority that is effectively integrated into the key policies and settings in society

3.10.1.1 Australia

3.10.1.1.1 What are the relevant mental health indicators?

3.10.1.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

None of the performance indicators included in Australia's *Fifth National Mental Health and Suicide Prevention Plan* were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.1.1.2 The services for mental health performance indicator framework

None of the outcome or output indicators included in the services for mental health performance indicator framework were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.2 Canada

3.10.1.2.1 What are the relevant mental health indicators?

3.10.1.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

None of the mental health indicators included in *Informing the Future: Mental Health Indicators for Canada* were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information’s mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.3 England (UK)

3.10.1.3.1 What are the relevant mental health indicators?

3.10.1.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.3.1.4 The NHS mental health dashboard

None of the indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.4 New Zealand

3.10.1.4.1 What are the relevant mental health indicators?

3.10.1.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission’s *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission's *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.5 Scotland (UK)

3.10.1.5.1 What are the relevant mental health indicators?

3.10.1.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.5.1.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 4(a).

3.10.1.6 The OECD

3.10.1.6.1 What are the relevant mental health indicators?

3.10.1.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. Of these indicators, only one was deemed relevant to *Sharing the Vision* outcome 4(a). This indicator, which falls under dimension 6, 'Building future-focused and innovative mental health systems', is 'Availability of mental health indicators – national mental health data set'. It should be noted that limited information pertaining to the development and nature of the indicators is provided in the OECD's 2021 report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

According to the OECD's report, "Tracking and comparing health system data across settings and services, across time, and across countries are powerful tools for understanding performance. Availability of mental health data, nationally and internationally, has long lagged behind broader health data development" [27 p39], and building a strong information system for mental health is identified as one of six principles of establishing a future-focused, innovative, and high-performing mental health system. In the report, 19 out of the 38 OECD member countries reported having established some form of national mental health dataset, including Australia, Canada, New Zealand, the UK, and Ireland. However, the report emphasises that the majority of available data pertained to inputs (e.g. beds, spending) or processes (e.g. length of stay, admissions, contacts with specialist care) rather than providing insight into continuity of care, care quality, or care outcomes (e.g. repeat admissions, follow-up after discharge, repeat emergency department visits). Ultimately, the report concludes that, "With a few exceptions, countries are unable to comprehensively measure the dimensions of mental health performance that they defined as most important" [27 p231]. The data for this indicator were sourced from the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires. However, limited information pertaining to the development and nature of these questionnaires is provided in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

In addition to the above indicator, it is worth mentioning another benchmark indicator that is included in the OECD Mental Health System Performance Benchmark in relation to outcome 4(a) (although it is not directly in line with the recommendations and actions set out in *Sharing the Vision* under domain 4), specifically the goal of embedding mental health into various settings in society. This indicator, which falls under dimension 3, 'An integrated and multi-sectoral approach to mental health', is 'Mental health training is provided to front line actors'. Specifically, there is a sub-indicator for the following seven groups of frontline actors [27]:

1. Teachers
2. Emergency department staff
3. Paramedics
4. General practitioners (GPs)/family doctors
5. Fire department
6. Police, and
7. Unemployment staff/counsellors.

In *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, 26 out of the 38 OECD member countries reported the provision of training for one or more of these seven groups of frontline actors, including Australia, Canada, New Zealand, the UK, and Ireland (most commonly to GPs/family doctors, teachers, and emergency department staff, and less commonly to unemployment staff/counsellors, paramedics, and the fire department). However, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* states that "most countries indicated that only 'some training' was provided to these front line actors, and coverage tended to be through relatively ad-hoc courses, or depend on local or regional initiatives" [27 p31]. In other words, mental health first aid training is rarely mandatory or comprehensive for frontline actors in many OECD member countries. As with the previous indicator, data for these sub-indicators were sourced from the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires. However, limited information pertaining to the development and nature of these questionnaires is provided in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.10.1.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.1.6.2.1 The OECD Mental Health System Performance Benchmark

There were no explicit benefits or limitations associated with the benchmarking indicators deemed relevant to *Sharing the Vision* outcome 4(a) described in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.10.2 Outcome 4(b): Dynamic performance reporting provides visibility of the performance and impact of *Sharing the Vision*

3.10.2.1 Australia

3.10.2.1.1 What are the relevant mental health indicators?

3.10.2.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

None of the individual performance indicators included in Australia's *Fifth National Mental Health and Suicide Prevention Plan* were deemed relevant to *Sharing the Vision* outcome 4(b). However, the indicators were developed specifically to monitor and evaluate the performance of The Fifth Plan in the

eight national priority areas. As such, this collection of indicators is a resource that is particularly relevant to *Sharing the Vision* outcome 4(b) (see Section 3.1.1 for more information).

3.10.2.1.1.2 The services for mental health performance indicator framework

None of the individual outcome or output indicators included in the services for mental health performance indicator framework were deemed relevant to *Sharing the Vision* outcome 4(b). However, outcome 4(b) relates to the development of a set of standardised performance indicators and targeted service outcome data at a national level. The services for mental health performance indicator framework was developed to provide information on the performance of the mental health services in Australia in relation to service equity, effectiveness, and efficiency. As such, the collection of indicators itself is relevant to this outcome (see Section 3.1.2 for more information).

3.10.2.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

None of the individual key performance indicators for Australian public mental health services were deemed relevant to *Sharing the Vision* outcome 4(b). However, the indicators were established to monitor mental health service delivery and measure performance and quality of care. As such, the collection of indicators itself is relevant to this outcome (see Section 3.1.3 for more information).

3.10.2.2 Canada

3.10.2.2.1 What are the relevant mental health indicators?

3.10.2.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

None of the mental health indicators included in *Informing the Future: Mental Health Indicators for Canada* were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the individual outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 4(b). However, outcome 4(b) focuses on dynamic reporting on the performance and impact of *Sharing the Vision*. The Positive Mental Health Surveillance Indicator Framework was established to gather and report on comprehensive data on population-level mental health and well-being outcomes, and as such, it may be a particularly useful resource to draw from in order to develop performance indicators to measure the outcomes in *Sharing the Vision* outcome domain 4 (see Section 3.2.2).

3.10.2.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.2.1.4 The mental health and substance use indicators

None of the individual indicators included in the Canadian Institute for Health Information’s mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 4(b). However, as previously noted, outcome 4(b) focuses on the development of a set of standardised performance indicators and targeted service outcome data at a national level. The mental health and substance use indicators, which measure mental health and substance use services access, organisation, and coordination, form a set of indicators which in and of itself is relevant to *Sharing the Vision* outcome 4(b) (see Section 3.2.4 for more information).

3.10.2.3 England (UK)

3.10.2.3.1 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.2.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.3.1.4 The NHS mental health dashboard

None of the individual indicators included in the NHS mental health dashboard were deemed relevant to *Sharing the Vision* outcome 4(b). However, as previously noted, outcome 4(b) focuses on the development of a set of standardised performance indicators and targeted service outcome data at a national level. As the NHS mental health dashboard was established by NHS England in order to monitor key performance and outcomes data, it is in and of itself relevant to *Sharing the Vision* outcome 4(b) (see Section 3.3.2.1 for more information).

3.10.2.4 New Zealand

3.10.2.4.1 What are the relevant mental health indicators?

3.10.2.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.4.1.2 The Key Performance Indicator Programme

None of the individual indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 4(b). However, as outcome 4(b) focuses on the development of a set of standardised performance indicators and targeted service outcome data at a national level, the Key Performance Indicator Programme, which was established in order to improve outcomes for users of mental health and addiction services and to support the effective use of resources across the mental health system in New Zealand, is itself relevant to *Sharing the Vision* outcome 4(b) (see Section 3.4.2 for more information).

3.10.2.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission's *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.5 Scotland (UK)

3.10.2.5.1 What are the relevant mental health indicators?

3.10.2.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.5.1.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 4(b).

3.10.2.6 The OECD

3.10.2.6.1 What are the relevant mental health indicators?

3.10.2.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. Of these indicators, only one was deemed relevant to *Sharing the Vision* outcome 4(b). This indicator, which falls under dimension 6, 'Building future-focused and innovative mental health systems', is 'Availability of mental health indicators – OECD Healthcare Quality and Outcomes (HCQO) mental health indicators'. It should be noted that limited information pertaining to the development and nature of the indicators is provided in the OECD report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

The OECD mental health indicators were developed as part of the OECD HCQO programme (previously known as the Healthcare Quality Indicators (HCQI) Project), an international project which commenced in 2001 and aims to develop a set of indicators that are based on comparable data on healthcare quality in order to allow for shared benchmarking and learning between countries with regard to quality and safety [298,299]. The HCQO programme is part of a collaborative effort to progressively expand the coverage of the dimensions of the OECD framework for health system performance measurement [300]. To do so requires a continuous dialogue between the OECD secretariat and a representative group of experts from OECD and non-OECD member countries, international organisations – including the World Health Organization and the European Commission – and other relevant collaborating institutions, including universities, subject matter experts, and research organisations [300].

The HCQO programme's data collection process includes a total of 64 indicators covering 7 healthcare themes [300]:

1. Primary care
2. Safe prescribing in primary care
3. Acute care
4. Mental health care
5. Cancer care
6. Patient safety, and
7. Patient experiences.

The entire HCQO programme's dataset reports data from 40 countries, including non-OECD member countries such as Malta, Romania, and Singapore [300]. The following four indicators are reported under the 'Mental health care' theme [301]:

1. Suicide within 1 year after discharge among patients diagnosed with a mental disorder
2. Suicide within 30 days after discharge among patients diagnosed with a mental disorder

3. Excess mortality among patients diagnosed with schizophrenia compared to the general population, and
4. Excess mortality among patients diagnosed with bipolar disorder compared to the general population.

'Availability of mental health indicators – OECD HCQO mental health indicators' assesses which of the OECD member countries collect and report on these four mental health care quality indicators. In *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, 22 out of the 38 OECD member countries reported on the HCQO mental health indicators, including Canada, New Zealand, and the UK (they were not reported in Australia or Ireland) [27]. The data source for this benchmarking indicator was the OECD Health Statistics 2020 publication [302].

3.10.2.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.2.6.2.1 The OECD Mental Health System Performance Benchmark

There were no explicit benefits or limitations associated with 'Availability of mental health indicators – OECD HCQO mental health indicators' described in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.10.3 Outcome 4(c): Services that deliver consistently high-quality person-centred supports that meet the needs and have the confidence of service users and family, carers, and supporters

3.10.3.1 Australia

3.10.3.1.1 What are the relevant mental health indicators?

3.10.3.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains, which are used to capture and track the performance of The Fifth Plan over its lifespan ('Healthy start to life', 'Better physical health and living longer', 'Good mental health and wellbeing', 'Meaningful and contributing life', 'Effective support, care and treatment', 'Less avoidable harm', and 'Stigma and discrimination') [21]. The following four indicators were deemed relevant to *Sharing the Vision* outcome 4(c) [21]:

1. Mental health consumer experience of service (domain 5, 'Effective support, care and treatment')
2. Suicide of people in inpatient mental health units (domain 6, 'Less avoidable harm')
3. Seclusion rate (domain 6, 'Less avoidable harm'), and
4. Involuntary hospital treatment (domain 6, 'Less avoidable harm').

'Mental health consumer experience of service' measures the percentage of mental health service consumers who give the service a score equal to or higher than 80 using the Your Experience of Service survey, a tool designed by the Australian Mental Health Outcomes and Classification Network to gather information from mental health consumers about their experiences of care with the aim of supporting collaboration between mental health services and consumers in order to build better services [303]. The Australian Mental Health Outcomes and Classification Network is a national network established by the Australian Government to work collaboratively with states and territories, as well as others in the mental health sector, in order to implement routine outcome measurement in public mental health services [304]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, this indicator was selected because understanding consumers' experiences of care is vital for informing

continuous improvement efforts for mental health services [124]. Although this indicator relates to continuous improvement of mental health services, well-organised services are more likely to result in positive experiences of care, increasing the likelihood of consumers achieving personal recovery. The data, which are collected annually, were first published in the second progress report on The Fifth Plan in 2019 and updated in subsequent progress reports, with the most recent report (as of completion of this evidence brief in September 2023) being published in 2021. This indicator can be disaggregated by age group, Indigenous status, mental health service delivery setting, and involuntary treatment status. A higher proportion of consumers with a positive experience of service suggests a higher-performing mental health system [124].

'Suicide of people in inpatient mental health units' measures the number of suicides that occur in admitted patient specialised mental health services [21]. When this indicator was identified, it was anticipated that the data source would be Australian state and territory data systems [21]. As of the publication of the most recent progress report on The Fifth Plan in 2021, however, this indicator is not available for reporting, as it requires further development [47].

'Seclusion rate' measures the number of seclusion events per 1,000 patient days within public acute admitted patient specialised mental health service units. In the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, seclusion is defined as "the confinement of a consumer or patient at any time of the day or night alone in a room or area from which free exit is prevented" [124 p20]. Reduction and, where possible, elimination of the use of seclusion in mental health services is identified as a national priority in Australia. Only seclusion that occurs in state and territory public acute admitted patient mental health service units is in scope for this indicator; seclusion that occurs in other mental health settings, such as emergency departments, is excluded. The data source for this indicator is the Australian Institute of Health and Welfare's National Seclusion and Restraint Database, which contains aggregate data submitted by Australian jurisdictions on seclusion and restraint events, episodes of care, mental health care days, and episodes with seclusion in Australian mental health services [305]. Seclusion rate is calculated as the number of seclusion events per 1,000 bed days that occur in public sector acute specialised mental health hospital services [180]. According to the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report*, the data are collected annually [124], and at the time this evidence brief was completed (September 2023), data were available for each year from 2008–09 to 2020–21 [180]. Data for this indicator were first published in the first progress report on The Fifth Plan in 2018 and updated in subsequent progress reports, with the most recent progress report being published in 2021. This indicator can be disaggregated by target population of the service (general, child and adolescent, older person, and forensic), state/territory, and remoteness of the hospital [180]. Higher rates of seclusion indicate poorer performance of the mental health system [124]. The *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* states that this indicator should be interpreted in conjunction with the 'Involuntary patient days' sub-indicator in the *Key Performance Indicators for Australian Public Mental Health Services* (see Section 3.10.3.1.1.3).

'Involuntary hospital treatment' measures the percentage of separations with specialised mental health care days that are involuntary [124]. This indicator was selected because "involuntary care is considered a type of restrictive practice, [and so] monitoring involuntary care is an important component of understanding and reducing the use of restrictive practices" [124 p21]. There is no official data source for this indicator; rather, the Australian Institute of Health and Welfare gathers data annually from state and territory governments [180]. This indicator was first published in the second progress report on The Fifth Plan in 2019 for the reported period 2017–18 and updated in subsequent progress reports, first in the 2020 report and most recently in the 2021 report for the reporting period 2019–20 [47,124]. This indicator can be disaggregated by age group, sex, Indigenous status, and whether the unit is acute or non-

acute [180]. Higher rates of involuntary hospital treatment indicate that more consumers are experiencing restrictive and coercive practices in the mental health system [124].

3.10.3.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness, and efficiency [183]. The following two indicators were deemed relevant to *Sharing the Vision* outcome 4(c) [30]:

1. Adverse events, and
2. Consumer and carer experiences of mental health services.

'Adverse events' is an output indicator that is categorised under service effectiveness, and more specifically, service safety. It is defined as "an indicator of governments' objective to provide services that promote recovery, and are high quality, safe and responsive to consumer and carer goals" [30]. This indicator is reported on using a total of seven indicator measures [30]:

1. Restrictive practices:
    - Seclusion, defined as:
        - The number of seclusion events per 1,000 bed days in state and territory governments' specialised mental health acute inpatient units.
    - Restraint, defined as:
        - The number of mechanical restraint events per 1,000 bed days in state and territory governments' specialised mental health acute inpatient units
        - The number of physical restraint events per 1,000 bed days in state and territory governments' specialised mental health acute inpatient units, and
        - The number of chemical restraint events (measurement of this concept is still under development).
2. Suicide in an inpatient facility, defined as:
    - The suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward, reported as a number and by jurisdiction.
3. Self-harm in an inpatient facility, defined as:
    - The deliberate injuring or hurting of oneself, with or without the intention of dying (measurement of this concept is still under development).
4. Assault in an inpatient facility, defined as:
    - The physical or sexual assault of a patient in an inpatient facility (measurement of this concept is still under development).
5. Medical errors in an inpatient facility, defined as:
    - The administration of an incorrect diagnosis, intervention, or medication, or delay in administration resulting in harm or deterioration (measurement of this concept is still under development).
6. Abscondment from an inpatient facility, defined as:

- Leaving or not returning to an admitted healthcare facility without prior agreement (measurement of this concept is under development).

