

QUALITY IN MENTAL HEALTHCARE – A NEW FRAMEWORK FOR IMPROVEMENT OF SERVICES

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KVALITET ZAŠTITE MENTALNOG ZDRAVLJA – NOVI OKVIR ZA UNAPREĐIVANJE SLUŽBI

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ABSTRACT

The issues of quality in health care have been studied extensively during last decades. The area of mental healthcare was somewhat excluded from these activities, following only partially the "quality movement". The current position of the mental healthcare in the world is changing, at least partly because the contribution of mental disorders to overall morbidity is increasing. This creates an increase in demands for efficacy, effectiveness, efficiency and equity of care, resulting in more and more activities related to the quality improvement.

Development of different quality indicators, structure, process and outcome measures, together with constant activities in education of all stakeholders, are giving entirely new perspective to the mental health, shifting focus from „clinical quality“, the sole responsibility of medical professionals, doctors in particular, to the more comprehensive understanding of quality.

Serbian health system is just beginning to recognize this more comprehensive approach to the issue of the mental healthcare quality. The National Strategy for Mental Health lists quality improvement as one of the priority areas and basic strategies, but more activities are needed to inform mental health professionals and other stakeholders about current quality improvement framework. This paper aims to give a short introduction to mental health professionals, to define basic terminology and to discuss possible obstacles in wider implementation of quality measurement and improvement in Serbian mental healthcare.

Key words: mental disorders, mental health services, quality of health care, quality indicators

Abbreviations: AHMAC – Australian Health Ministers' Advisory Council; QI – quality improvement; WHO – the World Health Organization

QUALITY IN MENTAL HEALTHCARE

„Everyone in need should have access to basic mental health care. This key principle, identified by the World Health Organization (WHO), requires that mental health care be affordable, equitable, geographically accessible, available on a voluntary basis and of adequate quality.“

This is a part of the executive summary of the WHO Quality Improvement for Mental Health document, published in 2003 (1). In order to understand what is „adequate quality“, it is necessary to define quality. There are a lot of definitions of quality. The current concept evolved from the „clinical quality“ concept, that considered medical professionals, i.e. doctors, to be responsible for quality of care. Clinical quality refers to evaluation of what is done, and how it is done (2). This approach was additionally complicated by „traditional tribal divisions“ within the heterogenous group of health care providers, as described by Moss (3), that was introducing different activities, depending on the profession (nurses – quality assurance, doctors – medical audit, managers – risk man-

SAŽETAK

Poslednjih decenija, pitanja kvaliteta u oblasti zdravstvene zaštite predmet su brojnih istraživanja. Oblast zaštite mentalnog zdravlja bila je donekle isključena iz ovih aktivnosti, samo delimično prateći „pokret“ unapređenja kvaliteta. U svetu se menja sadašnja pozicija ove oblasti, barem delom zbog porasta učešća mentalnih poremećaja u ukupnom morbiditetu, a to dovodi do povećane potrebe za efikasnijom, delotvornijom, efektivnijom i jednako dostupnom zaštitom, što uzrokuje sve više aktivnosti usmerenih na unapređenje kvaliteta.

Razvoj različitih pokazatelja kvaliteta, instrumenata za merenje strukture, procesa i ishoda, zajedno sa stalnim aktivnostima na obrazovanju svih interesnih grupa, daje potpuno novu perspektivu za posmatranje zaštite mentalnog zdravlja, premeštajući fokus sa „kliničkog kvaliteta“, za koji su odgovorni zdravstveni radnici, prevashodno lekari, na jedno šire sagledavanje ovog pojma.

Zdravstveni sistem Srbije tek počinje da prepoznaje ovaj širi pristup pitanju kvaliteta u oblasti mentalnog zdravlja. Nacionalna strategija u oblasti mentalnog zdravlja uključuje unapređenje kvaliteta u prioritetne oblasti i osnovne strategije, ali je potrebno više aktivnosti da se profesionalcima u oblasti mentalnog zdravlja, kao i ostalim učesnicima, približi savremeni koncept kvaliteta. Ovaj rad ima za cilj da da kratki uvod, definiše osnovnu terminologiju i prokomentariše moguće prepreke široj primeni koncepta merenja i unapređivanja kvaliteta u zaštiti mentalnog zdravlja u Srbiji.

