Mental Health Care Indicators and their Importance for Mental Health Care Monitoring and Evaluation of Mental Health Care Reform in the CZ Republic

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Mental Health Care Indicators and their Importance for Mental Health Care Monitoring and Evaluation of Mental Health Care Reform in the CZ Republic

- Quality Assurance in (Mental) Healthcare
  - Introduction to Quality Assurance: Definitions, Terms, Instruments
  - QA Instruments: Quality Indicators and Treatment Guidelines
- Quality Assurance Tools in Reform Evaluation: Example of Czech Reforms
- Mental Healthcare Indicators Development: Example of the DAQUMECA Project
- Conclusion
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Definitions of Quality in Healthcare

Quality of care is the extent to which actual care is in conformity with preset criteria for good care

Donabedian, 1966

The degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge

US Institute of Medicine (IOM), Lohr et al. 1990

≈ ISO 9000: degree of fulfillment of requirements (ISO-9000 (2005))

- Focus on individual and overall system levels
- Quality improvement does not "determine" the improvement of outcomes
- Perspectives of providers and patients
- Evidence-based, continuing further education

„Quality in psychiatry“ is a complex construct with multiple quality dimensions (structures, processes and outcomes on different macro-, meso- and micro-levels) that is being assessed, assured and optimized by means of different instruments and methods taking different perspectives into account.
Domains of Quality in Healthcare

- **Structures**
  Attributes of care settings, e.g. facilities, equipment, human resources, funding, organizational structures

- **Processes**
  Actions taken in giving and receiving care including patients’ help seeking behavior and practitioners’ activities in providing health care

- **Outcomes**
  Effects of health care on the patients’ and populations’ health status (including patients’ knowledge, behavior and degree of satisfaction)

→ The prerequisite for quality assessment is that relationships between the three domains have been established

Quality in Mental Healthcare

Quality is a complex **construct** with different …

**… categories of observation**
- structures, processes, outcomes

**… levels of observation (what is being assessed?)**
- macro/meso/micro-level, system functions;
- institutions (in/out-patient), human resources, hospital quality;
- processes: guideline conformity, provider coordination;
- patient-oriented criteria: symptoms, psychosocial functioning, quality of life; mortality

**… observers (who assesses quality?)**
- health care providers, patients and their relatives, providers, governmental institutions …

→ Quality is a multidimensional construct that can be defined according to various components and dimensions

modified after Wobrock T et al., Die Psychiatrie 2010;7:1-11.
Quality in Healthcare: Aspects of Quality Management

<table>
<thead>
<tr>
<th>Poor</th>
<th>Optimal</th>
<th>Maximal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achievable</td>
<td>Not achievable</td>
</tr>
<tr>
<td>Not achieved</td>
<td>Quality monitoring</td>
<td>Resource allocation of medical research</td>
</tr>
<tr>
<td>Achieved</td>
<td>Quality assurance</td>
<td>Quality management</td>
</tr>
</tbody>
</table>

Definitions of Quality Assurance in Mental Healthcare

Quality assurance as activities intended to ensure the quality of care in a defined setting or programme

( WHO, 2003 )

Quality assurance in healthcare has two different complementary meanings. On the one hand, it refers to an assessment process of care provided. On the other hand, it refers to a mechanism for action to maintain quality improvements.

( WHO, 1997 )

Gaebel W et al., European Psychiatry 2015; 30: 360-387.

www.europsy.net
Continuous Quality Assurance: the PDCA - Cycle

**ACT I**
- Quality assurance
- Preventive quality assurance measures

**ACT II**
- Problem detection
- Spontaneous report, Routine monitoring of quality indicators, Priority setting

**CHECK**
- Evaluation
- Evaluation of problem solving

**PLAN**
- Problem analysis
- Process analysis, Study of causes, Search for problem solving option

**DO**
- Problem solving
- Implementation of problem solving

**Organizational and political context**


*Selbmann HK, In: Gaebel W (Hg.): Qualitätssicherung im psychiatrischen Krankenhaus. Wien, New York: Springer Verlag, 1995, S. 3-10.*

www.europsy.net
Limits of Quality Improvement in Healthcare: Economic vs. Medical Efficiency

- Benefit
- Medical interventions
- Health outcome
- Costs
- Optimum of economical efficiency
- Optimum of medical efficiency (EBM)

Schlander M, ZEFQ 2009; 103:117-125
Evidence-based Medicine (EbM)

The integration of external scientific knowledge into the practice of mental healthcare complements and amends the ‘art of medicine’ earlier including experience only


Clinical practice of EbM

- Current status of external scientific knowledge
- Experience of care provider
- Patient values and preferences

Sackett et al., 1996, BMJ; 312: 71-72.
Implementation of Quality Assurance Measures: Three Pre-conditions

1. The political will to do so:

This concerns mental health authorities, decision-makers, managers, community and patient representatives.

2. The existence of an evaluative culture:

Accountability determines the evaluative culture. It depends on background of care providers themselves, organizational structures of the service setting and its management style.