7. Falls in an inpatient facility, defined as:
   - A loss of balance resulting in serious harm (measurement of this concept is still under development).

In relation to the first measure, 'Restrictive practices', the 'Seclusion' measure is the same as the seclusion indicator included in The Fifth Plan (see Section 3.10.3.1.1.1). The data source for the 'Restraint' measure is also the Australian Institute of Health and Welfare's National Seclusion and Restraint Database [305]. Data for this measure are collected annually by the Australian Institute of Health and Welfare and are available since the financial year 2015–16 up until 2021–22. Data are available by jurisdiction and restraint type (mechanical or physical) [184]. A low or decreasing rate of restraint events per 1,000 bed days in specialised public mental health inpatient units is desirable [30].

'Consumer and carer experiences of mental health services' is an output indicator that is categorised under service effectiveness, and more specifically, service responsiveness [30]. This indicator (including the indicator data source) is the same as the consumer experience indicator included in *The Fifth National Mental Health and Suicide Prevention Plan* (Section 3.10.3.1.1.1), with one difference; the services for mental health performance indicator framework includes carer experiences as well as consumer experiences. Under the services for mental health performance indicator framework, this indicator is defined as "an indicator of governments' objective to provide access to services that are responsive to consumer and carer goals" [30]. It is estimated via two measures [30]:

1. The proportion of mental health service consumers reporting positive experiences of mental health services, and
2. The proportion of carers of mental health service consumers reporting positive experiences of mental health services.

Since the financial year 2015–16, annual data for this indicator are sourced and reported by the Australian Institute of Health and Welfare from the Your Experience of Service survey [303], with the most recent data reported (as of the completion of this evidence brief in September 2023) being from the financial year 2020–21 [184]. The data are disaggregated by service delivery setting (residential care, admitted care, and ambulatory care). A high or increasing proportion of mental health consumers and carers with positive experiences of service is desirable [30].

3.10.3.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

As described in Section 3.1.3, the National Mental Health Performance Subcommittee established 16 key performance indicators for Australian public mental health services in order to address the 'Health system' dimension in the National Mental Health Performance Measurement Framework in Australia. This dimension contains six sub-domains ('Accessibility', 'Appropriateness', 'Continuity of care', 'Effectiveness', 'Efficiency and sustainability', and 'Safety') [55]. Of the 16 key performance indicators, the following 4 were deemed relevant to *Sharing the Vision* outcome 4(c) [39]:

1. Mental health consumer outcomes participation ('Appropriateness' sub-domain)
2. Seclusion rate ('Safety' sub-domain)
3. Restraint rate ('Safety' sub-domain)
4. Involuntary treatment ('Safety' sub-domain); with sub-indicators for:
   - Involuntary patient days, and

- Involuntary hospital treatment.

As of the most recent publication of *Key Performance Indicators for Australian Public Mental Health Services* in May 2023, 'Mental health consumer outcomes participation' has yet to be developed, and as such, information pertaining to the nature of and data source for this indicator is not yet available [39].

'Seclusion rate' is the same indicator as the 'Seclusion rate' indicator included in *The Fifth National Mental Health and Suicide Prevention Plan* (see Section 3.10.3.1.1.1).

'Restraint rate' is the same indicator as the restraint measure in the 'Adverse events' indicator included in the services for mental health performance indicator framework (see Section 3.10.3.1.1.2).

'Involuntary patient days' is measured as the percentage of admitted specialised mental health care patient days where the consumer has a mental health legal status of 'involuntary' [306]. For this indicator, 'mental health legal status' is defined as "whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation" [306]. In addition, involuntary patients are defined as those who are "compulsorily treated in hospital or in the community under relevant state and territory legislation for the purpose of assessment or provision of appropriate treatment or care" [306]. All types of treatment orders are in scope for this indicator, regardless of setting. For example, admitted patients who are under a community treatment order are in scope. This indicator was selected because monitoring the proportion (and frequency) of patient care provided on an involuntary basis is important in order to understand the use of restrictive practices in Australian public hospitals. There is no official data source for this indicator; rather, data are gathered annually from state and territory governments by the Australian Institute of Health and Welfare. The data for this indicator are disaggregated by state/territory, age group, sex, Indigenous status, and type of unit (acute or non-acute), and are available for the financial years 2019–20 and 2020–21 [207]

'Involuntary hospital treatment' is the same indicator as the 'Involuntary hospital treatment' indicator included in *The Fifth National Mental Health and Suicide Prevention Plan* (see Section 3.10.3.1.1.1). Moreover, all the information provided in the previous paragraph (e.g. indicator rationale, scope, etc.) in relation to 'Involuntary patient days' also applies to this indicator [307].

3.10.3.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.3.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

The Fifth National Mental Health and Suicide Prevention Plan and the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describe the limitations that should be considered when using and interpreting The Fifth Plan performance indicators [21,124]. The documents do not explicitly identify the benefits associated with using each indicator.

In relation to 'Mental health consumer experience of service', the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* describes several limitations [124]. First, a significant proportion of people with mental health conditions disengage from or choose not to access mental health services and supports; data on the experiences of mental health service consumers cannot indicate whether existing services would be rated positively by these people. Second, for the purposes of this indicator, a mental health consumer is defined as a person who uses or has used a public mental health service and has responded to the Your Experience of Service survey [303]. Third, individual mental health service consumers may complete the Your Experience of Service survey more than once in the reporting year [124]. Finally, it is noted in the original 2017 publication of The Fifth Plan that the methodologies for implementing the Your Experience of Service survey differ between jurisdictions, and the impact that has on whether data are nationally comparable is yet to be determined [21].

In relation to 'Suicide of people in inpatient mental health units', as this indicator is not yet available for reporting [47], there was no information relevant to understanding its limitations.

In relation to 'Seclusion rate', the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* notes that, while high seclusion rates may suggest inadequacies in the functioning of the mental health care system, they do not indicate where inadequacies may exist. In addition, the data source for this indicator, the National Seclusion and Restraint Database [305], does not include the demographic information of consumers or patients, and as such, the data cannot be disaggregated for Aboriginal and Torres Strait Islander peoples [124].

In relation to 'Involuntary hospital treatment', the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* notes that while this indicator provides information on the proportion of public hospital separations with specialised mental health care that involved care provided without the individual's consent, it cannot indicate what type or how much care was provided without consent [124].

3.10.3.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

There were no relevant limitations described in the services for mental health performance indicator framework in relation to 'Adverse events'.

There were no relevant limitations described in the services for mental health performance indicator framework in relation to 'Consumer and carer experiences of mental health services'. However, as mentioned in Section 3.10.3.1.1.2, a version of this indicator is also included in The Fifth Plan. As such, the limitations associated with this indicator as described in the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* are outlined in Section 3.10.3.1.2.1.

3.10.3.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

The indicator specification web pages and the data tables for the 2020–21 indicator set provided by the Australian Institute of Health and Welfare describe the limitations associated with each of the key performance indicators for Australian public mental health services. The benefits associated with the indicators are not explicitly described.

As the 'Mental health consumer outcomes participation' indicator has yet to be developed, information pertaining to its limitations is not yet available [39].

'Seclusion rate' is the same indicator as the 'Seclusion rate' indicator included in The Fifth Plan, and as such, information pertaining to the limitations associated with this indicator as reported in The Fifth Plan can be found in Section 3.10.3.1.2.1. However, the indicator specification web page for 'Seclusion rate' as one of the key performance indicators for Australian public mental health services also notes that the capacity to collect information regarding the duration of seclusion episodes varies greatly across jurisdictions, and as such, work is being carried out at a national level to facilitate the development of a meaningful indicator of seclusion duration [308].

'Restraint rate' is the same indicator as the restraint measure in the seclusion indicator included in services for mental health performance indicator framework. However, the mental health performance indicator framework did not describe any relevant limitations. The indicator specification web page for 'Restraint rate' as one of the key performance indicators for Australian public mental health services notes that the type of restraint used (physical or mechanical) provides information in relation to an

organisation's management and use of restraint. However, the capacity to collect information regarding the type of restraint used varies across jurisdictions [309].

In relation to 'Involuntary patient days', it is noted on the indicator specification web page that the use of involuntary treatment is governed within each state and territory, either in legislation or mandatory policy. As a result, the definition of involuntary treatment varies between jurisdictions, which should be considered when interpreting the indicator [306].

As 'Involuntary hospital treatment' is the same as the 'Involuntary hospital treatment' indicator included in The Fifth Plan, information pertaining to the limitations associated with this indicator can be found in Section 3.10.3.1.2.1. However, the limitation described in the previous paragraph for 'Involuntary patient days' also applies to 'Involuntary hospital treatment' [307].

3.10.3.2 Canada

3.10.3.2.1 What are the relevant mental health indicators?

3.10.3.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

None of the mental health indicators included in *Informing the Future: Mental Health Indicators for Canada* were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information's mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.3 England (UK)

3.10.3.3.1 What are the relevant mental health indicators?

3.10.3.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.3.1.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, the NHS Outcomes Framework contains 17 overarching outcome indicators and 55 improvement area indicators categorised into 5 outcome domains ('Preventing people from dying prematurely', 'Enhancing quality of life for people with long-term conditions', 'Helping people to recover from episodes of ill health or following injury', 'Ensuring that people have a positive experience of care', and 'Treating and caring for people in a safe environment and protecting them from avoidable harm') [35]. Of these indicators, one was deemed relevant to *Sharing the Vision* outcome 4(c). This indicator, which is included in the NHS Outcomes Framework under domain 4, 'Ensuring that people have a positive experience of care', is 'Patient experience of community mental health services' [79].

This indicator is a measure of patient experience of community mental health services based on contact with a health and social care worker [310]. The data source for this indicator is the Community Mental Health Survey, an annual survey conducted by the Care Quality Commission (the independent regulator of health and adult social care in England [311]) that looks at the experiences of people aged 18 years and over who use community mental health services [312]. The indicator is a composite measure, calculated as the average score across the following four survey questions from the Community Mental Health Survey [310]: "Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition:

1. Did this person listen carefully to you?
2. Did this person take your views into account?
3. Did you have trust and confidence in this person?
4. Did this person treat you with respect and dignity?"

While the 'Patient experience of community mental health services' indicator is a composite measure, performance can be disaggregated at the level of each individual survey question, and a breakdown of responses to the individual questions within the survey is available online [310]. In the March 2022 publication of the NHS Outcomes Framework, annual data from the 2010 through 2013 Community Mental Health Survey were still reported on, with this indicator remaining similar over that 4-year time period. However, it is noted that this indicator is currently under review due to changes in the data source. The data are available only by service provider [310].

3.10.3.3.1.4 The NHS mental health dashboard

As mentioned in Section 3.3.2.1, the NHS mental health dashboard includes a total of 55 indicators organised into 11 categories ('Children and young people mental health', 'Perinatal mental health', 'Adult mental health (NHS talking therapies for depression and anxiety)', 'Early intervention in psychosis', 'Employment support', 'Physical health checks for people with severe mental illness', 'Crisis and acute care and use of the Mental Health Act', 'Acute hospital mental health liaisons', 'Health and justice', 'Mental health service backlog', and 'Meeting commitment to increase mental health funding'). The data reported on the NHS mental health dashboard are available by region, integrated care board, or sub-integrated care board [41]. However, it should be noted that the NHS mental health dashboard publications provide limited information about the indicators. The following 9 out of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 4(c) [92]:

1. Percentage adult home treatment services staffed in line with recommended levels
2. Number of detentions under the Mental Health Act
3. Standardised rate of detentions for people detained under the Mental Health Act from a white British ethnicity
4. Standardised rate of detentions for people detained under the Mental Health Act from a Black or Black British ethnicity
5. Number of section 136 place of safety orders to hospital
6. Number of section 136 detentions taken to police cells as a place of safety
7. Number of section 136 detentions taken to police cells as a place of safety that are under 18
8. Mental health liaison staffing levels, and

9. Number of mental health secure transfers within 2 weeks of acceptance under the Mental Health Act – age 18+.

‘Percentage adult home treatment services staffed in line with recommended levels’ is categorised under ‘Crisis and acute care and use of the Mental Health Act’. This indicator reflects the staffing reported via a 2020–21 national survey of crisis resolution and home treatment teams, which included the full staffing mix (i.e. medical, nursing, social work, psychology, administrative, peer support, or other). However, information pertaining to this data source is lacking in that the title and nature of the survey are not described. It is noted that the indicator is reported annually; however, as suggested by the indicator description, the most recent data available for this indicator are from the 2020–21 financial year [41].

‘Number of detentions under the Mental Health Act’ is categorised under ‘Crisis and acute care and use of the Mental Health Act’. This indicator is a measure of the number of detentions under the Mental Health Act 1983, a law in England and Wales that outlines the rights of people with mental health problems regarding [313]:

- Assessment and treatment in hospital
- Treatment in the community, and
- Pathways into hospital, which can be civil or criminal.

The indicator includes people who were detained (or ‘sectioned’) in any hospital for assessment or treatment under the Act [314]. It does not include detentions under Section 136 of the Act that take place in non-healthcare settings, such as police cells. The data source for this indicator is the Mental Health Act Statistics, an annual publication by NHS Digital which contains the official statistics about uses of the Mental Health Act 1983 in England [315]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported annually [41].

‘Standardised rate of detentions for people detained under the Mental Health Act from a white British ethnicity’ and ‘Standardised rate of detentions for people detained under the Mental Health Act from a Black or Black British ethnicity’ are categorised under ‘Crisis and acute care and use of the Mental Health Act’. These indicators are measures of the standardised rate of detentions under the Mental Health Act 1983 [313] per 100,000 population for people from a white British ethnicity, and from a Black or Black British ethnicity, respectively. The data source and reporting period described for the previous indicator, ‘Number of detentions under the Mental Health Act’, is the same for these two indicators [41].

‘Number of section 136 place of safety orders to hospital’ is categorised under ‘Crisis and acute care and use of the Mental Health Act’. This indicator is a measure of the number of Mental Health Act Section 136 place of safety orders to hospital [41]. This section of the Mental Health Act is the part that gives police emergency powers [316]. The figures only include cases where the place of safety was a hospital. The data source for this indicator is the Mental Health Act Statistics [315]. The most recent version of the NHS mental health dashboard states that this indicator is reported annually [41].

‘Number of section 136 detentions taken to police cells as a place of safety’ and ‘Number of section 136 detentions taken to police cells as a place of safety that are under 18’ are categorised under ‘Crisis and acute care and use of the Mental Health Act’. These indicators are measures of the number of Section 136 detentions (of adults aged 18 years and over, and children and young people aged under 18 years, respectively) taken to police cells as a place of safety in England [41]. The data source for these indicators is the Home Office’s statistics on police powers and procedures [317]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that these indicators are reported annually [41].

‘Mental health liaison staffing levels’ is categorised under ‘Acute hospital mental health liaisons’. This indicator represents the total whole-time equivalent staffing level in mental health services. The data source for this indicator is the Survey of Liaison Psychiatry in England [236]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported annually, and that data are available at the Sustainability and Transformation Partnership, regional, and national levels [41].

‘Number of mental health secure transfers within 2 weeks of acceptance under the Mental Health Act – age 18+’ is categorised under ‘Health and justice’. This indicator is a measure of the number of mental health secure transfers for patients aged 18 years and over within 2 weeks of acceptance under the Mental Health Act 1983. The NHS mental health dashboard publications provide almost no information in relation to this indicator. The data source is the NHS England Health and Justice Indicators of Performance (see Section 3.8.1.3.1.4) [237]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported on a quarterly basis [41].

3.10.3.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.3.3.2.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.3.2.3 The NHS Outcomes Framework

As mentioned in Section 3.3.1.3, an indicator quality statement is published alongside each indicator in the NHS Outcomes Framework, with the exception of those still in development. These documents do not explicitly identify the benefits and limitations associated with each indicator; however, they do provide some noteworthy information in relation to the use and interpretation of the indicators.

In relation to ‘Patient experience of community mental health services’, it is noted that the four questions used in this indicator focus on the individual’s contact with a mental health worker rather than on the wider provision given by mental health services, and that analysis of the other relevant questions in the Community Mental Health Survey [310] may provide a more complete measure of the patient experience [318].

3.10.3.3.2.4 The NHS mental health dashboard

The NHS mental health dashboard publications do not explicitly describe the benefits and limitations associated with the 55 indicators included in the dashboard.

