
QUALITY ASSURANCE IN MENTAL HEALTH



DIVISION OF MENTAL HEALTH

WORLD HEALTH ORGANIZATION

GENEVA

Geneva, 10-12 September 1990

Summary Report

This informal consultation was convened to discuss WHO's future work on quality assurance in mental health care. It recommended that assessments of quality of care take into consideration the whole system of mental health care - from the policy and programme governing it to the institutions delivering services. The need for establishing local standards of care and involving the community in doing so - e.g. through consumer associations and patient advocacy groups - was also stressed.

This document is a first step in WHO's project to deal with these matters and it is expected that it will be followed by a series of publications and activities on this topic. Its main goal is to stimulate discussion; it is not intended to be a final product. It is open for comments and suggestions which are, therefore, most welcome.

Division of Mental Health

Geneva - 1991

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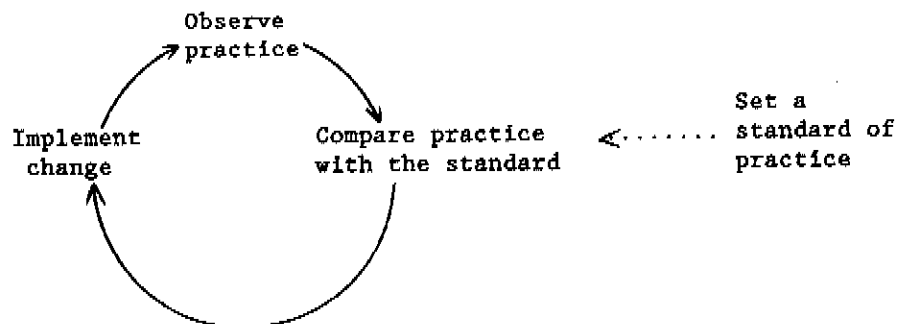
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Introduction

This meeting was opened by Dr J. Bertolote who welcomed the participants (see list of participants in Annex 1). Dr G. Harnois was elected to the Chair and Mrs C. Holleran to act as Rapporteur. The agenda of the meeting is attached (Annex 2).

Overall there was a consensus that a meaningful assessment of quality of care requires the assessment of the mental health programme as a whole rather than only an evaluation of care for the mentally ill. It was also felt that quality assurance in mental health has some peculiar characteristics that differentiate it from quality assurance in health programmes in general. For instance, indicators and standards of mental health and mental health care have been - due to a variety of reasons - less developed than similar items for other aspects of health care, e.g. for hospital infection control, clinical laboratory, radiology, immunization, pre-natal care, etc.

If we consider Fowkes' "audit cycle" model (*), we can approach quality assurance starting from any point in the circle:



Nevertheless, in the field of mental health, standards of practice and instruments for objectively observing practice (in all three levels mentioned above) are still missing. Therefore, before moving on to the establishment of specific mechanisms for quality assurance in mental health, efforts should be directed towards the development of basic tools such as instruments, indicators and standards.

Given time constraints, the Group concentrated on:

- (i) the development of general guidelines on quality assurance in mental health care;
- (ii) providing detailed comments concerning evaluation in some areas (e.g. for those which WHO has already produced draft instruments); and
- (iii) pointing out other areas that deserve future attention.

(*) Fowkes, F.G.R. Medical audit cycle: a review of methods and research in clinical practice. Medical Education, 16:228-238, 1982.

Guidelines

The following Guidelines for Setting up the Quality Assurance of Mental Health Care were agreed upon:

1. The Quality Assurance of Mental Health Care programmes should cover the whole range of mental health activities with at least three levels of assessment and evaluation:
 - a) policy;
 - b) programme; and
 - c) services. (See Annex 3).
2. For each of the three levels mentioned above, the main components for analysis should be identified. (See Annex 3).
3. When defining standards/indicators of care, due attention should be given to local conditions (e.g. level of development of general health care; availability, structure and qualification of personnel; attitudes and beliefs related to mental health and mental illness) and at the same time try to promote and preserve at least a reasonable level of quality of care.
4. Assessments should be "functional", possibly following the classic scheme of structure/process/outcome. In this respect, however, it was noted that:
 - a) Structure and process analyses point quicker and more directly to areas in need of change, whereas poor outcome indicators do not necessarily identify at which level or in which component the deficiency lies.
 - b) Many of the outcome measures are not specific to the treatment the patient has gone through and can be properly analysed only when the objectives of programmes and services have been clearly and objectively formulated, or when similar measures prior to the treatment are available, which are not always the case; hence, the importance of the utilization of sentinel (negative) events, i.e. those whose occurrence could indicate the existence of avoidable risk factors or avoidable service deficiencies.
 - c) Process evaluation can be more telling when "soft" variables (e.g. overall climate of the service, staff's degree of genuine dedication to patients problems and complaints) which are difficult to measure are added to more conventional process measures;
5. Instruments for assessing the quality of care should be kept to a minimum; they should be accompanied by detailed instructions.
6. The use of terms should be uniform and consistent; providing a glossary in operational terms is desirable.
7. The programmes of the Quality Assurance of Mental Health Care are facilitated when monitoring/evaluation activities are built into the programmes and services as their functional components.