3. The availability of technical instruments:

Reliable, valid, feasible and widely accepted QA instruments (e.g. quality indicators, guidelines) need to be available. Development of those instruments depends mostly on professional organizations and health services researchers.

Developing Community Mental Health Care: Barriers

Barriers impacting on the transition process (%)

- Low political priority
- Insufficient funding
- Inadequate financing
- Centralised resources
- Lack of training
- Lack of consensus among SH
- HR resistance to change
- Weakness in Health & Social care
- Difficulties integration in PHC
- Lack of clear/strong leadership

Chart Key:
- SH - Stakeholders
- HR - Human Resources
- coop. - Cooperation
- PHC - Primary Health Care

Developing Community Mental Health Care: Facilitating Factors

Facilitating Factors - % of impact rated high

Influencing Factors on Mental Health Policy

1. Burden of mental disorders
2. Historical perspective
3. Mental health policy
4. Recent developments in the understanding, treatment and care of persons with mental disorders
5. (Global) Health reform trends and implications for mental health
6. Government policies outside the health sector which influence mental health

Own figure, based on WHO 2003 The Mental Health Context http://www.who.int/mental_health/resources/en/context.PDF
Patient Orientation in Quality Assurance in Mental Healthcare

- Increasing the relevance of measuring outcomes of mental health services, especially with regard to the assessment of patients’ perspectives, experiences and preferences
- Evaluation of mental health services from a patient perspective by means of patient surveys
- Patient satisfaction as a measure for quality of mental healthcare

→ Patients can provide valuable insights into mental health service gaps and quality problems that cannot be identified by means of secondary data analyses
Important Quality Assurance Instruments in Mental Healthcare

- **Quality indicators** for measuring the quality of structures, processes and/or outcomes of mental healthcare
- **Treatment guidelines** for the provision of up-to-date evidence-and consensus-based recommendations
- **Care pathways** for the optimization of guideline conformity and harmonization of treatment quality in clinical practice
- **Continuous training** of care providers (Further education, quality circles)
- **Inpatient/outpatient quality management**: certification e.g., with ISO9000, other organizational and/or process-oriented frameworks such as EFQM model, PDCA-cycle

→ Quality management instruments have to be developed in an evidence-based process
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Definition and Use of Quality Indicators

Quantitative measures that can be used to monitor and evaluate the quality of important governance, management, clinical, and support functions that affect patient outcomes.


- Review of course of treatment and evidence-base of diagnostics and therapy
- Evaluation of mental healthcare outcome
- Standardization/review of mental healthcare structures
- Benchmarking (among providers, provinces, countries...)
- Monitoring of impact of health policy measures
Assessing the Quality of Quality Indicators

The German QUALIFY-Instrument

1) Relevance:
   - Importance for patients and the health care system
   - Benefit
   - Consideration of potential risks / side effects

2) Scientific soundness:
   - Indicator evidence
   - Clarity of the definitions (of the indicator and its application)
   - Reliability
   - Ability of statistical differentiation
   - Risk adjustment
   - Sensitivity
   - Specificity
   - Validity

3) Feasibility:
   - Understandability and interpretability for patients and the interested public
   - Understandability for physicians and nurses
   - Indicator expression can be influenced by providers
   - Data availability
   - Data collection effort
   - Barriers for implementation considered
   - Correctness of data can be verified
   - Completeness of data can be verified
   - Complete count of data sets can be verified

Clinical Practice Guidelines

Clinical practice guidelines are defined as “statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options”.

(IOM Report 2011 „Clinical guidelines we can trust“)

Levels for Evidence Base

Ia  Evidence obtained from a single large randomised trial or a meta-analysis of at least three randomised controlled trials

Ib  Evidence obtained from a small randomised controlled trial or a meta-analysis of less than three randomised controlled trials

IIa Evidence obtained from at least one well-designed controlled study without randomisation

IIb Evidence obtained from at least one other well-designed quasi-experimental study

III Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies

IV  Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities

NICE (2002)
Levels for Recommendations

A  At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence levels Ia and Ib) without extrapolation

B  Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels IIa, IIb, III), or with extrapolation from level I evidence

C  Expert committee reports or opinions and/or clinical experiences of respected authorities. This grading indicates that directly applicable clinical studies of good quality are absent (evidence level IV), or with extrapolation from higher levels of evidence

NICE  Recommendation drawn from the NICE 2002 technology appraisal of the use of the newer (atypical) antipsychotic drugs for schizophrenia

Good Practice  Recommended good practice based on the point of clinical experience of the Guideline Development Group

NICE (2002)
Adaptation by Means of Modifying the Grade of Recommendations

Level of Evidence vs. Grade of Recommendation

1. National conditions and requirements, e.g.:
   - Ethical issues
   - Cultural expectations and norms
   - Patient preference
   - Practicability
   - Cost-benefit issues
Improving Quality and Outcome in Healthcare
The Guideline Cascade