3.10.3.4 New Zealand

3.10.3.4.1 What are the relevant mental health indicators?

3.10.3.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission’s *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.4.1.2 The Key Performance Indicator Programme

As mentioned in Section 3.4.2, the Key Performance Indicator Programme consists of six key performance indicators distributed across three streams: an adult stream, a child and youth stream, and a non-

governmental organisation (NGO) stream [104]. The adult stream contains five indicators, the child and youth stream contains three indicators, and the NGO stream contains two indicators (some indicators are common to multiple streams). Of the six key performance indicators, the following two were deemed relevant to *Sharing the Vision* outcome 4(c):

1. Seclusion, and
2. Whānau (‘family’) engagement.

‘Seclusion’ is included in both the adult stream and the child and youth stream in the Key Performance Indicator Programme [40]. The indicator description is the same in both streams. This indicator provides information about the frequency and duration of seclusion events that occur in acute mental health inpatient units across New Zealand using six indicator measures [319]:

1. Total number of seclusion events (the distinct count of seclusion events where the seclusion event start date falls within the reporting period)
2. Number of people secluded (the distinct count of people with a seclusion event where the seclusion event start date falls within the reporting period)
3. Seclusion events per 1,000 bed nights
4. Seclusion events per 100,000 population
5. Number of people secluded per 100,000 population, and
6. Hours of seclusion (the sum of the hours of seclusion activity that occur within the reporting period).

In relation to ‘Total number of seclusion events’, where there are fewer than 60 minutes between seclusion activities (for the same person and the same referral), these activities are merged into a single event. Therefore, a seclusion event combines overlapping or adjacent seclusion activities for an individual within a single referral. In addition, seclusion events are allocated to a shift based on the seclusion event start time (12.00 am to 6.59 am (night), 7.00 am to 2.59 pm (morning), and 3.00 pm to 11.59 pm (afternoon)), and allocated to a weekday based on the seclusion event start day. In relation to ‘Hours of seclusion’, it is noted that when a single seclusion event crosses multiple reporting periods, only the hours within the applicable reporting period are counted [319]. There are two data sources for this indicator:

1. The Programme for the Integration of Mental Health Data (PRIMHD) [102], the primary data source for all indicators in the Key Performance Indicator Programme, and
2. Statistics New Zealand [156] (for population estimates).

There are three data dashboards available for this indicator [319]:

1. A national summary dashboard
2. A health division dashboard, and
3. A forensic national summary dashboard.

These dashboards were developed using criteria specific to adults aged 20–64 years. However, they also provide age filters for children and youth (aged 0–19 years) and older people (aged 65 years and over), where services have reported these data to PRIMHD. Results for this indicator are available for each financial quarter, and can be filtered by age, gender, ethnicity, and health division [261].

‘Whānau (‘family’) engagement’ is included in all three streams of the Key Performance Indicator Programme (the adult, child and youth, and NGO streams) [40]. The indicator description is the same

across all three streams. For the purposes of this indicator, some types of service episode activities are considered out of scope, including [320]:

- Care/liaison coordination contacts
- Seclusion
- Community support contacts
- Advocacy
- Peer support, and
- Health coaching contacts.

In addition, the following types of family engagement are considered out of scope [320]:

- Written correspondence
- SMS text messaging, and
- Other social media contact.

Family engagement that is in scope is included regardless of whether or not the consumer themselves was present. As previously mentioned, the data source for all indicators in the Key Performance Indicator Programme is PRIMHD [102]. There are two data dashboards available for this indicator [320]:

1. The tāngata whai ora ('person seeking health') view summary, which provides a national overview of the percentage of service consumers who had family engagement within the selected reporting period, split by patterns of engagement over time, and
2. The service episode summary, which provides a national overview of family engagement from a service episode view rather than a person view. For all service episodes started within the selected reporting period, this dashboard provides the percentage that had family engagement and explores the wait times between a service episode's first in-scope activity and its first family engagement, and the average number of days to the first family engagement.

These dashboards were developed using criteria for all populations, where services have reported these data to PRIMHD. Results of this indicator are available for each financial quarter, and can be filtered by age, gender, ethnicity, and health division [261].

3.10.3.4.1.3 *National Indicators 2012*

As mentioned in Section 3.4.3, the Mental Health and Wellbeing Commission's *National Indicators 2012* report was the second (and seemingly final) publication of a set of 15 population-level mental health and addiction indicators described across 3 outcome domains ('Mental health of the population', 'Health service delivery', and 'Social inclusion') [43]. Of these indicators, three were deemed relevant to *Sharing the Vision* outcome 4(c), all of which fall under the 'Health service delivery' outcome domain. These indicators are [43]:

1. Input into treatment
2. Family participation, and
3. Seclusion.

'Input into treatment' was measured as the proportion of people who used mental health and addiction services who chose 'agree' or 'strongly agree' when asked if they felt that their opinions and ideas were included in their treatment plan [43]. The data source for this indicator was the National Mental Health

Consumer Satisfaction Survey (data from the survey were provided by the New Zealand Ministry of Health for the purposes of the *National Indicators 2012* indicators). The National Mental Health Consumer Satisfaction Survey was an annual survey that was undertaken by district health boards in New Zealand beginning in 2006–07 in order to gather information about satisfaction with mental health services among consumers of specialist mental health services [321]. Data from 2006–07 to 2010–11 were reported on in the *National Indicators 2012* report in order to measure trends over time [43].

'Family participation' was measured as the proportion of people who used mental health and addiction services who chose 'agree' or 'strongly agree' when asked if they felt that staff provided their family with the education or supports they needed in order to be helpful to service recipients [43]. The data source for this indicator was the National Mental Health Consumer Satisfaction Survey (data from the survey were provided by the New Zealand Ministry of Health for the purposes of the *National Indicators 2012* indicators) [321]. Like the previous indicator, data from 2006–07 to 2010–11 were collected and reported on in the *National Indicators 2012* report in order to measure trends over time [43].

'Seclusion' was measured as the number of seclusion events, number of people secluded per 100,000 population, and average duration of seclusion [43]. The data source for this indicator was the New Zealand Ministry of Health. Annual data from 2007 to 2010 were collected and reported on in the *National Indicators 2012* report in order to measure trends over time. Data were also reported by gender [43].

3.10.3.4.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.3.4.2.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission's *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.4.2.2 The Key Performance Indicator Programme

There were no benefits or limitations described in relation to the 'Seclusion' or 'Whānau ('family') engagement' indicators in the supporting information provided on the Key Performance Indicator Programme website.

3.10.3.4.2.3 *National Indicators 2012*

There were no benefits or limitations described in relation to any of the three mental health and addiction indicators deemed relevant to *Sharing the Vision* outcome 4(c) in the Mental Health and Wellbeing Commission's *National Indicators 2012* report.

3.10.3.5 Scotland (UK)

3.10.3.5.1 What are the relevant mental health indicators?

3.10.3.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.5.1.3 Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health includes a total of 30 quality indicators categorised into 6 quality dimensions ('Timely', 'Safe', 'Person-centred', 'Effective',

‘Efficient’, and ‘Equitable’) [120]. Of these indicators, the following seven were deemed relevant to *Sharing the Vision* outcome 4(c) [120]:

1. Percentage of people prescribed lithium who experienced lithium toxicity in the last 12 months (‘Safe’ dimension of service quality)
2. Incidents of physical violence per 1,000 occupied psychiatric bed days (‘Safe’ dimension of service quality)
3. Percentage of adults with mental health problems supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (‘Person-centred’ dimension of service quality)
4. Percentage of replies for people with mental health problems that agree with the statement “people took account of the things that mattered to me” in the Health and Care Experience Survey (‘Person-centred’ dimension of service quality)
5. Number of people with advance statements registered per year with the Mental Welfare Commission for Scotland (‘Person-centred’ dimension of service quality)
6. Percentage of people prescribed antipsychotics for reasons other than psychosis and bipolar disorder treatment (‘Effective’ dimension of service quality), and
7. Number of emergency detention certificates per 100,000 population (‘Equitable’ dimension of service quality).

‘Percentage of people prescribed lithium who experienced lithium toxicity in the last 12 months’ is still under development as of the completion of this evidence brief in September 2023 [44]. However, in its introductory publication of the Quality Indicator Profile for Mental Health*,* the Scottish Government defined lithium toxicity as any lithium level greater than 1.2 millimoles per litre for adults and 0.8 millimoles per litre for people aged 65 years and over [120]. This indicator was selected because it can be considered a proxy measure for the routine monitoring of lithium levels, which should be well established [120]. The data source for this indicator is still undetermined, but the introductory publication of the Quality Indicator Profile for Mental Health states that the relevant data will likely be sourced from local prescribing registers and clinical systems [120].

‘Incidents of physical violence per 1,000 occupied psychiatric bed days’ is measured as the number of incidents of physical violence per 1,000 occupied psychiatric bed days, with ‘physical violence’ being defined as physical harm being inflicted by one person on another person, including violence committed on or by staff, patients, or visitors [120]. Limited information is provided in relation to this indicator. However, it is stated that Public Health Scotland collects the data for this indicator from NHS Scotland health boards [44].

‘Percentage of adults with mental health problems supported at home who agree that their services and support had an impact in improving or maintaining their quality of life’ is also a patient experience indicator, and is measured as the percentage of respondents who ‘strongly agree’ or ‘agree’ with the following statement from the Health and Care Experience Survey [322]: “The help, care or support improved or maintained my quality of life” [120]. Limited information is provided in relation to this indicator. However, it is noted that the data are presented as a range owing to the fact that the data are drawn from a survey of a sample and not from population data [44].

‘Percentage of replies for people with mental health problems that agree with the statement “people took account of the things that mattered to me” in the Health and Care Experience Survey’ is a patient experience indicator. As the indicator title suggests, data for this indicator are sourced from the biennial

national Health and Care Experience Survey, a Scottish Government initiative that has gathered information about people's experiences of GP practices and other local health and care services since 2009 [322]. Limited information is provided in relation to this indicator; however, like the previous indicator, it is noted that the data are presented as a range owing to the fact that the data are drawn from a survey of a sample and not from population data [44].

'Number of people with advance statements registered per year with the Mental Welfare Commission for Scotland' includes any person of any age who generates an advance statement [120]. These are "written statements made by a person when they are well, setting out the care and treatment they would prefer or would dislike should they become mentally unwell in the future" [44 p15]. An advance statement register has been in operation in Scotland since 2017; each time a person either writes or withdraws a statement, the relevant NHS health board should notify the Mental Welfare Commission for Scotland (an independent organisation that carries out statutory duties under mental health and incapacity law in Scotland [323]). Limited information is provided in relation to this indicator; however, the data source for this indicator is the Mental Welfare Commission for Scotland's *Mental Health Act monitoring report 2021–22*, which is a statistical report based on detentions and the wider use of compulsion [324].

The 'Percentage of people prescribed antipsychotics for reasons other than psychosis and bipolar disorder treatment' indicator is still under development as of the completion of this evidence brief in September 2023 [44]. However, in its introductory publication of the Quality Indicator Profile for Mental Health, the Scottish Government described how the indicator will be calculated; specifically, it stated that the denominator will be all patients prescribed an antipsychotic medication from Section 4.3.6 of the British National Formulary publication (which reflects current best practice as well as legal and professional guidelines relating to the use of medications [325]), and the numerator will be all patients with a diagnosis other than psychosis (including schizophrenia) and bipolar disorder [120]. This indicator was selected because "identification of the level of use of these drugs for purposes other than their primary licensed indications is a potential marker for the effectiveness and quality of care" [120 p18]. The data source is still undetermined, but the introductory publication of the Quality Indicator Profile for Mental Health states that the relevant data will likely be sourced from local clinical systems [120].

'Number of emergency detention certificates per 100,000 population' is calculated using the number of emergency detention certificate notifications received by the Mental Welfare Commission for Scotland and Scottish mid-year population estimates [44]. An emergency detention certificate is a type of compulsory treatment under mental health legislation which can be issued by any doctor with the input of a mental health officer. They are designed to be used only in crisis situations in order to detain individuals who require urgent care for mental ill health in hospital for up to 72 hours [44]. Limited information is provided in relation to this indicator. However, the data source for this indicator is the Mental Welfare Commission for Scotland's *Mental Health Act monitoring report 2021–22* [324].

3.10.3.5.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.3.5.2.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.5.2.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 4(c).

3.10.3.5.2.3 Quality Indicator Profile for Mental Health

The benefits and limitations associated with the quality indicators included in the Quality Indicator Profile for Mental Health were not described in the literature we sourced. However, as noted in Section 3.5.3.1, at the time that Public Health Scotland published the most recent Quality Indicator Profile for Mental Health in April 2023, it was still considered an experimental statistics publication [44].

3.10.3.6 The OECD

3.10.3.6.1 What are the relevant mental health indicators?

3.10.3.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. Of these indicators, three were deemed relevant to *Sharing the Vision* outcome 4(c), all three of which fall under dimension 1, 'Person-centred mental health policies and services'. It should be noted that limited information pertaining to the development and nature of the indicators is provided in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*. One of the indicators is repeated across multiple groups (see 'Care Plans in mental health service' in the list below). These indicators are [27]:

1. Care Plans in mental health services involve the service user
2. Care Plans in mental health services involve the service user's carer or representative, and
3. People with a mental health problem who reported being treated with courtesy and respect by doctors and nurses during hospitalisation.

'Care Plans in mental health service involve the service user' and 'Care Plans in mental health service involve a carer or representative' are indicators of the number of OECD member countries that require that personal mental health care plans be developed by clinicians and service users (and/or a service user's carer or representative) working together in order to agree care and treatment decisions [27]. In the OECD's 2021 report, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, one or both of these indicators was reported by 23 out of 38 OECD member countries, including Canada, New Zealand, the UK, and Ireland (it was not reported by Australia) [27]. Data for these indicators were sourced from the OECD Mental Health Performance Benchmarking Data and Policy Questionnaires [27]. However, limited information pertaining to the development and nature of these questionnaires is provided in the report [27].

'People with a mental health problem who reported being treated with courtesy and respect by doctors and nurses during hospitalisation' is an indicator of the proportion of people with a mental health problem who reported being treated with courtesy and respect by doctors and nurses during hospitalisation for a mental health issue. In *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, this indicator was only available for 11 out of 38 OECD member countries, including Canada, New Zealand, and the UK [27]. Data for this indicator were sourced from the *2020 Commonwealth Fund International Health Policy Survey*, which was conducted in 11 countries and showed that people who reported having a mental health problem were less likely to report being treated with courtesy and respect during a hospital stay than people without a mental health problem [27,253].

3.10.3.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.3.6.2.1 The OECD Mental Health System Performance Benchmark

A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health does not describe any explicit benefits of the benchmarking indicators identified in the report. It does, however, describe some limitations associated with the indicators discussed in Section 3.10.3.6.1.1.

In relation to the 'Care Plans in mental health service involve the service user' and 'Care Plans in mental health service involve a carer or representative' indicators, the report notes that while these indicators capture whether service user/carer or representative involvement in the development of a personal care plan is required in OECD member countries, it cannot capture the degree of involvement [27]. Moreover, while service user (or carer or representative) involvement in the development of a personal care plan may technically be required, the report notes that in some countries, this requirement is merely in principle, and therefore is not always met, often depending on the setting [27].

In relation to the 'People with a mental health problem who reported being treated with courtesy and respect by doctors and nurses during hospitalisation' indicator, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* states that it is not possible to distinguish between people who were suffering from a mental health problem at the time of data collection and those who had experienced a mental health problem previously but had since recovered. In addition, the indicator does not reveal whether the hospitalisation was for a mental health problem or for another type of health problem [27].

3.10.4 Outcome 4(d): Continuous improvement is future focussed and driven by adequately resourced innovation across the mental health system and related sectors

3.10.4.1 Australia

3.10.4.1.1 What are the relevant mental health indicators?

3.10.4.1.1.1 *The Fifth National Mental Health and Suicide Prevention Plan*

None of the performance indicators included in Australia's *Fifth National Mental Health and Suicide Prevention Plan* were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.1.1.2 The services for mental health performance indicator framework

As described in Section 3.1.2, the services for mental health performance indicator framework includes a total of 6 outcome indicators and 13 output indicators, which are grouped under equity, effectiveness, and efficiency [183]. Of these, one indicators was deemed relevant to *Sharing the Vision* outcome 4(d). This indicator, which is an output indicator, categorised under service effectiveness, and more specifically, service safety, is 'Services reviewed against the national standards' [30]. It is defined as "an indicator of governments' objective to provide universal access to services that are high quality" [30], and measured as the proportion of expenditure on state and territory governments' specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services and met all standards (level 1; see the list below). The National Standards for Mental Health Services were introduced in Australia in 1996 "to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services" [326]. Following review, services are assigned to one of the following four levels depending on their level of adherence to the National Standards for Mental Health Services [30]:

1. Level 1: services reviewed by an external accreditation agency and judged to have met all National Standards
2. Level 2: services reviewed by an external accreditation agency and judged to have met some but not all National Standards
3. Level 3: services either in the process of being reviewed by an external accreditation agency but the outcomes are not known, or booked for review by an external accreditation agency, and
4. Level 4: services that do not meet the criteria detailed under levels 1 to 3.

