Advocacy in mental health
The (ab)use of data and indicators for (inter)national advocacy and lobby

Mental Health Europe
Capacity Building Seminar
Brussels, December 11, 2015
What are we going to do in the next 1.5 hours

- Advocacy, lobby, framing
- Example 1: Getting rid of one single graph
- Indicators
- Example 2: Impact of mental ill health
- Available data sources and benchmarks
Advocacy, lobbying and framing

• **Advocacy**
  – Influencing (a group of) policies
  – In political, economic and social systems/institutions

• **Lobbying**
  – Influencing a specific decision or outcome
  – By legislators or agencies.

• **Framing**
  – Influencing individuals, groups and societies how they perceive and communicate about reality.
  – Using existing clusters of meaning to place a message, issue or fact in a certain perspective
Frame: Mental resilience determines the future of our European society

• well-educated children, productive adults and active senior citizens increase the cohesion, stability and security;

• mentally well-functioning people are in better physical health, are more productive, earn higher incomes on average and hence have a higher socioeconomic status;

• higher productivity, lower absenteeism and less work accidents lead to lower costs for healthcare and social security systems, thus increasing GDP growth in Europe.
Could efficiency really be determined only by counting the number of beds and psychiatrists?

“In contrast Netherlands, Ireland and Czech Republic tend to emerge relatively consistently as the poorer performers”.

Source: OECD: (2012) draft paper
Compared to OECD average, Dutch mental health care does indeed have a huge professional staff.

Between 2000 and 2011, the number of psychiatrists per 100,000 population increased from 15.00 to 20.46 in the Netherlands.

Compared to OECD average, Dutch mental health care does indeed have a huge professional staff.

Mental health nurses per 100 000 population, 2011 (or nearest year)

And also still a high number of psychiatric beds...
... with a strong focus on assisted independent living and sheltered housing.

The popularity of other residential facilities (e.g. sheltered houses, group homes) is demonstrated by the sharp increase in the places used: from 4 000 places in 1993 to approximately 13 000 in 2009.

### Types of residential services for people with mental health problems in 2009

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Total number of beds</th>
<th>Rate per 100 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical beds (cure) out of which:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Adults and elderly</td>
<td>17 786</td>
<td>107.9</td>
</tr>
<tr>
<td>- Children and youth</td>
<td>1 772</td>
<td>10.7</td>
</tr>
<tr>
<td>- Addiction care</td>
<td>2 038</td>
<td>12.4</td>
</tr>
<tr>
<td>Sheltered housing, mainly group homes (care)</td>
<td>12 978</td>
<td>78.7</td>
</tr>
</tbody>
</table>

Source: Van Hoof F. et al. (2012), Bedden tellen – afbouw van de intramurale ggz [Counting the number of beds, phasing out institutional mental health care], MGv, jaargang 67 (2012) 6, 298-310. [In Dutch].
March 2012: are the number of beds / psychiatrist per 100 000 population a measure for efficiency?

“In contrast Netherlands, Ireland and Czech Republic tend to emerge relatively consistently as the poorer performers”.

Source: OECD: (2012) draft paper
On the basis of other OECD research, the question was: “Are outcomes not relevant at all?”

Suicide deaths per 100 000 population (standardised rates) in OECD countries, 2011 (or latest available).

Such as a very low percentage of unmet need?

Self-reported utilisation of medication and any form of health care because of psychiatric problems, alcohol or drug related problems by the Dutch population between 18 – 64 years old.

<table>
<thead>
<tr>
<th></th>
<th>Medication (%)</th>
<th>Any form of mental health care (%)</th>
<th>Unmet need (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorder</td>
<td>36.8</td>
<td>58.7</td>
<td>8.7</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>20.5</td>
<td>34.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>15.3</td>
<td>29.0</td>
<td>5.3</td>
</tr>
<tr>
<td>ADHD</td>
<td>24.9</td>
<td>35.2</td>
<td>5.1</td>
</tr>
<tr>
<td>Any Axis-1 disorder</td>
<td>19.6</td>
<td>33.8</td>
<td>5.6</td>
</tr>
<tr>
<td>No axis-1 disorder</td>
<td>2.7</td>
<td>6.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Total population</td>
<td>5.7</td>
<td>11.4</td>
<td>1.8</td>
</tr>
</tbody>
</table>

