

## 6. QUALITY AND OUTCOMES OF CARE

### Care for people with mental health disorders

The burden of mental illness is substantial, affecting an estimated one in four of the OECD population at any time, and one in two across the life course (see indicator on “Mental health” in Chapter 3; OECD, 2014a). High quality, timely care has the potential to improve outcomes and may help reduce suicide and excess mortality for individuals with psychiatric disorders.

High quality care for mental disorders in inpatient settings is vital, and inpatient suicide is a ‘never event’, which should be closely monitored as an indication of how well inpatient settings are able to keep patients safe from harm. Figure 6.29 shows rates of inpatient suicide amongst all psychiatric hospital admissions. Most countries report rates below 1 per 1 000 patients, but Costa Rica, the Netherlands, Denmark, and Israel are exceptions with rates of over 1. Steps to prevent inpatient suicide include identification and removal of likely opportunities for self-harm, risk assessment of patients, monitoring and appropriate treatment plans.

Suicide rate after hospital discharge can indicate the quality of care in the community, and co-ordination between inpatient and community settings. Across countries, suicide rate among patients who had been hospitalised in the previous year was as low as 1 per 1 000 patients in the United Kingdom but it was higher than 5 in the Netherlands and Lithuania (Figure 6.30). Denmark also has high suicide rates, but this may reflect that hospitalised patients have more severe psychiatric disorders than other countries. Patients with milder psychiatric disorders are usually treated in ambulatory settings.

Patients with a psychiatric illness are particularly at risk immediately following discharge from hospital. In most countries, over one quarter of suicides within the first year following discharge occurs in the first month, and in New Zealand and Sweden, as many as half of suicides among patients discharged in the previous year happen in the first month of discharge. It is known that suicide in the high-risk days following discharge can be reduced by good discharge planning and follow-up, and enhanced levels of care immediately following discharge (OECD, 2014a).

Individuals with a psychiatric illness have a higher mortality rate than the general population. An “excess mortality” value that is greater than one implies that people with mental disorders face a higher risk of death than the rest of the population. Figures 6.31 and 6.32 show the excess mortality for schizophrenia and bipolar disorder, which is above two in most countries. In order to reduce their high mortality, a multifaceted approach is needed for people with mental disorders, including primary care prevention of physical ill health, better integration of physical and mental health care, behavioural interventions, and changing professional attitudes. In view of improving quality of health care for people with mental disorders, these efforts

can be assessed regularly. For example, Sweden monitors the use of inpatient physical care for patients with a mental disorder that could have been avoided if primary care and/or primary or secondary prevention was sufficient (OECD, 2014a; OECD, 2014b).

#### Definition and comparability

The inpatient suicide indicator is composed of a denominator of patients discharged with a principal diagnosis or first two secondary diagnosis code of mental health and behavioural disorders (ICD-10 codes F10-F69 and F90-99) and a numerator of these patients with a discharge code of “suicide” (ICD-10 codes: X60-X84). Data should be interpreted with caution due to a very small number of cases. Reported rates can vary over time, so where possible a 3-year average has been calculated to give more stability to the indicator.

Suicide within 30 days and within one year of discharge is established by linking discharge following hospitalisation with a principal diagnosis or first two listed secondary diagnosis code of mental health and behavioural disorders (ICD-10 codes F10-F69 and F90-99), with suicides recorded in death registries (ICD-10 codes: X60-X84). In cases with several admissions during the reference year, the follow-up period starts from the last discharge.

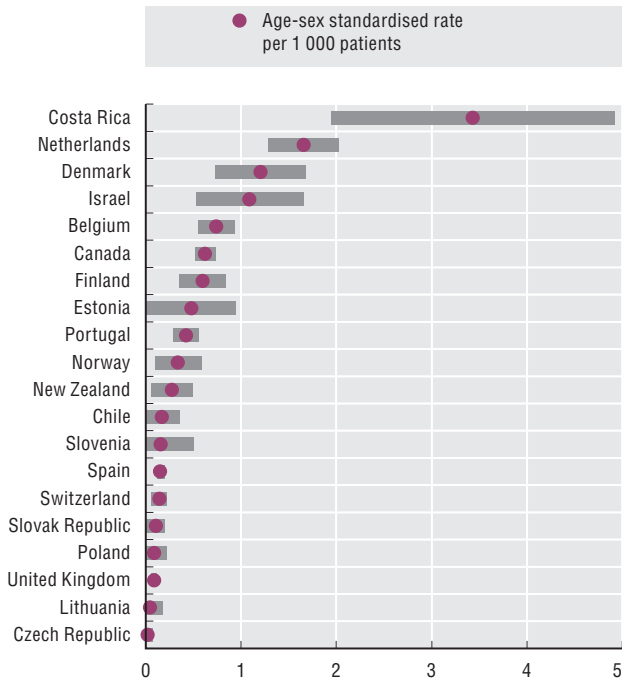
For the excess mortality indicators the numerator is the overall mortality rate for persons aged between 15 and 74 years old diagnosed with schizophrenia or bipolar disorder. Most countries use registry data as a data source. The denominator is the overall mortality rate for the general population in the same age group. The relatively small number of people with schizophrenia or bipolar disorder dying in any given year can cause substantial variations from year-to-year, so three-year averages were presented.