The data source for this indicator is the Australian Institute of Health and Welfare's Mental Health Establishments National Minimum Data Set, a national collection of establishment-level data for specialised mental health services under the Australian Institute of Health and Welfare [327]. Annual data for this indicator are available for the years 2012–2021, inclusive. The data are disaggregated by review level (services assigned to level 1, 2, 3, and 4) [184]. High or increasing proportions of patients seen within the recommended waiting times is desirable [30]. A high or increasing proportion of expenditure on specialised mental health services that have completed a review by an external accreditation agency and been assessed against the National Standards for Mental Health Services is desirable [30]. It should be noted that services that are undergoing review and services that have been booked for review and were engaged in self-assessment preparation at the time of data collection are not reported on in that particular reporting period. Therefore, if a service has not been assessed against the National Standards for Mental Health Services, this does not necessarily mean that the service in question is of lower quality [30].

3.10.4.1.1.3 The *Key Performance Indicators for Australian Public Mental Health Services*

As described in Section 3.1.3, the National Mental Health Performance Subcommittee established 16 key performance indicators for Australian public mental health services in order to address the 'Health system' dimension in the National Mental Health Performance Measurement Framework in Australia. This dimension contains six sub-domains ('Accessibility', 'Appropriateness', 'Continuity of care', 'Effectiveness', 'Efficiency and sustainability', and 'Safety') [55]. Of the 16 key performance indicators, 1 was deemed relevant to *Sharing the Vision* outcome 4(c) [39]. This indicator, which falls under the 'Effectiveness' sub-domain, is 'National mental health service standards compliance'. However, this indicator is the same indicator as the 'Services reviewed against the national standards' indicator included in the services for mental health performance indicator framework (see Section 3.10.4.1.1.2).

3.10.4.1.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.4.1.2.1 *The Fifth National Mental Health and Suicide Prevention Plan*

None of the performance indicators included in Australia's *Fifth National Mental Health and Suicide Prevention Plan* were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.1.2.2 The services for mental health performance indicator framework

The mental health section of the annual Report on Government Services does not explicitly identify indicator benefits and limitations. However, where relevant, we highlight any information provided that could be considered a benefit or a limitation of any given indicator.

In relation to 'Services reviewed against the national standards', the 2023 Report on Government Services states that while this indicator reflects progress made in meeting the National Standards for Mental Health Services [326], it cannot indicate whether the assessment process was appropriate [30].

3.10.4.1.2.3 The *Key Performance Indicators for Australian Public Mental Health Services*

The indicator specification web pages and the data tables for the 2020–21 indicator set provided by the Australian Institute of Health and Welfare describe the limitations associated with each of the key performance indicators for Australian public mental health services. The benefits associated with the indicators are not explicitly described.

As ‘National mental health service standards compliance’ is the same indicator as the ‘Services reviewed against the national standards’ indicator included in the services for mental health performance indicator framework, information pertaining to a limitation associated with this indicator can be found in Section 3.10.4.1.2.2.

3.10.4.2 Canada

3.10.4.2.1 What are the relevant mental health indicators?

3.10.4.2.1.1 *Informing the Future: Mental Health Indicators for Canada*

None of the mental health indicators included in *Informing the Future: Mental Health Indicators for Canada* were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.2.1.2 The Positive Mental Health Surveillance Indicator Framework

None of the outcome or determinant indicators included in the Positive Mental Health Surveillance Indicator Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.2.1.3 The Canadian Chronic Disease Indicators

None of the Canadian chronic disease indicators were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.2.1.4 The mental health and substance use indicators

None of the Canadian Institute for Health Information’s mental health and substance use indicators were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.3 England (UK)

3.10.4.3.1 What are the relevant mental health indicators?

3.10.4.3.1.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.3.1.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.3.1.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.3.1.4 The NHS mental health dashboard

As mentioned in Section 3.3.2.1, the NHS mental health dashboard includes a total of 55 indicators organised into 11 categories (‘Children and young people mental health’, ‘Perinatal mental health’, ‘Adult mental health (NHS talking therapies for depression and anxiety)’, ‘Early intervention in psychosis’, ‘Employment support’, ‘Physical health checks for people with severe mental illness’, ‘Crisis and acute care and use of the Mental Health Act’, ‘Acute hospital mental health liaisons’, ‘Health and justice’, ‘Mental health service backlog’, and ‘Meeting commitment to increase mental health funding’). The data reported on the NHS mental health dashboard are available by region, integrated care board, or sub-

integrated care board [41]. However, it should be noted that the NHS mental health dashboard publications provide limited information about the indicators. The following 5 out of the 55 indicators were deemed relevant to *Sharing the Vision* outcome 4(c) [92]:

1. Percentage of clinical commissioning group commissioned early intervention in psychosis services meeting National Institute for Health and Care Excellence (NICE) level 2
2. Percentage of clinical commissioning group commissioned early intervention in psychosis services meeting NICE level 3 or above
3. Percentage adult home treatment services staffed in line with recommended levels
4. Percentage of acute hospitals meeting the 'Core 24' service standard, and
5. Mental health liaison staffing levels.

'Percentage of clinical commissioning group commissioned early intervention in psychosis services meeting NICE level 2' is categorised under 'Early intervention in psychosis'. This indicator is a measure of the proportion of services graded at level 2 in the annual early intervention in psychosis self-assessment of specialist early intervention in psychosis service provision in line with NICE recommendations [228]. The scoring matrix for this self-assessment comprises three domains (timely access, effective treatment, and recording outcome measures), and an overall score is calculated from these domains. Each item, each domain, and an overall rating is scored at one of four levels [328]:

1. Level 1: Greatest need for improvement
2. Level 2: Needs improvement
3. Level 3: Performing well, and
4. Level 4: Top performing.

This indicator tracks progress against the national target of 100%. The data source for this indicator is the National Clinical Audit of Psychosis, an annual audit commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and NHS Improvement [328]. The National Clinical Audit of Psychosis is conducted by the Royal College of Psychiatrists in order to assess the ability of early intervention in psychosis services to provide timely access to NICE-approved packages of care [329]. The four-level rating scale outlined above was developed for the purposes of this audit [328]. *The NHS Long Term Plan* specified that by the end of the 2019–20 reporting period, all early intervention in psychosis services should be graded at least at NICE level 2. This indicator is reported on annually [41].

'Percentage of clinical commissioning group commissioned early intervention in psychosis services meeting NICE level 3 or above' is categorised under 'Early intervention in psychosis'. This indicator is a measure of the proportion of services graded at level 3 or above in the annual early intervention in psychosis self-assessment of specialist early intervention in psychosis service provision in line with NICE recommendations [228]. The indicator tracks progress against the national target outlined in *The NHS Long Term Plan*, which specified that by the end of the 2023–24 reporting period, 95% of services should provide NICE level 3 concordance care [328]. The data source and reporting period for this indicator are the same as those outlined for the previous indicator [41].

'Percentage adult home treatment services staffed in line with recommended levels' was also deemed relevant to *Sharing the Vision* outcome 4(c). Therefore, information pertaining to this indicator can be found in Section 3.10.3.3.1.4.

‘Percentage of acute hospitals meeting the ‘Core 24’ service standard’ is categorised under ‘Acute hospital mental health liaisons’. This indicator is a measure of the proportion of acute hospitals meeting all three Core 24 criteria. A liaison service is considered to be operating according to the Core 24 model if [41]:

1. The team is commissioned to operate as an on-site, distinct service on a 24/7 basis
2. The team is commissioned to deliver care in line with the recommended response times following referral (1 hour for emergency department referrals, 24 hours for urgent care ward referrals), and
3. The team is resourced in line with or close to the recommended liaison mental health staffing levels and skill mix in order to operate effectively and sustainably on a 24/7 rota.

This indicator tracks progress against the national standard: the baseline for this was set at 7% in *The NHS Long Term Plan* in 2015, and it was increased to 20% in 2018–19, 50% in 2020–21, and 70% by 2023–24, working towards 100% coverage thereafter [330]. The data source for this indicator is the Survey of Liaison Psychiatry in England (see Section 3.8.1.3.1.4) [236]. The most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) states that this indicator is reported annually, and that data are available at the Sustainability and Transformation Partnership, regional, and national levels [41].

‘Mental health liaison staffing levels’ was also deemed relevant to *Sharing the Vision* outcome 4(c). Therefore, information pertaining to this indicator can be found in Section 3.10.3.3.1.4.

3.10.4.3.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.4.3.2.1 The Public Health Outcomes Framework

None of the outcome or supporting indicators included in the Public Health Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.3.2.2 The Adult Social Care Outcomes Framework

None of the outcome indicators included in the Adult Social Care Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.3.2.3 The NHS Outcomes Framework

None of the outcome or improvement area indicators included in the NHS Outcomes Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.3.2.4 The NHS mental health dashboard

The NHS mental health dashboard publications do not explicitly describe the benefits and limitations associated with the 55 indicators included in the dashboard.

3.10.4.4 New Zealand

3.10.4.4.1 What are the relevant mental health indicators?

3.10.4.4.1.1 *He Ara Oranga wellbeing outcomes framework*

None of the outcome indicators included in the Mental Health and Wellbeing Commission’s *He Ara Oranga wellbeing outcomes framework* were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.4.1.2 The Key Performance Indicator Programme

None of the indicators included in the Key Performance Indicator Programme were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.4.1.3 *National Indicators 2012*

None of the mental health and addiction indicators included in the Mental Health and Wellbeing Commission's *National Indicators 2012* report were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.5 Scotland (UK)

3.10.4.5.1 What are the relevant mental health indicators?

3.10.4.5.1.1 Public Health Scotland mental health indicators

None of the outcome and determinant indicators included in the Public Health Scotland mental health indicators were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.5.1.2 The National Performance Framework

None of the indicators included in the National Performance Framework were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.5.1.3 Quality Indicator Profile for Mental Health

None of the quality indicators included in the Quality Indicator Profile for Mental Health were deemed relevant to *Sharing the Vision* outcome 4(d).

3.10.4.6 The OECD

3.10.4.6.1 What are the relevant mental health indicators?

3.10.4.6.1.1 The OECD Mental Health System Performance Benchmark

As mentioned in Section 3.6.1, the OECD Mental Health System Performance Benchmark includes a set of 23 benchmarking indicators for measuring mental health performance in OECD member countries across 6 dimensions ('Person-centred mental health policies and services', 'Accessible, high-quality mental health services', 'An integrated and multi-sectoral approach to mental health', 'Preventing mental illness and promoting mental well-being', 'Strong leadership and good governance', and 'Building future-focused and innovative mental health systems') [27]. Of these indicators, four were deemed relevant to *Sharing the Vision* outcome 4(d). It should be noted that limited information pertaining to the development and nature of the indicators is provided in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*. The four indicators are [27]:

1. Patient-reported outcomes (dimension 1, 'Person-centred mental health policies and services')
2. Use of telemedicine in mental health services (dimension 6, 'Building future-focused and innovative mental health systems')
3. Availability of mental health indicators – national mental health data set (dimension 6, 'Building future-focused and innovative mental health systems'), and
4. Availability of mental health indicators – OECD Healthcare Quality and Outcomes (HCQO) mental health indicators (dimension 6, 'Building future-focused and innovative mental health systems').

'Patient-reported outcomes' was also deemed relevant to *Sharing the Vision* outcome 2(b), and so further information pertaining to this indicator can be found in Section 3.8.2.6.1.1.

'Use of telemedicine in mental health services' is presented in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* as an innovative and future-focused new approach to mental health support, and as critical for better understanding system performance. However, as of the publication of that report in 2021, the indicator was not yet internationally available because it was not yet possible to report it in a consistent way across countries [27].

‘Availability of mental health indicators – national mental health dataset’ was also deemed relevant to *Sharing the Vision* outcome 4(a), and so further information pertaining to this indicator can be found in Section 3.10.1.6.1.1.

‘Availability of mental health indicators – OECD HCQO mental health indicators’ was also deemed relevant to *Sharing the Vision* outcome 4(b), and so further information pertaining to this indicator can be found in Section 3.10.2.6.1.1.

3.10.4.6.2 What are the reported benefits and challenges regarding the use of these indicators for mental health policy?

3.10.4.6.2.1 The OECD Mental Health System Performance Benchmark

There were no explicit benefits or limitations associated with the benchmarking indicators deemed relevant to *Sharing the Vision* outcome 4(d) described in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* [27].

3.11 Indicator analysis

As described in Section 2.7, we undertook an analysis of the collection of indicators considered relevant to each of the 15 high-level outcomes in *Sharing the Vision* in order to determine which could be used as indicators of these outcomes, regardless of how they were identified in their respective indicator sets. As part of this analysis process, we identified two other types of indicators that will be important to consider when measuring the performance and impact of *Sharing the Vision*: mental health determinant indicators and service quality indicators. This findings section summarises the overarching themes of outcome, determinant, and/or quality indicators that we identified under each high-level outcome.

3.11.1 Outcome domain 1 analysis

3.11.1.1 Outcome 1(a): Positive mental health, resilience and psychological wellbeing amongst the population as a whole

A total of 85 indicators were deemed relevant to *Sharing the Vision* outcome 1(a); 44 were considered outcome/proxy outcome indicators, 39 were considered determinant/proxy determinant indicators, and 2 were excluded from this summary, as they were considered output indicators which merely describe the delivery of agreed products [15] (see Section 1.1). These indicators were drawn from 10 indicator sets from all five of the selected countries and the OECD. For the purposes of this evidence brief, the outcome/proxy outcome indicators have been organised into five overarching indicator themes, which are outlined in Table 2 along with example indicators. The determinant and proxy determinant indicators were organised according to the following ecological levels: individual determinants, family- and friends-related determinants, community determinants, and learning environment determinants. These are outlined in Table 3 along with example indicators. As noted in Section 2.7, there was significant overlap between the outcome indicators and determinant indicators across the indicator sets in outcome domain 1.

Tab 3 ('HRB_Analysis_Summaries_Domain1') of the supplementary Excel spreadsheet provides an overview of all indicator themes and their constituent outcome/proxy outcome and determinant/proxy determinant indicators for all four high-level outcomes in outcome domain 1.

Table 2 Outcome 1(a) outcome indicator themes and example indicators

	Outcome 1(a) outcome indicators
Theme	**Positive mental health and well-being**
Description	Indicators of positive mental health and well-being
Number of indicators	8 outcome indicators 7 proxy outcome indicators
Example indicator	'Psychological wellbeing'
Theme	**Poor mental health and well-being**
Description	Indicators of poor mental health/well-being, excluding mental health disorders
Number of indicators	0 outcome indicators 6 proxy outcome indicators
Example indicator	'Chronic stress'
Theme	**Life satisfaction**
Description	Indicators of life satisfaction, sense of control over life, and feeling that life is worthwhile
Number of indicators	7 outcome indicators 4 proxy outcome indicators
Example indicator	'The proportion of people who score 7 out of 10 or higher for life satisfaction'
Theme	**Social well-being**
Description	Indicators of social well-being
Number of indicators	7 outcome indicators 2 proxy outcome indicators
Example indicator	'A sense of belonging'
Theme	**Poor social well-being**
Description	Indicators of poor social well-being, isolation, or loneliness
Number of indicators	1 outcome indicator 2 proxy outcome indicators
Example indicator	'Loneliness: percentage of adults who feel lonely often or always or some of the time'

Table 3 Outcome 1(a) determinant indicator themes and example indicators

	Outcome 1(a) determinant indicators
Theme	**Individual determinants of mental health outcomes**
Description	Indicators of individual-level characteristics that influence mental health
Number of indicators	3 determinant indicators 6 proxy determinant indicators
Example indicator	'Child social and physical development'
Theme	**Family- and friends-related determinants of mental health outcomes**
Description	Indicators of family and friend relationships that influence mental health
Number of indicators	5 determinant indicators 1 proxy determinant indicator
Example indicator	'Communication with parents'
Theme	**Community determinants of mental health outcomes**
Description	Indicators of community-level factors that influence mental health
Number of indicators	13 determinant indicators 6 proxy determinant indicators
Example indicator	'Adult involvement in their local community'
Theme	**Learning environment determinants of mental health outcomes**
Description	Indicators of factors in one's learning environment that influence mental health
Number of indicators	5 determinant indicators 0 proxy determinant indicators
Example indicator	'Liking school'

3.11.1.2 Outcome 1(b): Positive mental health, resilience, and psychological wellbeing amongst priority groups…through targeted promotion and preventive mechanisms

A total of nine indicators were deemed relevant to Sharing the Vision outcome 1(b), all of which were considered proxy outcome indicators (none of the indicators deemed relevant to this high-level outcome were explicitly described as outcome indicators). These indicators were drawn from two indicator sets from two of the selected countries (Canada and England). For the purposes of this evidence brief, the indicators have been organised into three overarching indicator themes, which are outlined in Table 4 along with example indicators. The priority groups emphasised in the two indicator sets were immigrants; lesbian, gay, or bisexual individuals; residents of Northern communities in Canada; people with mental health difficulties; and children in care. However, these indicators may be adapted in order to measure outcomes in any priority group.

