QUALITY ASSURANCE INDICATORS IN MENTAL HEALTH CARE

WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

TARGET 12

REDUCING MENTAL DISORDERS AND SUICIDE

By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.

TARGET 31

QUALITY OF CARE AND APPROPRIATE TECHNOLOGY

By the year 2000, there should be structures and processes in all Member States to ensure continuous improvement in the quality of health care and appropriate development and use of health technologies.

EUR/ICP/CLR 062
01344
ORIGINAL: ENGLISH

QUALITY ASSURANCE INDICATORS IN MENTAL HEALTH CARE

Report on a WHO Consensus Meeting

Stockholm
30–31 August 1993

1994

EUR/HFA targets 12 and 31

ABSTRACT

In collaboration with the Swedish Medical Association, the WHO Regional Office for Europe organized a Consensus Meeting on Quality Assurance Indicators in Mental Health Care. The participants were asked to review existing tools and indicators for quality assessment and reach consensus on indicators of outcome that health professionals could use to assess their work. The participants formed three working groups to propose indicators for three types of mental health care: long-term care for chronic conditions, acute care for depression and care to prevent suicide. The groups proposed measurable indicators in all three areas. Finally, the participants recommended that the proposed indicators be tested and a further meeting held to revise them in the light of the results.

Keywords

MENTAL HEALTH
QUALITY ASSURANCE, HEALTH CARE
HEALTH STATUS INDICATORS

CONTENTS

INTRODUCTION

The Consensus Meeting on Quality Assurance Indicators in Mental Health Care was organized by the WHO Regional Office for Europe in collaboration with the Swedish Medical Association. It was attended by 23 experts from 11 countries. Dr A. Milton chaired the Meeting and Dr J.G. Sampaio Faria served as Rapporteur; the participants are listed in Annex 1.

The participants were asked to review existing tools and indicators for measuring the quality of mental health care and reach consensus on indicators of outcome that health personnel could use to assess the quality of the care and services that they provide.

DISCUSSION

The participants gave presentations on:

- the role of medical associations in developing the quality of care
- the targets for health for all and quality of care development in the WHO European Region
- the need for quality development indicators in mental health care
- an overview of existing indicators in this field
- the Swedish experience with quality assessment in psychiatric care.

Three main working groups were organized to discuss indicators of quality for the services provided to people receiving:

- long-term care (Dr P. Bech, coordinator, and Dr L. Boydell, rapporteur);
- acute care for depression (Professor J.-D. Guelfi, coordinator, and Dr C. Allgulander, rapporteur);
- care to prevent suicide (Professor M. Åsberg, coordinator and rapporteur).

The groups were asked to identify indicators for the assessment of quality in terms of the impact of the care provided on the client's mental, physical and social health and quality of life. Such indicators were particularly needed for care for people receiving long-term care for mental or somatic disorders or disabilities.

The aim of the working group on indicators of quality of chronic care was to agree on a generic measure of quality of life for people with chronic diseases, including those suffering from chronic mental disease. Several instruments were discussed, such as the wellbeing questionnaire of the WHO Regional Office for Europe, the psychological general wellbeing scale, short form 36 (usually called SF36), the WHO quality of life instrument (WHOQOL), the general health questionnaire, the anamnestic comparative self-assessment and the Philadelphia Geriatric Center morale scale. The group members debated the question of whether a single scale for measuring quality of life in mental and physical illness is feasible, particularly if a generic measure were required, using simple, unambiguous questions and being suitable for use in routine clinical practice. While the dimensions of anxiety and depression are important components of wellbeing when measuring quality of life in physical illness, they may be components of the disease state in mental illness. The importance of separating indicators of quality of life from measures of psychopathology was emphasized during the discussion. Other dimensions considered to be important, but not usually included in scales of wellbeing, were: the side effects of treatment, the quality of life of care-givers, satisfaction with care and contact with relatives.

The members of the working group on quality indicators in suicide prevention agreed in their discussions that, although suicide is a concern in most conditions treated by psychiatrists, certain risk groups are well known. The psychiatric diagnoses most often associated with suicide are depression, substance abuse and personality disorder. Suicide mortality is also high in schizophrenia.

To be effective, suicide prevention must focus on high-risk groups. The present quality indicators focus on one such risk group: people who have attempted suicide. The ultimate suicide mortality for this group is known to be high: usually 10–15%. In most studies,

the deaths are concentrated in the year following the first suicide attempt.

Although many demographic, psychological and biological factors are known to correlate with subsequent suicide, their sensitivity and specificity as predictors is modest at best. Attempts to construct instruments to predict risk have not been very successful, partly because suicide is a rare event, even in high-risk groups. This should not be taken to mean, however, that risk assessment instruments are not valuable. They need to be used to systematize risk evaluation, but there is little reason to prefer one instrument to the others.

In addition, one should remember that the empirical evidence of the success of suicide prevention is quite meagre. Well run lithium clinics probably reduce the suicide rate in bipolar disorder. Education and training of general practitioners on the island of Gotland, Sweden, decreased the suicide rate on the island for a limited time. In one study, drug treatment with flupentixol reduced the incidence of repeated attempts better than a placebo. On the other hand, a recent study of the prevention of depression relapse showed a greater number of suicide attempts in subjects taking maprotiline than in those with a placebo. Finally, psychotherapy (in the cognitive psychotherapy tradition) has reduced the number of repeated attempts in two controlled studies.