Research evidence

Guideline development

Clinical experience

Approval by association

Dissemination

Social Norms
Ethics
Regulations
Rewards or incentives
Decision-support system
Patient problems
Motivation

Factors affecting implementation

Sociopolitical
Professional
Practice
Patient
Intraprovider

Practitioner knowledge, skills, attitudes, behaviours

Patient or health care outcomes

Fox et al 1989
Changing and learning in the lives of physicians.
<table>
<thead>
<tr>
<th>Probability of being effective</th>
<th>Development strategy</th>
<th>Dissemination strategy</th>
<th>Implementation strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Internal</td>
<td>Specific educational intervention</td>
<td>Patient-specific reminder at time of consultation</td>
</tr>
<tr>
<td>Above average</td>
<td>Intermediate</td>
<td>Continuing education feedback</td>
<td>Patient specific</td>
</tr>
<tr>
<td>Below average</td>
<td>External, local</td>
<td>Mailing targeted groups</td>
<td>General feedback</td>
</tr>
<tr>
<td>Low</td>
<td>External, national</td>
<td>Publication in journal</td>
<td>General reminder</td>
</tr>
</tbody>
</table>

*Grimshaw & Russell 1993 Lancet*
Effectiveness of Dissemination/Implementation

US AHRQ HTA review

- 61 articles that directly (i.e., head to head) compared strategies to communicate and disseminate evidence

- Compared with single dissemination strategies, *multicomponent dissemination strategies* are more effective at enhancing clinician behavior, particularly for guideline adherence

Conclusions:

- The lack of comparative research evidence impedes timely awareness, uptake, and use of evidence to improve the quality of care.

- Expanding *investment in communication, dissemination, and implementation research* is critical

McCormack et al 2013 US Agency for Healthcare Research and Quality (AHRQ) HTA review
Effectiveness of Dissemination/Implementation

Review on "Implementing clinical guidelines in low-income settings":

- Systematic review on the implementation of WHO clinical guidelines for hospital care in low-income settings.

- 17 studies met the inclusion criteria.

Factors affecting guideline implementation in low-income countries:

(1) Degree of support from facility management and Ministry of Health,

(2) Credibility and acceptability of clinical guidelines from the perspective of health care providers,

(3) Efforts to adapt clinical guidelines to local circumstances and

(4) Use of guides and checklists for implementation.

Chakkalakal et al 2013 Implementing clinical guidelines in low-income settings: a review of the literature Glob Public Health 8:784-95
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**Key Events in the Development of Mental Health Policies in the Czech Republic**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992–2000</td>
<td>Informal work group was appointed in 1992 to create the Framework of Psychiatry. The Framework of Psychiatry was published by the Psychiatric Association in 2000</td>
</tr>
<tr>
<td>2002</td>
<td>The national strategy Health 21 was acknowledged by the Czech Government; the Framework of Psychiatry was acknowledged by the Scientific Council of the Czech Ministry of Health</td>
</tr>
<tr>
<td>2004</td>
<td>The Ministry of Health appointed the Framework of Psychiatry Implementation Committee</td>
</tr>
<tr>
<td>2005</td>
<td>Several members of the Implementation Committee published a document titled <em>Mental Health Care Policy – Roads to Implementation</em></td>
</tr>
<tr>
<td>2007</td>
<td>The National Psychiatric Programme was created by the Committee of the Psychiatric Association in collaboration with the regional WHO office</td>
</tr>
<tr>
<td>2008</td>
<td>The Congress of the Psychiatric Association endorsed the Revised Framework of Psychiatry</td>
</tr>
<tr>
<td>2012</td>
<td>The Czech Minister of Health established a team to produce a new Psychiatric Care Reform Strategy</td>
</tr>
<tr>
<td>2013</td>
<td>The Psychiatric Care Reform Strategy was adopted as a part of the National Reform Programme</td>
</tr>
</tbody>
</table>

Active involvement of the Czech Psychiatric Association

* Responding to earlier strategic documents and UNCRPD & WHO EMHAP

Background

Documents Reviewed


• Mental Health Care in the Czech Republic. Mission Report November 2014. WHO-Europe, provided by M. Holly and I. Duskov

• Document ”Professional supporting materials for standards of care in Centres for Mental Health (CMH)”, provided by M. Holly and I. Duskov

• Brochure on Czech Mental healthcare reform ”The Strategy for the Reform of Psychiatric Care” (in Czech), provided by I. Duskov

• English translation of selected parts of ”The Strategy for the Reform of Psychiatric Care” (in Czech), provided by M. Holly and I. Duskov


• Based on an invited presentation given in 6/2015 on occasion of a Governmental Experts Group Meeting at the EC DG Sante in Luxembourg
Cornerstones of the Reform (1)

The Reform Strategy focuses on 4 Main Pillars:

• Supporting *outpatient care* by psychiatric and clinical psychological outpatient departments

• Extending the care system with *new Mental Health Centres* which are sets of interrelated services provided by one or more organizations for people with *Severe Mental Illnesses* (SMI) in one particular region so that care can be provided locally in the patients’ own social environment (locally organized, low-threshold 30 mins. access, 1 center per 100,000 inhabitants, 2 psychiatrists per 100,000, 24/7 multidisciplinary services; includes psychiatric, social and rehabilitative services, implement programs for families and user organizations).