Table 4 Outcome 1(b) outcome indicator themes and example indicators

	Outcome 1(b) outcome indicators
Theme	**Positive mental health and well-being**
Description	Indicators of positive mental health and well-being
Number of indicators	0 outcome indicators 4 proxy outcome indicators
Example indicator	'Self-rated mental health – residents of Northern communities'
Theme	**Poor mental health and well-being**
Description	Indicators of poor overall mental health/well-being, excluding mental health disorders
Number of indicators	0 outcome indicators 4 proxy outcome indicators
Example indicator	'Stress – lesbian, gay, or bisexual individuals'
Theme	**Social well-being**
Description	Indicators of social well-being
Number of indicators	0 outcome indicators 1 proxy outcome indicator
Indicator	'Sense of belonging among immigrants'

3.11.1.3 Outcome 1(c): Reduced stigma and discrimination arising through improved community wide understanding of mental health difficulties

A total of 8 indicators were deemed relevant to *Sharing the Vision* outcome 1(c); 6 were considered outcome/proxy outcome indicators and 6 were considered determinant indicators. These indicators were drawn from six indicator sets from four of the selected countries (Australia, Canada, New Zealand, and Scotland). The outcome and proxy outcome indicators were organised into two overarching indicator themes, which are outlined in Table 5 along with example indicators. The two determinant indicators are essentially the same indicator, except one was drawn from the adult version of a mental health indicator set and the other was drawn from the children and young people version of the same indicator set. These are outlined in Table 6.

Table 5 Outcome 1(c) outcome indicator themes and example indicators

	Outcome 1(c) outcome indicators
Theme	**Experience of stigma and discrimination**
Description	Indicators of stigma and discrimination experienced by people with mental health difficulties
Number of indicators	1 outcome indicator 3 proxy outcome indicators
Example indicator	'Stigma and discrimination experienced by people living with mental health problems or mental illness'
Theme	**Outcomes of initiatives to reduce stigma**
Description	Indicators of the success of initiatives to reduce perceived mental health stigma in society
Number of indicators	1 outcome indicator 1 proxy outcome indicator
Example indicator	'The proportion of people who say it would be 'easy' or 'very easy' to talk to someone if they felt down or a bit depressed'

Table 6 Outcome 1(c) determinant indicator theme and example indicators

	Outcome 1(c) determinant indicators
Theme	**Structural determinants of mental health outcomes**
Description	Indicators of structural factors that can lead to adverse mental health outcomes
Number of indicators	2 determinant indicators 0 proxy determinant indicators
Indicators	'Stigma around mental health' (adult mental health indicator set) 'Mental health stigma' (children and young people mental health indicator set)

3.11.1.4 Outcome 1(d): Reduced prevalence of mental health difficulties and/or reduced severity of impact(s) through early intervention and prevention work

A total of 24 indicators were deemed relevant to *Sharing the Vision* outcome 1(d); 21 were considered outcome/proxy outcome indicators, 2 were considered proxy determinant indicators, and 1 was excluded from this summary as it was considered an output indicator. These indicators were drawn from seven indicators sets from all five of the selected countries. For the purposes of this evidence brief, the outcome/proxy outcome indicators have been organised into two overarching indicator themes, which are outlined in Table 7 along with example indicators. The two proxy determinant indicators were very similar despite coming from different indicator sets, with both representing developmental vulnerability in children. These are outlined in Table 8.

Table 7 Outcome 1(d) outcome indicator themes and example indicators

	Outcome 1(d) outcome indicators
Theme	**Prevalence of mental ill health - general**
Description	Indicators of the prevalence of mental health difficulties generally
Number of indicators	5 outcome indicators 4 proxy outcome indicators
Example indicator	'Prevalence of mental illness'
Theme	**Prevalence of mental ill health - specific conditions**
Description	Indicators of the prevalence of specific mental health conditions
Number of indicators	4 outcome indicators 8 proxy outcome indicators
Example indicator	'Adults with moderate or high severity symptoms of depression'

Table 8 Outcome 1(d) determinant indicator theme and example indicators

	Outcome 1(d) determinant indicators
Theme	**Individual determinants of mental health conditions**
Description	Indicators of individual characteristics that influence the development of mental health conditions
Number of indicators	0 determinant indicators 2 proxy determinant indicators
Indicators	'Children who are developmentally vulnerable' 'Vulnerable children – general population'

3.11.2 Outcome domain 2 analysis

3.11.2.1 Outcome 2(a): All service users have access to timely, evidence informed interventions

A total of 56 indicators were deemed relevant to *Sharing the Vision* outcome 2(a); 31 were considered proxy outcome indicators (none of the indicators deemed relevant to this outcome were explicitly described as outcome indicators), 12 were considered quality/proxy quality indicators, and 13 were excluded from this summary as they were considered output indicators. The indicators were drawn from 10 indicator sets from all 5 of the selected countries and the OECD. For the purposes of this evidence brief, the proxy outcome indicators have been grouped into four overarching indicator themes, which are outlined in Table 9 along with example indicators. The quality/proxy quality indicators were organised into two overarching indicator themes, which are outlined in Table 10 along with example indicators.

Tab 4 ('HRB_Analysis_Summaries_Domain2') of the supplementary Excel spreadsheet provides an overview of all indicator themes and their constituent outcome/proxy outcome and quality/proxy quality indicators for all four high-level outcomes under outcome domain 2.

Table 9 Outcome 2(a) outcome indicator themes and example indicators

	Outcome 2(a) outcome indicators
Theme	**Direct service access indicators**
Description	Direct indicators of service access as an outcome
Number of indicators	0 outcome indicators 7 proxy outcome indicators
Example indicator	'Population access to clinical mental health care'
Theme	**Direct service access indicators – timeliness of mental health assessment and care**
Description	Waiting time indicators that indirectly address service access as an outcome
Number of indicators	0 outcome indicators 13 proxy outcome indicators
Example indicator	'Wait times for community mental health counselling'
Theme	**Indirect service access indicators – unmet need**
Description	Unmet need indicators that indirectly address service access as an outcome
Number of indicators	0 outcome indicators 6 proxy outcome indicators
Example indicator	'Unmet need for mental health care among people with mental disorders'
Theme	**Indirect service access indicators – miscellaneous**
Description	All other indicators that indirectly address service access as an outcome
Number of indicators	0 outcome indicators 5 proxy outcome indicators
Example indicator	'Mental health new client index'

Table 10 Outcome 2(a) quality indicator themes and example indicators

	Outcome 2(a) quality indicators
Theme	**Indirect access indicators – inappropriate care**
Description	Quality indicators that indirectly measure service access by providing insight into inappropriate care that may occur due to a lack of access
Number of indicators	3 quality indicators 5 proxy quality indicators
Example indicator	'Number of days people spend in hospital when they are ready to be discharged per 1,000 population'
Theme	**Indirect access indicators – length of stay and discharges**
Description	Quality indicators that indirectly measure service access via length of hospital stay and hospital discharges (e.g. prolonged length of hospital stay indirectly indicates a lack of access to community-based care)
Number of indicators	0 quality indicators 4 proxy quality indicators
Example indicator	'Individuals hospitalised for more than 30 days in a year'

3.11.2.2 Outcome 2(b): Service delivery is organised to enable increased numbers of people to achieve personal recovery

A total of 18 indicators were deemed relevant to *Sharing the Vision* outcome 2(b); 6 were considered outcome/proxy outcome indicators, 10 were considered quality/proxy quality indicators, and 2 were

excluded from this summary as it was considered an output indicator. The indicators were drawn from 10 indicator sets from all 5 of the selected countries and the OECD. For the purposes of this evidence brief, the outcome/proxy outcome indicators have been grouped into one overarching indicator theme, which is outlined in Table 11 along with an example indicator. The quality/proxy quality indicators were also organised into one overarching indicator theme, which is outlined in Table 12 along with an example indicator.

Table 11 Outcome 2(b) outcome indicator theme and example indicator

	Outcome 2(b) outcome indicators
Theme	**Patient recovery outcomes**
Description	Indicators of patient-reported and clinician-observed recovery outcomes
Number of indicators	1 outcome indicator 6 proxy outcome indicators
Example indicator	'Mental health outcomes of consumers of specialised public mental health services'

Table 12 Outcome 2(b) quality indicator theme and example indicator

	Outcome 2(b) quality indicators
Theme	**Service effectiveness and efficiency**
Description	Quality indicators of effectiveness and efficiency in mental health services that indirectly measure mental health service organisation
Number of indicators	2 quality indicators 8 proxy quality indicators
Example indicator	'One-year rate of repeat hospitalisations for persons with a mental illness'

3.11.2.3 Outcome 2(c): Services are coordinated through a 'stepped care' approach to provide continuity of care that will deliver the best possible outcomes for each service user

A total of 42 indicators were deemed relevant to *Sharing the Vision* outcome 2(c); 17 were considered outcome/proxy outcome indicators, 20 were considered quality/proxy quality indicators, and 5 were excluded from this summary as they were considered output indicators or ineligible for inclusion. The indicators were drawn from 11 indicator sets from all 5 of the selected countries and the OECD. For the purposes of this evidence brief, the outcome/proxy outcome indicators have been grouped into three overarching indicator themes, which are outlined in Table 13 along with example indicators. The quality/proxy quality indicators were organised into two overarching indicator themes, which are outlined in Table 14 along with example indicators.

Table 13 Outcome 2(c) outcome indicator themes and example indicators

	Outcome 2(c) outcome indicators
Theme	**Patient recovery outcomes**
Description	Indicators of patient-reported and clinician-observed outcomes
Number of indicators	1 outcome indicator 3 proxy outcome indicators
Example indicator	'Total health gain as assessed by patients for elective procedures – psychological therapies'
Theme	**Direct indicators of continuity of care – mental health services**
Description	Indicators that directly measure continuity of care between acute and community-based mental health services
Number of indicators	0 outcome indicators 7 proxy outcome indicators
Example indicator	'Post-discharge community mental health care'
Theme	**Direct indicators of continuity of care – mental and physical health services**
Description	Indicators that directly measure continuity of care between mental and physical health care services
Number of indicators	1 outcome indicator 5 proxy outcome indicators
Example indicator	'Physical health outcomes for people with a mental illness'

Table 14 Outcome 2(c) quality indicator themes and example indicators

	Outcome 2(c) quality indicators
Theme	**Indirect indicators of continuity of care – mental health services**
Description	Quality indicators that indirectly measure continuity of care between mental health services (e.g. repeat hospital readmissions and prolonged length of hospital stay indirectly indicate a lack of continuity between acute and community-based mental health care)
Number of indicators	5 quality indicators 10 proxy quality indicators
Example indicator	'One-year rate of repeat hospitalisations for persons with a mental illness'
Theme	**Indirect indicators of continuity of care – mental and physical health services**
Description	Quality indicators that indirectly measure collaboration between physical and mental health services
Number of indicators	3 quality indicators 2 proxy quality indicators
Example indicator	'Percentage of people with severe and enduring mental illness and/or learning disability who have had an annual health check within the previous 12 months'

3.11.2.4 Outcome 2(d): Health outcomes for people with dual diagnosis are improved by ensuring greater collaboration between mental health and other relevant services

Only one indicator was deemed relevant to *Sharing the Vision* outcome 2(d), which was drawn from the Canadian mental health and substance use indicators [42]. This indicator is 'Navigation of mental health

and substance use services' (see Section 3.8.2.2.1.4). However, the indicator was excluded from this summary as it was considered an output indicator.

3.11.3 Outcome domain 3 analysis

3.11.3.1 Outcome 3(a): Service users are respected, connected, and valued in their community

A total of 10 indicators were deemed relevant to *Sharing the Vision* outcome 3(a), all of which were considered outcome/proxy outcome indicators. These indicators were drawn from five indicator sets from four of the selected countries (Australia, Canada, New Zealand, and Scotland). The indicators were organised into three overarching indicator themes, which are outlined in Table 15 along with example indicators.

Tab 5 ('HRB_Analysis_Summaries_Domain3') of the supplementary Excel spreadsheet provides an overview of all indicator themes and their constituent outcome/proxy outcome and determinant/proxy determinant indicators for all three high-level outcomes under outcome domain 3.

Table 15 Outcome 3(a) outcome indicator themes and example indicators

	Outcome 3(a) outcome indicators
Theme	**Stigma and discrimination**
Description	Indicators of stigma or discrimination experienced by people with mental health difficulties
Number of indicators	1 outcome indicator 3 proxy outcome indicators
Example indicator	'Experience of discrimination in people with mental illness'
Theme	**Sense of belonging**
Description	Indicators of a sense of belonging in people with mental health difficulties
Number of indicators	0 outcome indicators 3 proxy outcome indicators
Example indicator	'Connectedness and meaning in life'
Theme	**Social functioning**
Description	Indicators of social functioning in people with mental health difficulties
Number of indicators	1 outcome indicator 2 proxy outcome indicators
Example indicator	'Social participation in adults with mental illness'

3.11.3.2 Outcome 3(b): Increased ability of service users to manage their own lives [self-determination] via stronger social relationships and sense of purpose

A total of seven indicators were deemed relevant to *Sharing the Vision* outcome 3(b), all of which were considered outcome/proxy outcome indicators. These indicators were drawn from five indicator sets from four of the selected countries (Australia, Canada, England, and Scotland). The indicators were organised into three overarching indicator themes, which are outlined in Table 16 along with example indicators. It should be noted that several of the indicators deemed relevant to outcome 3(b) were also deemed relevant to outcome 3(a), given the similarities between the outcomes in relation to social relationships and community connectedness. As a result, there is substantial overlap between the indicators selected to assess these two high-level outcomes.

Table 16 Outcome 3(b) outcome indicator themes and example indicators

	Outcome 3(b) outcome indicators
Theme	**Improved quality of life**
Description	Indicators of improved quality of life for people with mental health difficulties
Number of indicators	0 outcome indicators 2 proxy outcome indicators
Example indicator	'Recovery in quality of life for patients with mental illness'
Theme	**Sense of belonging**
Description	Indicators of a sense of belonging in people with mental health difficulties
Number of indicators	0 outcome indicator 2 proxy outcome indicators
Example indicator	'Sense of belonging – people with mental health conditions'
Theme	**Social functioning**
Description	Indicators of social functioning in people with mental health difficulties
Number of indicators	1 outcome indicators 2 proxy outcome indicators
Example indicator	'Percentage of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month'*

*For this indicator, 'functioning' was defined as social functioning including employment, education, and participation in social activities [120] (see Section 3.9.1.5.1.3).

3.11.3.3 Outcome 3(c): Improved outcomes in relation to education, housing, employment, and income for service users relative to the population as a whole (i.e. reduced disparity)

A total of 19 indicators were deemed relevant to *Sharing the Vision* outcome 3(c); 14 were considered outcome/proxy outcome indicators, 2 were considered proxy determinant indicators, and 3 were excluded from this summary as they were considered output indicators. These indicators were drawn from 10 indicator sets from all 5 selected countries and the OECD. For the purposes of this evidence brief, the outcome/proxy outcome indicators have been organised into two overarching indicator themes, which are outlined in Table 17Table 17 Outcome 3(c) outcome indicator themes and example indicators along with example indicators. The two proxy determinant indicators were both considered structural determinants of mental health outcomes, as both assessed the gap in employment between people with mental health conditions and the general population. These are outlined in Table 18 along with an example indicator.

Table 17 Outcome 3(c) outcome indicator themes and example indicators

	Outcome 3(c) outcome indicators
Theme	**Socioeconomic functioning**
Description	Indicators of how people with mental health difficulties are functioning in relation to socioeconomic variables such as employment, education, and housing
Number of indicators	3 outcome indicators 9 proxy outcome indicators
Example indicator	'Proportion of adults in contact with secondary mental health services in paid employment'
Theme	**Socioeconomic satisfaction**
Description	Indicators of how satisfied people with mental health difficulties are in relation to their socioeconomic situation
Number of indicators	0 outcome indicators 2 proxy outcome indicators
Example indicator	'Employed and satisfied with job'

Table 18 Outcome 3(c) determinant indicator theme and example indicator

	Outcome 3(c) determinant indicators
Theme	**Structural determinants of mental health outcomes**
Description	Indicators of structural factors that can lead to adverse mental health outcomes
Number of indicators	0 determinant indicators 2 proxy determinant indicators
Example indicator	'Gap in the employment rate between those with a long-term physical or mental health condition (16–64 years) and the overall employment rate'

3.11.4 Outcome domain 4 analysis

3.11.4.1 Outcome 4(a): Mental health is embedded as a national cross cutting priority that is effectively integrated into the key policies and settings in society

Only one indicator was deemed relevant to *Sharing the Vision* outcome 4(a), which was drawn from the OECD Mental Health System Performance Benchmark [27]. This indicator is 'Availability of mental health indicators – national mental health data set' (see Section 3.10.1.6.1.1). However, the indicator was excluded from this summary, as it was considered an output indicator.