The data have been age-sex standardised to the 2010 OECD population structure, to remove the effect of different population structures across countries.

#### References

- OECD (2014a), *Making Mental Health Count. The Social and Economic Costs of Neglecting Mental Health Care*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264208445-en>.
- OECD (2014b), *OECD Reviews of Health Care Quality: Norway: Raising Standards*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264208469-en>.

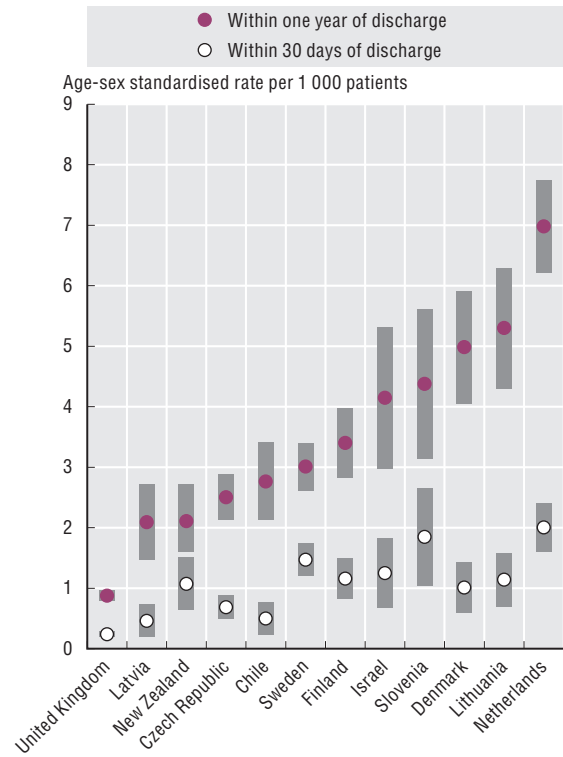
**6.29. Inpatient suicide amongst patients with a psychiatric disorder, 2014 (or nearest year)**



Note: multiple year average when data available. 95% confidence intervals have been calculated for all countries, represented by grey areas.  
Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933603887>

**6.30. Suicide following hospitalisation for a psychiatric disorder, within 30 days and one year of discharge, 2015 (or nearest year)**



Note: 95% confidence intervals have been calculated for all countries, represented by grey areas.

Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933603906>

**6.31. Excess mortality from schizophrenia, 2014**

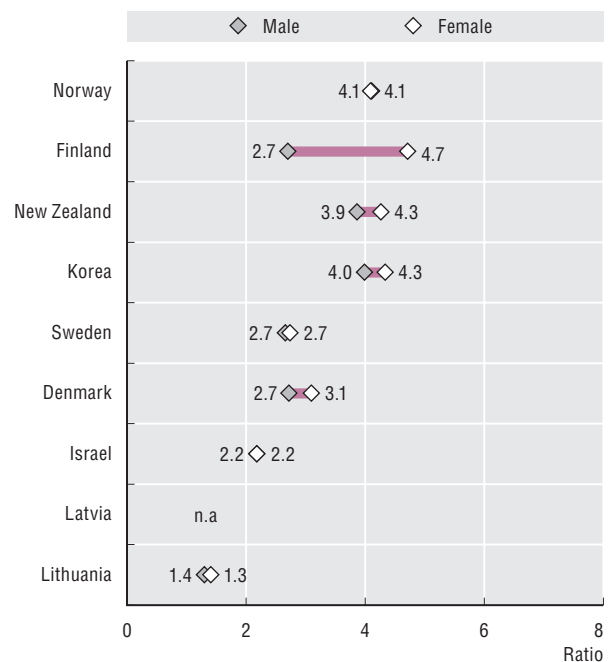


Note: Three-year average for all countries.

Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933603925>

**6.32. Excess mortality from bipolar disorder, 2014**



Note: Three-year average for all countries.

Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933603944>



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