The burden of mental illness is substantial, both in the Asia/Pacific region and beyond. According to WHO's most recent estimates (WHO, 2008b), depression is the second leading cause of disease in the Western Pacific region, accounting for 15.2 million lost disability adjusted life years (DALYs) per year, and second only to stroke. In the Southeast Asia region, depression is the fourth leading cause of diseases, accounting for 21.1 million DALYs per year. A broader sweep which includes unipolar and bipolar affective disorders, schizophrenia, alcohol and drug use disorders, post-traumatic stress disorder, obsessive-compulsive disorder and panic disorder totals 36.6 million DALYs per year in the Western Pacific region and 39.5 million in the Southeast Asia region.

Quality is as important an objective in mental care as in other areas of health. Given that the mentally unwell patient may not always be competent to determine his or her choices regarding treatment, the dimensions of patient centredness and safety become acutely important. But mental health care quality can be hard to measure. Data are typically sparse and, despite efforts to systematise diagnosis, sociocultural differences may complicate the comparability of internationally collected metrics. Even an apparently robust indicator such as life expectancy (LE) becomes problematic in the context of mental illness. LE is shorter in individuals with severe mental illness for several reasons, including higher rates of undiagnosed or undertreated physical illness and poorer social and economic environments (Brown, 1997). Hence, it may be that mental health services have a limited role in determining the general health of these individuals, and that LE has limited utility as an indicator of the quality of mental health care.

Despite these challenges, the OECD is a focal point for international work on exploring mental health care quality indicators. *30-day readmission rates* after an admission for severe mental illness has been agreed as a robust, useful and feasible indicator, since patients are not usually readmitted to hospital within a short interval if given appropriate care whilst in hospital and co-ordinated follow-up at discharge (Hermann, 2006). Hence, rate of unplanned readmissions may reflect the quality of several dimensions of the mental health system.

The indicators entail the need to identify an initial admission in which the patient is recognised as suffering the condition and apply a unique patient identifier, so that readmissions can be identified. This is challenging in itself. Furthermore, the absence of unique patient identifiers in many countries does not allow the tracking of patients across hospitals. Rates are often biased downwards, therefore, as re-admissions to a different hospital cannot be observed.

In addition, differences in how mental illness is treated means that re-admission rates need to be interpreted with care. Some countries, for example, use interval care protocols to place unstable patients into hospital care for short periods and/or are more proactive in identifying patients in need of care through outreach teams, possibly leading to high re-admissions. Unplanned re-admission is only one measure of the quality and performance of mental health care systems, and further indicators in domains such as treatment, care continuity, co-ordination and outcomes are needed to contribute to a better and more complete understanding of the performance of mental health care systems across countries.

Hence, collecting and interpreting comparable data in the Asia/Pacific setting raises significant challenges. Some countries are beginning to produce these data, whether at national or facility level, demonstrating the commitment to measuring and improving the quality of mental health care services in the region. For example, two studies from a teaching hospital in Malaysia (treating mainly Chinese descendants, urbanised and middle income patients) examined six-month readmission rate amongst all psychiatric patients (except those admitted for drug trials or for electroconvulsive therapy) and found that readmission rates after six months were between 16.8% and 32.2%, between 2006 and 2008 (Siddiq, 2009; Ng *et al.*, 2012). The factors most associated with risk of readmission were severity of illness and poor compliance with medication, implying that measures to improve compliance to medication are required to reduce psychiatric readmission.

In the Republic of Korea, unplanned 30-day readmission rates are estimated at 10.3% for bipolar disorder and 12.5% for schizophrenia in 2007 (Paik, 2012). In Japan,

the 30-day readmission rate for schizophrenia was 4.0-5.3% in data from 1995-96 (Mayahara, 2002). In Australia, 28-day readmission rate (planned and unplanned, 2008-09) after admission for any psychiatric illness varied between 5 and 16%, depending on the jurisdiction (COAG, 2012).

Looking at the wider OECD data currently available, re-admission rates for schizophrenia vary markedly, with Norway, Poland and Sweden at the higher end (24.4-28.9%), and the Slovak Republic (4.5%) and the United Kingdom (8.1%) at the lower end. The pattern of re-admission rates for bipolar disorders is similar, ranging from 22.6-30.5% in Norway, Poland and Sweden to 4.9% in the Slovak Republic (OECD, 2011). The rates reported from the Asia/Pacific area are broadly similar, an encouraging sign that further regional efforts to collect these data will support international efforts to benchmark and improve the quality of care for those suffering from mental illness.

Definitions and comparability

In OECD work, the indicator "30-day readmission rates after an admission for severe mental illness" is defined as the total number of unplanned re-admissions in a calendar year to any hospital for patients (age 15+) discharged at least once in the referred year with a principal diagnosis (or first two listed secondary diagnoses) of severe mental illness, divided by the total number of discharged patients meeting the same age/diagnosis critiera. Two indicators are defined, for schizophrenia and bipolar disorder separately. Readmission for any mental health condition is considered as a re-admission and, since few administrative databases can distinguish between unplanned and planned (foreseen as part of the treatment plan) readmissions, any re-admission is considered unplanned.