3.11.4.2 Outcome 4(b): Dynamic performance reporting provides visibility of the performance and impact of *Sharing the Vision*

Only one indicator was deemed relevant to *Sharing the Vision* outcome 4(b), which was drawn from the OECD Mental Health System Performance Benchmark [27]. This indicator is 'Availability of mental health indicators – OECD Healthcare Quality and Outcomes (HCQO) mental health indicators' (see Section 3.10.2.6.1.1). However, the indicator was excluded from this summary, as it was considered an output indicator.

3.11.4.3 Outcome 4(c): Services that deliver consistently high-quality person-centred supports that meet the needs and have the confidence of service users and family, carers, and supporters

A total of 33 indicators were deemed relevant to *Sharing the Vision* outcome 4(c); 6 were considered proxy outcome indicators (none of the indicators deemed relevant to this outcome were explicitly described as outcome indicators), 21 were considered quality/proxy quality indicators, 5 were excluded from this summary, as they were considered output indicators, and 1 was excluded from this summary because it is not yet available for reporting and is not well defined, so it was not possible to place the indicator into an overarching theme (see 'Mental health consumer outcomes participation' in Section 3.10.3.1.1.3). The 33 indicators were drawn from 9 indicator sets from 4 of the selected countries (Australia, England, New Zealand, and Scotland) and the OECD. For the purposes of this evidence brief, the proxy outcome indicators have been grouped into one overarching indicator theme, which is outlined in Table 19 along with an example indicator. The quality/proxy quality indicators were organised into four overarching indicator themes, which reflect the various aspects of mental health care covered under outcome 4(c), including patient experience and the quality and safety of care. These are outlined in Table 20 along with example indicators.

Tab 6 ('HRB_Analysis_Summaries_Domain4') of the supplementary Excel spreadsheet provides an overview of all indicator themes and their constituent outcome/proxy outcome and quality/proxy quality indicators for all four high-level outcomes under outcome domain 4.

Table 19 Outcome 4(c) outcome indicator theme and example indicator

	Outcome 4(c) outcome indicators
Theme	**Patient and carer experience**
Description	Indicators of patient and carer experience of mental health services
Number of indicators	0 outcome indicators 6 proxy outcome indicators
Example indicator	'Patient experience of community mental health services'

Table 20 Outcome 4(c) quality indicator themes and example indicators

	Outcome 4(c) quality indicators
Theme	**Respecting patients' wishes**
Description	Indicators related to respecting the wishes of patients with regard to their treatment
Number of indicators	1 quality indicator 0 proxy quality indicators
Indicator	'Number of people with advance statements registered per year with the Mental Welfare Commission for Scotland'
Theme	**Involuntary detention and restrictive practices**
Description	Indicators related to involuntary detention and restrictive practices, including seclusion and restraint
Number of indicators	1 quality indicator 12 proxy quality indicators
Example indicator	'Seclusion rate'
Theme	**Patient safety**
Description	Indicators of patient safety, including adverse events and inappropriate prescribing
Number of indicators	3 quality indicators 2 proxy quality indicators
Example indicator	'Incidents of physical violence per 1,000 occupied psychiatric bed days'
Theme	**Staffing levels**
Description	Indicators related to the adequacy of staffing levels in mental health services
Number of indicators	0 quality indicators 2 proxy quality indicators
Example indicator	'Percentage adult home treatment services staffed in line with recommended levels'

3.11.4.4 Outcome 4(d): Continuous improvement is future focussed and driven by adequately resourced innovation across the mental health system and related sectors

A total of 10 indicators were deemed relevant to this *Sharing the Vision* outcome 4(d); none of the indicators deemed relevant to this outcome were considered outcome or proxy outcome indicators, 6 were considered proxy quality indicators (none of the indicators deemed relevant to this outcome were explicitly described as quality indicators), and 4 were excluded from this summary because they were considered output indicators. The indicators were drawn from three indicators sets from two of the selected countries (Australia and England) and the OECD. The proxy quality indicators were organised into two overarching indicator themes, which are outlined in Table 21 along with example indicators.

Table 21 Outcome 4(d) quality indicator themes and example indicators

	Outcome 4(d) quality indicators
Theme	**Service standards**
Description	Indicators of whether mental health services are meeting quality standards
Number of indicators	0 quality indicators 4 proxy quality indicators
Example indicator	'Services reviewed against the national standards'
Theme	**Staffing levels**
Description	Indicators related to staffing levels in mental health services
Number of indicators	0 quality indicators 2 proxy quality indicators
Indicator	'Mental health liaison staffing levels'

3.12 How are indicators used to monitor and evaluate mental health policies/plans/strategies?

This section describes how the indicator sets and frameworks identified for each of the included countries are used to monitor and/or evaluate a national mental health policy/plan/strategy. Note that the use of indicators for monitoring and evaluating policy will only be described for the indicators that have been developed or co-opted in order to monitor and evaluate a mental health policy/plan/strategy in each country (i.e. indicators that are reported on independently of a mental health policy/plan/strategy (such as the Canadian Institute for Health Information's mental health and substance use indicators, and the key performance indicators for Australian public mental health services) are not described in this section).

3.12.1 Australia

3.12.1.1 The Fifth National Mental Health and Suicide Prevention Plan

As mentioned in Section 3.1.1, *The Fifth National Mental Health and Suicide Prevention Plan* in Australia included a set of 24 nationally agreed performance indicators organised into 7 domains and mapped onto one or more of the 8 priority areas. The Australian Government committed to measuring and reporting on these indicators over the lifespan of The Fifth Plan [21].

Australia's National Mental Health Commission is responsible for publishing an annual progress report on the implementation progress of The Fifth Plan's actions and performance against the identified indicators. To date, four progress reports have been published [47,280,331,332]. As per Action v of The Fifth Plan [21], the first progress report (which was published in 2018) established a baseline for each indicator against which subsequent reporting measured (and presumably will continue to measure) performance [331].

Each progress report contains a dedicated section for the strategy performance indicators, which provides an update on the status of the indicators (i.e. an overview of which indicators are (un)available for reporting) and a broad overview of the limitations of the collection of indicators as a whole. The reports then provide selected high-level analyses for the available indicators, with commentary on trends over time and progress towards the desired outcomes. All four progress reports to date have broadly distinguished between indicators of the mental health and well-being of Australians and indicators of mental health system performance. In particular, the second progress report (which was published in 2019) provides more in-depth commentary on what the data can and cannot tell us for each of the available indicators [332]. Additional data, data disaggregation, and importantly, data on performance trends over time are made available alongside each progress report in a downloadable Excel spreadsheet [331]. There does not appear to be an official system or framework by which the indicators are used to monitor the progress and performance of The Fifth Plan; rather, the progress reports provide a narrative overview of performance against the identified indicators.

Implementation of *The Fifth National Mental Health and Suicide Prevention Plan* was expected to finish in 2022. However, at the time this evidence brief was completed (September 2023), there had not yet been a progress report published for the year 2022, or an official evaluation of the impact and overall performance of The Fifth Plan against the indicators (should these become available, they will be published on the National Mental Health Commission's web page for The Fifth Plan [48]).

3.12.2 Canada

3.12.2.1 Informing the Future: Mental Health Indicators for Canada

As mentioned in Section 3.2.1.1, the Mental Health Commission of Canada's publication of *Informing the Future: Mental Health Indicators for Canada* in 2015 [31] was considered an important step in the implementation of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, Canada's 10-year national mental health strategy, which was published in 2012 [59]. *Informing the Future: Mental Health Indicators for Canada* presented a total of 55 mental health indicators that were mapped onto the 6 strategic directions outlined in [59].

In *Informing the Future: Mental Health Indicators for Canada*, each indicator was given a colour to illustrate its status, as follows [31]:

- Green indicated good performance and/or that the indicator was moving in a desirable direction.
- Yellow indicated no change, some concern, or uncertain results (e.g. an increase in the diagnosis rate of a mental health condition could either mean that the prevalence is increasing or that healthcare professionals are getting better at detecting it).
- Red indicated significant concerns and/or that the indicator was moving in an undesirable direction.

The 2015 report, *Informing the Future: Mental Health Indicators for Canada*, appears to be the first and only official report on this set of mental health indicators. However, for the purposes of that publication, historical data for each indicator were gathered in order to analyse trends over time, where possible. The report initially presents a dashboard which lists the 55 indicators alongside their corresponding strategic direction, overall result, and performance status, which is illustrated by either a green, yellow, or red dot. A more detailed description (i.e. a definition, rationale, etc.) of each indicator is provided later in the report, including a more detailed explanation of the indicator's status. For example, the indicator 'Employment among people with common mental health conditions' (see Section 3.9.3.2.1.1 of this evidence brief) was given a red status because, even though the percentage of people with a common mental health condition who worked at a job or business in 2011–12 (the most recent period for which data were available for the indicator) had remained stable since 2003 (the earliest period for which data were available for the indicator), it remained lower than the rate for the general population [31].

It is worth noting that, while the publication of the mental health indicators in *Informing the Future: Mental Health Indicators for Canada* was considered an important step in the implementation of the national mental health strategy, it appears as though the use of the traffic light system in the 2015 report provides information on the performance of the individual indicators rather than on the use of the indicators to monitor or evaluate the progress and performance of the national mental health strategy itself.

3.12.3 England (UK)

3.12.3.1 The Public Health Outcomes Framework, the Adult Social Care Outcomes Framework, and the NHS Outcomes Framework

As mentioned in Section 3.3.1, in 2011, the UK Government launched *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, an outcomes-based national strategy for mental health which sought to improve services and bring about a transformation in public attitudes towards mental health [69]. The Strategy encompassed six high-level mental health objectives along with several key areas for action under each objective. The Strategy's implementation framework [70], which was published in 2012, states that the high-level objectives are consistent with the indicators from three outcomes frameworks: the Public Health Outcomes Framework [33], the Adult Social Care Outcomes Framework [34], and the NHS Outcomes Framework [35]. There is some overlap between the

three frameworks; however, the Strategy states that, "Together, [the frameworks] will provide a coherent and comprehensive approach to tracking national progress against an agreed range of critical outcomes" [69 p47]. While the implementation framework provides examples of how the indicators might be used to achieve this, we could not find any reports (e.g. progress reports or evaluations of the Strategy) that described how the frameworks were subsequently used to track national progress against the outcomes identified in *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. This is likely because, while the high-level objectives set out in the Strategy are consistent with the indicators in the frameworks, the frameworks were established independently of the Strategy.

3.12.3.2 The NHS mental health dashboard

As mentioned in Section 3.3.2.1, the NHS mental health dashboard (formerly called the Mental Health Five Year Forward View Dashboard) was established in order to track the delivery of the national ambitions for mental health that were first set out in *The Five Year Forward View for Mental Health* and subsequently in *The NHS Long Term Plan* [94]. The NHS mental health dashboard, which contains a total of 55 performance indicators categorised into 11 domains, presents key data from across the mental health services in England in order to assess the NHS's performance in delivering the targets set out in both plans (*The Five Year Forward View for Mental Health* and *The NHS Long Term Plan*) [94]. Each quarterly issue of the NHS mental health dashboard is available as a downloadable Excel file that contains a Dashboard tab, which provides the following information for each indicator: the value, the standard met, trend data, information about whether a higher or lower value is considered better for the indicator, and the percentage change (from 12 months prior and 24 months prior) [92]. In relation to the standard met in particular, a colour system indicates whether the indicator's performance is better (green circle) or worse (red circle) than the national standard set for the indicator in *The Five Year Forward View for Mental Health* and subsequently in *The NHS Long Term Plan* (but not all indicators are linked to national standards or targets; for example, see 'Percentage of acute hospitals meeting the 'Core 24' service standard' indicator in Section 3.10.4.3.1.4 of this evidence brief). Where relevant, the national standards are reported alongside the description of each indicator in the Metadata tab in each quarterly issue of the NHS mental health dashboard. To provide an example, the indicator 'NHS talking therapies recovery rate' was given a red circle in the most recent version of the NHS mental health dashboard (for quarter 3 of 2022–23) because it did not meet the national target of 50% set out in *The Five Year Forward View for Mental Health* [86], and a 2.5% decrease was observed over the previous 24 months [41]. However, the literature sourced on the NHS mental health dashboard for this evidence brief did not provide any insight into whether action is taken in response to indicators with red circles, or the nature of any actions that have or may be taken.

In 2021, the Health and Social Care Committee's Expert Panel, which was established by the House of Commons to support scrutinisation of the work carried out by parliamentary committees [333], completed an evaluation of the Government's progress against its policy commitments in the area of mental health services in England, which also incorporated the use of the NHS mental health dashboard indicators to evaluate the progress towards the national targets set out in *The Five Year Forward View for Mental Health* and *The NHS Long Term Plan* [334].

3.12.4 New Zealand

3.12.4.1 He Ara Oranga wellbeing outcomes framework

As previously mentioned in Section 3.4.1, the 2021 report *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* (referred to as *Kia Manawanui*) aimed to transform New Zealand's approach to

mental well-being [97]. *Kia Manawanui* identifies five focus areas, each with a corresponding high-level outcome. In the chapter on measuring progress, the *He Ara Oranga wellbeing outcomes framework* [36] is identified as an appropriate tool with which to assess changes in population-level mental well-being outcomes as a result of the actions implemented. As described in Section 3.4.1.1, the *He Ara Oranga wellbeing outcomes framework* was published in 2021 and consists of 31 outcome indicators which were developed to understand well-being across 6 shared perspective outcome domains [36]. At the time of completing this evidence brief (September 2023), however, the Health Research Board (HRB) could not source any subsequent information or reports on the use of the *He Ara Oranga wellbeing outcomes framework* to measure the progress on the national-level actions set out in *Kia Manawanui Aotearoa*.

3.12.5 Scotland (UK)

3.12.5.1 The Quality Indicator Profile for Mental Health

As mentioned in Section 3.5.3.1, the Quality Indicator Profile for Mental Health was introduced by the Scottish Government in 2018 in order to meet Action 38 of the *Mental Health Strategy 2017–2027* [120]. To date, three progress reports on the *Mental Health Strategy 2017–2027* have been published [117–119]. Although the Quality Indicator Profile for Mental Health was developed in order to meet an action set out in the Strategy implementation plan rather than to track the Strategy's progress, the first two progress reports present the results of a handful of the available Quality Indicator Profile for Mental Health indicators in order to demonstrate progress on other actions set out in the Strategy [117,118]. However, the Quality Indicator Profile for Mental Health is primarily discussed in the reports as a positive outcome of the Strategy's implementation, rather than as a method for measuring the other actions set out in the Strategy.

3.12.6 The OECD

The OECD Mental Health System Performance Benchmark [27] is not used to monitor or evaluate the performance of any particular mental health policy and therefore is not described in this section.

4 Discussion

4.1 Summary of findings

Outcome indicators have been described as the most important type of indicator for monitoring and evaluating the effectiveness of a policy [13]. While mental health plans, inquiries, and recommendations are plentiful (see [335] for an example), many OECD countries have struggled to assess whether their mental health policies and systems are producing desirable outcomes [27]. Mental health outcome measurement is still in its infancy, which is reflected in the number of indicator sets included in this evidence brief that have not yet been fully developed or implemented (for example, Public Health Scotland's *Mental Health Indicators* project [37] (see Section 3.5.1)), as well as those that have been developed and seemingly discarded for reasons that were not documented in the literature sourced for this evidence brief (for example, the 63 (55 available) mental health indicators published in *Informing the Future: Mental Health Indicators for Canada* [31] and the 15 mental health and addiction indicators published in the *National Indicators 2012* report in New Zealand [43]).

The supplementary excel spreadsheet provided alongside this evidence brief identifies all of the indicators in each indicator set from the five selected countries and the OECD (tab 1, 'All_Indicators'), the collection of indicators that the HRB deemed relevant to each of the 15 high-level outcomes described in *Sharing the Vision* (tab 2, 'HRB_Selected_Indicators'), and the results of our analysis of the collection indicators under each high-level outcome to identify outcome/proxy outcome, determinant/proxy determinant, and quality/proxy quality indicators (tabs 3–6, 'HRB_Analysis_Summaries' for domains 1–4).