Because suicide is a rare event, death as an outcome measure is of very limited value at the clinical level, although it is a valuable marker at regional and national levels.

CONCLUSIONS

Quality indicators for care for chronic conditions

In the absence of consensus on the essential dimensions of quality of life, the members of the working group on chronic conditions agreed to focus on a measure of subjective wellbeing as one dimension of quality of life. There was no scientific basis for choosing one

measure of wellbeing over another, owing to the lack of sufficient information on the use of these measures in different situations and in different disease states. Because no other measure is known to be superior to the Regional Office wellbeing questionnaire and it is available in several languages, the group agreed to support its use. The group recognized that this measure includes only some of the important dimensions in quality of life, and that its use is still exploratory and needs to be introduced as part of an ongoing development process. With any new translation or population of patients, its validity and reliability need to be assessed.

Quality indicators for acute care for depression

The members of the working group on acute care for depression proposed four indicators:

- diagnostic precision, as measured by:
  - the proportion of cases of depression in which co-morbidity was diagnosed;
  - the proportion of cases in which the diagnosis was changed;
  - the proportion of cases assessed for severity of the condition;
  - the number of days of delay in starting the treatment (the period from the patient's first contact with a doctor and the beginning of the treatment);
- symptom reduction, or the proportion of patients assessed for symptom reduction through the use of an appropriate scale or instrument during the first six months after starting treatment;
- adverse drug reaction, or the proportion of newly diagnosed patients who have interrupted treatment because of adverse reactions to drugs; and
- premature discontinuation of treatment, as measured by:
  - the proportion of drop-outs early (under two weeks), intermediate (six months), and late (1–2 years) stages;

- the proportion of relapses within the first six months of treatment.

Quality indicators for suicide prevention

The members of the working group on suicide prevention proposed five outcome indicators: mortality rates, repeated suicide attempts, patients' wellbeing, their social functioning and their satisfaction with their treatment.

First, rates of death not only from suicide but also from other causes of both violent and natural death should be recorded. This marker will be valuable at the regional and national levels, but of less value at the clinical or individual level.

Second, a computerized register of repeated suicide attempts kept at the clinical or preferably the regional level, is a practical necessity. Regional registers will be needed to trace patients in most areas; as a rule, several facilities care for people who attempt suicide. Although the creation of such registers will raise important and difficult questions of confidentiality and ethics, the working group thought that these issues can be dealt with satisfactorily, at least at the regional and clinical levels.

Third, in most cases a self-assessment instrument will be useful to measure patients' wellbeing. Most of the items on most scales used for this purpose reflect psychiatric symptomatology, not wellbeing. A simple self-rating scale for psychopathology may be an alternative. This marker will be valuable at the individual and clinical levels, but less so at the regional level.

Fourth, social functioning requires assessment by a rating procedure requiring a trained assessor and will be a valuable marker at the individual and clinical levels. Many rating scales are available, but empirical evidence is insufficient to allow definite recommendations of any. Some experience has been gained, however, with using the Global Assessment of Functioning (GAF) scale to assess suicidal patients. This scale allows people with only modest training to give reliable ratings and is therefore a viable alternative. GAF is a simplified version of the Menninger health and

sickness rating scale, and is included in the classification system of the Diagnostic and Statistical Manual III (DSM III).

In addition, the GAF scale covers some psychopathological symptoms. If the wellbeing instrument used does so, too, the two instruments may overlap. This is no real disadvantage, however, because the two types of measure are based on different sources of data.

Fifth, the patient's satisfaction can be assessed by a questionnaire, preferably including questions as to whether the treatment was a positive experience, whether it was helpful, and whether the patient has any specific complaints. In addition, assessment of non-compliance (such as "no shows") might be valuable. This marker will be valuable at the individual and clinical levels, but less so at the regional level.

Further, the working group proposed five quality indicators for the process of care to prevent suicide. The first is the availability of a local programme for the care of suicidal patients. Such a programme should be an integral part of clinical routine, and include the following:

- a system to assess suicidal behaviour
- a catalogue of available treatment options, and principles for selecting treatment
- routines for the surveillance of suicidal patients
- procedures for the transfer of patients
- routines for liaison with other facilities
- principles for the teaching and training of staff.

The programme should preferably also include principles for working with the relatives of people who have attempted or committed suicide.

The second process indicator is the proportion of people who attempt suicide that is examined by a specialist in psychiatry. This refers to patients seen at emergency units.

The third is the proportion of patients seen at a clinic or contacted by telephone within a week of a suicide attempt. This refers to patients who were seen at emergency units but not hospitalized immediately afterwards.

The fourth is the frequency of psychiatric autopsy of suicide victims; this refers to people who committed suicide as inpatients in a psychiatric facility or within one month of their discharge.

The fifth is epidemiological data; a unit at the regional or national level should collect current statistics and feed them back to clinical units.

RECOMMENDATIONS

1. The proposed indicators and instruments should be tested in a selected number of areas in several European countries.

2. The WHO Regional Office for Europe, in collaboration with the participants of the Consensus Meeting, should identify institutions and experts in the countries that are interested in the field testing of the proposed indicators.

3. The Regional Office should organize a further meeting on the same theme one year after the start of the testing period.

Annex 1

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