• Support *psychiatric departments of hospitals* for acute inpatient psychiatric care as providers of counselling services for the hospital.

• Support *mental institutions/hospitals* as in-patient medical facilities providing comprehensive psychiatric care for hospitalized patients with or without consent (as stipulated by the law).

*English translation of selected parts of the 2013 ”The Strategy for the Reform of Psychiatric Care” (in Czech)*
Cornerstones of the Reform (2)

Additional points

• Finances: *Develop* a model of systematic funding

• Legislation: *Specify* services providers and framework operating rules

• Education: *Implement* community-oriented services in undergraduate education and in the mental health centres for nurses, social workers et al.
Indicators

1. Outcome Indicators
1.1 Capacity for new and innovative services
1.2 Capacity for psychiatric nursing services
1.3 Number of new and innovative services
1.4 Total number of supported participants: 78
1.5 Total number of new programs: 79
1.6 Capacity of the supported services
1.7 Number of supported procedures for the provision of mental healthcare

2. Results Indicators
2.1 Population with access to new and innovative services
2.2 Population with access to non-institutional mental healthcare nursing services
2.3 Number of newly qualified participants
2.4 Reduction of the number of patients with long-time care in mental institutions
2.5 Capacity of the supported services
2.6 Average number of long-time beds in institutional mental healthcare

Steps and Time Plan

Phase 1 Initiation and assurance of conditions for implementation (2014-2015)
- Area 1 Standards and methods (including the development of assessments for stigmatization and quality of life, infrastructural quality, cost efficiency and user satisfaction)
- Area 2 Establishing a network of mental healthcare
- Area 3 Humanization of mental healthcare
- Area 4 Destigmatisation and communication
- Area 5 Research and education
- Area 6 Legal reforms
- Area 7 Sustainability, financing
- Area 8 Transsectoral cooperation

Phase 2 Implementation and operation (2016-2023)
- Areas similar to Phase 1

Phase 3 Evaluation (2023-2025)
- Includes preparation of future stages of the reform process

Benchmarking the Model against European Recommendations

Preliminary Benchmarking with JA MHWB (WP5), WHO EMHAP, EPA MHSQG based on:

• A partial German translation of the Reform Agenda document in Czech based on a machine translation process (Google Translator)
• A partial English translation of the Reform Agenda in Czech provided by I. Duskov and M. Holly
• An unpublished script including a section with comments on the Reform Agenda by I. Duskov (personal communication)
• Brief Reform Agenda Summary and Comments by P. Winkler

☑ Appears to be well covered    ❓ More information would be needed to assess
Towards Community-Based and Socially Inclusive MHC

Objectives:

• Analysing the situation of community-based and socially-inclusive approaches to mental health in participating countries, as well as in EU countries at large

• Mapping the scientific evidence, best practices and the available technical resources relevant for the implementation of community-based and socially inclusive approaches to mental health in Europe

• Developing recommendations for action at EU-level and in Member States for this work package

• Supporting the engagement and commitment of Member States and other stakeholders in effective action to develop community-based and socially inclusive approaches to mental health in Europe
EU Joint Action on Mental Health and Wellbeing - WP 5
Towards Community-Based and Socially Inclusive Health Care
Integrated Strategies and Actions – their consideration in the CR reform

1. Generating political commitment for mental health system development
2. Developing or updating mental health policies and legislation
3. Mobilising the shift from mental hospitals/psychiatric hospitals to a system based on general hospitals and community mental health services
4. Improve the use and effectiveness of mechanisms to monitor the implementation of mental health reform
5. Promote the use of relevant EU instruments

Appears to be well covered

? More information would be needed to assess
WHO European Mental Health Action Plan (1)

4 Core objectives:
• Everyone has an equal opportunity to realize mental wellbeing [...] 
• People with mental health problems are full citizens whose human rights are valued, protected and promoted.
• Mental health services are accessible and affordable, available in the community according to need.
• People are entitled to respectful, safe and effective treatment, and to share in decisions.

3 cross-cutting objectives:
• Health systems provide good physical and mental health care [...] 
• Mental health systems work in well coordinated partnerships with other sectors.
• Mental health governance and delivery are driven by good information and knowledge.

http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf
WHO European Mental Health Action Plan (2)

Aim:
Development of a comprehensive plan that covers mental health care services, policies, legislation, plans, strategies and programs...