4.1.1 Outcome domain 1 summary

The majority of the indicators deemed relevant to this domain were categorised under outcome 1(a) ('Positive mental health, resilience and psychological wellbeing amongst the population as a whole'), wherein the overarching outcome indicator themes identified were: positive mental health and well-being outcome indicators (e.g. 'Psychological wellbeing'), poor mental health and well-being outcome indicators (e.g. 'Chronic stress'), life satisfaction outcome indicators (e.g. 'The proportion of people who score 7 out of 10 or higher for life satisfaction'), social well-being outcome indicators (e.g. 'A sense of belonging'), and poor social well-being outcome indicators (e.g. 'Loneliness: percentage of adults who feel lonely often or always or some of the time').

In relation to outcome 1(b) ('Positive mental health, resilience, and psychological wellbeing amongst priority groups…through targeted promotion and preventive mechanisms'), there was a notable dearth of indicators developed specifically for priority groups, likely because in the majority of indicator sets included in this evidence brief, data for most or all of the indicators are made available by demographic, socioeconomic, and other factors so that users can make comparisons across different groups. The only indicator set that included a distinct set of outcome indicators tailored to a particular priority group known to be at a higher risk for mental ill health compared with the general population was the *He Ara Oranga wellbeing outcomes framework* in New Zealand [36] (see Section 3.4.1.1). This Framework encompasses six Māori-specific well-being outcome domains, each of which is accompanied by a set of outcome indicators to measure well-being, and the factors that promote well-being, among Māori people in the New Zealand context. These components of the Framework were not described in this evidence brief because Māori are Indigenous Polynesian people of mainland New Zealand, and thus those indicators would not be relevant to the Irish context; however, the approach may be a useful one to adopt in relation to priority groups that are relevant to the Irish context, such as Irish Travellers. Beyond the *He Ara Oranga wellbeing outcomes framework*, the only indicator set included in this evidence brief that prioritised specific populations was reported in *Informing the Future: Mental Health Indicators for*

Canada (see Section 3.2.1.1), in which several of the mental health indicators are reported for the general population as well as for selected populations, such as immigrants; lesbian, gay, or bisexual individuals; and residents of Northern communities (e.g. the 'Stress' and 'Self-rated mental health' indicators) [31].

The overarching outcome indicator themes identified for outcome 1(c) ('Reduced stigma and discrimination arising through improved community wide understanding of mental health difficulties') distinguish between indicators of stigma and discrimination experienced by people with mental health conditions (e.g. 'Stigma and discrimination experienced by people living with mental health problems or mental illness') and indicators of the potential impacts of initiatives to reduce mental health stigma and discrimination in the community. The two outcome indicators categorised into the latter theme ('The proportion of people who say it would be 'easy' or 'very easy' to talk to someone if they felt down or a bit depressed' and 'Willingness to seek help from a mental health professional – college and university students') were included under this outcome because initiatives aiming to reduce stigma and discrimination around mental ill health should, in theory, result in an increase in the proportion of people who are able to seek support if they are experiencing mental health difficulties.

The overarching outcome indicator themes identified for outcome 1(d) ('Reduced prevalence of mental health difficulties and/or reduced severity of impact(s) through early intervention and prevention work') distinguish between indicators of the prevalence of mental health challenges generally (e.g. 'Prevalence of mental illness') and indicators of the prevalence of specific mental health conditions (e.g. 'Adults with moderate or high severity symptoms of depression') in the general population.

As previously mentioned in Section 2.7, mental health determinant indicators were included in the indicator analysis and summary alongside outcome and proxy outcome indicators for outcome domains 1 and 3. This is because the effectiveness of the mental-health-related promotion, prevention, and early intervention actions set out in *Sharing the Vision* will be best determined by capturing the causal factors of mental ill health and positive mental health and well-being, as well as by capturing mental health outcomes. In addition, throughout outcome domain 1, depending on the outcome, some indicators could be considered both a mental health determinant indicator and an outcome indicator (e.g. 'Willingness to seek help from a mental health professional – college and university students' was categorised as a determinant indicator under outcome 1(a) and as an outcome indicator under outcome 1(c)), while others were best captured as determinant indicators rather than as outcome indicators (e.g. the resilience-related indicators in outcomes 1(a) and 1(b)).

In relation to the benefits and limitations of the indicators deemed relevant to outcome domain 1, the collection of indicator data using self-report measures in local and national surveys was emphasised. The benefit of this approach is that it allows decision-makers to gain a broad understanding of and measure trends in population-level mental health and well-being over time, as well as to make comparisons across the population and identify where inequalities might lie. However, self-report measures are subject to a range of response biases, and should be complemented by measures of objective conditions (for example, suicide rates, employment rates, and standard of living) [43]. In addition, a representative sample of the target population is required in order to draw meaningful conclusions about a given phenomenon. However, a representative sample is not always achievable, and any estimates derived from a non-representative sample are subject to sampling error. Small sample sizes and inaccurate results are particular concerns for gathering indicator data for minority groups. The mode of data collection can also affect individuals' responses (for example, in the Public Health Outcomes Framework in England, higher than average ratings for the life satisfaction question of the Annual Population Survey in the United Kingdom (UK) were provided by respondents interviewed via the telephone compared with those who were interviewed face to face [149]). It is also important to consider that when survey measures are used as indicators of well-being or mental ill health in an entire population, lower or higher rates among

distinct groups within that population may be masked; however, by making data available by demographic, socioeconomic, and other factors, meaningful comparisons can be made across specific groups. Another recurring and important limitation of the indicators deemed relevant to outcome domain 1 pertained to the importance of recognising what indicator data can and cannot denote. For example, in the Australian services for mental health performance indicator framework (see Section 3.7.3.1.2.2), 'Stigma and discrimination experienced by people living with mental health problems or mental illness' measures discrimination among people with a diagnosed mental health condition; however, the data cannot indicate whether the discrimination was perceived to be due to a person's mental health condition or due to another factor [30] [30].

While the abovementioned indicator benefits and limitations were the most commonly reported in the literature sourced for outcome domain 1, the individual benefits and limitations of the included indicators are described throughout Section 3.7 of this report, where relevant information was provided.

4.1.2 Outcome domain 2 summary

The majority of outcome/proxy outcome indicators deemed relevant to this domain were categorised under outcome 2(a) ('All service users have access to timely, evidence informed interventions'), wherein the overarching outcome indicator themes we identified broadly distinguished between direct and indirect outcome indicators of access to timely mental health care. Two themes of direct indicators of service access were identified. The first includes outcome indicators that focus directly on the level of access individuals have to mental health care (e.g. 'Population access to clinical mental health care') as well as indicators of the proportion of a population that has been able to access a particular type of mental health care over a given time period (e.g. 'Early intervention for mental health and substance use among children and youth'). The second theme includes outcome indicators of the timeliness or responsiveness of mental health services, including wait times (e.g. 'Wait times for community mental health counselling') and time-to-treatment indicators, which measure the proportion of a population that has been able to access treatment or an assessment for a particular mental health condition within a specified and reasonable period of time (e.g. 'Percentage of children and young people with eating disorders seen within 1 week (urgent)'). Two themes of indirect outcome indicators of service access were also identified. The first theme includes indicators of unmet need (e.g. 'Unmet need for mental health care among people with mental disorders'); although these indicators do not directly measure access to timely and effective treatment, they provide an indirect picture of service access by identifying gaps in the mental health care system's ability to meet mental health care demands. The second theme is a miscellaneous theme which contains five indicators that also provide an indirect picture of service access but did not fit into any of the previously defined themes and lacked sufficient similarity to form a new theme (e.g. 'Mental health new client index' and 'Mental health service use by selected equity groups'). It should be noted that, while the outcome indicators deemed relevant to outcome 2(a) collectively address access to timely mental health care, the 'evidence informed' dimension of outcome 2(a) was not covered by any of the included indicators from the five selected countries and the OECD.

As previously described in Section 2.7, quality indicators were included in the indicator analysis and summary alongside outcome and proxy outcome indicators for outcome domains 2 and 4. This is because certain aspects of the high-level outcomes under these domains are in fact service quality outcomes, and are therefore appropriately captured using indicators of mental health service quality. In addition, quality indicators often provided indirect insight into the high-level outcomes in outcome domains 2 and 4. The quality indicators included under outcome 2(a), for example, were grouped into two overarching quality indicator themes, both of which could be considered indirect indicators of service access. The first theme included quality indicators related to the occurrence of inappropriate mental health care, which indirectly

address service access by providing insight into the provision of inappropriate care due to a lack of access to appropriate services (e.g. 'Number of days people spend in hospital when they are ready to be discharged per 1,000 population'). The second theme included quality indicators related to length of hospital stay (e.g. 'Individuals hospitalised for more than 30 days in a year') and hospital discharges (e.g. 'Mental health and substance use disorder discharges'), both of which also indirectly measure service access (for example, prolonged length of hospital stay may indicate a lack of access to community-based care).

Only one overarching outcome indicator theme was identified for outcome 2(b) ('Service delivery is organised to enable increased numbers of people to achieve personal recovery'); this was patient recovery outcomes, and it included indicators of patient-reported and clinician-observed mental health and recovery outcomes following treatment (e.g. 'Mental health outcomes of consumers of specialised public mental health services'). There were no outcome/proxy outcome indicators that directly assessed service organisation and/or the effect of service organisation on patient outcomes; rather, the service organisation dimension of outcome 2(b) was more appropriately captured by quality indicators. These indicators were categorised into the overarching quality indicator theme of service effectiveness and efficiency, which provides insight into service organisation via indicators of repeat mental health readmissions (e.g. 'Mental illness hospital readmissions within 30 days'), prolonged length of hospital stay (e.g. 'Adults in adult mental health beds length of stay rate (over 60 days)'), and missed appointments (e.g. 'Percentage of did not attend appointments for community-based services of people with mental health problems'), which may signal service errors such as failure to inform patients of their appointment [336] or patients' perceived lack of benefit from outpatient appointments.

A total of three overarching outcome indicator themes were identified for outcome 2(c) ('Services are coordinated through a 'stepped care' approach to provide continuity of care that will deliver the best possible outcomes for each service user'). The first is patient recovery outcomes, which predominantly includes the same indicators of patient-reported and clinician-observed mental health and recovery outcomes as outcome 2(b). This is to be expected because both outcome 2(b) and outcome 2(c) present patient recovery as the ultimate end goal. The remaining two overarching outcome indicator themes identified for outcome 2(c) represent direct indicators of the outcomes that can be expected when continuity of care is optimal. The first represents outcomes of good care continuity between the different tiers of the mental health service (e.g. 'Post-discharge community mental health care'), and the second represents outcomes of good care continuity between physical and mental health services (e.g. 'Physical health outcomes for people with a mental illness'). Outcome indicators in this second theme were deemed relevant to outcome 2(c) because of the emphasis that *Sharing the Vision* outcome domain 2 places on the physical health of people with mental health difficulties; taking a common sense approach, outcome 2(c) appeared to be the most appropriate outcome under which to categorise these indicators because continuity between physical and mental health services is critical for achieving optimal outcomes for people with both physical and mental health needs. The quality/proxy quality indicators in outcome 2(c), which overlapped substantially with those in outcome 2(b), were categorised into two overarching quality indicator themes. The first represents indirect indicators of care continuity between the different tiers of the mental health service, and includes indicators that measure repeat mental health readmissions (e.g. 'One-year rate of repeat hospitalisations for persons with a mental illness') and prolonged length of hospital stay (e.g. 'Older adults in acute mental health beds length of stay rate (over 90 days)'), providing an indirect picture of the consequences of a lack of coordination between acute and community-based mental health services. The second overarching quality indicator theme represents indirect indicators of care continuity between physical and mental health services, and includes indicators that measure timely physical health checks for people with mental health conditions (e.g. 'Percentage of

people with severe and enduring mental illness and/or learning disability who have had an annual health check within the previous 12 months') and avoidable physical-health-related hospitalisations (e.g. 'Avoidable hospitalisations for physical illness in people with mental illness').

There were no outcome or quality indicators deemed relevant to outcome 2(d) ('Health outcomes for people with dual diagnosis are improved by ensuring greater collaboration between mental health and other relevant services'). This is likely due to the model of mental health services in Ireland, which departs from the international classification system by not including substance use disorders among the categories of mental health problems covered in Ireland's mental health system. Under this model, the responsibility of care for individuals with substance use disorders is delegated away from the mental health service to separate services that operate with their own distinct funding structure in the Irish healthcare system.

The importance of having targets or standards against which to evaluate progress towards or achievement of a service outcome (or quality) goal should be emphasised at this point. Several of the outcome and quality indicators in the outcome domain 2 indicator themes (the majority of which were obtained from the National Health Service (NHS) mental health dashboard (see Section 3.3.2.1)) did not appear to be measured against a particular target or standard, but rather were reported as raw figures (e.g. 'Number of children and young people accessing support by NHS funded community services'). These indicators should have been categorised as output indicators and therefore excluded from the process of analysing and categorising indicators into overarching themes because they cannot provide meaningful insight into a service-related outcome or quality attribute. However, we decided to retain these indicators because of their relevance to the subject matter, but emphasise the importance of having a specific target or standard against which to evaluate progress or achievement.

Another important consideration is the distinction between mental health outcome indicators and mental health service quality indicators. As described in Section 1.1, outcome indicators denote whether an action (or policy) has achieved the expected effects/changes in the short, intermediate, and long term [16], whereas quality indicators provide information about the effectiveness and safety of care [20]. In this evidence brief, some indicators labelled as outcome indicators in one domain were labelled as quality indicators in another domain, depending on the nature of the high-level outcome. For example, 'Number of people with a severe mental illness eligible but waiting for all six components of a physical health check in the last 12 months', which is not defined as any particular type of indicator in the NHS mental health dashboard, was considered an outcome indicator for the purposes of outcome 2(a) and a quality indicator for the purposes of outcome 2(d). In addition (and as already described earlier in this subsection), some of the quality indicators deemed relevant to outcome domain 2 provide indirect insight into a high-level outcome. However, the distinction between outcome indicators and quality indicators is an important one, and care should be taken when identifying whether indicators – either newly developed or co-opted for a particular purpose – represent a measure of a given outcome or a measure of service quality. Relatedly, while some quality indicators may indirectly shed light on a particular outcome, indirect measures of any phenomenon may in fact be measuring a related phenomenon or, indeed, something else entirely. This is reflected in the extent of overlap between the quality indicators deemed relevant to outcomes 2(a), 2(b), and 2(c). For example, quality indicators that measure the length of hospital stay for people with a mental health condition may signal a lack of access to appropriate community-based mental health care (outcome 2(a)) or a lack of service efficiency (outcome 2(b)). Likewise, quality indicators that measure repeat readmissions may signal a lack of service organisation (outcome 2(b)) or a lack of continuity between acute and community-based mental health care (outcome 2(d)). In this sense, any measure that indirectly assesses a given outcome should be interpreted with caution, and should only be used as a supplementary tool to complement more precise indicators.

In relation to indicator benefits and limitations, we identified four common limitations of the indicators deemed relevant to outcome domain 2 (no explicit benefits of the indicators that were deemed relevant to outcome domain 2 were described in the literature sourced). First, the importance of understanding what indicator data can and cannot denote was greatly emphasised throughout this domain. Some key examples are:

- 'Population access to clinical mental health care', an indicator from *The Fifth National Mental Health and Suicide Prevention Plan* in Australia that was considered a proxy outcome indicator under outcome 2(a), "cannot indicate whether people are accessing the right services to meet their needs…[or] the proportion of people who might benefit from accessing clinical mental health care who do not access care, or their reasons for not accessing care" [124 p15].
- 'Mental health service use by selected equity groups', an indicator from the Australian services for mental health performance indicator framework that was also considered a proxy outcome indicator under outcome 2(a), cannot provide information as to whether the mental health services that people access are appropriate for their needs, or whether the mental health services are correctly targeted to those most in need [30].
- 'Mental health readmissions to hospital', an indicator from *The Fifth National Mental Health and Suicide Prevention Plan* in Australia that was considered a proxy quality indicator under outcomes 2(b) and 2(d), may reflect deficiencies in the functioning of the mental health system but cannot indicate where the deficiencies exist [21].

The second common limitation found among the indicators deemed relevant to outcome domain 2 relates to indicator data collection; specifically, the use of surveys and self-report measures to collect data and the collection of data from regional or provincial (or other equivalent) systems to form national-level indicators. The limitations associated with the use of surveys and self-report measures in the context of outcome indicators are described previously in Section 4.1.1 and in more detail throughout Sections 3.7–3.10. In relation to data collection from regions or provinces, some of the indicators deemed relevant to outcome domain 2 relied on data supplied from regional or provincial systems because available national datasets did not share a common unique patient identifier to allow service users to be tracked across acute and community-based services (e.g. see 'Admission preceded by community mental health care' in Section 3.8.1.1.2.3). While data collection from regional or provincial (or other equivalent) systems to form national-level indicators is not uncommon, it may result in gaps in data coverage [218]. In addition, a range of factors need to be considered when interpreting the results of indicator data collected from regional or provincial data systems, as well as when comparing results across regions/provinces, such as variations in healthcare practices and resources across jurisdictions, urban/rural population distribution, and the types of patients cared for and the acuity of their illness (see 'Mental health and substance use disorder discharges' and 'Total days stayed for mental health and substance use disorder hospitalisations' in Section 3.8.1.2.2.4 for a full description).