Ključne reči: mentalni poremećaji, zaštita mentalnog zdravlja, kvalitet zdravstvene službe, indikatori kvaliteta

Skraćenice: AHMAC – Australian Health Ministers' Advisory Council; QI – quality improvement; WHO – the World Health Organization

agement). Within this framework, inspite of its shortcomings, originates development of norms, standards, protocols and guidelines. This leads to the improvement of services, from the provider point of view, but this concept proved to be insufficient, for the overall quality improvement, since the only successful way to improve quality seems to be the one that includes all participants in the process, or all parts of the system.

Some authors question this wider approach when related to mental healthcare, discussing issues of „condition – related“ response to the satisfaction surveys (4, 5) or „condition - and treatment – related social stigma“ and privacy regulations (6). Even if it is so, the „consumer's“ role in the improvement of service quality is still beyond dispute. This is best viewed by definitions of quality given by the Australian AHMAC (7) or by WHO. In the Australian paper quality „encapsulates appropriate care that leads to good results for consumers of mental health services and which improves their quality of life“. The WHO defines quality as „a measure of whether services increase the likelihood of desired mental health out-

comes and are consistent with current evidence – based practice“ (1).

Both of these definitions place consumers in the front, assessing quality through achievement of desired outcomes, and securing safety for patients through the use of evidence-based practice or „appropriate care“. On the other hand, providers of the care, payers, policy makers, etc., have to be sure that the mental healthcare system will deliver the best possible services, using contemporary knowledge. There are also issues of accessibility, continuation, coordination, cost-effectiveness, and number of other different characteristics of the mental healthcare services.

All of these appear as characteristics of all health systems, no matter how developed they are. We might argue need for quality in systems with scarce resources, saying that it is premature to discuss quality of services if there are only few of those who will deliver those services, but the WHO document (1) supports the quality in all systems, since it creates a strong basis for future development.

Fortunately, our mental healthcare system is far from scarcity, at least in some aspects. The organizational structure is sufficiently defined, total number of providers high, or as some might say „too high“ (e.g. total number of psychiatrists/neuropsychiatrists in Serbia is 947, or 2.7 psychiatrists and 9.93 neuropsychiatrists per general population of 100.000) (8). Development of social psychiatry, psychosocial approach and wide network of institutions on primary, secondary and tertiary levels of care, resulted in relatively high availability of services.

On the other hand, the National Strategy for Mental Health (8) describes shortcomings of the current situation in this field, thus providing directions for the further development. The Quality of services is included in the Values and principles section, and represents one of the Strategic challenges. The Strategy recognizes need for procedures to monitor and supervise services, and procedures for quality evaluation and improvement, for delivered services.

In order to monitor and supervise services, to evaluate and improve quality, it is necessary to introduce the process of measurement and to decide on the measures and instruments. Measurement is offering us a possibility to expand our views beyond the individual patient and work of the individual provider, and perceive outcomes as a result of all interactions with the healthcare system (9). There is a considerable opposition to measurement of quality, understanding it as a source of data for superficial rating or punishment, or as means for discrimination of institutions and/or clinicians. The common attitude toward measurement – based quality improvement in our mental health, observed during interviews with providers, is that figures are just figures, that it is difficult to apply statistical methods for evaluation of care or services, when patients differ or methodology differs, or that payment does not follow quality. Another often heard statement is: „We need computers and information system“.

On the other hand, „measurement is best used for learning rather than for selection, reward, or punishment... measurement helps to know whether innovations should be kept, changed or rejected; to understand causes; and to clarify aims“, as Berwick stated eleven years ago (10).

If we accept what Berwick said, then some of the above mentioned reasons for resistance are not important any more. Involvement of providers of care (all professions involved in the services delivery) in the process of development, testing and use of measures and tools, could further lower the number of reasons. Evidence- and/or measurement-based arguments, as a result of the measurement of service quality, represent good basis in negotiations with policy-makers and purchasers of services (i.e. health insurance funds, other sources of payment), thus providing possibility for „more money“.