8. Once the basic steps - namely, policy and programme formulation, definition of objectives, choice of assessment approach and instrument, and establishment of local standards of good care and practice - have been defined, audit mechanisms should be put into operation by Ministries of Health specifying procedures for periodic (at specified intervals) review of policies, programmes and services paying due attention to:

a) the promotion of research on service functioning, preferably with the inclusion of advisory research personnel at policy-making level;

b) the incorporation of external, independent reviewers (including representatives from consumers associations and patients advocacy groups and from other social services sectors).

Recommendations

As further steps in the development of activities related to the quality assurance of mental health care, the following are recommended:

- WHO should strengthen its capabilities in assisting countries in directing attention to the quality of mental health care, from the national mental health policy to the services delivery level; Regional Offices, particularly, should set up programmes on quality of care to assist countries in their regions.

- On the basis of the schedules presented in this report, WHO should develop instruments and methodologies for comprehensively assessing the quality of mental health care and propose a protocol for testing them.

- A Task Group should be appointed by WHO to further develop and improve instruments and methodologies for assessing National Mental Health policies, programmes and services.

- WHO instruments and drafts for assessing the quality of care should be based on a public mental health perspective.

- WHO should develop mechanisms for recording, at country level, the costs of mental health care activities, eventually with a specification of cost per service unit.

- Mechanisms for quality evaluation should be made explicit at all organizational levels of mental health care.

- National mental health programmes should be prepared and include explicit mechanisms for quality assurance.

- Funds should be made available for service-oriented research, particularly research related to the process component of care, which involves "soft" variables such as interpersonal quality of contact, amount of time actually spent with and attention given to patients.

- Specific training curricula should be developed for assisting health officers in evaluating and monitoring ongoing activities of mental health care services.

Annex 1

List of participants

- Dr G. HARNOIS, President, World Association of Psychosocial Rehabilitation;
Director, WHO Collaborating Centre, Montreal, Canada
- Ms C. HOLLERAN, Executive Director, International Council of Nurses
- Mrs M. MORSINK, Representative, International Organization of Consumers
Unions
- Prof. B. Nickel*, Medical Director, Wilhelm Griesinger Krankenhaus, Berlin-
Biesdorf, Germany
- Mrs J. PIERGROSSI, Representative, World Federation of Occupational
Therapists
- Dr B. SARACENO, Director, WHO Collaborating Centre. Istituto di Ricerche
Farmacologiche "Mario Negri". Milan, Italy

Secretariat

- Dr. J. BERTOLOTE, Senior Medical Officer, Division of Mental Health.
- Dr I. LEVAV, Regional Adviser in Mental Health, WHO/PAHO, Washington, D.C.,
USA
- Dr H. SELL, Regional Adviser, Health and Behaviour, WHO-SEARO, Delhi, India
- Dr. G. GIROLAMO, Associated Medical Officer, Division of Mental Health.
- Dr. F. STARACE, Consultant, Division of Mental Health.

*Unable to attend

Invited but unable to attend

Representative from the World Federation for Mental Health
Representative from the World Psychiatric Association

Annex 2

Agenda

1. Conceptual and priority issues: mental health, generally speaking, or mental health care?
2. Instruments for and indicators of the quality of mental health and of mental health care.
3. Review of previous WHO production in this field.
4. Schedules and scales for assessing the quality of mental health care.
5. A practical guide for assessing the quality of mental health care.