... for the treatment, recovery and prevention of mental disorders
... for the promotion of mental health
... for the empowerment of people with mental disorders

Scope of key interventions:

• Improvement of mental wellbeing
• Respect for peoples’ rights
• Establishment of accessible, safe and effective services

http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf
WHO European Mental Health Action Plan Indicators I

**Objective 1**: Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk

Objective 1 aims to achieve the following outcomes:

(a) raised awareness of mental well-being and factors that support it – in lifestyles, in the family, at work, in schools and kindergartens, in the community and in wider society;

(b) increased support for mental health needs in antenatal and postnatal care, including screening for domestic violence and alcohol abuse;

(c) capacity in primary care to enhance mental health promotion, the prevention and early recognition of mental disorders and low-threshold psychological support;

(d) increased return to work of people with mental health conditions;

(e) reduced suicide rates among the population as a whole and in subgroups related to age, sex, ethnicity and other vulnerable groups; and

(f) means of measuring well-being and the determinants of well-being (in addition to measures of mental disorder) throughout the life-course agreed and implemented.

Appears to be well covered

More information would be needed to assess

[Link to more information](http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf)
Objective 2: People with mental health problems are citizens whose human rights are fully valued, respected and promoted

Objective 2 aims to achieve the following outcomes:

(a) all human rights are guaranteed and protection against discrimination is safeguarded for people with mental health problems;
(b) opportunities associated with full citizenship, including employment, housing and education for people with mental health problems are equal to those of other people, taking into account adjustments required to compensate for any disability; and
(c) people subjected to involuntary care and/or treatment have access to free information and legal advice.

Appears to be well covered

More information would be needed to assess

http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf
Objective 3: Mental health services are accessible, competent and affordable, available in the community according to need

Objective 3 aims to achieve the following outcomes:

(a) mental health services are organized in order to facilitate a (normal) life in society and comprise a spectrum of care, integrating specialist mental health and generic services; ✔

(b) primary care can ensure correct early diagnosis, treatment and referral for people with mental disorders; ?

(c) community-based mental health services are accessible to all groups in the population; ✔

(d) large institutions, associated with neglect and abuse, are closed; ✔

(e) hospital care is therapeutic, offering a range of treatment, care and support tailored to individual needs, rather than simply confining patients; ✔

(f) mental health services are provided in decent settings; ✔

(g) mental health services offer appropriate care for different age groups; ✔

(h) family capacity and needs are assessed periodically, and training and support provided; ✔

(i) a multidisciplinary workforce is available in sufficient numbers; and ✔

(j) mental health services can be accessed without unfair financial barriers. ✔

 Appears to be well covered  ? More information would be needed to assess

http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf
Objective 4: People are entitled to respectful, safe and effective treatment

Objective 4 aims to achieve the following outcomes:

(a) all mental health treatments, whether medical, social or psychological are therapeutic, and respect the dignity and preferences of the service users and, where indicated, their families;

(b) effective treatments are made available on criteria of both efficiency and fairness;

(c) the workforce is properly qualified and competent, able to maintain a high morale; and

(d) international cooperation is established between governments and professional stakeholders to benchmark training, competencies and standards of care.

Where EPA and NPAs may come into play!

Appears to be well covered

? More information would be needed to assess

http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf
WHO European Mental Health Action Plan Indicators V

Objective 5: Health systems provide good physical and mental health care for all

Objective 5 aims to achieve the following outcomes:

(a) people with mental health problems have a life expectancy equal to the age-/sex-matched general population;

(b) access of people with mental health problems to physical health services such as cardiovascular diseases, diabetes, cancer and dental care and the quality of the physical health care they receive is equal to access for the general population; and

(c) mental health problems in people with physical diseases are recognized and treated adequately.

Appears to be well covered
Objective 6: Mental health systems work in well coordinated partnership with other sectors

Objective 6 aims to achieve the following outcomes:

(a) people with mental health problems receive the benefits and services to which they are entitled;

(b) patients can access care, including specialized services, through an integrated assessment procedure;

(c) funding systems offer incentives for efficient ways of working; and

(d) the expertise of service users and family members is used to allocate resources for their care.

Appears to be well covered

More information would be needed to assess

http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf
Objective 7: Mental health governance and delivery are driven by good information and knowledge

Objective 7 aims to achieve the following outcomes:

(a) indicator sets for outcomes are selected, relevant to the needs of the target audience;
(b) quality and safety is independently inspected, involving service users and families;
(c) research is coordinated and disseminated internationally;
(d) staff numbers, distribution and their causes are known; and
(e) definitions of terminology are internationally agreed.

Appears to be well covered

More information would be needed to assess
EPA Guidance on the Quality of Mental Health Services

Recommendations

30 recommendations covering structure, process and outcome quality both on a generic and a setting-specific level.

Further pan-European research will need to show whether the implementation of this guidance will lead to improved quality of mental healthcare, and may help to develop useful country-specific cutoffs for the suggested quality indicators.