Some of the questions still remain. The link between measurement and subsequent actions is still insufficiently developed, the number of factors from the outside of the health system influence measurements and processes, thus modifying the results and outcomes. The issue of trust and other social and organizational features of healthcare still remain as potential sources of quality, that can't be substituted by external measurement and auditing(11).

Even with these open questions, it is obvious that certain level of measurement is necessary. It remains still to decide on the comprehensiveness, and to use means to adjust to special demands of mental health (e.g. case mix adjustment).

MEASURES AND MEASUREMENT OF QUALITY

Several frameworks are used in the theory of quality and quality improvement. In this paper, we shall use Donabedian's tripartite model, the one we consider as the most useful in order to comment on measurement. Within this model there are three dimensions of the healthcare quality: structure, process and outcome (12). All three can be evaluated, and for all three of them, measures have been developed. The numbers of measures / indicators in the literature vary, from only 4 (6), in one approach concerning USA nationwide actions in quality improvement, and from 86 (13) to 275 (9) in the other approach, that follows development of numerous indicators over time. Different stakeholders have different needs for measurement and different opinions on different measures / indicators. In general, the measures „should be meaningful, evidence – based, valid, yield actionable results,...feasible, i.e. precisely specified, reliably collected, adequately case mix adjusted, and based on available and affordable data“ (14). Our system of data gathering so far provides small number of measures for the measurement – based quality improvement. The problem of reliability is also often encountered, and the question of affordability, among others, is always present.

In order to better understand the quality measures/indicators, we shall firstly define three dimensions of the

quality and general characteristics of their measures. Structure relates to resources in the healthcare system (12), describing personnel/staff characteristics (e.g. number of psychiatrists, or number of certified psychotherapists), organizational characteristics (facilities, material resources), communities, consumers (15), and financial characteristics (e.g. proportion of population with health insurance). Measures of structure are, more or less, easily available from the existing databases, at least in systems with higher organizational culture. In Serbian mental healthcare system, these databases are still „under development“. The problem with structural measures is that these measures can be true measures of quality only if they are associated with superior results/outcomes, and direct evidence for such connections are rarely available (9).

Process consists of two subcomponents: interpersonal processes and technical processes. Processes refer to the consumer's interaction with the healthcare system, where technical processes are actually those that have clinical content, and interpersonal are related to the patient (consumer)/healthcare staff interactions.

Interpersonal processes are evaluated through surveys and interviews with patients. Due to still present stigmatisation of mental healthcare consumers, and predominantly authoritative model of patient – carer interaction, this aspect of processes has not been adequately evaluated in Serbia.

Technical processes are far more acceptable, from the clinicians point of view, for evaluation, measurement and improvement. They include all „clinical“ activities, i.e. prevention, detection, access, assessment, treatment/fidelity, coordination, continuity, safety. All of these reflect our values, what we want from our healthcare system (15). Regarding more specific characteristics, we could divide these technical processes into „pure clinical processes“ and administrative processes, but in both cases the care is compared to certain standards, to provide basis to evaluate quality (9). Often, the sole mentioning of quality of care provokes us to think about quality of treatment (underuse, overuse, misuse), but treatment is just a part of the process. Herman writes about seven, above listed, domains, while the Organisation for Economic Co-operation and Development (OECD) Mental Health Panel uses only three process areas for indicator selection, (continuity, coordination, treatment) considering them the key areas for quality, and restricting activities only to the existing indicators (16). This OECD project is the first step toward international benchmarking of quality in mental health care (17). Some authors suggest that benchmarking is more efficient in quality improvement than comparison to the average achievement, but it still remains to be confirmed for mental healthcare (18). In this context, it seems important to keep in mind that technical processes consist of number of domains, because the „treatment centeredness“ (e.g. measurement of continuation of depression treatment, or side effect monitoring with mood stabilizers, to name just two of many fully operationalized indicators, (9)) leaves out

