2022 Match Summary

Name of Match: **Mental Health Metrics: Benchmarking through crisis: lessons for building more resilient mental health services**

Location of Match: Online via Zoom

1. Describe the **purpose** of the match: (Maximum 500 words)

To collate, analyse, benchmark and learn from international mental health service data collections.

Benchmarking is the process of collaboration to make meaning of data. In times of crisis or traumatic events, it can act as the great equalizer, giving voice to people and communities who are not able to directly share their experiences or be physically included in policy setting or official decision-making processes. When an equity lens is applied to data metrics, participants in the benchmarking process can identify the areas of greatest need within a service or system so policies and practices can be tailored, and resources allocated to where they will have the greatest impact.

Using the COVID-19 pandemic as a real-life example, match participants put attention on comparative analysis and questioning of mental health service data so they could identify improvements in how they apply data and benchmarking in their contexts to grow collective capacity for making meaning, learning, and adapting, to better anticipate and/or withstand adverse events.

2. Describe the **leaders** who participated in the match (for example, were some of them peers, youth, family/caregivers, practitioners, policy makers, clinicians? Were they from community settings, government, NGOs, clinical settings?): (Maximum 500 words)

Three virtual sessions were delivered across three days with more than 30 participants attending via Zoom each day.

The leaders who participated in the Mental Health Metrics match came from ten different countries with another two registered but unable to attend. There were four NGO based attendees, with the remaining attendees representing Government funded agencies.

Most of the participants were service directors, chief executives or leaders in their regions/countries, with three in workforce development, eight working in data/information analysis, two professors and one benchmarking expert.

Participants represented ten countries and included the following organisations:

- OECD
- NHS Benchmarking Network
- Te Pou, New Zealand
- New Zealand Ministry of Health
- Australian Institute of Health and Welfare
- Department of Health – Belfast
- Australian Department of Health and Aged Care
- NSW Ministry of Health
- University of Canberra, Australia
- Swedish Association for Local Authorities and Regions
- Canadian Mental Health Association - Ontario Division
- National Collaborative Commissioning Unit – Wales
- St Loman's Hospital – Dublin
- Canadian Institute for Health Information
- Health Service Executive – Ireland
- Te Whatu Ora Southern
- Health Canada
- Thomas Scattergood Behavioral Health Foundation – United States
- Mental Health and Addiction KPI Programme – Aotearoa New Zealand
- NHS Wales National Collaborative Commissioning Unit

- University of Queensland – Australia
- Mental Health Commission of Canada.

3. What do you see as the **game changer** for this match topic? (Game changer is defined as: a newly introduced element or factor that changes an existing situation or activity in a significant way.) (Max 500 words)

Insights from the three-day match highlighted several possible game changers:

- The ability to collect, analyse and present international mental health metrics in web-based data dashboards improves access to global data collections to support ongoing benchmarking discussions.
- COVID-19 driven global shifts to the use of more virtual meeting tools enables services to plan more regular benchmarking focused networking events. There is a desire from multiple countries to connect more frequently between IIMHL Leadership Exchanges.
- Bringing together people working in mental health services who value the role of benchmarking in the continuous improvement of services broadens perspectives on shared challenges and possible solutions and supports data informed learning to drive collective action.
- Building collective international awareness of critical data gaps increases opportunities for networking and engagement to uncover where greater advocacy is required. For example, there is a global gap in the collection of outcomes and patient experience data resulting in an inability for most mental health services to accurately describe how they improve wellbeing outcomes for people and families who access those services.
- Using an equity lens over data metrics can help participants in the benchmarking process to identify the areas of greatest need for different socioeconomic and cultural groups, equipping decision makers with the information they need to develop policies and prioritise the allocation of resources to where they will have the most significant positive impact.

4. How will the match **support inclusion, resilience and growth** for this match topic and for the leaders who attended: (Maximum 500 words)

Almedom and Tumwine (2008) define resilience as *"the capacity of individuals, families, communities, systems, and institutions to anticipate, withstand and/or judiciously engage with catastrophic events and/or experiences; actively making meaning with the goal of maintaining normal function without fundamental loss of identify"*. It is a definition that highlights the importance of how people, their family/whānau and communities make meaning of their experiences, rather than putting focus on analysing the metrics of how they respond during traumatic or adverse events.

Never on such a global scale has human, community, systems, and institutional resilience been tested so holistically as has been experienced since early 2020 with the emergence of COVID-19. For countries across the world, it has been the ability of individuals, communities, and institutions to continually adapt, work together and take collective actions based on data and science that have determined their experiences and the impact of the global pandemic on their respective health and economic systems.

Data collected globally on the prevalence and impact of COVID-19 has been used by Governments and other relevant expert organisations to compare their performance and identify approaches and practices that could be applied in their context. Their effectiveness however has been reliant on their ability to humanize the data and draw out meaningful insights about how to apply these practices in a way that addresses the known inequities and disparities which exist for their citizens.

Supporting participants to put attention on comparative analysis and questioning, benchmarking enables data scrutiny so that learning occurs. Presentations on latest research, models of care and data informed responses applied across different countries created opportunities for knowledge sharing and the ability to form connections on challenges commonly shared in mental health services around the world.

While the COVID-19 pandemic is only one example of the many significant crises or challenges our global community is facing, it presented a unique opportunity to improve how we use data and benchmarking to continually grow our collective capacity to make meaning of our experiences, learn, and adapt, to better anticipate and/or withstand adversity.