The paradox when it comes to international indicators and benchmarks

- Indicators are not reality, nor truth
- It is a simplification, a model
- International indicators are NOT reliable
- International benchmarks are NOT reliable

- We need indicators to measure
- We need international benchmarks to learn
- We need to know what the data represent
Already in 1863, Florence Nightingale introduced outcome measurements for hospitals

“It is proposed that one and the same form should be used for each statistical element. Seven elements are required to enable us to tabulate the results of hospital experience:

1. Remaining in hospital on the first day of the year.
2. Admitted during the year.
3. Recovered or relieved during the year.
4. Discharged incurable, unrelieved, for irregularities, or at their own request.
5. Died during the year.
6. Remaining in hospital on the last day of the year.
7. Mean duration of cases in days and fractions of a day.”

European Alliance for Mental Health in All Policies
Mental ill health is very common ...

In the Netherlands
- Mental ill health in lifetime: 43.5% of population
- People with mental ill health in lifetime: 7.3 million
- People with mental ill health in a year: 1.9 million
- People using specialist mental health care: 0.8 million

In WHO Europe:
- Affect more than a third of the population every year
- 1-2% of population with diagnosis psychotic disorders
- 5.6% of men and 1.3% of women have substance abuse disorders

... starting in youth where 15 – 25 % of adolescents have had experience with mental ill health...

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

Source: OECD (2012), Sick on the job? Myths and realities about mental health and work, page 178.
... affecting their education.

Share of people who stopped full-time education before age 15, by severity of mental disorder, 2010

Employed people as proportion of the working-age population in 10 OECD countries, by severity of mental disorders, latest available year

... and their income.

Poverty risks for people with a severe, moderate or no mental disorder in 9 OECD countries, latest year available


a) Per person net income adjusted for household size. For Australia and Denmark, data refer to gross income.
b) The low-income threshold determining poverty risk is 60% of median income.
Mental ill health leads to productivity loss...

Workers who have not taken sick leave, but show reduced productivity due to an emotional problem (in the previous four weeks) by mental health status and country.

Source: OECD (2015) Fit Mind, Fit Job
... this makes the impact of mental ill health on Europe’s economy huge.

Annual direct costs (work-related)

- employers (absenteeism and presenteeism) € 610 billion
- economy (lost output) € 270 billion
- healthcare systems (treatment) € 240 billion
- social welfare (disability benefit payments) € 60 billion
- employers (absenteeism and presenteeism) € 40 billion

Sources: Matrix (2013), Economic analysis of workplace mental health promotion and mental disorder prevention programmes and of their potential contribution to EU health, social and economic policy objectives; OECD (2015) Fit Mind, Fit Job.
Core messages in every presentation of the Alliance

• Mental ill health is common (part of human condition)
• Mental ill health does have a huge social and economic impact
• This impact will only increase in the next few years
• Mental health in all policies is not a luxury, it is a necessity
The data of WHO is limited in scope, not always accurate and often too old.

http://www.who.int/gho/mental_health/en/
WHO Mindbank is a recent expansion ...
With information on legislation, policies and so on