European Psychiatry 2012; 27: 87-113
Specific recommendation topics

- Essential inpatient, outpatient and rehabilitation service structural requirements
- Community mental health teams for people with severe mental illness
- Intensive case management
- Integrated care models

Generic recommendation topics

- Mental health education
- Mental health reporting and monitoring
- Structural requirements to ascertain patients’ dignity and needs
- Multiprofessionality of services
- Access to good primary and specialised psychiatric care
- Availability of technological equipment for assessment and treatment
- Psychiatric workforce
- Catchment areas
- Day hospitals for people with acute mental disorders
- Psychiatric care for minority groups

EPA Guidance recommendation

Structure recommendation topics

Process recommendation topics

Macro-, meso-, microlevel as further subdivisions

*European Psychiatry, 2012;27(2):87-113*
3.1. Structure recommendations
3.1.1. Generic structure recommendations

3.1.1.1. Macrolevel recommendations.
3.1.1.1.1. **Recommendation 1:** Mental health education. Provide coordinating bodies (e.g., committees, boards, offices) that coordinate and oversee public education and awareness campaigns on mental health and mental disorders.

3.1.1.2. Mesolevel recommendations. (cont. on next slide)
3.1.1.2.1. **Recommendation 3:** Structural requirements to ascertain patients’ dignity and basic needs. Implement the ITHACA Toolkit items to ascertain that the structural requirements of in- and outpatient mental healthcare facilities are met for the fulfilment of patients’ basic needs, and to ascertain that patients’ dignity and human rights are observed at all times.
3.1.1.2. Mesolevel recommendations. (cont. on next slide)

3.1.1.2.2. Recommendation 4: Multiprofessionality of services. Assemble multiprofessional teams with competences in social occupational-, work- and housing-related service provision.

3.1.1.2.3. Recommendation 5: Access to good primary mental healthcare and specialised psychiatric care. Provide access to good primary care for mental health problems by developing primary care services with the capacity to detect and treat mental health problems, and create centres of competence and promote networks in each region; ensure access to specialised psychiatric services for those in need.

3.1.1.2.4. Recommendation 6: Availability of technological equipment for assessment and treatment. Provide all state of the art evidence based technological diagnostic and therapeutic equipment and services within 72 hours.
3.1.1.2. Mesolevel recommendations.

3.1.1.2.5. **Recommendation 7: Psychiatric Workforce.** Create a sufficient and competent workforce ensuring an equitable distribution and develop specialist training streams.

3.1.1.2.6. **Recommendation 8: Catchment areas.** Ensure that catchment areas/service areas are implemented as a way to organise mental health services to communities.

3.1.1.2.7. **Recommendation 9: Day hospitals for people with acute mental disorders.** Develop day hospital services for people with acute mental disorders.

3.1.1.2.8. **Recommendation 10: Psychiatric care for members of minority groups.** Provide adequate psychiatric care facilities for linguistic, ethnic and religious minority groups.
3.1.2. Specific structure recommendations

3.1.2.1. Microlevel recommendations. (cont. on next slide)

3.1.2.1.1. **Recommendation 11:** Essential in-patient services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) “Staffing” of Section 1 (“General Standards”) and Section 4 (“Environment and Facilities”).

3.1.2.1.2. **Recommendation 12:** Essential out-patient services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance for in-patient services (Part 2) “Staffing” of Section 1 (“General Standards”) and Section 4 (“Environment and Facilities”).

3.1.2.1.3. **Recommendation 13:** Essential rehabilitation services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) “Staffing” of Section 1 (“General Standards”) and Section 4 (“Environment and Facilities”).
3.1.2. Specific structure recommendations

3.1.2.1. Microlevel recommendations.

3.1.2.1.4. **Recommendation 14:** Community mental health teams for people with severe mental illness. Develop a system of community mental health teams for people with severe mental illnesses and disordered personality.

3.1.2.1.5. **Recommendation 15:** Intensive case management. Implement Intensive Case Management services for severely mentally ill persons with high hospital use.

3.1.2.1.6. **Recommendation 16:** Integrated care models. Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers.
3.2. Process recommendations

3.2.1. Generic process recommendations

3.2.1.1. Mesolevel recommendations.

3.2.1.1.1. **Recommendation 17: Implementation of evidence-based medicine.** Follow the rules of evidence-based medicine in diagnostic and therapeutic decisions.

3.2.1.2. Microlevel recommendations. (cont. on next slide)

3.2.1.2.1. **Recommendation 18: Safety procedures.** Implement operational policies in mental health facilities to ascertain patient and staff safety, e.g., with efficient alarm systems, and to manage violent patient behaviour.

3.2.1.2.2. **Recommendation 19: Informed consent.** Ascertain that the choice of treatment is made jointly by the patient and the responsible clinician based on an informed consent.
3.2.1.2. Microlevel recommendations.

3.2.1.2.3. **Recommendation 20:** Monitoring of physical illness and access to general and specialised medical services. Monitor physical illness and provide timely access to general and specialised medical services when necessary.

3.2.2. Specific process recommendations

3.2.2.1. Microlevel recommendations. (cont. on next slide)

3.2.2.1.1. **Recommendation 21:** Hospitals/in-patient services: basic requirements. Implement the essential process requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS (Section 2 “Timely and Purposeful Admission” and Section 3 “Safety”).