Annex 3

Quality assurance in mental health

Schedule 1: Mental Health Policy

Policies can - and should - be described in detail. Even when a policy has not been explicitly written down, it can be inferred from analyses of related programmes and, at least, of concrete actions. On the other hand, a written policy does not always reflect what is actually done. Since we still lack specific technology for properly evaluating mental health policies, the following principles - with respective indicators - are proposed for consideration when critically describing mental health policies:

1. Decentralization

- Indicators:
- evidence of a formal effort to increase planning and management capabilities at the district level, including the provision of a "model plan of action";
 - allocation of funds to district level authorities with the flexibility for using at least a substantial part of these funds according to locally perceived needs and priorities, even when these needs/priorities are not considered so at central level.

2. Intersectoral action

- Indicators:
- involvement of other sectors in the government dealing with areas variously designated as Health, Social Services, Welfare, Justice, Education, Housing, Income, Work/Labour, Youth;
 - involvement of NGOs and religious organizations.

3. Comprehensiveness

- Indicators:
- levels of prevention, i.e. promotion, prevention, treatment and rehabilitation indicated;
 - age groups mentioned;
 - psychosocial needs addressed, in addition to specific mental disorders; and
 - training and research orientation indicated.

4. Equity

- Indicators:
- accessibility of care;
 - distribution of care coverage.

5. Continuity

- Indicators: - degree of integration with general health care;
- linkage for services.

6. Consumer input

- Indicators: - participation of consumers (patients' associations, families' associations, labour organizations, consumers' unions, etc.) in:
- a) planning
 - b) implementation, and
 - c) evaluation of services and of activities.

7. Based on research findings

- Indicators: - priorities have been defined on the basis of research findings.

8. Periodic reviews

- Indicators: - composition of group to undertake reviews (e.g. peer group, multidisciplinary committee, external auditors, etc.);
- frequency of reviews;

- evidence of implementation of changes as indicated by reviews.

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Schedule 2: Mental Health Programmes

Previous WHO documents (e.g. WHO-EM/MENT/113-E(1986); MNH/POL/87.8) have already indicated that Mental Health Programmes should include at least the following components:

1. Promotion of mental health;
2. Prevention of mental disorders;
3. Treatment of the mentally ill;
4. Improving the functioning of general health services;
5. Contribution to overall socio-economic development;
6. Enhancing the quality of life; and
7. Education, research and information dissemination.

The current evaluation schedule covers some of the above components; the remaining (e.g. nos. 5 and 6) will be developed at a further stage.

The plan of work of a Mental Health Programme should cover the following areas:

1. Assessment of the current situation:
 - 1.1 Morbidity assessment: (indicators of)
 - 1.1.1 Mental health: rates on suicide, homicide and other crimes, divorce, child abuse, violence, alcohol and drug abuse, etc.
 - 1.1.2 General morbidity: more frequent diseases and general psychosocial factors affecting health.
 - 1.1.3 Psychiatric morbidity: including results of prevalence and incidence population surveys, if available, and annual statistics from mental and general health services.
 - 1.2 Existing resources:
 - 1.2.1 Facilities: hospitals (both general hospitals with psychiatric beds or wards and psychiatric or mental hospitals) and number of beds, outpatient clinics, emergency services, etc. How many facilities are in public, in private and in charity sectors?
 - 1.2.2 Human resources: number of psychiatrists, nurses, occupational therapists, psychologists, social workers, etc.
 - 1.2.3 Training facilities: medical schools, health schools, specialist training facilities (number and places available per year).
 - 1.2.4 Other resources: intersectoral and community resources.
 - 1.2.5 Budget available for mental health activities.
2. Objectives of the programme: overall, general and specific objectives, eventually with targets specified in terms of output units in a given time frame.
3. Strategies and approaches: general guiding principles in line with those expressed in Mental Health Policy.

4. Activities: of promotion, prevention, treatment and rehabilitation expressed in terms of both short- and long-term targets focussing particularly on various aspects of service and training. It is important to have an indication of priorities, be they in terms of clinical conditions (e.g. psychoses, dementia, epilepsy, mental retardation, etc.), or vulnerable groups (e.g. children, pregnant women, elderly, etc.) or special situations (e.g. natural disasters, war, etc.)
5. Coordination: it is desirable to have indications of:
 - 5.1 A focal point at national level.
 - 5.2 Integration of the Programme with the general health sector: primary health care settings, general hospitals and clinics, emergency rooms, etc.
 - 5.3 Intersectoral integration with sectors such as Justice, Police, Education, Housing, Welfare, Social Services, etc.
 - 5.4 Mechanisms for coordination and information exchange across national, regional, sub-regional and local levels, with clear descriptions of referral and back-referral systems.
6. Financial implications: cost estimates should include provisions of direct services (including essential drugs), in-service training, strengthening of existing cadres and institutions, national workshops and meetings and administrative expenses.
7. Monitoring and evaluation: mechanisms for monitoring and evaluation should be built into mental health programmes.