of focus some important aspects of mental healthcare, i.e. prevention, detection, access, assessment, and safety. When discussing prevention, all three levels of prevention should be included, even with the existing scepticism toward primary prevention of mental disorders. The new research in early psychosis seems promising (19, 20, 21, 22), but it will take time until these activities could become measurable in Serbia. The secondary and tertiary prevention are more measurable, so we should focus on them. Another, relatively easily measurable domain is assessment. All the necessary data could be extracted from the existing medical documentation, provided that this documentation is in accordance with current doctrine, and that everything is recorded. The access measures are useful in evaluating availability of services. The well chosen measures could confirm or discard our beliefs and views on the mental healthcare, and service availability. Measures of safety are more and more used in the assessment of processes, and, with the growing culture of comparison and selection, we face development of new indicators, as well as increase in improvement activities. Having in mind historical abuse of mental healthcare services, and current seclusion, restraint and commitment to care activities, it is understandable that we, regardless of current high level, have to insist on improvement, both of the processes and the working conditions.

It is obvious that measurement of quality within all seven domains depends highly on attitude of mental healthcare providers. The importance of all stakeholders in mental healthcare and quality improvement is high, but the measurement itself is field in which opinions and beliefs of „frontline provider“ count a lot. Not many studies assessed these opinions, but Valenstein et al. study offers new and useful data on the role of „frontline providers“ in the process (23). In our healthcare system, quality indicators are developed mostly by policy-makers and public health specialists. Anecdotal evidence suggest that considerable resistance of the providers comes from the experience that the indicator set, although small and insufficient, is forced on them, demanding just additional work, and not providing adequate overview. These impressions still have to be checked by the research.

The outcome represents a third dimension of the healthcare quality. Measures for this dimension offer the most meaningful information, because the ultimate question in healthcare is the outcome (24), „whether symptoms remit, functioning and quality of life improve, adverse events are avoided, and consumers are satisfied“ (9). Symptoms, functional impairment and quality of life are considered to be dimensions of severity of illness, and for those involvement of providers is essential. Adverse events, satisfaction and cost - effectiveness are including other stakeholders. For a number of medical specialties clinical outcome measures have been developed, but mental health is not following them as closely as it should. One core characteristic of mental healthcare, „complex range of interacting services and diversified interventions“ (25), makes it difficult to assess outcomes. There is also an issue of complexity of diagnosis – care

(type, intensity, duration) relation, with lot of influence from outside of healthcare system. Mc Grath and Tempier (25) place an emphasis on the role of psychiatrists in quality improvement, stating that „it is the psychiatrists who retain ultimate responsibility for the delivery of care...psychiatrists are the only mental health professionals who can make a comprehensive biopsychosocial diagnosis“. In this way, psychiatrists are those that should be able to evaluate outcomes in the best way possible. The role of consumers is essential in the measurement of outcomes, only they themselves can provide information on satisfaction and quality of life. One possible drawback is influence of individual characteristics, that could bias assessment of satisfaction, without reflecting differences in the care itself (4). To prevent all this, case – mix adjustments have to be made. But, to be able to improve data and indicators, we should have data and indicators. Our healthcare system still excludes consumers of the mental healthcare from patient satisfaction surveys. An explanation is that psychiatric patients are not able to evaluate services adequately, which is contradiction in itself, because this survey usually includes discharged inpatients, who should be well enough to function outside the hospital. Outpatients or consumers of other types of services within the mental healthcare were not included too. So far there was only sporadic interest for possibilities to perform psychiatric patient satisfaction survey.

Overall impression is that outcome measures could be a useful tool, provided that they are standardised, acceptable to clinicians, and routinely used (26).

However, understanding importance of the issue of quality improvement, we have to ask ourselves would all these efforts be enough, to improve quality of care, or as Martin wrote: „What actually does go on in the clinical consulting room?“ (27). Answering this question he stressed the importance of training, building of commitment and passion for what we do, a thorough knowledge of what it means to be ethical, learning how to be effective and efficient.

Any of the quality indicators can give an overview of the current situation, and also provide information on possible areas for improvement of services. As often cited Berwick said: „Every system is perfectly designed to achieve the results it achieves“ (10). In order to improve itself, the system has to change. Unless we change, we shall continue on doing what we know the best, but the best that we know sometimes is not good enough. In the end, keeping this in mind, we must again consider something that is in the core of our professional identities – the concern for the benefit of our patients. The continuous improvement of the mental healthcare quality, together with education and scientific development, provides good enough basis for the future benefit.

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