3.2.2.1.2. **Recommendation 22:** Hospitals/in-patient services: admission procedures. Ensure that on the day of their admission to a psychiatric ward, patients receive a basic structured psychiatric and medical assessment.
3.2.2.1. Microlevel recommendations (cont. on next slide)

3.2.2.1.3. **Recommendation 23**: Hospitals/in-patient services: access of wards to special services. Implement access of psychiatric wards to the following services: psychology, occupational therapy, social work, administration, pharmacy.

3.2.2.1.4. **Recommendation 24**: Hospitals/in-patient services: detained patients procedures. Give detained patients prompt-written information on their rights according to national rules and regulations.

3.2.2.1.5. **Recommendation 25**: Elimination of waiting times for outpatient appointments. Implement processes to eliminate waiting times for out-patient appointments.
EPA Guidance on the Quality of Mental Health Services
Recommendations IX

3.2.2.1. Microlevel recommendations (cont. on next slide)
3.2.2.1.6. Recommendation 26: Rehabilitation units. Implement the essential process requirements as outlined as Type 1 recommendations by the Royal College of Psychiatrists AIMS guidance: Part 1 “Policies and Protocols” of Section 1 (“General Standards”); Part 15 “Initial Assessment and Care Planning” of Section 4 (“Timely and Purposeful Admission”) and Section 3 (“Safety”).

3.2.2.1.7. Recommendation 27: Effective components of home-based treatment. Implementation of the effective process components of home treatment teams are included: small case load, regular visits at home, high percentage of contacts at home, responsibility for health and social care.

3.2.2.1. Microlevel recommendations

3.2.2.1.9. **Recommendation 29:** Active components of intensive case management. Implement the known active components of intensive case management, if intensive case management is used.

3.2.2.1.10. **Recommendation 30:** Organisational integration of psychiatric in-patient and out-patient services. Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers.
European Guidance on Quality Assurance in Mental Healthcare

Original article

European Psychiatric Association (EPA) guidance on quality assurance in mental healthcare

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Gaebel W et al., European Psychiatry 2015;30:360-387.
Mental Health Care Indicators and their Importance for Mental Health Care Monitoring and Evaluation of Mental Health Care Reform in the CZ Republic

- Quality Assurance in (Mental) Healthcare
  - Introduction to Quality Assurance: Definitions, Terms, Instruments
  - QA Instruments: Quality Indicators and Treatment Guidelines
- Quality Assurance Tools in Reform Evaluation: Example of Czech Reforms
- Mental Healthcare Indicators Development: Example of the DAQUMECA Project
- Conclusion
Integrated Care - WHO Definition

“The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.”

"Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."

Community based mental health services: Values and objectives

“There are today many reasons why the development of community-based mental health services is central to improving mental health systems. Community care contributes to improved access to services, enables people with mental disorders to maintain family relationships, friendships, and employment while receiving treatment, so facilitating early treatment and psychosocial rehabilitation.

Community mental health care is associated with continuity of care, greater user satisfaction, increased adherence to treatment, better protection of human rights, and prevention of stigmatisation.

Community mental health care aids the establishment of a structured collaboration with primary healthcare services, which plays an important role in the identification and treatment of people with mental disorders. These collaborative models of care are particularly effective in the treatment of people with mental and physical comorbidities.“

Community Mental Health Care: elements

- Community mental health Teams
- Crisis resolution
- Intensive case management
- Early intervention
- Assertive community treatment (ACT)
- Home treatment teams

Joint Action, 2015
Community Mental Health Care in Europe

• There is an ongoing shift from institution-based (or long-stay) mental healthcare to community-based services in Europe.
• Some countries continue to provide long-stay hospital care, some of which are still in transition towards community based mental health services.
• The number of inpatient psychiatric care beds and admissions varies considerably between countries.
• Community mental health services in different forms are present in almost all countries. Only few countries have a comprehensive range of community-based services.
• There are considerable variations and gaps in mental health services among the countries from relatively well-developed community based services to a lack of even basic community services.
Developing Community Mental Health Care: Achievements

Achievements in Europe (% of high achievement)

The DAQUMECA Project: Objectives

- The overall objective is to develop and implement quality indicators as a means to improve mental healthcare of the population.
- Strengthening and connecting the Danube region.
- Sustain and develop a network of experts among the Danube region to improve the knowledge and experiences with different health reforms.
- Development of better diagnostics and more effective therapies as well as utilizing new technologies promoting mental health wellbeing and quality of life.
DAQUMECA: Project Partners

Project Lead
1. Wolfgang Gaebel (WHO CC on Quality Assurance and Empowerment in Mental Health Care, LVR-Institute for Healthcare Research, LVR-Klinikum Düsseldorf, Heinrich Heine University) Germany

Project Partners
1. Dan Chisholm/Matt Muijen (WHO Regional Office for Europe) – Denmark
2. Cyril Höschl/Petr Winkler (National Institute of Mental Health, Charles University Prague) – Czech Republic
3. Tamas Kurimay (Semmelweis University) – Hungary
4. Hristo Hinkov (Ministry of Health) – Bulgaria
5. Dusica Lecic-Tosevski (Belgrade University School of Medicine, Serbian Academy of Sciences and Arts, Institute of mental Health, WHO Collaborating Center) – Serbia
## Overview of Included Quality Domains (1)