http://www.mindbank.info/collection/region/europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Country</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>Greece</td>
<td>Principality of Liechtenstein</td>
</tr>
<tr>
<td>Andorra</td>
<td>Hungary</td>
<td>Republic of Moldova</td>
</tr>
<tr>
<td>Austria</td>
<td>Iceland</td>
<td>Romania</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>Ireland</td>
<td>Russian Federation</td>
</tr>
<tr>
<td>Belarus</td>
<td>Israel</td>
<td>San Marino</td>
</tr>
<tr>
<td>Belgium</td>
<td>Italy</td>
<td>Sorbia</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>Kyrgyzstan</td>
<td>Slovakia</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Latvia</td>
<td>Slovenia</td>
</tr>
<tr>
<td>Croatia</td>
<td>Lithuania</td>
<td>Spain</td>
</tr>
<tr>
<td>Cyprus</td>
<td>Luxembourg</td>
<td>Sweden</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Malta</td>
<td>Switzerland</td>
</tr>
<tr>
<td>Denmark</td>
<td>Monaco</td>
<td>The former Yugoslav Republic of Macedonia</td>
</tr>
<tr>
<td>Estonia</td>
<td>Montenegro</td>
<td>Turkey</td>
</tr>
<tr>
<td>Finland</td>
<td>Netherlands</td>
<td>Ukraine</td>
</tr>
<tr>
<td>France</td>
<td>Norway</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Georgia</td>
<td>Poland</td>
<td>Uzbekistan</td>
</tr>
<tr>
<td>Germany</td>
<td>Portugal</td>
<td></td>
</tr>
</tbody>
</table>

Show all resources from countries in the European Region
... but is also severely limited.
The HSPM is a cooperation between WHO and EU.
And a good instrument to compare countries on specific topics, such as mental health

http://www.hspm.org/searchandcompare.aspx
The OECD does have a health department with one person responsible for mental health.
A second department of the OECD is working on Mental Health and Work

Mental Health and Work

Tackling mental ill-health of the working-age population is becoming a key issue for labour market and social policies in OECD countries. OECD governments increasingly recognise that policy has a major role to play in keeping people with mental ill-health in employment or bringing those outside of the labour market back to it, and in preventing mental illness.

Time to act on mental health

The costs of poor mental health are high: the total cost of mental illness is estimated at around 3.5% of GDP. People with mild to moderate disorders, such as anxiety or depression, are twice as likely to be unemployed. They also run a much higher risk of living in poverty and social marginalisation. The facts are clear: it’s time to act.

KEY PUBLICATION ON MENTAL HEALTH AND WORK

"Fit Mind, Fit Job - From Evidence to Practice in Mental Health and Work"

This report provides a synthesis of the findings of the OECD’s four-year review. It concludes that a transformation is required in policy thinking about mental health and work and sets out the key elements for an integrated policy approach to promoting better mental health and employment outcomes.

COUNTRY REPORTS ON MENTAL HEALTH AND WORK

This series of reports is looking at how the broader education, health, social and labour market policy challenges identified in "Fit on the Job? Myths and Realities about Mental Health and Work" are being tackled in a number of OECD countries.

Nine countries reports are published:

- Australia | 7 December 2015
- Austria | October 2015
- Belgium | January 2013
- Denmark | February 2013
- Netherlands | December 2014
- Norway | March 2013
- Sweden | March 2013
- Switzerland | January 2014
- United Kingdom | February 2014
The EU does have a specific program on health indicators, including some on mental health.

http://ec.europa.eu/health/indicators/echi/list/index_en.htm#id4
With options to select indicators, years and countries.

http://ec.europa.eu/health/dyna/echi/datatool/index.cfm?indlist=70
Like Average Length of Stay

http://ec.europa.eu/health/dyna/echi/datatool/index.cfm?indlist=70
Private organisations and NGO’s are also benchmarking more and more
GGZ Nederland is the sector organisation of specialist mental health and addiction care providers in the Netherlands. The aim of GGZ Nederland and its members is to ensure the availability of high quality, accessible, affordable and sustainable mental health care.

In 2013, its 113 members employed 89,500 staff who provided specialist mental health care to 815,800 clients.

Together they have an annual turnover of €5.66 billion (6.1% of Dutch health care expenditure and deliver a Return On Investment for the Dutch society of €14.6 billion. This is a market share of 80.6% in the health insurance market and more than 90% in child and youth care, sheltered housing, addiction care and forensic care.

Source: GGZ Nederland (2013), GGZ in de Zorgverzekeringswet
Seated in Amersfoort, its 60 employees represent the interests of its members in an on-going and constructive dialogue with client organisations, health insurers, national and local governments, professional associations and trade unions.

contact: GGZ Nederland
PO Box 830,
3800 AV Amersfoort

e-mail: cnas@ggznederland.nl

website: www.ggznederland.nl/pagina/english