The third common limitation found among the indicators deemed relevant to outcome domain 2 relates to the coverage of mental health disorders in indicator data. Specifically, by including data for individuals diagnosed with some mental health conditions but not others, indicator results may not accurately reflect the relevant outcome. For example, for 'Unmet need for mental health care among people with mental disorders', a mental health indicator included in *Informing the Future: Mental Health Indicators for Canada* [31], the findings are limited to a subsample of individuals with certain diagnosed mental health conditions only (mood, anxiety, and substance use disorders) [31] (see Section 3.8.1.2.2.1).

The fourth and final common limitation found among the indicators deemed relevant to outcome domain 2 relates to indicator results based only on State-provided mental health services. In the limitations

described for several of the indicators deemed relevant to outcome domain 2, users of services other than public mental health services (e.g. private care providers, non-profit and voluntary services, general practitioner (GP) services, etc.) were considered out of scope, and this may impact the accuracy of the findings if the goal is to obtain a national-level understanding of the outcome of interest (e.g. see 'Post-discharge community mental health care' in Section 3.8.3.1.2.1).

While the abovementioned limitations were the most commonly reported in the literature sourced for outcome domain 2, the individual limitations of the included indicators are described throughout Section 3.8 of this report, where relevant information was provided.

4.1.3 Outcome domain 3 summary

Fewer outcome indicators were deemed relevant to outcome domain 3 relative to outcome domains 1 and 2. The overarching outcome indicator themes identified for outcome 3(a) ('Service users are respected, connected, and valued in their community') were: stigma and discrimination (e.g. 'Experience of discrimination in people with mental illness'), sense of belonging (e.g. 'Connectedness and meaning in life'), and social functioning (e.g. 'Social participation in adults with mental illness'). Measures of stigma and discrimination experienced by people with mental health conditions speak to the extent to which people with such conditions do or do not feel respected and valued in their community, and measures of social functioning (social participation) provide insight into how connected people with mental health conditions are to their community. There were no objective indicators of how much service users are actually respected, connected, and valued in their community (and these are unlikely to exist); however, the extent to which they feel respected, connected, and valued is nevertheless of greater importance.

Similarly, in relation to outcome 3(b) ('Increased ability of service users to manage their own lives [self-determination] via stronger social relationships and sense of purpose'), we found no objective indicators of the ability of service users to manage their own lives (i.e. self-determination). However, the overarching indicator themes identified for this outcome speak to the pathways through which self-determined recovery can be achieved, namely through strengthened social relationships and sense of purpose. These themes, which overlap to some degree with the indicator themes identified for outcome 3(a), were: sense of belonging (e.g. 'Sense of belonging – people with mental health conditions'), social functioning (e.g. 'Percentage of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month'), and improved quality of life (e.g. 'Recovery in quality of life for patients with mental illness'). It should be noted that while the two indicators under the improved quality of life theme ('Health related quality of life for people with mental illness' and 'Recovery in quality of life for patients with mental illness') appear relevant to this outcome, both require additional developmental work, and therefore have yet to be implemented [83].

In relation to outcome 3(c) ('Improved outcomes in relation to education, housing, employment, and income for service users relative to the population as a whole (i.e. reduced disparity)'), the first overarching outcome indicator theme identified was socioeconomic functioning, which includes indicators that measure the proportion of people with mental health conditions who are in employment (or education or training), with suitable housing, and with sufficient income compared with those without mental health conditions (e.g. 'Proportion of adults in contact with secondary mental health services in paid employment'). The second outcome indicator theme was socioeconomic satisfaction, which includes indicators that assess the extent to which people with mental health conditions are satisfied with their employment, financial, and housing status (e.g. 'Employed and satisfied with job').

Limited information pertaining to the benefits and limitations of the indicators included under outcome domain 3 was provided in the literature sourced. However, as with outcome domains 1 (Section 4.1.1) and 2 (Section 4.1.2), the importance of understanding what indicator data can and cannot denote was

also a recurring limitation of the indicators deemed relevant to outcome domain 3. For example, it is noted in the mental health section of the Australian *Report on Government Services 2023* (see Section 3.9.1.1.2.2) that the outcome indicator 'Social and economic inclusion of people with a mental illness' does not provide information on whether the employment or social activities people reported on were appropriate or meaningful, nor does it provide information on why people who were not employed may not be looking for work [183].

The individual limitations of some of the indicators included under domain 3 are described throughout Section 3.9 of this report, where relevant information was provided.

4.1.4 Outcome domain 4 summary

There were no outcome/proxy outcome indicators or quality/proxy quality indicators deemed relevant to outcome 4(a) ('Mental health is embedded as a national cross cutting priority that is effectively integrated into the key policies and settings in society') or 4(b) ('Dynamic performance reporting provides visibility of the performance and impact of *Sharing the Vision*'). However, several of the indicator sets described in this evidence brief are in and of themselves relevant to outcome 4(b), which relates to the development of a set of standardised performance indicators and targeted service outcome data at a national level. The majority of all indicators deemed relevant to this domain were categorised under outcome 4(c) ('Services that deliver consistently high-quality person-centred supports that meet the needs and have the confidence of service users and family, carers, and supporters'). In relation to outcome/proxy outcome indicators, we identified one overarching outcome indicator theme, which was patient and carer experience (e.g. 'Patient experience of community mental health services'). While outcome domain 2 focuses on the outcomes of mental health service users, outcome domain 4 – and outcome 4(c) specifically – places a particular emphasis on "regular tracking of the views of service users about their experiences with the mental health system and the impact of these experiences on their health and wellbeing outcomes" [24 p75] as an important aspect of measuring and monitoring performance. Employing qualitative approaches to gain more valid insights into the lived experiences of patients and carers in the mental health service would be a valuable supplement to quantitative outcome measures.

As previously noted, quality indicators were included in the indicator analysis and summary alongside outcome and proxy outcome indicators for outcome domain 4, for the same reasons outlined in the outcome domain 2 summary (see Section 4.1.2). A total of four overarching quality indicator themes were identified for outcome 4(c). The first, which only contained a single quality indicator, represented the importance of respecting the wishes of service users ('Number of people with advance statements registered per year with the Mental Welfare Commission for Scotland'). The second and third quality indicator themes represented indicators related to involuntary detention and restrictive practices (e.g. 'Number of emergency detention certificates per 100,000 population') and patient safety (e.g. 'Percentage of people prescribed antipsychotics for reasons other than psychosis and bipolar disorder treatment'). The indicators in the second and third themes were deemed relevant to outcome 4(c) because of the emphasis on these topics described in *Sharing the Vision* outcome domain 4; taking a common sense approach, outcome 4(c) appeared to be the most appropriate outcome under which to categorise the indicators included in these themes because of its emphasis on high-quality, person-centred supports that meet the needs of service users. The final quality indicator theme identified for outcome 4(c) represented indicators related to staffing levels (e.g. 'Percentage adult home treatment services staffed in line with recommended levels'). Like the previous two themes, the indicators included under this theme were deemed relevant to outcome 4(c) because of its emphasis on high-quality supports.

There were no outcome or proxy outcome indicators considered relevant to outcome 4(d) ('Continuous improvement is future focussed and driven by adequately resourced innovation across the mental health system and related sectors'). However, two overarching quality indicator themes were identified for this outcome. The first represents indicators that measure the extent to which mental health services meet national or international standards (e.g. 'Services reviewed against the national standards'), which we considered a critical aspect of accountability and continuous improvement. The second quality indicator theme included the same indicators of staffing levels as outcome 4(c), because appropriate staffing levels were considered a key aspect of enabling continuous improvement.

The points outlined in Section 4.1.2 in relation to the inclusion of both outcome and quality indicators in outcome domain 2 and the distinction between these types of indicators also apply to, and should therefore be considered in relation to, outcome domain 4.

Limited information pertaining to the benefits and limitations of the indicators included under outcome domain 4 was provided in the literature sourced. However, as in outcome domains 1 (Section 4.1.1), 2 (Section 4.1.2), and 3 (Section 4.1.3), the importance of understanding what indicator data can and cannot denote was also a recurring limitation of the indicators deemed relevant to outcome domain 4. For example, in relation to 'Seclusion rate', it is noted in the *Fifth National Mental Health and Suicide Prevention Plan 2020 Technical Report* that while high seclusion rates may suggest inadequacies in the functioning of the mental health care system, they do not indicate where these inadequacies may exist [124] (see Section 3.10.3.1.2.1). A related and important limitation to consider concerning patient experience outcome indicators in particular is that a significant proportion of people with mental health conditions disengage from or choose not to access mental health services and supports; patient experience outcome indicators cannot denote whether services would be rated positively by these people. Another recurring limitation of the indicators deemed relevant to outcome domain 4 concerns the collection of data from regions or provinces (or other equivalent). As described previously in the summary of findings for outcome domain 2 (see Section 4.1.2), data collection from regional or provincial (or other equivalent) systems to form national-level indicators is not uncommon; however, this approach may result in gaps in data coverage. In addition, methodologies for data collection may vary across jurisdictions within a country. For example, in relation to 'Mental health consumer experience of service', *The Fifth National Mental Health and Suicide Prevention Plan* in Australia noted that the methodologies for implementing the Your Experience of Service survey (the data source for that indicator) differ between jurisdictions, and the impact that has on whether data are nationally comparable is yet to be determined [21] (see Section 3.10.3.1.2.1). Moreover, the indicator specification web page for 'Seclusion rate' (one of the key performance indicators for Australian public mental health services) notes that the capacity to collect information regarding the duration of seclusion episodes varies greatly across jurisdictions [308] (see Section 3.10.3.1.2.3).

The individual limitations of the indicators included under domain 4 are described throughout Section 3.10 of this report, where relevant information was provided.

4.1.5 Use of indicators for strategy monitoring and evaluation

Only 7 out of the 18 indicator sets described in this evidence brief were developed or co-opted to measure the priorities or actions set out in a mental health policy; this includes all 4 of the indicator sets from England, and 1 indicator set each from Australia, Canada, and New Zealand. Despite this, none of the included countries or the OECD implemented an official system or framework by which the indicator sets would be used to monitor the progress and/or evaluate the overall performance of the relevant mental health strategy, although Australia, Canada, and England have made some progress in this regard.

In Australia, four progress reports on *The Fifth National Mental Health and Suicide Prevention Plan* (known as The Fifth Plan) have been published as of September 2023 [47,280,331,332], with the first establishing a baseline for each of the 24 performance indicators against which subsequent reporting measured performance of The Fifth Plan [331]. The indicators have a dedicated section in each of the progress reports, which provides an update on the status of the indicators and a broad overview of indicator limitations. Selected high-level analyses are provided for the available indicators, with commentary on trends over time and progress towards the desired outcomes. Additional data and information on performance trends over time are made available alongside each progress report in a downloadable Excel spreadsheet [331]. However, implementation of The Fifth Plan was expected to finish in 2022, and at the time this evidence brief was completed in September 2023, there had not yet been a progress report published for the year 2022, or an official evaluation of the overall performance and impact of The Fifth Plan using the indicators.

A colour system was adopted for the indicator sets in Canada and England. In Canada, each of the 55 mental health indicators in *Informing the Future: Mental Health Indicators for Canada* (which was published in 2015) [31] was assigned a colour in order to illustrate its status (green to indicate good performance; yellow to indicate no change, some concern, or uncertain results; and red to indicate significant concerns) [31]. However, the 2015 report seems to be the first and only official report on this set of mental health indicators, and it appears as though the use of the traffic light system is limited to assessing the performance of the individual indicators, rather than assessing the use of the indicators to monitor or evaluate the progress and performance of the national mental health strategy (*Changing Directions, Changing Lives: The Mental Health Strategy for Canada*) as a whole [59]. In England, the colour system used in each quarterly publication of the NHS mental health dashboard indicates whether the performance of certain indicators is better (green circle) or worse (red circle) than the national standard set for those indicators in *The Five Year Forward View for Mental Health* [86] and subsequently in *The NHS Long Term Plan* [88]. However, the literature sourced on the NHS mental health dashboard for this evidence brief did not provide any insight into whether action is taken in response to indicators with red circles, or the nature of any action that may be taken.

While it was anticipated that the indicators included in the Public Health Outcomes Framework [33], the Adult Social Care Outcomes Framework [34], and the NHS Outcomes Framework [35] would be used to track national progress against the objectives set out in the 2012 outcomes-based mental health strategy, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages* [69], we could not find any progress reports or evaluations of the Strategy that presented the use of the frameworks for this purpose. Likewise, in New Zealand, while the *He Ara Oranga wellbeing outcomes framework* [36] was identified as an appropriate tool with which to assess changes in population mental well-being outcomes as a result of the actions set out in the 2021 report *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* [97], we could not source any information or reports on the use of the *He Ara Oranga wellbeing outcomes framework* for this purpose.

4.2 Strengths and limitations

The indicators described in this evidence brief were selected from a variety of indicator sets developed across five countries and the OECD. Together they provide a broad range of examples for measuring outcomes related to population-level mental health, mental health service delivery, recovery from mental ill health, and mental health system performance. Although some of the indicator sets described are no longer in use (for example, the *National Indicators 2012* in New Zealand [43]), they were chosen because of their relevance to the high-level outcomes described in *Sharing the Vision*. Similarly, information pertaining to the nature and development of the indicators included in some indicator sets was lacking

relative to that provided for others. However, we included all indicators that appeared relevant to the purposes of this evidence brief, which was to describe mental health indicators used internationally as part of an initial scoping exercise.

While the breadth and variety of indicators presented is a key strength of this report, we acknowledge that there are likely to be other useful international examples of mental health outcome indicators that have not been covered here. In addition, some of the indicators included in this brief were drawn from indicator sets that are not fully developed or implemented. However, the research team for this evidence brief included an experienced information specialist, and the search strategy employed was robust and comprehensive in order to ensure that the information provided was up to date and accurate.

4.3 Conclusions

This evidence brief set out to describe the mental health outcome indicators used internationally as part of an initial scoping exercise to inform the development of a set of outcome indicators for assessing the impact of *Sharing the Vision: A Mental Health Policy for Everyone*, Ireland's national mental health policy. We identified a range of example indicators used for measuring the high-level outcomes described in outcome domains 1, 2, and 3 (with the exception of outcome 2(c), which focuses on health outcomes for people with dual diagnosis). In the context of outcome domain 1, understanding and measuring the determinants of mental health is imperative; capturing the risk and protective factors for mental health outcomes at the individual, family, community, and societal levels will be a key step in evaluating the performance and impact of the actions set out in *Sharing the Vision* with regard to promoting population-level mental health and well-being and fostering a healthier and more resilient society as a whole.

While the distinctions between different types of indicators used for monitoring and evaluation purposes are critically important to consider when developing a new set of indicators for any purpose (e.g. to measure policy impact or assess healthcare service effectiveness), this report demonstrates that these distinctions are not absolute across different contexts, as the nomenclature of certain indicators varied across the high-level outcomes under a given outcome domain. In addition, certain aspects of some of the high-level outcomes (particularly those under outcome domain 2) were quality-related outcomes, and would therefore be most appropriately captured using both service quality and mental health outcome indicators.

The collection of outcome indicators identified in relation to outcome domain 3 are a good foundation from which to develop a set of outcome indicators that accurately and reliably capture people's progress in mental health recovery. However, we found relatively few outcome indicators relevant to the high-level outcomes in outcome domain 4 (and no outcome indicators in the case of outcomes 4(a) and 4(b)). It may be necessary to look beyond the mental health sphere in order to gain insights for assessing accountability and continuous improvement in the mental health system. In relation to the service user and carer experience aspect of outcome domain 4, the application of appropriate qualitative research methodologies would be an essential supplement for understanding people's lived experiences of mental health services alongside the planned quantitative outcome measures.

Understanding the limitations of indicator data, specifically what indicator data can and cannot denote, is critically important when developing and applying any set of indicators; what indicators could not reflect was the most common limitation described in the literature sourced for this evidence brief, which was unsurprising given that mental health outcome measurement is still an emerging area in policy development. The infancy of mental health outcome measurement is also reflected in the observation that, while much is being measured in the mental health arena internationally, the interpretation of

indicators in order to make data-driven adjustments to planned policy-led actions and assess the safety and effectiveness of mental health policy in achieving the desired outcomes is limited.

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