<table>
<thead>
<tr>
<th>No.</th>
<th>Quality domain</th>
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<tbody>
<tr>
<td>1</td>
<td>Financing, costs and efficiency of mental healthcare</td>
</tr>
<tr>
<td>2</td>
<td>Availability, accessibility and utilization of care service structures</td>
</tr>
<tr>
<td>3</td>
<td>Workforce in mental healthcare</td>
</tr>
<tr>
<td>4</td>
<td>Promotion of mental health, and preventing mental disorders, stigma and discrimination</td>
</tr>
<tr>
<td>5</td>
<td>Continuity, coordination and cooperation incl. somatic care</td>
</tr>
<tr>
<td>6</td>
<td>Mental health policies and legislation, incl. forensic and legal (HR) issues</td>
</tr>
<tr>
<td>7</td>
<td>Integration of research and innovation (e.g. equipment/state-of-the-art of diagnostics and treatment, availability, use and implementation of guidelines)</td>
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## Overview of Included Quality Domains (2)

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<tr>
<td>8</td>
<td>Recovery, participation and integration of persons with mental disorders</td>
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<td>9</td>
<td>Involvement of care providers outside mental healthcare (e.g. GP/primary care)</td>
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<tr>
<td>10</td>
<td>Patient safety (incl. restrictive measures)</td>
</tr>
<tr>
<td>11</td>
<td>Mental health reporting and monitoring</td>
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# Overview of Merged/Excluded Quality Domains (1)

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<td>Somatic care for persons with mental disorders</td>
<td>Merge with QD 5</td>
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<tr>
<td>13</td>
<td>Medical, social, occupational rehabilitation</td>
<td>Merge with QD 5</td>
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<tr>
<td>14</td>
<td>Patient orientation, information and involvement in treatment</td>
<td>Exclude (divide involvement/Information)</td>
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<td>15</td>
<td>Critical outcomes (mortality, suicide)</td>
<td>Merge with QD 11</td>
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<tr>
<td>16</td>
<td>Patient or care giver satisfaction and other (self-) assessments</td>
<td>Exclude (surveys?)</td>
</tr>
<tr>
<td>17</td>
<td>Involvement of relatives</td>
<td>Exclude (surveys?)</td>
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# Overview of Merged/Excluded Quality Domains (2)

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<td>18</td>
<td>Cultural or ethnic issues/psychiatric care for minority groups</td>
<td>Merge with QD 6</td>
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<tr>
<td>19</td>
<td>Symptom or diagnostic procedures/assessments</td>
<td>Merge with QD 7</td>
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<td>Evidence-based psychotherapeutic interventions</td>
<td>Merge with QD 7</td>
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<td>21</td>
<td>Evidence-based psychopharmacological &amp; other somatic interventions (e.g. ECT)</td>
<td>Merge with QD 7</td>
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<tr>
<td>22</td>
<td>Complementary interventions</td>
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<tr>
<td>23</td>
<td>Psychopathology and functioning</td>
<td>Merge with QD 8</td>
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DAQUMECA: Milestones of the Project

Phase I (Year 1):
• Establishment and development of the network
• Memorandum of Understanding
• Development of a set of European quality indicators for mental health on the basis of approved quality domains
• Delphi consensus process on the proposed QIs among relevant stakeholders
• Drafting of a follow-up project to be started after Phase II

Phase II (Year 2):
• Implementation of the defined quality indicators
Mental Health Care Indicators and their Importance for Mental Health Care Monitoring and Evaluation of Mental Health Care Reform in the CZ Republic

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Conclusion 1

• Quality management and quality assurance (QA) are essential tools to improve quality of care in mental health

• The pre-conditions for the implementation of QA programmes include not only the political will to do so and the existence of an evaluative culture but also the availability of feasible, valid and reliable instruments

• Quality assurance measures (e.g., guidelines and quality indicators) are bound to certain requirements (e.g., evidence-based development, preferred cross-sectoral use, availability of data sources)

• The CZ reform strategy fits with the main recommendations of the EU JAMHWB, the WHO EMHAP, and 50% of the EPA MHC quality indicators, all addressing major issues of deinstitutionalization to improve the quality of mental healthcare in Europe
Conclusion 2

- The reform plans are strong at the structural level and would take many important steps in the right direction with a focus on improving accessibility of services, comprehensiveness of services, community-orientation and micro-level coordination (i.e., case management) of services.

- Even if transitory financing is ensured (although detailed information is lacking), sustainability of political commitment and guaranteed financial resources are key for success of the reform; also financial resource allocation rules according to priority setting need to be specified.

- Local/regional piloting of prioritized reform elements following PDCA principles before countrywide roll-out is advisable.

- Cooperation of the CZ national MERRPS and the German Danuvian region DAQUMECA project on transnational QIs could assist the CZ reform project.
Thank you for your attention!