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Schedule 3: Services for Mental Health Care

The assessment of the quality of care provided by mental health services only acquires its full meaning when these services are considered as pragmatic aspects of a given mental health policy and of given mental health programmes - and jointly analysed. It can be approached either by assessing services - the most frequently employed approach - or by assessing the type of care provided - seldom done. It must be stressed that in order to assess any service, or type of care, it is fundamental to do so taking into consideration:

- a) its institutional aims; and
- b) its catchment area.

When assessing the quality of care provided by those services we might consider the following types:

1. Primary health care settings.
2. Out-patient mental health (psychiatric) facilities.
3. Psychiatric wards in general hospitals.
4. Psychiatric (mental) hospitals.
5. Board-and-care facilities for the chronic mentally ill.
6. Board-and-care facilities for the elderly mentally ill.
7. Board-and care-facilities for the mentally retarded.

An alternative approach would be to consider, instead of types of services, the following types of care:

1. Emergency psychiatric care.
2. Acute (short-term) psychiatric care.
3. Chronic (long-term) psychiatric care.
4. Management of non-psychiatric co-morbidity.
5. Management of psycho-social disabilities.
6. Consultation at community institutions (e.g. schools, work places, prisons, courts, etc.)

Irrespective of the option in favour of assessing types of services or care, the following categories should be singled out for in-depth assessment:

Structure:

1. Physical environment:
 - a) space;
 - b) space distribution for: (i) patients, (ii) staff, and (iii) doctors.
2. Availability of equipment/drugs.

3. Staffing:
 - a) number of staff (by professional profile) per population;
 - b) number of staff (by professional profile) per patient or user; (in both cases expressed both in absolute numbers and in work load units);
 - c) age;
 - d) sex;
 - e) training background of staff; and
 - f) activity descriptions.
4. Organization and management:
 - a) information (on patients and on staff) management;
 - b) linkage with other levels for information exchange,

Process:

1. Availability/Accessibility:
 - a) opening hours (when closed, where to go).
2. Initial assessment:
 - a) how patients are welcomed: number of persons involved, where, for how long, etc.;
 - b) family members participation.
3. Care process:
 - a) how are activities/staff/time/place matched;
 - b) usefulness of negative indicators (e.g. things "forbidden" to patients);
 - c) inter-staff relationship quality (as an indirect indicator of what happens in the place at large).
 - d) treatment process (e.g. psychopharmacotherapy, electroconvulsive therapy) standards/norms/criteria for inclusion and exclusion existing in written format;
 - e) family is informed and involved in the treatment process (eventually receiveing adequate support).
4. Discharge criteria/process:
 - a) criteria clearly spelt out and informed to patient and family.
5. Patient information management:
 - a) confidentiality of information;
 - b) patient access to own records;
 - c) recordings of assessments made by all types of professionals in the team.
6. After care (follow-up/referral):
 - a) patient and family informed orally and in writing on how, where and when to continue treatment or to get social services;
 - b) service to follow-up the patient is contacted by the time of discharge and receives basic information on the patient and on the treatment received.

7. Patients' (or his/her legal representative's) rights:
 - a) clear information on: (i) nature of treatment being proposed; (ii) expected duration of treatment; (iii) possible side-effects of treatment
 - b) to refuse treatment;
 - c) to refuse admission;
 - d) access to his/her own records;
 - e) access to own family/legal representative;
 - f) to appeal any decision or action against his/her interests.

8. Outreach:
 - a) service periodically contacts former patients in order to assess needs and compliance with prescribed follow-up.
 - b) service is available to provide support and orientation to families of both current and former patients

Outcome:

1. Classic indicators (e.g.: mortality rate, bed occupancy rate, discharge rate, turn-over rate, etc.);
2. Indicators of social re-insertion (e.g.: work, social relations, leisure, etc.);
3. Disablement level (e.g.: DAS ratings);
4. Quality of life (including patients' degree of satisfaction);
5. Burden to the family and to communities; and
6. Undesirable effects (e.g.: side-effects);
7. Sentinel events (e.g.: patient imprisoned, suicide soon after discharge, development of alcohol or drug dependence, loss to follow-up of patient with threatening condition, etc.).